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ADDRESSING GENDER-BASED VIOLENCE THROUGH USAID'S HEALTH PROGRAMS

A GUIDE FOR HEALTH SECTOR PROGRAM OFFICERS

SECOND EDITION, SEPTEMBER 2008

Suggested citation: IGWG of USAID. 2008. *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers*. Second Edition. Washington, D.C.

This document was prepared with POLICY Project funds from the U.S. Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00 for the Interagency Gender Working Group (IGWG). The project was implemented by Futures Group International in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI). Funds for printing were made available by Task Order 1 of the USAID | Health Policy Initiative, funded under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. TO1 is implemented by Futures Group International, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Religions for Peace.

Cover photo from *broken bodies, broken dreams: violence against women exposed*, IRIN/OCHA, 2005. Georgina Cranston, photographer. To order the book, contact: brokenbodies@irinnews.org

IGWG

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Acknowledgments

The Interagency Gender Working Group (IGWG) would like to thank **Alessandra Guedes** and **Sarah Bott**, whose work provided the foundation for these guidelines. We thank them for their technical insight and unrelenting commitment to seeing this document through to its fruition.

The IGWG also thanks the following colleagues who kindly reviewed sections of this document at various stages of its development: Amy Bank, Gary Barker, Deborah Caro, Mary Ellsberg, Stacey Gage, Claudia Garcia-Moreno, Rachel Jewkes, Julia Kim, Mary Kincaid, Sunita Kishor, Lori Michau, Margarita Quintanilla, Marcos Nascimento, Sonia Navani, Julie Pulerwitz, Esca Scheepers, Beth Vann, Jeanne Ward, and Ellen Weiss.

In addition, we would like to thank the following USAID reviewers for their comments and assistance in developing these guidelines: Vathani Amirthanayagam, Michal Avni, Sarah Harbison, Kent Hill, Virginia Lampert, Ann Lion, Trish MacDonald, Mahua Mandal, Rose McCullough, Margaret Neuse, Diana Prieto, Lois Schaefer, Jim Shelton, Mary Ellen Stanton, Ellen Starbird, and Gloria Steele.

Thanks are also due to the following consultation meeting participants:

Trish Ahern
Sharon Arscott-Mills
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PART I

SETTING THE CONTEXT

Preface

The present guide is intended to help USAID program officers integrate gender-based violence (GBV) activities into their health sector portfolio during project design, implementation, and evaluation. The guide focuses on what the health sector can do, keeping in mind that preventing and responding to gender-based violence requires a multisectoral approach. For each type of health program—from community mobilization to health policy—the guide explores reasons why these programs should address gender-based violence and how to support GBV activities based on what is known about promising approaches from literature reviews, (e.g. Heise et al., 1999; Guedes, 2004; Bott et al., 2005), the opinions of leading experts, and feedback from USAID and cooperating agency staff.

Because this document focuses on specific design and implementation guidance, it does not contain in-depth programmatic examples. For more detailed information about interventions and country-specific examples, please refer to the resources listed in Part III—in particular, the 2004 literature review by Guedes titled "Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis." The literature review can be accessed at http://www.prb.org/pdf04/AddressGendrBasedViolence.pdf.

Gender-based Violence

DEFINITION, PREVALENCE, AND RISK FACTORS

Research demonstrates that gender-based violence has implications for almost every aspect of health policy and programming, from primary care to reproductive health programs (Heise et al., 1999; Guedes, 2004). Not only do women experience substantial morbidity and mortality as a result of physical and sexual violence, but violence exacerbates other health conditions, including HIV transmission. Increasingly, donors have been addressing violence against women in their health policy and programming portfolios. Indeed, a recent strategic assessment of USAID's global health work revealed that USAID already invests substantial resources in preventing and responding to gender-based violence as a public health issue—albeit in a decentralized way (Bott and Betron, 2005). Furthermore, the President's Emergency Plan for AIDS Relief supports reducing violence and coercion as one of its five high-priority gender strategies.

What is "gender-based" violence?

Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm… It includes that violence which is perpetuated or condoned by the state. [United National Population Fund (UNFPA) Gender Theme Group]

Forms of gender-based violence include: physical, sexual, and psychological/emotional violence within the family; child sexual abuse; dowry-related violence; rape and sexual abuse; marital rape; sexual harassment in the workplace and educational institutions; forced prostitution; trafficking of girls and women; and female genital cutting. However, to limit the scope of this document, the guidelines that follow focus on two common forms of gender-based violence: intimate partner violence (physical, sexual, and emotional) and sexual violence by any perpetrator. For additional information on trafficking and female genital cutting, please refer to USAID's official guidance on these two topics.

Guidelines on female genital cutting can be found at: http://www.usaid.gov/our_work/global_health/pop/techareas/fgc/index.html.
Guidance on trafficking can be found at: http://www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/pd-abx-358-final.pdf.

Although men can also be victims of intimate partner and sexual violence, this type of violence affects women disproportionately. For instance, both males and females report sexual coercion, but the majority of victims are female (CDC, 2003), and the vast majority of perpetrators are male (Heise et al., 1995). In terms of murders committed by an intimate partner of the opposite sex, the World Report on Violence and Health (Krug et al., 2002) shows that between 40 percent and 70 percent of all women who are murdered are killed by a (male) intimate partner. In contrast, between 4 percent and 8.6 percent of men who are murdered are killed by a (female) intimate partner. Moreover, a sizeable proportion of these homicides may have been committed by women in self-defense, either in response to an attack or in a situation of long-term, chronic abuse by her partner. In summary, while men are much more likely to be attacked by a stranger or an acquaintance, women are much more likely to be attacked by someone close to them, such as a husband or male partner.

Why "gender-based" violence?

Violence against women cannot be understood in isolation from the gender norms, beliefs, and social structures that influence women's vulnerability to violence. For example, women are more likely than men to be sexually or physically assaulted or killed by someone they know—often by their own husband/

partner. Women's subordinate social, economic, and legal status in different settings often makes it difficult for them to get help once violence occurs. Because violence against women is rooted in gender inequality (Jewkes, 2002), "gender-based violence" has become an internationally accepted way to refer to physical, sexual, and psychological violence against women. However, gender-based violence can also include violence directed toward men and boys who may be perceived as acting outside of gender norms that dictate rigid ideas of masculinity (Barker and Ricardo, 2005; Betron and Gonzalez, forthcoming). While data on gender-based violence related to men and boys does exist, it is limited. Furthermore, there are gaps in resources, knowledge of programming responses, and recommendations focusing on men's and boys' vulnerabilities to GBV. This guide focuses specifically on gender-based violence as related to women and girls because they are disproportionately more affected by GBV (as noted above), there are more data available, and there is consensus on programmatic recommendations to address GBV against women and girls.

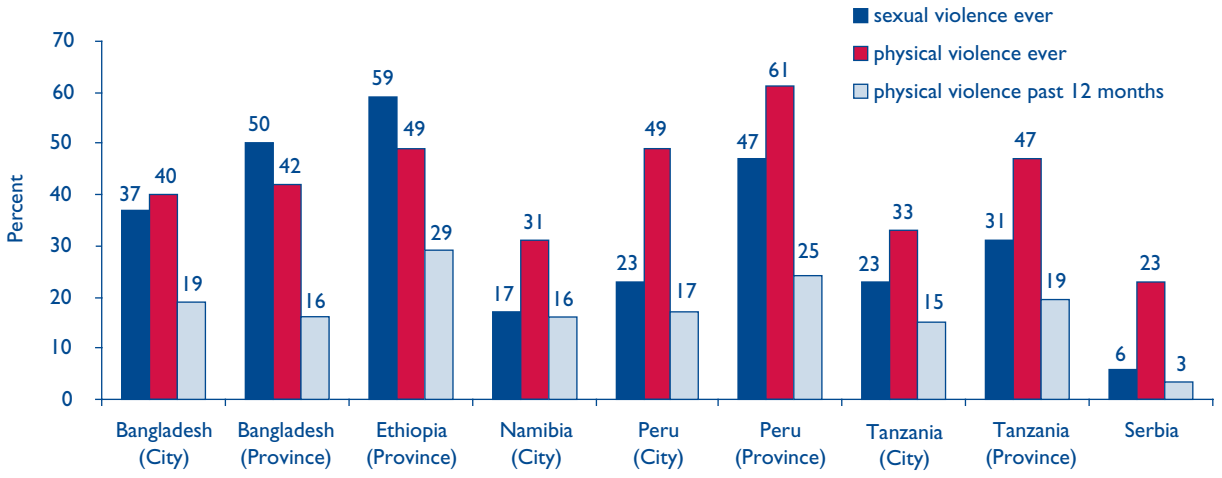
How common is it?

Comparative data on the prevalence of gender-based violence are difficult to collect, as prevalence estimates vary depending on how researchers define gender-based violence, the questions they ask, the timeframes they explore, and the sample characteristics (Bott et

Table 1. Prevalence Estimates of Different Forms of Gender-based Violence

Physical violence	10 percent to over 69 percent of women around the world report being hit or physically harmed by an intimate partner at some point in their lives (WHO, 2002).
Sexual violence	Nearly one in four women report sexual violence by an intimate partner in their lifetime (Ellsberg et al., 2000; Mooney, 1993; Hakimi et al., 2001).
Forced sexual initiation	Rates of "forced" sexual debut range from 7 percent in New Zealand to 46 percent in the Caribbean (Heise and Garcia Moreno, 2002).

Figure 1. Percentage of Women Reporting Gender-based Violence, by Type of Violence



Source: WHO multi-country study, Garcia-Moreno et al., 2005.

Note: Physical violence was defined as: slapped; had something thrown at her that could hurt her; pushed or shoved; hit with a fist or something else that could hurt; kicked, dragged, or beaten; choked or burnt on purpose; threatened with or experienced use of a gun, knife, or other weapon. Sexual violence was defined as: physically forced to have sexual intercourse when she did not want to; had sexual intercourse because she was afraid of what her partner might do; was forced to do something sexual that she found degrading or humiliating (Garcia-Moreno et al., 2005).

al., 2005). Furthermore, most surveys are believed to underestimate prevalence, as survivors may not report gender-based violence because of fear, shame, and lack of adequate services—among other reasons. Nonetheless, a multi-country study on the prevalence of gender-based violence conducted by the World Health Organization (WHO) confirms its widespread nature. In virtually all settings where researchers have collected population-based data, surveys have found that gender-based violence affects significant proportions of girls and women across all groups and classes (see Table 1 and Figure 1).

Data on prevalence of violence against women are also collected in several developing countries by the USAID-funded Demographic and Health Surveys (DHS). DHS data on violence have several distinct programmatic and policy advantages: they are nationally representative, fairly standardized across countries, and are an inherent part of a package of data available for each individual, including data on background and demographic, nutritional, and health characteristics. The DHS violence data thus provide insight into both the risk factors for violence and the demographic and health correlates of violence. In spite of these advantages, it should be noted that small in-depth studies solely dedicated to measurement of GBV may be more likely to yield more accurate prevalence estimates of violence (Ellsberg et al., 2001). (A comparison of the results of three population-based studies on violence against women in Nicaragua found that small studies that focus on violence tend to result in higher prevalence rates.) Table 2 lists prevalence rates for countries where DHS data are currently available. Other countries for which new and updated violence data will soon be available include Bangladesh, the Democratic Republic of Congo, Ghana, Jordan, Liberia, Mali, Turkmenistan, Ukraine, and Zambia.

Examples of factors associated with high levels of violence against women at the community level

- Traditional gender norms that support male superiority and entitlement
- Gender norms that tolerate or even justify violence against women
- Weak community sanctions against perpetrators
- Poverty
- High levels of crime and conflict in society more generally

What are risk factors for perpetrating and experiencing gender-based violence?

To understand why physical and sexual violence against women is more common or severe in some settings, researchers have identified ***community and societal-level risk factors*** that appear to be associated with higher rates of gender-based violence. This body of research is incomplete and tentative, but the World Health Organization (Krug et al., 2002) highlights a number of factors supported by evidence.

Evidence suggests that rates of GBV are highest in settings where social norms support gender inequality, where communities fail to punish men who use physical or sexual violence against women, and where violence against women is considered normal or justified (e.g., see Counts, Brown, and Campbell). Even when a society does not openly support male violence against women, social norms may isolate women from seeking help, for example by reinforcing the idea that family violence is a private matter in which outsiders should not intervene, or that sexual violence

Examples of individual factors associated with a higher risk of becoming a perpetrator	Examples of individual factors associated with a higher risk of experiencing GBV
• Alcohol or drug use • Low income or academic achievement • Witnessing/experiencing violence as a child • Attitudes that justify violence against women	• Consumption of alcohol or drugs • Previous history of abuse • Becoming empowered through education or economic advancement, in traditional settings • Poverty (especially for sexual violence)

Table 2. Percentages of Ever-married or Ever-partnered Women Ages 15–49 Who Have Experienced Physical or Sexual Violence by any Husband/Partner Ever and in the 12 Months Preceding the Survey by Country

Source: Various Demographic and Health Surveys, 1998–2007

Country	Ever-married/partnered women	
	Percentage who have ever experienced violence by a spouse/partner	Percentage who have experienced violence by a spouse/partner in the past 12 months
Azerbaijan 2006	13.5 *(n=3,847)*[2]	10.2 *(n=3,691)*[3]
Bolivia 2003	53.3 *(n=12,005)*	na
Cambodia 2005	13.7 *(n=2,037)*	8.7 *(n=2,037)*
Cameroon 2004	43.4 *(n=2,160)*	28.0 *(n=2,160)*
Colombia 2005[1]	39.0 *(n=25,279)*	na
Dominican Republic 2007	17.2 *(n=7,719)*	11.7 *(n=7,719)*
Egypt 2005	33.7 *(n=5,613)*	21.7 *(n=5,613)*
Haiti 2005	20.0 *(n=2,420)*	16.8 *(n=2,420)*
India 2005–2006	37.2 *(n=66,658)*[2]	23.9 *(n=63,966)*[3]
Kenya 2003	42.9 *(n=3,856)*	28.2 *(n=3,856)*
Malawi 2004	*28.4* *(n=8,054)*	*18.5* *(n=8,054)*
Moldova 2005	*24.3* *(n=4,209)*	*14.6* *(n=4,209)*
Nicaragua 1998	30.2 *(n=8,507)*	13.2 *(n=8,507)*
Peru 2004	42.3 *(n=2,861)*	14.5 (n=2,861)
Rwanda 2005	*33.8* *(n=2,338)*	25.6 (n=2,338)
Uganda 2006	*59.1* *(n=1,598)*[2]	45.0 (n=1,518)[3]
Zambia 2001–2002	48.4 *(n=3,792)*	26.5 *(n=3,792)*
Zimbabwe 2005–2006	*38.2* *(n=4,658)*[2]	*30.5* *(n=4,188)*[3]

na: Not available.
[1] Does not ask about sexual violence explicitly.
[2] Includes widows.
[3] Excludes widows.

References for DHS data on violence: DHS national country reports; the website www.measuredhs.com; and Kishor, Sunita and Kiersten Johnson, 2004. "Profiling Domestic Violence—A Multi-country Study." Calverton, Maryland: ORC Macro.

is shameful for the victim. One important finding from numerous studies is that violence against women may actually increase in communities when women begin to break from traditional gender norms through educational or economic empowerment—at least until they attain a high enough status to be protected from backlash against these changes (Krug et al., 2002).

There is strong evidence that crime levels and conflict in society more generally are not only correlated but causally linked with higher levels of violence against women. For example, physical and sexual violence against women tends to increase during or after armed conflicts (Human Rights Watch, 2004; IRC, 2004). Violence against women also tends to rise following natural disasters—perhaps due to the erosion of legal and social structures that would normally act as protective factors (Enarson, 1998).

A substantial body of research has explored ***individual-level risk factors*** associated with an increased likelihood that a man will become a perpetrator or that a girl or woman may experience physical or sexual abuse. For example, studies have repeatedly shown that boys who witness or experience violence as children are at heightened risk of using violence against women as adults—one of many findings that support the idea that violence against women is a learned behavior. The World Health Organization cites other individual risk factors associated with perpetration or vulnerability to violence.

It is essential to note, however, that risk factors that are **associated** or **correlated** with a higher risk of perpetration or victimization have not always been shown to have a **causal link.** For example, alcohol use is widely associated with perpetrating and experiencing violence, but perpetrators sometimes use alcohol to prepare themselves to commit premeditated acts of violence, and victims of violence may use alcohol to self-medicate emotional sequelae of abuse (Jewkes, 2002). In these examples, the violence (or intention to commit violence) may come before the alcohol use, clouding the issue of which is the cause and which is the result. Other contested individual risk factors include poverty, experiences of transactional sex, economic stress, and so forth. Unfortunately, most studies in this area have been cross-sectional surveys that can neither determine whether the risk factor preceded the violence nor provide qualitative insights into complex social dynamics. Causal relationships between risk factors and violence should not be assumed without an in-depth understanding of how they influence men's propensity to use violence against women.

From a public health perspective, *community-level risk factors* may be the most helpful for identifying promising ways to reduce violence against women. Focusing too much on individual risk factors may obscure the fact that violence against women tends to occur throughout society and across all demographic and socioeconomic groups and appears to be heavily influenced by community norms and responses.

The Links between Gender-based Violence and Sexual and Reproductive Health and HIV/AIDS

Gender-based violence can result in many negative consequences for women's health and well-being. The consequences of gender-based violence can be fatal, such as homicide, suicide, and AIDS-related deaths; or non-fatal, such as chronic pain syndromes, traumatic injury, or traumatic gynecologic fistula. The effect of gender-based violence on women's sexual and reproductive health are well documented and may occur through direct pathways, such as when women are forced to have sex, as well as through indirect pathways, such as childhood sexual abuse that sometimes leads to greater sexual risk-taking during adolescence and adulthood. By addressing gender-based violence, health programs may be able to enhance their effectiveness, may enable women who have experienced violence to benefit from existing programs, and may prevent the escalation of such violence.

There is a dearth of research exploring links between gender-based violence and infectious diseases, apart from sexually transmitted infections such as HIV. Nonetheless, given what is known about the link between HIV and diseases such as tuberculosis, it is possible that such relationships may exist. Further research in this area is warranted.

Table 3. Documented Impact of Gender-based Violence on Sexual and Reproductive Health Outcomes, according to USAID Global Health Program Elements

USAID Global Health Program Elements	Key area	How gender-based violence relates to the achievement of USAID's program elements
USAID Family Planning/ Reproductive Health Element – Advance and support voluntary family planning and reproductive health programs worldwide	Reduced unintended pregnancy	Women *who have experienced intimate partner violence and/or sexual abuse* are more likely to • Use family planning clandestinely; • Have their partner stop them from using family planning; • Have a partner refuse to use a condom (Garcia-Moreno, 2002); • Experience a higher rate of unintended pregnancies (Gazmararian et al., 1995; Morrison and Orlando, 2004); • Experience a higher incidence of unsafe abortion (Campbell, 2002); and • Become pregnant in adolescence (Heise et al., 1999).
USAID Maternal and Child Health Element – Increased use of key maternal health and nutrition interventions – Increased use of key child health and nutrition interventions	Reduced maternal mortality Improved child survival	• Physical abuse occurs in approximately 4 percent to 15 percent of pregnancies (Campbell, 2002; Jewkes et al., 2001; Muhajarine, 1999). • Abuse during pregnancy poses direct risks to mother and child through physical trauma and increased chronic illnesses, and indirect risks, including depression, substance abuse, smoking, anemia, first and second semester bleeding, delay in seeking prenatal care, and poor maternal weight gain (Campbell et al., 2004; Amaro et al., 1990; Campbell et al., 1992; Goodwin et al., 2000; McFarlane et al., 1996; Heise et al., 1999). • Women who have experienced physical intimate partner violence are more likely to have complications during delivery (Morrison and Orlando, 2004). • Intimate partner violence may be more common among pregnant women than pre-eclampsia or gestational diabetes—conditions routinely screened for in prenatal care (Gazmararian et al., 1996; Campbell et al., 2004). • Abuse during pregnancy has been linked to a significant, albeit small, reduction in birth weight (Murphy et al., 2001). • Children of abused women may be more likely to die before the age of five (Asling-Monemi et al., 2003). • Children of abused women indicate higher rates of malnutrition, as evidenced through higher rates of diarrhea, anemia, and lower height for age (Morrison and Orlando, 2004).

Table 3. Documented Impact of Gender-based Violence on Sexual and Reproductive Health Outcomes, according to USAID Global Health Program Elements

USAID Global Health Program Elements	Key area	How gender-based violence relates to the achievement of USAID's program elements
USAID HIV/AIDS Element – Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS epidemic	Reduced STIs/HIV	• Rape can result in HIV transmission. Not only is most sexual violence unprotected, but vaginal lacerations and trauma increase the risk of transmitting the virus (Jansen et al., 2002). • Victims of gender-based violence are more likely to engage in risk behaviors, such as injection drug use, which may increase their risk of exposure to HIV (Abdool, 2001; Choi et al., 1998; Gilbert et al., 2002; Heise et al., 1999; Wyatt et al., 2002). • Intimate partner violence has been shown to be a risk factor for STIs, which, in turn, may increase the rate of HIV transmission (Bogart et al., 2005; Fonck et al., 2005; Lichtenstein, 2005; Thompson et al., 2002). • Victims of gender-based violence are often unable to negotiate the use of a condom (Campbell and Soeken, 1999; Davila, 2002; Davila and Brakley, 1999; Wingood and Clemente, 1997). • Proposing the use of a condom may increase women's risk of violence (Gielen et al., 2000; Heise et al., 1999). • Violence or fear of violence may keep women from HIV testing and violence may occur as a consequence of testing (Gielen et al., 2000; Heise et al., 1999; Maman et al., 2001; Maman et al., 2002; Zierler et al., 2000). • Gender-based violence affects HIV-positive women's ability to live positively[1] and access care, treatment, and support (Gruskin et al., 2002; Lichtenstein, 2006; Liebschutz et al., 2005; Sowell et al., 1999; Stevens and Richards, 1998). • Alcohol abuse by both men and women is associated with women's increased risk of experiencing gender-based violence, as well as HIV infection (Ashley et al., 2006; Dunkle et al., 2004; Mackenzie et al., 2007; McDonnell et al., 2003; Morris et al., 2006; Phorano et al., 2005).

[1]To "live positively" refers to the ability of HIV-positive individuals to maintain and promote their own physical, psychological, and emotional health, along with promoting the health and well-being of others.

Guiding Principles in GBV Programming

As is the case for family planning, maternal health, and HIV services, work in the area of gender-based violence requires careful attention to confidentiality, privacy, informed consent, and issues of disclosure. Given the potential risks to survivors, existing data on "good practice" in this field suggests that organizations should follow some basic principles when designing and implementing GBV activities. Overall, the principle of "doing no harm" should guide every decision made. More specific principles include:

Ensure that all activities respect survivors' safety and autonomy first and foremost

- Encourage programs and health providers to address GBV with clients only after taking the necessary steps (sensitization, ongoing training, monitoring) to guarantee providers' appropriate attitudes and actions and clients' privacy and confidentiality.
- Encourage programs and providers to inform women of their options and to allow them to make their own decisions without undue influence from providers.
- If health organizations are not equipped to address gender-based violence directly during medical consultations (e.g., for lack of private space), they should find other ways to assist clients experiencing abuse, for example, by promoting and providing information on referral services for victims of violence in waiting rooms or bathrooms.
- Whenever possible, involve women and communities in the design, implementation, and evaluation of interventions.

Ensure the relevance and appropriateness of interventions to the local setting

- Conduct a situational analysis before designing any interventions.
- Ensure the cultural appropriateness of interventions, particularly when adapting activities originally implemented in other settings.
- Support the collection and dissemination of local data for the purposes of sensitization and advocacy (using WHO's ethical guidelines, WHO, 2001).

Employ both a public health and a human rights perspective

- Use existing data to highlight the magnitude and the health effects of gender-based violence.
- Do not allow "culture" or "tradition" to be used to justify gender-based violence; reframe the issue as a public health problem and a human rights violation.
- Challenge norms that view intimate partner violence as acceptable (such as men's right to 'discipline their wives') or as a private matter.
- Promote the idea that human rights are inalienable and indivisible; women should have the right to live free of gender-based violence under all circumstances.
- Empower communities to challenge norms that condone gender-based violence.

Encourage multisectoral interventions at multiple levels

- Carry out situational analyses to identify local organizations active in the area of gender-based violence and to decide strategically on a course of action.
- Work collaboratively with organizations from various sectors (police, judiciary, social support, etc.) and with programs focusing on other areas, such as those tackling teenage pregnancy, substance abuse, etc.
- Support activities at both local and national levels.

Invest in evaluation both for the sake of assessing results and for protecting survivors' safety

- Ensure that programs are based on lessons learned from the field about best practices (refer to Bott et al., 2005 and Guedes, 2004 for detailed information on promising GBV initiatives).

- Monitor and evaluate GBV activities as rigorously as possible.
- Involve women and other program beneficiaries in the evaluation process whenever feasible.
- Document and disseminate lessons learned as widely as possible.

PART II

RATIONALE AND ACTIONS

NOTE:

The following section addresses "why" and "how" different approaches (community mobilization, health services, etc.) might address gender-based violence. It is based on currently available information regarding promising interventions in the field. Although specific programs are not discussed in detail in this document, additional information on promising interventions can be found in the USAID-commissioned literature review, titled "Addressing GBV from the Reproductive Health / HIV Sector: A Literature Review and Analysis" (Guedes, 2004) http://www.prb.org/pdf04/AddressGendrBasedViolence.pdf.

While health service delivery programs have a key role to play in responding to GBV and mitigating its effects, other approaches—such as community mobilization and communication for social and behavior change—may be better suited to preventing violence against women in the first place and reducing overall levels of GBV in the longrun. With this rationale in mind, **the sequence in which topics are presented is intended to draw attention to the strategies that show the most promise in the area of prevention.**

Community Mobilization Programs

Reasons WHY community mobilization programs should address gender-based violence

Studies suggest that norms about gender and the acceptability of violence greatly influence the prevalence of gender-based violence. For example, in various countries, DHS data show that men and women believe that husbands are justified in beating their wives if they disobey them and/or refuse sex (Kishor and Johnson, 2004). Even in settings without such open support for violence against women, society often blames and stigmatizes women—rather than male perpetrators—for physical and sexual violence. Community mobilization strategies offer promising ways to prevent GBV by changing community norms about gender and the acceptability of violence.

Community mobilization strategies also offer an important way to improve the community response to gender-based violence once it occurs. First, in many countries, violence within the family is considered a private affair in which outsiders should not intervene. These norms prevent service providers from offering appropriate assistance to survivors; they also prevent women from seeking help from family, friends, and other community members. A second reason why community mobilization is essential for improving the response to violence is that service-providing organizations need to collaborate with one another and with the broader community to ensure that referral networks are in place and that women can access a range of services of adequate quality, such as emergency shelter, medical care, counseling, police protection, and economic assistance among other services.

Selected reasons why community mobilization programs should address gender-based violence

- GBV prevention depends on changing community norms about gender equality and the acceptability of violence against women; interventions targeted at individuals are not enough.
- Community mobilization programs can change violence-related attitudes and behaviors and promote more equitable relationships between men and women.
- GBV prevention requires that society hold perpetrators accountable rather than blame the victim.
- Ensuring a comprehensive service response often requires mobilizing coalitions and referral networks of service providers in the community to work together.
- Changing norms is essential for helping survivors get help from families and community services.
- Community mobilization programs have the potential to improve women's economic empowerment—another long-term strategy for preventing gender-based violence.

HOW community mobilization programs can address gender-based violence

1) **Support activities that integrate community mobilization around GBV into existing health and development programs.** Because women's vulnerability to violence is often tied to their broader social, economic, and political status, programs that work on women's health and empowerment have the potential to contribute to the prevention of gender-based violence, or at least to improving the community response to GBV. A growing body of evidence suggests that HIV programs should explicitly take gender-based violence into account as a way to address both issues (see for instance Dunkle et al., 2004; Garcia-Moreno and Watts, 2000; Maman et al., 2000), and there are opportunities to incorporate gender-based violence interventions within maternal health and other reproductive health programs.

2) **Support programs that seek to reduce tolerance for GBV at the community level by working with boys and men.** Evidence suggests that one of the most promising ways to reduce communities' tolerance

for gender-based violence is to promote nonviolence and gender-equitable norms among boys and men. Promising initiatives in this area (such as Men as Partners, Raising Voices, and Stepping Stones, all profiled in Guedes, 2004) point to several lessons learned (for an assessment of programs, see Barker, Ricardo, and Nascimento, 2007). For example, changing norms may be easier among boys and young men when norms are not as deeply set. Second, programs appear to have more success when they emphasize positive benefits of gender equity rather than relying solely on shame and other negative messages. Some small-scale community mobilization programs have reported success at changing the behavior of violent men through social sanctions from the community. For example, the Stepping Stones program in the Gambia (Shaw and Jawo, 2000) and ReproSalud in Peru (Rogow and Bruce, 2000), found qualitative evidence that their programs had reduced intimate partner violence in select communities. However, these programs achieved these results—not through negative messages alone—but by carefully working to build support among men for nonviolence and by creating opportunities for community-wide dialogue among women and men about their concerns.

3) **Support programs that mobilize a broad cross-section of the community at the grassroots level.** Community mobilization programs are more likely to be effective when they reach out to all parts of the community (women, men, youth, and children), as well as different community organizations (village health councils, religious and traditional leaders, sports groups, police, schools, NGOs, faith-based organizations, etc.). Rather than imposing solutions from the outside, programs can work with communities to understand the patterns and consequences of violence against women and develop their own strategies for preventing and responding to GBV.

4) **Support efforts to mobilize partnerships among community leaders, government officials, and NGOs to address GBV at the community level.** Program experiences from diverse settings highlight the importance of enlisting local leaders (both formal and nonformal) in the effort to develop community-wide strategies for addressing GBV. Collaboration between civil society and local governments can be essential for both improving the community response to violence and helping to reduce levels of violence in the long run (Michau and Naker, 2004). In some settings, (e.g., Costa Rica, South Africa, Uganda), programs have produced promising results by building formal or informal networks, coalitions, and task forces at the local or national levels (e.g., Bott et al., 2005). Such networks can produce or advocate for legislative and policy reform, increase public and private investment in GBV programming, develop referral networks, build support for institutional reforms, ensure a more comprehensive service response to survivors, and facilitate awareness-raising among the broader community.

5) **Support community mobilization efforts to improve survivors' access to services.** Community-based programs can facilitate women's access to services by first mobilizing community organizations to provide a better response to gender-based violence (e.g., such as shelters, counseling, medical care, police protection, economic assistance, or other types of social services), and second, raising awareness among the community about the services that exist for survivors of violence. Large-scale campaigns to encourage women to seek help should not be launched before ensuring adequate community resources for survivors of GBV, lest women be stigmatized and blamed rather than supported. Steps for improving the community response may include:

- Create a supportive community environment where women feel safe seeking help;
- Identify existing community resources, including gaps;
- Improve the capacity of existing institutions—informal and formal (including NGOs)—to respond to women who experience violence;
- Strengthen partnerships among organizations; and
- Disseminate information about existing services through community groups, advertising campaigns, and referral mechanisms (including hotlines where the infrastructure permits).

6) **Provide long-term financial support to give community mobilization activities enough time to produce change and document results.** Mobilizing the community to reduce violence against women requires a long-term commitment to changing deeply held beliefs and behaviors. Donors need to commit enough funds over several years to achieve meaningful change

in a community. Community mobilization programs also need time to evaluate their progress and document evidence about what does and does not work. Estimating an appropriate timeframe for such programs is challenging given that many factors influence the time needed to produce sustainable change, including geographic size of the program area, population size, number of staff, their level of capacity to implement the program, level of resistance in the community, whether there is adequate and uninterrupted funding, willingness of local institutions and community members to collaborate, strength of governmental and NGO leadership, and so forth. Keeping in mind these variables, however, Lori Michau, the coordinator of Raising Voices (an NGO with extensive experience in this area), estimates that two years would be the absolute bare minimum duration for a community mobilization program, and three to four years would be a more reasonable timeframe (personal communication).

Promising initiatives: Raising Voices

The Domestic Violence Prevention Project was established in 2000 as a partnership among Raising Voices, the National Association of Women's Organizations in Uganda (NAWOU), and ActionAid for the purpose of field testing the approach set forth by "Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa." Due to the success of the project, it became an independent entity in 2003 in partnership with Raising Voices and changed its name to Center for Domestic Violence Prevention (CEDOVIP).

This community-based initiative is aimed at preventing domestic violence by working closely and over an extended period of time with a cross-section of community members and leaders to change attitudes and behaviors that perpetuate violence against women. The program is grounded in a human rights framework. Not only is it based on the belief of the right of women to live free of violence, but it also focuses on the collective responsibility to uphold and respect this right.

The process of community mobilization proposed by the project follows five phases:

- Phase 1: *Community Assessment* to gather baseline information on attitudes and beliefs about domestic violence. More than 400 community members participated in interviews, focus group discussions, and questionnaires during this phase.
- Phase 2: *Raising Awareness* of domestic violence and its negative consequences with the community-at-large and among key professional sectors, such as health services, law enforcement agents, etc.
- Phase 3: *Building Networks* of support, action, and strength to empower individuals to take action and make change.
- Phase 4: *Integrating Action* against domestic violence into daily life and systematically within institutions.
- Phase 5: *Consolidating Efforts* to ensure their sustainability, continued growth, and progress.

Source: Guedes, 2004.

In Summary...

Community Mobilization Programs SHOULD	Community Mobilization Programs SHOULD NOT
Encourage the participation of all sectors of the community in the effort to understand GBV, design solutions, and implement and evaluate programs.	Impose solutions or norms from the outside without adequate community participation and input.
Mobilize existing structures (local councils, women's groups, mother's unions, traditional courts, leadership committees, etc.) and organizations in the community to collaborate on providing a comprehensive response to survivors.	Launch campaigns to encourage women to seek assistance before community resources are in place to ensure an adequate response to survivors.
Engage men as allies in the effort to promote the benefits of more equitable gender relationships for the whole community and promote positive male models.	Underestimate the importance, the challenge, and the time needed to change men's beliefs about gender norms and nonviolence.
Encourage communities to hold perpetrators accountable and to challenge norms that tolerate violence against women as an acceptable practice.	Use strategies that rely solely on shame, rather than on positive messages about gender equity and healthy relationships.
Integrate community mobilization strategies against GBV into existing health and development projects, such as reproductive health and HIV projects.	Underestimate the challenges of forming effective partnerships with organizations working on different but related issues.
Consider the need to adapt community-based strategies that are being imported from other settings.	Overlook socio-cultural norms, religious customs, and local practices.
Employ multiple strategies to change community norms, including local media and advocacy, local activism, training, and communication materials.	Focus on a single strategy that will only reach a limited segment of the community.
Make long-term investments in promising activities that aim to change community norms.	Expect immediate change in norms and attitudes about gender and violence.

Communication for Social and Behavior Change Programs

Reasons WHY Communication for Social and Behavior Change (CSBC) programs should address gender-based violence

"Communication for Social and Behavior Change" (CSBC) encompasses a range of mass media as well as interpersonal communication strategies such as radio, television, community theatre, workshops, magazines, awareness campaigns, posters, flyers, and pamphlets. Many health programs have successfully used CSBC to address other public health issues, and the women's movement has a long history of using communication strategies to address gender-based violence (see Drezin, 2001 and Drezin and Lloyd-Laney, 2003). Moreover, because GBV is closely linked to other health issues, evidence suggests that many existing health communication campaigns could be more effective if they integrated attention to GBV into their work, especially those working in the area of prevention of unintended pregnancies and HIV transmission. Finally, communications work is also an important part of other strategies used to address GBV, including advocacy with decisionmakers, sensitization and training of providers, and community mobilization strategies.

HOW Communication for Social and Behavior Change programs can address GBV

1) **Support activities that aim to reduce the acceptability of violence and that promote a model of gender-equitable norms and behaviors.** The first step in reducing levels of gender-based violence is to change norms and attitudes that encourage or tolerate gender-based violence in the first place. Communication strategies can contribute to changing norms and attitudes on at least three levels:

- At the ***individual level,*** CSBC can provide information, increase awareness, and shift attitudes. CSBC may also influence behaviors including violence by perpetrators (for instance, by promoting nonviolent men as positive role models); help-seeking by survivors; and the compassionate response of family, friends, and service providers.
- At the ***community level,*** CSBC can influence the social and political environment, generate dialogue and debate, and influence public policy initiatives.
- At the ***societal or national level,*** CSBC can influence the public discourse and the policy environment nationally and internationally.

2) **Support efforts to integrate the issue of GBV into existing CSBC programs.** Many programs already using CSBC strategies to address issues linked to gender-based violence, including HIV and family planning, can incorporate messages and components on gender-based violence into the program's overall activities. Communication programs can also design campaigns primarily focused on gender-based violence, such as on sexual coercion among young people, intimate partner violence, or rape.

Selected reasons why CSBC programs should address gender-based violence

- Raising awareness and changing attitudes, cultural and social norms, and behaviors are essential for preventing and responding to gender-based violence.
- CSBC programs can contribute to improving the community response to GBV and to developing support systems to facilitate survivors' access to assistance.
- CSBC programs could be made more effective by recognizing that many health focus areas—such as HIV or family planning—are linked to GBV and thus should be addressed simultaneously.
- CSBC strategies complement other GBV prevention and response activities by changing the social environment and raising women's awareness of services.

3) **Support efforts to link communication activities with other types of GBV activities.** Partnerships between CSBC efforts and other types of programs are essential. For example, they can help audiences to find services in the community and build support for policy changes. To this end, it is important for CSBC programs to establish relationships with other organizations in the community or country; and to consider carrying out joint activities such as campaigns that publicize services or distribute educational materials through clinics, schools, and other venues.

4) **Support activities that seek to improve norms and attitudes among boys and men.** Eliminating gender-based violence in the long run will only be achieved by promoting nonviolent and more gender-equitable norms among boys and men. CSBC activities can contribute to this end by a) challenging prevailing beliefs and norms that contribute to the acceptability and perpetuation of gender-based violence, and b) influencing boys' and men's awareness, attitudes and behaviors, including by using mass media to promote gender-equitable and nonviolent men as positive role models. Within this context, it may be important to collaborate with tribal and traditional leaders, as well as with faith-based organizations.

5) **Support activities that use multiple media channels to address wide audiences, including young people and men.** The experiences of several promising CSBC activities point to the importance of using multiple media formats—such as prime-time television drama, radio drama, print—to capitalize on each medium's strength and to reach a variety of audiences. They also highlight the potential of 'edutainment' (see box below) to influence social norms among young people before attitudes about gender and violence become as deeply set as those among adults.

6) **Support investment in rigorous evaluation studies of CSBC activities.** Although rigorous evaluation is important for all types of gender-based violence programs, CSBC activities offer a particular challenge because of the difficulty involved in measuring long-term social change. Hence, it is important to support well-designed, longer-term evaluations that can advance the field by identifying which communication strategies work best in addressing different types of gender-based violence, as well as by measuring possible unintended consequences. (Please refer to section G on monitoring and evaluation for further information on evaluation of CSBC activities).

Promising initiatives: "Edutainment"

"Puntos de Encuentro" in Nicaragua and **"Soul City"** in South Africa are two of the best known examples of using "edutainment" to address GBV—a strategy that combines entertainment and education using serial dramas on radio and prime-time television, complemented with many other communication strategies. These organizations have designed campaigns to raise awareness, model behaviors, change social norms and attitudes, and demonstrate the consequences of choices related to a myriad of health and development issues.

A recent evaluation of Puntos de Encuentro's project Somos Diferentes, Somos Iguales (SDSI, We are Different, We are Equal in Spanish) reveals that exposure to its interventions was widespread. This exposure resulted in a significant reduction of stigmatizing and gender-inequitable attitudes; an increase in knowledge and use of HIV-related services; and a significant increase in interpersonal communication about HIV prevention and sexual behavior. In addition, findings indicate that SDSI played an important role in promoting community-based dialogue on key topics and fostered alliances between organizations.

Source: Solórzano et al., 2008 and Guedes, 2004.

In Summary...

CSBC Programs SHOULD	CSBC Programs SHOULD NOT
Support long-term, sustained activities rather than short-term ones.	Expect profound or sustained effects resulting from short-term campaigns.
Integrate the issue of gender-based violence into existing public health communication programs.	Ignore links between GBV and other health issues such as unintended pregnancy and HIV and overlook opportunities to integrate the issue of GBV.
Combine mass media communication strategies with other strategies such as service provision and community mobilization.	Underestimate the effort required to build the relationships needed to implement strategies in coordination with other social actors and organizations.
Ensure that images and messages are empowering and that they do not reinforce stereotypes, such as women as "victims" and men as "aggressors."	Ignore the need to carry out formative research and to validate materials with members of the target population to avoid unintended/unwanted interpretations.
Support programs that use many different types of media channels and formats, including "edutainment."	Underfund mass media campaigns (such as educational soap operas) since they may require a significant initial investment.
Promote partnerships among organizations with complementary programs and seek opportunities to fund "missing pieces" or activities that complement others.	Support organizations that are unwilling or unable to work collaboratively.
Prioritize investments in rigorous, long-term evaluations of CSBC activities.	Underestimate the time required to produce complex social change regarding GBV.
Support activities that promote changes in norms among multiple segments of the population (including men and women, adolescents and adults) and other audiences, such as teachers, the police, and the justice system.	Use a single set of messages for different target populations. Program experience suggests that "One size does not fit all." Instead, if the activity targets multiple populations, it needs to tailor specific strategies/messages for each group.

Health Service Delivery Programs

Reasons WHY health service delivery programs should address gender-based violence

Healthcare organizations—particularly those working in the field of sexual and reproductive health—cannot provide the highest quality healthcare to women unless they make a commitment to the needs and safety of women who experience violence. Moreover, health programs that overlook the implications of sexual violence and intimate partner violence among their clients may inadvertently put women and girls at risk of additional violence—for example, by paying insufficient attention to confidentiality.

HOW health service delivery programs can address gender-based violence

The main role of health services is to provide for the needs of women who have been affected by GBV and to assist them in avoiding additional exposure to violence. While primary prevention (preventing violence before it begins) is equally important as treatment, the other approaches described in this document (community mobilization, CSBC, etc.) may be better placed to tackle GBV prevention.

1) **Use a "systems approach" to improve the health service response to GBV.** Many healthcare organizations have tried to address gender-based violence by offering a single training for providers or by implementing a single policy change (e.g., requiring providers to ask women about violence). Program evaluations suggest that these limited efforts often fail to improve the healthcare response or fail to produce long-term, sustainable change. Moreover, in resource-poor settings where legal systems are weak and referral services do not exist in the community, half-hearted measures may do more harm than good. A growing body of evidence indicates that the most effective way to improve the quality of healthcare for survivors of violence is to make changes throughout a healthcare organization— a strategy called a "systems approach" (Heise et al., 1999). The idea behind the systems approach is that gender-based violence has implications for every aspect of health services, from the physical infrastructure of the clinic (e.g. whether consultation rooms are private), to patient flow, staff support, supervision and training, and referral networks. In fact, changing the professional culture of an entire organization may be essential for convincing many health workers that violence against women is a health concern that should be part of their job.

Selected reasons why health services should address gender-based violence

- Gender-based violence is a major cause of disability and death among women.
- Health programs—including those devoted to HIV/AIDS—can be more effective if they recognize the reproductive health implications of violence against women.
- Health providers who do not ask about gender-based violence may misdiagnose victims or offer inappropriate care.
- Health service organizations may be the first or only point of contact outside the home for women experiencing violence.
- Health providers who counsel women and provide information may be strategically placed to help women get assistance before violence escalates.
- Providers may inadvertently put women at further risk if they are uninformed or unprepared, especially those working in voluntary counseling and testing (VCT) and STI diagnosis/partner notification (see for instance USAID/Synergy, 2004).
- Addressing GBV can improve the overall quality of women's healthcare by being more attuned to their medical and psychological needs.
- Healthcare organizations can raise society's awareness of GBV as a public health problem.

Source: Adapted from Bott et al., 2004.

Components of a "systems approach"
(For more details on each of these points, see Table 4 at the end of the section.)

- An institutional commitment to GBV as a public health and human rights issue
- Sexual harassment policies
- Policies and infrastructure that protect patient privacy and confidentiality
- Awareness of local GBV laws
- Ongoing training and support for staff
- Referral networks to help survivors access legal services, counseling, shelters, etc.
- Protocols for the care of survivors
- Emergency supplies such as STI prophylaxis, post-exposure prophylaxis (PEP), and emergency contraception (EC), where supported by the government
- Educational materials on GBV for clients
- Data collection systems
- Monitoring and evaluation of quality of care

2) **Support efforts to fully integrate attention to GBV within existing health programs.** Some health programs address GBV by setting up parallel services for survivors and limiting physicians' role to the identification and referral of GBV cases. Creating separate GBV services may appear easier in the short term, but improved quality of care and sustainable interventions can only be achieved if programs fully integrate attention to GBV into all health services. By providing appropriate, ongoing training and institutional support, programs can encourage providers to consider the implications of gender-based violence in all aspects of their practice. Examples of this integrated approach include providers who consider the possibility that women may be vulnerable to violence by their partner when counseling them about contraceptive methods, condom negotiation, STI/HIV prevention, and prenatal care; providers who consider GBV as a possible explanation for conditions such as recurrent STIs and for contraceptive discontinuation; providers who recognize physical and emotional signs of abuse during clinical exams; and HIV VCT programs that have policies that acknowledge the risk of violence against women following a disclosure of a patient's HIV status. Health programs should also be able to provide compassionate emergency medical examination and treatment for survivors of GBV, including the provision of post-exposure prophylaxis for HIV and emergency contraception where supported by the government for survivors of sexual violence.

3) **Support long-term efforts to sensitize and train health professionals about GBV.** As noted above, health professionals need institutional support, supervision, incentives, and training to address GBV adequately. For various reasons, however, training providers has posed particular challenges. For example, many health professionals have not been trained to recognize violence against women as a public health issue, and they often share prejudices and misconceptions about GBV common in the wider society. Health programs are still learning how to train effectively in this area, but the following are some key lessons learned:

- Training should be accompanied by a broader institutional commitment and performance improvement efforts (feedback, supervision, clear expectations, etc.) to enhance the health service response to GBV as a public health and human rights issue.
- One-shot trainings are not generally sufficient to change providers' attitudes or practices. Programs should provide ongoing, repeated training and should train new staff as they are hired.
- Selecting the right trainer is crucial. The trainer should be knowledgeable about the epidemiology of violence; able to present sensitive material in nonthreatening ways; familiar with local culture; professionally credible in front of physicians; and committed to gender equity and human rights.
- Training should start by exploring participants' own beliefs, concerns, and personal experiences regarding violence, recognizing that staff may have experienced or perpetrated violence themselves.
- All staff members should be sensitized/trained—from management to administrative staff; professionals such as physicians and psychologists may need specialized training.
- When possible and appropriate, the issue of GBV should be integrated into training on other topics such as HIV and sexual education.
- The best way to prepare the next generation of health professionals may be to encourage schools of

medicine, nursing, social work, psychology, and so forth to integrate GBV into their curricula.

4) **Support "routine screening" or "routine enquiry" policies *only* when programs have implemented basic protections for women's physical and emotional safety.** Many healthcare organizations have begun encouraging staff to ask women about violence as part of the routine medical history—a practice called "routine screening" or "routine enquiry." No randomized clinical trials have been done on routine enquiry to clarify whether the benefits outweigh the risks. As long as health programs can ensure basic protections for women's safety and well being, the potential benefits of early identification of violence offer a compelling reason why health organizations should ensure that providers have the skills and institutional support to offer women safe and multiple opportunities to disclose violence to their healthcare providers. **But one thing that is agreed upon is that health organizations must be able to ensure basic precautions to protect women's lives, health, and well being before they implement routine enquiry.**

Before implementing routine screening, health programs need to ensure the following:

- They can protect women's privacy and confidentiality.
- Their healthcare providers have adequate knowledge, attitudes, and skills.
- They have something to offer women who experience violence, even if it is limited to providing a compassionate response, appropriate medical care, information about legal rights and resources in the community, and safety planning for women in danger.

5) **Support the participation of healthcare organizations in broader prevention efforts, referral networks, and advocacy campaigns.** The main role of health services in the area of gender-based violence is to respond to women who have already experienced violence, to mitigate the negative consequences, and to help them find ways to avoid additional violence. However, health programs should also look beyond their clinic wall in the following ways and for the following reasons:

- Building referral networks between health, social, and legal services in the community can be an essential way to facilitate women's access to services, reduce duplication of services, and to identify gaps in services for policymakers and donors.
- By participating in public policy advocacy campaigns, task forces, and other public fora, healthcare professionals and organizations can encourage policymakers to address gender-based violence as a public health problem.
- By building links and alliances with broader GBV prevention efforts, such as those launched by other NGOs, healthcare organizations can raise their profile as a resource for women who experience violence.

6) **Encourage health programs to consider economic sustainability before launching specialized social services for victims (e.g., counseling, support groups).** In settings where adequate social or legal services for survivors do not exist in the community, health programs sometimes consider providing specialized services, such as legal advice, psychological counseling, victim's advocate services, and other services. Some

The ongoing debate about the comparative risks and benefits of routine enquiry

Some researchers have raised concerns that "routine enquiry" might cause more harm than good in settings where few referral services exist, where legal systems are weak, and where negative attitudes and lack of training may prevent health providers from responding compassionately when women disclose abuse. On the other hand, some argue that "routine enquiry" is an essential way to ensure appropriate, high-quality healthcare for women and to identify women in danger of additional violence. Even in resource-poor settings where referral services are not available, asking women about violence and responding compassionately may have benefits for women, such as reassuring women that they are not to blame; raising women's awareness about the health risks of violence for themselves and their children; and helping women and girls get help before violence escalates. The evidence suggests, therefore, that if health programs implement the basic precautions to protect women's safety as described under the "systems approach," then it is likely that the benefits of screening will outweigh the risks.

health programs have reported positive experiences in this area (for example, see Bott et al., 2004). However, such investments should be done carefully keeping the following points in mind:

- Health programs should be mindful not to duplicate services that already exist or to compete with organizations that are better equipped. In some cases, it may be better for a health program to strengthen other social or legal organizations in the community through partnerships, training, and coordinated fundraising.
- Health programs should try to identify the most economically feasible, cost-effective, and sustainable social services to provide. For example, individual psychotherapy services and shelters for battered women are extremely expensive approaches that are rarely feasible, cost-effective, or sustainable in resource-poor settings and may be problematic for other social or cultural reasons. In low-income countries, some health programs have found low-cost alternatives, such as support groups for survivors instead of individual psychotherapy, or strategies to help women find informal safe havens with extended family, friends, or volunteers as an alternative to formal, stand-alone shelters.

In Summary…

Health Service Delivery Programs SHOULD	Health Service Delivery Programs SHOULD NOT
Encourage existing HIV/AIDS and other reproductive health programs to address GBV in existing activities.	Overlook the implications of GBV, especially in the area of sexual and reproductive health, for instance, within family planning counseling and VCT for HIV.
Support institution-wide efforts to address GBV—the "systems approach" (if USAID cannot fund all elements, collaborate with public sector agencies, nongovernmental organizations, and others actively addressing GBV and fund pieces of the system).	Support one-shot trainings unless they are part of a broader institutional effort to integrate concern for GBV into women's healthcare.
Support long-term efforts to sensitize and train health professionals, including integrating GBV into the curricula of schools of medicine, nursing, etc.	Use trainers who have inadequate experience or who lack a commitment to GBV as a public health and human rights issue.
Ensure providers acknowledge and listen to women's experiences with GBV in a nonjudgmental and compassionate way.	Allow providers and other health services personnel to ignore or blame the women who experience violence.
Require programs to protect women's safety, privacy, and confidentiality before launching routine screening policies.	Support routine screening activities unless health programs have put in place basic measures to protect women's safety and to offer them assistance.
Invest in research to build the evidence base about effective health service interventions.	Fund programs that overlook the existing literature on best practices or fail to evaluate the safety and effectiveness of efforts.
Support health programs that want to provide certain types of social services to survivors in settings where alternatives do not exist, as long as they are appropriate to the setting, sustainable, and do not supplant services provided elsewhere in the community.	Encourage health programs to invest in services that are not economically sustainable.

Table 4. Key Elements of a Systems Approach to Improving the Health Service Response to GBV

The following table is adapted from *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries* (Bott et al., 2004).

Key elements	Why this element is important
Strengthen the institutional commitment to address gender-based violence	The overall commitment of an institution can have a powerful influence on the professional culture of healthcare organizations. Ideally, senior managers should recognize GBV as a public health problem and a human rights violation and support the effort to improve the health service response to violence. The work environment should promote respect for all staff members, including women and subordinates, and demonstrate a commitment to nonviolence with a policy prohibiting sexual harassment in the workplace.
Collaborate with other organizations actively addressing GBV	Addressing GBV requires multidisciplinary action. Because a single organization may not be able to carry out or fund all required steps, institutions need to collaborate to assess the existing situation and decide what piece of the puzzle each one can take on. The inability to undertake all necessary steps should be a motivating factor to collaborate rather than a justification for not addressing the issue.
Strengthen privacy and confidentiality for all women who come for health services through infrastructure improvements and clinic policies	Privacy and confidentiality are essential for women's safety in any healthcare setting. Breaching confidentiality about pregnancy, HIV status, and other issues may unwittingly put women and girls at risk of future violence. Moreover, women need privacy and confidentiality to disclose GBV without fearing retaliation. Programs need to ensure that consultation rooms cannot be overheard from outside; that clinic procedures do not require women to share personal information in public areas, such as the reception area; and that policies outline when and where providers may discuss personal information about clients.
Improve health workers' and law enforcement's understanding of local and national laws and policies regarding violence against women and the health sector	Both managers and service providers need to be familiar with laws about GBV, including what constitutes a crime, how to preserve forensic evidence, how to report GBV, whether and how women can obtain protection orders, what women need to do if they wish to separate from a violent spouse, and what healthcare providers are legally required to do when they detect a case of childhood sexual abuse. This knowledge allows health workers to provide accurate information to survivors and to ensure the collection of forensic evidence (when applicable). This knowledge may also alleviate providers' concerns about getting involved in legal proceedings.
Improve providers' knowledge, attitudes, and skills through sensitization and training	All women's healthcare providers need to be prepared to respond to disclosures of GBV with compassion and skill. Even when providers do not ask about violence, women may disclose such experiences voluntarily. Providers who respond poorly can inflict great emotional harm or fail to provide essential medical care. Moreover, ignoring the possibility that women live with gender-based violence may make it impossible for providers to counsel women effectively about contraception, HIV prevention, or to treat health conditions such as recurrent STIs. Each institution must decide how much training it can afford to provide. At a minimum, staff should understand the epidemiology of GBV and the needs of survivors. Organizations should also offer emotional support to providers working in the area of gender-based violence.
Strengthen referral networks and facilitate survivors access to other services	Because it is difficult for a single organization to address all of survivors' needs, health programs should investigate local social and legal services, compile this information for health providers, and build referral networks to facilitate survivors' access. Additionally, organizations can consider implementing in-house services, including low-cost interventions such as support groups for women and girls, which have been identified as an important intervention by survivors. Networks and alliances also allow the health sector to play a role in the broader policy debate by raising awareness of violence against women as a public health problem.

Table 4. Key Elements of a Systems Approach to Improving the Health Service Response to GBV

Key elements	Why this element is important
Develop or improve written institutional policies and protocols for caring for women who have experienced violence	Health programs should develop written protocols for staff that outline how to ask about violence, care for women and girls who disclose violence, and refer women and girls for specialized services (e.g., see Warshaw and Ganley, 1998; Bott et al., 2004). Clear, written policies can reduce the risk of harm to patients posed by negative attitudes from staff, especially if they are developed with the participation of frontline providers and management. Although many prototypes already exist, such policies work best if they are adapted to the particular context of each institution.
Ensure the provision of emergency services and supplies	Women who experience violence may need emergency services and supplies, including first aid, STI prophylaxis (in some settings HIV prophylaxis), forensic exams, emergency contraception (where access is supported by the government), and so forth. Health programs need to have the necessary supplies and to train providers to use them.
Ensure/improve educational materials available to clients on topics related to GBV	Displaying and distributing posters, pamphlets, and/or cards about GBV can be an important way to indicate the organization's commitment to combating violence, as well as to raise awareness of the problem, educate clients, and inform women about their legal rights and where they can turn for help.
Strengthen medical records and information systems to enable staff to document and monitor cases of GBV	Information systems play an important role in the response to GBV. Documenting information about violence in medical records may be an important way to ensure that women's medical records are complete, and in some cases may provide evidence for future legal proceedings. To protect women's safety and well being, records need to be securely stored. Information systems are also important for monitoring a health organizations' work in the area of GBV. Healthcare organizations can gather service statistics on the number of women identified as victims of violence to help determine the demand for services.
Ensure adequate monitoring and evaluation related to GBV	Monitoring and evaluating quality of care is another essential way to ensure that health services are responding to violence appropriately. At the level of management, administrators should receive ongoing feedback from providers to identify problems and ways to improve the services. The input of women who have experienced violence can be crucial for successfully refining the design of health services. Programs should also make an effort to document unanticipated consequences.

Health Policy Programs

Reasons WHY health policy programs should address gender-based violence

The health sector has enormous potential to influence GBV-related laws and policies. Policymakers and other segments of society who might not be swayed by arguments of women's rights advocates may be motivated to change criminal and civil legal codes if health professionals can demonstrate that GBV is a serious cause of morbidity and mortality among women (and children). Moreover, many laws and policies directly or indirectly affect the ability of health professionals to address GBV in their daily practice. Too often, such laws and policies are badly designed or implemented, and the health sector's participation can be essential for crafting more effective public policies.

HOW health policy programs can address gender-based violence

In many parts of the world, there is an urgent need to reform and strengthen criminal legislation, women's legal rights as granted by civil legal codes, and police and judicial procedures as they relate to gender-based violence (see Bott et al., 2005). To varying degrees, all these legal and policy reforms have implications for women's health and safety. However, given the focus of this document on health, the section below highlights the areas of legal and policy reform that are most directly relevant for the health sector.

1) **Support research and dissemination of research findings on GBV.** Expanding the knowledge base about the magnitude, patterns, and consequences of GBV as well as about promising interventions can be a powerful way to convince policymakers that violence against women is a serious public health problem in their community. In many settings, more research is needed; in other settings, evidence exists but has not been adequately shared with policymakers. Priority topics may include research or analysis of data on:

- The prevalence and patterns of different types of violence against women;
- The consequences of GBV and the help-seeking behaviors of women and girls who experience GBV;
- Situation analyses documenting weaknesses and strengths of existing public policies; and
- Evaluation of promising interventions and newly implemented public policies and programs.

Selected reasons why health policy programs should address gender-based violence

- Health sector operational policies/protocols can help standardize appropriate GBV interventions at the institutional level.
- Health sector participation in the policy discourse is essential for drafting sensible policies and approaches and mobilizing resources for the health service response to GBV.
- The health sector has the ability to reframe the policy debate around GBV as a high-priority public health and human rights issue, not just a social practice.
- Health policy organizations can use epidemiological research on the magnitude of GBV consequences to convince policymakers that they should address gender-based violence.
- The justice and health sectors must collaborate to ensure a comprehensive service response to survivors of GBV.
- Flawed civil codes and the inability to exercise civil rights can deprive women of the legal tools they need to protect the health and safety of themselves and their children.
- Weak or unenforced criminal legislation helps to perpetuate GBV by failing to hold perpetrators accountable—with serious consequences for women's health.

2) **Support public and private coalitions that design and implement GBV public policy approaches.** In many countries (e.g., Costa Rica, South Africa, and the United States), multisectoral coalitions have successfully worked to craft better GBV legislation, develop more sensible and comprehensive government policies, encourage enforcement of existing laws, and convince the government to devote public funds to implement existing policies. These coalitions work best when they include government ministries, service-providing agencies, community leaders, law enforcement, and survivors themselves.

Examples of health policy issues related (directly or indirectly) to GBV

- Promote institutional policies that mandate quality care for survivors within public agencies.
- Ensure adequate government funding for policies and programs.
- Develop national plans and policies to promote a comprehensive service response to GBV.
- Include a response to GBV in national reproductive health, HIV, and maternal health policies and legislation.
- Clarify the legal obligations of healthcare providers, including laws that stipulate who can provide PEP and EC and who can gather forensic evidence.
- Improve the medico-legal system.
- Ensure criminal sanctions for perpetrators of violence against women and girls.
- Strengthen women's civil rights within marriage.

3) **Support efforts to educate key groups and the broader population about GBV as a public health problem.** Health professionals are strategically placed to educate those sectors of society responsible for implementing and enforcing laws and policies, including police, judges, parliamentarians, public health administrators, and others because they can reframe gender-based violence as a public health problem. In addition, health organizations can promote better understanding of the law among their client population and the broader community. Examples of promising strategies include training workshops for law enforcement agents (including police, judges, and traditional mediating bodies), conferences for parliamentarians, booklets and posters for their clients, and mass media campaigns (radio, television) for the whole population.

4) **Support advocacy efforts to change specific laws and policies.** Activities may include supporting civil society groups to work with policymakers to improve laws and policies that address GBV. Advocacy efforts may also include community-based campaigns for specific changes in laws and policies. In addition, nongovernmental organizations can research and report on the status of laws and policies and monitor the extent to which signatory governments have complied with international human rights agreements that they have signed.

5) **Support efforts to reform and strengthen the institutional policies of public agencies.** The internal policies of publicly funded institutions can have a positive or negative impact on the experience of GBV survivors who seek help from health services, law enforcement, or other institutions. Strengthening institutional policies is, therefore, another way to address GBV. For example,

- ***Within publicly-funded health services:*** Protocols that mandate and help implement an adequate service response to GBV.
- ***Within law enforcement institutions:*** Require police to help survivors to access forensic exams.
- ***Within educational systems:*** Require teachers and administrators to report emotional, physical, and sexual violence against minors to the authorities.

In Summary…

Health Policy Programs SHOULD	Health Policy Programs SHOULD NOT
Support research and promote effective dissemination of findings to convince decisionmakers to address GBV.	Underestimate the potential for the health sector to change traditional beliefs that condone GBV.
Support public/private coalitions to develop a comprehensive service response to GBV.	Exclude survivors and other community groups in public policy and advocacy efforts.
Advocate for changes in the criminal and civil code as a way of supporting improved public health.	Replicate policies that have proven harmful elsewhere, such as requiring healthcare workers to report cases of GBV against adult women.
Educate key groups and the broader population about GBV as a public health problem.	Exclude health professionals' contributions to reframing violence against women as a serious and widespread health problem.
Use advocacy strategies to ensure that all changes in government policies and programs are backed up with adequate funding.	Underfund new laws and policies.
Advocate for improving the institutional policies of publicly funded agencies, including police, the judiciary, and ministries of health.	Overlook the importance of a "systems approach" for achieving any type of institutional reform. Changing the written policies of a public institution will not produce change unless backed up with more comprehensive efforts to implement reform throughout various institutions.

Youth Programs

Reasons WHY youth programs should address gender-based violence

Substantial proportions of girls and young women experience physical and sexual violence in nearly every geographical setting (Krug et al., 2002). Surveys among sexually experienced adolescent girls in countries around the world have found rates of forced sexual debut ranging from 7 percent in New Zealand to 46 percent in the Caribbean (Heise and Garcia-Moreno, 2002), and these rates are likely to be underreported. Physical violence by intimate partners often begins within the first few years of dating and marriage, and young married women are particularly vulnerable in some settings. The consequences of violence and abuse for the health and development of girls and young women are considerable. For example, sexual coercion and abuse has been linked to unintended pregnancy, early childbearing, abortion, substance abuse, depression, suicide, and STI/HIV transmission. Unfortunately, the response from families, schools, healthcare providers, law enforcement, and social services is often poor or nonexistent.

Selected reasons why youth programs should address gender-based violence

- Substantial proportions of girls and young women experience forced sexual debut, child sexual abuse, and other forms of sexual violence in virtually every geographical setting.
- Physical violence by intimate partners often begins within the first years of dating and marriage.
- Sexual abuse in childhood and adolescence has been linked to a host of poor health consequences, including unintended pregnancy, abortion, depression, and STI/HIV transmission.
- Survivors of sexual abuse face a higher risk of substance abuse, multiple sexual partners, and inability to negotiate contraception.
- Youth reproductive health programs cannot assume that sexual activity is always voluntary or consensual.
- Ignoring gender-based violence can jeopardize the effectiveness of interventions, such as prevention of unintended pregnancy and STI/HIV.
- Youth represents an ideal opportunity for GBV prevention because attitudes and beliefs about gender norms and violence are still forming.
- There is an urgent need to improve the institutional response to girls and young women who experience violence—particularly sexual violence.

Source: Krug et al., 2002.

Many reproductive health programs for youth—particularly those devoted to preventing unintended pregnancy and HIV transmission—often promote "responsible" decisionmaking, without acknowledging the extent to which sexual and reproductive behaviors and outcomes are affected by violence and coercion. This should change in order to improve the effectiveness of these programs.

Moreover, adolescence is a time in life when attitudes and beliefs are still forming, and it appears to be easier to change norms and attitudes about gender equity and nonviolence among youth than among older women and men. Thus, youth represents a major opportunity for preventing gender-based violence.

HOW youth programs can address gender-based violence

1) **Require all reproductive health programming for youth to address sexual coercion and abuse.** Reproductive health programs for youth cannot assume that sexual activity is always voluntary or free from coercion. Providing information, promoting "responsible" decisionmaking, or encouraging abstinence alone is not enough given what is known about the prevalence and patterns of sexual violence among young people. Sexual and reproductive health programs need to address gender equitable norms, power imbalances within relationships, nonviolence, and negotiation skills among both girls and boys.

In particular, programs should be sensitive to girls' limited power in cross-generational sexual relationships and to the conditions that propel them to engage in transactional sex.

2) **Support activities that improve the family, peer, and community environments.** Both to prevent gender-based violence among young people and to improve the community response to survivors once violence occurs, it is essential to work not only with youth, but also with families, schools, healthcare organizations, faith-based organizations, and other institutions to improve the overall environment in which young people live. For example, educating the broader community about sexual violence and harassment can be a critical way to reduce tolerance of sexual violence and harassment in the community. Within this context, it is important to make efforts to reach out-of-school youth.

3) **Support efforts to promote gender-equitable norms and nonviolence among young men.** Because gender-based violence is a learned behavior, targeting boys and male youth provides an opportunity to influence male attitudes and behaviors before they become deeply ingrained. One promising strategy is to promote models of behavior and relationships that highlight the positive benefits of gender equity for both men and women. There is also a need to support action research to determine a) how best to target younger boys with messages about gender equity and nonviolence; and b) how best to prevent at-risk young men (for example, those who witnessed or experienced violence as children) from becoming aggressors themselves.

4) **Support efforts to empower girls by improving self-esteem, negotiation skills, economic opportunities, and other skills.** Programs to empower girls by improving self-esteem, negotiating ability, and other skills offer another way to prevent gender-based violence and to give young women the resources they need to seek help when violence occurs. These programs may include "life-skills" curriculum, sex education that includes negotiation skills training, or programs aimed at providing income-generating skills and opportunities.

5) **Support efforts to improve the institutional response to young survivors of GBV.** Efforts are needed to improve the response of healthcare providers, law enforcement, schools, and social service agencies to girls and young women who experience violence. While a poor institutional response is often a serious problem for adult survivors as well, programs aimed at youth may need to address young people's unique situation, including, for example, a) service providers' discomfort with adolescent sexuality; b) economic and emotional dependence on parents or in-laws who may or may not be supportive of adolescents' needs; and c) financial barriers to care, among others.

6) **Support efforts to increase the safety of girls and young women in educational settings.** There is an urgent need to address sexual violence within schools and universities, including:

- Policies and enforcement mechanisms to prohibit sexual harassment and abuse of students, including zero tolerance for staff who perpetrate such acts;
- Efforts to educate school personnel (from faculty to administrators) about gender and violence;
- Curriculum changes to incorporate the issue of gender equity and gender-based violence; and
- Other measures to increase the safety of girls and young women at schools and on the way to and from school.

In Summary…

Youth Programs SHOULD	Youth Programs SHOULD NOT
Require reproductive health programs for youth to address GBV, particularly sexual violence.	Design youth programs on the assumption that sexual behavior is voluntary, even within marriage.
Work with families, peers, and community organizations to improve community attitudes about violence.	Overlook the importance of peers and adults in the lives of young people.
Work with girls and boys, and young women and men to influence attitudes and norms about gender and nonviolence.	Focus exclusively on negative messages about young men; instead, emphasize the positive benefits of gender equity for both men and women.
Empower girls with self-esteem, negotiation skills, and economic opportunities and promote institutional structures to support girls.	Work exclusively with girls; it is also essential to influence the attitudes of boys, men, and older women.
Improve the institutional response to GBV by addressing the particular situation of young people (e.g., social and economic dependence).	Assume that service providers will respond compassionately to young GBV survivors without training in the particular needs of youth.
Support efforts to decrease sexual violence and harassment at schools and universities.	Ignore enforcement of sexual harassment policies even if it means taking action against administrators and teachers who may have perpetrated such violence.

Humanitarian Programs

Reasons WHY humanitarian programs should address gender-based violence

Armed conflict and natural disasters (such as hurricanes and tsunamis) increase the risk of physical and sexual violence against women and girls by eroding the legal and social structures in society that normally act as a protective factor for girls and women and by increasing stress and social disruption (e.g., see Enarson, 1998). Sexual violence, including rape and sexual abuse and exploitation, has long accompanied armed conflict, and has been widely used as an organized weapon of war in settings such as the former Yugoslavia, Rwanda, and Chechnya (Human Rights Watch, 2004; IRC, 2004). In addition, sexual abuse and exploitation within the context of humanitarian emergencies (sometimes perpetrated by humanitarian aid workers and peacekeepers) is a serious emerging issue.

The consequences of violence against girls and women in conflict and disaster situations are serious and life threatening, ranging from physical and emotional trauma to unintended pregnancies, traumatic gynecologic fistula, and sexually transmitted infections, including HIV. Access to emergency medical, psychosocial, and legal services is therefore an urgent priority, in addition to more traditional forms of humanitarian assistance such as shelter and food. Moreover, survivors of sexual violence in armed conflict may face stigmatization that makes it difficult to return to their families and communities—an issue that humanitarian programs should also help address. Humanitarian organizations also have an obligation to lower the vulnerability of girls and women to gender-based violence by giving priority to their physical security during the relief phase and by incorporating prevention and response to gender-based violence into acute emergency planning, as well as long-term reconstruction efforts.

Selected reasons why humanitarian programs should address gender-based violence

- In most armed conflict, large proportions of women and girls experience sexual violence.
- Levels of both physical and sexual violence against women are significant during and after armed conflict and natural disaster, since these events are accompanied by displacement from communities and breakdowns in legal and traditional social structures.
- Women and girls are among the most vulnerable populations in conflict and natural disaster settings and, as such, the humanitarian community has an obligation to adequately address survivors' urgent needs for medical, psychosocial, and legal services.
- Humanitarian programs have the potential to reduce girls' and women's vulnerability to GBV by giving priority to their safety and investing in GBV prevention and response activities.
- Reconstruction efforts need to address the stigmatization of sexual violence survivors to ensure that they can be reintegrated into their communities and ensure the full participation of women and girls in the process of developing programs during the reconstruction phase.
- Women and girls continue to be at risk of gender-based violence, such as intimate partner violence, during the reconstruction phase, when longer-term prevention strategies are needed.

HOW humanitarian programs can address gender-based violence

1) **Ensure that humanitarian organizations comply with international guidelines regarding GBV.** Organizations should be familiar with and should agree to comply with international guidelines and codes of conduct as described in key documents from the United Nations Secretary General and the Inter-Agency Standing Committee (United Nations, 2003; IASC, 2005).

2) **Support humanitarian efforts that implement the minimum initial service package (MISP) at the onset of each humanitarian crisis.** MISP is an internationally recognized series of actions designed to meet the reproductive health needs of populations affected by conflict or natural disaster in the acute emergency phase. The package includes activities aimed at preventing and responding to the consequences of sexual violence (RHRC, 2004), including ensuring an appropriate medical response to survivors of sexual violence and monitoring the number of cases of sexual violence reported to health services, security officers, and so forth. This includes training key staff on the clinical management for treatment of rape victims; development of a basic protocol and provision of appropriate treatments, including emergency contraception in cases of rape (where access is supported by the government); and post-exposure prophylaxis for HIV. The MISP also includes a framework for planning for the provision of comprehensive reproductive healthcare in humanitarian situations. Given the close link between harmful reproductive health consequences and GBV, access to these services is critical to survivors of all types of gender-based violence.

3) **Ensure that humanitarian organizations collaborate to avoid gaps when addressing GBV.** From the outset of any humanitarian intervention, all sectors and agencies should collaborate to prevent gaps in addressing gender-based violence. Coordination is important for organizations working on gender-based violence in any setting, but it becomes indispensable in situations of conflict or natural disaster. Even though an agency may only be able to address one particular area—for instance, health—that agency must engage and coordinate with other sectors.

4) **Ensure that all programming for humanitarian assistance addresses GBV.** Donors and humanitarian organizations need to address gender-based violence within all areas of their work. Programs should target, for example, a) measures to protect women's safety and rights; b) actions for addressing violations of women's rights; and c) services to meet the needs of girls and women who experience gender-based violence (IRC, 2004). Programs should develop an approach that addresses at least one of the above mentioned levels of GBV programming in a context-appropriate manner. Given that many service-delivery agencies do not have extensive experience in the area of gender-based violence, humanitarian organizations need to ensure that their personnel receive appropriate GBV training.

5) **Ensure that humanitarian agencies give priority to girls' and women's safety and security.** In recent years, much has been learned about how to improve girls' and women's safety in humanitarian settings. Examples include: a) all distributions (food and other necessities) should be organized with the active participation of women in the community to prevent men from using exclusive control of resources for sexual leverage over women and girls; and b) refugee camps should be designed with active participation of women and laid out in ways that protect women's physical security (for example, ensuring adequate lighting, safe locations of latrines, access to water and firewood sources that are not isolated and distant). These experiences should be taken into account when designing camps and mechanisms for assistance and require the sensitization and involvement of all sectors such as water/sanitation, camp management, and others. Additionally, programs should be encouraged to identify traditional structures/cultural systems that could be drawn upon to protect women and to support those who speak out against violence.

6) **Integrate GBV health response into all primary healthcare and HIV/AIDS services.** Given the levels of gender-based violence in situations of conflict and natural disasters, existing health services need to be adequately prepared to address survivors' needs. This includes adequate training in the clinical management of rape, development of written protocols for caring for survivors (including the provision of post-exposure prophylaxis and emergency contraception, where supported by the government), protections for privacy and confidentiality, and other measures previously discussed in the health service section of this document.

7) **Support innovative efforts to pilot and evaluate GBV activities in natural disasters.** Little is known about the best way to respond to gender-based violence following natural disasters, and there is still a lot to be learned about how best to address GBV in conflict affected areas. Therefore, there is a need to fund and evaluate new approaches. One creative effort was launched by an NGO called "Puntos de Encuentro" in response to increased gender-based violence in Nicaragua following Hurricane Mitch. They organized

an information campaign using multiple media channels to transmit one simple message—"Violence against women is one disaster that men can prevent."

8) **Support programs that change and adapt as situations stabilize.** During the emergency phase of man-made or natural disasters, activities may be primarily response-driven. Once the situation has stabilized, however, and reconstruction work is underway, humanitarian programs should adapt their work—for example by emphasizing prevention and local capacity building.

9) **Support rigorous monitoring and evaluation of GBV activities in humanitarian settings.** Although the lack of evaluation is felt in most GBV programming, it is even more accentuated in programs working within humanitarian settings. Improved data collection is also needed and could include conducting comprehensive baseline assessments at the onset of humanitarian programming; creating standardized reporting methods across sectors (health, psychosocial, police); and developing methods for sharing and analyzing data.

Selected roles of different sectors in preventing and responding to GBV in humanitarian settings

The **health sector** should be able to:

- Provide compassionate emergency medical examination and treatment for survivors of GBV, including the provision of post-exposure prophylaxis and emergency contraception where appropriate and supported by the government, for survivors of sexual violence.
- Facilitate girls' and women's access to other services in the community through referrals.
- Collect forensic evidence (ensuring women's safety) when appropriate and provide testimony when needed.
- Raise awareness of the health consequences of gender-based violence in the community.

Social services should be able to:

- Provide emotional support through culturally appropriate and sustainable mechanisms.
- Promote girls' and women's safety, including by offering survivors safe haven when possible.
- Offer income-generation and skills-building opportunities and training to women and girls (and ensure that men do not have control over the resources generated).
- Conduct community-based education on GBV prevention and availability of services, targeting key stakeholders.

The **legal sector** should be able to:

- Provide free or low-cost legal assistance and representation to survivors.
- Train law enforcement agents, including peacekeepers and members of the judiciary.
- Advocate for the revision of laws and policies that reinforce gender discrimination and violence.
- Raise awareness of existing legislation.

The **security sector** should be able to:

- Implement a zero tolerance policy for police, military, and peacekeeping staff who perpetrate GBV.
- Ensure that refugee camps are designed to ensure the physical safety of its inhabitants, particularly of girls and women.
- Build or rebuild law enforcement capacity to assist survivors of GBV without further victimization.
- Conduct community policing and education.

Source: Adapted from Ward, 2002.

In Summary…

Humanitarian Programs SHOULD	Humanitarian Programs SHOULD NOT
Promote the use of key guidelines and compliance with established standards for prevention and response to GBV in humanitarian emergencies.	Delay compliance with international standards or "reinvent the wheel" by trying to develop their own standards.
Promote coordinated action among all humanitarian agencies in the area of GBV.	Allow gaps in services to develop in humanitarian settings.
Ensure that all humanitarian assistance addresses the implications of GBV, including girls' and women's safety and security.	Ignore the safety and security of girls and women in emergency situations. For example, do not collect forensic evidence if this could endanger women.
Integrate a better response to gender-based violence into primary healthcare and HIV services.	Overlook the importance of implementing the "Minimum Initial Service Package," including services for survivors of sexual violence.
Ensure that humanitarian agencies adapt their work as emergency situations stabilize and enter the reconstruction phases.	Underestimate the need for long-term funding for GBV activities during the reconstruction phase.
Prioritize the need to help survivors of sexual violence overcome stigmatization and return to their families and communities when possible.	Neglect the counseling needs of returning military, who have been exposed to high levels of violence and conflict, as they adjust back to their communities.
Ensure that all staff are trained and adhere to a code of conduct.	Overlook the need for managers of humanitarian programs to implement a zero tolerance policy regarding perpetration of gender-based violence by staff.

Monitoring and Evaluation

Reasons WHY USAID-funded programs should invest in monitoring and evaluation of GBV interventions

Over the past two decades, donors have funded a large and growing number of programs aimed at preventing and responding to gender-based violence in developing countries. Unfortunately, few have been rigorously evaluated. The implementation of sound monitoring and evaluation (M&E) techniques will help the development field as a whole identify the most effective programmatic approaches that are most worthy of replication and scale-up. Therefore, investment is needed to build a stronger evidence base to allow informed decisions about GBV programming and to ensure that the health and safety of girls and women are protected throughout health sector programming more generally.

HOW USAID-funded programs can invest in monitoring and evaluation

1) **Support efforts to improve research and evaluation methods related to GBV.** Because GBV is a relatively new area of focus for the health sector, there is a need to improve and standardize the indicators, research methods, and data collection tools used to evaluate many types of GBV interventions:

a. ***Develop valid and reliable indicators.*** Indicators are valid to the extent that they clearly and directly measure the results they are intended to measure. Therefore, indicators should always be field-tested. Researchers have made progress in measuring levels, types, and severity of gender-based violence. Less work has been done on standardizing indicators to measure the impact of GBV interventions on women's health and well-being, particularly as interpreted by women themselves (clients' perspectives). In addition, particular attention needs to be paid to the measurement of unintended consequences of GBV interventions.

Selected reasons why USAID-funded programs should address gender-based violence

- Need to expand the knowledge base about effective ways to prevent and respond to gender-based violence, particularly in developing countries.
- Need to improve program designs to ensure that GBV interventions benefit women, as intended.
- Monitoring and evaluation of GBV in all health programs can help to fix flaws in program design that may be inadvertently placing girls and women at increased risk of violence.
- Policymakers and donors need more scientific information about which approaches to GBV actually work to ensure that they are making wise investment choices.

b. ***Develop better evaluation study designs and tools.*** There are challenges related to study designs and data collection tools for evaluating GBV programs. Careful attention must be paid to baseline data collection and clear definition of the intervention population. Most often, evaluation designs are able to attribute *association* between variables rather than *causality*. For example—because many programs focus on knowledge and attitudes toward violence, their evaluations are designed to measure changes in attitudes related to GBV. It is important to note that attitudes measure levels of tolerance/acceptability of GBV and cannot be predictive of who will perpetrate violence or where violence levels are likely to be higher.

c. ***Improve understanding of what constitutes "success."*** Success should always be defined based on the goals and methodologies of the intervention at hand. For example, reduced levels of violence would seem like obvious measures of success in the area of prevention, but if the intervention focuses on decreasing community acceptance for GBV, "success" should be measured along changes in attitudes that tolerate GBV. In addition, a measure

of success should also consider that a short-term increase of GBV could be the effect of increased awareness and reporting of cases. Evidence suggests that long-term reductions in GBV sometimes occur only after short-term increases—both for individuals (Sullivan and Bybee, 1999) and communities (Jewkes, 2002). At the community level, empowering women—an important factor in long-term prevention efforts—may create a violent backlash from men trying to enforce traditional gender norms. Hence, short-term levels of violence may not be a useful way to determine whether a program has achieved success.

2) **Require all GBV programs to have a strong M&E component.** Too often, programs are designed and implemented with M&E only as an afterthought. Regardless of the type of GBV intervention, programs should be required to incorporate the following into their work before they begin a new project:

a. ***Identify results-oriented objectives.*** Program objectives should explicitly state intended results and should capture what it would mean to achieve success—even at the intermediate level. For example, instead of objectives such as "to train 20 doctors in the area of GBV," programs should use "results-oriented" objectives such as "to improve the GBV knowledge and intervention skills of 20 doctors." If the objective is to improve the quality of care for those affected by GBV, then indicators of quality should be developed, measured, and used for evaluation (see Table 5). Without results-oriented objectives, programs generally have difficulty evaluating their work.

b. ***Ensure comparable baseline and follow-up data collection.*** Instead of relying only on "needs assessments" or "situation analyses," programs should also devote resources to gathering baseline data that can be used to measure quantitative indicators of change over time. Retrospective evaluations are inherently limited and usually inadequate.

c. ***Include data collection on the perspectives of women and/or GBV survivors as part of the evaluation plan.*** Depending on the type of program, gathering data on women's own perspectives—and when possible, the perspectives of GBV survivors—is an essential way to understand the quality and effectiveness of any GBV intervention.

d. ***Devote a significant portion of the budget to monitoring and evaluation.*** High-quality evaluation costs money, and programmers often hesitate to divert scarce program funding to evaluation. Substantial investment should be devoted to rigorous monitoring and evaluation. As a rule of thumb, programs should allocate 10 percent of their total budget to monitoring and evaluation efforts. This can include paying external evaluation consultants or including line items for full-time evaluation staff.

Table 5. Examples of Objectives and Indicators for Different Types of GBV Programs

As discussed above, few standardized indicators have been widely accepted as reliable measures of effectiveness in the area of GBV programming. Ideally, reported levels of violence would be the ultimate outcome; however, for methodological reasons, most programs rely on intermediate indicators. The examples below have been used in some form in programs. Some of these are limited in scope as to what is measured; for example, it is unclear whether changes in reported attitudes translate into behavior change or merely reflect changes in what respondents consider to be socially acceptable answers. However, they provide illustrative examples of indicators to be included in USAID-funded programs that address GBV.

Type of program	Results-oriented objectives	Examples of indicators that have been used in the field
Community mobilization	Reduce community tolerance for violence against women	• Proportion of survey respondents who say that wife-beating is considered an acceptable way for husbands to discipline their wives in their community (under specific circumstances).
	Improve the community response to violence	• Proportion of respondents who say they would assist a woman being beaten by her husband (could be asked of anyone about women in their extended family, of police about women who lodge a complaint, or of judges who preside over cases before the courts, etc.) versus those who say that intimate partner violence is a private matter between a couple and others should not intervene. • Number and types of organizations equipped to provide services to survivors of violence in the community; numbers of survivors who receive services over a 12-month period; perspectives of survivors about the quality of services, benefits, and risks of those services.
Communication for social and behavior change	Improve attitudes and behaviors (of specific groups)	• Proportion of respondents who say that men cannot be held responsible for controlling their sexual behavior (or other specific attitude or behavior depending on the local situation and the focus of the intervention). • Proportion of men or women among beneficiary group who believe that violence (specify behavior) is not an acceptable way of dealing with intimate partners.
Health service delivery	Improve the quality of health services for survivors of GBV	• Qualitative perspectives of women generally/survivors about the quality of the services received, the benefits, and the risks of those services (gathered through focus groups/ in-depth interviews, respectively).
	Strengthen privacy and confidentiality within health clinics	• Proportion of clinics with private consultation areas that cannot be overheard or seen from outside; have written confidentiality policies and secure places to store records; collect intake information in public areas; and have a majority of providers who follow written confidentiality policies.

Table 5. Examples of Objectives and Indicators for Different Types of GBV Programs

Type of program	Results-oriented objectives	Examples of indicators that have been used in the field
Health policy	Improve laws/policies related to GBV	• Types of changes in laws or policies related to GBV (could be positive or negative); if positive, with some evidence of a causal link to program.
	Improve survivors access to legal protections accorded by law	• Proportion of women who know their rights under the law (civil and criminal). • Proportion of women who know how to access the legal system. • Perspectives of survivors who have sought to exercise specific legal rights about the benefits and harm experienced in the process (qualitative).
Youth	Improve the institutional response of schools, health clinics, etc., to young survivors of sexual violence	• Proportion of girls who say they would be willing to report an experience of sexual violence at their school. • Proportion of personnel in an institution who know the policies related to sexual harassment/care for young survivors of sexual abuse, etc. • Proportion of personnel in a given institution who report compliance with those policies; and who report that other staff comply with those policies. • Percent of young survivors of sexual abuse who were referred to professional counselors (or legal services) in the past 12 months.
	Improve attitudes and behaviors related to sexual coercion among young men	• Proportion of young men who say that they had ever or would ever force a girl to have sex if she 'led him on' (again, the indicator would have to be adapted to local norms, attitudes, and documented practices). • Proportion of girls reporting certain types of sexual harassment, coercion, or abuse in a given setting over a given period of time.
Humanitarian	Reduce sexual violence and exploitation by UN peacekeepers	• Proportion of peacekeeping personnel reporting attitudes that tolerate sexual violence and exploitation (would be more specific). • Proportion of peacekeeping personnel reporting practices that tolerate sexual violence and exploitation (would be more specific). • Proportion of complaints investigated at different levels during a specified period. • Proportion of complaints that resulted in a given outcome in a specified period. • Changes in enforcement mechanism (qualitative).

3) **Ensure that evaluations of all relevant health programs consider the issue of GBV, even if GBV is not the main focus of their work.** Virtually all health sector programming could benefit from paying closer attention to the implications of gender-based violence. USAID should encourage programs to include attention to GBV in their evaluations, even if violence is not the primary focus of their work. For example:

a. ***HIV/AIDS testing and counseling programs*** should monitor whether policies and practices minimize the risk that female patients experience violence from family members after learning their HIV status or upon disclosure of their HIV status.

b. ***Reproductive health programs for youth*** should evaluate whether their strategies reduce or exacerbate attitudes that condone sexual harassment against girls (shown to be a problem in some cases; e.g., see Campbell and MacPhail, 2002).

c. ***Programs aimed at empowering women*** through income generation, education, and microcredit should evaluate whether they are doing enough to minimize the risk that participants will experience a violent backlash by male partners.

d. ***Health service delivery programs*** should evaluate whether providers are prepared to care for survivors of sexual violence in a compassionate and competent way.

4) **Support scientific evaluations of existing GBV programs funded by other donors.** Many promising interventions in the area of GBV prevention and response have worked for years without receiving sufficient funds for rigorous, longitudinal evaluations. USAID could contribute to the field by investing in scientific evaluations of promising approaches, such as selected programs described in the literature review by Guedes (2004).

5) **Invest in intervention research projects specifically designed to build the evidence base about effective GBV prevention and response strategies.** In some cases, interventions research projects are needed to answer specific questions about effective ways to prevent or respond to gender-based violence. Such research may contribute to national-level decisionmaking or the international debates about best practices. For example, well-designed research projects such as clinical trials may be able to quell the debate over the benefits and risks of routine enquiry within health services in developing countries.

For more information on monitoring and evaluation related to GBV, see Bloom, forthcoming, www.igwg.org.

In Summary…

USAID-funded Programs SHOULD	USAID-funded Programs SHOULD NOT
Invest in methodological work to improve the indicators, study designs, and tools available for GBV evaluation.	Miss opportunities to invest in effective monitoring and evaluation of programs that address gender-based violence.
Require all GBV programs to monitor and evaluate their work rigorously.	Neglect to devote an adequate proportion of the budget to monitoring and evaluation.
Encourage all health programming to evaluate their work in light of gender-based violence.	Overlook the possibility that health programs may unintentionally increase risk of gender-based violence for certain women.
Support scientific evaluations of promising programs funded by other donors.	Overlook opportunities to cost-share investments that can result in expanding the evidence base of effective GBV interventions.
Support interventions research projects to answer key questions in the area of gender-based violence.	Consider research a lower priority than program implementation/service-delivery activities.

PART III

KEY RESOURCES AND WORKS CITED

Key Resources

Academic Research

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