

# addressing violence against women: piloting and programming

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# preface

Around the world, at least one in three women has been beaten, coerced into sex or abused in some other way — most often by someone she knows, including her husband or another male family member; one woman in four has been abused during pregnancy, according to UNFPA's *State of World Population 2000* report. Until recently, this type of violence, which affects females of all races, ethnic groups and classes, was viewed as a private matter. Today, it is recognized as a human rights violation and a public health problem with legal, social, cultural, economic and psychological dimensions.

Still, gender-based violence is shrouded in silence and shame. Victims of violence are often the most difficult to treat. Their chronic ailments and silent suffering frequently go undiagnosed, and the serious long-term effects can include irreparable damage to a woman's sexual and reproductive health.

UNFPA is committed to addressing this difficult issue, both because it falls clearly within our mandate and because of our expertise in working on sensitive issues dealing with reproductive health and gender inequity.

The publication in 2001 of *A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers*

*& Managers* was a major step forward by UNFPA in piloting the prevention and assessment of gender-based violence into its reproductive health services. The guide was tested in ten countries in five regions, with overwhelmingly positive results.

Integrating lessons learned from these ten countries into UNFPA's inter-country programme was the objective of a subsequent consultation in Rome, which is documented in this report. Held from 15-19 September 2003, the consultation included some of the world's leading experts on gender-based violence, whose views are already helping to shape UNFPA policy and programming.

UNFPA would like to thank Lynne Stevens for her excellent work in authoring the programme guide; the experts who attended the Rome consultation and shared their knowledge; and AIDOS, the Italian Association for Women in Development, which helped organize the consultation and has, for the past 20 years, dedicated itself to ending female genital mutilation and other forms of violence against women and girls. We would also like to thank those whose commitment to the pilot projects helped break down the walls of silence and gender inequality that enable violence against women to exist.

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# executive summary

The United Nations Declaration on Violence Against Women defines gender-based violence as an act “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 deprivations of liberty, whether occurring in public or private life.”

Gender-based violence encompasses a wide range of human rights violations, including the sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health and, in some instances, result in death.

Women’s groups have spoken out against gender-based violence, advocating that it be treated as a societal problem, rather than a private matter. Legislators have been lobbied to enact and implement laws that criminalize gender-based violence, and global conferences have passed resolutions condemning it.

Yet despite widespread recognition of the problem, there is a lack of coordinated services for those who suffer from it. Gender-based violence thrives in a culture of silence and denial. As a result, addressing the issue through mainstream programming and legislation is complex. Health-care providers do not routinely ask about incidences of violence, even though women may exhibit symptoms that suggest that abuses have occurred. Such symptoms include undiagnosable pain, repeated bouts of sexually transmitted diseases and unintended pregnancies.

UNFPA recognizes that violence against women is inextricably linked to gender-based inequalities. When women and girls are expected to be generally subservient, their behaviour in relation to their health, including reproductive health, is negatively affected – at all stages of their life cycle. In addressing the issue of gender-based violence, UNFPA advocates for:

- legislative reform and enforcement of laws for the promotion and the protection of women’s right to reproductive choice and informed consent, including promotion of women’s awareness of laws, regulations and policies that affect their rights and responsibilities in family life;
- promoting zero-tolerance of all forms of violence against girls and women and working for the eradication of traditional practices that are harmful to women’s reproductive and sexual health, such as rituals associated with puberty.

UNFPA also supports:

- training to ensure that all health-service providers are gender-sensitive and responsive to the health needs of women and adolescents;
- the development of skills and attitudes for dealing with victims of sexual abuse in the training of health-service providers, including diagnosis and treatment.

The UNFPA consultation on gender-based violence, which is the subject of this report, represents the summation of several years’ work on the part of the organization to confront the issue of violence in a meaningful and practical way. The meeting was organized to discuss the results of projects in ten countries (see Annex III) in which a new programming guide to address gender-based violence was piloted. In four of those countries, evaluations were subsequently carried out.

Building on lessons drawn from the pilot projects, the consultation focused on ways to mainstream the prevention and assessment of gender-based violence into UNFPA policies and programming. It also reviewed

current knowledge about various types of violence against women. The consultation concluded by making the following recommendations for key programming and policy actions:

### Research and Standardization

- Support research on gender-based violence.
- Promote agreement on standard definitions and on a core set of indicators.
- Support studies on masculinity and fatherhood and review existing programmes dealing with men as offenders and as protectors.

### Policy and Advocacy

- Promote implementation of relevant laws and policies along with government accountability.
- Prioritize integration of issues related to gender-based violence into policy frameworks, including Common Country Assessments and UN Development Assistance Frameworks.
- Estimate the macroeconomic impact of gender-based violence and the cost of interventions to prevent it.
- Include gender-based violence in gender and health accounts and advocate for more resources to address it.
- Support public education campaigns.
- Advocate for the implementation and monitoring of international agreements and conventions on the subject.
- Develop a directory of laws and regulations relating to gender-based violence.
- Map existing programmes and projects.

### Services and Communities

- Integrate training on gender-based violence in curricula of schoolteachers, health-care providers, the police, the judiciary, planners and statisticians.
- Focus on target populations in UNFPA programmes, including young people, pregnant women, the displaced and refugees.
- Strengthen referral networks (including shelters, safe houses and legal and psychological services).

- Develop a system for sentinel screening (with technical guidance from the World Health Organization) and integrate screening and care into standard medical services.
- Promote a code of conduct for United Nations personnel.
- Develop knowledge assets on gender-based violence.





# piloting an innovative approach

## The Programme Guide

*A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers & Managers* offers step-by-step guidance in designing and implementing a project to combat gender-based violence. Available in Arabic, English, French, Nepali, Portuguese, Russian, Singhalese, Spanish and other languages, it can be adapted for use in any part of the world. The guide outlines three options available to reproductive health facilities seeking to integrate attention to gender-based violence into their programmes:

- **Option A** involves only the distribution of information materials (including referral information) in the public and private rooms of the clinic.
- **Option B** includes information materials as well as asking clients about gender-based violence; the clients' responses are then included in their medical histories. If the client discloses that violence has occurred, she is referred to off-site groups for help.
- **Option C** includes all of the above as well as in-depth assessments of each case. Clients are then referred to either on-site or off-site treatment.

The guide also offers practical advice on integrating these options into existing activities. This includes guidelines on:

- choosing the most appropriate option for a particular facility;
- developing planning and monitoring tools, information materials and forms;
- setting up of referral mechanisms, protocols and policies;
- re-routing clients, providing continuity of

- care and follow-up mechanisms;
- educating staff through sensitization, training and supervision;
- expanding staffing and services;
- educating the community.

Before any of these steps are carried out, health-care providers and administrators should be sensitized to the connections between reproductive and sexual health and gender-based violence. The myths and barriers to effectively tackling the issue should also be explained, and tips provided on how they can be overcome. Helping staff to look at their own responses, beliefs and biases can be key to an effective programme.

The theme of the guide is creating choices, so that people interested in making a difference can establish a project that is of a size and scope that is realistic for them. The following principles will help ensure success:

- offer services in facilities women already use;
- choose a programme option that is an appropriate fit;
- involve and sensitize the community;
- create an environment conducive to discussion about gender-based violence by means of printed materials or audiovisual aids;
- develop gender-based violence protocols and policies;
- sensitize and train the whole staff, not only health-care providers.

Information and forms for monitoring and evaluation are included in the guide and can be adapted for use.

## Piloting the Guide in Ten Countries

Presentations and discussions of the ten pilot projects revealed that they were innovations in most of the countries in which they were carried out. (See Annex III for a description of each project along with a summary of key problems and successes.) Often, the projects represented the first time that health-care providers had been actively involved in identifying gender-based violence among their clients and developing methods to deal with it.

Most of the pilot projects focused on domestic violence. Other forms of violence, including sexual violence, were seldom discussed or included in screenings because of their sensitivity and the difficulty in dealing with them. In many cases, there was limited understanding of gender-based violence. The concept of marital rape, for example, was not widely understood. Child abuse or incest was generally regarded as a problem for girls exclusively.

Not all of the women coming for health services in the pilot sites were asked whether they had experienced gender-based violence; in some countries, the staff interviewed only those women they believed might have a problem. Married women were the primary clients, since most of the projects were based in reproductive health centres.

Project representatives were sharply divided on the issue of client screening. In countries where there is a legal requirement to report gender-based violence, health-care providers are at risk of prosecution if they do not notify the authorities that their client is being abused. Since in many cases the client does not want the incident(s) reported, divulging this information is a serious breach of confidentiality and trust. In such instances, health-care providers prefer not to document their screenings at all. In other countries, patients keep their own medical records. Lack of documentation causes serious problems in terms of follow-up, since it becomes impossible to ascertain if clients are making use of referral systems. Moreover, valuable information that may benefit a project is lost. Various options were subsequently presented for collecting data without disclosing the identity of clients and incurring unnecessary risk.

### Evaluating the Projects

In four of the pilot countries (Lebanon, Mozambique, Nepal and Romania), external evaluations were carried out. The evaluations focused on the following areas:

- progress made in addressing gender-based violence in reproductive health clinics and the role of the programme guide;

- advances made in universal screening and referral of victims;
- effectiveness of information and advocacy materials developed and used in each project site.

Data for the evaluations were collected through individual interviews with project personnel, health-care providers, resource persons involved in the training and development of information materials, and focus group discussions among clients. Project documents, progress and evaluation reports and socio-economic and demographic data on clients provided other sources of information.

The following general conclusions were drawn:

- Women from all cultures suffer from gender-based violence, irrespective of the socio-economic development of a country.
- The percentage of women who disclosed gender-based violence in the four pilot projects studied ranged from 10.5 per cent in Lebanon to 47.7 per cent in Mozambique.
- Women most at risk are between 20 and 35 years of age, although women of all ages are affected.
- Unemployed women are more likely to face violence than women who are working.
- The most common form of gender-based violence in all four pilot projects was domestic violence.
- Women are vulnerable to multiple forms of violence.
- Almost invariably perpetrators are women's own husbands or close family members.

All four countries made progress, despite the fact that they chose different project options. Their achievements include:

- greater capacity among health facility staff to service the needs of clients who have experienced gender-based violence;
- production and widespread use of behaviour change communication and advocacy materials

in public and private health facilities (except Mozambique);

- an increase in the number of health facilities providing screening and on-site treatment;
- the establishment of referral services, though their effectiveness was uneven; links were also established among medical and non-medical services;
- an increase in the number of abused clients who chose to speak about their experiences;
- use of the programme guide by other health facilities and the start of a database on gender-based violence.

## Lessons Learned

The following are key lessons from the ten pilot projects:

- **Integration of the issue:** Gender-based violence can be effectively introduced as a public health issue within regular health facilities. This suggests tremendous potential for addressing reproductive health issues in a holistic way, using the perspectives of gender and human rights.
- **Multidisciplinary approach to health care:** Confronting gender-based violence requires both medical and non-medical aspects of care. Such services should be carefully integrated within a multidisciplinary programme.
- **No single model:** There is no single model for addressing gender-based violence. It can be initiated as a community-based project, NGO-operated intervention or government undertaking, depending on the sensitivity and politics of the issue and available resources.
- **Community support:** When introducing a new initiative, particularly one that is culturally sensitive, community participation and ownership are essential.
- **New dimension in health-care services:** Discussion of gender-based violence among clients and health providers adds a new meaning to the notion of quality care.
- **Prevention of gender-based violence as a public health issue:** If gender-based violence is

recognized as a public health issue, it is imperative to look at it in terms of prevention as well as treatment.

- **Focus on attitudes and values:** Educational and advocacy materials not only provide information about gender-based violence and related services. They can also bring about attitude and behaviour changes. Development of such materials should therefore take into account prevailing attitudes and values.
- **Community participation:** Alliances involving leadership at the local level are a significant factor in the success and sustainability of any project addressing gender-based violence.
- **Role of the programme guide:** The programme guide played a catalytic role in operationalizing gender-based violence as a public health issue. Training was critical in bringing about behaviour and attitude changes on the part of health providers.
- **Empowering clients:** Sustained support of women (in the legal, social, psychological and moral spheres) through the projects was a significant factor in their empowerment.
- **Database development:** Well-planned and systematic record-keeping at screening centres can be a rich source for development of a database on gender-based violence and related issues.
- **Government commitment:** Effective government support and participation can be generated through a well-planned project document that is sensitive to the socio-cultural context of the country.

## An Additional Perspective:

### The Case of Colombia

Although Colombia was not one of the countries that piloted the programme guide, it has made significant progress in raising awareness and motivating action institutionally and socio-culturally on issues related to sexual violence. Efforts in Colombia helped to transform cultural ideas regarding sexual violence by contextualizing the issue in a gender and human rights-based framework.

Through a programme that brought together numer-

ous government institutions and non-governmental groups, a national action framework was developed for the prevention and treatment of sexual violence among victims and survivors. By positioning sexual violence in the public agenda, including national development plans, protocols were developed regarding institutional roles that would guarantee that sexual violence would be addressed and victims' rights restored.

Early phases of the programme, which have now been expanded to 30 main principalities in Colombia, contributed to a rise in reporting on incidences of sexual violence – from 9,305 cases in 1999 to nearly 14,800 in 2002.

Among the lessons learned was the critical importance of tools and guidelines to increase capacity at all levels. Also stressed was the need to establish linkages among multiple institutions if the rights of victims and survivors are to be ensured. In this case, this included institutions involved in justice, protection, social welfare, human rights, women's empowerment, education and sexual and reproductive health.

## Main Recommendations

The following are among the recommendations resulting from the ten pilot projects:

- **Refining the guide:** The programme guide works and should be made available to health-care managers and providers as a short 'pocket-guide'. Sections could also be added to provide guidelines on working with communities.
- **Advocacy and communication materials:** Information, education and advocacy materials produced were considered valuable, as evidenced by the fact that clients frequently shared them with family and friends. Such materials could also be distributed through clinics and schools.
- **Working with men:** Sensitizing men, especially influential male leaders, to the far-reaching impact of gender-based violence is an important area of prevention that has received little attention to date. In dealing with men as

perpetrators, evidence is scarce on what works. Depending on the gravity of the problem, legal or psychological approaches, or both, are advisable. Additionally, protocols should be developed to help health-care providers understand and counsel perpetrators.

- **Training:** Training for health-care providers should emphasize that gender-based violence is not only a violation of human rights (with legal implications), but also a public health problem that requires a network of referral services.
- **Project options:** Option A is feasible in all cases and option C in most. Option B, which refers clients to off-site facilities, can be problematic since there is no control over the quality of support provided and since a large number of cases are never followed up upon.
- **Support services for health-care staff:** Health-care providers also require support. Providers frequently feel overwhelmed, have their own abuse issues to deal with, or need help in dealing with confidentiality issues or integrating gender-based violence into their work.
- **Media:** Gender-based violence projects could benefit from guidance on working with the media to ensure sensitive reporting on the issue. Advocacy materials could also be developed that target a media audience.
- **Scaling-up:** Expanding an approach should be considered only when sufficient data are available and a project is functioning well. When taking a project to scale, emphasize monitoring and evaluation and develop a checklist to alert project managers to key actions at each stage of implementation.
- **Expanding target beneficiaries:** Focus on ways to target interventions to children and older women and to integrate protection against gender-based violence into school curricula.
- **Supply and demand:** In areas where services to address gender-based violence are insufficient or non-existent, it is better not to raise expectations and create demand. In such areas, it is helpful to find groups to work with to

strengthen or develop appropriate services. This would be a first step. There are groups that can assist NGOs that already work with women to develop psychological, legal and other services for survivors of gender-based violence. Having these in place would then allow health-care services to develop programmes that screen for gender-based violence. Partnering with these NGOs would allow for cross-referrals between health-care facilities and women's NGOs and visa versa. It might also be possible as part of the partnership for the NGO to put one of their trained staff on-site at the health-care facility in order to see victims of violence.

- **Partnerships:** Since solutions to gender-based violence are multisectoral, there is a need to collaborate with partners, especially UN agencies, to define roles in a global strategy on the issue. A coalition of partners could also be established to address specific challenges, such as the development of a standardized curricula for the training of health-care workers, or guidelines for service providers other than those in the health sector, such as teachers, social workers and law enforcement personnel.



# learning from the experts

Ten experts in their field made presentations on various aspects of gender-based violence, which are summarized below. Working group discussions concluded with recommendations on elements of a UNFPA programming framework.

## Gender-based Violence: An Issue of Social Justice, Human Rights and Public Health

For many women, violence begins at home. Husbands, boyfriends and other family members are among the perpetrators of such violence, which can range from female infanticide to spousal abuse and even result in suicide. Health problems that result include injury, disabilities, disease, depression, eating disorders and anxiety. Domestic violence is closely related to sexual and reproductive health problems such as difficulties in pregnancy, sexually transmitted infections including HIV/AIDS, miscarriage and maternal mortality.

Patriarchal power is the prime cause of such violence in almost all societies: when male control of females is widely accepted and culturally condoned, domestic violence is legitimized.

Gender-based violence not only affects women and girls; it also has a negative impact on children living in an abusive household. Studies show that children who grow up in such an environment are likely to resort to violent behaviour as adults.

Violence against women also has a negative impact on the economy as the work force is reduced, productivity shrinks, and earnings and investments are diminished. In addition, more public funds must be channelled into medical treatment, shelters, counselling and other services for battered women, and into improved law enforcement and justice systems.

Every human being has the right to a life free from violence. Policies, programming, research and resources must focus on the prevention, care and follow-up of gender-based violence.

## Sexual and Reproductive Health Programming and Gender-based Violence

Collecting solid data on the impact of gender-based violence on sexual and reproductive health is key to effective advocacy and to planning viable programmes.

Gender-based violence can negatively affect sexual and reproductive health by increasing the risk of gynaecological problems such as vaginal bleeding and discharge, painful menstruation, sexual dysfunction, pelvic inflammatory disease, painful intercourse and chronic pelvic pain. Sexual violence against women leads to unwanted pregnancies, and has been used as a weapon in war. Violent behaviour on the part of husbands is also linked to an interruption in women's use of contraceptives: some data indicate that both men and women feel a husband is justified in beating his wife if she uses family planning methods without his permission.

Children who have been victims of gender-based violence are more vulnerable to high-risk sexual practices as adults and to increased risk of sexually transmitted infections. They are also at higher risk of teenage pregnancy. In many countries, men and women alike justify marital rape, coerced sex and associated partner violence, which increases vulnerability to sexually transmitted infections, including HIV/AIDS. What's more, women's ability to negotiate the use of condoms is compromised by fear of violence and abandonment.

Astonishingly, the prevalence of gender-based violence in pregnancy is high, and pregnancy is considered a time of heightened risk for such abuse. Violence during pregnancy is associated with increased smoking and substance abuse, vaginal and cervical infections, bleeding during pregnancy, premature labour, miscarriages, stillbirths, unsafe abortions, increased

risk of low birth rates in newborns, reduced use of prenatal care, infant and child mortality, maternal mortality, suicide and homicide.

The following actions were proposed to lessen the impact of gender-based violence on sexual and reproductive health in UNFPA's programmes:

- The prevention of gender-based violence must become an integral part of UNFPA's country programmes and should be reflected in various cooperation frameworks, including the Common Country Assessment and UN Development Assistance Framework.
- Programmes that encourage the involvement of service providers must be supported, including finalization of the UNFPA programme guide and promotion of its methodology and use.
- Evidence-based programming to address the sexual and reproductive health outcomes of gender-based violence must be promoted. This includes support for the collection, analysis and dissemination of data that link gender-based violence and sexual and reproductive health and the sharing of best practices. Baseline studies and surveys and formative research for the implementation of projects should be used as benchmarks for monitoring and evaluation. Audience-targeted programmes must be designed and implemented.
- Global advocacy campaigns for the prevention of gender-based violence should be conducted. Partnerships towards this end should also be built at the country, regional and global level, identifying the comparative advantages of each partner and establishing modalities of collaboration and coordination.
- Behaviour change communication campaigns directed to individuals and communities must be designed and implemented to educate and instil positive attitudes and actions.

### Gender-based Violence in a Legal Framework

The role of governments in the area of gender-based violence is to protect the human rights of all women, to take action to prevent and punish violent acts, and

to fulfil international obligations under the various conventions they have ratified. International legal milestones related to the protection of women against violence and discrimination include the Universal Declaration of Human Rights (1948), the Convention on the Elimination of All Forms of Discrimination against Women (1979), the Declaration on the Elimination of Violence against Women (1993), the World Conference on Human Rights (1993), the appointment of the UN Special Rapporteur on Violence Against Women (1994), the International Conference on Population and Development (1994), and the Fourth World Conference on Women (1995).

Most international agreements recommend that governments periodically review all their laws, including family laws and various codes, practices, and religious norms and standards in order to make them as effective as possible in preventing violence and discrimination against women and in removing provisions that permit or condone them.

Why is legislation important? First, because without appropriate legislation and policies, there are no legal means to fight gender-based violence. Second, because legislation sends a strong message that gender-based violence is an issue of public health, not a private matter. Third, because it provides clear definitions of the various forms of violence. Definitions are important in establishing what is acceptable and what is not, which actions are defined as criminal and which are not. Legislation is the necessary precondition for action.

Legislation is often outdated and needs to be revised. Frequently it excludes diverse forms of violence (domestic violence, marital violence, trafficking, sexual abuse of children, sexual harassment) and deals mostly with rape by a non-family member. It often treats sexual harassment as a crime against morality, not against a person. Protection measures are rarely included in legislation. For example, outdated legislation often allows for a review of the sexual history of the victim.

A critical review of legislation is being carried out in



many countries with the support of international donors, including UNFPA. Necessary steps include:

- Revision of existing legislation (identifying gaps or incorrect approaches; draft revising of legislation; lobbying for political and public support for the adoption of new laws; and, after adoption, reviewing the effectiveness of the new legislation). Answers to the following questions must be provided: Do the laws reflect reality? Is there equal protection before the law for men and women? Are the rights of the victim protected? Are there sufficient means in place to effectively enforce the law?
- Research and gathering of statistics on the extent, causes and effects of violence.
- Creation of legislation that is closely linked to the availability of protection and support services for the victims of violence.
- Gender-sensitive training of the judiciary, police and health workers, all of whom must adhere to established standards of behaviour when dealing with the victims. For this purpose, protocols must be developed.

Women's organizations and NGOs need to participate in legislative reviews, since it is usually these groups, and not the legislators, that are demanding and initiating change. There is a wealth of information on the Internet on different models of legislation that have been developed by governments and other groups, and discussion on the pitfalls of one choice over the other.

Good practices in legislation include the following: good access for women to legal aid; special training for police officers; establishment of more women police officers and special police units to deal with gender-based violence; changing of the rules of evidence in rape cases; free legal representation for women; and recognition of psychological violence in the law.

### Violence Among Intimate Partners: The Challenges of Measurement

Quality data is necessary to make a compelling case against gender-based violence. Similarly, a clear definition of gender-based violence is important to raise

awareness and to make people think differently about the issue. Being clear about what is being said and saying it accurately is fundamental.

Measuring domestic violence entails specific challenges: First, the kind of violence that is being measured must be defined and could include economic, emotional, psychological, physical or sexual violence, or violence during pregnancy. The severity of the act must also be measured. This can be defined both in terms of the act (some acts are seen as more violent than others, for example being hit with an instrument versus being slapped across the face) and of the outcome (taking into consideration, for example, that a less severe act can result in very severe outcomes). Another question to ask concerns the perpetrators you want to include in the survey. Policy implications of the outcomes are going to be different if dealing with rape in the home versus rape outside the home, with family violence versus a random act of violence on the street. Although there are many forms of gender-based violence, policies will deal with them differently based on the kind of violence that occurs and the expectation of who the perpetrators are likely to be.

The denominator (total number of women interviewed/visited/listened to/screened) but also the numerator (the number of women who answered affirmatively to the gender-based violence question) must be specified. The denominator has to be specific: Are they married women? Single? Who comes to the clinic where the survey is being carried out?

The denominator depends on how you want to describe your data; it will be the number at the bottom of the ratio. Demographic and Health Surveys (DHS) are examples of good data collections and are revised every five years. DHS collect data for different types of gender-based violence nationally. All surveys are representative, with a denominator and a numerator.

A definition of domestic violence that lumps together emotional, mental and physical violence is questionable. When emotional and physical violence are merged, the strength of the gender-based violence indicators is weakened.

Validity is another concern. The data is valid if it is measuring what it is intended to measure. To ascertain this, questions must be asked in a specific and unequivocal way. The interviewer and interviewee have different perspectives on violence. The DHS module deals with this ambiguity by asking about specific acts (pushing, slapping, shaking, throwing objects, twisting). Similarly, the question about coerced sex in marriage can be posed not by asking about 'sexual violence' or 'rape', but if a woman has been physically forced to have sexual intercourse when she did not want it. This specificity is necessary to come out with a valid measurement and to know precisely what is being measured.

Research and data collection must be guided by the principles of 'Do good' and, at minimum, 'Do no harm'. DHS has an informed consent procedure for safety and ethical concerns. This ensures that the interview be ended if privacy cannot be assured, that in a household no more than one woman will be interviewed on the domestic violence module, and that men and women in the same household are not both asked about violence.

Causality and the direction of causality are difficult to establish. Similarly, it is difficult to distinguish between 'prevalence of domestic violence' estimates and the 'norm socialization question' (how many men and women justify a specific form of violence in a certain context). This last question, in fact, is not about violence but about empowerment, and can be used as one of the indicators of empowerment.

Even if one is not directly involved in collecting data, one can request that reports look at specific topics of interest or push for certain survey modules to be added, such as the domestic gender-based module.

### Crimes Against Women in the Name of Honour

'Honour' crimes are defined as murder, harm and or/threats committed by a family member against another member of the family, usually female, who is accused of acts that violate moral guidelines. When these acts lead to murder, they are called honour killings.

Honour killings usually occur to erase a scandal caused by women's inappropriate behaviour or alleged inappropriate behaviour, disobedience, loss of virginity, pregnancy out of wedlock or an illicit relationship with a man, including adultery.

The murderers in these cases are always male relatives of the victim: a father, brother, husband or son. On occasion, a female relative may be involved, under direct pressure from male members of the family.

Honour crimes are premised on the notion that men are superior to women; that a man has certain rights over female members of his family, including disciplining them should they disobey or behave inappropriately; that a family's honour is personified in a woman's sexuality; and that a woman's body represents the family's social status and moral righteousness.

Because of social conditioning, women are raised to feel an enormous amount of guilt and responsibility towards family honour, and that they are constantly at risk of bringing shame upon their family.

In Jordan, an average of 25 women a year are victims of honour killings. Studies show that while most killings are committed by those who are uneducated, some offenders are students or hold university degrees. Often religion is used as an excuse for honour killings. However, there is no religious basis for crimes of honour. In fact, religious literature dramatically contradicts the use of these practices, placing the highest value on the preservation of human life and the dignity of human beings, both male and female.

Nevertheless, Articles 340 and 98 of Jordan's penal code give leniency to men convicted of honour crimes. Women do not have access to the same leniency. And once a woman's reputation is tainted, her family will often drop the charges against the defendant, thereby giving the judiciary no choice but to issue a reduced sentence.

Since the mid 1990s, the issue of violence against

women has become a key topic of interest among women's groups. The Jordanian Women's Union established a committee dedicated to confronting the issue and, in 1999, a national campaign was held. Fifteen thousand citizens signed a petition demanding an end to honour crimes, along with amendments to legislation that give leniency to perpetrators. A government draft was prepared that proposed cancelling Article 340 and imposing heavier penalties on adultery. Since that time, it has been rejected twice by the Lower House. The problem of honour crimes is complex and will not be solved with just the amendment of a law. Religious, moral, cultural and ideological awareness, along with education, are required. Only when the government implements rigorous social and media campaigns can this form of gender-based violence be prevented.

### Domestic Violence and Women's Vulnerability to HIV in Uganda

For two months beginning in December 2002, Human Rights Watch, the largest international NGO based in the United States, travelled to Uganda to examine the link between domestic violence and women's vulnerability to HIV infection. Uganda was selected because it was one of the countries hardest hit by the epidemic, one of the first countries to respond to the crisis in a decisive way, and because it has a reputation for gender progressiveness, bolstered by a Constitution that protects women.

Despite these positive attributes, the following conclusions were drawn by Human Rights Watch after examining the situation of women in that country:

- the failure to protect women from violence in the home was proving fatal to Ugandan women;
- women are raped and physically abused in marriage;
- marital and property laws discriminate against women;
- court officials and police are biased;
- women tolerate violence and remain silent because of social pressure;
- traditional attitudes maintain that women are the physical property of their husbands and

sexually subordinate;

- bride price and widow inheritance practices are still rampant;
- children are considered the property of their fathers unless they are not yet weaned;
- most men are in polygamous relationships in which all wives share sexually transmitted infections;
- economic dependency forces wives to remain with their husbands.

One of the effects of domestic violence is increased vulnerability to HIV infection through:

- rape within marriage by an HIV-positive husband;
- a wife's inability to insist on condom use, thereby increasing her risk of infection;
- a wife's inability to access HIV/AIDS information, testing and treatment because of violence or the fear of violence.

So far, the Government has been reluctant to undermine male authority in the home and to interfere in matters relating to marriage. Domestic violence is still ignored as a crime, and women have insufficient legal protection. Legislation to provide better protection for women, outlaw harmful traditional practices and improve women's property ownership rights has not yet been enacted, even though it has been pending since 1960. And few domestic violence cases are actually prosecuted. Instead, government officials attempt to reconcile the parties by pressing women to return to their abusive husbands. Statutory law recognizes the right of all Ugandans to own land, but in reality women are left with user rights only. Their access to land is regulated through marriage and kinship ties, and rights of devolution are limited by the interests of men's families and extended families. The State is reluctant to address this issue, despite women's rights campaigns that target women's co-ownership in marriage.

The most important lessons that can be drawn from the Uganda case include the following:

- Make an attempt to understand domestic violence in the context of power relations.

- Put specific and targeted legislation in place to ensure that police are mandated to address domestic violence and protect its victims.
- Enact draft bills and repeal or amend discriminatory laws.
- Target vulnerable communities through HIV/AIDS programming.

### Harmful Practices: Female Genital Mutilation

Demographic and Health Surveys conducted in the 1990s show that female genital mutilation persists in significant numbers, even in countries where action against it has been ongoing for some time. As a result, donors and international organizations are beginning to rethink their programmes. In general, past programmes have been based on advocacy targeting the community, especially women, teachers and students, and community and religious leaders. Advocacy activities stressed the consequences of female genital mutilation on health, particularly reproductive health, in the belief that awareness and understanding of the practice will lead to different behaviour.

Patriarchal attitudes contribute to female genital cutting by depriving women of power and perpetuating their low status. Women themselves are often willing to undergo genital cutting since they will be seen as compliant with social norms and more suitable for marriage. Many women are unable to withstand the social pressure coming from relatives, particularly in-laws, to undergo the practice and are unaware of their legal rights to resist it.

Any action to eradicate female genital mutilation must therefore be multifaceted, and address women's empowerment, starting from their sexual and reproductive rights. Community involvement through specially trained social agents should also be emphasized, as well as broader action that seeks to change public opinion. When the public at large favours the abandonment of female genital mutilation, an environment will be created in which behaviour change can take root and flourish. The media play an important role in this regard, but attention must be paid to ensuring that they get the message right.

UNFPA can help to end female genital mutilation by:

- coordinating the collection and dissemination of information and research;
- contributing to the development and adoption of a training module that mainstreams activities to eradicate female genital mutilation into other development projects and programmes;
- addressing the issue through sexual and reproductive health services, or by including specific programmes within existing services;
- empowering women and girls to access legal remedies specified by law;
- supporting media campaigns focused on female genital mutilation and behaviour change;
- integrating a media and awareness-raising component on female genital mutilation in all information and education activities relating to sexual and reproductive health in Africa;
- harmonizing responses to female genital mutilation at the regional level.

### Trafficking of Women and Girls

The United Nations estimates that as many as 4 million women and girls fall victim to trafficking globally, and evidence suggests that it is an expanding form of exploitation and violence. A recent report by the UN Office on Drugs and Crime states that the most prevalent form of human trafficking is trafficking for sex, including prostitution, sex tourism, the mail order/Internet bride industry and pornography. Women and girls are also trafficked as domestic servants, and often end up being sexually abused and exploited in these situations.

As with other forms of gender-based violence, being trafficked for sex compromises a girl's dignity, equality and physical and emotional health. Males who buy the services of commercial sex workers often end up with women and girls trafficked from more impoverished countries, a practice that is rooted in the dominant status of men in society and racial, ethnic and economic inequalities.

The physical and mental impact of prostitution and sex trafficking are virtually identical, and pose a global threat. The effects include physical violence, sexual assault, stress, depression and anxiety, self-medication through alcohol and drug abuse, self-mutilation, suicide and homicide, HIV and other sexually transmitted infections, gynaecological problems, unwanted pregnancies, miscarriages and unsafe abortions.

One of the responses to the global problem of human trafficking is the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, which supplements the UN Convention against Transnational Organized Crime. The protocol establishes a comprehensive definition of trafficking and addresses protection of victims, prevention and cooperation at various levels. The protocol makes victim consent irrelevant, thereby ensuring that women do not have to bear the burden of proof in establishing that they were trafficked. It also recommends that states parties, in cooperation with NGOs and other members of civil society, consider implementation of “measures to provide for the physical, psychological and social recovery of victims,” including medical and psychological assistance.

Strategies and interventions to address trafficking include:

- information and awareness-raising campaigns about health consequences;
- campaigns targeting male ‘buyers’;
- provision of general and reproductive health services, including education;
- technical assistance and training for government agencies;
- cooperation among sending, transit and receiving countries;
- advocacy for the provision of economic alternatives for women engaged in commercial sex and trafficking.

### Gender-based Violence in Conflict Situations

Gender-based violence, including rape, is a well-known weapon of war and is used to destabilize

communities, advance ethnic cleansing and express hatred for the enemy. Women and girls are sometimes forced to become sexual ‘slaves’ of enemy combatants. Trafficking also appears to increase in an insecure environment where the absence of law and protection are the norm. An increase in child marriages may also occur in conflict situations, when, for example, some women refugees in a bordering country marry-off their young daughters to local men to avoid repatriation to their homeland.

International support for gender-based violence programmes in conflict-affected areas dates back to the 1980s. In the early 1990s, media attention to sexual crimes in Rwanda and Bosnia and Herzegovina highlighted the issue in the international humanitarian aid community.

In 1989, a senior coordinator for refugee women was appointed to the Office of the UN High Commissioner for Refugees (UNHCR) and, in 1991, protection guidelines focusing on women and girls were published. In 1993, there was the first declaration on the elimination of violence against women, and, in 1994, a UN Special Rapporteur on Violence Against Women was appointed. All of these actions increased awareness of gender and the need to protect women and girls affected by conflict.

The International Conference on Population and Development in 1994 established the fight against gender-based violence as a pillar of reproductive health services. In fact, it was reproductive health workers in conflict situations that developed programming against gender-based violence.

The first such programme, in Kenya, was funded by UNHCR and implemented by CARE. In 1995, UNHCR published its first guidelines on addressing sexual violence among refugees and internally displaced persons. A second programme, supported by UNHCR and implemented by the International Red Cross, was started in 1996 in the United Republic of Tanzania. Since then, the leader in programmes to combat gender-based violence around the world has been the International Red Cross.

In the late 1990s, UNHCR received a grant from the United Nations Foundation, funded by Ted Turner, to initiate new gender-based violence programmes in Africa and to review the programmes implemented since 1996. As a result, a best practice model for instituting multisectoral programmes that respond to gender-based violence was produced in 2001. Although highly recommended, the model has rarely been applied in a comprehensive manner. Gender-based violence programmes have historically entered through the portal of reproductive health, which means that they tend to be medically oriented. Even where there is a multisectoral approach to gender-based violence in conflict settings, health programmes usually take the lead in responding to survivors' needs. The capacity of health programmes to respond to the spectrum of survivor needs is limited, however. And the issue of gender-based violence is rarely integrated across sectors to provide a full complement of prevention and response services.

In 2002, the Reproductive Health for Refugees Consortium produced a global assessment entitled 'If Not Now, When?: Addressing Gender-Based Violence in Refugee, Internally Displaced, and Post-Conflict Settings'. Major findings include: the absence of multisectoral programming for gender-based violence; a lack of hard data on gender-based violence and its prevalence; weak protection for survivors in almost all countries; disparities in policies and practice in many countries; and a gap in donor funding for relevant programmes since funding for conflict situations is not drawn from the pool of funds used for development.

Priority recommendations include:

- collaboration and coordination among donors on funding programmes to address gender-based violence in conflict situations;
- coordination among UN agencies and international, national and local NGOs to avoid gaps or duplication in programming;
- use of a participatory approach that fully engages the target community when planning programmes and coordinating activities;

- supplementing existing programmes to foster greater involvement on the part of men, to use active screening as a data collection tool and to uncover incidences of violence, and to train health-care and psychosocial providers in counselling and communication skills.

### The Mifumi Bride Price and Domestic Violence Project

The Mifumi Bride Price and Domestic Violence Project is a pilot in Uganda set up by the Mifumi Project with funds from Comic Relief. It provides women who have experienced domestic violence with legal advice, creates support and education groups for survivors, and mobilizes communities to tackle the issue of bride price and domestic violence.

Bride price in Africa is a practice associated with marriage under customary law. Traditionally, bride price was supposed to consist of gifts given to the parents of a bride in appreciation of their role in the bride's upbringing. However, through the years bride price has become increasingly commercialized and abused. Poverty is forcing many parents and clan members to ask for exorbitant sums of money or commodities, and rising costs of living have pushed many families into selling their daughters as soon as possible in order to supplement the family income or pay for a son's bride.

Bride price contributes to violence against women since it promotes the idea of wives as 'property', establishes unequal power relations within the family, and instils the notion that women should be subservient to men.

Furthermore, bride price is discriminatory since a woman must ask her father for permission to marry (since he sets the bride price, he has control over who she will marry). A woman must also ask her father for permission to divorce, since the bride price has to be returned to the husband if the divorce occurs. Bride price is a contributing factor in the spread of HIV/AIDS since:

- young girls are in high demand because men believe sex with a virgin will cure AIDS;

- women are often powerless to insist on condom use;
- husbands expect wives to stay faithful while they have unprotected, extramarital sex;
- high bride price means many young men are choosing to live with a woman instead of marrying her, which encourages high-risk sexual behaviour;
- young men turn to commercial sex workers since they can't afford a wife.

There is no law in Uganda at present that specifically prohibits payment of bride price. Customary marriages are governed by a Customary Marriages Registration Decree, which permits that marriages be celebrated according to the rites of the community. According to African marriage rites, bride price is essential for the validity of a customary marriage. Ugandan courts have taken the additional step of stating that a marriage is not valid under customary law if bride price has not been exchanged. However, bride price contravenes the Ugandan Constitution as well as numerous international rights and conventions signed by the Ugandan Government. As a result, the Government recently proposed the Domestic Relations Bill, which stipulates that marriage gifts shall not be essential requirements for any marriage under this act, but if marriage gifts have been given, it is an offence to demand their return.

The practice of bride price is a gross violation of human rights that exposes the victim to violence and abuse as well as numerous health risks and dangers. Although the proposed Domestic Relations Bill is one step towards the abolition of bride price, much more still needs to be done to eradicate it.





# developing a programming framework

Three working groups made the following recommendations for key programming and policy actions:

## Research and Standardization

- Support research on gender-based violence and the integration of related issues into existing research mechanisms.
- Promote agreement on standard definitions.
- Build consensus on a core set of indicators.
- Support specific studies on masculinity and fatherhood and review existing programmes dealing with men as offenders and as protectors.

## Policy and Advocacy

- Promote effective implementation of laws and policies related to gender-based violence as well as government accountability.
- Prioritize integration of gender-based violence into policy frameworks, including Common Country Assessments and UN Development Assistance Frameworks.
- Estimate the macroeconomic impact of gender-based violence and the cost of interventions to prevent it.
- Include gender-based violence in gender and health accounts and advocate for more resources.
- Support public education campaigns.
- Advocate for the implementation and monitoring of international agreements and conventions.
- Develop a directory of laws and regulations relating to gender-based violence.
- Map existing programmes and projects.

## Services and Communities

- Integrate training on gender-based violence into the curricula of schoolteachers, health-care providers, the police, the judiciary, planners and statisticians.
- Focus on target populations in UNFPA programmes, including young people, pregnant women, the displaced and refugees.
- Strengthen referral networks (including shelters, safe houses and legal and psychological services).
- Develop a system for sentinel screening as appropriate (with technical guidance from WHO) and integrate screening and care into standard medical services. Sentinel screening is routine screening in certain priority areas where abused women are more likely to be identified (for example, in emergency services or mental health programmes) or in areas where identifying a history of violence is most likely to improve the overall quality of services (such as prenatal care, treatment of sexually transmitted infections, family planning, etc.).
- Promote a code of conduct for UN personnel.
- Develop knowledge assets on gender-based violence.

To further thinking on these issues, a working group was formed to draft a policy framework, which will be shared with all consultation participants for information and feedback. The working group included representatives from UNFPA's Reproductive Health Branch, Culture, Gender and Human Rights Branch, Country Technical Services Teams and geographic divisions. A draft programming framework will also be drawn up, in collaboration with UN agencies including UNIFEM and WHO.



# annex I: agenda

Overview of Day	9:30-11:00	11:00-11:30	11:30-1:00	1:00-2:30	2:30-4:00	4:00-4:30	4:30-6:00
<b>Monday 15</b>	<b>Chair: D. Colombo</b>				<b>Chair: A. Kurdahi</b>		
Presentations on pilot projects  Evaluation report  Introduction to working groups on policies, health sector and community responses	<b>Opening session:</b> <i>D. Colombo</i> <i>F. Donnay</i> <i>L. Stevens</i>  <b>Presentations on Romania:</b> <i>D. Bologna</i> <b>Nepal:</b> <i>T. Shakya</i>	Tea/coffee break	<b>Presentations on Lebanon:</b> <i>A. Kurdahi</i> <b>Mozambique:</b> <i>M. da Luz Vaz</i>  <b>Evaluation Report:</b> <i>B. Pradhan</i>	Lunch	<b>Presentations on Cape Verde:</b> <i>B. Miranda</i>  Introduction to working groups and general discussion on main issues arising from implementation and evaluation	Tea/coffee break	<b>Presentations on Ecuador:</b> <i>L. Rodriguez</i> <b>Guatemala:</b> <i>M. Aguilar</i>
<b>Tuesday 16</b>	<b>Chair: D. Bologna</b>				<b>Chair: S. Pant</b>		
Presentations on pilot projects continue  Working group discussion on scaling up, replication, documentation, and monitoring and evaluation	<b>Presentations on Russian Federation:</b> <i>Y. Kachalova</i> , <i>A. Gorbunova</i> <b>Lithuania:</b> <i>V. Bucaite</i>  Discussion on documentation and use of indicators	Tea/coffee break	<b>Presentations on Sri Lanka:</b> <i>M. Weerasoorya</i>  Discussion on scaling up		Working groups: 1. Policies & protocols 2. Working with health providers, including training and screening 3. Working with clients & communities	Tea/coffee break	Reports from working groups and discussion
<b>Wednesday 17</b>	<b>Chair: F. Donnay</b>				<b>Chair: M. Aguilar</b>		
Recommendations for integrating pilots in country programmes and revising the programme guide  UNFPA's broader strategy to address gender-based violence	<b>Presentation and discussion on recommendations for revising the programme guide</b>	Tea/coffee break	11:30 -12:30 Final recommendations on future implementation  12:30 -1:00 UNFPA strategy to address gender-based violence  <b>Opening remarks:</b> <i>M. Simonen</i>		<b>Objectives:</b> <i>S. Abdul Hadi</i>  <b>Overview:</b> <b>Gender-based violence, an issue of social justice, human rights, public health</b> Discussion: <i>S. Kabir</i>  <b>Domestic violence &amp; human rights:</b> <i>L. Karanja</i>	Tea/coffee break	
<b>Thursday 18</b>	<b>Chair: M. Borrero</b>				<b>Chair: R. Groenen</b>		
UNFPA's broader strategy to address gender-based violence or Mini-workshops for project directors	Design and implementation of public policies related to:  <b>Harmful practices, female genital mutilation:</b> <i>C Scoppa</i>  <b>Honour killings:</b> <i>A. Khader</i>  <b>Trafficking:</b> <i>B. Kryszico</i>  <b>Gender-based violence and reproductive health</b> <i>M. Jato</i>  * First topic mini-workshop	Tea/coffee break	(continued)  <b>Gender-based violence in legal frameworks:</b> <i>R. Groenen</i>  <b>Gender-based violence in Demographic and Health Surveys:</b> <i>S. Kishor</i>  <b>Gender-based violence in conflict situations</b> <i>J. Ward</i> ..... <i>P. Ndira</i>  ** Second topic mini-workshop		Group 1 & 2 Discussions on incorporating gender-based violence in UNFPA programmes  *** Third topic mini-workshop	Tea/coffee break	Recommendations for gender-based violence strategy from Groups 1 & 2  **** Fourth topic mini-workshop
<b>Friday 19</b>	<b>Chair: L. Baqi</b>				<b>Chair: M. Jato</b>		
Recommendations for UNFPA's broader strategy to address gender-based violence	Recommendations from Group 1  Discussion	Tea/coffee break	Recommendations from Group 2  Discussion		Finalization of recommendations and conclusion	Tea/coffee break	Free

The goal of the mini-workshops is to assist project directors in developing knowledge and skills that will further enhance their gender-based violence projects. Topics for the workshops were as follows:

\* Sensitization and training of staff \*\* Screening of clients \*\*\* Documentation \*\*\*\* Monitoring, evaluation and data collection

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# annex III: ten pilot projects

Ten pilot projects, implemented with different sources of funding, were initiated to test the UNFPA programme guide. The projects were based in Cape Verde, Ecuador, Guatemala, Lebanon, Lithuania, Mozambique, Nepal, Romania, the Russian Federation and Sri Lanka. The first four projects listed were externally evaluated.

## Lebanon

**Project duration:** March 2002 – April 2003

**Option:** B

### Agencies involved:

Young Women's Christian Association  
(YWCA) (NGO)  
Lebanese Council to Resist Violence against  
Women (LCRVAW) (NGO)  
Marchreq-Maghreb Gender Linking Information  
Project (NGO)  
UNFPA

### Additional partners:

First Lady  
Members of Parliament  
Ministry of Social Affairs  
Ministry of Public Health  
National Council for Lebanese Women  
Community leaders  
Media

### Testing sites:

NGO (Lebanon Family Planning Association)  
Health centre in Beirut  
Social Development Service Centre under the  
Ministry of Social Affairs in Mount Lebanon  
Primary health care centre in north Lebanon  
NGO (Secours Populaire) dispensary in south  
Lebanon

### Processes:

Establishment of referral resource – LCRVAW is  
main resource  
Mapping and development of behaviour change  
communication and advocacy materials  
Design and adaptation of monitoring tools  
Translation of programme guide into Arabic

### Problems:

Lack of incentives for some health-care  
providers  
Absence of referral system and resources on  
gender-based violence  
Difficulty in carrying out awareness-raising  
activities in the community  
Project not integrated into existing programmes  
Failure to document information on client  
screening, which led to difficulty in tracking  
identified victims of gender-based violence  
for follow-up  
Only certain questions related to gender-based  
violence asked

### Successes:

Coordination among concerned NGOs  
Strong support at the national level  
High response of clients and willingness to  
disclose information  
The media played a role in advocacy  
Distribution of testing sites in various regions  
of the country

### Future plans:

Collaboration with other NGOs  
Linking gender-based violence with existing  
and related projects  
Integrating gender-based violence into the  
ongoing training plan of the reproductive  
health programme  
Ensuring screening for gender-based violence in  
reproductive health history

## Mozambique

**Starting date:** February 2002

**Option:** C

**Agencies involved:**

Ministry of Health (Gender Unit)  
City Health  
Kulaya (national NGO)  
UNFPA

**Additional partners:**

Police  
Ministry of Women and Coordination of Social  
Action  
Ministry of Interior  
Forum: 'Todos Contra a Violencia'  
Community-based organizations

**Testing sites:**

Maputo (capital): three emergency units within  
hospitals, one general hospital, three health  
centres

**Process:**

Training for health-care providers in hospitals  
and health centres  
Establishment of referral resource  
Capacity development  
Monitoring and evaluation  
Advocacy

**Problems:**

Shortage of trained personnel  
Lack of space and privacy in health units for  
providing counselling services and conducting  
screenings  
Lack of behaviour change communication materials  
Insufficient and weak referral organizations to  
provide psychological assistance  
Weak integration of gender-based violence into  
overall policies, programmes and training  
curricula  
Weak data collection system; current health  
information does not disaggregate by sex or  
collect data on violence

**Successes:**

Mapping of existing resources  
Forms developed and introduced to collect data  
Better coordination among various partners  
involved in gender-based violence  
Network created for dealing with gender-based  
violence

**Future plans:**

Expand activities to reproductive health  
services and other health departments  
Integrate gender-based violence into overall  
policies and programmes  
Conduct more advocacy and lobbying  
Reform health information collection process

## Nepal

**Starting date:** April 2002

**Option:** C

**Agencies involved:**

Phect-Nepal  
AIDOS

**Additional partners:**

Local-level government  
Support groups within the community  
WOREC (national gender NGO)

**Testing sites:**

Kirtipur reproductive health centre  
Six outreach clinics operated by the  
Kirtipur centre  
Home visits

**Process:**

Survey/research on gender-based violence  
in Kirtipur  
Involvement of local community  
Consensus-building workshop  
Training by international expert on project  
methodology  
Adaptation of programme guide to local context  
Identification of referral resources/production  
of referral book  
Training of all senior and other staff at centre  
by WOREC staff  
Trained screener to use questionnaire  
Development of behaviour change  
communication materials

**Problems:**

Gender-based violence seen as a private matter,  
not a public health concern  
Staff threatened by perpetrator  
Off-site referrals limited due to space  
constraints in shelters  
Long process for referring cases  
Low disclosure rate so far

**Successes:**

Change in attitude among health-service  
providers  
Community awareness of gender-based violence  
Victims reached through home visits  
Community leaders more supportive  
On-site services  
Translation of programme guide

**Future plans:**

Advocacy to link reproductive health with  
gender-based violence in government  
programming and planning  
Replicate project in other parts of the country



## Romania

**Starting date:** April 2002

**Option:** C

**Agencies involved:**

UNFPA  
Government

**Additional partners:**

National Inter-ministerial Committee  
(Ministry of Health and Family, Ministry of Labour and Social Protection and Ministry of Public Administration)

**Testing sites:**

Bufta Family Health Care Centre  
APACA Polimed  
Centre in Mures district  
Centre in Hunedoara  
Centre in Maramures

**Process:**

Project coordinator is the link between the ministry and UNFPA  
Establishment of referral resource  
Training/sensitization of all medical/clinical staff and referral sources  
Development of behaviour change communication materials  
Monitoring of gender-based violence  
Support for the development of a national strategy for the prevention, monitoring and control of domestic violence  
Capacity-building of the health sector to address the issue of gender-based violence (training of medical staff)  
Informed the population about the consequences of domestic violence

**Problems:**

Law for protection against gender-based violence still to be implemented  
Lack of funding  
Perpetrators not targeted  
Tracking of referral services

**Successes:**

Developed informational flyers and brochures  
New knowledge about gender-based violence  
Advocacy on women's rights and gender-based violence

**Future plans:**

In-depth research on gender-based violence at national and local level  
Connections with programmes that work with human trafficking  
Strengthen existing networks  
Improve collaboration with law enforcement officials  
More funding  
Programmes to deal with perpetrators

## Cape Verde

**Starting date:** January 2003

**Option:** B

**Agencies involved:**

Sanitary Department of Praia  
Three health centres

**Additional partners:**

Ministry of Health, Ministry of Justice, NGOs

**Testing sites:**

Three health centres in the capital city, Praia

**Process:**

Translation of programme guide into Portuguese  
Sensitization/training workshops for health-care providers and police  
Support network for gender-based violence victims formed by police and health-care providers  
Meetings held with community associations  
Establishment of referral protocols

**Problems:**

Discussion of gender-based violence still taboo; treated as a private problem  
Health and justice administration personnel ill equipped to deal with gender-based violence issues  
Lack of human resources  
Victims want quick solution and don't attend counselling

**Successes:**

Information on gender-based violence is now being systematically collected and processed  
Victims of gender-based violence are now referred to project coordination unit for psychological assistance as well as information on their rights and legal options  
Psychologist on hand to work with victims

**Future plans:**

Ministry of Health intends to develop additional programmes for dealing with gender-based violence  
Ministry of Justice has drafted gender-based violence programme, which calls for new legislation for the protection of women and creation of centres where women can obtain easy access to justice and faster conflict-resolution

## Ecuador

**Starting date:** June 2002

**Option: B** (with multicultural approach since Ecuador has 14 different local languages and over a third of the population is indigenous)

**Agencies involved:**

Ministry of Health  
UNFPA  
Municipality of Guaranda  
Health Provincial Direction

**Additional partners:**

NGOs  
Community-based organizations

**Testing site:**

Municipality of Guaranda

**Process:**

Training and sensitization of health-care providers  
Development of behaviour change communication materials, including comic books and pamphlets  
Development of a local network focusing on gender-based violence  
Community involvement  
Registering of gender-based violence cases in health units  
Provision of information about the law against violence to indigenous women

**Problems:**

Gender-based violence considered a sensitive topic  
Health-care providers are responsible for reporting cases of gender-based violence; this creates conflicts of confidentiality  
Health-care providers fear being charged with not reporting incidents of abuse  
Health-care centres do not have educational materials  
Illiterate women (14 per cent) require specialized educational materials  
Ministry of Health does not provide materials in native languages  
Health-care providers do not speak native languages  
Funds for networking not available  
Long distances to health centres and lack of transportation affect community participation

**Successes:**

All health units now have local referral resources and information  
Coordination among local institutions  
More indigenous women know about their rights and laws related to gender-based violence  
Radio spots highlight gender-based violence  
Women's groups have become involved in project

**Future plans:**

Expand pilot project within the same Ministry of Health  
Share experiences with other municipalities  
New country programme (2004-2008) will address gender-based violence

## Guatemala

**Starting date:** February 2002

**Option:** C

**Agencies involved:**

Family Planning Clinic  
Coordinator Group

**Additional partners:**

Local authorities  
NGOs  
Police  
Army  
Firefighters

**Testing site:**

Family Planning Clinic in Chimaltenango

**Process:**

Sensitization/training for authorities and local leaders  
Workshops on analysing and recognizing effects of gender-based violence on women's health  
Workshops on importance of detection, prevention and assistance for victims of gender-based violence  
Sensitization/training for all clinic staff and personnel  
Development of behaviour change communication materials, including fliers, posters, brochures

**Problems:**

Health-care providers afraid of getting involved in legal problems or violence  
Institutions for referral not sensitized to gender-based violence  
Deficiencies in administrative and legal systems  
Only available shelter for women and children violates human rights  
No treatment for perpetrators

**Successes:**

Radio spots in Spanish and local language  
Monthly network meetings keep everyone connected  
Expertise through Coordinator Group  
Counselling for women set up at times convenient to them

**Future plans:**

Expand project to other areas

## Lithuania

**Starting date:** July 2002

**Option:** B

**Agencies involved:**

- Women's crisis centres
- Women's shelters
- Women's NGOs
- Forensic Institute

**Additional partners:**

- Psychologists
- Social workers
- Lawyers
- Police

**Testing site:**

Vilnius Maternity Hospital

**Process:**

- Clarifying hospital staff attitudes towards gender-based violence
- Two training sessions for health providers at hospital
- 'Booster' training several months later
- Development of off-site referral resources
- Translation of programme guide into Lithuanian
- Development of leaflet, flyers and poster
- Screening of clients for gender-based violence
- Information through website
- Articles on Internet newsletter, 'Woman's World'

**Problems:**

- Gender-based violence considered private issue, not public health concern
- Inadequate statistics on gender-based violence
- Hospital selected for pilot study was too large
- Staff only asked once and only asked certain women
- Did not ask about sexual violence
- Staff must report severe gender-based violence so confidentiality becomes an issue
- No documentation of screening so as to avoid reporting of gender-based violence to authorities

**Successes:**

- Triggered support from the Parliamentary Committees on Health and Family
- Refreshed data on gender-based violence; large numbers of women disclosed abuses
- Translation of programme guide into Lithuanian
- Medical staff's attitudes on their role in reducing gender-based violence changed from sceptical to enthusiastic
- Advocacy

**Future plans:**

- Holding a national conference on the role of medical professionals in fighting gender-based violence in the Parliament
- Applying a similar approach to other hospitals
- Strengthening the referral system
- Involving the men's crisis centre and other partners that work with adolescents and the mental health programme

## Russian Federation

**Starting date:** January 2002

**Options:** A, B and C

### Agencies involved:

Focus Foundation (Moscow)  
Crisis centres in Murmansk, St. Petersburg,  
Pskov, Tver, Voronezh, Naberezhnie Chelny,  
Moscow  
N.V. Sklifosovsky Institute of Emergency  
Medical Care (Moscow)  
'Sanam' Medical Association for Prevention of  
Sexually Transmitted Diseases (Moscow)

### Additional partners:

AIDOS

### Testing sites:

Murmansk, St. Petersburg, Pskov, Tver, Tula,  
Voronezh, Naberezhnie Chelny, Moscow  
Option A - 34 medical centres  
Option B - 21 medical centres  
Option C - 1 emergency hospital

### Process:

Translation of programme guide into Russian  
Training of crisis centres staff on programme  
methodology (AIDOS)  
Adaptation of programme guide  
Identification of off-site referral resources  
Consensus-building workshops  
Contact database placed on website  
Posters, cards and reference directory  
Training of medical staff/health-care providers  
International conference on legislation to  
combat gender-based violence  
Monitoring by the Focus Foundation and  
AIDOS staff

### Problems:

Medical facilities reluctant to participate;  
low motivation  
Lack of psychologists at facilities  
Insufficient funds for staff  
Lack of time for training; heavy workload  
among doctors  
Did not ask about certain types of gender-based  
violence  
Limited visit time (12 minutes); doctors are  
reluctant to ask patients about gender-based  
violence  
Quality of service low; doctors work both as  
specialists and support staff  
Screening not always followed; doctors acted  
'on suspicion'  
Clients keep their own medical charts so no  
documentation of screening

### Successes:

Victims referred for counselling or given on-site  
therapy  
Establishment of hotlines  
Acquisition of data on gender-based violence  
(large numbers of women disclosed incidents  
of abuse)  
Advocacy network established

### Future plans:

Enlist support of legislative and executive  
branches

## Sri Lanka

**Starting date:** September 2001

**Option:** B

**Agencies involved:**

Ministry of Health

**Additional partners:**

Women-in-Need (WIN) Colombo

Health Education Bureau

**Testing sites:**

General hospital and base hospital in

Anuradapura district

Gynaecological clinics and antenatal clinics

**Process:**

Sensitization of all public health staff in the district

Sensitization of community leaders and civil servants

Development of new behaviour change communication materials, including posters and handouts

Display of materials in government medical institutions, schools, factories, public places and NGO centres

Screening of all female clinic patients for gender-based violence and referring them, if necessary

Ensuring confidentiality by assigning clients coded numbers

**Problems:**

Reluctance of health-care providers to intervene in issues related to gender-based violence

Apathy

Administrative difficulties

Reluctance of women to avail themselves of counselling services

Coded client screening does not allow for identification later

**Successes:**

Setting up of three counselling centres with part-time counsellors

Partnership between NGO and Ministry of Health

New information on gender-based violence

**Future plans:**

Disseminate findings to policy makers

Start Option C project at Castle Street Hospital for Women, Colombo

