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ADDRESSING
**INTIMATE PARTNER
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EVIDENCE FOR INTERVENTIONS
IN THE HEALTH SECTOR, WOMEN'S COLLECTIVES,
AND LOCAL GOVERNANCE MECHANISMS

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EVIDENCE FOR INTERVENTIONS IN THE HEALTH SECTOR, WOMEN'S COLLECTIVES, AND LOCAL GOVERNANCE MECHANISMS

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1.

INTRODUCTION

Intimate partner violence (IPV) is defined as sexual, physical or psychological violence inflicted by a partner or ex-partner. Women across the world experience gender-based violence (GBV) and IPV. While there is agreement on the need to develop multi-sector, large-scale systemic responses to address this situation (Lancet 2014)[1], there is only fragmented evidence on what constitutes an effective response. This is particularly true at the community level, where there is a convergence of several factors that influence IPV.

This review seeks to understand how best to design responsive IPV interventions by examining relevant programs that were or are being implemented in South Asia. These interventions have all been evaluated to some extent and offer rich learning for future interventions.

The specific objectives of this review are as follows:

1. To identify past or current IPV interventions in South Asia implemented at a systemic level using one or more of the following platforms:
   a. The public health system,
   b. Local governance systems, or
   c. Women's collectives.

2. To gather, synthesize and analyze existing evidence from these programs to identify key implementation challenges and understand how to design more responsive programs, especially in India.

The three community-based platforms mentioned above have been selected because they are easily and frequently accessed by women; cover the range of interactions that a woman has with her community; and are relevant to the Indian context.

The Public Health System: The frontline (community) health workers are the most visible face of the healthcare delivery system in rural India. They are the most intimate contact that women in the community have with the government healthcare system. These workers interact with the women on personal issues such as fertility and childbirth; this makes them the institutional actors best placed to engage with women on issues as private as IPV.

Local Governance System: The Panchayati Raj Institutions (PRIs) are an extension of the state system in a village setting. Thanks to decentralization and the consequent devolution of power, the PRIs have become strong local bodies with the wherewithal to effect change at the grassroots. If mandated and sensitized, they could help

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[1] The Lancet. *Violence against women and girls (series).* Retrieved on May 25, 2016, from http://thelancet.com/series/violence-against-women-and-girls

tackle violence against women. PRIs are also an important forum because they have women's representation. Elected women's representatives understand the dynamics of their community as well as the vulnerability of their gender and are therefore well placed to drive change.

Women Collectives: Most villages in India have collectives such as self-help groups (SHGs). These groups concentrate on financial inclusion of women while also building their social capital. SHGs can therefore play an important role in negotiating power shifts in the community thereby helping address violence against women. Other groups such as those that serve as alternate dispute resolution mechanisms in rural India can serve the IPV agenda effectively.

While these platforms can play an important role in addressing violence against women, it is also important to acknowledge that, as in other parts of the world, intimate partner violence is considered a private, family conflict. Most platform-based actors would be reluctant to interfere with these matters in their individual capacity. Which is why their individual role is likely to be ad hoc and discretionary.

Institutionalized responses would fare better and this could be achieved if all platforms were to be strongly linked to each other. This review seeks to generate knowledge on how each of these platforms can work, their relative advantages and challenges, and what is required to strengthen them, both from within, as well as, in an interactive space of mutual inter dependence.

The document has been structured to this end. We have devoted a separate section to each of the platforms. Every section describes the interventions that have or are using the said platform, the challenges that these interventions face and the collective learning that can be gleaned to inform future interventions.

2.

METHODS

This report is based on a systematic review of literature. Literature accessed included published peer reviewed journal articles, books and book chapters, unpublished working papers, university theses, government reports, and donor and other organizational reports including final project reports as well as more informal progress and monitoring reports. The large majority of sources were accessed on-line, and so our review is likely an underestimate of the numbers and types of evaluated interventions. Still, we believe that we were able to find documentation and discuss major such interventions in the region.

Sources were accessed in multiple ways. We started with reviewing the evaluated interventions analyzed in a recent publication on addressing violence against women in South Asia named Violence Against Women and Girls: Lessons from South Asia (Solotaroff & Pande, 2014). We included relevant interventions from that review, and looked for references to additional programs in the bibliographies of literature on those interventions. Next, to find published journal articles and other academic pieces such as working papers or theses, key words were used in a number of search engines, including Google Scholar, PubMed, and JStor. Unpublished documents available on-line were accessed primarily through Google. Other articles were found from bibliographies of key published and unpublished papers found online. For government documents we searched through a range of government websites from Afghanistan, Bangladesh, India, Nepal, Maldives, Sri Lanka and Pakistan. These included ministries of health and ministries related to gender or women and development. We accessed donor reports via Google or donor websites; some documents were requested directly from donors via email or phone calls.

A range of search words was used in an iterative process. The most frequently used key words are listed in Table 1 on the next page.

Table 1: Illustrative key words used for literature search

Topic	Illustrative key words
General	Violence, domestic violence, interpersonal violence, violence & women, violence & gender; South Asia, each country name; evaluation, lessons learned
Public Health Sector	Various search words for domestic violence and a combination of the following: public health, community health, community health workers, hospital, one-stop crisis centers, counseling, ASHA, primary health worker
Women's Collectives	Various search words for domestic violence and a combination of the following: women's collectives, collectives, SHGs, alternate dispute resolution groups, women's justice, mahila samakhya
Local Governance	Various search words for domestic violence and a combination of the following: local governance, panchayat, jirga, shalish, village courts

3.

BACKGROUND: INTIMATE PARTNER VIOLENCE IN SOUTH ASIA

Intimate partner violence (IPV), defined as sexual, physical or psychological violence or harm committed by a partner or ex-partner, is the most common form of violence experienced by women. It is estimated that one in three women globally have experienced IPV at least once in their lifetime.[2] Recent regional estimates calculated by the WHO suggest that South Asia has the highest regional rate of IPV in the world, at 43 percent (WHO, 2013). Four South Asian countries feature among the fifteen countries with the highest national prevalence of physical intimate partner violence as reported by the Demographic and Health Surveys, with India seventh on the list. Data shows that large proportions of men and women across the region condone intimate partner violence by husbands against wives (Solotaroff & Pande, 2014).

In India, IPV is rooted in the same historical, social and cultural practices that reinforce rigid patriarchal norms of son preference and gender-biased sex selection. Patriarchal norms generate and maintain spousal power relations that sanction husbands' almost unlimited control and power over their wives. Meanwhile, a "good woman" is considered one who submits to and obeys her husband

(Pande, Falle, Rathod, Edmeades, & Krishnan, 2011). These norms contribute to high levels of acceptance of IPV by men and women both. They also contribute to a lack of openness to acknowledge and address IPV as a problem, due to stigma against those who have experienced violence and the fact that women are socialized to accept and tolerate the practice.

In the 2005-06 India National Family Health Survey (IIPS & Macro International, 2007), 40 percent of women reported having experienced some form of violence from their spouse, with 62 percent reportedly having experienced sexual or physical coercion in the first two years of marriage. A recent study in six large Indian states (Nanda, et al., 2014) reported even higher rates of IPV: more than half (52 percent) of surveyed women reported having experienced some form of spousal abuse in their lifetimes, and almost two-thirds of men (60 percent) admitted to having been violent against their wife and/or partner some time in their lives.

Unique to India, inadequate dowry is a common cause of IPV. According to Government of India statistics, in 2012, 8,233 women died violent deaths (also referred

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[2] World Health Organization. Intimate Partner and Sexual Violence against Women. 2016. Retrieved on May 25, 2016, from http://www.who.int/mediacentre/factsheets/fs239/en/

Box 1: IPV in India, some illustrative recent estimates

1 35% of women have ever suffered physical IPV

2 62% of women who ever experienced marital violence first experienced it in the initial 2 years of marriage

3 Almost twice as many married adolescents (11%) as married adults (6%) reported recent sexual spousal violence

4 46.7% of ever-married women agree that a husband may be justified in beating his wife

to as "kitchen deaths") at the hands of their husbands or in-laws due to inadequate dowry or not being able to meet excessive demands for dowry (NCRB, 2012).

Married adolescents are significantly more vulnerable than are older adult married women across South Asia, including in India where almost twice as many married adolescents (11%) as married adults (6%) reported recent sexual spousal violence (Box 1). Much of the marital abuse that South Asian women suffer likely occurs in the first few years of marriage, which, given the early average age at marriage in much of South Asia, means by adolescent married women. Because of their subservient place in the home and their stage of life as newlyweds or first-time mothers, married adolescents have little power to counter spousal harassment (Solotaroff & Pande, 2014). Thus, significant proportions of young women may try to refuse sex, but in many cases husbands force sex (Santhya, Haberland, Ram, Sinha,

& Mohanty, 2007). In Nepal, young married women enter marriage with no information about sexuality or skills to negotiate sex and are thus highly vulnerable to sexual abuse within their marriage (Pradhan, Poudel, Thomas, & Barnett, 2011). Similar is the case for physical abuse.

Programs exist across the sub-continent to address multiple forms of violence against women. Yet, as a recent review by Solotaroff and Pande (2014) concludes, a lack of rigorous evaluations makes it difficult to unequivocally identify promising approaches for prevention or response, providing services or changing societal norms and attitudes towards IPV. The review, perhaps the most comprehensive regional review of its kind to-date, does not, however, examine the specific opportunities and challenges inherent in community-based sectoral programming that integrates attention to IPV in its design and implementation. This report seeks to address this gap.

4.

RATIONALE FOR FOCUS ON THE IDENTIFIED PLATFORMS

In this report, we focus on interventions to address IPV at the community level. Because the community is the level of society closest to a woman and her family wherein different institutions of the larger ecosystem operate, this focus, we believe, offers a promising location for designing and testing multi-component strategies to address IPV that could be further scaled.

For the Indian context, we conceptualize three 'sub-levels' of the community, each of which can be considered the primary location for each of the platforms we consider (Figure 1). The three platforms of interest are: the public health system (at the service institutions level), the local governance system of the Panchayati Raj (at the political level of a community) and women's collectives (at the immediate community level). In this review paper, we critically examine the evidence from interventions that seek to use any of these platforms to also address IPV, as well as those that try combination approaches over two or all three platforms.

4.1 INSTITUTIONAL COMMUNITY LEVEL: FRONTLINE HEALTH PROVIDERS

A huge body of research recognizes the health burden of IPV and the importance of working with health care providers as key institutional actors to identify women at risk of or suffering violence, and to provide prevention and response services (Garcia-Moreno, Hegarty, d'Oliveira, Koziol-McLain, Colombini, & Feder, 2015) (Jejeebhoy, Santhya & Acharya, 2014). In India, frontline health workers like Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANM) are likely particularly critical, as they occupy an important space in women's lives such as in providing services related to fertility and childbearing. Times when women seek their services may be opportunities to screen, counsel and refer women at risk of or facing IPV to support and services.

Figure 1: Three community platforms to address IPV

Institutional Community Level	Political/Administrative Community Level	Immediate Community Level
• Public Health System at the Frontline	• Panchayati Raj Institutions	• Women's Self-Help and other Group Collectives

4.2 POLITICAL/ADMINISTRATIVE COMMUNITY LEVEL: PANCHAYATI RAJ INSTITUTIONS (PRI)

PRIs – as the form of local governance in India – incorporate the political boundaries within which community organizations link to government programs and entitlements. With decentralization and devolution of power and resources to the level of the Panchayats, not only are the elected representatives closest to understanding the power dynamics and the concerns within their communities, they also hold information and resources for some important government programs, including entitlements for women. Panchayats are also responsible for judicial mediation and justice. An IPV agenda that builds Panchayat members' perspective and ability to respond to women's needs as survivors of IPV could potentially be added to these responsibilities. PRIs also have the mandate to establish village level committees to improve and monitor delivery of essential services like health and education. These committees could be additionally charged with initiating dialogues in the community to address the detrimental influence of patriarchal norms on women's vulnerability to violence.

4.3 IMMEDIATE COMMUNITY LEVEL: WOMEN'S SHGs AND OTHER COLLECTIVES

At the level of the immediate community lies the power of women's collectivization. Such collectivization could be protective for IPV, it is argued, because it gives a woman exposure to the outside world and the opportunity to be part of a group with other women who could support her from spousal violence. Also, there is some evidence that when women join microcredit groups they get added respect or at least added value in their marital home (Jewkes, 2002) (Schuler, Hashemi, Riley, & Akhter, 1996).

There are many types of women's collectives that could potentially serve as platforms to address IPV. SHGs are one such. Through their work on women's financial inclusion and other outcomes, these groups typically focus on building the capacity of women to use the social capital they generate as a group to negotiate for shifts in gender inequitable norms and behaviors. These programs could be leveraged as viable platforms to deliver interventions to also address various types of violence against women. Broader community women's groups or women's courts (such as nyaya adalats) are another example. Their potential to counter the tendency of formal community mediation mechanisms (such as panchayats or religious-based community mediation like the shalish in Bangladesh or the jirga in Afghanistan) to want to maintain the patriarchal status quo (Vazirova, 2012) could provide an opening to also include interventions on justice for IPV.

4.4 STRUCTURE OF THIS REVIEW PAPER

We examine lessons from a range of evaluated interventions implemented via the three platforms, starting with the health sector. In each section, we do not aim to cover the entire universe of interventions currently or recently implemented across South Asia; that would be an impossible task. Rather, we focus on reviewing a critical mass of interventions that are large, well known in the field, and/or evaluated so that lessons can be drawn for future efforts. Also, we attempt to include a range of models of programmatic structure, stakeholders, and intervention activities. Finally, analysis of lessons learned from combination approaches is distributed throughout the document, placed in the section about the platform that program design suggested was the primary platform for that combination approach.

5.

INTERVENTIONS VIA THE PUBLIC HEALTH SECTOR

Primary, secondary or tertiary levels of the health sector can be engaged to provide services to IPV survivors within a community. Thus, we group the interventions analyzed in this section by level of health system at which implementation is focused (Table 2).

Table 2: Interventions for GBV using health system as a platform

Level	Program Examples

Primary Health Center (PHC) and Block level	• Training of primary health workers to screen IPV survivors (Sri Lanka)
	• Engaging community health workers to address IPV (India)
	   > Bhoomika program at block level, Kerala
	   > Mitanin program, Chhattisgarh
	   > Soukhya program, Bengaluru

Centered in a hospital + community-level engagement	• Women Friendly Hospital Initiative (Bangladesh)
	• Family Protection Unit, Indira Gandhi Memorial Hospital (IGMH), Maldives
	• GBV desks and Mithuru Piyasa service points (Sri Lanka)
	• One-Stop Crisis Centers, various (India)
	   > Up-scaled Bhoomika-OSCC, Kerala
	   > Gauravi, Madhya Pradesh
	• Multisectoral Program on Violence against Women (MSPVAW), Bangladesh
	• One-Stop Crisis Management Centers (OCMC), Nepal
	• Dilaasa Crisis Center for Women (India)
	• Comprehensive Health Sector Response to Sexual Assault (India)
	• Center for Vulnerable Women and Children (India)

These efforts do not focus solely on intimate partner violence. Rather, services are established and offered for women seeking medical care or other recourse for any type of gender-based violence they may have suffered. Still, though exact data on the distribution of users by type of violence is lacking, it is likely that IPV survivors are a large proportion, simply by virtue of its overwhelming presence in the lives of South Asian women.

5.1 INTERVENTIONS USING PHC AND BLOCK LEVEL HEALTH SYSTEM AS A PLATFORM

5.1.1 Training of frontline (community) healthcare workers

Development of a Screening Instrument to Detect Physical Abuse and its Use in a Cohort of Pregnant Women, Sri Lanka: We found one documented example of a program focused primarily on training primary health care workers. The program trained health workers to screen patients for IPV. The study in question was conducted in Badulla district, Uva province in Sri Lanka, and described an effort to develop an instrument to screen for abuse. The screening tool was tested with a cohort of pregnant women seeking ANC (Moonesinghe, Rajapaksa, & Samarasinghe, 2004). Reliability of the screening tool was tested by administering it twice with a gap of 2 weeks to 10 women. The tool was then validated by comparing results of interviews of eligible women in the hospital by public health midwives and interviews carried out independently by a clinical psychologist. More than 400 women were interviewed for the validation. Based on these assessments, the tool was judged to be reliable, and have a high sensitivity and specificity. The screening tool was then administered to a random cross-section of 1200 women by trained primary health workers. Unfortunately, we found no follow up studies that provided

any information on subsequent use of the screening tool, nor any documentation on its contents and structure. Still, this effort throws up a few lessons and questions.

First and foremost, as the authors themselves note, proper training of the community health worker who will use the screening tool is essential, as is a rigorous system of continuous monitoring and refresher trainings. The authors also note that the effort's focus on pregnant women was a project-enabling factor as pregnant women are most likely of all women to be in regular touch with, get to know, and trust the community health worker. However, the focus on pregnant women raises a question of access and generalizability. Integrating IPV-screening into pregnancy-related health services, by design, excludes non-pregnant women. In particular, such services exclude non-pregnant adolescents, older women of reproductive age who are no longer bearing children, and women post-

"The experience of a Sri Lankan program to develop an instrument to screen for abuse at the community level illustrates that proper training of the community health worker who will use the screening tool is essential, as is a rigorous system of continuous monitoring and refresher trainings."

reproductive age, all of whom are likely to be at least as much at risk of IPV – if not at higher risk – than pregnant women of childbearing age. Finally, it is unclear whether a screening instrument – or any other intervention – designed specifically with pregnant women in mind can be generalized to the population of women at risk more broadly.

5.1.2 Engaging community health workers to address GBV

Gender-based violence has been recognized as a health-related issue to be addressed under India's National Rural Health Mission (NRHM). The active engagement of community health workers such as the ASHA was envisaged as a key anchor for such activities. There are comprehensive guidelines and training manuals for ASHAs on mobilizing to address issues of gender-based violence against women[3], as well as on engaging with communities (NRHM, 2013). Yet, there is little formal evaluation of these efforts. We found some information on two programs: the pilot version of the Bhoomika program in Kerala, and the Mitanin program in Chhattisgarh. A third, the Soukhya program in Bengaluru, is not run by the government but by a coalition of organizations in collaboration with the Bengaluru municipal corporation and using local public hospitals and health providers.

Mitanin Program, Chattisgarh, India: The Mitanin program, which is considered the precursor to and motivation for the ASHA engagement in GBV-related activities in other parts of the country, has been running in Chhattisgarh since 2002. The mitanins are local women volunteers who undertake family outreach, community mobilization and social mobilization on health and its determinants, including gender-based violence. The community is engaged right from the start, including identifying and hiring the mitanin (Box 2). Mitanins were envisaged to be 'activists' who would focus on addressing issues of the poor and the marginalized in ways that would empower them, as well as providing a range of primary health services. Mitanins use a range of methods, including folk media, for social mobilization. They organize hamlet-level women's meetings to discuss GBV and other topics. Through these meetings, women are encouraged to come to the mitanins with their problems related to violence. When women bring a case, a meeting is held where the accused is also invited to attend. This meeting serves almost as an alternative dispute resolution mechanism whereby a solution is arrived at and, if the woman desires it, a police case is filed. The mitanin is then mandated to follow up and ensure that the decisions at the meeting are being followed. If the mitanin in a certain case feels she alone cannot

Box 2: The Mitanin program: engaging stakeholders to identify and select field-level program staff

The Mitanin program explicitly involved the community and explicitly considered the needs, potential and constraints of field-level workers. Selection for the mitanins was done in a collaborative way, engaging the village councils as well as the local administration, thus creating a sense of ownership. Program implementers recognized the reality of rural women's high burden of work and time limitations. Thus, the amount of household responsibilities and availability of time a woman had were seriously considered in selection, and attempts were made to select those women as mitanins who would have the time to undertake all the activities. Finally, the mitanins had strong support from Block Coordinators with whom they would discuss cases of GBV (Nandi 2012).

[3] National Rural Health Mission, Government of India. Mobilizing for Action on Violence against Women: Notes for ASHA Trainers. Retrieved June 7, 2016, from http://nrhm.gov.in/images/pdf/communitisation/asha/ASHA_Handbook-Mobilizing_for_Action_on_Violence_against_ Women_English.pdf

resolve a problem, she asks mitanins from other villages, or block coordinator level functionaries, to intervene (Nandi & Schneider, 2014) (Nandi, 2012).

By 2010, there were 10,000 mitanins spread across almost all blocks of the state. However, this was a rapid scale-up without any quantitative baseline that would enable a rigorous evaluation (Nandi & Schneider, 2014). Nonetheless, a qualitative case study in one block of the role of mitanins in resolving domestic violence disputes suggested that their presence and intervention contributed to providing a social support system for women, and also empowering women to some degree to assert themselves in the household, understand the gender-based social underpinnings of violence, and become more active in community discussions (Nandi & Schneider, 2014).

Bhoomika Centers, Kerala, India: The Bhoomika Centers in Kerala are another example. In 2009 the government of Kerala launched its Bhoomika centers in district and selected block hospitals to provide medical care to survivors of GBV. At each center, one female counselor serves as the coordinator, and medical staff at several levels are trained to work with GBV survivors. The centers are linked with a range of other service providers and stakeholders such as legal cells, police and NGOs. There is also a strong focus on community connections, and the ASHA is considered the critical link to the community. An update on the ASHA program notes that, by 2013, 10,000 ASHAs were trained under this program to discuss gender issues with the community at large, work with women to support them to report cases of violence, identify women at risk, and initiate referrals of GBV survivors to the Bhoomika centers (National Rural Health Mission, 2013). Finally, Jagriti Samithys were created at ward levels as a platform wherein women could report cases of violence to the Anganwadi workers, ASHAs and ward members. However, we found no

further evaluations of the effectiveness of these efforts.

Soukhya, Bengaluru, India: The Soukhya program, Bengaluru (2011-2014)[4] has recently concluded and thus only preliminary analyses were available at the time of writing this report. The program, in Bengaluru slums, aimed to build the capacity of the primary health care system to promote women's sexual and reproductive health and rights by responding to domestic violence. It was structured as an intervention study that used pre and post-intervention quantitative data to assess program impact on primary health care workers' knowledge, attitudes and practices related to domestic violence and women's health, and to explore the impact of the intervention on women's awareness of their rights and knowledge of resources for domestic violence-related services. Using the health center and health providers as the anchor, the program combined health services with legal aid, crisis centers, counseling, active community mobilization and awareness-raising, and advocacy with the municipal government.

Preliminary analyses show promising changes. Comparisons of pre-intervention and Round 1 post-training surveys showed that providers trained felt better equipped to identify and work with survivors of domestic abuse, felt a sense of responsibility to this work, and felt they had the skills to work with women survivors. Concomitantly, data show significant increases in domestic violence-related information given to women by doctors, nurses and community level workers trained in the program. Responses from exit interviews of a sub-sample of women using the program's health centers showed an increase in respondents' awareness of various aspects of domestic violence relative to baseline, as well as in women's confidence in the clinic and its providers.[5]

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[4] National Rural Health Mission, Government of India. Reports and Studies. Retrieved June 8, 2016, from http://nrhm.gov.in/communitisation/asha/resources/reports-studies.html

[5] Krishnan, S. *Moving from Research to Practice: Responses to Domestic Violence in Urban India.* RTI International. Retrieved on June 7, 2016, from http://www.igwg.org/igwg_media/suneeta_krishnan.pdf

5.2 INTERVENTIONS CENTERED AT A HOSPITAL

We found a much larger number of health platform-based interventions to address GBV that were centered at a district- or higher-level hospital, compared to at the level of community-based frontline health workers. Many of the examples we located are one-stop crisis center models of varying types. Others are comprehensive programs, often community-based, that link with a range of non-health sector providers including NGOs. Though evaluations are weak in most cases, assessments suggest that the extent and manner in which programs are operationalized varies systematically between those that are directed by government entities and those that are directed by NGOs. Thus, we divide our analysis of these centers here by governmental versus NGO initiative (Figure 2).

Evaluations are primarily qualitative and quantitative data are largely only provided on outputs and targets reached rather than on changes in outcomes or on attribution for changes to interventions, thus limiting the extent to which we can glean rigorous, replicable lessons.

Figure 2: Types of Health Platform-Based Interventions

5.2.1 Interventions established by government

The Bangladesh government's Women Friendly Hospital Initiative (WFHI): This initiative focuses specifically on domestic violence faced by pregnant women. Started in 1998, the initiative sought to broaden the care provided to pregnant survivors of violence beyond crisis medical care, to encompass also psychological and social issues (Haque, 2001) (Haque & Clarke, 2002). The aim was to create a hospital with 'women friendly' environment and services. The initiative encompasses four strategies: providing high-quality care, a package of mother-baby services, addressing issues of gender equity, and GBV services for violence that women face during pregnancy and childbirth. Training is given particular attention, with a focus on transforming the attitudes of – and not just providing knowledge to – health providers in the participating hospitals. Recently the program also started social mobilization and awareness raising activities about GBV and gender inequality with the broader community. This initiative is in the process of being scaled up within the current 10 program district hospitals and upazila health complexes, and another 6 district hospitals and 4 upazila health complexes are being added to the program. Documentation found on-line noted that evaluation results are not available. However, anecdotal evidence showed that the trainers themselves noted a change in their attitudes about domestic violence (Haque & Clarke, 2002).

The Maldives' Family Protection Unit (FPU) at Indira Gandhi Memorial Hospital (IGMH): This was established as a first-response center for GBV cases in Male, the capital of Maldives, in response to a qualitative study in 2004 that highlighted the need for a support center within the health system to address GBV (WHO, 2010). Under this program, 188 staff members have been trained, including 41 doctors, 117 nurses and 30 paramedical staff. The unit is housed in the hospital's outpatient center and provides medico-legal and counseling services and referral. The unit is intended to function as a comprehensive first-unit service provider within the health

system that can provide all referrals needed, and also provide safe space on-site for examination and counseling. It aims to train medical providers in how to deal with GBV cases with sensitivity at all stages, including identification, and by following a protocol and procedures. The training also includes collection of forensic evidence. Data collected by UNFPA shows that most cases that come to the unit are sexual abuse cases (UNFPA, 2009). Unfortunately we were unable to find any evaluation documentation.

The GBV desks and Mithuru Piyasa program, Sri Lanka: This program began in 2000 with GBV desks that comprised a space within a hospital where women could have privacy to talk about their IPV experiences. This was officially a government program; however, the implementation in these centers was mostly the responsibility of partner NGOs, often because staff and capacity within the health sector to address IPV was limited. Thus, the services offered were bifurcated: nurses and doctors provided "supportive listening" and referral to other medical services, while NGOs provided a range of legal, social and shelter options based on their wider networks (Guruge, Jayasuriya-Illesinghe & Gunawardena, 2015).

> **"Though evaluations are weak in most cases, assessments suggest that the extent and manner in which health sector-based programs are operationalized varies systematically between those that are directed by government entities and those that are directed by NGOs."**

In some cases, other government stakeholders such as Public Health Midwives, Social Service Workers and Women's Development Officers – were also involved (Kodikara & Piyadasa, 2012).

In 2007, the government shifted the program from being NGO-led to being an institutionalized government-run program to be scaled up nationally. Rather than being evaluated, unfortunately, the GBV desks program was closed and replaced by a larger program akin to one-stop crisis centers but with comprehensive care, called Mithuru Piyasa (Guruge, Jayasuriya-Illesinghe, & Gunawardena, 2015). The program is structured as two parallel streams of activities: referrals and care for health-related concerns occur through health facilities, while referrals and care for other concerns such as legal aid and shelters are the responsibility of and offered by partnering NGOs. Program activities incorporate an explicit effort to increase awareness about IPV, across the health system and in the community at large.

The Gauravi Center, India: This is an example of a government-run health platform endeavor to address IPV via one-stop crisis centers placed in government hospitals that had some documentation at the state level. The Gauravi center, started in collaboration with Action Aid in June 2014, was inspired by and based on the Dilaasa model (see next section).

"Located in a large district hospital in Bhopal district, the government-run Gauravi center provides shelter, a safety plan, medical, legal and police services, and a toll-free helpline number. On the first day itself the line received over 100 calls."

Located in a large district hospital in Bhopal district, the center provides medical, legal and police services, as well as shelter and a safety plan to prevent future harm. The center also launched a toll-free helpline number. Despite there being no evaluations, the demand for such a service can be guessed by the fact that on the first day itself the line received over 100 calls.[6] Once again, however, though Action Aid provides numbers of women served[7], we found no systematic evaluation of the center.

The Bhoomika program, India: Another example is the transformation in 2013 of the Bhoomika program described in an earlier section into a program of one-stop crisis centers, called Bhoomika-OSCC. These OSCC are situated in hospitals and serve as a woman's first point of contact for all services such as medical, legal aid, justice, and police.[8] These OSCC are envisaged to cover the state at district and lower levels (UN Women, 2012). However, we could find no evaluation documentation.

The Multisectoral Program on Violence against Women (MSPVAW), Bangladesh: This is a large, multisectoral effort implemented since May 2000 with the Ministry of Women and Children Affairs as the lead coordinating agency. The MSPVAW has been instrumental in establishing and scaling up hospital-based One-Stop Crisis Centers in tertiary-level medical college hospitals and One-Stop Crisis Cells in district and upazila hospitals. The program, now in its third phase, engages ten other government ministries including the Ministries of Law, Information, Education,

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[6] Madhukalya, A. (2014, June 17). One stop crisis centre to help women fight abuse. Daily News & Analysis, New Delhi. Retrieved June 8, 2016, from http://www.dnaindia.com/india/report-one-stop-crisis-centre-to-help-women-fight-abuse-1996022

[7] MP Government Launches India's First One Stop Crisis Centre in Collaboration with Actionaid India. 2014. Retrieved on June 7, 2016, from https://www.actionaidindia.org/mp-government-launches-indias-first-one-stop-crisis-centre-in-collaboration-with-actionaid-india-provides-ray-of-hope-to-women-survivors-of-gender-based-violence/

[8] National Rural Health Mission, Government of India. Reports and Studies. Retrieved June 8, 2016, from http://nrhm.gov.in/communitisation/asha/resources/reports-studies.html

Health and Family Welfare, and involves NGOs, most notably by referring violence survivors to organizations that offer services for them. Another intervention set up by the MSPVAW is the National Helpline Center for violence against women, a 24-hour helpline that can be accessed from land lines and mobile numbers using the short code 10921, and that has handled close to 18,000 calls since its opening in June 2012.[9]

The crisis-center part of the MSPVAW is intimately linked with health care provision. One-Stop Crisis Centers (OCC) have been established at seven Medical College Hospitals in the country's seven main divisions. Also aligned with the program is a National Forensic DNA Profiling Laboratory (NFDPL) in Dhaka Medical College Hospital, divisional DNA screening laboratories at divisional medical college hospitals, a National Trauma Counseling Center (NTCC) at the Department of Women Affairs (DWA), a Violence Against Women (VAW) Database, and the VAW Helpline mentioned above. At the local levels, 60 one-stop crisis cells have been set up in 40 district and 20 upazila health complexes. These are charged with providing women with information about available services, and referring them to the relevant institution for the service(s) they require. Overall, after any required emergency medical services, the OCC provide further medical services, psychosocial counseling, legal support, police protection and security.

In a multi-method evaluation conducted in 2014 (albeit without a baseline) respondents reported an increase in women's awareness of GBV and of services available through the program; and increased use of services, including shelter, rehabilitation, and legal. The biggest weakness reported by respondents was the program's perceived inability to decrease the prevalence of domestic violence (Mahmud, Nessa, Haque, & Rashid Chowdhury, 2014).

Nepal's One-Stop Crisis Management Centers (OCMC): These are also structured as nation-wide one-stop crisis centers that are linked to public health facilities and are also multisectoral in terms of government engagement. Initiated in 2011, this effort constituted the first inter-ministerial, multisectoral, and hospital-based government initiative to address gender-based violence in Nepal. The OCMCs fall under the Ministry of Health and Population, and a central Coordination Committee administers the project. These OCMCs are charged with providing six services in coordination with relevant government institutions: immediate medical treatment, psycho-social counseling, legal counseling, a safe home, security, and rehabilitation, all services that were previously scattered across a number of organizations. The government plans to establish some version of OCMCs at each level of the health system, from primary health centers all the way to hospitals in Kathmandu. As of 2014, 15 OCMCs in hospitals had been established.[10]

An assessment in 2013, based on field visits and interviews with key stakeholders and with survivors who had used the services,

"Initiated in 2011, the OCMC program constituted the first interministerial, multi-sectoral, and hospital-based government initiative to address gender based violence in Nepal. As of 2014, 15 OCMCs in hospitals had been established."

[9] Ministry of Women and Children Affairs, Government of People's Republic of Bangladesh. Multi-Sectoral Programme on Violence Against Women. DOI: http://www.mspvaw.gov.bd/, accessed on May 15, 2016

[10] http://www.nhssp.org.np/pulse/Final%20OCMC%20PDF%2025th%20Feb%202014.pdf, accessed on April 14, 2016

examined the performance of four of the hospitals with OCMCs (Ministry of Health and Population, 2013). All those interviewed strongly supported the growth of and need for OCMCs. However, with some variation across centers, the assessment found inadequacies and problems in management, human resource capacity, coordination and communication, awareness-raising among communities, and other key operational issues such as supplies, staff and referrals. Equally seriously, the review found that doctors linked to the OCMCs were not adequately trained about GBV, sexual and reproductive health or medico-legal concerns. On the positive side, despite the lack of training it appears that staff were committed to their clients, though they largely had to act on their own initiative due to the lack of institutional support.

5.2.2 Interventions initiated by NGOs

We found examples of NGO-initiated initiatives in the health sector and linked to hospitals only from India. These programs are all expansions or modifications of a one-stop crisis center approach. On the whole, these appear to have been more successful than the programs evaluated above in expanding a center to encompass several platforms beyond the health system, engaging a range of stakeholders, and thus coming closer to providing the comprehensive set of services such centers promise. Each is somewhat different and so we briefly describe the key characteristics, evaluation methodology, successes and challenges of each below, identifying also commonalities and differences between them.

Figure 3: Dilaasa provider training model

Core group in each hospital intensively trained
- 8 days over 8 months with experts + ongoing input
- Responsible for training rest of staff - owned the training, owned the project
- Active participation of male doctors

Orientation program for all staff
- 1-3 hours depending on work load + follow-up sessions
- Participatory, interative methodology
- Complusory: packaged to fit into schedule

Institutionalize within Bombay Municipal Corporation
- Training cell for BMC with core group members
- Responsible for future orientation and training

Source: Bhate-Deosthali 2012

CEHAT-India's Dilaasa model: Perhaps the best-known example is CEHAT's Dilaasa model of a one-stop crisis center that takes forward the traditional model of such a center – as followed in the Nepal and Bangladesh cases – and transforms it into a multi-platform program. Established in 2001 in Mumbai, there are now 4 Dilaasa crisis centers in different Mumbai hospitals (Bhate-Deosthali, Ravindran, & Vindhya, 2012). As with the examples from Nepal and Bangladesh, the Dilaasa centers provide a combination of crisis counseling, training of providers, shelters, legal counseling and litigation support.

There are several differences, however, between the OCMC and MSPVAW models on the one hand, and the Dilaasa model on the other. First and foremost is Dilaasa's explicit focus on recognizing the societal and patriarchal underpinnings of GBV, situating itself within the women's movement, and working with survivors within this framework (Deosthali, Maghnani, & Malik, 2005) (Centre for Enquiry into Health and Allied Themes (CEHAT), 2010) (Centre for Enquiry into Health and Allied Themes (CEHAT), 2011). Second, the OCMC and MSPVAW models are primarily motivated by and centered around public health facilities and ministries of finance. The Dilaasa center, in contrast, is a very deliberate effort by CEHAT to create a collaboration between an NGO and a public hospital so as to tap into the comparative advantages of both; all decisions are taken jointly by both sets of organizations (Deosthali, Maghnani, & Malik, 2005). In this endeavor, the program also explicitly recognized that to truly provide comprehensive services requires the centers to reach out beyond the health sector. Thus, the hospital-based centers liaise with a range of organizations, such as Majlis (a Mumbai based legal services organization for legal support), shelters, CBOs, and mahila mandals. Also in contrast to the experience of the OCMC and MSPVAW models, the Dilaasa center's implementation included an explicit broad-based effort to increase awareness and visibility of GBV within the entire hospital and broader public health system in Mumbai.

The most recently available assessment of the Dilaasa model, based on an external evaluation, case records, and staff interviews, lays out a number of strengths and challenges. Dilaasa's training process and model is a key strength. Training followed a very precise structure, as described in Figure 3. The training evaluation findings suggest that doctors can be trained to overcome their prejudice and non-gender-friendly medical training, and health facilities reoriented to systematically institutionalize standardized protocols for informed consent, identification, medical and psychosocial services, and other support for survivors of IPV (Bhate-Deosthali, Ravindran, & Vindhya, 2012). The evaluation emphasizes, however, the absolute necessity of ensuring that such protocols are indeed institutionalized throughout the health facility in question, not just ghettoized within a crisis center in a facility. Counseling was considered another strength of the program.

Dilaasa did face several challenges in counseling and training as well. A key challenge in counseling was to overcome traditional societal stigmas about women who face violence, and the insensitivity of the whole system, especially police. Training was challenging with regards to being able to persuade doctors and the health centers

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"Dilaasa-India's evaluation suggests that doctors can be trained to overcome their prejudice and non-gender-friendly medical training, and health facilities reoriented to institutionalize standardized protocols for informed consent, medical and psychosocial services, and other support for survivors of IPV."

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to allocate sufficient time for doctors in their schedule so as to enable meaningful training. Post-training, efforts were needed to integrate what doctors had learned into their daily practice and interaction with women survivors or potential victims of IPV.

CEHAT's Comprehensive Health Sector Response to Sexual Assault, India: This program reflects the organization's effort to implement a similar 'one-stop' approach to address sexual violence. Based in Mumbai, these centers do not specifically deal with IPV but with sexual assault and rape more broadly. This holds lessons for identifying and addressing the needs of survivors of sexual partner violence. In particular, it is a good example of how limitations of an earlier version of an intervention were addressed to enable the intervention to grow and evolve.

The initial intervention model comprised a kit for thorough medical examination and collection of evidence for rape survivors, a detailed personal history form, and a manual that explains consent and other procedures. This kit, named the SAFE kit, was implemented by CEHAT in two hospitals in Mumbai, combined with intensive training and crisis intervention services for survivors (Contractor & Rege, 2009). Though we were unable to find a rigorous evaluation of the SAFE kit per se, still the observational assessment of the implementation of this kit highlighted several problems that are pertinent to efforts to address sexual marital violence (Contractor & Rege, 2009). These include: lack of proper consent procedures; the lack of privacy for an examination; the insistence on a gynecologist conducting the examination which can lead to delays; the lack of clear responsibility for custody of evidence collected, and no sensitivity or flexibility in how much information is collected and testing conducted keeping in

Figure 4: Dilaasa - response to sexual assault via health system

PROGRAM COMPONENTS	OPERATIONALIZATION
Seeking informed consent from the survivor	Standardized, gender-sensitive proforma for history, exam findings, medical opinion, treatment
Comprehensive medico-legal documentation & evidence collection	Capacity building & training for health care providers
Maintaining a fool-proof chain of custody re: forensic evidence	Ongoing assistance to examining doctor by CEHAT
Coordination with external agencies: forensic lab, police, media, courts	Crisis intervention services to survivors
Provision of medical treatment	Coordination with forensic laboratory and police
Provision of psycho-social and other support services	

Source: CEHAT 2012

mind the client's situation. The study suggested that protocols alone cannot change the way that health centers interact with survivors of sexual assault; rather, protocols need to be accompanied by high-quality training of providers, as well as additional services for survivors such as psycho-social services, counseling, crisis intervention, and access to police and/or judicial services.

CEHAT built on this model to create a more comprehensive approach to sexual assault intervention through the health sector. In addition to the SAFE kit and associated training, the comprehensive approach also included crisis centers, liaison with police and justice institutions, legal aid, provision of psychosocial support and shelters if needed, and free treatment for health and other consequences of the assault in question. The hospital in which the intervention was housed liaised with a number of other organizations, such as the Forensic Science Laboratory and community-based organizations (Figure 4). This program was conceptualized as an intervention research study. Though the evaluation was not experimental in design, the study report uses a large range of sources of information, including in-patient case papers, survivor information forms, and documentation of every case attended in participating hospitals, a total of 94 between 2008 and 2012. The report notes several key challenges faced by the program, such as follow-up. Its two main conclusions were the need for a multi-pronged approach to effectively address sexual violence, and the urgency to change medical training and practice so as to adopt more gender-sensitive training that could be responsive to sexual violence and other gender-related issues that women may bring to a health center. Also, findings showed that with adequate training, medical professionals would treat survivors appropriately, and would adopt consent and confidentiality forms and processes. Related is the need to adopt standard operating procedures, especially for issues that remain particularly sensitive in the Indian context, such as marital rape (Centre for Enquiry into Health and Allied Themes (CEHAT), 2012).

Sneha-India's Center for Vulnerable Women and Children, Mumbai, India: This NGO's program to address IPV started in 2000 as a crisis center (the Center for Vulnerable Women and Children) when health workers at Lokmanya Tilak Memorial General Hospital (LTMG) in Mumbai realized that they could provide basic injury care but couldn't provide other services, such as counseling, for survivors. The center was set up in response, and structured as a partnership between Mumbai Municipal Corporation and Sneha. In contrast to all other crisis center models explored in this review, Sneha's center was linked to the LTMG hospital but not situated inside the hospital – rather, it was placed within the community that the hospital served. The center aimed to provide comprehensive care addressing medical, psychosocial, shelter, legal, and economic issues. Women could access the center directly or be referred from elsewhere. We did not find an evaluation, but program records show that between 2001 and 2006, 715 clients sought help, with an annual increase in numbers. The initial challenges were similar to those faced by almost all types of programs that try to address IPV: the invisibility of domestic and intimate partner violence, the urgency among women to keep the family intact, and women's need for a range of services beyond health care but lack of awareness of many of these other services such as legal aid. Other key challenges included the lack of adequate space in the hospital. Of all the programs identified here, Sneha was the only one that also identified spousal alcoholism as a key risk factor for violence against women (Daruwalla, Fernandez, Salam, Shaikh, & Osrin, 2009).

5.3 CHALLENGES AND GAPS IN HEALTH SECTOR PLATFORM-BASED APPROACHES

Despite the lack of rigorous evaluations there are some clear challenges, gaps and questions to consider going forward. We group these into seven main types (Box 3).

Documentation and evaluation: The first clear challenge is the lack of systematic process

documentation and rigorous evaluation. This hampers learning from prior interventions in two ways. First, there are likely scores of good programs across South Asia but documentation is not publicly accessible. Second, without rigorous evaluation, it is impossible to tease out definitively what works, what doesn't, and why. This is particularly critical at this juncture for India as the one-stop crisis model starts to be increasingly institutionalized. In 2015, the Ministry for Women and Child Development laid out detailed guidelines for a One Stop Center Scheme for states and union territories.[11] However, as even our limited review clearly establishes, there are several alternate ways in which such centers can be structured, operationalized, and maintained. To make the envisaged scale up of the OSCC model successful we need more data and evaluation on what specifically works in what context. Further, there are now national guidelines to universalize women's helplines, with a recommendation that these be integrated with the One Stop Center Scheme,[12] but we found no documentation or analysis that evaluates the added value of a helpline to a center's functionality or how best to integrate such a helpline with a center's gamut of other services.

Provider challenges: There are several challenges in engaging health care professionals in IPV mitigation. First, the very health providers who are being tasked with addressing GBV may themselves have gender insensitive norms and beliefs, be it doctors, nurses or community health workers. For instance, in a study of 67 ASHAs in Karnataka cited by UN Women (2012), 87 per cent of those interviewed agreed that a husband has the right to beat his wife if she cheats on him and 78 per cent agreed that a woman should tolerate violence to keep her family together.

Another issue is the challenge of adding yet one more responsibility to health providers' tasks when IPV is included in their mandate and without accompanying support. This is especially true for the ASHA and other community-based workers. They are typically over-worked and underpaid, as reported by the Eleventh Report of the Parliamentary Committee on Empowerment of Women. ASHAs also reportedly themselves face discrimination and

Box 3: Types of challenges for health system as a platform to address IPV

1 — Lack of systematic process documentation & evaluation

2 — Provider challenges

3 — Operationalization problems

4 — Choice of and engagement with population served

5 — Engaging men in provision of services against intimate partner violence

6 — Addressing IPV effectively when mandate is for broader GBV

7 — Defining the scope of the health sector's engagement and responsibilities

[11] Ministry of Women and Child Development, Government of India. 2015. One Stop Centre Scheme: Implementation Guide for State Governments/UT Administrations. New Delhi. Retrieved on June 7, 2016, from http://www.wcdhry.gov.in/oscg.pdf

[12] Ministry of Women and Child Development, Government of India. 2015. Universalisation of Women Helpline Scheme: Implementation Guide for State Governments/UT Administrations. New Delhi. Retrieved on June 8, 2016, from http://wcd.nic.in/sites/default/files/GuidelineapprovedMinisterandwebsite_1.pdf

Box 4: Elements of Informed Consent operationalized by Sneha

1 Ethical considerations are explicitly core to program implementation

2 Women are assured complete confidentiality and their information is not shared with the perpetrator's family, community members or the media under any circumstances.

3 Women are informed that the information is anonymous and all names removed on the case sheet

4 Women are informed that their (anonymous) data could be used for analysis with an objective to improve service provision

5 Women are informed about their right to access their records for evidence building of their legal cases.

6 Consent is taken from all women who access services; for minor girls, consent is taken from their legal guardian.

7 Sneha community volunteers sign a formal agreement about voluntary consent, wherein they also agree to maintain confidentiality and a sensitive approach.

a lack of support for the 'extra' activities related to violence redressal that they are expected to implement (UN Women, 2012). Finally, they may face hostility from men in the community as they engage on issues of violence or gender inequality, as experienced by front line workers across some of the community programs reviewed here (Nandi, 2012). The Soukhya program in Bengaluru has ongoing efforts to advocate for the working and pay conditions of frontline female health workers to address this and related concerns.

The Dilaasa program notes another important challenge, namely, providers' hesitation to document forensic evidence of sexual assault because of reluctance to appear in court (WHO, 2010). This unwillingness may arise partly out of the time pressure that health providers typically already face; however, the reluctance may also reflect wide-ranging suspicion of the justice system in many parts of South Asia and a skepticism of its ability to provide a fair adjudication in cases of violence against women.

These challenges have serious implications for scale-up. The expectation from the front-

line health worker-based responses to IPV run by state governments such as the Bhoomika and Mitanin programs has been that such initiatives can be scaled up in the government system via the ASHAs. However, an overall recent assessment of the attempts to make the NRHM more gender sensitive suggests that very little progress has been made in addressing GBV under the NRHM and through the ASHAs (UN Women, 2012), quite possibly at least partly due to challenges such as the ones outlined above.

A key provider challenge is the limited discussion and use of established informed consent procedures. Notable exceptions are the Dilaasa and Sneha programs, which have a formal system for training providers in implementing an informed consent process (see Box 4 for Sneha's informed consent process), and the Mitanin program that has an informal consent process. Given the sensitivity – emotional, personal and social – of IPV, the lack of consent procedures is a concern.

Challenges in operationalization: The OCMC programs in particular face enormous challenges in operationalization. For instance, in the Nepal and Bangladesh government-

run centers, poor communication and coordination persisted among the different ministries, as well as between different governmental and non-governmental stakeholders, hampering efforts to convene meetings, to link survivors with NGOs for ongoing rehabilitation, and to place adequate female police officers in OCMCs (Solotaroff & Pande, 2014) (Guruge, Jayasuriya-Illesinghe, & Gunawardena, 2015) (Mahmud, Nessa, Haque, & Rashid Chowdhury, 2014). Also at least in part because of the lack of proper coordination, programs have suffered from an uncertain quality of services. In Nepal, these include an inability to provide the planned 24-hour service; lack of adequate and committed staff; inadequate medical and other supplies; poor follow-up of clients; inaccessible centers; lack of proper financial arrangements for referral; and ineffective provision of other services such as linking victims with lawyers for legal guidance, NGOs for rehabilitation, and police for security (Solotaroff & Pande, 2014). The Mithuru Piyasa program faced a different challenge in providing quality services: notable gaps in knowledge about IPV, and stigmatizing attitudes about survivors among health providers (Guruge, Jayasuriya-Illesinghe, & Gunawardena, 2015).

"For hospital-based approaches, raising awareness of their services may be a particularly critical issue, because, unlike community-based programming, efforts to address GBV through hospital-based centers reach only those who access services rather than women in the broader community."

All the programs identified face a challenge in raising awareness of their services. For hospital-based approaches this may be a particularly critical issue, because, unlike community-based programming, efforts to address GBV through hospital-based centers reach only those who access services rather than women in the broader community.

Hospital-based interventions also seem to face acute shortages of space, be it in India, Nepal or Bangladesh. Importantly, the lack of space impinges on the potential for maintaining confidentiality, and could potentially discourage women from seeking care. The Soukhya program also points to another challenge in providing such a broad range of services, namely, being able to find providers who are willing to provide community services, and to provide them free if needed.

Engaging NGOs as partners may mitigate some of these lacunae. However, when governments engage NGOs in running their centers but where the government ministry is in charge, other challenges can occur. For instance, the NGOs working alongside government in the Mithuru Piyasa program were expected to provide services and shelters but did not receive appropriate funding from the government. In addition, in the post-conflict situation particular to Sri Lanka, NGOs started to face increased restrictions on activities and fund raising. Finally, legal and administrative barriers can often discourage NGOs and women from seeking legal aid and other social services (Guruge, Jayasuriya-Illesinghe, & Gunawardena, 2015).

There is also some concern about combining health service provision with provision for gender-based violence services relating to stigma, which can go both ways and adversely affect the use of either set of services. For instance, staff of stand-alone shelters in Nepal found that women who need IPV-related services were sometimes reluctant to come to service centers that also served women and men with communicable diseases like HIV, or that housed trafficked women, because of the stigma associated with these populations (Solotaroff & Pande, 2014). Similarly, women who need health

services may be reluctant to come to a health facility that houses services for certain kinds of abuse – such as sexual abuse – that are considered particularly stigmatizing. This is not to suggest that health facilities not be used as a platform for GBV services; rather, this is to emphasize the need to address such potentially stigmatizing attitudes through appropriate, sensitive training of professionals and intensive sensitization and awareness-raising among the client communities of the health facility that serves as a platform for GBV-related services.

Finally, where women have had negative experiences in seeking health care they may be unwilling to trust or access health services for IPV issues. Thus, as the Soukhya program found, several kinds of efforts may be required to encourage women to open up to health providers.

Populations served: By and large, programs served all women of all ages in the communities that were within the ambit of the health provider or facility. Two programs (the Women Friendly Health Initiative in Bangladesh and the CHW training program in Sri Lanka) focused specifically on pregnant women. The focus on pregnant women is motivated by research showing higher risks of spousal and domestic violence during pregnancy. However, efforts to scale up or replicate such focused programs need to consider the extent to which approaches and activities specific to pregnant women can serve the general population of women equally effectively.

A second issue concerns adolescent versus adult women. Data from several parts of South Asia document that adolescent girls and women are at higher risk of partner abuse than are adult women; similarly, married adolescents face higher risks of spousal violence than do married adult women. Decades of intervention research in South Asia – including in India – have also demonstrated that a special effort needs to be made to make health services attractive to, accessible and used by married or unmarried adolescents (Pande, Kurz, Walia, McQuarrie, & Jain, 2006). Yet none of the

health sector-based programs assessed here mention this particular high-risk population or extra efforts made to identify or work with adolescent survivors of IPV.

Engaging men: Few of the health platform-based models reviewed above discuss the fact that in partner violence there are two actors: the survivor as well as the perpetrator. Thus, services are offered to the survivor alone. But in the absence of understanding and appreciating the societal and familial constraints that govern a woman's relationship with her spouse, it is likely to be difficult to provide any services except immediate medical attention. Even provision of legal aid, justice, rehabilitation or shelter is likely to be more effective if there is some engagement with men in the concerned community. Sneha's program in Mumbai slums provides some insight into how to engage men; further evaluation is needed, however.

Focus on GBV versus IPV: Almost all the programs identified focus on and provide services to address a broad range of gender-based violence that women may suffer

"Health facilities that address both partner and non-partner abuse need to ensure that providers are trained specifically on how to address the constraints arising out of either type of violence, and to address other differences between partner and non-partner violence, so as to make services effective for both types of abuse."

regardless of type of violence or perpetrator. Conceptually and in terms of what women need, this is likely essential. However, this broad-based focus does raise issues for the kinds of training and services offered. In particular, though all forms of gender-based violence arise from the same patriarchal underpinnings, the extent of stigma, willingness or lack thereof to disclose, family and community support and other factors may vary by type of violence, its location and the main perpetrator. For example, studies in South Asia and globally demonstrate that women are unwilling or unable to leave an abusive spouse. Thus, in the case of IPV, health providers engaged with survivors need to understand and work with this preference among abused women. This is not an issue for non-partner GBV. Thus health facilities that address both partner and non-partner abuse need to ensure that providers are trained specifically on how to address the constraints and norms arising out of either type of violence. Training needs also to isolate and address other differences between partner and non-partner violence so as to make services effective for both types of abuse.

Challenges related to scope of activities and reach: On the one hand, health facilities

seem to be the natural platform to combine IPV-prevention and response activities as this is the platform that is likely to be the first point of contact with an abused woman given the physical ramifications of violence. On the other hand, it is important to debate the expectations that can be held of health platform-based efforts. For instance, one critique of Bangladesh's one stop model is its apparent inability to prevent recurrence of violence (Mahmud, Nessa, Haque, & Rashid Chowdhury, 2014). Is it reasonable or realistic to expect a hospital to get engaged in the dynamics of households and communities at large? Taking this issue to its logical conclusion: how far should a hospital-based – or even ASHA-focused – approach go in trying to address all the different aspects, constraints, risk factors, perpetrators, circumstances surrounding GBV or even IPV, for the present and the future? It is likely critical to define the scope of health platform-based programs so as to accurately define what is 'success', and how to measure it; however, none of the documentation we reviewed included such a discussion.

Finally, for hospital-based one-stop crisis center models that do not have a strong element of community-based identification of survivors of IPV, only those women who specifically go to the hospital are going to be able to access services related to GBV. By design this is inevitable, unless hospital-based centers are firmly and actively linked to community-based mobilization and awareness-raising around GBV. This again raises the question of how far to stretch the mandate of hospital-based programs versus more community-based programs that use the health system as a platform to engage on GBV.

"It is important to debate the expectations held of health platform-based efforts, and to accurately define what is 'success' and how to measure it: for instance, is it reasonable to expect a hospital to get engaged in dynamics of households that underlie IPV?"

5.4 ELEMENTS CONTRIBUTING TO EFFECTIVENESS OF HEALTH PLATFORM APPROACHES

While in the absence of rigorous evaluation it is difficult to isolate exactly the extent to which particular elements of different programs may have contributed to their effectiveness, there are a few programmatic aspects that we would like to highlight as likely to be important.

Providing clear protocols, procedures and responsibilities: The most promising programs appear to have in place clear, unequivocal procedures and protocols for how each medical provider must interact with those seeking care for GBV. In addition, responsibilities are clearly demarcated and assigned between the different types of providers engaged.

Tenure and quality of training: Given the strength of the patriarchal norms that underlie gender-based violence, and the likelihood that many providers (at all levels of the health system) are likely to have internalized at least some of these norms, training needs to be carefully designed. The training modules used by CEHAT, Sneha and the Mitanin program provide good case studies on how field-level health workers can be trained using a feminist, activist perspective that looks to address GBV in the short, medium and long terms. CEHAT also provides an example of a curriculum that is suitable for hospital practitioners. The Soukhya experience suggests that the training has to be intensive and of a relatively long duration to begin with so as to overcome initial prejudices, stigma and lack of awareness. Once again, however, we have no objective evaluation that could point the way to which aspects of a training are stronger or weaker than others, and how best to implement and follow up on such training. Nonetheless, it seems clear that at the very least there is a need for training that (a) is rigorous; (b) is repeated in ways that reinforces lessons learned and learns from past mistakes; (c) relates observed GBV to underlying patriarchy, and, (d) addresses provider bias and acknowledges provider experiences.

Engaging other stakeholders and groups in the community: For the long-term success of all efforts to address GBV it is likely essential to engage the rest of the community, including men, panchayats, other influential individuals, other community groups, youth, and community members at large. For programs that work through community-based health workers or in close collaboration with NGOs, the reason is clear – these programs seek to change the underlying norms that perpetuate GBV and to do so, community members other than individual women need to be actively engaged. Some of the programs that engage other stakeholders in the community do so by becoming a multi-platform program, including engaging SHGs or panchayats, like the Mitanin program. Others do not create or work through other platforms like SHGs or panchayats, but still engage actively with the community, for instance by training health workers themselves to engage community members and other stakeholders, like the Soukhya program. For crisis centers that are based within hospitals, however, the importance of community engagement raises again the question as to what is the ideal, practical and feasible scope of activities and reach for such a program.

6.

INTERVENTIONS VIA WOMEN'S COMMUNITY LEVEL COLLECTIVES

We have grouped the collectives reviewed here into: (1) women's groups created as alternate dispute resolution mechanisms; (2) women's groups structured around finances (microfinance, microcredit, and SHGs); and (3) community-based women's groups of all other kinds (Table 3). We first describe examples and basic evaluation results for the efforts to address IPV via these collectives, and then move to a discussion of challenges and lessons learned for all forms of collectives together.

6.1 WOMEN'S GROUPS CREATED AS ALTERNATE DISPUTE RESOLUTION MECHANISMS

India has thousands of women's collectives spread across the country's villages and slums that serve as alternate dispute resolution avenues (Vatuk, 2013). These collectives not only provide petitioners with justice but also work on the larger issue of gender equality. This section looks at some important examples.

The Mahila Samakhya Program, India: Perhaps the largest number of collectives such as sanghas and nari adalats have been set up under the auspices of the Mahila Samakhya program. Of these, three have been evaluated qualitatively (Bhatla and Rajan 2003) (Burton, Rajan and Bhatla 2002):

- The Shramajibee Mahila Samity (SMS) in Bengal
- The Sahara Sangh and Nari Adalat in Uttar Pradesh.
- The Nari Adalat and Mahila Panch in Gujarat.

The three sets of collectives have been analyzed using a combination of case studies, qualitative interviews and small surveys. Though not an experimental design, from these evaluations it is possible to understand what contributed to reported program effectiveness. To begin with, these collectives were set up as formal groups that meant business. They had clear rules and regulations on aspects such as membership, transparency, operations and documentation. These rules are adhered to; the group takes both itself and its mandate seriously and resultantly so do others.

Another reason why these collectives are respected, especially by traditional patriarchal groups such as men, panchayats and government departments, is because they work with these very groups in dispensing justice. For example SMS in Bengal engages the Panchayat in deliberations as often as is relevant and possible. To work within traditional structures, it positions the collectives as a complementary structure and not a threatening one. While the collectives work in a non-threatening, participative way, their quasi-legal status and well-trained staff gives them the ability to hold firm and balance between justice and feasibility, given the norms.

Table 3: Interventions for GBV using women's collectives as a platform

Platforms	Example of programs
Alternate dispute resolution (ADR) groups	• Shramajibee Mahila Samity, India • Mahila Samakhya-based groups, India • Sahara Sangh and Nari Adalat in Uttar Pradesh, India • Nari Adalat and Mahila Panch in Gujarat, India • Saurashtra-Kutch Group on Violence Against Women, India • Women's Resource Centers, India • International NGOs Partnership Agreement Program (IPAP) ADRs, India • Integrated Development Program of Women-Cooperatives to Reduce Gender-Based Violence, Nepal • Mahila Panchayats, Delhi, India
Financial groups (microcredit, microfinance, SHG)	• BRAC microcredit and microfinance groups, Bangladesh • Grameen Bank, Bangladesh • Mahalir Thittam program, India • Karnataka Urban Infrastructure Development Project SHG federations, India • Velugu program, India
Other women's empowerment-focused collectives	• PROTIRODH program, Bangladesh • Prevention of Violence Against Women and Children, India • Western India Gender Justice Program, India

The processes and judgments are cognizant of local values and norms as far as possible, and women leaders attempt to arrive at judgments that are legally sound but culturally feasible without compromising a woman's dignity (Figure 5).

Figure 5: Illustrative process of adjudication by a women's collective

- Encourage women to protest IPV and refer to collective
- Provide support, legal and other services to supplicant
- Require a written application to be submitted by supplicant
- Gather information on dispute, contentions, neighborhood support
- Use persuasion + pressure to get perpetrator to the hearing

At the hearing
- Structured as a public hearing
- Includes the woman, family members, and influentials
- Participatory decision-making while respecting the woman's wishes
- Decision is written down, signed by both parties, witnessed

Post-hearing
- Main adjudicator keeps in touch with the couple to follow up
- Public committee ensures that decisions are taken and liaises with the collective
- Follow-up hearings arranged if needed

"The sanghas and nari adalats of India's Mahila Samakhya program adopted processes that recognized local values and norms, and women leaders attempted to arrive at judgments that were legally sound but culturally feasible without compromising a woman's dignity."

The Saurashtra-Kutch Group on Violence Against Women (SK-VAW), Gujarat, India: The SK-VAW was established in 2000 by a group of NGOs in Gujarat. At the heart of the program are women's justice collectives called mahila nyaya samiti. They aim to facilitate justice in a democratic and participatory manner. These collectives are supported by a federation of women's forums that are well connected to important constituencies: judicial organizations, international networks, governance institutions and policy makers.

A case study assessment has shown that training is considered critical within the organization as well as in the larger community. The staff and women leaders of the main federation are trained on subjects like various forms of VAW and the legal and extra legal mechanisms available to provide justice. These women then form a resource

team that trains women in the district who then train women in the local areas to form the nyaya samities. The SK-VAW also actively seeks the engagement of men, community groups, government bodies and other stakeholders in order to mainstream the issue of violence against women.

The Women's Resource Centers (WRC) Udaipur district, India: These centers are part of a larger community-development program run by Seva Mandir in the tribal belts of Rajasthan. They emerged as a SHG response to the increasing emergence of domestic violence in the immediate geography and were created as an alternate dispute resolution mechanism for tribal women who did not have access to conventional platforms. The only evaluation of this program found is a qualitative study (Cavas, 2013) based on 21 in-depth interviews, 2 focus group discussions and observations of several women's group meetings.

As with other collectives, WRCs focus on intensive training of women members and leaders. Additionally the centers have been able to leverage the skilled human resources available with Seva Mandir for its other programs related to women's justice. Conflicts do arise between staff of different, connected programs on the future course of the WRCs, creating a challenge to the collaboration. Qualitative analysis shows that these collectives seem to have had some influence on community norms about women's justice and empowerment.

The International NGOs Partnership Agreement Program (IPAP), India: This program sets up women's dispute resolution collectives to operationalize five of its larger program strategies: provision of support services to survivors; sensitizing a range of governmental and non-governmental providers; community mobilization against VAW; creating and strengthening village-level structures to provide support mechanisms for women facing violence; and, lobbying and advocating with policymakers on law and policy.

These collectives were structured to reach up to the district level, and – depending on the state in question – operated together with SHGs, support centers, etc. The evaluation

"IPAP-India's evaluation found that, compared to control areas, the program was effective in raising awareness of domestic violence, especially among men; contributing to a gendered understanding of the causes of domestic violence, especially among women; the use of police and legal mechanisms and higher reporting of domestic violence."

report's description of one collective, the Nyaya Samiti in Gujarat, provides some insights into the strengths of this strategy. The samiti operates at both village and block levels so women can choose the level to access. For domestic violence cases that are particularly sensitive, women can choose to seek the block-level samiti where they may consider the judgment more objective, coming from women from villages other than their own.

The samitis have sound principles of engagement: a deep empathy for supplicants; linking violence against women with the use of power; focusing on normative change as essential for lasting impact; ensuring that a woman's concerns are given ample space and time to be aired; and, using objective and impartial arguments to find a mutually acceptable solution, but where the woman's rights are upheld in the family (Oxfam India 2014). Adherence to these principles is seen as one of the reasons for the collective's success.

The evaluation found that the program as a whole was effective in addressing a number of VAW concerns compared to control areas. This included: raising awareness of domestic violence, especially among men; contributing

to a gendered understanding of the causes of domestic violence, especially among women; use of police and legal mechanisms and higher reporting of domestic violence (Oxfam India 2014).

Mahila panchayats, Delhi, India: These collectives, started by Action India in 1993, were staffed by trained NGO members who were themselves women from slum communities. The mahila panchayats provided emotional support, financial recourse, legal advice and conflict resolution for women who brought them cases. Over a period of nine years, nine mahila panchayats in different parts of Delhi resolved 24,000 cases.[13] Thereafter, Action India worked with the Delhi Commission for Women to scale up the program through a network of NGOs working in slums across Delhi.[14]

Unfortunately, we found no rigorous evaluation of either the initial program or the scale-up. A qualitative evaluation (Magar, 2003) suggests that the mahila panchayat was effective in promoting women's empowerment at both, the individual as well as the group level and bringing changes in community mindsets about gender roles and inequality. Importantly, these groups engaged men, not just as perpetrators who were compelled to take responsibility for their acts of violence,

"Qualitative assessments suggest that in depth training, exposure visits to police and courts, ongoing support, linkages with other services such as support centers, shelter homes, and one stop crisis management centers were important ingredients of effectiveness for Nepal's PLC program."

but also as people who needed social support to improve their interaction with their wives and families.

The Integrated Development Program of Women's Cooperatives to Reduce Gender-Based Violence, Nepal: This offers an example of a slightly different model (UNFPA Nepal, UNICEF Nepal, UN Women Nepal, 2011).[15] The program started in 2010, and worked with Para-Legal Committees (PLCs) made up of women volunteers; these committees had existed since 1999 across Nepali villages to address violence against women. The program aimed for: legal empowerment of women and children, early detection of GBV, referral, and follow-up.

At the time of the reviews used in this analysis, more than 1000 PLCs had been formed, under as many Village Development Councils.[16] Women participants received intensive inputs and training to build their confidence and knowledge as PLC members, facilitate their efforts to develop links with other stakeholders, and get greater community respect. As with some other programs reviewed in this report, the program sought to bring together multiple stakeholders at all levels. Unfortunately, the final evaluation is not yet available. Interviews held as part of the qualitative assessment in annual and progress reports revealed that key ingredients of success were considered to be: in depth training, exposure visits to police and courts, ongoing support, VDC level groups and linkages with other services where they exist such as support centers run by the district police, shelter homes managed by NGOs, and one stop crisis management centers managed by district hospitals.[17]

[13] http://old.action-india.org/mahila_panchayat.html, accessed on June 8, 2016

[14] http://www.delhi.gov.in/wps/wcm/connect/lib_dcw/DCW/Home/Projects/Mahila+Panchayats, accessed on June 8, 2016

[15] DFID annual review 2013 (iati.dfid.gov.uk/iati_documents/3898751.doc) and DFID program completion report 2014 (iati.dfid.gov.uk/iati_documents/4692034.odt).

[16] Village Development Councils or VDCs are the lowest level of governance in Nepal.

[17] DFID program completion report 2014 (iati.dfid.gov.uk/iati_documents/4692034.odt)

6.2 WOMEN'S MICRO-CREDIT AND OTHER FINANCIAL GROUPS

There is a vast literature debating how, whether and to what extent women's participation in microcredit, microfinance or SHGs can lower the risk of intimate partner violence. We summarize the main arguments here (Box 5).

6.2.1 Collectives at the SHG level

Microfinance programs, Bangladesh: While several organizations run microfinance programs in Bangladesh, we focus here on BRAC. Findings for BRAC's microfinance programs are mixed.

Based on qualitative data and a survey of members and non-members of BRAC's program in six villages, Schuler et al (1996) find that, participation in micro-credit groups may put women at higher risk of domestic violence because such participation is seen as threatening the status quo. However, as benefits start to flow to households and group participation becomes a norm, the risk of violence eventually decreases. Increased participation may also change women's perceptions of themselves and their rights, further contributing to a decline in risks of violence. Other reasons could include the possibility that husbands became used to their

wives' participation and the wives' ability to negotiate increased empowerment at home. However, in a different region of the country, also using survey data from members and non-members, Ahmed (2005) did not find any statistically significant effect for BRAC membership on women's risks of IPV.

Based on a review of several such studies, of microfinance programs by BRAC and others in Bangladesh, Kabeer (2000) (2005) concluded that microfinance or microcredit is not a "magic bullet" for women's empowerment. In certain contexts women experience an eventual decline in violence because of a combination of the extra resources they bring into the household and the power they gain from being a group. Others (Bates, Schuler, Islam, & Islam, 2004) (Bajracharya & Amin, 2013) (Husain, Mukherjee, & Dutta, 2010) argue that there may be a selection bias at work in many of these studies. Such a bias could operate in two directions. Women who join may be more empowered to begin with and thus less susceptible to violence in any case. Alternatively, women who join may be forced by the family to do so for the envisaged financial benefits, and thus may be less empowered than average and more susceptible to violence to begin with.

Box 5: Relationship between membership in financial collective and IPV vulnerability

Reasons for a beneficial association
- Financial benefits for spouse and household
- Skills training gives women ability to negotiate
- Group pressure and network to support the woman

Caveats and alternate findings
- No statistically significant effect on IPV risk
- Participation increases risks of IPV
- No individual effect, but there is a community effect
- Effect depends on context and services offered
- Non-linear effect: first higher risks as threaten status quo, then lower risks as financial benefits flow into household
- Selection bias

The Swarna Jayanti Shahari Swarojgar Yojana program, West Bengal, India: Under this, SHGs were formed as part of a larger urban self-employment program for people below the poverty line, with an explicit focus on women. The formation of women's self-help groups was one of the many strategies; that provided skills training and other inputs for micro-enterprise.[18]

An analysis by Husain et al. (2010) compared the effect of the program on empowerment between newly inducted members and older members to gauge a program effect. The authors found that seventy-five percent of members interviewed said they were treated with more respect after they joined the program. The main reported reasons were their income contribution to the household and an increase in their self-respect.

Yet, 60 percent of interviewed women in the program had been engaged in traditional income-generating enterprises even prior to the program. The SHGs had added an infusion of credit and organized individual efforts into a group dynamic, but added no new livelihood opportunities to the traditional ones. Based on this, the authors argue that the observed salutary effect of the program on IPV may in part be due to the fact that the program did not try to change the patriarchal nature of women's lives and work, but, rather, facilitated their earnings within the same socially-sanctioned types of work as already existed.

"Debate continues about how, whether and to what extent women's participation in microcredit, microfinance or SHGs can lower the risk of intimate partner violence."

6.2.2 Collectives at the SHG Federation Level

State-level efforts across many states in India have created large federations of SHGs that have at their center some element of micro-finance, micro credit or micro-enterprise. These platforms also provide broader benefits: economic, social and political.

For the most part these do not seem to have been evaluated specifically for their effectiveness in addressing intimate partner violence. Moreover, several of the evaluations are primarily descriptive or qualitative, thus making it difficult to ascribe causation to observed changes.

However given that women's empowerment is an explicit part of many of these initiatives, assessments of the observed changes in social and economic empowerment provide some insight into how SHG participation can serve as a platform to engage women, enhance their power, and thus hopefully decrease their vulnerability to spousal abuse. We review here three such SHG federations.

Mahalir Thittam and its follow-up Pudhu Vaazhvu Program (PVP), launched in 1996 by the Tamil Nadu state government, is the first statewide SHG program in India to be fully financed by the state government. In 2005, the PVP was created to further propel the SHG program by addressing some key concerns of the Mahalir Thittam program: challenges of exclusion of the poorest, debt reduction, diversification in livelihood portfolios, and stronger linkages to local government (Khanna, Kochhar, & Palaniswamy, 2015).

Both versions of the program, focused on poor and disadvantaged women, aimed to empower them socially and financially and build their capacity for leadership and other skills. Training is considered a critical element for success and is carefully structured for different stakeholders. SHGs are regularly evaluated and given a credit rating, based on

[18] Reserve Bank of India. Master Circular Priority Sector Lending- Special Programmes Swarna Jayanti Shahari Rozgar Yojana (SJSRY). 2010. Retrieved on June 9, 2016, from http://www.apmepma.gov.in/files/43

which members receive a subsidized amount to start a revolving fund; they are connected with different lenders and banks (Asalatha & Vijayamohanan, 2012). Importantly the SHG program is directly linked with the panchayati raj system (PRI) at village, block and state levels. The PVP stage of this program further strengthens this linkage, as illustrated in Figure 6.

There are a host of studies on both versions but none directly reports the success and challenges faced in addressing vulnerability to IPV. Findings on other indicators that indirectly influence vulnerability to IPV are instructive. A multivariate analysis using propensity score matching to account for self-selection into the program found significant improvements in the financial status of the households of women members of the PVP SHGs. The same analysis also reported a significant increase in intra-household decision-making by women members, on decisions such as purchase of household durables, livelihoods

choices, and children's education. Finally, the study found significant increase in women's participation and interaction with local government, including willingness to report on domestic violence cases (Khanna, Kochhar, & Palaniswamy, 2015).

Karnataka Urban Infrastructure Development Project (KUIDP), India: This program, run by the Asian Development Bank, focused on women in urban slums rather than rural women. Midway the focus shifted to specifically target the poorest women in the program's slum communities. SHGs under this program were envisaged to engage and empower women to access government services and credit, and also provided seed money for revolving loans and skills training.

The program's assessment reports that 40% of the urban poor were covered by SHGs in program areas (Sitaram, 2007). The same assessment reported that 'in a few cases' (p16) there had been a decline in physical spousal

Figure 6: Integration of MT and PVP with Panchayat institutions

MAHALIR THITTAM STAGE OF SHG PROGRAM	PUDHU VAAZHVU STAGE OF SHG PROGRAM
SHGs grouped into federations	All programming through Village Poverty Reduction Committee (VPRC)
Federations of SHGs correspond to PRI at panchayat, block and district levels	Village panchayat (VP) president submits formal memo to VPRC to request PVP interventions
Monthly meetings of panchayat level federation SHG members	Panchayat president serves as ex-officio president of local VPRC
Issues relevant to panchayat conveyed to panchayat president	VP initiates PVP initiatives by leading participatory process to identify target poor
	Project monitoring reports presented to Gram Sabha

abuse because of pressure on husbands from women members of the SHGs. However there is little in the report that elaborates how SHGs served as a platform to address violence per se.

The evaluation also states that the program was accompanied by notable economic and social changes for women. On the economic front, these included increases in entrepreneurial skills, access to credit, and establishment of businesses by women. On the social front, women reportedly experienced improved mobility, social support and awareness of a broad range of issues by virtue of SHG participation, and greater participation in household decision-making (Sitaram, 2007). It is plausible that these changes too may have helped mitigate participating women's vulnerability to spousal abuse.

The Velugu program, Andhra Pradesh, India:
This was started in 2000 and ran in five very poor districts as an expansion of a previous poverty reduction program. The program sought to use SHGs to reach the poorest of the poor, particularly women, and help them to set up collective economic enterprises and 'social action committees' focused on empowerment.[19] The program was intended from the start to be community-driven and participatory. To this end, the community used participatory methods to identify the poor with lists being ratified by the Gram Sabha (Deshmukh-Ranadive, 2004).

The program expanded between 2004 - 2008 and was renamed the Indira Kranti Patham (IKP). It was intended as a state-wide SHG program that provided initial seed money, bank linkages for cheap credit, training in economic and social skills, and assistance in accessing government programs. Federations of SHGs were set up at the village, block and district level. While the membership was primarily for women, the groups were also open to youth and men.

Around 2008, a number of additional economic, social and health interventions were added for SHG members, with the intention to make these SHG federations the "institutional platform of the poor" (Prennushi & Gupta, 2014) (Deshmukh-Ranadive, 2004). Thus, at its height, this program worked through all three platforms considered here: women's collectives, local governance, and health systems.

Qualitative and descriptive assessments have noted that the SHGs under this program were effective in addressing partner violence, for example through successful outlawing of arrack and accompanying violence (Deshmukh-Ranadive, 2004) (Badatya, Wadavi, & Ananthi, 2006). The one quantitative evaluation of the IKP we found uses propensity score matching to assess the impact of the program on various outcomes, between program and non-program individuals, as well as between poor and non-poor program participants. Empowerment for women was specifically examined; results show that IKP women members were significantly less likely to be afraid to disagree with their husband than non-participants, and had greater mobility (particularly among less-poor women). While not measuring violence directly, this result suggests that women were less afraid of – or less vulnerable to – abuse from their spouses. Other results suggest that the overall effect of the program on women's well-being and empowerment was mixed, varying by specific indicators (Prennushi & Gupta, 2014).

6.3 OTHER COMMUNITY BASED WOMEN'S GROUPS

There is a range of formal and informal women's groups established at the community level that aim to improve women's empowerment more broadly. Addressing violence against women is a key element of activities, which can also include self-help interventions, community mobilization, liaison with other stakeholders, etc. However, most seem to not have been evaluated. Three large programs, one in Bangladesh and two in India, which have been evaluated to some extent, are discussed here.

[19] Promising Approaches to Engendering Development: Collective Enterprise and Action as a Path to Empowering Poor Rural Women: The Andhra Pradesh Experience. DOI: http://siteresources.worldbank.org/INTGENDER/Resources/Velugu.pdf

PROTIRODH (Promoting Rights of the Disadvantaged by Preventing Violence Against Women) program, Bangladesh: This program ran from 2007-10. Over 1000 women from multiple areas of the country participated in this program. It was evaluated with a combination of baseline-endline quantitative data as well as a range of qualitative data analysis and document review. Under this program, several kinds of women's groups were established. In addition to GBV, these groups advocated against child marriage, dowry, and other related issues in their communities. They also worked with local justice mechanisms (shalish) in seeking recourse for women for domestic violence and other concerns.

The program helped put in place referral services for women. Women demonstrated increased awareness of services available for domestic violence survivors, and a keen perception of their enhanced power to speak up and access these services. Also, efforts to engage with the local dispute resolution mechanism, the shalish, and with other service providers were considered to have borne fruit; women reported that both the shalish and other service providers were more sensitized to their needs and constraints. Women respondents noted that they were now more willing to access the shalish for justice. According to the evaluation data, the program areas saw a decline in reported physical assault of between 29-69 percent, depending on the type of physical assault, and a decline of 26.5 percent in reported verbal assault (Mannan, 2010).

Interview and programmatic data revealed three key features to which the program's effectiveness may be attributed. First, the establishment of women-only groups created a space where women could engage with each other, gain confidence, and get rid of the shame of talking about violence. Second the program aimed to empower women to tackle the violence meted out to them. Finally, the program made a conscious effort to engage with the broader community especially traditional dispute resolution mechanisms such as the shalish (Mannan, 2010). The fact that the shalish tradition and institutions pre-existed probably added to the effectiveness of this program.

Program on Prevention of Violence against Women and Children, India: Run by Sneha, this was a large program of women's group formation in India. It was a scale up of a prior pilot program. The pilot program, described in the section on health-sector-based platform approaches, was primarily a crisis center. The larger program of women's group formation was derived from the experiences of the pilot program. While the connection with the hospital as a platform remained central, other platforms were explicitly included and coordination emphasized.

In addition to creating and expanding a range of women's groups (led by women called Sanginis) to address women's empowerment and gender inequality, the program also engaged local caste panchayats, perpetrators of violence, and youth volunteer groups, thus making IPV a community,as well as a cross-sectoral issue. Consequently confidentiality proved to be a tough challenge; it is difficult to

◆ ◆

"In Bangladesh's PROTIRODH program, women demonstrated increased awareness of services for survivors, and of their power to speak up and access these services. Program areas saw a decline in reported physical assault of between 29-69 percent, depending on the type of physical assault."

◆ ◆

mobilize the entire community to empathize with a victim and keep the object of the empathy anonymous.

Unfortunately there is no rigorous evaluation, and successes and challenges documented are based on tracking the reporting of violence cases, program data, process documentation (Daruwalla, Pinto, Ambavkar, Kakad, Wadia, & Pantvaidya, 2015), and in-depth interviews with Sanginis (Chakraborty, 2014). Success is measured in terms of an increase in reported cases coming to Sneha. In the interviews, members of the women's groups reported increased confidence and a sense of empowerment to handle IPV and other aspects of gender inequality in their lives.

While there has been some success in engaging youth and men, both activities had to be modified due to resistance, especially by men. Sneha overcame this by forming groups of men and women at the community level to work on other non-threatening aspects of development, and bringing in gender inequality and violence issues wherever possible (Daruwalla, Pinto, Ambavkar, Kakad, Wadia, & Pantvaidya, 2015). Youth groups were found to be easier to form than women's, but harder to sustain; the program had to change its approach accordingly.

The effectiveness of this program was attributed (qualitatively) to two key factors. First, it involved the entire community in participatory micro-planning exercises that led to GBV (especially IPV) being identified as a critical problem to be addressed. This set the stage for working on potentially contentious issues like women's empowerment and violence redressal. Second, Sneha was creative and flexible in how cases of violence were identified and services provided.

Western India Gender Justice Program: This program, run by Oxfam India, sought to address issues of violence against women, including IPV, by combining women's collectives with community mobilization and enhancing women's political power and participation. The program was implemented with six community-based NGO partners in

four states in western India, with the dual aim of reducing social acceptance of violence against women and increasing effective representation of women in decision-making forums of district-level governance institutions.

While each partner institution adopted different strategies to achieve these objectives, one strategy that they had in common was that of engaging women from the most socially excluded groups, particularly scheduled castes, scheduled tribes and minorities. Political empowerment (through participation in local government), economic empowerment (through financial SHGs) and vulnerability to violence were explicitly and clearly linked. Also, engaging and working with men to share household and other responsibilities was considered an explicit strategy (Oxfam India, 2015).

The primarily qualitative participatory evaluation of this program is based on FGDs, individual interviews and field visits to 16 project sites run by three partners. Analysis found that over two-thirds of participants were from socially excluded communities, an important achievement in itself. Community-based collectives of these women showed enhanced understanding of violence against women, gender equality and related issues, and of the patriarchal underpinnings of gender-based violence. These collectives also demonstrated stronger capacity for collective decision-making and action around a range of gender issues, including violence and increased capacity to monitor and report cases of violence, and to engage with decision-makers in the government.

Political participation in Panchayats and Gram Sabhas also appeared to empower women to resist violence against them. However, by and large, the programs were not able to engage men as systematically and consistently as had been envisaged, apparently due to the lack of a well-defined strategy to engage men. The report documented a number of challenges to the different aspects of the program that future iterations need to address (Oxfam India, 2015).

6.4 KEY MECHANISMS FOR EFFECTIVENESS

Despite the lack of rigorous evaluations for the most part, there are some clear repeated patterns across programs that suggest certain critical elements for success.

Break the culture of silence: Women's collectives have played an important role in helping break the culture of silence around IPV. They have thus been successful in facilitating a process whereby such violence becomes a publicly acknowledged issue that women, men and the community at large need to address.

Create a safe space and 'sisterhood' of support for women: These programs create a sisterhood amongst women. They provide women with a shared space that is separate from the one they share with their families. It is a space where they get support from other women, and it helps create a social network. Such a support system then provides the platform for collective action and empowers women to address their own problems. Several programs also noted that these groups serve as pressure groups to protect women against further abuse.

Fill gaps in access for the poorest: The alternate dispute resolution groups in particular were instrumental in filling the gap in accessing justice. This is especially true for the poorest women who were either unable to or not allowed to access formal systems of dispute resolution, such as the tribal women served by Seva Mandir's WRCs (Cavas, 2013).

Facilitate engagement with other service providers and institutions: Women used the collective as a platform from which to engage from a position of power with a range of other service providers and stakeholders at multiple levels of society. These included the police, formal justice mechanisms, panchayat members, health care providers, shelters, and any other services which women members may need.

Engage with men: All the broad women's groups and alternate dispute resolution

"Effective women's collectives strove to engage men, other community members, services providers and institutions; filled gaps in access to the poorest; created transparent protocols and processes; and provided a 'safe space' for women."

groups reviewed here stressed the imperative to engage with men, though all were not equally successful in doing so. This interaction was perhaps most explicit in the alternate dispute resolution programs as they sought to balance fair dealings with all those who brought disputes to them while placing a priority on the rights of women.

Engage with community structures: The documentation suggests that implementers and participating women understood well that to succeed they needed to gain the acceptance and respect of the patriarchal institutions in their environment. All groups strove to engage community structures in their interventions, and most were successful to some extent. Such engagement has also likely contributed to changing community attitudes towards women and what roles they could assume.

Function through transparent processes and clear protocols: The importance of a clear, publicly known structure was most evident in the case of the alternate dispute resolution and financial groups. Several studies noted the fact that the groups were formal entities with rules and procedures and this helped build the perception that they were more than just a 'collection' of women. Also, transparency in processes – particularly when judgments

are being meted out or money handed out – fostered credibility and respect for women and their ability to manage and run a group collective efficiently and effectively.

Adopt a community-driven process to identify target populations: Typically SHGs aim to focus on women who come from the most disadvantaged households. Program implementers find it challenging to identify these individuals. The SHG federations in Tamil-Nadu and Kerala illustrate the effectiveness of using a community-driven, participatory process to identify the poor, combined with a ratification of the resulting list by the Gram Sabha or a higher authority. While this method may not be water-tight, it is likely to be more accurate and create a sense of ownership in the community.

6.5 CHALLENGES AND FOOD FOR THOUGHT IN MOVING FORWARD

Sustaining and spreading interest, membership and benefits beyond initial core membership: Several programs noted that it can be challenging to sustain interest in and benefits from a women's collective beyond the first group. There may be a selection bias at work here that needs to be addressed. It is possible that the first groups of women who form a collective and struggle through the initial hurdles are more empowered to begin with than are women in general. Unless this challenge is addressed, while

"Women's collectives have to consider the situation of women members, and try to ensure that they don't add undue burden to women's daily responsibilities or increase members' risks of IPV."

attitudinal changes may trickle throughout the community, the more tangible benefits of group participation may remain limited.

Ensuring that leadership opportunities are provided to less empowered, most disadvantaged women: The IPAP program noted that it is a challenge to ensure that poorer, lower caste women have the opportunity to assume group leadership. In some cases this may be because such women have less time to engage in group activities; in others, because women's collectives themselves may mirror the caste and socio-economic hierarchy in village society (Oxfam India, 2014). The other challenge is to shake up entrenched leadership in cases where the women leaders of a group may not want to hand over power to newer or younger members, as documented for the Udaipur WRCs (Cavas, 2013). Oxfam's Gender Justice program's experience suggests that successful engagement of disadvantaged women may have to start from the beginning rather than as an add-on to later iterations of a program (Oxfam India, 2015). The participatory, community-based strategies used to identify the poorest of the poor by the Mahalir Thitam and Velugu programs also illustrate how the least empowered, most disadvantaged can be engaged from the start.

Maintaining confidentiality: Work with survivors of domestic violence requires the ability to maintain confidentiality, more so if a woman is in danger from disclosing her situation. However, this can be a challenge in the face of group dynamics. Organizations tread a fine line between maintaining an individual woman's confidentiality on the one hand, and keeping community and collective members engaged and motivated to report and address cases of violence on the other (Daruwalla, Pinto, Ambavkar, Kakad, Wadia, & Pantvaidya, 2015).

Training: All the larger programs of women's collectives emphasize the importance of a long period of intensive training, and follow-up training on a range of issues to make the collectives effective. However, often it is the quality and quantity of training that gets modified, curtailed or otherwise compromised

when program implementers have to cut corners (due to cost) or speed up the process of implementation.

Logistical challenges as a group grows: Physical space in which to house groups, particularly if they are growing, is a concrete challenge mentioned by several programs, including Protirodh, the program by Sneha and the groups created by Seva Mandir. The Seva Mandir women interviewed by Cavas (2013) noted the difficulty in holding regular meetings because of lack of a committed space.

Women's time constraints: Time is another challenge because women are typically overburdened with housework and livelihood activities. Programs need to consider the time engagement demanded of women in creating and joining such collectives, and ensure that they are not unduly increasing the women's burden of responsibility.

Risk of increasing women's vulnerability to violence: Membership of women's collectives may itself increase the risk of IPV for women members, regardless of the type of group. This would suggest that the training given to women members should include capacity-building to counter increased threats against themselves, as well as some form of monitoring and assessment to track increased risk and the success of collective members to counter it. However, the programs reviewed here do not describe any such measures as part of their intervention strategy.

Balancing local norms with women's interests: While women's collectives provide women-centered processes and opportunities, they have to balance their goal of gender-equal justice with the reality of the patriarchal system within which they function. Thus, they may be less effective than they would like at challenging the traditional patriarchal norms within which GBV occurs. The study of the Shramajibee Mahila Samity explicitly acknowledges this as a key problem (Shramajibee Mahila Samity, 2003).

Other qualitative assessments of both, the mahila panchayats in Delhi and the mahila adalats born out of the Mahila Samakhya program, report that they have had to respect women's preferences and community norms to keep the family intact. In some cases this has meant sending women back to abusive husbands (Vatuk, 2013). This challenge may be particularly potent for new collectives. In the case of the Delhi Mahila Panchayats, for instance, Magar (2003) points out that, newer groups, if not aided by NGOs, were susceptible to male dominance and sway because they had not yet garnered the respect from others in the community.

7.

INTERVENTIONS THROUGH LOCAL GOVERNANCE

I n South Asia, there are – broadly speaking – two systems of local governance. One is the formal system that is part of the national government and to which members and leadership is often elected. In India this is the panchayat system, in Bangladesh the Union Parishad, and in Pakistan the Union Councils, for example. The second is the non-formal, religious systems of local governance, such as caste panchayats, shalish, jirga or shura. These are not part of the national government machinery, function by religious and not secular law, and are typically led by older men in the community who are considered religious leaders and/or scholars. We divide our analysis of addressing IPV through local governance accordingly (Table 4).

Table 4: Interventions for GBV using local governance institutions as a platform

Platforms	Program Examples

Formal systems of local governance	• Engaging Men in GBV Prevention via Community Leadership Councils, India
	• Gender and Good Governance Project
	  > Bangladesh
	  > Nepal
	  > Pakistan
	• Activating Village Courts in Bangladesh (AVCB)

Informal, religious systems of local governance	• The Gender Justice Through Musalihat Anjuman Project (GJTMAP), Pakistan
	• Nagrik-Uddyog (NU)-shalish, Bangladesh
	• Programs for which evaluation was not found
	  > Madaripur Legal Aid Association (MLAA), Bangladesh
	  > Sanayee Development Organization peace shuras, Afghanistan
	• ActionAid and SWARAJ work with caste panchayats, India

7.1 WORKING WITH FORMAL GOVERNANCE SYSTEMS

Engaging Men in GBV Prevention via Community Leadership Councils, India: The first example is a program from 2010-12 led by Instituto Promundo and partners in Uttar Pradesh. This quasi-experimental study was part of MASVAW (Men's Action to Stop Violence Against Women), a political movement that seeks to address gender inequalities, including by engaging men to change their gendered beliefs. In particular, MASVAW has tried to engage men in various institutional settings, to which end it has been involved in a three-country pre-existing initiative to engage men to work with women in addressing the "institutionalized nature of gender and sexual violence". Under this broad umbrella, called Mobilizing Men in Institutional Settings, one of the initiatives in Uttar Pradesh, India, is the Engaging Men program (Edström, Shahrokh, & Singh, 2015).

The Engaging Men project aimed to increase awareness among men and boys about gender norms and the consequences of violence against women by engaging local (male) panchayat leaders and other community members though advocacy workshops and community campaigns. Findings from a quasi-experimental design combined with key informant interviews (Instituto Promundo, 2012) and a separate qualitative assessment (Edström, Shahrokh, & Singh, 2015) are mixed. Post-workshops, there were significant changes in self-reported gender-equitable attitudes. However, at the community level, no significant change was observed in men's or women's gender-equitable attitudes or

men's justification of wife-beating; women's justification of wife-beating dropped, as did the reported prevalence of domestic abuse. Moreover, changes were similar and significant in intervention and control sites both, making it difficult to gauge the effectiveness of intervention activities per se (Instituto Promundo, 2012). Also, while individual men modified some attitudes and behaviors in their home and in spousal relations, there was no meaningful change in how the Panchayat dealt with gender issues or the importance it gave to such issues: Edström et al (2015) in their qualitative study found that panchayats believed that the mandated 50% representation of women had removed all gender inequality from that institution. In contrast, process documentation of the program revealed that young men's groups formed and exposed to intensive gender sensitization training in the course of the program sometimes took it upon themselves to pressure a Panchayat to respond to an act of IPV and other gender issues, thus engaging panchayats in addressing GBV.[20] The program concluded that meaningful longer-term behavior changes would require more multi-faceted programming (Instituto Promundo, 2012).

Gender and Good Governance Project, Bangladesh, Nepal and Pakistan: In another example, this program, implemented by the Asian Development Bank from 2002-04, aimed to build the capacity of elected women representatives in local governance institutions. To do so, the project created an interface between elected women, their constituents, other community leaders and other relevant government institutions

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[20] Centre for Health and Social Justice. Supporting Men's Actions to Eliminate Violence against Women in Uttar Pradesh: A project supported through UN Trust Fund. 2009-2011. Retrieved on June 12, 2016, from http://www.chsj.org/uploads/1/0/2/1/10215849/supporting_men-_process_document.pdf

Ministry of Women and Child Development, Government of India. 2015. Universalisation of Women Helpline Scheme: Implementation Guide for State Governments/UT Administrations. New Delhi. Retrieved on June 8, 2016, from http://wcd.nic.in/sites/default/files/GuidelineapprovedMinisterandwebsite_1.pdf

in an effort to increase the standing of the women representatives; undertook social mobilization of key male and female stakeholders; and conducted capacity building exercises. To achieve the interface, special forums were created comprising currently or previously elected women representatives, representatives from other government agencies, men representatives of local governance bodies, and constituents. Men and women representatives received gender- sensitivity training as well as capacity-building exercises on a range of development and procedural issues, including dealing with gender concerns. Between 400-700 women who were current or previous local government representatives and about 100 current male local government representatives were trained in each of the countries (Asian Development Bank, 2004).

The assessment of this effort was based on a mix of qualitative and quantitative data (Asian Development Bank, 2004). Though specific interventions varied across country, in all three cases women's forums undertook a range of village development activities, including intervening on behalf of women and children, spousal abuse, child marriage, divorce, and other social issues. In terms of the effect of this approach on spousal violence, the assessment concluded that in all three countries, having more women representatives on local governance councils encouraged more women to come forward with their concerns, and forums were active

"In Bangladesh, Nepal and Pakistan, having more women representatives on local governance councils encouraged more women to come forward with their concerns, and forums were active in adjudicating cases of domestic violence."

in adjudicating cases of domestic violence. A count of the kinds of cases the Nepal forums addressed showed that domestic violence cases were the largest in number, for instance. It is also likely that the forums indirectly influenced women's vulnerability to domestic violence through their engagement in other aspects of gender inequality such as girls' education, child marriage, divorce, polygamy and land rights, as well as the forums' reported success in increasing women's access to resources via poverty-reduction programs and other government and social safety nets. What is less clear is whether – as seen with micro-credit groups – women's increased public engagement initially increased their vulnerability to domestic violence before any improvement was seen. Unfortunately this report does not conduct any such analysis.

The evaluators credit the overall effectiveness of these forums in engaging women in local governance to, among others, the improvement in women's ability to be credible members of local government and, thereby, role models for other women; simultaneous training and working together of both men and women representatives; that women representatives were able to mobilize funds for development work in their communities, thus further enhancing their status; and a focus on enhancing the interface between local governance, other government bodies, and the poorest constituents.

Activating Village Courts in Bangladesh (AVCB): In another example of engaging local dispute resolution mechanisms to improve access to justice for women, this program sought to rejuvenate the pre-existing Village Court (VC) system in the country, which had been established in 1976. The courts are local, justice is speedy, amounts of compensation are feasible for petitioners, and fees are low. Each Union Parishad (the smallest rural administrative unit) has one VC, with the chair of the UP serving as the chair also of the VC. Legally these courts are not supposed to hear disputes relating to violence against women, but multiple studies note that they do end up hearing such cases in reality (Valters & Jahan, 2016) (Barkat, Paddar, Khan, & Ullah, 2012). Because of this reason, as well as the fact that one key aim of the rejuvenation of

the VCs under this particular project was to empower women to seek justice, we include these courts in this analysis.[21]

Several studies have been conducted of the VCs, including a mid-term review (Jahan & Stapleton, 2013) and a randomized sample survey (Barkat, Paddar, Khan, & Ullah, 2012), both also combining qualitative data. However, neither can be considered a methodologically rigorous evaluation of the program, partly because of the lack of high-quality baseline information; moreover, both focus only minimally on women and VCs, including domestic violence. Findings on accessibility and use by women petitioners are mixed. The mid-term review noted that the VCs provide much-needed access to justice locally for women, who often don't receive recognition or redressal from the other widely-used system of local justice, the shalish. One respondent in the interviews carried out by the evaluators noted that: 'Previously women did not come out of their houses. Now they are beginning to come out and speak' (Jahan & Stapleton, 2013). Across the 6 districts where the review was carried out, women formed one-third of the petitioners. Another study noted that women petitioners more than doubled between 2011 and 2014 (Valters & Jahan, 2016).

In contrast, two-thirds or more of respondents to the survey (Barkat, Paddar, Khan, & Ullah, 2012) reported that poverty and gender-biased social norms were still significant barriers for women seeking justice. Also, by and large, respondents reported preferring the shalish to the more formal VCs: a majority (72%) thought the shalish was more effective than the VCs for justice for women. Reasons relate to awareness, costs, and perceived effectiveness, and qualitative data suggest that much more awareness-raising in communities is required about VCs, their scope, and the ways in which they differ from shalish. Scale-up plans for this project acknowledge and intend to address many of these problems. In particular, the scale-up phase plans to have a stronger focus

> **"Scale-up plans for a program to activate Village Courts in Bangladesh acknowledge the many problems raised by evaluations, and intend to foster a stronger focus on gender and on increasing the quality of women's participation in and access to Village Courts."**

on gender and on increasing the quality of women's participation in and access to VCs (UNDP Bangladesh, 2015).

7.2 WORKING WITH NON-FORMAL, RELIGIOUS LOCAL GOVERNANCE SYSTEMS

In recent decades, NGOs have experimented partnering with or creating and running religious local governance institutions to make these traditional systems more responsive to the poor and especially to women. There are myriad examples of these throughout South Asia. To name just a few: in the Madaripur Legal Aid Association (MLAA), in Bangladesh community elders facilitate a modified version of the traditional shalish. Modifications include an encouragement to women to be mediators (Goresh, 2009), in the hope that more women will then bring cases – including those related to GBV – to such forums. In Afghanistan, peace shuras administered by a local NGO, the Sanayee Development Organization (SDO) have reportedly been successful in lowering domestic violence by determining that beating wives was no longer acceptable (Waldman, 2008). In India, Action Aid and SWARAJ, a network of NGOs, are working in Bihar state to

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[21] For the purposes of this review, we summarize findings only related to justice for gender concerns, especially domestic violence.

persuade caste panchayats to address issues of violence against women.[22] However, it was difficult to find evaluations for these programs. Below we summarize two programs that were assessed to some extent.

The Gender Justice Through Musalihat Anjuman Project (GJTMAP), Pakistan: This project, started in 2005, was scaled up in 2006, and ran till 2010. Though not evaluated using experimental or quasi-experimental methods, benchmarking and mid-term assessments provide detailed documentation of the structure of the program, processes, limitations, and strengths. Spearheaded by UNDP, this program tapped into the Musalihat Anjumans (MAs), introduced through a 2001 Local Governance Ordinance, a law that created a new system of local governance in Pakistan. The MAs were established at the lowest tier of local governance, namely, the Union Councils (UNDP Pakistan, 2009). Other formal courts in the system were authorized to refer cases to the MAs (UNDP Pakistan, 2011), a situation that, in theory, allowed for the MAs to hear a range of community-level cases.

"The Musalihat Anjumans tapped for Pakistan's Gender Justice program aimed to provide women survivors of GBV an alternate avenue for justice. However, these became highly politicized, which undermined their credibility and hampered the access of poorer, more marginalized women."

The main goal of the GJTMAP was to provide women survivors of GBV an alternate avenue for justice. In addition, the program aimed to build MA capacity to dispense gender-responsive justice; enhance public engagement and use of MAs; promote women's awareness of legal rights; and encourage men's participation in ending GBV. The project also worked with a number of institutional stakeholders, including donors, the federal and local systems of government and NGOs.

Project documentation showed, however, that despite all attempts, domestic violence cases were only unevenly brought to this forum. For instance, though in 2006-07 almost one-third of cases heard were on domestic violence (UNDP Pakistan, 2009), these comprised mostly cases from Punjab province. In contrast, very few domestic violence cases were brought to the MAs in other provinces (UNDP Pakistan, 2011).Two key reasons are mentioned. First, though a potential strength of the MA design was to link it to the formal justice and governance systems, there has been limited success in linking it to police, judiciary and other levels of government (UNDP Pakistan, 2011). This may well have undermined the judgments of the MAs. Second, the MAs are highly politicized, which also undermined their credibility, and hampered the access of poorer, more marginalized women.

The NU-shalish program, Bangladesh: Initiated by Nagrik Uddyog (NU), the NU-shalish program is structured as a national movement. It has been working for over two decades on transforming and promoting shalish from a hierarchical, patriarchal institution, to one that can provide justice for disadvantaged groups and women. One-third of members or shalishkars in the NU-shalish are women. As with many dispute resolution mechanisms reviewed here, domestic violence is not the central or only issue that the NU-shalish address; however, enhancing women's access and

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[22] Actionaid India's Initiatives. DOI: http://actionaid.org/india/what-we-do/karnataka/addressing-issues-gender-discrimination-domesticviolence-and-work-place, Accessed on June 13, 2016

capacity to seek justice is a core aim. To this end, women's leadership training and programming is a critical input for shalish members. The NU-shalish have been linked to NU's Grassroots' Women's Leadership Network (GWLN) operational in multiple unions across the country. Several women shalishkars are members of the GWLN, thus bringing to their local governance experience their strength as part of a large women's collective. Community mobilization, leadership training and linking with other government institutions are a key aspect of the program (Siddiqi, 2004) (Valters & Jahan, 2016).

We did not find a specific evaluation of this program. However, an observational case study analysis (Valters & Jahan, 2016) found that the presence and visibility of more women on the NGO-shalish contributed to an increase in the number of women who brought cases to this forum. Yet, though women noted that they were able now to more forcefully and frequently argue cases of alimony and other issues arising from spousal separation, it was not clear to what extent these involved cases of domestic violence; neither was it clear whether the increase in participation was because the shalish is run by an NGO (whose specific aim was to make this shalish more gender equitable), or because there were more women serving on the shalish. Second, women shalishkars interviewed in this study were sensitive to what they considered negative social practices that harm women. However, they did not typically intervene from concerns of gender equality but from concerns of legality and logic. In fact – as we saw with mahila mandals in India – in cases of spousal dispute resolution, including domestic violence, all efforts were made to reconcile the spouses, since this was the pragmatic approach in that context. Nonetheless, NU's annual reports demonstrate that year after year, domestic and/or family violence are the largest category of disputes brought to the NU-shalish.[23]

However, women Shalishkars did not typically intervene from concerns of gender equality but from concerns of legality and logic. In fact – as we saw with mahila mandals in India – in cases of spousal dispute resolution, including domestic violence, all efforts were made to reconcile the spouses, since this was the pragmatic approach in that context.

7.3 ENABLING STRATEGIES FOR LOCAL GOVERNANCE AS A PLATFORM TO ADDRESS IPV

On the whole, interventions with local governance as a platform to address IPV use a range of strategies and activities, some quite innovative, to engage not just with male and female elected representatives, but also with men and boys, communities, and government institutions.

Working across and with a range of institutions: Analysis from the best-documented effort to work with local governance, the MASVAW program, notes that its effectiveness owed a great deal to the fact that the work with the panchayat as an institution was conducted as part of a broader sweep of similarly activist engagement with a range of community-based institutions, including schools and women's groups. This

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[23] Nagorik Uddyog: Citizen's Initiative. Annual Reports. DOI: http://www.nuhr.org/Pages/AnnualReports.aspx

enabled the gender norms of the community to be addressed more holistically; the simultaneous engagement with different stakeholder organizations can also be useful in creating mutual institutional pressure for change. Similarly, ADB's program emphasized their focus on strengthening the interface between women governance officials, men governance officials, other government bureaucrats and constituents.

Working with men (and women) in local governance institutions as members of an institution (to change their public actions) but also as individuals (to change their private beliefs and behavior): The multiple types of documentation from various MASVAW project sites suggest that transforming local governance institutions to address GBV requires working with the institution as a whole, but also separately with members in their capacity as individuals. This is at least partly because individuals in public roles may keep their private beliefs and public actions separate and not necessarily in tune with each other. Changing individuals' private behavior towards gender equality also provides role models and further impetus to changing the institutions with which these individuals are identified.

> **"Local governance systems that try to address GBV may face a backlash from panchayats and other male-dominated local governance groups if they perceive efforts to sensitize them to GBV as a threat to their social and patriarchal dominance."**

7.4 CHALLENGES IN WORKING WITH LOCAL GOVERNANCE SYSTEMS TO ADDRESS IPV

Backlash from traditional local governance organizations that perceive a challenge to their power: One key challenge is the backlash from panchayats and other male-dominated local governance groups if they perceive efforts to sensitize them to GBV as a threat to their social and patriarchal dominance. For instance, though the MASVAW program in India worked with panchayat leaders and other men, other young and adult men resisted and fought back against this perceived 'danger' of empowering women (Edström, Shahrokh, & Singh, 2015).

Structure of the local governance mechanism: The structure of the local mechanism needs to be well understood so as to create an appropriate system for adjudication. In one example: the panchayats in India may have several committees and it may be a challenge to work with the full hierarchy and structures of the institution. However, in the absence of engaging with all parts of the panchayat system, efforts to engage the panchayat in addressing GBV may suffer – this was the experience of the MASVAW program in Uttar Pradesh (Edström, Shahrokh, & Singh, 2015). In a second example, the way that the local governance mechanism is structured may create or support politicization that compromises its functioning if it makes it difficult to maintain impartiality in judgments, provide access to all regardless of political leanings or status, or retain credibility with all sections of the population it is meant to serve. For instance, in the case of the Musalihat Anjuman system in Pakistan, politicization was considered to have contributed to making the MAs inaccessible to women (UNDP Pakistan, 2011).

Links with other institutions, and with levels of and services in the system: While the local level governance structure may be the most accessible and fastest way of resolving a GBV case, adjudication may require intervention of other institutions in the system, such as

the police or the justice system at higher levels. It is important, therefore, for the local forum to have official, institutionalized links with other levels of the system. Yet, it may be challenging to do so: the Musalihat Anjuman system in Pakistan was unable to effectively link with the police and the justice system which did not consistently refer GBV and other relevant disputes to the MAs. This problem arose at least in part because of poor management, lack of resources (including space and remuneration for MA members), and intensifying politicization (UNDP Pakistan, 2011). Another challenge is linking local governance structures to other services for survivors of GBV, such as shelters. However, assessments do not discuss whether programs were able to do so. The Engaging Men program listed working with partner organizations as a key challenge because of different work styles and time-tables.

Adequate policy support: The provision of justice through local governance needs to have adequate policy support at all levels to legitimize and support its existence and functioning. For instance, the Musalihat Anjuman system at the Union Council level in Pakistan was unable to be effective at least in part because laws at local and provincial levels to support it were inadequate (UNDP Pakistan, 2011). Local engagement may be particularly difficult even when national level laws or policies improve. As the authors of UNDP's (2011, p. 34) assessment noted: "Working through the government at the local (sub-district) level requires an elaborate implementation framework, with strong

"Local governance systems already address several issues. If GBV concerns are to be added to their mandate, it is critical to ensure that officials have time, physical space, financial resources, and adequate policy support to do so."

coordination and support at the district, provincial and national levels. This is essential and costly, and it requires constant attention to detail at all levels, as well as a smoothly-functioning, high-quality M&E system."

Logistics and finances: Local governance systems already address several issues. If GBV concerns are to be added to their mandate, it is critical to ensure that (a) officials have time to add this to their agenda; (b) there is actual physical space in which to convene to address such issues; (c) if additional time or training or addition of individuals to the governance structure are needed to make GBV adjudication effective, then there are resources available to cover people's time and other needs.

8.

SCALE UP AND SUSTAINABILITY

8.1 EXAMPLES OF EVALUATED SCALE-UPS

Several programs reviewed above have been scaled up or replicated. The Dilaasa program has been repeatedly replicated; the other one-stop crisis programs reviewed here started on a pilot basis and were then replicated in other areas. Micro-credit women's groups in Bangladesh comprise another example. We found explicit analysis of the process and experience of scale-up and an assessment of sustainability for three programs: Oxfam's International NGOs Partnership Agreement Program (IPAP) in India; Sneha's Program on Prevention of Violence against Women and Children in India; and DFID and UNICEF's Integrated Development Program of Women-Cooperatives to Reduce Gender-Based Violence, in Nepal. There is also some documentation of the problems faced by a fourth program in scale up, the SHGs under the auspices of the Karnataka Urban Infrastructure Development Project (KUIDP).

International NGOs Partnership Agreement Program (IPAP), India: Oxfam's IPAP program defined its model of sustainability as: "…institutionalization of support centers by state governments and building capacities of community members and civil society groups to address cases of VAW, either on their own or through referral to appropriate services. Strengthening existing, innovative, community level support structures such as women's mediation groups has been viewed as another step…" (Oxfam India, 2014, p. 48). In order to achieve this sustainability, the program chose to focus on two among its many elements

for scale-up. The first was women's support centers (WSC), which were for the most part situated inside police stations, and provided a gamut of support services for violence survivors, including medical, social and legal aid. The second was community mobilization through community groups, including the women-led alternate dispute resolution groups that were reviewed earlier in this report.

Fourteen of 16 program partner NGOs noted in the final evaluation (Oxfam India, 2014) that they will continue these and also several of their other program activities even after IPAP ends. The main reason was that program activities were carried out within the current ambit and resources of participating NGOs, and thus once Oxfam and the other donors withdrew, the NGO could still continue the activities. However, certain elements of the program were clearly not going to be continued because of the lack of funds after IPAP, such as the individual case work, counseling and helplines that had been established in the course of the project.

The experiences with scale-up and sustainability of the WSCs varied across implementing states, and, in particular, were influenced by the nature of government engagement. In states where the partnering government institution(s) were eager to absorb or otherwise continue the program, scale-up succeeded with fewer challenges than in states where this was not the case. The report notes that the circumstances depended on whether or not the 'right' officials happened to be in place in the police

and bureaucracy. For instance, in Andhra Pradesh and Uttar Pradesh, sustainability was reportedly affected by inconsistent government support. In contrast, in Gujarat and Odisha, the enthusiasm of the state government contributed to effective scale up. Important in all cases, notes the report, were the purposeful consistent advocacy effort by Oxfam and partners with government counterparts, including a regular flow of information about the project, and the pre-existing credibility of NGO partners. Across all states, nonetheless, future sustainability and continued scale up will depend on whether and how community interest is sustained, and the extent of funds available.

Integrated Development Program of Women-Cooperatives to Reduce Gender-Based Violence, Nepal: Housed within this broader program, the challenges that DFID and UNICEF's Para-Legal Committee (PLC) program faced in scale up echoed some of IPAP's experiences. In 2012, the Nepal government requested UNICEF and DFID to integrate their PLCs into the government's efforts against GBV. The PLCs were integrated into the Nepal government's Gender-Based Violence Watch Groups (GBV-WG) under its Integrated Women's Development Program. Through a transition process, a total of 1026 PLCs in 59 districts were to be transformed into GBV-WGs, starting with an initial 156. DFID initially planned to fully withdraw but then shifted to continuing to support the government financially during the process of transition. This is because the transition proved to be challenging, involving as it did coordination between a range of government ministries; it was also delayed by the complexity of the country's political system.[24] Documentation suggests that in the process of scale up for the program changed significantly (Figure 7), casting questions on future effectiveness.[25]

Figure 7: Changes in Nepal's PLC Program When Scaled Up

Dilution of focus	Less training	Implementation and M&E challenges
• PLCs absorbed into larger women's development program • Emphasis on women's empowerment broadly • No community mediation • Focus on community awareness-raising above other project aspects	• Decline in funds • Shrank from 18 to 5 days • Spread across more groups • Absorbed into government gender training • No exposure visits • Limited training on legal updates • Low stipend for overnight training	• Lack of capacity to support local women's groups • Delays in national budget • Original M&E system not applicable given changes

[24] DFID Annual Review 2013 (iati.dfid.gov.uk/iati_documents/3898751.doc), first accessed in May 2016
[25] DFID Completion Report 2014, accessed in May 2016

Program on Prevention of Violence Against Women and Children, India: In contrast, Sneha's GBV program grew organically, in collaboration with community needs and demands. The initial Center for Women and Vulnerable Children responded to an immediate need expressed by the staff in the hospital for the community where Sneha worked, as described earlier in this report (Daruwalla, Fernandez, Salam, Shaikh, & Osrin, 2009). As the Center continued its work, Sneha's staff realized that they needed to do more. Specifically, recognizing the relative invisibility of domestic violence, women's desire to keep families together, and the need to engage with a range of services and their providers to truly provide succor to domestic violence survivors motivated Sneha to expand their program. Using a range of participatory processes with their community, and building relationships with other stakeholders, Sneha's program evolved from a crisis center to a community-based program that combined medical services with community mobilization, women's collectives, and working with local governance in efforts for prevention and service provision for domestic violence (Daruwalla, Pinto, Ambavkar, Kakad, Wadia, & Pantvaidya, 2015).

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"The most critical issue for sustainability and scale-up is cost and related program dilution. Other important concerns include inadequate training or ability of local groups to implement scaled up programs, and the challenge in maintaining intersectoral links when a program becomes larger."

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Karnataka Urban Infrastructure Development Project (KUIDP), India: Sitaram (2007) describes the pitfalls experienced by the federations of SHGs created by the Karnataka Urban Infrastructure Development Project (KUIDP) when the original donor, the Asian Development Bank, withdrew. The KUIDP officially ended in 2004, and the state government and associated NGOs became responsible for further intervention activities. At that time, the state government decided to group the 700+ programmatic SHGs into federations to increase their long-run survival chances. However, discussions with participating NGOs revealed that many SHGs were not sufficiently mature to understand, operate and succeed as a federated entity; moreover, the creation of federations forced the varying types of NGOs affiliated with this program to follow one modality of intervention rather than having the flexibility to build on each one's strengths and experiences. On the government side, at the time of the report, it was unclear which government department(s) would assume long-run responsibility for the financial support and operational support of these SHGs, further casting a pall on their sustainability. Finally, in many cases elected representatives, who could have shored up support, were not sufficiently engaged to have created any sense of ownership and thus responsibility. These and other issues have resulted in many SHGs or their federations becoming defunct, and only a few succeeding (Sitaram, 2007).

8.2 COMMON KEY CONCERNS WITH SCALE UP AND SUSTAINABILITY

Costs and sustainability: The most critical issue for sustainability and scale-up is cost. This arose explicitly as a concern for three of the four programs scaled up. It had not arisen as a concern in Sneha's program at the time of review, perhaps because – unlike the Oxfam and DFID scale-ups – Sneha was still engaged in programming including financially. However, the question remains for all scaled-up programs: what happens to sustainability and scale-up when the initial implementing organization and donor(s) withdraw their funding and staff?

The examples reviewed point to two elements most in danger of being adversely affected by lack of funds and/or staff at scale-up. The first is the intensity and content of training, which tended to dilute when a program was expanded or handed over to the government, likely because government departments rarely have the time, financial resources or human resources for the intensity of training that non-profits can implement. A particular concern with diluting training in domestic violence programs, however, as noted by DFID in the Nepal PLC program's expansion, is that less training for women who are part of the groups trying to address GBV may mean that they are at increased risk of backlash without having mastered the tools to adequately deal with it. The second concern relates to the intensity of a program as a whole. For similar capacity reasons as exist with training, an entire program may be diluted when scaled up, casting questions on its further effectiveness and sustainability.

Inadequate training or ability of local groups to continue programming: Several programs note that donor withdrawal and/or hand-over to the government, NGOs or community occurred before those to whom the program was handed over for scale up were adequately prepared to sustain the intervention. Withdrawal may need, therefore, to be a gradual process accompanied by training designed to help successors with the skills they will need to sustain and scale up program activities over the medium- and long-term.

Slow integration into government: In the Indian context, scale up can likely only be achieved in any large measure if a program is eventually integrated into the government system. However – as the PLC program in Nepal and the KIUDP program in Karnataka, India discovered – the integration process into government programs can be slower than anticipated. If financial constraints dictate that such a delay is further coupled with rolling out a diluted or badly implemented intervention, then a scaled-up version that is diluted,

ineffectual and delayed may fail to sustain interest among participants and communities. This would then have obvious implications for the program's subsequent effectiveness.

Maintaining intersectoral links: The programs reviewed illustrate the importance of linking across platforms and services to address the different aspects of GBV that women need addressed. Scale up plans need to keep in mind cost and other constraints highlighted above to consider how such links could be effectively maintained when the program is scaled up. The experience of the KIUDP also illustrates the importance of maintaining links with local government as a potential ally when original donors and programmers withdraw.

Structure and design of program when scaled up: Finally, there is a question as to the extent to which a program should remain faithful to its original design when scaled up. On the one hand, it is the original version that was (hopefully) evaluated and shown to be effective that one would want to scale up. On the other hand: should the scale up be exactly the same design everywhere? If implemented in a heterogeneous country with heterogeneous structures and needs – as is the case in most South Asian countries including India - then perhaps the scale up cannot be exactly the same everywhere. Even if the platform through which the program is being scaled up is the same everywhere, the content of the program, type of training etc. may need to be modified based on the context. The experience of the scale up of the Musalihat Anjuman (MA) program in Pakistan is a case in point: MAs were structured across the whole country in exactly the same way as the pilot MAs, but the contextual constraints for women and the marginalized, as well as key political issues, varied across provinces. Thus the rigidity of the sameness of the MAs across the country may have hampered its effectiveness in parts of the country (UNDP Pakistan, 2009) (UNDP Pakistan, 2011).

9.

CONCLUSION: IMPLICATIONS FOR NEXT STEPS FOR PROGRAMMING

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The evidence analyzed in this report provides insights into enabling factors to emulate and challenges to address in moving forward to enhance programming for IPV through the three platforms reviewed here. Several are common regardless of platform, while others are specific to one or the other platform. Documented enablers and challenges have been analyzed separately for each platform in earlier sections. For the most part, evaluations were more likely to focus on challenges, with far fewer teasing out enablers. Below we summarize some common enablers and challenges or obstacles to success that were mentioned repeatedly across programs as these are likely to be critical to address no matter what platform is chosen. We conclude with a check-list of essential elements for future pilot programs based on lessons learned.

9.1 ENABLING FACTORS AND CHALLENGES IN COMMON ACROSS TYPES OF PLATFORMS

9.1.1 Common enabling factors

Clear protocols, procedures and responsibilities: The programs considered effective have clear and transparent protocols and procedures for the processes to be followed in addressing IPV. In the case of the health sector, this means clear protocols and procedures and individual responsibilities assigned for every single type of health provider – or, as in OSCC, other linked providers – in the entire process from the moment that a survivor presents herself for care. The CEHAT experience provides an example of such protocols. In the case of women's collectives, this means a transparent process of engagement, adjudication and/or financial transactions.

The nari adalats reviewed here provide an example.

Intensive, high-quality, gendered training: Several evaluations point out that training is critical for staff or members of non-gendered platforms to address IPV. In addition to raising awareness and conducting training on quality of care, training also needs to address the gendered – and often patriarchal – views of those who are being tasked with addressing IPV.

Strategic engagement with other sectors and stakeholders: The more effective programs engaged other sectors and stakeholders right from the start. For the health platform-based programs this typically meant partnering with NGOs, non-health-related providers of services to IPV survivors and other ministries. All programs likely need to engage with justice and police sectors. At the same time, collaboration needs to be

strategic so that it is feasible and operational. Comprehensive engagement may not be necessary, and, in fact, may be counter-productive. For instance, the Bangladesh and Nepal one-stop crisis centers aimed to be as broadly inter-sectoral as they could but were unable to operationalize this effort because of the complexities in coordinating between too many entities.

Fostering community engagement: Being open with, and fostering the participation of the community is critical. This is critical for several reasons. Community engagement not only creates ownership but it may also be a bulwark against the chance of a higher vulnerability to violence for those women who are empowered in the course of violence-prevention programs. Making domestic violence a community issue (as against only a women's issue) can go a long way in removing the culture of silence. And, finally, for the survival of programs that threaten the status quo, it is likely essential to understand and find a way to work with the traditional power structures in a community (Valters & Jahan, 2016). Programs across platforms offer several good examples of how to do so. For example, the Mitanin program engaged the community right from the conceptualization and hiring stage (Box 2). Sneha expanded their crisis center into a community-based program in response to – and engaging widely across – their program community. The NU-shalish in Bangladesh were keenly aware of the need to work with the elites in the villages where they were trying to transform the shalish, and did so throughout the process.

Including men and boys in addressing domestic violence: Many of the programs reviewed either engaged with men from the start, or found they had to engage with them at some point. This should not be unexpected: domestic violence cannot stop unless men understand and accept its unacceptability. Also, making men the 'enemy' is unlikely to

be productive. It could increase women's risks of violence; also women themselves want to keep their family intact. Once again, there are multiple program examples on how to effectively engage men and boys, and the challenges likely to be faced while doing so.

9.1.2 Common challenges and obstacles

Lack of evaluation and documentation: Few programs are evaluated, and of those, few are rigorously evaluated. This makes it very difficult to glean lessons on best practices as well as what not to do. Process documentation is even more limited, as is documentation of training or other implementation experiences.

Time and availability of those addressing IPV: Across studies and platforms evaluations admit that time constraints of those tasked with IPV over and above their regular responsibilities is a critical constraint. In the health sector, this applies most particularly – but not only – to field level health workers who are overworked and underpaid. In the case of women's collectives, the concern is the lack of time that women already have in their day-to-day activities as well as their group activities, and the resultant feasibility – and appropriateness – of adding IPV concerns. In the case of local governance, the question is whether local governance representatives have the time to add IPV to the list of responsibilities they must address for their communities.

Lack of clarity about mandate: Related is the lack of clarity about the mandate of a program. For instance, reviews of the one-stop crisis centers in Nepal and in Bangladesh critiqued the programs for being unable to prevent re-victimization. However, is it reasonable or feasible to expect health workers to address an issue such as revictimization, which arises from broader gender and community norms? Similarly, to what extent and what aspects

of IPV should a micro-credit group address? Local panchayats do not have adjudication of IPV in their mandate; should this be added? A lack of clarity on what is the mandate of the platform in question to address IPV is important to address because in the absence of clear parameters of responsibility it is hard to gauge whether a program can be deemed successful or not.

Community or peer hostility: Across platforms, those who work on IPV report in evaluations that they face hostility from their community, partners or peers. In the health sector, frontline (community) healthcare workers can face community hostility if they start to address the kind of gender concerns that underlie IPV; if IPV is stigmatized in a health facility, those addressing it may be stigmatized and face hostility for that reason. Women in collectives face hostility from community and spouses when they widen their mandate to include addressing IPV and its underpinnings. Finally, local leaders who are not gender-sensitized as part of introducing IPV programming in local governance, or leaders of traditional local governance mechanisms such as caste panchayats, may feel threatened

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and turn hostile to those among them who try and address IPV. Training and community awareness exercises before starting an intervention are likely critical, programs find.

Engaging with men and boys in ways that maintain interest, attention and participation: Most interventions recognize the importance of and attempt to engage with men and boys. However, most of those that describe this process report a series of challenges in maintaining such engagement. Sneha found that while it was easier to mobilize youth than women to form groups, it was much harder to sustain the interest of young men and that it required more effort to have young men consistently engaged in program activities (Daruwalla, Pinto, Ambavkar, Kakad, Wadia, & Pantvaidya, 2015). The Engaging Men program, despite specifically focusing on engaging men and boys, also reported that it was difficult to maintain their attention relative to women, primarily because they were a much more mobile population, particularly in urban areas (Instituto Promundo, 2012).

Limitations in reaching the most vulnerable women: We found limited analysis of whether programs reached the most vulnerable and, if they did not, why that was the case. One exception is the analysis of Seva Mandir's program. This program's qualitative analysis noted an issue likely to dog all programs through women's collectives: it can be difficult to sustain interest and benefits of addressing gender and IPV through a collective beyond the initial group; related, it may be difficult to offer leadership to more vulnerable women if initial leadership starts in the hands of more capable, more confident, higher-caste members of the community (Cavas, 2013). Similarly, for the most part it is unclear whether local governance-based initiatives are successful in reaching the most vulnerable women who are least likely to bring their problems to such a forum. An exception is Oxfam India's Gender Justice program that made it an explicit mandate from the start to focus on the most socially excluded. As such this program's evaluation and experience may provide lessons in how to successfully

engage the most vulnerable women (Oxfam India, 2015). Another vulnerable group that is largely ignored in evaluations is adolescents: across platforms there is no information whether they reach adolescents, who are also likely to be among the most vulnerable. Finally, in the case of the health system, there are two types of concerns in access to vulnerable women. First, OSCC's are likely to reach only the women who seek care, most likely not the most vulnerable, unless they have strong community links. Second, programs that focus on pregnant women alone do not reach others who are not pregnant but face similar or higher risks of IPV.

Consent and confidentiality: Though this issue is most frequently discussed for the health-sector-based approaches, it applies to other platforms as well. Most programs reviewed did not address the importance of and how to gain consent and keep information confidential; neither did they report explicit training of staff (or members in the case of governance and collectives) on consent and confidentiality. Yet, given the dangers and vulnerability faced by women who suffer IPV, and their reluctance to disclose because of fear of lack of confidentiality, these are likely to be important concerns. The Dilaasa and Sneha programs provide guidance on how to address these in health sector and community-based programming, respectively.

Logistical challenges: Programs across platforms noted logistical challenges, most notably the lack of adequate and appropriate space in which to work with women survivors of IPV. Part of the problem here is likely that IPV programming is not mainstreamed into pre-existing programming and logistics. Instead, attention to IPV is layered over other programming without adequate attention paid to other changes necessary vis-à-vis logistics, funding, training, staffing, and so on.

9.2 CONCLUDING THOUGHTS

This review provides an overview of experiences, enabling factors and challenges in designing IPV interventions as part of a

"Programmers and donors must arrive at a clear understanding of what are the elements of 'success' they expect programs to achieve. Equally importantly, the envisaged success must align with the goals, strengths and constraints of the chosen platform(s)."
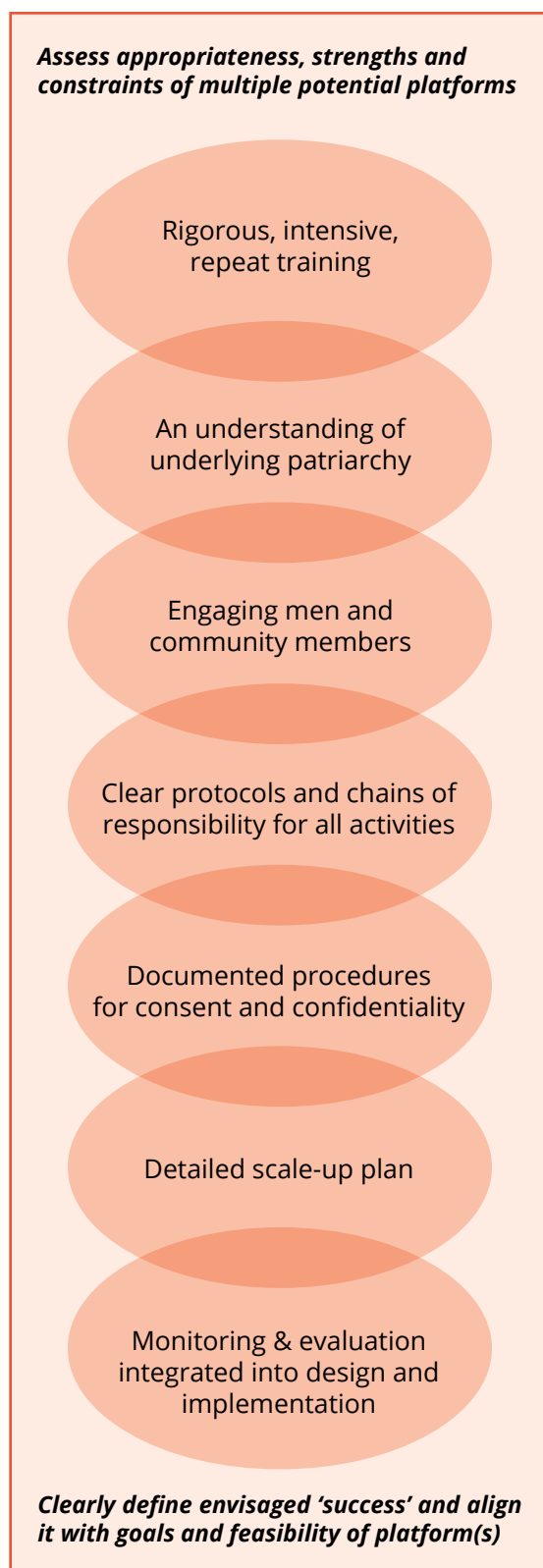
health sector response, the work of women's collectives, or the responsibilities of local governance. Unfortunately, many existing or recent programs were not rigorously evaluated: there was no baseline, or baselines were of too poor quality to use in an evaluation, or there were no control groups with which to compare outcomes. Often, programs themselves were too complex, with too many potential contributory elements to be able to tease out which were the most critical for success. Still, the richness of the variety of programming and documentation does provide some lessons learned in moving programming forward.

Based on available program documentation and analysis, Figure 8 illustrates seven likely essential program elements that repeat across the most successful programs. Pilot intervention studies going forward can test and rigorously evaluate the extent to which these apparently essential elements are, in fact, critical, as well as how to design and operationalize these.

While we reviewed a range of programs it must be stressed that this report is an overview. We feel that it is incumbent on programmers and policymakers, therefore, that they analyze more in-depth some of the key programs identified here that use the platform(s) of

Figure 8: Essential program elements for future pilots

Assess appropriateness, strengths and constraints of multiple potential platforms

Rigorous, intensive, repeat training

An understanding of underlying patriarchy

Engaging men and community members

Clear protocols and chains of responsibility for all activities

Documented procedures for consent and confidentiality

Detailed scale-up plan

Monitoring & evaluation integrated into design and implementation

Clearly define envisaged 'success' and align it with goals and feasibility of platform(s)

interest that are being considered for any new programming. Also, we only analyzed three of several potential platforms: the health sector, women's collectives, and local governance. However, these are not necessarily the most preferred platforms to consider. In fact, several interventions point to the critical role that the justice and police systems have to play, suggesting that no matter which platform is used to launch IPV-related interventions, justice and police have to be engaged. Programs provide several examples of how to engage the police, ranging from the bare minimum of facilitating access, to integrating police as a platform in programming (Figure 9). Overall, programmers and policymakers need to carefully assess the strengths and constraints of the potential platforms in their area of operation to gauge which one or which combination of platforms is most appropriate and most feasible for their pilots, given the context, funding, staff and time available.
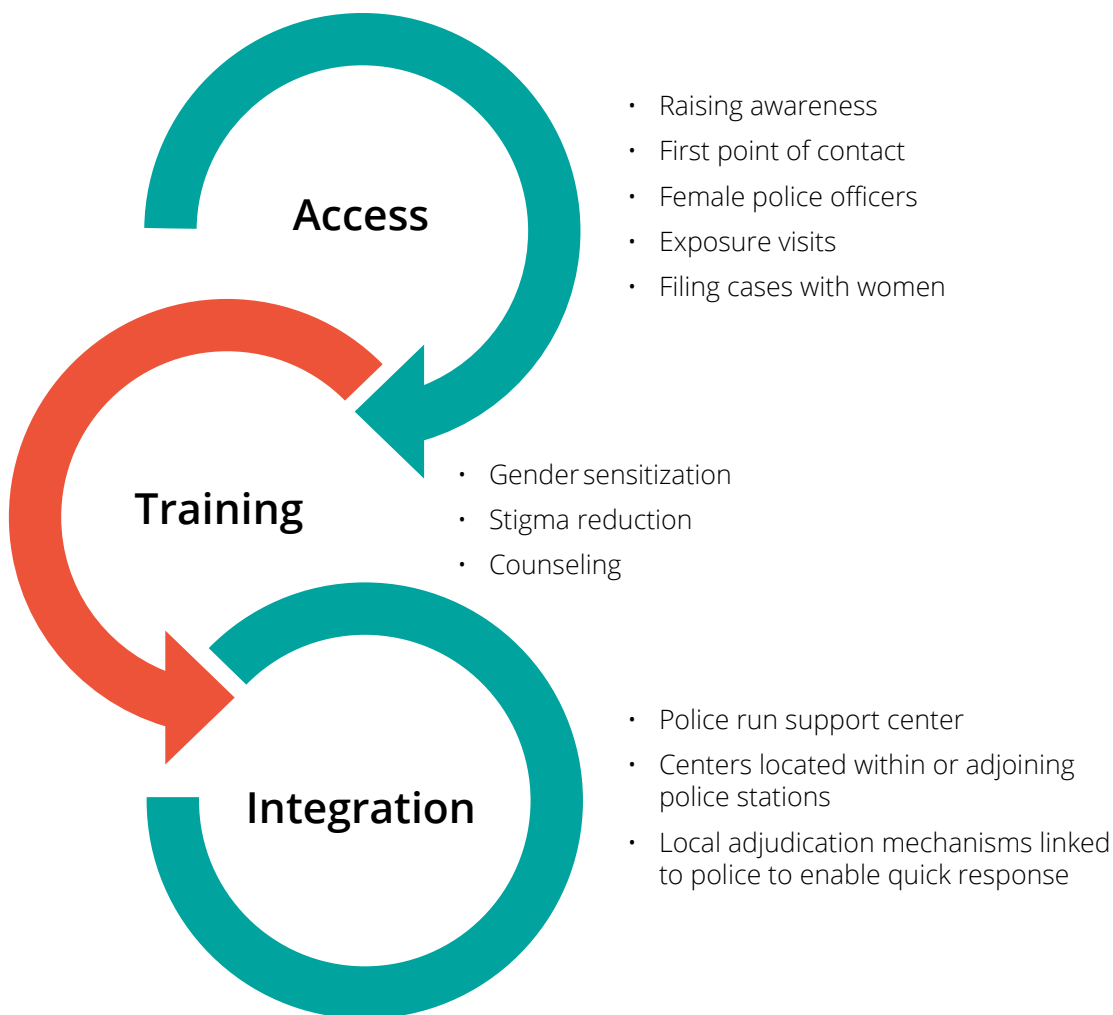
Despite the paucity of rigorous evaluation, documentation and programming experience and challenges also made clear the importance of reaching beyond the platform chosen to serve as the initial base for programming. Violence-prevention or response programs housed in the health sector found that without community engagement, in particular with women's groups, it was difficult to bring women to the health centers to access the violence-related programs offered. All the one-stop crisis centres are examples. Women's collectives and local governance platforms need to engage with the health sector to most effectively offer health care for injuries (physical or mental) borne by violence survivors. Women's collectives and efforts to engage local governance often go hand in hand, for example in the programming to activate village courts in Bangladesh. Finally, most programs across platforms recognized the need to engage at some level with police and justice systems.

The need for a multisectoral approach in programming can seem intimidating, suggesting as it does the need for large amounts of funding, staff and time to program effectively. Clarity on what constitutes 'success' is likely to be critical to ensure

that programming is realistic, feasible, and operational, given constraints of time and money, and the imperative to reach across more than one platform. As this review has illustrated, the 'success' of a program to address IPV can be linked to a range of single or multiple outcomes. In some cases, such as the Dilaasa program for sexual assault, outcomes were clearly defined and the ways to operationalize procedures, activities, reporting, and accountability delineated accordingly. In others, perhaps outcomes and goals were too ambitious, arrived at without a full acceptance of what is feasible, realistic, and measurable. Going forward, programmers and donors must discuss, delineate and arrive at a clearly documented understanding of what are the elements of 'success' they expect the programming to achieve. Equally important, the envisaged success must align with the goals, strengths and constraints of the platform(s) chosen as the base of IPV interventions. The experiences of the interventions – positive and negative - analyzed here provide a strong base from which to develop and test future efforts to design, integrate and scale-up IPV prevention and response through other systemic platforms.

Figure 9: Illustrative activities to engage police as a platform

Access
- Raising awareness
- First point of contact
- Female police officers
- Exposure visits
- Filing cases with women

Training
- Gender sensitization
- Stigma reduction
- Counseling

Integration
- Police run support center
- Centers located within or adjoining police stations
- Local adjudication mechanisms linked to police to enable quick response

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