

**Addressing Gender-Based Violence in the Latin American and Caribbean Region:
A Critical Review of Interventions**

**Andrew Morrison, World Bank
Mary Ellsberg, PATH
Sarah Bott, Consultant**

This document is a collaborative effort between the World Bank and PATH.

Portions of this paper were adapted from the working paper “Preventing and responding to gender-based violence in middle and low-income countries: a multi-sectoral literature review and analysis” by Sarah Bott, Andrew Morrison and Mary Ellsberg. The authors would like to thank Lisa Bhansali, Sandra Cesilini, Teresa Genta-Fons and Andrea Guedes, who offered very helpful comments and suggestions.

World Bank Policy Research Working Paper 3438, October 2004

The Policy Research Working Paper Series disseminates the findings of work in progress to encourage the exchange of ideas about development issues. An objective of the series is to get the findings out quickly, even if the presentations are less than fully polished. The papers carry the names of the authors and should be cited accordingly. The findings, interpretations, and conclusions expressed in this paper are entirely those of the authors. They do not necessarily represent the view of the World Bank, its Executive Directors, or the countries they represent. Policy Research Working Papers are available online at <http://econ.worldbank.org>.

Abstract

This working paper presents an overview of gender-based violence (GBV) in Latin America, with special emphasis on good practice interventions to prevent GBV or offer services to its survivors or perpetrators. Intimate partner violence and sexual coercion are the most common forms of GBV, and these are the types of GBV that analyzed in this working paper.

GBV has serious consequences for women's health and well-being, ranging from fatal outcomes, such as homicide, suicide and AIDS-related deaths to non-fatal outcomes such as physical injuries, chronic pain syndrome, gastrointestinal disorders, complications during pregnancy, miscarriage and low birth-weight of children. GBV also poses significant costs for the economies of developing countries, including lower worker productivity and incomes, and lower rates of accumulation of human and social capital.

The working paper examines good practices approaches in justice, health, education, and multi-sectoral approaches. In each sector, good practices are identified for: (i) law and policies; (ii) institutional reforms; (iii) community-level interventions; and (iv) individual behavior change strategies.

The paper offers conclusions and recommendations for future work on GBV: (i) it is essential to focus on the prevention of GBV, not just on services for its survivors; (ii) prevention is best achieved by empowering women and reducing gender disparities, and by changing norms and attitudes which foster violence; and (iii) interventions should employ a multi-sectoral approach and work at different levels: individual, community, institutional, and laws and policies. GBV may be common in Latin America and the Caribbean, but there are promising approaches available to begin working toward its elimination.



PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, PATH helps provide appropriate health technologies and vital strategies that change the way people think and act. PATH's work improves global health and well-being. For more information, please visit www.path.org.

Executive summary

This working paper presents an overview of gender-based violence (GBV) in Latin America, with special emphasis on good practice interventions to prevent GBV or offer services to its survivors or perpetrators.

Violence against women is often referred to as “GBV” because it is rooted in women’s lack of power in relationships and in society relative to men. Intimate partner violence and sexual coercion are the most common forms of GBV, and these are the types of GBV that analyzed in this paper. GBV includes, but is not limited to: (i) physical violence, such as slapping, kicking, hitting with a fist or other object, or use of weapons; (ii) emotional violence, such as systematic humiliation, controlling behavior, degrading treatment and threats of harm; (iii) sexual violence, including forcible sexual intercourse, coerced sex by intimidation or threats, or being forced to take part in sexual activities that are considered degrading or humiliating; and (iv) economic violence, such restricting access to financial or other resources with the purpose of controlling or subjugating a person.

Magnitude, risk factors and impacts of GBV

Although both men and women can be victims as well as perpetrators of violence, the characteristics of violence most commonly committed against women differ in critical respects from violence commonly committed against men. Women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner. They are also at much greater risk of being sexually assaulted or exploited, either in childhood, adolescence or as adults.

Prevalence estimates for intimate partner violence vary widely among countries, and sometimes even between studies conducted in the same countries. The majority of studies estimate lifetime prevalence of physical violence between intimate partners between 20 and 50 percent of women. Sexual violence within marriage is also common, with estimates in Latin America ranging from 4 percent of women in Ecuador to 47 percent in Cusco (Peru) reporting having been forced by a partner to have sex against their will at some point in their lives. International research within the last decade has revealed that between 8 and 26% of women and girls reported having been sexually abused, either as children or adults.

GBV is a complex phenomenon, shaped by forces that operate at the individual, relationship, community and societal levels. Key risk factors include witnessing or suffering abuse as a child, exposure to violence as a child, male control of household decision-making and wealth, cultural norms that support violence as a way of resolving conflicts or support male dominance over women, low educational levels of men and women, and policies and laws that discriminate against women. As a trigger, male abuse of alcohol is important.

GBV has serious consequences for women’s health and wellbeing, ranging from fatal outcomes, such as homicide, suicide and AIDS-related deaths to non-fatal outcomes such as physical injuries, chronic pain syndromes and gastrointestinal disorders. Sexual violence may lead to

gynecological problems, unwanted pregnancy, chronic pelvic pain, unsafe abortion, and sexual dysfunction; intimate partner violence has been linked to similar outcomes, as well as complications during pregnancy, miscarriage and low birth-weight. Sexual abuse in childhood and adolescence has been linked to a higher risk of subsequent victimization, early sexual activity, substance abuse, and multiple sexual partners. Researchers have also documented negative outcomes among children of women who experience violence, including increased levels of child mortality and emotional and behavioral problems. GBV also poses significant costs for the economies of developing countries, including lower worker productivity and incomes, lower rates of accumulation of human and social capital, and the generation of other forms of violence both now and in the future.

Good practice interventions

The working paper is divided into four different sections organized by sector, namely: justice, health, education, and multi-sectoral approaches (e.g. social services and economic development). A table at the beginning of each section succinctly summarizes the objectives of interventions in that sector and provides concrete examples of promising approaches. In each sector, good practices are identified for: (i) law and policies; (ii) institutional reforms; (iii) community-level interventions; and (iv) individual behavior change strategies.

Justice sector

There are a number of ways that the justice sector can contribute to prevention of intimate partner violence and sexual violence: by sanctioning those who perpetrate crimes against women; by increasing awareness throughout society that physical or sexual violence against women is considered a crime; by strengthening women's rights with regard to marriage, divorce, property and child custody; by increasing women's access to the legal system; by increasing the range of interventions to protect victims; by correcting procedural and evidentiary problems in criminal prosecutions; and by reducing mistreatment of women and children by the law enforcement institutions themselves.

In Latin America and the Caribbean, efforts to improve laws and policies have had two foci: (i) drafting and ratifying international conventions that provide an overarching legal framework to support national legislation, and (ii) enacting new specialized legislation on GBV or reforming national civil and criminal codes.

The overwhelming lesson from legislative reform is that changing the law is only the first step in a long process, since much legislation has been implemented poorly or not at all.

Throughout the region, several promising initiatives have been undertaken to sensitize and train police, judges and other law enforcement personnel to improve knowledge, attitudes, and practices related to GBV. Other important justice sector initiatives include: including initiatives to improve services to victims of GBV in justice sector reform projects; creating women's police stations; improving the medico-legal response to GBV; and improving knowledge of women's right to live free of violence.

Health sector

International professional associations have produced guidelines for identifying and treating GBV and exhorted their members to actively address violence in their clinical practice. These have proven to be an effective way to reach health professionals. In many Latin American countries specific legislation and policies specifying the obligation of the health sector to address violence against women have been enacted either through ministerial decrees or as part of national family violence legislation.

In the last decade, there have been many initiatives to strengthen the health sector approach to GBV in Latin America. The Pan American Health Organization, the Inter-American Development Bank, and the International Planned Parenthood Federation/Western Hemisphere Division (IPPF/WHF) have been pioneers in developing an integrated approach for working with violence in the health sector in Latin America. Unlike many of the programs implemented in industrialized countries, most of these programs have a broader focus than simply implementing a screening and referral protocol. At the level of health services, the most common activities carried out include: screening for abuse; risk assessment, medical care; documentation of the violent event and its health consequences; counseling; referrals to a network of service providers; and community-focused prevention initiatives.

Many NGOs have also launched programs to promote community-wide changes in attitudes and practices related to gender norms and violence against women--often as a component of HIV/AIDS prevention or reproductive health programs. The few that have been carefully evaluated suggest that community-level approaches can be effective in changing violence-related attitudes and behaviors.

Many health sector-based programs have attempted to produce individual behavior change by working with individual men and boys. Some programs report a positive impact on men's self-reported attitudes and behaviors, but most information is still preliminary or based on evaluations without control groups or baseline data.

Education sector

A growing body of evidence suggests that sexual harassment is widespread in educational settings in many parts of the world, but data remain scarce for Latin America and the Caribbean. Schools—and more broadly the educational system and communities—can engage in the prevention of GBV by: reforming laws and policies of the education sector, improving the institutional response at the school-level to GBV, and promoting community mobilization in support of girls' safety and rights.

In terms of policy reform of the education sector, potential interventions by an Education Ministry include: (i) preparing a national action plan to combat GBV in schools; (ii) developing a code of conduct for teachers that, among other elements, prohibits gender violence in schools; (iii) developing policies on how to deal with teacher misconduct, including investigative mechanisms; and (iv) including violence against women and harassment as themes to be covered within health and sexual education programs for students.

Efforts to improve the institutional response to GBV at the school-level include efforts to: improve girls' safety at and on the way to school; train teachers and school staff to reduce sexual harassment and promote gender equitable norms and nonviolence; expand counseling and referral services; include prevention of GBV in sexual and reproductive health curricula; and initiate school-based programs to prevent GBV and other forms of violence

Multi-sectoral approaches

Improving coordination between sector-specific approaches as well as between civil society initiatives and government institutions has been underscored by numerous experts as a critical component of an effective strategy for addressing GBV.

Virtually all Latin American governments have established national commissions for the purpose of improving inter-sectoral coordination and monitoring progress on the development of national plans and policies on violence. Although there are no rigorous evaluations of the effectiveness of the national plans, qualitative reports suggest that the existence of a national plan on violence against women is an important achievement in itself, as it creates a political space for greater dialogue between civil society and the state, while simultaneously committing government to a public discourse that encourages sanctions against violence.

Services for survivors of GBV frequently provided in multi-sectoral initiatives include telephone hotlines, emergency shelters, police intervention, legal assistance, counseling services, psychological care, support groups, income-generation programs, programs for batterers, shelters and child welfare services. A large literature exists on caring for survivors of physical and sexual abuse within specific professional disciplines, but research on the effectiveness, quality and impact of social service programs is scarce in low and middle-income countries.

A relatively new approach is to develop community-based networks for coordinating services to victims, improving access to justice and promoting violence prevention. These networks may be made up entirely of governmental agencies such as the criminal justice sector, social welfare and education. Another type of network coordinates the response of civil society to violence, and a third type integrates public and private agencies addressing GBV. These networks can greatly enhance the quality of care provided to survivors. They can also play an important role at a community level in mobilizing public support for survivors of violence and decreasing tolerance of violent behavior.

Community-based educational activities can increase women's knowledge of legal and social rights and empower them to seek help for abuse. They can also challenge the underlying beliefs that justify women's subordination and the use of violence for settling conflicts. Promoting non-violent and equitable relationships between men and women is the key to preventing future violence.

Conclusions and recommendations

Of first and foremost importance are what Guedes (2004) identifies as "guiding principles" for work on GBV, which include: ensuring that all programs and projects prioritize survivors' safety and autonomy; employing a human rights perspective in order to explicitly challenge

prevailing norms that make violence acceptable within a society; and ensuring that interventions are culturally appropriate before transferring interventions from one cultural context to another.

There are other important conclusions as well. It is essential to focus on the prevention of GBV, not just on services for its survivors. Prevention is best achieved by empowering women and reducing gender disparities, and by changing norms and attitudes which foster violence. Interventions should employ a multi-sectoral approach and work at different levels: individual, community, institutional, and laws and policies. They should create and foster partnerships between government and nongovernmental agencies. GBV may still be common in Latin America and the Caribbean, but there are promising approaches available to begin working toward its elimination.

Introduction

During the last decade, violence against women and girls, also referred to as “gender-based violence,” has gained international recognition as a grave social and human rights concern affecting virtually all societies.¹ Epidemiological research has demonstrated that gender-based violence is a major cause of ill health among women and girls, whose impact can be seen directly through death and disability due to injuries, as well as indirectly through increased vulnerability to a host of physical and mental health problems. Violence and the fear of violence severely limit women’s contribution to social and economic development, thereby hindering the achievement of important national and international development goals such as the Millennium Development Goals of eradicating extreme poverty and hunger and improving maternal and child health.

This working paper presents an overview of gender-based violence (GBV) in Latin America, with special emphasis on good practice interventions to prevent GBV or offer services to its survivors or perpetrators. Section 1 begins with definitions and magnitudes, a theoretical framework for understanding the risk factors that increase the likelihood of GBV, and the health consequences and socioeconomic costs generated by GBV. Section 2 identifies the challenges in identifying good practice responses to GBV and presents good practice interventions in the justice, health, education sectors, respectively. It also includes a description of multi-sectoral interventions that involve economic and social empowerment of women, improved access to services for survivors of GBV, and the transformation of community norms about GBV. Section 3 presents overarching conclusions and recommendations.

1. Gender-Based Violence: Definitions, Prevalence, Risk Factors and Consequences

1.1 Definitions of GBV

The United National Declaration on the Elimination of Violence against women (1993) defines violence against women as “any act of GBV 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” (United Nations General Assembly 1993—see Box 1.1 for the complete definition). GBV takes place in the home as well as in schools, workplaces, and in the community at large. Although most violence is perpetrated by individuals or groups of individuals, the UN definition also encompasses violence perpetrated by the state, either through direct actions or through failure to protect its citizens from harm.

¹ The term GBV is commonly used synonymously with violence against women, although, in reality, virtually all violence is “gendered,” in that men and women have different risks of participating in or being victimized by violent behavior.

GBV includes, but is not limited to:

- Physical violence, such as slapping, kicking, hitting with a fist or other object, or use of weapons
- Emotional violence, such as systematic humiliation, controlling behavior, degrading treatment and threats of harm
- Sexual violence, including forcible sexual intercourse, coerced sex by intimidation or threats, or being forced to take part in sexual activities that are considered degrading or humiliating
- Economic violence, such as restricting access to financial or other resources with the purpose of controlling or subjugating a person.

Box 1.1

United Nations Definition of Violence against Women

The term “violence against women” refers to any act of GBV that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

- a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilization and forced abortion, coercive/ forced use of contraceptives, female infanticide and prenatal sex selection.

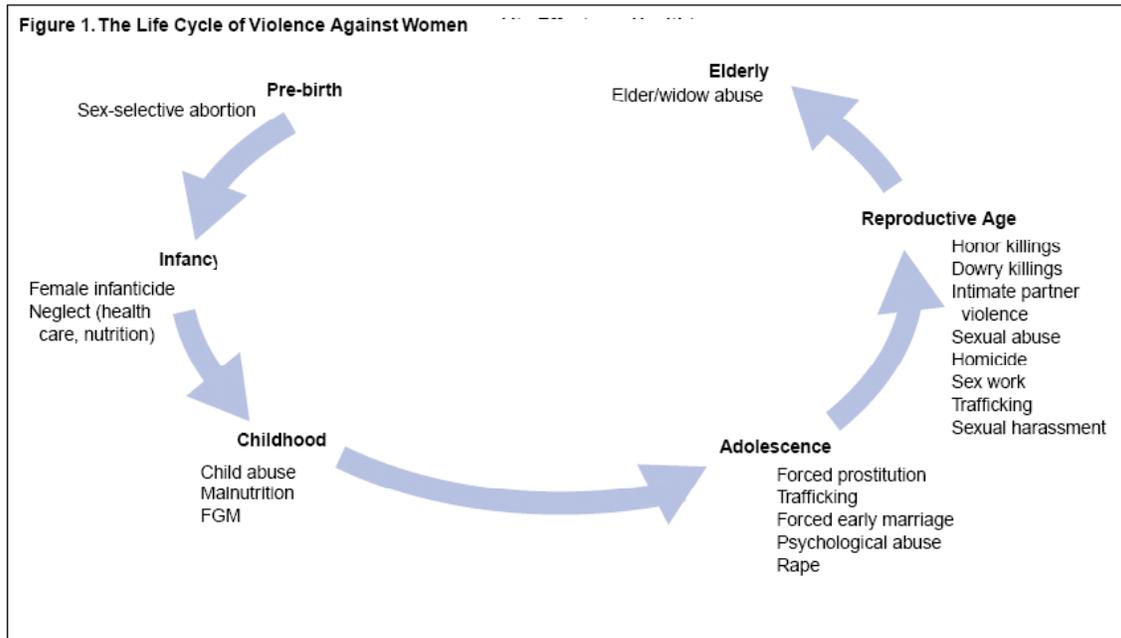
Beijing Declaration and Platform for Action

Although both men and women can be victims as well as perpetrators of violence, the characteristics of violence most commonly committed against women differ in critical respects from violence commonly committed against men. Men are more likely to be killed or injured in wars or in youth and gang-related violence than women, and they are more likely to be physically assaulted or killed on the street by a stranger. Men are also more likely to be the perpetrators of violence, regardless of the sex of the victim (World Health Organization 2002). In contrast, women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner (Heise, Ellsberg et al. 1999). They are also at much greater risk of being sexually assaulted or exploited, either in childhood, adolescence or as adults. Women are vulnerable to different types of violence at different moments in their lives (see Figure 1.1).

Violence against women is often referred to as gender-based because it is rooted in women's lack of power in relationships and in society relative to men. In many societies, women are expected to be submissive and sexually available to their husbands at all times, and it is considered both a right and an obligation for men to use violence in order to "correct" or chastise women for perceived transgressions. For unmarried women, sexual violence is so stigmatizing that most women prefer to suffer in silence than to risk the shame and discrimination that would result from disclosure. Violence within the family has been traditionally considered a private matter in which outsiders, including government authorities, should not intervene. The bonds of family, economic and emotional dependence that often surround perpetrators and their victims distinguishes violence against women from most violence against men, and therefore requires distinct strategies for prevention and protection of victims.

Intimate partner violence and sexual coercion are the most common forms of GBV, and these are the types of GBV that analyzed in this paper. Thus, forms of GBV such as trafficking or violence against women in the context of armed conflict are not discussed; while important, space constraints preclude including them in this paper.²

² Most experts agree that trafficking of women and girls has grown rapidly during the past decade, largely as a result of war, displacement and economic and social inequities between and within countries. The Pan American Health Organization notes that social unrest and political instability in Latin America and the Caribbean, together with increased popularity of the region as a destination for sex tourists has led to an alarming growth of trafficking in recent years. For example, it is estimated that as many as 35,000 Colombian women are trafficked each year and 50,000 women from the Dominican Republic are working abroad in the sex industry. As many as 2,000 children are sexually exploited in 600 brothels in Guatemala City (Phinney, 2002). Violence against women in situations of armed conflict has been largely overlooked until recently, when reports documented systematic rape in many conflict situations throughout the world (Swiss and Jennings, 1998; Ward, 2002). International relief agencies are also calling attention to the precarious situation of women in refugee settings, where rape, child sexual abuse, intimate partner violence and other forms of sexual exploitation are widespread.



1.2. Magnitude and Dynamics of Gender-Based Violence

GBV exists to some degree in virtually all societies and all socio-economic and cultural groups. Based on international reviews, it has been estimated that approximately one out of every three women globally is beaten, raped or otherwise abused during her lifetime (Heise, Ellsberg et al. 1999).

Prevalence estimates for intimate partner violence vary widely among countries, and sometimes even between studies conducted in the same countries. In Latin America and the Caribbean, 22 studies in 15 different countries indicate that between 7 and 69 percent of women have been physically abused by an intimate partner at some point in their lives (Table 1.1, based on Ellsberg, Heise et al. forthcoming). The majority of studies estimate lifetime prevalence of intimate partner violence between 20 and 50 percent of women.

Sexual violence within marriage is also common, with estimates in Latin America ranging from 4 percent of women in Ecuador to 47 percent in Cusco (Peru) reporting having been forced by a partner to have sex against their will at some point in their lives (Heise, Ellsberg, and Gottemoeller, 1999). Sexual violence often accompanies physical battery by intimate partners; moreover, women who experience physical violence by intimate partners may be less able to negotiate when and how they have sex. Nonetheless, large variations exist in patterns and prevalence levels of sexual violence among different countries and regions.³

³ For example, a study from León, Nicaragua found that nearly all women who reported sexual violence had also experienced physical violence (Ellsberg et al, 2000). In contrast, a study from Indonesia found that sexual violence often occurs outside the context of physical violence and may be even more common than physical violence (Hakimi et al., 2001).

Table 1.1. Physical and sexual violence against women by an intimate male partner, selected population-based studies from Latin America and the Caribbean, 1993-2003.

Country	Year of study	Coverage	Sample			% women ever sexually assaulted by a partner	% women physically assaulted by a partner	
			Size	Study population*	Age (years)		During the previous 12 months	Ever
**Barbados	1990	National	264	I	20-45			30 ^{a,b}
Brazil	2001	Sao Paulo	940	III	15-49	10	8	27
	2001	Pernambuco	1188	III	15-49	14	13	34
Chile	1993	Santiago province	1000	II	22-55			26 ^c
	1997	Santiago	310	II	15-49		23	
Colombia	1995	National	6097	II	15-49			19 ^c
	2000	National	7602	III	15-49	11	3	44
Dominican Republic	2002	National	6807	III	15-49	6	11	22
El Salvador	2002	National	10689	III	15-49			7 ^c
Guatemala	2002	National	6595 ^f	IV	15-49		8	
Honduras	2001	National	6827	IV	15-49		6	10
Haiti	2000	National	2347	III	15-49	17	21	29
Mexico	1996	Guadalajara	650	III	>15			27
		Monterrey	1064	III	>15			17
Nicaragua	1995	Leon	360	III	15-49	10	27	52
	1997	Managua	378	III	15-49		33	69
	1998	National	8507	III	15-49	10	13	30
Paraguay	1995-96	National	5940	III	15-49			10
Peru	2000	National	17369	III	15-49		2	42
	2001	Lima	1019	III	15-49	23	17	50
	2001	Cusco	1497	III	15-49	47	25	62
Puerto Rico	1995-96	National	4755	III	15-49			13 ^c
Uruguay	1997	National		II	22-55		10 ^b	

Key

Study population: I = all women; II = currently married/partnered women; III = ever-married/partnered women; IV = women who had a partner within the last 12 months

^a Sample group included women who had never been in a relationship and therefore were not in exposed group

^b Physical or sexual assault.

^c During current relationship

Source: Ellsberg, Heise et al.. forthcoming.

Research indicates that young women in partnerships have generally less autonomy and are at greater risk for both physical and sexual violence than older women. In Nicaragua, for example, not only did women between 15-19 report more physical and sexual violence within the last 12 months than older women, but they also experienced more severe acts of violence (Rosales, et al., 1999).

International research within the last decade has revealed that sexual abuse of women and girls by non-partners is also much more common than previously thought. Between 8 and 26% of women and girls reported having been sexually abused, either as children or adults (World Health Organization 2002). These figures are likely to be under-estimates of the true prevalence of abuse, as many women are reluctant to disclose violence due to shame and fear of reprisals (Koss 1993).

One of the main challenges for addressing GBV stems from the lack of evidence on the magnitude and characteristics of violence in different settings. There are many inconsistencies in the methods used by different researchers that make comparisons difficult across countries or even among studies within a given country. These include the reference period used (lifetime prevalence, 12 month prevalence or ongoing violence), the number and wording of questions asked, the age cut-off for abuse (before and after 12 years, before and after 15).

During the last decade, however, there have been several efforts to improve the measurement of GBV. The World Health Organization has conducted a multi-country study on domestic violence and women's health in 15 sites and 10 countries. This study has produced comprehensive set of research tools, including instruments, field manuals and data entry programs (Garcia Moreno, Watts et al. 2003). The United Nations Interregional Crime and Justice Research Institute (UNICRI) has also initiated surveys in several countries on violence against women. Both the Demographic and Health Surveys conducted by Macro International and the Centers for Disease Control's Reproductive Health Surveys have begun to incorporate questions on violence in their surveys (Kishor and Johnson 2004).

There is some evidence that large-scale surveys designed primarily for other purposes such as the Demographic and Health Surveys are more likely to under-estimate the prevalence of violence than studies that focus specifically on violence. Characteristics of violence-specific surveys such as specialized training of interviewers, greater emphasis on privacy and safety of respondents, and multiple opportunities to disclose violence have been found to have a positive effect on women's reporting of violence (Ellsberg, Heise et al. 2001; Jansen, Watts et al. 2004).

1.3 A Causal Framework for Understanding Gender-Based Violence

GBV is a complex phenomenon, shaped by forces that operate at different levels. An ecological framework that combines factors which operate at the individual, relationship, community and societal levels thus provides an appropriate lens through which to examine

GBV. It is particularly useful for examining the combination of risk factors that increase the likelihood that GBV will occur in a particular setting.⁴

Although the ecological framework has gained broad acceptance for conceptualizing violence, there have been few attempts to explore how individual- and community-level risk factors relate to each other and ultimately influence women's vulnerability to violence. A study in Bangladesh, for example, found that some aspects of women's status could either increase or decrease a woman's risk of being beaten, depending on the socio-cultural conditions of the community in which she lives.⁵ These findings suggest that the same condition (autonomy of movement or participating in a credit group) may have different effects on a woman's risk of violence depending on whether the activity is seen as acceptable or not by community norms. These findings underscore the complexity of GBV and the danger in applying knowledge gained from one site to another without understanding of the broader cultural context.⁶

Within a given cultural context, the most appropriate way to identify risk factors for GBV is in a multivariate framework rather than through bivariate correlations. A multivariate framework allows one to control for the presence of potentially confounding factors and to establish the relative importance of different factors. To date, the majority of multivariate analysis on risk factors has been conducted in the United States and Europe, although there are some recent findings from South Africa, Bangladesh, Uganda, Chile and Nicaragua (Larrain 1994; Ellsberg, Liljestrand et al. 1997; Jewkes, Levin et al. 2002; Koenig, Lutalo et al. 2003; Koenig, Ahmed et al. 2003).

It is also important to note that risk factors should be identified for particular manifestations of GBV. While there are certainly common causes across different manifestations of GBV—such as intimate partner violence, rape by non-partners, and elder abuse, for example—the risk factors may vary somewhat between the different manifestations of abuse, as too will the relative importance of specific risk factors.

Table 1.2 reports the risk factors which have been identified for intimate partner violence, the form of GBV for which the most empirical research on risk factors has been undertaken internationally. It is immediately apparent that certain types of risk factors operate at all

⁴ The term "risk factors" is used quite intentionally, rather than the more common term "determinants". The term determinants implies a mechanistic (indeed, deterministic) relationship between variables: if a man abuses alcohol, for example, intimate partner violence will result. This is clearly not the case; alcohol abuse increases the likelihood of intimate partner violence, but does not mechanistically indicate the presence of violence.

⁵ In one site, characterized by more conservative norms regarding women's roles and status, women with greater personal autonomy and those who participated for a short time in savings and credit groups experienced more violence than women with less autonomy. Community-level measures of women's status had no effect on the risk of violence. The opposite was true in the less conservative setting where women had better overall status. In this site, individual measures of autonomy and participation in credit schemes had no impact on the risk of violence, while living in a community where more women participated in credit groups and where women had a higher status overall had a protective effect (Koenig, M. A., S. Ahmed, et al. 2003).

⁶ Most of the evidence addressing the influence of cultural norms of the prevalence of gender based violence has come from ethnographic research (Levinson, 1989; Counts, D., J. K. Brown, et al., (1999).

Table 1.2. Correlates for intimate partner violence

Individual-level⁷	Relationship-level⁸	Community-level⁹	Societal level¹⁰
<i>Socialization and learning</i>			
witnessing intimate partner violence as a child (+) ¹¹		neighborhood crime rates (+)	cultural norms that support violence as an accepted way to resolve conflicts or to punish transgressions(+)
suffering abuse as a child (+)	association with gang, delinquent or patriarchal peers (+)	absent or maladaptive teaching of alternatives to violence (+)	
<i>Power relations and patriarchal gender norms</i>			
absent or rejecting father (+)	male control of household decision-making and wealth (+)		norms that support male dominance over women and that require women's obedience and sexual availability (+)
	Controlling behavior on the part of the husband (+)		
	Multiple partners/wives for the husband (+)		Policies and laws that discriminate against women in social, economic and political spheres
	Differences in spousal age and education (+)		
<i>Human capital and employment</i>			
female educational level (-)	economic hardship (+)	Lack of economic opportunities for men (+)	
male educational level (-)			access and control over economic resources for women (+/-)
Women engaged in income generation activities (+/-)			
<i>Life cycle</i>			
age of woman (-)	length of relationship (-)		
Triggers			
HIV status of man or woman (+)	alcohol and substance abuse by male (+)		

Sources: Gordon and Crehan (n/d); Heise (1998); Hindin and Adair (2002); Jewkes (2002a); Jewkes (2002b); Koenig (2003) Koss; Loi et al. (n/d); Martin (2002); WHO (2002).

⁷ Individual level: biological and personal history factors among both victims and perpetrators

⁸ Relationship level: proximal social relationships, including relations with friends, peers and family.

⁹ Community level: community context in which social relationships are embedded, including schools, workplaces and neighborhoods

¹⁰ Societal level: larger societal factors that “create an acceptable climate for violence, reduce inhibitions against violence, create an sustain gaps between segments of society (WHO, 2002: 13).”

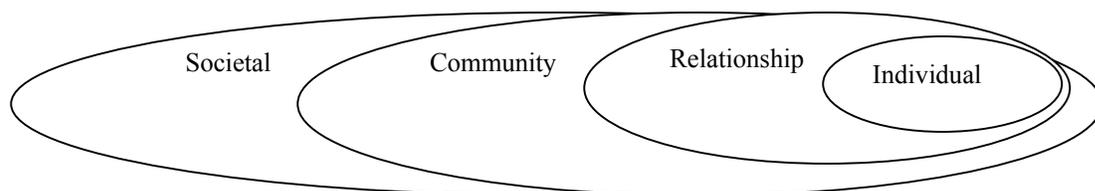
¹¹ For boys, witnessing violence increases the risk of becoming an abuser, whereas for girls it increases the risk for future victimization.

levels of the ecological model (individual, relationship-level, community and society). Socialization and learning of violent behaviors, for example, occurs at the individual level if a child witnesses intimate partner violence between adults in his or her household, or if a child is a victim of abuse (Ellsberg, Peña et al. 1999; Kishor and Johnson 2004). At the relationship level, association with peers who themselves commit intimate partner violence or who promote norms of male dominance over women increases the likelihood of intimate partner violence (Heise 1998). At the community level, one study found that neighborhood crime rates affect the probability of intimate partner violence, presumably through community norms about violence and criminality (O'Campo, Gielen et al. 1995). At the societal level, cultural norms that support violence as an accepted way to resolve conflicts reinforce household norms to this effect.

Other types of risk factors operate at multiple levels. Power relations and patriarchal gender norms operate at the individual level by influencing the degree to which women can attain education and financial autonomy, themselves risk or protective factors for intimate partner violence. At the relationship level, power relations manifest themselves through male control of wealth and household decision-making and through marital conflict. Finally, at the community and societal levels, power and patriarchy play out in norms that support male dominance of women, and in limited public roles for women.

The fact that risk factors operate at multiple levels has important implications for the design of interventions to address GBV. Interventions, to be effective, will generally need to address risk factors at these different levels of aggregation.¹² Thus, we use the ecological model as a way to organize the presentation of the good practice interventions in the following sections. (See Figure 1.2 for a graphical representation of the ecological model.)

Figure 1.2 Ecological Model



Source: WHO, 2002

¹² This does *not* mean that each and every intervention must intervene at multiple levels, but rather that each level should be addressed by some intervention.

1.4 Health Consequences of Gender-Based Violence

A growing body of epidemiological evidence documents the consequences of GBV for women's health and well-being, ranging from fatal outcomes such as homicide, suicide and AIDS-related deaths to non-fatal outcomes such as physical injuries, chronic pain syndrome, gastrointestinal disorders, and unintended pregnancies and sexually-transmitted infections—the latter two largely as a result of being less able to negotiate family planning or condom use (Gazmararian et al., 1995; Heise, Ellsberg et al. 1999; Garcia Moreno, 2002).

Physical and sexual violence has consequences for women's mental health, such as post-traumatic stress syndrome, depression, anxiety, and low self-esteem, as well as behavioral outcomes such as alcohol and drug abuse, and sexual risk-taking and a higher risk of subsequent victimization. It has become increasingly clear that injuries—previously considered the most common outcome of violence—represent only the tip of the iceberg in terms of negative health effects, and that violence is more appropriately conceptualized as a risk factor for health problems than as a health condition in itself. (See table 1.3 for a summary of the health consequences of intimate partner violence and sexual violence by any perpetrator.)

Table 1.3. Health consequences of intimate partner violence and sexual violence by any perpetrator

Fatal outcomes	Nonfatal outcomes		
	Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioral outcomes
Femicide	Fractures	Gynecological disorders	Depression and anxiety
Suicide	Abdominal/thoracic injuries	Pelvic Inflammatory disease	Eating and sleep disorders
AIDS-related mortality	Chronic pain syndromes	Sexually-transmitted infections, including HIV	Drug and alcohol abuse
Maternal mortality	Fibromyalgia	Unwanted pregnancy	Phobias and panic disorder
	Permanent disability	Pregnancy complications	Poor self-esteem
	Gastrointestinal disorders	Miscarriage / low birth weight	Post-traumatic stress disorder
	Irritable bowel syndrome	Sexual dysfunction	Psychosomatic disorders
	Lacerations and abrasions	Unsafe abortion	Self harm
	Ocular damage		Unsafe sexual behavior

Source: Adapted from Heise, Ellsberg and Gottemoeller (1999).

Sexual violence has particularly serious consequences for women's sexual and reproductive health. It may lead to gynecological problems, unwanted pregnancy, chronic pelvic pain, unsafe abortion, and sexual dysfunction; intimate partner violence has been linked to similar outcomes, as well as complications during pregnancy, miscarriage and low birth-weight (Campbell, 2002). Sexual abuse in childhood and adolescence has been linked to a higher risk of subsequent victimization, early sexual activity, substance abuse, and multiple sexual partners (Felitti et al., 1998; Heise, Ellsberg, and Gottemoeller, 1999; Walker et al., 1999).

Many women consider the psychological consequences of physical, sexual and emotional abuse to be even more serious than its physical effects. Recent results from the WHO Multi-Country Study on Women's Health and Domestic Violence found that women with a history of physical and/or sexual partner abuse were as much as three times more likely to consider and/or attempt suicide. In all 10 countries surveyed, women who had experienced intimate partner violence at any point in their lives were significantly more likely to be suffering from symptoms of emotional distress at the time of the interview (World Health Organization, 2004).

Researchers have also documented negative outcomes among children of women who experience violence. For example, researchers in Nicaragua found that children of women who were physically and sexually abused by their partners were six times more likely than other children to die before the age of five, with one third of all child deaths in this setting being attributed to partner violence (Åsling-Monemi et al., 2003). Boys and girls who witness violence in the home may be at increased risk for emotional and behavioral problems, such as anxiety, depression and violence towards their peers (Jaffe and Sudermann, 1995) and, in the case of boys, for perpetrating intimate partner violence and/or sexual violence as adults (Straus and Gelles 1986; Ellsberg, Peña et al. 1999; Kishor and Johnson 2004).

1.5 Socioeconomic Costs of Gender-Based Violence

GBV poses significant costs for the economies of developing countries, including lower worker productivity and incomes, lower rates of accumulation of human and social capital, and the generation of other forms of violence both now and in the future. This section will present methodological options for measuring the costs of violence, as well as some estimates produced by these methodologies.

Before presenting the methodological options, however, a more fundamental question must be addressed: why produce cost estimates at all? GBV is already recognized as a serious human rights issue, a priority issue for women's organizations, and an important public health issue. What additional purpose is served by producing cost estimates? The answer is simple: estimates of economic costs facilitate the "dimensioning" of the issue, i.e., determining the relative importance of GBV violence among the panoply of pressing development issues.

The most common approach used to calculate the costs of GBV has been an “accounting methodology”, in which costs are calculated for specific categories of costs, and total cost to society is simply the sum of all distinct categories of costs. Typical of this approach is CDC (2003), which specifies two types of costs:

- *Direct costs* are actual expenditures related to GBV, including health care services, judicial services and social services.
- *Indirect costs* represent the value of lost productivity from both paid work and unpaid work, as well as the foregone value of lifetime earnings for women who have died as a result of GBV.

A recent estimate of the direct health care costs of intimate partner violence against adult women in the U.S. found costs of over 4 billion dollars in 1995, including both mental health and medical care costs (CDC, 2003). Similar methodologies have been employed by to generate estimates for the U.S. (Spalter-Roth, 1995), Canada (Greaves et al., 1995; Health Canada, 2002), Holland (Korf et al., 1997), the U.K. (Stanko et al., 1998), Switzerland (Godenzi and Yodanis, 1998), and Australia (Australian Institute of Criminology, 2002), as well as for the states and provinces of Queensland (Blumel et al., 1993), British Columbia (Kerr and McLean, 1996), Northern Territory (Office of Women’s Policy, 1996), and Washington (New and Berliner, 2000).¹³

To the best of our knowledge, there are only two such direct cost studies for GBV in developing countries. Mansingh and Ramphal (1993) estimate that the direct costs of treating victims of intimate partner violence in Kingston Public Hospital (Jamaica) totaled U.S. \$454,000 in 1991 (in 2001 dollars). Sánchez et al. (2004) find that the Colombian national government spent approximately 184 billion pesos (U.S. \$73.7 million) in 2003 to prevent, detect and offer services to survivors of family violence—an amount equal to approximately 0.6% of the total national budget.¹⁴

One of the weaknesses of the accounting approach to estimate direct costs is that any list of categories is essentially arbitrary and alternative categorizations can always be devised (Buvinic and Morrison, 1999). An even more serious weakness is that key categories of costs can be inadvertently left out of the calculations. For example, most estimates of direct costs do not include the costs generated by children witnessing or being a victim of family violence.¹⁵

¹³ These studies are reviewed in Yodanis et al. (2000) and WHO (2004).

¹⁴ These represent expenditures of the following institutions: Colombian Social Welfare Institute (Instituto Colombiano de Bienestar Social), Sub-secretariat for security and peaceful coexistence (Subsecretaria para asuntos de seguridad y convivencia ciudadana), Attorney General’s Office (Fiscalía General de la Nación) and the National Medical-Legal Institute (Instituto Nacional de Medicina Legal). The \$73.7 million refers only to services related to family violence.

¹⁵ These impacts may include: poorer performance in school (Larraín et al., 1997); increased probability of delinquency, both as a juvenile and as an adult (Windom, 1989; Dahlberg, 1998; Thornberry et al., 2001); children leaving abusive homes to live on the street (Hernández Rosete, 1998); substance abuse (Molnar et al., 2001); attempted suicide (Dube et al., 2001); higher probability of committing family violence as an adult (Strauss, et al 1980).

Direct cost estimates are especially problematic in a developing country context: lack of availability of services or serious under-funding of services means that direct costs associated with GBV will be low—perhaps giving the mistaken impression that that the problem is not important when in fact prevalence rates may be quite high. If estimates of direct costs of GBV are not particularly useful in a developing country context, what options are left to document the socioeconomic costs of GBV? One option is to concentrate on estimating indirect costs.

Indirect cost estimates have focused on: (i) foregone earnings due to death and lost productivity (CDC, 2003); (ii) job loss, lost productivity of the women, lost productivity of the abuser due to incarceration, and mortality (Laurence and Spalter-Roth, 1995); (iii) loss of tax revenues due to death and incarceration (Greaves et al., 1995); and (iv) reduced earnings of women (Morrison and Orlando, 1999; Sánchez et al. 2004). By estimating earnings equations of the determinants of women’s earnings, Morrison and Orlando (1999) find that lost wages due to family violence amounted to 1.6 and 2.0% of GDP in Nicaragua and Chile, respectively. Using a non-parametric matching methodology on DHS data from 1995, Sánchez et al. (2004), find that Colombian women who suffer physical violence have 14% lower earnings than women who do not suffer violence; using more recent data from 2003, they estimate that the wage loss due to family violence was equivalent to 0.85% of 2003 GDP.¹⁶

While the indirect costing approach offers more methodological rigor and perhaps better precision in the estimation of the labor market impacts of violence, it is subject to one of the same criticisms leveled at the accounting approach: important categories of costs are not examined—although in this case the methodology makes no claim of producing a comprehensive estimate of the costs of GBV.

Another option for estimating the socioeconomic costs associated with GBV—and one frequently employed by economists to establish the market value of non-market goods—is to estimate the willingness of individuals (and by extension society) to pay for lives free of GBV. This approach has the advantage of producing a comprehensive estimate of the cost of GBV in a specific locale. The approach, however, has been used only very infrequently to gauge the welfare loss occasioned by GBV (see Sorenson (2003) for one of the few examples), presumably for two reasons. First, as the CEDAW and Belém do Pará conventions make explicit, living lives free of violence is a human right; estimating the willingness to pay for a right—while demonstrating the importance society attaches to an issue—may itself be controversial. A second unattractive feature of willingness to pay estimates is that they are sensitive to income levels and income distribution.

A final option for estimating the socioeconomic costs of GBV it to use the metric of disability adjusted life years (DALYs) lost to GBV. DALYs have the great advantage of including years lost due not only to premature mortality, but also due to disability or illness;

¹⁶ The matching methodology estimates a reduced form equation for the determinants of the probability of suffering violence; it then matches women who suffered violence with those who did not, but had a similar “a priori” probability of having done so. Determinants of violence included in this regression were age, marital status, education level, and many others.

DALY calculations, however, are methodologically complex and data intensive. The first estimate of the DALY costs of GBV was presented by Heise et al. (1994), who estimated that more than nine million DALYs are lost each year worldwide as a result of rape and family violence, more than that from all types of cancer and more than twice that lost by women in motor vehicle accidents. More recently, Lozano (1999) estimated that rape and family violence against women were the third most important cause of DALYs lost in Mexico City—behind diabetes and perinatal conditions, but ahead of auto accidents, congenital anomalies, rheumatoid and osteo-arthritis, cardiovascular disease, stroke and pneumonia.

DALY estimates produce a number—x number of years lost—but it is necessary to compare this number to DALY estimates for other conditions in order to make some sense of the number. If this comparative exercise is undertaken, DALY estimates are useful for dimensioning the importance of GBV relative to other public health problems. The weakness of this approach is that outcomes which do not result in mortality or morbidity—such as lost productivity or increased future criminality children—are not captured in the DALY estimates.

In sum, there is no perfect methodology with which to gauge the socioeconomic costs of GBV. All methodologies have strengths and weaknesses, and the challenge is to choose the appropriate methodology given both data constraints and the potential consumers of the estimates.

2. Initiatives to Prevent and Respond to Gender-Based Violence

2.1. Introduction

Over the past 20 years, many initiatives have sought to address GBV; unfortunately, relatively few have been rigorously evaluated. Evidence about effective approaches is particularly sparse in middle and low-income countries, but even in high-income countries, a review by Chalk and King (1998) found that among several hundred relevant intervention studies only 34 were deemed methodologically sound.¹⁷

Evaluating initiatives to prevent or respond to violence against women involves a host of methodological challenges. First, preventing violence often appears to require multiple organizations, strategies and sectors—which often makes it difficult to determine which specific strategies can be credited with any changes measured; narrow approaches are easier to evaluate, but may be less effective (Chalk and King, 1998). Second, defining and measuring levels of violence against women have not proven to be straightforward tasks (Campbell, 2000; (Ellsberg, Heise et al. 2001). Third, “successful” programs may actually appear to increase levels of violence as measured by the number of women reporting cases;

¹⁷ In general, evaluations have been characterized by a number of weaknesses such as: exclusive reliance on “process” or “output indicators”; failure to measure (or even specify) the outcomes that the interventions were expected to achieve; lack of baseline data because evaluations did not begin until after programs were fully implemented; lack of control groups (or communities); short follow-up periods or no follow-up at all; and Small sample sizes.

this “increase in violence” is illusory in the sense that underlying prevalence has not changed, but the increase in reported cases may have real consequences for police and other service providers. Finally, few evaluations have measured program outcomes over a long period of time; evaluations which measure only short-term effects cannot determine whether attitudinal or behavior changes are sustained in the long run.

2.1.1 The structure of this section

The following sections review what is known about more and less effective ways to prevent and respond to GBV. The review is divided into four different sections organized by sector, namely: justice, health, education, and multi-sectoral approaches (i.e., social services and economic development). A table at the beginning of each section succinctly summarizes the objectives of interventions in that sector and provides concrete examples of promising approaches.

In keeping with the ecological model, each sectoral section is subdivided into four sub-sections, depending on the level at which programs have operated, namely:

- Law and policies
- Institutional reforms
- Community level interventions
- Individual behavior change strategies

This review emphasizes efforts to prevent violence against women rather than initiatives aimed solely at assisting survivors with recovery. Unfortunately, even less is known about how to prevent violence than about how to care for survivors once it has occurred. While this review will explore some initiatives that address the needs of survivors, a reader looking for a comprehensive discussion of survivor services should look elsewhere (e.g. Warshaw and Ganley, 1998, for the health sector response).

Finally, as mentioned earlier, this review will focus primarily on the two most common types of GBV: intimate partner violence (physical and sexual) and sexual violence by any perpetrator. As a result, this review will not provide a comprehensive discussion of interventions that address other types of GBV, such as trafficking of women, female genital mutilation, dowry deaths, or rape used as a weapon of war.

2.1.2 Methods used to compile the review

This review draws from many published and unpublished sources, using databases such as Popline, Medline and Current Contents. Many program evaluations from middle and low-income countries appear only the grey literature, so this review relies heavily on unpublished sources. Many national and international organizations have produced reviews of GBV initiatives in recent years. These reviews often focus on a single sector, such as health, education or communication, and they sometimes place a greater emphasis on describing program strategies than on synthesizing what is known about effective prevention. This paper benefited greatly from their work, notably the reviews of unpublished evaluations by the

Inter-American Development Bank (Morrison and Biehl 1999), World Health Organization (World Health Organization 2002), the Panos Institute (Mirsky, 2003), and USAID (Guedes, 2004; White, Greene and Murphy, 2003)).

2.2 Interventions in the Justice Sector¹⁸

2.2.1 Overview of GBV and the justice sector

There are a number of ways that the justice sector may contribute to prevention of intimate partner violence and sexual violence: by sanctioning those who perpetrate crimes against women; by increasing awareness throughout society that physical or sexual violence against women is considered a crime; by strengthening women's rights with regard to marriage, divorce, property and child custody; by increasing women's access to the legal system; by increasing the range of interventions to protect victims; by correcting procedural and evidentiary problems in criminal prosecutions; and by reducing mistreatment of women and children by the law enforcement institutions themselves (National Research Council, 1998).

While the empirical evidence demonstrating a link between criminal justice and the prevention of intimate partner and sexual violence is somewhat weak, most researchers consider criminal justice reform to be a crucial component of efforts to reduce violence against women.¹⁹ If nothing else, some argue, failure to sanction offenders sends a message that society condones violence against women (e.g. Larráin, 1999). Also, since law enforcement institutions in many settings inflict additional trauma on survivors of violence through bias and mistreatment by police, judges, forensic doctors, and other members of the justice system (Human Rights Watch, 1997), reducing bias and mistreatment by these institutions would be worthwhile as an end in itself.

At the same time, strengthening women's rights may be just as important as criminal justice reforms in reducing GBV. In many settings—whether by law or in practice—women still have limited rights to voluntary marriage, inheritance, divorce, division of property, child custody, and child support. Strengthening women's rights may strengthen the position of women in the household and make it easier for women to leave abusive partners once violence begins to escalate. Indeed, some legal aid programs have found that the greatest need expressed by women living in violent situations is not for criminal prosecution, but for assistance with divorce, property and child custody (for example, see Guedes et al., 2002).

¹⁸ The justice sector includes but is not limited to actors and institutions in the judicial system (courts, public defenders, etc.). It also includes the legal framework of a country, which is drafted and approved the legislature, as well as the parts of the executive branch which deal with judicial issues, such as the ministry of justice and (generally) prosecutors. Finally, the justice sector also includes civil society actors promoting knowledge of women's legal rights, providing legal advice and services to survivors of GBV and lobbying to change existing legislation.

¹⁹ One of the few papers to document a link between a strong criminal justice response to GBV and lower rates of violence is Counts, Brown and Campbell (1999), who found that the lowest rates of violence against women in 16 societies studied occurred in societies that consistently imposed sanctions (including legal sanctions) on perpetrators.

2.2.2 Justice sector initiatives

A great variety of initiatives have aimed to improve the justice sector's response to GBV. Table 2.1 illustrates the types of objectives and strategies that have been pursued; the following sub-sections describe the initiatives in more detail and present evidence about what approaches have been more and less effective.

2.2.3 Initiatives to improve laws and policies

In Latin America and the Caribbean, efforts to improve laws and policies have had two foci: (i) drafting and ratifying international conventions that provide an overarching legal framework to support (or in some cases supercede) national legislation, and (ii) enacting new specialized legislation on GBV and/or reforming national civil and criminal codes.

Legal advocacy and international conventions: Over the past 20 years, international organizations, donors, courts and United Nations monitoring bodies have encouraged governments to sign, ratify, and comply with human rights conventions. One influential convention has been the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, frequently known as the Belém do Pará Convention.²⁰ To-date, 31 countries of the region have ratified the convention (see Box 2.1 for provisions of the Convention).

A recent study (IACW, 2004) notes that the Convention has contributed to promoting an increased awareness in the region that violence against women is a serious human rights violation; the study also documents significant progress in the implementation of some of the policies and programs called for in the Convention. Also noteworthy has been the use of Article 12 of the Convention (the right to lodge petitions with the Inter-American Commission on Human Rights) by petitioners and supporting NGOs to hold national governments accountable to the commitments acquired upon signing the Belem do Para convention.²¹

²⁰ It is known as the Belém do Pará Convention because the General Assembly of the OAS adopted the convention in the General Assembly held in Belem do Pará, Brazil, on June 9, 1994.

²¹ Relatively few women are able to bring cases to the Inter-American Commission on Human Rights; Article 12 is more important as a mechanism for civil society to hold governments accountable, rather than as a mechanism for redress of individual cases. The Inter-American Commission on Human Rights has received petitions under the provisions of the Belém de Pará Convention on forced sterilization, family violence, conjugal visits, and child sexual abuse (CLADEM, 2000). A recent decision by the Inter-American Commission on Human Rights, for example, found the Brazilian government guilty of negligence and recommended that the state pay compensation to a women the state failed to protect from family violence (the case of María Pehna (2001), discussed in Pandijiarjian, 2004). The Inter-American Human Rights Commission, aside from its function as arbiter of cases brought before it, has also made violence against women more visible through its country reports—which invariably contain a section on the rights of women, including the right to live a life free of violence—and its Special Rapporteurship on the Rights of Women.

Table 2.1 Objectives and strategies used to address GBV in the justice sector

Objectives:	Examples of Specific Initiatives:
<p>To improve laws and policies</p> <ul style="list-style-type: none"> • To strengthen women’s rights • To strengthen and better implement criminal sanctions for perpetrators • To improve criminal law procedures • To ensure protection for survivors (privacy and security) by police and judicial institutions • To require a multi-disciplinary and comprehensive response to survivors 	<ul style="list-style-type: none"> • National and international advocacy campaigns • Ratification of international human rights agreements and—where ratified—improvement in implementation • Revision of relevant provisions of the civil, family and criminal code • Specific legislation on family, domestic or sexual violence, as well as resources required for its implementation • Legal tools such as protection orders
<p>To strengthen the institutional response of: police, judiciary, and the forensic medical system.</p> <ul style="list-style-type: none"> • To improve capacity to enforce laws • To reduce bias and mistreatment • To increase access to justice and the legal system • To improve the quality and comprehensiveness of survivor services • To improve legal protections for women in danger 	<ul style="list-style-type: none"> • Policies, procedures and protocols to improve the response of police, judges, forensic doctors, and other professionals. • Investment in resources and equipment • Sensitization and training of justice system personnel • Monitoring mechanisms such as human rights ombudsmen • Increasing access to modern forensic services provided by forensic nurses and doctors specially trained in GBV • Women's police stations or cells • Court-appointed advocates • Improved coordination among all justice sector operators (state attorneys, public defenders, prosecutors, and police)
<p>To increase community mobilization in defense of women’s legal rights</p> <ul style="list-style-type: none"> • To strengthen community support for women's rights and access to justice • To strengthen networks providing legal services • To increase community action to bring perpetrators to justice 	<ul style="list-style-type: none"> • Legal literacy training for key groups and stakeholders • NGO provision of legal aid and social/psychological services • Efforts to monitor the justice system at the community level with civil society participation • Human rights promoters and <i>defensoras populares</i> • Informal / traditional arbitration mechanisms

To improve knowledge, attitudes and practices of key groups and the broader population

- To increase public awareness of and support for VAW laws and women's rights
- To increase women's awareness of and ability to exercise rights

- Mass media campaigns on laws and rights
- Legal literacy training for women and youth

While progress has been registered in implementing some provisions of the Convention, serious problems remain with respect to countries meeting their commitments in the areas of data and statistical systems, access to justice, services and protection for victims and education and training for women (CLADEM, 2004). The Inter-American Commission of Women notes that “if the changes in institutions, attitudes and programs called for in the Belém do Pará Convention have truly been implemented, in most countries it is still not reflected in measurable decreases in violence against women (IACW, 2004).”

Another influential agreement has been the CEDAW Convention (Convention on the Elimination of All Forms of Discrimination against Women), which requires signatory governments to implement specific reforms and report on their progress to United Nations monitoring committees. Currently, 33 Latin American and Caribbean governments have ratified CEDAW. While the original CEDAW convention does not explicitly mention violence against women, in 1992 a new general recommendation (number 19) was appended to the convention that prohibits GBV by individuals, groups or the state; it also requires national monitoring reports to the Committee to include data on the incidence of violence against women, as well as information on the services available for victims and legislative and other actions taken to protect women from violence.

One final important international milestone was the Declaration and Programme of Action that emerged from the Vienna World Conference on Human Rights in 1993. The Declaration defined GBV as a human rights violation and called upon the United Nations High Commissioner for Human Rights to name a special rapporteur on violence against women, a step which was taken in 1994.²²

These international declarations, agreements and conventions are important in part because they serve as models for domestic legislation. Aided by international rights agreements such as CEDAW and Belém do Pará, women's advocacy organizations have lobbied to improve laws and their application in almost every country of the region.²³ Although much remains to be done in the field of legal advocacy, these efforts have succeeded in convincing many

²² The declaration that violence against women is a human rights violation is consistent with the spirit of the Universal Declaration of Human Rights, which makes explicit reference to the rights to (inter alia) security of person, education, freedom of expression, and the right to participate freely in the cultural life of the community—all rights whose exercise is compromised by gender-based violence.

²³ In Nicaragua, for example, a mass media campaign spearheaded by the Nicaraguan Network of Women against Violence contributed to legislative change (Ellsberg, Liljestrand and Winkvist, 1997).

Box 2.1 Provisions of the Belém do Pará Convention.

The Belém do Pará Convention makes the simple declaration that “every woman has the right to be free from violence in both the public and private spheres (article 3).” It defines violence against women as physical, sexual or psychological violence that:

- “occurs within the family of domestic unit or within any other interpersonal relationship
- occurs in the community and is perpetrated by any person, including, among others, rape, sexual abuse, torture, trafficking in persons, forced prostitution, kidnapping and sexual harassment in the workplace, as well as in educational institutions, health facilities or any other place; and
- that is perpetrated or condoned by the state or its agents, regardless of where it occurs (Article 2).”

The convention (Article 7) obligates member states who have ratified it to pursue policies to prevent, punish and eradicate violence against women. It also requires states to undertake to:

- “refrain from engaging in any act or practice of violence against women...
- apply due diligence to prevent, investigate and impose penalties for violence against women
- include in their domestic legislation penal, civil, administrative and any other type of provisions that may be needed to prevent, punish and eradicate violence against women...
- adopt legal measures that require the perpetrator to refrain from harassing, intimidating or threatening the woman...
- take all appropriate measures...to amend or repeal existing laws and regulations or to modify legal or customary practices which sustain the persistence and tolerance of violence against women
- establish fair and effective legal procedures for women who have been subjected to violence...
- establish the necessary legal and administrative mechanisms to ensure that women subjected to violence have effective access to restitution
- adopt...legislative or other measures as may be necessary to give effect to this Convention.”

Importantly, Article 12 of the Convention gives any person, group of persons or NGO the right to lodge petitions with the Inter-American Commission on Human Rights if their government does not meet the commitments in Article 7. The procedure followed is the following:

1. Victim or representative exhausts the domestic judicial system remedies (provided that none of the exceptions for this requirement applies).
2. When no recourse is adequately provided by the local system, the a claim is lodged with the Inter-American Commission on Human Rights, which is competent to receive petitions from any person or group of persons concerning violations of human rights recognized in, among other international instruments, the Belen do Para Convention.
3. The Commission may decide for or against the claim. If the Commission decides the claim is valid, it will issue recommendations to the State in that specific case.
4. If the Commission considers that the State has not complied with these recommendations, the Commission can refer the case to the inter-American Court of Human Rights, which will hear the case according to its rules and procedures. There is not automatic consideration by the Court of cases in which a government has not followed the recommendations of the Commission, although there are discussions and reforms being proposed to give the Court the competence to hear claims directly without the need for referral by the Commission. Note that to-date, the Commission has not forwarded any cases based on Article 12 to the Court.

The Convention also obliges signatory states to undertake “progressively specific measures”, including programs to promote awareness of the right of women to be free from violence, to modify social and cultural patterns of conduct, to promote education and training of those who administer justice (including police), to provide specialized services for women survivors of violence, among other programs (Article 8).

Source: OAS, Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women. Teresa Genta-Fons and Lisa Bhansali (World Bank) contributed to this box.

governments to improve women's rights and to strengthen criminal legislation regarding GBV (Center for Reproductive Law and Policy, 2002; Mehotra, 1998).²⁴

Reform of civil and criminal law: As illustrated in Box 2.2, governments in the Latin American region have enacted significant legislative reforms related to women's rights and GBV in the past 20 years. These legal reforms have typically fallen into the following categories:

- a) Revisions of the civil and family legal framework to reduce discrimination against women and improve women's rights with regard to marriage, divorce, property, inheritance, child custody and support;
- b) revision of the criminal law to strengthen sanctions related to family, domestic and/or sexual violence; and
- c) legislation and public policies regulating criminal procedures and public and private sector responses to survivors of violence.²⁵

Box 2.2. Examples of recent legislative reforms that address GBV in Latin America

- Revision of the criminal code to allow public prosecution of sexual offenses (e.g. Peru)
- Introduction of marital rape as a criminal offense (e.g. Federal District, Mexico)
- Elimination of provisions that allow rapists to escape criminal sanctions by agreeing to marry the victim (e.g. Argentina, Peru)
- Laws that require police to inform rape victims about the possibility of legal abortion (e.g. Brazil)
- Establishment of protection orders (e.g., Belize, Costa Rica, El Salvador, Guatemala and Nicaragua)
- Broadening of the concept of injury so that the infliction of severe psychological trauma can be considered a criminal offense (e.g., Nicaragua)
- Specification of family relations as an aggravating circumstance which triggers harsher sentences (e.g., Nicaragua)
- Criminalization of sexual offenses and spousal rape, as well as the widening of the definition and increasing sanctions for rape (e.g., Belize, Costa Rica, Honduras, Nicaragua and Panama)
- Enactment of specialized laws on domestic violence in many countries, with specific provisions as described above

Source : Velzeboer et al., 2003 ; Bott, Ellsberg and Morrison, 2004.

²⁴ And, if domestic legislation is deficient or is not adequately enforced, international conventions offer women at least some modest opportunity to obtain reparations (see the discussion above of Article 12 of the Belém do Pará Convention).

²⁵ For a detailed country-by-country review of laws on GBV as of 2000, see CLADEM (2000).

These legal reforms represent a significant achievement in the effort to strengthen women's rights and reduce violence against women. A substantial body of research has documented their positive impact on intermediate outcomes such as increasing reporting levels, increasing the number of convictions, and improving the quality of the police and judicial response (Ellsberg, Liljestrand et al. 1997).

This should not be interpreted to mean that legislation in the region has been perfected; problems do remain. Particular areas of concern include:

- Spousal rape is not uniformly considered a crime in the region
- In some countries rape is still typified according to the victim's reputation, and "defense of honor" is still accepted as a defense against a charge of rape
- Intimidation and sexual harassment frequently are not considered serious crimes
- Family violence cases are frequently heard in family courts, but this approach's effectiveness has not been evaluated, and there are frequently serious problems of coordination between family courts and criminal courts²⁶
- Women are not familiar with their right to live free of violence and have little or no access to free and effective legal counsel
- Judges and other judicial personnel are frequently unfamiliar with legislation prohibiting violence against women
- The use of mediation and/or conciliation in cases of violence against women—quite common in the region—is problematic (IACW, 2004; CLADEM, 2000).²⁷

The overwhelming lesson from legislative reform is that changing the law is only the first step in a long process—much legislation has been implemented poorly or not at all. An important technical consideration is to better integrate new GBV legislation within a country's legal system, laws and procedures. Failure to do so will limit the effective application of the GBV laws. Common implementation problems in Latin America include: lack of coordination between family courts and criminal courts; reluctance by police or prosecutors to investigate cases or protect women in danger; and unwillingness or inability of the judiciary—the latter frequently due to lack of resources and specialized knowledge—to enforce the laws.

2.2.4 Initiatives to improve the response of key institutions: police, judiciary, forensic medicine, and public sector legal aid

²⁶ In particular, family courts frequently choose to preserve the family at the cost of women's rights and liberties (CLADEM, 2000).

²⁷ Mediation has become popular in many countries as a means to expedite solutions for misdemeanor offenses. However, when used in domestic violence or rape cases, it can be very counterproductive. Mediation assumes that both parties are negotiating under equal conditions; however, this is clearly not the case when a woman has been beaten or raped by her partner. The agreements that result from the mediation often disguise the aggression. They are usually registered as "marital disputes" rather than "assaults," and in return for a husband promising not to hit his wife, she is often has to promise not to provoke her husband or maintain order in the household—as if both parties were equally responsible: the husband for using violence and the wife for provoking him. Even in countries that do not permit mediation in cases of domestic violence such as Nicaragua, judges have admitted that in practice it is frequently used (Velzeboer et al., 2003).

In many countries of the region, legal and judicial institutions, including the judiciary, the forensic medical system, and legal aid services face a severe lack of resources for personnel, equipment, training, and transportation—and law enforcement institutions such as police and prosecutors may fare no better. Many countries are plagued by police corruption, expensive, slow and inaccessible courts, and an unaccountable judiciary (Human Rights Watch, 2000). Even in countries with relatively strong legal systems, law enforcement institutions have historically responded poorly to intimate partner and sexual violence in particular.

A growing number of initiatives have tried to improve the response to GBV by training professionals, reorganizing police and/or courts, and providing a more comprehensive and supportive response to survivors. Evidence of their effectiveness is relatively limited; most well-evaluated initiatives come from the United States or Britain, which may not be applicable to Latin American and Caribbean countries.

Training personnel in the police and judiciary

Throughout the region, organizations have launched efforts to sensitize and train police, judges and other law enforcement personnel to improve knowledge, attitudes, and practices related to GBV. In the area of police training, several promising initiatives have recently been implemented in the region, frequently with financing from international agencies or bilateral donors. The trainings have been of two types: in-service training delivered to active duty police, and pre-service training offered in the police academy.

Examples of in-service training include IDB initiatives to train the Surinamese police and all the police forces of the English-Speaking Caribbean in the area of family violence (undertaken in partnership with the Association of Caribbean Commissioners of Police) and, as well as the development by the United Nations' Latin American Institute for Crime Prevention and Offender Treatment (ILANUD) of a procedural manual and accompanying in-service training to improve the Honduran police's ability to deal with family violence (Siloa Cruz, 1997).

Improving pre-service training in police academies, has been the focus of a joint GTZ-Policía de Nicaragua initiative. This course, developed initially in 1998, offers instruction at three levels (basic, intermediate, and superior), depending on the amount of time and material covered in the training course (Policía Nacional de Nicaragua-GTZ, 1998); it has now been mainstreamed into the curriculum of the Nicaraguan police academy. ILANUD has also produced a methodological guide for instructors in police academies to improve their ability to teach about family violence (Batrés Méndez and Portuguéz Calderon, 1997).

Ideally, training of police forces should combine both pre-service and in-service training, where in-service training can consist of periodic “refresher” courses or of more specialized training. Unfortunately, few initiatives have been rigorously evaluated.²⁸ Most evidence of

²⁸ In the United States, a recent review by the National Research Council (1998) found no scientifically rigorous evaluations of law enforcement/judicial training.

effectiveness has been based on case studies, anecdotal information, and surveys conducted before and after training sessions. However limited this evidence may be, it nonetheless suggest that these efforts are both constructive and essential (for example, see: Rashid, 2001; Villanueva, 1999).

Training of judges and judicial personnel is also important. A survey of a small number of judicial personnel in El Salvador, for example, revealed that while the vast majority considered the problem of family violence to be important and believed that the existing legislation on family violence was necessary, none had received any training on recent reforms to the family violence law (CLADEM, n/d). This situation is not uncommon in the region.

Judicial training should focus on interpretation and enforcement of domestic legislation on gender based violence; it should also cover the application of international human rights conventions such as CEDAW, Belém do Pará and other broader human rights legal frameworks to which countries are signatories. (See Box 2.3 for an example of training of judges in international conventions.) Other justice-sector institutions where training is necessary include prosecutors, social services, ancillary institutions, public defenders and pathologists (Villanueva, 1999).

Evaluations of training initiatives suggest a number of common themes. First, changing attitudes towards violence against women and children is a challenging, long-term process. The quality of the content and skills of the trainer is essential. Training appears to be most effective when all levels of personnel receive training (including high level officials), and when training is backed up with changes throughout the institution, such as policies, procedures, adequate resources, and continual monitoring and evaluation.

GBV in the context of transition from inquisitory to accusatory legal systems

While training of judges and judicial personnel can improve the quality of judicial services for survivors of GBV, it does not address the structural and systemic problems that plague many judicial systems of the region; corruption, lack of transparency, procedural delays and often quite simply a lack of judicial presence in rural areas that translates into a lack of access to judicial services for the poor. If these broader themes of access to justice are to be addressed, the most promising approach to improve access to judicial services for survivors of GBV may in the context of an overall reform of the judicial system that addresses these more systemic problems. This approach allows issues of quality of services and access to services to be dealt with simultaneously.

The most important judicial reform in the Latin American and Caribbean region in recent years has been the shift from the inquisitive system (inherited from the Spaniards) to the accusatory system based on the U.S. or U.K. adversarial model. Little is known about the impact of this change in legal systems on the treatment of cases of GBV. A recent study by Casas and Mera (2004), however, does examine the effect of the reform of the Chilean criminal code in 1999 on the handling of cases of GBV. In addition to moving toward an

Box 2.3. Training of judicial personnel in the application of international human rights conventions in Argentina, Brazil, Chile and Uruguay.

With grant support from the Inter-American Development Bank, the International Women Judges Foundation undertook training of judicial personnel and law school faculty on the application of international human rights conventions such as Belém do Pará. The project used a train the trainers approach in which a core of trainers from participating countries received training in the preparation of interactive seminars for judges and were given materials for use in future seminars. These core trainers then trained a wider cadre of trainers, who in turn agreed to organize future training seminars in their countries. A web site was created to disseminate decisions by judges trained by the program in which international human rights conventions were cited in their decisions on cases involving violence against women.

An initial evaluation of the project was quite positive:

- Second-generation trainees have evaluated the core trainers as excellent or very good
- Teaching materials were judged of high quality
- Significant numbers of judges have received training (251 in Argentina, 152 in Brazil, 141 in Chile, and 121 in Uruguay)
- Trained judges credit the program with:
 - alerting them to the nature and scope of family violence and gender discrimination, as well as the hidden biases and stereotypes that legitimate violence and discrimination
 - demonstrating more effective and sensitive ways to question witnesses

Of course, the true test of the project is whether judges' rulings are influenced by the project, and this was not examined in the evaluation.

Source: Pfund (2000); International Women's Judges Federation (2004).

accusatory system, the reform allowed doctors other than government pathologists to collect evidence of sexual crimes and to testify in court, with the goal of increasing access to these services for women and child victims.

The impact of the reform on the handling of GBV cases in Chile is decidedly mixed. On the negative side, the percentage of cases in which a conviction is handed down has declined significantly.²⁹ Casas and Mera (2004) attribute this to two factors: prosecutors only bringing cases almost certain to result in conviction to trial, and doctors (aside from pathologists) being very reticent to testify in cases of sexual violence. On the positive side, the regional victim service units established by the reform have significantly reduced problems of secondary victimization during the investigative process and trial, and prosecutors have improved their treatment of women victims. In addition, the accusatory system offers somewhat speedier resolution of cases than the previous inquisitory system.

Development banks such as the World Bank and Inter-American Development Bank have a long track record in promoting judicial reforms in Latin American countries. These projects

²⁹ The percentage of sexual violence cases that end in conviction is about 1/10th that of homicide cases, and is lower than that for robbery cases (Casas and Mera, 2004).

recently have begun to explicitly deal with the issue of GBV.³⁰ (See Box 2.4 for information on the way in which the World Bank's judicial reform projects in Ecuador and Uruguay have dealt with GBV).

Box 2.4 . Treatment of GBV in two World Bank judicial reform projects: Ecuador and Uruguay

The first World Bank judicial reform loan in Latin America to explicitly deal with GBV was the Ecuador judicial reform project, approved in 1996. Among many other activities, the project funded legal aid services for poor women in the cities of Quito, Guayaquil and Cuenca. During the project's execution, the two NGOs hired provided services to more than 20,000 women, frequently on family violence cases. They also provided referrals to complementary services such as medical and psychological treatment, and support groups for survivors of family violence were created. Legal education was provided to judges in the use of international conventions on violence against women, such as Belem do Para and CEDAW. An evaluation (using interviews with beneficiaries and a control group of non-beneficiaries, as well as focus groups) showed that the legal aid activity has produced several notable results for beneficiaries: women were better off legally and economically, had a better knowledge of their own and their children's rights, and their children were more likely to stay in school. Of course, sustainability of service provision after project completion is a concern. It hinges on both political commitment and fiscal health, since cost-recovery possibilities are limited.

A World Bank project in Uruguay was more narrowly focused on gender issues; funded with non-reimbursable resources, the project supports Uruguay's implementation of the CEDAW and Belém do Pará Conventions. Technical assistance and training are designed to: (a) strengthen local institutions charged with the implementation of the National Plan for the Eradication of Violence Against Women and (b) promote access to justice for survivors. The project also finances legal and institutional diagnostic work to develop a more comprehensive response to GBV, as well as the development and implementation of a multidisciplinary training program to promote coordinated responses among judicial staff (judges, state attorneys, public defenders), social services and law enforcement agencies. The Project builds on a strong partnership between government and civil society, by integrating a participatory process and awareness-raising activities in the area of women's human rights.

Sources: World Bank (2003) and World Bank (2004).

Special police stations or police cells for women³¹

Specialized women's police stations (WPS) exist in several countries of the region, including Argentina, Brazil, Colombia, Costa Rica, Ecuador, Nicaragua, Peru, and Uruguay. There is no single model for these stations; target populations, type of violence cases received, range

³⁰ IDBjudicial reform projects in El Salvador, Guatemala and Venezuela have explicitly dealt with the issue of GBV, as have World Bank projects in Chile, Ecuador, Guatemala, Peru and Uruguay.

³¹ This sub-section draws heavily on Jubb and Izumino (2003).

of services offered, and whether or not services are offered in partnership with civil society organizations all vary among the countries with WPS (Jubb and Izumino, 2003).

In some countries, WPS receive cases only of intimate partner violence and child/adolescent abuse—as is the case in Ecuador. The WPS in Argentina, Brazil, and Nicaragua also take complaints of sexual violence, but the Brazilian WPS do not address issues of child/adolescent abuse, providing services only to adult women (Jubb and Izumino, 2003).

WPS stations offer two types of services: direct services to users and prevention programs targeting the wider community. Both types of services may be provided by police or by other public or private agencies. Direct services provided by police usually include taking statements, undertaking police investigations, and mediating agreements between a complainant and her assailant.³² Services typically offered by other state agencies or NGOs include gynecological services, forensic medical exams, psychological exams and/or counseling services, and legal services. These services may be provided within the WPS (a “one-stop-shop”) or via a network of service providers in different locations. Prevention activities undertaken by WPS include public awareness and education campaigns, which are typically carried out by the NGOs in collaboration with the police officers assigned to the WPS.

These stations have been extensively evaluated using case study methods; most evaluators have assessed their effectiveness by gathering data on the number, nature and outcomes of cases reported to the stations, as well as on stakeholder perspectives from police, judges, NGO staff, lawyers, prosecutors, judges, detectives, and women who report cases.

Special police stations generally appear to increase reporting of abuse and the likelihood that women will receive forensic exams, counseling, emergency contraception and STI prophylaxis. Research, however, has demonstrated a number of problems. First, women officers have not necessarily demonstrated better attitudes towards victims of violence simply by virtue of their sex. Second, special stations have been severely under-funded in many cases; staff have received inadequate training and stations have lacked key resources such as equipment and transportation. Third, even when the WPS work relatively well, their efforts are often undermined by other parts of the justice system system that are unwilling or unable to enforce the law. As a result, prosecution rates often remain unchanged. Finally, women’s police stations have been criticized for encouraging regular police stations to abdicate responsibility for crimes against women.

Alternatively, some countries have experimented with special police “cells” for women and children, composed of one or more police officers who work within a regular station but specifically handle cases of family and sexual violence. Finally, at the other extreme is a complete mainstreaming approach in which all police, whether male or female, receive pre-

³² Out-of court mediated settlements typically take the form of formal or informal agreements between spouses mediated by a police officer in several countries and, in Peru, a legal advisor (Jubb and Pasinato, 2003). Women’s movements in Nicaragua and elsewhere have rejected these agreements because they preclude women’s access to justice and ignore a human rights violation, thereby fostering impunity (Tamayo 1999, cited in Jubb and Izumino Pasinato, 2003).

service and in-service training on how to treat cases of GBV. While few police forces—whether in Latin America or elsewhere—have completely mainstreamed gender in policing, the “whole system” approach has led to impressive results in Nicaragua. El Salvador has also advanced toward gender mainstreaming in police training (Jubb and Izumino, 2003).

Justices of the Peace

In Latin America, Justices of the Peace are frequently the only presence of the judicial system in rural and peri-urban areas. In many countries of the region, domestic violence legislation confers upon justices of the peace the authority to handle family violence cases and, in many cases, to mediate them. Mediations undertaken by justices of the peace in rural areas—where traditional gender roles are deeply rooted—are likely not only to reaffirm an unjust and unequal distribution of roles according to gender stereotypes, but are also likely to perpetuate family violence.³³

It is unrealistic, however, to expect that the formal judicial systems will be expanded to remote rural areas any time in the near future. Thus, prohibiting justices of the peace from handling family violence cases would leave survivors of violence without any legal recourse. A middle course is to allow justices of the peace to deal with family violence cases if: 1) there are clear procedures for handling such cases, including interviewing men and women separately and privately, and ensuring the safety of the women before, during and after meeting with the justice of the peace; and 2) justices of the peace receive training in how to deal with family violence (Lovaton, 2000).³⁴

Reform of the medico-legal response to sexual violence

A key component of the justice system is the “medico-legal” system of collecting forensic evidence. In many countries, forensic evidence can only be admitted in courts when collected by specially certified forensic physicians. These professionals are typically employed by the public sector and—in many settings—are notorious for poor access, poor treatment of survivors, and unwillingness or inability to provide urgent medical care including emergency contraception and prophylaxis for sexually-transmitted infections. The World Health Organization and PAHO have recently developed a series of guidelines for improving the medico-legal response to sexual and domestic violence. In Latin America, several promising measures have been initiated, such as appointing forensic doctors nominated and trained by women’s organizations and allowing general physicians and in some cases nurses to collect forensic specimens in Nicaragua (see Velzeboer, Ellsberg et al. 2003, but note the

³³ For example, a mediation outcome which specifies that a man stop abusing his partner and that she agree to better perform domestic tasks implies that it is justified for a man to abuse a woman for what he views as unsatisfactory performance of domestic duties.

³⁴ Lovaton (2000) includes a third stipulation: that outcomes not be mediated accords, but rather protection accords which guarantee the safety of the victim. It is, however, difficult to imagine that governments would have the capacity, in the near future, to enforce protection accords in rural areas and small towns. Instead, creative responses will be needed in which civil society organizations partner with the judicial system to offer safe haven for women who are at ongoing risk of violence.

unexpected problems that this measure generated in Chile--see the section on the transition to accusatory legal systems).

2.2.5 Community mobilization

Evidence suggests that community collaboration and support is an essential element of the justice sector's response to GBV. Two elements are particularly important: promoting recognition by women of their right to a life free of violence, and providing community support to women who have sought redress from the judicial system.

Community-based organizations are uniquely placed to promote knowledge of women's rights: neighborhood and grass-roots women's organizations have detailed knowledge of their target populations and community norms that can be used to mobilize the community in defense of women's rights. In Nicaragua, Guatemala and elsewhere, community women have been trained as *defensoras populares*. These women serve as voluntary advocates for abused women, giving them advice regarding their specific rights, helping them negotiate their way through the legal system to obtain, divorces, protection orders, child support, etc. In some areas, *defensoras populares* may also participate in mediation sessions between women and their abusive spouses.

Another role of community mobilization is to provide support to women who have received services from the justice system. A promising—but unfortunately unevaluated—initiative in this vein are the *Consejerías de Familia* (Family Counselors) in Cali, Colombia. Supported by the Paz y Bien Foundation and working in one of Cali's poorest and most violent neighborhoods, 120 community residents (mostly women) offer support to women affected by family violence; counselors monitor cases referred to them by Cali's multi-service judicial centers (*Casas de Justicia*), providing support and counseling to women that the overburdened centers are unable to do. In addition, they are trained and willing to provide temporary shelter to women who choose to leave an abusive relationship, and offer talks to community groups on the prevention of family violence.

2.2.6 Initiatives aimed at improving knowledge, attitudes and behaviors of the general population

An essential component of implementing GBV legislation is to raise awareness of and build support for the legislation among the general population. Access to justice requires that women are aware of and understand their rights and feel that they can exercise them. Thus, many civil society organizations have launched media campaigns and community-based legal literacy efforts to raise awareness of new legislation and encourage women to exercise their rights. Unfortunately, most such initiatives have limited scope, targeting selected populations or regions, and few have been evaluated for effectiveness.

2.2.7 Policy Recommendations

The existing evidence on effectiveness of judicial responses to GBV suggest several recommendations for policy makers:

- *Strengthen respect for the Belém do Pará convention.* The Belém do Pará convention has played a key role in promoting changes in national legislation and in generating political will to address GBV. A formal proposal for systematic follow-up has been presented to member states of the OAS by the Inter-American Commission of Women; the proposal advocates the formation of a treaty monitoring body similar to the CEDAW committee, with representatives of member states and a committee of experts (IACW, 2004). It would be useful for national governments to form their own committees of experts to monitor progress in the implementation of the convention.
- *Invest in the justice sector to improve its response to GBV.* Effective implementation of new laws requires both political will by policy makers and substantial investment in justice sector institutions. A logical sequence of investment priorities is: a) revising procedures that prevent access or create hardship for survivors, such as requiring women to pay for exams and reports; b) appointing specialized staff; c) developing mechanisms to hold police and judges accountable for failing to uphold and enforce GBV legislation; d) upgrading resources such as transport, office equipment, supplies for investigation and forensic exams; and e) training law enforcement and judicial personnel. Of course, the exact point of departure in a given country will depend on progress registered to-date, but the fundamental point is that training may not always be the best place to begin.
- *Imbed initiatives to address GBV in wider justice sector reform projects.* While initiatives such as all-women police stations (Brazil, Peru, Nicaragua, etc.) or judicial training may be promising as a way to improve the response to GBV in the short run, they cannot overcome broader institutional problems such as bias, neglect, corruption, and incompetence. In many settings, the response to GBV should be imbedded in broader institutional reform programs.
- *Strengthen women's rights.* Efforts to prevent GBV should include civil as well as criminal law reform. Strengthening women's rights is an important way to improve women's position in the household and makes it easier and safer for survivors to leave when violence escalates.
- *Ensure that women are aware of and understand their rights.* Even the most perfect legislation and most highly trained judicial and police personnel will have a limited effect unless women themselves are cognizant of their rights, including a life free of violence. Media campaigns to raise awareness of new legislation and efforts to boost community-based legal literacy are also essential.

2.3. Health sector approaches to GBV

2.3.1 Overview of GBV and the health sector

As more epidemiological evidence has emerged highlighting the links between GBV and a wide variety of serious health problems, international attention is increasingly focused on the role of the health sector in addressing violence. In 1996 the World Health Assembly declared violence to be a public health priority, and followed this up in 2002 with the publication of the World Report on Violence and Health, with in-depth discussions of intimate partner and sexual violence (World Health Organization 2002). The World Health Organization has carried out a multi-country study with detailed information on the prevalence and health effects of violence in ten countries. This report, which will be published in late 2004, will provide the first in-depth overview of violence using standardized methods.

Health services, and particularly reproductive health programs, provide a unique window of opportunity to address the needs of abused women, since most women come into contact with the health system at some point in their lives. Because violence presents serious risks to women's health, routine screening for violence among all women who attend health services, regardless of the reason for the visit is increasingly considered the standard of care in the United States and many industrialized countries (American Medical Association, 1992; Buel, 2001).

In the United States, despite extensive training of providers, progress in implementing family violence screening policies has been slow. Research indicates that although battered women use primary and secondary health services more than non-abused women, a very small percentage of them are identified by health workers (Cohen, De Vos et al., 1997; Sagot, 2000)

In developing countries violence is even less likely to be detected within health services. A Demographic and Health Survey in Nicaragua found that over one-third of women who had experienced partner abuse had never told anyone about their situation, Although 57% of the women had suffered one or more injuries as a result of violence, only 13% had ever received medical attention for injuries. Even then, most women still did not disclose the cause of their injuries. Only 7% of women reported having ever sought help for violence at a health center or hospital (Rosales, Loaiza et al., 1999).

Most research indicates that if women are asked about violence in private, in a non-judgmental and empathetic way, they will answer truthfully. In fact most women, regardless of whether they have been abused themselves, feel that physicians should ask their patients routinely about violence (Friedman, Samet et al., 1992; Velzeboer, Ellsberg et al., 2003) However, health providers are typically reluctant to ask women about experiences of violence, even when women show clear signs of abuse, for fear of offending women, or of opening up "a Pandora's box" of issues that they will not know how to address (Sugg and Inui, 1992). Many providers worry that screening for abuse will add yet another burden to

their already overstretched capacity. In the majority of health centers, treating cases of violence is not yet part of the professional profile, and there are no information systems in place that would allow them to justify the time spent on such cases.

Another factor shaping providers' discomfort in addressing violence are their attitudes and values. Providers are likely to have the same attitudes towards violence as most members of the societies that they live in, and in many parts of the world, violence against women is tolerated, if not actually condoned. A study carried out among reproductive health providers by the International Federation of Planned Parenthood (IPPF) in three Latin American affiliates found that many reproductive health providers expressed attitudes that place blame for violence on women rather than on aggressors. Over half felt that women's inappropriate behavior provokes their husband's aggression. Nearly one-fourth felt that women do not leave violent partners because on some level they like to be treated with violence (Guedes, Bott et al., 2002). These discriminatory attitudes are often reflected in the way abused women who seek help are subjected to hostile interrogations and invasive procedures by health providers. This mistreatment amounts to revictimization and can even exacerbate the traumatic effects of the abuse itself.

Looking beyond the clinic setting, a weakness found in many health programs that attempt to improve health outcomes through behavior change and communication programs is that they do not consider the impact of violence on the lives of women and youth. For example, many HIV prevention programs for youth in developing countries promote abstinence, under the assumption that most sexual activity among youth is consensual, even though there is now a considerable body of evidence to the contrary. Similarly, many international family planning programs do not take into account whether women are actually able to use birth control, or whether to do so would expose them to greater levels of violence. Not only are these programs missing opportunities to address violence as an integral part of sexual and reproductive health promotion, but they are also jeopardizing the achievement of their primary goals.

2.3.2 Health sector initiatives to address GBV

Several innovative projects have been implemented within the last decade to strengthen the response of the health sector in developing countries. The types of initiatives and their objectives are described in Table 2.2.

Few, of the initiatives, whether in industrialized countries or developing countries, have been rigorously evaluated, so it is not possible to state with assurance the most effective interventions. Based on available documentation, consisting primarily of case-studies and qualitative reviews, however, several promising interventions have provided insights to guide future programming (Velzeboer, Ellsberg et al., 2003; Guedes, 2004).

Table 2.2. Objectives and strategies used to address GBV in the health sector

Level	Objectives:	Examples of Specific Initiatives:
Laws and policies	<p>To improve laws and policies</p> <ul style="list-style-type: none"> • Clarify providers' legal responsibilities • Encourage a better health sector response to GBV through national, regional, and municipal policies regarding screening, referral, documentation and counseling for victims of violence • Ensure survivors' rights to services (e.g. emergency contraception, STI prophylaxis, etc.) 	<ul style="list-style-type: none"> • Reforms of laws and policies regulating the medico-legal system (e.g. introduction of forensic nurses) • Reform of laws and policies regulating health care providers' obligations vis-à-vis victims of GBV • National health policies and protocols • Laws/policies governing forensic medicine; provider obligations, abortion, EC and patient confidentiality
Institutional reform	<p>To strengthen the response of health care and public health institutions to gender based violence</p> <ul style="list-style-type: none"> • Raise awareness of the links between violence and health among service providers, managers, and public health policy makers. • Improve the quality of care for survivors of violence, including identification, treatment, documentation, information, referrals and follow-up. • Increase coordination with other sectors that provide services or work on violence prevention. 	<ul style="list-style-type: none"> • Policies, procedures and protocols to improve the health care response • Sensitization and training of health professionals • Routine screening and referral systems • Development of information systems such as epidemiological surveillance and morbidity statistics on violence • Specialized survivor services (counseling, support groups) • Improved coordination and referrals to NGOs and other sectors • Curricular changes in training of nurses and medical personnel
Community Mobilization	<p>To increase community mobilization to address GBV as a public health problem</p> <ul style="list-style-type: none"> • Strengthen community support for survivor services • Strengthen coalitions and networks • Improve attitudes, norms, practices and resources at the community level 	<ul style="list-style-type: none"> • Coalitions for public health research and advocacy • Community level prevention and mobilization initiatives • Community-based awareness campaigns aimed at mobilizing journalists, policy makers and opinion leaders

Individual behavior change**To improve knowledge, attitudes and practices of key groups and the broader population**

- Promote gender-equitable, nonviolent sexual partnerships
- Increase women's ability to make decisions about the timing and nature of sexual relationships
- Decrease tolerance for GBV by raising awareness of GBV as a public health problem
- Encourage victims of abuse to seek help and to disclose violence to service providers

- Clinic and community-based education efforts (theatre, videos, pamphlets, talks, etc.)
- Behavior change mass and multi-media campaigns, such as edutainment programs (e.g. Sexto Sentido in Nicaragua).
- Programs for men aimed at promoting gender equitable relationships and changing norms, attitudes and behaviors.
- GBV prevention within HIV/AIDS and adolescent reproductive health programs.

2.3.3 Initiatives aimed at improving laws and policies

International professional associations such as the American Medical Association and the International Federation of Obstetricians and Gynecologists (FIGO) have produced guidelines for identifying and treating GBV and exhorted their members to actively address violence in their clinical practice.(American Medical Association, 1992). UNFPA has also developed guidelines for addressing GBV in the health care setting that are currently being tested in several countries (Stevens, 2001). Such guidelines have proven to be an effective way to reach health professionals.

In many Latin American countries specific legislation and policies specifying the obligation of the health sector to address violence against women have been enacted either through ministerial decrees, or as part of national family violence legislation. The policies are generally fairly general, and by and large are limited to recognizing violence as a public health problem and outlining basic principles for caring for victims of violence and coordinating with other state institutions and non-governmental organizations to ensure an integrated approach to care. Although they often lack specificity, adopting policies on violence is a critical step in sensitizing health providers and program managers to the issue, and in creating awareness among personnel that violence is an important health issue that all providers need to address. A review of Central American countries in 2001-3, however, found that the policies had not been widely disseminated and most health providers were either not aware of the policies or did not know their specific contents (Velzeboer, Ellsberg et al., 2003).

In some cases, national legislation regarding GBV has occasioned unforeseen problems for the health sector. For example, several countries, including Panama and Guatemala have passed laws requiring health providers to report suspected cases of family violence to legal authorities. This puts providers in the position of violating the privacy and confidentiality of their clients, and could reduce women's willingness to disclose violence. Providers may also

be more reluctant to ask clients about violence for fear of becoming involved in legal cases. Another example of problematic legislation are laws requiring the health sector to provide certain services—such as specialized services for victims or treatment for batterers—without allocating resources to finance them.

2.3.4 Initiatives to improve the institutional response of the health sector

In the last decade, there have been many initiatives to strengthen the health sector approach to GBV in Latin America. The Pan American Health Organization (PAHO), the Inter-American Development Bank (IDB) and the International Planned Parenthood Federation/Western Hemisphere Division (IPPF/WHD) have been pioneers in developing an integrated approach for working with violence in the health sector in Latin America. PAHO has developed a model for violence prevention and care in 10 countries of Central America and the Andes, with support from Sweden, Norway and the Netherlands. Unlike many of the programs implemented in industrialized countries, most of these programs have a much broader focus than simply implementing a screening and referral protocol. The PAHO program, for example, includes interventions to improve policy and legislation on GBV, to increase access to services and forge multi-sectoral networks at a community level for violence prevention.

At the level of health services, there is great variation in the types of activities carried out, however, in general some combination of the following activities are carried out:

- **Screening for abuse**, either through routine questions or upon suspicion of abuse.
- **Risk assessment** to determine the woman's immediate risk of future violence.
- **Appropriate care**, including treatment for injuries, addressing reproductive health needs and crisis intervention.
- **Documentation** of the violent event and health consequences in the medical charts or on special registration forms.
- **Counseling** to provide women with basic information about legal rights and other options, to assist in developing a safety plan, etc..
- **Referrals**, either for specialized services within the health system (psychology, forensic medicine), or to outside institutions (police, child welfare, courts, etc.)
- **Scheduling follow-up visits** to provide continuing support.

A critical step in the improvement of health services for survivors of violence is the development of norms and protocols that provide specific guidance as to how violence should be identified, treated and documented within the health system.

One of the more controversial aspects is the feasibility of universal screening for family violence. Most experts do not deem universal screening—where all women visiting a health center or clinic are queried about whether they have been victimized by family violence—feasible in the majority of Latin American health services, given the scarcity of resources and time pressures experienced by health personnel. At the same time, experience has demonstrated that institutions without a screening policy identify only a fraction of women

who have experienced violence and who require assistance. A middle ground and promising approach is to engage in selective screening of women who show signs of abuse, while screening all women in selected services such as reproductive health, mental health and emergency services. This would allow providers to optimize resources by targeting women who are at greatest risk for abuse; moreover, integrating screening and care for survivors of violence into reproductive and mental health programs would contribute to enhancing the quality of care in these programs as well.

In addition to the questionable feasibility of universal screening, the effectiveness of screening has also been questioned. While several studies have shown that provider training and the use of a screening instrument can greatly increase the identification of survivors of violence, there is little evidence to-date that screening alone contributes to better outcomes for women, such as reduced violence, improved self-esteem and quality of life (Guedes, Bott et al., 2002; Ramsey, Richardson et al., 2002; Nelson, Nygren et al., 2004).

A final concern with regard to screening is the potential for harmful consequences to women suffering violence. No studies have evaluated the risks of screening, but some experts argue that it may be unethical to implement routine screening if services for referral and follow-up, as well as privacy and confidentiality, cannot be ensured (O'Conner, 2001; Garcia-Moreno, 2002).

IPPF/WHO carried out an ambitious three-year program in the Dominican Republic, Peru and Venezuela to integrate care for survivors of GBV into reproductive health services. This program, which involved intensive training and follow-up for providers, was rigorously evaluated; the evaluation demonstrated that the program was successful not only in increasing the levels of screening and identification of survivors of violence, but also in reducing stereotypes and bias among health workers (Guedes, Bott et al., 2002).

In a few Latin American countries (for example in Honduras and Panama), family violence laws require the health sector to provide care for offenders, and the courts may require offenders to attend a batterers' treatment program as an alternative sentence. Many experts consider these programs to be problematic, particularly because the additional resources allocated for them may come at the expense of services for women victims. Even in industrialized countries, where there is by now considerable experience in batterers' treatment programs, the effectiveness of these programs is not clear. In the case of Honduras and Panama, some experts feel that treatment programs for offenders may actually jeopardize women's safety, given the current lack of specific norms, trained personnel, and resources for supervision and follow-up (Velzeboer, Ellsberg et al. 2003).

2.3.5 Community mobilization

Community-level initiatives to reduce GBV

Many NGOs have launched programs to promote community-wide changes in attitudes and practices related to gender norms and violence against women--often as a component of

HIV/AIDS prevention or reproductive health programs. The few that have been well evaluated suggest that community level approaches can be effective in changing violence-related attitudes and behaviors. The following programs exemplify this approach:

Program H (Bolivia, Brazil, Colombia, Jamaica, Mexico and Peru) is being carried out by four NGOs. It aims to change gender norms and sexual behaviors in Bolivia, Brazil, Colombia, Jamaica, Mexico and Peru (Barker, 2003; White, Greene and Murphy, 2003; Guedes, 2004). The initiative includes four components: a) training professionals to work with young men in the area of health and gender-equity using a set of manuals and videos; b) social marketing of condoms; c) promoting health services; and d) evaluating changes in gender norms. In 2002, PROMUNDO and Horizons began a two-year evaluation to measure the effectiveness of two different approaches, compared to a control site. Researchers have developed a "Gender-Equitable Men" (Leichert) scale with 24 items for measuring attitudes. Methods include pre- and post-tests as well as a six-month follow-up community-based survey. In addition, they are gathering qualitative information among men and their female partners. Preliminary results suggest that the program has been successful at increasing gender equitable norms and reducing behavior that put men at increased risk of HIV/AIDS (Pulerwitz, Barker et al. 2004).

ReproSalud (Peru) was launched by the NGO Manuela Ramos in 1995 as a USAID-funded rural reproductive health program. *ReproSalud* used participatory rural appraisal (PLA) to help women's groups identify women's reproductive health needs and to organize community meetings to design strategies to address those needs. Domestic violence and forced sex within marriage emerged as an important problem in those communities. In response, *ReproSalud* organized workshops for women and men on gender issues, carried out community awareness campaigns and established a microcredit program for women. By 2002, *ReproSalud* had reached over 123,000 women and 66,000 men. Qualitative and quantitative evaluation data suggest that the community-based, PLA approach had a positive impact on attitudes and behaviors related to GBV (Rogow and Bruce 2000; Ferrando, Serrano, and Pure, 2002, cited in Boender et al., 2004). The quantitative evaluation (using community based surveys) was complicated by the fact that project coincided with a time of strong investment by the Ministry of Health, which made it difficult to isolate the project's impact. Perhaps as a result, gender-equitable attitudes and practices increased significantly in both intervention and control communities, though improvements in program sites were slightly higher. The qualitative data suggested a much greater difference in intervention and control sites and documented dramatic changes in social relations and men's behavior. Respondents spoke at length about decreased alcohol consumption, domestic violence, and forced sex in all intervention villages studied. In the words of one 35 year-old woman, "*Before, they brutally forced sex. They hit, especially when they were drunk. Now no more*" (Rogow and Bruce, 2000, page 20).

2.3.6 Individual behavior change strategies

Many other programs have attempted to produce individual behavior change (rather than change community-level norms) by working with individual men and boys. White, Greene

and Murphy (2003) reviewed the literature on such programs aimed at men. That review suggests that less information is available on the effectiveness of individual behavior change strategies compared to community-level approaches. Some programs report a positive impact on men's self-reported attitudes and behaviors, but most information is still preliminary or based on evaluations without control groups or baseline data; nonetheless, the following examples illustrate promising work being done in this area.

Community-based workshops for men

Several organizations in Latin America, including CANTERA (Population Education and Communication Center) and The Nicaraguan Association of Men against Violence in Nicaragua, CORIAC and Salud y Género in Mexico, carry out workshops for men on masculinities, gender, power, and violence. A 1997 evaluation of CANTERA's work suggested that as a result of the project, men expressed less "macho" attitudes, assumed more responsibility for household chores and demonstrated more solidarity with women. The evaluation, however, lacked a control group or baseline data, and the participants appeared to be a highly self-selected group.

Violence prevention within reproductive health, HIV prevention and life skills programs for youth

Many NGOs have tried to change attitudes and behaviors related to GBV among youth, often in the context of reproductive health programs, HIV/AIDS prevention, "life skills" and/or peer education. Many are school-based and will be discussed in the section devoted to the education sector. Research on the effectiveness of these initiatives is still preliminary; nonetheless, these initiatives appear to be promising—both for violence prevention and for prevention of HIV/AIDS, unwanted pregnancy, and unsafe abortion.

Mass media entertainment-education ('edutainment') programs

"Edutainment"—the use of radio and television to promote health and social change—was pioneered by Televisa, the largest broadcast network in Mexico, which used television soap operas to model behaviors, promote values, and demonstrate the consequences of choices. This strategy has been used in Asia, Africa, and Latin America and has demonstrated effectiveness in changing behaviors related to reproductive health, AIDS education and the status of women (CDC, 2004). NGOs have recently begun to use radio and television edutainment to address violence against women. Whether it can be effective in changing violent behavior has not yet been demonstrated, but its success in other areas suggests promise for violence prevention.

In Latin America, the most well known example of using edutainment for GBV prevention is *Sexto Sentido*, carried out by Puntos de Encuentro in Nicaragua. *Sexto Sentido* is part of a multi-media strategy called "We are different, we are equal" (*Somos Diferentes Somos Iguales*) that uses prime time television soap operas, radio programs, school-based work, and other media to address violence against women, gender, sexuality and rights. Some research suggests that *Sexto Sentido* has had a positive impact (Abaunza, 2002; UNFPA, 2002; Berliner, 2002), but little quantitative evidence of effectiveness has been published or disseminated. However, an ambitious qualitative and quantitative evaluation is underway

involving a three-year panel/cohort study among more than 4500 young respondents and at least three rounds of data collection--in 2003, 2004, and 2005(Solorzano, Peña et al. 2004). This study will measure the program's success in changing attitudes and behavior around gender, stigma, HIV/AIDS and GBV.

2.3.6 Policy recommendations

It is clear that the health sector can play a key role in the identification and support of survivors of violence. Based on existing evidence, the following approaches are recommended for strengthening the capacity of health providers to address GBV:

Integrate violence issues horizontally into health care services, especially sexual and reproductive health services. The accumulated experience in the region has shown that GBV cannot be addressed as a vertical stand-alone program. Vertical programs are likely to reach only a fraction of women who are in need of support. In contrast, horizontal integration of violence into primary care services permits the expansion of basic support for abused women and children throughout the health sector; moreover, because of the serious impact of violence on women's sexual and reproductive health, it is particularly important that providers of services for pre-natal care, family planning, sexually transmitted infections and other reproductive health services routinely ask women about violence and be prepared to address the specific needs of abused women. The ongoing processes of health sector reform throughout the region provide an excellent opportunity for integration of services for GBV into health services more generally.

Use a systems approach for institutional change. Numerous studies have demonstrated that training of health providers to address GBV has no appreciable effect on provider behavior unless it is accompanied by changes in procedures and systems. Even in institutions where successful screening programs have been implemented, gains are quickly lost in the absence of continuous followup and supervision. Institutional change must include implementation of new procedures with regard to patient flow, documentation, measures to ensure privacy and confidentiality, and the creation of referral networks. Although norms and protocols cannot change providers' behavior unless they are given the tools and skills to implement them, the creation of national policies and norms provides a critical enabling environment for initiating change. Providing emotional and technical support for staff dealing with violence victims is also essential for maintaining the quality of care and the emotional health of providers.

Address provider attitudes. As mentioned above, health providers often share the same stigmatizing attitudes as the population at large, and these can be a serious barrier towards improving the quality of care for victims of abuse. Therefore, provider training must deal with gender and power relations and allow providers an opportunity to challenge their own beliefs and prejudices.

Encourage coordination with other sectors. Currently, as noted above, there is a generalized lack of coordination between the health sector and other key sectors such as the justice and social welfare sectors; moreover, contradictory policies and procedures between different

institutions make it nearly impossible for women to obtain access to justice and to effective support for violence. Therefore, improved coordination between the health sector and other governmental and non governmental institutions at a community as well as a national level is critical.

Address the underlying gender norms that support violence in the community. Throughout this report we have underscored the need to transform prevailing community norms that support violence and discrimination against women and girls. In particular, in order to effectively promote sexual and reproductive health, it is necessary to create awareness at a community level on the health effects of GBV and how GBV itself is rooted in unequal gender relations.

2.4 . The Education Sector

2.4.1 Overview of GBV and the education sector

GBV in schools is an important topic both in its own right and because of its potential impacts on girls' enrollment in schools.³⁵ A growing body of evidence suggests that sexual harassment is widespread in educational settings in many parts of the world (UNICEF, 2002; Mirsky, 2003; Leach et al, 2003; Wellesley Centers for Research on Women, 2003). Data on harassment and sexual abuse in schools, however, are uneven: while there is compelling evidence that GBV is rife in African schools, little is known about the phenomenon in Latin America.³⁶ There are very few studies of GBV in schools in Latin America. Leon (1994) provides one notable exception: in a one-school study in Ecuador, she found that 22% of adolescent girls reported being victims of sexual abuse. A more recent study of violence in Brazilian schools found that 8% of students from 5th to 8th grade had witnessed sexual violence within the school environment (Abramovay and Franco, 2004).³⁷ Data on sexual violence, however, remain spotty for Latin America and the Caribbean.

³⁵ An unsafe environment in school may dissuade parents from enrolling girls in school or may lead to increased rates of school abandonment (WCRW, n/d). While this has been documented for the African context, it may or may not be important in Latin America and the Caribbean, where girls' enrollment rates typically exceed boys' rates.

³⁶ According to recent studies in six African countries, between 16% and 47% of girls in primary and secondary schools report sexual abuse or harassment, with both male fellow students and male teachers responsible for the abuse (Leach et al., 2003). In Botswana, 20% of female students reported having been asked by teachers for sexual relations (Rosetti, 2001, cited in Leach, 2003). In Cameroon, 8% of sexual abuse towards girls was accounted for by teachers (Mbassa Menick, 2001, reported in Leach, 2003). The DHS survey in South Africa, surveying women between 15 and 49 years of age, found that 37.7% of all rape victims identified a teacher or principal as the rapist (Medical Research Council, 2000). At the same time, girls in South Africa are more likely to be sexually assaulted by their male classmates than by teachers or school personnel (Human Rights Watch, 2001).

³⁷ The study covered middle schools in 14 Brazilian state capitals. The percentage of students who had witnessed sexual violence ranged from a low of 5% in Vitoria (Espirito Santo) and Fortaleza (Ceara) to a high of 12% in Cuiaba (Mato Grosso). The way in which the question was formulated does not permit identifying what percentage of girls were victimized by sexual violence.

Schools paradoxically are both the location where a significant amount of GBV takes place and an institution that potentially can play a key role in preventing GBV. The challenge for schools is two-fold: to reduce discrimination and GBV within the school setting and to strengthen the capacity of schools to promote non-violence in families and communities. Schools—and more broadly the educational system and communities—can engage in the prevention of GBV by: reforming laws and policies of the education sector, improving the institutional response at the school-level to GBV, and promoting community mobilization in support of girls’ safety and rights. Because relatively few initiatives have been undertaken in the education sector in Latin America and the Caribbean to address GBV, this section draws heavily on African experiences.³⁸ (Table 2.3 summarizes the types of initiatives and their objectives.)

2.4.2 Reforming laws and policies of the education sector

In many settings, the legal and policy framework for addressing sexual harassment and sexual violence in schools is notoriously weak. Few developing countries have strong comprehensive, national, state or provincial laws and policies to sanction educators who violate codes of conduct. Few educational ministries have promulgated a clear policy statement that sexual violence and harassment are unacceptable and will not be tolerated (Mirsky, 2003) or developed guidelines detailing what types of activities constitute harassment and how individual educational institutions are expected to respond to cases of harassment (WCRW, n/d). Frequently, only the most egregious cases of sexual violence result in criminal prosecution.

Some countries, however, have attempted to address this issue. For example, after researchers documented widespread sexual harassment and rape in schools, the South African Department of Education established a task force to study the problem and make policy recommendations (Jewkes, 2000). Their efforts contributed to the Employment of Educators Act and new Department of Education guidelines, both of which were introduced in 2000. These regulations mandate dismissal of educators found guilty of sexual or physical assault, or of having a sexual relationship with a student; they also define penalties for failing to report abuse. To-date, however, there has been no evaluation of the impact of these guidelines. In Latin America, the Costa Rican Ministry of Education’s Office on Gender Equality, has identified the prevention of sexual harassment as a priority and has begun work on the issue (Costa Rica, 2004).³⁹

In terms of policy reform of the education sector, potential interventions by the Education Ministry include:

- preparing a national action plan to combat GBV in schools

³⁸ Also note that since the institutional interventions examined in the education sector invariably work through individual behavior change, we will not present a separate analysis of individual level interventions in this section.

³⁹ Overall, there is a higher percentage of female teachers in primary and secondary schools in Latin America and the Caribbean than in Africa. This may be reflected in lower rates of sexual harassment of students by teachers, although limited availability prevents confirmation of this hypothesis.

Table 2.3. Objectives and strategies used to address GBV in the education sector

	Objectives	Specific Initiatives
Laws and policies	<p>To improve laws and policies</p> <ul style="list-style-type: none"> To develop a clear policy statement that sexual violence and harassment are unacceptable and will not be tolerated To strengthen legal and administrative sanctions against sexual harassment in schools 	<ul style="list-style-type: none"> Sexual harassment laws and policies for educators, including enforcement mechanisms
Institutional reform	<p>To strengthen the institutional response of schools, universities, school districts, ministries of education, teachers unions, etc.</p> <ul style="list-style-type: none"> To improve the capacity of schools to prevent sexual violence/harassment on school grounds To improve the institutional response to sexual harassment/violence when it occurs To improve the capacity of staff to teach violence prevention content, including gender and human rights 	<ul style="list-style-type: none"> Inclusion of sexual harassment prevention and gender in teacher training and certification requirements Institutional codes of conduct and administrative enforcement mechanism In-service sensitization and training of school personnel Inclusion of gender, rights, and violence within the health and family life education, life-skills curriculum Other school-based violence prevention programs (e.g. awareness campaigns, peer educators, theater) School-based counseling and referral services Replacement of textbooks that promote gender stereotypes
Community mobilization	<p>To increase community mobilization in support of girls safety and rights</p> <ul style="list-style-type: none"> To increase participation of parents in monitoring the safety of the school environment To increase collaboration between schools and community services related to violence To increase awareness of sexual harassment and violence at the community level 	<ul style="list-style-type: none"> Campaigns to address community concerns about girls' safety and increase support for girls education School- and community-based workshops, theater, etc. to raise awareness and decrease tolerance of sexual harassment/violence among the broader community Efforts to strengthen the capacity of parent organizations to monitor the performance of schools Alliances and collaboration between schools and NGOs

- developing a code of conduct for teachers that, among other elements, prohibits sexual harassment or abuse of students
- developing policies on how to deal with teacher misconduct, including investigative mechanisms
- including violence against women and harassment as themes to be covered within health and sexual education programs for students (WCRW, n/d)

2.4.3 Institutional reform

Efforts to improve the institutional response to GBV at the school-level include efforts to: improve girls' safety at and on the way to school; train teachers and school staff to reduce sexual harassment and promote gender equitable norms and nonviolence; expand counseling and referral services; include prevention of GBV in sexual and reproductive health curricula; and initiate school-based programs to prevent GBV and other forms of violence. Some of these initiatives may be undertaken by a particular school whose parents or administrators are interested in combating GBV. Alternatively, they may be implemented on a wider pilot basis in several schools, or as a national program under the auspices of the education ministry.

Initiatives to improve girls' safety at and on the way to school

As mentioned earlier, parental concerns about girls' safety in school appear to lower female school enrolment in settings such as South Asia, Africa and the Middle East. It also may be a relevant concern—albeit undocumented to-date—in rural areas of Latin America. Some initiatives have addressed these concerns by hiring more female teachers, building separate latrines or canteens for girls, reducing the distance that girls must travel to receive an education, and/or providing in-service gender sensitivity training to teachers, principles, inspectors, etc (UNICEF, 2004). For example, the UNICEF African Girls Education Initiative (AGEI) used a combination of these approaches, (along with many other strategies) to boost girls' enrolment in 34 African countries (UNICEF, 2003a). Evidence of this projects' effectiveness is limited. While some sites demonstrated significant enrolment increases (for example, 15% in Guinea, 12% in Senegal, and 9% in Benin) in relatively short periods of time, the extent to which this was due to the project was not clear. The experience of this project does suggest, however, that addressing concerns about girls' safety and reducing the risk of sexual harassment and violence in schools is both a high priority for parents and a promising way of improving girls' access to education. (UNICEF, 2003b).

Improving attitudes, knowledge, skills and practices of educators

Several initiatives have aimed to improve educators' attitudes, knowledge and practices in regards to gender discrimination, sexual violence and sexual harassment, but few have been well-documented or evaluated. The South African National Department of Education (in collaboration with international organizations) has developed a training module for educators (South African National Department of Education, 2001). Composed of eight interactive

workshops and other materials, the module aims to increase educators' awareness of sexual harassment and gender violence, highlight the links between violence and HIV/AIDS and increase the safety of the school environment. The module is a professional development tool, rather than part of the national curriculum.

Another school-based approach to preventing GBV is to train educators to teach courses promoting gender-equitable norms and nonviolence among students. For example, a consortium of researchers and advocates field-tested the "Gender and conflict" Model Curriculum in South Africa (Dreyer et al., 2001; Guedes, 2004) to compare a "whole school" approach (which trained the entire primary school staff, including principals and auxiliary staff) with a "train the trainers" approach (which trained two teachers from each school and expected them to transfer their training to their colleagues). The evaluation produced two key findings virtually identical to those from other sectors. First, training all staff—the "whole school" approach—was more effective than the "train the trainers" approach. Second, effective training must address teachers' own experiences of abuse and perpetration.⁴⁰

Few experiences of this type exist in Latin America or the Caribbean. One exception is a project in Costa Rica that attempts to modify teacher training curricula at two universities so that the curricula become gender-sensitive, with the hope that teachers trained in such a manner will themselves promote gender equality in their classrooms. One participating university (the University of Costa Rica) offers pre-service training to future teachers, and the other (the National Distance Learning University) offers in-service training to current teachers.⁴¹

Expanding and improving school-based counseling and referral services

A number of schools have tried to improve their response to sexual violence and harassment by providing counseling and referral services to students. For example, the TANESA "Guardian Project" in Tanzania aimed to improve girls' safety by designating one teacher from each of 185 primary schools as a "guardian" or *mlezi* (Mgalla et al, 1998; Mirsky, 2003; Guedes, 2004). *Mlezi's* were trained to counsel girls who experienced sexual violence or harassment, or who needed advice about other sexual and reproductive health issues. Evaluators assessed the results of the program through interviews with teachers, 'guardians' and 1219 students in 40 schools with a guardian and 22 schools without. Over 61% of girls consulted the guardians during the first year. In control schools, not a single girl said that she would ever report sexual harassment by a teacher, compared to 52% of girls in schools with a *mlezi*. The program had less success in other areas; for example, it was not able to change teachers' negative attitudes towards girls who became pregnant or who contracted an STI.

⁴⁰ In South Africa, almost half the female teachers reported having been physically abused by a male partner at some point in their lives; almost one-third reported experiences of sexual abuse; and several male teachers admitted to physically or sexually abusing their partners or colleagues.

⁴¹ The project is jointly executed by the University of Costa Rica's Research Center in Women's Studies and the University of Toronto's Centre for Research in Women's Health.

Including violence prevention in sexual and reproductive health education

The inclusion of sexual and reproductive health modules in national or provincial educational curricula is common in Latin America. These modules tend to focus on the prevention of teen pregnancy, as well as the prevention of HIV/AIDS and sexually transmitted diseases. They have only infrequently incorporated the issue of GBV. While school-based programs have successfully improved students' knowledge about HIV/AIDS and other health issues in many settings, they have had a more limited impact on sexual behavior (Leach et al., 2003). In many cases, researchers suggest that weak programming may be to blame; school-based programs often suffer from poor content, lack of teacher training, resistance by teachers, cultural barriers, and parental objections to sex education. Little is known about the ability of these programs to improve violence-related attitudes or behaviors, especially in Latin America. One quasi-experimental study of life skills education among 9th graders in South Africa found that the program had only a minor impact on attitudes towards sexual coercion. Even when GBV prevention is incorporated into sexual and reproductive health curricula, what is generally missing is recognition that gender roles play—and more specifically norms surrounding masculinity—not only in sexual and reproductive health risk taking (Stern et al., 2001), but also in reinforcing and perpetuating GBV.

School-based programs to prevent GBV and other forms of violence

Beginning in the 1970s, schools and universities throughout the United States launched programs designed to prevent child sexual abuse, “dating violence,” or other forms of sexual coercion among students. Typically these programs were based on the theory that children and young women could be taught to protect themselves by recognizing abuse, reporting threatening situations, and adopting basic safety precautions. Few low and middle-income countries have adopted this model, but the number of program experiences and the breadth of the research on these initiatives make them worthy of mention. By 1992, these programs were so widespread in the United States that a national survey of young people (aged 10-16, n = 2000) found that approximately two-thirds had participated in a sexual abuse prevention program through their school (Finkelhor and Dziuba-Leatherman, 1995b).

A large number of evaluations have gauged the effectiveness of these programs (Finkelhor and Strapko, 1992; Meyer and Stein 2000; Bolen, 2003; Chalk and King, 1998), some with rigorous scientific designs, control groups, extensive quantitative outcome measures, and long-term follow-up. This research indicates that while programs can improve knowledge and reported willingness to report abuse, they do not appear to reduce victimization among participants compared to controls. Thus, many researchers and advocates argue against focusing on girls' ability to protect themselves; instead, they argue that initiatives should aim to change male norms and behaviors and to promote positive models of forming relationships (Chalk and King, 1998; Bolen, 2003).

In Latin America, in contrast, we are unaware of any school-based programs that directly address GBV, whether child sexual abuse, dating violence, other sexual abuse among students, or sexual abuse of students by teachers or other school staff, with the exception of

one program in Medellin, Colombia that screens primary students to detect children who are victims or witnesses of family violence. What *is* relatively common in Latin America are school-based programs to prevent youth violence. The Partnership for Educational Revitalization in the Americas (PREAL, 2003) recently produced an annotated list of school-based youth violence prevention programs encountered in nine South American countries.⁴² Of these 34 programs, none explicitly deals with issues of GBV.⁴³

It is not clear that youth violence prevention programs, typically focusing on changing school climate or providing training for students in conflict mediation or other techniques for non-violent dispute resolution, will provide spillover effects that reduce levels of GBV. With respect to changes in school climate or disciplinary rules/procedures, it is easy to imagine that a reduced tolerance for youth violence might produce a spillover reduction of sexual violence—but it is also probable that this effect will not be as large as it might be if explicit attention were paid to GBV in the school environment. With respect to interventions focused on changing individual behaviors, there is perhaps less room for optimism, since reducing GBV probably involves more fundamental changes in norms than does reducing male-on-male youth violence. But all this is speculation: scientific studies will be needed to test for the presence of these spillover effects, and these studies have not yet been undertaken.

2.4.4 Community mobilization

In theory, parent organizations and other community groups could pressure schools to ensure students' safety and enforce sexual harassment policies; in practice, parents and community groups are likely to have internalized societal norms which are permissive of GBV. Emerging evaluation research in Zimbabwe, Ghana, and Malawi (Leach et al., 2003) found that community workshops and theater did raise awareness of abuse, increase parents' willingness to report abuse and allow the community to confront the problem of abuse without putting individual girls at risk of retaliation (Leach et al., 2003).

2.4.5 Policy recommendations

It is difficult to formulate policy recommendations for policy makers in Latin America and the Caribbean based on the lessons learned about initiatives in the educational sector to combat GBV, since there have been so few initiatives in the region. Based on experience in Africa and in developed nations, however, we offer a few recommendations:

Collect more data on the prevalence of gender-based violence in schools. These data are urgently needed; at present, we have only imperfect data for two countries of the region, that

⁴² The number of programs encountered by country was: Argentina (3), Brazil (8), Chile (4), Colombia (10), Ecuador (1), Peru (4), Uruguay (3), and Venezuela (1).

⁴³ One program in Peru did so, but is no longer operational. Executed by the Centro de Desarrollo y Asesoría Psicosocial (CEDAPP) from 1994 to 2002, the program attempted to detect sexual abuse of children by training “defensores escolares” in schools located in three neighborhoods in Lima, Peru and in the department of Huancavelica, Peru.

either suffer from extremely limited coverage (Ecuador) or are not true prevalence estimates (Brazil).

Develop a policy on sexual violence and harassment. The first and most important step toward eliminating sexual abuse of girls in schools is to develop a strong and unequivocal policy statement that sexual violence and harassment are unacceptable in educational institutions and will not be tolerated, accompanied by clear definitions about what constitutes harassment and sexual violence.

Train teachers and school staff to detect and prevent sexual abuse. If teachers are to be trained to recognize and prevent sexual abuse in school settings, two considerations should be kept in mind: i) “whole school” approaches in which the entire teaching and administrative staff are trained have been documented to be much more effective than a “train the trainers” approach; and ii) since male teachers are likely to be part of the problem, training must be accompanied by detection and enforcement mechanisms; such mechanisms must involve parents and the wider community as well as the education ministry.

Focus school-based prevention efforts on boys’ norms and behaviors, not teaching girls to protect themselves. The lessons-learned from programs addressing youth violence should also be incorporated into GBV prevention programs: interventions should involve span multiple domains, including students, parents and peers; cognitive-behavioral interventions that teach new behaviors and then offer students the opportunity to practice these new behaviors are particularly effective; and programs which simply preach the danger or inappropriateness of a conduct are ineffective.

Include edutainment programming within the school environment. Edutainment approaches are powerful tools for modifying norms and behaviors—especially among youth—and can be easily adapted for use in the school environment.

2.5. Multi-Sectoral interventions: Socio-economic development, services, transforming community norms and public safety

2.5.1 Overview of multisectoral interventions and GBV

Throughout this review, we have emphasized the value of collaboration between justice, health, education and other sectors to ensure an effective and comprehensive response to GBV. However, this section will address over-arching goals that—almost by definition—require a multi-sectoral approach, namely:

- Economic and social empowerment of women
- Improved quality and access to integrated services for girls and women who experience GBV
- Transforming community norms about GBV.

Research highlights the links between socio-economic factors and intimate partner violence against women. In many settings, women with high economic and social status appear to be somewhat protected, but the relationship between socio-economic status and violence is not necessarily linear (Jewkes, 2002b). Evidence suggests that violence against women may actually rise as women initially gain greater access to social and economic opportunities and resources; in some settings, women in the poorest households may be somewhat protected from violence. Jewkes argues that social and economic empowerment appears to increase women's risk of violence in some settings by challenging traditional gender roles and increasing conflict in the household until, she writes, "a high enough level [of empowerment] has been reached for the protective effects to predominate." The World Health Organization World Report on Violence came to the same conclusion, arguing:

Where women have a very low status, violence is not "needed" to enforce male authority . . . Partner violence is thus usually highest at the point where women begin to assume nontraditional roles or enter the workforce (Heise and Garcia Moreno, 2002, page 99).

Clearly, these observations should not be used as an excuse to deny women access to social and economic empowerment, since short-term increases in violence against women do not necessarily mean that a program which generates empowerment will fail to reduce violence in the long run. Under some conditions, however, increases in violence may be a temporary but unavoidable by-product of challenging traditional gender norms. The important lesson is that programs should find ways to mitigate a violent male response—whether via communication strategies such as mass media and edutainment programs or by increasing women's participation in decision-making bodies at a community, municipal and national level as a way of transforming community norms (and consequently creating a favorable environment for violence prevention).

Improving coordination between sector-specific approaches as well as between civil society initiatives and government institutions has been underscored by numerous experts as a critical component of an effective strategy for addressing GBV. A multi-country study carried out by the Pan American Health Organization (PAHO) in ten Central American and Andean countries examined the barriers encountered by women and girls suffering violence who attempted to seek help through formal channels. Serious deficiencies were found at an institutional level in all of the countries. These deficiencies effectively denied women access to care and protection. In particular, the lack of a coordinated institutional response was cited as the greatest obstacle to violence prevention and support for survivors. The study documented such problems as:

- **Lack of coordination among government institutions that deal with violence (justice, child welfare, health, etc.)** In many settings there are NGOs or local women's groups who also provide a variety of support services for survivors of violence, but no formal mechanisms exist to facilitate referrals or coordination with government institutions. As a result women are often forced to negotiate their way through a complex and costly maze of contradictory information and requirements,

telling the same story repeatedly, enduring hostile interrogations and countless obstacles until many eventually give up in frustration.

- **Inconsistent and cumbersome procedures for gathering forensic data.** Women were often denied care by health providers who were not authorized to collect forensic evidence, and might be forced to travel long distances to reach the nearest medical examiner. Because medical examiners are often not available at night and on weekends, a woman might have to wait several days after a rape before being examined, by which time most of the evidence would be gone and the opportunity for prosecution of offenders effectively lost.
- **Information systems are woefully inadequate** and are rarely compatible across institutions. Consequently, it is nearly impossible to track cases or provide any kind of comprehensive follow-up (Velzeboer, Ellsberg et al. 2003).

2.5.2 Multi-sectoral initiatives to address GBV

Table 2.4 presents examples of initiatives that have the potential to reduce women's vulnerability to violence through multi-sectoral efforts such as economic development, increased opportunities for labor force participation, education, public safety, and access to comprehensive social services once physical or sexual violence begins.

2.5.3 Reforming laws and policies

Reforming laws that discriminate against women

As noted in section 2.2.3, civil codes in many countries restrict women's legal rights. An important component of multi-sectoral approaches to women's socio-economic status is the effort to strengthen women's ability to exercise their legal rights, including access to divorce, paternity and child support laws, ownership of property, inheritance, labor force participation and access to land reform and credit. International and national advocacy efforts have produced many recent improvements in this area. In Latin America, Guatemala recently granted women the right to manage marital property and decide to work outside the home without their spouses' permission. Brazil, Mexico, and Jamaica have all recently considered or enacted laws to improve women's rights to inheritance and property (Center for Reproductive Law and Policy, 2000).

As in other areas of legal reform, research highlights the difficulty of implementing legislative reforms and the need to complement them with other types of initiatives, especially advocacy and legal literacy programs that enable women to exercise their rights effectively. For example, a Nicaraguan NGO (FIDEG) developed a methodology for estimating the value of women's non-monetary contribution to the household. This tool has been particularly useful for helping rural

Table 2.4 Multi-sectoral objectives and strategies used to address GBV

Level	Objectives	Specific interventions
Laws and policies	<p>To improve social and economic laws and policies</p> <ul style="list-style-type: none"> • Increase investment in women's social and economic development and political participation • Strengthen economic and social policies that address GBV • Ensure a comprehensive service response to survivors of GBV 	<ul style="list-style-type: none"> • Revised laws and policies to improve women's economic rights to property and inheritance, and to reduce discrimination against women and girls • Multi-sectoral national or state plans for addressing GBV • Policies mandating comprehensive social, medical and legal services for survivors of GBV
Institutional reform	<p>To improve the response and capacity of social service and economic development programs to address GBV</p> <ul style="list-style-type: none"> • Increase attention to violence against women by institutions devoted to social and economic development • Increase attention to violence in the design of urban planning and transport projects • Improve the quality and comprehensiveness of the social service response to violence 	<ul style="list-style-type: none"> • Creation or strengthening of government offices dedicated to the advancement of women. • Integration of violence prevention into the programming of social and economic development projects (e.g. urban upgrading, microcredit) • Efforts to expand, improve and coordinate services for survivors: (e.g. counseling, shelters, victim advocacy, hotlines, women's support groups, children's services, legal aid, batterer treatment, etc.)
Community Mobilization	<p>To increase community mobilization in support of women's safety, support, access to services and economic opportunities</p> <ul style="list-style-type: none"> • Strengthen collaboration between public sector institutions and civil society with regard to women's rights and safety • Strengthen community-based women's organizations and networks • Increase community support for survivors and social sanctions against perpetrators 	<ul style="list-style-type: none"> • Public safety programs (e.g. camera surveillance in public spaces and neighborhood watch programs) • National and local networks of organizations working to improve the rights, safety and well-being of women in general and survivors in particular • Community-based awareness campaigns (e.g. mass media, workshops, community theatre, protests, etc.)

Individual behavior change	<p>To improve individuals' knowledge, attitudes behaviors and access to services/economic opportunities</p> <ul style="list-style-type: none"> • Encourage family members and friends to support and care for victims of violence • Increase women's awareness of and access to social services and economic opportunities • Decrease tolerance for abuse and discrimination against women and girls 	<ul style="list-style-type: none"> • Behavior change communication strategies (e.g. mass media campaigns, community based workshops, community theatre) • Economic development programs aimed at women (e.g. micro-credit programs, small business development, housing, etc.)
-----------------------------------	--	--

women obtain fair settlements in the case of divorce, thereby increasing options for women to leave an abusive relationship.

National plans and commissions against Violence

In accordance with the Belen do Pará Convention, virtually all Latin American governments have established national commissions for the purpose of improving inter-sectoral coordination and monitoring progress on the development of national plans and policies on violence against women. Most commissions are headed by the national institutions for the promotion of women's rights and include representatives from the ministries of justice, education, health and child welfare, as well as women's NGOs that work on violence. One of the first goals of each of the commissions was to achieve a basic agreement among the sectors on how to coordinate a national violence prevention effort. One of the oldest and most successful national plans is Costa Rica's National Plan for the Elimination of Violence (PLANOVI), which has been implemented since 1994 (for more details on PLANOVI, see Box 2.4; for an overview of the national plans of Bolivia, Brazil, Chile, Costa Rica, see IDB, 2001).

Although there are no rigorous evaluations of the effectiveness of the national plans on violence, qualitative reports suggest that the existence of a national plan on violence against women is an important achievement in itself, as it creates a political space for greater dialogue between civil society and the state while simultaneously committing government to a public discourse that encourages sanctions against violence. Nevertheless, in most countries the transition from developing plans to putting them into practice seems to be problematic. This is partly due to budgetary constraints, but may also reflect a lack of political will. In Nicaragua, the National Committee for the Elimination of Violence against Women carried out a highly participatory planning process on violence against women, which resulted in an ambitious and comprehensive proposal. Since the approval of the Plan in 2002, however, the plan has languished for lack of resources to implement it. Another constraint faced by many countries is the lack of coordination between national plans and local plans developed by municipal- or community-level commissions, which creates a duplication of efforts,

inefficient use of resources, and lack of coherence in the implementation of national and local strategies.

Box 2.4. The National Plan for the Care and Prevention of Family Violence (PLANOVI) of Costa Rica

In 1994 a number of public and non-governmental organizations drafted a national plan to address violence against women. The plan reflected the need for a national policy that embodied the spirit of the work that these groups had carried on for many years in addressing the issue of violence against women in Costa Rica. After much lobbying, especially on the part of women's organizations, this plan became PLANOVI. In 1998 an Executive Order established PLANOVI as the official *National System for Treating and Preventing Family Violence* that was called for in the Domestic Violence Law of 1996. This system is coordinated by the National Institute of Women (INAMU) and is made up of governmental and non-governmental organizations that provide services and support to women affected by GBV.

The goals of PLANOVI are to:

- implement an integrated system for detecting family violence and extra-family sexual abuse, preventing aggression, and providing care to affected persons so that they may recuperate and begin living healthier lives free of violence; and
- promote actions to change sociocultural norms that encourage and justify violent behaviors and promote non-violent lifestyles that are based on respect for individual differences.

PLANOVI is considered a model plan by neighboring Central American countries because of its intersectoral membership and its effectiveness in coordinating training, the development of materials, and lobbying under the leadership of INAMU.

Source: Velzeboer, Ellsberg, et al., 2003.

2.5.4 Institutional reforms

Women's social and economic development has been a major focus of many programs over the past few decades. However, most low-income settings still have limited social services and economic programs for women relative to the size of their populations; staff members are often poorly prepared to address violence against women; and services tend to be fragmented and difficult to access.

Improving comprehensive services for abused women and children

As noted above, most of the initiatives to strengthen comprehensive services for survivors of GBV are led by national women's institutes. Typically, these efforts aim to expand, improve and integrate services such as telephone hotlines, emergency shelters, police intervention, legal assistance, counseling services, psychological care, support groups, income generation

programs, programs for batterers and child welfare services. For example, in El Salvador, the Salvadoran Institute for the Development of Women is a government agency that coordinates the “Program to Strengthen the Family” (*Programa de Saneamiento de la Relación Familiar*), a multi-sectoral effort to address GBV among public and private institutions in El Salvador (Valdez, 1999).

A large literature exists on caring for survivors of physical and sexual abuse within specific professional disciplines, but research on the effectiveness, quality and impact of social service programs is scarce in low and middle-income countries. Most evaluations document numbers of persons served, services provided, and types of cases reported (e.g. Inter-American Development Bank, 2002). Some conduct informal studies of quality, by gathering information on service quality, client satisfaction, or qualitative perspectives of survivors (e.g., Guedes et al., 2002).

One of the few rigorous evaluations of integrated services for abused women was conducted in the United States by Sullivan and Bybee (1999). This randomized, longitudinal study evaluated the impact of community-based advocacy services in the United States on outcomes such as levels of physical violence, psychological abuse, depression, quality of life, and social support. This study found that women who received advocacy services were more than twice as likely to experience no violence in the two-year post-intervention period, compared with women who did not receive such services; moreover, these women reported a higher quality of life and social support, and had less difficulty obtaining community resources. While research has documented the impact of comprehensive services in Latin America and the Caribbean on the proportion of women who know what services exist and where and the number of women who seek help, the final impact on probability of re-victimization is unknown.

Batterer programs

Most batterer programs have been carried out in high-income countries. In Canada, Europe, and the United States, there are many treatment programs for abusers that include a variety of theoretical and programmatic approaches. Most programs have a duration of 8–12 weeks and are court-mandated. Few evaluations have been conducted to measure the effectiveness of this strategy. Attendance data, however, indicate that approximately half of the men drop out before completing the program. Of those that do finish, approximately half of them stop using physical violence, at least for some period of time (Edelson 1995). The only randomized controlled trial to-date was carried out on a batterers program run by the United States Navy, which found no reduction in abuse compared with controls (Dunford, 2000).

Increasingly, NGOs and governments in Latin America and the Caribbean have attempted to reduce violence against women by organizing treatment programs for male batterers. Most are run by NGOs, but they often depend on court-mandated attendance as an alternative to criminal sanctions. Prominent examples include the Instituto Noos in Brazil (White, Greene, and Murphy, 2003) and CORIAC in Mexico (Morrison and Biehl, 1999). Battered women often identify treatment or counseling for their husbands as a high priority (e.g. Ellsberg,

2001), but it remains to be seen whether cost-effective strategies for changing batterer behavior can be found.

Shelters

Many researchers and advocates have called on governments and donors to create shelters for women who experience GBV. Typically, these facilities offer emergency refuge as well as counseling, medical and legal assistance, job training, telephone hotlines, and other services. Most rigorous evaluation studies on the effectiveness and quality of shelters come from settings such as the United States, where over 1200 were in operation as of 1998 (Chalk and King, 1998). In high-income settings, survivors consistently rated shelter services highly, relative to mixed reviews of other institutions such as health services, police and courts. Many, however, question the feasibility and cost-effectiveness of shelters in middle and low-income settings, where they remain rare (e.g. Larrain, 1999).⁴⁴ Documentation of the Acción Ya shelter in Estelí, Nicaragua indicates that for some women, the shelter provides a crucial opportunity to escape from immediate violence and to explore alternatives, particularly when the shelter is coordinated with other social and counselling services (Centro Acción Ya, 1999). Shelters, however, are very expensive to maintain and it is difficult to keep their location secret, particularly in small towns or rural areas. In Latin America, women's groups have tended to focus efforts on organizing informal strategies that help women and children find refuge among friends, family or volunteers.

Support groups for survivors

Support groups are effective and low-cost techniques for helping survivors overcome their experiences of violence. There are several Latin American organizations—CEFEMINA in Costa Rica and the Flora Tristán Center in Peru are good examples—with extensive experience in organizing self-help or support groups for violence survivors. The PAHO-supported networks in Central America and the Andes have also developed a model for facilitating support groups in institutional settings such as health centers.

One of the main advantages of support groups is that they enable centers to respond to many more individuals than would be possible with individual psychological care. Additionally, the group facilitator does not have to be a mental health professional, although special training is necessary. Another advantage is that women are given the opportunity to help each other and to realize that they are not the only person suffering from violence. In some cases, support groups have led to collective action. These have all been identified in qualitative studies as key factors that enable women to leave violent relationships. Unfortunately, there are no quantitative evaluations of the impact of support groups on re-victimization in Latin America or the Caribbean.

⁴⁴ Activists, on the other hand, often question why victims should be forced to leave their homes and neighborhoods, rather than perpetrators.

2.5.5 Community mobilization

Many initiatives have aimed to improve the response to violence against women by mobilizing the community through mass media campaigns, community-outreach, community-based awareness raising campaigns, and service provision.

Multi-sectoral initiatives to mobilize a better community response to GBV

Based on the recommendations PAHO multi-country study of institutional barriers for abused women, both the PAHO and IDB programs in Latin America placed a great emphasis on the development of community-based networks for coordinating services to victims as well as access to justice and violence prevention. These networks may be made up entirely of governmental agencies such as the criminal justice sector, social welfare, education. Another type of network, such as the Nicaraguan Network of Women against Violence exists for the purpose of coordinating the response of civil society to violence, while a third type integrates public and private agencies addressing GBV. The most promising interventions combine the goals of primary and secondary prevention and help engage governmental and non-governmental institutions in a joint strategy. These networks can greatly enhance the quality of care provided to survivors and help coordinate the services women receive from multiple institutions. They can also play an important role at a community level in mobilizing public support for survivors of violence and decreasing tolerance of violent behavior. A description of a local community network in Los Altos, Bolivia is presented in Box 2.5.

2.5.6 Individual behavior change strategies

Evaluations of initiatives to change individual behaviors highlight the complexity of violence prevention; many evaluations document that changing attitudes and awareness appears to be much easier than changing violent behaviors.

Mass media campaigns to increase awareness of women's rights

As discussed earlier in this paper, one of the major findings of international research on the causes of GBV is that, although individual risk factors such as witnessing violence as a child or use of alcohol may increase a specific individual's likelihood to use violence, cultural norms play a large role in overall levels of violence in a community. Community-based educational activities can increase women's knowledge of legal and social rights and empower them to seek help for abuse. They can also challenge the underlying beliefs that justify women's subordination and the use of violence for settling conflicts. Promoting non-violent and equitable relationships between men and women is the key to preventing future violence. Organizations (mostly NGOs) around the world have used mass-media campaigns to raise awareness of GBV, promote nonviolent behavior and to encourage women and men to be more supportive of their friends and family members who experience violence. These

Box 2.5
The Experience of Bolivia: the Network for the Prevention and Care of Family Violence

In September 1998 in the city of El Alto, Bolivia, a group of governmental, nongovernmental, and community organizations formed the Network for the Prevention and Care of Family Violence. Together they developed a work plan and set up committees for implementing the plan and for mobilizing technical and financial resources among the member organizations.

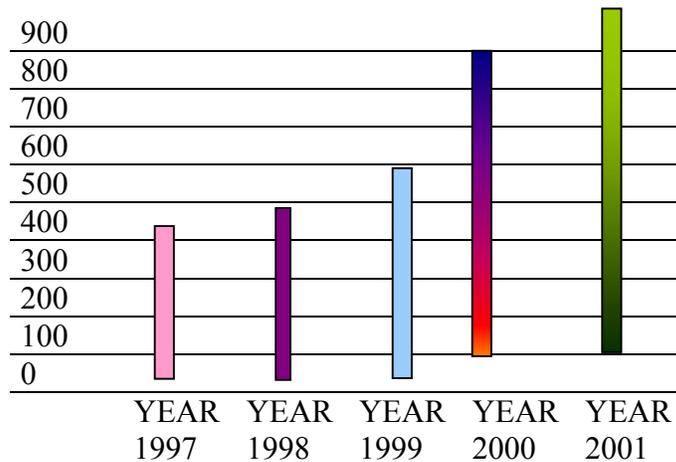
Since its beginning, the Network has been successful in coordinating the work of a wide variety of city government entities, such as the Office of Gender Affairs, the Office of Social Administration, the health center, the public defender's office, the police unit responding to family-related and emergency situations, the local team of Doctors without Borders, and a confederation of more than 100 grassroots organizations.

With their shared agenda, these members worked together to achieve the following:

- In 2001, member organizations registered 15,371 cases of violence out of a total population of 98,670 women.
- The health center recorded 297 cases of family violence, of which 36% were referred to the police and/or other legal authorities. Before the establishment of the network there were no such referrals..

Demand for Legal Services for Domestic Violence

El Alto, Bolivia, 1997-2001



The lessons learned from the Bolivia case study are:

- Effective systems for collecting and analyzing information on GBV are critical for: determining its scope; raising awareness among service providers, particularly from the health sector; and for influencing political decision-making at the local level.

- Partnerships among governmental, nongovernmental, and local organizations that are built on sustained commitment and incorporate each member's expertise are essential for the delivery of well-integrated and high-quality services.
- The community's ethnic identity (in this case, of predominately Aymara origins) must be recognized and incorporated in the targeting of interventions and in the promotion of rights and equity.

Source: Gregoria Apaza Center for the Promotion of Women, 2003

campaigns have included international campaigns (such as the 16 Days of Activism Against Gender Violence Campaign), national campaigns (such as the annual campaigns conducted by the Nicaraguan Network of Women against Violence), and local campaigns conducted within individual communities. These campaigns often appear to successfully raise awareness and increase knowledge. For example, national surveys suggest that—at least partly due to the annual campaigns—women in Nicaragua are increasingly aware of their rights. A Demographic and Health Survey (DHS) found that more than two-thirds of women believed that violence against women was never justified and that they should be able to refuse sex with their partner for any reason. While it is difficult to disentangle the contributions of multiple initiatives on changes in awareness and attitudes, the DHS found that one half of women in the country had seen or heard at least one campaign message and one out of four women surveyed were able to repeat one or more of the messages (Ellsberg, Liljestrand et al. 1997; Rosales, Loaiza et al. 1999). Once again, however, researchers have not yet been able to measure the impact of these initiatives on levels of violence against women; moreover, experiences from other fields suggest that while these types of mass media campaigns play an important role in awareness-raising, strategies such as 'edutainment' are more likely to change behaviors over time (CDC, 2004).

Other organizations in Nicaragua have targeted specific populations such as men and youth. An example of this was a campaign carried out by the Nicaraguan organization Puntos de Encuentro. The campaign was based on the results of a qualitative study of men who did not practice violence, and tried to draw attention to reports that violence against women had increased greatly in the aftermath of Hurricane Mitch (Montoya 1998). The main message of the campaign, which included TV and radio advertisements, highway billboards, bumper stickers, caps, posters, brochures and training for community promoters, was that "Domestic violence is one disaster that we **can** prevent." It drew a series of parallels between the devastation wrought by the hurricane and the devastation and suffering caused by domestic violence. A subsequent evaluation of this campaign showed that 60% of men surveyed had heard of the campaign. The men who had been exposed to the campaign were more likely than those who had not to endorse the view that violence was preventable and that it was bad for the community. Over half of those who heard the messages had discussed them with somebody else, and nearly 90% of men surveyed felt that the campaign had made a difference in the way men behaved (Puntos de Encuentro 2000).

3. Conclusions and Recommendations

This working paper highlights both the limits and progress made in building a knowledge base about effective ways to reduce levels of intimate partner and sexual violence. In general, GBV prevention has received far less attention than treatment for survivors. Empirical evidence about effective interventions is scarce, though numerous research projects are underway that may contribute to the scientific knowledge base in the near future. While recognizing the limited number of high quality studies on program effectiveness, this review has attempted to highlight emerging good practices. Table 3.1 summarizes some of the most promising approaches profiled, as well as typical challenges and pitfalls by sector.

Table 3.1. Potentially promising approaches to GBV prevention and typical problems by sector

Potentially promising approaches	Typical problems and problematic approaches
JUSTICE	
Educating law enforcement personnel and the public about new laws	Failure to allocate resources for implementing new laws and policies
Broad investment in strengthening law enforcement response to GBV (protocols, training, etc.)	Failure to monitor and evaluate implementation or impact of laws/policies
Long-term efforts to educate police/ judiciary on the implications of GBV	Underinvestment in police and courts more generally
Specific GBV related legal reforms (special stations, cells or courts, etc.)	Family courts that require survivors to attempt reconciliation with abusers
Comprehensive medico-legal system reform (e.g. forensic nursing)	Separate women's police stations without broader law enforcement reforms
Networks and alliances between legal, social health organizations	Policies restricting collection of legal evidence to forensic physicians
Efforts to publicize enforcement of laws that protect women's rights	Failure of law enforcement to coordinate with social and medical services
Reform of informal justice systems (e.g. traditional courts and councils)	Lack of legal aid services for divorce and child support
	Practices that allow traditional authorities to block women's access to courts

HEALTH

Policies clarifying providers' role and responsibilities in cases of GBV

Broad institutional reforms to improve the health care response to GBV

Networks and coalitions for referrals, advocacy and education

Community education to change awareness, knowledge, attitudes, behaviors and access to services of GBV as a public health problem

Reproductive / HIV education for youth that addresses gender and GBV

Policies facilitating access to emergency contraception, prophylaxis for sexually transmitted infections and safe abortion for survivors of violence

Mandatory reporting requirements for cases of GBV

Routine screening for GBV without broader institutional reforms

Failure of health sector to coordinate with other community services

Health education programs that lack a human rights framework

Reproductive health programs that fail to address gender or sexual coercion

Campaigns that use "macho" imagery (e.g. for condom promotion)

EDUCATION

Implementation and enforcement of sexual harassment laws and policies

Improved school infrastructure (more rural schools; more female teachers; safe, working latrines for girls, etc.)

The "whole school" approach to educator training about GBV

School-based counseling and referrals

School-based programs focused on changing male gender norms

School-based sexual and reproductive health programs that encourage a critical consciousness about gender and violence

Vague, unenforced or nonexistent national sexual harassment policies

Schools that ignore parents' concerns about girls' safety

Educator training limited to a single session or of poor quality

Schools with no links to external GBV services

Abuse prevention programs focused solely on girls

School-based health education focused primarily on anatomy

MULTI-SECTORAL

Laws/policies to enhance women's ability to exercise economic rights

National Plans for a comprehensive approach to GBV

Networks and coalitions for expanding social services

Micro-credit and income-generating programs that integrate attention to GBV

Community mobilization and mass media campaigns to change attitudes and behaviors, as well as increase access to social services

Policies that restrict women's economic rights or privilege men's access to economic opportunities

Inadequately funded, implemented or evaluated national GBV plans

Lack of investment in social services; lack of coordination among service providers

Micro-credit institutions that ignore GBV

Cross-cutting conclusions

The sectoral structure of this review was designed to identify good practice approaches for policymakers who frequently work within a specific sector. The specificity of this sectoral approach, however, should not obscure some important overarching conclusions. Of first and foremost importance are what Guedes (2004) identifies as “guiding principles” for work on GBV:

- Ensure that all programs and projects prioritize survivors’ safety and autonomy.
- Employ a human rights perspective in order to explicitly challenge prevailing norms that make violence acceptable within a society.
- Ensure that interventions are culturally appropriate before transferring interventions from one cultural milieu to another.

Other important conclusions include:

- **Focusing on the prevention of GBV, not just on services for its survivors.** Of the scant resources devoted to GBV in developing countries, the vast majority are allocated to providing services to its survivors. While few would dispute the moral imperative of offering these services, prevention initiatives that avoid future GBV may be a more cost-effective response, especially if they focus on young males. At the same time, it must be noted that it is not always easy to distinguish prevention from treatment, since women receiving quality services may be less likely to be re-victimized.
- **Employing a multi-sectoral approach.** This paper reviewed initiatives from each individual sector separately, including justice, health and education; however, one consistent finding from all sectors is the need for collaboration between law enforcement, the judicial system, legal aid services, health care organizations, public health programs, educational

institutions and agencies devoted to social services and economic development. This collaboration appears to be important not only for providing an integrated service response to women who experience violence, but also for developing effective strategies for reducing levels of violence against women in society.

- **Working at different levels.** Effective approaches to prevention generally require working at different levels: individual, community, institutional, and laws and policies. For example, simply changing the criminal code may not be effective if law enforcement institutions remain weak, if judges are unaware of the change, if communities resist changes in women's legal rights, and if women remain unaware of the laws or unable to access services.
- **Empowering women and reducing gender disparities.** Research has provided compelling evidence that violence against women is rooted in gender inequality. Thus, any intervention to address GBV should be framed within an overarching strategy to reduce gender disparities and improve women's status in general.
- **Creating partnerships between government and nongovernmental agencies.** This review highlights many examples of benefits from collaboration between government and civil society. Both of these groups have an essential role to play and are unlikely to change levels of violence or provide quality services to its survivors working in isolation from one another.
- **Addressing norms, attitudes and beliefs at all levels of society.** Attitudes that condone or tolerate violence against women and blame the victim are deeply entrenched throughout society in nearly all parts of the world—albeit to varying degrees. Changing these attitudes and beliefs is a challenging, long-term process that requires a sustained commitment by institutions providing services, as well as organizations with the capacity to harness mass media strategies.
- **Targeting young people.** Evidence suggests that young people are more open to changing their views about the acceptability of violence than older adults. Youth-oriented education programs may represent one of the most important strategies for reducing violence against women in the long run. Similarly, schools and universities have an opportunity to improve the response of the next generation of professionals by integrating attention to violence into the training of lawyers, judges, physicians, nurses, psychologists and teachers. This approach may ultimately be more effective than trying to change attitudes and practices of experienced professionals, although both are needed.
- **Demonstrating the developmental impact of GBV.** GBV is clearly a women's issue and an issue of human rights. But it is also a serious public health issue and an important barrier to the socio-economic development of many countries. Rigorous research that documents the health and developmental impacts will attract new actors to the fight against GBV, with a concomitant increase in visibility of the issue and resources devoted to it.
- **Building the knowledge base through rigorous evaluation.** The dearth of evidence about effective programs to address GBV leaves policy makers and program managers

without the ability to make informed decisions. Lack of data not only impedes evidence-based decision-making, but makes it more difficult to argue for allocating increased resources for preventing and responding to GBV. Researchers and programmers need to collaborate on more rigorous evaluations—particularly in the area of prevention. Too often, GBV initiatives have not been based on a clear hypothesis or theory about how their strategies may produce results; even fewer have tested their theories with baseline and follow-up data collection, much less with control groups and longitudinal designs.

Comparative advantage of multilateral institutions and bilateral donors

Bilateral donors and multilateral institutions can play an important role in addressing GBV in developing countries. International actors are in a unique position to encourage science-based evaluations of GBV programs, to share the results of these evaluations across countries, and to use those findings to promote investment in effective prevention and treatment initiatives. Second, international actors can promote effective public-private partnerships and in particular coalitions between governments and NGOs. As this working paper notes, these types of coalitions appear to be essential for developing effective community or national efforts to reduce violence and assist survivors. Third, this review highlights the value of integrating attention to violence into existing multi-sectoral programs and operations that target justice, health, education, social services, and community-driven development—all areas in which multilateral agencies and bilateral agencies routinely work. Within these individual sectors, specific recommendations from this review (see Table 3.1) represent possible avenues of technical and financial support. Especially promising avenues include:

- a) integrating actions to prevent GBV and ensure survivors' access to justice in reforms of the judicial sector;
- b) encouraging governments to revise their legislation in accordance with Belem do Pará and other international human rights agreements;
- c) encouraging national and local government agencies to develop and enforce stronger sexual harassment policies for schools;
- d) including attention to sexual violence and harassment in initiatives to boost girls' school enrolment in areas where this is an issue;
- e) ensuring that GBV (particularly sexual coercion) is fully integrated into HIV/AIDS programming;
- f) ensuring that initiatives to combat violence are eligible for funding in social investment funds and community-driven development projects; and
- f) promoting rigorous impact evaluations of GBV initiatives.

The best hope for reducing levels of violence against women may lie in mobilizing all levels of society—from international donors and national governments, to grassroots women's organizations, private firms and local governments. The challenge is not only to raise awareness of violence against women, but to maintain a long-run commitment by all these actors to address GBV as an impediment to economic development, a public health problem and an egregious violation of human rights.

REFERENCES

Note: all websites accessed July 2004.

Abaunza, H. 2002. "Puntos de Encuentro: Communication for Development in Nicaragua." *Sexual Health Exchange 2002-1*. Amsterdam: KIT Information Services, Royal Tropical Institute.

Abramovay, M. and M. Ranco Avancini. 2004. "A Violencia e a Escola: O Caso Brasil." Downloaded from www.ucb.br/observatorio/news/artigos.asp on 8/24/04.

American Medical Association. 1992. *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago.

Australian Institute of Criminology. 2002. "Australian Crime: Facts and Figures 2001." Canberra: Australian Institute of Criminology.

Åsling-Monemi, Kajsa et al. 2003. "Violence Against Women Increases the Risk of Infant and Child Mortality: A Case-Referent Study in Nicaragua." *The Bulletin of the World Health Organization* 8:10-18

Barker, Gary. 2003. "How Do We Know if Men have Changed? Promoting and Measuring Attitude Change with Young Men. Lessons From Program H in Latin America." Paper Presented at the Expert Group Meeting on 'the Role of Men and Boys in Achieving Gender Equality'. United Nations: Brasilia, Brazil.

Berliner, D. 2002. "Nicaraguan Youth Empowerment Through Mass Media." Unpublished Summer 2002 Research Report for the Center for Latin American Studies, University of California: Berkeley.

Blumel, D.K. et al., 1993. "Who Pays? The Economic Costs of Violence against Women." Women's Policy Unit, Office of the Cabinet: Queensland.

Boender, Carol et al. 2004. *The So What Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes*. Interagency Gender Working Group Task Force Report: Washington, D.C.

Bolen, Rebecca. 2003. "Child Sexual Abuse: Prevention or Promotion?" *Social Work* 48(12):174-185.

Bott, S., A. Morrison, et al. (2004). What is known about preventing and responding to gender-based violence: a multi-sectoral literature review and analysis. Washington, D.C., World Bank.

Buel, Sara. 2001. "Treatment Guidelines for Healthcare Providers' Interventions with Domestic Violence Victims: Experience From the USA." *International Journal of Gynecology & Obstetrics* 78(Supplement No. 1): S39-S44.

Buvinic, Mayra and Andrew Morrison. 1999. Technical Notes: Violence Prevention. Washington, D.C.: Inter-American Development Bank.

Campbell, Jacqueline et al. 2002. Health Consequences of Intimate Partner Violence. *The Lancet* 359(9314):1331-1336.

Campbell, Jacqueline. 2000. "Promise and Perils of Surveillance in Addressing Violence Against Women." *Violence Against Women* 6(7):705-727.

Casas Becerra, Lidia and Alejandra Mera González-Ballesteros. 2004. "Delitos Sexuales y Lesiones: La Violencia de Género en la Reforma Procesal Penal en Chile. Santiago, Chile: Centro de Estudios de Justicia en las Americas.

CDC. 2003. "Costs of Intimate Partner Violence against Women in the United States." Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: Atlanta, Georgia.

CDC. 2004. "Behavior Change Communications" In: CDC. *Global AIDS Program Strategies*. Centers for Disease Control and Prevention National Center for HIV, STD and TB Prevention Global AIDS Program: Atlanta. Available at: www.cdc.gov/nchstp/od/gap/strategies/2_7_bcc.htm

Center for Reproductive Law and Policy. 2000. *Women of the World: Laws and Policies Affecting Their Reproductive Lives Latin America and the Caribbean, Progress Report*. New York. Available at: <http://bookstore.reproductiverights.org/womofworlawa2.html>

Center for Reproductive Law and Policy. 2002. *Bringing Rights to Bear: An Analysis of the Work of the UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. New York. Available at <http://bookstore.reproductiverights.org/brinrigitbea.html>

Centro Acción Ya (1999). Evaluación de Actividades de las Actividades del Centro Acción Ya. Esteli, Nicaragua, Centro Acción Ya.

Chalk, Rosemary, and Patricia King, Eds. 1998. *Violence in Families: Assessing Prevention and Treatment Programs*. National Research Council and the Institution of Medicine. National Academy Press: Washington, D.C.

CLADEM. 2004. "Circular electrónica: Violencia de género." Edición especial. febrero/marzo/abril/mayo 2004.

CLADEM. 2000. Cuestión de Vida: Balance regional y desafíos sobre el derecho de las mujeres a una vida libre de violencia.

CLADEM. n/d. "Entrevistas a operadores de justicia y funcionarios policiales en relación a la violencia contra las mujeres en El Salvador." [available on-line at www.cladem.com/espanol/regionales/violenciadegenero/proyecto]

Cohen, S., E. De Vos, et al. (1997). "Barriers to physician identification and treatment of family violence: lessons from five communities." *Academic Medicine* 72(1 Suppl.): S19-S25.

Counts, D., J. K. Brown, et al., Eds. (1999). To Have and To Hit. Chicago, University of Chicago Press.

Counts, Dorothy Ayers, Judith Brown, and Jacqueline Campbell. 1992. *Sanctions and Sanctuary: Cultural Perspectives on the Beating of Wives*. Westview Press: Boulder, Colorado.

Dahlberg, L. 1998. Youth Violence in the United States: Major Trends, Risk Factors and Prevention Approaches." *American Journal of Preventive Medicine* 14(4): 259-72.

Dreyer, A et al. 2001. "What Do We Want to Tell Our Children About Violence Against Women? Evaluation Report for the Project Developing a Model 'Gender and Conflict' Component of the Primary School Curriculum." School of Public Health, University of the Western Cape: South Africa. Cited in Mirsky, Judith. 2003. *Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector*. The Panos Institute: London.

Dube, S. et al. 2001. "Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide throughout the Life Span: Findings from the Adverse Childhood Experiences Study." *Journal of the American Medical Association* 286(24): 3089-96.

Edelson, J. (1995). Controversy and change in batterer's programs. Future Interventions With Battered Women and Their Families. J. L. Edleson and Z. C. Eisikovits. Thousand Oaks, California, Sage Publications: 154-169.

Ellsberg, Mary et. al. 1999. "Domestic Violence and Emotional Distress Among Nicaraguan Women: Results from a Population-Based Study." *American Psychologist*, 54: 30-36.

Ellsberg, Mary et al. 2000. "Candies in Hell: Women's Experiences of Violence in Nicaragua." *Social Science and Medicine* 51(11):1,595-1610.

Ellsberg, Mary et al. 2001. "Researching Violence Against Women: Methodological and Ethical Considerations." *Studies in Family Planning* 32(1):1-16.

Ellsberg, Mary, et al. Forthcoming. *Researching violence against women: A practical guide for Researchers and Advocates*. World Health Organization, Center for Health and Gender Equity: Washington, D.C.

Ellsberg, M. C., R. Peña, et al. (1999). "Wife abuse among women of childbearing age in Nicaragua." American Journal of Public Health 89(2): 241-4.

- Ellsberg, Mary, Jerker Liljestrand, Anna Winkvist. 1997. "The Nicaraguan Network of Women Against Violence: Using Research and Action for Change." *Reproductive Health Matters* 10:82-92.
- Felitti, VJ et al. 1998. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4): 245-258.
- Ferrando, Delicia, Nery Serrano, and Carlos Pure. 2002. "Perú: Salud Reproductiva en Comunidades. Educando y Empoderando a Mujeres de Escasos Recursos: Evaluación de Impacto de Medio término del Proyecto ReproSalud." Unpublished report, cited in: Boender, Carol et al. 2004. The So What Report: A Look at Whether Integrating a Gender Focus into Programs Makes a Difference to Outcomes. Interagency Gender Working Group Task Force Report: Washington, D.C.
- Finkelhor, David, and Nancy Strapko. 1992. "Sexual Abuse Prevention Education: A Review of Evaluation Studies." In Willis, Diane J., E.Wayne Holden, and Mindy Rosenberg, Eds. *Prevention of Child Maltreatment: Developmental and Ecological Perspectives*, pages 150-167. John Wiley and Sons: New York.
- Finkelhor, David, and Jennifer Dziuba-Leatherman. 1995a. "Victimization Prevention Programs: A National Survey of Children's Exposure and Reactions." *Child Abuse & Neglect* 19:129-139.
- Finkelhor, David, and Jennifer Dziuba-Leatherman. 1995b. "The Effectiveness of Victimization Prevention Instruction: an Evaluation of Children's Responses to Actual Threats and Assaults." *Child Abuse and Neglect* 10:141-153.
- Friedman, L. S., J. H. Samet, et al. (1992). "Inquiry about victimization experiences. A survey of patient preferences and physician practices." *Archives of Internal Medicine* 152(6): 1186-1190.
- Garcia-Moreno, Claudia. 2002. "Dilemmas and Opportunities for an Appropriate Health-Service Response to Violence Against Women." *The Lancet* 359:1509-14.
- Garcia Moreno, Claudia, et al. 2003. "Responding to Violence Against Women: WHO's Multicountry Study on Women's Health and Domestic Violence." *Health and Human Rights* 6(2): 112-127.
- Garcia Moreno, C., C. Watts, et al. (2003). "Responding to violence against women: WHO's Multicountry Study on Women's Health and Domestic Violence." *Health and Human Rights* 6(2): 112-127.
- Gazmararian, JA et al. 1995. "The Relationship Between Intendedness and Physical Violence in Mothers of Newborns." *Obstetrics and Gynecology*, 85:131-138.
- Godenzi, A. and C. Yodanis. 1998. "Report on the Economic Costs of Violence against Women." University of Fribourg: Fribourg.
- Gordon, P. and K. Crehan. (n/d). "Dying of sadness: gender, sexual violence and the HIV epidemic." SEPED Conference Paper.
- Greaves, L. et al. 1995. "Selected Estimates of the Costs of Violence against Women." Centre for Research on Violence against Women and Children: London: Ontario.
- Guedes, Alessandra. 2004. "Addressing Gender-based Violence from the PHN Sector: A Literature Review and Analysis." USAID, Bureau for Global Health: Washington, D.C.
- Guedes, Alessandra, et al. 2002. "Gender-based violence, Human Rights, and the Health Sector: Lessons from Latin America." *Health and Human Rights*. 6(1):177-194.
- Guedes, Alessandra, Sarah Bott, and Yvette Cuca. 2002. "Integrating systematic screening for gender-based violence into sexual and reproductive health services: Results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere Region." *International Journal of Gynecology and Obstetrics* 78: 557-563.
- Hakimi, Mohammad et al. 2001. *Silence for the Sake of Harmony. Domestic Violence and Women's Health in Central Java, Indonesia*. Yogyakarta, Indonesia. CHN-RL GMU. xvi.
- Health Canada. 2002. "Violence against Women. Impact of Violence on Women's Health." Ottawa: Health Canada.

- Heise, Lori, and Claudia Garcia-Moreno. 2002. "Violence by Intimate Partners." In: Krug, Etienne et al., eds. *World Report on Violence and Health*. World Health Organization: Geneva. Pages 89-121.
- Heise, Lori, Jacqueline Pitanguy, and Adrienne Germain. 1994. "Violence against Women: The Hidden Health Burden." World Bank Discussion Paper #255. World Bank: Washington, D.C.
- Heise, Lori, Mary Ellsberg, and Megan Gottemoeller. 1999. "Ending Violence Against Women," *Population Reports*, Volume XXVII, Number 4, Series L, Number 11.
- Heise, Lori. 1998. "Violence Against Women: an Integrated Ecological Framework." *Violence Against Women* 4(3):262-290.
- Hernández Rosete, D. 1998. "Pobreza Urbana y Violencia Doméstica en Hogares de la Ciudad de México." *Acta Sociológica* (enero-abril): 25-43.
- Herrera, M. 2001. "Women's Network Against Violence, Nicaragua." Paper presented at the Gender Violence, Health and Rights in the Americas Symposium in Cancun, Q.R., Mexico, June 4-7, 2001.
- Hindin, M.J. and L.S. Adair. 2002. "Who's at risk? Factors associated with intimate partner violence in the Philippines." *Social Science and Medicine* 55: 1385-1399.
- Human Rights Watch. 2000. *What will it take? Stopping Violence Against Women: a Challenge to Governments*. New York.
- ILANUD. n.d. *The United Nations Latin American Institute for the Prevention of Crime and the Treatment of Offenders. ILANUD Activities in 2002 and 2003 Work Programme*. San José, Costa Rica. Available at: <http://www.ilanud.or.cr/InformeING2002.doc>.
- Inter-American Commission on Women (IACW). 2004. "Proposal for a follow-up mechanism for implementation of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, Convention of Belém do Pará." Meeting of Experts on the Follow-up Mechanism, July 20-21, 2004. Washington, D.C.: IACW.
- Inter-American Development Bank, 2001. "Planes Nacionales contra la Violencia Doméstica, in Violencia Domestica: Intervenciones para su Prevención y Tratamiento.
- Inter-American Development Bank. 2002. *Inventario de Programas de Atención y Prevención de la violencia a Nivel Municipal*. [Violence Prevention Programs Database]. Electronic document. Washington, D.C. Available in Spanish only at: www.iadb.org/sds/publication/publication_1535_s.htm
- Jaffe, P, and M Sudermann. 1995. "Child Witness of Women Abuse: Research and Community Responses." In: Stith S, and M Straus, Eds. *Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions. Families in Focus Services, Vol. II*. National Council on Family Relations: Minneapolis.
- Jansen, H. A. F. M., C. Watts, et al. (2004). "Interviewer training in the WHO multi-country study on women's health and domestic violence." *Violence against Women* 10(7): 831-849.
- Jewkes, Rachel. 2000. *The HIV/AIDS Emergency: Department of Education Guidelines for Educators*. Department of Education: Pretoria, South Africa.
- Jewkes, Rachel, Purna Sen, and Claudia Garcia-Moreno. 2002. "Sexual Violence." In: Krug, Etienne, et. al, Eds. *World Report on Violence and Health*. World Health Organization: Geneva, pages 149-181.
- Jewkes, Rachel. 2002a. "Preventing Domestic Violence." Editorial. *British Medical Journal* 324:253-254.
- Jewkes, R. 2002b. "Risk factors for domestic violence: findings from a South African cross-sectional study." *Social Science and Medicine* 55: 1603-1617.
- Jubb, Nadine and Wânia Pasinato Izumino. 2003. "Women and Policing in Latin America: A Revised Background Paper." Presented at the 2003 meeting of the Latin American Studies Association.
- Kerr, R. and J. McLean, 1996. "Paying for Violence: Some of the Costs of Violence against Women in B.C." Ministry of Women's Equality: British Columbia.

- Kishor, Sunita, and Kiersten Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study*. ORC Macro: Calverton, Maryland.
- Koenig, M.A., et al. 2003. "Domestic violence in rural Uganda : evidence from a community-based study." *Bulletin of the World Health Organization* 81 (1): 53-60.
- Koenig, Michael et al. 2003. "Women's Status and Domestic Violence in Rural Bangladesh: Individual- and Community-Level Effects." *Demography* 40(2): 269-88.
- Korf, D.J. et al. 1997. "Economic Costs of Domestic Violence against Women." Utrecht, Netherlands: Dutch Foundation of Women's Shelters.
- Koss, M.P. 1993."Detecting the Scope of Rape: A Review of Prevalence Research Methods." *Journal of Interpersonal Violence* 8(2):198-222.
- Larrain, Soledad. 1999. Curbing Domestic Violence: Two Decades of Action. In: Morrison, Andrew and María Loreto Biehl, Eds. *Too Close to Home: Domestic Violence in the Americas*. Inter-American Bank: Washington, D.C., pages 105-130.
- Larrain, Soledad et al. 1997. *Relaciones Familiares y Maltrato Infantil*. UNICEF: Santiago, Chile.
- Larrain, S. H. (1994). *Violencia Puertas Adentro: La Mujer Golpeada*. Santiago, Chile, Editorial Universitaria.
- Laurence, L. and R. Spalter-Roth. 1995. "Measuring the Costs of Domestic Violence against Women and the Cost-Effectiveness of Interventions: An Initial Assessment and Proposals for Further Research." Washington, D.C.: Institute for Women's Policy Research.
- Leach, Fiona et al. 2003. *An Investigative Study of the Abuse of Girls in African Schools*. Policy Division of the Department for International Development: London.
- Levinson, D. 1989. *Family Violence in Cross-Cultural Perspective*. Sage Publications: Thousand Oaks, California.
- Loi, V.M. (n/d). Gender-based violence : the case of Vietnam. World Bank working paper.
- Lovaton, David. 2000. " Justicia de paz y violencia familiar: Conciliar o no conciliar? Es ese el dilema?" *Idéele* 133: 89-91.
- Lozano Ascencio, Rafael. 1999. "The Impacts of Domestic Violence on Health: Mexico City." In: Morrison, Andrew and María Loreto Biehl, Eds. *Too Close to Home: Domestic Violence in the Americas*. Inter-American Development Bank: Washington, D.C.
- Mansingh A. and P. Ramphal. 1993. "The Nature of Interpersonal Violence in Jamaica." *West Indian Medical Journal* 42: 53-6.
- Martin, S.L. et al. 2002. Domestic violence across generations : findings from northern India. *International Journal of Epidemiology* 31: 560-572.
- Mehrotra, Aparna. 1998. *Gender and Legislation in Latin America and the Caribbean*. United Nations Development Programme, Regional Bureau for Latin America and the Caribbean: New York.
- Mesquita da Rocha, Martha. 1999. "Dealing with Crimes against Women: Brazil." In: Morrison, Andrew and María Loreto Biehl, Eds. *Too Close to Home: Domestic Violence in the Americas*. Inter-American Bank: Washington, D.C.
- Meyer, Heather, and Nan Stein. 2000. "Review of Teen Dating violence Prevention." [Electronic publication.] National Violence Against Women Prevention Research Center, Wellesley Centers for Women, Wellesley College. Available at: www.musc.edu/vawprevention/research/teendating.shtml
- Mgalla Z et al. 1998. "Protecting School Girls Against Sexual Exploitation: A Guardian Programme in Mwanza Tanzania." *Reproductive Health Matters* 7(12):19-30.
- Mirsky, Judith. 2003. *Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector*. The Panos Institute: London.

- Molnar, B. et al. 2001. "Child Sexual Abuse and Subsequent Pathology: Results from the National Comorbidity Survey." *American Journal of Public Health* 91(5): 753-60.
- Montoya (1998). Nadando contra Corriente: Buscando Pistas para Prevenir la Violencia Masculina en las relaciones de Pareja. Managua, Fundación Puntos de Encuentro.
- Morrison, A. R. and M. L. Biehl, Eds. (1999). Too Close to Home: Domestic Violence in the Americas. Washington, D.C., Inter-American Development Bank.
- Morrison, Andrew, and María Beatriz Orlando. 1999. "Socioeconomic Costs of Domestic Violence: Chile and Nicaragua." In: Morrison, Andrew and María Loreto Biehl, Eds. *Too Close to Home: Domestic Violence in the Americas*. Inter-American Development Bank: Washington, D.C.
- National Research Council. 2004. *Advancing the Federal Research Agenda on Violence against women*. National Academy Press: Washington, D.C.
- Nelson, H., P. Nygren, et al. (2004). "Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. preventive services." *Annals of Internal Medicine* 140(5): 387-404.
- Office of Women's Policy. 1996. "The Financial and Economic Costs of Domestic Violence in the Northern Territory." Northern Territory: KPMG.
- O'Campo, P., A. C. Gielen, et al. (1995). "Violence by male partners against women during the childbearing year: A contextual analysis." *American Journal of Public Health* 85(8): 1092-1097.
- O'Conner, M. (2001). "Consequences and outcomes of disclosure for abused women." *International Journal of Gynecology & Obstetrics* 78(Supplement 1): S83-S90.
- Pandjartjian, Valéria. 2004. "Los estereotipos de género en los procesos judiciales y la violencia contra la mujer en la legislación." Sao Paulo: CLADEM. (available on CLADEM website)
- Pfund, Alicia. 2000. "Jurisprudence of Equality Project-JEP: Consolidated report based on the evaluations in Argentina, Brazil, Chile and Uruguay." IDB document, available at http://www.iadb.org/sds/doc/SOC_jepfinalreport.pdf.
- Phinney, A. (2002). *Trafficking of women and children for sexual exploitation in the Americas*. Washington, DC, Organization of American States, Pan American Health Organization.
- Policia Nacional de Nicaragua-GTZ. 1998. "Violencia de género y seguridad ciudadana: Guía metodológica."
- PREAL. 2003. "Prevención de la violencia en escuelas de América del Sur: Catastro de programas y proyectos."
- Pulerwitz, J., G. Barker, et al. (2004). Promoting healthy relationships and HIV/STI prevention for young men: Positive findings from an intervention study in Brazil. Horizons Research Update. Washington, DC, Population Council.
- Puntos de Encuentro (2000). *Impact Evaluation of Puntos de Encuentro's Multi-media Campaign "Violence against women: A Disaster Men Can Avoid"*. Managua, Nicaragua, Puntos de Encuentro.
- Ramsay, Jean et al. 2002. "Should Health Professionals Screen Women for Domestic Violence? Systematic Review." *British Medical Journal* 325:314-326.
- Rashid, Maria. 2001. *Giving Men Choices: A Rozan Project with the Police Force in Pakistan. Working Paper Series on Men's Roles and Responsibilities in Ending Gender Based Violence*. Working Paper Number 2. Rozan: Islamabad.
- Rosales, J., E. Loaiza, et al. (1999). *Encuesta Nicaraguense de Demografía y Salud, 1998*. Managua, Nicaragua, Instituto Nacional de Estadísticas y Censos, INEC.
- Rogow, Debra, and Judith Bruce. 2000. "Alone You Are nobody, Together We Float: the Manuela Ramos Movement." *Calité/Calidad/Quality*, Number 10. Population Council: New York. Available at: www.popcouncil.org/publications/qc/qc10.pdf

- Sánchez, Fabio et al. 2004. "Los costos de la violencia intrafamiliar en Colombia." Bogotá: Universidad de los Andes, Centro de Estudios sobre Desarrollo Económico.
- Sagot, M. (2000). *La Ruta crítica de las mujeres afectadas por la violencia intrafamiliar en América Latina* Estudio de caso en diez países. Washington, D.C., OPS/OMS Programa Mujer, Salud y Desarrollo.
- Silva Cruz, Francisco. 1997. "Manual de procedimiento policial en casos de violencia doméstica en Honduras." San José, Costa Rica: ILANUD.
- Snively, Suzanne. 1994. "The New Zealand Economic Cost of Family Violence." Wellington, New Zealand: Coopers and Lybrand.
- Solorzano, I., R. Peña, et al. (2004). Preliminary Report of Baseline Study for the Impact Evaluation of Puntos de Encuentro's Communication for Social Change Project "Somos Diferentes Somos Iguales". Managua, Puntos de Encuentro.
- Sorenson, Susan. 2003. "Funding Public Health: The Public's Willingness to Pay for Domestic Violence Prevention Programming." *American Journal of Public Health* 93: 1934-38.
- Stanko, E.A. et al., 1998. "Counting the Costs: Estimating the Impact of Domestic Violence in the London Borough of Hackney." Middlesex, UK: Brunel University.
- Straus, M. et al. 1980. *Behind Closed Doors*. New York: Doubleday.
- Straus, Murry, Richard Gelles, and Christine Smith. 1990. *Physical Violence in American Families; Risk Factors and Adaptations to Violence in 8,145 Families*. Transaction Publishers: New Brunswick.
- Stevens, L. (2001). *A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers*. New York, UNFPA.
- Sugg, N. K. and T. Inui (1992). "Primary care physicians' response to domestic violence. Opening Pandora's box." *Journal of the American Medical Association* 267(23): 3157-3160.
- Sullivan, CM, and D Bybee. 1999. "Reducing Violence Using Community-Based Advocacy for Women with Abusive Partners." *Journal of Consulting and Clinical Psychology* 67(1):43-53.
- Swiss, S., P. J. Jennings, et al. (1998). "Violence Against Women During the Liberian Civil Conflict." *Journal of the American Medical Association* 279: 625 - 629.
- Thomas, DQ. 1994. "In Search of Solutions: Women's Police Stations in Brazil." In: Davies, M, Ed. *Women and Violence: Realities and Responses Worldwide*. Zed Books: London, pages 32-42.
- Thornberry, T.P. et al. 2001. "The Importance of Timing: The Varying Impact of Childhood and Adolescent Maltreatment on Multiple Problem Outcomes." *Development and Psychopathology* 13(4): 957-79.
- UNFPA. 2002. "Communication/Behaviour Change Tools: Entertainment-Education." *Programme Briefs* No. 1, January 2002. New York.
- UNICEF. 2003a. *Partnerships in Practice: From AGEI to UNGEI*. Summary Report of a Workshop on Girls' Education. Bamako, Mali, 17-20 November 2003. New York. Available at: www.unicef.org/girlseducation/UNICEF_Mali_Meeting_Report_Final.pdf
- UNICEF. 2003b. *Gender and Education for All—the Leap to Equality*. EFA Global Monitoring Report 2003/4. UNESCO: Paris.
- UNICEF. 2004. *Strategies for Girls' Education*. New York. Available at: www.unicef.org/publications/English_Version_A.pdf
- United Nations General Assembly. 1993. *Declaration on the Elimination of Violence Against Women*. Proceedings of the 85th Plenary Meeting, Geneva, Dec. 20, 1993. United Nations: Geneva.
- Valdez, Enrique. 1999. "Using Hotlines to Deal with Domestic Violence in El Salvador." In: Morrison, Andrew, and María Loreto Biehl, Eds. *Too Close to Home: Domestic Violence in the Americas*. Inter-American Bank: Washington, D.C.

- Velzeboer, Marijke et al. 2003. *Violence Against Women: The Health Sector Responds*. Pan American Health Organization: Washington, D.C.
- Villanueva, Zarela. 1999. "Legislative and Judicial Reforms Regarding Domestic Violence: Costa Rica." In: Morrison, Andrew, and María Loreto Biehl (Eds.) *Too Close to Home: Domestic Violence in the Americas*. Inter-American Development Bank: Washington, D.C.
- Walker, E, et al. 1999 "Adult Health Status of Women HMO Members with Histories of Childhood Abuse and Neglect." *American Journal of Medicine* 107(4): 332-339.
- Ward, J. and B. Vann (2002). "Gender-based violence in refugee settings." *Lancet* 360 Suppl: s13-4.
- Wellesley Centers for Research on Women and DTS. 2003. "Unsafe Schools: A literature Review of School-Related Gender-Based Violence in Developing Countries." United States Agency for International Development: Washington, D.C. [Available at: www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/unsafe_schools_literature_review.pdf]
- White, Victoria, Margaret Greene, and Elaine Murphy. 2003. "Men and Reproductive Health Programs: Influencing Gender Norms." U.S. Agency for International Development: Office of HIV/AIDS: Washington, D.C. Available at: http://www.synergyaids.com/SynergyPublications/Gender_Norms.pdf
- Windom, Cathy. 1989. "The Cycle of Violence." *Science* 244: 160-166.
- World Bank. 2002. "Infrastructure & Gender Equality: Gender and Development Briefing Notes." The World Bank, Gender and Development Group: Washington, D.C.
- World Bank. 2003. "Impact of Legal Aid: Ecuador." Washington, D.C.: World Bank, Legal Vice Presidency.
- World Bank. 2004. Institutional Development Fund Letter-Agreement, "Strengthening Uruguay's Justice Institutions for Equitable Development Project."
- World Health Organization, Ed. (2002). World report on violence and health. Geneva, World Health Organization.
- World Health Organization. 2004. "The Economic Dimensions of Interpersonal Violence." Geneva: WHO, Department of Injuries and Violence Prevention.
- Yodanis, C., A. Godenzi, and EA Stanko. 2000. "The Benefits of Studying Costs: A Review and Agenda for Studies on the Economic Costs of Violence against Women." *Policy Studies* 21(3): 263-76.