Integrated Services for Violence Against Women Survivors and Women Living with HIV

The Integration of Separate Services:
Results, Changes and Personal Experiences from a 2-year Pilot Project in Indonesia

"One Stop Service"
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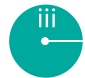

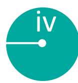
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Acknowledgments

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Setting the Stage

Violence Against Women (VAW) interacts with the human immunodeficiency virus (HIV) in many ways, to the detriment of women and girls. Women who are subjected to sexual violence are more likely to contract HIV than other women, and violence can influence women's willingness to get tested for HIV, affecting HIV control, treatment, and prevention of mother to child transmission (PMTCT). At the same time, HIV-positive women are nearly three times as likely to have experienced violence from their partners compared to HIV-negative women, while younger HIV-positive women are up to ten times as likely to have experienced violence compared to their HIV-negative peers.

In Indonesia, VAW as an influencing factor of the AIDS epidemic is not considered as a main factor of concern but as a separate issue. As a consequence, the response and services are separated. This represents a major gap in addressing women's issues, including VAW. In order to address this gap, in 2013, the 2-year project "One Stop Service: Integrated services for VAW survivors and Women Living with HIV (WLHIV)" was launched.

The project's goal was to improve the lives of women and girls who are living with HIV and/or experiencing VAW in DKI Jakarta and North Sumatera by increasing the awareness of their rights and ensuring their better health overall. We aimed to accomplish this through the implementation of several activities focusing on (1) the integration of services for VAW and HIV/AIDS, (2) an increased quality of care, and (3) a reduction in discrimination

against women and girls who are living with HIV and/or experience VAW.

This model of integrating responses and services in order to deal with the intersection of HIV/AIDS and VAW issues was the first of its kind, not only in Indonesia but also in the Asia Pacific region. Ultimately, the project was expected to contribute to the reduction of the occurrence of VAW cases, as well as HIV infections among survivors of VAW.

This publication presents some of the main project results and offers insights in the lessons that were learned during its implementation. Its main goal, however, is to offer evidence-based illustrations of these results and the context in which the project was implemented, presenting personal perceptions and experiences of the people who were – directly or indirectly – affected by the project.

An IPPI staff member raising awareness on the issue of VAW during the National Conference on AIDS in Makassar, 27 October 2015.

CEDAW: The International Bill of Rights for Women

The Convention on the Elimination of All Forms of Discrimination Against Women defines the right of women to be free from discrimination and sets the core principles to protect this right. It establishes an agenda for national action to end discrimination, and provides the basis for achieving equality between men and women through ensuring women's equal access to, and equal opportunities in, political and public life as well as education, health and employment. CEDAW is the only human rights treaty that affirms the reproductive rights of women.

Indonesia has signed the CEDAW (Convention on the Elimination of All Forms of Discrimination against Women). Despite the post-ratification of CEDAW into National Law No.7 (in force since 1984), some contradicting regulatory laws and other regulations that undermine the operationalization of CEDAW exist, which creates ambiguity and doubt at the implementation level. In addition to these legal complications regarding the elimination of discrimination against women (including WLHIV), discrimination occurs in the form of restrictions on freedom of expression, restrictions upon women in terms of clothing regulation and reduced legal protection.

Sexual and Reproductive Rights of WLHIV

When it comes to the sexual and reproductive rights women in general, including WLHIV, these can be translated into the following:

- **Sexual rights**

  The rights of all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexualhealth, be free from discrimination, coercion or violence in their sexual lives and in all sexual decisions, expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.

- **Reproductive rights**

  The rights of couples and individuals to decide freely and responsibly on the number and spacing of their children, to have the information, education and means to do so, attain the highest standards of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence.

- **The right to reproductive care**

  This includes, at a minimum, family planning services, counselling and information, antenatal, postnatal and delivery care, health care for infants, treatment for reproductive tract infections and sexually transmitted diseases, safe abortion services, prevention and appropriate treatment for infertility, information, education and counselling on human sexuality, reproductive health and responsible parenting and discouragement of harmful practices.

Chapter 1.

VIOLENCE & HIV: INEXTRICABLY LINKED

Women and HIV

HIV attacks the body's immune system. If left untreated, HIV can gradually weaken the immune system, making it more difficult for the infected person to fight the disease. Unlike some other viruses, the body cannot get rid of HIV completely: once you have HIV, you have it for life. HIV is usually transmitted to another personthrough (1) unprotected anal or vaginal sex, (2) from a mother to her baby, (3) through blood-to-blood contact including the sharing of unclean needles among drug users.

Heterosexual transmission of HIV has become the main mode of transmission in recent years, and the number of women affected by HIV/AIDS is increasing significantly. Women now account for more than half of the world's population living with HIV, with the disease being one of the main causes of death for women of a reproductive age (15-44).

The number of women living with HIV in Indonesia increased tremendously. Women's vulnerability to contract HIV is amplified by various cultural practices, such as female genital mutilation (through the use of unsterilized instruments or genital wounds),

(child) marriage with a skewed power relationship (a lack of awareness regarding self-protection, family pressure forcing girls to obey their husbands), or lack of sex education. In addition, this group faces specific challenges when it comes to (access) to health care, experiencing stigma and discrimination in their private and public lives.

Violence Against Women

Violence against women forms a significant public health problem, as well as a gross and fundamental violation of women's human rights. It affects approximately one third of the female population worldwide. Violence often prohibits women from fully participating in society and damages their health and overall well-being.

Although reliable statistics for Indonesia are hard to come by, due to an underreporting of cases, recent data from Komnas Perempuan (Indonesia's National Commission on Violence against Women) shows that there were at least 279,760 cases of violence against women in the archipelago throughout 2013. This is a significant increase of almost 30% compared to the 216,156 cases in the previous yearand most probably only a fraction of the real number of cases. A massive majority (an estimated 96%) of the violent acts against women takes place in the domestic sphere, with intimate partners.

Connecting VAW & HIV

There exists an undeniable link between VAW and HIV. This link works in two directions. First of all, VAW provides a risk factor for HIV. Particularly sexual violence forms a direct pathway to the contraction of HIV, through rape/sexual assault. In addition, a fear of violence and general difficulties encountered by women when trying to control and negotiate safe sex and condom use

may indirectly lead to HIV. Furthermore, trauma and violence that occurred in the childhood of women and girls may increase their tendency to exhibit sexual risk behaviour and thereby risking HIV infection.

Secondly, evidence shows women living with HIV often have to deal with the fear of, or actual experience of violence by their partners, family and community members which keeps them from seeking HIV treatment. Women living with HIV may be marginalized, abandoned by their families or partners, thrown out of their homes, beaten, and even killed. They face forced sterilization and abortion, denial of treatment, and disclosure of their status without their consent. Fear of (additional) violence makes WLHIV reluctant to be tested or treated which is increased by their weak position in society. This subordinate position that many women and girls hold within their families, communities and societies restricts their access to accurate information about sexual and reproductive health, their use of health-care services and their capacity to negotiate safer sexual practices and/or escape violent situations. Women tend to suffer in silence, which can have big consequences in terms of their physical and mental health, and their general participation in society.

In addition to this, WLHIV do not seem to be familiar with the meaning of VAW and what it entails – which illustrates a lack of awareness in terms of their rights, which will influence their willingness and courage to seek help when they experience violence. Furthermore, due to the stigma that rests on being HIV positive, WLHIV do not dare to speak out about the reasons for the violence they endure, in fear of disclosure of their status.

- **Experiences of Violence**

As part of the "One Stop Service" project, an operational

research was carried out among women living with HIV, service providers and other stakeholders (government represent-tatives) on the link between VAW and an increased risk of HIV/AIDS. The research aimed to investigate the experiences of WLHIV who suffered from VAW and to develop a better understanding of the types of (integrated) services available and their utilization by WLHIV.

Findings of the research showed that most WLHIV are to some degree familiar with HIV service providers. Almost none of them ever used services designated for victims of violence. Obstacles distinguished are (1) limited exposure to information regarding the availability of the services, (2) perception of violence as something normal and therefore not experiencing the need to seek help, (3) their partner forbidding them to seek help, (4) fearing they will not receive help due to their positive status (based on personal experiences or those of friends), or (5) not wanting other people to know that they are HIV positive.

Findings of the research showed that most WLHIV are to some degree familiar with HIV service providers. Almost none of them ever used services designated for victims of violence.

Almost all of the WLHIV who were interviewed experienced various forms of violence throughout their lives. Physical violence was most frequently experiences, the majority of which occurred within the domestic sphere, as did experiences of sexual violence. In the public sphere, WLHIV often had to demonstrate certain sexual acts and experienced sexual harassment. When it comes to psychological violence,

The story of Mardiyah

Mardiyah has experienced multiple types of violence in her life time. She's been married twice. Her first husband passed away in 2000, the second left her two years ago. She is now raising her six children alone.

She discovered that she was HIV positive soon after her first husband died. Mardiyah's family supported her when she informed them, and her second husband accepted it. During her first marriage, Mardiyah already had to endure verbal aggression on a frequent basis and her husband often forced her to have sex with him. Things unfortunately did not get better during her second marriage. Her husband physically and psychologically abused her, threatening to disclose her HIV status:

"He still keeps my number. He sends text messages saying "I will tell people that you have been infected with HIV, you got this and that..."

Her husband eventually abandoned her soon after delivering their youngest child, leaving her to fend for herself.

the most common experience is the threat of disclosure, followed by discrimination (by health providers and in obtaining health-related information) and stigmatization (by their husband or relatives). In addition, women experienced verbal abuse, the threat of divorce or being forced to get marries. Women also experienced economic violence, in the

form of abandonment (by their husband) and robbery. Aside from troubled childhoods, and problems in the domestic sphere (e.g. alcohol, unemployment), the women perceived their HIV status to be an important cause of the violence they experienced.

- **Stigma & Discrimination**

Both female victims of violence and WLHIV often deal with experiences of stigma and discrimination. These experiences often increase and intensify when a woman is living with HIV and is suffering from violence. A lack of knowledge and prejudiced ideas on VAW and HIV/AIDS – especially on the parts of service providers – significantly hinder the integration of VAW and HIV/AIDS services.

The most significant stigma and discrimination experienced (and feared) by WLHIV and survivors of violence is from health providers and other relevant institutions who are supposed to help women who have experienced violence, such as the police.

In Indonesia, HIV is perceived to be the consequence of sinful sexual behaviour. A person who has contracted the HIV virus has engaged him or herself in "free sex", which is considered a sin and is therefore surrounded by stigma. Due to this stigma, and the prejudiced beliefs that stem from it, WLHIV often have to endure discriminatory behaviour of their partners, family, community members and service providers.

Data collected in 2014 [Baseline "One Stop Service" Project] showed that stigma and discrimination were still strongly perceived and experienced by WLHIV and survivors of

violence. Particularly when it comes to access to health care services and referral to proper aid (e.g. from police to health care providers, or the other way around), stigma and discrimination constitute substantial barriers in accessing quality care. The most significant stigma and discrimination experienced (and feared) by WLHIV and survivors of violence is from health providers and other relevant institutions who are supposed to help women who have experienced violence, such as the police. Types of discrimination ranged from their HIV status being revealed to treatment refusal by health providers or even watching health professionals take unnecessary precautions when treating WLHIV (wearing gloves, masks, etc.).

This significantly hinders the efforts to integrate service delivery. The lack of knowledge, prejudiced opinions and stigma attached to VAW and WLHIV may cause some service providers and institutions to avoid (in-depth) questions when encountering a victim of violence or a WLHIV, exploring other social issues attached to their situation. In addition, they may not be aware of integrated services available for VAW and HIV/AIDS, be unwilling to cater to all the needs of the patient, or refuse treat/assist altogether.

Stigma & Discrimination among Health Providers

In 2011, the pregnant, HIV positive N (24 years old) from North Sumatera, visited the hospital. Due to the stigma surrounding her HIV status, she experienced two specific forms of violence. First, she was subjected to severe psychological and physical violence when the service providers forced her to be sterilized and refusing to treat her as long as she did not sign an agreement:

"When it was close to my due date and I came to the hospital, I was ignored by the hospital staff, they did not want to treat me because I did not want to sign an agreement letter to be sterilized. The doctor gave me the letter when I was under influence of anaesthetic, I was so determined not to sign the letter, however the other doctor talked to my family to force me to sign the letter. [...] In the end, seeing my condition was becoming weaker, my husband decided to sign the letter since I still did not want to sign it."

In addition, she suffered additional psychological violence when the hospital personnel abandoned her due to her refusal to sign the documents:

"I was abandoned for about 8 hours without being treated and I was brought to a kind of a storage room during that process. The doctor was very upset and said to my family that with my HIV virus I could infect medical staffs if the HIV infected women are pregnant like me".

The lack of awareness of and inhumane treatment by the service providers that N experienced illustrates the stigma and discriminative behaviour that surround HIV in Indonesian society.

Available Services & Their Lack of Integration

When it comes to VAW, Indonesian women can access the Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak (P2TP2A) – Centre for Integrated Services on Women and Children Empowerment. This is a public health care institution providing free services for women and children who are survivors of violence. The centre offers information on VAW, psychological counselling, provision of legal support, companionship and advocacy, and shelter.

However, the centre has not integrated HIV-related services. Although the Minimum Standard of Violence Services (SPM in Indonesian) – published by the Ministry of Women Empowerment and Child Protection in 2011 – prescribes the examination of the risk for HIV, HIV screening, and HIV counselling for victims and their family, these activities are currently not part of the centre's services.

In the case of HIV/AIDS, services are generally available in comprehensive clinics at hospitals at the provincial and district levels. The facilities offer Voluntary Counselling and Testing (VCT), Care Support Treatment (CST), screening and treatment of Sexually Transmitted Diseases (STIs) and PMTCT. VCT is typically delivered by tertiary level hospitals, as this is where most individuals present for testing. However, the services are only accessed by approximately 30% of all high-risk groups, and it has been stressed that more efforts are needed to increase early testing at the community level.

Furthermore, a survey and observations carried out by IPPI in 2012 showed that the counselling performed at VCT clinics to female clients does not yet explore if women are experiencing VAW. As a consequence, the violence often remains unidentified and the physical and psychological health of the women and girls continues to be at risk. In the long run, this situation can deteriorate and may influence not only their health, but also their social, economic and political development and participation.

Chapter 2.

AN INTEGRATED APPROACH?

Integration at Different Levels

Looking at available research and literature, the connection between VAW and HIV is undeniable. Unfortunately, in Indonesia, activities and services that address the two pandemics have not been properly integrated. In practice, there either exists a lack of awareness on the linkage between the two issues, or the awareness is there but is not supported by the institutional and/or societal setting in which a person finds him or herself.

- **Services**

  While in Indonesia health policies, systems and services for women experiencing violence and for those affected by HIV are available, they are not interlinked. The lack of a comprehensive strategy regarding VAW and HIV/AIDS is particularly visible at the service level, where women are not receiving integrated care in which the connection between HIV and VAW is actively addressed and referral systems between VAW and HIV/AIDS services are not in place.

  Service providers tend to focus on their own separate fields.

VAW services mainly focus on legal aid and psychological support for the survivors. HIV service providers focus on prevention, care and treatment of HIV/AIDS. When a woman visits services focusing on VAW, she will not receive information on HIV risks and testing, nor will she be referred to services that can provide her with this information. The other way around, the same thing happens: at HIV services, women will not be asked about experiences with violence, nor will they be made aware of additional services that may be available to them.

Research within the project has shown that service providers and WLHIV agree that survivors of violence are responsible for solving their own problems. There exists a lack of awareness on the rights of women, and a general acceptance of violence towards them (especially in the domestic sphere). Cultural norms, values and beliefs enforcing stigma and discrimination form important boundaries to the use and integration of HIV and VAW services. This puts the victim in a vulnerable situation. The separate approach of the service providers causes a situation in which the providers do not look for, recognize, or address "additional issues". As a result, the provision of services for WLHIV and victims of violence is rather limited and often does not match the actual needs of the women.

In addition, it is important to note that no integration has taken place when it comes to the existing policies regarding VAW and HIV/AIDS, hindering the operational integration of both fields in the practical realities on the ground. Furthermore, there does not exist a proper referral system between the (health care) services available for HIV and VAW. The lack of understanding of the connection between HIV

and VAW, the prejudice that exists among service providers when it comes to these issues, and the fact that there is little to no communication between providers, significantly hinders the acknowledgement and comprehensive care for WLHIV experiencing violence.

- **Community**

  At the community level, familiarity with the correlation between the two epidemics is very limited. In addition, most of the awareness raising activities and national campaigns focusing on the two topics are conducted separately. Furthermore, the strategies of governmental, non-governmental and grass-roots organisations focusing on VAW and HIV/AIDS are not connected, although they often face similar challenges. These challenges have to do with the acknowledgment and inclusion of other social issues that are connected to the services they provide. Examples of such social issues are strong cultural and religious norms leading to gender inequality, stigma and discrimination.

- **Policy**

  When it comes to the practical realities of existing international and national laws and policies, VAW and HIV service providers are dealing with difficulties in terms of operationalization. These difficulties stem from the fact that government bodies focusing on HIV/AIDS and HIV/AIDS-related Non-Governmental Organisations (NGOs) perceive VAW as a separate issue, disassociated from HIV problems.

  For example, Indonesia's AIDS Strategy on women and children was developed in 2007. However, this strategy has not been translated optimally in a tangible program due to the unavailability of an adequate monitoring and evaluation

system. In addition, in the National AIDS Prevention Program (2010-2014), women, adolescents and children are not given special attention. There is a gap in addressing women's issues including VAW, and the involvement of men and policy makers in its implementation.

- **Data Management**

  At the data management level, the system unfortunately does not take into account – and cannot register – cases facing both problems. For example, Komnas Perempuan has developed the 'Annual Notes' (Catatan Tahunan - CATAHU in Indonesian) - a recording system of VAW cases, published annually. This system provides an overview of data on violence experienced by women (physical, psychological, and sexual) in all regions in Indonesia over the past year. The data are compiled from information of service providers handling VAW cases, as well as monitoring data and analyses conducted by Komnas Perempuan itself. It documents subjects such as handling of complaints, referrals to health providers, social rehabilitation services, legal assistance, and counselling services. However, the report does not provide details about the different types of violence, nor does it provide information on specific risk groups such as WLHIV.

Integration as a Priority

The integration of VAW and HIV/AIDS, including the strengthening of referral systems and harmonizing efforts of governmental and non-governmental networks is complex. Therefore, it is key to establish multi-sectorial collaborations and involvement. At the province level, P2TP2A and VCT clinics should be fully involved, while at the national level, the National AIDS Commission as well as the Ministry of Health and Ministry of Women Empowerment

and Child Protection should be involved. In efforts to promote this integration, changes in working relationship, behaviour and practices of service providers are needed.

Fortunately in recent years, due to extensive advocacy efforts done by IPPI and others, the integration of VAW and HIV/AIDS has increasingly become a priority area for the Government of Indonesia. If better integrated services for VAW and HIV/AIDS would be in place, built on the commitment of the Government, both epidemics can be addressed through a much more effective strategy.

Defining Violence Against Women

The Council of Europe Convention on preventing and combating VAW and domestic violence, also known as the Istanbul Convention, defines Violence Against Women as:

"A violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

In the "One Stop Service" project, we worked with a specific definition for violence against WLHIV:

"Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV".

Within this definition, we distinguished 4 main forms of violence:

(1) Physical Violence; entails the deliberate use of physical force against WLHIV within the private and/or public sphere. For example, being hit, punched or slapped by intimate partners, family or community members (including police)

(2) Sexual Violence; which occurs when a person is forced to unwillingly take part in sexual activity. It includes forcing a person to have sex against her will, sexual harassment, assault and rape.

(3)Psychological Violence; includes subjecting, or exposing a person to behaviour that may result in psychological trauma. This includes verbal abuse and threats, but may also mean involuntary disclosure of someone's HIV status or denial of treatment.

(4) Economic violence; is a type of violence committed by a person preying on economically disadvantaged individuals. In the case of WLHIV this may include abandonment by their partner, not being allowed to work or not being provided for by their partner.

Chapter 3.

"ONE STOP SERVICE" PILOTING INTEGRATION

In order to address the gap that exists when it comes to the provision of integrated services for VAW and WLHIV, in 2013, the Indonesian Positive Women Network (IPPI) and ResultsinHealth (RiH) were awarded a grant by the United Nations Trust Fund to End Violence Against Women for their joint project "One Stop Service: Integrated Services for Survivors of Violence Against Women and Women Living with HIV".

Project Goals

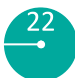
Considering the fact that Indonesia is an immense and varied country, the project proposed a model of integrated services for VAW and HIV which was piloted in two provinces (DKI Jakarta and North Sumatera). The 2 year pilot project aimed to improve the lives of women and girls who are living with HIV and/or experiencing VAW in DKI Jakarta and North Sumatera by increasing the awareness of their rights and giving them better health overall. In order to reach this goal, the project had three main outcomes:

1. the provision of an integrated service through the improvement of existing separated services on VAW and HIV.

2. An Increased quality of care of integrated services through the use of information collected within the project.
3. Reduced discrimination against women and girls living with HIV and experiencing VAW in the two pilot provinces.

To reach these goals, multiple strategies were defined such as the development of integrated service delivery, capacity building, knowledge transfer, and the promotion and improvement of community awareness.

As proposed, the integrated services included the protection of, health service provision, psychological and legal support for WLHIV and survivors of violence. The services were characterized by their interconnectedness and being client friendly, providing non-discriminative services based on the client's needs. If successful, the integrated services would cover capacity building for care providers and peer educators, quality assurance through supervision and mentoring, and institutionalization of this newly developed form of service.



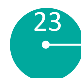
Through its activities, the project was expected to contribute to the reduction of the twin epidemics and ultimately, limiting the occurrence of VAW cases, as well as HIV infections among survivors of VAW. Furthermore, after 2 years of project implementation, the project was expected to result in more and better knowledge and data regarding the forms of violence experienced by women and girls living with HIV. Ultimately, the lessons learnt during the project implementation were intended to be used to scale up the pilot project in other provinces in Indonesia.

This comprehensive model focusing on integrating responses and services to deal with the intersection of HIV and VAW issues is the first of its kind, not only in Indonesia but also in the Asia

Pacific region.

Expected Changes

Within the "One Stop Service" project several changes were expected to occur in addressing the link between VAW and WLHIV, particularly when it comes to the service and community level. First of all, it was expected that a solid working relationship, collaboration and network would be established amongst relevant organisations and service providers in the field of VAW and HIV. Secondly, the project was expected to ensure that essential actions would be taken by relevant organizations in order to improve the provision of integrated service on VAW and HIV in DKI Jakarta and North Sumatera. Thirdly, behavioural, as well as attitudinal changes regarding VAW and HIV are expected to be observed among health care providers, primary beneficiaries and policy makers to reduce discrimination against WLHIV and survivors of VAW.



Project Results

When it comes to the changes observed throughout the implementation of the project, results show that these changes have particularly occurred at the organisational level (expanding networks and collaboration between different partners) and the individual level (e.g. personal changes among WLHIV and service providers).

- **Collaboration & Networking**

  One of the consequences of the lack of acknowledgement regarding the link between VAW and HIV, is that Indonesian care providers within the HIV and VAW system are not known to each other, let alone working together.

Therefore, in order to reduce the separation of VAW and HIV services, the project helped to build coordination and collaboration between service providers at the community level. This was realized in the form of Memorandum of Understanding (MoU) between IPPI and the different service providers. This MoU was circulated among 13 community based organisations and included agreements on the provision of integrated services, referral, and client-friendly (and stigma/discrimination-fee) services. It was used to, for example, improve the collaboration between peer educators and counsellors and to reduce discrimination and stigma against WLHIV and survivors of violence.

The project helped build coordination and collaboration between service providers at the community level.

When it comes to coordination between institutions/ organisations, the project has formed, expanded and maintained networks and partnerships with the assistance of UN Women, the National AIDS Commission, the Women Empowerment Bureau North Sumatera, and the District AIDS Commission in Jakarta and Medan. In addition, to realize an integrated service, the project approached relevant local (governmental and non-governmental) institutions, with the intention to build partnerships with them. Coordination meetings were organised, raising the topics connected to HIV and VAW, contributed to improved knowledge and awareness. Such meetings included coordination meetings on the provision of services or MoUs and meetings for validation of results of research.

Particular efforts were directed to engaging the VAW sector,

especially governmental services (P2TP2A). As observed, it was difficult for the project to raise awareness among the staff on the link between and the importance of integrated services for VAW and HIV among the staff. This was due to the fact that in the staff's perception, the two issues are, and should stay, separated. P2TP2A in North Sumatera was of the opinion that HIV issues had nothing to do with their services and the P2TP2A in Jakarta believed HIV issues to be the responsibility of the AIDS Commission. However, despite their scepticism, representatives of the P2TP2A in both North Sumatera and DKI Jakarta were involved in project activities.

At the policy level, IPPI has been involved in the preparation of the national action plan strategy for HIV and AIDS prevention 2015-2018, which started mid-2014. Given that violence does not only occur in WLHIV but also in other risk groups such as sex workers, men who have sex with men (MSM), people who use drugs and the transgender population, IPPI provided the government with input on paying more attention to, and dealing with issues such as gender equality and the integration of violence in HIV policies and services. At this time, the final draft has been completed and is waiting to be signed.

- **Integrated Services at the Service Level**

Even though fully integrated services are not yet in place in DKI Jakarta and North Sumatera, the project did make considerable contributions to bringing together the various parties working at the service level of the HIV and VAW response. By the end of the project, more referral systems were in place and gradually working effectively, especially among peer educators and counsellors who assisted WLHIV and victims of VAW to access legal aid support. These service

providers previously worked on the issues of HIV and VAW separately, but the project gave them a chance to share their experiences, discuss approaches and be exposed to new knowledge on the interlinkages between the two topics. In addition, MoUs strengthened the referral systems from HIV to VAW services.

To support the development and provision of integrated services, a guideline was developed to be used in addressing services on VAW and HIV. The development of the guideline started in March 2015. Eighteen existing guidelines and documents on VAW and HIV/AIDS were reviewed to identify the presence of diagnostic items that indicate if a women needs to receive additional assistance in the area of HIV or VAW, or other areas and information on the necessary referral. A revised guideline was developed from these sources, with consultation and feedback from relevant stakeholders.

These changes show that the project has been able to bring together two groups of organisations previously working separately. It established networks among organisations working on different issues, sharing and discussing the links between them and the opportunities to complement each other. Organisations from both groups acknowledge that their involvement in the project meant an expansion of their networks which gives them the opportunity to collaborate effectively towards the integration of their services and to better assist their clients.

In addition, following their involvement in the project, several organisations went through some positive developments with regards to their institutional capacities and focus. Some partners have gradually taken the issue of VAW experienced

by WLHIV more seriously and employees have improved skills in terms of dealing with the interlinkage between the two issues. In Jakarta, LBH APIK (Lembaga Bantuan Hukum APIK), an organisation that provides legal assistance to victims of violence, released an annual report describing stigma and discrimination faced by WLHIV when accessing services. Yayasan Hidup Positif has committed itself to tackle VAW and added it to the strategy and work of their peer educators. In North Sumatera, LBH APIK Medan, Haji Adam Malik hospital, and Pringadi hospital were ready to use integrated VAW forms and adjusted them to fit their counselling procedures.

- **Knowledge, Skills & Behaviour**

The project has made considerable contributions to the strengthening of individual knowledge and capacities of targeted beneficiaries. Evaluation data indicate that in both provinces the project has contributed to raising the awareness with regards to knowledge on the linkage between HIV and VAW, the impact of VAW on WLHIV, breaking the cycle of violence and silence for victims of VAW among the WLHIV population, the availability of services and an improved 'victim-friendly' approach in terms of counselling skills.

As part of the efforts to provide integrated services, the project conducted activities with HIV and VAW counsellors and peer educators. These capacity building efforts were meant to increase their skills and knowledge on providing integrated services, and included the development of practical guidelines. Trainings and modules including information on HIV and VAW were developed, teaching the counsellors and peer educators on the link between the two issues and the necessary referral. It turned out that, those who were trained did have more knowledge and understanding of HIV

and VAW issues, women's rights, prevention of VAW and access and availability of the appropriate services.

This project managed to raise awareness on the importance of integrating HIV and VAW among service providers and WLHIV:

"Before, I only knew about the issues, but after I met the IPPI counsellors in person during the training, I have come to understand better on how and have direct experience in working alongside survivors as buddy/counsellor. Knowing these people in person has made me understand the struggle of women with HIV better, especially those who also survive from violence" [EP, female, Jakarta].

Through the training of 66 peer educators (representing 17 institutions from Jakarta and 13 from North Sumatera) and 104 trained counsellors (representing 17 institutions from Jakarta and 15 from North Sumatera), women living with HIV now know more about the forms of violence, which before they believed to be fair and reasonable (considering their HIV positive status and/or their subordinate place as women).

The capacity building activities have led to concrete changes in the practices of peer educators and VCT counsellors. They are now able to explain the link between both issues in a client-friendly manner, talk about prevention of VAW and how to deal with experiences of violence. In addition, they are now better able to build a trusting relationship with the clients, providing them with a safe space in which they can share their experiences.

"I am now more skilful in exploring questions and probing in depth about the violence that my clients experience to give them solutions. Such changes are important as they improve

the role of counsellors in supporting and empowering clients" [RKL, male, Medan].

"The trainings and meetings I attended increased my knowledge about violence, for example now I know that it can consist of more than only physical violence. I now know that violence also can take the form of economic, psychological, and sexual violence" [EC, buddy, Jakarta].

The counsellors and buddies are now more sensitive in exploring questions related to the issue of violence experienced by their clients and can provide better solutions. Where previously they did not know what to do when dealing with clients who have experienced violence they are now better equipped to provide support.

"Since I learned of this project and participated in some of its activities I have changed, for example my counselling, before I just asked HIV related questions but now I also ask questions related to violence. Also I further explore the questions, if I find a small indication that violence has happened then I will explore this further with more open questions. I also found out that my clients have more courage to open up about their problem because they feel there is a way out" [RK, counsellor, Medan].

Several counsellors have applied the detection of risk behaviour related to HIV in their counselling activities. Peer educators have supported WLHIV who experienced VAW and accompanied those in need of VAW services. Others expressed to their organisations their need for more time in order to support this particular group. Some of the peer educators who were trained in this project, were themselves living with HIV and experiencing violence. Due to their training and experiences with the project they were able to

break out of the cycle of violence. Their personal experiences as survivors have had a positive impact in the project; their empathy towards WLHIV experiencing violence playing a significant role in the support they provided.

For some of the counsellors and peer educators, the integration of HIV and VAW proved to be difficult. This had to do with the fact that their institutions do not accommodate any reporting activities related to violence experienced by the client. In addition, often very limited time is given to address cases that entail violence and there is a lack of support when working on or providing accompaniment for cases of violence. Furthermore, counsellors and peer educators are sometimes faced with clients who are not ready to disclose their experiences as they fear humiliation, or where the perpetrator is an intimate partner who runs the risk of being imprisoned. Finally, clients often are not aware of the importance, nor the existence of the link between their HIV status and the violence they experience.

Counsellors and buddies have often been applying their new knowledge and skills on their own initiative, not as part of complying with standard operating procedures at their respective organisations. In addition, the monitoring of the counsellors/buddies who provide services directly to their clients has not been optimal in all organisations involved in the project. Therefore, there is still a lot of room for improvement regarding the institutionalization of the newly acquired knowledge and skills of these service providers.

Despite the difficulties, however, new information on VAW and the willingness of peer educators to follow up cases of VAW among WLHIV has brought about changes in WLHIV. Violence was generally considered normal and acceptable behaviour,

but through peer support and counselling sessions, a few WLHIV have stood up for their rights by reporting their cases to the police, and reportedly feel better able to reach out to relevant VAW services (such as hospitals, community health centres, psychological counselling services and legal aid).

"I think the most significant change that happen with me is that now I have more courage and strength to deal with my husband's threats, especially since I have had the accompaniment support when filing a report to the police" [RN, female, Jakarta].

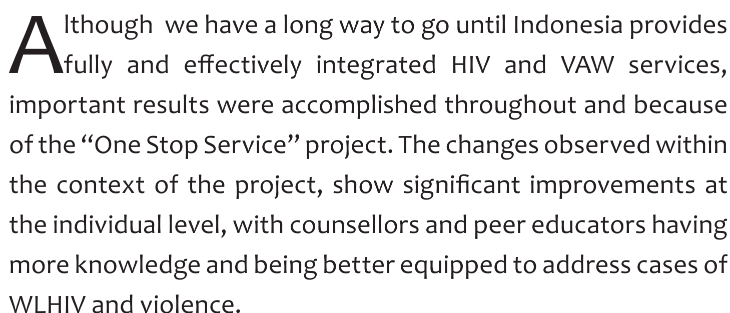
The women who decided not to make use of VAW services, nevertheless feel that their enhanced awareness about their rights has increased their negotiation power with their husbands. Changes thus not only occurred regarding the women's knowledge of VAW, and their rights, but also with regards to their attitudes and behaviour.

- **Knowledge of General Public/Advocacy Efforts**

The project aimed to increase the awareness of the general population on the linkages between HIV and VAW and the available services in their community through the involvement of media. Mass media (printed and electronic) were used for this dissemination, and the project collaborated with a private radio station in Jakarta to broadcast information about HIV, sexual and reproductive health and rights, violence (especially violence against WLHIV). The project also conducted a blog competition to receive responses from the general public on issues related to HIV and VAW. The current situation shows that some of the online messages have been published, but that the content and way of writing needs to be improved further.

Losari Beach, Makassar (26 October 2015)
Group picture after a march and campaign to raise awareness on the issue of VAW during the National Conference on AIDS.

Concluding Remarks



Although we have a long way to go until Indonesia provides fully and effectively integrated HIV and VAW services, important results were accomplished throughout and because of the “One Stop Service” project. The changes observed within the context of the project, show significant improvements at the individual level, with counsellors and peer educators having more knowledge and being better equipped to address cases of WLHIV and violence.

In addition, significant changes occurred in terms of familiarity with and collaboration between the different service providers in the HIV and VAW fields. Organisations that were not familiar with each other at the start of the project have started to approach each other and built networks among themselves. These networks are crucial in raising concerns about the linkages between HIV and VAW both to the general public and to policy makers. Moreover, these collaborations are essential in the development and implementation of effective referral systems.

Furthermore, the documentation of existing cases through monitoring and evaluation efforts can play an important role in providing evidence and tools for advocacy efforts towards a fully, effective integrated service for WLHIV and VAW, which will contribute to the general protection of these women and a reduction of discriminatory behaviour towards them.

It can be concluded that the project has provided a valuable, evidence-based starting point from which to further build effective integrated services for WLHIV and VAW in Indonesia.

Resources

The following resources were used to develop this publication. They are available upon request.

- **One Stop Service: Integrated Services for Survivors of VAW and WLHIV**

  Baseline Report

  June 2014

  The Baseline Research was conducted before the start of the project in order to gain a better understanding of the current situation of the integration of HIV and VAW-related services in the DKI Jakarta and North Sumatera provinces of Indonesia.

- **Guideline for Service Providers**

  September 2015

  The guideline was developed to improve and update the existing guidelines on provision of integrated services for Violence Against Women (VAW) and HIV/AIDS in Indonesia. This guideline is particularly aimed to support HIV and/or violence service providers in implementing an integrated services for WLHIV.

- **External Evaluation**

  January 2016

  At the end of project implementation the final external evaluation was conducted to assess effectiveness, relevance, efficiency, sustainability and impact of the project, with a strong focus on assessing the results at the outcome level and to generate lessons learned and good practices from the 24 months project implementation.

- **Implementation Report**

  January 2016

  The implementation report was prepared at the end of project

implementation. It is aimed to document and describe the project implementation process of "One Stop Services on HIV and Violence against Women Project".

- **MSC Report**

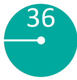
  December 2015

  The monitoring and evaluation using the Most Significant Change (MSC) technique in the project was conducted to identify changes - expected and the unexpected changes - after 2 years project implementation

- **Research Report**

  June 2015

  An operational research was conducted as part of the "One Stop Service" project. It aimed to explore the perceptions and experiences of WLHIV who experienced violence in respect to HIV and VAW services, and to develop a better understanding of the types of integrated service providers available in Jakarta and North Sumatra and its utilization by WLHIV.



List of Abbreviations

CATAHU	:	Catatan Tahunan - a recording system of VAW cases
CEDAW	:	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	:	Civil Society Organisation
CST	:	Care Support Treatment
HIV	:	Human Immunodeficiency Virus
IPPI	:	Indonesian Positive Women Network
MARP	:	Most At Risk Population
MoU	:	Memorandum of Understanding
NAC	:	National AIDS Commission
NGO	:	Non-Governmental Organisation
P2TP2A -	:	Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak / Centre for Integrated Services on Women and Children Empowerment
PMTCT	:	Prevention of Mother to Child Transmission
RiH	:	ResultsinHealth
SOP	:	Standard Operating Procedures
STI	:	Sexually Transmitted Infection
VAW	:	Violence Against Women
VCT	:	Voluntary Counselling and Testing
WLHIV	:	Women Living with HIV

Colophon

"One Stop Service" – Integrated Services for Violence Against Women Survivors and Women Living with HIV. The Integration of Separate Services: Results, Changes and Personal Experiences from a 2-year Pilot Project in Indonesia.

Author:
Marije Veenstra, ResultsinHealth

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For more information please contact:
Indonesia Positive Women Network (IPPI)
Jl. Kakap III No. 13A
Kelurahan Jati – Rawamangun, Jakarta Timur
Indonesia
E-mail: ippi.indonesia@yahoo.com
website: www.ippi.or.id

This publication presents some of the main results of the "One Stop Service – Integrated Services for Violence Against Women Survivors and Women Living with HIV". Its main goal is to offer evidence-based illustrations of these results and the context in which the project was implemented, presenting personal perceptions and experiences of the people who were – directly or indirectly – affected by the project.

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Results inHealth
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