Inside the FP Story Podcast

SEASON 3

EPISODE 2: Gender-based violence and family planning

[About the *Inside the FP Story* Podcast]

A note for our listeners: This episode contains content that some may find upsetting. Please take care while listening.

From Knowledge SUCCESS, Breakthrough ACTION, and the USAID Interagency Gender Working Group (IGWG) GBV Task Force, this is Season 3 of *Inside the FP Story*—a podcast *with* the family planning workforce, *for* the family planning workforce.

The international family planning field has generated a *lot* of data, reports, and lessons learned. But we don't often have the opportunity to get *behind* that information, to hear directly from the people who implemented a program, or who did the analysis, and so we reinvent the wheel or miss the mark because we don't know what could be *really* critical in a particular context. *Inside the FP Story* is that opportunity.

Each season, we hear directly from program implementers and decision makers from around the world on issues that matter to family planning programs. Through these honest conversations, we'll learn how we can improve our family planning programs as we work together to build a better future for all.

[Recap of Season 2, Intro to Season 3]

Narrator
This season on *Inside the FP Story*, we are exploring the importance of gender integration in family planning programs and services. Last episode—which we presented in two parts—we examined reproductive empowerment as both a process and an outcome. We discussed different components of reproductive empowerment, such as the freedom to exercise autonomy and choice in family planning decision-making. This episode, we will explore how gender-based violence—abbreviated as GBV—intersects with family planning and reproductive health. Our featured guests will share their experiences and offer guidance and recommendations on how we can and *should* address GBV in our *own* family planning programs.

[music break]

[What is “Gender-Based Violence”?]

Narrator
Before we begin let’s make sure we have some common definitions.

Gender-based violence refers to “violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation.” GBV takes on many forms and can occur throughout the life cycle.

The term GBV is also sometimes used to describe targeted violence against LGBTQI+ individuals. **LGBTQI+** stands for lesbian, gay, bisexual, transgender, queer, and intersex individuals—also referred to in some contexts as “gender and sexual minorities.” The “plus” sign refers to the many other self-identifications related to sexuality and gender. Violence can be directed at someone based on their sex assigned at birth, their gender identity, their gender expression, their sexual orientation, or all of the above.

GBV can occur in public *and* private settings, including but not limited to: digital and online spaces, educational settings and schools, the home, the workplace, and in transit. Forms of GBV that are prominent in the context of family planning include: intimate partner violence; sexual coercion and abuse; child, early, and forced marriage; and female genital mutilation or cutting.

As we discussed in the last episode, the concept of reproductive empowerment includes the ability to act on one’s own fertility preferences free from coercion, violence, or fear. It’s important to keep this in mind as we continue to discuss the intersections of family planning and GBV throughout this episode.

[music break]

[How do family planning and gender-based violence intersect?]

Narrator
When thinking about the intersection of family planning and gender-based violence, it is important to understand how social norms tie these two issues together. Here is Anita Raj, Director of the Center on Gender Equity and Health at the University of California at San Diego.

Anita Raj

> You know, ultimately we view gender-based violence as a manifestation of patriarchal norms and the acceptability—and perhaps more than the acceptability, the expectations, again the norms—of male dominance over women and female partners in particular. And to that end, we think of gender-based violence as a means of reinforcing that control and that authority because of the entitlement to that control. So, if that's really underlying

what creates gender-based violence, why would we be surprised that that is so heavily connected to women's reproductive control?

Narrator

The vast majority of societies are patriarchal, giving men more power and privilege than women in nearly every facet of life. As Anita highlighted, gender and other social norms that place men as superior to women in society underlie both gender-based violence *and* family planning—or the ability of individuals and couples to anticipate and attain their desired number of children, and the spacing and timing of their births.

As mentioned in the earlier definition, gender-based violence is not limited to physical violence. The violent expression of gendered power and privilege, in both public and private spaces, manifests in many different ways and across different *types* of relationships. **Intimate partner violence** (abbreviated as IPV) is defined by the World Health Organization as "behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors." Intimate partner violence is one of the most common forms of GBV and is disproportionally experienced by women and girls. The World Health Organization estimates that 27%—or roughly one in four—of women aged 15–49 have experienced physical and/or sexual intimate partner violence at least once in their lifetime.

So how does this intersect with family planning programming? While there is not currently a robust evidence base, research does suggest that instances of intimate partner violence are associated with lower rates of contraceptive use and higher rates of unintended pregnancies. An example of this is **reproductive coercion**, an umbrella term for behaviors that interfere with decision-making related to family planning and pregnancy. Reproductive coercion can be perpetrated through intimate partner violence—for example, a male partner may force a female partner to have sex without contraception. It can also be experienced *outside* of intimate relationships—for example, if a parent or older relative prevents someone from using contraception to prevent pregnancy. While there is still more to learn about reproductive coercion, our guests shared their insights into these expressions of gendered power and privilege. Here is Anita:

Anita Raj

And I think that gender-based violence is a piece of this, and we often discuss it with regard to male partner violence. But when I think of gender-based violence, I think of many forms of control and oppression of women.

I think it fundamentally is a manifestation of how we value women and what we view as our right—and I think sometimes this can come from society broadly, which is inclusive of women—our right to make decisions for what is best for women.

Narrator

Prabu Deepan, the Asia Regional Head of Tearfund, explained the intersection of GBV and family planning in a similar way—drawing on an understanding of gender and other social norms, inequalities, and power dynamics.

Prabu Deepan

> Most often the burden of preventing pregnancies are imposed on women, almost explicitly, or implicitly expected that they would somehow plan their births, and also the access to contraceptives, family planning methods, and all of that. It falls on women in many ways.
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> And I think when it doesn't, when these expectations, societal expectations, are either broken or not met, then they could lead to different forms of violence—either unexpected pregnancies, complications around that, but violence, coersive practices that lead to, outcomes that are not necessarily decided or, consented for in that space and, unconsented sex and, for sex and marital rape as well.
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> I think the opportunity therefore is really around looking at, addressing the gender dynamics of family planning in a decision-making process and not necessarily starting with better family planning practices, but really exploring at what costs. I think we talk about women's autonomy and bodily autonomy in that space and decision-making rights and things like that to, not to have children, to choose contraceptives, etc.

Narrator

As Prabu recommended, health programs should gain a firm understanding of the family planning decision-making process in a given context—for example, how it is talked about in regards to women's bodily autonomy? He also shared that some family planning programs that integrate GBV response have seen success by using family planning as an entry point to talking about gender norms and power dynamics with clients.

Mabel Sengendo, who is based in Uganda and serves as the Regional Unit Manager with Sonke Gender Justice, also discussed this topic.

Mabel Sengendo

> Men look at family planning as a point of taking away their power and their control over their wives or their girlfriends. The issue of GBV usually then comes in at that point where, you know, if either the husband or the partner finds family planning material or medication that they were not part of the discussion, and therefore violence is used. Or even the discussion around, "Can I get family planning?" And the question is, "Why do you want to get it?" And I know in the earlier research, it was indicating that men think that family planning makes their women promiscuous. How that happens, God knows, but that was the assumption. And therefore, again, this communication is really to just help them understand first and foremost, family planning does not make a woman promiscuous, does not make her anything but safe because she's trying to space or decide when she wants to have a child. So I think that's the biggest intersection where

> you find men feeling that their power is being taken away. And women feeling like, you know, the one to be able to control and decide. But I think the biggest issue around violence is the inequalities that happen in our society, you know? Where women cannot make decisions on when they want to have a child. How many children they want to have, this is usually really made by either the man, the spouse, or his family. So those are always a point of contention within our context, because the woman is not allowed to make that decision. Her body is a vessel for the family to extend their lineage. So when you have discussions that are not very well facilitated, then that's where the violence sort of begins to jump in, in the family context.

Narrator
Autonomy is the ability to make decisions about our own lives. *Bodily* autonomy, as defined by UNFPA, is "the power and agency of individuals to make choices about their bodies without fear, violence or coercion." This relates to our previous episode on reproductive empowerment, where we explored reproductive coercion as a power mechanism that takes away one's bodily autonomy and *disempowers* their reproductive decision-making ability.

These concepts are highly relevant to the intersection of family planning and gender-based violence. Inequitable gender norms underlie gender-based violence in its many forms—including intimate partner violence—and influence access to power and decision-making about contraceptive use.

Therefore, health programs need to address family planning and GBV needs together. But what exactly *are* those needs, and how are family planning needs different for GBV survivors than for those who have not experienced violence? We will hear more from our guests—but for one thing, GBV increases the risk of unintended pregnancies. It can also cause other maternal health complications—for example, increasing the likelihood of miscarriage, stillbirth, and early labor.

As with any type of integrated program, there are different approaches and ways to blend the two areas. One program may start out *only* offering family planning and then incorporating GBV prevention and response. Others may be broader, or may focus on GBV first, and then add family planning services. The model that works best is highly dependent on the context and the situation.

With this in mind, we will now turn to some program examples. This will put our definitions into context, and will help us get a flavor for what family planning and GBV integration can look like in practice.

[Family planning and gender-based violence in Tanzania]

Narrator
Our first program example takes us to Tanzania, where we spoke with Dr. Lucy Mphuru and Msafiri Swai, who led the Family Planning Outreach Programme from 2014 through

2019—which trained health providers to deliver high-quality family planning and GBV services. Lucy is Strategic Information Director for IntraHealth International, and was formerly their Tanzania Country Director. Msafiri is the Head of Programs for Afya Plus in Tanzania, and he was the Technical Advisor for the Family Planning Outreach Program.

Lucy explained the context that informed their program.

Lucy Mphuru

Forty percent of women in Tanzania who are aged 15 to 49 years of age have experienced physical violence at some point. And almost 20% have experienced sexual violence in their lifetime. The magnitude is even higher among married women, whereby half of all ever married women have experienced physical abuse or emotional violence or sexual violence. And many acts of this violence are widely, really considered to be common, to be normal, to be acceptable in our society. And therefore, if someone is being beaten or hurt by a partner or being abused, it seems as if that is just normal in our society.

And accessing these essential services really has been difficult for survivors. They often face ineffective police involvement. There are a limited number of health workers that have been trained to provide comprehensive post-gender-based violence services. There's also poor coordination among multi-sector partners as well as among the service providers and referral system.

Therefore, based on that, frequently, the victims do not report their incidents to anyone, including the police, including the health workers. So IntraHealth, with funding from DFID, implemented a family planning outreach program in Tanzania that worked to improve the availability and quality of family planning services—including increasing use of the modern contraceptive methods, access to specialized clinical services for GBV survivors, particularly rural women, and linkage and referral system for survivors to health, policy, social, and legal services. That four-year program was also implemented in collaboration with Population Services International and Restless Development. So we implemented the program in public health facilities in 10 regions in Tanzania and 165 health facilities, whereby we used what we called a hub and spoke model approach to deliver GBV services to family planning clients.

Narrator

In the hub and spoke model, the “hub” facilities provided comprehensive primary health care services–including a range of family planning methods, post-GBV care, and maternal and child health services. Healthcare workers at the hubs participated in intensive GBV training, so they could adequately provide services to clients coming to the facilities for family planning.

Meanwhile, at the “spoke” facilities, providers received an abbreviated training—but were able to provide basic GBV screening, and offered referrals for more comprehensive GBV services.

Since GBV services were being integrated *into* existing family planning services, some preparatory work was necessary—including community engagement. They held planning sessions with a variety of stakeholders—including police, community groups, and others—to develop a joint work plan for integrating GBV in family planning services in each location. Here is Lucy on why this was important.

Lucy Mphuru

Establishing ownership of the program by the local health authority was really a step towards sustainability and these meetings were key to ensure program activities had buy-in and ownership from the central and local government and also from different multi-sectoral partners.

Narrator

At this point, they did an audit before implementing the program.

Lucy Mphuru

Thereafter, we conducted a facility audit, really to gauge the facility readiness, barriers and opportunities, and service provider capacity to accommodate and integrate GBV clinical services into family planning services. And that facility audit also assisted us to understand the capacity building approach to help health workers who were trained to provide services. So health workers were trained to provide selective screening to clients who were accessing family planning services, and also provide post-GBV services. And therefore they were able to reach survivors with clinical care, treatment, and referrals who otherwise may never have come forward. And this training also created awareness and really promoted a sense of responsibility among health workers to care for their potential violence survivors, as well as refer and link them to other supportive services in the community, including the legal services in the community.

Narrator

The program also disseminated national guidelines for clinical management of GBV services. They made sure that the wider GBV prevention community—from social welfare officers to legal aid representatives—had access to these guidelines. At this point, they launched the integrated program.

Lucy Mphuru

We integrated GBV services into family planning services at the reproductive and child health clinic, whereby the family planning client was able to receive everything in one room, with the exception of the non-health clinical services, that we had to refer them outside the facility. Providers used the GBV screening tool that really used a selective screening approach. We provided a package of post-GBV services—that included psychosocial support, injury management for those that had physical injury, emergency contraceptives for those that were in need of that, post-exposure prophylaxis, risk assessment and safety planning, STI screening and also referral to other supportive services needed, like legal aid, police shelters, etcetera.

Narrator
Msafiri and Lucy explained the impact of this successful comprehensive program.

Msafiri Swai

> One of the most successful indicators that we measured was our ability to reach a good number of family planning users or family planning clients who were encountering gender-based violence. For us, that was a huge success. We reached more than 16,000 GBV survivors through family planning service outlets. We felt that there was a huge missed opportunity of not integrating family planning and GBV. So if you integrate family planning and GBV, you are actually leveraging the resources and you are able to reach a good number of women—the very same women who are family planning users, but the same women who are also facing challenges of gender-based violence.

Lucy Mphuru

> We were also able really to sustain the services in those facilities, and also help the government in establishing the process for reporting data on gender based violence and violence against children into the national district health information system.

Narrator
Another great achievement of this program was to demonstrate that integration of GBV into existing programs is possible—and to offer a model for how this can be done and sustained. And even after the completion of this particular project, facilities continue to screen family planning clients for GBV and provide GBV services. Beyond this, they were also able to increase awareness about GBV within the community.

Lucy Mphuru

> We were able to bring out the awareness and consciousness to the community and workplace that women from the community can stand up for their rights and know that they should not normalize violence. They should stand up for their rights and break the silence.

Narrator
This season of the podcast, we are exploring what makes a program “gender transformative.” To this end, we asked Msafiri to describe the gender transformative elements of their work.

Msafiri Swai

> We were dealing with service provision to the post-GBV survivors, and also training of healthcare providers, strengthening data systems and all that. But also, the program had an opportunity of working with the community, where we provided some different opportunities for the community members to come together and discuss some of the issues in the view of trying to challenge and to validate some of the cultural norms and traditions, which actually prompt and instigate violence in our communities. So for us, we were happy that this program had given that opportunity to the community to come

together and discuss some of the issues like power inequalities, power sharing, parenting issues, accessibility of the community resources, how women also need to be given a chance to take part in the decision-making platforms and all that.

Narrator

So this program was able to not only offer services for GBV survivors, but it also addressed gender and social norms, and challenged power and inequalities within the community. These are key elements of gender transformative programs.

We asked Msafiri and Lucy what advice they would give to others looking to implement similar programs.

Msafiri Swai

GBV and family planning services can be well integrated. But from the designing, I think we need to make sure that the level of investment of the community—prevention of violence and the community and the response should at a certain time go concurrent, because we found that we needed to keep a similar pace of progress between the prevention and response. This should go together. And the other thing is the issue for community engagement and giving people space to discuss their issues, to air out their concerns, which we feel that they are bringing intersectionality to the number of violence, especially to the women and the young girls.

Lucy Mphuru

This really requires the critical examination of the role gender norms, dynamic, and system plays in achieving gender equity. And therefore we would really like to start with a gender analysis to inform really where we can have the greatest impact.

Narrator

A gender analysis can help us apply a gender transformative approach to family planning programs—first by understanding gender-based biases and descrimination and how this can hinder access to and use of family planning services—and then by designing our programs to respond systematically to these needs. A gender analysis can also shed light on social, cultural, and religious constraints that can affect community perceptions and attitudes towards the health system. We can use this information to strengthen the communication and design strategies that mitigate taboos that can hinder the use of both family planning and GBV services.

In addition to recommending a gender analysis, Lucy and Msafiri provided other practical information we can use when integrating GBV into existing family planning services. Involving the community and partnering with multiple sectors ensures that the program not only delivers integrated services, but challenges gender and social norms within communities. Also, as Msafiri noted, this program seized the opportunity of meeting women where they are. As he aptly pointed out, the same clients often experience both the need for family planning *and* the need for GBV prevention and response—so including them in the same location maximizes the chance that they receive all the services they need.

Finally, this example showed us that training is key to ensuring that family planning providers are able to screen for—and treat—GBV survivors. One aspect of such training is using a trauma-informed lens when treating GBV survivors. This is particularly important in post-conflict or crisis settings, as we will discuss in our next example.

[Family planning and gender-based violence in humanitarian and conflict settings—the case of Iraq]

Narrator
In crisis situations—including war and conflict—cases of gender-based violence often spike, along with the need for reproductive health and family planning services. To learn more about the intersection of family planning and GBV in crisis settings, we spoke with several staff members from the Iraq Health Access Organization—or "IHAO". They respond to the needs of conflict-affected women and girls across Iraq.

The organization started out addressing a range of health and social issues, but ended up prioritizing GBV and reproductive health. Here is Dr. Hala Al Sarraf, the founder and executive director of IHAO.

Hala Al Sarraf

> Through assessments, we realized that whenever we want to address a priority, women tend to be the vulnerable ones. And in war, after food immediately comes reproductive health and health services to the population. So we started IHAO with a very strong family planning program in 2017 with UNFPA, and before that was basically through different donors. But we started the main focus on UNFPA reproductive health in 2017. And soon we realized that we need to deal with GBV. Because most of the cases we were visiting post-ISIS, we had to deal with GBV as well as reproductive health.

Narrator
Like the program in Tanzania, IHAO works to improve health outcomes, while *also* addressing gender inequality and power imbalances—thus implementing a gender transformative approach. They work holistically, by engaging with multiple sectors and partners. Here is Dr. Jaafar Taslimi, Board Advisor at IHAO, with more on their work.

Jaafar Taslimi

> We work on reproductive health and GBV. And not only that, but we work on many social determinants of health, for example, livelihood opportunities, food security, water sanitation and hygiene, and education also. And we work closely with the Ministry of Health, the Ministry of Education, the Ministry of Higher Education, the Ministry of Labor and Social Affairs.

Narrator

Dr. Nour Al Mousawi is the GBV Coordinator with IHAO. Here she is with more on what they include in their GBV programs.

Nour Al Mousawi

With GBV, with protection, of course it is case management that we are concerned with. We also do awareness, psychosocial support, as part of the GBV case management. We provide also recreational activities. This year, our recreational activities included access to technology, computer literacy, technology literacy trying to include more young girls in these courses or workshops as well as the usual sewing workshops that women in these areas are interested in.

Narrator

Political unrest and conflict has contributed to dramatic socio-economic challenges in Iraq, including almost 2 million people displaced inside the country. Communities have also faced numerous violations of human rights—including gender-based violence in the forms of domestic violence; intimate partner violence; and child, early, or forced marriage.

During the time of ISIS occupation, most GBV cases were identified in reproductive health clinics. After the liberation, IHAO worked closely with UNFPA to identify women captured by ISIS, and to reunite them with their families. During this process, IHAO gained important insights about trauma-informed care and psychological support services.

Since 2017, IHAO has worked to integrate GBV response into existing public health centers. Jaafar explained how the GBV centers were set up, and why this integration approach worked best in the Iraqi context.

Jaafar Taslimi

When we started the GBV project in 2017, we had some options to set up the GBV centers. And what we chose was that we make the GBV service and the social workers and the case managers inside the primary healthcare center. So in that case, it will be very easy for the doctor and the reproductive health clinic. If she sees that some women have signs of domestic violence or gender-based violence, it will be very easy for her to refer these cases to the social worker. The social worker is right next door. And by the same token, it will be easy for the social worker to refer cases that she sees to the reproductive health clinic. They are right nearby.

So the bilateral referral system that happens in the health center was one of the main reasons that we chose to provide the GBV services inside the health centers. And this option was not done by all departments. As far as I know, we were the only partner who performed this choice, let's say, with UNFPA, and it was very successful.

One of the other reasons that we went with this choice is to decrease the stigma that might be put on women who go to GBV centers. It might be known that if a woman goes to a GBV center, she's a case of domestic violence. But if the center is put inside the

health center, then people will not know if women and girls who go there are actually going to the GBV center. And the other point is that we did not call the center as a GBV center—rather we called it "family support center." So people who are not familiar with what we do will not put some form of a stigmatization to our cases and to the women that we serve.

Narrator

They also have a mobile outreach component, to serve those who cannot easily access the health centers.

In addition to reducing stigma and providing a wide array of care including family planning, it has been important for IHAO to also to consider gender and social norms—for example, in relation to child, early, and forced marriage.

Child marriage has been recognized in international law as a form of GBV, and as such, a violation of human rights. According to the organization Girls Not Brides, child marriage puts girls and women at an increased risk of physical, sexual, and psychological violence throughout their lives. Their age—combined with gender norms—can put them at a deep disadvantage, with little power, agency, or bodily autonomy. Decision-making power about when to start having children, how many to have, and how to space births, are often severely limited for these young brides.

Hala emphasized strong links between child, early, and forced marriage, big families, generational poverty, and intimate partner violence. She suggested that increasing family planning awareness is an important step to address these interconnected issues.

Hala Al Sarraf

So in terms of awareness, in terms of helping make family planning tools available in the centers, and encouraging more knowledge about family planning, it helps. It helps a lot. It helps the woman to think that a marriage is one thing, and having kids is another. But we have also a big problem of adolescent marriage, and that's part of the GBV problem, is that we see many 16 year olds and 17 year olds who are attending the gender case management. They are already married. It's a big issue for their families, for the youngest sisters to be so scared as early as the age of 10 to see her bigger sister getting married and taken away from home, and she's still a kid. These things are good entry points to a family to try to postpone, try to stick to education.

Narrator

Family planning awareness must of course be accompanied by other efforts—including increased access to a range of contraceptive methods.

We asked the IHAO team how they measure the success of their program. They have tailored indicators that are specific to GBV, and others specific to reproductive health. However, Jaafar

and his colleagues also highlighted the need for additional measures to better understand the quality of care.

Jaafar Taslimi

> In 2020, IHAO was able to reach 19,536 vulnerable women and girls from its GBV interventions and up until now in 2021, we were able to reach more than 26,000 beneficiaries with only our GBV services.
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> But these numbers only give you the general aspect of what we do and the amount of the services and the areas that we cover. But it will be also very worthwhile to look into the individual success stories that we have, not only from the beneficiaries, but also from our social workers and how working with IHAO and UNFPA has helped them with their lives.

Narrator

Hala agreed, and talked about supporting GBV survivors to pick up and rebuild their lives after leaving an abusive relationship or dangerous situation—and also highlighted that this can be difficult to implement and measure for myriad reasons.

Hala Al Sarraf

> I think once we start with always updating the trends to help women to support themselves with more confidence. Mind you, we are in the Middle East and we are working in very difficult zones. It's still very rural, so the resources are limited. Then success becomes something very much difficult to measure in numbers.

Narrator

When it comes to measurement, Hala also mentioned the need to improve overall data collection, to be able to make connections among interconnected issues—reproductive health, GBV, and child, early, and forced marriage—and to design more effective programs and services.

Hala Al Sarraf

> We need to be stronger with data. We have lots of information, but we don't have data. We don't have enough studies that associate academically—especially by reputable academic institutions—the strong relation between reproductive health and GBV, between adolescents and GBV, between early marriage, adolescents, GBV. It's a typical chain, early marriage, family planning, no family planning, and then GBV. And so it's all there in data and figures, in storytelling, it's all in the centers, but there isn't enough studies that were done to make the link stronger.

Narrator

Over the last two years, the COVID-19 situation has added even more nuance to an already complex situation. Nour shared a story that illustrates how COVID-19 further complicates issues of GBV and reproductive health.

Nour Al Mousawi

I'd like to just share a story about a woman I met in the center who was a beneficiary. She is a beneficiary of two years returning to the center and I heard her wisdom. She was married when she was an early woman. After I knew this after asking her if she has girls, if they are, how old is her daughter? Would she get her married or would she allow her to finish her education? I really liked that she said she learned that pain is necessary to grow and to learn. But I also want to emphasize the impact of COVID on women and even on their health. We did talk about reproductive health. But when I asked this woman if she was vaccinated, she said no, and after questioning her husband wouldn't like that because of videos he saw on social media, they would die after two years if they get the vaccine. Regardless, I somehow dared her to like pose the question of what if you bring him here, and would he be willing to hear it from the social workers themselves and the doctors? What I want to say is that GBV doesn't only affect the mental wellbeing. It doesn't only affect the reproductive health for women. It also affects their choices to vaccinate or not. So it affects all choices, including the pandemic that we are going through.

Narrator

Jaafar emphasized that in the Iraqi context, the most vulnerable members of society disproportionately experience GBV and lack access to family planning services and methods.

Jaafar Taslimi

People who usually lack family planning services are those who are affected the most by GBV, and vice versa. And these are the people who are in the rural areas, who have the largest number of families and family members. We are talking about the same beneficiary group here who are people who have both needs. They need GBV services and they need family planning services too.

Narrator

Our IHAO guests shared important insights about how GBV manifests across Iraq—not on its own, but as part of the larger context of the humanitarian crisis, war, gender, inequality, and other health issues like COVID-19. The issue is complex, and so is the solution. But their insights and recommendations for integrating GBV and family planning programs offer helpful guidance.

For one thing, including GBV services within primary health care centers was more cost effective than offering services in separate spaces—and this eased the referral process and helped reduce stigma of GBV services.

Like the Tanzania program, IHAO also involved a range of government institutions and partners to address larger gender and social norms. Strengthening data systems can help us make a stronger case for integration among these partners. And finally, the IHAO model of working *with* the government—integrating family planning and GBV inside primary health centers—makes

these services more sustainable. Once the project is over, the Iraqi government can subsume full ownership of this model and take over ongoing service delivery.

Although the IHAO program was implemented within a very specific crisis situation, these are valuable lessons that we can apply in other settings as well, as we strive for gender transformative programs.

[Integrating gender-based violence response into FP programming—the case of DRC]

Narrator
Let's turn to one of our other guests, Prabu Deepan, who shared his experience working with a program in another conflict setting—this time in the Democratic Republic of the Congo (DRC). The program "Masculinities, Family, and Faith" (abbreviated as MFF) was part of the USAID-funded Passages project—and it successfully reduced GBV rates and improved family planning outcomes in a fragile setting.

Prabu started out with some advice: Change may not happen all at once, but change *is* possible.

Prabu

> Change pathways are not always linear. They're not insular like a project environment, so when we were doing programming in DRC, there was an election that they postponed there's high turnover of staff members, not only from the election violence, but just the conditions in that space. It's to be looking at the whole ecosystem in the waiting process, it's a pleasant, that's a learning in, especially in programming in fragile settings. But also knowing that change is possible. I think that's important.

Narrator
He mentioned a related program in the DRC, funded by the UK government, that shed further light on these opportunities for change.

Prabu Deepan

> GBV programming works quite well in a humanitarian setting. I think that the kind of impact of that could be exponential. So for example, we had an intervention in the Eastern DRC, where we saw massive reduction of intimate partner violence. It was UK government funded project under What Works Consortium. And we had about 60% reduction of intimate partner violence between baseline and endline. And we also saw non-partner sexual violence reduced 83%. So I think it's really quite fascinating to see. So it didn't necessarily shift individual mindsets or attitudes of people, but it changed behavior or forced behavior to change, because of the normative environment where violence became unacceptable in that space.

Again, Why? because of the conflict in that area, it's so it almost, it's a secluded inaccessible space. So there's not a lot of influence in, massively from external factors. So you, if you have a targeted dimension, it's saturated, the message got diffused over and over again. And so the key thing, violence being unacceptable in different ways, just over saturated in that space. I think it just led to a positive outcome in that way.

Narrator
He explained that there are often situational norms that operate in humanitarian settings and within displaced communities, and they can sometimes adapt and morph more quickly than in more permanent communities. While these are challenging situations to work in, there are also opportunities to address GBV, as social norms may be somewhat in flux.

Prabu also shared insights about co-creating programs with communities and involving relevant community leaders and members in addressing social norms around gender, power, and violence. He described a tool that can be helpful in identifying and understanding social norms that influence how people act or behave.

Prabu Deepan
I think the context analysis is really important. And I think one of the key, really good tools that we use from the Passages project in DRC is this tool called Social Norms Exploration Tool, SNET.

You start diagnosing the social norms that you're seeking to shift, and also key reference groups as well. So finding out, like you have a hypothesis, like in our project, which we said, okay, religious leaders, lay leaders, couple members, they were the key reference groups in that space for us for, because it was a GBV intervention. And we realized that there were other people who were important to make the male partner, a female partner, like your grandparents or paternal grandfather or mother. So how do you integrate, bring them into the intervention design? Or can you? I think that's the question of that because we already go with pre-set mindset and intervention, rigid intervention designsI think definitely SNET is a way that could allow us to explore social norms and diagnose, and then start to use an adaptation for an efficient process as well.

Narrator
Let’s share some more details on the MFF intervention in DRC. The program sought to capitalize on life course changes to reform social norms—an approach that you will hear more about in our next episode on male engagement. The approach entails working with community members throughout different points in their lives as their reproductive needs and family situations change. MFF also engaged with faith leaders to help promote gender equality and family planning use within communities.

Using the social norms exploration tool that Prabu introduced, the program was able to identify the social norms in place related to gender equality, masculinity, family planning, and violence.

One such norm was the acceptance of men forcing their wives into non-consensual sex—also known as marital rape.

MFF intervened by training faith leaders to act as gender champions—facilitating community dialogues and establishing couple communication counseling. In a strategy called “organized diffusion,” MFF tapped into existing communication channels—for example, sermons—to share stories of change from couples who had participated in this counseling. To make the overall environment more favorable for family planning, clinics were linked to congregations and providers were trained in youth-friendly service provision. These clinics distributed referral cards and established a family planning and sexual health hotline for young couples, which provided free services and information.

During the intervention, over 5,000 young couples sought services for either GBV or family planning. Endline survey results revealed that—compared with those outside of the intervention area—first-time parents in this program were more likely to hold supportive attitudes towards family planning, discuss the topic with their partner, have confidence that they could obtain family planning, and ultimately to use modern contraception. 53% of non-pregnant respondents in the intervention area reported that they were currently using a modern method voluntarily within their relationship, up from 40% at the beginning of the intervention.

MFF is an adaptation of the Transforming Masculinities (TM) program, which was implemented in DRC and scaled in the DRC and Rwanda. One further adaptation of MFF in Nigeria—known as "Masculinities, Faith and Peace"—worked with both Christian and Muslim communites. The original TM model has also been adapted and scaled around the world to address issues such as women's economic empowerment and female genital mutilation and cutting.

While the challenges for integrating GBV and FP are many, these insights from Tanzania, Iraq, and the DRC show us that—while it may take time and careful planning—it is possible to change gender and social norms.

[What are the opportunities for integrating GBV-focused goals into FP programs]

Narrator
Our guests have shared some important recommendations and opportunities for integrating family planning and GBV in a way that opens up a space for inequitable norms to shift.

We learned some tips for delivering joint services, including integrating GBV prevention and response services within existing primary health and family planning centers. Further, by using a trauma-informed lens, the family planning workforce can be prepared to recognize GBV and respond to it when faced with clients seeking care.

Our guests also shared ways to make sure that programs are gender transformative—and highlighted strategies for community engagement to address harmful gender and social norms.

By using existing tools like the Social Norms Exploration Tool, and fostering partnerships with government institutions and civil society networks, we can work to increase the acceptability of family planning and make GBV less acceptable in communities. We also learned about the importance of centering the needs of women and girls and involving faith leaders to ensure an enabling environment for challenging social norms around gender and violence.

One additional strategy and opportunity is finding ways to engage men and boys. Specifically, including men and boys in programs that seek to shift harmful and restrictive gender norms can help prevent GBV while promoting women's and girls' autonomy when it comes to family planning and related areas.

For these conversations with men and boys on masculinities and harmful gender norms, Mabel and her organization uses tools that are part of a campaign called "One Man Can"—which promotes the idea that every individual has a role to play in creating and sustaining a more equitable and just world for all.

Mabel Sengendo

It helps men to think, "Oh my goodness, what's this?" If you talk about for example, things like power, you know, there's an exercise called gender values clarification where you just help think through the things that they believe. Do they even make sense? Sometimes when you have those discussions in a space where you help them just know, think about your own values. How does that affect how you behave or how you act across different areas of life?

You see men sort of getting to an awareness of, oh, this is what this is what it means. I'll give you an example, when we are training, how does sexual violence affects your everyday life. This we talk about in a room that has men and women, and you have the women fill on the flip charts, how they go about their day preventing sexual violence. And you ask men to do the same. And when you bring them back together in plenary, it's always very interesting to see how men look at the flip charts, not even one flip chart, the flip charts that are coming in from women in terms of what they do on a daily basis to prevent themselves from sexual violence. And the men either sometimes have nothing on their flip charts or they'll put some very, you know, fun trying to be funny. But I think when you begin to interrogate what that means, looking at the women's chart and the men's chart, you see that awareness of men, like this is what women have to go through every day and you help them understand—these women are your wives, they're your daughters, they're your sisters, they're your mother, who have to go through all these things for them to be safe on a daily basis. So when you begin from that point of values clarification, you sort of bring men down to a level where they can begin to understand any topic that you bring to the table, whether it's GBV, whether it's family planning. So for us, that's a very good starting point when we, when we are engaging men or communities at that.

Narrator

This is one practical exercise programmers can incorporate into our programming to help address the pervasive social and gender norms within communities—and to help prevent GBV.

This episode has highlighted a range of challenges and opportunities to respond to, and prevent, GBV across diverse settings and contexts. We hope you will take these recommendations and apply them as you consider how to integrate GBV prevention and response in your own programs.

Next time, we will continue with a more in-depth discussion of how to engage men and boys in family planning. What exactly does it mean to engage men and boys in family planning programs? Which strategies work, and which ones do not work? And how can we support women's and girls' decision-making while also working with men and boys? Join us as we answer these questions, and more, in our next episode—the final episode this season—of *Inside the FP Story*.

[Credits]

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If you have any questions or suggestions for future episodes, feel free to reach out to us at info@knowledgesuccess.org.

Thank you for listening.

More Resources

- A conceptual re-evaluation of reproductive coercion: centring intent, fear and control
- Family Planning And Intimate Partner Violence: An Intersection Deserving Of More Attention
- Seeking Breakthroughs In Social And Behavior Change At The Intersection Of Family Planning And Intimate Partner Violence

- Tanzania Family Planning Outreach Programme
- “One Man Can” Toolkit
- Social Norms Exploration Tool (SNET)
- Masculinité, Famille et Foi (MFF) End of Project Report
- Transforming Masculinities in Kinshasa, DRC (PowerPoint Presentation)
- What Works to Prevent Violence
- The Prevention Collaborative
- GBV Prevention Network
- Promundo: Key Takeaways Learned from Prevention+
- Me Too: A Toolkit for Survivors During COVID-19
- GBV is Surging & Family Planning is Threatened. We Can Do Better