SOUTHERN AFRICAN DEVELOPMENT COMMUNITY

TOWARDS A COMMON FUTURE

HANDBOOK TO PROMOTE EFFECTIVE GENDER-BASED VIOLENCE PREVENTION INITIATIVES IN THE SADC REGION

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Handbook to Promote Effective Gender-Based Violence Prevention Initiatives in the SADC Region

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

AA	Alcoholic Anonymous
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CETA	Common Elements Treatment Approach
GBV	Gender-Based Violence
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
PTSD	Post Traumatic Stress Disorder
SADC	Southern African Development Community
SASA!	Start Awareness Support Action
SDGs	Agenda 2030 and Sustainable Development Goals
SFL	Sisters for Life
SHG's	Self Help Groups
STIs	Sexually transmitted infections
VAC	Violence Against Children
VATU	Violence and Alcohol Treatment
VAW	Violence Against Women
VAWG	Violence against Women and Girls
VCT	Voluntary Counselling Test
VSLA's	Village Savings and Loan Association

FOREWORD

Gender-based violence (GBV) continues to be a threat to human security, peace and development globally, and in the Southern African Development Community (SADC) region. Peace and security have always been central to SADC's regional integration agenda. The Revised SADC Protocol on Gender and Development (2016), aligned to the African Union's Agenda 2063 and the Sustainable Development Goals (SDGs), clearly identifies GBV as an area of concern and has proposed several approaches for addressing this social-ill within the SADC context. Furthermore, the SADC Gender Policy explicitly suggests that SADC's approach of addressing GBV should go beyond just looking at the act of violence, but to also develop evidence-based strategies and anti-GBV programmes that address the root causes of GBV. The Revised Regional Indicative Strategic Development Plan (RISDP) 2020-2030, the SADC blueprint for regional integration agenda, recognises the prevention and reduction of GBV as a catalyst for creating a conducive environment for sustainable peace and security.

The approaches highlighted in the SADC Protocol on Gender and Development are further elaborated in the SADC Regional Strategy and Framework of Action for addressing Gender Based Violence, 2018-2030. This Strategy, in line with the target of reducing GBV incidences by half by 2030, serves to identify priority areas of action and provides for a holistic and coordinated approach to addressing GBV in the Region. The Strategy identifies GBV prevention as a priority for the SADC region and emphasizes the need for SADC and its Member States to strengthen effective GBV prevention and mitigation programmes, including early identification of GBV.

Research in the region has also indicated that, despite the existence of policies and legal frameworks, GBV continues to worsen and claim the lives of women and girls in the Region. Evidence has also revealed the different challenges the region faces in addressing this epidemic. These challenges include, among others, ineffective and ad-hoc GBV prevention initiatives, under-reporting of GBV cases, impunity, inadequate coordination and implementation of policies, and limited collection and use of data to inform policy and appropriate action. In this regard, addressing GBV requires strengthening of prevention efforts at national level. In response to this, the SADC Secretariat has developed this Handbook to provide guidance to SADC Member States and other stakeholders on effective GBV prevention strategies and approaches. The Handbook identifies key entry points for effective GBV prevention, including at household, community and societal levels.

On behalf of the SADC Secretariat, I would like to encourage SADC Member States to use this resource as a guide for GBV prevention interventions, in particular, to strengthen national efforts to address the harmful and negative cultural and social norms and practices that perpetuate GBV. I hope you will find the Handbook useful in implementing initiatives and programmes towards preventing and ending GBV in the region.

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Elias M. Magosi
SADC EXECUTIVE SECRETARY

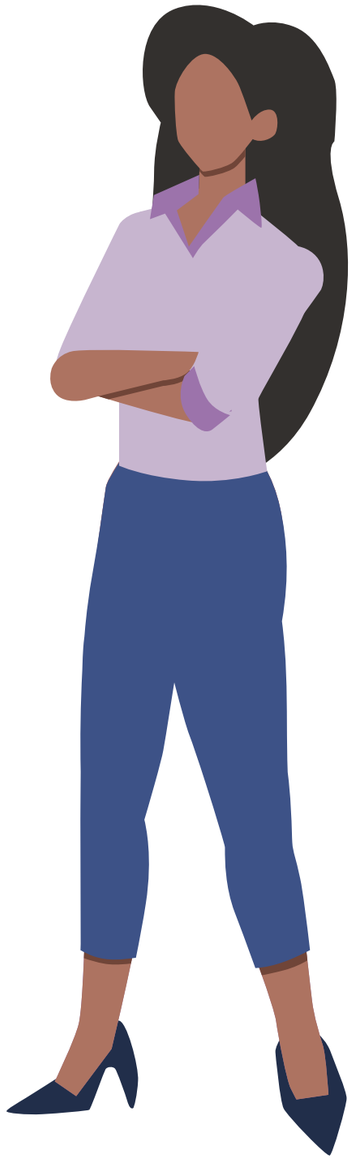
ACKNOWLEDGEMENT

The SADC Secretariat is grateful to the SADC Ministers of Gender and Women's Affairs for their leadership through approving the Handbook to Promote Effective Gender-Based Violence Prevention Initiatives in the SADC Region. The Handbook is intended to guide and accelerate implementation of effective Gender-Based Violence (GBV) prevention interventions by state and non-state actors in the SADC region.

The SADC Secretariat also recognises the contribution of technical officers from Member States and the input of other regional GBV partners in the development and validation of this Handbook. Member States provided relevant country information and shared experiences on addressing GBV to ensure delivery of a guideline that is relevant for the SADC Region. Regional partners offered substantive input through sharing their regional and international experience in addressing GBV to enhance the quality of this Handbook.

The contribution of GIZ through the *Partnerships for Prevention of Gender based Violence in Southern Africa (PfP-II)*, is duly acknowledged and appreciated. GIZ accorded strategic financial and technical support for the development of this Handbook. The Secretariat is equally grateful to the lead Consultant Dr Lina Digolo, who was the technical expert in the development of this guide on implementing effective GBV prevention initiatives. Dr Digolo diligently facilitated the process and accommodated input from all the contributors.

Appreciation should also go to the SADC Secretariat staff under the Gender Unit, with technical leadership and coordination by Ms Kealeboga Kelly Dambuza. The successful implementation of the proposed GBV prevention interventions will immensely contribute towards reducing the different forms of this violence in our region.



INTRODUCTION

Gender-based violence (GBV) is among the most severe and widespread human rights violations, mainly affecting women and girls.

Globally, 1 in 3 women has experienced GBV at some point. Unfortunately, some countries register even higher than the global average in the Southern African Development Community (SADC) region. As a result, GBV continues to impact the region by hindering peace and security, social and economic development, and achieving internationally agreed sustainable development targets such as poverty reduction.

The development and implementation of targeted actions to combat and reduce GBV have been a longstanding priority in the SADC region, as evidenced by the adoption of the SADC Declaration on Gender and Development in 1997 and the Addendum on the Prevention and Eradication of Violence against Women and Children in 1998. Additional policy frameworks that have been developed and implemented include the Revised SADC Protocol on Gender and Development, the SADC Gender Policy, the SADC Regional Strategy and Framework of Action for Addressing GBV (2018-2030), the Regional Indicative Strategic Development Plan (2020-2030), and the SADC Vision 2050. These frameworks align with continental and international GBV frameworks, including the African Union's Agenda 2063 and the Sustainable Development Goals (SDGs) 5 and 16, which are specifically dedicated to Gender Equality, Peace, Justice, and Strong Institutions.

The SADC Gender Policy explicitly suggests that SADC's approach to addressing GBV should go beyond just looking at the act of violence and consider the need to develop evidence-based strategies that encompass education, prevention, and victim assistance. Additionally, the Revised SADC Protocol on Gender and Development, 2016, provides a context within which the SADC community should strategically direct the development of their anti-GBV programmes and proposes several approaches to combat GBV. Furthermore, the Regional Strategy and Framework of Action for addressing GBV provides an effective holistic and coordinated approach to addressing GBV in the region. It also emphasises the need for SADC and its Member States to strengthen effective GBV prevention and mitigation programmes.

In line with the policy mentioned above, all SADC Member States have lawsaddressing GBV in general or specific GBV aspects, including violation of children, trafficking in persons, unequal treatment of males and females, and sexual harassment. In addition, the Member States continue to develop and improve operating procedures and guidelines for providing services to GBV victims and survivors, though to varying extents. However, despite the good efforts, implementation of actions proposed in the SADC Protocol on Gender and Development, particularly those concerned with prevention and mitigation against GBV, are generally slow to realise. Results do not always match the stated commitments. Furthermore, realised gains are often fragile and can be easily reversed because of limited knowledge of where GBV manifests itself. The absence of effective and sustained prevention programs and systems for addressing the negative cultural or religious beliefs and harmful practices that drive GBV, focus on awareness creation activities as main prevention interventions, and inadequate knowledge of GBV at all levels - including by at service delivery points; limited engagement of men and boys as critical game-

changers in the prevention of and response to GBV, lack of dedicated resources, weak monitoring and evaluation of GBV programs at different levels and coordination of GBV interventions largely because of different approaches adopted by the SADC Member States, among others, continue to stall progress. Nevertheless, these gaps notwithstanding, collective action and commitment to action have increased in frequency and intensity at all levels over time in the SADC region.

WHAT IS THIS HANDBOOK?

This handbook provides information to guide the implementation of evidence-based programmes for preventing GBV in the SADC region. It draws upon sound global and regional evidence on risk factors of GBV and the effectiveness of prevention programmes to outline how prevention strategies tailored to settings' needs, capacities, and resources can be developed and implemented.

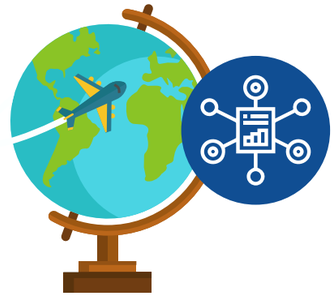
This handbook adopts a public health approach that, rather than focusing on individuals, aims to provide the maximum benefit for the largest number of people and extend better care and safety to entire populations. Because GBV is a multi-faceted issue, the public health approach emphasises a multi-sectoral response. The public health approach considers that violence, rather than being the result of any single factor, is the outcome of multiple risk factors and causes, interacting at four levels of a nested hierarchy (individual, close relationship/family, community, and wider society).

This handbook acknowledges that men may also be victims of GBV. However, women and girls are at a higher risk of violence globally, including in the SADC region. Therefore, most evidence-based interventions highlighted in this book are designed to prevent violence against women and adolescent girls (VAWG). However, much of the advice is also applicable to prevention programmes for boys and men.

This handbook aligns with the key global and regional frameworks for tackling GBV summarised in Table 1. In addition, it accommodates the recommendations from the Report on the Regional Conference for Prevention of Violence Against Women and Girls in Southern Africa- from Evidence to Action, held in December 2019 in Johannesburg, South Africa.

[1] WHO factsheet on violence against women http://www.who.int/mediacentre/factsheets/fs239/en/
[2] SADC, SADC Regional Comprehensive Gender-Based Violence Study, Gaborone, Botswana, 2018
[3] SADC, SADC Regional Comprehensive Gender Based Violence Study, Gaborone, Botswana, 2018

TABLE 1: GLOBAL AND REGIONAL FRAMEWORKS FOR TACKLING GBV



INTERNATIONAL FRAMEWORKS

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)
- Vienna Declaration and Platform for Action (1993)
- Declaration on the Elimination of Violence Against Women (1993)
- Beijing Platform and Declaration for Action (1995)
- Agenda 2030 and Sustainable Development Goals (SDGs) (2015)
- ILO Convention No. 190, Recommendation No.206
- The WHO RESPECT Women framework and accompanying Implementation Package guide (2019)

CONTINENTAL FRAMEWORKS

- The AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol) (2003)
- African Union's Agenda 2063

SADC GBV FRAMEWORKS

- SADC Declaration on Gender and Development (1997)
- The Addendum on the Prevention and Eradication of Violence against Women and Children (1998)
- SADC Vision 2050
- SADC Regional Indicative Strategic Development Plan (2020-2030)
- SADC Gender Policy
- The Revised SADC Protocol on Gender and Development (2016)
- SADC Regional Strategy on Women's Peace and Security (2018-2022)
- SADC Regional Strategy and Framework of Action for Addressing GBV (2018-2030)

THE HANDBOOK IS DIVIDED INTO THE FOLLOWING CHAPTERS:

CHAPTER 1 outlines the nature, magnitude, and consequences of GBV.

CHAPTER 2 identifies the risk and protective factors for GBV and the importance of addressing both risk and protective factors in prevention efforts

CHAPTER 3 describes prevention programmes and why it is key to focus on primary prevention.

CHAPTER 4 summarises the scientific evidence base for GBV primary prevention strategies and describes programmes of known effectiveness, those supported by emerging evidence and those that could potentially be effective but have yet to be sufficiently evaluated for their impact.

CHAPTER 5 describes the key considerations for the adaptation and scale-up of GBV prevention programme

CHAPTER 6 summarises implementation considerations for GBV prevention programmes.

WHO SHOULD USE THIS HANDBOOK?

This handbook is primarily aimed at programme developers and planners, policymakers, and funding bodies in public health and related sectors that aim to advance the prevention of GBV. In addition to the principal audience, other interested parties will include those working in other government sectors such as education, departments of women or gender equality, child welfare, social care, and criminal justice; non-governmental organisations working in the GBV prevention space; local authorities; environmental and urban planners; and researchers.

It is intended that practitioners and other professionals working in these sectors will find this document a useful source of information on state-of-the-science efforts to enhance and strengthen multi-sectoral collaboration in the design, delivery, and evaluation of programmes for the primary prevention of GBV.

WHAT IS NOT COVERED IN THE HANDBOOK?

Although response services are necessary to support the survivors of violence, it is vital to ensure that the circumstances and conditions that give rise to this violence in the first place must be addressed to realise a world free of GBV in the long term. Therefore, the focus of this handbook is on the primary prevention of violence. It does not necessarily address programmes that focus solely on responding to violence survivors. This has been well covered elsewhere, including through the SADC Guideline on Developing Gender-Based Violence, Standard Operating Procedures and the "Essential Services Package for Women and Girls Subject to Violence".

[4] Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. 2002. The world report on violence and health. The Lancet, 360 (9339). Heise, L. (2011). What works to prevent partner violence? Evidence overview

CHAPTER 1: THE NATURE, MAGNITUDE, AND CONSEQUENCES OF GENDER-BASED VIOLENCE (GBV)

1.1. What is Gender-Based Violence (GBV)?

This document adopts the definition of GBV from the SADC Protocol on Gender and Development

Gender-Based Violence (GBV) means all acts perpetrated against women, men, girls and boys on the basis of their sex which cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict (The SADC Protocol on Gender and Development, SADC).

1.2. Why greater focus on Violence Against Women and Girls (VAWG)?

While both women and men experience GBV, violence against women and girls (VAWG), irrespective of their social or economic status, is one of the world's most prevalent human rights violations. One in three (30%) women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.[5]

The prevalence of the lifetime experience of GBV in the SADC region is much higher ranging from 50% to 86%.[6] The majority of those affected are women and girls. This is emphasised by the SADC Regional Strategy and Framework of Action for Addressing GBV. The Strategy states that "***By referring to violence as "gender-based", this definition highlights the need to understand this type of violence within the context of women and girls' subordinate status in society.*** Furthermore, many cultures and traditions have beliefs, norms and social institutions that legitimise violence against women and girls. Therefore, such violence cannot be understood in isolation from the norms and social structure and gender roles within the community, which greatly influence women's vulnerability to GBV." [7]

1.3. Forms of GBV

GBV takes many different forms, as shown in Table 2. It can also be distinguished according to the age or life stage during which it occurs, highlighting the specific risks and experiences or by perpetrator type, for example, intimate partner or non-partner violence.

Globally, the most common forms of GBV include physical and sexual intimate partner violence, non-partner sexual violence (including rape) and sexual harassment, and emotional or psychological abuse. However, as shown in figure 1, emotional violence is the most predominant form of violence in the SADC region, followed by physical and sexual violence." [8]

It is important to note that some survivors of GBV may suffer multiple forms of abuse simultaneously or at different stages of their lives. This especially occurs in intimate partner violence, where physical, sexual, and emotional violence often overlap.

[5] WHO factsheet on violence against women http://www.who.int/mediacentre/factsheets/fs239/en/
[6] Report on the Regional Conference for Prevention of Violence Against Women and Girls in Southern Africa-from Evidence to Action,4-5 December 2019, Johannesburg, South Africa
[7] SADC, SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence: 2018-2030, Gaborone, Botswana, 2019
[8] SADC, SADC Regional Comprehensive Gender-Based Violence Study, Gaborone, Botswana, 2018.

TABLE 2: COMMON FORMS OF GBV

EMOTIONAL VIOLENCE

Can take the form of provocation of the victim, which is likely to invoke emotional reactions that can lead to other forms of GBV (e.g., physical violence) or personal harm. It also involves intimidation and threats.

VERBAL ABUSE

Refers to insulting or disrespectful language to undermine the victim, defamation, or harassment.

PHYSICAL VIOLENCE

Involves acts such as killing, battering, strangling, suffocating, throwing things at the victim to hurt and acid throwing

SEXUAL VIOLENCE

Includes acts like rape/sexual assault, sexual abuse of minors, sexual harassment, incest, trafficking of women and girls and forced prostitution, marriage by abduction – mostly during armed conflicts, war rape, and reproductive coercion.

TABLE 2: COMMON FORMS OF GBV

ECONOMIC VIOLENCE

Involves withholding or denying access to resources, denying the victim independent decisions regarding employment and use of earned resources, property damage, and failure to comply with economic responsibilities.

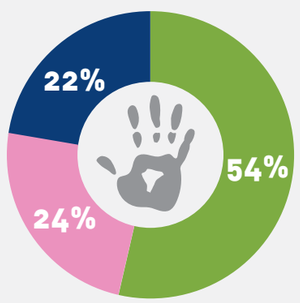
PSYCHOLOGICAL ABUSE

Can include manipulation and isolation and setting the victim up to over-depend on the abuser – deprivation of liberty, coercion, stalking, use of social media to molest victims, and denial of access to services.

HARMFUL PRACTICES

These include forced or early marriage, so-called 'honour-based violence, and female genital mutilation or cutting (FGM).

FIGURE 1: COMMON FORMS OF GBV IN SADC



1.4. What are the consequences of GBV?

GBV undermines equal rights and has severe physical, emotional, social, and economic consequences for women, their children, families, communities, and societies.

Violence has serious short- and long-term consequences on the survivors' physical, sexual, reproductive, and mental health. It also affects their personal and social well-being. For example, the health consequences of GBV, particularly VAWG, include injuries, unintended pregnancy, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistula, genital injuries, pregnancy complications, and chronic conditions. The mental health impacts for survivors of gender-based violence include Post Traumatic Stress Disorder (PTSD), depression, anxiety, substance misuse, self-harm and suicidal behaviour, and sleep disturbances. In addition, a survivor of violence may also face stigma and rejection from their community and family.

GBV, particularly against women, also has negative consequences for their children. For example, research reports that these children are more likely to have emotional and behavioural problems and perform poorly at school. Additionally, a boy who witnesses violence against his mother is more likely to become a perpetrator of intimate partner violence in later life. In contrast, a girl who witnesses violence is more likely to experience intimate partner violence in later life.

Violence against women and girls can lower household income and productivity at the **family or household level** due to losing women in the workforce due to injury or ill-health. It also leads to increased expenditures on medical, protection, social, or justice services.

At a **community level**, high levels of GBV can reinforce acceptance of violence and impunity for perpetrators and deprive the community of women's economic, social, and leadership contributions.

At a **societal level**, high levels of violence can increase demand for key services such as health, police, and justice and reduce gross domestic product (national economy).

CHAPTER 2: WHAT ARE THE RISKS AND PROTECTIVE FACTORS FOR GBV?

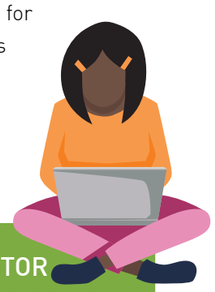
To prevent GBV, we need to address the underlying causes of the problem and promote protective factors.

Risk factors increase the likelihood of someone becoming a victim and/or perpetrator of violence. Therefore, reducing risk factors should be a key target of prevention efforts and an integral concept in programme monitoring and evaluation efforts.

Similarly, protective factors, which buffer against the risk of becoming a victim and/or perpetrator of violence, may need to be fostered – including through structural and other interventions for achieving gender equality and women's empowerment.

Evidence shows that no single factor causes violence, nor is there a single pathway to perpetration. Therefore, understanding the multiple contributing factors and how they intersect can help us develop programmes to address them and prevent violence.

Many different theoretical models attempt to describe the risk factors for VAW. However, this handbook will use the **socio-ecological model** because it allows for the inclusion of risk and protective factors from multiple domains of influence.



RISK FACTOR
A characteristic of an individual, setting or society that increases the likelihood of violence occurring.

PROTECTIVE FACTOR
A characteristic of an individual, setting or society that reduces the likelihood of violence occurring.

2.1. The Socio-Ecological Model

The socio-ecological model is a useful tool for exploring the interaction between the multiple risks and protective factors across individuals, relationships, family, community, and societal levels. The model highlights the complex interplay of factors across and between these levels and indicates key points for intervention. It suggests that it is necessary to act to address multiple factors across these levels to prevent violence. This approach is more likely to result in effective and sustained prevention over time than any intervention.

The model organises risk and protective factors according to the following four levels of influence:

1. **Individual:** includes biological and personal history factors that may increase or decrease the likelihood that an individual will become a victim or perpetrator of violence.

2. **Relationship:** includes factors that increase or decrease the risk because of relationships with peers, intimate partners, and family members. These are a person's closest social circle and can shape their behaviour and range of experiences.

3. **Community:** refers to the community contexts in which social relationships are embedded – such as schools, workplaces, and neighbourhoods – and seeks to identify the characteristics of these settings that put people at risk or protect them from violence.

4. **Societal:** includes the larger, macro-level factors that influence GBV, such as gender inequality, religious or cultural belief systems, societal norms and economic or social policies that create or sustain gaps and tensions between groups.

2.2. Exploring the Risks and Protective Factors for GBV

When using the socio-ecological model to explore GBV, it's important to think about several things.

Firstly, the specific type of violence you are addressing. Since different types of violence (e.g., IPV, non-partner sexual violence etc.) have distinct risk factors, a socio-ecological model is most useful when tailored to a specific type of violence and setting. For example, figure 2 uses the social-ecological model to outline the risk factors, which have been shown through research in multiple settings to increase women experiencing IPV. These risk factors can also be framed as protective factors. For example, poor communication skills can increase VAWG, while good communication skills are protective.

Secondly, it is important to analyse factors in the specific setting where you are trying to prevent violence. Although many factors are common across contexts, evidence shows us that some are more important than others in specific settings. To understand which risk factors are most relevant in a specific context, it is important to read existing studies and programme reports or commission research to build on your learning on the causes of violence in this specific setting.

Thirdly, you should also take a life course perspective, which means considering the individual's age and circumstances, as some relevant factors for young children are different from those relevant for adolescents and younger and older adults.

Finally, factors that are important for perpetration may differ from those important for victimisation. Therefore, it is important to be clear about the focus of your analysis.

These considerations will enable the identification of the most salient factors and strategies to address those factors.

FIGURE 2: THE SOCIAL-ECOLOGICAL MODEL FOR IPV RISK FACTORS[9]

SOCIETY
- Gender-discriminatory laws/policy
- Other forms of discrimination (e.g., racial, religious)
- Collectivist cultural orientation
- Armed conflict
- Political instability
- Corrosive macro-economic forces

COMMUNITY
- Rigid norms around expected male and female roles and behavior's
- Norms condoning male authority over women and children
- Norms linking men's honor to women's behavior
- Norms accepting VAW
- Norms of family privacy
- Lack of social/legal sanction for VAW
- Local poverty + employment

INTERPERSONAL
- Male dominance in decision-making
- Violence seen as appropriate 'discipline
- Poor communication skills
- High relationship conflict
- Lack of trust/emotional intimacy
- Association with violent and antisocial peers
- Social isolation

INDIVIDUAL (Risk of experiencing violence)
- Age (young women are at a higher risk)
- Depression
- Experiencing violence in childhood
- Witnessing violence in childhood
- Attitudes accepting violence/VAW

Useful Resources

1. World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010. https://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf

2. RESPECT women: Preventing violence against women. Geneva: World Health Organization; 2019. https://apps.who.int/iris/bitstream/handle/10665/312261/WHO-RHR-18.19-eng.pdf?ua=1

3. Brief 2: Understanding the causes of Violence Against Women. Prevention Collaborative. 2020. https://prevention-collaborative.org/wp-content/uploads/2021/08/Prevention-Collaborative_2020_Understanding-Causes-of-VAW.pdf

[9] Adapted from Brief 2: Understanding the causes of Violence Against Women. Prevention Collaborative

CHAPTER 3: UNDERSTANDING VIOLENCE PREVENTION PROGRAMMING

3.1. What is GBV prevention?

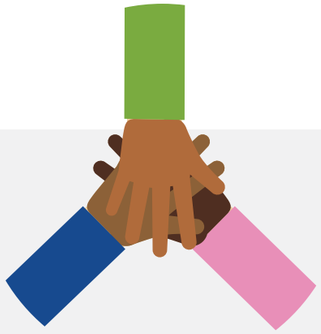
Preventing GBV means stopping violence before it starts or reducing the frequency and severity of further episodes of violence where it has previously occurred. This is different from response services, which involve providing services to survivors after the incident of violence has occurred.

While addressing the needs of victims is critical, we cannot reduce today's high levels of violence by assisting one survivor at a time. It is helpful to think about a continuum of prevention to response as part of a comprehensive, contextually adapted approach to addressing violence.

3.2. Prevention approaches

Historically in public health, interventions have been categorised as primary, secondary, or tertiary prevention (also called response) depending on the timing of the intervention. Primary prevention aims to stop violence before it starts; secondary prevention aims to detect violence early and prevent its recurrence; and tertiary prevention, or response, works to meet survivors' immediate needs to limit the impacts of violence.

For this handbook, a simplified classification that categories interventions into either Primary prevention or Response has been used. The focus of the handbook will be on primary prevention interventions.



3.3. Why prioritise primary prevention of violence?

1. GBV is highly prevalent, ranging between 50% to 86% in the SADC region.

2. GBV has severe social, health and economic costs for women, their children, families, communities, and societies.

3. While response services are an essential element of any well-rounded programme designed to address GBV, **achieving the long-term vision of a world substantially free of GBV, particularly VAWG, or at least greatly reduced in frequency and severity, requires that emphasis is placed on stopping violence before it starts.** Unfortunately, this aspect of programming has received less attention from existing programmes.

4. **Gender-Based Violence (GBV) is preventable.** GBV prevention practitioners and researchers have been developing and testing interventions to stop violence, particularly VAWG, from occurring and mitigating its consequences. The evidence base now shows that we can prevent VAWG through a range of interventions within programmatic timeframes. The next chapter will review examples of these programmes in detail.

5. **Primary Prevention is a priority area for addressing GBV in the SADC region**[10]. The SADC Strategy and Framework of Action for Addressing GBV: 2018-2030 highlights primary prevention as a priority for addressing GBV in the SADC region. The framework outlines the following key strategic actions to prevent new GBV incidents and to protect GBV survivors from further harm:

   a) Raising evidence-based awareness against GBV, including trafficking of persons, and promoting social and behavioural change towards GBV zero tolerance. Mobilise communities and institutions to support prevention interventions.
   b) Addressing and changing social, cultural, and religious norms, attitudes and behaviours that condone gender stereotypes and perpetuate GBV and other factors that can increase women's and girls' vulnerability to such violence through transformative actions.
   c) Social mobilisation and engaging specific groups, such as men and boys, parents, people with disability, children, young people, and community leaders through targeted and relevant interventions and messages.
   d) Specific focus on engaging men and boys in finding innovative non-traditional sustainable solutions to prevent GBV.
   e) Prevention of GBV in armed conflict and post-conflict situations.
   f) Setting accountability measures to ensure that perpetrators are prosecuted and to end impunity by strengthening legal and judicial systems.
   g) Facilitating economic and social empowerment of women and girls to fight GBV.
   h) Ensure coordination, communication, and monitoring among those involved in implementing prevention interventions.

Useful Resources

1. Brief 1: What is Prevention of Violence Against Women? Prevention Collaborative. 2020. https://prevention-collaborative.org/wp-content/uploads/2022/05/Prevention-Essentials-Brief-1.pdf

2. Preventing Violence against Women: A primer for African women's organisations. Raising Voices, African Women's Development Fund (AWDF). 2019. https://awdf.org/wp-content/uploads/VAWPrimer.RaisingVoices.AWDF_.English.FINAL_.aug2019.pdf

[10] SADC, SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence: 2018-2030, Gaborone, Botswana, 2019

CHAPTER 4: EFFECTIVE PROGRAMMES AIMED AT PREVENTING GBV

Over the last two decades, there has been a significant increase in studies to evaluate what works to reduce the prevalence, frequency, and severity of GBV, with more focus on VAWG. We now know that:

1. While no single programme has prevented violence entirely, various approaches have successfully reduced men's perpetration of women's and girls' experiences of violence by addressing the causes.

2. The successful violence prevention programmes:
   a. reduced one or more forms of violence within programmatic time frames
   b. reduced known GBV risk factors such as shifted gender inequitable beliefs, improved mental health, reduced harmful substance use, etc
   c. had the potential to be adapted to other contexts in the same country or different countries and
   d. had the potential to be scaled up to reach more people or communities.

3. Some approaches are more effective than others in changing attitudes and beliefs and reducing incidences of violence and related behaviours. For example, more general awareness-raising is useful in sustaining public discussion on GBV but has not been shown to lead directly to a change in attitudes or reduce acts of violence.

4. Transformative approaches that engage both women and men are more effective than initiatives that target specific groups.

This chapter will highlight the prevention programmes that are effective in reducing GBV. These programme examples do not form a comprehensive list but focus on the most common and promising intervention areas, grouped by entry point or platform.

NOTE: While there remains much to be learned, knowledge and practice relating to intimate partner violence (IPV) and sexual violence are better developed relative to other forms of GBV. For these reasons, many of the programmes suggested in this handbook are drawn from research and practice in addressing these two forms of GBV. However, many of the general principles, approaches, and strategies identified may also apply to other forms of violence and harmful practices against women and girls since many of these forms of violence are interrelated and share common risk factors.

4.1. Examples of Effective GBV prevention interventions

Different organisations and frameworks use different ways to categorise GBV prevention programmes depending on the types of violence they address, who they engage, and how they work. Table 3 presents the interventions in four overlapping areas of the socio-ecological model or the level at which the programme primarily tries to intervene or create change, i.e., working with and trying to change individuals, relationships, communities, or institutions.

Note that some specific interventions do not necessarily fit neatly into pre-defined categories and may cut across multiple entry points and platforms.

TABLE 3: GBV PREVENTION INTERVENTIONS ACROSS THE VARIOUS LEVELS OF THE SOCIO-ECOLOGICAL MODEL

SOCIO-ECOLOGICAL MODEL LEVEL	TYPES OF INTERVENTIONS
 INTERVENTIONS THAT PRIMARILY FOCUS ON THE **INDIVIDUAL LEVEL**	i. Economic empowerment interventions ii. Interventions to tackle substance abuse as a key risk factor for VAWG
 INTERVENTIONS THAT PRIMARILY FOCUS ON THE **RELATIONSHIP OR FAMILY LEVEL**	i. Couples' interventions ii. Parenting interventions
 INTERVENTIONS THAT PRIMARILY FOCUS ON **GROUPS OR AT THE COMMUNITY LEVEL**	i. Awareness creation programmes and campaigns ii. Group education (outside school) combined with community mobilisation, primarily engaging men and boys iii. Community Activism to shift harmful gender attitudes, roles, and social norms
 INTERVENTIONS THAT PRIMARILY FOCUS ON A **STRUCTURAL OR INSTITUTIONAL LEVEL**	i. School curriculum-based interventions

4.1.1. Interventions that focus on Individual-level change

This section focuses on interventions that primarily target individuals or individual-level change. Sometimes these interventions are also implemented in groups. However, they focus on changing individual-level risk factors for violence, such as economic or social disempowerment and alcohol abuse.

4.1.1.1. Economic Empowerment Interventions

The relationship between poverty and GBV is bidirectional: Poverty is a key risk factor for VAWG, and VAWG increases women and girls' poverty. For example, poorer women and girls have a greater dependency on relationships with men and less decision-making power in households, putting them at higher risk of violence and making it harder for them to leave abusive relationships. While on the other hand, VAWG keeps women from getting an education, working, and earning the income they need to lift their families out of poverty.

Economic empowerment programmes have the potential to reduce violence in several ways. First, improving economic security is likely to improve the physical well-being of household members, which protects against IPV. Second, if poverty and food insecurity are key stressors and triggers of conflict in a relationship, economic transfers alleviate this stress and reduce the potential for conflict. Third, economic theories for IPV suggest that if women receive financial support, their bargaining power increases in relationships, which provides them with an option of exiting a violent relationship.

These interventions focus on three types of economic approaches:

1. Economic transfers, including cash, food transfers and food vouchers.

2. Microfinance, savings, or livelihood strengthening only interventions include using microfinance, village savings and loan associations (VSLAs) or other income-generating activities or vocational/job training approaches only.

3. Combined economic and social empowerment interventions – in these interventions, the economic components are overlaid with social empowerment components (often with a strong emphasis on gender transformation). The economic component of these interventions is designed to reduce poverty and the immediate stress in relationships.

TABLE 4: SUMMARY OF ECONOMIC EMPOWERMENT INTERVENTIONS FOR VIOLENCE PREVENTION

TYPE OF INTERVENTION	EVIDENCE AND LEARNING	EXAMPLES OF PROGRAMMES WITH A POSITIVE IMPACT
Economic transfers, including cash, food transfers and food vouchers	Cash transfers to poor households can reduce physical and/or sexual IPV (in addition to positive impacts on food security and poverty reduction). **The impact is primarily achieved through:** 1. Increased economic security and emotional well being 2. Reduced intra-household conflict 3. Increased women's empowerment.	**HPTN068 (South Africa)** **Give Directly (Kenya)** **Economic transfers (Bangladesh, Ecuador)**
Combined economic and social empowerment interventions	There is good evidence that economic empowerment programmes, e.g., microfinance, savings, and livelihoods interventions alone, are not effective at reducing women's experiences of IPV. Therefore, they are not recommended as standalone interventions to reduce IPV. Adding a social empowerment intervention to an existing economic empowerment programme could lead to greater decreases in physical IPV beyond those from economic empowerment programmes alone. The most effective programmes comprised 12 months of economic interventions and at least ten social empowerment sessions.	**Intervention for Microfinance for AIDS and Gender Equity (IMAGE) –(South Africa), *see Case Study 1 below.*** **Adolescent Girls Initiative combines schooling, cash transfer and violence prevention (Kenya)** **MAISHA programme (Tanzania)**

CASE STUDY 1: IMAGE, SOUTH AFRICA

IMAGE aims to improve the economic well-being and independence of communities, reduce vulnerability to both HIV and gender-based violence, and foster robust community mobilization to address common concerns. The two components of the intervention are as follows:

a. **The Microfinance component** was delivered in partnership with the Small Enterprise Foundation, which administers loans exclusively to the poorest women in rural villages to develop income-generating activities. Loans support small businesses (e.g., selling fruit and vegetables or second-hand clothes). Loan centres of approximately 40 women meet fortnightly to repay loans, apply for additional credit and discuss business plans. This microfinance component of the intervention facilitates social and economic well-being and provides an entry point and client base for the SFL curriculum.

b. **Empowering women leaders to catalyze broader activism and social mobilization**- includes a participatory gender and HIV training programme called - Sisters for Life (SFL), which is fully integrated into routine loan centre meetings and is delivered alongside microfinance services by a separate team of trainers. SFL comprises two phases delivered over 12 -15 months.

- **Phase One (first six months)** consists of ten one-hour training sessions and covers gender roles, cultural beliefs, power relations, self-esteem, domestic violence, and HIV. Participatory methods aim to increase confidence and communication skills and encourage critical thinking about the links between GBV and HIV.
- **Phase Two (Community Mobilization)** encourages wider community mobilization to engage both youth and men in the intervention villages. Women deemed "natural leaders" by their peers are elected by loan centres to undertake a further week of training in leadership skills and community mobilization. They return to their loan centres and, over the subsequent six months, work with their centres to develop 'village-level action plans' that address a range of challenges, including priority issues such as HIV and GBV.

The IMAGE Project was rigorously evaluated from 2001-to 2005 as a research trial which compared villages receiving the full intervention package with a similar number of comparison villages. After two years, relative to matched controls, IMAGE participants showed impacts on:

1. Poverty: increased household expenditure and assets and increased membership in savings groups;

2. Gender-based violence: 55% reduction in risk of physical or sexual violence from an intimate partner

3. Women's empowerment: improvement in self-confidence, challenging gender norms, autonomy in decision-making, and collective action.

4. HIV risk - among young women participants, greater HIV communication with partners, access to Voluntary Counseling and Testing (VCT) services, and greater condom use (Pronyk et al. AIDS 22, 2008).

Link: http://www.image-sa.co.za/

Common elements and principles of effective approaches to women's economic and social empowerment programmes[11]

Programme design and adaptation

i. Identify the target population. Before designing the intervention, a situation analysis and needs assessment should be conducted to explore barriers facing sub-groups of women and intervention designs should be designed and adjusted. Participatory tools and consultation processes can identify context-specific vulnerabilities and reach particularly marginalised subpopulations such as out-of-school girls and women and girls with disabilities.

ii. Conduct formative research on norms around gender roles and income earning. This is critical to understand under what circumstances it is deemed acceptable for unmarried and married women to be earning income, doing what kinds of work and why. This has a big impact on how men, family and community members react to a woman working. Where interventions are challenging gender roles, prepare for how to mitigate potential backlash.

iii. Ensure economic empowerment components are based on local livelihood opportunities. Economic empowerment interventions need to be designed based on a market analysis of the livelihood options for women and build, where possible, on any existing support available. (e.g., microloans, village savings and loan associations (VSLAs), self-help groups (SHGs)).

iv. Recognise and mitigate against the potential backlash. This strategy may directly challenge traditional gender roles in patriarchal settings, so it must include efforts to mitigate against the potential backlash, including the risk of increasing violence. This should include training on handling financial conflict within relationships or the household and strategies to engage with male partners. For example, promoting the notion of working together for household economic development can help to ensure that women's increased financial gains are seen as contributions to the household. Where in-law dynamics constrain women's lives, family-based approaches may be appropriate.

v. Ensure sufficient time and resources for facilitator training and capacity building. Gender transformative interventions require well-trained facilitators and on-going support with sufficient time for personal reflection debriefing and for facilitators to learn how to handle different situations and participant questions. It is strongly recommended that facilitators experience the training first as participants. For example, MAISHA included extensive training to allow facilitators to become familiar with the curriculum and practice skills.

vi. Ensure implementing partners have sufficient expertise. Empowerment interventions like micro-finance require skills and experience, both institutionally (such as appropriate M&E systems) and individual staff competencies (such as strong facilitation skills and gender-equitable attitudes). Strong implementing partners should deliver work with relevant expertise who have received intensive training in delivering the intervention, including the values, principles, and approach.

Implementation and scale-up

vii. Secure enough funds and allow enough time for sufficient intensity and duration of economic empowerment components to ensure a significant change in women's economic situation. The economic benefits of microfinance and small-scale IGAs take time to be realised by women and their households (12 months+). Economic gains for women should be significant enough to give women the economic assets needed to transform their relationships.

viii. Maintain separate funding for each component when scaling up to ensure the gender empowerment costs do not affect the microfinance costs, which may be self-sustainable. The gender empowerment component is more likely to require external funding.

ix. Carefully monitor how increased savings and income are used at the household level. For example, to ensure that women have control or joint control over resources and that violence within relationships and households does not increase because of the intervention.

[11] RESPECT: Preventing Violence Against Women. Strategy summary. Empowerment of Women. WHO 2020. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Strategy-summary-Empowerment-of-women-en.pdf

x. Integrate empowerment interventions with education and health to address girls' complex and multi-faceted needs to maximise the impact and cost-effectiveness of interventions working with adolescent girls at a critical time in their lives.

xi. Plan activities to fit around the lived realities and constraints of women and girls. For example, domestic and childcare responsibilities, school or university studies, restrictions on women's and girls' mobility after dark, safety and travel concerns, etc.

xii. Avoid tokenistic participation of women and girls, but instead build in opportunities for continuous reflection on how best to empower women throughout the project, with coproduction in mind.

xiii. Provide safe spaces where women and girls can meet, socialise, discuss matters of concern, and develop skills. For example, group-based interventions that provide a platform for women to support each other - sharing advice regarding relationship-building, communication, problem-solving, and business skills have reduced the risk of economic, emotional, and physical sexual violence. Safe spaces need to be accessible to all women and girls, including those with specific vulnerabilities, and acceptable to other family members and the women and girls themselves.

4.1.1.2. Interventions to tackle substance abuse as a key risk factor for VAWG

Both research and experience suggest that substance abuse is one of several important factors which increase the risk of GBV, especially IPV against women. The relationship between substance use and IPV is bidirectional in women. While substance use places individuals at increased risk of IPV, the reverse is also true, with women exposed to IPV being at higher risk for substance abuse. A wide range of drug use has been associated with IPV, but the relationship between alcohol use and IPV has been most closely studied. This section will focus on interventions to tackle alcohol abuse as a key risk factor for VAWG.

There are four categories of alcohol reduction interventions:

1. Brief interventions involve screening in primary care settings and using a brief intake questionnaire or enquiry during history taking.
2. Structural interventions that restrict access to alcohol by developing laws and policies to make alcohol more expensive and less available.
3. Community-based interventions that aim at changing the drinking environment through social norms campaigns, education in schools or public dialogues; and
4. Treatment and self-help support systems, such as Alcoholics Anonymous (AA).

Alcohol reduction interventions

TABLE 5: SUMMARY OF ALCOHOL REDUCTION INTERVENTIONS FOR PREVENTING VIOLENCE

There is good evidence that therapeutic interventions to reduce alcohol abuse can reduce violence against women and girls.

Violence and Alcohol Treatment (VATU) (Zambia), *see Case Study 2 below.*

Women's Health Co-op (WHC, South Africa)

CASE STUDY 2: VIOLENCE AND ALCOHOL TREATMENT (VATU) (ZAMBIA)

- This intervention was built off the Common Elements Treatment Approach (CETA) and aimed to reduce poor mental health symptoms (trauma, anxiety, depression), substance abuse and IPV.
- It was delivered by trained lay counsellors to couples who were known to be experiencing IPV as a series of 6-12 weekly individual sessions (1-2 hours) for male and female partners separately.
- The sessions were based on an individualised treatment plan determined by the clinical team. The core elements of CETA include:
  - Engagement and education
  - Cognitive coping/thinking differently
  - Behavioural activation
  - Confronting fears and memories of trauma
  - Safety assessment and planning
  - Harmful substance use intervention
  - Problem-solving
  - Anxiety management
- An evaluation found positive outcomes in terms of reductions in both physical and sexual IPV as well as reductions in hazardous alcohol use among both men and women (Murray et al., 2019).

Link https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5719477/

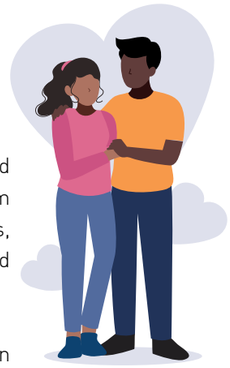
4.1.2. Interventions that primarily focus on the Relationship or Family level

The risk of GBV is higher in relationships where there is gender inequality and unequal power relations, controlling behaviours or where the partner holds attitudes and beliefs that condone violence within relationships. On the other hand, women are less likely to experience IPV in a relationship where couple communication is strong, and both partners have gender-equitable attitudes and decision-making.

In addition, there is a strong link between witnessing IPV in the home by children and future perpetration (for boys) or experiencing violence (for girls). This suggests that GBV may have learnt behaviour and /or trauma elements that need to be addressed.

This section focuses on the evidence from programmes that work with couples to strengthen gender equality and relationship dynamics and those that work with parents to promote positive parenting practices to reduce GBV.

4.1.2.1. Couples' interventions



These interventions work directly with both members of cohabiting intimate partners. These interventions aim to equip men and women with the skills to communicate and negotiate with their partners, manage violence triggers, and adopt positive, non-violent alternatives.

Couple's programmes:

o Focus on the unequal power relations, relationship conflict, and poor communication that drive intimate partner violence.

o Work with both members of a couple to promote healthy relationships.

o Are typically group-based and follow a participatory curriculum of 10 to 20-plus workshops, combining single-sex and mixed sessions.

o Emphasise critical reflection about gender roles and norms and about building knowledge and skills for healthy, non-violent relationships.

These programmes foster change processes at the couples' level, directly addressing risks for intimate

partner violence. They improve communication and conflict management skills, reduce depression and alcohol use, and contribute to more equitable decision-making, reducing the risk for intimate partner violence.

The core components of couples' programmes—critical reflection on gender, power, and violence and strengthened skills around self-regulation, conflict resolution, and communication—may reduce intimate partner violence and violence against children. For instance, several programmes focusing on couples have reduced the harsh corporal punishment of children, e.g., Indashykirwa and Bandebereho programmes both implemented and evaluated in Rwanda. However, there is great potential to incorporate additional content and skills around non-violent parenting into couples' programmes and to measure both intimate partner violence and violence against children as outcomes.

TABLE 6: SUMMARY OF EVIDENCE FROM COUPLES INTERVENTIONS

Couples' interventions

- There is good evidence that couples' interventions are effective approaches for reducing women's experiences of IPV and can be delivered safely.
- Couples' programmes grounded on a solid theory of change and allow space for analysis of gendered power and norms within relationships have effectively transformed gender relations within the couples.
- Comprehensive training and support to facilitators—including information about vicarious trauma and how to provide psychosocial support to those who disclose abuse—are key to achieving positive impacts. Without skilled facilitation, couples-based programming may put women at increased risk of violence.

Indashyikirwa (Rwanda), *see Case Study 3 below.*

Becoming One (Uganda)

Stepping Stones (South Africa)

Unite for a better life (UBL), (Ethiopia)

Bandebereho, (Rwanda)

Common elements and principles of effective approaches to strengthen relationship skill[12]

Design and adaptation

i. Ensure sufficient resources for designing, adapting, and piloting a gender transformative couples' curriculum. Successful approaches are structured around well-designed curricula tailored for the local context and rigorously tested and piloted to ensure the content is appropriate to the local context and that key messages resonate with the target population. When adapting existing curricula, it is strongly recommended to engage with the original developers/implementers, ensure fidelity to the core principles of the approach, and learn from experiences of adaptation elsewhere.

ii. Ground couples' curricula in theory and analysis of gendered power and norms within relationships. The Indashyikirwa couple's curriculum introduced the concept of positive and negative types and uses of power to help couples identify, prevent, and respond to IPV in their relationships and communities. Promoting new positive and aspirational relationship norms such as 'working together for household development', 'being good parents together, and 'improved sexual relationships', rather than focusing on messaging around harmful norms, can better incentivise behaviour change and help avoid potential backlash.

iii. Align and connect programmes with existing local values, languages, and community structures: Approaches that have successfully adapted to the local context have intentionally aligned their curriculum with existing positive cultural and religious values and used appropriate concepts in the local language. They also include key individuals and stakeholders who influence relationships within a particular setting and utilise existing community structures as key entry points to engage with couples, families, men, and women.

Implementation and scale-up

iv. Critically engage both men and women and, where appropriate other family members. Engaging both individuals within an intimate relationship helps sustain commitment and enables couples to support one another to address household gender and power dynamics. Efforts may be needed to ensure and sustain male engagement.

v. Create a safe space for equal participation between partners. The groups' size, location, and timing must be carefully considered to ensure the programme creates a safe and effective environment for couples to share and learn. This should include separate sex-specific and age-specific sessions for men and women and joint sessions including both partners.

vi. Build skills in communication and conflict resolution to strengthen relationships. Successful approaches focus on skills building and opportunities to practice new skills through take-home activities.

vii. Carefully select and train male and female facilitators. Given the intensive nature of these interventions, facilitators should experience the programme first as participants go through their transformation and learning process before they are ready to be facilitators. Further, facilitators need to be equipped and supported to adopt a participatory facilitation style and to be able to provide sufficient support to participants on their journey of change.

viii. Adopt participatory approaches with opportunities for reflection and support. Effective participatory learning techniques encourage dialogue and support critical thinking about gender roles, promote women's position, challenge the unequal distribution of resources, and address power imbalances between men and women.

ix. Use accessible, relevant, and engaging communication materials. Colourful and positive visual communication materials, including take-home resources, are essential in areas with low literacy and are key to capturing participants' interest, aiding in the communication of key messages. Adopt inclusive approaches to engage the most marginalised couples. The Indashyikirwa programme used specific strategies to ensure the programme was accessible for people with disabilities. This included partnering with the National Council for People with Disabilities, targeted outreach for 280 people with disabilities, and tailored accessible communication materials.

[12] RESPECT: Preventing Violence Against Women. Strategy summary. Relationship skills strengthened. WHO 2020.https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Strategy-summary-Relationship-skills-strengthened-en.pdf

CASE STUDY 3: INDASHYIKIRWA, RWANDA

• *Indashyikirwa* ('agents of change' in Kinyarwanda) is a programme designed to reduce levels of intimate partner violence, as well as to improve the response to survivors.

• The programme shifts attitudes and behaviours at the individual and relationship levels, as well as transforms wider social norms that tolerate violence and underpin inequalities between men and women.

• The programme has four components:

  - o A 21-session participatory training curriculum for couples
  - o Community-based activism (based on the SASA! model) led by a subset of individuals who completed the couples' curriculum and received ten additional days of activist training
  - o Direct support to survivors of intimate partner violence through women's safe spaces
  - o Training and engagement of opinion leaders

• Heterosexual couples were voluntarily recruited from Village Savings and Loans Associations (VSLA) and enrolled in a 21-session (3 hours each) curriculum over 5 months.

• In each group, a male and a female facilitator worked together to deliver the curriculum to 15 couples.

• The curriculum used a framework focused on exploring positive and negative uses of power, gender relations and skills building. It included sessions on addressing key triggers of IPV including alcohol abuse, jealousy, and disagreements over money. Some couples were also trained to be community activists and engage other community members in dialogue and activities around power, gender and VAW.

• Among participating couples, there was a 55% reduction in the odds of women reporting experience of physical and/or sexual IPV and a 47% reduction in the odds of men reporting perpetration of physical and/or sexual IPV (Dunkle et al., 2019).

Link https://prevention-collaborative.org/wp-content/uploads/2021/08/PROGRAMME-SUMMARY-Indashyikirwa-FINAL-1.pdf

4.1.2.2. Parenting Programmes to prevent IPV and Child maltreatment

Parenting programmes work with parents to create healthy family relationships, non-violent forms of conflict resolution, positive parenting approaches and healthy and safe home environments. Although they traditionally focused on reducing child maltreatment and violence against children (VAC), there have recently been efforts to integrate a focus on transforming gender relations and preventing IPV within these programmes. These programmes recognise the close association between the use of IPV in a household and violence towards children, including that:

1. Men who are violent toward their partners are more likely to be violent towards their children.
2. Women who experience IPV are more likely to use violent discipline against their children and other harsh parenting practices.
3. Children who witness or experience violence in childhood are more likely to experience (girls) or perpetrate (boys) violence later in life.

These associations suggest that preventing children's exposure to IPV and/or their own experience of maltreatment may be essential for the long-term prevention of GBV to disrupt the cycle and co-occurrence of abuse. These close associations also suggest that preventing IPV could lead to reduced rates of child maltreatment.

Promoting **respectful family relationships, non-violent forms of conflict resolutions** and **parenting practices**, and **healthy and safe home environment**s is central to preventing IPV and child maltreatment.

TABLE 7: SUMMARY OF PARENTING INTERVENTIONS TO PREVENT IPV AND CHILD MALTREATMENT

Parenting interventions

• Parenting programmes that explicitly integrate specific content on gender relations can effectively reduce both VAC and IPV and improve other parenting and health outcomes.

• Successful programmes promote critical reflection on gender inequality, gender socialisation, power imbalances and family well-being.

• The programmes need to be of sufficient intensity. The most successful ones are curriculum-based, with 10-15 participatory sessions.

Bandebereho, (Rwanda), *see Case Study 4 below.*

REAL Fathers programme (Uganda)

Parenting for Respectability (Uganda)

Common elements and principles of effective parenting and caregiver interventions that have been successful in preventing IPV and Child maltreatment[13]

Curriculum content

i. Promote nurturing and caring relationships between parents and children

Most successful interventions focus on supporting parents in developing positive relationships with their children and understanding the importance of emotional closeness to their children. For example, the REAL Fathers programme in Uganda and Bandebereho in Rwanda helped strengthen interactions between male caregivers and children and reduce IPV. Encouraging engaged fatherhood was the entry point that facilitated discussions about violence.

ii. Build skills to manage a child's behaviour through positive reinforcement and non-violent discipline

Successful interventions have focussed on developing knowledge and skills to foster nurturing and safe relationships between parents and their children and to use non-violent discipline methods when needed. For example, learning positive reinforcement and discipline methods can help parents replace spanking with more constructive discipline methods such as offering positive non-verbal attention through body language, ignoring capricious requests for attention, and redirecting children's attention when they are about to misbehave.

iii. Develop parents' and caregiver's emotional self-regulation skills

Parenting and caregiver programmes that effectively reduce violence aim to build parents' awareness of their own emotions, which is critical for them to help their children's emotions and behaviour. For example, *Bandebereho* in Rwanda helped parents to identify, recognise and manage difficult emotions such as anger, anxiety, and frustration by helping them master simple techniques such as mindful breathing, stepping aside and taking a walk - which can de-escalate family tension, enhance parents' patience and understanding of children's behaviour and needs and respond in a more empathic and non-reactive way. In addition, parental self-regulation helps diffuse tension and manage frustrations and conflicts around parenting and as a couple.

iv. Promote gender-equitable relationships in the family

Supporting couples to reflect and shift their attitudes and behaviours around shared decision-making among female and male caregivers, collaborative problem-solving and caregiver communication skills can lay the groundwork for more comprehensive community-based efforts to shift norms around gender roles, parenting, and child discipline. *For example*, *Bandebereho* and REAL Fathers facilitated group discussions and guided parents to question restrictive gender norms that negatively affect their health, relationships, and children's opportunities in life.

v. Engage fathers or male caregivers in caregiving

Programmes that explicitly seek to work with fathers can help deconstruct restrictive gender norms that assign full responsibility to mothers and women for children's health, development, and safety. *Bandebereho* and REAL Fathers sought to identify men's concerns around parenting to motivate them to come and learn how to address them. Both programmes include separate sessions of male-only group discussions to create a safe space for men to exchange their concerns related to parenting and couple relationships.

Approach, delivery methods and format

vi. Use modelling behaviour and interactive exercises

Most effective parenting and caregiver interventions are informed by the social learning theory, which encourages reflection through participants' observation of others, practising new skills and behaviour in safe spaces and internalising these skills to apply them outside the session. In addition, the interventions include participatory sessions, which allow participants to share their experiences and concerns; participate in hands-on activities and interactive exercises (open-ended story, role-playing, drawings). These approaches can lead to changes across various behaviours that are key to building a caring couple and parenting relationships.

vii. Consider combining a group-based format and Individual sessions

Group formats favour interpersonal/observational learning but instil hope and generate social support, which contributes to the adoption of healthier behaviours. In addition, it can help reduce anxiety around parenting through participants realising that others face similar challenges by offering and working through common problems and finding solutions to parenting issues among the group members. On the other hand, personalised sessions are also important to allow individual participants or family members to open up and share more intimate concerns with their mentors. For example, REAL Fathers included one-on-one mentoring sessions, couple sessions, and structured activities in a larger group setting.

viii. Balance the breadth and depth of interventions to balance intensity with the number of relationship and parenting skills building pursued.

Programme intensity is critical to intervention success because changing attitudes and behaviour takes time and is impossible to achieve in a few sessions. Reinforcing opportunities to unpack beliefs and practice skills across sessions may yield more lasting outcomes than including a 'checklist' of topics to cover. Therefore, most successful programmes provided the intervention for a minimum of 10 sessions and a maximum of 15. For example, Bandebereho in Rwanda included 15 sessions for men and eight for women. At the same time, in REAL Fathers in Uganda, male participants were engaged in six individually-delivered sessions and six group sessions (12 sessions).

CASE STUDY 4: BANDEBEREHO, RWANDA

- *Bandebereho* ('role model' in Kinyarwanda) is a fatherhood and couples' intervention in Rwanda adapted from *Program P* and designed to promote positive fatherhood and gender equality amongst expectant and current fathers (of children under 5 years) and their partners, to shift gender-power imbalances and reduce IPV.
- The theory of change for the *Bandebereho* intervention was premised on sociological theories of gender and masculinities that highlight how gender inequalities are reproduced, sustained, or transformed through everyday interactions in the home.
- The intervention aimed to provide a structured space for intimate partners to:
  - question and critically reflect on gender norms and how these shape their lives.
  - rehearse equitable and non-violent attitudes and behaviours in a comfortable space with supportive peers
  - internalise these new gender attitudes and behaviours and apply them in their own lives and relationships.
- It comprised a 15-session curriculum of small group participatory workshops (all with men, eight with their female partners) covering gender and power, fatherhood, couples' communication, joint decision making, IPV, caregiving, and male engagement in maternal, new born and child health.
- The programme engaged men and their partners in participatory, small group sessions in three intervention cycles (each with 570–576 couples) to promote critical reflection and dialogue on inequitable gender norms, attitudes, and behaviours in the home.
- The meetings were facilitated by trained community volunteers who met weekly with the same group of 12 men/couples. Several sessions were co-facilitated by local nurses and police officers on pregnancy, family planning and local laws. The sessions were held in local schools and offices.
- During the intervention period, men attended 15 sessions (max. 45 hours) and their partners attended 8 sessions (max. 24 hours).
- Men/couples who attended were provided with a transportation stipend of 2000 Rwandan francs (about US$2.50) each per session
- Among participating parents, there were lower levels of physical and sexual IPV reported by women as well as lower levels of child physical punishment and other increases in gender equality e.g., related to decision-making (Doyle et al., 2018).

Link:https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Programme-summary-Bandebereho-en.pdf

[13] The Prevention Collaborative (2019) "Evidence Review: Parenting and Caregiver Support Programmes to Prevent and Respond to Violence in the Home

4.1.3. Interventions that primarily focus on groups or at the community level

GBV is considered normal or acceptable in many societies and communities under certain circumstances. It is often considered a private issue and shrouded in secrecy and silence. Efforts to break the silence and challenge social norms that promote or tolerate violence are therefore one key component in addressing the problem. Working across whole communities to change attitudes, behaviours and social norms around gender, power, and VAWG is now well recognised as a valuable approach to GBV prevention. The aim is to create an enabling environment where a critical mass of support can grow among community members, leaders, and institutions to promote gender equality and non-violence.

Several interventions have been used in different country contexts to transform attitudes, beliefs, and norms around GBV. This section highlights interventions that have effectively used community activism/ mobilisation interventions to shift harmful gender attitudes, roles, social norms, engaged faith-based and traditional actors and group education (outside school) combined with community mobilisation to prevent GBV, particularly VAWG.

4.1.3.1. Community Activism/ mobilisation interventions to shift harmful gender attitudes, roles, and social norms

This set of interventions often worked through volunteer community activists who live within the same communities. They are usually carefully selected, trained, and supported to engage with men and women in the community through informal activities to challenge harmful norms and attitudes towards GBV. The activists use a range of materials to engage in structured discussions, community dialogues and activities with men and women in the community around power, gender and GBV. In addition, these programmes often work with opinion leaders such as religious and traditional leaders, the police, health, and social services to strengthen their responses to survivors and influence their attitudes and practices in their work.

The community activists' programmes require at least two to three years and extensive engagement to ensure that many community members are meaningfully exposed to the interventions.

TABLE 8: SUMMARY OF COMMUNITY ACTIVISM TO SHIFT HARMFUL GENDER ATTITUDES, ROLES, AND SOCIAL NORMS

Community Activism to shift harmful gender attitudes, roles, and social norms

- There is good evidence from various studies showing how well-designed and implemented community mobilisation interventions can reduce VAWG. *(Note: Only strongly designed and implemented can achieve this- see box 1 below)*
- Achieving community-level impact requires extensive engagement over at least two years and specific mechanisms for diffusing programme ideas to ensure a high proportion (critical mass) of community members are meaningfully exposed to the intervention.
- Community activists need intensive gender transformative training, skills building and mentoring.

SASA! (Uganda), *see Case Study 5 below.*

Safe Homes and Respect for Everyone (SHARE) project (Uganda)

Rural Response System - COMBAT (Ghana)

Common elements and principles of effective approaches to tackling harmful practices and promoting positive attitudes, beliefs, and norms[14]

Programme design and adaptation

i. Undertake high-quality formative contextual analysis and research to identify the specific norms and attitudes driving GBV in any given context. Successful interventions:

a. take on a gender power analysis of the root cause of GBV,
b. are specific about the behaviour they want to promote or change,
c. have a good understanding of the norms and attitudes which influence these behaviours in the local context and the social rewards and sanctions that keep norms in place.
d. When adapting existing programmes, it is strongly recommended to involve the originators to ensure fidelity to the core principles and learn from adaptation experiences elsewhere.

ii. Ensure strong organisational buy-in for the intervention. Not all types of organisations are well suited to engage in gender-transformative and social norms programming at a community level. However, successful interventions have been delivered by values-driven organisations that are willing to take time to support their staff, including their leaders, to reflect on violence, discrimination, power, and relationships within their own lives and within the organisation.

iii. Focus on promoting context-specific positive norms and behaviours. It is usually more effective to promote positive norms, attitudes, and behaviours across multiple platforms over time, i.e., 'what can be', rather than highlighting harmful norms and behaviours, i.e., 'the problem'. Highlighting more harmful norms and behaviours may inadvertently communicate that this behaviour is normal. For example, aspirational messages such as 'working together for household development' or 'men's role as fathers' may resonate with target populations and help avoid potential backlash. However, it is important not to ignore deep-seated inequitable beliefs and power dynamics in the household, which may be harder and take more time to shift.

iv. Design to catalyse broader societal change rather than focus on individuals and small target groups. Community mobilisation approaches differ from many other strategies, as they attempt to influence change at a population level rather than just the individual and group level. To reach a tipping point or critical mass of individuals supportive of change, interventions must aim to reach a high proportion of the community or institution through an organised process or strategy. For example, working with influential community members to role model positive behaviours in public settings and pairing communication strategies to amplify key messages and enhance the impact of face-to-face interactions.

v. Avoid standalone awareness-raising activities. Although these have been one of the most common approaches to tackling GBV, evidence shows that standalone awareness-raising activities are not intensive enough. They rely more on messaging or information-giving than sparking critical thinking or are not sufficiently theory-driven to transform deeply entrenched norms or reduce GBV on their own.

[14] RESPECT: Preventing Violence Against Women. Strategy summary. Transformed attitudes, beliefs, and norms. WHO 2020. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Strategy-summary-Transformed-attitudes-beliefs-and-norms-en.pdf

CASE STUDY 5: SASA!, UGANDA

- *SASA!* is a community-mobilisation project designed by Raising Voices to transform gender relations and power dynamics to prevent HIV and violence against women (VAW).
- It works through trained community activists based on a "stages of change" (Start, Awareness, Support, Action) model over a minimum 30-month period.
- The *SASA!* Activist Kit includes different strategies and activities which encourage participants and communities to explore different dimensions of power, analyse and transform inequitable gender norms, and prevent VAW.
- Community members are also supported to take action to prevent and also better respond to IPV survivors.
- A study on *SASA!* in Uganda found that this intervention was associated with reductions in past year experience of physical and sexual IPV among women in *SASA!* communities and lower acceptance of IPV among both women and men (Abramsky et al., 2014).
- *SASA!* has now been adapted and implemented in 20+ countries worldwide and in 2020, Raising Voices launched a revised version called *SASA! Together*

Link http://raisingvoices.org/sasa/

4.1.3.2. Interventions that engage faith-based and traditional actors in preventing violence against women and girls

Faith-based actors (e.g., formal and informal faith-based leaders and organizations) and traditional actors (e.g., chiefs, traditional healers, headmen and headwomen, elders, mothers-in-law, and aunts) are key actors in the prevention of VAWG. They are well recognized and respected by the community members and can promote beliefs, norms and practices that support and enable VAWG prevention. But, on the other hand, they can also encourage those that hinder the prevention and even encourage and legitimize certain forms of violence. Therefore, their reach and influence cannot be ignored, especially given their unique position in households and communities.

Studies have revealed several reasons for working with faith-based and traditional actors to reduce GBV. First, these actors can provide access to communities as authority figures and gatekeepers of the community. Second, faith-based and traditional actors have social capital and influence, including access to funds, buildings and institutions that can be used for VAWG prevention interventions. Finally, these actors have unique assets, namely knowledge and skills relating to sacred texts, rituals and prayers that uphold beliefs, norms and practices based on faith and tradition. Finally, their ability to facilitate dialogue at community, local government, and state levels mean that these actors' mobilisation can have a far-reaching impact.

TABLE 9: SUMMARY OF INTERVENTIONS THAT ENGAGE FAITH-BASED AND TRADITIONAL ACTORS IN PREVENTING VAWG

Interventions that engage faith-based and traditional actors in preventing violence against women and girls

VAWG prevention requires a multisectoral approach, with faith-based and traditional actors treated as stakeholders in a wider system. This integrates these actors into wider VAWG prevention work and creates accountability to their peers in other sectors.

Faith Leaders can have a meaningful and positive role in transforming relationships to reduce VAW. They are recognised community leaders, common mediators of relationship conflict, and respected figures in deeply religious environments

Becoming One (Uganda)

4.1.3.3. Group-based workshops with men and women to promote change in attitudes and norms

Preventing violence requires working with those who are responsible for it. It is important to recognise that not all men are violent. Still, in many societies, boys are raised, and men are expected to accept patriarchal practices and policies as natural and normal and see violence as a legitimate way to exert control over those with less power. Therefore, some group-based workshop interventions were designed to target men and boys alone to promote gender-equitable attitudes, norms, and behaviours to reduce men's perpetration of violence. However, evidence now shows that **working with men and boys alone is ineffective in reducing violence outcomes. Interventions working with men and women (and boys and girls) are more effective at reducing violence than single-sex interventions.**

The group-based workshops with men and women typically include participatory group education approaches which critically engage participants in discussions around gender, power and GBV. These approaches can also equip a small group of people with the skills and confidence to influence wider community change. Some of the successful interventions focused on male engagement activities and invited the female partners into specific sessions for joint discussions as appropriate to the cultural context. In contrast, others held separate sessions with male and female groups in addition to the joint sessions.

TABLE 10: SUMMARY OF GROUP - BASED WORKSHOPS WITH MEN AND WOMEN TO PROMOTE CHANGE IN ATTITUDES AND NORMS

Group-based workshops with men and women to promote changes in attitude and norms

- There is evidence that intensive group-based workshops with men and women can improve individual attitudes and behaviours of those targeted, including reducing violence against women prevalence.
- These approaches work best when they combine work with men, women, boys, and girls, either as couples or in coordinated peer-group education activities, which typically work separately and then come together.

Stepping Stones (South Africa)

Indashyikirwa (Rwanda),

Transforming Masculinities (DRC), ***see Case Study 6 below.***

4.1.3.4. Digital technology for GBV prevention

A lot of investments have been put toward developing and using the digital space, such as applications, websites, and social media platforms, to prevent GBV. Examples of digital interventions include online safety decision aids for women experiencing violence (e.g., Isafe, I-DECIDE etc.) and websites and apps that map incidences of violence (e.g., SafetiPin in India, Colombia, Kenya, Indonesia and the Philippines and HarassMap in Egypt). Online social media platforms are also more frequently been used as an advocacy tool to inspire reflection, share experiences, and challenge social norms and legislative reforms (e.g., #MeTOO movement and #BringBackOurGirls).

Most of these initiatives provide a community for survivors of GBV, knowledge about where to receive services and provide decision support related to safety. Of note is that on their own, these interventions are unlikely to prevent GBV from occurring and most have not been assessed for their impact on GBV.

CASE STUDY 6: TRANSFORMING MASCULINITIES, DRC

- Transforming Masculinities is an evidence-based approach to promote gender equality and positive masculinities within faith communities.
- It is based upon the understanding that spiritual beliefs and faith leaders are part of the structure that shapes social and gender norms, and focuses on prevention and response to sexual and gender-based violence
- It consists of a series of trainings, group discussions called 'community dialogues,' and diffusion activities that guide faith leaders, young couples, and congregations to identify, create, and embrace positive masculine identities and gender-equitable behaviors.
- **Faith leaders (Protestant) at national, provincial, and congregational levels** receive training and commit to creating an environment that supports family planning use and rejects family violence. These influential leaders provide sermons and guidance to congregations to spread positive change, working alongside selected Gender Champions
- **Gender champions** are congregation members selected by faith leaders to act as change agents and peer mentors. They facilitate group discussions with young couples called 'community dialogues'. Working with newly married couples and first-time parents, the intervention encourages reflection, dialogue, and action to build norms that condemn violence and enable access to family planning services
- **Newly married couples & first-time parents** (ages 18-35) participate in community dialogues for eight weeks. The final two sessions on family planning include a family planning health talk. They engage in other congregation wide activities and receive support from their peers.
- **Congregations** receive sermons and testimonies and participate in group discussions and mobilizing events. They reflect on gender equity, and the ways in which they interact and make decisions.

Link: https://irh.org/wp content/uploads/2017/04/Transforming_Masculinities_brief.pdf

TABLE 11: DO 'S & DON'TS FOR ENGAGING MEN & BOYS

DO RECOGNISE AND MEET MEN'S DISTINCT NEEDS

- Engage men and boys in ways that acknowledge and meet their unique needs—as clients, partners, and agents of change.
- Consider the high rates of violence, depression, and substance abuse men experience, linked to harmful norms around masculinity. Ideally, seek to prevent these experiences through intervention and legal/policy reform.

DO NOT ENGAGE MEN AT THE EXPENSE OF WOMEN

- Ensure that male engagement efforts do not compromise women's safety and ability to make decisions and access services. Track this carefully.
- Provide sufficient staff training—including refresher training—around balancing engaging men and women and monitoring programs to ensure that women aren't left out.

DO NOT START WITH THE ASSUMPTION THAT ALL MEN ARE BAD ACTORS

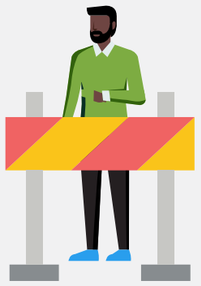
- It is counter-productive to hold negative assumptions about men as a group, even though men who engage in harmful behaviours like partner violence must be held accountable.
- Find and amplify the voices of men who support gender equity and those who are positively changing.
- Engage men and boys in recognising how restrictive masculine norms negatively affect their health and well-being and that of partners, children, and families—and how moving away from these norms can benefit everyone.

DO GATHER EVIDENCE WITH MEN AND BOYS (AND NOT JUST WOMEN AND GIRLS)

- Speak directly to men and boys, in addition to women and girls, when designing a male engagement program/ policy or evaluating its effects.

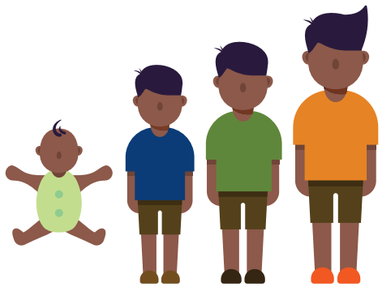
DO SEEK TO TRANSFORM HARMFUL GENDER RELATIONS AND NORMS

- Recognise that some common gender norms and dynamics are harmful.
- Implement programs that explicitly seek to shift gender norms—called "gender transformative" programming—which is more effective in improving health outcomes than those that do not
- Engage men in caregiving as a powerful entry point for transforming gender relations and norms.



DO NOT DISCOUNT THE STRUCTURAL BARRIERS MEN FACE WHEN ACCESSING HEALTH SERVICES

- Ensure privacy, convenience (e.g., after-work hours), and a welcoming environment (e.g., staff prepared to receive men). Like other clients, men need options and information that meet their needs.
- Don't assume that health facilities are necessarily the best place to provide health services. Often, community-based services can best reach men.
- Advocate for policy change that breaks down structural barriers preventing men from accessing services



DO START EARLY IN THE LIFE COURSE

- Start building equitable gender norms in childhood to promote healthier decision-making later in life. Messages about men's and women's expected roles and behaviour are internalised early in life.
- Ensure boys' and young men's access to mentors who endorse equitable gender norms and model healthy behaviour.
- Implement evidence-based interventions to prevent and address children's exposure to adverse experiences like violence and trauma, which are common among boys and girls. In addition, these experiences affect men's and their partners' health outcomes later in life.

DO ENGAGE MEN ON THEIR OWN AND IN GROUPS OF MEN, AS WELL AS TOGETHER WITH WOMEN

- Consider implementing male-only groups as spaces for men to consider harmful gender norms and the benefits of change and freely discuss sensitive topics, express worries, practice healthy communication, and seek advice.
- Avoid ONLY engaging men in male-only spaces, which can reinforce inequitable gender norms. Instead, ensure opportunities for men and boys to dialogue with women and girls.
- Seek to build skills around positive communication and shared decision-making among genders within couples and families in all program activities.

DO NOT OVERLOOK THE DIVERSITY OF MEN AND BOYS IN THE POPULATION

- Design programming and activities to reflect critical dimensions of men's diversity, such as race/ethnicity, fatherhood, class, religion/faith, age, gender identity, and sexual orientation.
- Intervene during transformative moments in the life of men and boys (e.g., puberty, school graduation, marriage, parenthood), when their needs and outlooks are changing

DO NOT OVERLOOK SCALE AND SUSTAINABILITY TO ACHIEVE IMPACT

- Consider how to reach entire populations or communities and sustain those efforts over time.
- Seek to build effective male engagement strategies into policies, institutions, and systems in healthcare, education, the workplace, and government.
- Use one of the existing, evidence-based male engagement strategies and activities whenever possible

4.1.4. Interventions that primarily focus on a structural or institutional level

4.1.4.1. Implementation and enforcement of Laws

Law and legal systems reflect wider cultural values, and in this respect, they have been implicated as structures that have reflected and re-created gender-based power relations. Therefore, legal reform has been a core strategy to create gender equality. Legal strategies concerning GBV need to take account of the explicit and implicit ways law and its implementation have failed survivors of violence, leaving them unprotected and with no route to redress and justice.

Good law practice extends beyond creating new or reformed legal statutes to the equally, if not more, important questions of implementation and procedure.

In several countries, new laws have been introduced that appear positive on paper, but lack of implementation or failures to address procedural issues - such as enabling reporting, ensuring that the process is timely and providing legal aid/advocacy- dampen their potential.

Legislation can be a key part of preventing and responding to GBV. Effective enforcement of laws that define and prohibit all forms of GBV may deter violence and ensure justice for victims. In addition, different types of laws address risk factors for GBV, such as misuse of alcohol, Early and forced marriage, inadequate victim care services etc.

TABLE 12: EXAMPLES OF LAWS TO PREVENT GBV

Type of Intervention	Laws that prevent Alcohol abuse
Laws protecting individuals from sexual abuse and exploitation	Laws protecting children and adolescents from physical punishment
Laws that put the age of consent for sex at 18 or above, depending on the country's context	Laws protecting individuals from domestic violence
Laws and policies regarding institutional and duty bearer responses to GBV	

CASE STUDY 7: WESTERN CAPE ALCOHOL-RELATED HARMS REDUCTION POLICY, SOUTH AFRICA

- After assessing the causes behind the biggest disease burden in South Africa, public health leaders in the Western Cape noted that alcohol misuse was a common factor in everything from violence to HIV and from road traffic accidents to chronic diseases.
- The province's violence's prevention policy framework offered an opportunity to move beyond programmatic responses and make longer- lasting, sustainable change through policy.
- The work began by describing the problem rates of alcohol consumption, its impact on health outcomes and the cost to society of alcohol-related harm relative to the liquor industry's contribution to the economy
- A broad public-sector coalition put forward policy recommendations for public consultation. This input, along with a regulatory impact assessment, was compiled into a White Paper published by the Western Cape government in 2017

Link https://www.westerncape.gov.za/text/2017/September/white_paper_alcohol-related_harms_reduction.pdf

Considerations for implementation and enforcement of Laws

1 **Understand who the key stakeholders involved in implementing and enforcing laws are.**

Implementation and enforcement of laws occur at multiple levels and involve multiple actors, including:

- legislators and policymakers who pass laws and allocate resources
- ministry and government staff who translate law and policy into protocols and standards for their sector
- members of the service workforce who carry out actions
- civil society and the private sector who help support the community to comply with the law
- families and individuals who change their behaviour

2 **Assess in-country legal framework and policy frameworks**

Before developing new laws and policies to prevent GBV, it is important to note that many countries already have very robust legal and policy frameworks. Therefore, the first step should be to assess what already exists and what gaps remain. Examples of questions that could help guide the assessment include:

- What are the current legal and policy frameworks for GBV?
- What are the gaps?
- Are the existing laws and policies effectively enforced? If not, can the enforcement be strengthened?
- Are additional policies or other prevention measures needed to reduce GBV?

3 **Recognise that implementation and enforcement of laws work best when:**

- they are part of a broader strategy to promote and protect human rights, including measures to monitor and evaluate the implementation
- national and local stakeholders throughout the government and civil society, including women and children who are the most vulnerable to GBV, are fully engaged in the process
- legislation that requires infrastructure or services is costed accurately and supported by the allocation of sufficient resources
- implementation is accompanied by on-going awareness-raising, efforts to change social norms and professional training or other supportive programmes skill building for couples in communication.

4.1.4.2. Interventions that establish a safe and enabling school environment

School-based interventions aim to prevent violence in schools and use schools as an entry point to prevent GBV, including VAWG, dating violence, peer violence, and corporal punishment. In addition, school systems provide an opportunity to reach many students, teachers, and parents in a teaching-learning environment and thus hold great potential for taking GBV prevention to scale.

Life skills training can prevent violence against children by enhancing their communication, conflict management and problem-solving skills and assisting them in building positive peer-to-peer relationships. While schools are an important space where life skills training programmes can be delivered, they can also be provided in informal settings such as community centres (for children not in school).

These interventions are usually delivered over several years and involve 20-150 classroom-based sessions. In addition, many programmes include age-specific modules, ranging from pre-school through primary and up to secondary school age.

4.1.4.2.1. School curriculum-based interventions

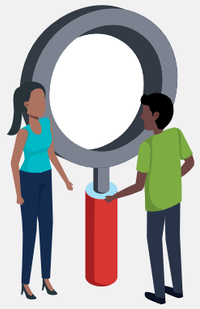
By the teaching of specific gender-themed curricula, schools are uniquely placed to influence and shape children's understanding of gender stereotypes and roles and the prevention of GBV. School interventions target either male or female peer groups separately or together and address gender norms and attitudes before these become deeply ingrained in youth. The sessions are delivered in class by teachers or facilitators or after school, usually by trained facilitators. Some school interventions move beyond teacher/facilitator-student interactions to engage the wider school and/or others- such as parents or school governing bodies. Such interventions are referred to as '*Whole school*' interventions.

TABLE 13: SUMMARY OF EVIDENCE FROM SCHOOL CURRICULUM-BASED INTERVENTIONS

Interventions to prevent dating or sexual violence

There is good evidence that school-based interventions can prevent dating violence.
The effective interventions:
- had longer programmes delivered by highly trained facilitators or teachers
- used participatory learning approaches
- included critical reflection and skills building
- were based on theories of gender and power.

Stepping Stones (South Africa)



Peer violence prevention interventions with a gender component

- There is good evidence that peer violence can be prevented through the right school-based interventions, and results can be sustained.
- Successful interventions used participatory methods, built skills and addressed violence prevention through a gender lens.

Good school toolkit (Uganda)

Right to Play (Pakistan)

Self-defence training delivered in schools and colleges to prevent sexual assault

- Although the name implies that these are largely physical strategies, the self-defence training often emphasises consent and pressure, assessing risk and non-physical strategies to reduce [...] or deter attack and fight off- assailants.
- Training sessions can range from short one-off, one-hour sessions to 10–15-week courses.

There is promising evidence that more rigorously developed and tested college self-defence interventions can reduce women's experience of sexual abuse. However, more research is still needed to determine whether the self-defence interventions work for school girls.

IMPower (Malawi), *see Case Study 8 below.*

CASE STUDY 8: IMPOWER, MALAWI

- IMPower consists of weekly, 2-h sessions for 6 weeks for a total of 12 h of interactive, empowerment self-defence training.
- It was implemented with primary (average age 15) and secondary-school (average age 19) girls in rural Malawi.
- Because physical interventions can escalate situations of potential violence, IMPower emphasizes early recognition of boundary testing, negotiation, diffusion and distraction tactics, and verbal assertiveness over physical self-defence, with the guidance that physical tactics should only be used if they are the last and best option.
- IMPower teaches boundary recognition and boundary setting (e.g., name harmful behaviors, warn about consequences), negotiation and diffusion tactics, verbal assertiveness (e.g., yell if threatened), and physical defence skills, with the self-efficacy to implement these skills. The physical skills comprise closed target skills, weapons, and targets.
- After the six weeks, two-hour refresher courses are performed every 3–6 months.
- An evaluation of the programme showed significant reduction of the incident rate of sexual assault reported in intervention schools (Decker et al., 2018). However, a recent study of IMPower implemented among young girls in urban Kenya did not find conclusive evidence of positive impact.

Link https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-018-6220-0.pdf

4.2. Critical elements required for effective GBV prevention

Programme design and adaptation

Over the last decade, there has been increasing investment in expanding the evidence on what works to prevent GBV, particularly VAWG. As a result, it is now possible to compare different programme designs and implementation across different settings. This has allowed the identification of the common elements of successful GBV prevention programmes, with a greater focus on preventing VAWG.

4.2.1. Ten elements of the design and implementation of effective GBV prevention programmes[15]

Design Elements

1. Rigorously planned with a robust theory of change rooted in knowledge of local context. It is important to carefully plan interventions built on deep local knowledge, ensuring that all the relevant components of the interventions are designed around a well-conceived theory of change aimed at preventing GBV. Interventions that have successfully reduced GBV were developed based on formative research and building on practitioner experience to understand the context, piloting and redefining the intervention manuals and materials before finalisation and implementation.

2. Tackle multiple drivers of VAWG, such as gender inequity, poverty, poor communication, and marital conflict. A critical aspect of designing a GBV prevention programme is understanding the key drivers of violence within the specific context. Successful GBV prevention interventions have focussed on addressing multiple drivers of violence, including the most important drivers in the participants' lives. For example, the Indashykirwa couples' intervention (case study 4) challenged gender inequity and the use of violence while building stronger, more harmonious relationships, empowered with better communication.

3. Work with women and men, and where relevant, work with families. Women experiencing violence, their husbands/partners and other potential perpetrators or key influencers must be engaged in the intervention appropriately. It is also important to involve other family members, particularly in-laws, where the socio-cultural context points to their deep engagement with the couple. This is critical for enabling young women's attendance in the intervention activities and supporting them in implementing new ideas.

4. Integrate support for survivors of violence. Most of the interventions that have successfully prevented violence provided support for violence survivors despite being designed as primary prevention interventions. For example, the Rural Response System (RRS) programme in Ghana had community activists trained in mediation skills, and they enabled conversations between couples and around problems in relationships, while the Indashykirwa in Rwanda had survivor safe spaces offering aid to female and male survivors.

5. Use group-based participatory learning methods for adults and children that emphasise empowerment, critical reflection, communication, and conflict resolution skills building. These programmes were designed with participatory learning methods and used workshops or group sessions which encouraged personal and group transformation through critical reflection and working through problems and positions.

6. Gender and social empowerment and fostering positive interpersonal relationships. Most successful violence prevention interventions included gender and social empowerment components, understanding the gendered nature of violence, building equity, fostering conflict resolution, and positive interpersonal relationships. The interventions were developed because behaviour change is a collective process rather than individual change alone and requires challenging deeply held values and opinions in group sessions.

7. Carefully designed user-friendly manuals and materials supporting all intervention components to accomplish their goals. Most successful interventions had well designed, easy to use manuals for training and supporting the staff and volunteers. The manual content was most often mapped to the intervention theory of change and included clear curriculum approaches from beginning to end.

8. Age-appropriate design for children with a longer time for learning and an engaging teaching method such as sport and play. Programmes designed for children need to be empowering, engaging and fun. For example, the Right to Play, a sport-based intervention to reduce peer violence in schools implemented in Pakistan, worked with pre-teen children and included sessions on critical reflection, communication and conflict resolution skills building delivered through sports and play. Additionally, the most effective interventions for children were delivered consistently over two years, reflecting that children need time to develop learning skills.

Implementation Elements

9. Optimal intensity: duration and frequency of sessions and overall programme length enable time for reflection and experiential learning. Having optimal intensity for the intervention is important for successful implementation. This includes having sufficient staff employed to deliver the services, appropriate intervention length, number, duration, and frequency of sessions. For example, SASA! Intervention in Uganda had many community activists deployed based on the population to be reached, many activities and a long duration. In addition, to ensure success, the workshop-based interventions were time-intensive. They held weekly or twice weekly sessions that built on each other, with adequate time allocated for experiential learning and reflection between the sessions. The workshops mostly lasted for 2-3hours at a time to enable in-depth discussions.

10. Staff and volunteers were selected for their gender-equitable attitudes and non-violent behaviour and thoroughly trained, supervised and supported. Careful selection, training and support for staff and volunteers are important for intervention success. For example, the RRS intervention in Ghana selected activists that were nominated from local communities as individuals with gender-equitable and non-violent attitudes and behaviours before training. The more successful interventions also trained staff for longer. This included taking the programme staff and volunteers through the entire intervention as participants. For example, for Stepping Stones and Creating Futures, the training lasted six weeks, with two weeks for attending the intervention as participants, two weeks for other content on the subject matter and how to facilitate and two weeks for practising the session facilitators. On-going support and supervision of staff and volunteers were also notable for successful interventions.

[15] Jewkes R, Willan S, Heise L,et.al. Elements of the Design and Implementation of Interventions to Prevent Violence against Women and Girls Associated with Success: Reflections from the What Works to Prevent Violence against Women and Girls? Global Programme. Int J Environ Res Public Health. 2021 Nov 19;18(22):12129. doi: 10.3390/ijerph182212129. PMID: 34831885; PMCID: PMC8621962.

CHAPTER 5: ADAPTATION AND SCALE-UP OF GBV PREVENTION PROGRAMMES

As discussed in chapter 4, we now have multiple programme models that effectively prevent GBV, with more on VAWG specifically. This provides options for organisations to build on the existing evidence and best practices. It is common for organisations to be eager to adopt successful or popular intervention models. However, it is essential to remember that importing an intervention as-is into a new context or with a new population is not possible. Programmes must be carefully selected to fit your goals, budget, and time frame and then adapted to the context in a planned and purposeful way.

5.1. Adaptation of GBV prevention programmes

Adaptation means changing our plans to fit a new environment. Adaptation can be reactive when something happens unexpectedly, and we change in response. Adaptation can also be proactive. The complex and shifting nature of the problem of GBV requires adaptation.

During scale-up, the National Coordination Mechanisms in each member country will need to think ahead for future adaptations before they are needed. They will need to identify parts of activities to end GBV that may need to change in different environments.

5.1.1. Why is adaptation important?

- Contexts are different and unique; therefore, the implementation of a particular program will vary depending on where it is rolled out
- Adaptation allows practitioners and programmers to develop new/ innovative components that work for their contexts
- Adaptation may produce more effective programs than the original model
- Adaptation can support local ownership because the program is culturally tailored

Therefore, there is a need for clear guidance on adapting programming while being true to different contexts effectively. Quality adaptation needs to consider elements of the model and elements of implementation that were key to the programme's success. Both components are equally important, yet the focus tends to be on adhering to the model rather than key implementation elements.

TABLE 14: KEY STEPS FOR ADAPTING A NEW PROGRAMME

SELECT A SUITABLE EFFECTIVE PROGRAMME

- Does the intervention have relevant attitude & behavioural goals?
- Has the intervention shown evidence of achieving one or more of these goals?
- Does the intervention address knowledge, attitudes, and skills relevant to the new population?
- Does the intervention use content and methods likely to be accessible and appealing to the new priority population?
- Does implementing agency have access to the resources needed to plan and deliver the program?

GATHER ORIGINAL PROGRAM MATERIALS

The materials include programme theory of change, Training curriculum, facilitator training manual etc

DEVELOP A NEW PROGRAM MODEL

Consider the population, program goals, activities/ services to be provided to the population to achieve the objective

IDENTIFY CORE COMPONENTS AND BEST PRACTICE CHARACTERISTICS OF THE ORIGINAL PROGRAM

Program developers and evaluators identify core components through an analysis of the program's underlying theory, research studies comparing different versions of a program, and experience with the program

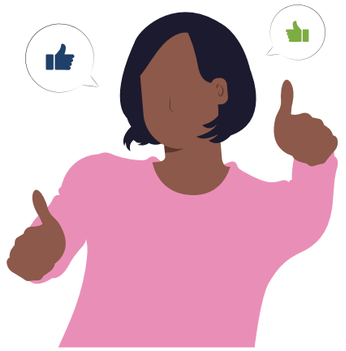
IDENTIFY THE DIFFERENCE BETWEEN THE ORIGINAL MODEL, MATERIALS, AND NEW CONTEXT

- Are program goals, approaches, and activities contextually relevant?
- Do Characteristics of the population differ, i.e., developmental age level?
- Do the Cultural beliefs, norms, values, and language differ?
- Do the Characteristics of implementing partners differ, i.e., staff experience and funding?
- Do the Characteristics of the community differ, i.e., laws, regulations, policies, and services?

ADAPT ORIGINAL PROGRAM MATERIALS

Ask questions about the difference between the original model and the new context, for example:

- Are language, images, and examples from the original model relevant considering development level, cultural norms, literacy etc.?
- Do training materials reflect changes made to content and delivery



PRE-TEST NEW PROGRAM MODEL

- Gathering feedback from individuals of the piloted program can identify population differences (e.g. cultural, language, educational) to improve the program if addressed.
- Ideally, participants are drawn from the population for whom the program is intended.

Examples of Pre-Testing Approaches

- Observing dynamics of curriculum sessions: i.e., comprehension, engagement, facilitator style
- Collecting participant/facilitator feedback after each curriculum session through individual interviews
- Conducting focus groups with participants/facilitators at the end of the pre-tested program.

EVALUATE PRE-TESTED FEEDBACK

- Not all suggestions from the pre-test for program changes will be possible.
- The pre-test feedback can be evaluated using the following criteria:
  - Importance: Perceived to improve program effectiveness, reach the new target population, and address concerns of multiple participants
  - Feasibility: How feasible are recommendations for participants, facilitators/funders
  - Congruence: Whether recommendations work with core components of the program.

** Goal of adaptation is to meet the community's unique needs within the existing program and not invent a new program based on every participant's concern.*

**Adapted from Card 2009. How to adapt effective programs for use in a new context. Health Promotion Practice.*

5.2. Scaling-up of GBV prevention programmes

Scale-up involves investing in an intervention approach that has already proven effective in reducing GBV or violence against women to increase impact. When considering whether to 'scale up' an intervention, the focus should be on **scaling up the desired impact**, not just scaling up the intervention. There are two main types of scale-up:

1. Vertical scale up, or institutionalisation. This requires integrating an activity into laws, policies, budgets, work plans, and institutional structures such as training centres and health information systems. To keep vertical scale up on track, the National Coordination Mechanism should establish benchmarks that will be used to track different elements of institutionalisation, including the degree to which:

- National policies are supportive of the activity
- Social norms are shifting to accommodate the activity
- Activities are included in national, regional, or district-level budgets
- Routine training and supervision practices support the activity
- Service protocols reflect and advance the goals of the activity.

2. Horizontal scale-up or expansion. This means successfully getting an activity functioning in more sites or having it reach additional populations. It entails training more individuals to offer the intervention, creating more resources, and implementing activities to reach more people across the country. For instance, an activity may be taken from a single pilot site where it was proven effective to a larger scale: an entire district, region, or maybe the entire nation. Horizontal scale-up may also expand the reach of an intervention by focusing on additional groups. Examples might be an activity designed for women being expanded to include adolescent girls or an activity that was designed for urban children being expanded to reach rural children

Successful, sustained scale-up of an innovation requires attention to vertical and horizontal scale-up. We must take advantage of opportunities for both institutionalisation and expansion as they arise. Horizontal scale without vertical scale will not be sustainable. Equally, vertical scale without horizontal scale will not have the desired impact.

5.2.1. What are the key challenges in scaling up GBV prevention programmes?

Several challenges have been identified in scaling up GBV prevention programming, particularly social norm change interventions. These include:

1. Maintaining intervention quality and intensity. This requires understanding and defining the essential elements of an intervention (described in chapter 4) and ensuring fidelity to these as the intervention is taken to scale. Pressures to shorten timeframes or reduce the intensity to fit available funding can mean that scaled-up interventions fail to replicate the original effective approach and put women and girls at risk of harm.
2. There is limited evidence on how complex interventions can be scaled-up and how to scale up in new or changing contexts.

3. Understanding how international external actors (including international organisations) can appropriately support change involving politically and socially sensitive issues and affects personal aspects of others' lives.

It is therefore important to consider these factors when taking programmes to scale to ensure that they are effective and ethical:

- **Maintain fidelity to the core elements of the original methodology** - social norms-change programming is not merely a collection of activities but rather systematic and theoretically grounded work with key structured aspects that make an approach effective. Neglecting any of these elements can compromise programme success while potentially harming the community. It is particularly important to ensure that interventions remain transformative in shifting gendered power relations.

- **Engage with originators** - organisations that create methodologies have much experience-based learning behind their work and therefore play an essential role in ensuring quality adaptations of their programme to new contexts. Ideally, the programme originators should be consulted throughout the adaptation and implementation processes.

- **Work with values-driven partners** - when scaling up, it is tempting to recruit one organisation with high reach and capacity, but often these organisations do not have the necessary commitment to women's rights or experience in VAWG programming. Instead, it may be better to support several smaller partners who are willing to take time to support their staff, including leadership, to reflect on violence, power, and relationships within their own lives and the organisation.

- **Ensure sufficient time, intensity, and funding for programming** - even where an intervention has proven effective, it is important to allocate sufficient time for inception and implementation, including adapting interventions to new contexts and investing in training and supporting new partners, field staff and community activists. In addition, funding should be commensurate with the scale of ambition. Ensure accountability to communities and programme participants - accountability remains important when working at scale, particularly where risks around programme quality are heightened. Accountability requires community insights and substantive community involvement in planning, implementing, and monitoring social norms-change programming.

- **Do no harm** - closely monitor unintended programming consequences to ensure no harm. It is key to remember that risks of backlash against women and interventions when existing structures of power are challenged are still high, and these risks increase when operating at scale.

Useful Resources

1. UN Women and Social Development Direct (2020) Overview: How to Use the RESPECT Framework Implementation Guide. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Overview-en.pdf
2. USAID Learning Lab. Knowing When to Adapt. https://usaidlearninglab.org/lab-notes/knowing-when-adapt
3. Wiltsey Stirman, S., Baumann, A.A. & Miller, C.J. (2019). The FRAME: An Expanded Framework for Reporting Adaptations and Modifications to Evidence-Based Interventions. Implementation Science 14, (58) https://implementationscience.biomedcentral.com/articles/10.1186/s13012-019-0898-y
4. Community for Understanding Scale Up (CUSP), (2018) "Social Norm Change at Scale: CUSP's Collective Insights," CUSP 2018 Case Study Collection, Community for Understanding Scale Up
5. World Health Organization. (2010). Nine Steps for Developing a Scaling-Up Strategy. https://www.who.int/immunization/hpv/deliver/nine_steps_for_developing_a_scalingup_strategy_who_2010.pdf

CHAPTER 6: IMPLEMENTATION CONSIDERATIONS FOR GBV PREVENTION

6.1. Building National Commitment

To ensure long term sustainability and foster multisectoral collaboration, an essential first step is to build national commitment to the goals, strategies and interventions outlined in the country's GBV policies and guidelines. This requires bringing together key actors and institutions to play a role in national programme development and implementation.

6.2. Coordination, Networking and Partnerships on Prevention of GBV

Primary prevention is complex, and there is a need for ongoing and widespread advocacy for these evidence-based models. Yet even though stakeholders in many countries are working to eliminate GBV, their efforts are not always well-coordinated and supported. Successful implementation of GBV prevention interventions requires input from stakeholders from various sectors and institutions, including national and local governments such as education, health, social services, law enforcement, the judiciary, the security forces, gender/women's ministries, and child protection authorities, the private sector, civil society organisations and academic institutions. Therefore, establishing strong multi-sectoral partnerships at the outset allows for cross-sectoral sharing and learning, strengthening programming. However, this partnership needs to be grounded in effective primary prevention principles and core components to collaborate well and maximise the innovative and positive impact.

6.3. Identify sustainable sources of financial support

When planning your GBV prevention programmes, it is important to allocate adequate financial resources to ensure quality implementation and results. Country governments need to allocate budgets towards GBV prevention and work with interest partners to support as needed. Initial consultation with interested donors and technical support agencies promotes collaboration, strengthens national planning and can help avoid duplication and waste of resources. One of the first steps in identifying financial support should be convening a meeting of interested parties to understand the countries' GBV prevention action plans and requirements.

6.4. Monitor and evaluate

Monitoring systems are important for providing data on the magnitude and circumstance of GBV, tracking the implementation of planned activities and assessing their impact. Monitoring can also help guide efforts to improve strategies, address gaps and promote a sustained focus on prevention. Therefore, countries need to institute robust monitoring and evaluation systems to collect population surveillance and routine administrative data. This data should be readily available to all stakeholders who are implementing GBV programmes.

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