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LESSONS FROM THE GENDER-BASED VIOLENCE INITIATIVE IN THE DEMOCRATIC REPUBLIC OF CONGO

APRIL 2016

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JSI Research & Training Institute, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: aidsfree.usaid.gov

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CONTENTS

ACRONYMS

C-Change	Communication for Change project
DRC	Democratic Republic of Congo
GBV	gender-based violence
GBVI	Gender-based Violence Initiative
KSPH	Kinshasa School of Public Health
MPSMRM	Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité
MSP	*Ministère de la Santé Publique*
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission of HIV
PNSR	*Programme National de Santé Reproductive* (National Reproductive Health Program)
SBCC	social and behavior change communication
SIDA	*syndrome d'immuno-deficience acquis* (acquired immune deficiency syndrome; AIDS)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

INTRODUCTION

In 2011, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) launched the US$55 million, three-year, interagency Gender-based Violence Initiative (GBVI) in the Democratic Republic of Congo (DRC), Mozambique, and Tanzania. The GBVI aimed to integrate gender-based violence (GBV) prevention and response into existing HIV prevention, care, and treatment programs at health facility, community, and policy levels. See Box 1 for a definition of GBV.

The GBVI focused on multiplying the effects of PEPFAR investments to integrate GBV prevention and response into existing HIV programs. This included developing national guidelines, strengthening coordination across sectors, and building the capacity of and linkages between clinic- and community-based services in GBV prevention, as well as response, within the context of existing HIV prevention, care, and treatment.

There are important lessons to learn about the potential for synergy created by various models for GBV prevention and response interventions, such as addressing GBV prevention and response simultaneously; taking a selected set of approaches or a multicomponent GBV program model across the PEPFAR platform of services; and building linkages between facility- and community-based GBV interventions. The PEPFAR Gender and Adolescent Girls Technical Working Group asked AIDSFree to conduct a review of the GBVI in all three countries to inform programming, specifically the integration of GBV prevention and response into the context of the HIV cascade of services. These lessons, in turn, can inform PEPFAR and other donor initiatives in designing future investments in GBV prevention and response.

In the DRC, the AIDSFree team reviewed 21 documents and gathered information in Kinshasa from 26 global and in-country stakeholders (implementing partners, community-based organizations, nongovernmental organizations [NGOs], government officials, U.S. Government agencies, United Nations organizations, and Congolese service providers) through semi-structured interviews, focus group discussions, and a one-week country visit.

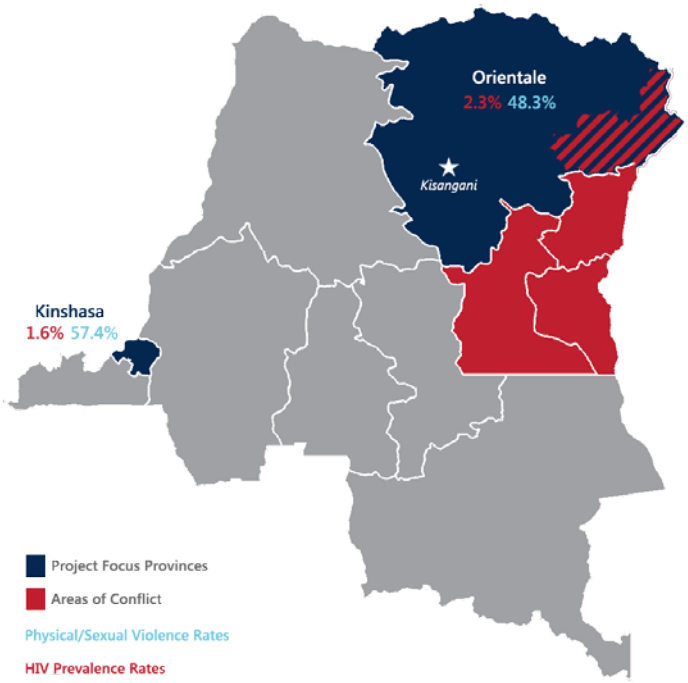
It should be noted that GBVI-funding for most DRC activities ended by September 2013, two years prior to data collection for this report. As such, it was difficult to obtain necessary project reports, and contact information for some of the key individuals involved in implementation because they no longer worked at the organizations that had carried out activities.

This report presents findings and describes lessons learned from the GBVI in the DRC based on the limited information available.

GBV and HIV Prevalence in the DRC

Although HIV prevalence in the DRC (estimated at 1 percent among adults aged 15 to 49) is not the highest in sub-Saharan Africa, the size of the country's population (77.8 million, according to current population projections) means that the DRC has a large number of people living with HIV, including 390,000 adults aged 15 and older and 59,000 children under the age of 14. There is considerable variation in adult HIV prevalence across provinces. HIV prevalence in Kinshasa and Oriental provinces is among the country's highest, at 1.6 percent and 2.3 percent, respectively as shown in Figure 1 (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité [MPSMRM], Ministère de la Santé Publique [MSP], and MEASURE DHS, ICF International 2014).

Figure 1. GBVI Provinces of the DRC with HIV and GBV Prevalence



As in many other settings, biological and sociocultural factors put women at a greater risk of HIV infection than men. In 2014, of all the HIV-infected adults living in the DRC, 58 percent were women (Joint United Nations Programme on HIV/AIDS 2014), and the DRC was ranked close to the bottom of the Gender Equality Index (144 of 148 countries), reflecting inequalities in education, political participation, and health, as well as limitations on women's access to opportunities for economic empowerment and resources (Davis, Fabbri, and Alphonse 2014).

Although sexual violence is a brutal hallmark of conflict-related areas in the east of the country, research shows that GBV affects women, girls, men, and boys across the DRC and that it significantly impacts individuals, families, and communities. According to the 2014 Demographic and Health Survey report, more than half of all Congolese women surveyed had experienced physical violence since the age of 15, most often at the hands of their husband or partner. This included 57.4 percent and 48.3 percent of female respondents in Kinshasa and Orientale provinces respectively as shown in Figure 1 (MPSMRM, MSP, and MEASURE DHS, ICF International 2014).

Findings from GBVI-funded research in Kinshasa and Kisangani indicated that for approximately 36 percent of women interviewed, their first sexual intercourse was forced, coerced, or unwanted (Nanda et al. 2013). Human Rights Watch estimates that tens of thousands of children are living

on the streets of Kinshasa and other urban areas throughout the DRC. Interviews with female street children provided vivid testimony to the harsh realities of sexual violence perpetrated by police, military, and male street children, as well as the sexual exploitation of the transactional and coercive sex that are a key means to survival for many girls (Human Rights Watch 2006). The HIV risks for these and other girls living in poverty are obvious.

Many women in Kinshasa and Kisangani live under their partners' controlling behaviors, and attitudes toward inequitable gender norms are often held by both men and women. Research shows that almost 90 percent of women living in these areas who have ever been in an intimate partnership report having experienced at least one of five kinds of personal control exercised by their husbands or partners, such as denial of permission for the woman to meet her female friends, insistence on knowing where she is at all times, and frequent accusations of infidelity. Additionally, large proportions of both men and women adhere to beliefs that support a man beating his wife for a variety of reasons, such as suspicion of infidelity or disobedience to him. Acceptability of wife beating was found to be higher in rural than urban areas and higher in Kisangani than in Kinshasa (Nanda et al. 2013).

Box 1. United States Government Definition of GBV

Violence that is directed at an individual based on biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

Gender-based violence takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control.

*(*U.S. Government 2012*)*

OVERVIEW

The GBVI in the DRC

Box 2. GBVI DRC Objectives

GBVI DRC National Objectives

- To increase and improve the coordination of the integrated response to GBV and HIV.
- To increase availability, use, and quality of GBV services.
- To strengthen the GBV prevention response through increasing awareness of GBV and its relationship to HIV, as well as of GBV laws, policies, and guidelines.

GBVI DRC Provincial Objectives

- To increase availability, utilization and quality of GBV services.
- To change attitudes and behaviors that perpetuate GBV.
- To increase the capacity of social institutions, civil society organizations, and communities to respond to GBV.

In the DRC, the $10 million, two-year GBVI aimed to leverage PEPFAR and other U. S. Government investments to build national capacities across sectors to integrate GBV prevention and response into the existing HIV platform of services. GBVI objectives for the DRC are shown in Box 2. The GBVI channeled funds for activities during fiscal years 2011 to 2012, although some activities continued into fiscal year 2013 and onward. Four U.S. Government agencies/departments collaborated in the design and management of the GBVI: the United States Agency for International Development (USAID), the U.S. Centers for Disease Control and Prevention, the Department of Defense, and the Department of State. Four primary funding recipients implemented activities through the GBVI: the Kinshasa School of Public Health (KSPH), the University of North Carolina, the Communication for Change project (C-Change, implemented by FHI 360), and Population Services International.

The GBVI in the DRC was unique in that it provided a distinct funding mechanism within a country in which USAID and other U.S. Government agencies were already making substantial GBV program investments to address needs in the conflict-related humanitarian setting of eastern DRC. The GBVI activities specifically targeted other parts of the country, in particular Kinshasa and Orientale provinces). While some activities were province-wide or national in scope, the GBVI focused mainly on urban and peri-urban areas around Kinshasa and Kisangani (the provincial capital of Province Orientale). These areas were chosen in part because of relatively high GBV prevalence. For example, nearly 59 percent of females in Kinshasa Province

and more than 60 percent in Province Orientale have experienced physical violence since the age of 15 (Demographic and Health Survey 2007).

Kinshasa was also considered especially appropriate for the GBVI given its high population density, the most HIV-positive individuals in the country, and its large number of PEPFAR sites (PEPFAR 2010). All four PEPFAR agencies managed ongoing GBV activities in Kinshasa Province and were starting PEPFAR programming in Province Orientale at the same time. This provided a significant opportunity to fold GBV activities into those for HIV as an integral part of the initiative. Underlying GBV and HIV risk factors were considered as well, including urban poverty in Kinshasa and geographic location on key land and river transportation in the case of Kisangani (Province Orientale). Research from various sub-Saharan African contexts pointed to higher HIV prevalence among transportation workers than in the general population, and the sex workers who are often concentrated in transportation hubs also experience elevated HIV and GBV risks in many instances.

To achieve the initiative's overarching goal of mitigating the impact of GBV and HIV on survivors and communities, the GBVI in the DRC was designed to include both national and provincial-level objectives and activities (see Table 1). At both levels, activities strongly focused on increasing the availability, use, and quality of GBV services within the health sector using the HIV program platform.

Table 1. GBVI Linkages at National and Provincial and Community Levels

	 Social and Behavior Change Communication	 Clinical Capacity Strengthening	 Referrals
National Level	• Collected data • Conducted media content analysis • Developed materials for social and behavior change communication (SBCC) • Launched a national media campaign • Inserted key GBV/HIV messages into radio/ television shows • Integrated of GBV into training within the military system	• Disseminated updated GBV health standards and protocols • Integrated GBV into health training curricula • Strengthened capacity to improve health care provider response to GBV	• Updated national resource guide with inventory of GBV services • Expanded capacity of national HIV hotline to incorporate GBV counseling
Provincial Level	• Reestablished working groups to harmonize interventions • Built capacity of journalists to report appropriately on GBV cases	• Supported training and advocacy to target provincial government leaders	
Community Level	• Adapted the Stepping Stones approach to increase awareness of the links between GBV and HIV and to promote dialogue	• Provided support for a cascade training of health care providers	• Provided training and information to volunteers to better link community members to GBV services

The GBVI in the DRC used multiple programmatic approaches to achieve objectives at the national and provincial levels—which, in turn, included both facility- and community-based levels as illustrated in Table 1. At the national level, to achieve strong coordination, the GBVI was designed to help align PEPFAR GBV activities and indicators with the DRC government's GBV and HIV strategies, while increasing both PEPFAR partner engagement in relevant national coordinating groups and support for national GBV health standards and protocols. To increase and improve GBV clinical service delivery, GBVI approaches included updating GBV health standards and protocols and disseminating them to health facilities, supporting the integration of GBV into pre-service and in-service health training curricula, and strengthening capacity to improve health care provider response to GBV. The GBVI also facilitated an inventory of GBV services in order to update a national resource guide, and expanded the capacity of the country's national HIV hotline (*La Ligne Verte,* or the Green Line) to incorporate GBV counseling.

These approaches were complementary in that hotline counselors could provide information about GBV services to callers across the country and help improve the GBV referral system. Approaches to GBV prevention at the national level also focused on support for SBCC activities, including baseline data collection to inform SBCC interventions, media content analysis, the development of SBCC materials and a national media campaign, and the insertion of key GBV and HIV messages into radio and television serial dramas. Another intervention worked with the military to integrate GBV into training for peer educators, recruits, and health care providers within the military system.

Although the GBVI focused on coordinating GBV stakeholders at the national level, much of the coordination effort actually happened at the provincial level by reestablishing working groups called the *Synergies Provinciales* (Provincial Synergies), which met regularly to harmonize interventions, discuss lessons learned, and find ways to overcome obstacles together. The GBVI also supported training and advocacy to target provincial government leaders and other community leaders (e.g., religious leaders) who could be convened at a provincial level. Within each province, facility-based activities focused on support for a cascade training of health care providers, based on the new curriculum, to address the medical management of GBV; integration of sexual and gender-based violence screening and referrals into specific HIV service sites; provision of kits for HIV post-exposure prophylaxis to facilities; integration of GBV screening at HIV counseling and testing sites to reach military members and their families; and technical assistance and clinical supervision support to clinical partners around GBV and HIV service integration, especially within the platform for prevention of mother-to-child transmission of HIV (PMTCT). One of the main community-level approaches focused on SBCC activities; it adapted the successful Stepping Stones approach, developed in South Africa to help communities gain awareness of the links between GBV and HIV and to promote dialogue on related issues at the household level. The GBVI provided training and information to the *relais communautaires* (community volunteers) so that they could better link community members to GBV services and promote the Stepping Stones approach. These efforts were focused within communities with high rape prevalence, located in five health zones in Kisangani and three health zones in Kinshasa. The GBVI partners also worked with provincial-level journalists to build their capacity to report appropriately on GBV cases and to reinforce knowledge among newspaper readers and radio program listeners about the links between HIV and GBV, the consequences of GBV, and the resources available at the local level to address GBV-related needs.

Activities at the provincial level complemented efforts to address GBV at the national level by working with provincial leadership and provincial coordination mechanisms and supporting the implementation of specific facility- and community-based activities in Kinshasa and Orientale provinces. A list of GBVI implementing partners and their respective activities is in Table 2.

Table 2. GBVI Partners and Activities

Partner	Activities
FHI 360/C-Change	• Developed SBCC materials and media activities at national and provincial levels, with training for journalists • Supported coordination of national and provincial stakeholders engaged in GBV prevention and response • Strengthened capacity of civil society organizations and community stakeholders, including the adaptation of Stepping Stones • Conducted multisectoral mapping of GBV resources and services for referrals • Trained counselors for the La Ligne Verte national HIV/GBV telephone hotline
Kinshasa School of Public Health	• Finalized and disseminated a national protocol for the medical care of sexual violence survivors in collaboration with the Ministry of Health National Reproductive Health Program (*Programme National de Santé Reproductive* [PNSR]) • Developed national GBV training curricula for health care workers focused on medical care and for community stakeholders focused on GBV awareness, prevention, and access to services • Facilitated a cascade training for health care workers, based on a new national GBV training curriculum, in collaboration with the PNSR • Supported La Ligne Verte hotline counseling program, with increased staffing, equipment, and office space
Population Services International	• Supported *Programme de l'Armée pour la Lutte Contre le SIDA* (Army Program for the Struggle against HIV) to: o Train military instructors at all levels on GBV and HIV o Train health care workers in medical care for GBV survivors at facilities serving the military and their families o Support GBV screening, services, and referrals at health facilities serving the military and their families o Establish community centers for life skills programming for youth o Train spouses and children of military members as peer educators to inform others about GBV prevention and the availability of services
University of North Carolina	• Developed a GBV screening tool for use in health facilities • Conducted GBV awareness-raising and education for clients at PMTCT facilities • Trained health care workers in medical care for GBV survivors at PMTCT sites, maternities, and other health facilities • Referred GBV survivors to trained psychologists as needed; provided referrals for legal and socioeconomic support as needed • Trained community leaders and volunteers in community sensitization on GBV prevention and availability of services

The DRC Government's Response to GBV

To address the country's significant GBV-related challenges and underlying gender inequities, the DRC government has promulgated a series of national laws, policies, and guidelines. The country's 2005 national constitution addresses the promotion and protection of a variety of human rights, including the elimination of all forms of discrimination against women. This includes discrimination in civil, political, economic, social, and cultural domains, and the constitution further pledges the government to take measures to fight against all forms of violence against women in both public and private life. In 2006, amendments to the country's penal code were adopted including provisions that outlaw rape and other forms of sexual assault, sexual harassment, sexual slavery, forced marriage, sexual mutilation, the deliberate transmission of sexually transmitted infections, sexual relations with minors, forced pregnancy, and other acts. Notably, this law does not specifically mention spousal rape and violence between domestic partners does not appear to be clearly addressed by the country's penal codes in general (Canada: Immigration and Refugee Board of Canada 2012).

In 2009, the Ministry of Gender, Family and Children (*Ministère du Genre, Famille et de l'Enfant*), issued the National Strategy Against Gender-based Violence (*Stratégie Nationale de Lutte Contre les Violences Basées sur le Genre*), which lays out actions to be taken around a number of issues, including enforcement of laws and actions against impunity; prevention and protection; support for reforms within the army, police, security forces, and the legal system; response to the multisectoral needs of GBV survivors; data and information management; sensitization about GBV among government actors and political, traditional, and religious leaders; institutional capacity strengthening; and support for women's rights (République Démocratique du Congo 2009). Given the major conflict-related GBV that has affected eastern DRC, the government has also adopted United Nations Security Council resolutions that address violence in conflict. These include Resolution 1325, which highlights the crucial role of women in the prevention and resolution of conflicts and calls for the participation of women and a gendered perspective in all United Nations peace and security efforts and efforts to protect women and girls from GBV in conflict; and Resolution 1820, which, among other things, formally recognizes that rape and other forms of sexual violence can constitute war crimes (United Nations Security Council 2000; United Nations Security Council 2008).

A number of government actors are charged with helping to implement national laws and policies. Government institutions engaged in GBV prevention and response include the Ministry of Gender, Family and Children; the PNSR; the National Program for the Fight against AIDS; the Ministry of Justice; the Ministry of Education; and the Ministry of Youth, Sports and Recreation. There is also a special representative on sexual violence and child recruitment appointed by the president. At the provincial level, gender focal points are tasked with supporting the implementation of a separate National Gender Policy, while the Ministry of Gender, Family and Children is the mandated focal point for national and international actors addressing gender

inequality, including GBV. Gender focal points also exist within other ministries. However, they have been characterized as underused and with insufficient capacity on gender issues, while an organizational assessment of the Ministry of Gender, Family and Children itself identified limited capacities to implement its mandate and promote its agenda with other ministries (Davis, Fabbri, and Alphonse 2014).

GBVI SUCCESSES AND CONTRIBUTIONS

> *"One of the biggest contributions of the GBVI was to show that this work is possible—something can be done about GBV."* (Implementing partner)

> *"It was the first time the donor had asked us to make a link between HIV and violence. For me it was a 'prise de conscience,' a starting point, and I began to really understand more in-depth what these links are about, and that we should talk about these links every time, not as separate things."* (Implementing partner)

The GBVI has been a significant driver of action on GBV prevention and response in the DRC, especially in areas outside conflict zones. Although worldwide attention has been focused on conflict-related GBV perpetrated by armed actors against civilians in eastern DRC and although large donor investments have attempted to prevent further abuses and respond to urgent needs, relatively few resources had been directed to other parts of the country; GBV work was to some extent "new" for many respondents in Kinshasa and Orientale provinces. In this way, the GBVI was seen to have arrived in the DRC at an opportune moment, and it provided a major push toward building the knowledge, services, and systems needed to address GBV at the national, provincial, and community levels elsewhere in the country. In DRC, as in all three countries where the GBVI was implemented, integration of GBV into HIV service delivery was a signature element of the initiative. This is evidenced both by the documented accomplishments of PEPFAR implementing partners and by the ways in which stakeholders described the contributions of the GBVI in the DRC. Interview respondents at both global and country levels pointed to successes in GBV and HIV service delivery integration, which is now institutionalized both in clinical practice and in national and provincial planning. Community-level stakeholders, including teachers, religious leaders, and *relais communautaires* are more aware of the causes and consequences of GBV and its links to HIV. The public discourse has also started to shift, in part due to the GBVI's work with print, radio, and television journalists, and they are now more aware of and better able to discuss GBV and HIV and in doing so, to help spread the knowledge needed for change. Thus, program activities undertaken by a small but effective set of four main implementing partners reinforced one another's efforts to build stronger GBV prevention and response actions that will extend beyond the GBVI's two-year life in the DRC.

National/Policy-level Contributions

Given the clear focus on GBV and HIV service integration, the GBVI in the DRC operated mainly within the health sector. One of the initiative's main contributions at the national level was the completion of the *Protocole de Prise en Charge Medicale des Victimes des Violences Sexuelles,* a national protocol for the medical management of sexual violence survivors, facilitated by the GBVI through work undertaken by the KSPH in collaboration with the Ministry of Health's PNSR.

In original plans, the KSPH's work on the protocol was to be carried out after conducting a situation analysis of health facilities focused on GBV service delivery to inform the protocol. The health facility situation analysis was not undertaken due to lack of funding at the time, but the protocol is nevertheless a cornerstone in the country's health sector response to GBV. This comprehensive document provides detailed guidance to health care providers on a full range of topics, including how to create a supportive environment for GBV survivors seeking care, the type of information to collect from GBV survivors, how to undertake a medical examination and collect forensic evidence, relevant treatment options, and basic psychosocial counseling and referral practices. The protocol also includes a list of materials and equipment that should be available at facilities in order to provide the required GBV-related services.

Although grounded in the health sector, the KSPH and PNSR used a multisectoral approach to develop the range of topics covered by the protocols. The protocols were based on a document review and validation process conducted through a series of workshops whose participants included representatives of various Ministry of Health programs as well as the National Program for the Fight against AIDS, the Ministry of Gender, Family and Children, the Ministry of Social Affairs, the Ministry of Justice, the Ministry of Economic Affairs, the Office of the President, and various United Nations organizations. The protocol was printed by the Ministry of Health and has been distributed nationally. It complements national protocols focused on psychosocial care, socioeconomic support, and legal assistance created under the Ministry of Gender, Family and Children.

The GBVI also supported the KSPH to draft two training curricula that constitute another major contribution of the GBVI at the national level. One focuses on the medical management of GBV cases by health care providers, while the other is directed at community-level actors to help promote community awareness of GBV, its consequences, and available services. KSPH and the PNSR adopted a training of trainers approach for the medical management training in order to reach as many facilities and communities as possible, focusing first on Kinshasa and Kisangani. Other GBVI implementing partners whose activities focused on clinical services were well positioned to use both the medical protocol and the training program at the facility level in Kinshasa and Kisangani; other PEPFAR partners in the DRC further extended the rapid adoption of the national GBV medical protocol and training across the large networks of health facilities they support in multiple provinces.

Another contribution at the national level was the development of a screening tool to identify clients presenting for HIV testing and other clinical services who are currently experiencing, or have previously experienced, GBV. In some facilities, the screening tool was used mainly within HIV services; other facilities used it across a variety of service delivery areas, including maternity wards. By 2012, GBVI implementing partners were using the tool in 49 maternities and three HIV counseling and testing centers and had plans to expand the number of facilities providing GBV

screening and referral to PMTCT sites through other PEPFAR partners. The tool helps health care providers connect clients to needed medical care and GBV services; improve data collection to provide a picture of GBV prevalence in the clinical population; and document services provided, including referrals provided to each client for additional services outside the health facility.

La Ligne Verte is a national HIV hotline operated since 2005 by a local nongovernmental organization, *Fondation Femme Plus,* providing psychosocial counseling and support to persons living with HIV/AIDS, persons affected by HIV, and sexual violence survivors. This organization had received other PEPFAR funding for its HIV work, and the GBVI was able to leverage those investments by funding the KSPH to provide technical support to *Fondation Femme Plus* staff to help them address callers' needs related to GBV. The KSPH provided training for additional telephone counselors working three shifts per day—counselors who, at the height of the program, numbered 90. The training focused on how to identify callers who might need GBV-related services, how to provide callers with initial psychosocial support, and how to link them to the health and other GBV services closest to them. This program benefited from yet another GBVI national-level investment, in the form of a national GBV services mapping undertaken in the second year of the GBVI. This mapping tool was used by hotline counselors and service providers to refer GBV survivors not only to medical services but also to other existing support organizations offering psychosocial, socioeconomic, and/or legal assistance. The GBVI also provided training to 37 *Ligne Verte* HIV advisors about protection laws for children and people living with HIV and prevention of sexual violence. Between 2011 and 2013, telephone counselors provided support to 47,977 callers with GBV-related needs, according to records maintained by *Fondation Femme Plus*. Records do not break out the number of referrals provided to these callers, but during this period, counselors provided referrals to approximately 40 percent of all callers during that period. At the time, *Fondation Femme Plus* did not have a mechanism for following up with callers to determine the quality of services received or whether they required additional support, but more recently the organization's leadership has been investigating ways to follow up with callers by delivering a set of questions via SMS. *La Ligne Verte* illustrates some of the important synergies realized through the GBVI.

Institutional-level Contributions

> *"The big success was getting GBV integrated into HIV—that is to say, the technical integration. They are now inseparable. We have gone past the initiative. This integration is profound and leads to sustainability, and this all started with the GBVI."* (U.S. Government agency)

Institutionalizing GBV integration into HIV service delivery and efforts to help communities understand the dual risks of GBV and HIV, increase the likelihood of programmatic sustainability and scale-up. Although the GBVI in the DRC was not designed to make major investments in

national or local institutions per se, the activities it funded clearly helped institutions at both levels fulfill their mandates and extend GBV and HIV services. For example, one implementing partner explained:

> *"…the GBV funds, even if they were specifically for GBV, it helped integration. . . . You see, in the use of funds, there are always interrelated effects. For example, for all of the HIV clients who have been sensitized, those who screen positive for GBV receive care, first through psychosocial support. [But] we also developed women's support groups and this helped [the women] in the management of HIV as well. So, we had one principle objective for the use of these funds, but [they] also supported achieving other activities."*

Many of the accomplishments focused on ways in which the GBVI contributed to the institutionalization of GBV clinical services through the HIV platform, national protocols, training, and service delivery. Many in-country interviewees noted that the true integration of GBV and HIV in both stakeholders' conceptual understanding of the linkages and service delivery approaches have been institutionalized as a result of GBVI investments.

The GBVI also contributed to increasing the capacity of national and provincial mass media actors to appropriately report GBV cases in an ethical manner and with attention to the linkages between HIV and GBV. The GBVI undertook a content analysis of newspaper coverage on GBV and found that, although much attention had been focused on sexual violence in eastern DRC, a large number of cases were being reported in other areas daily, sometimes in ways that revealed misconceptions and biases among journalists about gender. More specifically, the analysis revealed that the media were not reporting on GBV frequently, relative to the burden of the problem, and that most articles and radio programs about GBV happened primarily only around special events and commemorative days (e.g., International Women's Days, 16 Days of Activism against GBV). Due to lack of information and orientation, some journalists described events in ways that placed blame on GBV survivors, based on their manner of dressing. The analysis further pointed to inadequate rigor in reporting these cases. To understand the general neglect of GBV in news reporting and identify knowledge gaps, the GBVI also collected information from journalists and learned that many did not have information about GBV (i.e., key concepts on the different forms of violence); about the links between gender, GBV, and HIV; about the role of the media in addressing GBV; about possible GBV advocacy activities; and about ways to process and verify information for reporting on gender and health. The GBVI trained 48 media professionals in Kisangani, distributed fact sheets on important GBV issues to journalists in both provinces, and developed a GBV resource guide for journalists. The GBVI also supported the press by creating communication materials to help journalists disseminate information about GBV laws, and in Kisangani facilitated the broadcasting of TV and radio shows focused on ending violence against women. Box 3 summarizes GBVI-supported institutional-level achievements in the DRC.

Box 3. GBVI-supported Institutional-level Achievements at National, Provincial, and Community Levels

- **Development and dissemination of a national protocol** on medical care for GBV survivors
- **Development of training package for health care workers** on GBV prevention, screening, and response
- **Development of a training package for community actors** on GBV prevention and linking community members to services
- **Development of a GBV screening tool** for use in health facilities
- **Training clinical staff** to provide integrated care to GBV survivors based on newly formed PNSR protocol for the medical management of GBV
- **Training to increase awareness of GBV and provide job guidance** for health clinic staff, police officers, national HIV/GBV hotline counselors (37), community leaders, teachers, journalists (48), and military peer educators, and counselors
- **Training for 628 *relais communautaires*** in the Stepping Stones approach to community empowerment and change, with an emphasis on GBV and HIV
- **Training for 40 local and provincial government officials** in situational analysis and the design of programs for SBCC
- **Support for provincial GBV synergy meetings** designed for stakeholders to share information, discuss lessons learned, and find solutions to challenges
- **Support to the national HIV/GBV hotline** in the form of trainings, a national referral resource, and an increase in the number of counselors and equipment.

Community-level Contributions

Much of the community-level work undertaken through the GBVI was implemented using two main SBCC approaches. The first adapted the successful Stepping Stones training package, initially developed in Uganda as a training package on gender, HIV, communication, and relationship skills for the DRC context. This participatory, non-formal learning program, which uses discussions and creative activities, had already been adapted for use in South Africa, and the GBVI benefitted from the technical guidance of Sonke Gender Justice's One Man Can Campaign team, as it adapted the program for the DRC. The GBVI supported the development of communication materials based on Stepping Stones, with a focus on GBV and its linkages to HIV, and trained *relais communautaires* in Kinshasa and Kisangani to conduct household visits in order to facilitate critical thinking and dialogue at the individual, couple, and family levels. The *relais communautaires* also worked with women's groups, adolescents, and commercial sex workers using the Stepping Stones approach, helping these individuals find a voice and support to overcome the fear and stigma surrounding both GBV and HIV in ways that had not previously happened. This work by the *relais communautaires* was complemented by other community mobilization and information efforts, as well as by local media coverage.

The GBVI conducted additional GBV trainings to help teachers identify and understand inequitable gender norms and ways in which they might have been reinforcing those norms in the classroom. In addition, the GBVI supported implementation of community activities near military bases, including peer education, information dissemination through schools, and the establishment of life skills centers for youth. However, some interviewees pointed to the lack of more comprehensive community information and mobilization as a hindrance in connecting communities to health facilities. For example, one implementing partner reported seeing a drop-off in GBV service use after community activities ended, attributing this to a lack of community awareness of available services. Another implementing partner said that female rape survivors often came to facilities after the period during which they could be offered HIV post-exposure prophylaxis and emergency contraception, and that support for more synergy between community actors and health facilities to mobilize people to use the services could have allowed them to help more women in a timely fashion.

Multisectoral and Partner Synergies

The GBVI in the DRC focused mainly on health sector investments to establish and reinforce the integration of GBV into HIV prevention, care, and treatment. PEPFAR's strategic expansion of PMTCT programming coincided with the rollout of the GBVI, so implementing partners increasingly focused on integrating GBV into PMTCT services. According to some stakeholders interviewed, the strong focus on clinical services did not promote as many multisectoral synergies as there might have been, especially in terms of service delivery. However, GBVI investments did strengthen synergies between health and military systems in areas where military communities were reached. First, the GBVI funded the training of health care providers in military health facilities by the PNSR, and the equipment and supplies necessary to manage GBV cases following the national protocol. Where a GBV survivor's medical needs were beyond the level of service available at military health facilities, staff engaged with health care providers at other government and private facilities to make the appropriate referrals. In describing coordination with others in the health sector, a project staff member based at one of the military health facilities explained, "The goodwill [of the health partners] to reach out to us, first of all, is already something big. . . . it was a good experience in collaboration and partnership. It's good. It's outstanding." The more obvious multisectoral synergies occurred at the provincial and community levels, where the GBVI facilitated the delivery of critical health (and other) information about GBV and the linkages with HIV to those in the education sector, journalists, religious leaders, *relais communautaires*, and other community groups.

Partner synergies resulted in linkages within the group of implementing partners, synergies between GBVI implementing partners and other PEPFAR partners, and collaboration between the GBVI implementing partners and other institutions more broadly. The design of the GBVI in the DRC promoted inherent synergies between GBVI implementing partners. While one partner

facilitated the development of a national protocol and training curricula to address the reach and quality of medical care for GBV survivors, another developed a screening tool that was included in some of those same trainings and that formed part of a package of clinic-based capacity-strengthening efforts. The GBVI implementing partner that worked with the military helped forge connections with health facilities serving military communities to ensure that they also received the new protocol and training. Two additional GBVI implementing partners worked with the national HIV/GBV hotline, *La Ligne Verte*—one to provide a set of referral services and training for HIV/GBV advisors on legal protection frameworks, and the other to provide GBV training and the resources to increase the number of counselors. Interviewees indicated that focusing more on these community–clinical linkages could further increase service use.

One of the major benefits of implementing the GBVI in the DRC, with the strong focus on GBV integration in HIV service delivery, lay in the advantage of having a wide network of public and private health facilities already tapped for capacity strengthening through large HIV prevention, care, and treatment programs across multiple provinces. Although PEPFAR partners implementing other projects, such as ICAP, IHP/Prosani, and ProVIC, did not receive GBVI funding, they benefited from the GBVI's technical investments in the integration of GBV into HIV programming. For example, these projects helped roll out GBV training for health care providers through integration with other training activities, supported clinical partners to implement the national medical protocol for GBV, and screened clients for GBV and provided referrals as needed. Ultimately, GBV integration translated into more comprehensive HIV services under those projects. As one PEPFAR implementing partner that did not receive GBVI funds expressed:

> *"There is no quality if there are not trained health care providers, protocols, referral norms. . . . [We] wanted to be sure that services were being offered according to the national norms. We ensured that there was training in all of the health zones where we worked, we remodeled health facilities to ensure confidentiality, which is important for quality of service delivery."*

In this way, IHP/Prosani and other implementing partners that did not directly receive GBVI funds were still able to improve the quality of care offered in facilities they supported with PMTCT and other HIV-related services by taking concrete actions to integrate GBV. This extended GBVI's reach beyond facilities and specific geographic locations targeted by the initiative.

Synergies between GBVI implementing partners and other institutions took two forms. First, each GBVI implementing partner collaborated directly with government or other non-implementing partners on activity design. These partners included the military, the PNSR, media partners, and provincial authorities. A GBVI implementing partner (FHI 360/C-Change) took the leading role in reestablishing a provincial-level coordination mechanism, *Synergie Provinciale* meetings. In Province Orientale, government partners and other stakeholders were very much

engaged. Meetings were used to share information, lessons learned, and solutions to hindrances, and the mechanism was reported to have been extremely valuable. However, *Synergie Provenciale* meetings proved more difficult in Kinshasa Province, where national-level coordination mechanisms appear to have broader challenges, as highlighted in a report from the February 2015 meeting of ministers and provincial division leaders for gender (République Démocratique du Congo 2015). The forward of the report points out that the Ministry of Gender, Family and Children is the sole national-level government structure that can assume leadership for questions related to gender, but that interactions between the national and provincial levels must be strengthened in order to create a national vision, and improve coordination on gender equality and women's empowerment. Issues of national coordination, therefore, may be larger than the GBVI was designed to address, and government leadership to improve synergies at this level is ongoing.

Building the Evidence Base

Information gathering for this review did not identify any specific project evaluations related to the GBVI in the DRC. Although one GBVI-funded partner collected baseline data in Kinshasa and Kisangani, the abbreviated implementation period, shortened from three years to two, resulted in funding cuts that forced cancellation of endline data collection. Interviews generated some feedback with regard to the three PEPFAR GBV pilot indicators. Among those GBVI and non-GBVI implementing partners that were required to report on these, the main comments focused on difficulties understanding how to interpret them and perceptions that the GBV indicators changed frequently. As one implementing partner described:

> *"In general, PEPFAR changes the indicators all the time, and it poses serious problems because we make a data collection form and system according to one thing and then you have to change it. It would be better to look at what data collection tool you're using and see if it can't already generate the information needed."*

As for the utility of the data generated from those indicators, most interviewees said that the numbers provided limited value and suggested that information about the types of violence reported and the follow-up of cases would be important to consider. Another interviewee pointed out that the indicators had been useful for seeing whether programs were targeted well enough and were reaching people as envisioned. A U.S. Government respondent spoke of the challenge of attributing change to GBVI funding, specifically when the GBVI investments were integrated with other investments. For example, one of the GBVI indicators related to the number of people reached with individual-, small-group-, or community-level interventions that explicitly addressed GBV. This allows for counting the number of people reached with GBV services, but because the indicator is rolled up into the wider set of HIV service investments, increases cannot be attributed to GBVI funding separately from all the other HIV investments in

those facilities. This could include sensitization activities that cover both HIV and GBV, funded by non-GBVI PEPFAR funds. These are included in the total figure and cannot be attributed solely to GBVI funding.

Partners also reported that they regularly collected data for other GBV-related indicators, in addition to the three GBVI indicators piloted, but because they were only required to report the three, the additional data stayed primarily within their organizations. Among those interviewed, there was a perception that the three PEPFAR GBV indicators were not harmonized with data collected through the national health management information system or the Ministry of Gender, Family and Children. More specifically, with the support of the United Nations Population Fund, the Ministry of Gender, Family and Children had developed a national GBV data collection system that initially covered seven provinces, including Kinshasa and Katanga, with plans for rollout to all provinces. This system was developed in consultation with various stakeholders, including the health sector, and there are guidelines on the types of service delivery and prevention data that are to be transmitted to the Ministry of Gender, Family and Children. Although there is overlap between the information collected through this national system and the PEPFAR GBV indicators, during interviews several stakeholders expressed a perception that the way in which the information was collected and reported was not coordinated (i.e., that different data tools were used).

Country Ownership/Sustainability

Two main factors beyond the scope and control of the GBVI make country ownership and sustainability a challenge in the DRC. First, coordination of national government mechanisms, specifically the Ministry of Gender, Family and Children—which would normally provide a structure for GBV prevention and a response strategy, policies, data collection, and advocacy—is in a transition. Although GBVI activities facilitated the mandates of various government entities, such as the PNSR and the military, further development of the overarching mechanisms for country ownership is needed. Needs include, for example, a system to strengthen adherence to national data collection requirements, and investments in the government's ability to provide ongoing support supervision, and quality assessments at service delivery structures, including health, judicial, psychosocial, and other sectors. As well, national-level coordination of stakeholders and activities needs to be more robust. Second, the continuing emphasis of donors, and consequently of government entities and others, is on addressing acute needs related to sexual and gender-based violence in the conflict-affected eastern part of the country. Given the differences in funding structures, stakeholders, and to some extent programmatic approaches, building cohesion around GBV as a national issue has been a challenge.

At the same time, there are clear ways in which the GBVI has contributed to country ownership and sustainability at the levels at which it intervened. By creating and distributing a medical

protocol, and other protocols, by training health service providers, and by developing a GBV screening tool, the GBVI effectively improved service delivery, while also strengthening government ownership of GBV and HIV integration. The GBVI also helped insert GBV into the public discourse, beyond the focus on sexual violence in the east, through its work with journalists and provincial leadership. The manner in which the GBVI did this, by reinforcing messages about the linkages between GBV and HIV, aligns with country-led efforts to enact policy frameworks, with an emphasis on the need for effective GBV prevention and response actions.

CONCLUSIONS

With a relatively small budget and timeframe (two years), the scope of the GBVI activities in the DRC was impressive. By targeting efforts to improve clinical services by institutionalizing tools and processes designed to be implemented nationally, the GBVI has had a larger reach than might have been expected, especially in a country as large and varied as the DRC. Its outputs included the national protocol for the medical management of GBV cases, the national GBV training curriculum, and a national screening tool. The GBVI also made important contributions to the national dialogue about GBV prevention and response, via systematic efforts to help journalists and other media professionals better understand GBV and to promote responsible reporting on gender inequality, GBV, and linkages with HIV. The GBVI investments in the national GBV/HIV telephone hotline also allowed the initiative to reach individuals in need at a national level. The GBVI also catalyzed important developments in the delivery of medical care to GBV survivors that stretched beyond the initiative's geographic focus through the integration of GBV activities in HIV services supported by PEPFAR implementing partners that did not receive GBVI funds. All partners took onboard the integration of GBV into ongoing HIV programming at both the clinical and community levels wherever possible. In this way, the GBVI demonstrated how community mobilization and behavior change interventions can increase the use of GBV clinical response services in conjunction with the institutionalization of medical care for GBV survivors. By building clinical capacity and increasing community awareness concurrently, the GBVI was able to maximize GBV and HIV investments.

LESSONS LEARNED

1. **GBV prevention and response activities should be mutually reinforcing to achieve the greatest impact with limited funds.** The GBVI was able to achieve some important synergies around the quality of clinical services and ways to respond to GBV survivors within the context of the larger HIV platform framework. This was possible in part because the activities, from the development of a screening tool and a national protocol to the training of health care providers and the strengthening of the national HIV/GBV hotline, reinforced and built upon one another. Future programs that seek to integrate GBV prevention and response into HIV services should identify any gaps in national systems, including protocol development and training, and support country governments to address those gaps effectively.
2. **Investments in the health sector should continue, but multisectoral collaboration at all levels can improve GBV prevention and response integration into HIV services.** The GBVI focused on the health sector, specifically on the integration of GBV prevention and response into the HIV platform of services. Although this was a natural and effective approach for the GBVI in the DRC, future GBV prevention and response interventions should include other sectors in order to translate clinical investments into quality of services for GBV survivors. For example, the GBVI facilitated the creation of a GBV service mapping tool, but the quality of services provided by non-health sectors (e.g., legal services, socioeconomic support, and psychosocial counseling) were in some cases very limited. By designing and implementing multisectoral GBV prevention and response interventions, donors and program managers can ensure that the range of needs experienced by GBV survivors is fully met.
3. **Coordinated data collection systems, including the use of agreed upon indicators, is a priority for all stakeholders.** Different stakeholders may have somewhat different data needs, but the GBVI in the DRC showed the importance of having a GBV data collection system that is clear, fits well with both government and donor needs, and can be implemented by facilities and other stakeholders. Having a harmonized system between stakeholders can reduce confusion about what is being reported, increase the validity of information and, ultimately, allow any stakeholder to use the data.
4. **GBV prevention and response efforts should be harmonized with national and provincial government structures.** The GBVI in the DRC was intentional about harmonizing approaches with health sector government entities, about coordinating with provincial-level leadership, and about promoting synergies at the subnational level. Country ownership and harmonization around key programmatic components such as data collection, which typically involves additional ministerial sectors, is also an important component. Although it was beyond the scope of the GBVI, because it was planned for the DRC, initiatives such as

the GBVI should proactively find ways to forge those synergies by supporting, for example, the Ministry of Gender, Family and Children to fulfill its coordination role with other ministries, ensuring partners' data collection is harmonized with government systems and facilitating institutional capacity development of relevant government structures (e.g., institutional capacity assessment, gap identification, and action plans to address gaps).

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AIDSFree
1616 Fort Myer Drive 16th Floor
Arlington, VA 22209
Phone: 703-528-7474
Fax: 703-528-7480
Web: aidsfree.usaid.gov