Gender-Based Violence

AND

Reproductive Health & HIV/AIDS

SUMMARY OF A TECHNICAL UPDATE

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EXECUTIVE SUMMARY

On May 1, 2002, more than 130 program managers, policymakers, service providers, and trainers attended a day-long Technical Update on Gender-Based Violence (GBV) and Reproductive Health / HIV (RH / HIV) hosted by the Interagency Gender Working Group (IGWG) of USAID, in collaboration with the Center for Health and Gender Equity (CHANGE). The objective of the meeting was to: 1) launch a process for considering GBV in relation to RH and HIV in USAID's population, health, and nutrition portfolio; and 2) explore ways of integrating GBV into RH / HIV programs. While the term GBV encompasses many forms of aggression toward and abuse of girls and women, the Technical Update focused specifically on intimate partner violence (IPV).

The session began with epidemiological data from the Demographic and Health Surveys (DHS), the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO) elucidating how pervasive the problem is, the social norms that help keep it invisible, and the serious consequences it has on women's reproductive health.

CHANGE presented initial results from its worldwide mapping survey on programs that address GBV and its plans for developing a framework for integrating GBV into RH programs based on the information collected through survey responses. Participants then heard about different ways of integrating GBV into existing programs. Representatives from the following organizations spoke:

- The Women's Resource Center in India, which succeeded in including gender and GBV in the required training for health professionals in the public sector;
- The Medical Research Council, which adapted the *Stepping Stones* methodology to South African culture and integrated GBV into its health program;
- The International Planned Parenthood Federation / Western Hemisphere Region (IPPF / WHR), whose affiliates in the Dominican Republic, Peru and Venezuela are screening women for GBV, treating survivors, and referring them to appropriate agencies for counseling, support, and legal advice;
- EngenderHealth, which, in collaboration with the Planned Parenthood Association of South Africa, is working with men to challenge the social

norms that accept the use of violence against women;

- The Philippines Partnership for Development of Human Resources in Rural Areas (PhilDHRRA), a network of NGOs in the Philippines that is integrating GBV into its rural development programs; and
- *Puntos de Encuentro*, a Nicaraguan NGO that is using television and radio to present alternative gender role models and raise the issue of GBV in a public forum.

Throughout the day, participants actively provided feedback on the pros and cons of the strategies presented. The feedback was categorized into six major interest areas: behavior change communication (BCC) / media; community participation / mobilization; monitoring and evaluation; policy; provider training; or service delivery. Participants expressed concern about reaching those who do not come to health centers, overburdening providers, and challenging social norms.

The difficulties of measuring the prevalence of GBV and assessing progress toward reducing its occurrence also came up repeatedly. Speakers and participants addressed the need to standardize methodologies in surveying populations about GBV, and to develop indicators for measuring success. Since change takes time, one suggestion was to find indicators that measure change in slight increments within a short time span.

At the end of the session, participants were asked to outline the next steps needed to incorporate GBV into their own RH / HIV projects, and to consider the helping factors, barriers, resources, and technical assistance that would be required. Participants expressed their conviction that GBV is integrally linked to women's health. Many felt that RH goals can only be achieved by addressing GBV, and that GBV must be dealt with in order to increase:

- Access to family planning and continued use of contraceptive methods;
- The ability to negotiate safer sex;
- Access to other RH services, such as antenatal care;
- HIV testing and support services; and
- Gender equity.

Participants identified two common barriers to moving ahead in integrating GBV into RH / HIV programs and services: limited financial resources and time limitations imposed by short-term (3-5 years) grants.

The audience suggested that USAID and the Global Health Bureau could further this integration by:

- Allocating core funding for global programs to GBV initiatives;
- Holding CAs accountable for addressing GBV in their RH programs; and
- Educating the missions on the importance of GBV, including the key role policy plays in addressing this problem.

Participants emphasized that IGWG plays an important role, not only as an advocate within USAID but also in providing training, developing materials, sharing information, and supporting more research.

INTRODUCTION

1

Gender-based violence (GBV)[1] is increasingly recognized as a public health problem and a violation of human rights. Furthermore, reproductive health workers are often the only health care providers many women see. These professionals are on the front line in treating women who survive physical, sexual, and mental abuse. Yet, most reproductive health programs are not equipped to handle such cases.

These factors convinced organizers of the Technical Update on Gender-Based Violence and Reproductive Health / HIV (RH / HIV) that there was a need to 1) explore if and how GBV and RH / HIV intersect, and 2) if they do, to consider ways in which GBV concerns could be integrated into RH / HIV programs. On May 1, 2002, over 130 program managers, policymakers, service providers, and trainers participated in a day-long Technical Update, hosted by the USAID Interagency Gender Working Group (IGWG) with the Center for Health and Gender Equity (CHANGE). Participants at the meeting heard data linking GBV to RH / HIV, were informed about pilot efforts to integrate GBV into RH / HIV programs, and provided their input about whether and how to proceed in integrating the issue of violence against women (VAW) into these programs.

1 Although GBV encompasses a range of harmful practices and behaviors against girls and women, in this report GBV is used interchangeably with domestic violence (DV), intimate partner violence (IPV) and violence against women (VAW).

2 OPENING REMARKS

"When my husband wants sex, he never asks. If I try to refuse, he beats me and forces himself into me. When I refuse, he accuses me of having a lover…. That's when he kicks me from the bed onto the floor, and then drags me back onto the bed and rapes me. I can sometimes feel my fury pouring from my eyes in my tears."

(Cambodian woman)

Anne Peterson, Assistant Administrator of the USAID Bureau for Global Health, opened the meeting with stories that illustrate the devastating effect that intimate-partner violence has on the lives and health of women and children. She spoke about the violence she witnessed through her work in the field and expressed her surprise that such behavior was often assumed to be normal.

Peterson reflected on the information that USAID has collected, which indicates that intimate-partner violence (IPV) is a serious public health problem with significant health implications. Peterson urged audience members, as they participated in the day's discussions, to keep in mind three questions: 1) How does GBV or IPV hinder the achievement of population, health, and nutrition results? 2) What reasonable steps should be taken to address GBV in the projects participants undertake? 3) What specific niche does their project or collaborating agency (CA) have that can contribute to addressing the issue?

Michal Avni of the USAID

Interagency Gender Working Group (IGWG) said that IGWG's Technical Advisory Group recently identified GBV as a thematic priority area. Hence, this Technical Update was a seminal event for considering GBV in relation to RH and HIV in USAID's population, health, and nutrition portfolio. In defining GBV, Avni described it as a multitude of harmful behaviors, most frequently perpetrated by men against girls and women. Cultural beliefs and values that subordinate the status of females contribute to legitimizing GBV.

Prior to the Technical Update, 11 senior staff members of the Bureau for Global Health were interviewed, Avni said. Among the interviewees who had worked overseas, all had witnessed the consequences of GBV firsthand. Furthermore, they agreed that GBV:

- Is a serious and pervasive problem that undermines progress in RH and HIV;
- Directly affects women's access to services, specifically their ability to obtain contraceptives;
- Jeopardizes informed choice;
- Poses serious challenges to sexual negotiation, particularly the use of condoms;
- Is a factor in spreading HIV; and
- Burdens overwhelmed health care systems, as it increases the likelihood of maternal deaths and contributes to poor birth outcomes.

Those interviewed expressed a range of responses as to how to proceed, from those who were cautious about adding components to the RH portfolio to those who believed it would be negligent not to address GBV, an acknowledged public health problem.

Recognizing that there are divergent opinions about integrating GBV into RH / HIV programs, Avni encouraged participants to voice their concerns along with their suggestions on how to address the issue of violence against women within RH / HIV programs and services.

3 DEFINING THE MAGNITUDE OF GENDER-BASED VIOLENCE AND ITS IMPLICATIONS FOR REPRODUCTIVE HEALTH

The first set of presentations began with a definition of the terms "gender" and "gender-based violence." Using survey information, the speakers then identified factors that contribute to GBV. They presented recent data that link GBV with negative RH outcomes.

INTIMATE-PARTNER VIOLENCE: CONTEXT AND PREVALENCE

(Sunita Kishor, ORC Macro/Measure DHS)

Sunita Kishor set the stage for the day's discussion by defining "gender" and "gender-based violence" and by providing an overview of the problem and the factors that contribute to it. She defined gender as "the different *roles*, *rights*, and *obligations* that culture and society attach to individuals according to whether they are born with male or female sex characteristics," and placed gender within a hierarchical and human rights-based continuum in which women are subordinate to men.

GBV can pervade the entire life cycle of a woman, from the moment a girl child is conceived (e.g., sex-selective abortion) throughout her life cycle (e.g., female infanticide, female genital cutting [FGC]). Men who hurt women can be intimate partners, family members, and/or other men. Violence against women can take many forms: sexual abuse, physical violence, emotional or psychological abuse, verbal abuse, and specific acts of violence during pregnancy. Men can harm women by limiting their access to food and medical care, carrying out dowry deaths and honor killings, and coercing them—especially adolescent girls—to have sex through rape and/or sexual harassment.

Factors that Perpetuate GBV

Kishor attributed GBV to gender norms and to women's low status—gender norms that give men permission to control wives, view

domestic violence as a private family matter, and rigidly define a "good" woman, and to women's low status that limits their access to resources and makes them dependent on men because they have no skills valued outside the home.

She presented data from the Demographic and Health Surveys (DHS)[2] for six countries in different parts of the world (Armenia, Cambodia, Egypt, Eritrea, Haiti, India, and Zimbabwe) to support the thesis that women and men are socialized to accept GBV as normative. These survey results showed that men *and* women believe that husbands are justified in beating their wives for such reasons as neglecting the children, answering back and / or arguing with him, going out without telling him, refusing to have sex, and burning the food. Between 10 and 50 percent of the women interviewed believed they should be beaten if they refused to have sex with their husbands. The most likely reason women identified as an appropriate justification for abuse from husbands was neglecting the children.

Prevalence of GBV

Prevalence estimates vary widely because of variations in 1) data collection methodology, 2) definitions of what constitutes violence, 3) the populations that are studied, 4) definitions of the types of perpetrators who commit violence against women, and 5) the time periods to which studies refer.

Overall, a review of available estimates of over 30 developing and developed countries shows that between 8 and 70 percent of women say they have ever experienced violence from a male intimate partner.[3] Preliminary data from the DHS suggests that women who report *sexual* abuse by their husbands / partners often also report *physical* abuse.

DEFINITION OF GBV

"Any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

— United Nations General Assembly, Declaration on the Elimination of Violence Against Women, 1993

2 www.measuredhs.com

3 Heise, L., M. Ellsberg, and M. Gottemoeller, "Ending Violence Against Women," *Population Reports*, Series L, No. 11. (Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program, 1999).

Risk Factors

From the data available and research results, Kishor identified the following risk factors associated with violence:

- Rigid gender roles;
- Isolation of women;
- Poverty;
- Less education (both for women and men);
- Higher parity (e.g., having more children);
- Alcohol use; and
- Experiencing or witnessing abuse as a child.

Kishor reiterated that most studies agree one in every three or four women has experienced intimate partner violence (IPV). In conclusion, she presented this challenge to anyone working on women's health: "If we knew that one-fourth of all women were suffering from a debilitating disease, would we continue to ignore it?"

PREVALENCE OF INTIMATE PARTNER VIOLENCE AND ITS IMPACT ON WOMEN'S HEALTH AND RH OUTCOMES

(Mary Goodwin, Centers for Disease Control and Prevention)

Explaining the methods used by the Centers for Disease Control and Prevention (CDC) to conduct its USAID-funded research on GBV, Mary Goodwin provided participants with results of recent findings and gave examples of how the data can be used to influence policy.

CDC's Survey Methodology and Results

CDC conducts surveys comparable to those of the Demographic and Health Survey (DHS). The surveys cover a broad spectrum of reproductive health and family planning issues and have been expanded over the years to include questions about infant mortality, maternal characteristics, behavioral risk factors, and demographic data.

CDC conducts door-to-door surveys and trains interviewers to be mindful of protecting women's safety. Participation in these surveys is restricted to one person in the household. This differs from DHS, which includes all household members.

Recently, CDC undertook a survey that included questions on verbal, physical, and sexual violence against women in 12 countries (Albania, Azerbaijan, Ecuador, Georgia, Guatemala, Honduras, Moldova, Mozambique, Paraguay, Romania, Russia, and Ukraine). The indicators CDC used for this study included:

- Witnessing parental abuse;
- Experience of abuse as a child;

- Verbal or physical abuse by partner in the last year;
- Physical injuries due to violence;
- Reporting of violence;
- Partner alcohol use at time of most recent incident;
- Forced sex (ever and by age at last occurrence); and
- Gender roles and attitudes.

The data collected are not comparable across countries because the surveys are modular and countries can choose the models they want to apply. However, survey results indicate that women in Ecuador reported the highest prevalence of abuse (30 percent), closely followed by women in Romania (29 percent). Women in Georgia reported the lowest levels (5 percent).[4]

Use of Data to Legislate

Goodwin gave examples of how the data were used in campaigns to outlaw violence against women. In Paraguay, the CDC data was used along with findings from the National Reproductive Health and Demographic Survey to develop a legislative proposal for the Law Against Violence Toward Women and the Family. The law was passed by the Senate and is awaiting passage by the House of Deputies. In Romania, the dissemination of survey-based evidence showing that most forced sexual intercourse was perpetrated by husbands resulted in a revision of the national Penal Code. The revision allows women to press charges against a sexually abusive husband and establishes new guidelines for restraining orders, allowing women to register restraining orders against an abusive spouse and exclude him from the family home. The revised Penal Code went into effect in November 1999.

Yet, the CDC does not know exactly who uses the data or to what ends. A tracking system was developed in Ecuador that shows the data are frequently requested, but the CDC is not sure how the information is being used.

Challenges

In addition to standardization of surveys, Goodwin mentioned several other challenges for improving data collection and use:

- Tracking requests for data;

4 The surveys which have already been published include: Centro Paraguayo de Estudios de Poblacion (CEPEP). *Encuesta Nacional de Salud Materno Infantil, 1998: Informe Final* (Paraguay, 1999); Serbanescu, F. et al., *Reproductive Health Survey Romania, 1999: Final Report* (Atlanta, 2001); Serbanescu, F. et al., *Reproductive Health Survey Moldova, 1997: Final Report* (Atlanta, 1998); Serbanescu, F. et al., *Women's Reproductive Health Survey Georgia, 1999-2000: Final Report* (Atlanta, 2001); Kiev International Institute of Sociology, *1999 Ukraine Reproductive Health Survey: Final Report* (Atlanta, 2001); Centro de Estudios de Poblacion y Desarollo Social (CEPAR), *Encuesta Demografica y de Salud Materna e Infantil, ENDEMAIN-99: Informe General* (Quito, 2001); and Russian Center for Public Opinion and Market Research, *1999 Russia Women's Reproductive Health Survey: Follow-up Study at Three Sites, Preliminary Report* (Atlanta, 2000).

- Identifying potential uses prior to data collection;
- Informing potential users about the availability of data;
- Assuring that special topics, such as GBV, do not get "buried" in the data collected;
- Linking health and violence; and
- Generating interest in more specialized topics (e.g., maternal mortality due to violence).

Goodwin added that data is critical in identifying projected needs before asking donor organizations to support services for abused women (e.g., shelters, interventions, etc.).

REPRODUCTIVE HEALTH CONSEQUENCES OF GENDER-BASED VIOLENCE

(Mary Ellsberg, Program for Appropriate Technology in Health [PATH])

Mary Ellsberg presented several studies that show the implications of GBV, including preliminary results from new studies by the World Health Organization (WHO) that begin to link the effects of GBV to negative RH outcomes. Previous studies found that violence against women increases their risk of fatal (homicide, suicide, maternal deaths, AIDS-related deaths) and non-fatal (physical and mental, high-risk health behaviors, reproductive health) outcomes. They also confirmed that there are health risk factors associated with GBV since abused women tend to exhibit more physical symptoms, reduced physical functioning, worse subjective health, more lifetime diagnoses, and higher health care utilization.[5]

Preliminary Results

WHO has undertaken a study[6] on women's health and domestic violence that measures life-time experiences of physical, sexual, and emotional violence by partners and non-partners among women ages 15-49 in Peru, Brazil, Japan, Thailand, Tanzania, Bangladesh, and Namibia. Fieldwork in the last three countries has only recently been concluded, but preliminary results from countries where the survey has been completed, as well as other population-based studies, indicate that:

- Forced sex is common in marriage.
- Women are frequently abused sexually in childhood.
- Violence leads to unwanted pregnancies.
- Abused women have more children. Although researchers formerly hypothesized that having

5 Heise, L. et al. 1999.
6 The WHO study can be found on www.who.int/en/

more children was a risk factor for abuse, research in Nicaragua has found that abuse typically begins early in marriage, often before the first child, indicating that high parity may be a result of abuse because women's control over their own fertility is reduced.[7]

- Childhood sexual abuse leads to younger age at first sex; an increase in risky behaviors (e.g., numbers of partners, unprotected sex); and more unwanted pregnancies, HIV, sexually transmitted infections (STIs), etc. A Nicaraguan study showed that the combination of child sexual abuse and witnessing mother's abuse doubled the likelihood of pregnancy in adolescence.[8]
- Violence is a risk factor for HIV and is also often a consequence of disclosure of HIV status.[9]
- Violence is related to a number of negative pregnancy outcomes, such as delayed prenatal care, smoking and drug use, no postpartum check-up or postnatal care, and more infections. There is a significant association between miscarriage, abortions, child mortality, and violence against women during pregnancy.

GBV Affects Family Planning and Safer Sex

The WHO's study shows an inverse relationship between GBV and practicing safer sex. Sexual violence limits women's ability to practice safer sex and protect themselves from STIs and unwanted pregnancies. Thirty percent of women who have been abused reported that their husbands refused to use condoms to prevent disease compared to 10 percent of non-abused women.

Evidence is beginning to emerge that abuse can lead to unwanted pregnancy and STIs since women who have been abused begin sexual relations earlier and abused girls are more likely to practice high-risk behaviors, such as having unprotected sex and / or multiple partners. A study in Nicaragua associates 15 percent of all adolescent pregnancies with a history of sexual abuse. To date, there are no statistics that support the thesis that age at first marriage is a risk factor for violence.

GBV and Low Birth Weight

A study by Valladares[10] correlates abuse with low birth weight

7 Ellsberg, M. et al., "Candies in Hell: Women's Experiences of Violence in Nicaragua," *Social Science and Medicine* (2000) 51(11): 1595-1610.
8 Heise, L. et al. 1999.
9 Maman, S. et al., *HIV and Violence: Implications for Voluntary Counseling and Testing in Dar es Salaam*, Tanzania (Washington, DC: Horizons Project / ICRW: 2000): 35.
10 Valladares, E. et al., "Physical Abuse During Pregnancy: A Risk Factor for Low Birth Weight," *Journal of Obstetrics and Gynecology* (forthcoming).

among infants. This hospital-based case study found that:

- Physical abuse by a partner was associated with a four-fold increase in low birth weight after controlling for smoking and substance abuse;
- Violence slows fetal growth due to stress-related factors rather than pre-term delivery; and
- Mechanisms that cause low birth weight appear to be related to stress rather than trauma or lifestyle factors.

In the United States, violence appears to affect birth weight through its impact on smoking and drug use.[11]

GBV and AIDS

The evidence linking violence and HIV / AIDS is not as clearly documented, but recent studies in the U.S. and Africa suggest a complex dynamic between the two. The studies view violence as a risk factor for HIV. And equally disturbing, women who disclose their HIV status are at risk for being battered.[12]

Ellsberg cautioned that participants should be mindful of differences in survey methodologies, which could account for inconsistencies in the literature.[13] Nevertheless, she concluded, GBV is a significant public health problem with serious consequences for women's sexual and reproductive health. For this reason RH programs provide an important opportunity to address GBV, which is currently being lost.

Discussion

For follow-up discussion, participants broken into small groups based on six categories: behavior change communication (BCC) / media; community participation / mobilization; monitoring and evaluation; policy; provider training; or service delivery.

The comments that followed these presentations focused on the ethics of conducting such surveys. Ellsberg related that the WHO and the Pan American Health Organization (PAHO) have developed guidelines for investigating GBV.[14] These are being used by DHS, which distributes them along with the module on domestic violence. The CDC, however, uses its own set of guidelines. In all cases, the questions on violence are asked only if the criteria for privacy are met.

11 Petersen, R. et al., "Violence and Adverse Pregnancy Outcomes: A Review of the Literature and Directions for Future Research," *American Journal of Preventive Medicine* 13(5)(1997): 366-373.
12 Maman, S. et al. 2000.
13 Ellsberg, M. et al., "Researching Domestic Violence Against Women: Methodological and Ethical Considerations," *Studies in Family Planning* 32(1)(2001):1-16.
14 World Health Organization, *Putting Women's Safety First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women* (Geneva: Global Programme on Evidence for Health Policy, WHO, 1999):13.

MAPPING RH AND GBV PROGRAMS 4

The next presentation examined what types of organizations work on GBV, their approaches, the obstacles they face, and the results they have achieved.

INTEGRATING GBV AND RH: FRAMING AN APPROACH

(Suzanna Banwell, CHANGE [Center for Health and Gender Equity])

Suzanna Banwell presented preliminary results from surveys intended to map GBV programs and outlined the framework that CHANGE is developing to guide integration of GBV prevention and care into RH programs on a broader scale.

The survey that CHANGE sent to programs worldwide centered on five key questions:

- What is the nature and scope of integrated GBV and RH programming?
- What is a "reasonable and appropriate" response by a RH program to GBV?
- What do integrated approaches look like?
- What is realistic in a particular context in light of social, political, cultural, and resource realities?
- How are "success" and "effectiveness" determined and by whom?

CHANGE used a broad definition for reproductive health and received responses from a wide range of RH programs that integrate GBV. To date, they have received 235 responses from 69 countries. An analysis of the information is still underway, but preliminary results have highlighted some interesting commonalities in terms of obstacles and achievements.

Obstacles to Integrating GBV in RH

CHANGE's mapping exercise is still underway and all findings are

therefore quite preliminary and subject to change. However, from what has been learned so far, the returned surveys corroborate Kishor's findings (see page 4 above) regarding factors that perpetuate GBV. These factors are grounded in socio-cultural attitudes, such as accepting GBV as normal behavior. CHANGE also found there is little awareness of GBV as an issue that merits attention, and an absence of integrated responses or awareness of other efforts to help victims and survivors. Factors associated with individual-level resistance also seem to be common across countries. These include victims/survivors blaming themselves for the violence and men not believing that there is a problem with violence against women.

Another common observation found throughout the survey responses is the entrenchment of these beliefs among providers, who—even if they see a problem—often fear the reactions if they try to address it and, in cases where they do attempt to address it, encounter resistance from supervisors.

At the socio-cultural level, obstacles stem from political environments that have outdated and/or unenforced laws; from policymakers, primarily men, who do not see there is a problem and, therefore, are not responsive to addressing it; and from active resistance to addressing the problem by some sectors of society. Insufficient, short-term funding that tends to be tied to unrealistic expectations is another serious challenge faced by reproductive health and other organizations trying to help victims/survivors. Furthermore, the lack of research data, well-trained providers, organizational structure and leadership, strategic and systematic approaches, and institutional backing make it difficult to foster and maintain support for programs willing to address GBV.

Achievements in Integrating GBV in RH

Despite serious and seemingly overwhelming obstacles, survey results indicate that there have been significant and numerous achievements in such areas as:

- Heightened awareness as a result of disseminating research through the media, building community support to change attitudes, discussing issues with stakeholders, and promoting prevention;
- Capacity-building efforts that include cooperation among NGOs, development of referral networks, and enhancement of organizational ability and legitimacy to GBV work; and
- Advocacy at the individual and

institutional levels to influence NGO and government programs, communities, and legislation.

Framework for Integrating GBV

CHANGE is developing a framework to guide the integration of GBV services into sexual and reproductive health care as part of their own ongoing work in this area, of which the survey is just one activity. The framework, which is very practically oriented, is based on three core principles:

- Women's agency: Women must be empowered to make critical decisions about their own bodies and lives based on real choices, and be supported in their decisionmaking;
- Context: Context and "on the ground realities" are essential elements that must similarly be taken into account, and
- Blended empowerment: Realizing rights meaningfully requires a blending of public health, human rights, and social theory aims and approaches.

Using these principles, the framework addresses key reproductive health program components; for example, screening and care, counseling, referrals, and behavior change and communication. The framework also delineates what programs "must, should, could, and must not do" in order to carry out these activities in ways consistent with the overarching goal of assisting women in attaining and maintaining their reproductive health free from violence and coercion. Feedback from participants at the Technical Update indicated that if these "must, should, coulds" were "strictures" they would be problematic, but because they are process-oriented rather than content-oriented, and because they are designed to be flexible, they are holistic and helpful rather than rigid and dictatorial.

Banwell urged participants to "be creative" and "do something" in this area of work. She cautioned against promoting male involvement without first asking a woman if she wants her intimate partner involved or not. Finally, she warned, programs that integrate GBV and RH cannot be sustainable nor can they have an impact without sufficient resources.

Discussion

The idea of a framework was well received by participants who expressed relief that the "wealth of information" is being organized into a user-friendly structure helpful to program planners and managers. Participants reacted favorably to the connection of GBV to other services and the de-emphasis on clinic-based strategies to address violence against women. Specifi-

cally, discussions centered on:

- **Service provision.** The concern of overburdening providers emerged early on and was a recurring theme throughout the day. Some participants suggested that this was *not* a problem since integrating GBV will require changes in *how* providers do their work. The consensus, however, was that if GBV is so harmful to women's health, it simply cannot be excluded from RH programs. Participants also agreed on the need for pre- and in-service training of providers. Some audience members advocated that, even in the absence of a screening system, women who spontaneously disclosed GBV be given referrals.
- **Community participation.** There was a wide range of input by participants knowledgeable and interested in community participation. Some addressed the complexity of changing social norms that widely accept GBV and traditional gender roles, and proposed possible strategies. For instance, one participant noted, "The police and law enforcement do not yet accept that men shouldn't beat wives.... Thus, law enforcement education should include gender training."

  Several audience members asked for more grassroots activities, saying: "The very best efforts tend to be local."
- **Measuring and evaluating social change.** Suggestions from participants interested in monitoring and evaluation centered on tools that could be used to help providers integrate GBV into their services, such as including GBV in job descriptions and developing protocols that could be collapsed into job aids to guide providers. It was pointed out that normative change takes a lifetime, so assessing the impact of GBV programs on reproductive health is difficult.

Some participants mentioned the need for further research beyond looking at "standard activities that do not work." Other participants pleaded for risk-taking and that integrated GBV programs be started and their impact assessed.

REPRODUCTIVE HEALTH SERVICES AS AN ENTRY POINT

5

Integrating gender-based violence issues into health services requires working at various levels within health systems and with local communities. The first presentation on field-based programs focused on examples of such integration. One program raised awareness about GBV as a health problem among health care workers, while another focused on introducing the problem to trainers-of-trainers and people in small communities. Another program described the process an agency used in integrating screening and referral for survivors of intimate partner violence (IPV) into existing RH services.

INTEGRATING GBV INTO GENDER TRAINING IN INDIA

(Kanchan Mathur, Women's Resource Center)

Kanchan Mathur discussed the role of the Women's Resource Center (WRC) based in Rajasthan, India, in raising awareness about gender and GBV. WRC was created to promote gender equity and equality as part of a larger UNFPA program to implement in India the mandate of the 1994 International Conference on Population and Development. The Center, which believes that GBV should be addressed through the public health care system, works through India's primary health system.

Despite initial resistance from the health department and policymakers, WRC succeeded in having a day of gender and RH training added to an existing 12-day training module for public health care providers. The training focuses on a number of gender issues related to RH, including links between GBV and RH. Mathur explained that integrating gender, in general, into reproductive health services requires "soft inputs" (e.g., training, gender sensitization, communication), which in turn have translated into demands for "hard

inputs" (e.g., more female doctors, separate female toilets, safety of the auxiliary nurse midwife, and improved mobility for midwives to reach more women.)

Echoing some of the previous speakers, Kanchan outlined some of the main obstacles that WRC faced in addressing GBV:

- Convincing providers and others that women's subordination is neither acceptable nor justifiable;
- Changing attitudes among women who themselves accept violence because husbands are their breadwinners;
- Inspiring health care providers to help women break the silence surrounding GBV; and
- Dispelling the myth that GBV does not exist or is very limited.

Health department and health care personnel and policymakers initially were opposed to addressing GBV in the trainings because they only wanted to look at the medical consequences of GBV and did not want to address the social causes. Mathur recalled that it took sustained dialogue with policymakers to establish that GBV is a serious problem that must be addressed at all levels of society.

Mathur said that after gender and GBV were inserted into the training program as required disciplines gender permeated the entire training session. In conclusion, Mathur outlined the following essential mechanisms for integrating GBV into RH / HIV programs:

- Convincing policymakers at all levels that GBV is an issue that needs to be addressed;
- Establishing the fact that issues related to GBV are integral to RH and are directly linked to several RH problems, such as RTIs, STDs, and HIV / AIDS;
- Working with health care centers to develop a sensitivity toward GBV as a social malaise and not just a medical problem; and
- Recognizing that trainers and managers need to develop a comfort level with their own body and sexuality to deal with GBV.

INCORPORATING GBV IN RH INTERVENTIONS IN AFRICA

(Mzikazi Nduna, Gender and Health Group, South African Medical Research Council)

Mzikazi Nduna discussed a communication, relationships, and life-skills training package called "Stepping Stones" that the Medical Research Council adapted to promote sexual and reproductive health in South Africa. The program includes a manual, which is used in a series of 14 workshops (over the course of three months) with same sex and age peer groups

who meet with a trained facilitator. The manual can be used in different contexts and is designed to be used in its entirety.

To date, the South African Medical Research Council has trained master trainers from different organizations; conducted a number of workshops in rural areas, squatter camps, townships, and urban settings; developed an evaluation tool; and conducted a pilot evaluation project.

Objectives and Evaluations

The objectives of the program are to:

- Mobilize the whole community to fight against HIV by addressing GBV;
- Increase knowledge about sexuality and reproductive health;
- Promote safer sex practices;
- Explore and change "gendered" attitudes;
- Build more equitable sexual relationships; and
- Enhance communication and assertiveness skills.

The Medical Research Council pilot tested an evaluation of the program, involving pre- and post-workshop questionnaires with 95 women and 107 men, as well as in-depth interviews. A Sexual Relationship Power Scale[15], a tool to measure power dynamics in a relationship, was used to determine changes in relationships. The evaluation found changes in power sharing, in condom use, and in attitudes toward gender relationships, particularly among women.

Qualitative information collected during the evaluation shows that the program influenced and changed women's and men's ideas

STEPPING STONES: A Series of 14 Workshops

1. **Introduction/development of group skills**
2. **Images of men and women; Exploration of ideals and realities**
3. **Images of sex and sexual health problems**
4. **Exploration of love: What we look for and expect to give**
5. **Exploring our sexuality: Problems and concerns about sex and reproductive health**
6. **Conception and contraception**
7. **STDs and HIV**
8. **Safer sex**
9. **Gender violence**
10. **Let's look deeper: Why we behave in the ways we do**
11. **Assertiveness skills: Part 1**
12. **Assertiveness skills: Part 2**
13. **Dealing with loss**
14. **Let's prepare for the future**

15 For more information, see Julie Pulerwitz, Steven Gortmaker, and William DeJohn, "Measuring Sexual Relationship Power in HIV/STD Research," *Sex Roles* 42, no.7/8 (April 2000): 637-660.

and practices. Stepping Stones reinforced women's independence and responsibility, and increased their confidence. Similarly, men reported that their ideas changed as a result of the program. They were no longer threatened by gender equality, but wanted "her to feel equal." They acknowledged that emotional abuse exists and regretted past abuse and non-condom use. Men who graduated from the program saw communication as a problem-solving strategy and thus were better able to communicate and express their feelings—something they did not do before participating in the program. Other behavior and attitude changes that men attributed to their participation in the program include: the realization that "fighting solves nothing"; a reduction in sexual play with female schoolmates; having one intimate partner instead of multiple partners; and being confident in their decision not to have sex.

Challenges of Stepping Stones

The program faced several challenges. Among them was the need to train and re-train peer educators due to attrition. The program found that trained peer educators often take other jobs as soon as they have completed the training and have an employable skill. The selection of peer educators also required careful attention, because it involved finding people with the right combination of skills and personality. Other challenges were mobilizing men and other adults (parents in particular), funding workshops, and constantly supervising to assure that monitoring is ongoing. In many cases, NGOs who implemented the program were responsible for supervising peer educators, but follow-through on supervision was inconsistent.

INTEGRATING SCREENING AND SERVICES FOR GENDER-BASED VIOLENCE WITHIN SRH PROGRAMS IN LATIN AMERICA AND THE CARIBBEAN

(Alessandra Guedes, International Planned Parenthood Federation [IPPF]/Western Hemisphere Region [WHR])

Alessandra Guedes described a multi-country GBV project being implemented by IPPF / WHR in partnership with affiliates in the Dominican Republic (PROFAMILIA), Peru (INPPARES), and Venezuela (PLAFAM). The project involves three components: 1) improving the institutional response to GBV through adjustments to infrastructure, patient flow, and clinic resources, as well as training health providers to detect, treat, and refer GBV survivors; 2) conducting information, education,

and communication (IEC) activities to raise awareness of GBV in the broader community; and 3) collaborating with other organizations to improve laws and their application. In contrast to initiatives that focus exclusively on intimate partner violence, IPPF/WHR and its affiliates chose to address a broader definition that includes all kinds of sexual violence, including a history of childhood sexual abuse, as well as physical, sexual, and emotional abuse by an intimate partner.

Guedes explained that support for integration of GBV issues into sexual and reproductive health (SRH) programs can be strengthened by emphasizing a gender and human rights approach; ensuring that staff receive ongoing support (not just a one-time training); demonstrating how health care is improved through such integration; and by addressing staff concerns (e.g., feeling overburdened or powerless to address an issue like GBV). A human rights approach will also work to ensure that clients' safety and well-being are respected. Some of the challenges to integration include a lack of referral services and the need to assess existing resources, sensitize and train staff, and adapt clinics.

Therefore, before providing screening services, IPPF/WHR affiliates identified existing referrals sites in the community, strengthened a referral network, and created a directory of service providers. They then sensitized staff and stakeholders, and assessed resources and the infrastructure in each clinic to assure that privacy and confidentiality would be protected, and emergency contraceptives would be provided. Additionally, in-depth training was provided to all staff members who were to have direct contact with survivors of violence. These affiliates then created tools for screening, adapted existing protocols and forms, and modified their information and management systems in order to be able to collect and document screening data.

Lessons Learned from Screening

Although there was some initial resistance from providers to questioning women directly about violence, results from a field-test of the screening tool in Venezuela found that screening levels increased from an average of seven percent with indirect screening to 44 percent in the first month that the screening tool was introduced. Other lessons learned from providing screening and referral services were:

- First and foremost, women's autonomy should be respected. Their privacy should be ensured

and disclosures should be treated as confidential.

- Staff members need ongoing support.
- Providers from all levels can be trained to screen but providers who are not sensitive to violence should NOT screen women because they may place women at risk.
- Having a written tool facilitates the process because providers do not have to come up with the right questions with each client. This also allows for comparability of data collected in different settings.
- Service providers need to be flexible in deciding which services are best positioned to screen women. One may need to stratify women according to levels of risk and prioritize services on this basis if the demand exceeds capacity.
- The service must be prepared to offer basic intervention: detection, documentation, support, risk assessment / safety planning, referral, and follow-up.
- Screening should be repeated periodically since a woman may not be willing to disclose information initially and also because a woman's situation may change over time.

BENEFITS OF SCREENING

Impact on Women

- Realization that GBV is a problem ("It lifted a screen from my eyes")
- Decreasing sense of isolation
- Feeling that the provider cared about them

Impact on Providers

- Improvement in quality of care
- Integrated approach to women's health
- Greater efficiency (can detect and treat the pathologies brought about by GBV)

Lessons Learned from Training

The program's managers found that not all individuals are suited to be trainers; they must be chosen carefully and the commonly-used trainer-of-trainers approach may not be appropriate, given the knowledge and skills needed to confront the complex issues raised by GBV. Also, training must address provider beliefs and attitudes, and it is easier to start with hard data and research rather than with concepts like "gender" and "power."

IPPF / WHR is developing a training guide that compiles its experience.

Lessons Learned from Evaluation

Evaluation was built in from the very beginning in order to learn what works and what does not, and to make these lessons applicable to other sexual and reproductive health programs. The evaluation tools IPPF/WHR used included a baseline study (KAP survey, Observation/Interview Guide and an Institutional Assessment), comparable service statistics, and a mid-term evaluation (qualitative protocol and a quantitative client satisfaction survey). They observed role-plays rather than direct supervision. The support group for providers is also essential, because it can be a means of supervision to see what actions they take in a given case.

Guedes distinguished between evaluating training and supervising training. The former looks at *how* and the latter *if* training occurs. IPPF/WHR has been able to evaluate *if* it is being done; *how* it is being done is more difficult to evaluate.

IPPF/WHR's experience suggests that ignoring GBV can lead to the wrong diagnoses and the wrong interventions, and that integrating a response to GBV (screening and services) can improve quality of care and improve women's self-esteem and self-image.

Discussion

Participants generally agreed that clients coming to service delivery points would be more receptive to receiving help in cases of GBV and more willing to change their behaviors. Another advantage of using service delivery as an entry point is that it facilitates the collection of statistics in a non-stigmatized setting, which can be used to influence policy. Furthermore, training staff about GBV will raise their awareness about factors that are associated with violence and increase the likelihood of discussions with their communities and their peers, family members, and neighbors. And, from a policy perspective, providers are important advocates and can put pressure on local institutions to integrate GBV services.

The main concerns voiced by participants centered on 1) reaching people who do not come to clinics, especially men, and 2) overloading providers. Participants cautioned against immersing providers in a sensitive issue that they may not be able to address, regardless of the amount of training they undergo. Others were concerned about proper management of cases and the fact that the issue may become "medicalized" if GBV programs are concentrated in health settings rather than taken up by other organizations (e.g., faith-

based or community organizations). Some participants cautioned that an emphasis on service delivery would focus on the treatment of victims of GBV and would do little to prevent future cases of GBV. They also discussed challenges in terms of follow-up—making sure that survivors and victims are getting the services they need without endangering them.

Participants suggested outreach as a strategy to reach people who do not come to clinics.

They explored innovative ways to train and supervise providers, and addressed the fact that governments and ministries of health resist training because it is costly since a provider in training is not providing services.

The discussion ended with consideration of policy issues, specifically referrals to legal and support groups, and their effect on women. Participants expressed a concern about violating confidentiality in countries that require clinics to report incidents of GBV. For instance, would a mandatory reporting law put women at increased risk for GBV?

LUNCH TIME PRESENTATION
Siula Bulu, Wan Smolbag Theatre: "Positive"

During the lunch break Siula Bulu presented a video made in Vanuatu, a South Pacific island nation. The video depicts the absence of communication among couples about safer sex and the attendant risks of violence and STIs. The film is an example of the videos and dramas that Wan Smolbag Theatre produces as tools for workshops they lead on health and social issues. A guide accompanies this film with the intent of raising awareness about HIV. Officially there are no cases of HIV in Vanuatu to date (as of May 2002), but couple communication needs to be encouraged and GBV is a problem.

Bulu provided background information about Wan Smolbag Theatre, an NGO based in Port Vila, Vanuatu, and founded in 1989. The theatre uses drama, plays, and radio as a means of disseminating information on various areas including RH.

In 1998, Wan Smolbag conducted a community play in Blacksands, a peri-urban squatter settlement. In the discussions that followed the play, community members raised the idea of Wan Smolbag running a clinic. After consultations with the Department of Health, the *Kam Pussum Hed* Clinic opened in 1999 to serve the reproductive health needs of the community. The clinic provides services that primarily test and treat STIs, and counsel on family planning and general reproductive health matters. Nurses report coming across few cases of GBV. They are not aware of women whose partners sometimes violently object to their using contraceptives without their (the men's) knowledge or approval. Yet, clinic nurses are aware that there are a lot of GBV incidences in the community that are not reported to the clinic.

Bulu also described growing demand for the video throughout the South Pacific region where reproductive health clinic staff members use the video to raise awareness and elicit discussion about GBV.

6 COMMUNITY MOBILIZATION/BEHAVIOR CHANGE COMMUNICATION (BCC) STRATEGIES

This session focused on field-based projects that address GBV through community mobilization and behavior change communication (BCC) campaigns. Three very different approaches were presented. One works with men, another with men and women in rural communities, and the third aims to raise awareness about gender and GBV issues among the public through the use of mass media, particularly television.

ADDRESSING GENDER, RH, AND VIOLENCE THROUGH COMMUNITY EDUCATION

(Manisha Mehta, EngenderHealth)

Manisha Mehta presented the Men as Partners (MAP) Program that is underway in South Africa as a collaboration by EngenderHealth with the Planned Parenthood Association of South Africa (PPASA). Mehta noted that South Africa has one of the fastest growing HIV/AIDS epidemics and also the highest per capita rate of reported rape cases. GBV is a common factor that contributes to both problems. The MAP program seeks to build men's awareness and support for their partners' reproductive health choices, increase men's responsibility for disease prevention, and improve men's access to RH services. It has been used with a variety of groups, including adolescents, the military, and faith-based groups. The program seeks to address such attitudes as the belief that women cannot be raped by their husbands or that women provoke attacks.

The EngenderHealth/PPASA community education program operates in various settings and reaches different audiences, from tribal leaders and traditional healers to youth in school and those living on the streets. It is conducted in prisons, in vineyards, with taxi drivers, with department store labor unions, in rural communities, and the most difficult parts of townships and inner cities.

As EngenderHealth and PPASA started developing a MAP program both parties realized they had to broach the issue of violence because it is so prevalent in South Africa. Women and men, girls and boys all reported seeing a great deal of violence, including their fathers beating their mothers. In fact most households have *shamboks*, a long stick that is used to punish women and which women are required to "take care of" and "store". Husbands will order women to "go get their *shamboks*" for a beating.

Mehta emphasized the connection between gender and violence. Gender inequity is a fundamental factor behind both HIV/AIDS and violence against women. Women's subordinate status in society contributes to the inability to negotiate condom use. And men do not escape the negative impact of gender dynamics. Existing gender norms emphasize that manhood must involve the sexual domination of women, including the pursuit of multiple partners, thus putting men at higher risk for HIV infection.

A Curriculum-Based Program

The MAP program in South Africa is a curriculum-based program that was developed through a step-by-step process of learning and listening that included:

RESULTS OF A BASELINE SURVEY OF SOUTH AFRICAN MEN AGED 16-60

- 22% of men approved of men hitting their partners;
- 48% believed that women were raped because of the way they dress;
- 58% believed a woman could not be raped by her husband;
- 35% had previously had an STI;
- 32% were currently using condoms, but 58% never had.

(Information provided by Anita Bhuyan of the Futures Group.)

- Informal discussion with PPASA staff;
- Focus groups with youth in "formal" settings;
- Talking with youth in "informal" settings;
- Talking with key adults;
- Revising ideas for the manual and program;
- Creating a draft curriculum and then testing, revising, and redrafting the curriculum.

The curriculum, based on a context of working in a culture with pervasive violence, keeps rights and safety at the forefront and explores new paradigms for sexuality and RH. The topics it covers include

gender and sexuality, sexual and domestic violence, relationships, male and female sexual health, HIV/AIDS and other STIs, and gender and social norms.

Working With Men, Women, and Adolescents

Mehta shared findings from the program that support two theses: 1) discussions on gender should be conducted with men and women together since it may be the first time men and women have an opportunity to hear each other's perspectives; and 2) discussions among men and women are much more fruitful after they have had a chance to talk about these issues separately, in single sex groups.

The topic of GBV may be particularly difficult to broach within a mixed-sex group. Observations of MAP workshops found that men were much less likely to acknowledge rape as a serious issue in workshops where both men and women were present. A safe environment (i.e., men only) gives men the opportunity to discuss with peers how they use violence. Occasionally, discussions about violence in men-only groups give some men the idea that it is okay to beat their wives. In such cases, the educators are trained to move the group away from this belief.

The PPASA Adolescent Reproductive Health Project found, however, that youth respond enthusiastically to gender activities conducted with a mixed group of male and female participants.

To the Future

Results from recent evaluations are promising. Findings show that 71 percent of MAP workshop participants believed that women should have the same rights as men; 82 percent of the participants thought that it was *not* normal for men to sometimes beat their wives; and 82 percent of the participants thought that sex workers could be the victims of rape.[16]

Future challenges for the program are the need to recruit adult men; the need to have facilitators that take a strong stand against GBV while at the same time creating an environment in which men can discuss these issues candidly; and the need to build partnerships with male community groups to implement programs against GBV.

INTEGRATING GENDER AND GENDER-BASED VIOLENCE INTO RURAL DEVELOPMENT

(Bruce Ragas, Philippines Partnership for Development of Human Resources in Rural Areas [PhilDHRRA])

Bruce Ragas, the Gender and RH

16 EngenderHealth, internal evaluation document.

Program Officer of PhilDHRRA, recounted some of the recent successes of the organization's Gender and RH Program. PhilDHRRA is an association of 64 NGOs that addresses the status of women and reproductive health as well as other rural development issues, including local governance, agrarian reform, and resource management.

PhilDHRRA's Gender and RH Program focuses on improving the status of women and increasing knowledge on gender and RH issues, such as family planning and violence in rural communities. The organization promotes equality, equity, and the right of both men and women to access social, cultural, and economic opportunities. It emphasizes women's needs because women are marginalized, victimized, and carry the burden of poverty.

A PhilDHRRA project in Inopacan municipality, entitled "Upscaling Toward Sustainable Integrated Development (SIAD): Integrating Reproductive Health and Local Government in Community-Based Initiatives," is one of the few efforts in the Philippines that integrates GBV and RH issues along with those associated with rural development.

KEYS TO INTEGRATION

- Women's empowerment
- Gender sensitivity
- Community participation
- Constant consultation
- Authentic partnerships with stakeholders
- Strong alliances with local government

Objectives

The objectives of the gender and RH component of the SIAD project are:

- To establish a sustained, integrated, and comprehensive partnership among and between local government units, NGOs, and people's organizations working toward improved access to and control of community resources by women and men; and
- To address RH concerns through institutionalized mechanisms that provide coordinated support services to women, specifically in relation to violence against women and pregnancy-related problems.

Results

The project in Inopacan has achieved multiple outcomes, including establishment of the Inopacan Bantay Benay Intervention Group (IBBIG), a community-based organization that monitors GBV in the community

through a "family watch." IBBIG monitors and intervenes in cases of domestic and other gender-related violence in the community. It has strengthened the skills and knowledge of *barangay* health workers – providers who are on the frontline of health care delivery. Their skills go beyond delivering basic health care; since they encounter GBV and child abuse, they are trained in counseling, networking, and referring survivors of GBV, and are familiar with the legal aspects of violence against women. The project also succeeded in including GBV and RH in the comprehensive land-use plan of the province. Moreover, it established four *barangay* health centers and increased women's participation in community organizations.

In conclusion, Ragas said that integrating gender actually transforms development work so that rural development programs address gender and RH goals. Factors that need to be considered in this integration are:

- Women's empowerment;
- Cultivating gender sensitivity;
- Community participation;
- Ongoing consultation with stakeholders; and
- Forging strong alliances with local governments.

DEVELOPING AN INTEGRATED MULTI-MEDIA/MULTI-METHOD APPROACH FOR INDIVIDUAL AND SOCIAL CHANGE AROUND GBV AND SRH ISSUES

Amy Bank, Puntos de Encuentro, Nicaragua

Amy Bank presented a nationwide behavior change communication (BCC) program that uses a multi-pronged approach, including television and radio. After showing a short documentary with clips from episodes of *Sexto Sentido* ("Sixth Sense"), a soap opera that raises social issues such as gender and GBV, as well as footage of how the series is used in community organizing and capacity-building activities, Bank talked about the evolution of *Puntos de Encuentro's* (Meeting Points) approach to behavior change communication strategies.

Intersection of GBV and Sexual and Reproductive Health

Bank underscored the fact that sexual and reproductive health and GBV were integrated into her organization's work from the outset. *Puntos de Encuentro's* mission is to help increase women's and young people's ability to take control of their own lives and participate at all levels of society; or, as a popular Chilean slogan says: *"Democracia en la calle, en la casa y en la cama* (Democracy in the

street, at home, and in the bed)." This philosophy links the public and private spheres. This is important not only so that issues such as GBV that have been hidden in the private sphere are brought into the public realm, Bank said, but also to highlight the fact that the kinds of dynamics and power relations that are at work in the most intimate spheres of life are often replicated and transferred to the public and political realm.

Campaigns and Beyond

Puntos' experience of developing and implementing several successful national behavior change campaigns led the organization to the conclusion that time-specific campaigns, while very useful for visibility of an issue, can be very costly and often oversimplify complex issues. This, in addition to a commitment to promote people's sense of individual and collective efficacy rather than message-driven "behavior change," led *Puntos* to develop its "social soap" television series, *Sexto Sentido*.

Social soaps—both on television and more often on radio—model behavior over time and give topics a more holistic, in-depth treatment, according to Bank. Research has shown that they are successful for reasons that include popularity, emotional identification, modeling that promotes a sense of self-efficacy, the intertwining and ongoing storylines that allow complex and layered treatment of several themes at once, and long-term, repeated exposure to different aspects of the same theme.

The Magic Is in the Mix

Puntos recognized that mass media is a cost-effective way to reach lots of people and create a favorable environment for change, while community mobilization and interpersonal reinforcement increase impact of the media messages. They developed a strategy that combines individual and social change catalysts that operate simultaneously and over time, to get the benefits of:

- Mass media appeal;
- Ongoing coverage and broad reach;
- Enabling-environment benefits of the television and radios shows backed up by local media;
- Community mobilization and network building;
- Interpersonal reinforcement activities; and
- Links to organization and services.

Investment and Cost Analysis

For *Puntos*, impact evaluation is a challenge it takes very seriously. It is continually testing methods and

indicators. The kind of broad individual and social change the organization is trying to achieve involves long and complicated processes. Nevertheless, *Puntos* views this experience as an opportunity to learn more about how individual and collective change happens by looking at how larger and longer-term goals relate to the specific short-term goals of particular projects and programs.

After an initial investment in infrastructure, including both the technical / skills and the building of organizational relationships and networks, the ongoing marginal costs now are quite low. The cost of the television program comes to an estimated US$0.03 per viewer per episode, while the cost of the entire multi-media strategy comes to US$2.00 per viewer per year. This includes overhead, salaries, and direct costs.

Evaluation

In evaluating *Sexto Sentido*, *Puntos* looked for evidence of exposure and its impact by using the following set of tools:

- Analysis of commercial television ratings;
- Survey of 1,400 young men and women in 14 of the country's 17 departments;
- Focus groups with young television viewers;
- Monitoring of calls made to radio programs;
- Interviews with 22 cooperating organizations;
- Letters to Sexto Sentido (300+); and
- "Anecdote" book.

Evidence of exposure. The results of the survey of 1,400 urban and semi-rural teens and young adults indicate that 75 percent have seen the show, which, according to commercial ratings, garners 70 percent of the TV-watching audience during its time slot—giving it a reach of slightly more than 20 percent of the Nicaraguan urban and semi-rural population. More than two-thirds of the viewers discuss the episodes they watch with someone else. The sexual and reproductive health and GBV topics were the topics on which viewers most frequently commented. In terms of the radio show, virtually every program that dealt with some kind of gender-based or family violence elicited at least one phone call from a young woman who would tell of sexual abuse by someone close to her and who would confess that it was the first time she had ever disclosed this information.

Impact of the strategy in relation to emergency contraception. Two episodes of *Sexto Sentido* dealt

with emergency contraception (EC) as an option for preventing a pregnancy after unprotected sex. Airing these episodes was a challenge given that in Nicaragua, as in many countries where the Catholic Church is strong, there is opposition to contraception in general, and even more to emergency contraception. The second episode dealing with EC involved a young woman who was raped and got pregnant. Her friend laments that she didn't tell her about EC right away; if she had, she could have avoided both the pregnancy and the abortion she finally decided to have.

In addition to the TV episodes and radio coverage, *Puntos* published an informational pamphlet in coordination with several other groups. More than 50,000 copies were distributed by over 60 organizations around the country and were reprinted as a newspaper supplement. In the survey of the 1400 young women and men, *Puntos* measured both awareness and acceptability of emergency contraception. Awareness of EC is related to exposure to the different elements of the strategy; only 28 percent of young people who had never seen *Sexto Sentido* had heard of emergency contraception, compared to 45 percent of frequent viewers and 77 percent of those who had been exposed to three or more elements. In addition, despite the controversial nature of EC, the acceptance of the method was quite high along with reporting of intention to act; 91 percent of those who knew about EC said they would recommend it to a friend in need.

Discussion

Participants at the Technical Update discussed what they thought were the advantages of community mobilization and BCC as well as their concerns about them.

In general, they were very supportive of community mobilization and BCC as useful strategies for addressing GBV. These strategies can help reduce the stigma surrounding GBV, making it less taboo for public discussion, and eliminate the isolation that women may experience. Involving communities catalyzes grassroots involvement that can get attention and demand changes in policies. Participants also noted the sustainability of community efforts to change behaviors because such efforts get women to talk among themselves and identify with others. By doing this, they break the silence on stigmatized issues while also challenging gender norms. Advantages of working through mass media such as television and radio are that they allow for mass

communication of personal testimonials and validate experiences that may not be common within the family or community.

The concerns regarding community mobilization and BCC programs centered on community involvement and measuring results. Participants acknowledged the challenges of assessing such programs since results are not immediate. Although they mentioned the need to develop indicators, they also recognized the difficulty of coming up with indicators and evaluation tools that people will accept. They cautioned about the validity of pre- and post-assessments because the likelihood of respondents giving socially desirable answers is high. Some members of the audience mentioned the problem of censorship and questioned the receptiveness of policymakers and the general public to such topics as gender and GBV.

Participants in the discussion groups recommended the integration of monitoring and evaluation into project design. They acknowledged that there is a challenge in measuring the impact of campaigns to change behaviors and proposed the use of case studies to illustrate the need for a policy on GBV or to show how a policy helped. They also urged that messages about violence against women be clear and target a diverse audience, and that they be culturally sensitive and balanced. Other suggestions were: to find safe spaces for men and women to discuss these issues separately; to integrate GBV into adolescent RH education; and to identify appropriate intermediary or "process indicators" that show progress in achieving the intended outcomes.

NEXT STEPS

7

One of the final exercises of the day focused on taking steps to incorporate GBV into RH / HIV projects. Participants were asked to determine how integrating GBV interventions into their programs would help achieve RH goals, and to identify the barriers, facilitating factors, resources, and technical assistance they would need to achieve this integration.

In an interactive exercise, participants placed a card on a continuum that ranged from "strongly believe that GBV should *not* be integrated into RH / HIV" to "strongly believe that GBV should be integrated into RH / HIV." The consensus leaned heavily in the direction of integrating GBV into RH / HIV programs.

Advantages of Linking GBV to RH

There was overwhelming agreement that addressing GBV is integrally linked to RH and thus to achieving RH / HIV goals because it would increase:

- Access to family planning and continued use of contraceptive methods;
- The ability to negotiate safer sex;
- Access to other RH services, such as antenatal care;
- HIV testing and support services; and
- Gender equity.

Addressing GBV also reduces the negative effects of GBV on women's physical and mental state; and subsequent risky behavior by survivors or witnesses of abuse.

Other benefits of integrating GBV into RH / HIV services that participants mentioned were improved provider-client interaction, provider efficiency, and quality of overall care. Proponents of community participation encouraged raising awareness through discussions since these tend to initiate a search for community-based solutions.

Participants with a policy perspective pointed out the need to

BENEFITS OF INTEGRATING GBV INTO RH/HIV PROGRAMS

- Increase access to family planning and improve continued use of contraceptive methods;
- Improve ability to negotiate safer sex;
- Increase access to other RH services, such as antenatal care;
- Increase HIV testing and support services; and
- Increase gender equity.

encourage policymakers to act by raising their awareness of the problem. This could be achieved by sharing with them current data that shows the pervasiveness of the problem as well as its links to women's health.

Barriers to be Considered

Although participants solidly supported integrating GBV into RH / HIV services, they were realistic about the difficult challenges this would entail. The barriers they identified include:

- Changing institutional structures and policies;
- Dealing with provider attitudes, not only in terms of personal and social biases, but their resistance to taking on another issue that adds to their work load;
- Restructuring services to address the problem of overburdening staff;
- Staff training, keeping in mind that training that addresses attitude change requires more time than training that increases medical knowledge;
- Adapting monitoring and evaluation tools; and
- Addressing funding constraints, including the increased cost of longer, sequenced attitudinal training.

Other obstacles participants mentioned include the difficulty of changing social norms, such as traditionally accepted gender roles; resistance from individuals and groups who have a vested interest in maintaining the status quo or who are ignorant of the magnitude and root causes of GBV; and the need to de-stigmatize the issue. At the policy level, the biggest challenge is convincing policymakers to address a complicated and controversial issue that may be competing with other urgent priorities in countries where there are too many needs and not enough resources. Some of the actions participants proposed to address these obstacles are early prevention (e.g., before puberty) and gender education.

Useful Technical Resources

Participants felt that in order to

maximize public health results, certain tools are necessary to establish the pervasiveness of GBV and the link between GBV and RH. Technical resources that would be useful fall into three categories:

- **Development of materials:** This might include guidelines that link GBV and RH / HIV; monitoring and evaluation tools; an orientation package on GBV; an interactive tutorial (CD-ROM) on GBV; and a literature review outlining effective interventions.
- **Research:** For instance, it might be useful to conduct research studies that link gender, GBV, RH, and HIV; that provide more conclusive data on the relationship between GBV and contraceptive use; and that provide more information on the impact of GBV initiatives, especially barrier methods. Also helpful would be studies that provide statistics regarding youth and GBV worldwide, and that field test tools to help providers diagnose and manage victims of GBV.
- **Information sharing:** Sharing of research findings, as named above, as well as information about strategies that work; where to find relevant videos and radio programs; names and contact information of local NGOs and consultants willing to train providers on GBV counseling; behavior change communications (BCC) resources, manuals, frameworks, and copies of curricula (available electronically); and examples of some simple clinical interventions.

Participants felt strongly that standard indicators, frameworks, and guidelines, if they exist, need to be shared; and if they don't exist, they need to be developed.

Other resources mentioned were: collaborating with other CAs in the field; funding for pilot projects; more support for intersectoral efforts; commitments to long-term versus immediate results; and training on integration.

And finally, it was pointed out that GBV and HIV / AIDS have a unique interrelationship: GBV can increase risk for HIV and disclosure of HIV-positive status can increase risk for GBV. It was felt that this interrelationship could be used to advantage.

The Role of USAID and the Bureau for Global Health

Participants noted that USAID has a large role to play in overcoming obstacles. On the practical side, it was suggested that CAs work for USAID Missions, so if the CAs are expected to begin addressing GBV, more requests and interest must first come from the Missions themselves. Moreover, within USAID and within in-country programs

and services, RH and HIV themselves are not well-integrated, and that USAID funding is somewhat rigid—it is categorized as either FP/RH or HIV/AIDS, with little flexibility.

USAID, particularly the Bureau for Global Health, could play an important role in furthering the integration of GBV with RH programs by:

- Allocating core funding for global programs to GBV initiatives;
- Holding CAs accountable for addressing GBV in their RH programs; and
- Educating the missions on the importance of GBV, including the key role policy plays in addressing this problem.

Some participants proposed integrating GBV into RFPs, saying that "just as gender has been integrated since Cairo (the 1994 ICPD), GBV has to become an integral part of all programs, and USAID has a role to play in it."

The Role of IGWG

The role of the Interagency Gender Working Group (IGWG) within USAID was emphasized as one that could:

- Increase understanding of the importance of GBV in achieving overall development and USAID goals;
- Emphasize the importance of allocating funding for global programs to GBV work and holding global programs accountable; and
- Urge missions to address GBV, including recognition of the key role that policies play.

In order to accomplish these goals, participants felt that the IGWG would need to find ways to address the concern about overburdening the system; ensure that GBV is included in supervision and performance appraisals in some model sites; encourage missions to take the lead and provide funding; and convince USAID that GBV is not only important to the Office of Population, Health and Nutrition but to the entire organization. Concrete steps that participants proposed were for IGWG to host an intensive training workshop for program planners and/or a traveling workshop to raise awareness among mission staff.

APPENDIX

Agenda for
GENDER-BASED VIOLENCE and Reproductive Health & HIV/AIDS:
A Technical Update
May 1, 2002

1. OPENING REMARKS

(8:45am – 9:15am)

Anne Peterson, Assistant Administrator, Bureau for Global Health, USAID

Michal Avni, Interagency Gender Working Group, USAID

2. DEFINITION, MAGNITUDE, AND RH SEQUELAE OF GENDER-BASED VIOLENCE

(9:15am – 10:00am)

Sunita Kishor, ORC Macro / DHS

Mary Goodwin, CDC

Mary Ellsberg, PATH

3. MAPPING RH AND GBV PROGRAMS

(10:00am – 11:00am)

Suzanna Banwell, CHANGE

Table discussions regarding presentation with guided questions, followed by plenary discussion to address concerns and reactions to the information presented and what it means to those in the field.

4. REPRODUCTIVE HEALTH SERVICES AS AN ENTRY POINT

(11:00am – 1:00pm)

Kanchan Mathur, Women's Resource Center / India

Mzikazi Nduna, Stepping Stones / South Africa

Alessandra Guedes, IPPF / WHR

Table discussions followed by plenary discussions.

LUNCH

Lunch time presentation: "Positive", a video produced by Wan Smolbag Theatre, a Vanuatu-based organization, linking GBV, couple communication, and HIV.

5. COMMUNITY MOBILIZATION/BCC STRATEGIES

(2:00pm –4:00pm)

Manisha Mehta, EngenderHealth

Bruce Ragas, PhilDHRRA / Philippines

Amy Bank, Puntos de Encuentro / Nicaragua

Table discussions followed by plenary discussions.

6. WORKING SESSION: PUTTING GBV & RH INTO PERSPECTIVE

(4:00pm - 4:45pm)

HOW DO WE MOVE FORWARD?

What are the issues that we need to think about in order to take GBV forward within our RH projects? What next steps are needed? Who needs to be involved?

Participants will outline next steps necessary to incorporate GBV into their RH / HIV projects, according to the six technical areas: general service delivery, provider training, policy, behavior change communication / media, community participation, monitoring & evaluation. Participants will discuss helping factors, barriers, resources / TA needed.

7. CLOSING REMARKS

(4:45pm – 5:00pm)

Diana Prieto, Interagency Gender Working Group, USAID

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The Interagency Gender Working Group (IGWG), established in 1997, is a network comprising non-governmental organizations (NGOs), the United States Agency for International Development (USAID), cooperating agencies (CAs), and the Bureau for Global Health (GH) of USAID. The IGWG promotes gender equity within population, health, and nutrition (PHN) programs with the goal of improving reproductive health/HIV/AIDS outcomes and fostering sustainable development. For more information, go to www.igwg.org.

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