Evidence Review on Violence against Women and Girls (VAWG) and its relationship with Women's Economic Empowerment (WEE)

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Contents

Evidence Review Summary and Key Readings

The impact of violence against women and girls (VAWG) threatens not only the health and well-being of victims but also has negative impact on economic growth of communities and nations. Further, VAWG is also a significant risk to the success of other developmental outcomes, such as women's empowerment and economic security. Growing evidence also shows VAWG is a potential unintended outcome of interventions such as microfinance when social and gender norms are challenged and begin to evolve. For these reasons, understanding the evidence of interventions designed to prevent and respond to VAWG in high-, middle-, and low-income countries is important to our work at Grameen Foundation as it informs current and future programs.

In partnership with graduate student researchers from Brigham Young University and leveraging Grameen Foundation's own literature reviews, this short evidence review presents three different summaries that outline the current research and evidence regarding the incidences of VAWG, what is working to prevent and/or support victims of VAWG, and the evidence gaps that remain to be filled. Fulbright's review highlights the consequences of VAWG on women's well-being with an emphasis on the potential impact of the lockdowns caused by the Covid-19 virus. Kleinhenz and Cornia present the evidence of interventions implemented at the individual (such as microfinance), community (such as social norm change activities), and facility levels (such as school-based programs). Brown, Kim, and Stewart draw on evidence in both the United States as well as middle and low-income countries to demonstrate what has worked or not worked to prevent VAWG and also support survivors in different contexts.

This introduction seeks to summarize key findings found in the existing literature as well as key readings that are influencing the work of Grameen Foundation, and that of our technical and in-country partners.

The World Health Organization (WHO) estimates globally that 35% of women experience violence in their lifetime and it not only negatively impacts the woman and her family, but the negative impact trickles down to a country's human, social and economic development.

While some women display violence of their own in both mixed and same-sex relationships, most abuse is perpetrated by men against their female partners. The World Health Organization estimates that most violence experienced by women is intimate partner violence (IPV); IPV ranks lowest in high income countries (23%) and highest in Southeast Asia (38%). VAWG is not limited to physical or sexual abuse but also includes any form of mental, emotional, and verbal abuse that coerces or threatens the life of women and perpetuates female subordination. Drivers that cause and exacerbate VAWG include age (younger women tend to face more IPV than older women), rural residence, poverty, substance abuse, witnessing family violence as a child and gender inequalities in education,

autonomy, food security, among others. VAWG negatively impacts women's mobility, morbidity and mortality. Women who experience violence face higher risks of health problems, are twice as likely to experience depression, and use health services at higher rates than other women.

Because women who experience violence may experience wage loss, inability to work and limited ability to care for themselves and their children, it is estimated that VAWG accounts for an approximate loss of 4% of a country's gross domestic product due to lost productivity. With the emergence of Covid-19, while there has been increased reporting of VAWG to helplines, police, and service providers—in some cases reporting has tripled—the estimates are likely still underestimated due to the inability of women and girls to seek help safely. Women and girls who experience violence tend not to report or seek help due to cultural acceptance of VAWG, stigma, fear and shame of reporting violence, as well as potential social and economic repercussions from family and the community.

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Interventions designed to directly respond to and prevent GBV can have variable impacts.

VAWG programs often provide support after the incident of violence has occurred. These programs include counseling, medical care, place of shelter or legal support.

School-based programs implemented with boys and girls, particularly among at-risk youth, and that help youth develop positive dating and communication skills and that engage youth in community projects have been found to reduce incidences of emotional and physical abuse, emotional stress and trauma over time and reduce violent behaviors among men. In

one study, girls who reported the highest rates of victimization and violence at baseline attended the highest number of intervention sessions and experienced the greatest reductions in violence and victimization, which suggests youth who are at the highest risk of violent behaviors and victimization are the most likely to benefit from school-based interventions.

In a review of 22 evaluations, Ellsberg et al found that programs that only offer support services to victims of violence (such as referrals to specialized services, psychosocial support, advocacy and counseling, home visitation) and that most often happen through health providers appear to have limited ability to decrease violence but may reduce depression. Similarly, services provided through women's shelters may improve mental health and other social outcomes and have been shown to both increase as well as reduce incidences of re-abuse depending on whether women return to their abusers. Evidence on long-term effects of shelters on re-abuse is lacking. Policing strategies, such as mandatory reporting and arrest, proactive arrest without a protection order, second responder programs and screening have been found to increase the risk of VAWG. Positive impacts improve when survivors of violence can control access to services rather than having these imposed or mandated.

Efforts to influence the intra-household distribution of economic resources, promotion of gender equitable norms and joint decision-making and increasing coverage of messages (such as through media) to the general public regarding alternatives to violence and community-based volunteers that can counsel couples to resolve conflict are strategies proven to reduce the likelihood of VAWG. One well-documented program, known as SASA! which stands for Start, Awareness, Support, Action and means "now" in Kiswahili engages community activists, community leaders, health care professionals and police to play different roles in promoting and implementing activities related to gender and power. Multiple studies have shown that the SASA! program—originally implemented in Uganda and adapted for Rwanda and Tanzania—has positively impacted attitudes regarding VAWG, reduced incidences of IPV, and increased discussions regarding gender equality.

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Abramsky, T., Devries, K.M., Michau, L., Nakuti, J., Musuya, T., Kiss, L., Kyegombe, N., Watts, C. (2016). Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women?. *BMC Public Health*. 16(339).

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Women's engagement in microfinance and other economic strengthening programs can also have variable relationships with the prevalence of VAWG. Integrated approaches combining microfinance with social empowerment interventions such as gender dialogues and other male engagement strategies and rights-based education can mitigate IPV.

Microfinance, in the forms of micro-savings, micro-credit, micro-insurance, payments and remittances are designed to alleviate poverty, increase resilience, and increase assets and financial independence, particularly among women. Research demonstrates cases where microfinance and other economic strengthening activities increases likelihood of VAWG, particularly during early stages of programs when women engage in new economic opportunities, gain access to new assets and financial resources and begin to challenge existing social norms regarding their mobility and caretaking responsibilities. Microfinance can reduce the likelihood of VAWG as women increase their financial contributions to the household, build financial assets and gain bargaining power within the household, or are able to leave an abusive relationship. Microfinance can also have a neutral effect on GBV, neither increasing risks nor mitigating risks of VAWG.

Krishnan et al in India found that women who had recently become employed during the study period had 80% higher odds of violence as compared to women who maintained their unemployed status. On the other hand, a recent study by Yount et al in Bangladesh did not find any evidence to support the theory that women's participation in microfinance is harmful to their mental health or exposure to IPV, but rather that microfinance enhanced women's agency, including mobility, decision-making power, leadership and influence in the community. Although microcredit did not have a negative effect on IPV, women participating in microcredit experienced both the stress of loan obligations and the stress of balancing unpaid caretaking duties at home. Several studies suggest that microfinance programs could consider introducing a) gender norms components that promote gender equity within unpaid labor to resolve time burden constraints, b) mental health services to offset initial stress of participating in microfinance as gender norms are shifting within the household, c) flexible loan repayment schedules to reduce loan-related stress on women, and d) promoting group-based rather

than individual services so that women experience the mental health benefits of group identity and solidarity. Several studies support these recommendations. The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program in South Africa which combined microfinance, participatory gender and HIV awareness education, the offshoot of IMAGE implemented in Tanzania called MAISHA, and a recent savings group plus gender dialogues program in Cote d'Ivoire all found that the combined financial services and social empowerment programs reduced incidences of IPV, especially among those who participated in more sessions.

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Comprehensive and scalable approaches that integrate police and justice sectors along with couples' support programs, women's shelters, women's economic empowerment as well as those that allow victims to control their own access to services should be prioritized.

Evidence on interventions designed to reduce VAWG have found that working with men and women had more success than interventions that worked with women or men only, suggesting that family-centered models, particularly in highly patriarchal societies, builds trust and prevents backlash. Male partners must be engaged to increase intervention success and decrease VAWG.

Jewkes et al (2015), after documenting the evidence for violence prevention mechanisms, recommend the following priorities:

1. **Comprehensive interventions within the police and justice sectors that start with a robust legislative framework and include interventions such as protection orders with proactive arrest, specialized courts, paralegal or lay support, and training for police and judiciary.**
2. **Psychotherapeutic interventions with couples and/or cognitive behavioral therapy offered by lay counselors.**
3. **Interventions that are accessible to those who perceive themselves ready and determined to live without violence.**
4. **Shelters combined with other support services and gender and economic empowerment interventions.**
5. **Interventions that are scalable in terms of human and financial resources.**

In addition to these priority intervention areas, Jewkes et al (2020) propose nine elements that cut across intervention areas that influence success of programs to prevent VAWG:

Design:
1. **Rigorously planned, with a robust theory of change, rooted in knowledge of local context.**
2. **Address multiple drivers of VAWG, such as gender inequity, poverty, poor communication and marital conflict.**
3. **Especially in highly patriarchal contexts, work with women and men and where relevant, families.**
4. **Based on theories of gender and social empowerment that view behavior change as a collective rather than solely individual process and foster positive interpersonal relations and gender equity.**
5. **Use group-based participatory learning methods, for adults and children that emphasize empowerment, critical reflection, and communication and conflict resolution skills building.**
6. **Age-appropriate design for children with a longer time for learning and an engaging pedagogy such as sport and play.**
7. **Carefully designed, user-friendly manuals and materials supporting all intervention components to accomplish their goals.**
8. **Integrate support for survivors of violence.**

Implementation:
9. **Optimal intensity: duration and frequency of sessions and overall program length enables time for reflection and experiential learning.**
10. **Staff and volunteers are selected for their gender equitable and nonviolence behaviors, and are thoroughly trained, supervised, and supported.**

Key Readings

Jewkes, R., Khan, S., Hilker, L.M., Fulu, E., Busiello, F., Fraser, E. (2015). What works to prevent violence against women and girls - Evidence Reviews. The Prevention Collaborative.

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Research on VAWG faces limitations, particularly regarding women's intersectional identities and the lack of evidence of long-term effects of VAWG interventions.

While research is growing on the evidence of interventions that do and do not work to prevent or limit impact of VAWG, little research investigates violence within marginalized populations. Crooks et al note this gap among disabled women and girls, women of color, indigenous women, migrant women, sexually-diverse women, women in poverty, sex workers, women who are precariously housed, and women abused as children. A lack of research on VAWG in humanitarian settings, and a lack of long-term follow up on VAWG research are also of concern. Many published program evaluations are limited to data collected immediately after a program ends, so long-term follow up is largely unavailable and long-term effects of a program are often unknown. Methodological challenges for research on VAWG influence the quality and quantity of data available regarding incidences of and impact of interventions on VAWG and can put women at risk. Both the risks and benefits of conducting research in this field should be acknowledged.

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Crooks, C.V., Jaffe, P., Dunlop, C., Kerry, A., Exner-Cortens, D. (2019). Preventing gender-based violence among adolescents and young adults: Lessons from 25 years of program development and evaluation. *Violence Against Women*, 25(1), 29-55.

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Impact of Violence Against Women and Girls

Emma Fulbright

Literature Review

Approximately 30% of women experience sexual or physical violence in their lifetime (WHO, 2017). Intimate partner violence (IPV) ranks lowest in high-income countries (23.2%) and highest in the South-East Asia region (37.7%) (See Figure 1) (WHO, 2017). In 2015, the United Nations (UN) listed gender equality as one of the 17 Sustainable Development Goals with hopes to eradicate all forms of violence against women and girls by 2030 (UN, n.d.). The goal to extinguish violence against women and girls (VAWG) necessitates further understanding of how violent behaviors are perpetuated throughout societies and which risk factors contribute to this issue.
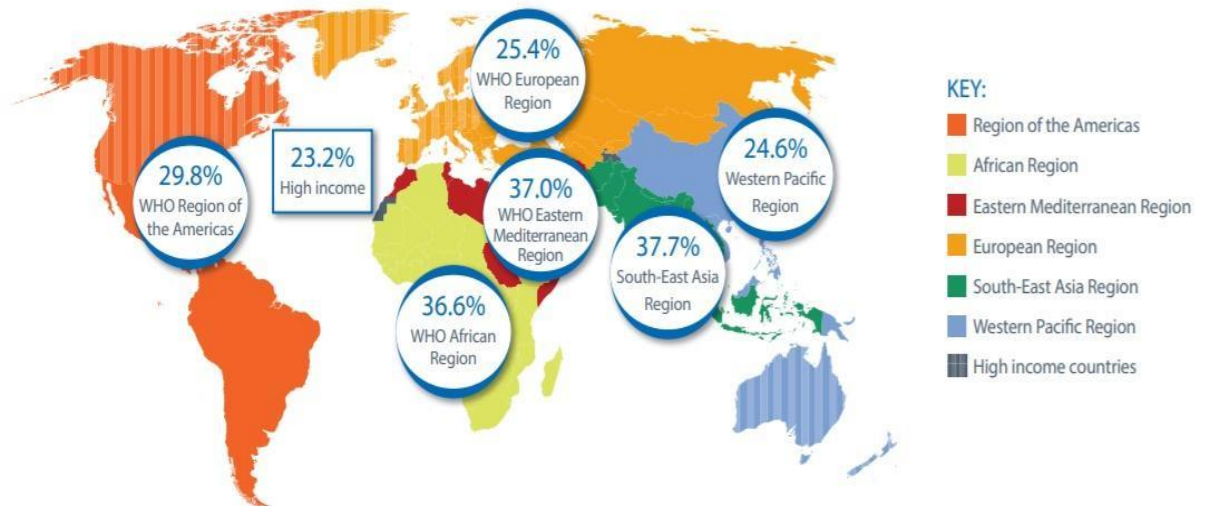
Figure 1: Prevalence of Intimate Partner Violence

Image Source: WHO.

Risk factors that continue to cause and exacerbate VAWG include poverty, alcohol abuse, and gender inequalities that normalize violence against women (WHO, 2017; Settergren et al., 2018). Behaviors that promote gender *in*equality include denying women and girls access to education, impeding autonomy, women justifying the practice of 'wife-beating,' female genital mutilation, childhood sexual abuse, selective malnourishment of female children, and forced prostitution (Semahegn et al., 2019).

Violence against women is not limited to physical or sexual abuse, and can include any form of mental, emotional, or verbal abuse that coerces or threatens the life of a woman and perpetuates female subordination (Heise et al., 2002). Research shows that perpetration and victimization against women and girls are associated with age, rural residence, education

level, number of children, marital discord, previously witnessing family violence as a child, and substance abuse (Beyene et al., 2019).

VAWG negatively impacts women's mobility and mortality (Maquibar et al., 2019). Women who have been abused by current or past partners experience a higher risk of health problems, including injury, chronic pain, gastrointestinal and gynecological problems, suicidal thoughts, and post-traumatic stress disorder. These women are twice as likely to experience depression, 1.5 times as likely to acquire HIV, and almost twice as likely to acquire an alcohol abuse problem (Maquibar et al., 2019).

Women experiencing violence utilize healthcare services at higher rates than those who do not experience violence (Maquibar et al., 2019). Healthcare professionals often serve as the first point of contact with these individuals and therefore have a unique and important role to identify and prevent VAWG. Healthcare professionals facilitate disclosure, connect the woman with social services, and offer emotional support (Maquibar et al., 2019). Additional training to increase knowledge, self-efficacy, and skill acquisition to successfully respond to women exposed to violence is necessary for healthcare professionals (Maquibar et al., 2019). Studies show that although nurses recognize VAWG as a serious problem, preexisting myths about violence negatively impact their performance (Maquibar et al., 2018; Kim et al., 2002). Myths commonly include the belief that false accusations by women against their partner lead nurses to question the credibility of these patients, especially in reports of rape when there are no physical injuries such as 'vaginal tear[ing]' (Maquibar et al., 2018).

Although survivors feel the immediate effects of VAWG, these effects trickle down into a country's human, social, and economic development (Beyene et al., 2019). Women who experience violence may be unable to work, experience a loss of wages, and have a limited ability to care for themselves and their children. The costs associated with the loss of productivity due to VAWG is approximately 3.7% of some countries' gross domestic product, which is comparable to what some countries allot for primary education (World Bank, 2019; Semahegn et al., 2019). GBV also undermines the efforts of those trying to abolish poverty and build peace.

The COVID-19 pandemic has affected many countries and led to an increase in cases of domestic violence and intimate partner violence (IPV) reported from helplines, police forces, and other service providers (WHO, 2020; Sánchez et al., 2020). However, cases reported during the COVID-19 pandemic likely do not reflect the magnitude of this issue as most incidents often go unreported (Sánchez et al., 2020). When lock down measures were instituted, many countries saw a decrease in women who sought help both in-person and remotely. This could be attributed to the increased time women spent with their abusive partners while unable to leave their home or access services discreetly (WHO, 2020). Furthermore, women were likely torn from their family and friends who offered support and protection from the violence experienced at home (Sánchez et al., 2020).

Possible solutions for consideration

Due to the devastating effects of VAWG there have been numerous interventions and studies enacted to reduce the prevalence of violence (Morrison et al., 2007). A review of 18 non-duplicated systematic reviews were analyzed for effectiveness based on the various interventions implemented in these studies to combat IPV (Yount et al., 2017). In this systematic review, single-component interventions such as skills-development programs, were found to be the least impactful on reducing IPV as they only focus on one form of abuse, even though women are more likely to experience multiple forms of abuse (child abuse, IPV, female genital mutilation, child marriage, etc.). In contrast, combined individual and multilevel interventions had the most impact. Components with the greatest positive impact include skill-building to improve voice and agency, community engagement, strengthening social networks, and increasing the number of women role models outside of the family (Semahegn et al., 2019).

Figure 2: SASA!

Image Source: Kyegombe et al, 2014.

One such model was designed by the nonprofit Raising Voices and implemented in Kampala, Uganda. The *SASA! Activist Kit for Preventing Violence against Women and HIV* is a community mobilization intervention that directed its efforts to changing attitudes, norms and behaviors that lead to VAWG, gender inequality, and HIV susceptibility for women (Abramsky et al., 2016). "SASA," which means "now" in Kiswahili, also serves as an acronym for the four phases of the intervention: Start, Awareness, Support, Action (Kyegombe et al., 2014). See Figure 2. The fundamental goal of this intervention is to increase critical analyses and discussions on power, power inequalities, and how to use that power in a positive way. This project was designed around the Ecological Model of Violence

which acknowledges the intricate nature of IPV operating at the individual, relationship, community, and societal levels by involving a wide variety of stakeholders (Heise, 2011; Abramsky et al., 2016). This allows for continued support among the entire community while going through the four phases of the SASA! process. The main actors recruited for this program are community activists, community leaders including traditional marriage counselors, professionals including health care providers and police officers, and institutional leaders. Each actor plays an important role in promoting, preventing, and implementing change on ideas of gender and power. These actors are introduced to new concepts encouraging further analysis of imbalances of power based upon gender. They are then supported as they carry out a range of local activism activities that introduce community members to the principles of SASA! (Kyegombe et al., 2014).

Multiple studies have found that implementation of the SASA! Program, or the adaptation of the key concepts of this program, have positively impacted attitudes and behaviors by reducing incidences of IPV and increasing discussions on gender equality (Kyegombe et al., 2014; Namy et al., 2019). One study that analyzed the effectiveness of a health facility and community-based program in Tanzania was delivered by an HIV/AIDS program to reduce rates of VAWG and enhance care for survivors. Inspired by the strategies of SASA!, the main program components consisted of (1) improving VAWG service delivery at public health facilities, (2) community sensitization and dialogues, (3) group education, (4) couples skills building, and (5) building linkages among services (Settergren et al., 2018). The intervention positively affected women's knowledge, attitudes, and beliefs about GBV with a heightened awareness of laws on violence, decreased acceptance of partner violence for refusal of sex, and a change to more gender equitable norms (Settergren et al., 2018). At the community level, the intervention led to positive changes including less tolerance of specific types of violence, more gender equitable norms, improved knowledge about VAWG, and increased community actions to address violence. Additionally, the program led to increased usage of VAWG services at healthcare facilities. Although only about 25% of respondents in the intervention reported direct exposure to the program, these positive results are attributed to the increased likelihood of women in this study starting discussions about violence with others in their communities (Settergren et al., 2018). These results were achieved in a two-year period, which suggests that ample community change can occur in a relatively short amount of time with modest program exposure (Settergren et al., 2018).

Recommendations

It is essential to include community members in the design phase of an intervention. Instead of imposing a given program upon a population who may have conflicting beliefs and opinions regarding an issue, encouraging community involvement should be utilized to effectively develop a culturally inclusive campaign. If followed, the intervention has a higher likelihood of success.

To address common misconceptions regarding VAWG, comprehensive training should be provided for stakeholders, especially healthcare professionals. Such trainings should expand

beyond identifying the signs of abuse to address personal or cultural beliefs where it may be common to question the credibility of the patient claiming to have experienced an incident of violence. By doing so, healthcare professionals will be more equipped to respond, care for, and connect survivors to available support and social services. If the credibility of a woman is questioned when she discloses a personal exposure to violence, the results can be devastating. It is imperative that nurses and health care professionals receive adequate training in order to overcome these beliefs.

Utilizing the SASA! intervention should be considered when looking to implement a program to address VAWG, as SASA! has shown significant positive results. It may be more useful, however, to use the program components to serve as a base model when efforts are made to address VAWG in countries throughout the world. These adaptations should consider the needs and culture of the community. It could also be beneficial to combine SASA! with an existing public health program (HIV/AIDS, refugees, poverty, etc).

Conclusion

VAWG is a significant issue, and the consequences are felt around the world. The multidimensional and complex nature of VAWG necessitates more holistic interventions in order to effectively reduce the incidence of violence against women. As the COVID-19 pandemic has limited the availability and access to support services, gender inequalities promoting attitudes of violence to women need to be addressed now more than ever to spare women and societies from the devastating effects of violence.

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Individual-, Community-, Facility-Level Interventions to Prevent Violence Against Women and Girls

Gwen Kleinhenz, Alise Cornia

Gender-based violence (GBV) is defined as violence against a person based on his or her gender, or violence that affects one gender disproportionately (European Commission, n.d.). Although both men and women experience GBV, women and girls are more frequently affected and are at higher risk of GBV compared to men, both in the United States and internationally (USAID, 2011). Data suggests 1 in 4 women in the United States experience intimate partner violence (IPV), with the United Nations reporting rates of up to 70% of women experiencing some form of GBV in specific countries (City of New York, n.d.). According to the World Health Organization (WHO), about 35% of women worldwide have experienced physical and/or sexual violence in their lifetime (WHO, 2017). Both in the United States and globally, risk factors for experiencing gender-based violence include being female, having low socioeconomic status, witnessing domestic violence during childhood, having low education, experiencing abuse during childhood, and living in places with attitudes of male privilege and women's subordinate status (WHO, 2017). Although various programs have been implemented to reduce GBV, limited research is available about the effectiveness of such programs.

Several common GBV program strategies exist and can be categorized into three broad areas: individual-level programs, community-level interventions, and facility-level programs. The purpose of this essay is to review evidence of various interventions at these three levels, including microfinance programs (individual level), community mobilization programs (community level), and school-based interventions (facility level). Evidence of the effectiveness of each type of program will be addressed. Additionally, limitations of available literature about each program type will be outlined, and cultural considerations for effective GBV programs will be analyzed.

Individual-level Programs: Microfinance and Microfinance-Plus

Evidence of the effects of microfinance programs on GBV is varied. In recent years, arguments have been made that microfinance programs, which typically aim to increase economic independence and provide credit for low socioeconomic populations, may also lead to increased financial independence for women, potential increased social power for women in family structures, and increased social networks for women, which may collectively reduce the risk of IPV. The MAISHA study, which tested the effects of including a social empowerment curriculum in a microfinancing program led to significantly lower reports of physical IPV after 10 intervention sessions for women in Tanzania (Halim et al., 2019).

However, conflicting claims suggest that microfinance programs may lead to increased risk of GBV and IPV because men may feel threatened by a woman's increase of independence and financial power. Similarly, financial risks associated with microfinance programs may

lead to increased stress between partners, which is associated with increased risk of IPV (De & Christian, 2020). A study analyzing data of microfinance programs in Bangladesh found that women who gained employment between program visits were at an 80% higher risk of experiencing IPV compared to women who did not gain employment (Krishnan et al., 2010).

Many studies, however, claim microfinance programs either negatively affect rates of GBV or did not impact rates of violence either positively or negatively. A study by De and Christian (2020) that analyzed the effects of various microfinancing programs found that those who participated in one of three major microfinance groups in Bangladesh, including BRAC, Proshika, or ASA, reported increased rates of IPV. However, the study did not find sufficient evidence that other microfinance programs, such as Grameen Bank, affected rates of IPV either positively or negatively if analyses were controlled for disadvantaged characteristics of many microfinance participants such as low education, poor, and low levels of autonomy (De & Christian, 2020). Authors suggest the reason for such discrepancies in IPV and microfinance correlation is that BRAC, Proshika, and ASA do not focus solely on microfinance and offer other services such as legal representation, disaster management, health, sanitation, agriculture programs, and education which may be designed to raise awareness of IPV and therefore build confidence among women to report IPV (De & Christian, 2020). Authors suggest that microfinancing alone may not address complex gender and cultural norms that contribute to GBV (De & Christian, 2020). The findings in another study demonstrated that initiatives aiming to prevent IPV by way of increased financial autonomy for women may be ineffective in changing the broader root causes of societal beliefs (Mcdougal, 2019). Therefore, programs that seek to reduce IPV likely need to focus on underlying cultural factors that affect IPV; microfinancing alone is unlikely to make an impact.

Another study supported the claim that microfinance programs may not increase rates of violence. Authors found that a particular microfinance program in Bihar, India significantly reduced rates of GBV (Yaron, Gordon, Best, & Choudhary, 2018). Participants who experienced a reduced risk of GBV reported that the results were directly related to having the money from microfinancing programs; participants claimed the available money from the program reduced stress levels and tension with their partners (Yaron et al., 2018). However, the conclusions of Gordon's study are somewhat unique; most available research about microfinancing programs have limited evidence suggesting microfinancing programs reduce rates of IPV or affect the likelihood of participants reaching out to others when they experience IPV (Murshid & Zippay, 2017).

Community-level Programs: Community Mobilization

Some evidence suggests that community mobilization programs such as public debates and forums, which focus on changing social norms in communities, may be effective at reducing GBV. For example, a systematic review of GBV interventions published in 2015 suggested that community mobilization programs had a "fair" amount of evidence, suggesting potential effectiveness at reducing violence risk factors (Ellsberg, 2015). However, the review said

insufficient evidence is available to establish a linear connection between attitudes about violence and behavior; therefore, further research needs to be conducted to determine if community mobilization programs can lead to lasting changes in violent behaviors across communities (Ellsberg et al., 2015). To address this lack of evidence, a study in India comparing 24 slum clusters in Mumbai that offered only support services (crisis intervention, counseling services) with 24 slum clusters that offered a combination of support services, volunteer programs, and community outreach programs began in 2019. A 3-year evaluation of the effectiveness of the community mobilization program will be published after results are analyzed (Daruwalla et al., 2019). Another study found that a community mobilization pilot program including 16 participatory learning and hands-on community meetings in Jharkhand, India was effective at reducing attitudes of acceptability of violence and rates of past year physical and emotional violence experienced by women in the community (Nair et al., 2020). Authors concluded that including community mobilization efforts in violence-reduction interventions could benefit many women and girls in rural areas and help reduce rates of GBV in affected areas (Nair et al., 2020).

Facility-level Programs: School-based Programs

Several major interventions focus on education and programs within schools. Some interventions, such as the *Youth Relationship Program* in Ontario, Canada, are geared towards both boys and girls in high school. The *Youth Relationship Program* was designed to develop positive, safe skills in dating relationships for at-risk youth who had experienced maltreatment growing up and were therefore at higher risk of displaying violent behaviors themselves (Crooks, Jaffe, Dunlop, Kerry, & Exner-Cortens, 2019). The intervention included a manual for instructors to provide information, facilitate a community service project, and teach skill development for positive dating (Crooks et al., 2019). The intervention was shown to be effective at reducing incidents of both emotional and physical abuse over time, and reduced symptoms of emotional distress and trauma, even though the intervention was not designed to target those areas (Crooks et al., 2019).

Other school-based interventions contain components targeting either girls or boys, specifically. For example, the *Expect Respect Program* involved a comprehensive model including community engagement, school-wide strategies for violence prevention, targeted support groups for at-risk youth, and youth leadership training. The targeted support groups for at-risk youth involved 24 interventions over the school year, with interventions segregated for boys and girls (Crooks et al., 2019). The interventions, which involved teaching healthy communication skills and helping participants reframe attitudes of condoning violence, showed different results depending on the number of sessions attended (Reidy, Holland, Cortina, Ball, & Rosenbluth, 2017). An analysis of the program's effectiveness, completed in 2017, showed that as the number of sessions attended increased, reports of violence victimization, violence perpetration, and both reactive and proactive violent behaviors for men all decreased incrementally (Reidy et al., 2017). For women, however, an increase in sessions attended was associated with marginally higher rates of reported sexual violence (Reidy et al., 2017). Interestingly, researchers also found that

participants who reported the highest rates of victimization and violence at baseline attended the highest number of intervention sessions, and therefore experienced the greatest reductions in violence and victimization, which suggests that those who are at the highest risk of violent behaviors and victimization are the most likely to benefit from school-based interventions (Reidy et al., 2017).

Cultural and Religious Considerations

While some women display violence of their own in both mixed and same-sex relationships, most abuse is perpetrated by men against their female partners (Heise, 2002). The factors of GBV often correlate to cultural practices or beliefs. When addressing GBV with prevention and treatment programs, it becomes important to look at the cultural aspects including community gender roles and religious beliefs.

Gender-roles are a large factor in whether GBV exists in a community. To address the root causes of GBV, it is important to look further into gender-roles and to be able to address these at the individual and community level. Studies have found that violence against women is most common where gender roles are more rigid and where being a male is linked to masculinity factors including toughness, male-honor, or dominance (Heise, 1998). Violence is often justified in communities with more defined, separate roles for men and women exist and where men hold the right to control their wives. In multiple studies performed in different locations, violence can be viewed as chastisement for not doing something correct (Heise, 1999). These may include a woman asking for money, expressing needs for children, or eating without permission (Heise, 1999). When considering or implementing GBV programs, it is important to look at and address the cultural views regarding gender roles.

GBV programs often provide support after the incident of GBV. These programs include counseling, medical care, place of shelter or legal support (Graaff, 2017). While these programs are important, they do little to prevent GBV in a community. Multiple studies have identified that these forms of aftercare do little to prevent masculine beliefs and GBV, which are often the root cause of GBV (Graaff, 2017). In one study, the One Man Can (OMC) intervention, a masculinity-focused, gender-transformative workshop was held with participants in South Africa. The workshop included a series of discussions challenging these men to question traditional gender roles in their community. Results from this study showed the discussions encouraged participants to recognize harmful masculinity beliefs and to discover alternatives to these issues (Graaff, 2017). However, the workshop intervention did not significantly shift the underlying beliefs which encourage these behaviors (Graaff, 2017). While programs that encourage open discussions regarding masculinity and gender roles may be somewhat beneficial, interventions that focus on more than discussion are necessary to address underlying beliefs regarding GBV and gender roles.

Additionally, religious views within a community may enable GBV and therefore are important factors to address when implementing prevention programs. One intervention tested and showcased the importance of pastoral leaders in addressing and speaking out

against GBV (Magezi, 2019). In communities where religion plays a large role in the actions of the people, it is important to include community church leaders in being a public voice against GBV. Having religious leaders teach men that there are alternative ways to address issues without engaging in GBV can prove to be successful in decreasing rates of GBV in a community (Magezi, 2019). In addition, communities in which sexual exploitation and female genital mutilation is correlated to religious practices, the literature suggests the importance of addressing the issues as a whole community. In regard to genital mutilation and sexual coercion as a form of GBV, one study found that creating community awareness projects, enforcing strict laws, and increasing the amount of health professional involvement may reduce the incidence of genital mutilation as a form of GBV (Elamin, 2019). Coupling religious leaders with community law makers and health professionals may decrease the prevalence of GBV in communities.

Maintaining Victim Safety

As identified previously in this report, protecting the safety and preventing further harm to GBV victims is important when considering programs and interventions to address these issues. Much can be done to protect women's rights and eliminate GBV, including legislation for human rights violations, prevention programs for GBV, protocols for treatment and support of GBV victims, collaboration with community resources, prosecution of perpetrators, and continued protection support following GBV (Tozija, 2020). An important factor in maintaining safety of victims is ensuring communities and individuals can support one another and potentially provide for themselves outside of the partnership in which GBV is taking place.

When communities have the capacity to support female victims, technology may play an important role in passively alerting help when an individual is in need. Because GBV is often a series of events rather than a single event, violence may happen again after the first incident, after the relationship has ended, during a criminal trial, and after a victim has been released from jail (Rodriguez, 2020). Technology has increased the ability to anticipate violent events and alert help while maintaining the safety and autonomy of the individual. In one study, an alarm system worn by the victim can alert help with a system of biosensors (Rodriguez, 2020). The use of passive alert systems can ensure the victim remains autonomous and that the perpetrator does not inflict more violence if help is sought at the time of the incident (Rodriguez, 2020). In communities with built in support, technological advances such as these can be helpful.

In communities where the societal beliefs or norms do not support the protection of women from GBV, evidence suggests advocacy and empowerment counseling services and home visitations within communities are promising factors in preventing GBV and promoting safety (WHO, 2017). More research is needed regarding GBV safety techniques, however, societies that view women with respect and invest in empowering them are more likely to have systems to protect victims of GBV. Focusing on interventions and programs that

encourage men to question gender roles and neglect rigid masculinity may be most effective in preventing the occurrence of GBV and supporting the safety of women.

Research Limitations

Available GBV program research has several significant limitations. First, although research has been completed regarding many violence-prevention programs around the world, a significant research gap exists regarding violence within marginalized populations. Crooks (2019) suggests research needs to be done regarding violence in populations including disabled women and girls, women of color, indigenous women, migrant women, sexually diverse women, women in poverty, sex workers, women who are precariously housed, and women abused as children (Crooks et al., 2019). The author also suggests marginalized women are often studied, but not actually included in the planning and implementation of interventions. Therefore, collaborating with marginalized women to develop interventions, rather than simply including them as study subjects, would improve advocacy for minority groups who are highly affected by GBV.

Another limitation to available research on GBV is a lack of long-term follow up research. Many published program evaluations are limited to data collected immediately after a program ends, so long-term follow up is largely unavailable. Therefore, long-term effects of a program are often unknown.

Finally, most available program evaluations are based on data about changes in attitudes, not changes in actions. For example, a program may successfully increase a group's knowledge about available resources in a community or may help to change preconceived stereotypes about gender roles, but such changes do not necessarily translate to changes in violent behaviors. Therefore, limited evidence is available about whether GBV programs successfully change behaviors over time.

Conclusion

While research in some areas is limited, the literature suggests that addressing GBV in communities can be effective. A productive way to do so is to design programs that focus on changing risk factors for GBV including the victim having low socioeconomic status, witnessing domestic violence during childhood, having limited education, experiencing abuse during childhood, and living in places with attitudes of male privilege and women's subordinate status (WHO, 2017). Addressing these factors may decrease GBV in communities around the world.

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Comparing High-, Middle-, and Low-Income Country Interventions to Reduce Violence Against Women and Girls.

Janaya Brown, Lily Kim, Rebekah Stewart

Gender-based violence (GBV) has gained increasing recognition in recent years. GBV originally focused only on war- and conflict-related violence and genital cutting/mutilation; however, in recent years, GBV has come to include violence in domestic settings (Jakobsen, 2014). The definition and scope of GBV differs depending on the researcher or organization, but broadly speaking, it is any violent act directed toward an individual based on gender or sex, including any physical, verbal, emotional, mental, or sexual abuse (Ott, 2017; Jakobsen, 2014). While GBV and violence against women (VAW) are often used interchangeably, GBV includes violence against men, boys, sexual minorities, or those with gender-noncomforming identities. VAW is violence specifically directed towards women (Terminology, 2014). The most common form of VAW is intimate partner violence (IPV) (El-Nimr, Gouda, & Wahdan, 2020), affecting almost 36% of women who have been in a relationship (WHO & HRP, 2019). IPV is defined as any type of abuse or harm against a person from a former or current partner or spouse (Intimate Partner Violence, 2020). It is important to recognize that GBV is viewed differently throughout the world, with varying levels of acceptability; thus, rates of violence are not always comparable across countries and cultures (Morrison, Ellsberg, & Bott, 2007). For the purpose of this paper, we will speak mostly of VAW and violence against women and girls (VAWG).

Mitigation and Prevention of GBV

Many different interventions have been put in place to mitigate GBV in both high-income countries and in middle- to low-income countries; however, GBV programs often create a risk for retaliation and increased stigma towards survivors. Though limited research has been done regarding the long-term effectiveness of many GBV programs, evidence points towards the importance of building on sustainable local capacity in order to mitigate intervention-related retaliation and stigma. The current literature has found a few key factors that are consistent with successful interventions that build on local capacity. These key factors include increasing community engagement and involving civil society organizations (Spangaro et al., 2013), educating and bringing awareness to available resources, and creating safe and anonymous systems for reporting and/or seeking help. When carried out together, these factors appear to be most successful (Tappis, Freeman, Glass, & Doocy, 2016). This section will outline interventions that have utilized all or parts of these factors, as well as their levels of success.

GBV Programs in High-Income Countries

Many GBV interventions have been implemented in high-income countries and focus on GBV response (Ellsberg, Arango, Morton, Kiplesund, & Contreras, 2015). A review evaluating the effectiveness of interventions for IPV found that a combination of strategies is

most often used. These strategies include advocacy and counseling, psychosocial support, and at-home visits to provide women resources to improve their overall physical and psychological health and reduce risk of future violence. Many of these strategies are carried out in clinical settings where services such as family planning and antenatal care are being delivered (Ellsberg et al., 2015). Some evidence suggests that these health-sector-based interventions have positive outcomes, such as reduction of depression, but very few studies have shown significant decreases in violence (Ellsberg et al., 2015).

Women's shelters, designed to provide women and children a safe place to receive help and resources, are found throughout countries such as the United States. A meta-analysis of ten studies suggested that interventions such as group counseling to improve coping skills, parent and child classes, and individual counseling and advocacy services provided during and after a shelter-stay may lower the rate of re-abuse; however, none of the studies definitively established effective solutions or provided follow-up data that would take into account long-term effects of shelter interventions (Jonker, Sijbrandij, van Luijtelaar, Cuijpers, & Wolf, 2015). A report by The Prevention Collaborative organization found some evidence that shelters have helped reduce the incidence of VAW, although a proportion of women did report increased violence against them. Other studies have indicated that shelters have been associated with women deciding to leave an abusive relationship (Jewkes et al., 2015). Due to studies relying on self-reports of violence and the benefits of shelters, it is difficult to conclude the role that shelters play in reducing violence. Other unaccounted for influences or resources may have had variable effects on the reduction of violence or the decision to leave an abusive relationship. Furthermore, it is difficult to measure the effect that specific shelter programs have on a woman's success in leaving an abusive relationship (Jewkes et al., 2015).

GBV prevention programs have also been used in high-income countries. These programs are usually school-based group training sessions focusing on prevention of IPV and non-partner sexual assault. Although many of the programs did not show statistical success in reducing violence, a few exceptions exist. Healthy Relationships, a program carried out in Canada, was implemented in both a high school and a community setting with boys and girls; both programs showed reductions in dating violence for each gender (Ellsberg et al., 2015). Two other programs, Shifting Boundaries and Safe Dates, also showed improvement in dating violence among adolescents (Ellsberg et al., 2015).

GBV Interventions in Middle- and Low-Income Countries

Many GBV interventions have been implemented throughout middle- and low-income countries with varying levels of effectiveness. A small, but growing, body of evidence has begun to show the effectiveness of reducing GBV with the use of microfinance in combination with additional social empowerment interventions. An example of this is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program in South Africa. This program utilized microfinance in tandem with HIV and gender training (Tappis et al., 2016). IMAGE found a 55% reduction in sexual and/or physical violence by an intimate partner or relative among participants. Related studies also conducted in South

Africa found that the program was feasible, cost effective, and accepted by the majority of participants (Tappis et al., 2016). A more recent trial in Tanzania assessed if implementing a combined microfinance and social empowerment intervention would influence the rate of IPV when compared to microfinance interventions alone. This trial consisted of a microfinance program combined with 10 sessions of the MAISHA intervention—a social empowerment curriculum developed to empower women, promote healthy relationships, and help participants develop relationship skills. Each session was delivered in a 1.5-2 hour period over the course of 20 weeks. A 2-year follow up study found that within the microfinance and MAISHA intervention group, there was a reduction in either past-year physical or sexual IPV, or both, although more limited reductions occurred for sexual violence. Participants in the microfinance and MAISHA group were also less likely to be accepting of IPV, or express beliefs that IPV is a private matter, or that a woman should tolerate IPV to keep her family together (Kapiga et al., 2019). This study provides promising new evidence that IPV can be mitigated and/or prevented in high-risk settings.

The inclusion of both men and boys in GBV response and prevention programs is also showing to be beneficial and important, especially when programs aim to economically empower women. Men who already feel economically vulnerable may be more likely to engage in GBV when women-empowering programs are implemented and where men are excluded (Slegh, Barker, Kimonyo, Ndolimana, & Bannerman, 2013). In order to combat GBV in these situations, interventions such as directly engaging men to question economic and household roles, can be implemented. These interventions can help men embrace cooperation and sharing of household activities (Slegh et al., 2013). Other studies have found that programs focused on group training with men and boys have a positive change in young men's attitudes regarding violence and gender equality, although no significant changes in behavior were found (Ellsberg et al., 2015). There is still limited evidence regarding the relationship of educational GBV interventions and the reduction of VAW, although attitude changes towards the application of such interventions is promising (Slegh et al., 2013).

Educating adolescent girls has been shown to help reduce sexual violence. In Uganda and Kenya, two randomized control trials were implemented in which girls were taught self-defense, life skills, and vocational training; these programs showed improvements in the girls' knowledge and behavior regarding sexual and reproductive health. They also found a reduction in coerced sex, especially in Kenya; when compared to the control group, the intervention group saw a 60% reduction in the number of sexual assaults (Ellsberg et al., 2015). Other programs carried out in India and Ethiopia used several different tools such as community conversations, mentorships, intensive life skills training for unmarried girls, and community activities in order to encourage parents to keep their girls in school and delay early marriage. Both programs affected community attitudes, helping to delay marriage by at least one year, and empowered girls by giving them skills and knowledge they may not have otherwise obtained (Ellsberg et al., 2015).

Many interventions have focused on trying to prevent GBV at the governmental and community levels through the integration of educational programs for judges and police, as well as increased legislation regarding domestic violence. These interventions have often been met with barriers such as lack of funding and push-back from male-dominated police and judiciary bodies (Ellsberg et al., 2015). Other initiatives such as the establishment of specialized police stations for women and girls have also been tried, particularly in Latin America and South Asia. Although these police stations have drawn more attention to the problem of GBV and have increased reporting in some areas, there is limited evidence regarding long-term efficacy. Research suggests that improved legislation and training alone are not enough to prompt large changes in violence or improvement in outcomes of women affected by GBV; instead, a more system-wide change needs to occur in order to improve GBV outcomes and the enforcement of laws (Ellsberg et al., 2015).

Barriers to Safe Implementation of GBV Programs

Although many organizations and programs seek to help GBV victims, there is a dearth of information on how to aid women in a way that does not increase shame or danger. This is likely due, in part, because of the many cultural and societal barriers in mitigating GBV, as well as the lack of data regarding the prevalence of VAW.

One of the foundational difficulties women may face in regards to VAW is a cultural acceptance of violence towards women. For example, researchers have found that in some areas of Africa, VAW, especially IPV, is accepted and even expected for women who disregard or disrespect their husbands (Davies & True, 2015; Jakobsen, 2014; McCleary-Sills et al., 2016; Muche, Adekunle, & Arowojolu, 2017; Tappis et al., 2016). In Ethiopia and Tanzania, researchers found that most did not believe marital rape exists: a man has the right to have sex with his wife however and whenever he desires (McCleary-Sills et al., 2016; Muche et al., 2017). Honor killings and dowry-related violence are also accepted in many communities, and thus perpetrated (Garcia-Moreno, Guedes, & Knerr, 2012). Without believing in the dangers and inequalities of VAWG, women will not seek help, and the society will continue to condone violence (see McCleary-Sills et al., 2016).

Another barrier comes from the stigma and fear of reporting violence. Fewer than 40% of women who experience violence seek help and/or support; most of them turning to family and friends, with only 7% going to the police or getting formal help (Palermo, Bleck, & Peterman, 2014). Often, women may fear for the safety of their children, their partner, or themselves if they report violence. As one Tanzanian woman explained, "[If you seek help or even speak about IPV, your husband] will be called and warned, but he will feel like you have humiliated him and when you go back home things will get worse . . ." (McCleary-Sills et al., 2016, pg 232; see also Muche et al., 2017). Women may also fear possible societal or familial repercussions from parents, siblings, or the community in general (Muche et al., 2017). It has been found that in many communities it is the reporting of violence, more than the violence itself, which brings the most shame to women (Carbin 2013; Garcia-Moreno et al., 2012; McCleary-Sills et al., 2016). Views such as these lead women to fear possible

economic repercussions, especially if speaking up leads to divorce and a lack of future suitors (Muche et al., 2017); this would likely cause the most concern in areas where women are not seen as heads of households or fit for work.

It is important to note that it is likely that every culture and community has varying views on which types of violence are condoned or condemned. These need to be evaluated and understood on an individual and community basis.

Interventions for Safe Implementation of GBV Programs

Though not much research and significant evidence was found regarding safely implementing GBV programs, interventions have been created and various researchers have weighed in on best practices.

A USAID program, "Mobilise," is a mobile application that helps front-line healthcare employees screen and recognize clinical signs of VAW in women who seek routine health services. If any signs of VAW are present, healthcare workers can refer those patients to appropriate services and organizations (USAID, 2019); however, programs such as these have been evaluated as ineffective in reducing violence (Jewkes et al., 2014). There is currently no evidence showing that screening for VAW leads to decreased levels of violence and/or increased quality of life for women; however some studies have shown improvements in awareness of and resources for GBV. Women who felt ready to talk about their experiences of abuse appreciated the opportunity to discuss them during their routine health services, though these studies were mostly done in high-income countries, so their ability to transfer to other areas of the world is unknown (Jewkes et al., 2015). Another intervention implemented by the organization CARE has hired female activists to work directly with women. This intervention seems promising in helping women feel more comfortable asking for help and support (CARE, 2013). Spangaro et al. (2013) also recommends anonymity for women seeking refuge from VAW.

Researchers have found that the more accepting society is of traditional gender roles—i.e., a man is the head of the household and holds dominance over women—the more likely the society is to be accepting and even supportive of VAWG (Davies & True, 2015; Jakobsen, 2014; Muche et al., 2017; Tappis et al., 2016). This suggests that changing traditional gender roles may help to change perspectives on VAWG. In humanitarian settings, gender roles are often not as relevant because there is a higher likelihood for an absent male head of household and survival often takes precedence over gender roles. This creates a unique environment that may prompt a shift towards more non-traditional gender roles in a culturally safe way. To that end, Tapis et al. (2016), posits that humanitarian settings can be ideal for helping to change cultures of VAWG in a way beneficial to women. With this in mind, UNICEF developed the Communities Care program to end VAWG in conflict-ridden areas, beginning in South Sudan and Somalia. While the program is still being evaluated, implementation strategies include improving access to care, providing support for those

affected by GBV, and reshaping deleterious social norms by teaching basic human rights using a culturally accepted framework (Glass et al., 2018; UNICEF, 2018).

To address the deep roots of GBV, CARE works not only with individuals and communities, but also with public, civic, and religious leaders. In many of CARE's projects, the work done at the community level is the most successful. For example, they have found that interventions such as couples' dialogue sessions have been effective in encouraging men to play a more active role in domestic duties. Working at this basic community level, as well as with government and civil organizations, has helped to change cultural and social attitudes, leading to a more favorable climate for GBV prevention (CARE, 2013).

After reviewing several response mechanisms for the prevention of VAWG, Jewkes et al. (2014), found that most response mechanisms have very little evidence to recommend them; subsequently, they suggest that programs related to response mechanisms may not be the best use of time or resources. However, if the mechanisms are to be used, best practices include intervening at a system-wide judicial and police level, using couples-therapy, creating shelters (making sure the shelter services include economic empowerment programs), as well as ensuring that the interventions are aimed at people who are ready and determined to live a violence-free life. Mandatory reporting of IPV is not recommended as this may increase risk of abuse and contribute to women feeling unsafe (for a more complete list of recommendations, see Jewkes et al., 2015).

Conclusion

GBV is a public health problem that affects women and girls throughout the globe. Though GBV interventions have not been extensively evaluated, our research has found several promising principles to create successful programs to mitigate and prevent violence. Conducting research regarding the target area/community before starting an intervention is strongly recommended. By truly understanding a culture's gender norms, as well as why violence exists in the area, an intervention can be selected and catered to the needs of the community, ultimately increasing the effectiveness of the intervention. A multi-faceted approach to ending GBV, such as the partnership of microfinance and social empowerment, also appears to be a promising solution. Lastly, it is recommended to increase follow-up research to determine long-term impacts of GBV interventions. GBV is a worldwide problem, and it deserves to be studied in more depth.

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Brigham Young University

Faculty and graduate student researchers for this collaboration come from the Masters of Public Health (MPH) program in Brigham Young University's Department of Public Health. The program consists of 20 faculty members and admits approximately 20 graduate students each year. The mission of the BYU MPH program is to develop future public health leaders who drive change that improves the health and well-being of communities, families, and individuals. To this end, the program prepares students to conduct public health surveillance, and to plan, implement, and evaluate public health programs and policies that focus on at-risk populations in both domestic and international settings. For more information, please visit https://ph.byu.edu/mph

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