ADDRESSING GENDER–BASED VIOLENCE

FROM THE

REPRODUCTIVE HEALTH/HIV SECTOR

A LITERATURE REVIEW AND ANALYSIS

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For more information, visit www.igwg.org.

ACRONYMS

ACASAC	Asesoría, Capacitación y Asistencia en Salud
AusAID	Australian Agency for International Development
BCC	Behavior change communication
CEDOVIP	Center for Domestic Violence Prevention
CEJIL	Center for Justice and International Law
CEPS	Center for the Study of Social Promotion
CIDA/GESP II	Canadian International Development Agency/Government Education Support Program II
CLADEM	Latin American and Caribbean Committee for the Defense of Women's Rights
CPC	Carolina Population Center
CRR	Center for Reproductive Rights
CWCC	Cambodian Women's Crisis Centre
DHS	Demographic and Health Survey
FVPF	Family Violence Prevention Fund
GEM	Gender equitable men
GH	Bureau for Global Health
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ICPD	International Conference on Population and Development (Cairo, 1994)
ICRW	International Center for Research on Women
IDP	Internally displaced populations
IEC	Information, education, and communication
IGWG	Interagency Gender Working Group
ILANUD	El Instituto Legal de Los Naciones Unidas y Desarollo
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IMSS	Mexican Institute of Social Security
INPPARES	Instituto Peruano de Paternidad Responsable
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IRC	International Rescue Committee
IWHC	International Women's Health Coalition
KAP	Knowledge, attitudes, and practices
MAP	Men as Partners
NAMEC	Namibian Men for Change
NAWOU	National Association of Women's Organizations in Uganda
NGO	Nongovernmental organization
NNVAW	National Network on Violence Against Women
PADV	Project Against Domestic Violence
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PLAFAM	Asociación Civil de Planificación Familiar
PPASA	Planned Parenthood Association of South Africa
PROFAMILIA	Asociación Pro-Bienestar de la Familia
PROWID	Promoting Women in Development
RADAR	Rural AIDS and Development Action Research Programme
RH	Reproductive health
RHR	Reproductive Health for Refugees
SAGBVHI	South African Gender-Based Violence and Health Initiative
SIDH	Society for the Integrated Development of the Himalayas
SRH	Sexual and reproductive health
SRR	Sexual and reproductive rights
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TANESA	Tanzania–Netherlands Project to Support HIV/AIDS Control in Mwanza Region

TARSC	Training and Research Support Centre
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organization
WRC	White Ribbon Campaign

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EXECUTIVE SUMMARY

Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place. Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime.[1] Gender-based violence can result in many negative consequences for women's health and well-being. It can also affect their children and undermine the economic well-being of societies.

Gender-based violence and HIV/AIDS are also inextricably linked. The experience of violence affects the risk of HIV and other sexually transmitted infections (STIs) directly when it interferes with women's ability to negotiate condom use. Fear of violence not only hinders women's ability to propose condom use but may also keep them from voluntary HIV/AIDS counseling and testing. Furthermore, women may be at risk of violence after disclosing their HIV status to their partner, suggesting that domestic violence should be considered when formulating partner notification policies and HIV counseling.[2] [3]

The sheer magnitude of violence and its consequences justifies the need for greater investment in this area.

This document provides a literature review and analysis to the United States Agency for International Development's (USAID) Bureau for Global Health (GH) on programs in developing countries that have addressed or challenged gender-based violence with a link to the reproductive health (RH)/HIV sectors.

For this review, programs addressing both adult and adolescent populations were eligible for inclusion and an effort was made to identify programs that involved men. Gender-based violence is defined as any act of intimate partner physical violence and sexual violence by strangers or intimate partners. It is noteworthy that although sexual coercion has been defined in various ways, two elements seem key in understanding this type of violence. First, sexual coercion exists along a continuum of behaviors that range from threats and unwanted touch to rape. Second, women who are victims of such violence lack options to pursue that will not bring about severe physical and/or social consequences.[4] The recent *World Report on Violence and Health* defines sexual violence as

> any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim.[5]

Although there are numerous gender-based violence–related initiatives taking place in various parts of the world, many of them are quite small and few have been rigorously evaluated and/or

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[1]Heise L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Reports*, 27(4), 1999. [Available in English at http://www.infoforhealth.org/pr/l11edsum.shtml.]

[2]USAID/Synergy. *Women's Experiences With HIV Serodisclosure in Africa: Implications for VCT and PMTCT.* Meeting Report. Washington, DC: USAID, March 2004.

[3]Gielen, A.C. et al. "Women's Disclosure of HIV Status: Experiences of Mistreatment and Violence in an Urban Setting." *Women's Health,* 25(3):19–31, 1997.

[4]Heise, L.L., K. Moore, and N. Toubia. *Sexual Coercion and Reproductive Health: A Focus on Research*. New York: The Population Council, New York, 1995.

[5]World Health Organization. *World Report on Violence and Health*. Geneva: World Health Organization, 2002.

documented. When evaluations have been implemented, their quality tends to be uneven. There is a general perception in the field that little funding has been available in the area of violence and even less for evaluating existing initiatives. In many cases, evaluations have assessed changes in knowledge and attitudes among providers, men, and women, but have not been able to assess or demonstrate changes in corresponding behaviors. In other instances, no baseline data are available to serve as a point of comparison. Additionally, because gender-based violence interventions are about enhancing knowledge and changing attitudes, behavior, and practices, long-term intervention and financial support are required. At least part of the weakness of the evaluation of these programs results from the limited time between intervention and follow-up evaluations. These findings signal the need for greater investment in well-designed program evaluations and point to the present challenge of determining the most effective interventions in addressing and challenging gender-based violence.

Given the lack of rigorous evaluation data, it is too early to characterize initiatives in the area of gender-based violence as best practices. This review offers the reader an idea of the range of approaches available to address gender-based violence, with an understanding that

- these are not necessarily exhaustive;
- although they have demonstrated some degree of success, they should be seen as promising and not necessarily best practices; and
- there may be initiatives that are equally or more promising in addressing gender-based violence as the ones presented here.

However, because they have not been documented, currently information about these programs is inaccessible.

When deciding how best to support programs in the area of gender-based violence, it is important to note that programs have an impact on survivors' lives and community norms regardless of whether they are implementing specific violence initiatives. Health care providers, for example, are likely to have cared for survivors of violence (whether or not they know it) and their actions can have an impact on women's ability to overcome a situation of violence. Similarly, communication programs can unknowingly have an impact on gender-based violence by unintentionally promoting negative gender norms, such as appealing to macho and aggressive imagery when promoting condom use. Consequently, initiatives in the RH/HIV sectors should consider gender norms and violence regardless of whether this is their main area of focus.

This review highlights the unique contribution of four approaches to addressing gender-based violence, including behavior change communication (BCC), community mobilization, service provision, and policy. Two additional sections are organized around the audiences targeted by the various programs, namely youth and refugees, internally displaced populations, and returnees.

The overview to each section outlines the unique contribution of the different approaches in challenging gender-based violence. The following observations, however, point to some of the common characteristics of promising interventions.

- Promising initiatives tend to use multiple strategies, from training health providers to carrying out information, education, and communication (IEC) campaigns.

Promising initiatives also make an effort to link experiences from different levels, for example, linking local and national initiatives so that practice feeds back into policy and vice versa.

- Programs tend to establish partnerships among sectors that build on each other's strengths to cover the wide needs of survivors and effect change on multiple levels. Partnerships are important between different sectors (health, justice, education), but also between civil society and governments and between researchers, activists, policymakers, and service providers.

- Promising efforts to improve the response to violence tend to follow what Heise et al. call a systems approach, which involves the whole organization. In the health sector, for example, training is accompanied by a broad effort to review an institution's policies and resources, including infrastructure, service protocols, screening tools, and referral directories.

- Various programs emphasize the importance of employing a human rights perspective in addition to a gender perspective. Such a perspective recognizes that gender-based violence constitutes a violation of basic human rights (such as the right to be free from torture and ill treatment). It further accepts that human rights are inalienable and indivisible—women have a right to live free of violence under all circumstances and they should not have to give up this right in order to maintain a family or to ensure economic support for their children.

- Programs also point to the importance of ensuring a wide buy in among all staff or all community members. For example, a broad range of staff—from management to administrative—should be included when conducting training. Additionally, support from upper management can make or break an initiative. When working at the community level, efforts should be made to involve community members from the earliest stages of program design.

- Gender-based violence is an extremely sensitive issue and is deeply rooted in cultural values. Any initiative should ensure the cultural appropriateness of proposed interventions and careful consideration should be given when transferring experiences from one setting to another.

- When attempting to change attitudes among specific groups, such as teachers, health care providers, or young men, initiatives should highlight the importance of addressing individual experiences and perceptions of violence first and foremost.

- At the same time, because the roots of violence permeate individual and collective values, promising initiatives have sought to promote change at both the individual and community levels; some have also sought to create an environment of nonacceptance and shame for perpetrators of violence.

Program evaluation data presently available are generally weak and have not focused on the impact of gender-based violence initiatives on sexual reproductive health (SRH) outcomes. However, even though improving SRH outcomes is a legitimate concern, gender-based violence should be seen as a valid issue in its own right because it represents one of the worst violations of human rights and has a tremendous effect on women's health. The only way to improve the

current state of knowledge in the field is to invest in sound programs that include well-designed evaluation components. Although the lack of evaluation data makes it a challenge to ascertain the most effective interventions in the field, the following should be considered when programming future gender-based violence initiatives:

- Logistic Support
  - Invest in long-term, multisectoral programs
  - Invest in well-designed evaluations

- Guiding Principles in Gender-Based Violence Programming
  - Ensure that all initiatives respect survivors' safety and autonomy first and foremost
  - Employ a human rights perspective[6]
  - Ensure cultural appropriateness of interventions

- Program Structure
  - Work in partnerships
  - Use multiple strategies and link different levels of interventions
  - Promote systemwide changes
  - Promote change at individual and collective levels
  - Integrate gender-based violence components into existing programs

- Sensitization and Training
  - Address program staff's own experiences and perceptions of violence
  - Do not assume that training of trainers is suitable for such sensitive topics as gender-based violence
  - Promote wide buy in among all staff and/or community members

- Programmatic Priorities
  - Promote programs that challenge norms that perpetuate violence
  - Empower women and girls
  - Ensure that survivors have access to needed services
  - Involve young and adult men
  - Increase negative consequences of violent behavior to abusers
  - Ensure that programs in humanitarian settings systematically address gender-based violence

[6]A rights-based approach places the discussion of gender-based violence within a broader framework of human rights and justice to challenge prevailing norms, such as the notion that domestic violence is a private issue, and to empower individuals and communities to promote change. It further accepts that human rights are inalienable and indivisible: that women have a right to live free of violence under all circumstances and that they should not have to give up this right in order to maintain a family or to ensure economic support for their children. More information on what it means to apply a human rights framework is provided later in this review.

I. INTRODUCTION

In 1993, the United Nations adopted the first international definition of violence against women. By referring to violence against women as gender-based, the United Nations highlighted the need to understand violence against women within the context of women's and girls' subordinate status to men and boys in society. While both women and men experience violence, evidence suggests that the risk factors, patterns, and consequences of violence against women are different than violence against men.[7] As argued by Heise et al., "many cultures have beliefs, norms and social institutions that legitimize and therefore perpetuate violence against women."[8] Violence against women, therefore, cannot be separated from the norms, social structures, and gender roles that influence women's vulnerability to violence.

Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place. Worldwide, at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime.[9] Additionally, in some parts of the world, economic violence (for example, deliberately and capriciously withholding money from a woman, often to the point where she cannot feed herself or her children) is also thought to be widespread. Gender-based violence can result in many negative consequences for women's health and well-being. It can also have an impact on their children and undermine the economic well-being of societies. The sheer magnitude of violence and its consequences justifies the need for greater investment in this area.

The purpose of this document is to provide a literature review and analysis to the United States Agency for International Development's (USAID) Bureau for Global Health (GH) on programs in developing countries that have addressed or challenged gender-based violence with a link to the reproductive health (RH)/HIV sectors. The product of the review is intended to inform GH staff on the range of approaches available to address gender-based violence within sexual reproductive health (SRH) and HIV programs, help clarify future USAID activities in this area, and provide guidance for GH implementing partners.

For the purposes of this review, gender-based violence was defined as any act of intimate partner physical violence, sexual violence, and rape (whether by strangers or intimate partners). Programs addressing both adult and adolescent populations were eligible for inclusion and an effort was made to identify programs that involved men.

Although there is great interest at present to determine the strategies that produce the best results in terms of preventing and/or combating gender-based violence, in general little investment has been made to date in rigorously evaluating existing initiatives. For this reason, it is simply too early to characterize initiatives in the area of gender-based violence as best practices. In the words of one respondent, "I have trouble with the term best practices because often the only project working on a given issue with a certain approach is lumped into this category and it may

[7]For example, see "Gender Matters: WHO's Gender Policy and the Importance of Gender in Health Interventions and Research." PowerPoint presentation. Geneva: World Health Organization, 2003. [Available online at www.who.int, reviewed February 2004.]
[8]Heise, L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Reports,* 27(4), 1999. [Available in English at http://www.infoforhealth.org/pr/l11edsum.shtml.]
[9]Ibid.

not be 'best.'" Therefore, this review presents an idea of the range of approaches in addressing gender-based violence, with an understanding that

- these are not necessarily exhaustive;
- although they have demonstrated some degree of success, they should be seen as promising and not necessarily best practices; and
- there may be initiatives that are as equally or more promising in addressing gender-based violence as the ones presented here.

However, because they have not been documented, information about these programs is not accessible currently.

II. METHODOLOGY

This review was primarily based on unpublished documents and data collected through informants active in the area of gender-based violence as well as published documents produced between 1995 and the present in English, Spanish, and Portuguese.

An initial list of experts in the field was created through collaboration between the consultant and USAID staff members. The list was expanded until it reached 87 individuals, representing a wide range of programmatic and geographic areas (see appendix B). These individuals were then contacted via e-mail and/or telephone. A minimum of two attempts was made to contact each informant, obtaining a response rate of over 80 percent. Informants were asked to provide information about promising programs in the area of gender-based violence that fit any of the six following categories (or additional ones) previously defined by USAID:

- Behavior change communication (BCC)
- Service delivery programs
- Community mobilization
- Policy
- Programs aimed at youth
- Programs working with refugees, internally displaced populations (IDPs), and/or returnees

While the first four categories refer to specific approaches, such as BCC and service delivery, the latter are based not on approaches but on the populations targeted. This choice of structure resulted from the recognition of the particular relevance of working with youth and of the specific characteristics applicable to refugees, returnees, and IDPs.

Individuals who were associated with specific programs were asked to provide information on their programs and, in particular, the results of any evaluations carried out.

To compile the bibliography of published documents, the following sources were used:

- search engines such as POPLINE® and MedlinePlus® using the general key words "violence against women," "violence prevention," and "violence control;" and
- compiled reviews of interventions and strategies used worldwide to address violence against women. These reports were an important source of leads on published and unpublished articles about strategies and interventions. These include reports compiled by the United Nations Development Fund for Women (UNIFEM), the Pan American Health Organization (PAHO), *Population Reports*, the United Nations Population Fund (UNFPA), the Panos Institute, the Family Violence Prevention Fund (FVPF), the World Health Organization (WHO), and the Inter-American Development Bank.

It is important to note that the present review distinguishes itself from previous reviews by

- including a broad range of programs (BCC, service delivery programs);
- focusing exclusively on programs in developing countries in various regions of the world; and
- using evaluation as one criteria for inclusion.

After reviewing the documents and carrying out additional discussions with colleagues in the field, two or three programs representing each of the six categories above were selected to embody their potential in addressing gender-based violence. In the process of selecting programs to be highlighted, four main criteria were taken into consideration:

- The initiatives had been evaluated and/or well documented.
- Multiple informants had identified the initiative as a promising program.
- The initiative seemed to offer the potential for scaling up or replication.
- Program staff was able/willing to share relevant documents.

Each section of this review (e.g., BCC, Community Mobilization) is followed by an annotated bibliography containing additional programs in those specific areas. Those publications and articles that cover more than one topic are compiled in appendix C.

Many programs and reviews have employed multiple approaches, such as mass media for behavior change and advocacy for policy reform and implementation. In this case, programs were included under the categories that best described the main focus of their approach.

Although an effort was made to unearth innovative and promising approaches, this review was limited to those programs based in developing countries, which had produced accessible documentation in English, Spanish, and/or Portuguese. It was also limited by time constraints. Consequently, there may be other promising initiatives that for various reasons have either not been documented or have not been written in these languages. Additionally, although a good response rate was obtained, some key respondents were not able to respond. Fore these reasons, it is possible that some important programs may not have been identified.

III. FINDINGS

BEHAVIOR CHANGE COMMUNICATION (BCC) PROGRAMS

OVERVIEW

BCC, like community mobilization strategies, has an important role in challenging prevailing beliefs and norms that contribute to the acceptability and perpetuation of gender-based violence. Communication strategies can contribute to shifting gender-based violence from a private matter to one that merits public attention and intervention. Acknowledging the widespread nature of the problem can also contribute to reducing survivors' isolation and creating an environment conducive to broad changes.

Communication strategies can contribute to social change on at least two levels.

- On the **individual level,** BCC can impart information and influence individuals' awareness, attitudes, and potentially, behaviors.

- On the **community level,** BCC can influence individuals' external environment, influence public and policy initiatives, and create the necessary conditions for change at both the individual and group levels.

The two initiatives presented here employ the entertainment-education, or edutainment, strategy to address gender-based violence. Edutainment is described as the "process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience members' knowledge about an educational issue, create favorable attitudes, shift social norms, and change overt behavior."[10] Edutainment may have a particular appeal to young people and thus may present a special opportunity to affect norms before they are fully set.

There are a number of characteristics that such programs have in common.

- Many initiatives have used multiple media channels, including radio, print, and in some cases, soap operas, to address a wide audience, including young people and men.

- The programs seek to effect change at both the individual and collective levels.

- They have established partnerships with other organizations to reach their goals.

- Although programs target gender-based violence, they also address a number of other issues, ranging from HIV prevention and gender equity to small business and hypertension.

- Some of these initiatives have an impressive reach in their communities. For example, Soul City 4 has reached 16.2 million people, while Sexto Sentido has

[10]Singhal, A., S. Usdin, E. Scheepers, S. Goldstein, and G. Japhet. "Entertainment-Education Strategy in Development Communication." In *Development and Communication in Africa,* C. Okigbo and F. Eribo, editors. Lanham, MD: Rowman & Littlefield Publishers, pp. 141–153, 2004.

reached half a million 13 to 24-year-olds, or the equivalent of 10 percent of the country's population.

- Additionally, once well established, such initiatives may be capable of generating revenue that can contribute to covering the costs of production; however, these programs tend to be costly and require a significant initial investment.

In terms of evaluations, although some initiatives have been able to measure changes in awareness and attitudes, most have been unable to measure changes in behaviors. In fact, one of the main challenges for BCC programs ensues from the difficulty of evaluating long-term, complex social change processes. Sexto Sentido, which is highlighted in this section, is currently collaborating on an ambitious evaluation effort that will use both qualitative and quantitative methods, including a three-year cohort study involving more than 4,000 individuals. The study—which will begin in the fall of 2004 and repeat during 2005 and 2006—may provide evidence regarding the potential of such initiatives in promoting behavior changes. However, the fact that they have been able to produce some changes in awareness and attitudes as well as create a wider environment conducive to policy change (such as the approval of national legislation on domestic violence in South Africa) provides persuasive clues concerning the potential of such initiatives in combating gender-based violence and other negative outcomes of inequitable gender norms.

Other BCC strategies have been used to address gender-based violence, including campaigns to disseminate information on gender-based violence legislation. However, few of these have been documented and even fewer have been evaluated. Oxfam recently carried out a study in South Asia to examine how men, women, youth, survivors, and perpetrators of domestic violence consume and process communication by examining four product advertisements, four public service announcements, and four spots produced by the International Center for Research on Women (ICRW). The results of the study are not yet available but will serve to guide Oxfam's campaign on domestic violence in the South Asia region.[11]

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

The two programs selected to exemplify the potential of BCC initiatives in addressing gender-based violence are Sexto Sentido in Nicaragua and Soul City in South Africa. As mentioned in the methodology section, the programs were selected based on the following criteria:

- both programs have been evaluated and well documented,
- multiple informants identified them as promising initiatives,
- the programs have potential for scaling up or replication, and
- the programs staffs were able to share relevant documents.

The fact that these programs target multiple populations (men and women, adolescents and adults) was also considered in their selection and points to the importance of involving men in BCC efforts as well as the importance of reaching populations before attitudes and normative behaviors are well established.

[11] Personal communication with Neelanjana Mukhia, Campaign Strategist, Campaign to End Violence Against Women (CEVAW), Oxfam Great Britain, South Asia. (no date)

POTENTIAL CONTRIBUTIONS OF PROGRAMS THAT EMPLOY BCC IN ADDRESSING GENDER–BASED VIOLENCE

BCC has a key role in challenging gender-based violence given its potential to create public awareness and debate and to change individual and collective attitudes. Some of the potential contributions of BCC programs include

- challenging prevailing beliefs and norms that contribute to the acceptability and perpetuation of gender-based violence;
- contributing to shifting gender-based violence from a private matter to one that merits public attention and intervention;
- contributing to social change by influencing individuals (awareness, attitudes, and behaviors) and their external environment; and
- reducing survivors' isolation and creating an environment conducive to wider changes by acknowledging the widespread nature of gender-based violence.

Although changing women's and girls' attitudes and behavior (such as seeking help) is a key step in addressing gender-based violence, the only way to end this type of violence in the long term is to effect changes in the norms and attitudes that enable gender-based violence to occur. BCC strategies can call into question existing norms that deem violence acceptable and enable gender-equitable norms and behaviors to be modeled. Involving and targeting men (young men in particular) in these efforts is crucial.

PUNTOS DE ENCUENTRO (Nicaragua)

Sexto Sentido (or *Sixth Sense*) is the name of a soap opera that is but one element of the BCC strategies employed by the feminist organization, Puntos de Encuentro (Puntos), based in Nicaragua. Puntos's mission is to help increase women's and young people's ability to take control of their lives and participate in all levels of society. To this end, Puntos is currently implementing the second phase of its multimedia/multimethod strategy, "We're Different, We're Equal," which is aimed at Nicaraguan youth. The objective of this initiative is to promote young people's rights and individual and collective empowerment, particularly in relation to sexual and reproductive health and rights issues by combining individual and social change catalysts operating simultaneously and over time.

The main components of this strategy include

- *Sexto Sentido*, a socially conscious soap opera that is broadcast weekly on national, commercial television as well as cable stations;
- *Sexto Sentido Radio*, a nightly youth call-in talk radio show that broadcasts live on six commercial radio stations;
- youth leadership training with community leaders, aimed at building leadership skills around sexual and reproductive health and rights issues, particularly gender, stigma, discrimination, and gender-based violence;

- coordination with journalists and media outlets;

- coordination with a variety of organized youth and women's groups, including youth leaders in other Central American countries; and

- ongoing monitoring and operations research, currently carried out in conjunction with the Horizons project.

Sexto Sentido is the main component of this strategy and uses edutainment to portray how such abstract issues as human rights and gender issues play out in daily life. A nightly youth talk radio program that encourages young people to call in and express their opinions and feelings follows each episode. Puntos also coordinates with local media and organizations around the country so that the same issues discussed on the show are raised in the media and in youth leadership training. Articles on the same topics are featured in Puntos' feminist magazine, *La Boletina*, which at 26,000 copies is the largest circulation magazine in the country.

After initial investments in infrastructure, the current cost of the television program is estimated at US $ .30 per viewer per episode, while the cost of the entire multimedia strategy totals $2.00 per viewer per year.

Evaluation

The first phase of the project was evaluated using the following methodologies:

- an analysis of commercial television ratings,
- a survey of 1,400 young men and women in 14 of the country's 17 departments,
- focus groups with young television reviewers,
- monitoring of calls to the radio program,
- interviews with 22 cooperating organizations, and
- letters to *Sexto Sentido.*

Based on television commercial ratings and surveys, Puntos estimates that more than half a million young people between the ages of 13 and 24 (over 10 percent of the country's overall population) had seen at least one or more episodes of the show and that 140,000 young people had heard of the radio program. According to the survey, two thirds of the viewers discussed the content of the episodes with someone else, with episodes relating to sexual and reproductive health and gender-based violence being singled out as the ones resulting in greater levels of reflection and discussion.

The story line used to address domestic violence was designed to raise awareness of existing legislation and to promote the idea that such violence is not a private issue. It also sought to inform viewers as to what to do in cases of violence. The evaluation revealed that frequent viewers of the show were more likely to have heard of the law and could correctly identify a related organization (43 percent of viewers compared with 34 percent of nonviewers). In terms of viewing domestic violence as a private matter, greater impact was observed among men, leading researchers to hypothesize that this was possibly a result of women's higher prior exposure to the issue in their daily lives, either as a result of being a victim of violence or because they have heard of other women's experiences.

The second phase of *Sexto Sentido*, "We're Different, We're Equal," is currently being evaluated in partnership with the Program for Appropriate Technology in Health (PATH), Leon University, and the Horizons project. The evaluation includes the following components:

- a panel survey with 4,500 respondents in three different sites;
- a qualitative component with young people, local leaders, and media figures; and
- a test of the impact of the multimedia campaign on gender equity, violence, youth rights, self-efficacy and collective efficacy, discrimination, and HIV prevention.

The study is scheduled for the fall of 2004 and will be repeated during 2005 and 2006.

Funding

Sexto Sentido is currently funded by a consortium of donors, including the embassies of Norway, Austria, and Denmark; the Ford Foundation; the United Nations Children's Fund (UNICEF); PATH; Terre des Hommes; and Forum Syd.

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SOUL CITY (South Africa)[12]

The Soul City Institute for Health and Development Communication (Soul City) is a nongovernmental organization based in South Africa that has been using mass media for social change since 1992. Soul City integrates a number of existing models of behavior change—social

[12] Soul City's programs have also been broadcast in other African countries as well as in Latin America, the Caribbean, and Southeast Asia. However, results presented here are based on the South African experience and evaluation.

learning theory, social network theory, and others[13]—to focus not only on individuals but also on their immediate interpersonal and social environments to create a supportive environment for behavior change.

Soul City uses edutainment, defining it as the art of integrating social issues into popular and high-quality entertainment formats based on a thorough research process. It also uses multiple media formats—prime-time television drama, radio drama, and print media—to capitalize on each medium's strength and to reach a variety of audiences. Soul City's media reaches more than 16 million South Africans. Soul City also has a number of offshoot projects, including a children's edutainment vehicle, *Soul Buddyz*.

Soul City's fourth series (*Soul City 4*) addressed gender-based violence (including domestic violence and sexual harassment) as well as AIDS (including date rape), small business development and personal savings, and hypertension. The series consisted of

- a 13–episode prime time television drama,
- a 45–episode radio drama in nine languages, and
- three full-color informational booklets (with a nationwide distribution of 1 million copies each).

Two elements are at the heart of Soul City's work: formative research and partnerships.

Formative research is carried out with both audiences and experts to develop and field test materials to ensure their effectiveness. The formative research process involves the following steps:

1. consulting widely with experts and key stakeholders on the topic issues;
2. consulting with audience members about their knowledge, concerns, and attitudes towards the issue as well as existing barriers to positive change;
3. presenting the findings from the first two steps to role players and experts;
4. developing a message brief or blueprint for the creative team who will develop the television and radio dramas;
5. integrating issues into the entertainment vehicle by the creative team;
6. producing and testing a draft outline (with experts, role players, and audience members);

[13] In social learning theory, behavior is explained via a three-way, dynamic, reciprocal theory in which personal factors, environmental influences, and behavior continually interact. Behavior changes result from interactions between person and environment, with change being bidirectional. Social network theory is an aspect of social science that applies to a wide range of human organizations, from small groups of people to entire nations. In social network theory, emphasis is placed on people or groups of people and a mapping of the relationship between them to study how the social structure of relationships around a person, group, or organization affects beliefs and behaviors. More information on the Soul City model of social change is available in detail in "Soul City—Theory and Impact" (synopsis) at http://www.soulcity.org.za.

7. writing and testing scripts;

8. producing, broadcasting, and distributing the material; and

9. evaluating the material and integrating lessons learned into future productions.

Partnerships are established with organizations active in the relevant issues. To address gender-based violence, Soul City established a partnership with the National Network on Violence Against Women (NNVAW), a coalition of 1,500 activists and community organizations from rural and urban areas. The objectives of the partnership included

- conveying information on women's rights, raising awareness of the topic, and promoting changes in attitudes, social norms, and practices around gender-based violence;

- helping connect audiences to needed services, including through a toll-free helpline;

- promoting individual and community action;

- creating an environment conducive to legislative change; and

- developing training materials on gender-based violence for various audiences.

Evaluation

The evaluation of *Soul City 4* involved several independently contracted studies that collectively formed the integrated evaluation of the initiative. The studies included the following:

- A national survey was carried out at baseline (preintervention) and evaluation (9 months after the baseline), consisting of standardized, face-to-face interviews conducted with different but largely comparable samples of 2,000 respondents for each survey.

- A sentinel site study was conducted in a rural and an urban site, which used the same instrument and methodology (standardized, face-to-face interviews) as the national survey, allowing for slight adaptations to take into account the differences in design and objectives. Interviews were carried out with a cohort sample of 500 respondents per site (with an additional 100 interviews controlling for the research effect) at baseline, twice during the time that *Soul City 4* was on the air, and postintervention.

- National qualitative impact assessment data comprised of 31 focus group interviews and individual interviews was conducted with *Soul City's* target audience. Approximately two thirds of the fieldwork was conducted in the two sentinel sites, and the remaining one third was extended to four other provinces. Respondents in the sentinel sites were part of the cohort study; in the other sites, respondents were selected based on exposure to *Soul City 4*. Thirty additional semi-structured interviews were conducted with community leaders.

Soul City 4 reached an estimated 16.2 million people in South Africa though radio, television, and print.

The research results presented here focus on the impact of *Soul City 4* on gender-based violence. However, detailed results are available on the program's impact on other issues, such as AIDS, hypertension, and personal finance.

Quantitative and qualitative results indicate an association between exposure to Soul City media and small increases in **knowledge and awareness** of the severity of domestic violence, the definition of violence against women (in particular of domestic violence), and the status of the law on violence against women as well as increased knowledge of what to do and where to go in cases of violence. Table 1 on the following page illustrates some of the changes observed.

Table 1
Changes in Knowledge and Awareness Between Baseline and Evaluation
(percentage)

Questions/Statements	Baseline (n = 1,694)	Evaluation (n = 1,750)
Do you think that domestic violence is a serious problem? (yes)	83	89
A man who forces his wife to have sex, even though she does not want to, is raping her. (agree)	86	90
If a man hits his wife, he is breaking the law, even if she is his wife or girlfriend. (agree)	87	93
Have you heard about the Domestic Violence Act? (yes)	8	51*

*Among those exposed to the three media sources of information for Soul City: television, radio, and print.

It is interesting that the baseline percentages are so high to begin with, possibly reflecting the widespread nature of violence against women. At the same time, these numbers contrast with the small percentage of the population who had heard of the Domestic Violence Act.

The evaluation also demonstrated an association between exposure to *Soul City* and improvements in **attitudes** around violence, including whether violence against women is a private issue, whether women should put up with abuse, whether women deserve to be beaten, and attitudes regarding the seriousness of violence against women.

Table 2
Changes in Attitudes Between Baseline and Evaluation
(percentage)

Statements	Baseline (n = 1,694)	Evaluation (n = 1,750)
Violence between a man and a woman is a private affair. (disagree)	56	66
If a man beats his wife or girlfriend, he probably has a good reason for it. (disagree)	48	58
No woman ever deserves to be beaten. (agree)	77	88
Women who are abused are expected to put up with it. (disagree)	68	72

However, there were no changes observed in some important attitudes, including, "As a head of household, a man has the right to beat his wife;" and "It is culturally acceptable for a man to beat his wife."

Negative changes were observed in terms of understanding what constitutes sexual harassment (one of the aims of the program), with a decrease between baseline (69 percent) and follow up (64 percent) in the number of respondents who indicated that they had heard of sexual harassment. However, there was an increase (from 46 percent at baseline to 70 percent at follow up) in the percentage of respondents who indicated that they could report someone who touched them against their will or made them feel uncomfortable at work.

In terms of **interpersonal communication**, exposure to Soul City media and multimedia was consistently associated with interpersonal communication about domestic violence, indicating that the program contributed to bringing domestic violence—a sensitive issue–out in the open. The program also helped raise women's awareness that talking about violence is a health-seeking behavior. As stated by a woman participating in the qualitative evaluation,

> Sometimes you are afraid to talk about it because you think this is only happening to you. So what *Soul City* has done is to show us that these things do happen at home. Remember that you are not alone—just talk about it and you will get help.

Although the numbers are small, exposure to the program was also associated with other support-seeking behavior, including contacting organizations in the area of violence and using the Stop Women Abuse helpline. Five percent of viewers exposed to Soul City's three components indicated that they had contacted an organization dealing with violence against women in the previous 6 months, compared to no viewers among those not exposed to *Soul City*.

Where **self-efficacy** is concerned, thematic analysis of qualitative data suggests that Soul City was able to sensitize women to their rights, facilitate access to services, and raise knowledge and awareness among both men and women around issues related to gender roles and equality. The following quote exemplifies the type of changes observed:

> It [*Soul City*] also touched my life about abuse. As I am a woman, I should not be [disrespected]. When you are a woman, I also have a right to say whatever I want to say.
>
> Rural female

Because of the small number of responses (and perhaps due to limited time lapse between intervention and assessment), the evaluation was not able to determine whether an association between *Soul City* and actual domestic violence behavior change took place. It is unclear whether the program intends to look into this in the future.

The evaluation also looked at the impact *Soul City* had on creating an environment conducive to change. By establishing the helpline and raising awareness of existing local service delivery programs, it may have contributed to helping those affected by violence connect with needed services. However, as in most developing (and many developed) countries, services are often limited, difficult to access, and of poor quality. The evaluation also indicated that *Soul City* helped contribute to the implementation of national legislation on domestic violence by putting pressure on and changing the discourse of national government officials and mobilizing funds that enabled the implementation of the legislation (by training service providers and educating communities).

Funding

Soul City's fourth series was funded by the European Union, the Department for International Development, the Japanese government, Kagiso Trust, and the Commission on Gender Equality. Commercial sponsorship came from BP and MTN.

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Available in English, Spanish, French, and many other languages at http://www.hcpartnership.org/index.php.

Review by UNIFEM

UNIFEM. *Picturing a Life Free of Violence: Media and Communication Strategies to End Violence Against Women*. New York: United Nations Development Fund for Women. 2001.

This report was a collaborative effort by UNIFEM and Johns Hopkins University. It presents a variety of media and communications strategies used in different parts of the world to reduce violence against women.

Available in English only at http://www.unifem.org.

Review by UNFPA

UNFPA. "Communication/Behaviour Change Tools: Entertainment–Education." *Programme Briefs No. 1*. New York: UNFPA, January 2002.

This issue of *Programme Briefs* reviews the lessons learned from entertainment–education programs throughout the world, many of which address the issue of violence against women. The issue profiles programs such as *Sexto Sentido*, Nicaragua, and *Soul City*, South Africa, and provides a nice summary of the state of knowledge about these efforts.

Available in English at
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The White Ribbon Campaign

Kaufman, M. *The AIM Framework: Addressing and Involving Men and Boys to Promote Gender Equality and End Gender Discrimination and Violence.* 2003.

The White Ribbon Campaign (WRC), which began in Canada in 1991, seeks to mobilize the voice of men and boys. Participants wear or display a white ribbon in public to pledge never to commit, condone, nor remain silent about violence against women. It is a call for governments and other institutions controlled by men to seriously address the issue. WRC's basic philosophy is that while not all men are responsible for committing violence against women, they must take responsibility for helping end it. WRC is nonpartisan and attempts to include men from across the social and political spectrum. It works with women's organizations and urges men to listen to the voices and concerns of women, conducts public awareness campaigns and involves high-profile men in speaking out against the violence, and provides resources for work in schools. There are currently or have been WRC activities—or use of the WRC symbol—in at least 35 countries, including Cambodia, China, India, Namibia, South Africa and Brazil. For more information, go to *http://www.whiteribbon.com*.

Available in English at http://www.michaelkaufman.com/articles/pdf/the-aim-framework.pdf.

The Nicaraguan Network of Women Against Violence

Ellsberg, M., J. Liljestrand, and A. Winkvist. "The Nicaraguan Network of Women Against Violence: Using Research and Action for Change." *Reproductive Health Matters*, 10:82–92, 1997.

The Nicaraguan Network of Women Against Violence has used several of the key strategies highlighted in this report, including mass media campaigns to reduce violence against women. During the 1990s, it carried out mass media campaigns on an annual basis. (See detailed write up in the policy section of this review.)

Full article available in English only; summaries available in Spanish and French.

COMMUNITY MOBILIZATION PROGRAMS

OVERVIEW

One of the major findings of international research on the causes of gender-based violence is that although individual risk factors—witnessing violence as a child, poverty, or use of alcohol—may increase a specific individual's likelihood to use violence, cultural norms play a large role in the overall levels of violence in a community. In many parts of the world, it is considered both a right and even an obligation for men to physically chastise their wives in the face of perceived transgressions. Women are taught to be submissive and obedient to their partners, and a man's honor often depends on his ability to control his wife's behavior.

Women have also internalized this norm. According to a recent Demographic and Health Survey (DHS) in Egypt, 69 percent of women believe that a man is justified in beating his wife if she disobeys him, and 70 percent believe that he has this right if she refuses him sex. In Ghana, 43 percent of men and 33 percent of women believe a beating is justified if a woman refuses sex.

These cultural norms not only encourage male violence against women, but also serve to entrap women in violent relationships by teaching them that violence is normal and deserved. Another common norm, that family affairs should be kept private and that outsiders should not intervene, isolates women from potential sources of support.

Community-based interventions have been used by health projects to address a variety of issues, ranging from family planning promotion to HIV/AIDS prevention. Similar techniques involving community mobilization and participation can also be used to address gender-based violence. Community-based education activities can serve to increase women's knowledge of legal and social rights and to empower them to seek help for abuse. They also aim to challenge the underlying beliefs that justify women's subordination and violence against women by promoting nonviolent and equitable relationships between men and women, particularly among youth. Additionally, since survivors often turn to their immediate family or neighborhood for help, local-level networks can facilitate women's access to the services they need. Such initiatives can also serve to create an environment that discourages violence by reprimanding or bringing shame upon perpetrators.

Initiatives that seek to mobilize communities to address gender-based violence tend to target multiple community members and organizations. These can include religious and traditional leaders, sports groups (particularly when working with youth and adult men), and more formal structures, such as police stations, schools, health organizations, and other nongovernmental organizations (NGOs). Helping a community identify key issues and ensuring collective buy in are important steps and are accomplished in different manners by different programs, but often involve an initial community assessment. This can be done in a variety of ways, including through focus group discussions, questionnaires, and indepth interviews with key informants. The key aspect of such initiatives is that problems and solutions are not imposed from the outside, but rather, the community is guided and empowered so that it can establish priorities for issues of concern and offer potential solutions.

The following five principles guide the Raising Voices initiative profiled in this section and synthesize some of the prerequisites for effective community-based initiatives.

- Domestic violence prevention requires the participation of all community members, including women, men, youth, and children.

- Individual behavioral options are greatly influenced by the attitudes and value system of one's community and, consequently, initiatives aimed at individual behavior change should also aim to influence the wider community.

- Each community should choose its value system and attitudes and not change under direction from outside forces.

- Communities need to feel engaged, supported, and empowered to make changes.

- Behavior change is a long-term process that requires long-term commitment from organizations and donors who undertake these processes.

The experiences presented in this section represent a broad range of strategies that seek to mobilize the community to address gender-based violence, from an alternative justice system initiative in India to a program targeting men in South Africa. These initiatives have a number of traits in common, including

- an underlying belief that protecting women's rights should be a collective responsibility;

- recognition that normative change needs to occur at both the individual and collective levels;

- the employment of multiple strategies to accomplish change of norms, including using the media, local activism, training, and information, education, and communication (IEC) initiatives;

- an emphasis on cultural relevance and appropriateness and on relying on local solutions and resources (some of these initiatives also tend to be highly culturally specific and may not lend themselves to easy replication, at least not without adaptation);

- the goal of creating a deterrent to men by reducing the community's tolerance to violence and improving the resources available to women; and

- a need for long-term investment. Effecting lasting community change is a long process that requires long-term investment and commitment.

With few exceptions, the evaluations were primarily qualitative and participatory in nature.

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

The programs selected to exemplify the potential of community involvement initiatives in addressing gender-based violence include Raising Voices (Uganda), the Nari Adalat and Mahila Panch initiatives under the Mahila Samakhya program (India), and the Men as Partners (MAP) program (South Africa). As mentioned in the methodology section, some of the criteria used to select these programs include

- the programs have been evaluated and well documented,
- multiple informants identified them as promising initiatives,
- the programs had potential for scaling up or replication, and
- program staff were able to share relevant documents.

Additionally, they represent a range of possible strategies for working at the community level, ranging from alternative justice systems in India to wide, long-term community mobilization in Uganda.

POTENTIAL CONTRIBUTIONS OF PROGRAMS THAT EMPLOY COMMUNITY MOBILIZATION IN ADDRESSING GENDER-BASED VIOLENCE

Community mobilization initiatives have a unique role in the fight against gender-based violence; similar to BCC strategies, they can challenge the cultural norms that contribute to the overall levels of violence in a community.

Community-based education activities can serve many purposes, such as

- increasing women's knowledge of legal and social rights;
- empowering them to seek help for abuse;
- promoting nonviolent and equitable relationships between men and women, particularly among youth;
- facilitating women's access to the services they need by improving resources available to women and by mobilizing local-level networks; and
- creating a deterrent to aggressors by reducing the community's tolerance to violence and creating an environment where perpetrators fear being publicly shamed for their actions.

Because community mobilization initiatives attempt to engage wide community participation and seek to promote change at both individual and collective levels, the involvement of men can be an important component of such programs. At an individual level, changing men's attitudes and behaviors towards gender-based violence is a long-term but essential strategy. One approach that can be used to this end is to involve adult gender-equitable men as role models to younger men. At the collective level, working to reduce the community's level of tolerance to gender-based violence may deter men who might fear being ostracized for the violence they commit.

DOMESTIC VIOLENCE PREVENTION PROJECT (RAISING VOICES) (Uganda)

The Domestic Violence Prevention Project was established in 2000 as a partnership between Raising Voices, the National Association of Women's Organizations in Uganda (NAWOU), and ActionAid for the purposes 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 the Center for Domestic Violence Prevention (CEDOVIP).

CEDOVIP works in 22 parishes in the Kawempe Division, which is located in the northern part of the Kampala District. The population is estimated at 350,000 people living in a densely populated urban area, most without access to such basic services as water, electricity, and sanitation.

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 based on a human rights framework. Not only is it based on the belief that women have the right to live free of violence, 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 which mirror Prochaska's theory of individual behavior change adapted to the community level.

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.

2. **Raising awareness** of domestic violence and its negative consequences with the community-at-large and among key professional sectors, such as health services and law enforcement.

3. **Building networks** of support, action, and strength to empower individuals to take action and make change.

4. **Integrating action** against domestic violence into daily life and systematically within institutions.

5. **Consolidating efforts** to ensure their sustainability, continued growth, and progress.

The project in Kampala is currently in phase 3. The idea of building networks is to create linkages between people at the community level so that they feel as though their work is connected to and building on the work of others. This helps create community ownership and solidarity around the issue. In this phase, multiple networks—nonformal and formal institution-based networks—are created. Nonformal networks have included beauty salons and barber shops that are now working together to prevent domestic violence as well as community action groups that formed in response to domestic violence. More formal networks include those created by health care providers and the police. There are also higher level networks consisting of leaders of health centers/hospitals as well as within the hierarchy of the police.

A variety of strategies and activities are used to influence change at each of the five phases mentioned above, including

- developing learning materials with rights-affirming messages;
- building the capacity of key groups, such as police officers and health care workers;
- carrying out local activism through community theater and door-to-door visits;
- using media and public events to bring these issues to the foreground; and
- carrying out local-level advocacy with key stakeholders to promote understanding.

Evaluation

An impact assessment of this initiative was carried out in July 2003 within four parishes in Kawempe Division. At the time that this assessment was conducted, only the first two phases of the project—community assessment and raising awareness—had been completed. Due to lack of funds to hire external evaluators, this assessment was carried out internally. An external evaluation is planned for June 2004.

This assessment used primarily qualitative research methods, including

- 40 semi-structured indepth interviews with 20 men and 20 women; and
- five focus group discussions with eight participants in each group (two groups were composed of all females, two were all males, and one was mixed).

Additionally, a questionnaire was administered to 100 community members in order to sample a large number of individuals and to allow for the triangulation of information. In total, 180 married men and women participated in the assessment.

The assessment indicated that human rights discourse seemed to contribute to a decrease in levels of violence against women in the home, as seen in table 3.

Table 3
Decreases in Levels of Domestic Violence
(percentage)

Reported Decreases in Violence	Women	Men
Physical Violence	48	48
Emotional Violence	54	52
Sexual Violence	52	42
Economic Violence	48	48

Men's reported fear of being publicly shamed by having their personal issues exposed seemed to have an important role in reducing violence in relationships. There was also a shift in the perception of community members of institutions such as local councils and police, which were now seen to be easier for women to access. Men mentioned that this reduced tolerance to violence affected their behavior. At the same time, 20 percent of men reported increased emotional violence in their relationship, commenting that this somewhat less tangible form of violence was used as an alternative to other forms of violence. In response to this, Raising Voices has started several new activities, including

- strengthening its work with men, including new men's groups and a new drama depicting the process of change one man undergoes and emphasizing the support of other men;
- implementing seminars on communication skills with local council leaders who are predominantly men (they are in charge of receiving domestic violence cases and operating the local/traditional courts);

- creating forums for men and women to talk about safe and happy relationships (to move away from talking about physical violence and promote ways in which couples can be more equal and respectful); and

- producing new learning materials that show the benefits of nonviolence.

Additionally, some women reported increased levels of physical violence (8 percent), emotional violence (10 percent), and sexual violence (12 percent). The program interprets this as the consequences of backlash. For some men, one way to demonstrate their resistance to the work and ideas is through exercising greater power and control over their partners. This is an issue of concern that has led Raising Voices to respond by

- increasing the visibility of community counselors,

- strengthening the community-based response mechanisms so that men feel they will be held accountable, and

- ensuring that women experiencing violence have access to support and services.

Additionally, the program has created a new drama about economic violence and women's right to work to specifically address the rise in economic violence.

Funding

Raising Voices is supported by The Moriah Fund, The Richard and Rhoda Goldman Fund, The McKnight Foundation, UNIFEM, and the Canadian International Development Agency/Government and Education Support Program II.

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NARI ADALAT AND MAHILA PANCH INITIATIVES UNDER THE MAHILA SAMAKHYA PROGRAM (Gujarat, India)

Mahila Samakhya is based upon the belief that women coming together to form a group, meeting together, analyzing their life situations, discussing what can be done, accessing the appropriate information, and acting on the issues they identify is an educational process. Consequently, Mahila Samakhya is a women-led initiative that aims to build village-level collectives of rural, poor, landless women that become forums for reflection, learning, and collective action. These sanghas, as they are known, were initially mobilized around issues of concern to the entire

village, such as water or health facilities. Success with these initiatives allowed them to address more controversial issues, such as domestic violence, which emerged from the beginning as an issue of concern to the communities. Because kinship ties placed restrictions on the extent to which women of the collectives could take objective stands on the issue of violence within their own villages, gradually village-level sanghas were created as separate forums to address violence against women.

Two such mechanisms were born out of the community-perceived need to address domestic violence: Nari Adalat (Women's Courts) and Mahila Panch (Women's Council). Although these exist in other Indian states, the initiatives described in this section are all based in the state of Gujarat to facilitate an analysis of existing evaluation results. Similar initiatives in other Indian states as well as additional women-initiated responses to domestic violence can be found in the ICRW publication, *Women-Initiated Community Level Responses to Domestic Violence: Summary Report of Three Studies.*

Both the Nari Adalat and the Mahila Panch were born out of a need to allow women to access justice that was inexpensive, accessible, and respectful towards them. They consist of women-initiated forums that enable a public, face-to-face arbitration between the two sides involved in violence disputes. Typically, a complainant files an application with the forum and activists of the Nari Adalat or Mahila Panch then write letters to summon the opposite side. Only when both sides are present is the process of arbitration initiated. A number of sessions may be required before a mutually agreeable solution is reached; the solution is then formalized through a written and signed agreement. Following up on the situation is also an important aspect of the process, particularly when the man and woman opt to live together. In such cases, a representative from the Nari Adalat or Mahila Panch calls on the woman to determine if her situation has improved.

The process undertaken by either of these forums is guided by a belief that reinstating women's rights is more important than simply punishing the perpetrator. Additionally, of central concern is the degree to which an atmosphere of physical and psychological safety is created for the woman to articulate her rights.

A key aspect of these mechanisms is the training afforded to the sangha women as well as to the group facilitators, known as sahyoginis. Both the content and the design of the training are based on a strong feminist critique of the legal system that allowed for the development of alternative definitions of violence against women and custody rights. Because self-reliance and locally determined ideals and solutions are key to these strategies, outside professionals, such as counselors and lawyers, are not necessarily included in or viewed as important to the process. None of the women who participate in the Mahila Panch and Nari Adalat are paid any honorarium or fee and they cover their own transportation costs. However, the applicant is asked to pay a fee based upon a sliding scale. These funds assist in offsetting costs related to the case, such as postage and travel.

The fact that these forums are seen as transparent, quick, and democratic places them in a good position to negotiate with perpetrators. Additionally, the ongoing threat of community ostracism (receiving a summons from either forum is shameful) and the threat of action by authorities are mechanisms that motivate the perpetrator to change his behavior.

Evaluation

This program was evaluated as part of a larger study of women-initiated community responses carried out in partnership with ICRW. The research design, which was not determined in advance but rather evolved through a participatory process, included

- process documentation, which followed six accounts of arbitration processes and their outcomes;
- documentation of the history and evolution of these initiatives (four organizational processes workshops were held in Gujarat); and
- a qualitative component, including 27 case studies of resolved cases and focus group discussions (5 with people in the villages and 36 with women from the programs) and semi-structured interviews with 10 influential community members.

The research methodology was based on two key principles:

- the research process should be participatory and
- the process should serve to strengthen the capacity of partner organizations.

A majority of the women studied reported that there was complete resolution of the problem without the occurrence of new problems. Of the 27 case studies conducted, there were only two cases in which a person (woman or man) reported complete unhappiness with the outcome. Personal gains among the women include self-expressed increased confidence and the sense of continuing support should any new issue arise. Knowing that they would be supported not only increased their confidence but seemed to serve as a deterrent to husbands and in-laws. Women reported an increased role in decision-making and improved relations within the family. Additionally, women's understanding of violence and their rights changed, with only two women reporting no change in their thinking. This new understanding is captured in the following quote, "We should not tolerate any wrong, or any beatings. We now protest and fight against violence."

Nonetheless, one significant drawback of such initiatives is that they tend to rely heavily on mediation and reconciliation. In some cases, this may lead them to place a higher priority on keeping families intact rather than on women's safety or well-being. This is a serious shortcoming of such programs and may undermine the safe space that they seek to promote within communities.

Sources

International Center for Research on Women. *Women-Initiated Community Level Responses to Domestic Violence: Summary Report of Three Studies.* Washington, DC: ICRW, 2002. Available at http://www.icrw.org/docs/DVIndia_Report5_702.pdf, accessed February 9, 2004.

MEN AS PARTNERS PROGRAM (South Africa)[14]

The Men as Partners (MAP) initiative began in 1998 as a collaboration between the New York-based EngenderHealth (formerly AVSC International) and the Planned Parenthood Association of South Africa (PPASA). The program was triggered by the urgent need to address both gender-based violence and HIV/AIDS in South Africa. It seeks to promote men's active and constructive involvement in preventing gender-based violence and in HIV/AIDS–related prevention, care, and support. MAP's primary goals are to

- challenge the attitudes, values, and behaviors of men that compromise their health and safety and that of women and children; and

- encourage men to become actively involved in preventing gender-based violence and the spread of HIV/AIDS.

In order to maximize the impact of the MAP program, EngenderHealth has built close working relationships with organizations capable of reaching millions of South African men. In partnership with the PPASA and the Women's Health Project, MAP has trained thousands of men within the South African National Defense Force. EngenderHealth also works in four provinces with Hope Worldwide, a national NGO working in the area of HIV/AIDS prevention, care, and support. In addition, to ensure that MAP is integrated into more clinical settings, MAP is working with the Perinatal HIV Research Unit at Africa's largest hospital to develop strategies that increase men's use of voluntary counseling and testing as well as encourage men to play an engaged role in preventing mother-to-child transmission.

One of the central elements of this program involves education workshops—usually a week long and often in a residential setting—with male and mixed sex audiences. Based on the premise that gender inequity contributes to both AIDS and violence against women in South Africa, the MAP program focuses on promoting discussions of gender issues, power dynamics, and gender stereotypes. Workshops are implemented by male and female educators (ranging in age from 20 to 35) who are trained through a training-of-trainers model.

The MAP program is based on the following three principles that recognize the importance of addressing the unequal balance of power between men and women:

- a recognition that contemporary gender roles confer on men the ability to influence and/or determine the reproductive choices made by their partners,

- an understanding that current gender roles also compromise men's health by equating certain risky behaviors as a sign of being manly and health-seeking behaviors as a sign of weakness, and

- an appreciation that men have a personal investment in challenging current gender roles both for their own health and for the well-being of the women they care about.

In addition to the workshops, MAP promotes a range of other activities in partnership with other organizations, including street theater in Johannesburg and Soweto, orientations for key

[14] Men As Partners has started to expand to other countries, including Kenya. However, the experience and data reported here are based on the implementation of the program in South Africa.

community stakeholders, outreach and discussions on commuter trains, forming community-based advisory councils, and integrating a gender analysis into condom distribution. MAP has also started to collaborate with the national government and may in the future train and support public officials.

Evaluation

EngenderHealth has conducted two evaluation studies of MAP to date that focus on assessing the attitudes, knowledge, and practices of workshop participants, including

- an evaluation in 2000 composed of preworkshop and postworkshop assessments of changes in men's attitudes, which did not include behavior change and partner interviews; and

- a longitudinal evaluation in 2003 that assessed 200 male workshop participants' changes in gender and reproductive health attitudes, knowledge, and practices before, immediately after, and 3 to 6 months after participating in the workshop. Additionally, this evaluation included 50 female partners of the male participants and interviews with participants and nonparticipants in a control group.

Table 4 highlights some of the findings of the 2003 report.

Table 4
Findings Related to Attitudes and Practices Among Men Attending Training, Prior to Training, and 3 Months After Training
(percentage)

Attitudes and Practices Among Men	Prior to Training	3 Months Following Training
Those who think it's okay for a woman to refuse to have sex without a condom	57	70
Those who disagreed or strongly disagreed that sometimes when a woman says no to sex, she does not really mean it	43	59
Those who disagreed or strongly disagreed that women who dress sexy want to be raped	61	82
Those who indicate that they had jointly decided with their partner whether or not to use contraception	70	79
Those who said that their partner did not have to listen to what they say/do what they tell her	57	68

Notwithstanding the positive changes documented, the evaluation also highlighted some areas that merit further attention during training. For instance, there was only a slight increase in participants' level of understanding of the forms of sexual violence (from 25 percent prior to training to 29 percent 3 months after training). Similarly, only modest increases were observed in the participants' understanding that rape is a manifestation of power relations and not the result of a need for sex (from 25 percent prior to training to 31 percent 3 months following training).

Despite the evaluations carried out to date, the program recognizes that there has been little systematic study to assess the effectiveness and impact of this model at the community level in achieving both gender-based violence and SRH/HIV goals. Therefore, a recently funded study

(in partnership with Frontiers/Population Council) will aim to answer the question of how effective involving men in RH/HIV/AIDS intervention is in reducing the risk of violence and promoting gender equitable relationships in

- increasing attitudes and behaviors supportive of gender egalitarian relations;
- reducing all forms of gender-based violence;
- reducing unwanted pregnancy and risky HIV and sexually transmitted infection (STI) behaviors;
- increasing men's involvement in HIV/AIDS–related prevention, care, and support activities; and
- having men proactively take a stand against men's violence against women.

This prospective study will be carried out as MAP is expanded to new sites in Soweto, Durban, Cape Town, and Umtata in the Eastern Cape in partnership with Hope Worldwide.

Funding

Funding agencies include USAID, the MacArthur Foundation, and the Ford Foundation.

Sources

EngenderHealth. *MAP Evaluation Report.* April 2003.

_____. "The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote HIV/STI Prevention." A Men As Partners briefing paper. New York: EngenderHealth, 2002.

International HIV/AIDS Alliance. *Working with Men, Responding to AIDS, Gender, Sexuality and HIV: A Case Study Collection*. London: International HIV/AIDS Alliance, 2003.

Kruger, V. *Evaluation Report: Men As Partners Program, Project Evaluation and Research Service*. September 2000.

Personal communication with Manisha Mehta, Dean Peacock, and Andrew Levack.

ANNOTATED BIBLIOGRAPHY

Stepping Stones, The Gambia

- Shaw. M. "'Before We Were Sleeping But Now We Are Awake:' The Stepping Stones Workshop Programme in the Gambia." In *Realising Rights: Transforming Approaches to Sexual and Reproductive Well-Being*, A. Cornwall and A. Welbourn, editors, pp.128–140, 2002.
  Summary available in English at http://www.id21.org/health/h6ms3g1.html.

- Paine, K. et al. "'Before We Were Sleeping, Now We Are Awake:' Preliminary Evaluation of the Stepping Stones Sexual Health Programme in the Gambia." *African Journal of AIDS Research* 1(1):41–52, 2002.
  Available in English only.
- Shaw, M. "A Qualitative Evaluation of the Impact of the Stepping Stones Sexual Health Programme on Domestic Violence and Relationship Power in Rural Gambia." Unpublished paper presented at the 6th Global Forum for Health Research, Arusha, Tanzania, November 2002.
  Available in English only.

  These articles describe the Stepping Stones STI/HIV–prevention project carried out in the Gambia. This program aimed to challenge attitudes about family planning, condoms, gender roles, and communication through drama workshops, assertiveness training, and peer group discussions about sexual health. The Medical Research Council (United Kingdom) evaluated the effectiveness of the program and found that it had a positive impact on both attitudes and behavior. In particular, the evaluation found that the program greatly reduced the social acceptability of wife-beating and induced a corresponding drop in that behavior.

Salud y Género, Mexico
Society for Integrated Development of Himalayas, India
Stepping Stones, Africa and Asia

Interagency Gender Working Group (IGWG). *Involving Men To Address Gender Inequities*. Washington, DC: Population Reference Bureau, 2003.
Available in English at
http://www.measurecommunication.org/Content/NavigationMenu/Measure_Communication/Gender3/InvolvMenToAddressGendr.pdf.

This publication documents three innovative programs that have engaged men and youth in efforts to improve reproductive health outcomes for both men and women. Salud y Género of Mexico has worked with men in Latin America to reduce gender-based violence and improve men's support for women's reproductive health. The Society for the Integrated Development of the Himalayas (SIDH) in India has focused on education as a means of achieving social justice in its work with young people of both sexes to improve gender equity and reproductive health outcomes. The Stepping Stones program, first developed in Uganda, is a communication, relationships, and life skills training package that has worked with men and women, including youth, to increase awareness of gender issues to prevent the transmission of HIV.

Changing Community Responses to Wife Abuse in Mexico

Fawcett, G.M., L.L. Heise, L. Isita-Espejel, and S. Pick. "Changing Community Responses to Wife Abuse: a Research and Demonstration Project in Iztacalco, Mexico. *American Psychologist,* January 1999:41–49.
Available in English.

This article reports on a project aimed at challenging community norms that perpetuate violence towards intimate partners. It comprised two main strategies: a 12–session pilot workshop aimed to form a cadre of local women who could model attitudes and behaviors, counsel abused women, and help identify support systems; and a 6–month community awareness and education campaign. The program's evaluation included interviews with several participants at the beginning and end of the pilot workshop program, pretest and posttest questionnaires administered to participants, and an end-line survey carried out in the community. The evaluation demonstrated that the community

campaign raised awareness and generated discussion about partner violence. According to the end-line survey, the proportion of residents who ranked domestic violence high among social problems increased from about 15 to 23 percent, and the number of people who reported having witnessed an incident of such violence rose from 30 to 36 percent. In addition, the proportion that reported that they would talk to an abused woman or her partner nearly tripled, from 11 to 30 percent. In terms of practical support, 24 percent (increase from 10 percent) of respondents mentioned that they would accompany a woman to a support center.

Guy to Guy Project, Brazil

- Barker, G. "'Cool Your Head, Man:' Preventing Gender-Based Violence in Favelas." *Development,* 44(3):94–98, 2001.
- Barker, G. "Gender Equitable Boys in a Gender Inequitable World: Reflections from Qualitative Research and Programme Development in Rio de Janeiro." *Sexual and Relationship Therapy*, 15(3):263–82, 2000.
- Nascimento, M. et al. "Guy to Guy Project: Engaging Young Men in Gender-Based Violence Prevention and STI/AIDS." Abstract E11676, XIV International AIDS Conference, July 7–12, 2002.

  The above articles are available in English only; however, other documents of this program are available in Portuguese and Spanish.

  These articles present the results of an intervention project that aimed to identify young men in a community of Rio de Janeiro with more gender-equitable views and to understand the factors that contributed to their views. The findings were then incorporated into a community-based intervention that seeks to change young men's attitudes towards women.

Agisanang Domestic Abuse Prevention and Training, South Africa

Levi, R. "South Africa: Peace Starts at Home." In *Ending Violence Against Women: Report from the Global Frontlines.* L. Marin, H. Zia, and E. Soler, editors. San Francisco: Family Violence Prevention Fund, 1998.

Available in English only.

This is one article in a collection of case studies compiled by the FVPF. It profiles the work of an NGO working to end violence against women through community-based efforts in South Africa.

Shalishi, West Bengal

- Samity, S.M. "Shalishi in West Bengal: A Community-Based Response to Domestic Violence." *Economic and Political Weekly Review of Women Studies,* April 26, 2003. *Available in English at www.epw.org.in.*
- Talwar, A. and S.M. Samity. "The Shalishi in West Bengal: A Community Response to Domestic Violence." In *Domestic Violence in India 5: Women-Initiated Community Level Responses to Domestic Violence*. *Summary Report of Three Studies*. Washington, DC: International Center for Research on Women, 2002.

  Available in English at http://www.icrw.org/docs/DVIndia_Report5_702.pdf.

  NGOs in West Bengal have used the traditional village-level dispute resolution system (i.e., the Shalishi) to settle domestic violence cases. The Shalishi has some advantages over the formal legal system, but because it works to keep families intact, it often works in ways that contradict the principles and recommendations of women's rights advocates. Researchers have carried out an evaluation of this mechanism and the above-mentioned article presents an analysis of the strengths and weaknesses of these efforts.

Nari Adalat, Sahara Singh and Mahila Panch, Uttar Pradesh and Gujarat, India

- Saharanpur, M.S. et al. "Women Initiated Responses to Domestic Violence in Uttar Pradesh: A Study of the Nari Adalat and Sahara Sangh." In *Domestic Violence in India 5: Women-Initiated Community Level Responses to Domestic Violence*. *Summary Report of Three Studies*. Washington, DC: International Center for Research on Women, 2002.
- Baroda, M.S. et al. "Women-Initiated Responses to Domestic Violence in Gujarat: A Study of the Nari Adalat and Mahila Panch." In *Domestic Violence in India 5: Women-Initiated Community Level Responses to Domestic Violence*. *Summary Report of Three Studie*s. Washington, DC: International Center for Research on Women, 2002.

Both available in English only at http://www.icrw.org/docs/DVIndia_Report5_702.pdf.

These articles present the results of case studies that aimed to evaluate the work of community-level mechanisms to address violence against women in rural India, such as the work of women's collectives (sanghas) and women's courts (nari *adalats*) in Uttar Pradesh and Gujarat, India. These articles provide an indepth, qualitative view of the strengths and weaknesses of these approaches. Recent evaluations have found that these institutions rely heavily on mediation and reconciliation. One problem with these institutions is that in many cases, they place a higher priority on keeping families intact than on women's safety or well-being.

Dharna, India

Mitra, Nishi. "Best Practices Among Responses to Domestic Violence in Maharahtra and Madhya Pradesh." In *Domestic Violence in India 1: A Summary Report of Three Studies*. Washington, DC: International Center for Research on Women and The Centre for Development and Population Activities, 1999.

Available in English only.

Dharna is a form of public shaming and protest that has been used by activists in India in the homes or workplaces of abusive men. This is one of a number of community-based strategies profiled in the review of best practices published by ICRW noted above.

An Intervention Project for Violence Prevention in Motor Parks, Southwestern Nigeria

Fawole, O.I., A.J. Ajuwon, K.O. Osungbade, and O.C. Faweya. "Interventions for Violence Prevention Among Young Female Hawkers in Motor Parks in Southwestern Nigeria: A Review of Effectiveness." *African Journal of Reproductive Health*, 7(1):71–82, April 2003.

Available in English and French.

This article describes a program that aimed to reduce physical and sexual violence against young female hawkers through multidisciplinary interventions involving hawkers, drivers, instructors, and police and judicial officers. The evaluation found that knowledge, risk perception, and willingness to seek help increased, while the reported level of recent violence decreased.

Project Against Domestic Violence (PADV) and Cambodian Women's Crisis Centre (CWCC)

Surtees, R. "Negotiating Violence and Nonviolence in Cambodian Marriages." *Gender and Development*, 11(2):30–41, 2003.

Available in English only.

This article presents background information about domestic violence in Cambodia and describes the work of two Cambodian NGOs: the Cambodian Women's Crisis Centre (CWCC) and the Project Against Domestic Violence (PADV). Both of these NGOs base

their work on an understanding of the cultural context of violence in Cambodia as well as international human rights standards.

The Men Against Violence Against Women Campaign, Namibia

Odendaal, W. "The Men Against Violence Against Women Movement in Namibia." *Development*, 44(3):90–93, 2001.
Available in English only.

Namibian Men for Change (NAMEC) works to raise awareness among young adult men of such issues as masculinity, parenthood, sexual abuse, and the creation of a nonviolent culture in Namibia. This article describes the campaign, which involves visiting schools and organizing discussions among men in communities throughout Namibia.

AMKENI Project, Kenya

AMKENI Project. "Addressing Gender-Based Violence in Western Kenya, Project Update for October 2002–February 2004." (Obtained from Anjala Kanesathasan, AMKENI Project, Akanesathasan@amkeni.org)

The AMKENI project is a partnership between EngenderHealth, Family Health International, Intrah/Carolina Population Center (CPC), and PATH. AMKENI is funded by USAID/Kenya and operates under the auspices of the Kenyan Ministry of Health. This particular activity is funded by the IGWG. The project works in 50 villages around eight health facilities to increase awareness of gender-based violence and test community-generated gender-based violence interventions. AMKENI brings women, men, youth, elders, and health care providers together to define gender-based violence in their own context and develop appropriate solutions. Project objectives include raising awareness of gender-based violence and its impact, developing and testing community-generated interventions, and identifying lessons learned that successfully address gender-based violence. Monitoring and evaluation implemented thus far includes a situational analysis in the beginning of the initiative and a midterm qualitative evaluation (using focus groups and interviews).

CANTERA, Nicaragua

- Norori Munoz, V. and J. Munoz Lopez. Conceptualizing Masculinity Through a Gender-Based Violence Approach." *Sexual Health Exchange*, (2):3–6, 1998.
  Available in English.
- CANTERA web site: *http://www.oneworld.org/cantera/education/*
  CANTERA is a Nicaraguan-based NGO that was founded in1988. CANTERA offers a number of workshops on masculinity, gender, power, and violence that are defined as popular education. The aim of these workshops is to empower individuals and encourage critical thinking. These workshops helped formulate a methodology for men to work with other members of their sex to promote participation and responsibility in promoting gender equitable norms. During an evaluation of the courses conducted in 1997, many men reported that the workshops resulted in positive transformations in their own lives.

Intervention with Microfinance for AIDS and Gender Equity (IMAGE), South Africa

- IMAGE Study Evaluation Monograph No. 1.
  http://www.wits.ac.za/radar/PDFpercent20files/Monograph.pdf, accessed February 16, 2004.
- IMAGE Intervention Monograph No. 1.
  http://www.wits.ac.za/radar/PDFpercent20files/Intervention_monograph_pics.pdf.pdf, accessed February 16, 2004.
  Both available in English.

The IMAGE intervention is an innovative approach to tackling gender equity and HIV/AIDS prevention through a two-part strategy:

- community-level access to a microlending scheme and
- a two-phase participatory learning and action curriculum, *Sisters for Life*, for loan recipients.

An ongoing complex evaluation study of IMAGE aims to evaluate the potential role of a microfinance-based poverty alleviation and empowerment strategy in behavior change and the prevention of HIV and gender-based violence.

SERVICE DELIVERY PROGRAMS

OVERVIEW

In 1996, the World Health Assembly declared violence against women a major public health problem that urgently needed to be addressed by governments and health organizations.[15] However, despite evidence that it is a pervasive public health problem throughout the world, gender-based violence is often ignored by the health sector. Even though research indicates that battered women use primary and secondary health services more than nonabused women, a very small percentage of them are identified by health workers. There are a number of obstacles that tend to prevent health providers from asking women about violence, including time constraints, the fear of offending women, the fear of possible repercussions, and providers' lack of exposure to appropriate training on how to address survivors' needs. Additionally, health care professionals often fail to recognize the impact of gender-based violence on women's health, and many continue to consider it a social or cultural issue that is not relevant to their work.

Nonetheless, health care organizations—particularly those working in the field of sexual and reproductive health—cannot provide adequate quality health care to women unless they make a commitment to the needs and safety of women who experience violence. Health care providers who ignore violence against women not only miss the opportunity to address an important public health problem, but can inadvertently harm women or put women at additional risk of violence by failing to keep information confidential or by failing to provide needed care. This is the case, for example, when HIV/AIDS prevention programs fail to consider violence as a potential negative outcome of serostatus disclosure. Although research shows that the majority of women who choose to disclose their HIV status experience positive outcomes (such as greater psychosocial support), one cannot overlook the fact that for some women HIV status disclosure can result in negative outcomes that include violence.[16]

As highlighted by Bott et al., there are several reasons why health organizations should address gender-based violence:[17]

- Gender-based violence is a major cause of disability and death among women.
- Gender-based violence has adverse consequences for women's sexual and reproductive health.
- If providers do not ask about violence, they may misdiagnose victims or offer inappropriate care.
- Health programs—particularly those that provide sexual and reproductive health services—are often among the few institutions that have routine contact with most

[15]World Health Organization. Resolution WHA49.25 of the Forty-ninth World Health Assembly. Geneva: World Health Organization, 1996.
[16] USAID/Synergy. *Women's Experiences with HIV Serodisclosure in Africa: Implications for VCT and PMTCT.* Meeting Report. Washington, DC: USAID, March 2004.
[17] Bott S., A. Guedes, C. Claramunt, and A. Guezmes. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Managers in Developing Countries.* New York: International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). (forthcoming)

adult women in developing countries. Health professionals are thus strategically placed to identify women who experience gender-based violence.

- Health professionals are in a unique position to change societal attitudes about violence against women because they can reframe violence as a health problem rather than a social custom. Because of the position of prestige that physicians usually hold in communities, they can sometimes lead conservative elements of society that tolerate or justify violence against women to question their views by demonstrating the negative consequences of gender-based violence for women's and children's health.

- Responding to gender-based violence can improve the overall quality of health care.

- Health professionals may inadvertently put women at risk if they are uninformed or unprepared.

The programs included in this section illustrate a variety of strategies that can be used to improve the health sector's response to gender-based violence. Along with the other programs included in the annotated bibliography, the programs discussed in this section share the following common characteristics:

- Need for partnerships and multiple strategies. The needs of survivors of violence are complex; women may need medical services, emotional support, legal counseling, and access to employment. It is unrealistic to think that the health sector by itself would be able to cover all these needs. Most programs have established partnerships not only to provide the full range of services needed by women (through referral mechanisms), but also to carry out initiatives not strictly within the scope of the health sector, such as public education campaigns.

- Need to adopt a systemwide approach. Efforts to improve the health care response to violence, should follow what Heise et al. call a systems approach—one that involves the whole organization and does not expect individual providers to act alone.[18] In other words, training should be accompanied by a broad effort to review an institution's policies and resources, including infrastructure, service protocols, screening tools, and referral directories.

- Training should start with participants' own beliefs and concerns, be sustained over time, and incorporate ongoing support and monitoring. Training should also be based on a human rights framework and involve a broad range of staff members from upper management to administrative staff.

- Women's safety and autonomy should be at the forefront of any initiative. This means that screening for violence should not be implemented if the organization cannot guarantee the privacy and confidentiality of clients or if it cannot vouch for the attitudes of its staff members. It also means that women should be informed of their options and allowed to make decisions without undue influence from providers.

[18]Heise L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Reports*, 27(4), 1999. [Available in English at http://www.infoforhealth.org/pr/l11edsum.shtml.]

These programs also tend to face common challenges. The following challenges are the two cited most often:

- All initiatives point to the scarcity of community resources, such as shelters or legal services. This requires that the health sector develop creative strategies to address women's needs. In addition to working to raise awareness of gender-based violence as a public health problem and to strengthen existing services, health organizations can implement low-cost interventions, such as support groups for women.

- Following up with external referrals is mentioned as a challenge by many of the programs.

In terms of evaluation, most of these initiatives have not rigorously assessed their actions. The IPPF/WHR initiative seems to have made the greatest effort because it includes preintervention and postintervention assessments, a mix of qualitative and quantitative methods, and the use of external evaluators. In light of the paucity of evaluation data, some key questions remain, such as whether certain policies (e.g., routine screening) can place women at additional risk under certain circumstances. Garcia-Moreno's *Lancet* review highlights a number of important additional concerns.

When evaluations are carried out, they seldom address women's perspectives. However, evaluations that have asked women directly about their health needs have found that women find screening acceptable and believe that it is a health care provider's role to address gender-based violence (see the following section on IPPF/WHR's program).

One important concern relating to the integration of gender-based violence services within the health sector involves the fear of overburdening providers. Providers themselves may be concerned that they do not have time to raise an additional issue with their clients/patients. They may also be concerned that if the client does disclose experience with violence, this disclosure will lead to an increased need to devote even more time to counseling the client and/or following up with referrals. This concern may be compounded by the idea that they lack the skills to help the patient, and therefore the extra time is not worth investing. Although this is a valid issue, it is not insurmountable. Once a program develops a standardized screening tool and referral protocol, the process of screening and necessary follow-up steps need not take more than a few minutes. It is also important to note that research suggests that gender-based violence and its medical consequences are as or more prevalent than many common conditions for which providers routinely screen, such as preeclampsia or gestational diabetes in the case of prenatal care. Additionally, gender-based violence has been linked to repeat visits and increased use of health services, and in many cases it is the underlying cause of chronic or repeated SRH problems. If providers fail to address this underlying cause, they will spend a great deal of time unsuccessfully treating its consequences. Thus, detecting and referring or treating cases of violence can, in the long term, save time rather than consume it.

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

The programs selected to exemplify the relevance of service provision initiatives in addressing gender-based violence include *¡Basta!* (IPPF/WHR's Regional Gender-Based Violence Initiative [Dominican Republic, Peru, and Venezuela]), two programs implemented in Mexico through a partnership with the FVPF, and a South African experience documenting the implementation of the Western Cape Provincial Department of Health's policy on sexual assault.

The IPPF/WHR program was selected based on the following criteria that were highlighted in the methodology section of this review:

- it has been evaluated and well documented,
- multiple informants referred to it as a promising initiative,
- it has potential for scaling up or replication, and
- the program staff was able to share relevant documents.

Although the evaluation component of the Mexico-based programs is somewhat weak, they were selected because they offer interesting strategies for working within the health sector—including indigenous populations and traditional birth attendants—and because they provide appealing examples of partnerships that bring together foreign organizations with U.S.–based groups working with immigrant populations from those nations. The South African experience highlights some of the gaps that can occur between a policy and its implementation and stresses the importance of taking into account a health system's reality when formulating programs in the area of gender-based violence.

POTENTIAL CONTRIBUTIONS OF SERVICE DELIVERY PROGRAMS IN ADDRESSING GENDER–BASED VIOLENCE

Providing for the needs of victims and their children is a crucial element in the area of gender-based violence. Women's needs are complex and services to address these needs may range from the provision of emotional support to shelters and legal counseling. Given the focus of this review on RH and HIV programs, focus has been placed on health care service delivery programs. However, it is important to highlight that women need more than just health care, and that the health sector can help provide women with additional services by collaborating with other organizations.

Health service delivery programs can assist women in the following ways:

- detecting cases of violence;
- documenting the information in ways that can be used as evidence in court should a woman decide to pursue legal action;
- ensuring the privacy and confidentiality of shared information;
- addressing the consequences of violence on a woman's health;
- helping women understand the health consequences of violence on themselves and their children;
- informing women of their legal rights;
- adapting existing service, such as family planning and HIV counseling so that a woman's potential experience with violence is considered;
- providing emergency contraception information to all women in advance of need and ensuring that survivors of sexual violence have access to emergency contraception;

- assessing women's risk and assisting with safety planning;
- whenever possible, creating additional services for women (e.g., support groups) that can be a low-cost and effective intervention in reducing women's sense of isolation;
- facilitating women's access to additional services, including legal and social help;
- seeking appropriate ways to involve men; and
- respecting women's autonomy.

It is important to highlight again that health care organizations—particularly those addressing reproductive health and HIV—may not be able to accurately diagnose, treat, or provide women with adequate quality health care unless they are familiar with a woman's experience with violence.

IPPF/WHR REGIONAL INITIATIVE TO ADDRESS GENDER–BASED VIOLENCE (Dominican Republic, Peru, and Venezuela)

WHR is one of six regions that compose IPPF. Following the International Conference on Population and Development in Cairo, 1994 (ICPD), IPPF/WHR took steps to help member associations incorporate a new vision of sexual and reproductive health and to improve the quality of service delivery programs by integrating a gender perspective. Within this context, IPPF/WHR carried out training and evaluations focused on gender to raise consciousness among associations' staff. During this process, clients and providers repeatedly mentioned physical and sexual violence as an issue that merited attention. The Asociación Pro-Bienestar de la Familia (PROFAMILIA) in the Dominican Republic, Instituto Peruano de Paternidad Responsable (INPPARES) in Peru, and the Asociación de Planificación Familiar (PLAFAM) in Venezuela, joined with the regional Office to improve the response to gender-based violence. The initiative involved the following four components:

1. improving the capacity of sexual and reproductive health service delivery programs to care for women who experience violence,
2. raising awareness of violence against women as a public health problem and a violation of human rights,
3. advocating for better laws and application of the laws related to gender-based violence, and
4. increasing knowledge about effective health service interventions in the area of gender-based violence.

The first objective—strengthening the health services response—involved a broad package of reforms throughout the organizations. These included

- sensitizing and training all staff, from the board of directors to the frontline service providers;

- improving the clinic infrastructure to ensure private consultations;
- strengthening policies and staff awareness related to confidentiality;
- adjusting patient flow, information systems, and clinic policies to allow the introduction of routine screening with written questions about violence;
- providing ongoing staff training and support;
- implementing policies and procedures to guide the process of detecting, referring, and providing services to women who experience gender-based violence;
- providing better referral arrangements with external service delivery programs in the community; and
- offering specialized services offered in-house, including counseling, legal assistance, and support groups.

This was done in a variety of ways. In some affiliates, services already existed (such as emotional support units), but were strengthened through training and the implementation of institutional policies. In other cases, affiliates had to hire staff capable of providing the needed assistance. In some locations, IPPF member associations were able to establish partnerships with existing NGOs to which they could refer women for specialized services, such as in the Dominican Republic, where women were referred to two NGOs (depending on their city of residence) who provided legal counseling.

Evaluation

To ensure a rigorous evaluation of the initiative, the participating facilities developed baseline, midterm, and follow-up studies using standardized indicators and instruments as well as systems for gathering service statistics on screening levels, detection rates, referrals, and specialized services. Each association documented case studies on pilot services, and regional office staff monitored the work of the associations through site visits and informal interviews with providers, managers, and clients.

The evaluation of IPPF/WHR's initiative included four main components.

1. A **baseline evaluation** study was carried out in 2000 that included the following elements:
   - a knowledge, attitudes, and practices (KAP) survey of providers using face-to-face interviews (79 providers); and
   - a clinic observation/interview guide (11 clinics).
2. Throughout the project, service statistics on detection rates and services provided using standardized screening questions and indicators were collected.

3. A midterm evaluation, primarily qualitative in nature, was carried out in 2001 and included the following elements:

   - 16 group discussions with providers, survivors, and external stakeholders;
   - indepth interviews with survivors (14) and key informants in the associations (14);
   - a client satisfaction survey (691 female clients); and
   - case studies of pilot strategies to address various aspects of gender-based violence.

4. A final evaluation, which served as a follow up to the baseline, was carried out in 2002 with the following components:

   - a KAP survey of providers using face-to-face interviews (98 providers),
   - a clinic observation/interview guide (12 clinics), and
   - random records reviews.

External consultants who were entirely independent of IPPF or its member associations carried out all the evaluations.

One potentially important finding from the baseline was that even without routine screening, over half of the providers reported that they had asked women about physical or sexual violence in the past year, and a majority (85 percent) reported that a client had disclosed physical or sexual violence at some point. This highlights the importance of preparing health care providers to respond appropriately to a woman's disclosure of gender-based violence, regardless of whether a screening policy is implemented.

In terms of privacy, confidentiality, and clinic resources, the midterm and final evaluations suggest that by the follow up, the associations had

- resolved the infrastructure problems (such as having a private room to screen and provide counseling to women),
- strengthened confidentiality and privacy, and
- greatly increased the written resources available in the clinics, including policies and protocols.

Nonetheless, some problems remained, including

- frequent interruptions during consultations;
- difficulty finding opportunities to speak to clients alone without family members present, particularly in the case of adolescent clients; and

- in large clinics, some providers still expressed hesitation about recording details of violence in medical records for fear that the information would not be kept confidential.

Over the course of the initiative, providers' discomfort with asking about sexual abuse appeared to decline, and the percent of providers who reported that most victims of sexual abuse would deny the abuse if asked dropped by half (from 67 to 32 percent).

The midterm exit surveys found that nearly all women interviewed (96 percent) reported that they felt comfortable when asked the screening questions, and that health service delivery programs should address the issue of violence against women.

Service statistics, random records reviews, and other data sources indicated that the comprehensive package of modifications was fairly successful at changing provider behaviors. Screening and detection rates varied from clinic to clinic and were never perfect in any site. Nonetheless, detection rates rose sharply after standardized questions were introduced and remained fairly constant over the next three years. Over the course of the initiative, approximately 168,160 women sought services at the participating clinics. Of those, 17,144 women (just over 10 percent) reported any kind of physical or sexual abuse; 4,720 (3 percent) reported forced sexual contact/intercourse; and 4,245 (3 percent) reported uncomfortable (sexual) touch in childhood. (These percentages reflect imperfect screening rates as well as disclosure rates and should not be confused with prevalence levels.)

Table 5 on the following page illustrates that self-reported perceived barriers to screening decreased between baseline and follow-up data collection.

Table 5
Perceived Barriers to Screening Women for Gender-Based Violence
(percentage)

Perceived Barriers	Baseline (n = 79)	Final (n = 98)
Fear of offending client	53	29
There are not sufficient resources in my community	51	34
There is no private space to address gender-based violence with women	34	13
There is little I can do to help	31	20

Baseline interviews found that a substantial minority of health care providers reported attitudes that blamed girls and women for having experienced violence/coercion. Some providers expressed classic stereotypical attitudes (e.g., suggesting that adolescent girls bring sexual abuse upon themselves "by the way that they dress and the places that they go"). As table 6 illustrates (following page), at follow up, such attitudes had decreased considerably.

Table 6
Attitudes Related to Physical and Sexual Violence
(percentage)

Attitude	Baseline (n = 79)	Final (n = 98)
Men cannot control their sexual behavior	20	7
Women stay with violent partners because they like being treated with violence	23	9
Adolescents provoke sexual abuse through their inappropriate sexual behavior	40	16

An important finding that emerged from the midterm qualitative data was the extent to which many female clients and providers believed that a fundamental role and responsibility of health care providers was to help women recognize physical and sexual force as abuse rather than as a normal or acceptable part of life for women. Specifically, they noted that health providers have the opportunity to make women aware that violence and coercion can put a woman and her children at serious risk of health problems, injury, and in some cases, death.

Funding

The IPPF/WHR Regional Gender-Based Violence Initiative was funded by the European Commission and the Bill and Melinda Gates Foundation. Additional support was provided by the Ford Foundation and the MacArthur Foundation.

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IPPF/WHR. *¡Basta! A Newsletter from IPPF on Integrating the Issue of Gender-Based Violence into Sexual and Reproductive Health.* New York: International Planned Parenthood Federation Western Hemisphere Region, 2000–02.

Most of the above documents, additional information, and tools are available at http://www.ippfwhr.org.

FVPF's PROGRAMS ADDRESSING DOMESTIC VIOLENCE

The FVPF is a nonprofit organization based in California. It has been working in the area of family violence prevention in the United States for more than two decades and has also started to expand its reach to other areas around the world. With support from the MacArthur Foundation, the fund is currently implementing a number of initiatives in India and Mexico. For the sake of brevity, only two of these initiatives are highlighted in this section.

- FVPF and Alaide Foppa Collaboration in Baja California and
- FVPF and Asesoría, Capacitación y Asistencia en Salud (ACASAC) Collaboration in Chiapas

In general, the evaluation of these efforts has been weak, and in the case of ACASAC, has not yet been implemented. However, these examples are included in this review for two reasons. First, they offer interesting strategies for working within the health sector, including with indigenous populations and traditional birth attendants. Second, they provide appealing examples of partnerships that bring together foreign organizations with U.S.–based organizations working with immigrant populations from those nations. In this context, great effort is made to adapt the experience and materials created in a developed country context (in this case the United States) so that they are culturally relevant.

FVPF's The Next Frontier: Addressing Domestic Violence and Reproductive Health at Home and Abroad (Baja California)

Alaide Foppa is a Mexican NGO and a member of the Red de Mujeres de la Peninsula de Baja California (local women's network). In partnership with the FVPF, the organization has been working to have an impact on primary and secondary intervention strategies within the health care system to both address and prevent violence. The idea is to improve the capacity of the Mexican Institute of Social Security (IMSS in Spanish) to address gender-based violence. To achieve this result, this project has initially targeted one of IMSS' health centers to test and validate a model that will then be extended to other IMSS sites. The project's main objectives include

- increasing health care providers' knowledge and capacity to identify and screen for gender-based violence;
- developing accessible and effective response systems in partnership with governmental and nongovernmental organizations;
- establishing protocols, policies, resources, and ongoing training to sustain screening and intervention efforts; and

- carrying out public education efforts to convey the idea that health care institutions are places where survivors can seek help.

In its effort to increase health care providers' capacity to address gender-based violence, this project has carried out a number of sensitization and training efforts, including workshops, video presentations and discussions, and ongoing training. Training has involved multidisciplinary teams and in addition to direct service providers, has included administrators, clerical staff, and community members. Additional training was carried out with operators from the local emergency hotline. The project has also adapted, reproduced, and distributed materials developed by the FVPF, such as the *Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*.

A number of activities have been carried out with the goal of promoting a wider cultural change in the community. These include

- establishing a Mexicali-wide network of organizations dedicated to domestic violence prevention;

- creating and distributing IEC materials, such as posters and brochures;

- extending training efforts to other health sector organizations throughout the state; and

- raising awareness through regular participation in print, radio, and television.

Evaluation

This initiative has been evaluated primarily through process indicators collected at baseline (May 2001) and follow up (May 2003). The project coordinators themselves collected data through observations and informal face-to-face individual interviews. In this process, they were aided by a 35–point assessment tool originally developed by the FVPF but adapted to this project's context. This assessment, created in the format of a checklist, addressed numerous aspects of the program, including the availability of staff, staff exposure to training on gender-based violence, and the availability of IEC materials. Table 7 presents some of the evaluation results.

Table 7
Project Evaluation Findings
(percentage)

Process Indicator	Baseline	Follow Up
Proportion of health clinic staff who report knowing about policies and procedures relating to domestic violence intervention	0	90
Proportion of respondents who believe that there was no interdisciplinary team to prevent domestic violence	83	5
Proportion of health personnel who had received any training on domestic violence	11	90

Additional findings include

- elaboration of the *Protocol for Medical Attention on Domestic Violence,* currently under revision by the IMSS for broader dissemination and implementation;

- implementation of support groups for women at the model clinic; and

- creation of local and statewide networks of organizations working together to prevent domestic violence.

Reducing the Social Causes of Maternal Morbidity and Mortality (Chiapas)

This project is implemented through collaboration between the FVPF and ACASAC. The goal of this partnership is to develop a coordinated health care response to abuse during pregnancy in order to reduce morbidity and mortality of both pregnant women and their babies. There are a number of strategies that are being implemented to achieve this goal, including

- training regional health care providers and traditional birth attendants (parteras) to identify and assist women abused during pregnancy,

- producing a culturally and linguistically accessible training module and video for indigenous women in Mexico,

- facilitating linkages between formal health care facilities and local lay health care providers,

- producing and implementing a protocol for screening and responding to abuse during pregnancy, and

- identifying and evaluating promising practices that could be replicated in other regions beyond Mexico.

This initiative is in its early stages, having started in January of 2003. However, it is being included in this review because of its innovative strategy of working with indigenous traditional birth attendants to address abuse during pregnancy through the use of a creative training model. The design of this model was informed by experiences in education for illiterate adults in Latin America and revolves around the following three components:

- the ability to be employed both via radio, or through an audio recorder and a group of people (the latter being the method employed by this project);

- the use of ethnographic material (in this case with a focus on gender) to sustain thematic contents; and

- the promotion of the exercise of citizenship (being an active member of the community) in daily life.

The development of the curriculum involves several phases and the use of reactors (in this case, two indigenous women, one bilingual and another trilingual) who had the opportunity to assess the content and structure of the model throughout its development.

In terms of its application, presenters lead listeners through a story, which portrays the subject matter of that particular module. Participants are prompted to share their personal experiences

and to discuss different aspects of the story both before and during the story. Presenters then reiterate important points of the module.

For example, module four—which focuses on safety planning and an examination of legal options available to indigenous women suffering from violence—presents the following scenario (which is a continuation of the story from the previous module):

> Doña Flor [a traditional midwife] comes to María's house to check on her pregnancy. They are able to continue talking privately about the abuse and the possibility of María leaving. Doña Flor explains to María that she needs to think of people she can rely on for support, should she decide to leave her husband. […] They discuss the fact that Juan [the husband] takes the money, even though it is earmarked to help mothers and children. María remembers some other people that may be able to help her and grows more encouraged about the situation. They discuss the need to hide money and documents in a safe place so she can take them when she leaves. María is encouraged, but still scared.
>
> The midwife explains that many women are scared, but that it's important for María to not let her fear paralyze her. She also tells María about other strategies to ask others for help…She suggests that she can take María around town one day to point out important places where María can go to get free legal representation and help. María decides to think about what she needs to do to move forward.

Discussion points are provided for each module. With this particular module, discussion points include

- what problems María may face if she takes the midwife's advice, and
- the support systems within communities that help abused women.

Evaluation

As mentioned above, this initiative is only a year old and has not yet been evaluated. Its methodology is still under development, but may include some of the same instruments (such as the 35–point checklist) used in the Baja California program.

Funding

MacArthur Foundation

Sources

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Personal communication with Leni Marin, Managing Director, Family Violence Prevention Fund

WESTERN CAPE PROVINCIAL DEPARTMENT OF HEALTH POLICY AND MANAGEMENT GUIDELINES FOR THE MANAGEMENT OF SURVIVORS OF RAPE OR SEXUAL ASSAULT (South Africa)

The creation of the Western Cape Provincial Department of Health's policy on sexual assault was triggered by requests from health workers and NGOs who recognized the widespread nature of the problem in their catchment area. A provincial reference group was established in 1999 to develop a provincial policy and standardized guidelines for the management of rape survivors (female and male, aged 14 years and older) at the health care facilities in the Western Cape Province. This reference group consisted of public health workers, gynecologists, forensic pathologists, psychologists, health managers, NGOs, and legal advisors.

Drafts of both the policy and the guidelines were distributed to the regions, districts, NGOs, and other relevant role-players for comments and input. The implementation of the guidelines was subsequently piloted at the Tuthuzela 24–hour rape management center at a hospital in Cape Town. In October 2000 the policy was expanded to include guidelines on the provision of antiretroviral drugs, and in November 2000 the policy was released in the Western Cape Province.

The goal of the policy was to provide health managers and health workers (including physicians, nurses, and counselors) with a clear framework on the management of survivors of rape and sexual assault within primary health care service delivery programs in the province. One of the central elements of the policy was the recognition that the management of rape survivors requires special training and expertise on the part of providers as well as an integrated management approach.

The objectives of the policy are to provide

- an integrated and comprehensive service to survivors of rape or sexual assault that incorporates the best possible clinical, psychological, and forensic care available at the identified health care facilities;

- ongoing training, support, and supervision of health workers involved in the management of survivors of rape or sexual assault to ensure a consistently high standard of care (this will also ensure that the courts are provided with high-quality evidence to assist with the prosecutions and conviction of rapists); and

- health information to survivors and families that promotes ease of use of available services in the community and to inform them of their rights.

Evaluation

A formal evaluation of the process used to develop and implement the policy and management guidelines was carried out in October 2002 at the request of the Western Cape Provincial Department of Health. This evaluation adopted a dynamic and participatory approach and consisted of the following stages:

- participatory determination of targets and indicators to be evaluated;

- application of indepth interviews with core members of the provincial reference group, key health personnel at the provincial and regional levels, and health workers; and

- application of a written survey with health workers at the participating facilities.

It is important to note that the evaluation did not assess the clinical skills or competencies of the health care staff in this area, nor did it evaluate the outcomes of the use of the policy and guidelines.

In terms of the actual development of the policy, the evaluation revealed that the high level of commitment of the core members of the Provincial Reference Group as well as their individual and collective expertise led to the development of a policy that is considered excellent and much needed by health care providers. Central to the success of the policy's development were the support received from upper management, the intersectoral nature of the group's composition, and the participatory character of the process.

Despite being highly regarded by health workers, however, the findings of the evaluation suggest that the policy's implementation has faced many difficulties, which resulted in limited impact of its vision and objectives.

- Only 5 of the 29 health facilities are providing comprehensive health care to survivors of rape.

- Medical officers report that they do not feel they have the necessary medical or forensic expertise to provide the best possible care to survivors.

- Health workers report that some medical officers demonstrate resistance to providing medical and forensic care to rape survivors.

- Although the policy calls for health facilities to set up a designated room/area for rape survivors, few facilities have done so and in those that have such a space, the room was found to be poorly equipped.

- Service statistics were recorded inaccurately and were a burden to health workers.

- Funding earmarked for the implementation of the policy had not been spent.

The assessment of the shortcomings of the policy's implementation at the lcoal level led researchers and program staff to identify the following key issues that should be taken into account in order to improve the policy's implementation:

- Providing training on skills and knowledge is not enough. The right attitudes (principally compassion and empathy) are key and should be fostered.

- Training should be conducted continuously.

- It is important to identify local resources (to carry out training, for example) that are familiar with the culture and can be available long term.

- Providers need to be supported as they implement the policy.
- Increased attention should be given to ensure that professionals capable of providing psychological support to survivors are available.
- There should be increased collaboration on all levels, including among the financial and information management sectors.
- Health care facilities should designate both a medical officer and a coordinator to attend to the program.
- A database should be developed to allow for effective monitoring and evaluation of the program.
- A cost analysis of services should be implemented.

Source

Personal communication and documents shared by Leana Olivier, Deputy Director, Maternal, Child and Women's Health Subdirectorate, Department of Health, Western Cape Province.

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- Velzeboer, M., M. Ellsberg, Arcas C. Clavel, and C. Garcia-Moreno. *Violence Against Women: the Health Sector Responds.* Washington, DC: Pan American Health Organization, 2003.
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  Available in Spanish at http://www.paho.org/Spanish/DPM/GPP/GH/VAWhealthsector.htm.
  These documents describe PAHO's efforts to address gender-based violence in seven Central American countries. The latter includes the program evaluation results of those efforts, including the lessons learned from the clinical level, the community, and the broader local and national policy arena. The latter contains an extensive list of resources related to the health sector response to violence, including 16 different sets of training manuals and guides for health professionals in various languages, many of which are specifically tailored to the needs of professionals working in developing countries.

Review by Claudia Garcia-Moreno

Garcia-Moreno, Claudia. "Dilemmas and Opportunities for an Appropriate Health-Service Response to Violence Against Women." *The Lancet,* 359:1509–14, 2002.
Available in English only.

This article reviews what is known about the effectiveness and limitations of programs in developing countries that train providers to identify and care for women who have experienced intimate partner violence. This article raises significant concerns about

introducing routine screening programs in organizations that have not succeeding in transforming the attitudes and beliefs of providers.

Review by the International Federation of Gynecology and Obstetrics

Garcia-Moreno, C., G. Benegiano, and R. Guerra. "International Conference on the Role of Health Professionals in Addressing Violence Against Women, 15th October 2000, Naples, Italy." *International Journal of Gynecology and Obstetrics, Supplement*, 2000.

Available in English only.

As the title suggests, this journal issue contains a collection of papers from an international conference devoted to the role of health professionals in addressing violence against women. The collection includes descriptions of programs and evaluation data (when available) from developing countries, such as Bangladesh, Brazil, China, Russia, South Africa, and Thailand. In addition, it includes articles that present the ongoing efforts of international organizations such as WHO, UNFPA, the International Federation of Midwives, and the International Federation of Gynecology and Obstetrics.

UNFPA

UNFPA. *A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers*.

Available in English, Spanish and French at
http://www.unfpa.org/upload/lib_pub_file/99_filename_gender.pdf.

This publication outlines steps needed to integrate measures on gender-based violence into reproductive health facilities. It is also meant to help a wide range of readers understand the connections between reproductive and sexual health and violence. In past years, UNFPA has implemented the program model proposed by the guide in 10 pilot countries worldwide. Although no systematic evaluations have been carried out to date, UNFPA organized a conference of participating countries in September 2003 to discuss lessons learned. At this conference, presentations were made on each country's project, and data gathered by a consultant through interviews and observations in four countries was discussed.

Review of Forensic and Health Service Delivery Programs in Six Central American Countries

PAHO. *Situación de los servicios medico-legales y de salud para víctimas de violencia sexual en Centroamérica*. Série Genero y Salud 14. San José, Costa Rica: Pan American Health Organization, 2003.

Available in Spanish at http://www.paho.org/Spanish/DPM/GPP/GH/gph14.pdf.
Available in English: forthcoming at press time.

This report was jointly prepared by WHO and PAHO and consists of the results of a situational analysis of the health and forensic services available to victims of sexual violence in six countries in Central America—Belize, Costa Rica, El Salvador, Guatemala, Honduras, and Nicaragua.

Review of English Literature from 1989 to 1999

Davidson, L. et al. "Training Programs for Healthcare Professionals in Domestic Violence." *Journal of Women's Health and Gender-Based Medicine*, 10:953–969, 2001.

Available in English only.

This review of a published assessment of the education of health care providers in domestic violence found that most programs consisted of single training sessions of

limited duration and that few rigorously designed evaluations had been conducted to assess programs.

ReproSalud, Peru

Rogow, D. and J. Bruce. "Alone You Are Nobody, Together We Float: The Manuela Ramos Movement." *Calité/Calidad/Quality*, No. 10. New York: Population Council, 2000.
Available in English at http://www.popcouncil.org/publications/qcq/qcq10.pdf.
Available in Spanish at http://www.popcouncil.org/publications/qcq/QCQ10span.pdf.

This case study documents an innovative reproductive health program, ReproSalud, implemented by the Peruvian women's organization Manuela Ramos, which helps rural women organize to address important reproductive health issues. Domestic violence has been consistently mentioned as a priority. An evaluation of the program was recently conducted and should be available through http://www.manuela.org.pe.

Vezimfilho, South Africa

Jacobs, T. and R. Jewkes "Vezimfilho: a Model for Health Sector Response to Gender-Based Violence in South Africa." *International Journal of Gynecology and Obstetrics, 78 Suppl 1: S51–S56*, 2002.
Available in English only.

This article describes the development of a model program for training health care workers in South Africa. The program, called Vezimfilho, was implemented in two districts.

The Woman Friendly Hospital Initiative, Bangladesh

Haque, Y.A. "The Woman Friendly Hospital Initiative in Bangladesh: A Strategy for Addressing Violence Against Women." *Development,* 44(3):79–81, 2001.
Available in English only.

This article describes the Woman Friendly Hospital initiative in Bangladesh, a program that addresses violence against women in the context of health service delivery programs. No evaluation data are presented.

Increasing Access to Legal Abortions Among Survivors of Rape in Mexico

Billings, D. et al. "Constructing Access to Legal Abortion Services in Mexico City." *Reproductive Health Matters* (19) 86–94, 2002.
Full article available in English only; summaries available in Spanish and French.

This paper describes a collaborative project between Ipas Mexico and the Mexico City Department of Health to provide legal abortions in cases of rape and to ensure that comprehensive health services for survivors of sexual violence are available and accessible.

Improving Health Sector in Armenia

No published or unpublished documents yet available. For further information contact http://www.intrahealth.org.

The PRIME II project has been working with the government of Armenia and local NGOs since 2002 to improve provider and clinic response to gender-based violence. The Women's Consultation of Polyclinic 8 in Yerevan—with the support of the Ministry of Health, PRIME II, the Women's Rights Center, and other key NGOs—is working within a coordinated community action model to strengthen collaborative relationships between health providers, social services, law enforcement, the media, women's NGOs, and policymakers in support of Polyclinic 8 efforts to screen, counsel, refer, and educate

women living with violence, and to provide education in surrounding communities. While a formal evaluation is planned for May 2004, PRIME II already has training evaluation and monitoring data that demonstrate positive improvements in provider knowledge, attitudes, and both clinic-based and community outreach practice and integration of gender-based violence in health policy.

The Family Violence Prevention Fund, San Francisco

- Warshaw, C. and A.L. Ganley. *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.* San Francisco: Family Violence Prevention Fund, 1998.
- Ganley, A.L. *Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers.* San Francisco: Family Violence Prevention Fund, 1998.

Both manuals can be ordered online (in English only) at http://www.endabuse.org.

The FVPF has published a comprehensive set of guidelines and training materials for individual health care professionals. Although the information is largely based on research and clinical experiences from the United States, it is a tremendous resource for providers who care for survivors of violence and can be considered essential reading for the health sector. It is noteworthy that the FVPF has begun working with a number of international partners to improve the health service response to women who experience family violence; it is likely that in the near future, they will publish the findings and lessons learned from those international efforts. Current international initiatives implemented by the fund include a service delivery program and a community mobilization effort in India as well as two initiatives in Mexico, one in Chiapas, and another in Oaxaca.

The American Medical Association, Chicago

- AMA. "Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect." Chicago: American Medical Association, 1992.
- _____. "Diagnostic and Treatment Guidelines on Child Sexual Abuse." Chicago: American Medical Association, 1992.
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Available in English at http://www.ama-assn.org/ama/pub/category/3548.html.
Available in Spanish at http://www.ippfwhr.org/publications/print_publications_s.asp.

In 1992, the American Medical Association developed a series of diagnostic and treatment guidelines on various forms of violence against women. In 2001, the IPPF translated, updated, and adapted these publications for the Latin American and Caribbean region.

POLICY PROGRAMS

OVERVIEW

The area of policy encompasses a wide range of approaches, ranging from enforcing international treaties to training police officers. As such, programs in this category do not easily lend themselves to crosscutting comparisons and the distilling of lessons learned. Nonetheless, experiences highlighted in this section provide an understanding of the broad range of possible approaches and highlight two important lessons:

- there tends to be a wide gap between the development of a policy (be it national or institutional) and its implementation, and

- when developing policies, it is crucial to keep in mind the context within which they will be implemented as well as the resources available for the implementation or campaigns and programs at both the national and subnational levels.

Because gender-based violence is influenced by multiple factors and can have consequences beyond affecting a victim's health, policies that seek to combat gender-based violence should not be limited to those influencing the health sector alone. Policies affecting the legal sector, for example, can be as important as those that promote change in the health sector. Additionally, policies should be implemented at multiple levels, including international, national, and institutional.

INTERNATIONAL LEGAL INSTRUMENTS

A number of important international legal instruments have sought to address gender-based violence in recent years. In addition to raising awareness of gender-based violence and sending the message that it is an issue worthy of attention, such instruments provide an important framework for action by calling on governments to develop and monitor legislation and related programs. Such instruments can also be used to hold governments accountable for violations.

The following are particularly important international conventions that have addressed gender-based violence:

- The Convention on the Elimination of All Forms of Discrimination Against Women, 1979;

- The World Conference on Human Rights, Vienna, 1993;

- The United Nations Declaration on the Elimination of Violence Against Women, 1993;

- The International Conference on Population and Development, Cairo, 1994;

- The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women "Convention of Belém do Pará," 1994; and

- The United Nations Fourth World Conference on Women, Beijing, 1995.

NATIONAL LEGISLATION AND POLICIES

Following these conventions, a number of nations implemented local legislation and policies addressing gender-based violence. When well implemented and enforced, these efforts can serve the important role of protecting women and increasing the negative consequences of violent behavior to abusers—both key elements in the fight against gender-based violence. (In fact, research in the United States shows that rates of interpersonal violence decrease in response to policies and laws that make violent behavior more costly to abusers.[19])

INSTITUTIONAL POLICIES

Changing institutional policies may be as important as changing nationwide legislation. Outlawing sexual harassment in schools and health settings, for example, not only works to prevent gender-based violence in those settings, but also sends a strong message to the community that gender-based violence in all of its forms should not be tolerated.

Policies at all levels—international, national, and institutional—should be built upon sound evidence. Although there are still some important gaps in research in the area of violence, a substantial body of evidence documenting the prevalence and negative consequences of gender-based violence has emerged in recent years. It is important that these data be used to influence policymakers and that these findings reach those who are working for change locally.

Advocating for better policy, including through the dissemination of relevant research findings, can be an important step in addressing gender-based violence. Such experiences as those from the Soul City initiative highlight the importance of coalition building and the combined use of such advocacy tools as lobbying, media advocacy, and social mobilization. It also notes that while many advocacy efforts focus on the creation and approval of policies and laws, advocates should not overlook the need to ensure effective implementation by advocating for the allocation of sufficient resources, establishing systems to monitor the laws and policies, and holding individuals and states accountable for their failure to implement existing laws and policies.

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

Few well-documented and even fewer well-evaluated experiences in the policy area were identified, making it difficult to abide by all of the selection criteria outlined in the methodology section of this review. The programs highlighted in this section were chosen to exemplify policies implemented at various levels, even though not all of them were evaluated. The use of the Inter-American System for the Promotion and Protection of Human Rights illustrates how international instruments can be used in practical ways to hold states accountable and to promote incremental policy changes. The South African Gender-Based Violence and Health Initiative illustrates how interinstitutional collaboration and research can promote important policy changes at the national level. Finally, the experience of the Nicaraguan Network of Women Against Violence illustrates how local advocacy efforts can promote important changes at the national level.

[19]Fagan, J. "Cessation of Family Violence: Deterrence and Dissuasion." In *Family Violence, Crime and Justice: An Annual Review of Research,* L. Ohlin and M. Tonry, editors. Chicago: University of Chicago Press, pp. 377–425, 1989.

POTENTIAL CONTRIBUTIONS OF POLICY INITIATIVES IN ADDRESSING GENDER–BASED VIOLENCE

Although policies are only as good as their implementation, they can serve to make gender-based violence a legitimate public health and human rights issue. Additionally, policies can both provide guidance and serve to hold countries or individuals accountable for violating them. The unique contributions of policy initiatives will vary depending on the type of policy being implemented, but the following provide important examples of how policies can aid in the fight against gender-based violence:

- International legal instruments can both raise awareness of the problem and make gender-based violence a legitimate issue worthy of attention. Such instruments can also be used to influence national-level policies and legislation and can further be applied when holding governments accountable for violations.

- National legislation and policies can protect women, increase the negative consequences of violent behavior to abusers, and secure allocation of resources for programs and campaigns at the national and subnational levels.

- Institutional policies and protocols can provide guidance to staff members, reduce violence within particular settings (schools and health centers), and serve to send a message that violence is an issue that should not be tolerated.

- Advocacy can have a major role in both the introduction and adequate implementation of policies.

- Policy efforts also have a crucial role in influencing the allocation of appropriate resources that are indispensable to the implementation of any program.

PRESENTING PETITIONS TO THE INTER–AMERICAN SYSTEM FOR THE PROMOTION AND PROTECTION OF HUMAN RIGHTS (Various Countries in Latin America)

This is an initiative implemented by the New York-based Center for Reproductive Rights (CRR), formerly the Center for Reproductive Law and Policy, in partnership with local and regional organizations in Latin America, to document and analyze violations of human rights pertaining to sexual and reproductive health in Latin America. It is one component of a larger strategy implemented by CRR to integrate regional and international human rights principles into national laws and policies.

CRR and its regional partners have brought a number of representative cases before the Inter-American System for the Promotion and Protection of Human Rights.

A few issues are worth highlighting about the Inter-American System's structure and duties:

- It is composed of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights.

- As of 1967, the decisions of the Inter-American Commission are binding and its duties include overseeing member states' adherence to human rights, referring cases to the Inter-American Court, and appearing before the court during litigation.

- The Inter-American Court complements the function of the commission by resolving individual cases referred to it.

- Any individual, group, or NGO can present a petition to the commission on its own behalf or on behalf of another person within 6 months of exhausting remedies.

Evaluation

This is an initiative that does not lend itself to traditional social science evaluation methods. However, the following case represents the potential of the Inter-American System to promote women's rights broadly and to deter gender-based violence.

One of the cases presented by CRR involves MM, a 19–year old woman who sought medical care at a public hospital in Peru. At his private office, the attending physician anesthetized MM and then raped her. When MM regained consciousness and realized what had happened, she ran out of the hospital, to return the following day still hemorrhaging. The physician who saw her covered for the perpetrating provider by telling MM that the bleeding was the result of menstruation. When MM sought legal recourse, she was subject to discrimination and poor treatment, and the defendant was acquitted in spite of the evidence pointing to his guilt.

This case was presented to the Inter-American System by CRR, the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), and the Center for Justice and International Law (CEJIL). Following several months of negotiating, the Peruvian government agreed to compensate MM for her pain, suffering, and material damage, and to report the physician to the Medical College of Peru for professional sanctions.

As highlighted by CRR, presenting petitions in the Inter-American System can accomplish a number of goals, including

- providing a second chance to victims of human rights violations whose appeals were denied in their own countries;

- illustrating representative cases of human rights violations against specific groups, such as indigenous populations or women;

- raising awareness of human rights violations by making them visible and public;

- helping to delineate vague rights that are contained in international treaties; and

- raising recognition of sexual and reproductive rights (SRR) as human rights by linking women's SRR to human rights principles.

Funding

General support provided to CRR.

Sources

Cabal, L., M. Roa, and L. Sepúlveda-Oliva. "What Role Can International Litigation Play in the Promotion and Advancement of Reproductive Rights in Latin America?" *Health and Human Rights*, 7(1):50–88, 2003.

Center for Reproductive Rights. "Reproductive Rights in the Inter-American System for the Promotion and Protection of Human Rights." Briefing paper. New York: Center for Reproductive Rights, 2002.
Available online at http://www.reproductiverights.org/pub_bp_ias.html.

Personal communication with Luisa Cabal, Center for Reproductive Rights.

THE SOUTH AFRICAN GENDER–BASED VIOLENCE AND HEALTH INITIATIVE (South Africa)

The South African Gender-Based Violence and Health Initiative (SAGBVHI) provides an interesting model for close collaboration between research and action as well as between civil society organizations and government. The initiative was established in November 2000 and consists of an alliance of 15 partner organizations and individuals working at the intersection of gender-based violence and health in South Africa. It was created with the aim of capitalizing on individual resources and skills to improve the health sector response to gender-based violence. Its objectives included

- strengthening national research agendas on gender-based violence by building partnerships with government, NGOs, and researchers;
- building local research capacity;
- improving dissemination of research findings;
- transforming research into policy; and
- supporting a small number of projects.

A management structure was created that involved

- a steering committee composed of the 15 founder members and organizations,
- a three-person executive management team, and
- a project manager.

The first activity of the initiative was to hold a national workshop to set a national research agenda on gender-based violence and the health sector. This workshop, held in March 2001 with 43 participants, examined the health sector strategy and implementation plans for addressing gender-based violence and identified key gaps as well as areas for small-scale health systems and policy research that would inform the development and monitoring of the strategy and its implementation. The recommendations that resulted from this workshop were used to set the agenda for advocacy, research, and training for SAGBVHI over the following years. The workshop also helped the group forge an important alliance with the Gender and Women's Health Directorates of the National Department of Health.

Between its creation and 2003, the SAGBVHI organized two national conferences on gender-based violence and health that had an important role in bringing together people interested in the intersection of gender-based violence and health. The conferences provided a powerful message to representatives of the health system that gender-based violence was a valid issue of concern and that it should be addressed by health service delivery programs.

SAGBVHI also supported two research initiatives: one for a study on health workers' experiences of gender-based violence and its impact on their attitudes towards them and work in the area, and another for a study on what survivors of gender-based violence want from health service delivery programs.

Another priority of the research initiative was to increase the integration of gender-based violence into health professional training. To this end, it organized a meeting to assess existing training experiences both at medical and nursing schools.

Evaluation

The SAGBVHI was not formally evaluated, although concrete results in each of its strategic areas address the success of the initiative in raising the profile of gender-based violence, strengthening research capacity, and implementing important steps to improve services in the area of gender-based violence.

The following accomplishments highlight the fact that SAGBVHI came to be viewed by policymakers in various areas (national, university, and health department) as an organization with a valuable role in building a health sector response to gender-based violence because of its expertise and experience. By being able to influence policies at various levels—from universities to the national Department of Health—this group promoted incremental policy changes that ultimately contributed to the improvement of the health response to gender-based violence in South Africa. Some of the steps taken in this direction include

- involvement of members of SAGBVHI in the development of medical curricula at the medical schools of the two universities, ensuring that greater emphasis was given to gender-based violence (including the development of a 1–week module on rape at the University of Witwaterstrand's medical school);

- development of a curriculum for nursing students at the University of the Western Cape;

- development of a 2–day training program for health professionals on postexposure prophylaxis;

- implementation of a situational analysis of sexual assault services in the country in partnership with the National Department of Health (the methodology for this study was then developed by WHO into a proposal for a multicountry situational analysis of sexual assault services);

- development of research capacity at various levels through the implementation of collaborative research efforts that brought together NGOs and the public sector and

that combined clinical and qualitative research expertise, epidemiology, and health systems research;

- implementation of various research initiatives that provided important data for the development of improved policies, as was the case with the situational analysis of sexual assault services carried out through a partnership between SAGBVHI and the National Department of Health and which was eventually adapted for wider use by WHO; and

- participation of SAGBVHI in the development of national policy related to gender-based violence and health, including drafting the National Sexual Assault Policy (to be formally adopted in 2004) and the development (ongoing) of a national training curriculum on sexual assault care.

This alliance enabled participating organizations and individuals to share experiences, work collaboratively, and achieve greater impact on nationwide policy. Collaboration within a noncompetitive environment not only cut short the learning processes, but enabled greater impact to be made. This was particularly true of the area of sexual assault where an important collaboration between research, policy development, and transformation of service delivery programs was achieved.

Source

Medical Research Council. *South African Gender-Based Violence and Health Initiative: Final Report to the Rockefeller Foundation.* Pretoria, South Africa: Medical Research Council, 2003.

THE NICARAGUAN NETWORK OF WOMEN AGAINST VIOLENCE (Nicaragua)

In 1992, a coalition of groups and individual women organized a National Conference for Women that sought to formulate a strategy to respond to what was then a strongly antifeminist government. One of the outcomes of this conference was the creation of national networks addressing specific issues, such as sexuality, health, and violence. The Nicaraguan Network of Women Against Violence (Red de Mujeres Contra la Violencia) was one of these networks. Its initial goal was to organize national campaigns around the "16 Days of Activism on Violence Against Women," celebrated annually between November 25 and December 10. To achieve this goal, the network proposed combining public education messages with specific political demands, such as a demand presented to the National Assembly in 1994, calling on the country to ratify the Belém do Pará Convention.

By 1995, the network was carrying out ongoing activities, in addition to the annual campaigns. These included organizing national conferences and producing publications as well as supporting the creation of local-level domestic violence networks.

The network describes itself as a national space that enables coordination of the women's movement for the purposes of political action. It started with fewer than 20 members and has grown to an active membership of over 150 organizations and hundreds of individual women. Additionally, a group of men has created a smaller scale network of Men Against Violence Against Women, which coordinates with the women's network.

The women's network's leadership is decentralized and nonhierarchical, a characteristic that has promoted broad-based participation. Some of the network's important features include the following:

- Participation is limited to individual women and NGOs with equal rights. Governmental agencies cannot be members, although women who work for the government can participate as individuals.

- Participation is voluntary and members are free to enter and leave the network without obligation (meetings are advertised in national newspapers).

- Leadership is multiple and rotating. The network only has two staff members who facilitate communication and who follow up on agreements, but who are not authorized to make decisions on behalf of the group.

- The network promotes diversity by bringing together individuals from many walks of life.

- Decisions are made by consensus and action is only taken when there is full agreement among its members, a process that can be quite time consuming but that is highly valued by its members.

The main goal of the network is to pressure the government to take on increased responsibility for the elimination of domestic violence while confronting existing cultural norms that tolerate and encourage such violence.

In 1995, the network decided to focus its activities on the justice system. A group of women lawyers and judges drafted a reform domestic violence bill, which was presented by the network to the National Assembly along with 40,000 supporting signatures. This bill sought to change the existing Penal Code and contained the following important provisions:

- It allowed women to seek protection in the case of presumed violence (e.g., by prohibiting the offending spouse from entering the residence and confiscating weapons).

- It included psychological injuries in the definition of the crime of injurious assault.

- It included the existence of family ties between the offender and the victim as an aggravating circumstance, which warranted the maximum sentence (up to six years in prison).

The network used several strategies to build support for the legal reform initiative.

- **Collecting and disseminating epidemiological data**

  The lack of reliable and local data was seen as a major obstacle to raising public awareness on domestic violence. In partnership with two universities (one local, one Swedish), the network carried out a study on the prevalence and characteristics of domestic violence in León, Nicaragua's second largest city. The study found that of 360 women aged 15–49 who had ever been married, 52 percent had experienced

intimate partner violence. One third of the women who had been abused had also been raped by their partners, and one third had been beaten while pregnant. The results of the study were published in a book and presented at a national event with full media coverage. Additionally, a panel of high-level government officials was invited to comment on the study. In addition to helping educate policymakers about the widespread nature of violence and its destructive consequences, the data served to secure their support for the domestic violence bill.

- **Implementing participatory action research on legal reform**

  Anticipating strong resistance at the National Assembly, volunteers from the network carried out action research[20] in partnership with the local university.

- **Providing legislators with information on some of the most controversial issues**

  The goal of this initiative was to provide legislators with information on some of the most controversial issues, such as restraining orders and the criminalization of psychological injuries. Some of the issues tackled by the research included the kinds of acts that were perceived as constituting violence and the kinds of protective, punitive, and rehabilitating measures that were considered useful for victims and perpetrators. The study documented wide consensus on a number of issues, including the seriousness of psychological abuse and the importance of protective measures for women.

- **Lobbying in the National Assembly**

  The results of the action research were presented in formal testimony to the Justice Committee of the National Assembly who then decided to send the bill in a weak version to the full Assembly. Because elections were only a few months away and there were a number of important bills pending, the network had to lobby intensely both to restore the bill to its original version and to ensure that it would come to the floor. This was done in various ways, including placing advertisements in major media outlets, collecting and presenting 21,000 signatures to members of Parliament, producing briefing packets and presenting them to parliamentarians, and direct lobbying in the corridors by a team of well-known lawyers and psychologists.

As a result of all of these efforts, so much public support was created for the bill that voting against it would have been seen as endorsing gender-based violence—a risk too high for any politician to take in an election year. Consequently, the bill was unanimously approved in August 1996 and came into effect in October of the same year.

Evaluation

The network recently carried out an external evaluation that sought to assess its impact over a 10–year period (from 1992 to 2002). The methodology involved the following elements:

[20]Action research couples participatory methods and research to affect action and change. The participatory process is educative and empowering and interlinks problem identification, planning, action, and evaluation. It is a problem-focused, context-specific, and future-oriented approach. In this case, it aimed at providing legislators with practical information that would enable them to cast informed votes in the area of gender-based violence legislation.

- the application of a questionnaire among a representative sample of 402 young and adult women and men in the 38 territories where the network is active to gather their opinions regarding the network,
- an analysis of media coverage,
- indepth interviews with key stakeholders and with members of organizations belonging to the network,
- focus groups with representatives from member and nonmember organizations, and
- case studies focusing on various issues, including the domestic violence legislation and the network's campaigns.

Among the key achievements of the network is its role in ensuring the ratification of the Belém do Pará Convention, the approval of the domestic violence legislation; the signing of a ministerial agreement that recognizes domestic violence as a public health problem; the network's participation in the approval of the Child and Adolescence Code; and the creation of a nonvictimizing model of care at the existing women's police stations.

Some of the quantitative results gathered through the application of the questionnaire include the following (n = 402):

- 88 percent had heard of the network;
- 90 percent remembered the theme of the network's first campaign, "A life without violence: let's make this right a reality";
- 22 percent had signed a petition promoted by the network;
- 20 percent had participated in an activity sponsored by the network; and
- 82 percent affirmed that the network helps to prevent violence against women.

Sources

Sequeira, S. et al. "Contra la violencia: De la conciencia y la denuncia a las leyes, de las leyes a la acción. Evaluación de la incidencia en políticas públicas y en la opinión pública del quehacer de la Red de Mujeres Contra la Violencia (Período 1992–2002)." 2003. (Unpublished evaluation)
Available in Spanish. For information, contact http://www.path-dc.org.

Herrera, M. "Case Study: Women's Network Against Violence, Nicaragua." Paper presented at the Gender Violence, Health and Rights in the Americas Symposium in Cancun, Q.R., Mexico, June 4–7, 2001.
Available in English at http://www.paho.org/english/hdp/hdw/nicaragua.pdf.

Ellsberg, M., J. Liljestrand, and A. Winkvist. "The Nicaraguan Network of Women Against Violence: Using Research and Action for Change." *Reproductive Health Matters*, 10:82–92, 1997.
Full article available in English; summaries available in Spanish and French.

ANNOTATED BIBLIOGRAPHY

Soul City, South Africa

Usdin, S., N. Christofides, L. Malepe, and A. Maker. "The Value of Advocacy in Promoting Social Change: Implementing the New Domestic Violence Act in South Africa." *Reproductive Health Matters,* 8(16):55–65, 2000.

Full article available in English; summaries available in Spanish and French.

This article describes an advocacy campaign conducted by the Soul City Institute for Health and Development Communication in partnership with the National Network on Violence Against Women to lobby for the timely and effective implementation of the Domestic Violence Act, passed into law in 1998. Lessons from the campaign highlight the importance of coalition building and the combined use of advocacy tools, such as lobbying, media advocacy, and social mobilization. The paper also notes that while many advocacy efforts focus on the policies and laws, advocates cannot overlook the need to ensure effective implementation by dedicating sufficient resources and establishing systems to monitor the laws and policies and resolve problems as they are identified.

Symposium 2001: Gender Violence, Health and Rights in the Americas, Cancun, Mexico

PAHO. *Symposium 2001: Gender Violence, Health and Rights in the Americas, Final Report.* Washington, DC: Pan American Health Organization, 2001.

Available in English at http://www.paho.org/English/HDP/HDW/Symposium2001FinalReport.htm.
Available in Spanish at http://www.paho.org/spanish/hdp/hdw/Symposium2001FinalReportsp.pdf.

In 1999, a group of international agencies and organizations collaborated to convene this symposium, which was attended by representatives from the health sectors, national governments, NGOs, and other stakeholders in the region. The presentations made at this symposium included many reports on efforts to advocate for legislative, judicial, and policy reform in Latin America and the Caribbean. This report summarizes many of the key recommendations and lessons learned from those reports and provides an overview of organizations working to improve policies in the region.

Implementation of Domestic Violence Policies in Latin America

ICRW. "How to Make the Law Work? Budgetary Implications of Domestic Violence Policies in Latin America." 2003.

Available in English at http://www.icrw.org/docs/dv_budgets_703.pdf.

This document analyzes national domestic violence laws and policies in seven countries in Latin America as well as the budget allocations for the implementation of these policies. It also provides a framework to facilitate the process of systematically analyzing the budgetary implications of domestic violence. The report finds that none of the countries in the study had passed laws with actual budgetary appropriations, thus greatly limiting the implementation of the programs and services proposed.

Guerrero, Elizabeth. "Violence Against Women in Latin America and the Caribbean 1990–2000: Assessment of a Decade." Santiago: Isis International/UNIFEM, 2002.

Available in Spanish at http://www.isis.cl/temas/vi/balance/INFORMEpercent20FINAL11.doc.

This document outlines main international landmarks in the area of violence against women and then reviews progress and challenges made by governments through the generation and amendment of laws and policies in the region. It also analyzes the efforts made by women's movements in the 1990s and proposes future lines of action.

All–Women Police Stations, Latin America and parts of Asia

- Jubb, N. and W.P. Izumino. "Women and Policing in Latin America: A Revised Background Paper." Prepared for the Women and Policing in Latin America project, 2002.
  Available in English through POPLINE® at http://db.jhuccp.org/popinform/basic.html.
- Krug, E. et al. *World Report on Violence and Health*. Geneva: World Health Organization (in particular pp. 105–106), 2002.
  Full report available in English. Summary available in Spanish.
- Thomas, D.Q. "In Search of Solutions: Women's Police Stations in Brazil." In *Women and Violence: Realities and Responses Worldwide,* M. Davies, editor. London: Zed Books, pp. 32–42, 1994.
  Available in English.

  The publications noted above review some of the recent research on all-women's police stations. The strategy of establishing all-women police stations began in Brazil and was later tried in other countries in Latin America and Asia. Although this approach has a number of strengths, studies suggest that these initiatives have a number of potential problems. On the one hand, some research suggests that these police stations increase the number of women who come forward to report abuse. On the other hand, studies have found that the staff at these police stations may not necessarily have better attitudes towards victims simply because they are women. In many cases, these stations have not had the types of services or referral mechanisms (legal, counseling) that survivors of violence need. Moreover, in some cases, the creation of these stations has encouraged other police units to abdicate any responsibility for crimes against women. This can be a particularly serious problem in settings where neighborhood police refuse to act because they expect women to travel long distances to the nearest all-women police station.

Review by the Asian Forum Newsletter

"Advocacy for Legislation on Violence Against Women, Session 2." Asian Forum Newsletter, 2001.
Available in English through POPLINE® at http://db.jhuccp.org/popinform/basic.html.

This paper describes efforts of NGOs in Cambodia, the Philippines, and Thailand to advocate for changes in legislation related to violence against women as well as efforts to monitor the implementation of laws. It highlights the lessons learned as well as the challenges that confront advocates for women's rights in this area.

Review of Rights and Legislation by the Center for Reproductive Rights (previously the Center for Reproductive Law and Policy)

Center for Reproductive Law and Policy. *Bringing Rights to Bear: an Analysis of the Work of the UN Treaty Monitoring Bodies on Reproductive and Sexual Rights.* New York: Center for Reproductive Law and Policy, 2002.
Available in English at http://www.reproductiverights.org/pub_bo_tmb.html.
Available in Spanish at http://www.reproductiverights.org/pub_bo_tmb.html#spanish.

This report charts the collective work of six United Nations committees as they work to translate international human rights standards into state responsibility on a broad spectrum of reproductive rights issues, including violence against women. This publication represents an important source of information about how well international agreements have been implemented within individual countries worldwide and what different groups can do to improve progress.

Law Enforcement Policies

Krug, E.G. et al. *World Report on Violence and Health.* Geneva: World Health Organization, 2002.

Full report available in English at:
www.who.int/violence_injury_prevention/violence/world_report /wrvh1/en/;
summaries available in Spanish and French.

Pages 105–106 include a detailed review of the evidence related to effective law enforcement policies, including the impact of arrest on violence partners and the implications of protection orders. Unfortunately, while there has been extensive and fairly rigorous evaluation of many aspects of law enforcement policies, this research has come almost exclusively from developed countries, particularly the United States. It is not clear how applicable these findings are to developing country settings.

Review of Justice System Reforms Efforts, World Bank

Heise, L., J. Pitanguy, and A. Germain. "Violence Against Women, the Hidden Health Burden." World Bank Discussion Paper #255. Washington, DC: The World Bank, 1994. *Available in English.*

This publication includes a review of experiences and lessons learned related to justice system reforms in various countries. For example, the authors cite the example of the Musasa (or Musassa) project in Zimbabwe that has worked to improve the response of local police and prosecutors as well as El Instituto Legal de Los Naciones Unidas y Desarollo (ILANUD) in Costa Rica, which has provided training in issues related to gender sensitivity and violence against women for prosecutors, judges, lawyers, and other professionals. The authors also describe promising efforts in the Philippines of women's groups to change legislation related to sexual and physical violence against women.

PROGRAMS AIMED AT YOUTH

OVERVIEW

Many programs have paid increasing attention to the consequences of early and unprotected sexual activity among young people in developing countries, including unwanted pregnancy, early childbearing, unsafe abortion, and the spread of STIs, including HIV.[21] Programs have aimed to reduce these consequences by increasing adolescents' access to information and services related to SRH, including family planning, emergency contraception, prevention of STIs, and various kinds of SRH education and counseling, including programs that promote abstinence and delayed sexual debut. In the literature from developing countries, however, relatively less has been written about interventions addressing gender-based violence, particularly nonconsensual sex among adolescents. As a result, some researchers[22] argue that current intervention models are inadequate, particularly those that stress responsible sexual decision-making, assume that sexual activity is voluntary, and ignore the implications and consequences of sexual coercion.

Despite the recent attention given to gender-based violence at the international level, young people who experience sexual coercion and violence often face a poor institutional response, whether from health, social, or law enforcement services. In fact, recent research shows that violence (in particular, sexual violence) frequently occurs even in institutions normally regarded as safe, such as schools.[23]

Various approaches have been used to address gender-based violence among youth populations, including

- working with both male and female adolescents to change gender norms,
- strengthening the ability of teachers and school staff to address gender-based violence,
- implementing policies that address sexual violence and rape at schools, and
- empowering girls to protect themselves.

Examples of initiatives that have addressed violence among youth in the health sector are fewer in number. In fact, examples are available of the limited effectiveness of programs that fail to promote more equitable gender relations or to address sexual coercion when attempting, for example, to prevent HIV.[24]

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[21]For example, see a review of such programs in Focus on Young Adults. *Advancing Young Adult Reproductive Health: Actions for the Next Decade.* Washington, DC, 2001.

[22] Mensch, B., J. Bruce, and M. Greene. *The Uncharted Passage: Girls' Adolescence in the Developing World*. New York: Population Council, p. 52, 1998.

[23] WHO. *World Report on Violence and Health*. Geneva: World Health Organization, 2002.

[24] For instance, see Campbell and MacPhail in the annotated bibliography, and Petersen. I., A. Bhagwanjee, A. Bhana, and Z. Mahintsho, "The Development and Evaluation of a Manualised Participatory HIV/AIDS Risk Reduction Programme (Sex and Risk) for Tertiary Level Learners: A Pilot Study." *African Journal of AIDS Research*. (in press)

Although the programs presented in this section are quite diverse, the following lessons can be highlighted.

- There is a high rate of violence, particularly sexual violence, among adolescents, especially girls. Consequently, programs need to consider the possibility that sexual activity is not always voluntary and that even places regarded as safe, such as schools, present risks. Failing to address issues related to sexual coercion can jeopardize the effectiveness of interventions in such areas as HIV prevention and lead to long-term consequences, including negative health outcomes and school evasion.

- Conservative and judgmental attitudes regarding adolescents' sexuality among teachers or health care providers require attention. Sensitization and training activities should address participants' attitudes as well as their personal experiences with violence, be sustained over time, and include the provision of support when they begin to implement newly acquired knowledge and skills in practice.

- Some evidence indicates that the training-of-trainers approach may not be suitable for a sensitive topic such as gender-based violence—content can be diluted and/or incorrect information may be imparted.

- As demonstrated by Program H and other programs highlighted in White et al. (2003), working with boys to change gender norms is an important strategy to combat and prevent gender-based violence and to promote more equitable relationships in the long term.

- Among the programs identified, none made an effort to simultaneously work with older men, with the exception of programs that have implemented sanctions for teachers who perpetrate sexual violence. Given the lack of available information, it remains to be seen whether this could be an important component of programs addressing gender-based violence among youth.

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

The programs highlighted in this section provide a range of possible approaches to addressing gender-based violence among youth both in school and in the community. Unfortunately, no well-documented/evaluated initiatives addressing gender-based violence primarily through the health sector were identified. This highlights the importance of increasing efforts to address gender-based violence through the numerous SRH and HIV initiatives that currently target youth.

POTENTIAL CONTRIBUTIONS OF PROGRAMS AIMED AT YOUTH IN ADDRESSING GENDER–BASED VIOLENCE

Addressing gender-based violence among youth can serve the following purposes:

- **Changing norms and behaviors before they become deeply ingrained**

  This is one of the key contributions of programs that target youth, particularly those that work with young men. In fact, some informants for this review alluded to the importance of examining the possibility of intervening at an even earlier age,

suggesting that in some cases, it may be too late to achieve change among adolescents.

- **Creating safe spaces for youth**

  Addressing gender-based violence at schools—through the implementation of institutional policies or sanctions for teachers who sexually harass students—may prevent violence in these settings from taking place and may also send a message to the wider community that violence is not acceptable and will not be tolerated.

- **Minimizing the consequences of violence among survivors**

  The consequences of violence at an early age are multiple. Childhood sexual abuse, for example, has been shown to have long-term consequences on a survivor's sexual and reproductive health, including increased risk-taking behaviors, such as earlier sexual debut, drug and alcohol use, more sexual partners, and less contraceptive use.[25] [26] Consequently, victims of sexual abuse in childhood appear more likely than other teenagers to become pregnant in adolescence.[27] By addressing violence at an early age, programs have the potential to both prevent violence from occurring and to minimize these potential negative outcomes.

IN–SCHOOL GUARDIAN PROGRAM: TANESA (Tanzania)

This program was implemented within the context of the TANESA project (Tanzania–Netherlands Project to Support HIV/AIDS Control in Mwanza Region), which has been working since 1994 to develop interventions to reduce HIV/STD transmission. The Guardian (mlezi in Swahili) program was started when experiences of sexual exploitation of schoolgirls, including those perpetrated by teachers, older boys, and men, surfaced during research workshops with school pupils.

The main goal was to create a safer environment for schoolgirls to protect them from sexual exploitation by establishing a guardian program in every primary school in the Mwanza and Magu districts. Guardians were female teachers, selected by their fellow teachers and the school board, who were trained so that they could be consulted in cases of sexual violence and harassment. Guardians were also expected to be able to provide girls with advice on sexual and reproductive health issues, including contraception and HIV/AIDS prevention.

In order to keep program costs down, the initial 1–day training of guardians covered such issues as sexual and reproductive health, counseling techniques, and guardians' concerns when dealing with sexual abuse cases as well as procedural issues regarding reporting cases. The training costs were US $7.13 per guardian, including transportation, materials, and an allowance for the

[25]Felitti, V.J., R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, M.P. Koss, and J.S. Marks. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine,* 14(4):245–258, 1998.

[26]Walker, E., A. Gelfand, W. Katon, M. Koss, M.V. Korff, D. Bernstein, and J. Russo. "Adult Health Status of Women HMO Members with Histories of Childhood Abuse and Neglect." *American Journal of Medicine,* 107(4):332–339, 1999.

[27] Heise, L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Report*s Volume XXVII, Number 4, Series L, No. 11. Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program, 1999.

facilitators who were female staff members of the District Education Office and TANESA. By the end of 1996, the year guardian selection and training took place, 185 primary schools in the two districts had a guardian in place.

Evaluation

An initial assessment of the program was carried out in the last 2 months of 1996 and had the following objectives:

- assess the extent of the sexual experience of primary schoolgirls,
- find out the types and extent of sexual exploitation reported to guardians, and
- determine how well the program was meeting the sexual and reproductive health needs of girls and protecting them from sexual exploitation.

The evaluation was carried out in 40 schools with a guardian (half in a rural setting) and 22 schools without a guardian program. The schools were randomly selected after stratification by the presence of a guardian. The evaluation consisted of two steps:

- interviews with the head teachers and a guardian (or two female teachers in schools without guardians) using a structured questionnaire with an open-ended section, and
- interviews with a random sample of 1,219 schoolgirls conducted by girls who had left the school the previous year.

In the first 8 months of the program's operation, 61 percent of the girls in the 185 schools consulted with the guardian, 59 percent about harassment by a boy and 9 percent about harassment by a teacher. A comparison of schools with and without guardians showed that 52 percent of girls in schools with a guardian indicated that they would approach her if they were experiencing harassment by a teacher, while none of the girls in schools without a guardian suggested that they would approach a member of staff in a similar situation. Ninety-three percent of the girls in schools with a guardian had participated in at least one activity organized by the guardian and three fourths of the girls who had consulted a guardian reported that they were happy with the outcome of the consultation.

When asked about their sexual experiences, 26 percent of girls aged 12–13 and 80 percent of girls aged 16–19 reported having had sex. The median age at first sexual intercourse was 15; a larger proportion of urban girls had ever had sex compared with girls in rural settings. When girls were asked to list problems that were most common among girls their age, pregnancy was the single most commonly cited problem (50 percent), followed by harassment by boys, village men, and teachers (59.6 percent combined), and lack of information about STI/AIDS (26 percent).

Girls were then asked whom they would turn to for help with their problems. Mothers, female teachers (including guardians), and girlfriends at school were cited as potential sources of help in cases of sexual harassment. In contrast to the high number of girls who reported that they would seek assistance from a guardian in the case of sexual harassment, in the case of pregnancy, girls reported that they would turn most often to their mothers; 24 percent reported having no one from whom to seek assistance. Girls' reluctance to turn to teachers or the guardian may be a

result of the conservative attitudes prevalent among this group—the evaluation showed that most guardians and teachers are opposed to sexual activity among girls. Reluctance may also be a result of fear of expulsion from school. In fact, a total of 42 pregnancies were reported during the study period; all of them resulted in the expulsion of the schoolgirl, a course of action consistent with the national policy at the time.

Having guardians at school seems to be a valid and low-cost strategy to both prevent sexual violence and provide assistance to victims. However, the initiative seemed to have a limited impact in terms of addressing the issues of pregnancy and STI/HIV prevention given the conservative attitudes prevalent among staff. Therefore, increased emphasis needs to be given during training to the importance of providing SRH information to youth and to the attitudes of staff. Additional strategies for imparting SRH information that do not rely solely on teachers may also be considered.

Funding

TANESA was funded by the Netherlands Ministry for Development Corporation.

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DEVELOPING A MODEL GENDER AND CONFLICT COMPONENT FOR THE PRIMARY SCHOOL CURRICULUM (South Africa)

This program was developed by the Public Health Program at the University of Western Cape in association with The POLICY Project and the Rural AIDS and Development Action Research Programme (RADAR). It sought to incorporate the issue of gender-based violence into the primary school curriculum (grade 5 or the equivalent to about age 11). The impetus to work with teachers of young pupils resulted from the recognition of the links between gender-based violence and vulnerability to HIV/AIDS and of the high levels of sexual violence experienced by girls in schools.

This initiative further aimed to evaluate two training models:

- a whole-school approach, which offered a training package to the whole school, including principal, teachers, and auxiliary staff; and

- a train-the-trainer approach, which offered the same package to a subgroup of teachers who were then responsible for training their colleagues in a cascade effect. This approach is often preferred because it is less costly. The evaluation therefore aimed to assess its effectiveness.

Participating primary schoolteachers attended a master training program (eight 2–hour sessions) and were provided with accompanying instructional materials for use in the classroom setting. The teacher training focused on identifying and challenging teachers' own knowledge and attitudes regarding gender and gender-based violence, reflecting on the messages they were sending to students and identifying strategies for addressing gender-based violence in their own schools.

Evaluation

Given the short interval (a few months) between the intervention and the evaluation, this phase of the program sought to assess the impact of the intervention package at the level of the teachers and not at the level of the students.

The evaluation consisted of the application of a pretraining and posttraining questionnaire, which was completed by 20 of the 33 participating teachers. It also included a separate and confidential questionnaire to assess the prevalence of gender-based violence within the teachers' own experiences. For the whole-school approach, the evaluation also included the observation by researchers of the same lesson (which focused on gender-based violence) taught to five different classrooms.

The evaluation design (preintervention and postintervention questionnaires) and the small number of respondents posed some limitations to this evaluation (as did the fact that impact on students was not evaluated due to time limitations). However, several findings are noteworthy.

There was a general acceptance among teachers of the importance of addressing gender-based violence at the primary level and at an even earlier age. The proportion of teachers who believed that schools could have a meaningful role in addressing gender-based violence rose from 30 percent before the training to 70 percent afterwards. There was a high level (90 percent) of agreement even before training that gender-based violence should be included in the curriculum, but this figure rose to 100 percent following the intervention. While the proportion of teachers who believed that women provoke physical violence decreased from 26 to 5 percent, disturbingly, the proportion of teachers who believed that women provoke rape increased slightly from 10 percent before training to 20 percent following training. (Researchers hypothesize that this may be an indication of how entrenched and contested this view is in South Africa.) While initially only 22 percent of teachers indicated that they would feel more confident teaching about gender-based violence compared with other subjects, this proportion increased to 58 percent following training. Finally, teachers' confidence in being able to address a gender-based violence incident increased from 26 to 74 percent following training.

In terms of teachers' personal experiences with gender-based violence, 47 percent of female teachers indicated having been physically abused, 31 percent indicated having been sexually abused, and 69 percent indicated having been psychologically abused. Among men, 25 percent reported being physically abusive to their partners, 12 percent reported being sexually abusive, and 33 percent reported emotional abuse of their partners. These figures corroborate the need to address teachers' own experiences as part of the training process.

Observations of teachers taking part in the whole-school approach indicated that they were able to creatively adapt the lesson plans and materials provided to suit their students. Teachers also indicated that the students enjoyed the lessons and seemed to be familiar with the situations

provided, reinforcing the importance of starting to address gender-based violence at a young age. Teachers in this group emphasized the importance of counting on the support of management.

Although teachers participating in the train-the-trainers approach indicated in their questionnaires that they felt sufficiently prepared to teach their peers, none of them were actually able to train additional teachers. This seemed to stem from the teachers' difficulty in scheduling and convincing their colleagues to attend such training. Since many teachers are sent to various training sessions and expected to inform their colleagues upon their return, this creates a backlog that makes it difficult (and in the case of this project, impossible) for them to train their peers.

Funding

The first phase and a portion of the second phase of this project was funded by the Open Society Foundation for South Africa. The second phase also received support from the Australian Agency for International Development (AusAID) and USAID.

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Personal communication with Abigail Dreyer.

(A final report of the project is under revision.)

PROGRAM H (Bolivia, Brazil, Colombia, Jamaica, Mexico, and Peru)

Program H is a multipronged strategy to work with young men on various issues relating to sexual and reproductive health, including gender-based violence. The initiative is developed by a coalition of four NGOs that includes Instituto PROMUNDO, PAPAI, ECOS, and Salud y Género (Health and Gender). The first three are located in Brazil, while the latter is based in Mexico.

Program H (H is the first letter for the word men in both Portuguese [homem] and Spanish [hombre]) is composed of four main components described in the following sections.

Training Professionals To Work With Young Men in the Areas of Health and Gender Equity

The four organizations involved in Program H developed a methodology to train professionals to work with young men with the goal of fostering discussion and challenging traditional gender roles as they relate to masculinity, health, and gender relations. This methodology was validated in six countries in Latin America and the Caribbean among 271 young men. Subsequently, five training manuals and one video were created to enable the four organizations to replicate the methodology in multiple countries. Each of the five training manuals addresses a different topic,

including sexual and reproductive health, paternity, violence, emotions (including drug use) and HIV/AIDS. (The materials are currently available in Portuguese, Spanish, and English.)

Promoting a Gender Equitable Style of Life via the Social Marketing of Condoms

Program H's social marketing strategy aims first and foremost at promoting a lifestyle that is characterized by equitable gender relations between men and women. The first step of this initiative is to identify barriers to condom use among young men so that appropriate strategies can be designed that will promote safe relationships. This social marketing strategy also aims at increasing access to condoms and generating income to support the program via the sale of condoms by peer promoters, who also become role models within the community. An inexpensive condom, called Hora H (In the heat of the moment) was made available for sale at strategic locations throughout low-income communities.

Promoting Health Service Delivery Programs that Are Attractive and Well Equipped To Attend to the Needs of Young Men

This component of the initiative aims at both training health professionals to provide services for young men and at adapting health service delivery programs so that they are more appealing to this population. In Rio, Instituto PROMUNDO is working with six public health units with support from PAHO and WHO.

Evaluating Changes in Gender Norms

The fourth component of Program H, developed in partnership with Horizons, aims at evaluating the program through the creation and validation of a methodology that will enable similar programs to measure changes in gender equity. This methodology involves the gender-equitable men (GEM) scale, which measures young men's attitudes related to gender roles and masculinity as well as changes in attitudes. GEM is composed of two subscales measuring traditional and egalitarian norms by using 17 and 7 items, respectively.

Evaluation

Following the GEM scale's validation in 2002, PROMUNDO and Horizons began a two-year evaluation in May of the same year to measure the impact of the manuals and the video. In Rio, the evaluation involves 750 young men, 15–24, from three different communities but of similar socioeconomic status, one of which serves as a control group. Activities of different levels of intensity are carried out in each of the communities: 14 hours of activities for one group, 28 hours for the other, and intense group activities in combination with a lifestyle social marketing campaign for the third group.

Pretests and posttests are given and a second posttest is given 6 months after the end of the workshop. A qualitative component of the evaluation involves interviews with a subsample of the young men and those who know them, including their female partners. This information will be used to triangulate the quantitative results.

The following are examples of the traditional norms measured by the scale, "It is okay for a man to hit his wife if she won't have sex with him," and "I would be outraged if my wife asked me to use a condom." While "it is important that a father is present in the lives of his children, even if he is no longer with the mother" is an example of an egalitarian norm.

Baseline testing of the GEM scale found that it was highly correlated with a number of key behavioral outcomes, including self-reported violence against women. Working in low-income communities in Rio de Janeiro, the program carried out an impact evaluation study. This study included using a pretest before project activities, a posttest applied immediately after participating in the project, and a follow-up posttest to confirm if any changes last after the project activities have ended. Final results will only be available later in 2004; nonetheless, initial results from two communities with more than 400 young men found increased condom use with regular partners, decreased rates of STIs, and positive change on 14 of 17 attitude questions used to assess changes in views about gender. Differences in attitudes were statistically significant in both communities. Changes in condom use and rates of STIs were only statistically significant in the community where group educational activities were combined with the Hora H condom campaign.

Table 8
Proportion of Youth Who Report STI Symptoms at Baseline, Posttest 1, and Posttest 2
(percentage)

Community and Activity	Pretest	Posttest 1 (6 months after baseline)	Posttest 2 (12 months after baseline)
Community 1 (Bangu) (Workshops and condom campaign)	23	14	5
Community 2 (Maré) (Condom campaign only)	31	25	6.4

Program H was not able to measure changes in the self-reported use of violence against partners because the frequency of such behavior in the test group was too low to be able to measure a statistically significant change. Nonetheless, the statistically significant changes in both communities in the GEM scale questions suggest that attitude changes occurred in key attitudes that are correlated with men's use of violence against women.

The following table provides a glimpse of the data that are currently being analyzed. Data shown below are from one of the communities involved in the study (Bangu) and from the pretest and first posttest.

Table 9
Frequency of Young Men Who Agreed, Completely or Partially,
With Traditional Norms and Behaviors in Bangu
(percentage)

Norm or Behavior	Pretest	Posttest 1
Men need sex more than women do.	48.2	40.9
There are times when a woman deserves to be beaten.	32.6	28.7
A woman's most important role is to take care of her home and cook for her family.	63.1	49.1
It is okay for a man to hit his wife if she won't have sex with him.	2.2	3.5
I would never have a gay friend.	36.5	44.8

Although positive changes toward less traditional norms are observed in the majority of the items in the scale, two of the items above indicate negative changes towards more traditional norms.

Given that the study has not yet been completed and data have not been fully analyzed, it is still too early to hypothesize about these changes.

In addition to assessing the program's impact on attitudes and behavior change, PROMUNDO is also carrying out a cost-effectiveness assessment. Preliminary results suggest that a typical Program H project in an urban area with a population varying between 500,000 and 1 million inhabitants reaches

- 20,000 young men indirectly with messages relating to SRH promotion, HIV/AIDS, and gender equity;
- 2,000 young men directly involved in project activities;
- 15,000 young men with condoms (with more than 100,000 condoms sold); and
- 10,000 young women who are partners of the young men.

Although the operational costs of implementing such a program can vary tremendously, annual operational costs (excluding start-up costs) for an urban site with a population between 500,000 to 1 million ranges between US $150,000–$ 200,000.

Instituto PROMUNDO is currently working to expand the reach of Program H and to apply the experience to various parts of the world, including Africa, Asia, and Central America.

Funding

Instituto PROMUNDO and Program H receives financial support from various sources, including the Ford Foundation, UNFPA, and SSL International as well as additional sources for specific initiatives. The other three partners in the program are supported by additional funding organizations.

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Barker, G. *How do We Know if Men Have Changed? Promoting and Measuring Attitude Change with Young Men. Lessons from Program H in Latin America*. Paper presented at the Expert Group Meeting on "The Role of Men and Boys in Achieving Gender Equality." UN: Brasília, Brazil, 2003.
Available online at http://www.un.org/womenwatch/daw/egm/men-boys2003/OP2-Barker.pdf. accessed February 19, 2004.

Personal communication with Gary Barker and Marcos Nascimento of Instituto PROMUNDO.

White, V. et al. *Men and Reproductive Health Programs: Influencing Gender Norms*. Washington, DC: USAID, 2003.

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Available in English only.

A peer education HIV–prevention program was carried out in a setting in which 8 percent of 15-year-old girls were HIV positive compared with 0.2 percent of boys. The evaluation suggested that because the program failed to address gender issues and sexual coercion, the program may have entrenched them further. Female peer educators were bullied and harassed, while male peer educators encouraged peers to pressure girls for early and frequent sex.

The Girls' Power Initiative

Irvin, A. *Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroon.* New York: International Women's Health Coalition (IWHC), 2000.
Available in English only.

The Girls' Power Initiative in Nigeria promotes comprehensive sexuality education that explicitly addresses sexual violence. It also teaches economic skills, such as financial planning. It is primarily aimed at girls aged 10–18, with some programs for boys, parents, teachers, health care providers, and policymakers.

Review by the Panos Institute

Mirsky, J. "Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector." *Panos Report* No. 47. London: Panos Institute, 2003.
Available in English at http://www.panos.org.uk/PDF/reports/Beyondpercent20Victims.pdf.

This is an excellent and extensive review of the literature (published and unpublished) on sexual violence in educational settings, including interventions and strategies that have been used in developing countries to address all forms of sexual violence in schools and universities.

Auntie Stella, Zimbabwe

- Harnmeijer, J. *Adolescent Reproductive Health Education Project 'Auntie Stella,' Phase 1 Evaluation.* ETC International, 1999.
  Available in English at http://www.tarsc.org/publics5.html.
- Kaim, B. and R. Ndlovu. *Lessons from "Auntie Stella": Using PRA to Promote Reproductive Health Education in Zimbabwe's Secondary Schools.* Zimbabwe: Training and Research Support Centre (TARSC), 1999.
- Kaim, B. et al. *Auntie Stella: Teenagers Talk About Sex, Life and Relationships.* An adolescent reproductive health pack. Harare, Zimbabwe: Training and Research Support Centre (TARSC), 1999.
  Available in English at http://www.tarsc.org/auntstella/.

  Participatory, formative research among adolescents in Zimbabwe determined that many young people were concerned about fear of rape, sexual harassment, and lack of money leading to coercive sexual relationships as well as other related concerns such as fear of sexually transmitted diseases (STDs) and AIDS. In response, TARSC developed *Auntie Stella*, which is an activity pack that is produced in print and on the web for young Zimbabweans 13–17 years old. Essentially, it uses a question and answer format of letters written to "agony aunts" in magazines, a popular source of information for young people in Zimbabwe. The letters aim to encourage young people to discuss key teenage

issues, and also provide information that teenagers have difficulty obtaining elsewhere. *Auntie Stella* consists of 33 question and answer cards, the questions supposedly written by adolescents seeking information and/or advice on a variety of topics. The answer cards give Auntie Stella's reply. The topics covered include normal reproductive development, social and economic pressures to have sex, gender roles, forced sex, communication in relationships and with parents, depression, wanted and unwanted pregnancy, infertility, cervical cancer, HIV/AIDS, and STDs. This program underwent an external evaluation, and the report is available online (see Harnmeijer 1999). Overall, both internal and external evaluations have found the program results to be extremely positive.

Educational Guidelines, Department of Education, South Africa

Jewkes. R. *The HIV/AIDS Emergency: Department of Education Guidelines for Educator.* Pretoria: Department of Education, 2000.

Available in English only.

To address sexual harassment and rape in schools, the education department of the South African government set up the Equity Task Force in 1996 to address the issue and introduce new guidelines and legislation. Guidelines introduced in 2000 prohibit sex between educators and students and define specific penalties for violating these laws or failing to report such acts. (Unable to determine whether the implementation of the guidelines has been evaluated yet.)

Entre Amigas (Between Friends), Nicaragua

PATH. *Baseline Report of the Project Entre Amigas.* Shared by the Entre Amigas Project Coordinator (entreamigas@puntos.org.ni), 2004.

Available in English.

This is a project implemented through a partnership between PATH and three Nicaraguan organizations: Center for the Study of Social Promotion (CEPS in Spanish), the University of Leon, and Puntos de Encuentro. It targets girls between the ages of 10 and 14 through a mix of strategies that addresses both the girls themselves and their support network, particularly mothers and teachers. The project is still in its beginning stages, but since it involves a systematic evaluation, including baseline and follow-up qualitative and quantitative data collection, it may offer important lessons in terms of how to work with younger youth.

Promoting Equitable Gender Norms

White, V. et al. *Men and Reproductive Health Programs: Influencing Gender Norms*. Washington, DC: USAID, 2003.

Available in English.

This review, carried out by USAID, documents 14 reproductive health programs that have sought to influence gender norms among men. Many of the programs have focused on adolescent males.

PROGRAMS SERVING REFUGEES, INTERNALLY DISPLACED POPULATIONS, AND RETURNEES

OVERVIEW

Gender-based violence—sexual violence specifically—has long been an integral component of armed conflict. Sexual violence targeting women and girls has been used in all recent conflicts, including in the former Yugoslavia, Sierra Leone, Kashmir, Rwanda, Sri Lanka, and Chechnya.[28] Although rape has always led to direct physical and emotional harm for the victim, it now carries the added risk of potentially leading to HIV infection. By failing to uphold women's rights and to protect girls and women from sexual violence, states send an implicit message that such violence is acceptable.

In 1994, the Women's Commission for Refugee Women and Children, in its report, *Refugee Women and Reproductive Health: Reassessing Priorities*, called attention to the fact that even the most basic reproductive health service delivery programs, including gender-based violence services, were not available for refugees, internally displaced populations (IDPs), and returnees. In the same year, the ICPD highlighted the need to address gender-based violence and stressed the importance of implementing reproductive health service delivery programs for these populations. Since then, a number of agencies, including the International Rescue Committee (IRC), the United Nations High Commissioner for Refugees (UNHCR), UNFPA, and WHO, have worked to address gender-based violence among this population.

Addressing gender-based violence in conflict and postconflict settings presents a special set of challenges and requires close coordination among the many organizations that may be involved in delivering humanitarian services. The following is a partial list of the key responsibilities related to prevention of and response to gender-based violence in refugee and IDP settings as highlighted by Ward.[29]

The **health sector** should be able to

- actively screen women for gender-based violence and provide medical services in a way that is supportive and respectful,
- facilitate women's access to other service delivery programs in the community through referrals,
- collect forensic evidence and provide testimony when needed,
- document and analyze health-related data, and
- contribute to broad-based community efforts that aim at raising awareness of gender-based violence.

[28] Human Rights Watch. *World Report 2004: Human Rights and Armed Conflict*. New York: Human Rights Watch, 2004.
[29] Ward, J. *If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced, and Post-Conflict Settings: A Global Review*. New York: The Reproductive Health for Refugees Consortium, 2002.

Social services should be able to

- provide emotional support;
- promote women's safety, including offering victims a safe haven;
- offer income-generation opportunities and training to women and girls; and
- conduct community-based education on gender-based violence prevention and availability of services.

The **legal sector** should be able to

- provide free or low-cost legal assistance and representation to survivors,
- train law-enforcement agents and members of the judiciary,
- work to revise laws that reinforce gender discrimination and violence, and
- raise awareness of existing legislation.

The **security sector** should

- implement a zero tolerance policy for all police, military, and peacekeeping staff that engages in acts of gender-based violence;

- be prepared to intervene in cases of gender-based violence in ways that do not further victimize survivors; and

- conduct community policing and education.

A number of different programs addressing gender-based violence within refugees and IDP settings were identified; many of them were implemented by the IRC. However, none of the initiatives have been systematically or rigorously evaluated, making it difficult to identify the most effective strategies and pointing to the importance of investing in the evaluation of existing programs. The following challenges and gaps in current gender-based violence programming among this population were identified through this review and with the contribution of colleagues in the field.

Lack of Monitoring and Evaluation

As previously mentioned, most gender-based violence programs implemented in humanitarian settings have not been rigorously evaluated, making it difficult to assess their effectiveness. The lack of evaluation is likely due to a number of factors, including the fact that these programs tend to be supported by short-term funding cycles.

Lack of Adequate Data

Improved data collection is also needed and could include conducting prevalence research; conducting comprehensive baseline assessments at the onset of humanitarian programming; creating standardized reporting methods across sectors (health, psychosocial, police) and methods for sharing and analyzing data. (Some tools have been developed in recent years for this purpose; it is important now that they are widely disseminated in the field.) Screening for gender-based violence seldom takes place and could be an important part of the refugee registration process as long as staff is equipped to do this in a way that preserves survivors' dignity, privacy, and confidentiality and that leads to the receipt of adequate help.

Coordination

The lack of shared knowledge/coordination among agencies during the planning and implementation of gender-based violence services often leads to the duplication of services and competition among organizations, diluting the potential impact of already scarce resources.

Lack of Skills in the Area of Gender-Based Violence Across Sectors

Generally, service delivery agencies do not have extensive skills in working with gender-based violence so that health care providers, for example, cannot provide a forensic examination or provide emotional support. Security personnel are not equipped to investigate and/or pursue cases to the full extent of the law and the judicial system tends to be ineffective in dealing with such cases.

Lack of Knowledge of the Law

Increased knowledge of legal systems and legislation in the host/home countries could assist in clarifying the responsibilities of those engaged in protection, such as UNHCR, United Nations forces/police, local military/police, and judges. This, in turn, could lead to better protection for victims and to the appropriate sanction of perpetrators.

Lack of Adequate Funding

Because funding in these settings tends to be short term and provided by emergency phase donors, programs are not always participatory nor do they focus on capacity building as much as they could. If programs are to develop and implement strategies designed to have long-term impact, such as programming that fully integrates a gender-based violence response into health policy, hospitals, and clinics, then the support needs to be reliably long term.

CRITERIA FOR SELECTING PROGRAMS HIGHLIGHTED

The programs highlighted in this section partially followed the criteria outlined in the methodology section of this review, including availability of program documentation, identification by informants of the promising nature of the initiatives, and ability and willingness of program staff to share relevant documents. Although the evaluation of the program implemented by Najdeh Association showed some mixed results, the initiative was included in this review because it represents one of the few examples of organizations working in conflict-affected settings that focuses specifically on domestic violence. In addition, it is one of the few examples of gender-based violence programs functioning within conservative societies.

POTENTIAL CONTRIBUTIONS OF PROGRAMS SERVING REFUGEES, INTERNALLY DISPLACED POPULATIONS, AND RETURNEES

In spite of the limited availability of data on the prevalence of gender-based violence among refugees, IDPs, and returnees, the available statistics point to the widespread nature of violence against women during conflict and postconflict settings. As mentioned above, ensuring that gender-based violence services are seen as an integral component of service delivery programs implemented in humanitarian settings could serve many purposes, including

- preventing violence from occurring in these settings by increasing women and girls' safety,
- ensuring that victims of violence have adequate access to needed services,
- promoting the prosecution of offenders to the full extent of the law,
- contributing to changes of norms (e.g., by working with children and adolescents), and
- empowering women and girls (e.g., by offering them income-generating opportunities).

INTERNATIONAL RESCUE COMMITTEE'S (IRC) GENDER–BASED VIOLENCE PROGRAM IN SIERRA LEONE (Sierra Leone)

The International Rescue Committee began its first gender-based violence program seven years ago in Tanzania (1996). This was followed by programs in the Republic of Congo (1998), Sierra Leone, Guinea and Kosovo (1999), East Timor (2000), Liberia (2001), Rwanda (2002), and the Democratic Republic of the Congo (2002). The IRC recently carried out an analysis of its existing gender-based violence programs, focusing on six programs that have been operating long enough for lessons learned to emerge. For the purpose of this USAID review, the Sierra Leone experience will be profiled at the suggestion of IRC staff who, albeit recognizing the success of other initiatives, see in the Sierra Leone example a model for adequately addressing the multitude of needs of gender-based violence victims, including legal and medical. Information on the additional programs can be found in the IRC's review, *Gender-Based Violence: Lessons Learned and Critical Issues*.

The Sierra Leone gender-based violence program began in 1999 as a component of the IRC's emergency reproductive health program, which recognized that the special needs of women and girls sexually assaulted during the war were not being met. The program aimed to strengthen the capacity of community-based structures to respond to and prevent incidents of gender-based violence. The program currently operates in five districts and nine Liberian refugee camps.

In addition to addressing conflict-related sexual assault, the program expanded its activities to address nonconflict-related sexual assault as well as other forms of gender-based violence, including domestic violence, childhood sexual abuse, and harmful traditional practices, such as forced/early marriage.

The program implements a wide variety of strategies, often in partnership with other organizations. These include

- provision of services (directly or via referrals) to survivors, including counseling, medical assistance, and legal counseling;
- capacity building of community resources through the implementation of training seminars and via the coordination of existing efforts;
- training of staff in primary and secondary schools;

- implementation of social forums which serve as support groups to women;
- awareness-raising activities among law enforcers, religious leaders, chiefdom leaders, and health providers through training and the use of media and billboards;
- encouraging structural changes within government bodies in law and practice to promote the capacity of the state to take the responsibility for preventing and responding to gender-based violence; and
- implementation of skill-building activities for women.

Evaluation

Although no formal, systematic evaluation of the program has taken place, a consultant recently carried out a review of existing documents and implemented a series of interviews with key personnel as part of the IRC's review of its gender-based violence program. The consultant reported the following accomplishments in the ensuing report:

- provision of services to 1,000 survivors of conflict and postconflict gender-based violence assaults;
- increased access of survivors to STI treatment and medical care for vesico-vaginal fistulas resulting from sexual assault (no numbers are provided in the report);
- lobbying among medical professionals has led doctors to accept treating survivors free of charge; in addition to obtaining the needed medical care, survivors are also able to obtain reports that are crucial in legal proceedings against perpetrators;
- sensitization of staff has led to an increase in the reporting of cases and to an increase in the number of staff and beneficiaries who know their rights (although no specific numbers are documented in the report);
- some of the women who participated in the skill-training activities have started their own small businesses, thus reducing their economic dependence on men;
- local NGOs have begun to address gender-based violence issues in their programming;
- under the legal component of the program, 10 cases of postconflict sexual assault have been successfully prosecuted; and
- court decisions increasingly favor survivors and mandate more severe sentences for perpetrators (no numbers are provided in the report).

Funding

Several funding organizations fund this program, including the Bureau of Population, Refugees, and Migration of the U.S. Department of State.

Sources

IRC. "Gender-Based Violence: Lessons Learned and Critical Issues." New York: IRC Health Unit, December 2003.

Personal communication with Sonia Navani, International Rescue Committee.

ASSOCIATION NAJDEH (Lebanon)

Najdeh is an NGO that provides services primarily to Palestinian refugees in Lebanon. Najdeh carries out a number of initiatives, including

- vocational training;
- literacy efforts;
- preschool education;
- income-generation activities for women through embroidery as well as a small loans program for women in Tyre;
- community awareness-raising activities targeting both women and men on such topics as women and children's rights, domestic violence, and reproductive health; and
- a reproductive health project.

Najdeh's 26 centers are all located within refugee camps across Lebanon and reach about 4,000 direct beneficiaries a year.

Responding to a request by Palestinian refugee women for additional information on reproductive health, Najdeh began providing reproductive health education workshops in 1996. Women attending this workshop repeatedly raised the issue of domestic violence, leading Najdeh to apply for a grant that enabled it to expand its reproductive health programs and to carry out a domestic violence prevalence survey. The survey was implemented at the beginning of 1999 and sought to assess the levels of domestic violence among 452 Palestinian refugee mothers of children attending the NGO's kindergarten classes. The findings of this survey showed that 30 percent of the women had suffered physical violence, primarily at the hands of their husbands, and that 68 percent of the children had been beaten by either their mother or father.

Najdeh's domestic violence project involves several components, including

- action research: a knowledge, attitudes, and practices (KAP) survey was carried out with women and men at baseline and follow up;
- strengthening capacity: four in-house training sessions were carried out to strengthen the capacity of Najdeh's staff to address gender-based violence; additionally, Najdeh staff has participated in both national and international training opportunities;
- awareness-raising activities at the community level: including implementation of conflict management workshops; and

- implementation of counseling centers: four are operational and one is being implemented.

Evaluation

Najdeh carried baseline and follow-up studies to compare knowledge, attitudes, and practices of family relations among a sample of its target population. Domestic violence was considered to be an indicator of family relations.

The operational objectives of the studies were

- to assess indications of the impact of the domestic violence project on Najdeh beneficiaries and

- to explore community needs for interventions.

The same methodology was used for the baseline and follow-up studies both in terms of sampling and data collection and analysis. A sample of 301 families was drawn from 2025 families that participated in Najdeh's program in 2000. Interviews were conducted with all women and men 15 years and older that were deemed to be of "mental capacity." Baseline data were collected in May 2001 and follow-up data were collected in May 2003. A total of 1,064 individuals participated in the baseline study and 954 in the follow-up study. Trained interviewers, who were predominantly Najdeh staff, applied individual and household questionnaires through person-to-person interviews.

Table 10 provides some examples of changes in attitudes among respondents.

Table 10
Changes in Attitude from Baseline to Follow Up
(percentage)

Statements Agreed to by Respondents	Baseline (n = 1,064)	Evaluation (n = 954)
Nothing justifies hitting a wife, daughter, or sister.	58.2	70.5
Women have a right to decide whom to marry.	81.3	91.1
Women have a right to decide when to accept work outside the home.	36.3	45.3

In spite of some positive changes observed in terms of some improved attitudes, some results documented in the studies are not easy to interpret positively.

- There was a slight increase in reported hitting within households 3 months before each survey (16 percent at baseline and 18 percent at follow up). This could be interpreted as an actual increase in the prevalence of physical domestic violence or as an increased level of comfort in reporting such experiences.

- Although 13 percent of respondents (compared with none at baseline) indicated that they saw Najdeh as a place where they could go for help in cases of domestic violence, an increase was observed in the percentage of respondents who stated that they would opt for keeping any domestic violence situations "at home" (from 52 percent at baseline to 60 percent at follow up).

A number of factors could have led to some of these mixed results, including first and foremost the limited lapse of time (less than a year) between the implementation of Najdeh's major interventions (such as community outreach, conflict-resolution workshops, counseling, and legal aid) and the implementation of the evaluation. Some key methodological challenges may also be to blame, including the fact that interviews took place within the families. Nonetheless, this program was included in this review because of two reasons: this is one of the few examples of organizations working in conflict-affected settings that focus on domestic violence, and it is one of the few examples of gender-based violence programs functioning within conservative societies. Consequently, it may offer important lessons to future programs that meet these two criteria.

Funding

Funding for different phases of this initiative have been granted by the Reproductive Health for Refugees Consortium, Women's Commission for Refugee Women and Children, and Columbia University's Mailman School of Public Health—Heilbrunn Department of Population and Family Health.

Sources

Association Najdeh. *Domestic Violence Monitoring and Evaluation Project Report*. Report provided to Women's Commission for Refugee Women and Children and Columbia University Heilbrunn Department of Population and Family Health, September 2003.

Association Najdeh. Domestic Violence Project Proposal to Women's Commission for Refugee Women and Children, October 2003.

Khalidi, A., F. Chahine, H. Jammal, S. Purdin, and S. Krause. "KAP Surveys on Family Relations." Abstract and PowerPoint presentation. Presented to the Reproductive Health for Refugees Consortium Research Conference, Brussels, Belgium, 2003.

Personal communication with Sandra Krause, director of the Reproductive Health Project, Women's Commission for Refugee Women and Children.

ANNOTATED BIBLIOGRAPHY

Training Traditional Birth Attendants, Liberia

Women's Rights International. *Violence Against Women in War: A Manual for Training Certified Midwives in Liberia*. Laramie, Wyoming: WRI, 1998.
Available in English only.

This program is a partnership between Mother Patern College of Health Sciences in Monrovia, Liberia, and the U.S.–based NGO Women's Rights International. It trains traditional birth attendants to address the aftermath of rape following the country's seven-year civil war.

Vann, B. *Gender-Based Violence: Emerging Issues in Programs Serving Displaced Populations.* New York: The Reproductive Health for Refugees Consortium Global Gender-Based Violence Technical Support Project, 2002.

Available in English at http://www.rhrc.org/resources/gbv/EmergingIssues_change.pdf.
Available in French at http://www.rhrc.org/resources/gbv/vann_fr.doc.
Available in Portuguese at http://www.rhrc.org/resources/gbv/vann_pt.doc.

A compendium of key issues, themes, and lessons learned from gender-based violence programs in 12 countries, this book is designed to be read and used by staff and volunteers—from high-level policymakers to field-based workers—working with displaced populations. This report is divided into the following three sections: Emerging Standards; Common Issues, Practical Solutions; and Varied Programs, Shared Challenges. Appendices include recommended resource materials relevant to gender-based violence programming in populations affected by armed conflict and a sample interagency procedures manual.

Ward, J. *If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced, and Post-Conflict Settings: A Global Review*. New York: The Reproductive Health for Refugees Consortium, 2002.
Available in English at http://www.rhrc.org/resources/gbv/ifnotnow.html.

This report is composed of 12 country profiles: 3 each for Africa, Asia, Europe, and Latin America. It aims at providing a baseline narrative account of some of the major issues, programming efforts, and gaps in programming related to the prevention of and response to gender-based violence among conflict-affected populations worldwide.

GBV Initiative. Gender-Based Violence Bibliography.
Available at http://www.rhrc.org/resources/gbv/bib/index.php.

The *GBV Initiative*, a project of the Reproductive Health for Refugees (RHR) Consortium, has produced a web-based bibliography to improve international and local capacity to address gender-based violence among refugee and internally displaced populations. Training tools, manuals, and other literature listed have been selected specifically for their quality and relevance for work with refugee and IDP gender-based violence survivors, although many resources may have wider applicability.

UNHCR. *Guidelines for Prevention and Response: Sexual and Gender-Based Violence Against Refugees, Returnees, and Internally Displaced Persons*. Geneva: UNHCR, 2003.
Available in English from http://www.rhrc.org/pdf/gl_sgbv03.pdf.

These guidelines offer practical advice on how to design strategies and carry out activities aimed at preventing and responding to sexual and gender-based violence. They also contain information on basic health, legal, security, and human rights issues relevant to those strategies and activities.

A number of additional tools and resources are available from the Reproductive Health Response in Conflict Consortium Web page at
http://www.rhrc.org/resources/gbv/index.html.

IV. CONCLUSIONS AND RECOMMENDATIONS

Data on the prevalence of gender-based violence can be difficult to collect and compare and are often underreported.[30] Nonetheless, a growing body of evidence indicates that gender-based violence is widespread throughout the world. A review of more than 48 population surveys from around the world found that between 10 percent to more than 69 percent of women report being hit or otherwise *physically* harmed by an intimate partner at some point in their lives.[31] Limited information exists about *sexual coercion*, particularly in developing countries. However, selected studies from various settings suggest that nearly one in four women report having experienced sexual violence by an intimate partner in their lifetime.[32] [33] [34] In terms of violence among young people, population-based studies that have questions about forced sexual debut have found rates that range from 7 percent in New Zealand to 38 percent in South Africa to 46 percent in the Caribbean.[35] Abuse during pregnancy is also highly prevalent, with the range of prevalence found in developing countries much wider (3.8 to 33.5 percent) than that of industrialized countries (3.4 to 11 percent), including North America.[36]

Health consequences of gender-based violence range from physical injury and chronic pain syndromes to mental and emotional sequelae, such as anxiety and depression to fatal outcomes, including suicide and homicide. Fear of violence also prevents many women from using contraception or proposing condom use, thereby increasing their risk of unwanted pregnancies and STIs, including HIV.[37] Childhood sexual abuse often leads to risky behaviors, such as multiple sexual partners and unprotected sex.[38] [39] [40] Finally, evidence suggests that sexual violence from both intimate and dating partners as well as from acquaintances and strangers may increase the risk of gynecological disorders that are otherwise difficult to diagnose or treat, such as chronic pelvic pain and recurrent vaginal infections.[41]

The prevalence and outcomes of violence alone point to the need for prompt intervention, particularly by programs in the RH/HIV sectors.

One of the purposes of this review is to assist USAID in the definition of future investment in the area of gender-based violence. The diversity and limited availability of rigorous evaluations of

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[30]Ellsberg, M., L. Heise, R. Pena, R. Agurto, and A. Winkvist. "Researching Violence Against Women: Methodological Considerations from Three Nicaraguan Studies." *Studies in Family Planning,* 32:1–16, 2001.
[31]Krug, E.G. et al., eds. *World Report on Violence and Health.* Geneva: World Health Organization, 2002.
[32]Ellsberg, M.C. et al. "Candies in Hell: Women's Experience of Violence in Nicaragua." *Social Science and Medicine,* 51:1595–1610, 2000.
[33]Mooney, J. *The Hidden Figure: Domestic Violence in North London*. London: Middlesex University, 1993.
[34]Hakimi, M. et al. *Silence for the Sake of Harmony: Domestic Violence and Women's Health in Central Java, Indonesia*. Yogyakarta: Gadjah Mada University, 2001.
[35]Krug, E.G. et al., editors, 2002.
[36]Campbell, J., C. Garcia-Moreno, and P.W. Sharps. *Abuse During Pregnancy in Industrialized and Developing Countries. Violence Against Women.* (in press)
[37]Heise, L. et al. "Ending Violence Against Women." *Population Reports,* 27(4), 1999.
[38]Felitti, V.J. et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experience (ACE) Study." *American Journal of Preventive Medicine,* 14/4:245–258, 1998.
[39]Walker, E.A. et al. "Adult Health Status of Women with Histories of Childhood Abuse and Neglect." *American Journal of Medicine,* 107/4:332–339, 1999.
[40]International Planned Parenthood Federation. "International Medical Advisory Panel (IMAP) Statement on Gender-Based Violence." *IPPF Medical Bulletin,* 34/2:1–2, 2000.
[41]Heise, L. et al., 1999.

programs working in the area of gender-based violence make it a challenge to compare programs in search of common conclusions and to ascertain the most effective interventions. Initiatives highlighted in this review, in fact, point to the promising impact of multipronged interventions and also suggest that RH/HIV programs would be wise to integrate components to address gender-based violence. Integrating gender-based violence services not only serves to address this human rights violation and public health problem but may also contribute to improving the effectiveness of existing programs.

Addressing gender-based violence requires a coordinated response that promotes change on a number of different levels. Consequently, one approach should not be viewed as necessarily better than another; instead, they should work in a complementary fashion. BCC and community mobilization initiatives, for example, can challenge prevailing beliefs and norms that contribute to the acceptability and perpetuation of gender-based violence and can contribute to shifting gender-based violence from a private matter to one that merits public attention and intervention. Furthermore, community mobilization strategies can reduce a community's tolerance to violence and create an environment where perpetrators fear the consequences of their actions. Health service delivery programs can accomplish the key task of providing for the needs of victims and their children. Although only as good as their implementation, policies can serve to make gender-based violence a legitimate public health and human rights issue, can help provide resources for interventions, and can work to hold accountable those who perpetrate violence, whether individuals or states. Programs that target youth or refugees, returnees, and IDPs can accomplish the above tasks among these populations. Programs that work with youth, particularly with young men, have a particular role in changing norms and behaviors before they become deeply ingrained.

The programs documented represent a wide range of strategies to address gender-based violence. However, given the current state of the field, including the limited number of programs that have been rigorously evaluated, this review should be seen as offering the range of approaches to addressing gender-based violence, with an understanding that these are not necessarily exhaustive. In addition, although they have demonstrated some degree of success, they should be seen as promising and not necessarily best practices. In fact, one of the key findings of this review relates to the need for greater investment in the area of gender-based violence so that in the near future the most effective interventions in combating gender-based violence can be determined

In spite of these limitations, several recommendations can be made based on the present review and on the existing literature. These recommendations are organized according to the following categories:

- logistic support,
- guiding principles in gender-based violence programming,
- program structure,
- sensitization and training, and
- programmatic priorities.

LOGISTIC SUPPORT

Invest in Long-Term, Multisectoral Programs

Research from diverse settings documents the widespread prevalence and multiple consequences of gender-based violence. The lack of developing country data available to demonstrate reduced levels of violence or improved SRH outcomes as a consequence of gender-based violence initiatives should not delay investment in this area. Most programs address the need for long-term financial support and the lack of funding both for programs and their evaluations. Promising programs frequently are developed and discontinued once the funding cycle ends, often before having a chance to show results or to transfer lessons learned. An effort should be made to scale up promising initiatives and integrate small projects into large-scale programs, such as health care reforms, that will promote sustainability in the long term.

Invest in Well-Designed Evaluations

One of the main findings of this review is the extent to which better evaluation data is needed in all areas. Rigorous evaluations should be supported and results should be well documented and widely disseminated so that they can lead to concrete changes in program design and policy.

GUIDING PRINCIPLES IN GENDER–BASED VIOLENCE PROGRAMMING

Ensure All Initiatives Respect Survivors' Safety and Autonomy First and Foremost

Any initiative in the area of gender-based violence should recognize the risks posed to survivors by poorly implemented programs that fail to protect survivors' privacy, confidentiality, and physical integrity. Screening for violence, for example, should not be implemented if the organization cannot guarantee the privacy and confidentiality of information shared or cannot ensure that providers that will be asking the questions are appropriately supportive of victims. Therefore, initiatives should carefully and continuously evaluate any potential harm to survivors. At the same time, agencies should be encouraged and assisted to address gender-based violence so that these issues are not used as an excuse to continue to ignore the problem.

Employ a Human Rights Perspective

While a gender perspective is important for understanding attitudes about violence against women, a human rights perspective is another essential way to change those attitudes. Human rights have always been an integral part of theoretical writing about gender, but these ideas sometimes are overlooked in field training about gender among health workers. Various programs, including Raising Voices, highlight the need to make explicit use of human rights discourse and perspective in order to challenge prevailing norms that make violence acceptable. A rights-based approach places the discussion of gender-based violence within a broad framework of human rights and justice to challenge prevailing norms, such as the notion that domestic violence is a private issue, and to empower individuals and communities to promote change. It further accepts that human rights are inalienable and indivisible: that women have a right to live free of violence under all circumstances and that they should not have to give up this right in order to maintain a family or to ensure economic support for their children. The health perspective is another useful framework to use in convincing policymakers and the general public to change. For example, information regarding abuse during pregnancy often brings concern from persons who primarily advocate for children.

Ensure the Cultural Appropriateness of Interventions

Programs stress the need to ensure the cultural relevance of interventions and messages and the importance of involving the community in the design of interventions. Therefore, transferring programs from one setting to another requires that serious consideration be given to the cultural appropriateness of each initiative. It is also important that locally collected data be available for sensitization and advocacy purposes to counter the tendency among certain groups to believe that gender-based violence is not a problem that affects their own community.

PROGRAM STRUCTURE

Work in Partnerships

Most of the programs highlighted in this review, regardless of the type of intervention, address the need to work in partnerships and through networks. Not only are the factors that contribute to violence varied, but also survivors are likely to need multiple services. Consequently, it is unrealistic to think that a single organization will be able to effectively address violence. In the long term, joining networks of organizations can benefit individual programs and allow them to contribute to a broad effort to combat gender-based violence. Partnerships are important between different sectors (health, justice, education), and between civil society and governments as well as among researchers, activists, policymakers, and service providers. These collaborations will ensure that evidence is available to inform policies and programs in a timely manner.

Use Multiple Strategies and Link Different Levels of Interventions

Regardless of the main focus of the initiative, the majority of gender-based violence–related programs have used multipronged approaches to achieve their goals. Promising initiatives also make an effort to link experiences from different levels (e.g., linking local and national initiatives so that practice feeds back into the policy process and vice versa).

Promote Systemwide Changes

Many programs, particularly in the health and education sectors, train providers and expect them to implement these new skills into wide institutional changes. Such efforts have very limited impact and in fact may place women at risk when health providers, for example, are asked to start screening women after limited (often single-shot) training sessions. Efforts to improve the response to violence should follow what Heise et al. call a systems approach—one that involves the whole organization and does not expect individual providers to act alone.[42] [43] In other words, training should be accompanied by a broad effort to review a given institution's policies and resources, including infrastructure, service protocols, screening tools, and referral directories.

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[42] Heise, L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Reports*, 27(4), 1999. [Available in English at http://www.infoforhealth.org/pr/l11edsum.shtml.]

[43] Campbell, J.C., J.E. Coben, E. McLoughlin, S. Dearwater, G. Nah, N.E. Glass, L. Lee, and N. Durborow. "An Evaluation of a System-Change Training Model to Improve Emergency Department Response to Battered Women." *Academic Emergency Medicine,* 8 (2):131–138, 2001.

Promote Change at Individual and Collective Levels

These initiatives point to the importance of simultaneously changing individuals' attitudes regarding violence while promoting an environment that is less tolerant towards violence. This is exemplified by the BCC and community mobilization interventions included in this review. Some programs have been able to create community environments that serve as deterrents to violent behavior (e.g., by bringing public shame to perpetrators). This can be an important element in challenging gender-based violence, particularly in the absence of effective formal/legal sanctions to perpetrators.

Integrate Gender-Based Violence Components into Existing RH/HIV Programs

It is important to keep in mind that programs have an impact on survivors' lives and community norms even when their primary focus is not on violence. Health care providers, for example, are likely to have cared for survivors of violence whether they know it or not and their actions can have an impact on women's ability to overcome a situation of violence. Additionally, a program's effectiveness may be compromised when it fails to consider a woman's history of violence. Such is the case when providers counsel women on issues relating to family planning or HIV prevention without addressing whether the woman has autonomy over her sexual choices. Consequently, initiatives in the RH/HIV sectors should consider violence regardless of whether this is their main area of focus and should adapt existing service delivery programs. They should also seek to integrate components that specifically address gender-based violence within programs that establish priorities for other areas of concern, such as family planning or HIV/AIDS prevention.

SENSITIZATION AND TRAINING

Addressing Program Staff's Own Experiences and Perceptions of Violence

Health providers, teachers, and law enforcement agents reflect the norms and values of the culture in which they live and are likely to harbor myths that perpetuate violence prevalent in their communities. Any effort to sensitize and train them on issues related to violence should enable them to reflect upon their own personal experiences and challenge prevailing norms. This requires that training sessions be sustained over time and incorporate ongoing support and monitoring strategies.

Do Not Assume that Training of Trainers Is Suitable for Sensitive Topics, Such As Gender-Based Violence

Because training of trainers is less expensive, it tends to be widely promoted. Nonetheless, various initiatives highlighted in this review point to the limitations of such an approach when applied to such sensitive topics as gender-based violence. Content can be diluted and/or incorrect information may be imparted by trainers who are not fully prepared to address this issue.

Promote Wide Ownership Among All Staff and/or Community Members

Many of the programs highlight the importance of ensuring wide ownership of the initiatives. This can be accomplished by involving all personnel (including management, service providers, and administrative and support staff) in the design of the initiative as well as in sensitization and

training. Programs also document the need to ensure support from upper management as well as the potential pitfalls when such support is not obtained.

PROGRAMMATIC PRIORITIES

Promote Programs that Challenge Norms that Perpetuate Violence

Gender-based violence is perpetuated by cultural norms and beliefs that deem men's abusive behavior towards women as a normal part of life. Programs that challenge these beliefs and promote gender equitable norms—at individual, institutional, and community levels—are essential components in the fight against gender-based violence. Programs that reach out to young men and women may be particularly valuable in accomplishing long-lasting change. In fact, some informants have suggested the need to implement and evaluate interventions with ever-younger populations of both sexes.

Empower Women and Girls

Although boys and men can be victims of sexual and physical violence, research shows that gender-based violence (in all its forms) disproportionately affects girls and women. Programs should work to promote long-term changes in girls and women's self-esteem and control over their own bodies, but they should also work to address practical issues, such as enabling girls to continue in school by ensuring that schools are safe, providing economic and educational opportunities for girls and women, and eliminating discriminatory laws and policies in education, at home, and in the workplace.

Ensure that Survivors Have Access to Needed Services

Promoting changes in gender norms and empowering girls and women are important long-term steps. However, addressing the immediate needs of survivors of gender-based violence should not be overlooked. Victims' needs are multifaceted and should be met by various sectors, including health, social, and judicial systems. The health sector, and in particular SRH organizations, are well placed to identify and assist survivors. Although there are some valid concerns relating to ensuring that women are not exposed to additional risks through inappropriate interventions, experiences such as the IPPF/WHR project have shown that it is possible to safely integrate gender-based violence screening and services. A number of initiatives have also suggested that the effectiveness of SRH interventions can be compromised when organizations neglect to address violence.

Involve Young and Adult Men

Working preventively with men to change their attitudes and behaviors around gender-based violence is a key component of the fight against gender-based violence. In this context, the work with young men may be particularly important in preventing violence since it may be more feasible to effect change at a time when norms and behaviors are not as deeply rooted. Adult men have an important role by serving as positive examples to younger men, helping them distinguish gender-based violence as an unhealthy behavior, and publicly challenging norms that deem gender-based violence acceptable.[44] Programs that provide early support for young parents

[44] Although no such examples were identified in developing countries, some interesting initiatives exist in developed countries, including the Founding Fathers Campaign and the Coaching Boys into Men programs developed by the

to promote healthy relationships and parenting skills that do not propagate gender-based violence can also be an important strategy. At the same time, it is important to recognize the possible unintended consequences of working with men to end gender-based violence. This is highlighted, for example, by the program Raising Voices, when it documented an increase in emotional violence, which men indicated using as an alternative to physical violence.

Increase the Negative Consequences of Violent Behavior to Abusers

Programs such as the Nari Adalat and Mahila Panch initiatives in India have shown that men's fear of being publicly shamed for the violence they commit serves as an important deterrent. Additionally, research in the United States shows that policies and laws that make violent behavior more costly to abusers decrease the rates of interpersonal violence.[45] Many developing countries have gender-based violence legislations in place, but male judges and law enforcement agents who can be sympathetic to perpetrators often implement them inappropriately. Ensuring that adequate laws and policies exist and that they are properly implemented is as important as modeling gender equitable behaviors. In addition, changing community norms so that peers, community leaders, and extended family also provide negative sanctions against violence is extremely important.[46]

Ensure that Programs in Humanitarian Settings Systematically Address Gender-Based Violence

The lack of evaluation is even more accentuated in programs working with refugees, both internally displaced and returnee populations. Nonetheless, the use of sexual violence against women and girls in conflict settings is well documented. An effort should be made so that all agencies working within these settings incorporate a response to gender-based violence as an integral component of their work. It is particularly important in these settings that efforts be implemented in a coordinated manner.

Family Violence Prevention Fund (http://endabuse.org) as well as the Men Can Stop Rape initiative (http://www.mencanstoprape.org).

[45] Fagan, J. "Cessation of Family Violence: Deterrence and Dissuasion." In *Family Violence, Crime and Justice: An Annual Review of Research,* L. Ohlin and M. Tonry, editors. Chicago: University of Chicago Press, pp. 377–425, 1989.

[46] Counts, D.A., J.K. Brown, and J.C. Campbell. *To Have and To Hit: Cultural Perspectives on Wife Beating*. Chicago: University of Illinois Press, 1999.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. SUPPLEMENTARY ANNOTATIONS

APPENDIX A

SCOPE OF WORK
(from USAID)

Scope of Work
Literature Review and Analysis of Existing Information
on Programs that Address and Challenge Gender-based Violence

I. TECHNICAL ASSISTANCE REQUIREMENT

The purpose of this activity is to provide a comprehensive literature review and analysis to USAID's Bureau for Global Health (GH) on programs that have addressed or challenged gender-based violence (GBV) with a link to the PHN sector. The product is intended to inform GH staff on the range of approaches available to address GBV within the PHN sector, to help clarify future USAID activities in this area and to provide guidance for GH implementing partners.

The review will be limited to literature from developing countries, covering studies/programs since 1990 to present, in English, Spanish, or Portuguese. The review will result in an analysis of the range of approaches used to address GBV that are linked to the PHN sector, with an emphasis on programs that have been evaluated. The report should include, but is not limited to, the following approaches:

1. Behavior change communication (BCC)- (i.e. mass media)
2. Service delivery – (i.e. training, counseling protocols & services, referral systems, etc.)
3. Community mobilization – (i.e. 'shaming', pronouncements by leaders, community drama)
4. Peer education- (in workplace, in/out of schools, etc.)
5. Policy – (i.e. law enforcement training, legislative changes, political advocacy, etc. Examples of policy related approaches should be drawn from the PHN and DG sectors)

For the purposes of this review, GBV will be defined as any act of intimate partner physical violence, sexual violence, and rape.

The resulting report is expected to be structured along the above listed 5 (or more) approaches, with a theoretical description of each approach, followed by 2-3 descriptive "best practices" examples, with preference given to programs that have been evaluated. Each approach section should include a description of a noteworthy project example that focused on male involvement (if available). Each approach section will be followed by a longer reference bibliography of other relevant studies or publications. The final document is expected to be 35-50 pages long (and should not exceed 50 pages).

II. ACTIVITIES

1. Meet with GH contacts, Michal Avni (GH/PRH) and Diana Prieto (GH/OHA) to:

    - discuss scope,
    - define parameters and criteria for literature review,
    - define format of document, and
    - agree on timeline for development of the document.

2. Interview relevant staff from the USAID Interagency Gender Working Group (IGWG), and various USAID Cooperating Agencies, NGOs, and other donors, as agreed upon with GH contacts.

3. Conduct literature review and analyses based on diverse sources (including peer-reviewed journals and 'gray literature') and input from key informants, as agreed with GH contacts;

4. Submit draft of the document to USAID for comments.

5. Revise and complete document in electronic and print format.

III. EVENTS AND DELIVERABLES

1. Initial Meeting to brief consultant on issues, steps, and deliverables before the work begins.
2. Insofar as feasible, the final report should include:
   - Executive Summary- the most salient findings and recommendations
   - Introduction
   - Methodology, including constraints and gaps
   - Summary of findings (main portion of the paper)
   - List of gaps in knowledge in the programs identified
   - Proposed questions to be used for future focus group discussions
   - Conclusions and Recommendations
   - References (bibliography of programs examined, meetings, and interviews)
3. A Debriefing on the assignment.

IV. TASKS AND LEVEL OF EFFORT

The literature review and analysis will be completed by February 28, 2004. The timeline and level of effort will be determined by GH contacts and the consultant.

V. REFERENCE MATERIALS

To be determined in the course of the consultancy, as above.

VI. RELATIONSHIPS AND RESPONSIBILITIES

VII. LOGISTICS

VIII. FUNDING

This activity will be funded by the USAID Office of Population and Reproductive Health.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

Mmatshilo Motsei	Agisanang Domestic Abuse Prevention and Training (ADAPT)
Maria Grazia Pannunzi	Associazione Italiana Donne per lo Sviluppo (AIDOS; Italian Association for Women in Development)
Connie Kamara	American Refugee Committee
Anjala Kanesathasan	AMKENI Project
Alex Arriaga	Amnesty International
María Cecilia Claramunt	Armonie
Anabel Torres	Cantera (Nicaragua NGO)
Veronica Magar	CARE, Bangkok
Carme Clavel	Centers for Disease Control and Prevention
Mary Goodwin	Centers for Disease Control and Prevention
Anibal Faundes	CEMICAMP (Brazil)
Anna-Britt Coe	CHANGE Project, Academy for Educational Development
Jodi Jacobson	CHANGE Project, Academy for Educational Development
Adriana Ortiz Ortega	Colegio de Mexico
Lynn Freedman	Columbia University
Manisha Mehta	EngenderHealth
Dean Peacock	EngenderHealth
Donna McCarraher	Family Health International
Ondina Leal	Ford Foundation, Brazil
Sarah Costa	Ford Foundation, New York
Leni Marin	Family Violence Prevention Fund
Karin Ringheim	Global Health Council
Julie Pulerwitz	Horizons Project
Gary Barker	Instituto PROMUNDO
Marcos Nascimento	Instituto PROMUNDO
Nata Duvvury	International Center for Research on Women, India
Anuradha Rajan	International Center for Research on Women, India
Loreto Biehl	Inter-American Development Bank
Suzanna Banwell	Independent Consultant
Sarah Bott	Independent Consultant
Michele Burger	Independent Consultant
Meg Greene	Independent Consultant
Lynne Stevens	Independent Consultant
Debbie Billings	Ipas
Maria de Bruyn	Ipas
Naana Otoo-Oyortey	International Planned Parenthood (IPPF) Federation
Ilka Rondinelli	IPPF/Western Hemisphere Region
Jeanne Ward	International Rescue Committee
Sonia Navani	International Rescue Committee
Cynthia Steele	International Women's Health Coalition
Suzanne Maman	Johns Hopkins Univ. Bloomberg School of Public Health
Jacquelyn Campbell	Johns Hopkins Univ. School of Nursing
Sarah Martin	John Snow, Inc.
Beth Vann	John Snow, Inc./Reproductive Health of Refugees
Indira Jaisingh	Lawyers Collective (India)
Jo Nurse	London School of Hygiene and Tropical Medicine
Charlotte Watts	London School of Hygiene and Tropical Medicine

Cathy Zimmerman	London School of Hygiene and Tropical Medicine
Judith Helzner	MacArthur Foundation
Rachel Jewkes	Medical Research Council
David Sloane Rider	Men Can Stop Rape
Karen Plafker	Open Society Institute
Neelanjana Mukhia	Oxfam
Judith Mirsky	Panos London
Mary Ellsberg	Program for Appropriate Technology in Health (PATH)
Lori Heise	Program for Appropriate Technology in Health (PATH)
Margarita Quintanilla	PATH, Nicaragua
Mary Kincaid	POLICY Project, The Futures Group International
Debbie Rogow	Population Council
Shireen Jejeeboy	Population Council, India
Maria Isabel Plata	PROFAMILIA (Colombia)
Julia Kim	Rural AIDS and Development Action Research Programme (RADAR)
Lori Michau	Raising Voices
Carmen Yon	ReproSalud (Peru)
Marge Berer	Reproductive Health Matters
Elli Nur Hayati	Rifka Annisa Women's Crisis Center, Umea University
Maria Rashid	Rozan (Pakistan NGO)
Benno de Keijzer	Salud y Genero (Mexico NGO)
Amy Bank	Sexto Sentido (Nicaragua)
Esca Scheepers	Soul City (South Africa)
Matthew Shaw	Stepping Stones Gambia
Alice Welbourn	Stepping Stones Uganda
France Donnay	United Nations Population Fund (UNFPA)
Roxanna Carrillo	United Nations Development Fund for Women (UNIFEM)
Marijke Velzeboer	United Nations Development Fund for Women (UNIFEM)
Inge Peterson	University of Durban Westville
Fernanda Maffei	University of São Paulo
Andrew Levack	University of Washington
Abigail Dreyer	University of the Western Cape School of Public Health
Michael Kaufman	White Ribbon Campaign
Claudia Garcia-Moreno	World Health Organization
Ivy Josiah	Women's Aid Organization
Sandra Crause	Women's Commission
Jefferson Drezzet	
Victoria Frye	
Lorna Martin	
Various Individuals	Latin American Consortium on GBV and Health

APPENDIX C

SUPPLEMENTARY ANNOTATIONS

SUPPLEMENTARY ANNOTATIONS

Review by Ipas

de Bruyn, M. *Violence, Pregnancy and Abortion: Issues of Women's Rights and Public Health,* 2nd edition. Chapel Hill, NC: Ipas, 2003.
Available in English at http://www.ipas.org/english/publications/violence_womens_rights_en.pdf.
Available in Spanish at http://www.ipas.org/spanish/publications/VioUnPregAborSpanish.pdf.

This review of the literature aims to motivate researchers, policymakers, health professionals, legal and law enforcement sector personnel, and NGO program implementers to increase their efforts to address the problem of violence in relation to pregnancy and abortion. The monograph presents information on the possible links between violence, pregnancy, and abortion in section 1, then discusses measures that can be taken to address problems in section 2.

Review by the UNIFEM Trust Fund

- Spindel, C., E. Levy, and M. Connor. *With an End in Sight: Strategies from the UNIFEM Trust Fund to Eliminate Violence Against Women.* New York: UNIFEM, 2003.
  Available in English at http://www.unifem.org/index.php?f_page_pid=71.
- UNIFEM. *Not a Minute More: Ending Violence Against Women.* New York: UNIFEM, 2003.
  Available in English at http://www.unifem.org/index.php?f_page_pid=207.

  In 1996, the United Nations Development Fund for Women (UNIFEM) Trust Fund began funding innovative projects to address gender-based violence through advocacy, raising awareness, public education, legal advocacy, and youth projects. These publications describe the projects and document their achievements, limitations, lessons learned, and future challenges. They provide examples of good practices as well as of strategies that did not meet expectations. The reports also look at research and program gaps and make recommendations for the future.

Review by Population Reports

Heise, L., M. Ellsberg, and M. Gottemoeller. "Ending Violence Against Women." *Population Reports*, 27(4), 1999.
Available in English at http://www.infoforhealth.org/pr/l11/violence.pdf.
Available in Spanish at http://www.infoforhealth.org/pr/prs/sl11edsum.shtml.
Available in French at http://www.infoforhealth.org/pr/prf/fl11edsum.shtml.

This publication presents a comprehensive and wide-ranging review of the literature on violence against women, including information from both the published and unpublished literature about ways to prevent violence and care for survivors.

Review by the Family Violence Prevention Fund

Marin, L., H. Zia, and E. Soler, editors. *Ending Domestic Violence: Report from the Global Frontlines*. San Francisco: Family Violence Prevention Fund, 1998.
Available in English only at http://www.endabuse.org/programs/display.php3?DocID=94.

This report contains a collection of articles on programs addressing violence against women throughout the world, including Brazil, Cambodia, India, Russia, and South Africa. It highlights the efforts of many NGOs working to end gender-based violence through education, legal advocacy, community mobilization, education programs for youth, and mass media campaigns.

Review by the Journal *Development*

Harcourt, Wendy, editor. "Violence Against Women and the Culture of Masculinity." *Development* (Journal of the Society for International Development), 44(3), 2001.
Contents available in English only at
http://www.palgrave-journals.com/development/journal/v44/n3/index.html.

The September 2001 issue of this peer-reviewed journal was devoted to articles related to strategies to reduce violence against women and to change the culture of masculinity to stop violence. It includes articles from many developing countries, including Brazil, India, the Philippines, China, Malaysia, Uganda, Nepal, Indonesia, and Papua New Guinea. Many of the articles are reviews of specific types of strategies, such as organized responses to violence against women by men around the world (see the article by J. Hearn) or the review of strategies used by women's organizations in Uganda to improve women's rights (see the article by R.O. Ochieng).

Review by the Inter-American Development Bank

Larrain, S. "Curbing Domestic Violence: Two Decades of Action." In *Too Close to Home: Domestic Violence in the Americas*, A.R. Morrison and M.L. Biehl, editors. Washington, DC: Inter-American Development Bank, 1999.
Available in English at http://www.iadb.org/sds/SOC/publication/publication_546_451_e.htm.
Available in Spanish at http://www.iadb.org/sds/SOC/publication/publication_546_451_s.htm.

This paper presents a review of strategies, programs, and research over the past two decades aimed at ending domestic violence in Latin America and the Caribbean.

Reviews by the International Center for Research on Women

- Burton, B., N. Duvvury, and N. Varia. *Justice, Change and Human Rights: International Research and Responses to Domestic Violence.* PROWID synthesis paper. Washington, DC: International Center for Research on Women and CEDPA, 2000.
  Available in English at http://www.icrw.org/docs/domesticviolencesynthesis.pdf.
- ICRW. "Domestic Violence in India II: Exploring Strategies, Promoting Dialogue." *ICRW Information Bulletin*, January 2001. Washington, DC: International Center for Research on Women, 2001.
  Available in English only at http://www.icrw.org/docs/DV_India2_InfoBull_12001.pdf.

  These publications synthesize the findings and lessons learned from projects completed during the course of a four-year grant program, Promoting Women in Development (PROWID). Eleven of these projects addressed gender-based violence through research and interventions. Among other cases profiled, this collection includes the results of a public awareness campaign and efforts to build a network of service delivery programs and support systems for survivors of violence in Iztacalco, Mexico; a public education campaign on violence against women in Bulgaria; and an effort to improve the capacity of crisis center staff in Russia. In addition to the two publications above, the ICRW has produced numerous other reviews and case studies related to violence against women; these are available through the same web site. Some case studies specific to certain approaches (rather than crosscutting) are cited elsewhere in this bibliography.

Review by the World Health Organization

Krug, E.G. et al. *World Report on Violence and Health.* Geneva: World Health Organization, 2002.
Available in English at
http://www.who.int/violence_injury_prevention/violence/world_report/wrvh1/en/.
Available in French at
http://www.who.int/violence_injury_prevention/violence/world_report/wrvhfre/en/.

Summary available in Spanish at
http://www.who.int/violence_injury_prevention/violence/world_report/en/Summary_Spanish.pdf.

This publication provides a comprehensive and global review of evidence related to violence. Most relevant are the chapters devoted to violence by intimate partners (chapter 4) and to sexual violence (chapter 6). Both chapters include a review of evidence on interventions to prevent violence and care for survivors worldwide.

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