

Gender-Based Violence

Beyond Awareness: Contextualizing GBV response in SRH

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Beyond Awareness: Contextualizing GBV Response in Sexual and Reproductive Health

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A Collaboration of:

Strength and Serenity Initiative to End GBV • Massachusetts General Hospital

Harvard Medical School • Luziibangi International Health School

Learning Objectives

- Describe the intersection of GBV and Sexual & Reproductive Health
- Apply behavior change models (SEM, TPB) to GBV response
- Critically examine Uganda's legal frameworks and implementation gaps
- Design contextually appropriate strategies for healthcare settings

Agenda

Understanding the Landscape

- Recall GBV reality
- International legal principles and human rights framework
- Forms of GBV beyond physical violence
- GBV-SRH intersection

Behavior Change Frameworks

- Public health approach to GBV
- Social Ecological Model (SEM): Multi-level influences
- Theory of Planned Behavior (TPB): Attitudes, norms, control
- Health Belief Model (HBM): Understanding help-seeking

Contemporary Challenges

Legal frameworks vs. implementation gaps

Moving to Action

- Integrating GBV screening in SRH services
- Community and healthcare strategies
- Justice system strengthening
- Practical next steps for your context

“I took refuge in a camp for displaced people where three armed men raped me. . . . physical and psychological pain was immense. . . . distressed that I felt I could not look after my children after the attack. I felt like my family and community completely abandoned me.”



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(Lugova 2020)

Recall Uganda's GBV Reality

- 58% Intimate Partner Violence
- 40 Daily GBV Cases
- 2.9% Conviction Rate
- 49% Women Face Online Violence
- 249 Deaths (2023)
- 95% Unaware of Digital GBV Laws

Source: Uganda DHS 2022, Police Crime Report 2023

Definition: Gender-Based Violence

“Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

- Violence against women (VAW)
- Domestic violence (DV)
- Intimate Partner Violence (IPV)



(Photo by Anna Watts for IntraHealth International)

International legal principles

Any form of GBV constitutes a serious violation of human rights

- Right to **dignity**
- Right to **physical, mental and moral integrity**
- Right to **freedom from torture** and cruel, inhuman or **degrading treatment**



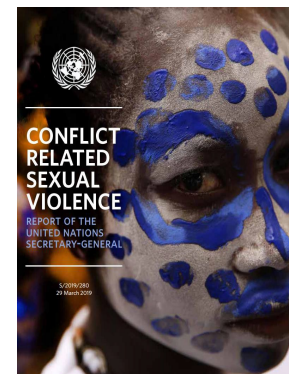
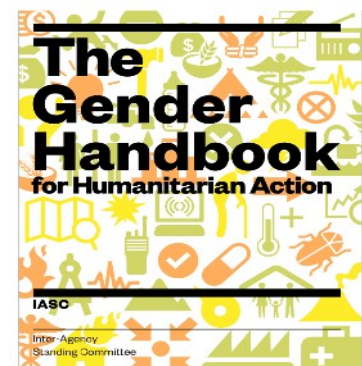
Key Frameworks

CEDAW (1979) • Beijing Declaration (1995) • UN Declaration on Elimination of Violence Against Women (1993)

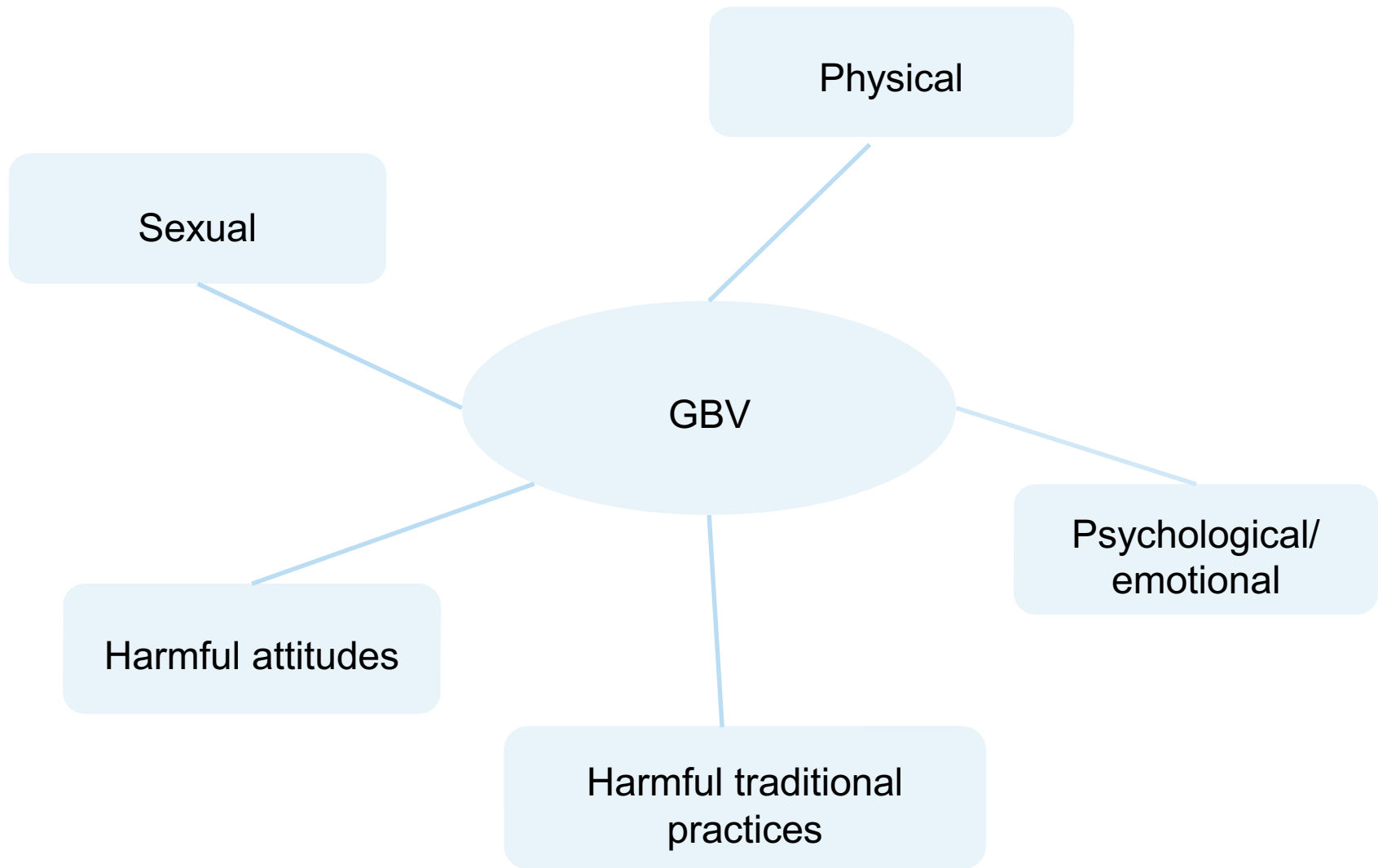
Council of Europe. Convention on preventing and combating violence against women and domestic violence (2011)

UN (SWAP) on Gender Equality and Empowerment of Women, 2018

New York Declaration for Refugees and Migrants, 2016



Types of GBV



Forms of GBV beyond physical violence

1. Physical Violence

Battering, slapping, beating

2. Sexual Violence

Rape, defilement, sexual harassment, exploitation

3. Economic Violence

Denying financial access, forcing income surrender, preventing employment

4. Emotional/Psychological

Verbal abuse, threats, confinement, humiliation, isolation

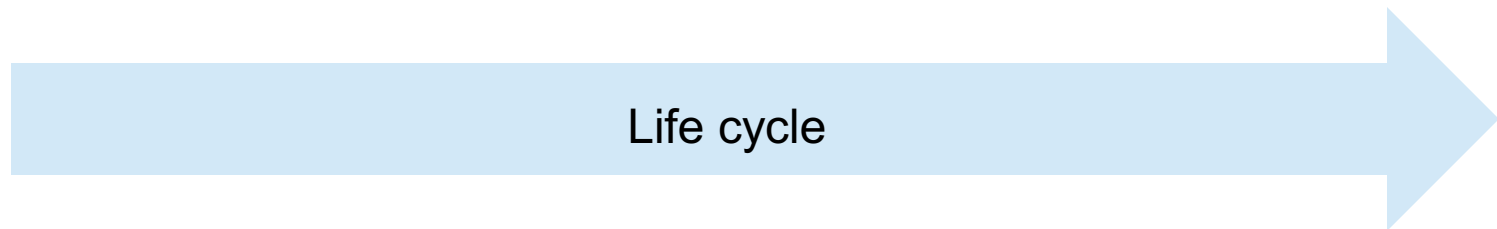
5. Digital Violence

Cyberbullying, image-based abuse, sextortion, online stalking

6. Harmful Practices

FGM, forced marriage, dowry violence

Common types of GBV



Physical violence

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either **results in or has a high likelihood of resulting** in injury, death, psychological harm, maldevelopment, or deprivation.”

Sexual Violence

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.”

Psychological Violence

“... any harmful behavior that isn’t physical, such as verbal abuse, intimidation, manipulation, degradation, and **humiliation.**”

- includes placing restrictions on liberty and freedom of movement.

Harmful Traditional Practices

- Female genital mutilation / Cutting (FGM/C)
- Forced marriage, child marriage
- Honor or dowry killings or maiming
- Infanticide, sex-selective abortion practices
- Sex selective neglect and abuse
- Denial of education / economic opportunities

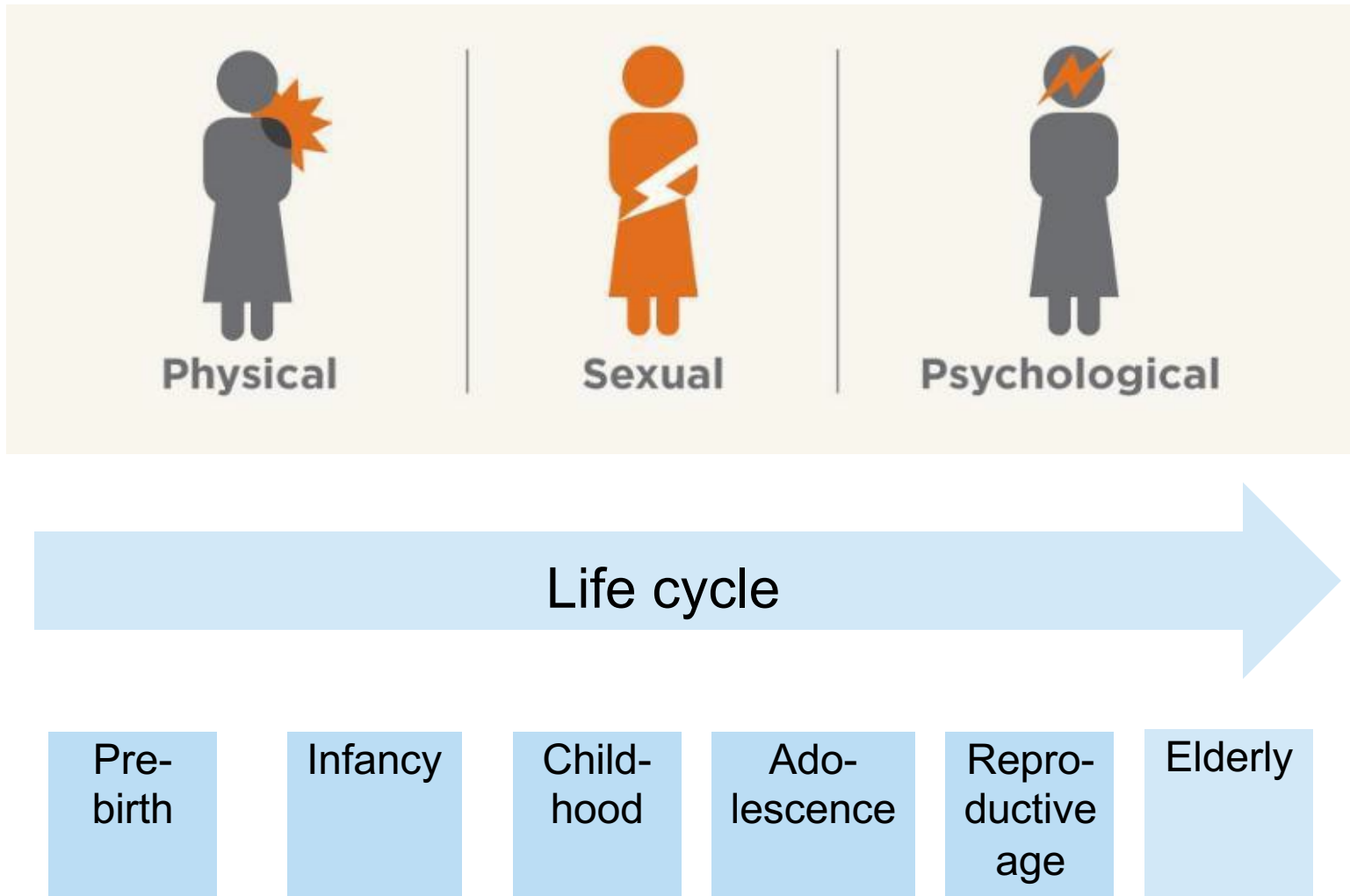


Harmful Attitudes

- Discrimination
- Denial of opportunities on the basis of gender
- Social exclusion
- Obstructive legal practices, such as denial or the exercise and enjoyment of civil, social, economic, cultural and political rights.



GBV is a global pandemic



GBV and Sexual & Reproductive Health

The Connection

GBV directly impacts SRH outcomes and shapes health-seeking behaviors

SRH Impacts of GBV

- Unintended pregnancies
- STIs including HIV
- Unsafe abortion
- Maternal morbidity & mortality
- Contraceptive sabotage
- Adolescent pregnancy
- Obstetric complications

Integration Points

- Antenatal care
- Family planning
- Post-abortion care
- HIV testing & counseling
- STI treatment
- Adolescent health services
- Emergency contraception

GBV = Public Health Crisis

GBV can be seen and analyzed as a preventable health issue using the **public health model**.

Surveillance: Are we able to identify GBV? That is why it is important to recognize ALL types of GBV – sexual, physical, psychological, digital, etc.

Risk Factor Identification: Who are at greater risk of GBV? What defines vulnerability?

Intervention Development: What are reasonable and sustainable solutions?

Evaluation: How do we evaluate the success of these interventions? What is our metric?

Public Health Approach to GBV

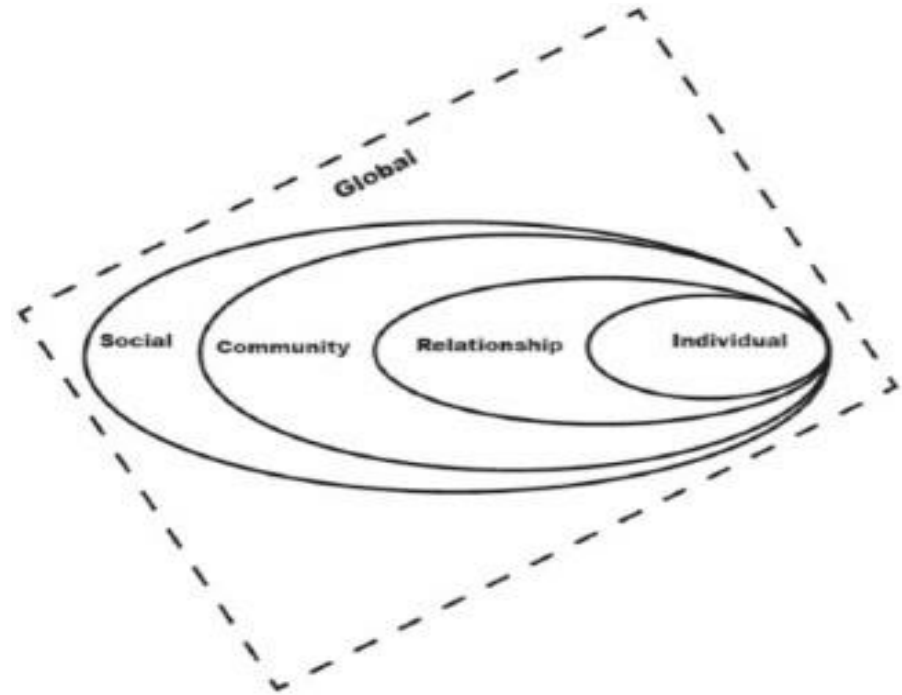
GBV as a Preventable Public Health Issue

Using systematic approaches to understand, prevent, and respond to GBV

- 1. Surveillance** - Monitoring prevalence, patterns, and trends (40 cases/day in Uganda)
- 2. Risk factor identification** - Understanding individual, relationship, community, and societal factors
- 3. Intervention development** - Designing evidence-based prevention and response strategies
- 4. Evaluation** - Assessing effectiveness and adapting approaches (NDP III: 30% reduction by 2025)

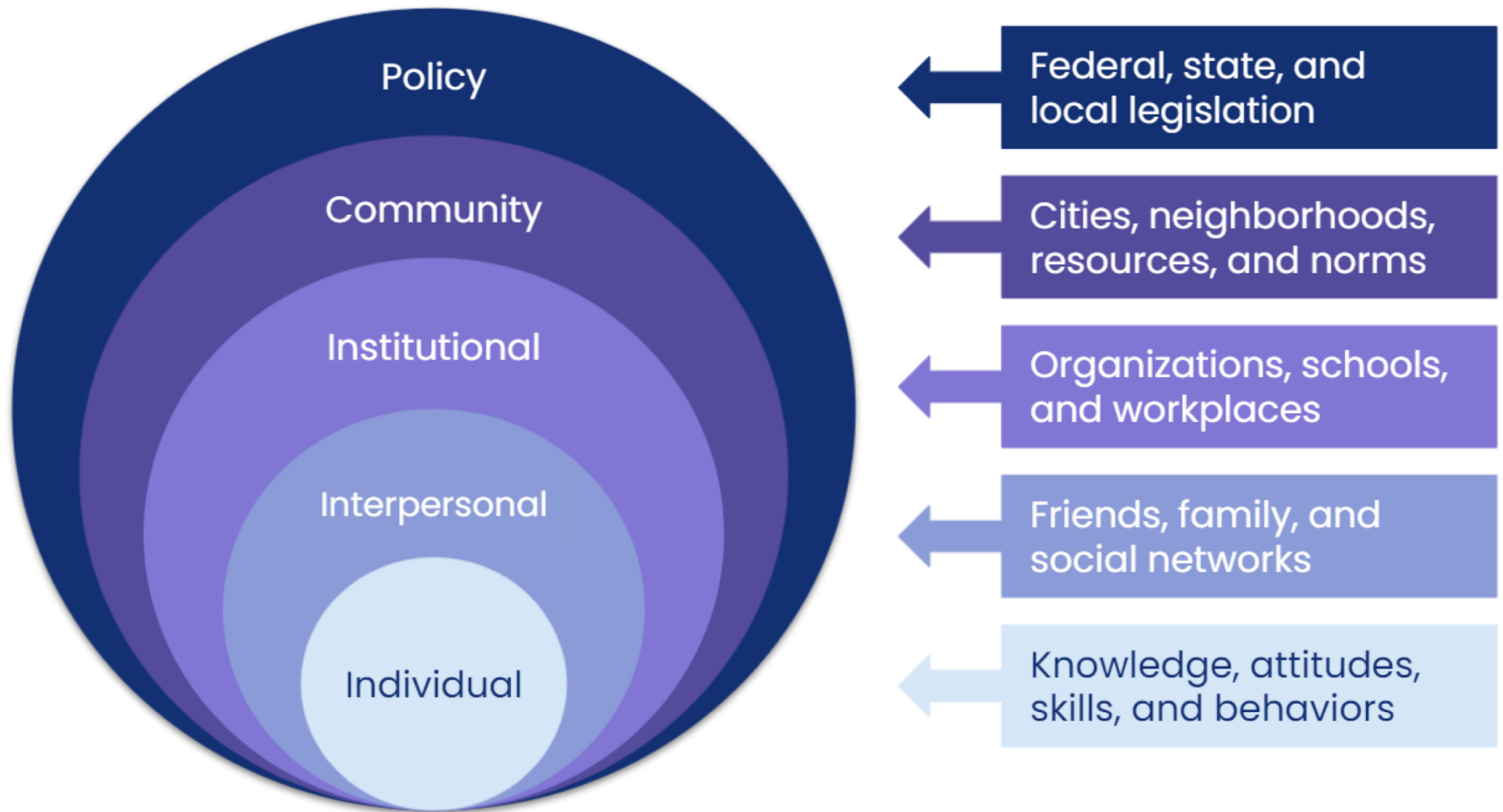
Determinants of GBV - Levels

- Individual
- Relational
- Community
- Societal



Heise L. Ecological model with integrated globalized framework through which to analyze violence against women across levels of social ecology.

Social Ecological Model (SEM)



Social Ecological Model (SEM)

Multi-Level Framework for Understanding GBV

Violence is influenced by factors at multiple levels - effective interventions must address all levels

- **Individual:** Personal history, knowledge gaps, mental health (75% report stress from online GBV)
- **Interpersonal:** Intimate partner dynamics, family attitudes (58% IPV prevalence)
- **Community:** Village Health Teams, cultural norms, regional variations (Acholi: 78% IPV)
- **Institutional:** Healthcare system capacity, police response (only 10.3% cases reach court)
- **Policy:** Laws, funding, enforcement (only 24% of required funding received)

Determinants of GBV: Individual level

- Women living in rural areas
- Adult survivors of GBV
- Husband's alcohol use
- Household socioeconomic status
- Younger age of women
- Low education
- Attitudinal acceptance of violence

Capaldi et al. A systematic review of risk factors for intimate partner violence. *Partner Abuse*. 2012;3(2): 231–80; Fulu et al. Multi-country Cross-sectional study on men and violence research team. Prevalence of and factors associated with male perpetration of intimate partner violence: Findings from the UN multi-country cross-sectional study on men and violence in Asia and the Pacific. *The Lancet Global Health*. 2013;1(4):187–207.

Determinants of GBV: Individual level

- Women living in rural areas
- Adult survivors of GBV
- Husbands alcohol use
- Low self-esteem
- Low socioeconomic status
- Low education
- Attitudinal acceptance of violence

Conflict factors

- Reduced access to support
- Forced proximity
- Witnessing conflict related violence
- Association of trauma /aggression among war-affected men

Determinants of GBV: Relational Level

- No decision making power
- Type of marriage (married to relatives, polygamous)
- Male decision making in family
- Male control of wealth in the family

Determinants of GBV: Relational Level

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Conflict factors

- Loss of a loved one
- Separation from family
- Loss of livelihood
- Increased number of child marriages
- Conflict-related changes in family structure / family functioning

Determinants of GBV: Community factors

- Inequitable gender norms and practices
- Religious and cultural justifications
“a good wife obeys her husband”
- Quality, affordable housing

Determinants of GBV: Community factors

- Inequitable gender norms and practices
- Religious and cultural justifications
- Quality, affordable housing

Conflict factors

- Increased insecurity
- Mistrust in institutions
- Separation from family members due to disruption of social structures
- Minority clan structure

Determinants of GBV: Societal level

- Discriminatory laws and practices
- Gender inequality
- Acceptance of violence as a mechanism of solving conflicts
- Patriarchy

Determinants of GBV: Societal level

- Discriminatory laws and practices
- Gender norms
- Acceptance of violence as a mechanism of solving conflicts
- Patriarchy

Additional factors in humanitarian settings

- Armed conflict
- Weakened legal structures
- Increasing rigid gender roles
- Weakening of educational, health, religious institutions

The SEM Tells Us...

Individual Level

There are personal history, attitudes, and behaviors that increase risk or resilience. Prevention focus: life skills education, mental health support, gender-equity education, economic empowerment.

Relationship / Interpersonal Level

Patterns within families, partnerships, and peer groups that shape risk. Prevention focuses: couple counseling, positive parenting, mentorship programs for boys, promoting equitable household decision-making.

Community/Institutional Level

Environments where social relationships occur — neighborhoods, workplaces, schools, religious institutions. Prevention focus: community mobilization (e.g., SASA! model), bystander intervention training, safe public spaces, strengthening local reporting and referral mechanisms.

Societal / Structural Level

Broad cultural, economic, and political factors that normalize or perpetuate violence. Prevention focus: policy reform, gender-equitable education, national campaigns to shift norms, enforcement of GBV laws, Women, Peace & Security agenda integration.

Applying SEM to Uganda's Context

Current Barriers

Individual: <1 in 3 identify non-physical GBV

Interpersonal: Economic dependence, controlling behaviors

Community: Normalization, victim-blaming

Institutional: Weak healthcare screening

Policy: Implementation gap (2.9% conviction)

Intervention Strategies

Individual: Education on all GBV forms

Interpersonal: Couples counseling, safety planning

Community: Male engagement, dialogues

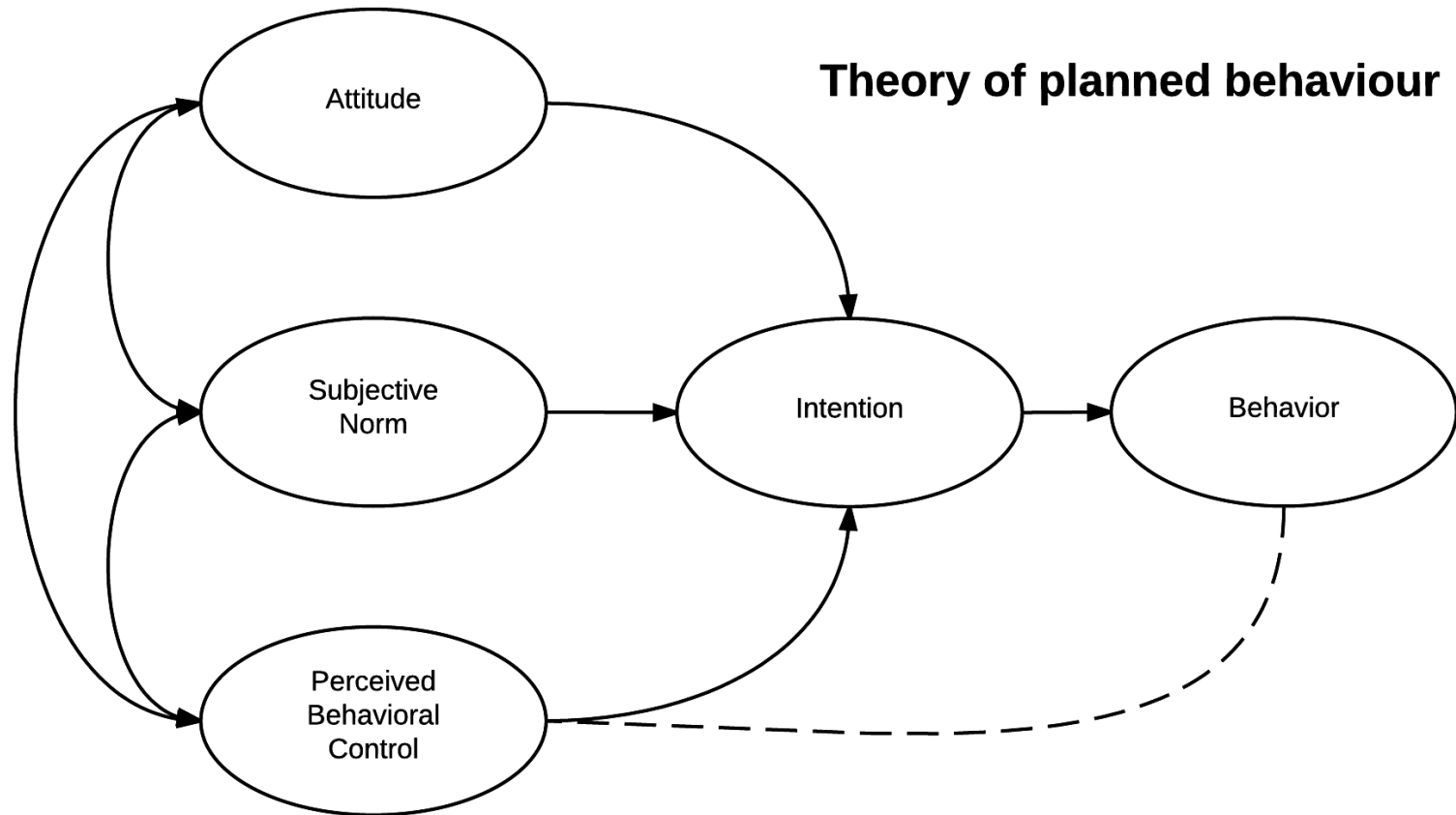
Institutional: Provider training, referral systems

Policy: Strengthen enforcement, funding

Lessons learnt

- Acts of GBV exist on a continuum
- Acts of GBV are facilitated by breakdown in law and order
- GBV is used in societies where it is culturally taboo and associated with women as lesser subjects
- Healthcare providers can

Theory of Planned Behavior (TPB): Understanding Health Workers' Response to GBV



Theory of Planned Behavior (TPB)

Understanding Behavior Change

Why do people take (or not take) action on GBV?

Three key factors:

- **Attitudes:** Beliefs about GBV screening, help-seeking, intervention
Example: "It's not my place to ask about violence" vs. "It's my duty to screen"
- **Subjective Norms:** Perceived social pressure and expectations
Example: Cultural acceptance of "wife discipline," professional norms about privacy
- **Perceived Behavioral Control:** Confidence in ability to act
Example: Healthcare workers' confidence in GBV screening, survivors' belief they can leave

Attitudes

- Beliefs about whether addressing GBV is part of their professional role.
- Personal views on survivors (e.g., victim-blaming vs. empathy).
- Perceived importance of GBV screening and documentation.
- Past experiences with survivors influencing comfort or motivation.
- Moral and emotional commitment to providing trauma-informed care.

Subjective Norms (Perceived Social Pressures)

- Institutional culture — whether supervisors and peers support or discourage GBV screening.
- Perception of leadership priority: *“Do my seniors value GBV response?”*
- Colleagues’ behaviors: if others routinely ask about GBV, it becomes normalized.
- Broader societal and cultural norms — gender roles, stigma around discussing violence.
- Pressure from time constraints or patient load that deprioritizes GBV care.

Perceived Behavioral Control (Confidence & Capacity)

- Knowledge and training on how to ask about and manage GBV cases.
- Availability of referral pathways, privacy spaces, and survivor resources.
- Confidence in communication skills and ability to respond empathetically.
- Institutional policies that empower or limit action (e.g., mandatory reporting laws).
- Emotional readiness and support systems for staff (to prevent secondary trauma).

Applying TPB to GBV Response

Healthcare Providers

Attitudes: "GBV screening is part of comprehensive care"

Norms: "My colleagues expect me to screen"

Control: "I have the skills and referral pathways"

Survivors

Attitudes: "Seeking help can protect me and my children"

Norms: "My community will support my decision"

Control: "I can access services and economic support"

Intervention Focus

Change attitudes through education, shift norms through community engagement, increase perceived control through skills training and resource provision

Health Belief Model (HBM)

Why Do Survivors Seek (or Not Seek) Help?

- **Perceived Susceptibility:** "It won't happen to me" vs. recognizing risk
- **Perceived Severity:** Minimizing emotional abuse vs. understanding full impact (249 deaths in 2023)
- **Perceived Benefits:** Safety, health care, legal protection, counseling
- **Perceived Barriers:** Stigma, economic dependence, system failures (2.9% conviction), fear of police
- **Cues to Action:** National campaigns, high-profile cases (Rebecca Cheptegei), provider screening
- **Self-Efficacy:** Confidence in ability to navigate services and create safety

Case Example: GBV Screening in Post-Abortion Clinic Setting

- Patient Jenny, 29, arrives for post-abortion follow up visit
- Provider Nurse Lillian notes signs of anxiety, bruising, and hesitancy when discussing home circumstances.
- Clinic recently trained staff in survivor-centered GBV screening using the SEM + TPB approach.

TPB:

Attitudes: The nurse views GBV screening a major part of her role and integral to respectful care

Subjective Norms: Clinic leadership and peers discuss GBV cases and screening protocols

Perceived Behavioral Control: The nurse has the space, skills and comfort to conduct GBV Screening

Behavioral Action + Intention: She successfully screens Jenny and is able to refer her to appropriate follow up resources

Discussion Questions:

1. How did Nurse Lillian's *attitudes, norms, and control* influence her decision to screen for GBV?
2. Which *SEM levels* could be strengthened in Jenny's setting to prevent recurrence of violence?
3. What policy or system supports are needed to make this model sustainable in low-resource settings?

Developing responses to GBV

- Improving research, quality & routine monitoring
- Economic empowerment
- Legal protection
- Participation /engagement
- Safety
- Health services

Case Study: Rebecca Cheptegei

September 2024: Femicide of Olympic Athlete

Rebecca Cheptegei, 33-year-old Ugandan Olympic marathoner, was murdered by her ex-partner who doused her in petrol and set her ablaze. She died from severe burns on September 5, 2024.

Key Facts

- Property dispute with ex-partner
- Attacked at home after church
- Children present
- Part of pattern: 4+ female athletes killed by partners since 2021

Lessons

- GBV affects ALL socioeconomic levels
- Economic control precedes femicide
- Systemic protection failures
- Need for specialized interventions

Uganda's Legal Framework

Strong Frameworks Exist

- Domestic Violence Act (2010)
- National Policy on Eliminating GBV (2019)
- Penal Code (Rape provisions)
- CEDAW (ratified 1985)
- NDP III (30% reduction by 2025)

Implementation Gaps

- 15,184 reports → 1,520 to court → 423 convictions (2.9%)
- No digital violence legislation
- Only 24% of required funding
- Weak rural enforcement
- Economic violence rarely prosecuted

The Crisis

Strong laws exist, but 97% of cases don't result in convictions, perpetuating impunity and discouraging reporting

Cultural & Social Barriers

- **Narrow understanding:** GBV = only physical violence (fewer than 1 in 3 recognize other forms)
- **Normalization:** "He can shout, that's fine" - emotional abuse tolerated
- **Gender norms:** Male economic control, women forced to surrender income
- **Community apathy:** Family/community pressure to stay silent, victim-blaming
- **Economic dependence:** Women lack financial independence to leave
- **Institutional dismissiveness:** Police and healthcare providers lack training

Integrating GBV in SRH Services

Universal Screening Approach

All women accessing SRH services should be screened for GBV in a safe, confidential manner

When to Screen

- Antenatal care visits
- Family planning consultations
- Post-abortion care
- STI/HIV services
- Adolescent health visits
- Emergency contraception requests

What to Screen For

- Physical violence
- Sexual violence
- Economic control
- Emotional/psychological abuse
- Digital violence
- Reproductive coercion

Principles of GBV Screening

Safety First: Ensure woman is alone, safe space, no partner/family present

Confidentiality: Explain limits, ensure privacy of records

Non-Judgmental: Supportive, believing, empowering approach

Trauma-Informed: Understand impact, avoid re-traumatization

Comprehensive: Ask about ALL forms of violence, not just physical

Document Carefully: Accurate records for potential legal use

Immediate Response: Emergency contraception, PEP, STI treatment as needed

Referral Pathways: Know where to refer for legal, shelter, counseling services

Healthcare Provider Competencies

Essential Skills for GBV Response

Knowledge

- All forms of GBV (not just physical)
- SRH impacts of violence
- Local referral pathways
- Legal rights and protections
- Cultural context

Skills

- Trauma-informed communication
- Safety assessment
- Documentation
- Emergency response (EC, PEP)
- Referral coordination

Attitude Shift Needed:

From "not my role" to "essential part of comprehensive SRH care"

Health System Integration

- Clinical guidelines for GBV screening in all SRH encounters
- Training healthcare providers to identify economic, emotional, and digital abuse
- Referral pathways connecting health facilities with legal aid, shelters, and counseling
- Creating safe spaces for disclosure within SRH consultations

Community-Level Strategies

Village Health Teams: Train as GBV first responders, identify all forms of violence

Community Dialogues: Challenge harmful norms, address misconceptions about GBV

Male Engagement Programs: Work with men and boys on healthy masculinity, control issues

Religious/Cultural Leaders: Partner to shift norms, challenge "wife discipline" acceptance

Digital Literacy Training: Address 95% awareness gap on online GBV protections

Economic Empowerment: Women's savings groups, income-generating activities

Regional Context Matters

Significant Regional Disparities

Acholi Region: 78% IPV rate compared to 43% national average

Why Context-Specific Approaches Are Essential

- Historical trauma and conflict exposure in certain regions
- Cultural practices vary across Uganda
- Access to services differs between rural and urban areas
- Economic opportunities and women's empowerment vary
- Community leadership structures differ

Strategy

One-size-fits-all approaches will fail. Interventions must be adapted to local context, cultural norms, and available resources.

Responding to Digital Violence

Prevention

- Digital literacy education
- Privacy settings training
- Recognizing online threats
- Safe social media use
- Password security

Response

Reporting platforms
Digital evidence preservation
Online safety planning
Mental health support
Legal advocacy

Urgent Priorities

1. Close the 95% awareness gap through mass education campaigns
2. Develop specific legislation for technology-facilitated GBV
3. Integrate digital violence screening into healthcare assessments

Strengthening Justice Response

The Justice Gap

15,184 cases reported → 1,520 reached court (10.3%) → 423 convictions (2.9%)

- **Improve Police Response:** Specialized GBV units, mandatory training, survivor-centered approach
- **Fast-Track Courts:** Dedicated GBV courts to reduce delays
- **Evidence Collection:** Better documentation, forensic capacity
- **Protection Orders:** Effective enforcement mechanisms
- **Legal Aid:** Free representation for survivors
- **Accountability:** Track and publish prosecution/conviction rates

Measuring Progress

How do we know if we're making progress?

Outcome Indicators

- IPV prevalence rates
- Femicide rates
- Knowledge of GBV forms
- Help-seeking behaviors
- Digital violence awareness

Process Indicators

- Healthcare screening rates
- Reporting to police
- Cases reaching court
- Conviction rates
- Service utilization

Current Challenge

*While physical violence decreased, IPV **increased** from 39% to 43%. We need better strategies for intimate partner violence specifically.*

What can you do tomorrow?

Healthcare Providers

- Start asking about ALL forms of violence
- Create private screening space
- Learn local referral pathways
- Document carefully and sensitively
- Provide immediate care (EC, PEP, STI treatment)

Program Managers

- Integrate GBV into all SRH programs
- Train staff on behavior change models
- Build referral networks
- Monitor and evaluate outcomes

Community Workers

- Expand GBV education beyond physical violence
- Challenge harmful norms in dialogues
- Connect survivors to services
- Work with male champions
- Conduct digital safety training

Advocates

- Push for digital violence legislation
- Demand justice system accountability
- Advocate for increased funding
- Share survivor stories (with consent)

Critical Barriers Summary

Knowledge gap: Fewer than 1 in 3 can identify non-physical GBV forms

Digital violence: 49% affected but 95% unaware of protections

Justice failure: Only 2.9% conviction rate despite thousands of cases

Funding gap: Only 24% of required \$25M received in 2024

Cultural norms: Normalization of emotional, economic violence

Provider capacity: Healthcare workers lack comprehensive GBV training

Regional disparities: Acholi 78% vs national 43% IPV rates

Stagnating progress: IPV increased from 39% to 43% (2016-2022)

Key Takeaways

1. GBV is more than physical violence

Includes economic, emotional, sexual, and digital forms, but most Ugandans only recognize physical abuse

2. Behavior change models provide frameworks

SEM reveals multi-level influences, TPB helps understand barriers, HBM explains help-seeking. Effective GBV screening in healthcare demands synergy

between **TPB**) and **multi-level system support (SEM)** — e.g. empowering survivors while embedding accountability at every layer.

3. SRH integration is essential

GBV directly impacts maternal health, family planning, HIV risk, screening must be universal

4. Implementation gap is the real crisis

Strong laws exist, but 97% of cases don't result in convictions, perpetuating impunity

Key Takeaways

GBV is a **multi-faceted public health crisis** that impacts a wide spectrum of people, communities, and systems.

Looking at it through this lens enables us, as researchers, providers, policymakers, to effect real sustainable change.

Conclusion

- GBV is a common women`s life experience,
- GBV affects 35–45% of women worldwide
- GBV has profound physical, psychological, and social impact on survivors
- Public health crises of GBV, violence and infectious disease are intersecting
- Efforts to situate GBV within the violence and infectious disease pandemic are needed.

Outlook

“It is clear that we cannot go back to the failed policies that have resulted in the fragility we see around us—in healthcare systems, in social protection, in access to justice. This is the time to rebuild equal, inclusive, and resilient societies.” (United Nations Secretary-General Antonio Guterres, August 2020)

Outlook

- Lack of knowledge about healing and recovery after GBV
- Lack of knowledge on **cultural nuances** of humiliation through GBV
- Lack of knowledge about the **impact of humiliation.**

Moving forward

Beyond Awareness to Action

- Expand understanding of what constitutes GBV
- Apply behavior change theory to design effective interventions
- Integrate GBV response into all SRH services
- Address emerging challenges like digital violence
- Strengthen systems from healthcare to justice
- Hold institutions accountable for implementation
- Support survivors with comprehensive, trauma-informed care

**“There is one universal truth,
applicable to all countries, cultures
and communities: violence
against women is never acceptable,
never excusable, never tolerable.”**

***United Nations Secretary-General, Ban Ki-Moon
(2008)***



Resources

- Guidelines for Gender-based Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. IASC, 2005. www.humanitarianinfo.org/iasc/gender
- Gender-based Violence Tools: Manual for Assessment, Programme Design, Monitoring and Evaluation in Conflict-affected Settings. Reproductive Health response in Crisis Consortium, 2004.
- Standard Operating Procedures for Prevention of and Response to Gender-based Violence. UNHCR, 2006.
- Early Marriage: A Harmful Traditional Practice: A Statistical Exploration, UNICEF, 2005.
- IT's in our hands: Stop Violence against Women. Amnesty International, 2004.
- United Nations System-Wide Action Plan (SWAP) on Gender equality and Empowerment of Women, 2018.