

Part III.K
Violence against
Women

- Existence of a policy on violence against women
- Number of VAW service visits provided, by type of service
- Attitudes of health care providers towards VAW or VAW services
- Percent of clients satisfied with the VAW service on multiple dimensions

VIOLENCE AGAINST WOMEN

Violence against women (VAW)¹ is a serious health and social problem that jeopardizes women's reproductive health and violates women's reproductive rights. Cross-national research into the scope and nature of violence against women has found very high prevalence rates of VAW and a strong relationship between VAW and adverse reproductive health (Heise, Ellsberg, and Gottemoeller, 1999). Women who experience forced or unwanted sex are at increased risk of STIs including HIV, and are less able to engage in behaviors that will protect them from STIs and HIV. Sexual dysfunction, poor mental health, adverse pregnancy outcomes, and drug and alcohol use are all more common among women who have experienced sexual and/or physical violence. The health sector has a critical role to play in the response to VAW, because it provides the only service that all women are likely to receive at some point in their life. Because violence increases the risk of many other health problems, identifying it early may help prevent other serious and life-threatening diseases (Heise, Ellsberg, and Gottemoeller, 1999).

Social science research indicates that VAW is a socially normative behavior in many societies (Sanday, 1981; Heise, Ellsberg, and Gottemoeller, 1999) and that it functions to achieve both short-term goals of social interaction and longer-term goals of maintaining female subservience and male dominance (Dobash et al., 1992). Thus, many societies may consider it "normal" for a husband to use physical force against his wife to "keep her in line"; other common excuses for VAW, domestic violence in particular, include real or imagined extra-relationship sexual activity or transgressions of expected sex-role behavior, such as performing household tasks. This violence can range from slapping, pushing, or shaking to strangling, burning, threatening with a weapon, or rape. Violence against women may take specific forms in specific countries, and thus we must understand how the local context conditions both the forms and consequences of VAW.

This section of the *Compendium* focuses on violence against women in the context of reproductive health program evaluation. In contrast to several other areas of reproductive health in which mature programs are underway at the national level to combat a given problem or to promote specific behaviors, programs on violence against women are still in their infancy. VAW services tend to be organized in one of two ways in developing countries. In a limited number of countries, stand-alone organizations (generally NGOs) primarily function to combat violence against women. Their programs often include a diverse array of activities and services (e.g., advocacy to legislators, communication programs through the mass media and interpersonal channels, onsite legal advocacy services, health and social services for victims of VAW, and related activities). In such cases, reproductive health is one part of a larger program of activities. Other countries do not have stand-alone programs but rather offer some assistance to victims of VAW as part of a larger range of health or social services. Such organizations tend to provide counseling and treatment for medical conditions and, in some cases, psychological trauma, but make referrals to other non-health services (e.g., legal). All of the indicators in this section apply to the stand-alone facility (assuming it gives health care or social services). By contrast, the indicator on the existence of a policy is much more relevant to a stand-alone program with an advocacy agenda than to an RH program offering VAW services among numerous other services.

Depending on the mission of the organization, the VAW programs have one or more of the following objectives:

¹Gender-based violence is an umbrella term for any harm that is perpetrated on a person against her/his will, and jeopardizes the physical and/or psychological health, development, and identity of the person. Violence results from gendered power relationships, determined by the social roles ascribed to males and females, disproportionately impacting women and children in almost all cultures. Violence may be physical, sexual, psychological, economic, or socio-cultural. Categories of perpetrators may include family members, community members, and/or those acting on behalf of cultural, religious, or state institutions.

- Developing national health and social policies on the issue;
- Sensitizing health care providers to VAW and training them in techniques to recognize appropriately and to respond compassionately to VAW;
- Training staff in specific protocols and procedures for VAW: collecting forensic data, conducting danger assessments, creating safety plans;
- Providing information/raising awareness within a clinic or hospital setting via educational materials;
- Identifying women who have experienced VAW via patient screening;
- Referring women to internal or external services (legal advocacy, shelter services, psychological support, among others); and
- Providing direct services such as legal advocacy or psychological counseling.

We have developed several indicators that reflect the activities related to policy development and service provision. In terms of the latter, we have included both a quantitative indicator on volume of services provided and a more qualitative assessment of client perceptions of the services. We have omitted population-based VAW indicators (even though decreasing violence against women is the ultimate objective) for the following reasons.

First, in the case of national-level programs such as family planning, one may expect to see the effects of the program at the population level (e.g., an increase in contraceptive use among married women of reproductive age). However, in programs aimed at a small subset of the population or having a limited reach (e.g., adolescent youth centers), we cannot expect to detect changes attributable to the program in population-level data. In programs like these, use of program-level data (e.g., information obtained from clients who come into contact with the program) is more appropriate.

Second, obtaining valid data on VAW from population-based surveys requires careful attention to a series of methodological and ethical issues. The WHO has developed a set of guidelines for conducting research on VAW with the goal of enhancing the safety of respondents and interviewers and of obtaining valid data. The most critical point is that many countries lack the ca-

capacity to address the VAW issues appropriately (once identified through research), given the dearth of official mechanisms or social services designed around VAW.

Third, research conducted in the absence of such measures often results in much smaller prevalence estimates than expected, based on similar population-based studies, thus causing policymakers to think that there is “no problem.” For these three reasons, we do not advocate using prevalence of VAW as a standard indicator of program effectiveness and have included instead an indicator on the existence of national- or institutional-level policies. Given the desirability of having some population-based measures, one alternative is to track attitudes at the community level concerning the justifiability of VAW, the forms it takes, and the perceived frequency of occurrence.

Finally, the goal of reducing violence against women is laudable but long-term. Achieving this goal through interventions by the health care system *alone* is unlikely. If evaluators use prevalence of VAW to measure “success” of an individual program, they may erroneously conclude that the program has “failed.”

Macro International Inc. has developed a module on domestic violence for use in connection with the Core DHS questionnaire. This module includes a series of questions on abusive or violent behavior on the part of the (last) husband/partner, when it started, what physical consequences occurred, whether he drinks excessively, and so forth. The module also includes questions on possible violent behavior of the woman toward her partner, on violent behaviors from other family members and acquaintances, violent behavior of the partner during pregnancy, help sought, reasons for not seeking help, and related topics. The primary purpose of the module is to determine the extent of domestic violence in a given society, the most common forms of violence, the context of these violent actions, the perpetrators, and related information. To date, no country has tried to use such data to evaluate program initiatives for eliminating violence.

The RHS has a module on Intimate Partner Violence (IPV) used in all surveys conducted in Eastern Europe since 1997 and some surveys in Latin America since 1995. The questions focus principally on two types of violence against women: 1) intimate partner violence during the respondent’s lifetime and within the past year;

and 2) sexual coercion at any point in a woman's life. Violence by an intimate partner – defined as verbal, physical and sexual abuse – is explored using a modified Conflict Tactic Scale (eight items). In addition, all respondents are asked about their history of witnessing physical abuse between parents or their experience of abuse as a child or adolescent. These data are powerful for advocacy purposes. An NGO and Senator in Paraguay used data from the 1995 RHS in Paraguay to get the first law against violence against women passed in that country.

Methodological Challenges of Evaluating VAW Programs

Although very little empirical work has been done to evaluate the effectiveness of programs designed to reduce violence against women in the international context, we have included this section on VAW in the *Compendium* to stimulate discussion of the most appropriate measures to use, in anticipation that more programs of this type will be implemented in the future. Despite the dearth of empirical data on these programs, researchers have already identified the following as methodological limitations of conducting work on this topic.

- **Program-based statistics on volume of clients are difficult to interpret.**

Often programs may identify reducing domestic violence as a long-term objective, while offering services to women in abusive situations in the short-term. Statistics generated by such programs are often used to describe the nature and scope of the problem of domestic violence; however, service utilization statistics are open to various interpretations and may not be an appropriate measure of the occurrence of violence within a certain area or among a certain population. If for example, the number of women enrolling in a domestic violence program increases, one might conclude that the incidence of domestic violence is actually on the rise. In fact, the change may be due to a greater awareness among women of the availability of such services and a willingness to try them, based on information they have received (e.g., favorable word-of-mouth, mass media messages) or an increase in resistance by women to men's use of violence against them. As such, the increase in the number of women using the services has an ambiguous meaning.² This difficulty of interpreting program data tends to be greatest during the early years of the program.

- **Quantitative program statistics do not reflect the quality of the service provided.**

Although a program may document that it has provided 400 units of service to female clients, quantitative data fail to reflect the quality of services provided and its effectiveness in empowering the client to face her situation. For example, a program may distribute a large volume of materials, but this activity may do more harm than good if the material carries a victim-blaming message. If health providers are callous and insensitive in screening women for intimate partner violence, then the benefit of this service to beneficiaries is questionable at best. Similarly, if providers screen for violence but do nothing for clients who are victims, the statistics on “numbers screened” are meaningless. Finally, if clients perceive the referral process simply to be a means for providers to get rid of them, then “number of referrals” inadequately measures program performance. Qualitative data that reflect clients' perceptions of the interaction with the service providers is essential to complement the quantitative objective indicators proposed in this section.

- **Identifying clients who received VAW support services for interview may endanger them and the interviewer.**

VAW program evaluation faces a further difficulty: identifying and interviewing women who received such services may place the woman at further risk. Evaluators must plan and execute data collection with utmost care to protect the client. In addition, the interview may place the interviewer in a position where she is ethically or morally obliged to intervene (e.g., if the respondent indicates that she may be in immediate lethal danger). In program evaluation, one discourages the interviewer from “switching roles” at the end of the interview and becoming a health educator or counselor. (Among other reasons, the interviewers are not trained to provide information or counseling, and their well-intentioned responses may be incorrect.) Collecting this information and doing nothing for the woman in this potentially dangerous situation would be unethical. Given the sensitive nature of the issue and the potential for endangering the client, only programs or program evaluators skilled in VAW research techniques should collect data directly

² This problem is not unique to VAW. For example, a rise in treatment-seeking for STIs following a campaign on the topic does not necessarily (and even likely) indicate a rise in STI incidence.

from program clients. Readers are referred to the WHO Guidelines (1999d) for further information on the topic.

- **Obtaining valid data on provider attitudes is difficult.**

Because of the difficulties involved in obtaining data from women who have experienced violence, a tempting alternative is to interview providers instead. However, attitudinal data may be of limited value, because (in VAW as in other areas) attitudes may not be predictive or strongly correlated with behavior. Maiuro et al. (2000) have published a useful article on the subject of measuring provider attitudes towards VAW within the U.S. health care system, though the results may not generalize to developing countries.

The following pages contain several indicators for evaluating initiatives to combat VAW. In contrast to other sections of the *Compendium* that focus on population-based outcome measures, this section focuses instead on policy issues and program-based measures. As outlined above, it is premature to think of population-based

measures for the evaluation of programs to combat violence against women, given the very small-scale on which such programs are implemented, not to mention the ethical issues involved with maintaining “scientific rigor” to the possible detriment of the subjects involved in such evaluation work.

Readers interested in pursuing this topic in greater detail are referred to a research brief entitled “Reproductive Health Program Responses to Gender-Based Violence Against Women: Conceptualizing Indicators for Monitoring and Evaluation” (Frye, Banwell, and Ellsberg, 2001). This paper further develops some of the ideas outlined herein (e.g., in regard to knowledge and practice indicators for providers, administrators, and managers).

Indicator

EXISTENCE OF A POLICY ON VIOLENCE AGAINST WOMEN

Definition

The existence of formal governmental declarations, laws, and statutes affecting VAW Policy also can refer to operational regulations, guidelines, norms, and standards (Cross, Jewell, and Hardee, 2001).

Data Requirements

Documentation outlining the policy

Data Source(s)

Legislative records, administrative records, and other government documents (national, regional, and local); also, internal policy documents of an organization

Purpose and Issues

The purpose of this indicator is to track changes in the policy environment that potentially affect the delivery of VAW services and the well-being of victims of VAW. Such changes can occur in the political arena (via formal governmental declarations and changes in legislature, which some refer to as Policy with a capital “P”) or at the organizational level (in terms of the policies and procedures used within RH health services and by institutions that refer women to these services, such as the police, judiciary, and social services (policy with a small “p”). This indicator is a specific case of the indicator on **Existence of Policies, Plans, Guidelines that Promote Access to and/or Quality of RH Services** presented in Part II.B.

Experts in this field maintain that any organization dealing with VAW should articulate a policy (small “p”) on its approach to gender-based violence. The organization may also take an advocacy stance and try to influence governmental policy and legislation (capital “P”), depending on its mission.

In analyzing policy-related documents on VAW, one should further consider how the document frames the issue:

- Does the policy acknowledge VAW as a complex and multi-determined social and health phenomenon?
- Does the policy use an integrated approach to respond to VAW or a fragmented, single-sector approach?
- Does the policy work collaboratively with women’s organizations that have been on the front line of the response to VAW up until the point of a formal policy development?

Whereas the existence of a policy on VAW signals political concern over the topic, it may be relatively meaningless if not translated into concrete actions. Any assessment of VAW policy should examine the actual structures in place to respond to the needs of victims of VAW, as well as the record of implementing the policy initiatives to prevent violence in the future. Thus, a related indicator involves the existence of structures to (1) provide services to those who experience VAW and (2) undertake initiatives aimed at reducing or eliminating VAW in the future.

Indicator

NUMBER OF VAW SERVICE VISITS PROVIDED, BY TYPE OF SERVICE

Definition

“Service visits” are counted as the number of occasions on which a woman seeks VAW assistance from a given center. The total number of visits may include repeat visits and thus may be larger than the total number of women using the center or program in a given year.

Note: A woman may receive more than one service on a given visit (counseling plus referral for other health problems). Program managers and evaluators may find it useful to track the different types of services (e.g., counseling, screening, referrals, treatment for injuries from violence) to better understand the needs of the clientele. For example, this tracking would yield data on the number of referrals made from VAW centers to related services in the course of a reference period (e.g., one year).

Data Requirements

Number of visits per center, aggregated across multiple centers (if such exist)

Data Source(s)

Service statistics from the center or program

Purpose and Issues

This indicator measures the volume of services the program provides to its clientele. During the early years of the program, evaluators should monitor details regarding the visits to better understand the problems and potential needs of the clientele (e.g., reason for the visit, type[s] of services provided).

Several related indicators (for RH facilities) include the following:

- Number of clients reporting violence as a percentage of all women seeking RH services;
- Active screening for VAW: percent of the total VAW reports that were identified through active screening; and

- Timely and appropriate post-rape care: percent of survivors who access service within three days of assault.

Clients coming to the facility for other services are more likely to divulge an episode of violence if they sense providers will be sensitive to their problem.

As noted in the introduction to this section, the interpretation of this indicator is somewhat ambiguous. The number of visits could increase over time, not because violence against women is mounting, but rather because women are more willing to come forward and disclose this problem, especially if the word-of-mouth information about the center is favorable. In fact, an increase in service delivery should reflect favorably upon the program.

This information is useful to demonstrate to donor agencies that the organization is providing a service within the community. Again, the indicator gives little sense of whether the women who receive the service perceive it to be helpful, although an increase in numbers may reflect favorable word-of-mouth publicity. Also, the number should rise as a result of mass media publicity or other BCC interventions on VAW. Ideally, the statistics on number of visits will also rise, especially during the early years of the program, as more women in need learn that services are available and helpful to women who experience violence.

Although the program may not be able to demonstrate effects at the population level, data on service utilization will help justify the continued existence of the services to donors interested in assisting women with the problem of domestic violence.

ATTITUDES OF HEALTH CARE PROVIDERS TOWARDS VAW OR VAW SERVICES

Definition

The attitudes of service providers towards women’s socially prescribed sex-roles, the issue of VAW, the VAW service they provide, and the women who receive the services

Attitude is defined as a person’s favorable or unfavorable assessment of a behavior or situation.

Data Requirements

Responses to surveys; transcripts from focus groups

Data Source(s)

Interviews of service providers; and focus groups

Purpose and Issues

The indicator identifies providers who hold victim-blaming, fatalistic, passive or other attitudes inconsistent with gender-sensitive quality of care. Illustrative examples of attitudes to measure are presented in Box III.K.1. These individual-level provider attitudes are important to track because they constitute barriers to (1) women’s reporting and seeking VAW services and (2) the delivery of sensitive and appropriate services.

This information demonstrates to donor agencies that the organization is providing the service compassionately and sensitively within the community. In addition, the indicator reflects the quality of training that the organization provides to its health care providers.

Box III.K.1 Illustrative Attitudes to be Assessed among Health Care Workers for VAW

Sex-stereotyping:

- A woman must be a virgin when she marries;
- A wife should never contradict her husband;
- It is acceptable for women to have a career, but marriage and family should come first; and
- There is something wrong with a woman who does not want to marry and raise children.

Acceptance of interpersonal violence:

- Being roughed-up is sexually stimulating and/or a sign of a man’s love for a woman;
- Women will pretend that they do not want to have intercourse because they do not want to seem loose, but they are really hoping the man will force them;
- A wife should move out of the house if her husband hits her; and
- A man is sometimes justified in hitting his wife.

Source: Burt (1980).

Indicator

PERCENT OF CLIENTS SATISFIED WITH THE VAW SERVICE ON MULTIPLE DIMENSIONS

Definition

The degree to which clients report satisfaction with various aspects of the services received.

This indicator is calculated as:

$$\frac{\text{\# of clients who report satisfaction with the services received}}{\text{Total \# of respondents}} \times 100$$

Data Requirements

Attitudinal responses (interviews) or verbatim text (focus groups) on different aspects of services received (see Box III.K.2)

Data Source(s)

In-depth interviews or surveys with clients; focus groups conducted with clients

Purpose and Issues

The clients' subjective perception of the service received is a critical element of the program evaluation. It allows the evaluator to assess the extent to which the program services meet the needs of its clientele. If the clients do not perceive the service as helpful or if they feel that it further frustrates or disempowers them, the intervention has failed. In addition, client feedback is critical to the process of identifying ways to improve the program. Finally, evaluators can compare feedback from clients to information from providers to arrive at a more balanced understanding of program dynamics.

This indicator is prone to courtesy bias on the part of respondents. The pervasive tendency of respondents in exit interviews to respond positively about the services they receive (more positively than they feel about the services) is widespread among clients of any services.

However, this tendency is probably more prevalent among women who experience domestic violence because they feel especially vulnerable and fear that any negative feedback may affect their future access to these services. Evaluators should particularly note any item that clients rate even slightly lower than others as indicative of possible areas in need of improvement. Also, because the likelihood of frank responses to this series of questions may differ from one country to another, this information is most useful in evaluating a given center over time, rather than in making cross-national comparisons.

Here the ethical issues around research with women who experience VAW is important (note: see discussion in introductory section). Representatives of local women's organizations may be useful in ensuring that data collection does not further jeopardize the client question.

This indicator on client satisfaction measures one aspect of quality of care. An alternative approach, which avoids the problem of courtesy bias, is to measure certain objective aspects of the service delivery environment: staff training, availability of private screening rooms, and existence of protocols and their implementation. Although the Service Provision Assessment (the facility-based survey available for use with the household DHS) does not address VAW *per se*, evaluators may adapt many of the items for this purpose.

Box III.K.2 Illustrative Attitudinal Questions on Client Satisfaction with VAW Services

Client Interview:

- Did the health care provider (HCP) assure you of privacy and confidentiality?
- Did the HCP respond to your concerns and meet your needs?
- In your opinion, did the HCP address your concerns and needs?
- Did you feel as if the HCP treated you with respect?
- Did you feel that the HCP listened to you?
- Were you able to articulate your concerns and needs concerning violence to the HCP?
- Did you feel as if the HCP was trying to force you into a certain decision regarding VAW?
- Did the HCP provide information about your health, social, and legal options in a way that you could understand?
- Did you understand your health, social, and legal options?
- Did the HCP give you concrete information that helped you make your decision?
- Did you feel that the HCP wanted you to make your own decisions?
- Did you feel that the HCP supported the decision you made?
- Did the HCP make you feel as if you were to blame for the VAW situation?
- *If received referrals*, Did the HCP seem to believe that the referrals provided would help you?
- *If received referrals*, Did the HCP provide these referrals in a way that showed they cared?

(Banwell, Ellsberg, and Frye, 2001)

