

**VIOLENCE
AGAINST
WOMEN
AND GIRLS
HELPDESK**

**DFID GUIDANCE NOTE: PART B
PRACTICAL GUIDANCE**

**Addressing Violence against Women and Girls in
Health Programming**

July 2015

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About this Guidance Note

This guidance note was produced by the DFID-funded Violence Against Women and Girls (VAWG) Helpdesk on behalf of the DFID VAWG team in the Inclusive Societies Department. The lead authors were Emma Bell and Kate Butcher, both of Social Development Direct, with research support from Rachel Mohun, also of Social Development Direct. The note was informed by technical advice from a group of experts: Dr Lyndsay McLean Hilker (Technical Team Leader of VAWG Helpdesk, Social Development Direct), Sanni Bundgaard (International Rescue Committee), Lynne Elliot (independent consultant), Gladys Kabura Mwangi, (Consultant in Clinical & Social Research) and Helen Parry (independent consultant).

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About the Violence against Women and Girls Helpdesk

The Violence against Women and Girls (VAWG) Helpdesk is a research and advice service for DFID (open across HMG) providing:

- Rapid Desk Research on all aspects of VAWG for advisers and programme managers across all sectors (requests for this service are called “queries”). This service is referred to as the “VAWG Query Service”.
- Short term VAWG expert Country Consultancy support in DFID programme countries including research and advice on programme design, formation of programme documentation, implementation, review and evaluation; referred to as “Short-term Country Assignments”;
- Technical Guidance Material primarily targeted to DFID staff, but also useful across HMG and development partners;
- Strategic Engagement and support to the DFID Inclusive Societies Department VAWG team The Violence against Women and Girls (VAWG) Helpdesk Service is provided by an Alliance comprising of Social Development Direct, ActionAid, the Institute of Development Studies (IDS), International Rescue Committee (IRC), Womankind and a wider roster of experts. For further information, please contact: enquiries@VAWGHelpdesk.org.uk

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Contents

Overview.....	4
1.0 Introduction: Key outcome areas.....	5
2.0 Enabling environment.....	5
3.0 Service Delivery	10
4.0 Capacity building	20
5.0 Bibliography	26
Annex 1. Suggested indicators	32
Annex 2. Value for money approaches to VAWG interventions.....	34
Annex 3. Summary of WHO recommended health sector interventions	39

Part B: Practical guidance on programme design

Overview

Violence against women and girls (VAWG) is the most widespread form of abuse worldwide, affecting one third of all women in their lifetime. VAWG undermines the mental and physical health of women and girls, violates their human rights and can have a negative impact on long-term peace and stability. In line with its international and national commitments, preventing VAWG is a top priority for the UK Government and DFID.

This two-part guidance note is part of a series of DFID guidance notes on VAWG (see Annex 1 for links to other guidance notes). It focuses specifically on **how to address VAWG in health programming**, where DFID aims to make progress towards one key impact:

- Women's and girls' health outcomes improve as a result of the health sector response to VAWG.

This guidance note aims to provide practical advice, tips and examples to support DFID advisors and programme managers and other UK government departments to **strengthen the impact of health programmes on preventing and responding to VAWG**. It is based on international good practice from bilateral and multilateral donors, UN agencies, international and national NGOs, and DFID's own programme experience, as well as the latest academic research on health and VAWG.

Part A out the strategic rationale and broad approach to addressing VAWG in health programming (see separate document).

Part B (this document) provides specific guidance on designing programmes for each key outcome area:

- ❖ Mini theories of change for each outcome
- ❖ Developing an engagement strategy
- ❖ Options for intervention
- ❖ Case studies of promising practices and lessons learned for help with business cases
- ❖ Examples of indicators (see Annex 1)
- ❖ Value for money approaches to VAWG interventions (see Annex 2)
- ❖ Summary of WHO recommended health sector interventions (see Annex 3)

1.0 Introduction: Key outcome areas

This paper focuses on health programming as an entry point to improved responses to VAWG. It summarises existing evidence and provides practical guidance to UK Government staff and others of points to consider when developing or revising a health programme. It is based on principles of social inclusion and considers health programming across different contexts including humanitarian and conflict-affected or fragile contexts.

As highlighted in Part A, in line with its overall Theory of Change on violence against women and girls (VAWG),¹ **DFID would like to make progress towards one key impact through its health programming:**

- Women's and girls' health outcomes improve as a result of the health sector response to VAWG.

DFID has defined **three key outcome areas** in which health programmes can be strengthened to achieve this impact and which are aligned with DFID's key strategy and position papers on health, for example, Health Position Paper: delivering health results (2013); Strategic Vision for girls and women: stopping poverty before it starts (2011, updated 2014) and Choices for women: planned pregnancies, safe births, healthy newborns: the UK's framework for results for improving reproductive, maternal and newborn health in the developing world (2010).

- Outcome 1 - Enabling Environment: health policies and protocols are in place which recognise VAWG and facilitate action to address it
- Outcome 2 - Service delivery: Appropriate and quality health services are delivered at all levels and in all contexts to meet the needs of women and girl survivors of VAWG and those at risk of VAWG.
- Outcome 3 - Capacity Building: Health service providers, managers and policy makers are equipped with the skills and knowledge to address VAWG as part of a multi-sectoral rights-based response.

This guidance note focuses on an **integrated** approach to health programming. It seeks to enable DFID advisors to ensure that VAWG is adequately institutionalised in the sector, properly acknowledged as a threat to improved health outcomes to women and girls and operationalised accordingly. It also acknowledges that programming for VAWG must be context-specific as no one model will be appropriate for all settings. Accordingly, fragile and conflict affected environments and issues of social inclusion (reaching particularly marginalised and vulnerable women and girls, for example those with disabilities) are addressed as cross-cutting issues across each outcome areas.

The next sections **provide mini Theories of Change, together with detailed guidance and suggestions for programming in each of the three outcome areas.**

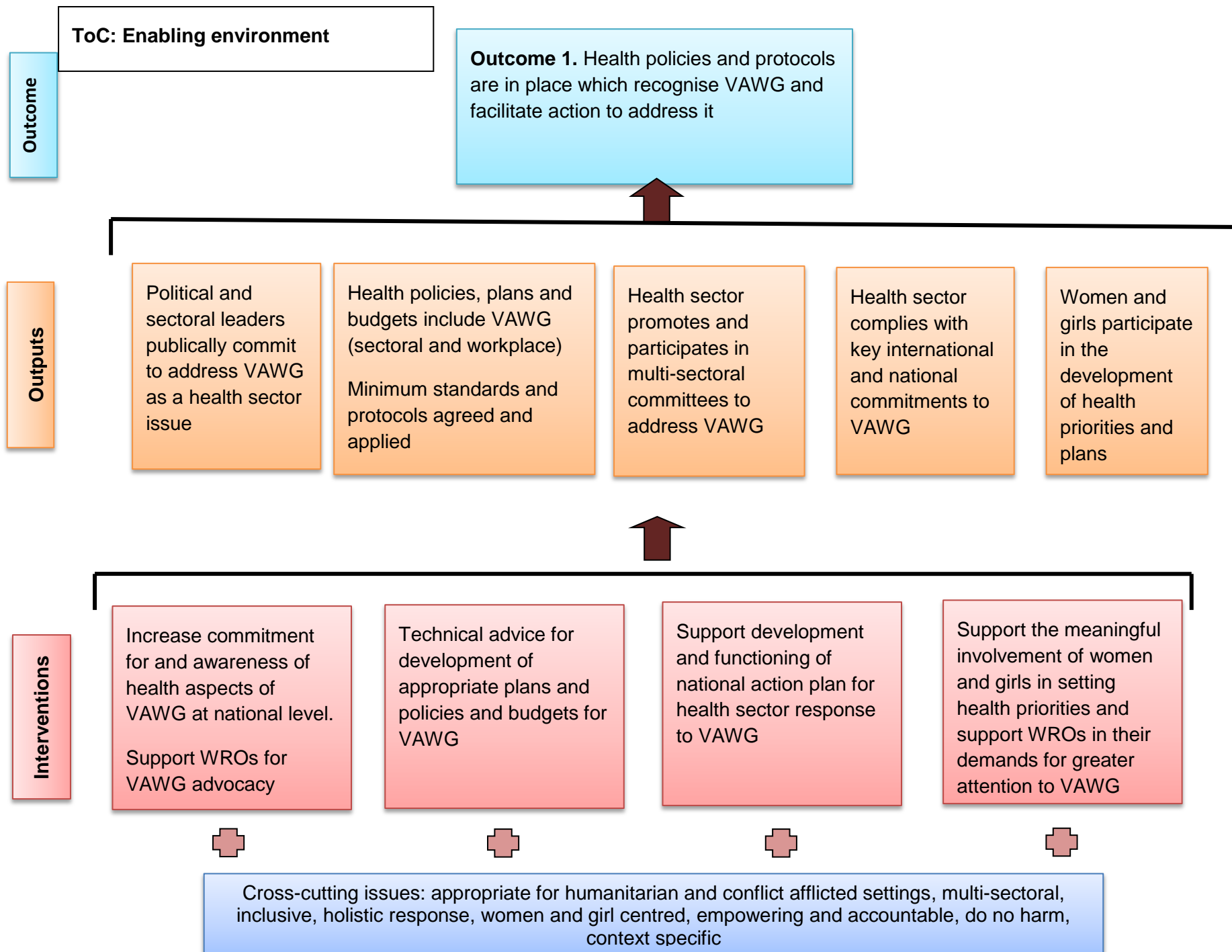
2.0 Enabling environment

Outcome 1 - Enabling Environment: Health policies and protocols are in place which recognise VAWG and facilitate action to address it

2.1 Developing an engagement strategy: Key questions for programmers

Engagement strategies for VAWG in the health sector should be based on an analysis of the current policy and legal environment, the levels and types of VAWG prevalent in the specific context and the capacity of the health sector. There is no blueprint for a VAWG response. IPV is a global concern but responses to VAWG need to be further tailored according to the country context including regional variations within countries. For example in some countries, female genital cutting/mutilation (FGC/M) may also be an issue, while in others it may be acid throwing. Undertaking a situation analysis is an important precursor to planning a response including identifying key entry points within the health sector.

¹ DFID, 2012



Box 1 lists a number of key questions which can help assess the policy and legal environment which influences a health sector response to VAWG.

Box 1: Key questions for an engagement strategy

Types and extent of VAWG

- What are the primary forms of VAWG and their impact on health?
- What data is there on incidence, prevalence and outcomes? What data is available on the reporting of violence? Is this data reliable and what are the gaps?
- What data/which indicators are currently being connected related to VAWG in the health facility and/or district level?
- Are there particular groups of women and girls who are vulnerable? What contextual factors are important (e.g. post-conflict, humanitarian, remote rural areas, social norms) to understanding the levels and types of VAWG experienced by women and girls?
- What analysis is available on the key drivers of different forms of VAWG and the challenges?
- What are women and girls' levels of awareness (according to age group) of what constitutes VAWG?

Existing legal and policy framework

- Has the government signed and/or ratified international legislation on children and women's rights, VAWG, and health (e.g. Convention on the Elimination of All Forms of Discrimination against Women,, UN Convention on the Rights of the Child, UN Covenant on Economic, Cultural and Social Rights,, Convention on the Rights of Persons with Disabilities) or relevant regional instruments (e.g. African Charter on Human and People's Rights and the additional (Maputo) protocol on Women's Rights)?
- What progress has been made in bringing these provisions into national legislation?
- What national legal frameworks are in place to address different types of GBV (FGC/M, child, early and forced marriage, IPV, comprehensive abortion care etc.). How are these implemented?
- Are minimum standards, standard operating procedures and protocols in place to address VAWG both with in health care settings and by health care staff?
- Are there specific legal commitments that mandate the health sector to prevent and respond to VAWG? Is there willingness and capacity to enforce sanctions?
- What are inter-institutional/cluster coordination mechanisms for addressing VAWG in which the health sector is participating?
- In what ways are women and girls participating in the development of policy and practice?
- Are there specific mechanisms and budgets in place to implement these laws and policies? Do they track expenditure on women's needs and priorities (e.g. gender-responsive budgeting approaches)
- Are there champions for action against VAWG in the health sector or other ministries who could be supported?
- Are there any plans to reform relevant legislation or update policies or plans (e.g. the national health sector strategy and plan)? Are there any upcoming relevant events (e.g. Commission on the Status of Women, UN committee on Economic, Cultural and Social Rights)?
- What are the capacities and interests of women's rights organisations, other civil society actors, parliamentarians and media actors to advocate for more effective action on VAWG by the health sector? What existing local, national or regional initiatives and coalitions might be built on and how?

2.2 Options for interventions

2.2.1 Increase commitment for and awareness of health aspects of VAWG at national level.

A lack of commitment may derive from a lack of awareness of the prevalence of VAWG and its impacts and/or the obligations arising from instruments such as CEDAW. A preliminary situation analysis can be used as a platform for policy dialogue with key ministries, including the Ministry of Health, as well as women's rights organisations (WROs). There are also a number of other entry points in the health sector that provide opportunities to put VAWG on the policy agenda for example:

- Supporting collection of data by specific surveys such as Violence against Children Surveys² or integrating VAWG questions into existing data collection mechanisms such as Demographic Health Surveys and national Health Information Systems (HIS)
- Joint sectoral reviews
- Co-ordination mechanisms such as National Aids or Nutrition Co-ordination committees, and
- Joint annual planning.

Awareness raising efforts and advocacy for the issue are particularly important in country contexts where VAWG is currently a low priority.

2.2.2 Provide technical advice for the development and implementation of appropriate plans, policies and budgets for VAWG

Promoting policy change and legal reform is critical for building an enabling environment³. Health data can be a powerful tool in advocating for this change by highlighting the impact of VAWG both socially and economically⁴.

The political economy and situational analysis will reveal to what extent existing policies and laws support or discourage increased action to address VAWG. In many cases a country will be signatory to international agreements, but these remain untranslated either into national policy or sectoral plans. Furthermore, recent research in Nepal shows that even though there is 'a consistent pattern of high policy priority and robust policy formulation, there remains weak patterns of implementation, resulting in relatively weak knowledge of and use of services'⁵.

The WHO also recommends a review of health sector policies and protocols to ensure that there are clinical and policy guidelines for VAWG.⁶ In conflict afflicted states or humanitarian crises relevant protocols are defined in the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations.^{7,8}

There are several toolkits and handbook available to guide programmers on approaches to integration including:

- Responding to Intimate partner Violence and Sexual Violence against women. WHO clinical and policy guidelines (WHO, 2013)
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>
- Improving the health sector response to gender based violence: a resource manual for health professionals (IPPF, 2010)
https://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf
- Minimum Initial service package for reproductive health in crisis situations. (IAWG, 2011)
<http://www.unhcr.org/4e8d6b3b14.pdf>

National policies and protocols for VAWG should be supported by credible workplace policies with reporting and supporting mechanisms focused on addressing violence experienced by health

² <http://www.cdc.gov/violenceprevention/vacs/vacs-survey-methods.html>

³ Heise, 2011

⁴ WHO, 2010

⁵ Office of the Prime Minister and Council of Ministers, Nepal, 2012

⁶ WHO, 2013

⁷ The MISP is a coordinated set of priority activities designed to: prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and neonatal mortality and morbidity; and plan for comprehensive RH services in the early days and weeks of an emergency. The resource was developed by the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations, a group made up of the UN, academic research, governmental and NGOs that came together in 1995 to address reproductive health for refugees. (source: IAWG, 2010, IAWG, 2011)

⁸ These guidelines are currently being revised.

workers in the home or at the hands of service users⁹ and violence perpetrated by health service workers against colleagues or service users. The health sector is a large employer and as such it plays an important role in setting social and cultural norms. At the same time, the sector employs a large number of women, many of them will have experienced violence themselves whether at the workplace or at home. A zero tolerance policy sends a strong message to others that VAWG is not appropriate. Feedback and accountability mechanisms such as, community health centre committees, can facilitate feedback on health facility and health worker performance. Further, complaints and grievance procedures for individuals to flag their concerns about quality of care are important. A Code of Conduct which describes appropriate practice and establishes reporting and investigation systems to prevent sexual abuse and exploitation by humanitarian workers.¹⁰

2.2.3 Support the development of a National Action Plan for a health sector response to VAWG.

A national action plan or strategy to guide the health sector VAWG response is an important to ensure consistency and quality of the response. Liberia offers a promising example of such a plan (box 2)

Box 2. Liberia's Multi-Sectoral Plan To Prevent and Respond to Gender-Based Violence

Liberia's plan (2006-2011) includes strategies to improve and strengthen the ability of the health care system to respond adequately to VAWG. Activities include developing national guidelines on the clinical management of violence against women and the training of health care providers in their use. Training for medical staff, including auxiliary and community health workers, is also included, as well as the improvement of referral mechanisms among police stations, health centres, referral hospitals and counselling centres.

Source: UN Women, 2012

UN Women has developed a handbook for the development of national VAWG action plans covering all sectors which provides useful templates and can be found at

<http://www.unwomen.org/~media/Headquarters/Attachments/Sections/Library/Publications/2012/7/HandbookNationalActionPlansOnVAW-en%20pdf.pdf>

2.2.4 Support the meaningful involvement of women and girls in planning

A central plank of DFID's strategic vision is 'putting women and girls central to all we do'. Consultation with WROs and community organisations enables a clear understanding of the specific types, forms, causes and consequences of VAWG, and offers opportunities to include the voices of marginalised women such as those living with disabilities, or those engaged in the sex industry. Further, civil society can play an influential role in holding government to account and demanding services. Meaningful participation of those most affected results in more effective and efficient programming. A multi country study in 70 countries over 30 years found that the involvement of women and organised feminist groups in planning resulted in the prioritisation of violence as a policy issue¹¹. Consultation is also key to applying the principle of 'Do no harm' as it can help to ensure that VAWG survivors and women and girls at risk – and those who support them are not put at *further* risk of stigma or violence¹².

⁹ <http://www.theguardian.com/global-development/2014/mar/14/uk-aid-improve-healthcare-kenya-watchdog-icai>; <http://blogafrica.allafrica.com/view/entry/main/main/id/0I9Ng9ks9E1bNvfe.html>

¹⁰ http://www.un.org/en/.../gbv_sub_cluster_strategy_and_action_plan_kenya

¹¹ Weldon and Htun, 2013

¹² Aidstar 2, 2013

Box 3: Tribal women's participation in health service planning in India

The Ekjut project in Jharkhand and Odisha has worked with Adivasi women in planning and evaluating health care and has significantly reduced deaths and empowered women among India's Adivasi communities. Many organisations and governments endorse the right to participate in the planning of health care, but methods to ensure this are rarely evaluated, and tribal women are seldom in control of the process. Using participatory methods to involve Adivasi women in planning and decision-making resulted in substantial reduction in mortality and a significant sense of empowerment among women. In the first local elections held in the areas where Ekjut implemented the programme, several facilitators of the women's groups won seats as people's representatives, testifying to women's increased confidence.

Source: Minority Rights Group International (2013), 2012

3.0 Service Delivery

Outcome 2 - Service delivery: Appropriate and quality health services are delivered at all levels and in all contexts to meet the needs women and girl survivors of VAWG and those at risk of VAWG

Health services are of critical importance to women and girls who are experiencing, or are at risk of, violence and are often the first or the only services used. Similarly to integrating HIV into health programming¹³, VAWG responses should be integrated into the health system's core business. Box 4 lists a number of key questions which can help assess the service delivery within the health sector response to VAWG.

¹³ DFID, 2013a

ToC Service Delivery

Outcome

Outcome 2. Appropriate and quality health services are delivered at all levels and in all contexts to meet the needs of women and girl survivors of VAWG and those at risk of VAWG

Outputs

VAWG services are integrated into existing health service delivery models at all levels and in all contexts addressing primary, secondary and tertiary prevention

Health facilities include adequate private spaces for VAWG services

Relevant commodities available and accessible for VAWG services

HMIS includes data on VAWG which informs planning and budgeting at local and national levels and is used to advocate for change at all levels

Public health system collaborates with private, faith-based and CSOs and is accountable to the community for effective delivery of VAWG services

Interventions

- Support countries to integrate VAWG responses into health service delivery: MCH services, SRH, HIV VMMC programmes. Support provision of minimum package of services

Health facility improvement programmes include provision of safe, sound proof spaces for VAWG work, materials on VAWG in waiting areas

Address VAWG through Health System strengthening and humanitarian programmes: include relevant commodities for VAWG procured and distributed and on essential medicines list

Health information systems includes VAWG data
VAWG data regularly monitored and used to inform annual operational plans and budgets and national strategy and budgets

Support multi sector collaboration and coordination at community level and ensure inclusive services'

Cross-cutting issues: appropriate for humanitarian and conflict afflicted settings, multi-sectoral, inclusive, holistic response, women and girl centred, empowering and accountable, do no harm, context specific

3.1 Developing an engagement strategy: Key questions for programmers

In designing an engagement strategy for improved service delivery, a range of questions can be answered. The list below (box 4) suggests some key questions to enable identification of entry points to reach women as survivors (secondary and tertiary prevention) and men as perpetrators (primary prevention¹⁴) – and design an improved response.

Box 4: Assessing health service responses to VAWG

- What are the existing health services for survivors and who provides them – public, private, civil society, faith-based organisations? Do these meet international standards? Do national protocols for these exist? Are they available in the health facilities?
- Is there data to show how available services differ by population and location?
- Are WHO patient intake forms available, used and kept safely in the health facilities?
- Have providers been trained on providing a first line response and clinical care for GBV survivors?
- How are these services coordinated?
- Are VAWG services freely accessible to all women and girls (children, adolescent, widowed, lesbian, transgender, elderly, disabled, economically disadvantaged)? Is there evidence that women and girls are using these services?
- How scalable are interventions and how can they be scaled?
- Are the key commodities required for a comprehensive clinical response to VAWG included on the essential medicine list? How are rape kits distributed during emergencies?
- In humanitarian crises, are decision makers aware of the Minimum Initial Service Package (MISP) and are the recommended services available and accessible?
- Is the VAWG response included in Universal Health Coverage (UHC) discussions?
- Is forensic evidence collection required and, if yes, have providers been trained? Are commodities available?
- Does the health sector have a system of referrals and counter-referrals to provide comprehensive care to survivors?
- What data is routinely collected from health facilities? Is this data being used effectively in planning and advocacy to improve services?
- How are VAWG survivors involved in monitoring VAWG services and improving service delivery?
- How does the health sector co-ordinate with community based health and development services to transform gender norms?

¹⁴ Primary prevention - Any programmes, interventions or strategies aimed at stopping violence before it occurs.

Secondary prevention - Any strategy aimed at minimising the harm that occurs once a violent event is taking place and immediate post-violence intervention aimed at preventing re-victimisation. Examples include interventions to reduce the duration of interpersonal violence events or damage inflicted, or the early identification by health professionals of child abuse, and subsequent interventions to prevent further abuse.

Tertiary prevention - All efforts aimed at treating and rehabilitating victims and perpetrators and facilitating their re-adaptation to society. Contrary to secondary prevention activities, which are usually in the short-term after the event, tertiary prevention activities are usually long-term.

3.2 Options for interventions

3.2.1 Support countries to Integrate VAWG responses into health service delivery

In line with the move towards integration of services,¹⁵ DFID health programmes should support ministries to determine which approach they will take to deliver VAWG services and how they will manage this. WHO guidelines recommend that¹⁶, as far as possible, care for women and girls who experience sexual violence and IPV should be integrated into primary care services.

In particular, **Maternal and Child Health services**¹⁷ are excellent entry points since most women visit them at some point and they offer:

- Greater continuity of care than other health settings
- Confidentiality and longer appointments with patients
- More predictable workload of health professionals
- Philosophy of care that recognises social aspects of ill health.¹⁸

Emerging evidence around the links between IPV and chronic malnutrition in women and children from India also supports the integration of IPV responses through MCH programmes¹⁹. This argument is also reinforced by data linking IPV with HIV and subsequent poor Prevention of Mother to Child Transmission Services (PMTCT) adherence²⁰.

Voluntary male circumcision programmes present an opportunity to reach young men with health promotion messages focusing on prevention of VAWG, while **HIV and broader SRH programmes** targeting adolescent girls and boys are good entry points for awareness raising on VAWG as a rights and health issue (See box 5).

Box 5: Liverpool VCT and Care Kenya

The nongovernmental organisation Liverpool VCT & Care Kenya (LVCT) provides HIV prevention and treatment services, including voluntary testing and counselling, and carries out research and advocacy to inform HIV policies and services in Kenya. Because women survivors of sexual violence are at high risk of HIV infection, LVCT wanted to help health programme managers and providers better understand sexual violence, and test the feasibility of providing care to survivors. Using a participatory approach among staff and managers, LVCT developed a standard of care that included emergency medical services, laboratory testing, counselling, preparation for the justice system, and post-exposure drug treatment for HIV and other STIs. As of early 2010, LVCT reports that its post-rape care programme has provided services to 9,500 survivors in 19 integrated post-rape care sites in Kenya. LVCT's research informed the development of national guidelines on the medical management of rape and training curricula by the Ministry of Health's Division of Reproductive Health. *Source: Liverpool VCT, 2010*

Although there is no consensus on definitions of integration there are generally three approaches²¹:

- **Provider-level integration** where the same provider offers a range of services, for example a nurse in a primary care clinic is trained and resourced to screen for domestic violence, treat her patient's injuries, provide counselling and refer her to external sources of support and legal advice.
- **Facility-level integration** where a range of services is available at the same facility.
- **Systems-level integration** where there is a coherent referral system between facilities so that, e.g. a family-planning patient who discloses violence can be referred.

¹⁵ DFID, 2013a

¹⁶ WHO, 2013

¹⁷ Devries et al, 2010

¹⁸ Bacchus et al, 2012

¹⁹ Ackerson and Subramanian, 2008

²⁰ Hatcher et al., 2014

²¹ Columbini et al, 2008

Considerable attention has been given to One Stop Service Centres (OSSCs) in low-income countries as a good example of facility-level integration, for example, e.g in Rwanda (See box 6)

Box 6: Isange One Stop Centre, Kigali (UN and Government of Rwanda).

Located in the Kacyiru Police Hospital (KPH), the IOSC is staffed by one coordinator, nine psychologists, one gynaecologist, six social workers, three medical doctors with medical forensic expertise, four general practitioners, one psychiatric nurse and one police officer. They provide a free 24-hour service, seven days a week, with provisions for emergency contraception, HIV prophylaxis, STI prevention, and other medication. Every survivor who arrives in the IOSC is initially seen by a social worker that provides information and access to medical, psychosocial, and police services. Once the survivor is assessed and examined the case is processed according to her/ his needs. There is a safe house available with three beds and basic provisions. *Source: Bernath and Gahongayire, 2013*

In post-conflict settings in particular, OSSCs have been a model for scaling up quality services. While there is limited evidence for the effectiveness of these centres in reducing violence²², qualitative data suggests the services can have an empowering effect for the women and girls who use them.

Lessons learned from OSSCs reveal that they also require adequate numbers of specialised staff, training, budgets and functional referral systems to be effective.²³ Further, OSSCs do not replace the need for a certain level of provider-level integration and systems level integration in order to identify and support women not attending OSSCs. Most of the current examples of OSSCs are from hospital settings and there is little evidence available at present of the effectiveness of integrating VAWG services into primary health care settings.

Supporting the provision of a minimum package of services: WHO makes recommendations for key health sector responses to VAWG which are supported by evidence. In summary, these are: identification of violence, provision of clinical support, provision of emotional and mental health support, integration of VAWG services into health policy and protocols (see box 7 and Annex 3).

At present, the evidence suggests that **universal screening** has not been proven effective as a prevention strategy and hence the health system may have a limited role in primary prevention but a significant one for secondary and tertiary prevention²⁴. Evidence shows that women who have suffered from IPV use multiple and more health services than other women, including emergency departments, hospital outpatient, primary care, pharmacy and mental health services²⁵. There is consensus, therefore, that **health care workers should attempt to identify women and girls** experiencing violence and offer them appropriate, sensitive first line care and treatment and referrals to other services where necessary²⁶.

For **humanitarian programmes**, the Guidelines for Gender-based Violence Interventions in Humanitarian Settings Focusing on Prevention of and Response to Sexual Violence in Emergencies include a detailed guide for the establishment of essential health services and how they should be delivered.²⁷

Critically, health programmers should support the health sector to translate these guidelines into their existing Standard Operating Procedures and advocate for emergency contraception kits, STI and HIV prophylaxis to be included in the national list of essential medicines, and free to women and girls who need

²² Jewkes et al., 2014

²³ Colombini et al., 2012; Ellsberg et al., 2012

²⁴ Jewkes et al, 2014

²⁵ Bonomi et al, 2009

²⁶ Garcia Moreno et al, 2014

²⁷ IASC, 2005, currently being updated

them. In more supportive environments health managers may be able to focus on coverage and quality while less supportive environments will require consistent advocacy for the issue.

Box 7: Recommended minimum service package of the health system

Identification of violence:

There is vigorous debate for and against routine screening for VAWG across the primary health care system, but WHO currently recommends that health providers ask about exposure to IPV when assessing conditions caused or complicated by IPV in order to improve diagnosis and care.

Health workers especially in MCH and SRH services and those in community-based facilities should be able to screen to identify possible VAWG experienced by women girls and children, and respond sensitively and appropriately (see Outcome 3: Capacity building). The enquiry should be conducted in a safe and confidential space and in a non-judgmental manner.

First line support:

When IPV is disclosed health care providers should offer immediate non-judgmental and practical support; sensitively take the history of violence; help the survivor to access services and resources whilst ensuring privacy and confidentiality.

Clinical support:

Where violence has been identified / reported, free basic services should be available including attention to injury, and specifically for sexual assault, emergency contraception, STI/HIV testing, STI treatment and HIV prophylaxis. For humanitarian crises, guidelines on appropriate clinical support are provided in the MISP.

Counselling, Therapy and Psychosocial Support:

A mid-term evaluation of the Ending Domestic Violence project in Rwanda found that 44.4% of participants felt that counselling services helped them improve dialogue with their partners in addressing issues that may lead to violence and that counselling had a positive impact on communication in relationships as well as on the psychological health of women and children.²⁸ In addition, a randomised control trial to assess the effectiveness of counselling for sexually exploited girls in the DRC showed that those girls who received trauma-focused cognitive behavioural therapy (TF-CBT) three times a week for five weeks experienced significant reduction in posttraumatic stress disorder, depression and anxiety, and experienced improved pro-social behaviours compared to girls in the control group, including at the three-month mark.²⁹

Collect forensic evidence and provide testimony:

The health sector can also play a key role in helping survivors to access justice by providing testimonies. In many developing countries this testimony is only admissible as evidence if provided by a qualified doctor. The chronic shortage of doctors in developing countries, especially in rural areas, fragile states and humanitarian settings, can therefore make prosecution impossible. WHO recommends that evidence not be obtained unless it is to be used for prosecution, however, health workers should know the correct procedure for this. WHO also advises against mandatory reporting of intimate partner violence to the police by the health-care provider as it both compromises confidentiality and can act as a disincentive to seek services.³⁰ Health programmers should generate greater awareness of this issue and work with other donors and national governments to ensure that the professional assessment of injuries by nurses, midwives and other suitably qualified health workers is admissible as evidence in courts of law in cases of VAWG .

²⁸ Omollo-Odhiambo, 2011

²⁹ Cohen, 2013

³⁰ WHO, 2013

Provide referrals:

Whichever model of integration is selected, referrals are needed both within the health sector and to other sectors, particularly the justice sector. Effective referral between different sectors is also linked to increasing programme effectiveness and efficiency (see VfM Annex 2)

Sources: Omollo-Odhiambo, 2011; Cohen, 2013; WHO, 2013

3.2.2 Addressing VAWG through Health Sector Strengthening Programmes

Effective health service delivery depends on the health system itself. Where DFID is supporting health sector strengthening programmes, VAWG should be a core consideration.

Health Information Systems (HIS) - Data on VAWG is vital for planning and costing services. Systematic recording of the cause of injury needs to become standardised in reporting formats and fed upwards from local to national level as routine part of the HIS. Findings from UNFPA show that consensus on terminology is required, especially when considering the multi-sectoral aspects of VAWG, and that differing definitions for categorising violence (e.g. in justice, health or police services) without a minimum set of indicators for inter-sectoral comparisons and analysis, challenge the ultimate utility of the data.³¹ This points to the need for a national multi-sectoral VAWG plan as highlighted earlier. Guidelines exist for health information systems (see box 8).

Box 8: Health Information Systems (HIS)

Various guidelines from the International Planned Parenthood Federation (IPPF), UN Women and UNFPA exist on capturing GBV through HIS. For example from UN Women's online guide to end violence:

- Each health facility providing services should keep statistics using a standardised data collection form.
- Client registration formats, at a minimum, should collect information on:
 - o The type of violence experienced
 - o The sex of the person
 - o The age of the survivor
 - o The age and relationship of the perpetrator to the survivor (Velzeboer, 2003)
- Additional demographic information may be collected on whether the incident was rural/urban, and by population sub-group (e.g. indigenous; ethnic and racial categories; migrant; women with disabilities; other prominent or especially excluded groups).
- The case record should also include a careful description of the violence, including the type of assault, the number of aggressors and time of aggression. The write-up should as much as possible use the woman's own words and should avoid any language that is judgemental or critical of the survivor's observed behaviour or appearance that may be used against the women in any subsequent legal proceedings.
- It is critical to guarantee complete confidentiality, not only on the files themselves (e.g. by using a patient number instead of the patient's name), but also by ensuring that all records are kept in locked files. Only select staff should have access to the keys for the files and management should develop a system for file distribution and sharing within the facility.

Source: <http://www.endvawnow.org/en/articles/853-ensure-medical-records-and-an-information-system-to-document-cases.html>; See also UNFPA, 2002 and IPPF, 2000

Supply Chain management: Ensure consistent supply of commodities - A further entry point in health programming is through supply chain management and procurement. A reliable supply of appropriate com-

³¹ UNFPA, 2013

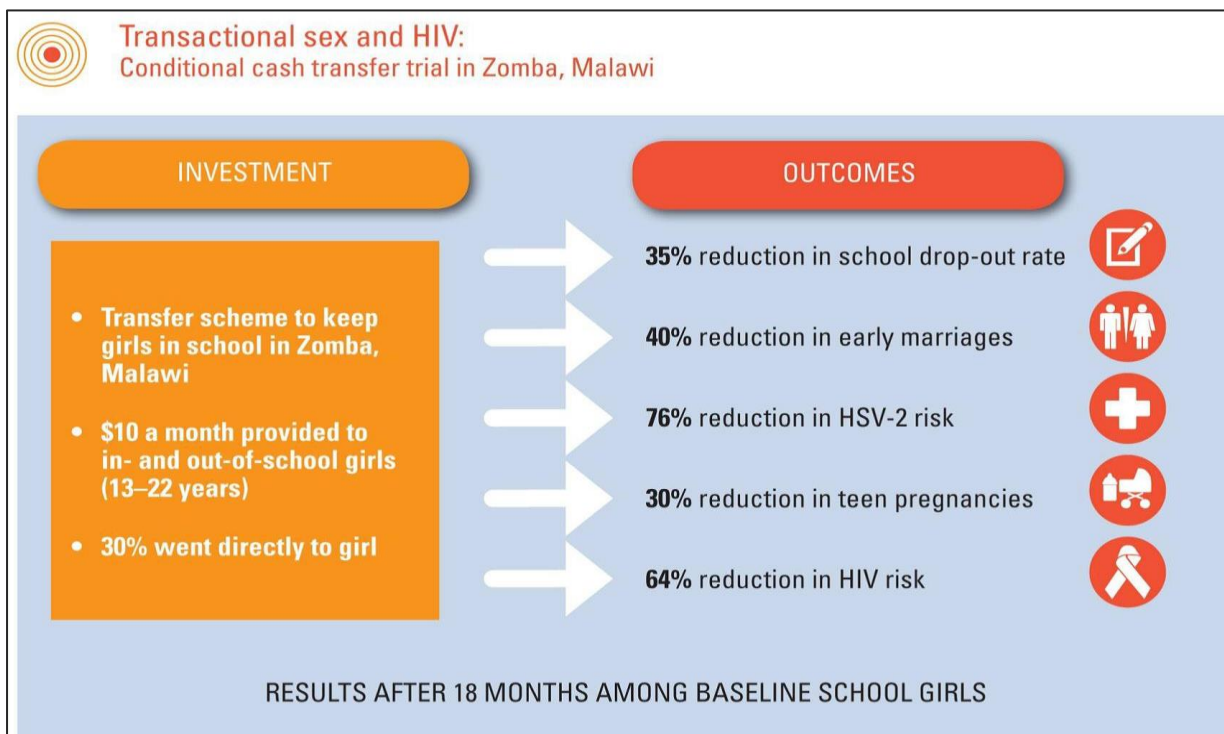
modities must be available at the point of VAWG service delivery. These include but are not limited to Post Exposure Prophylaxis (PEP) for HIV, emergency contraceptives, STI prophylaxis and treatment. For cases of sexual assault in particular, there is crucial 72/120-hour period in which HIV PEP/ emergency contraception are effective. Health programmers can advocate for the inclusion of these supplies in the essential medicines list and if possible in primary health care kits where these are part of the supply chain model

Health Facility Improvement programmes - Health programmes which include facility buildings or refurbishments offer an opportunity to ensure that the buildings provide the necessary privacy, usually outfitting a private room for counselling. This space must be secure and accessible to all seeking services.

Health financing: Costing GBV services - Financing for health is one of the essential building blocks of the health system. Negotiating a dedicated budget allocation for the response to VAWG raises the visibility of the issue and increases commitment from policy makers and managers. Budgets are required for staffing, training, commodities, campaigning and coordination. Furthermore, having dedicated staff within a health facility who are paid by the service institutionalises VAWG as part of the health sector’s ‘core business’, increases motivation of staff and enhances longer term sustainability.³²

Another approach to funding VAWG activities is ‘co-financing’. This concept is emerging from the HIV sector, where successful interventions also depend on multi-sectoral coordination and collaboration³³. Findings from the Zomba cash transfer scheme in Malawi (Box 9) show how a project designed to keep girls in school and avoid transactional sex generated multiple reproductive and sexual health, education and gender equality outcomes³⁴. An analysis of the project, by the DFID-funded STRIVE structural drivers research programme consortium, concluded that, if sectors made financing decisions in isolation based on their own sectoral cost effectiveness analysis, the intervention would not be funded, ‘but where they considered contributions from other sectors based on their willingness to pay for their own outcomes, the intervention would be fully funded and could potentially be taken to scale’³⁵.

Box 9: Multi sectoral outcomes from education cash transfer trial in Malawi



³² Bacchus et al, 2012

³³ Remme et al, 2014

³⁴ Strive, 2012

³⁵ Remme et al, 2014

Ensuring inclusive services - While WHO recommendations highlight the importance of women-centred services, women and girls are not a homogenous group. Lessons learned from the HIV sector show that health services are frequently inaccessible to particularly marginalised and vulnerable populations. Stigma and discrimination towards, for example, women selling sex and/or using drugs, women with disabilities, transgender women or sexually active unmarried adolescent girls, represent a serious barrier to services. Any integration programme, therefore, must address issues of inclusivity both in terms of physical and social accessibility. It is vital that health services to address VAWG be developed according to the country context and that they are accessible and welcoming to all women and girls regardless of their age, marital status, social or HIV status or sexual identity.

Box 10: Female Genital Cutting/Mutilation (FGC/M) refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It is a form of VAWG that needs integrating into health programming, including support and relevant treatment and care for survivors. WHO are currently developing guidelines on management of the health complications of FGC/M.³⁶ Given the increase in the medicalisation of FGM there is also a need to integrate prevention into health programming. According to the World Medical Association's Declaration of Helsinki, 1964, health professionals who perform FGC/M are violating girls' and women's right to life, right to physical integrity, and right to health. They are also violating the fundamental ethical principle "do no harm".³⁷

3.2.3 Supporting multi -sectoral collaboration at the community level

Communities and community-based organisations play a key role in providing services to community members, but also in shaping norms. There are many positive examples of social transformation through community development programmes which are beyond the remit of this paper, for example engaging young men and boys (Project H), socio-economic programmes (IMAGE), FGC/M programmes (TOSTAN), addressing VAWG and HIV (SASA!, Stepping Stones)³⁸, which demonstrate the importance of building alliances between the health sector, NGOs and local community partners particularly for primary prevention of VAWG. The community is also where empowerment and rights-based work is most effective.

Community health workers (CHWs), female community health volunteers and TBAs are all well placed to raise awareness of VAWG and its health consequences, as well as advocating for human rights and facilitating women and girls' access to services. WROs and community based women's groups also play a critical role in informing women and girls of their rights and in supporting their involvement in health programme implementation, monitoring and policy development.

The formal and informal actors within the health sector must be able to strengthen and balance the *supply* of sensitive and appropriate services with the *demand* for these services. For this reason, close collaboration between health service providers in the formal and informal sector is vital especially at community level. Where health services are so frail that they cannot yet manage to provide the minimum services, there are many examples of effective partnerships with NGOs to provide these services (see box 11). Collaboration with NGOs is important where public health services are particularly weak for example in the provision of psychosocial and mental health services.

³⁶ http://www.who.int/reproductivehealth/topics/fgm/survey_instructions/en/

³⁷ WHO, 2010

³⁸ Abramsky et al, 2012

Box 11: FORAL works with Community health workers to address GBV in the DRC

The Congolese NGO Foundation Rama Levina (FORAL) in rural South Kivu province, Eastern DRC, started a mobile health programme in 2004 for vulnerable women and men to address barriers to access (identified by GBV survivors and their families). Mobile health services were expanded in 2010, and a clinical monitoring and evaluation system was developed to record patients' histories, their experience of sexual violence, the medical care they had received after the assault, the results of the clinical exam, any symptoms indicative of physical and mental health problems and planned treatment and follow-up. FORAL also engaged community members through partnerships with community health workers (CHWs). Findings from a study of the revised programme show that access to healthcare for survivors of GBV and their male partners increased, the quality of services improved and community members participated more actively in education sessions held at the beginning of each mobile clinic. The evaluation system developed by FORAL helped care providers and CHWs set up appointments for follow-up in a confidential setting. Clinic activities begin with health education led by the FORAL physician and the health centre nurse, offered to all village members in the local language.

Source: Holmes and Bhuvanendra, 2014

Such collaboration is especially pertinent in terms of reaching key populations and those generally underserved by public health services for example adolescent girls and boys³⁹. Community-based HIV interventions have been used as platforms to expand VAWG prevention programmes, for example in India, where violence prevention has been integrated in interventions for Female Sex Workers (FSWs). Community development programmes also offer excellent entry points for rights-based work and primary prevention. For example, the Women's Group Led Community Empowerment for Improved Nutrition, Health and Water, Sanitation and Hygiene Outcomes programme in India uses proven methods for women's social and economic empowerment to address health issues including VAWG (see box 12).

Box 12: Women's community-based empowerment programmes in India through the participatory learning and action approach

The existing self-help groups have been primarily engaged in loan and savings activities, however, the experiences of Kudumbashree in Kerala and the Ekjut trials in Odisha and Jharkhand show that health and nutrition can be built into the programme and that using this platform enables fast scale up at a relatively low cost. Activities focused on health, nutrition and water and sanitation and violence against women get easily integrated in the SHG savings and loan programme, and can produce a similar impact (as economic empowerment) on health, nutrition and WASH outcomes of women and children.

DFID India under its Health, Nutrition and Water and Sanitation support to three state governments has adopted the participatory learning and action approach to reach over 200,000 women's groups with a membership of 2 million reaching a population of over 10 million. This approach has now been integrated into the government's own planning and programming.

Source: Roy Choudhury, 2015

³⁹ Vassall et al., 2014

3.2.4 Supporting multi-sectoral linkages and co-ordination

Inter- and intra-sectoral co-ordination of effort is necessary for an effective VAWG responses, particularly between the health system, the justice and social welfare systems. It is also important when working across different agencies and issues. For conflict-affected States, the Inter-Agency Standing Committee (IASC) has introduced the cluster approach as the standard for organising the international humanitarian response to any major emergency. This approach co-ordinates the actors responding to the emergency under a lead agency which is accountable at the field level to the Humanitarian Response Coordinator.⁴⁰

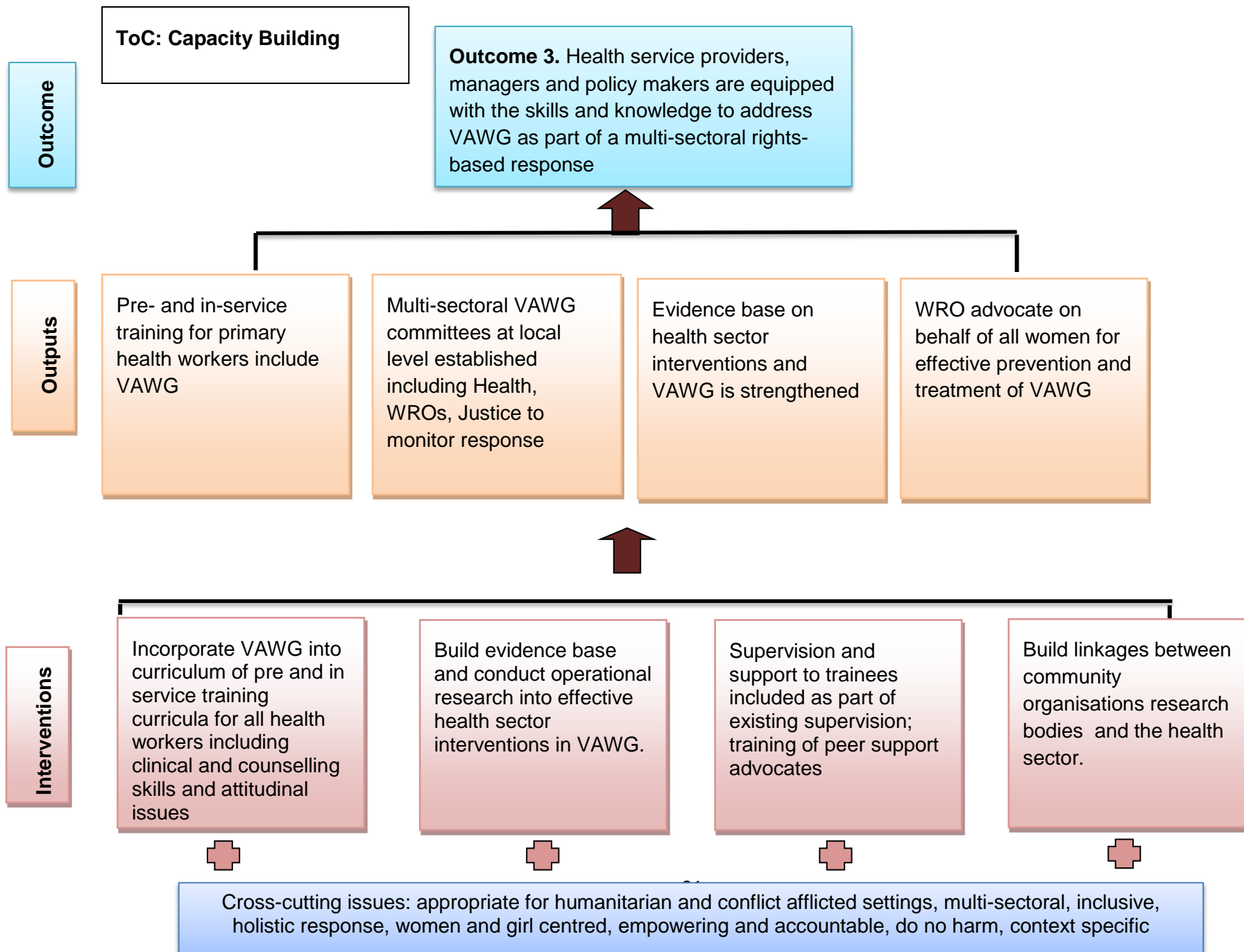
4.0 Capacity building

Outcome 3 – Capacity Building: Health service providers, managers and policy makers are equipped with the skills and knowledge to address prevention and care aspects of VAWG as part of a multi- sectoral rights-based response.

4.1 Developing an engagement strategy: Key questions for programmers

Understanding what the current gaps in skills and knowledge are among health professionals can help identify the hurdles that may hinder them in working to fully embed a response to VAWG. Box 13 lists a number of key questions which can help assess capacity building in order to strengthen the health sector response.

⁴⁰ IASC, 2005 (currently being updated)



Box 13: Key questions for an engagement strategy

- What is the current capacity of health workers to respond to violence? Do they have sufficient well-trained personnel? Is there evidence that staff are using their skills in delivering services addressing VAWG, resources? What are the gaps?
- Does the training include medico legal protocols?
- What barriers exist for capacity building of health workers in GBV prevention and response? How could these be overcome?
- Is a VAWG response included in the national training plan?
- Is VAWG response included in pre- and in- service training curricula for health workers (physicians, nurses, midwives, community health workers)?
- Does the training include first line response, clinical management, cross-sector collaboration, social attitudes and normative change human rights?
- Is the training inclusive addressing the needs of all women and girls including those from vulnerable populations and those living with disabilities?
- Does the training include the influence of social norms and gender equality and how to work with men?
- How does training equip health workers to participate in coordination mechanisms to share information and issues on VAWG?
- In Humanitarian crises, are protocols for VAWG data collection and health harmonized?
- Are there support mechanisms in place to support and supervise front line health workers?
- Is there a feedback mechanism from service users to inform future capacity development of health workers?
- Is training in management of VAWG compulsory for health service providers?
- What data is collected? How is data collected at local levels and fed into national health MIS systems?
- What barriers prevent health workers from collecting VAWG data?
- What policies exist on research and capacity building of VAWG at national levels?

4.2 Options for interventions

4.2.1 Including VAWG responses in pre- and in-service health worker curricula

Once there is an agreement that VAWG responses are part of the health sector remit, training curricula and materials for all levels of staff should be adapted to comply with national and international protocols and tailored to the specific socio-cultural context. Several curricula exist, for example, IPPF's Resource Manual for Health Care Professionals in Developing Countries 'Improving the Health Sector Response to Gender Based Violence'⁴¹ as well as the International Rescue Committee (IRC) clinical care for sexual assault survivors (CCSAS) tool. The IRC CCSAS multimedia tool includes clinical protocols, counselling skills, and rights-based approaches to VAWG related health service delivery. Both these curricula are participatory and allow for exploration of the social and cultural contexts of VAWG within which services are to be delivered.

Most examples of good practice involve collaborations with Civil Society Organisations. (see box 14)

Box 14: Vezimfilho! Health worker training. South Africa

The Vezimfilho! model for training health care workers was a collaboration between a non-government organisation and the Department of Health in South Africa and represented one of the first efforts to build capacity to address VAWG within the health sector. Findings from an evaluation highlighted the importance of a systemic response, political commitment, policies, protocols and effective referral systems. In addition, it

⁴¹ Bott et al, 2010

found that capacity building needed to include addressing values and attitudes toward gender-based violence and gender norms, as well as interpersonal skills of healthcare providers. Support from managers in the health system and strong relationships between multiple stakeholders were seen as being key to a sustainable approach.

Source: Rees et al, 2014

For humanitarian programmes, the Minimum Initial Service Package (MISP)⁴² provides minimum standards for disaster responses and is integrated into the Inter-agency Standing Committee (IASC) Health Cluster tools and guidance.⁴³ The module incorporates a multi-sectoral set of activities to be implemented by humanitarian workers operating in health, camp design and management, community services, protection and other sectors. The MISP module is particularly useful for members of emergency response teams and other humanitarian first responders in crisis settings, as it focuses on populations displaced by crises, such as armed conflict and natural disasters.

4.2.2 Institutionalise follow-up and support

Training needs to be underpinned by a functioning system. A recent study on different models of training for GBV responses showed that ‘training combined with system support interventions, such as brochures and posters, aids to remind physicians how to identify victims, improving doctors’ access to victim support services, and providing audits and feedback, seemed to benefit domestic violence survivors and increase referrals to domestic violence support resources⁴⁴.

Evidence from the IRIS (Identification and Referral to Improved Safety) intervention in the UK reinforces the importance of working with practice *teams* rather than selected individuals and of constant follow-up and support (see box 15). A similar approach was used by Profamilia in the Dominican Republic, which trained all clinic staff (including receptionists, security guards, physicians, psychologists, counsellors), and developed an agreed standard process for screening clients, and created private spaces on-site to provide psychological counselling and legal services.

Box 15: The IRIS intervention

The IRIS intervention demonstrated that training of health care workers in clinics, combined with the provision of technical support to practice teams and the establishment of a simple referral pathway to a specialist domestic violence organisation, led to improvements in the clinical response to violence. The intervention was implemented from 2007-2010 and targeted doctors, nurses and reception staff in 24 clinics in London and Bristol, UK. The evaluations compared the performance of those clinics which received the training with 24 control clinics who did not. Following the intervention, the number of referrals recorded in the intervention practices was 21 times larger than the control practices. Further, intervention practices recorded 3 times more identifications than control practices.

Source: Feder et al., 2011

The same is true for conflict-affected contexts. In a recent evaluation of a capacity building programme for humanitarian workers⁴⁵ participants noted that ‘building the knowledge, confidence, and skills of practitioners is necessary but not sufficient to ensure effective GBV emergency response. The institutional and funding environments within which humanitarian response occurs

⁴² IAWG, 2010; IAWG, 2011

⁴³ IASC, 2005 (currently being updated)

⁴⁴ Zaher et al, 2014

⁴⁵ IRC, 2014

have significant impact on the realization of the priority actions outlined in the Program Model’.

4.2.3 Training Advocates

As mentioned earlier, there is evidence from Maternal Health and HIV programming that peer support is effective at helping women access services. Building the capacity of women advocates as peer support and referral agents has proven to be a cost effective approach to improving health outcomes and could be replicated for VAWG services⁴⁶.

Box 16: Mother to Mother (m2m) programme in Uganda

The Mother to Mother programme in Uganda trains HIV positive mothers to work alongside doctors and nurses as members of the healthcare team. In one-on-one and group sessions, Mentor Mothers provide health education and psychosocial support to other HIV-positive mothers. They provide an important link between the community and the health services. An evaluation of the m2m programme collected information from 62 health facilities in Uganda divided into two groups: 31 of the health facilities were supported by m2m’s Mentor Mothers programme while another 31 control health facilities were without m2m presence. Results showed that m2m’s Mentor Mother programme had higher retention-in-care of HIV-positive women; greater uptake of early infant diagnosis test for HIV; and significantly greater psychosocial wellbeing.

Source: USAID, 2015

4.2.4 Building the evidence base, conducting operational research

At a national level, data needs to be collected to inform planning and budgeting. Furthermore, inclusion of VAWG data in the Demographic Health Surveys (DHS) should be standard in order to increase its visibility in relation to health outcomes. At the facility level, health workers need to be able to collect data on VAWG safely without endangering survivors.

There is a growing agreement that a harmonised approach to VAWG case management is needed for a more effective, efficient and sensitive response. This is important when there are many actors involved in VAWG case management (NGOs, FBOs, public sector) and different disciplines (primary care, counselling, social welfare) so that women using the service do not have to repeat themselves, receive conflicting responses and health workers do not have to collect data for various reporting systems. This highlights the need for a national and multi- sectoral strategy for VAWG. DFID health programmes could support national dialogue in this regard.

This harmonisation is equally important in humanitarian contexts where the GBV Information Management System (GBVIMS) and WHO forms are both required. DFID could play a valuable role globally by advocating for better harmonisation with key agencies, particularly IASC (Inter-Agency Standing Committee) and the Global Protection Cluster (which manages GBV) in Geneva and WHO.

Promising lessons are emerging from the implementation of the GBVIMS (Box 17).

Box 17: Illustrative GBVIMS results

In South Asia, data from the GBVIMS showed an increase in reported cases of sexual violence. Data also revealed sexual violence survivors were not reaching the health clinic within 72 hours. In response, a campaign was developed to inform the community about the importance of health services for all GBV

⁴⁶ USAID, 2015

survivors and how to access them.

In East Africa, data from the GBVIMS was used to dispel myths that sexual violence was committed primarily by strangers. Information from the health service provider showed that over 60% of survivors reported that the alleged perpetrator was someone they knew and the act of violence had been committed in locations that were assumed to be safe. This helped this helped advocate for a more coordinated response at the national level to tackle IPV

Source: <http://www.endvawnow.org/en/articles/1594-data-collection-.html>

Any data collection activities on the topic of VAWG, irrespective of whether women are being directly asked about their personal experiences or not, should not be undertaken without the guidance of an expert in VAWG. Failing to observe strict ethical guidelines may compromise the safety of the beneficiary and/or researcher.⁴⁷

4.2.5 Building linkages with key partners for multi-sectoral action at community level

Building the capacity of health sector workers and managers to link with civil society actors is also valuable, particularly in terms of primary prevention of VAWG and transformative action. **Participatory and inclusive approaches** which engage community members, in monitoring and evaluating the quality of services is gaining increased attention and support (including from DFID via empowerment and accountability programmes).

Evidence from South African Gender-Based Violence and Health Initiative (SAGBVHI) shows that a coalition between public health and research organisations not only contributes to the evidence base but also to advocacy for the issue of VAWG (Box 18).

Box 18: Coalitions for public health research and advocacy in South Africa

Health sector coalitions can play an important role in advocating for public policy and institutional reform. For example, SAGBVHI consists of 15 partner organisations and individuals in South Africa. They conduct research, build research capacity, disseminate research findings, and use research to advocate for policy reforms.

SAGBVHI works closely with the Gender and Women's Health Directorates of the National Department of Health. The impact such networks produce are difficult to measure, but informal assessments suggest that SAGBVHI has achieved important results. For example, they convinced two medical schools to increase their emphasis on gender-based violence within their curriculum, helped to develop a one-week module on rape for medical students, and contributed to new national policies on gender-based violence and health. Their work exemplifies how researchers can collaborate with government to translate research findings into policy.

Source: *Bott et al, 2005*

WROs and CBOs can advocate for attention to VAWG in their role as women's health and rights advocates and should be supported to do so, maximising existing mechanisms for community consultation as demonstrated in Box 19.

⁴⁷ World Bank, 2014

Box 19: The Health Facility Management Committees in Nepal.

The Health Facility Management Committees in Nepal are an example of a health sector mechanism which allows for enhanced women's engagement. The government has allocated 15% of each Village Development Committee budget for women's issues and this is determined at the health facility management committee. Reports that this budget was used for road building in Dhanghadi on the grounds that 'women use roads too' led to increased involvement of local WROs who were able to argue the case for the budget to be used specifically to support women survivors of VAWG.

Source: Amnesty International, 2014

Building links between WROs and the health system also depends on the capacity of the health workers to appreciate the added value that community involvement can bring. The Mobilising Access to Maternal Health Services in Zambia (MAMaZ) project in Zambia provides a model which develops the capacity of health service providers to work with the community, resulting in a relatively cost effective sustainable approach.

Box 20: The DFID-funded MAMaZ, Zambia

MAMaZ was a community initiative designed to increase women's access to maternal health services. It took a whole community approach and worked through existing government structures where possible, for example by building the capacity of the 'Safe motherhood action groups'. The programme worked in depth with communities to identify and address barriers to accessing health services. VAWG was cited as an important barrier to accessing services since it was linked to a sense of self stigma and shame as well as depression. Volunteers were coached and supported to encourage women to access health services and local health facilities played an important role in ensuring that such support was systematically provided. Much attention was paid to the development of an effective partnership with the District Health Management Teams and encouraging and facilitating the teams to take ownership of the interventions. The programme generated sufficient evidence of its effectiveness, which informed scaling up plans at district level. For example, skilled birth attendance rates increased by 27 percent over a period of less than two years.

Source: http://www.healthpartners-int.co.uk/our_projects/ProgrammeResources.html and Health Partners International, 2013

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Annex 1: Illustrative Indicators derived from MEASURE compendium of indicators for GBV⁴⁸ and WHO IPV guidelines⁴⁹ and IASC⁵⁰

Outcome/ output	Sample indicators
Outcome 1: - Enabling Environment: health policies and protocols are in place which recognise VAWG and facilitate action to address it.	
Outcome 1 indicators	<ul style="list-style-type: none"> • Decision makers include VAWG as a health issue in political and policy debates • National policies, action plans or contextualised Standard Operating Procedures are in place which reflect international commitments to VAWG including specific commitments for the health sector • Laws and policies regulating the medico-legal system (e.g. introduction of forensic nurses) are in place and applied. • Laws and policies regulating health care provider's obligations vis-à-vis survivors of VAWG are implemented • VAWG indicators are integrated into national data collection systems and M&E systems and relevant data collected . • Women participate in health policy development at all levels but particularly at the local level.
Output 1.1	<ul style="list-style-type: none"> • # of Health policies, plans and budgets include VAWG
Output 1.2	<ul style="list-style-type: none"> • National health sector VAWG committee established and meets regularly • Evidence based mechanism to advocate for inclusion of laws for forensic evidence on VAWG established
Output 1.3	<ul style="list-style-type: none"> • National policies, action plans or contextualised Standard Operating Procedures are in place which reflect international commitments to VAWG including specific commitments for the health sector
Output 1.4	<ul style="list-style-type: none"> • Mechanisms exist for women's participation in health policy development at all levels but particularly at the local level.
Outcome 2: Service delivery: Adequate quality health services are delivered at all levels and in all contexts to meet the needs of all women and girls including survivors of VAWG and those at risk of VAWG.	
Outcome 2 indicators	<ul style="list-style-type: none"> • Proportion of health facilities that have documented & adopted a protocol for the clinical management of VAW/G survivors • Proportion of health facilities that have done a readiness assessment for the delivery of VAWG services • Proportion of health units with clinical commodities for the clinical management of VAWG • Minimum standards/protocols for screening for VAWG in health settings • Functional multi-sectoral committees at District level on VAWG in place
Output 2.1	<ul style="list-style-type: none"> • Proportion of health facilities with at least one service provider trained to care for and refer VAW/G survivors • Proportion of health facilities that have documented & adopted a protocol for the clinical management of VAW/G survivors • Proportion of health service conducting consultation with VAWG affected population on access and quality of care • Proportion of women who were asked about physical and sexual violence

⁴⁸ Bloom, S. A compendium of indicators MEASURE. 2008

⁴⁹ WHO Responding to intimate partner violence and sexual violence against women: WHO Clinical and policy guidelines. Geneva: 2013.

⁵⁰ Guidelines for integrating GBV interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery. 2015 forthcoming.

	<ul style="list-style-type: none"> during a visit to a health unit Proportion of VAW/G survivors who received appropriate care disaggregated by age ethnicity and disability Proportion of rape survivors who received comprehensive care disaggregated by sex, age ethnicity and disability # of service providers trained to identify, refer, and care for VAW/G survivors # of health providers trained in FGC/M management and counselling Proportion of women who received or were referred for psychosocial counselling or other services.
Output 2.2	<ul style="list-style-type: none"> Health facilities have private spaces for counselling including in Humanitarian settings Proportion of health facilities that have done a readiness assessment for the delivery of VAWG services
Output 2.3	<ul style="list-style-type: none"> Commodities for clinical management of VAWG in essential medicines list and exempt from charge Proportion of health units with all clinical commodities for the clinical management of VAWG
Output 2.4	<ul style="list-style-type: none"> # of survivors presenting for Clinical care (disaggregated by age, sex) HIS includes sex and age disaggregated data Operational research identifies models of good practice of VAWG integration at primary care level
Output 2.5	<ul style="list-style-type: none"> Functional multi-sectoral committees at District level on VAWG in place #Consultations with WRO/community groups #community outreach activities
Outcome 3 - Capacity Building: Health service providers are equipped with the skills and knowledge to address prevention and care aspects of VAWG as part of a multisectoral rights-based response.	
Outcome 3 indicators	<ul style="list-style-type: none"> VAWG response included in pre and in service training curricula Minimum standards or protocols for psychological assessment of mental health issues associated with VAWG Number of VAWG cases reported through the health system Annual analysis of data by HMIS Multi-sectoral committees established and functional. % of trained providers that show increased knowledge about VAWG through pre/post tests and/or KAP surveys
Output 3.1	<ul style="list-style-type: none"> Proportion of health facilities with at least one service provider trained to care for and refer VAW/G survivors Percentage of health facilities trained to respond to VAWG Percentage of staff within health facilities trained Number of service providers trained to identify, refer, and care for VAW/G survivors Number of health providers trained in FGC/M management and counselling
Output 3.2	<ul style="list-style-type: none"> National level personnel trained to coordinate and collect data on VAWG
Output 3.3	<ul style="list-style-type: none"> National system to collect data on VAWG includes harmonised data set
Output 3.4	<ul style="list-style-type: none"> Country/district VAWG coordinating mechanisms instituted

Annex 2: Value for money approaches to VAWG interventions⁵¹

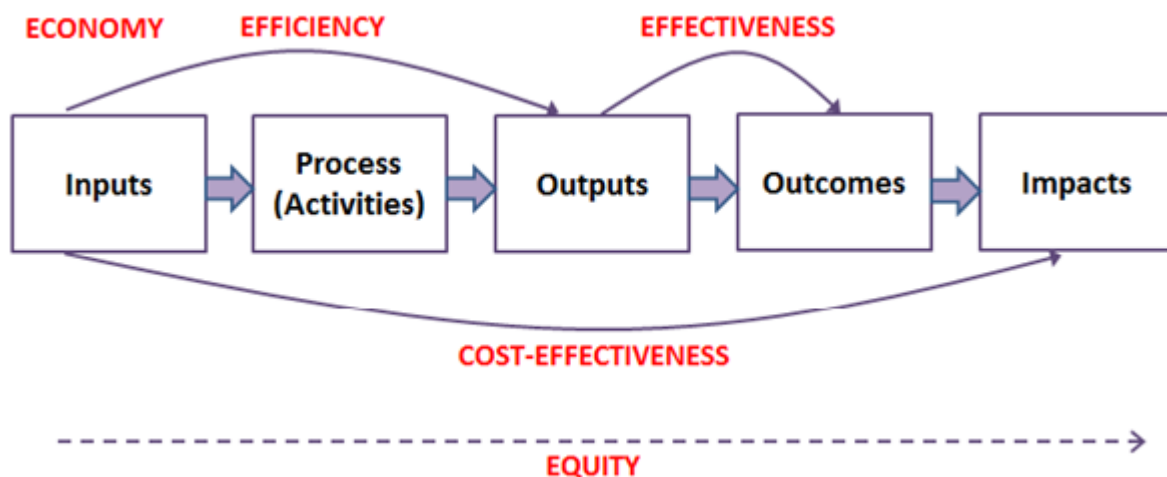
⁵¹ Adapted from Fancy and McAslan-Fraser, 2014 except where indicated

Calculating VfM (Value for Money) is much more than measuring 'how much a VAWG intervention costs'; it is about whether the development assistance provided is getting a good return in terms of impact on women and girls' lives. DFID's *Approach to Value for Money*⁵² describes the principles of VfM and provides examples of how these principles can be applied to DFID-funded programmes.

A focus on delivering value for money is often confused with a focus simply on **cost**. Delivering value for money is not simply a focus on costs and a race to the bottom, it is about asking questions on how the best use can be made of **all resources** for example: knowledge and best practices, staff time, use of partners experience and better coordination; assessing ones programme against set or well accepted standards; assessing additional benefits and checking whether equity has been promoted as well as identifying cost drivers. DFID emphasises **four main** principles to consider in its approach to VfM: **economy, efficiency, and effectiveness and equity**,⁵³ and "*whether the investment (development assistance) is getting a good return in terms of impact on women's and girls' lives*"⁵⁴ DFID explicitly recognises that programmes will be more expensive to deliver in fragile and violent contexts, but these additional costs should not be a barrier – a clear indication that cost is not the only factor to consider when considering VfM.

Deciding whether or not to invest in an intervention requires an assessment of whether the expected *results* of the intervention justify the resources required.. In order to make this assessment, it is important to understand the Results Chain and how inputs, generate activities (or 'processes') and produce outputs, and finally result in outcomes and impact (see Figure 3). Value for money depends on the strength of the links in the chain and the underlying assumptions (the theory of change and evidence base) upon which the Results Chain is built (See Figure below). DFID's approach considers the **cost-effectiveness** of interventions, i.e. how much impact an intervention achieves relative to the inputs used (see Figure 4 below and the short explanatory table below figure 4 with some practical examples of inputs, processes, outputs, outcomes and impacts in the context of addressing VAWG.)

Figure 4. DFID Results Chain



⁵² DFID, 2011b

⁵³ DFID, 2011b

⁵⁴ DFID, 2013b

Addressing VAWG in health programmes: Examples

Inputs - Training courses Positive IEC materials at health and other facilities for example social work settings, police stations, medical equipment, drugs	Process - Delivery of services which address VAWG	Outputs - No of health workers and other providers trained in addressing VAWG and acting as role models	Outcomes - Health facility practices and those of other service providers police, social work legal services promote and model non-violent and gender equitable norms	Impacts - More gender equitable social norms Increased unacceptability of VAWG Reduced VAWG
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It is important that the **design of health programmes that tackle VAWG includes an M&E framework capable of collecting and measuring VfM information at each level of the logframe** (see Table 1 below) and that once collected, this information is used for decision-making. It is recognised that “little is known currently about the costs and efficiency of VAWG interventions”⁵⁵ and calculating VfM of reducing violence is potentially sensitive and care needs to be taken when drawing up indicators (see Part B – Annex 1 for suggestions of possible indicators).

Table 1 provides basic information on factors to consider when measuring VfM including some examples of selected VfM indicators and key questions. Table 2 provides more detail on approaches to calculating VfM of VAWG interventions with reference to further examples which provide more in-depth information.

Table 1: Measuring VfM of addressing VAWG in health programming: Some key questions to ask

4Es	Description	Questions to ask:
Economy	<i>‘A measure of what goes into providing a service’.</i>	<p>Several factors can be considered:</p> <ul style="list-style-type: none"> At the start of the results chain, what are your main costs (inputs greater than 10% budget) and the cost drivers of implementing your programme. These could include costs such as: training, design, development or distribution of IEC materials (see UN Women, 2013 for example of input indicators from Spain, Kosovo, Indonesia and Cambodia – these resources also have a range of worksheets).⁵⁶ Consider the value of other non-financial inputs such as volunteer time or venue and office space made available for VAWG work. Focusing on a specific area (or output⁵⁷) on which your programme is delivering - What are the main costs of delivering one particular output, for example the costs of supporting a woman or girl to avoid or recover from violence. In this case the questions to ask would be – what are the combination of main costs needed to deliver this output? What are the costs saved by reducing VAWG? In this case the questions to ask should include: – what are the com-

Are the M&E systems designed to measure VfM VAWG interventions of

⁵⁵ Remme M, Michaels-Igbokwe C, Watts C., 2014

⁵⁶ See for example UN Women, 2013

http://www.endvawnow.org/uploads/browser/files/costing_manual_vaw_unwomen_sea_2013.pdf

⁵⁷ UN Women, 2013

http://www.endvawnow.org/uploads/browser/files/costing_manual_vaw_unwomen_sea_2013.pdf

		<p>combination of main costs which should be gathered as evidence to support costs saved. For example: costs of a young girl not being able to attend school, loss of earnings for a woman injured and prevented from working, medical costs of dealing with VAWGs.</p> <ul style="list-style-type: none"> As part of economic evaluations consider the unit costs⁵⁸ of delivering an intervention e.g. cost per treatment or participant trained, community member exposed or woman supported. The objective quantifying unit costs is not simply to select the cheapest options but rather to track trends, compare costs, identify outliers and ask why.
Efficiency	'A <i>measure of productivity</i> ' and relates to how well inputs are converted to outputs.	<p>Efficiency measures outputs (quantitative and qualitative) in relation to the inputs used.</p> <ul style="list-style-type: none"> Was the programme implemented in the most efficient way? For example: Where there alternative approaches which could have been used? Did the programme make use of learning and information on best practices (these could be local, regional or international best practices. Comparisons could be made with similar programmes or against quality standards for example organisations minimum service delivery standards.^{59,60} This is known as benchmarking and assessing the programme against tools and standards, using accountability tools. Are initiatives delivered on time and in the most cost efficient way? For example, is there good evidence of joint delivery of activities, use of existing delivery structures and opportunities for partnership working or are programmes delivered vertically and in isolation? An indicator could be set to track number of activities which are implemented jointly and the total value of savings made from joint working.
Effectiveness	Is the programme delivering its intended objectives	<ul style="list-style-type: none"> How effective is the health programme in delivering its objectives of improved outcomes on VAWG and health? (for example, improved mental and physical health, less violence experienced) What tools are there for measuring and monitoring outcomes on VAWG in the health programme? (see suggested indicators in Annex 1) What are the major factors influencing the achievement or non-achievement of objectives?
Equity	The extent to which <i>benefits are distributed fairly</i>	<ul style="list-style-type: none"> How is equity being promoted? Is the intervention addressing violence affecting the most vulnerable groups of girls and women? For example, sex workers, women with HIV, refugee and ethnic minority women and children, women and children from lower castes in parts of South Asia, and LBT women, children and youth.
Sources: DFID (2011; 2013b)		

⁵⁸Unit costs calculation methodology needs to be carefully structured. There needs to be transparency of methodologies across a project. Standardised definitions would be required and guidance such as whether or not overhead costs are included in unit costs to help to compare 'like for like' information

⁵⁹ Imkaan Accredited Quality Standards for working with black and minority ethnic (BME) women and girls and harmful practices: Forced marriage (FM), Female genital mutilation (FGM) and 'Honour-based' violence (HBV) Imkaan Accredited Quality Standards <http://imkaan.org.uk/iaqs>

⁶⁰ Akima, 2013

Practical Tips for: getting started, using VfM data and achieving greater VfM ⁶¹ :

- **Ensure all staff are routinely asking basic VfM questions-** “are there other ways to achieve the intended objective?”; “if I could only fund one programme which one would I select to fund?”; “Are we routinely using lessons learned to shape best practice?”; “are we making best use of all the resources we have?”
- **Check the programme accounting system. Does the accounting system allow the calculation of cost of each programme activity / output and spend against output or output indicator?**
- **Are reporting systems clear and do staff understand the data which is to be collected?**
- **VfM data needs to combine metrics (for example unit costs mentioned above) and narrative reporting.** Narrative reporting adds context and helps explain performance. Small case studies can be used to combine narrative and metrics and explain complexities in programme delivery and performance.
- **Narrative reporting should include** descriptions on how efficiency and effectiveness has been improved, any additional benefits achieved (see point below) and how equity has been promoted.
- As part of costing and cost benefit analysis calculations, consider the wider outcomes and costs of VAWG including: social, economic, health and human rights. In fact only focusing on one set of benefits could lead to undervaluation of investments. Use a range of outcomes and consider cost benefit analysis calculations. For example for DALYs, estimate how many DALYs would be averted from a year free of violence. This would allow for violence interventions to at least be considered alongside other health interventions. (See table 2 for examples). Wider benefits could be considered more simply, for example health staff trained in addressing VAWG are now teaching others – good evidence of the value which a partner programme is bringing.
- **VfM data should be used for decision-making.** Unit costs can be used in budgeting and planning. Actuals can be compared to plan and outliers reviewed and trends tracked. Benchmarks, targets; decision and trigger points⁶² should be used as part of analysis and decision making.
- Consider which elements of the programme are delivering impact and consider the scalability of interventions and how unit costs vary with scale.
- Existing platforms for VAWG programme scale-up can provide greater VfM: For example,
 - **Maternal and Child Health and Sexual and Reproductive Health Services** are valuable platforms to reach women of reproductive age and in relationships. These service points that women often access on a regular basis could be tapped to provide information on domestic conflict and violence prevention, as well as violence screening.
 - **Community-based HIV interventions** have been used as platforms to expand VAWG prevention programmes, for example: the model from India, integrating violence prevention in interventions for FSWs⁶³

⁶² **Decision points** these are points at which there may be a case to reallocate resources. **Trigger points** these are more critical performance points which if not reached decisions would be made on a shift in programme approach.

⁶³ Vassall, et al., 2014

- Community organisations since they are embedded within communities can translate group education models into locally-relevant content (see for example SASA!⁶⁴)

Table 2: More Detail on Approaches to calculating VfM of VAWG interventions

Main approaches to measuring the cost of violence	Examples of DFID Business Cases using this approach
Direct accounting is the most widely applied methodology for calculating the costs of violence. This approach estimates the total direct costs (typically to the health sector) in monetary terms by calculating the average costs of services per victim or incident (usually from targeted surveys of health providers); multiplying this unit cost by the prevalence or incidence rate; and then summing these across services to obtain a total estimate of costs.	Jamaica BC on Community Security and Justice Programme (CSJP)
Proportional methodology involves estimating the proportion of the total operational budget of different service providers that is spent on different VAWG services, and then aggregating for all providers.	Jamaica BC on Community Security and Justice Programme (CSJP) used a version of this to calculate the reduction in the health budget.
Disability Adjusted Life Years (DALY) is a time-based measure that combines years of healthy life lost due to premature mortality, pain and suffering. DALYs can then be converted to a monetary figure by assigning a value to a statistical life year (VSL).	South Africa BC on Strengthening South Africa's response to Gender-based Violence
Out-of-Pocket cost approaches involve calculating the amount paid out-of-pocket by households every time different services are used (e.g. police and legal aid services, housing and refuge services, civil legal costs and social services costs).	Uganda BC on Supporting Civil Society Organisations work on Gender and Sexual Based Violence
Economic gains of investing in VAWG approaches involve calculating the benefit-cost ratio of the programme vs. the economic gains of reducing GBV. In the Uganda BC, the intervention was calculated to generate £3.80 for every £1 spent, based on the assumption that reducing GBV would contribute to a 2% increase in economic growth.	Uganda BC on Supporting Civil Society Organisations work on Gender and Sexual Based Violence
(Source: DFID, 2013)	

CASE STUDY: Sauti ya Wanawake Pwani⁶⁵ (The Voice of Women) Demonstrating Value for Money. Multi-sectoral responses and improving access to Justice for Survivors of gender-based Violence

Sauti ya wanawake Pwani (a grassroot women's movement) demonstrates value for money approaches using existing platforms and creating more effective medico-legal linkages for GBV survivors. *"Grassroots women voluntarily take responsibility for coordinating responses to GBV cases within communities in collaboration with partners. Bringing administrative units such as police, village elders Chiefs, the Children's Department and medical services on board, creates synergy and efficiency in preventing, reporting and solving cases. Gaining the confidence of the police, judiciary and provincial administrators such as Gender and District Officers, is slowly leading to improvements in referral systems and the implementation of laws. Increased uptake of GBV cases has allowed more women and girls to access justice and to benefit from laws designed for their protection. In one Chapter alone over 10 cases of GBV per week are supported. This holistic approach is replicated in community based forums and legal aid clinics attended by survivors, lawyers, gender desk police, Chiefs, religious leaders and psycho-social counselors. These forums are regularly attended by at least 150 people with a quarter being men"*.

⁶⁴ Abramsky, et al., 2012

⁶⁵ Sauti ya Wanawake Pwani. (The Voice of Women). <http://www.sautiyanwanawakepwani.org/whatwedo.html>

Annex 3: Summary of WHO recommended health sector interventions for VAWG with strong evidence base

WHO (2013) *Responding to intimate partner violence and sexual violence against women: WHO Clinical and policy guidelines*. Geneva: WHO

Addressing IPV and sexual assault in health care settings		
Recommendations	Quality of evidence	Recommendation
1. Women centred care		
Women who disclose IPV (or other family member) or SV by anyone – to be offered immediate first line support by health care provider (or other appropriate person Non-judgmental and supportive <ul style="list-style-type: none"> • Practical support, responds to woman’s concerns, not intrusive. • Ask (sensitively) about history of violence • Help with access to info. about resources and services • Assist in increasing safety (for woman and children - where needed) • Provide or mobilise social support • Ensure privacy and confidentiality (although limits to confidentiality may exist e.g. where mandatory reporting) 	Indirect evidence	Strong
2. Identification and care for survivors of IPV		
2.1 identification of IPV		
Don’t implement universal screening and routine inquiry	Low moderate	Conditional
Ask about exposure to IPV when assessing conditions (box 1) caused or complicated by IPV in order to improve diagnosis and care	Indirect evidence	Strong
Written information should be available in private areas e.g. bathroom	None	Conditional
2.2 Care for survivors of IPV		
Women w- mental disorder (related to IPV or not) who experience IPV should receive mental health care (WHO has Guidelines) by HP with understanding of IPV	Indirect evidence	Strong
Therapy for IV survivors wh suffer from PTSD	Low-moderate	Strong
If spent at least 1 night in refuge/shelter – prog of advice,, support and/or empowerment .	Low	Conditional
Pregnant women who have disclosed – brief to medium duration empowerment counselling and adv support including safety components by trained HPs where systems can support this.	Low	Conditional
Children exposed to IPV – offer psychotherapeutic intervention w- and w-out mother.	Moderate	Conditional
3. Clinical care for survivors of sexual assault		
3.1 Interventions during the first 5 days after assault		
First line support (doc provides details including a complete history and physical examine)	Indirect evidence	Strong
Emergency Contraceptive (if presenting within 5 days),	Moderate	Strong
If woman pregnant offer abortion if nat’l laws allow	No relevant evidence	Strong
HIV PEP – discuss with women if PEP appropriate e.g. level of HIV risk and presenting w-in 72hrs. If appropriate start regime, provide VCT and follow-up at regular intervals.	Indirect evidence	Strong
PEP for STIs – (Chlamydia, gonorrhoea, trichomonas, and syphilis depending on prevalence)	low – based on indirect evidence	Strong
Hep B vaccine if does not have immunity	very low, low, indirect	Strong
Psychological interventions (first line support, written info on coping strategies dealing with stress. Don’t use Psych debriefing.	indirect or no relevant evidence	Strong
3.2 Psychological interventions after 5 days		
Interventions up to 3 months post trauma – care and support, unless mental health related problem apply ‘watchful waiting’ for 1-3 months, if she can’t function on a day to day basis offer Cognitive Behavioural therapy. if other problems such as depression then follow WHO Mental health Gap Action	Indirect, low to moderate, varies with intervention	Strong

Programme Guidelines (mhGAP GLs.)		
Interventions from 3 months post trauma – assess for mental health problems and treat using WHO Mental Health GAP GLs. If has PTSD then treat with CBT or EMDR. (eye movement desensitisation and reprocessing)	Indirect, low to moderate, varies with intervention	Strong
4. Training of HPs on IPV and sexual assault		
... at pre-qualification level in first line support	Very low	Strong
In-service training for HPs offering care to women (details provided)	Low, moderate	Strong
... on different aspects (identification, safety assessment and planning, communications, clinical skills, documentation, provision of referral pathways)	Low	Strong
... for IPV and sexual assault integrated in same programme	No relevant evid.	Strong
5. Health care policy and provision		
As far as possible integrated into existing health services	Very low	Strong
Multiple models of care at different levels are needed – however, prioritise training and service delivery at primary care level.	Very low	Strong
Trained provider in gender sensitive sexual assault care and exams available at all times at a district/area level.	Very low	Conditional