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APPLYING GENDER-INTEGRATED STRATEGIES AND APPROACHES TO ADDRESSING GENDER-BASED VIOLENCE IN INDIA

Evidence-based Strategies to Transform Gender Norms, Roles, and Power Dynamics for Better Health

Photo by: Arundati Muralidharan

Gender-based violence (GBV) is a serious problem in India, where slightly more than one-third of women ages 15–49 report experiencing violence—typically from an intimate partner or husband—at some point in their lives. Yet, a culture of silence persists, as Indian women are socialized to accept and tolerate GBV (IIPS and Macro International, 2007). Cultural practices, such as dowry, reinforce rigid patriarchal norms and beliefs and, in India, often lead to deadly outcomes. In 2012, according to government statistics, 8,233 women in India died violent deaths (also referred to as “kitchen accidents”) at the hands of their husbands or in-laws because their families were unable to meet dowry demands (National Crime Records Bureau, 2013). Sexual violence and rape have similarly become poignant and pressing issues in India, particularly after the highly publicized gang rape of a 23-year-old woman on a New Delhi bus in December 2012. The public outrage that followed greatly heightened the visibility and public awareness of the existence and frequency of rape nationwide. According to the National Crime Records Bureau, 92 women are raped every day in India

(National Crime Records Bureau, 2013). Harassment is also a significant problem: in Delhi alone, 73 percent of women and girls face sexual aggression in their own neighborhoods, 63 percent are fearful of going out after dark, and 5 percent report that they do not feel safe at all (UN Women and ICRW, 2012).

There is an urgent need to address violence in India; effective, evidence-based strategies are needed to challenge gender inequalities and improve health and gender outcomes related to GBV. To support an enabling environment for gender-aware initiatives and pinpoint

To read the full report—*Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Findings from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*—please visit www.healthpolicyproject.com?zp=381.

evidence-based strategies for inclusion in health programming, the Gender, Policy and Measurement (GPM) program—funded by the Asia bureau of USAID—conducted a systematic review of published and unpublished literature documenting gender-aware programs. GPM wished to identify strategies that health programs had used either to accommodate (work around) or transform areas of gender inequality, and whose influence on key health outcomes had been measured. This review, *Transforming Gender Norms, Roles, and Power Dynamics for Better Health*, yielded 145 gender-integrated interventions conducted in low- and middle-income countries (LMICs) worldwide—54 of these focused on GBV and 11 of the 54 were in India.

in India and other LMICs. Other approaches included empowering disadvantaged groups through economic opportunities, education, and collective action; and strengthening communication and negotiation skills for women, men, and couples. Outside India, few interventions employed gender-integrated strategies to strengthen linkages between health services and communities. Most interventions in India and LMICs used a combination, rather than just one. The most common combination was SBCC and critical reflection, and these strategies were also used on their own.¹

Global Findings At-a-Glance

- The majority of GBV interventions actively challenged gender norms to improve health outcomes; all interventions in India did this.
- Common beneficiaries included adolescents, youth of both sexes, and adult men; stakeholders such as healthcare providers were involved to increase the provision of gender-sensitive GBV services.
- The majority of interventions in India focused solely on GBV, but some also addressed HIV; in other LMICs, GBV interventions often addressed other health areas (adolescent health, HIV and sexually transmitted infections [STIs], and healthy timing and spacing of pregnancy [HTSP]).

Evidence-based Strategies to Tackle GBV

The vast majority of the interventions found in the systematic review (in India and other LMICs) sought to actively challenge gender inequities to improve GBV outcomes. Gender was integrated into a variety of health strategies, including social and behavior change communication (SBCC) and critical reflection—the two most commonly used strategies to address GBV

Programmatic Examples from Case Studies

Combining SBCC and critical reflection fosters gender-equitable attitudes that condemn GBV and encourage individuals to self-report, take action against, or intervene to prevent instances of violence

In India, SBCC and critical reflection were the most commonly used strategies to challenge gender norms. Critical reflection focuses on individual-level reflection and change, whereas SBCC often challenges unequal gender norms at the community level. When these strategies are used together, SBCC can help create an environment where changes brought about through critical reflection can be sustained. For example, Parivartan, an intervention in Mumbai, India, engaged cricket coaches in a slum community and mentors in the formal school system to teach young boys about violence—specifically how to control aggression, prevent violence, and respect women and girls (Das et al., 2012). The intervention employed a training-of-trainers (TOT) approach to teach the coaches and mentors to lead weekly interactive sessions on topics such as respect, responsibility, disrespectful and harmful behavior toward women and girls, and aggression and violence. As a result of the mentoring program, gender-equitable attitudes among the boys, coaches, and mentors increased, as did participants' likelihood of intervening against witnessed acts of violence. A reduction in violent behavior among the participants themselves was also observed. The intervention highlighted the need to impart sustainable, gender-equitable norms from a young age by working with adolescents and youth

to address GBV. Two other interventions in India, the Gender Equity in Schools Movement (GEMS) (Achyut et al., 2009; 2011) and Yaari Dosti (Khandekar et al., 2008; Verma et al., 2008), applied similar strategies in working with girls, boys, and young men to tackle issues related to inequitable gender norms and violence, such as existing attitudes justifying violence against women and girls.

In other LMICs, as compared to India, interventions were more likely to use SBCC as a strategy on its own. An intervention in South Africa, for example, addressed domestic violence by encouraging behavior change at many levels—individual, community, and socio-political—through the use of television, print booklets, and radio (Usdin et al., 2005). At the individual level, the intervention sought to shift attitudes toward and awareness of domestic violence while also connecting people to support services; at the community level, the emphasis was on shifting social norms and promoting community action; and at the societal level, advocacy for the implementation of the Domestic Violence Act was a primary focus. The intervention resulted in increased care seeking for intimate partner violence or sexual violence, as well as increased action and intent to act against violence.

Structural interventions improve GBV outcomes and other health outcomes that can be closely linked to violence, such as safer sex practices, increased condom use, and decreased prevalence of STIs and HIV

Structural interventions (i.e., economic opportunities, education, or collective action) can improve health outcomes by empowering disadvantaged groups to better advocate for and ensure access to health services, while also creating structures outside the health system to provide greater support. Avahan, an initiative to reduce the spread of HIV in India funded by the Bill & Melinda Gates Foundation, recognized the facilitating role of GBV in the HIV epidemic and worked to reduce the threat of violence by sensitizing stakeholders and empowering sex workers. Nongovernmental organization (NGO) partners under Avahan facilitated the formation of sex worker-led, community-based organizations (CBOs) to leverage collective action and reduce stigma, abuse, and violence. CBOs provided social support, helped sex workers report violence,

and in some cases, provided legal resources. With the technical assistance of NGOs, CBOs also undertook advocacy and sensitization efforts with community stakeholders, such as police, who were often the primary offenders in cases of violence and abuse. Under Avahan, collective action efforts led to safer sex practices, increases in STI and HIV service use, and decreased HIV prevalence rates. Avahan also observed a decrease in reports of violence.

Deeply rooted in gender inequities, GBV can take many forms and span the life cycle—from sex-selective abortion of a female fetus, to sexual violence and rape, to intimate partner violence, which can include psychological or emotional violence.

GBV can lead to serious health consequences, such as unintended pregnancy and unsafe abortion, decreased use of family planning and maternal health services, greater under-five mortality rates, and heightened risk for sexually transmitted infections (STIs) and HIV (PRB, 2010).

Integrating GBV services (screening, counseling, and referral) into existing maternal health services increases violence detection rates and strengthens the health system response to GBV

In India, none of the interventions addressed screening and referral for GBV, because most programs focused on prevention at the community level. While prevention efforts are important for long-term outcomes of reduced GBV, appropriate screening and referral for GBV survivors are imperative. One example of this was documented in Vietnam (Budiharsana and Tung, 2009), where health service providers in a large public hospital were trained to provide gender-sensitive GBV services. The training covered gender sensitivity, types of domestic violence and sexual violence, country and international GBV contexts, and survivor support and counseling skills. The connections among reproductive health, HIV, and GBV were also covered. The training emphasized effective strategies and skills including



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routine questioning about GBV; providing gender-sensitive, non-judgmental, and non-punitive support; psychological management; patient safety and privacy; documenting abuse; and providing useful information and resources. The program evaluation suggested an increase in the detection of violence, thus strengthening the health system to provide essential prevention, detection, and counseling services for GBV. A similar intervention in Kenya resulted in increased GBV detection rates at the health system level after health providers in rural areas were trained to integrate GBV screening, counseling, and referral services into existing antenatal care, which also included HIV testing and services (Turan et al., 2013).

Improvements in Health and Gender Equality²

In India and other LMICs, interventions that encouraged critical reflection on inequitable gender norms and

roles while promoting SBCC at the community level were the most commonly used, as well as the most effective in achieving a multitude of health and gender outcomes. When applied together in India, these strategies were effective in decreasing the justification of GBV and sexual violence, aggression, and self-reported perpetuation of GBV among boys and men; increasing the likelihood of managing anger through negotiation, rather than violence; and increasing the likelihood that mothers-in-law, boys, and men would intervene in instances of violence. These strategies were also effective in building negotiation skills for safer sex practices among women and adolescent girls and increasing condom use for safer sex practices.

Critical reflection and SBCC were effective in achieving similar health outcomes across LMICs (e.g., decreased self-reported violence perpetuation among men or increased safer sex practices which, in two separate interventions, was specific to youth). Interventions in LMICs that included additional strategies, such as

strengthening communication skills, were effective in increasing communication between parents and children on sex and sexuality. In one intervention, strengthening communication and negotiation skills, in conjunction with SBCC, was effective in increasing care-seeking behavior for GBV. Compared to India, interventions in other LMICs employed a greater variety of strategies and/or combinations of strategies to effectively achieve health outcomes, including gender outcomes.

SBCC and critical reflection were also effective in increasing gender-equitable attitudes, partner communication, and men's assistance with household chores in India. Applying SBCC and critical reflection, these gender outcomes were similarly observed across LMICs, with additional observed outcomes such as increased decision-making power and self-efficacy for women. The strategy of strengthening communication and negotiation skills was effective in achieving these two gender outcomes in LMICs.

Empowerment through collective action was found to be effective in achieving a number of health outcomes, particularly in demonstrating the link among HIV, STIs, and GBV. Encouraging the collective action of sex workers in India, the Avahan intervention reported the following outcomes: safer sex practices, increased health service use for the detection and treatment of STIs, decreased prevalence of HIV and STIs, increased self-advocacy against violence with the police, and decreased reports of violence. Avahan was the only intervention in India to report decreases in violence; the other interventions observed decreases in self-reporting of violence perpetuation. Similarly in LMICs, decreased violence prevalence rates were only reported for one intervention; however, this reduction in violence was achieved through SBCC, not collective action.

Recommendations

By integrating proven, evidence-based strategies into GBV programs, program planners can help to attain positive GBV outcomes among women, men, girls, and boys, while also helping to create an enabling environment for greater gender equality and GBV-related health-seeking behaviors. Drawing on the evidence from India and the evidence and lessons learned from other LMICs, program planners in India should do the following:

- **Inculcate sustainable gender-equitable norms from a young age** by implementing GBV programs with adolescent girls and boys that encourage critical reflection. Programs that encourage youth to examine notions of masculinity and gender norms can reduce GBV and change high-risk sexual behavior.
- **Engage men and boys through SBCC and critical reflection strategies** to challenge rigid gender norms and roles that justify violence against girls and women and to change behaviors that perpetuate violence and male aggression.
- **Use structural interventions to achieve other health outcomes, in addition to reducing the prevalence of GBV**, such as safer sex practices and reduced prevalence of HIV and STIs. In India, collective action by marginalized groups was particularly effective in encouraging safer sex practices and reducing the prevalence of HIV and STIs.
- **Integrate GBV services (screening, counseling, and referral) into existing maternal health services** to improve the health system response to GBV. Learning from other LMICs, India can also link HIV and STI testing, counseling, and treatment services within these structures.

Notes

1. For more information on individual strategies and their larger application to a variety of health areas, refer to the series of five strategy briefs, as part of the larger suite of materials associated with the full report, *Transforming Gender Norms, Roles and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*. Available at: www.healthpolicyproject.com/?p=381. For a complete list of all interventions examined in the review, including GBV-focused interventions, refer to *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Gender Integrated Programs Reference Document*.
2. Individual effectiveness ratings for each intervention are available in the *Transforming Gender Norms, Roles, and Dynamics for Better Health—Gender Integrated Programs Reference Document*. For an explanation of the rating scale, refer to the full report, *Transforming Gender Norms, Roles and*

Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries.

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