
Addressing Gender-Based Violence: A Critical Review of Interventions

Andrew Morrison, Mary Ellsberg, and Sarah Bott

This article highlights the progress in building a knowledge base on effective ways to increase access to justice for women who have experienced gender-based violence, offer quality services to survivors, and reduce levels of gender-based violence. While recognizing the limited number of high-quality studies on program effectiveness, this review of the literature highlights emerging good practices. Much progress has recently been made in measuring gender-based violence, most notably through a World Health Organization multicountry study and Demographic and Health Surveys. Even so, country coverage is still limited, and much of the information from other data sources cannot be meaningfully compared because of differences in how intimate partner violence is measured and reported. The dearth of high-quality evaluations means that policy recommendations in the short run must be based on emerging evidence in developing economies (process evaluations, qualitative evaluations, and imperfectly designed impact evaluations) and on more rigorous impact evaluations from developed countries. JEL codes: J16, K42, I18.

The United Nations Declaration on the Elimination of Violence against Women (United Nations General Assembly 1993) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.”

Although there is much emerging evidence on the magnitude of gender-based violence, only a small subset of this evidence is comparable across countries. According to a recent UN report, at least one survey had been conducted in 71 countries as of 2005, and in 41 countries, these surveys had been national in scope (United Nations 2006a, cited in United Nations 2006b). The World Health

Organization (WHO) has recently undertaken efforts to generate comparable estimates of the prevalence of violence by intimate partners (a subset of gender-based violence) across 15 sites in 11 countries. In urban areas between 12.9 percent (Japan) and 48.6 percent (Peru) of women have suffered physical violence at some point in their lives. In rural areas, the lifetime prevalence rates for physical violence range from 33.8 percent (Brazil and Thailand) to 61 percent (Peru). For sexual violence by an intimate partner, the rates range from a low of 6.1 percent in urban Japan to a high of 58.6 percent in rural Ethiopia (WHO 2005; Garcia-Moreno and others 2005).¹ ORC Macro, through the Demographic and Health Surveys, has measured the prevalence of intimate partner violence across nine countries, but these estimates are not completely comparable.² Lifetime prevalence rates for physical violence by an intimate partner range from a low of 17.5 percent in Cambodia to a high of 48.4 percent in Zambia. By any reasonable standard, the prevalence rates generated by the WHO and ORC Macro surveys are high.

This article presents an overview of gender-based violence, identifying the risk and protective factors associated with it and summarizing recent research on its socioeconomic costs and health consequences. The main contribution of the article is to identify good practice responses to gender-based violence in the three thematic areas that encompass the principal responses to date to gender-based violence: increasing access to justice for survivors of gender-based violence, providing support to women who have been affected by violence, and preventing gender-based violence.

Gender-Based Violence: Risk Factors and Consequences

This section examines the risk factors associated with gender-based violence and the socioeconomic and health consequences of gender-based violence.

Risk Factors Associated with Gender-Based Violence

Gender-based violence is a complex phenomenon, shaped by forces that operate at different levels. An ecological model that combines factors operating at the individual, relationship, community, and society levels is the appropriate framework for examining the combination of risk factors that increases the likelihood of gender-based violence in a particular setting.³ The risk and protective factors that have been empirically identified for intimate partner violence—the form of gender-based violence for which the most empirical research on risk factors has been undertaken internationally—are shown in table 1.⁴

Table 1. Risk and Protective Factors for Intimate Partner Violence

<i>Individual level^a</i>	<i>Relationship level^b</i>	<i>Community level^c</i>	<i>Societal level^d</i>
<i>Socialization and learning</i>			
Witnessing intimate partner violence as a child (+) ^e		High neighborhood crime rate (+)	Cultural norms that support violence as an accepted way to resolve conflicts or to punish transgressions (+)
Suffering abuse as a child (+)	Association with gang members, delinquent, or patriarchal peers (+)	Absent or maladaptive teaching of alternatives to violence (+)	
<i>Power relations and patriarchal gender norms</i>			
Absent or rejecting father (+)	Male control of household decision making and wealth (+)		Norms that support male dominance over women and that require women's obedience and sexual availability (+)
	Controlling behavior by the husband (+)		
	Multiple partners or wives for the husband; number of unions for the woman (+)		Policies and laws that discriminate against women in social, economic, and political spheres
	Differences in spousal age and education (+)		
<i>Human capital and employment</i>			
Female education level (-)	Economic hardship (+)	Lack of economic opportunities for men (+)	
Male education level (-)			Access and control over economic resources for women (+/-)
Women engaged in income generation activities (+/-)			

Continued

Table 1. *Continued*

<i>Individual level^a</i>	<i>Relationship level^b</i>	<i>Community level^c</i>	<i>Societal level^d</i>
<i>Life cycle</i>			
Age of woman (–)	Length of relationship (–)		
<i>Triggers</i>			
HIV status of man or woman (+)	Male alcohol and substance abuse (+)		

+ indicates a risk factor; – indicates a protective factor; +/- indicates an ambiguous factor.

^aBiological and personal history factors of victims and perpetrators.

^bProximal social relationships, including relations with friends, peers, and family.

^cCommunity context in which social relationships are embedded, including school, workplace, and neighborhood.

^dLarger societal factors that “create an acceptable climate for violence, reduce inhibitions against violence, create and sustain gaps between segments of society” (WHO 2002, p. 13).

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

Source: Gordon and Crehan 1999; Heise 1998; Hindin and Adair 2002; Jewkes 2002; Koenig 2003; Loi and others 1999; Martin and others 2002; WHO 2002; Kishor and Johnson 2004.

Certain types of risk and protective factors—socialization/learning and human capital/employment opportunities—operate at all levels of the ecological model (individual, relationship, community, and society). The fact that risk and protective factors operate at multiple levels has important implications for the design of interventions to address gender-based violence: to be effective, interventions will generally need to address factors at these different levels.⁵

Kishor and Johnson’s (2004) study is the most comprehensive, cross-country examination of these risk factors. Using Demographic and Health Survey data from nine countries and a logistic regression model, they examine the correlates of intimate partner violence for lifetime violence and for violence suffered in the 12 months before the survey.⁶ The coefficients in the regression explaining violence in the last 12 months are reported here, but the results would not be significantly different were lifetime violence used, with a few important exceptions noted below.

Data from seven countries (Cambodia, Dominican Republic, Egypt, Haiti, India, Nicaragua, and Zambia) are available on intimate partner violence suffered in the 12 months before the survey. Data on lifetime violence are available for these seven countries, plus Colombia and Peru. In most countries, older women are substantially less likely to suffer violence than are younger women. Older age at marriage is a protective factor in only two of the seven countries (India and

Zambia); when lifetime violence is used as the dependent variable, age at marriage matters in a much larger number of countries. This difference may result from the fact that some of the women queried about violence in the previous 12 months are no longer with their first partner; thus, age at first marriage is a less important predictor of current violence than it is of lifetime violence. The number of unions for the woman is a strong predictor of the likelihood of violence; women with more than one union are between 40 percent (Nicaragua) and 66 percent (Cambodia) more likely to have suffered violence in the preceding 12 months, although the effect of multiple unions is not statistically significant in Egypt, Haiti or Zambia. More educated women may be less likely to be victimized by violence. Although this effect is statistically significant in only three of the seven countries, the magnitude of the effect is quite large: women with some secondary education are only 40–70 percent as likely to suffer violence as their less educated peers.

Some characteristics of the male partner seem to matter, whereas others do not. Mirroring the results of many other studies, alcohol abuse by the male partner is strongly associated with violence. Women with male partners who “come home drunk frequently” are four to seven times more likely to suffer violence. The education level of the male partner seems unimportant as a protective factor (with the exception of India), but more relevant when the dependent variable is lifetime violence.

Age and educational differences between partners do not seem particularly important, although women whose male partner is more than 15 years older are at lower risk of suffering violence in three of the seven countries (Dominican Republic, Haiti, and India), a result that contradicts that of several other studies, where age and education gaps are associated with a higher likelihood of violence (see table 1). Martial duration does not seem to matter, with the exception of India, where women who have been married less than four years are less likely to suffer violence.

Women who live in rural areas are less likely to suffer violence in four of the seven countries; in the remaining three countries, rural and urban women are equally likely to suffer violence. This result is surprising, given that the WHO surveys report significantly higher prevalence rates in rural areas than in urban areas. The obvious interpretation is that several of the important risk factors for violence are correlated with rural residence. Once these other factors have been accounted for, rural residence is no longer a risk factor—and in fact becomes a protective factor in a number of countries.

Finally, the relation of income and wealth to violence has been extremely contentious in the literature. Since income and violence clearly have a simultaneous relationship for which it is difficult to find appropriate identifying instruments, Kishor and Johnson (2004) use only measures of household wealth (and not

income) in their regressions. The results are far from conclusive: in two of the seven countries (Egypt and India), women from the poorest quintile are more likely to suffer violence than those in wealthier quintiles. In the remaining countries, greater household wealth does not seem to be a protective factor. In India, parental wealth seems to be positively associated with the risk of a daughter suffering intimate partner violence, perhaps because men may use violence as a way to extract additional resource transfers—in addition to the initial dowry—from the parents of their wives (Bloch and Rao 2002).

Socioeconomic Costs of Gender-Based Violence

Gender-based violence poses significant costs for the economies of developing economies, including lower productivity and incomes, lower rates of accumulation of human and social capital, and the generation of other forms of violence both now and in the future. The most common approach used to calculate the costs of gender-based violence has been an accounting methodology that calculates specific categories of costs and then sums them to reach the total cost to society. The U.S. Centers for Disease Control and Prevention specify two types of costs: direct costs, which are expenditures related to gender-based violence, including healthcare services, judicial services, and social services, and indirect costs, which are the value of lost productivity from both paid work and unpaid work, as well as the forgone value of lifetime earnings for women who have died as a result of gender-based violence (USCDC 2003). A recent estimate of the direct healthcare costs of intimate partner violence against adult women in the United States found costs of more than \$4 billion in 1995, including both mental health and medical care costs (USCDC 2003). Similar methodologies have been employed to estimate costs for other countries.⁷

There are only two direct cost studies for gender-based violence in developing economies of which the authors are aware. Mansingh and Ramphal (1993) estimate that the direct costs of treating victims of intimate partner violence in Kingston Public Hospital, Jamaica, totaled US\$454,000 in 1991 (in 2001 dollars). Sánchez and others (2004) find that the Colombian national government spent approximately 184 billion pesos (US\$73.7 million) in 2003 to prevent, detect, and offer services to survivors of family violence—about 0.6 percent of the national budget.

One of the weaknesses of the accounting approach is that any selection of categories is to some extent arbitrary, and alternative categories can always be selected (Buvinic and Morrison 1999). A more serious weakness is that key categories of costs may be left out, such as the costs to children witnessing or being a victim of family violence.⁸

Direct cost estimates are especially problematic in a developing country context. Lack of services or serious underfunding means that direct costs associated with gender-based violence will be low, giving the impression that the problem is not important when in fact prevalence rates may be quite high.

If estimates of direct costs of gender-based violence are not particularly useful in a developing country context, another option is to concentrate on estimating indirect costs. Indirect cost estimates have focused on forgone earnings due to death and lost productivity (USCDC 2003), job loss and lost productivity of the women who suffer violence, lost productivity of the abuser due to incarceration and mortality (Laurence and Spalter-Roth 1995), loss of tax revenues due to death and incarceration (Greaves and others 1995), and reduced earnings of women (Morrison and Orlando 1999; Sánchez and others 2004). Using equations of the determinants of women's earnings, Morrison and Orlando (1999) estimate that lost wages due to family violence amounted to 1.6 percent of GDP in Nicaragua and 2.0 percent in Chile. With a nonparametric matching methodology on Demographic and Health Survey data from 1995, Sánchez and others (2004) find that earnings are 14 percent lower for Colombian women who suffer physical violence than for women who do not. Using more recent data from 2003, they estimate that the wage loss due to family violence was equivalent to 0.85 percent of 2003 GDP.

Although the indirect cost approach offers more methodological rigor and perhaps better precision in estimating the labor market impacts of violence, it is subject to one of the same criticisms leveled at the accounting approach. Important categories of costs are not examined, although in this case the methodology makes no claim of producing a comprehensive estimate of the costs of gender-based violence.

A final option for estimating the socioeconomic costs associated with gender-based violence—one frequently employed by economists to establish the market value of nonmarket goods—is to estimate the willingness of individuals (and by extension society) to pay for lives free of gender-based violence. This approach produces a comprehensive estimate of the cost of gender-based violence in a specific locale. The approach has been used very infrequently to gauge the welfare loss occasioned by gender-based violence (see Sorenson 2003 for one of the few examples), presumably because of reticence to estimate the willingness to pay for what most consider a human right—the right to live without violence.

In sum, there is no single method for gauging the socioeconomic costs of gender-based violence. All methods have strengths and weaknesses, and the challenge is to choose the appropriate one given data constraints and the intended use for the estimates.

Health Consequences of Gender-Based Violence

A growing body of evidence documents the consequences of gender-based violence for women's health and well-being, ranging from fatal outcomes such as homicide, suicide, and AIDS-related deaths to nonfatal outcomes such as physical injuries, chronic pain syndrome, gastrointestinal disorders, unintended pregnancies, and sexually transmitted infections (Heise and others 1999; Campbell 2002).

Physical and sexual violence has consequences for women's mental health, such as post-traumatic stress syndrome, depression, anxiety, and low self-esteem, as well as behavioral outcomes such as alcohol and drug abuse, sexual risk-taking, and a higher risk of subsequent victimization. It has become increasingly clear that injuries represent only the tip of the iceberg of negative health effects and that violence is more appropriately conceptualized as a risk factor for health problems than as a health condition in itself. (See table 2 for a summary of the health consequences of intimate partner violence and sexual violence.)

A promising approach to estimating the health impacts of gender-based violence is to use the metric of disability-adjusted life years (DALYs) lost. DALYs have the advantage of including years lost due not only to premature mortality, but also to disability or illness. The first such estimate for gender-based violence, by Heise and others (1994), concluded that more than 9 million DALYs are lost by women each year worldwide as a result of rape and family violence, more than that lost by women from all types of cancer and more than twice that lost by women in motor vehicle accidents. More recently, Lozano (1999) estimated that rape and intimate partner violence against women were the third most important cause of DALYs lost in Mexico City—behind diabetes and perinatal conditions, but ahead of auto accidents, congenital anomalies, rheumatoid and osteoarthritis, cardiovascular disease, stroke, and pneumonia.

DALY estimates include the health impacts on women themselves. But gender-based violence also affects the children of women who experience violence. Researchers have documented such negative health outcomes as increased infant and child mortality (Åsling-Monemi and others 2003), emotional and behavioral problems (Jaffe and Sudermann 1995), and in the case of boys increased risk of perpetrating intimate partner violence and sexual violence as adults (Straus and Gelles 1986; Ellsberg and others 1999; Kishor and Johnson 2004).

Initiatives to Prevent and Respond to Gender-Based Violence

This section reviews what is known about the effectiveness of three ways to prevent and respond to gender-based violence: increasing access to justice for survivors of gender-based violence, providing support to women who have been affected by violence, and preventing gender-based violence.⁹ Although the

Table 2. Health Consequences of Intimate Partner Violence and Sexual Violence

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

Source: Adapted from Heise and others (1999).

emphasis is on good practice approaches that have been evaluated in developing economies, such careful evaluations are in their infancy. Thus, these evaluations are complemented by results from evaluations for developed countries. Even in high-income countries, however, a comprehensive review in 1998 found only 34 among several hundred relevant intervention studies that were methodologically sound (Chalk and King 1998). Although this number has grown since then, the number remains small.

Increasing Access to Justice

Access to justice for women who have experienced gender-based violence has three dimensions. One dimension is offering protection to women from current and potential aggressors by improving laws and policies, mobilizing communities in defense of women's right to a life free of violence, and increasing knowledge of women's rights. A second is providing women with redress by strengthening institutional responses to gender-based violence. A third is raising the cost to men of engaging in gender-based violence by establishing or increasing criminal sanctions and mandating participation in treatment programs in the context of criminal prosecution of batterers. This section focuses on the three approaches for which relatively more information is available on impacts: improving laws and

policies, strengthening institutions in the criminal justice system, and implementing batterer treatment programs.

Improving laws and policies. Efforts to improve laws and policies have focused on international conventions to provide an overarching legal framework to support (or in some cases supersede) national legislation, new specialized legislation on gender-based violence, and reform of national civil and criminal codes.

In the past 25 years, many countries have signed international agreements that specifically mention violence against women. These include the Convention on the Elimination of All Forms of Discrimination against Women (entered into force in 1981), Convention on the Rights of the Child (1990), Vienna Declaration and Program of Action (adopted by the World Conference on Human Rights in 1993), Declaration on the Elimination of Violence against Women (adopted by the UN General Assembly in 1993), the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (1994), and the Beijing Declaration and Platform for Action (adopted by the Fourth World Conference on Women in 1995). (For more details on these conventions and declarations, see Bott, Ellsberg, and Morrison 2005.)

The Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, frequently known as the Belém do Pará Convention, has been particularly important. To date, 31 countries in the Latin American and Caribbean region have ratified the convention, which obligates signatory governments to pursue policies to prevent, punish, and eradicate violence against women, including the adoption of an appropriate domestic legal framework.

A recent study notes that the Belem do Pará Convention has generated increased awareness that violence against women is a serious human rights violation (IACW 2004). The study, based on government responses to a questionnaire sent by the Inter-American Commission of Women in April 2000, studies by consultants, and interviews with government agencies, government and nongovernmental organizations, and academic experts, also concludes that there has been significant progress implementing some of the policies and programs called for in the convention. Noteworthy is the use of Article 12 of the convention (the right to lodge petitions with the Inter-American Commission on Human Rights) by petitioners and supporting nongovernmental organizations to hold national governments accountable to their commitments under the convention.¹⁰ Although progress has been registered in implementing some provisions of the convention, serious problems remain with respect to countries meeting their commitments on access to justice, data and statistical systems, services and protection for victims, and education and training for women (CLADEM 2004).

At the level of domestic legislation, governments have enacted significant legal reforms related to women's rights and gender-based violence in the past 20 years.

(For a detailed country-by-country review of laws on gender-based violence as of 2000, see CLADEM 2000.) These reforms have typically included modification of the civil and family legal framework to reduce discrimination against women; changes to the criminal code to strengthen sanctions related to family, domestic, and sexual violence; and legislation and public policies regulating criminal procedures and public and private sector responses to survivors of violence (restraining orders, forensic procedures, victim assistance). These legal reforms have considerably advanced efforts to strengthen women's rights and reduce violence against women. A substantial body of research has documented their positive impact on intermediate outcomes such as increasing reporting levels, raising the number of convictions, and improving the quality of police and judicial response (Ellsberg and others 1997), but it is not known whether this legislation has reduced the prevalence of violence.

The main lesson from legislative reform is that changing the law is only the first step in a long process. Much legislation has been implemented poorly or not at all. Common implementation problems include lack of coordination between family courts and criminal courts, reluctance by police or prosecutors to investigate cases or protect women in danger, and unwillingness or inability of the judiciary to enforce the laws—frequently due to lack of resources and specialized knowledge.

Improving institutional response: police, judiciary, forensic medicine, and legal aid. Initiatives to improve the service response to gender-based violence have included training professionals, reorganizing police or courts, and providing a more comprehensive and supportive response to survivors. The most effective appear to be strengthening and reforming the justice sector as a whole and building partnerships between the justice system and other sectors. Evidence suggests that improving survivors' access to judicial services cannot be done without broad reform of the judicial system addressing systemic problems such as corruption, procedural delays, lack of transparency, and the lack of any formal judicial presence in rural or poor urban settings (World Bank 2006).

Costa Rica, Nicaragua, South Africa, and others have tried to improve women's access to justice by increasing collaboration between law enforcement, health, and social services, by coalition building, or by legislative or policy change. In the United States rigorous evaluation has demonstrated that this approach, known as the coordinated community response model, can significantly improve law enforcement outcomes in cases of gender-based violence, such as number of arrests, percentage of cases resulting in prosecution, and the percentage of men ordered to attend batterer treatment programs as part of sentencing (Pence 1995; Shepard 1999; Shepard and Pence 1999). Less is known about the impact of this model in developing economies, but informal assessments suggest the promise of this type of approach (Villanueva 1999).

Although broad judicial system reforms are common in developing economies, only rarely have they explicitly addressed gender-based violence or women's rights. Most developing country efforts to improve the institutional response to gender-based violence have focused on relatively narrow training programs for professionals. Examples include Inter-American Development Bank (IDB) financed initiatives to train the police forces of Suriname and of countries of the English-speaking Caribbean in the area of family violence, as well as the development by the United Nations Latin American Institute for the Prevention of Crime and the Treatment of Offenders (ILANUD) of a procedural manual and accompanying in-service training to improve the Honduran police's ability to deal with family violence (Siloa Cruz 1997). Improving training in police academies has been the focus of a joint Policía Nacional de Nicaragua–GTZ (1998) initiative. ILANUD has also produced a guide for police academy instructors to improve their ability to teach about family violence (Batres and others 1996).

Judicial training typically focuses on interpretation and enforcement of domestic legislation on gender-based violence. It can also cover the application of international human rights agreements such as the Convention on the Elimination of All Forms of Discrimination against Women, Belém do Pará, and other broader human rights legal frameworks. In addition to judicial personnel, training could be offered to prosecutors, social service workers, public defenders, and pathologists (Villanueva 1999).

Evaluations of training initiatives suggest that training is most effective when all levels of personnel receive training (including officials at the highest levels) and when training is linked to changes throughout the institution—in policies, procedures, resources, and monitoring and evaluation (Rashid 2001; Villanueva 1999). These evaluations are commonly based on surveys measuring knowledge, attitudes, and practices (KAP surveys) administered before training, immediately after training is completed, and (ideally) 6 months or more after training is completed.

Another common response has been to create specialized women's police stations. These exist in several Latin American countries, including Argentina, Brazil, Colombia, Costa Rica, Ecuador, Nicaragua, Peru, and Uruguay. Some countries have experimented with special police units for women and children, composed of one or more police officers who work in a regular station but specifically handle cases of family and sexual violence.

Women's police stations, typically staffed by female police, offer services to women survivors of violence and prevention programs targeting the wider community. Some services are provided by police, including taking statements, under taking investigations, and mediating agreements between a complainant and her assailant.¹¹ Other services are typically offered by various state agencies or non-governmental organizations, including gynecological services, forensic medical

exams, psychological exams, counseling services, and legal services. These services may be provided within the station (a one-stop-shop) or through a network of service providers.

Special police stations or units within police stations appear to increase reporting of abuse and the likelihood that women will receive forensic exams, counseling, emergency contraception, and protection against sexually transmitted infections. Evaluations have demonstrated a number of problems, however. First, female officers have not automatically demonstrated better attitudes toward victims of violence simply by virtue of their sex. Second, special stations have often been severely underfunded: officers have received inadequate training, and stations have lacked equipment, transportation, and other key resources. Third, even when the stations work well, their efforts are often undermined by other parts of the justice system that are unwilling or unable to enforce the law. Finally, women's police stations have been criticized for encouraging regular police stations to abdicate responsibility for crimes against women (Jubb and Izumino 2003; World Bank 2006).

It may be more effective to strengthen law enforcement across the board than to create separate women's police stations. A "whole system" approach, in which all police, male and female, receive pre-service and in-service training on how to treat cases of gender-based violence, though still uncommon, has led to impressive results in Nicaragua, improving the quality of police services for women survivors of violence. El Salvador has also advanced toward a whole system approach in police training (Jubb and Izumino 2003).

A key component of the criminal justice system is the medico-legal system of collecting forensic evidence. In many countries, forensic evidence can be admitted in courts only when collected by certified forensic physicians. These professionals are typically employed by the public sector and are notorious for their poor treatment of survivors and their unwillingness to provide urgent medical care, including emergency contraception and prophylaxis for sexually transmitted infections. The WHO and the Pan American Health Organization have recently developed guidelines for improving the medico-legal response to sexual and domestic violence. In Latin America, promising measures include appointing forensic doctors nominated and trained by women's organizations and allowing general physicians and in some cases nurses to collect forensic specimens (see Velzeboer and others 2003).

Implementing batterer treatment programs. Batterer treatment programs can be voluntary or court-ordered. Although voluntary treatment programs have existed in Latin America for several years (for example, the Men's Collective for Equal Relations in Mexico, Men's Association against Violence in Nicaragua, and the Argentine Association for the Prevention of Family Violence), only in a very few countries (for example, Honduras and Panama) can courts require male batterers

to attend a treatment program. The dearth of court-mandated programs in developing economies reflects both the lack of attention to gender-based violence in judicial systems and the lack of resources for ancillary programs in the judicial sector, even in countries where there is substantial awareness of the problem.

The effectiveness of these programs in developing economies has not been evaluated. What knowledge we do have about their effectiveness comes from developed countries, primarily the United States. Of five randomized trials of court-mandated batterer programs in the United States, three found no effect on the probability of re-offending (Dunford 2000; Feder and Dugan 2002; Labriola and others 2005), one found a lower probability of recidivism (but had a very small sample size; Palmer and others 1992), and one produced ambiguous results (battering was lower among men who went through a program, but since no cognitive changes were produced, it hypothesized that the result was due to court monitoring of offenders; Davis and others 2006). There may be other reasons for funding batterer programs aside from reducing violence, however. Victims may prefer sanctions that do not jeopardize the perpetrator's ability to earn an income, and judges may prefer an intermediate sanction between no action and jail time (Labriola and others 2005).

Support for Survivors of Violence

Over the past 30 years, the number of policies and programs that provide support for women in developing economies who experience violence has grown enormously. This section highlights the policies and programs that are national or sectorwide in scope and interventions that are embedded in specific institutions or communities.

Implementing national plans and policies against gender-based violence. Following the recommendations of the Beijing Plan of Action, many countries have established national plans for addressing gender-based violence. Some countries have established national commissions to improve intersectoral coordination and monitor progress in implementing the plans. One of the earliest, Costa Rica's National Plan for the Elimination of Violence, begun in 1994, coordinates actions among the judicial, health, education, and social welfare sectors of government, as well as with nongovernmental organizations that provide services to survivors of violence. Although there are no rigorous evaluations of the effectiveness of the national plans, qualitative reports suggest that they create political space for dialog between civil society and the state and commit the government to a public discourse that encourages sanctions against violence (Velzeboer and others 2003). Implementation of national plans is frequently problematic, however, whether due to budget constraints or a lack of political will.

Many countries have developed sectoral policies to address the needs of survivors of violence. For example, health services provide a unique opportunity to address the needs of abused women, since most women come into contact with the health system at some point in their lives. However, abundant research has shown that unless specifically asked, women are unlikely to disclose violence to health providers (Ellsberg 2006). For example, a Demographic and Health Survey in Nicaragua found that only 13 percent of women had ever received medical attention for injuries associated with family violence and that even in these cases most women did not disclose the cause of their injuries (INEC 1999).

Many countries have specific legislation and policies spelling out the obligations of the health sector to address violence against women. Adopting such policies, even though they often lack specificity, is a critical step in sensitizing health providers and program managers to violence as an important health issue. A review of the experiences of Central American countries between 2001 and 2003, however, found that the policies had not been widely disseminated and that most health providers were unaware of the policies or their specific contents (Velzeboer and others 2003). In some cases, national legislation has occasioned unforeseen problems for the health sector. For example, several countries, including Guatemala and Panama, require health providers to report suspected cases of family violence to legal authorities. This puts providers in the position of betraying the privacy and confidentiality of their clients and could reduce women's willingness to disclose violence. Providers may also be more reluctant to ask clients about violence for fear of becoming involved in legal cases.

The education sector has lagged far behind the health sector in developing a policy response to violence against women, despite growing evidence that sexual harassment and other forms of gender-based violence are widespread in educational settings (Leach and others 2003; Mirsky 2003; Wellesley Centers for Research on Women 2003). A recent study of violence in Brazilian schools in 14 state capitals found that 8 percent of students in fifth to eighth grades had witnessed sexual violence within the school (Abramovay and Franco 2004). Recent studies in six African countries found that 16–47 percent of girls in primary and secondary schools reported sexual abuse or harassment on the part of both male fellow students and teachers (Leach and others 2003). The Demographic and Health Survey in South Africa, surveying women aged 15–49, found that 38 percent of rape victims identified a teacher or principal as the rapist (Jewkes and others 2002).

Evidence suggests that sexual harassment and other forms of gender-based violence may affect girls' school enrollment in Africa, Asia, and the Middle East (Sathar and Lloyd 1993; Mensch and Lloyd 1998; UNICEF 2004) or may lead to increased rates of school abandonment (Wellesley Centers for Research on Women, 2003). Yet very few countries have enacted programs to prevent sexual abuse in schools or improve schools' response. South Africa and Uganda are

exceptions (see South Africa, National Department of Education 2001). Some evidence suggests that Uganda has had success in reducing tolerance for sexual harassment in schools (Bennel, Hyde, and Swainson 2002), but more research is needed to identify effective approaches.

Improving social services for survivors. Support services for survivors of violence are inadequate in most developing economies. Specialized services for survivors are run mainly by nongovernmental organizations, though many survivors turn to government institutions as well, depending on the setting. Typically, social service interventions aim to expand, improve, and integrate services such as telephone hotlines, emergency shelters, legal assistance, counseling services, psychological care, support groups, income generation programs, and child welfare services.

Most evaluations of social service interventions have been limited to process evaluations, which document numbers of people served, services provided, and types of cases reported (for example, Inter-American Development Bank 2002). Research on effectiveness, quality, and impact is scarce, even in industrial countries. In part, this is because researchers have found it challenging to define and measure reliable indicators of success, without long-term follow-up. Helping survivors escape and recover from violence is a long-term process, and women may experience an increased risk of violence in the short-term as a result of trying to change their situation.

Many programs have used qualitative data collection methods to evaluate the quality and effectiveness of services, relying heavily on the perspectives of survivors (for example, Guedes and others 2002). One of the few quantitative evaluations of integrated services for survivors of intimate partner violence from the United States highlights the challenges. Sullivan and Bybee (1999) conducted a randomized longitudinal study of the impact of advocacy services for women who sought refuge in a shelter. They measured quantitative outcomes such as levels of physical violence, psychological abuse, depression, quality of life, and social support. Women who received these advocacy services were more likely to experience violence in the short run than were controls. Only after 2 years did these women begin to experience less violence than women who did not receive such services. These women also reported a higher quality of life and social support and less difficulty in obtaining community resources. Had researchers followed these women for less time, they might have concluded that the program had failed.

Improving the health service response. In the past two decades, many programs have tried to strengthen the health service response to violence against women in developing economies. Few initiatives have been rigorously evaluated, but several promising interventions have provided insights to guide future programming, including those implemented by the Pan American Health Organization (PAHO),

the IDB, and the International Planned Parenthood Federation/Western Hemisphere Region (see Inter-American Development Bank 2002; Velzeboer and others 2003; Guedes 2004). Unlike many of the programs implemented in industrial countries, most of these programs have a much broader focus than implementing a screening and referral protocol. The PAHO program, for example, includes interventions to improve policy and legislation on gender-based violence, to increase access to services, and to forge multisectoral networks at a community level for violence prevention.

The central lesson of the past 20 years of work is that improving health service response requires a systemwide approach (Heise and others 1999). Examples include strengthening policies, protocols, and norms; upgrading the infrastructure of clinics to ensure privacy and adequate supplies; training all staff, including managers, to respond appropriately to gender-based violence; building referral networks; and ensuring that staff are trained to ask women about violence, provide emotional support and emergency medical treatment, assess a woman's level of danger, provide crisis interventions, document cases, and make referrals.

In recent years, a vigorous debate has emerged over the benefits and risks of having healthcare providers routinely ask women patients whether they have experienced violence (Garcia-Moreno 2002; Ramsay and others 2002). Some argue that in resource-poor settings, universal screening may harm women if providers are unprepared to respond appropriately, if privacy and confidentiality cannot be ensured, or if the community does not have adequate referral services. Others view routine enquiry about gender-based violence as an essential component of quality care for women.

Universal screening is probably not feasible in most developing economies because of the scarcity of resources and time pressures on health personnel. A promising approach is to engage in selective screening of women who show signs of abuse, while screening all women in selected services such as reproductive health, mental health, and emergency services (Heise and others 1999). Most experts would agree, however, that staff who are not prepared to respond appropriately to disclosures of violence against women put survivors at risk. Health programs have an ethical obligation to ensure that they have minimum resources in place to do no harm. Evidence suggests that routine screening should not be done until institutionwide reforms are in place (Bott and others 2004).

Prevention of Gender-Based Violence

Researchers, policymakers, and programmers are just beginning to understand what strategies may reduce gender-based violence in the long run. Some industrial countries have documented declines in certain types of violence against women (although those findings are not uncontroversial), but the reasons for the

declines are unclear—as are the implications for developing country settings (Dunne and others 2003; Rennison 2003). The evidence, however, supports a few general findings.

First, program evaluations suggest that in the short run it is easier to increase awareness and modify attitudes than to change violent behavior. Many theories of behavioral change in the marketing or communications fields identify a step-by-step process that starts with knowledge about a message and ends in behavioral change. Typical of this approach is the steps-to-behavior-change framework, which identifies five major stages of change: knowledge, approval, intention, practice, and advocacy (Piotrow and others 1997). Approval of a message of nonviolence may be a precursor to behavioral change, but they are not the same thing. This is problematic, since many prevention activities cite attitudinal change as their key indicator of success.

Second, substantial evidence suggests that violence prevention requires communitywide interventions. One of the major findings of international research on the causes of gender-based violence is that social and cultural factors at the community level play a large role in determining overall levels of violence, even though individual risk factors such as witnessing violence as a child may increase a specific individual's likelihood to use or experience violence (WHO 2002). In many settings, large numbers of women and men have internalized norms condoning violence. For example, the WHO multicountry study found that 50–90 percent of women in some countries agreed that it is acceptable for a man to beat his wife under one or more of the following circumstances: if she disobeys him, refuses him sex, does not complete housework on time, asks him about other women, or is unfaithful or suspected of being unfaithful (Garcia-Moreno and others 2005).

Organizations (mostly nongovernmental organizations) around the world have used mass media campaigns and community-based education to change community norms and attitudes related to gender-based violence. Typically, these have aimed to promote nonviolent behavior, challenge the underlying beliefs that justify women's subordination and the use of violence for settling conflicts, and encourage women and men to be more supportive of their friends and family members who experience violence. Mass media efforts have included international campaigns (such as the 16 Days of Activism against Gender Violence Campaign) and national campaigns (such as the annual campaigns conducted by the Nicaraguan Network of Women against Violence). These campaigns often appear to raise awareness and increase knowledge—an example is the Puntos de Encuentro's "Violence against Women: A Disaster That We Men Can Prevent" campaign in Nicaragua (Puntos de Encuentro 2000)—but their impact on levels of violence is less clear.

Many initiatives have aimed to prevent gender-based violence by mobilizing communities through outreach campaigns. Following the recommendations from

the PAHO multicountry study of institutional barriers for abused women, both the PAHO and IDB programs in Latin America emphasized the development of community-based networks that, in addition to providing services to victims, were charged with promoting prevention at the community level and decreasing tolerance of violent behavior. Community-based educational activities can challenge the underlying beliefs that justify women's subordination and the use of violence for settling conflicts. Preliminary evidence from two community-based projects in South Africa have shown promising results in reducing levels of violence through community mobilization and economic empowerment projects (Jewkes and others 2006; Guedes 2004).

One promising approach to behavioral change is "edutainment"—the use of radio and television to promote health and social change. The strategy, used in Africa, Asia, and Latin America, has demonstrated effectiveness in changing behaviors related to reproductive health, AIDS education, and the status of women (USCDC 2002; Campbell 2004). Nongovernmental organizations have recently begun to use radio and television edutainment to address violence against women. One well-evaluated example targeting gender relations (including gender-based violence) was the *Sexto Sentido* television program in Nicaragua. A longitudinal study of more than 4,000 young people found significant improvements in attitudes toward violence and gender equity among those who watched the show regularly (Solorzano and others 2006). Because of data constraints, however, researchers have not yet been able to measure the impact of this initiative on levels of violence against women.

A final general finding from the research on gender-based violence prevention is that programs need to focus on changing the attitudes and behaviors of young men. A large body of rigorous research from the United States has found that decades of violence prevention programs among school girls failed to reduce their individual risk of violence. Researchers concluded that programs cannot focus exclusively on equipping victims to protect themselves. Numerous programs in developing economies are currently working to promote nonviolence among men and boys. Several have been rigorously evaluated—such as Program H in Brazil, ReproSalud in Peru, and Men as Partners in South Africa—and they have shown promising results in changing male attitudes and behaviors (Guedes 2004; Pulerwitz and others 2004). One policy-relevant finding is that it appears to be easier to change attitudes and behaviors of boys and younger men than of older adults, highlighting the need to target young people.

Conclusions

This article describes the progress in building a knowledge base about effective ways to increase access to justice for women who have experienced gender-based

violence, offer quality services to survivors, and reduce levels of gender-based violence. While recognizing the limited number of high-quality studies on program effectiveness, this review has attempted to highlight emerging good practices.

The dearth of high-quality evaluations of interventions in developing economies has a practical implication: in the short run, policy recommendations must be based both on emerging evidence in developing economies (process evaluations, qualitative evaluations, and less than perfectly designed impact evaluations) and on more rigorous impact evaluations from developed countries—recognizing that solid evaluations are scarce even in developed countries. A second important conclusion is that no single intervention will address all the risk factors for gender-based violence and reduce gender-based violence in the short run. Multiple interventions at different levels of the ecological model (individual, community, institutional, legal, and policy) are necessary.

Much progress has recently been made in measuring gender-based violence. Most notable are the WHO multicountry study and the Demographic and Health Surveys. Both have contributed substantially to knowledge about the prevalence of intimate partner violence and have enabled important analyses of risk and protective factors. Even so, country coverage is still limited, and much of the information from other data sources cannot be meaningfully compared because of differences in the way intimate partner violence is measured and reported.

More fundamentally, information on other forms of gender-based violence—such as femicide, rape, sexual violence in situations of armed conflict, and trafficking in women and girls—continues to be scarce and incomplete. For these types of gender-based violence, methodologies that permit the collection of high-quality, comparable data across countries must be developed. Policy and program formulation in the absence of solid data is risky.

Notes

Andrew Morrison (corresponding author) is a lead economist in the Gender and Development Group at the World Bank; his email address is amorrison1@worldbank.org. Mary Ellsberg is senior advisor for Gender, Violence, and Human Rights at PATH; her email address is mellsberg@path-dc.org. Sarah Bott is an independent consultant; her email address is bott.fahey@adelphia.net. This article is the result of a collaborative effort between the World Bank and PATH. It draws on Morrison, Ellsberg, and Bott (2004) and Bott, Ellsberg, and Morrison (2005). The authors would like to thank Lisa Bhansali, Sandra Cesilini, Teresa Genta-Fons, and Andrea Guedes for helpful comments and suggestions on these two papers. Thanks are due as well to four anonymous reviewers for this journal.

1. Countries in the WHO multicountry study are Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Tanzania, and Thailand.

2. Countries in which ORC Macro has measured intimate partner violence include Cambodia, Colombia, Dominican Republic, Egypt, Haiti, India, Nicaragua, Peru, and Zambia. The surveys have used two different methods to measure intimate partner violence, so the data may not be completely

comparable across countries. One method was a single question threshold approach: a woman is asked a single question to determine whether she has ever experienced violence. Only if she answers “yes” are more detailed questions about violence administered. The second method, which should lead to less underreporting of violence, administers a series of questions on violence to all women (Kishor and Johnson 2004). There is some evidence, however, that even if a full-scale violence module is employed, large-scale surveys designed primarily for other purposes such as the Demographic and Health Surveys are likely to underestimate the prevalence of violence compared with surveys that focus exclusively on violence. Characteristics of violence-specific surveys such as specialized training of interviewers, greater emphasis on privacy and safety of respondents, and multiple opportunities to disclose violence have been found to have a positive effect on women’s reporting of violence. See Ellsberg and others (2001) and Jansen and others (2004).

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

4. It is important to identify risk factors for particular manifestations of gender-based violence. Although there are certainly common causes across different types of gender-based violence—such as intimate partner violence, rape by nonpartners, and elder abuse, for example—the risk factors may vary somewhat between the different manifestations of abuse, as will the relative importance of specific risk factors.

5. This does not mean that each intervention must occur at multiple levels, but rather that each level should be addressed by some intervention.

6. Violence refers to both physical and sexual violence in the majority of countries (Cambodia, Colombia, Dominican Republic, Haiti, Nicaragua, and Zambia). In the remaining countries, the survey did not specifically enquire about acts of sexual violence (see Kishore and Johnson 2004).

7. These include Australia (Laing and Bobic 2002), Canada (Greaves and others 1995; Health Canada 2002), Holland (Korf and others 1997), Switzerland (Godenzi and Yodanis 1998), and the United Kingdom (Stanko and others 1997), as well as for the states and provinces of Queensland (Blumel and others 1993), Northern Territory (Office of Women’s Policy 1996) and Victoria (VicHealth 2004) in Australia, British Columbia (Kerr and McLean 1996) in Canada, and Washington state in the United States (New and Berliner 2000). Many of these these studies are reviewed in Yodanis and others (2000) and WHO (2004).

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

9. This review draws from many published and unpublished sources, using databases such as Popline, Medline, and Current Contents. Many program evaluations from middle- and low-income countries appear only in the gray literature, so this review relies heavily on unpublished source; it also draws heavily on reviews of unpublished evaluations by the IDB (Inter-American Development Bank 2002); the WHO (2002); the Panos Institute (Mirsky 2003); and the United States Agency for International Development (Guedes 2004; White, Greene, and Murphy 2003).

10. Few women are able to bring cases to the Inter-American Commission on Human Rights. Article 12 is more important as a mechanism for civil society to hold governments accountable, rather than as a mechanism for redress of individual cases. The Inter-American Commission on Human Rights has received petitions on forced sterilization, family violence, conjugal visits, and child sexual abuse (CLADEM 2000). A recent decision found the Brazilian government guilty of negligence and recommended that the state pay compensation to a woman it failed to protect from family violence (the case of María Pehna, discussed in IACHR 2001). The Inter-American Human Rights Commission, aside from its function as arbiter of cases brought before it, has also made

violence against women more visible through its country reports—which contain a section on the rights of women, including the right to live a life free of violence—and its Special Rapporteurship on the Rights of Women.

11. Out-of-court-mediated settlements typically take the form of agreements between spouses mediated by a police officer and, in Peru, a legal advisor (Jubb and Izumino 2003). Women's movements in Nicaragua and elsewhere have rejected these agreements because they imply immunity from prosecution for human rights violations (Tamayo 2000, cited in Jubb and Izumino 2003).

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