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USAID's Collective Action to Reduce Gender-Based Violence (CARE-GBV)

Foundational Elements for Gender-Based Violence Programming in Development

SECTION 3.5. SECTOR-SPECIFIC PROGRAM ELEMENTS

Addressing GBV through Global Health Programs

Analytical Services IV Indefinite Delivery Indefinite Quantity (IDIQ)
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ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent girls and young women
ARCHES	Addressing Reproductive Coercion in Health Settings
CARE-GBV	Collective Action to Reduce Gender-Based Violence
CDC	The U.S. Centers for Disease Control and Prevention
CEFMU	Child, early, and forced marriage and unions
COP/ROP	(PEPFAR) Country Operational Plan/Regional Operational Plan
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EpiC	Meeting Targets and Maintaining Epidemic Control
FGM/C	Female genital mutilation/cutting
FP	Family planning
GBV	Gender-based violence
GBVI	Gender-Based Violence Initiative
GREAT	Gender Roles, Equality, and Transformation
IASC	Inter-Agency Standing Committee
IRH	Institute for Reproductive Health

ACRONYMS AND ABBREVIATIONS (CONTINUED)

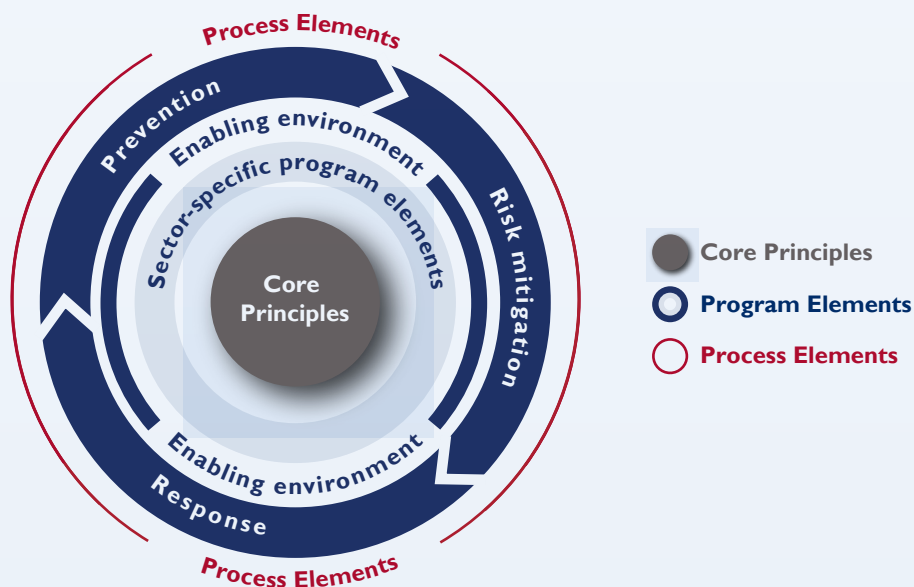
IPV	Intimate partner violence
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, and intersex people, and those of other diverse sexual orientations and gender identities
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
LIVES	Listening, Inquiring about needs and concerns, Validating, Enhancing safety, and Supporting
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
RH	Reproductive health
SOGIESC	Sexual orientation, gender identity, gender expression, and sex characteristics
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

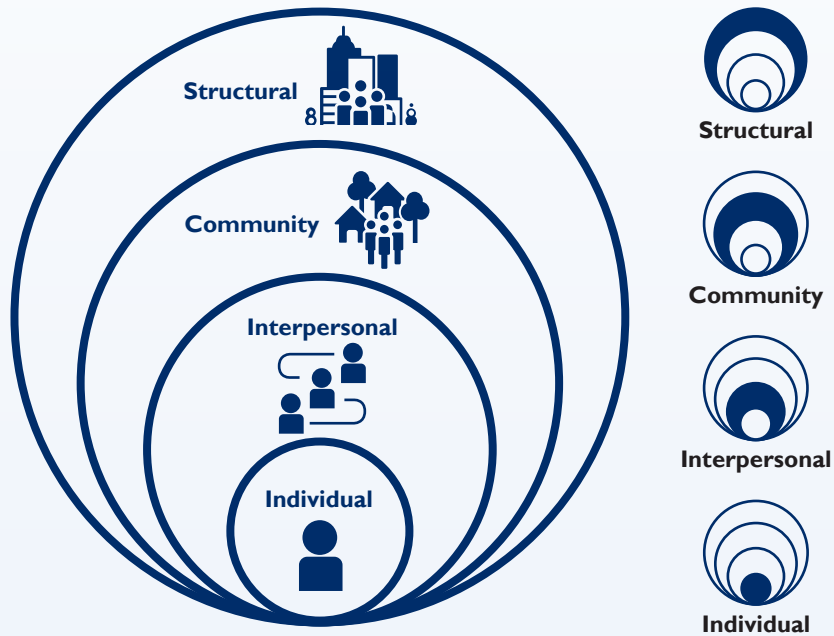
This document describes why USAID's global health programs should integrate programming to address gender-based violence (GBV) and details specific strategies for doing so. Program examples are provided to illustrate how the strategies can be incorporated into global health programs, and links to tools and resources are provided for additional information.

This document is part of the *Foundational Elements for Gender-Based Violence Programming in Development*, which include core principles, program elements (prevention, risk mitigation, response, enabling environment), and process elements. Ideally, readers will familiarize themselves with these sections of the *Foundational Elements* before reading this brief. At a minimum, readers should be familiar with the following sections before reviewing this brief:

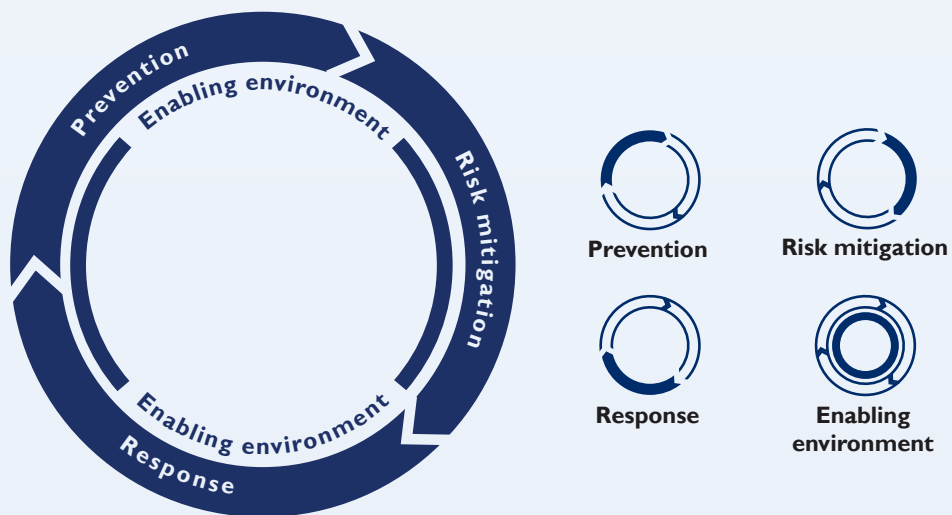
- Section 1.0. Introduction
- Section 3.2. Program Elements: Risk Mitigation
- Section 4.0. Process Elements:
 - Values, Organizational Culture, and Leadership (Program Example: A Framework for Safeguarding Program Participants)
 - Strategic Planning and Design (Gender Analysis and Referral Network Mapping)



The strategies described in this brief are organized by levels of the socio-ecological model: individual, interpersonal, community, and structural. Effective GBV interventions typically include strategies that address multiple levels of the socio-ecological model.



Each strategy is also labeled as prevention, risk mitigation, response, or enabling environment.



Why Global Health Programming Should Address GBV

GBV is a violation of human rights and has direct and indirect effects on physical and mental health outcomes. Negative health outcomes associated with GBV include injury, unintended pregnancy, maternal morbidity, transmission of HIV and other sexually transmitted infections (STIs), mental health disorders, childbirth complications, infant mortality (WHO 2021a), and lower initiation and continuation of antiretroviral therapy among HIV-positive individuals (Machtlinger et al. 2012). The social and economic costs of GBV—including higher health care use, loss of productivity and wages, and long-term emotional and mental impacts of witnessing GBV on children—are also well documented (Garcia-Moreno et al. 2015, CDC 2003, Walby 2009, Bonomi et al. 2009).

Examples of GBV (see Glossary for full definitions) and its effect on health outcomes include:

- Intimate partner violence (IPV) negatively affects health-seeking behavior, such as accessing antenatal care, HIV treatment and viral suppression, and child health services (WHO 2005, Bonomi et al. 2009).
- Reproductive coercion is a form of IPV that interferes with an individual's autonomous decision-making related to contraception and pregnancy. Examples include contraceptive sabotage and pregnancy coercion (Grace 2016). Reproductive coercion is associated with increased risk of unintended pregnancy (Grace 2018) and STI diagnosis (Fay 2018).
- Sexual violence increases the risk of HIV and STI infection, unintended pregnancy, and reproductive injuries such as fistula, and can cause emotional trauma and mental health disorders.
- Child, early, and forced marriage and unions (CEFMU) are closely associated with early pregnancy (UNFPA 2015), poor maternal and child nutrition, pregnancy complications, and increased maternal and child mortality (UNFPA 2015).
- Early marriage is also associated with increased STI and HIV risk, and increased risk of future IPV (Nour 2006).
- Female genital mutilation/cutting (FGM/C) can lead to infection, reproductive and sexual health complications, and in some cases, even death (WHO 2021a).
- Disrespect and abuse in maternity care can contribute to distrust of the health system, leading to avoidance of antenatal care and skilled labor and delivery services, resulting in negative maternal and newborn morbidity and mortality outcomes (Manning et al. 2018).

Emerging infectious disease epidemics, such as Ebola in West Africa and COVID-19 globally, have directly led to women and girls experiencing higher risk of IPV and other forms of family violence due to heightened tensions in the household and being confined with violent family members during lockdowns (UNFPA 2020).¹ This trend has led UN Women to call violence against women the “shadow pandemic” of COVID-19 (UN Women 2020). Increased risk of other forms of GBV, including sexual exploitation and abuse, have also been reported during Ebola and COVID-19 (UNFPA 2020). Moreover, access to life-saving care and support for survivors of GBV (i.e., clinical management of rape and psychosocial support) has decreased because of survivors' limitations on mobility and further de-prioritization in health care systems overburdened with epidemic response. The effects of the COVID-19 pandemic have also exacerbated the risk and incidence of CEFMU due to increased poverty, food insecurity, and girls being orphaned by the pandemic (UNICEF 2021).

¹ For more information, see: CARE-GBV. (forthcoming). “How to prevent, mitigate, and respond to gender-based violence during the COVID-19 pandemic.” Washington, D.C.: USAID.

While GBV is accepted as a critical public health issue, health policies in many countries do not adequately address it, and health providers—including community health volunteers and workers, facility-based doctors and nurses, midwives and traditional birth attendants, and mental health providers—are often ill equipped to effectively support GBV survivors (WHO 2013). If health providers fail to recognize the role of abuse in reproductive and child health outcomes, they may not fully appreciate the effect it can have on their clients' health and well-being, leading to suboptimal care and health outcomes, and an overall poor experience with the health care system. Moreover, in some cases, health providers perpetrate GBV and human rights violations, including denial of health services to people of diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) and sex workers (Evens et al. 2019, Lanham et al. 2019, Dayton et al. 2020) and medicalizing FGM/C. There is an ethical imperative for health actors and systems to be prepared to provide the highest level of care and support to GBV survivors, as well as reduce the threat of contributing to GBV risks and secondary trauma (Bott 2004).

Integrating GBV into USAID's global health programming is a valuable opportunity to provide quality health programs and services to people at risk of or experiencing GBV. In addition to being the right thing to do, integrating GBV can improve health outcomes that many USAID global health programs seek to affect, such as HIV incidence, unplanned pregnancy, mental health disorders, and reproductive and maternal health outcomes (Bott 2004).

How Global Health Programming Can Address GBV

The strategies noted below for integrating GBV into global health programming are interconnected. For example, to integrate GBV mitigation and response into routine and specialized health services (Strategy #4), health providers need to be trained to respond to GBV (Strategy #3). Combining strategies is recommended to effectively address GBV.

Strategy #1: Transform attitudes, beliefs, norms, and behaviors for GBV prevention and response



Program elements:
prevention, response,
enabling environment



Levels of socio-ecological model:
individual, interpersonal,
community, structural

Evidence-based strategies to prevent GBV include transforming harmful gender norms and behaviors at the individual, household, community, and structural levels (see Section 3.1. Program Elements: Prevention, Transformed Attitudes, Beliefs, and Norms). Health sector programs can and should integrate this strategy into project design to optimize project outcomes.

At the individual level, this entails interventions that reduce risk of experiencing GBV, including increasing social protection, reducing economic vulnerability, and increasing empowerment. One program example is DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership, which is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and implemented in 15 countries in Sub-Saharan Africa and the Caribbean. While the primary goal of the program is to reduce new HIV infections, it also has a strong focus on reducing GBV risk among adolescent girls and young women (AGYW) by providing a comprehensive package of core interventions to address key factors that make girls and young women vulnerable to HIV. In addition to GBV, these include factors such as economic vulnerability, school dropout, unintended pregnancy, and lack of access to support and youth-friendly sexual and reproductive health (SRH) services. DREAMS layers multiple interventions at once so that AGYW are surrounded with critical support to keep them safe from HIV and GBV. These supports include (1) mentoring and empowerment using evidence-based curricula through safe spaces, such as *Stepping Stones*; (2) economic strengthening activities, such as village savings and loans associations, job training, and pathways to employment; (3) strengthening parents' and caregivers' support; (4) community mobilization and norm-change activities within communities using approaches such as *SASA!*; and (5) improved access to youth-friendly SRH services (Birdthistle et al. 2021, Manda et al. 2021).

At the interpersonal level, interventions with parents and couples can reduce IPV, domestic violence, and violence against children. Parenting sessions using curricula such as *Families Matter! Program* or *Parenting for Lifelong Health* can help caregivers understand risks and signs of GBV in their children and develop communications skills to speak with their children about violence.

Interventions that engage couples to transform norms, beliefs, and attitudes can contribute to improved health outcomes, such as increases in family planning (FP) use. Approaches include separate facilitated dialogue groups with couples or facilitated combined couples' communication, conflict resolution, and decision-making dialogues. Interventions that engage men should employ a gender-transformative and synchronized, rights-based approach (so that male support does not become male control over women's health and behavior) through fostering of equitable decision-making among couples, and nonviolent conflict resolution and communication.

At the community level, this strategy involves using community mobilizers, champions, or women's organizations to lead community mobilization or interpersonal dialogues. The goal is to influence positive social norm change for GBV prevention and response. The dialogues stimulate self-reflection and transformational discussion with community leaders and members, partners, adolescents, and parents, and focus on addressing inequitable gender norms that contribute to high acceptance and prevalence of CEFMU, violence against children, victim-blaming, and stigma for GBV survivors. These dialogues can also provide community members with information about available, nearby GBV services and in some cases, trusted community members who can provide assisted referrals to health services for GBV clinical care, as well as to non-clinical GBV services. The SASA! approach, a community mobilization intervention focused on transforming gender norms to reduce HIV and IPV, has been rigorously evaluated and found to decrease social acceptance of IPV and reduce experiences of IPV for at least 12 months after completion of the intervention (Abramsky et al. 2014).

At the structural level, activities should focus on advocating for gender-responsive budgeting, coordination across stakeholders, accountability, and oversight (such as laws, policies, and implementation strategies). Additionally, activities should include capacity strengthening of national and local governments and health systems, as well as regular gender audits and quality assurance supervisions.

Strategy #2: Train health providers to respond to GBV by offering first-line support and, when appropriate, referrals and post-GBV clinical services



Program elements:
response



Levels of socio-ecological model:
individual, structural

GBV survivors identify health providers as the professionals they would most trust with disclosure of violence (WHO 2013). This puts health providers in a unique position to create a safe, private, and confidential environment for empathetic listening, while offering appropriate response and referrals to other services. Primary care, HIV, FP, reproductive health (RH), and antenatal care providers, as well as community and traditional health actors (e.g., traditional birth attendants and traditional healers) and peer educators should be trained to provide first-line support to clients who disclose experiences of violence using WHO's approach of **L**istening, **I**nquiring about needs and concerns, **V**alidating, **E**nhancing safety, and **S**upporting (summarized by the mnemonic LIVES). For survivors of sexual violence, health providers should also offer or refer clients for the following services, per WHO guidelines (WHO 2021b):

- Take history, examine, assess emotional state, plus perform a forensic exam, if needed
- Treat any physical injuries
- Offer post-exposure prophylaxis (PEP) for HIV prevention (within 72 hours of assault)
- Offer emergency contraception (within 5 days of assault)
- Offer STI prophylaxis/presumptive treatment
- Assess mental health, discuss self-care, and plan follow-up visits

Health providers not trained in GBV should be aware of the available resources, and understand how and when to provide a compassionate referral (HRH2030 2020).

The do-no-harm approach, providing non-judgmental care, and recognizing norms that drive GBV are fundamental to addressing GBV (see Section 2.0. Core Principles). Survivors may find it challenging to discuss GBV experiences with health providers because of fear of stigma, victim-blaming, or additional violence (Ali 2018). These challenges may be compounded for those who experience overlapping forms of oppression, such as older women, women from minority groups, women with disabilities, and lesbian, gay, bisexual, transgender, queer, and intersex people, and those of other diverse sexual orientations and gender identities (LGBTQI+) (Ali 2018). Men and boys may face barriers to discussing experiences of GBV due to norms around masculinities (Donne et al. 2018). Health providers can increase trust, comfort, and help seeking by providing empathetic and supportive listening and care to all clients, which in turn, enables survivors of GBV to seek help and support. Health providers need appropriate knowledge and skills to foster this trust and provide appropriate support (Ali 2018, WHO 2021b).

Health providers, as well as anyone else with the potential to interact with GBV survivors, must be trained and supervised not just on the above skills, but also on the do-no-harm approach, survivor-centered core principles, and trauma-informed care, which are key elements of the LIVES approach and described in the core principles (see Section 2.0. Core Principles). However, it is important to keep in mind that health providers are often designated as mandatory reporters for child abuse in many countries. Therefore, a balance must be struck between survivor-centered care and mandatory reporting requirements, where these two guidelines are at odds with one another. In most cases, this means that providers inform clients of their mandatory reporting requirements prior to asking about violence or abuse or if they anticipate a spontaneous disclosure of abuse from child survivors or about a child survivor. A 2021 WHO report found that only 26 percent of countries with a violence against women policy mention providers' obligations to inform clients about the limits to confidentiality (WHO 2021c). Mandatory reporting requirements should not interfere with providing appropriate care or referrals for suspected cases of GBV, including child abuse.

In addition to these skills, health providers should be led through a process of self-evaluation and reflection of their own biases and deeply held beliefs around gender and violence, because health providers are members of the community and often hold the same beliefs related to GBV as those around them. Even with proper skills training, if a provider believes the survivor to be responsible for their experience of violence or that violence is justified in certain situations, the survivor is likely to feel judged or uncomfortable disclosing violence and could be secondarily traumatized during disclosure. Health providers and facility staff should also have the capacity to provide gender-affirming, non-judgmental care to people of diverse SOGIESC to reduce experiences of emotional abuse perpetuated in health care settings. This is an essential risk-mitigation approach and part of creating a safe environment in a prevention model.

Another key component to assure quality service delivery for survivors of sexual violence is tracking the availability of commodities, including emergency contraception, PEP, and treatment for STIs.

Strategy #3: Integrate GBV mitigation and response into routine and specialized health care services



Program elements:
risk mitigation, response



Levels of socio-ecological model:
structural

Integrating GBV into health services is an opportunity to address the multiple health and social needs of clients. For example, integrating response services into FP and RH services has demonstrated a reduction in reproductive coercion and IPV and an increase in reproductive autonomy among women and girls (see example #3 below). In addition, it can enhance a woman's reproductive health status by increasing the adoption and continued use of a contraceptive method.

The PEPFAR 2022 Country Operational Plan/Regional Operational Plan (COP/ROP) recommends integrating routine or clinical GBV enquiry,² first-line support, and clinical and non-clinical GBV response into services across the HIV clinical cascade. Routine enquiry is required in PEPFAR-funded index case testing services, partner notification services, and pre-exposure prophylaxis (PrEP) services, while clinical enquiry is recommended in HIV care and treatment services. Asking about experiences of GBV through routine or clinical enquiry in health services (when minimum requirements for asking about violence can be met by facilities and health providers) increases the likelihood of identifying and effectively responding to GBV survivors and addressing GBV as an underlying driver of HIV risk. This approach contributes to GBV risk mitigation by identifying people for whom discussing certain health issues—such as HIV status—with their partners may not be safe. In addition, clients who disclose experiences or fear of GBV can be provided with tailored HIV services that consider the effect of GBV on HIV outcomes. For example, PrEP users can receive counseling on how to use PrEP safely in the context of a violent relationship, which promotes HIV prevention and mitigates IPV. Moreover, those who disclose violence can be connected to post-violence services, where providers offer “trauma-informed, client-centered support to meet the overall emotional, physical, safety, and support needs of survivors” (PEPFAR 2022 COP/ROP).

² “Routine enquiry for IPV is defined as asking all clients who present for specific services about their experiences of violence or fear of violence. [...] Clinical enquiry means that providers are trained to identify potential signs and symptoms of violence. When a trained clinician identifies someone who exhibits these signs and symptoms, the clinician then asks the client about their experiences of violence or fear of violence. [...] Clinical enquiry means that providers are trained to identify potential signs and symptoms of violence. When a trained clinician identifies someone who exhibits these signs and symptoms, the clinician then asks the client about experience of violence, rather than asking everyone about experiences of violence” (PEPFAR 2022 COP/ROP).

³ Minimum requirements for asking about violence: (1) a standard operating procedure, job aid, or algorithm stating what a provider should do if a client discloses violence; (2) providers trained on how to ask about violence and respond to disclosures of violence; (3) a private setting; (4) confidentiality ensured; and (5) system for referrals in place.

Strategy #4: Implement policies and protocols to prevent and respond to workplace harassment and violence against staff, and sexual exploitation and abuse of program participants



Program elements:
prevention, response



Levels of socio-ecological model:
structural

Health care facilities or systems—both public and private—should have policies and protocols in place to prevent and respond to workplace harassment and violence, including sexual harassment; physical, sexual, and emotional abuse; anti-retaliation for reporting violations; and child protection. All facility staff, as well as affiliated community health workers should be trained on the policies and reporting structures for suspected violations (UN Women 2019). Program participants should also be informed about the existing safeguarding policies and have access to community- and facility-based complaints mechanisms (IASC 2016), and external audits should regularly be conducted to document that policies are followed and appropriate actions are taken in response to reported violations (see Section 4.0. Process Elements: Values, Organizational Culture, and Leadership).

Strategy #5: Promote inclusion of GBV in national- and district-level health policies and strategies, and track their implementation



Program elements:
enabling environment



Levels of socio-ecological model:
structural

Policymakers, health care leaders, and funders all play a role in ensuring that a health system responds effectively to GBV. There are several actions that advocates and health care leaders can urge policymakers, local governments, and health facilities to take to address GBV at the structural and policy levels. It is important to note that while establishing GBV policies is a critical step in stopping violence, governments often fall short in translating policies into action (Rottach et al. 2018). A 2021 WHO report showed that four in five countries have national multi-sectoral action plans in place to prevent violence against women. However, less than half of countries have corresponding health guidelines to address violence against women (WHO 2021c).

The following actions are recommended and include both policy change and implementation activities (PRB et al. 2010, WHO 2016, PEPFAR 2022 COP/ROP, Rottach et al. 2018, WHO 2021c):

- Commit publicly to address GBV as a human rights abuse and public health concern.
- Ensure the availability of financing, including budget allocations, to address GBV and form coalitions to advocate for increased budget allocations.
- Approve guidelines and protocols for GBV response.
- Commit funds for training on GBV for health professionals and insist on changes to training curricula to include GBV.
- Support linkages and strengthen coordination across sectors, particularly among law enforcement, health care services, and other social services to support survivors.
- Conduct oversight and accountability for policy and program implementation.
- Remove fees for post-GBV clinical care, including collection of forensic evidence.
- Strengthen organizations that provide integrated HIV/GBV clinical and social services for survivors of violence.
- Develop GBV policy dissemination tools, such as infographics and job aids in local languages.
- Adequately disseminate policy and guidelines to districts and health providers.
- Expand community-based GBV prevention programs.

Address operational barriers (such as weak contraceptive supply systems) and rigid cultural and gender norms that conflict with GBV policy goals. One example of including GBV in national- and district-level policies is the PEPFAR Interagency Gender-Based Violence Initiative (GBVI) in Tanzania, which aimed to integrate GBV prevention and response into existing HIV programs, including at the policy level (see example #5 below). See other program approaches for creating an enabling environment for GBV programming in Section 3.4. Program Elements: Enabling Environment.

It is also important to support GBV policy development and implementation that guides a multi-sectoral response. WHO affirms that many of the risk factors and determinants of violence that exist within communities lie outside the health system (WHO 2016). This requires governments and policymakers to lead a holistic, integrated, and coordinated response across different sectors, professional disciplines, and governmental, private, and nongovernmental institutions. As a comprehensive multisectoral prevention effort, the health system can support the testing and evaluation of violence prevention in other sectors, inform multi-sectoral violence prevention policies, support strong referral mechanisms among survivors of violence, and advocate with other sectors to address the risk factors and determinants of violence. This aligns with Section 4.0. Process Elements: Coordination and Collaboration.

Program Examples

Example #1: The Gender Roles, Equality, and Transformation Project

The USAID Gender Roles, Equality, and Transformation (GREAT) project was developed with the goal of reducing GBV and improving FP and RH outcomes among adolescents and their communities in the post-conflict region of Northern Uganda. Institute for Reproductive Health (IRH), Save the Children, and Pathfinder International, together with local partners Straight Talk Foundation and the Concerned Parents Association, implemented the project from 2010 to 2019.

As a gender-transformative intervention, GREAT used participatory activities to encourage critical reflection and dialogue, address misinformation, and support collective action to foster healthier and more equitable norms. The GREAT model consists of four complementary components: (1) community mobilization led by community leaders to promote and sustain change,

(2) a radio drama series, (3) linkages to FP and RH services via community health workers, and (4) a community mobilization toolkit. It was designed for existing groups and local governing structures to implement and scale with modest time and financial inputs to reach a tipping point to achieve social change.

According to an endline evaluation of the project's impact, GREAT led to significant improvements in attitudes and behaviors among those the intervention reached (IRH 2016). Adolescents and adults who heard the radio program or participated in reflection activities reported positive changes in gender equality, partner communication, FP use, and attitudes towards GBV (IRH 2016). GREAT continues to be implemented by organizations in Northern Uganda, and has been adapted and implemented in several countries around the world.

Example #2: Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Project (LINKAGES) (2014–2019) and Meeting Targets and Maintaining Epidemic Control (EpiC) (2019–2024)

The USAID-funded LINKAGES and EpiC projects, led by FHI 360, conduct a range of activities to reduce HIV transmission among key populations—sex workers, men who have sex with men, transgender people, and people who inject drugs—and to improve their

enrollment and retention in HIV care. Project activities enhance the HIV prevention and care cascade by increasing reach to key populations most at risk of acquiring or transmitting HIV, promoting routine HIV testing and counseling, and

actively enrolling those with HIV into care and support interventions that enable them to remain in care.

As part of the LINKAGES and EpiC gender-integration approach, FHI 360 used global normative guidance and best practices for addressing violence against key populations to develop flexible programmatic guidelines that have been rolled out across more than 20 countries. Tools for operationalization include

protocols and standard operating procedures, as well as training on GBV prevention and response for project staff and partners, health providers, peer educators, and law enforcement. In the Dominican Republic, this approach translated into increased detection of cases of GBV; provision of first-line support to victims of violence; and links to health services, psychosocial support, and legal support (Dayton et al. 2020, FHI 360 2019).

Example #3: Addressing Reproductive Coercion in Health Settings (ARCHES) Project Funded by the Bill & Melinda Gates Foundation

The ARCHES project is an evidence-based program to reduce reproductive coercion and IPV, and is delivered in routine FP counseling services. Providers are trained to conduct the three components of the ARCHES intervention: (1) universal client education and assessment regarding IPV and reproductive coercion; (2) discussion of harm-reduction behaviors to reduce risk for unintended pregnancy, IPV victimization, and reproductive coercion; and (3) supported referrals to IPV victim services (including provision of IPV-related resources to all clients regardless of disclosure). The program demonstrated a reduction in reproductive coercion and IPV and an increase in reproductive autonomy among women and girls in the United States through two randomized controlled trials that involved more than 4,000 female FP clients (Miller et al. 2011, Miller et al. 2016, Tancredi 2015).

ARCHES was adapted for the Kenyan context, and is being implemented and evaluated in six community-based clinics across Nairobi. The initial evaluation results indicate that far higher rates of disclosure of GBV are occurring in this integrated model than in other clinical models seeking to identify and support GBV survivors: More than 80 percent of FP clients who had experienced reproductive coercion and 70 percent of clients who had experienced IPV subsequently, upon being screened, disclosed these experiences to an ARCHES-trained provider. Per the program protocol, they were supported with referrals to IPV services and resources as appropriate (Silverman et al. 2019). Most notably, women and girls receiving the ARCHES intervention were two times as likely to receive an FP method during their visit than clients visiting control clinics (AOR 2.0, 95 percent CI 1.1–3.5) (Silverman et al. 2019).

Example #4: A Campaign to Reach Survivors of IPV with FP Access in India

The USAID SHOPS Plus India project, led by Abt Associates, partnered with Momspresso to implement a digital campaign to raise awareness of reproductive coercion. The campaign was launched by a celebrity and subsequently, amplified by key Instagram influencers, as well as health professionals through popular online platform Momspresso, reaching 24 million women. The campaign's objectives were to increase knowledge among women of what constitutes IPV, help them understand that denial of contraception is a form of violence, and build their self-efficacy to access FP information.

Results from survey responses among women exposed to the campaign suggested that it helped to increase awareness of contraception denial as a form of IPV. Following exposure to the campaign, the percentage of women who

considered a male partner's refusal to use contraception as a form of domestic violence increased from 31 to 57 percent, and the percent of women who considered not having a say in contraception as a form of violence and abuse also rose from 56 to 81 percent. The campaign also encouraged women to call the SHOPS Plus helpline if they were experiencing IPV or wanted FP information. Women who called were screened and, if appropriate, referred to the Indian nongovernmental organization Shakti Shalini to receive specialized counselling and support on IPV. Following the campaign, calls to the helpline increased by 25 percent. Strategic partnerships, thoughtful messaging, and complementary social and behavior change communication activities were important components in the success of the campaign.

Example #5: PEPFAR Interagency Gender-Based Violence Initiative (GBVI), Tanzania

One example of including GBV in national- and district-level policies is the PEPFAR Interagency GBVI in Tanzania, which aimed to integrate GBV prevention and response into existing HIV programs, including at the policy level. Prior to the GBVI, the Government of Tanzania had limited national-level policy and guidelines for the implementation of GBV activities. Two of the GBVI's most significant achievements were supporting the Ministry of Health and Social Welfare and the Ministry of Community Development, Gender and Children in the creation and dissemination of the *National Policy Guideline for Health*

Sector Prevention and Response of GBV and the *National Management Guidelines for Prevention and Response to GBV* (Simmons et al. 2016). These guidance documents integrate and operationalize GBV services into the health facility, targeting HIV service delivery points, while engaging social welfare and police officers. The GBVI also worked with the Ministry of Health and Social Welfare to integrate GBV into pre-service curricula for clinicians and nurses so that GBV training could be mainstreamed into every level of the health sector (Simmons et al. 2016).

Tools and Resources

Intervention Guides

- Institute for Reproductive Health. 2019. *REAL Fathers Implementation Guidelines*. Washington, D.C.: IRH. Accessed June 10, 2022. <https://irh.org/resource-library/real-fathers-implementation-guidelines/>.
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Guidelines

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The goal of the Collective Action to Reduce Gender-Based Violence (CARE-GBV) activity is to strengthen USAID’s collective prevention and response, or “collective action” in gender-based violence (GBV) development programming across USAID. For more information about CARE-GBV, click [here](#).

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