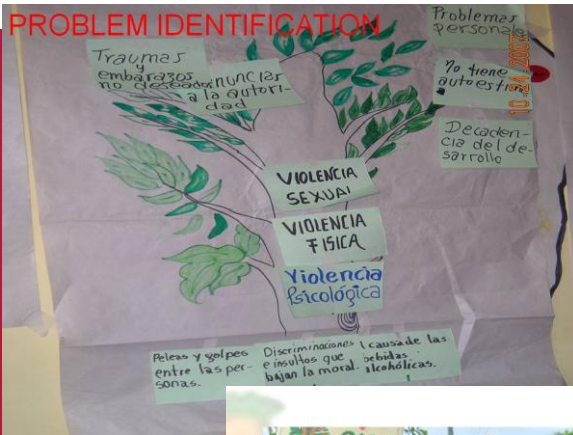




# STRENGTHENING IMPLEMENTATION OF GENDER-BASED VIOLENCE POLICIES IN BOLIVIA:

## Analysis and Implementation Advocacy in the *Avances de Paz* Project



### SEPTEMBER 2010

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Mary Kincaid, Sandra Aliaga, Deborah Caro, Anne Eckman, and Margaret Saunders of the Health Policy Initiative, Task Order I.

Cover photos: Courtesy of the *Avances de Paz Project*.

Suggested citation: Kincaid, M., S. Aliaga, D. Caro, A. Eckman, and M. Saunders. 2010. *Strengthening Implementation of Gender-Based Violence Policies in Bolivia: Analysis and Implementation Advocacy*. Washington, DC: Futures Group, Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order I, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order I is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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## **ACKNOWLEDGMENTS**

The Health Policy Initiative gratefully acknowledges the intellectual contributions, hard work, and dedication of the core project team in Bolivia—Sandra Aliaga, Project Director; Cintia Dávalos, Field Operations Coordinator/Youth Advisor; and Yecid Aliaga, Research Associate. The technical advisors for the project were Dr. Deborah Caro from Cultural Practices LLC, Dr. Anne Eckman, formerly of Futures Group and currently a consultant, and Mary Kincaid, Futures Group. Technical assistance on the integration of youth was provided in the initial phase by Dr. Nancy Murray of Futures Group and Dr. Remedios Ruiz of ALEPH, S.A. The project was implemented by four teams of Bolivian facilitators (26 total) from CIES Oruro, CIES Camiri (Macharef), APROSAR (Quillacas), and PROCOSI (El Alto). These facilitators were instrumental to the project’s success. Dr. Guido Pinto-Aguirre, consultant, led the project’s quantitative and qualitative research component, along with Beatriz Murillo Gutiérrez.

## EXECUTIVE SUMMARY

Gender-based violence (GBV) is increasingly recognized as both a public health and human rights issue that affects the majority of the world's women. Bolivia has a long history of high prevalence of GBV—particularly intimate partner violence. Although the country has long carried out advocacy for legal and policy measures to reduce GBV, the 2003 Demographic and Health Survey (DHS) report reveals that GBV persists to a great extent—with two-thirds of women of reproductive age reporting experience of one or more types of GBV. There is a pressing need to address barriers to the implementation of policies and programs designed to confront GBV and empower women affected by GBV to use family planning/reproductive health (FP/RH) services.

Beginning in June 2006, the Health Policy Initiative, Task Order 1 team launched a pilot project to support implementation of policies at the local level that prevent and respond to GBV in four municipalities in Bolivia. The project also focused on identifying and addressing barriers to the uptake of FP/RH services in the context of GBV. **The project's overall objectives were to**

1. Develop a model process, grounded in the realities of urban and rural communities in Bolivia, for strengthening municipal-level implementation of GBV policies;
2. Build the capacity and mechanisms for policy champions—young and adult—from a broad range of community constituencies to be able to define and advocate for effective local responses to GBV, especially in the context of FP/RH services, and to monitor the implementation of current laws and protocols related to GBV; and
3. “Unpack” the relationship between GBV and use of FP/RH services in Bolivia through quantitative and qualitative research, to inform future efforts to increase the demand for FP/RH, and particularly those that are considering holistic approaches to demand creation.

The two-year activity was carried out in Bolivia and integrated attention to youth issues throughout the program. The activity included (1) design and implementation of a pilot intervention to work with communities; (2) preparation of a methodological toolkit; and (3) quantitative and qualitative research to better understand the relationship between GBV and use of FP/RH services in Bolivia. In the year after the project officially ended, the field team continued to gather feedback from project participants about the methodological guides and to refine them in response. Final versions of the three guides initiated under the project were submitted in 2010, reflecting changes and improvements made to the methodology as it was applied in various settings in Bolivia.

The project team developed a participatory intervention methodology, called Avances de Paz, to promote institutional changes at the municipal level for preventing and addressing GBV. The methodology was created in collaboration with local implementing organizations and comprised four intervention phases: Discovery, Learning, Action, and Evaluation. The intervention activities were piloted in two large urban municipalities, El Alto and Oruro, and two rural municipalities, Quillacas (Department of Oruro) and Machareti (Department of Chuquisaca). Nearly 1,000 people participated in the process across the four municipalities: an estimated 40 percent of participants were youth, of which half were boys and half girls, whereas adult women outnumbered adult men (approximately 60–80% of adult participants were women). In all four municipalities, the outcome was an action plan for improving the capacity of communities to prevent and care for victims of GBV, focused on putting policies into action at the local level. In addition, the project team created methodological guides for the different intervention phases, including detailed training modules that provide a comprehensive framework for facilitators to conduct a participatory process in municipalities with community groups and key stakeholders.

Several important lessons emerged from the pilot intervention that can inform adaptations and future uses of the methodology. First, *Avances de Paz* builds local ownership of the process—which is particularly crucial to the analysis of structural relationships and social organization within the community itself. Second, it puts the onus on participants to discover GBV in their own community: no external agent or facilitator points out the existence of violence in the community. Third, by changing the view of GBV as solely a women’s issue, the door opened to support from municipal leaders and the broader community and brought men into the discussion of the problem, identification of solutions, and implementation of selected activities; men’s participation was considered crucial to preventing and eradicating GBV. Fourth, the decision to include youth as active participants in the process was both challenging and valuable. It created some complications due to different scheduling and obligations of the youth but was successful in prompting them to re-examine their own experience with GBV and to determine how to change their own futures and the future of their communities. Fifth, strategies to engage local partners should first engage local leadership, then engage diverse members/groups of local communities. An essential part of the project was putting together the parallel but linked process with local authorities and service providers across all sectors, as this increased the chances of funding and implementing the action plans. And finally, addressing the root causes of GBV (gender, power, broader societal violence) through a participatory approach requires strong facilitation skills, the trust of the community you are engaging, and intensive and supportive supervision of local facilitators. Another important part of the process was the selection, engagement, and ongoing capacity building (and co-learning) with/from local facilitators to carry out this process—to sequentially build their critical consciousness and analysis and advocacy skills and their skills to engage with and facilitate their communities’ ability to do the same.

As a complement to the community-level intervention, the team carried out quantitative and qualitative research to better understand how GBV affects the use of FP/RH services in Bolivia. Research findings from a secondary analysis of DHS data using multiple logit regression models showed a strong negative relationship between GBV and use of FP/RH services variables at the population level. Women subject to physical violence were 33 percent less likely to use FP (any modern or traditional contraceptive method) and 36 percent less likely to use RH services (prenatal care or Pap smear) than women who did not report experience of GBV, controlling for all other variables. Women who reported experiencing both physical and emotional violence were 27 percent less likely to use FP and 36 percent less likely to use RH services.

The qualitative research sought to further explore the regression analysis results, by asking people in the four pilot communities about their attitudes and behaviors regarding GBV, use of FP/RH services, and related themes. During focus group discussions and in-depth interviews, a total of 102 women, men, and youth participants discussed how GBV limits women’s choices, affects their health, restricts the scope of their activities, and undermines their self-confidence and self-esteem. They also discussed how men are adversely affected by constructions of masculinity that perpetuate GBV. With GBV and gender norms as the backdrop, participants discussed the relationship between GBV and FP/RH services, identifying a range of barriers to access and use of FP/RH services, including (1) opposition to practicing FP from the women’s partners or extended family; (2) healthcare providers’ (doctors and nurses) mistreatment and aggressive attitudes toward patients in general; and (3) clandestine use of FP methods as a reason for men to abuse partners.

**Both the quantitative and qualitative evidence presented in this assessment supports the conclusion that a reduction in GBV will overcome one of the major obstacles to women’s use of FP/RH services in Bolivia.** Quantitative analysis of the DHS data demonstrated a strong and significant negative relationship between GBV and use of FP/RH services. The qualitative analysis of the responses from focus groups and in-depth interviews revealed that the participants also perceive a negative association between women’s experience and fear of GBV and their access to RH services and use of family planning.



Initial results from the project suggest that it has had a far-reaching influence in Bolivia. During the focus group discussions in 2008, participants from Machareti cited the establishment and funding of a new public defender's office for GBV (Defensoria de la Mujer) as a concrete result of the project. In El Alto, participants from *Avances de Paz* formed a new youth network dedicated to reducing GBV: "Movimiento Ciudadano para Vivir con Armonía" (Citizen's Movement on Living in Harmony). In Oruro, the local partner, the Center for Information, Education and Services (CIES) Oruro, has carried out advocacy, education, and training activities since 2008, in line with the community action plan it helped develop under *Avances de Paz*. And in Quillacas, the Association of Rural Health Promoters (APROSAR) adapted the methodology for projects in eight municipalities and applied it in its entirety in several small municipalities in the Amazonian region of Beni.

**The impact of the project, including the results noted above, can be categorized into three main areas: increased resources allocated to GBV; knowledge generated and disseminated; and replication of the *Avances de Paz* methodology.** The project increased funding for GBV in the municipalities that participated in the project, primarily through (1) new funding from municipalities to carry out action plans and support ongoing work in GBV; (2) commitment from local partner agencies to fund and support the program and its expansion; and (3) funding from donors and agencies to support further expansion of the methodology. The *Avances de Paz* experience and the methodological guides provide a model for future expansion of interventions to address GBV by working at the community level to understand and address the root causes of violence. The pilot intervention made important contributions in the four pilot communities by helping participants discover GBV; shift the perception of GBV from a "women's issue" to a community, social, and development issue; and bring men into the process of changing community norms about GBV, sexuality, and power. Most participants interviewed in the focus groups and in-depth interviews reported that the project influenced their thinking and they now realize that GBV has negative consequences for its victims and perpetrators, as well as for households and communities. Finally, the influence of *Avances de Paz* is evident by commitment from USAID and local implementing partners to adopt the methodology and replicate the models in other areas of Bolivia. Starting in mid-2008, USAID/Bolivia implementing partners adopted the participatory diagnostic and planning methodology to engage municipal governments to improve their response to GBV within the context of FP/RH services and in collaboration with other sectors such as the police, the judiciary, schools, and other social services.

Recommendations from the *Avances de Paz* experience include the following:

- Promote a multisectoral approach to a multifaceted problem—recognize that GBV affects an entire community. Build critical consciousness from within communities, with stakeholders from various sectors, through an analysis of the role of power and gender-based inequalities in their communities—and the links to the root causes of GBV and barriers to adequate responses.
- Engage men in the fight against GBV, as their involvement is central to changing attitudes and practices around violence, sexuality, and masculinity.
- Integrate GBV prevention and care services into health services, especially into FP/RH services, to improve screening and services for women experiencing GBV. Pay special care to improving the quality of such services, especially for indigenous and rural women, as a means of increasing demand. Pay attention to improving the quality of provider services by ensuring that providers respect patient rights and treat patients in a more attentive, less aggressive manner in FP/RH services.
- Create information and education on FP/RH health, the importance of and potential benefits from healthy spacing of pregnancies, and use of FP and RH services for the health of children, mothers, families, and communities.

- Support the evaluation of GBV programs, including *Avances de Paz* in Bolivia, to improve understanding of programs and policies that work.
- Do not stop at analysis—help communities and other key actors/leaders to go deep and develop critical consciousness about the roots of GBV and the inequalities and social norms that sustain these, and then link this to intervention at the advocacy and policy action levels. Having built support for change, include as a target of change “going up the ladder” into budget and advocacy and public decisionmaking processes at a policy level. *Avances de Paz* provides a concrete actionable methodology to achieve these goals.
- Determine how countries in the region can share promising approaches and lessons learned on alternative methodologies to prevent and address GBV in local communities

Such actions will help government agencies and communities to prevent GBV and improve overall health, especially among women. The experience of *Avances de Paz* suggests that undertaking critical analysis at the community level—by community members—and then advocating for implementation of existing laws, policies, and programs can potentially make a positive difference in people’s quality of life, through the external (institutional) and internal (individual) changes it prompts.

## **ABBREVIATIONS**

<b>APROSAR</b>	Asociación de Promotores de Salud de Area Rural (Association of Rural Health Promoters)
<b>CCCV</b>	Consejo Consultivo Contra la Violencia (Consultative Council Against Violence)
<b>CIDEM</b>	Centro de Información y Desarrollo de la Mujer (Center for Information and Women’s Development)
<b>CIES</b>	Centro de Información, Educación y Servicios (Center for Information, Education and Services)
<b>DHS</b>	Demographic and Health Survey
<b>FP</b>	family planning
<b>GBV</b>	gender-based violence
<b>GTZ</b>	German Agency for Technical Support
<b>HIV</b>	human immunodeficiency virus
<b>NGO</b>	nongovernmental organization
<b>PCI</b>	Project Concern International
<b>PROCOSI</b>	Programa de Coordinación en Salud Integral (Integral Health Coordination Program)
<b>PROMUJER</b>	Bolivian NGO named PROMUJER
<b>PROSALUD</b>	Bolivian NGO named PROSALUD
<b>RH</b>	reproductive health
<b>SNIS</b>	National Health Information System
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development



## I. BACKGROUND

Development practitioners have begun, in the last decade, to recognize gender-based violence (GBV) as both a public health and human rights issue which affects the majority of the world's women. GBV has been proven to have serious reproductive health (RH) consequences, including unintended pregnancy and unsafe abortions, HIV and other sexually transmitted infections, and other gynecological disorders (Bott et al., 2005). In Bolivia, prevalence rates for all types of violence (physical, emotional, and sexual) have been documented in Demographic and Health Surveys (DHS) as ranging from 67 percent (2003) to 47 percent (2008) for women of reproductive age.

Bolivia is a country with a relatively strong policy framework for addressing two types of gender-based violence: domestic and sexual violence. GBV is recognized as a key health and development barrier. Implementation of laws is supported by specialized public services such as the offices of the public defender, family protection police brigades, and integrated municipal legal services. At a civil society level, networks against violence (Redes Contra Violencia) exist. These networks link legal, health, police, and educational services with citizen groups. Additionally, in the absence of legal services and the courts in more inaccessible parts of the country, the laws delegate responsibility for addressing intra-family and sexual violence to local authorities. The Ministry of Health has developed protocols to address GBV within its public health services and by incorporating the reporting of cases in the National Health Information System (SNIS). At present, however, the ministry has not fully implemented either the protocols or routine reporting through the SNIS.

Despite the favorable policy environment in Bolivia, the incidence of GBV continues to be alarmingly high.<sup>1</sup> Women reported high rates of both psychological (73%) and physical injury (80%) from violence perpetrated by their partners, yet only 14 percent visited health services for their injuries. The majority who sought medical help were over 40 years old and widowed or divorced.

Several organizations that work with women survivors of violence argue that the intra-family violence law (No. 1674) and the sexual crimes protection law (No. 2033) have done little to decrease violence against women or to sanction aggressors because of limitations in how the laws are written, as well as problems with the implementation of the laws, particularly at the municipal level and in rural areas. There are several barriers to realizing the full protections and due process of the law. There is still a pervasive attitude on the part of the judiciary and the citizenry as a whole that violence against women and girls is a natural part of relationships. Healthcare providers, police, and the judiciary, influenced by their own cultural and social norms, place the integrity and union of the family above the rights of its members, especially those of the victims of violence.

Thus, most instances of intimate partner violence and sexual violence remain behind closed doors. Those cases of domestic and sexual violence that become public rarely reach the attention of the courts, and those that do come to the attention of the courts seldom result in full adjudication and even fewer in punishment for the aggressors. According to CIDEM's (Centro de Información y Desarrollo de la Mujer or Center for Information and Women's Development) annual compilation of Departmental Capital statistics on domestic violence and sexual assault cases from the police, nongovernmental organizations

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<sup>1</sup> The 2003 DHS reported that 53 percent of women and 27 percent of men stated they had been physically abused by their spouses either frequently or sporadically. Psychological abuse was reported at comparable levels of 54 percent and 39 percent, respectively. Fifteen percent of women report forced sex by their partners. Women reported sexual assault by someone other than their married or conjugal partner at a rate of 4 percent, and men at 3 percent. Thirteen percent of women stated that they had suffered all three types of violence.

(NGOs), municipal integrated legal services, and the public defender's offices, less than half of the cases are ever fully adjudicated.

The impact of the tacit acceptance of violence in society has an added impact on adolescents whose experience of violence early in life often sets the stage for a pattern of violence in their relationships throughout life. It has also been shown to affect their decisions to stay in school, concentration, and ability to negotiate safe sex practices (Haffejee, 2006).

The lack of institutional capacity and systems to respond to gender-based violence is consistently cited as a key barrier to the implementation of GBV policies and programs. Related to this, international literature cites that one of the most frequent responses to attempt to build institutional capacity and change—training of providers—in and of itself does not provide the needed institutional change required to implement GBV policies and programs. As the World Health Organization concluded in its *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health*, “efforts to reform the response of institutions—including the police, healthcare workers, and the judiciary—should extend beyond training to changing institutional cultures” (Krug et al., 2002, emphasis added).

**In the end, *Avances de Paz* was about changing institutional culture—around GBV, gender and power, and the linkages with reproductive health.**

## II. PROJECT ACTIVITY

The Health Policy Initiative carried out the *Avances de Paz Project: Policy Implementation Model to Address and Prevent Gender-based Violence in Municipalities* in Bolivia from 2007–2008. The project included three separate but related components: a pilot intervention on critical analysis and implementation advocacy; preparation of a methodological toolkit to document the process; and quantitative analysis of DHS data on the relationship between GBV and family planning (FP)/RH in Bolivia, complemented by qualitative research to contextualize the results of the DHS analysis. In the year after the project officially ended, the field team continued to gather feedback from project participants about the methodological guides and to refine them in response. Final versions of the three guides initiated under the project were submitted in 2010, reflecting changes and improvements made to the methodology as it was applied in various settings in Bolivia.

### Objectives

The project's overall objectives were to

1. Develop a model process, grounded in the realities of urban and rural communities in Bolivia, for strengthening municipal-level implementation of GBV policies;
2. Build the capacity and mechanisms for policy champions—young and adult—from a broad range of community constituencies to be able to define and advocate for effective local responses to GBV, especially in the context of FP/RH services, and to monitor the implementation of current laws and protocols related to GBV; and

3. “Unpack” the relationship between GBV and use of FP/RH services in Bolivia through quantitative and qualitative research, to inform future efforts to increase the demand for FP/RH, and particularly those that are considering holistic approaches to demand creation.

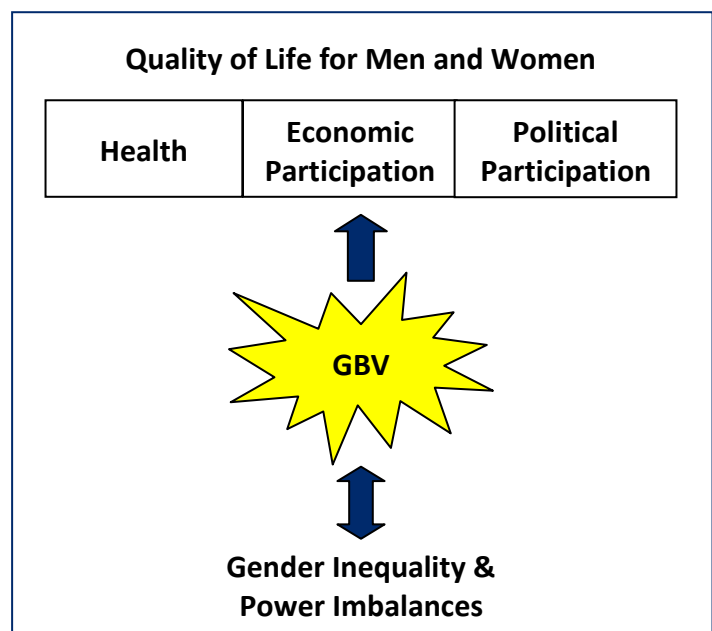
Underlying these objectives were several secondary objectives, including strengthening mechanisms for governance and citizenship within the context of health and particularly in relation to gender-based violence. The project also dealt in an important way with strengthening communities’ capacity to demand conditions for exercising the right to live free of violence. The involvement of youth in the two-year project was an intentional design element. It was expected to have lasting impact on the communities’ views about youth participation in development and social change efforts, as it represented the first systematic inclusion of youth in such activities in the rural pilot communities, in particular.

The project sought to identify and address barriers to the implementation of policies and programs designed to address GBV. To this end, the project team facilitated a participatory methodology in four municipalities to identify barriers to GBV responses; involve diverse actors and sectors equitably, including youth, in local-level advocacy and planning for improved responses to GBV; develop, implement, and monitor annual municipal plans, budgets, and community action plans; and systematize the methodology and lessons learned for replication.

## Assumptions

The methodological approach of *Avances de Paz* is based on the assumption that gender-based violence is intricately linked with women’s and men’s ability to realize full and equal citizenship, economic opportunities, and health outcomes (see Figure 1). The experience of gender-based violence, whether early in life, in adolescence, or as an adult, can severely constrain an individual’s ability to fully participate in political processes, earn a living, and enjoy good health. For women, GBV also limits their capacity to make informed decisions about their sexuality and reproduction and act upon those decisions. The roots of gender-based violence are in unequal relations of power and discrimination within the society that reinforce subordinate roles within the household and community. A focus on gender-based violence—whether it is intimate partner violence, sexual abuse, or violence in any context, including gender and sexual harassment in the home or workplace, such as violence experienced by women holding political office in Bolivia—highlights how the perpetration of violence in these contexts is a consequence of gender inequalities.

**Figure 1. Roots and Impacts of GBV**



A second assumption in this project was that men’s participation is crucial: preventing and responding to GBV is a social responsibility shared by both women and men. Project activities, therefore, were oriented to women, men, girls, and boys together as members of a shared social system with beliefs, practices, and attitudes related to GBV. The definition of GBV used in the project also departed from the norm in Bolivia: it went beyond the concept of “violence against women” to include all forms of violence related to gender. The broader definition allowed male participants to more easily reflect upon violence,

including how patriarchy reinforces behavior patterns of violence against women and men. The approach starts with a discussion of power and inequity in relationships—between men and women, women of different ages, and men of different ages—and looks at power imbalances and gender inequity as root causes of violence. Exploring violence from this multidimensional perspective permits the community to go deeper into the issue to more fully understand the problem and the potential solutions.

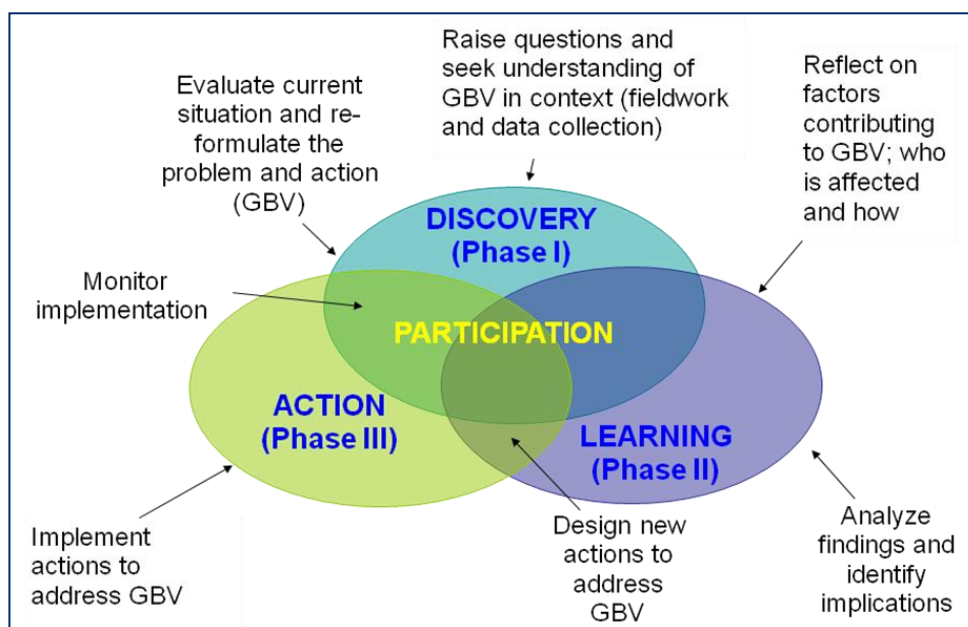
## Methodological Framework

Implementation of policies to address GBV requires actions to alter the social norms and institutions that perpetuate gender inequalities and GBV. Communities need to find ways to deconstruct traditional power structures and underlying cultural beliefs and practices that sustain GBV. Using social action and advocacy, concerned citizens can pressure different levels of government, civil society organizations, and service providers (healthcare facilities, schools, and courts) to assume responsibility for responding to GBV and to hold institutions accountable for implementing laws, policies, and protocols. Finally, an adequate response to GBV requires multi-faceted efforts and coordination of various sectors to maximize resources and make actions more effective. The *Avances de Paz* methodology incorporated all of these concerns in its design: it built critical consciousness from within communities, among a wide variety of actors and sectors, about the role of power and gender-based inequalities as root causes of GBV and as barriers to adequate responses to it.

What I like the most about this project is that it is **our project** and that we are responsible for its success, because we can see that violence does exist in our community, our families and our institutions, and we have to find alternatives to it.  
 -- *Municipal authority, Quillacas, Bolivia*

**Pilot Intervention on Critical Analysis and Implementation Advocacy.** Beginning in June 2006 and running through September 2008, the project team designed and implemented a pilot project to support implementation of policies at the local level that prevent and respond to GBV in four municipalities in Bolivia, with a special focus on the linkages with FP/RH services. The two-year activity integrated attention to youth issues throughout the program. The methodology was created in collaboration with local implementing organizations and comprised four intervention phases: Discovery, Learning, Action, and Evaluation (see Figure 2). Each phase is discussed in detail in Section III: Implementation Process in this report.

**Figure 2. Phases of the Pilot Intervention**





To ensure that the work was locally owned and managed, the project team convened a technical advisory group, the CCCV (Consejo Consultivo contra la Violencia Basada en Género or Consultative Council Against Violence), and identified local FP/RH NGOs to implement the project in the four sites. The CCCV included representatives of all the partner organizations, the Bolivian Parliament, women's rights organizations, the Ministry of Health, the Ministry of Justice, U.S. and Bolivian NGOs, and donor organizations. During the two-year period, the CCCV met three times for two day-long sessions with an average attendance of 25–30 persons to provide feedback on the project. During the first two phases of the project, the CCCV met twice to advise on these phases and to review the draft methodological guides (May 10–11 and October 29–30, 2007). The third and final meeting was an opportunity to hear about the results of the third phase, the action plans developed by the pilot communities and the evaluation of the project, as well as to review the draft of the methodological toolkit (August 14–15, 2008).

The intervention activities were piloted in two large urban municipalities, El Alto and Oruro, and two rural municipalities, Quillacas (Department of Oruro) and Machareti (Department of Chuquisaca). Because of the intensive nature of the community work, the project team partnered with NGO FP/RH service providers in the four sites. Each partner organization had a long-term organizational history in the communities being served, was respected and trusted for the work they do, and could provide facilitators from *within* the local communities/project sites. A further criteria for selection of the partner organizations was a demonstrated (or potential) organizational commitment to addressing GBV as part of their FP/RH programs. The four partner organizations were Centro de Información, Educación y Servicios or Center for Information, Education, and Services (CIES) Oruro, CIES Camiri (Machareti), Asociación de Promotores de Salud de Area Rural or Association of Rural Health Promoters (APROSAR) (Quillacas), and Programa de Coordinación en Salud Integral or Integral Health Coordination Program (PROCOSI) (El Alto). The organizations had experience in municipalities and communities on sexual and reproductive health, had longstanding relations with local leaders and population, worked respectfully and in a consultative fashion with local communities and municipalities, and had a strong national advocacy presence on their own or through PROCOSI (a network of 34 NGOs working on health). To support the local partners, the Project Coordinator and Field Coordinator conducted bi-monthly field visits to the four sites to monitor and assist the teams while they were applying the methodology. The Project Coordinator and Field Coordinator also liaised with the local health services and municipal authorities during their visits.

Nearly 1,000 people participated in the process across the four municipalities, and 40 percent of the participants were youth. Participation was roughly equal between boys and girls, whereas among adults, women outnumbered men, making up 60–80 percent of adult participants in the community groups. In all four municipalities, the outcome was an action plan designed by community members, with active participation of key stakeholders and local authorities for improving the capacity of communities to advocate for the implementation of policies to prevent and attend GBV. The project team created methodological guides for the different intervention phases, which were validated, revised, and produced. The guides include detailed training modules for community facilitators to conduct a participatory process in municipalities with community groups and key stakeholders.

For planning purposes, it is important to point out that this methodology is not appropriate for a short-term intervention. The *Avances de Paz* process requires sufficient time to allow complex and difficult changes in beliefs, attitudes, and practices around GBV. People need time between the 13 sessions of the first phase, the 8 sessions of the second phase, and the advocacy in the third phase to think about their findings through the exercises, dialogue, and debate. They need to talk it over with other people (friends, relatives, parents, children, neighbors) as they gradually change beliefs, attitudes, and practices. Such changes do not occur quickly or automatically but are subject to deep and complex internal processes whereby individuals and communities unlearn things, undo paths, and rethink life.

The *Avances de Paz* process deals with structural change and as such requires a minimum of two years to implement. In the Bolivian application, the first 14 months were devoted to carrying out the participatory activities of Phases 1–3, while the following 10 months included follow-up and technical assistance to the community for implementation of its action plan. The community action plans were not included in the formal project timeline: once a plan was developed by community members, leaders, and authorities, they took ownership of the process. The project team, provided technical assistance up through the start of the implementation of actions plans in each community.

**Quantitative and Qualitative Research.** To better understand how GBV affects the use of FP/RH services, the *Avances de Paz* team analyzed 2003 Bolivian DHS data on GBV, during the period March–July 2008. The objective of the research was to determine, through a secondary analysis of the data, the relationship between GBV (selected variables) and the use of FP/RH services (select variables) at the population level. A complementary set of focus group discussions with direct project participants and interviews with other stakeholders helped to contextualize the DHS analysis, as well as provide more nuanced understandings of the ways that GBV influences women’s capacity to access FP/RH services. A full presentation of the quantitative and qualitative research methods and finding is available in the Health Policy Initiative report, *Gender-Based Violence and Family Planning Services in Bolivia: A Review of the Evidence through the Lens of the Demographic Health Survey and the Health Policy Initiative Avances de Paz Project*” (Pinto-Aguirre, 2010). A discussion of the DHS analysis methods and findings can be found in the journal article, “The Relationship between Domestic Violence and Reproductive Health and Family Planning Services in Bolivia, 2003,” published in *Población y Salud en Mesoamérica* (vol. 7, no. 2, article 4), available at <http://ccp.ucr.ac.cr/revista/> (Pinto-Aguirre et al., 2010).

### III. IMPLEMENTATION PROCESS

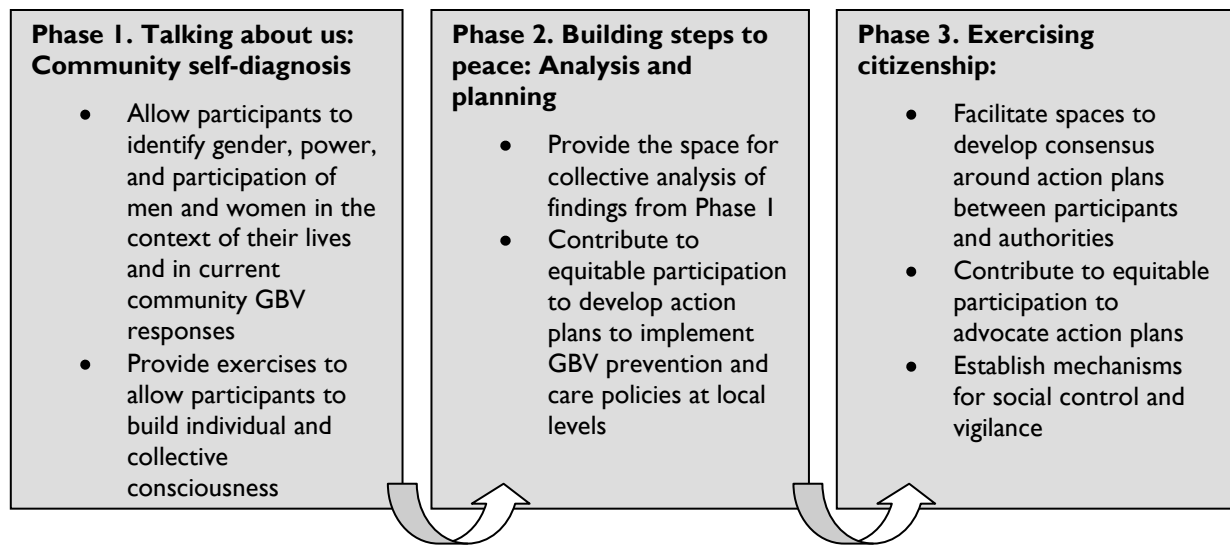
To build support among decisionmakers for addressing GBV, including community-level service providers in health, education, police, and the judiciary; indigenous traditional authorities; and leaders and municipal authorities, the project activity comprised the following components:

- Pilot intervention in three phases, carried out in four communities
- Preparation of a methodological toolkit
- Quantitative and qualitative research to document the relationship between GBV and FP/RH in Bolivia, as well as attitudes among stakeholders and community members in the pilot sites about GBV

#### Pilot Intervention in Three Phases

**Design of the Intervention.** The project team first collected information to inform the design and implementation of pilot interventions. Steps included interviewing organizations in Bolivia involved in GBV prevention and response to gather information about current responses and barriers and opportunities to implementing existing laws and policies (October 2006); an extensive review of the literature; and preparation of a concept paper, which was vetted with different stakeholders and potential partners in Bolivia between January and May 2007. The initial assessment included field visits and discussions with key partners and stakeholders, as well as interviews on the role of institutional norms and culture and the content of written laws and policies regarding GBV in Bolivia. The assessment provided support to the team’s hypothesis (see Figure 3) about enacting policy change at the local level: *communities and leaders need to have a critical consciousness of GBV in the context of locally identified, defined, internalized, reflected- upon links to power and gender inequalities (Phase 1) AND a systematic way to translate this analysis into plans for action (Phase 2) as a basis BEFORE (or ALONG WITH) undertaking advocacy and policy implementation (Phase 3).*

**Figure 3. Enacting Policy Change at the Local Level**



In conjunction with the Advisory Group (CCCV), the team selected four intervention sites representing Bolivia’s geographic and cultural diversity: urban and rural, Andean and lowland cultures. El Alto and Oruro both are large, urban municipalities, while Quillacas (Quechua and Aymara cultures in the Andean Department of Oruro) and Machareti (Guaraní culture in the lowland Department of Chuquisaca) both are rural municipalities. Working closely with partner organizations selected for their long-standing presence in the intervention sites, the project team developed a preliminary methodology and began a training process for four teams of facilitators (26 total) from the four municipalities.

**Working with Local Facilitators.** The methodology was refined over a period of 20 months through an iterative process with the local facilitators: each phase started with intensive, one-week training workshops, with the core cadre of facilitators to introduce the methodology for that phase. In Phases 2 and 3, these workshops also allowed for critical reflection of the previous phase prior to embarking on the next one. The process of critical reflection, action, and analysis at each phase of the training with the facilitators was part of their capacity building, as this process paralleled what the facilitators were doing at the community level. During the three phases, the project team provided additional training and technical assistance to the facilitators on an as-needed basis, responding to their individual situations. In all, the project team carried out four full weeks of workshops where facilitators from different municipalities shared their experiences and discussed the phase that finished and prepared for the phase that started. In between the project-wide workshops, the Bolivian team conducted six or more training and follow-up visits to each municipality to support the local facilitators. Facilitators also received technical and educational materials to update them about GBV.

**Community Process.** To launch the project, local facilitators in each municipality formed five groups of community members, each of around 20 participants: three groups of adult community members (men and women—normally more women because of the men’s resistance to participate) and two groups of young, adolescent boys and girls (the proportion of boys and girls was more even in the young groups). People were recruited from different institutions and sectors by the facilitators. The local facilitators then guided participants through the three intervention phases in each pilot site: self-diagnosis; participatory analysis of the situation, including analysis of the root causes of GBV and planning for change (action plans to implement these changes); and advocacy and implementation (see Figure 4).

The community process starts with a module whereby the participants identify different types of violence and how it affects their lives, using mapping techniques. In almost all instances, this process of identification is also a process of discovery or “uncovering” of a condition that is viewed in Bolivia as normal and natural, and thus invisible. The methodology included in this module provide space for people to recognize the presence of gender-based violence in their communities and to realize their responsibility in preventing it. The different exercises in the participatory methodology allow participants to reach their own conclusions, free of external pressure or theories; identify gender-based violence in their communities and lives; and finally, decide whether and how to address it. The methodology proposes that only participants/community members can plan activities and make commitments to address and prevent gender-based violence in their communities; the focus is on action from within rather than action imposed from the outside.

In Phase 2, participants analyze the information from their self-diagnosis, concluding this exercise with the development of an action plan for improving the capacity of their community and municipal services to implement GBV prevention and response policies and programs. During Phase 3, participants advocate for funding of these action plans under the municipal budget. Once funded, the communities continued to play an active role by participating in citizen monitoring and accountability mechanisms, such as the municipal-level social networks against violence.

**Figure 4. Community and Parallel Processes**



**Parallel Process with Local Authorities and Service Providers.** A parallel process was created to engage traditional indigenous and municipal authorities, key stakeholders, leaders and service providers (police, school teachers, healthcare providers, and judges) to follow the methodology—under the same approach and principles as used with the community groups but modified to reduce time commitments. Participants in the parallel process attended focus group discussions on the topics covered in the longer participatory community process. This adaptation to the methodology was introduced in recognition that it was impossible to secure participation from high-level local authorities and service providers in the 13 community-level sessions for Phase 1, another 8 sessions for Phase 2, and additional activities in Phase 3. This shortened version of the methodology was designed to run parallel with the more in-depth process happening with the community groups. It was instrumental in creating an enabling environment where

leaders were persuaded for the need to address GBV through local governance. By the end of Phase 2, the community and parallel processes converged as both groups came together to work on the final action plans. Authorities easily took ownership of the communities' action plans as they had been engaged and informed about the processes from the start.

### **Box 1: Main Activities by Phase, *Avances de Paz***

#### **Phase 1, May–September 2007**

- Development, validation, design, and production of methodological guide for Phase 1: Community Self-Exploration. Focuses on identifying the roles of gender, power, and participation in general and then looking at these at the light of current community responses to GBV. (In the context of future applications of the methodology, the existing guides should be locally validated and include the corresponding adjustments).
- Selection, contracting, and training of four teams of facilitators on an introduction to GBV and methodology for Phase 1.
- Selection and formation of 5 community groups in each of 4 municipalities.
- Initiation of the parallel process—making contact with authorities and mapping key actors from different sectors.
- Application of Phase 1 methodology with community groups.
- Evaluation and adjustments to process.

#### **Phase 2, October 2007–February 2008**

- Validation, design, and production of methodological guide for Phase 2: Participatory Analysis and Planning. Focuses on raising critical consciousness around GBV and providing time and dialogue to develop actions plans to deal with this collective problem.
- Expose participants to the systematization of their own self-discovery around gender and power issues to analyze GBV in depth from their own perspective and to come up with action plans that respond to their own analysis of the issue.
- Analysis and planning focuses on encouraging consensus around the issues, their root causes, and opportunities for change, as well as strengthens community participation in advocating for plans at the municipal level. Facilitators do not direct the analysis or action planning as that could invalidate the whole participatory process, counteracting the legitimacy of the community's input.

#### **Phase 3, March–June 2008**

- Development of capacity-building materials for advocacy, adapted from “Networking for Change” Advocacy Manual and “Guía de Incidencia Política en VIH/SIDA: hombres gay y otros HSH” (produced under the USAID-funded POLICY I and II Projects, respectively)
- Bring community and parallel process participants together to discuss how to implement the action plan.
- Obtain political support and funding for the proposed activities: advocate for inclusion of the action plan activities in the municipality's annual operational plan and budget, and/or obtain funding from state government or a private source (foundation or donor).
- In all four municipalities, participants were successful in making their action plans part of the official municipal plan and received funding from municipal budgets (Machareti and Quillacas), state government (Oruro City) or a foundation (El Alto).

## Finalization of the Methodological Toolkit

The project team designed, tested, and revised three methodological guides, for Phases 1, 2, and 3, with detailed training modules. The modules provide a comprehensive framework for facilitators to conduct a participatory process in municipalities with community groups (men, women, and youth). The project's advisory group, the CCCV, reviewed the guides for the three phases. The guides are available in Spanish at [www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com) and briefly described below. Outside of the scope of the Health Policy Initiative-funded project, members of the project team also designed, tested, and revised a methodological guide to work through a parallel process with traditional indigenous and municipal authorities, key stakeholders, leaders, and service providers; and a general guide to present the conceptual and methodological framework.

1. “Talking about us”—*Community self-exploratory diagnosis*  
This guide facilitates a community-level participatory research on the prevalence, perceptions, and contexts in which GBV occurs. The main objective of the Phase 1 process is to create dialogue and knowledge exchange among participants to learn of their reality in the context of gender-based violence. It addresses the critical role of fostering critical consciousness of power and gender inequality—and links to GBV—from within the community. This knowledge based on the local context informs the development of a flexible model that guides the participants in the elimination of existing barriers to addressing and preventing GBV. Phase 1 facilitates the mapping of selected municipalities with key local services and stakeholders, reviews past GBV incidence in the locations, maps critical routes followed by the GBV/survivors, and includes individual and group interviews on the perceptions of various stakeholders affected by GBV. Through the exercises, it stimulates participants to identify and recognize the existence of GBV in the community/municipality and try to understand what this means to community development. It also facilitates discussion to try to understand how this issue is addressed by members of the community and institutions and local government. The methodology is developed based on participatory methods used or adapted in Bolivia and facilitates community-based self-diagnosis, design of subsequent research and collection of evidence, and development of the intervention.
2. “Building steps to peace”—*Analysis and planning*  
This guide focuses on participatory analysis of the impact of GBV on individuals, families, communities, and the municipality and identifies viable actions for preventing and responding to GBV. The main objective is to analyze the implications of the research conducted in Phase 1 and agree on priority actions in each locality to contribute to GBV prevention and response in various settings (home, school, community, health services, police, municipal government, indigenous councils). The process gives priority to the sexual and reproductive health sector and other key sectors identified by the community. The process allows for completion and shared appraisal of the current situation experienced by communities in relation to GBV, providing vital and critical foundations for understanding the context of this reality. Finally, it provides exercises to build bridges that can lead to future situations free of GBV, proposing critical routes for institutional and political responses.
3. “Exercising citizenship”—*Advocacy and action plans*  
This guide focuses on citizen participation as the path to improving programs for the prevention and treatment of GBV. It provides strategies for advocacy and action planning targeted to women and men of all ages. The guide makes the fundamental assumption that everyone can contribute to make care for GBV accessible to all and to promote prevention programs; and that these programs should seek to create social, economic, and political conditions that empower people to pressure authorities to better protect people from GBV and to respect human rights for all. The guide starts with an overview of the current situation of GBV in Bolivia and then introduces advocacy as a valid strategy

to address GBV. It provides examples for each element of an advocacy strategy to show step by step how people can participate in the definition of laws, resolutions, and decisions that authorities enact, so that the government's response to GBV takes into account the perspective of those affected by it.

## **Design and Implementation of the Quantitative and Qualitative Research**

In Bolivia, as in many other countries, the direction of the relationship between experience of gender-based violence and the demand for/use of FP/RH services by women has been the subject of debate. Are women who experience GBV afraid to use contraceptive methods because they fear reprisal from their partners or more inclined to do so because pregnancy reinforces economic dependency on their partner? Do women who experience GBV seek out FP/RH services more or less frequently than women who live free from such violence? To “unpack” the relationship between GBV and the use of FP/RH services, the Health Policy Initiative team analyzed Bolivian DHS data from 2003 and subsequently complemented the analysis with qualitative research to contextualize the findings.

The quantitative analysis consisted of multiple logit regressions models applied to a population-based sample for Bolivian women of reproductive age during 2003–2004. The analysis assessed the relationship between different types of domestic violence (physical abuse and emotional/physical abuse) and use of FP/RH services. Control variables included wealth, education, age, and fertility desires, as well as behavior toward family planning services and partners' characteristics. Use of FP was represented by current use of any contraceptive method (modern or traditional), while use of RH services was represented by use of prenatal care or Pap smear. The regression analysis showed that the use of FP/RH services is significantly and negatively associated with domestic violence, even after the relationship was controlled for all other relevant factors. In other words, the models predict that Bolivian women who experience GBV are less likely to use FP or RH services.

The qualitative research sought to further explore the regression analysis results by asking people in the four pilot communities about their attitudes and behaviors regarding GBV and use of FP/RH services. The project team designed and tested qualitative instruments and then used them to gather data during focus group discussions and in-depth interviews. At each site, the review team conducted a series of focus groups and interviews with project participants and other stakeholders (adult women and men, adolescent girls and boys, and local authorities). Each focus group included 5–8 people who participated in a guided discussion for up to two hours; focus groups with young people (ages 13–22) were somewhat shorter in length. The team conducted a total of 10 focus groups: six, single-sex groups with adults, and four, mixed-sex groups with youth. Focus group participants were selected based on their participation in the four pilot interventions. Individual interviews were also conducted with other decisionmakers and stakeholders at the municipal level—some of them had participated in project activities while others had not. Across the project sites, 71 people participated in the focus group discussions, and 31 key informants were interviewed individually. An experienced facilitator led the focus groups and conducted the interviews. The data coordinator transcribed the recordings of the individual and group interviews into computerized matrix text files, reproducing verbatim what was recorded on the cassettes. The results were summarized in matrices and manually analyzed to identify key themes.

The findings of the quantitative and qualitative research are summarized in the next section, as part of the lessons learned and findings of the overall *Avances de Paz* project. A full discussion of both research components is presented in the Health Policy Initiative report by Pinto-Aguirre (2010), *Gender-Based Violence and Family Planning Services in Bolivia: A Review of the Evidence Through the Lens of the Demographic Health Survey and the Health Policy Initiative Avances de Paz Project*.

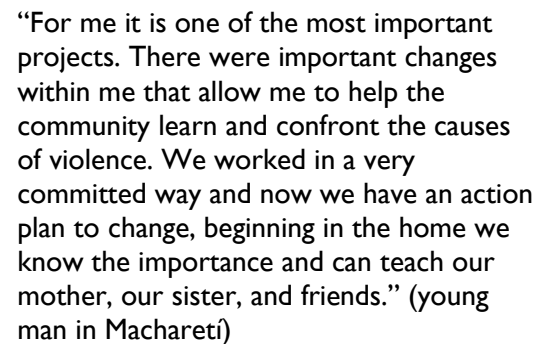
## IV. LESSONS LEARNED AND FINDINGS

The *Avances de Paz* Project in Bolivia provided important lessons about improving the implementation of GBV policies at the local level, as well as interesting findings on the relationship between GBV and use of FP/RH services.

### Lessons from the Pilot Intervention

The name of the project—*Avances de Paz* or Steps to Peace—was decided in the middle of the process, when community members and facilitators determined that they were not fighting against violence but rather working for peace. This revelation helped participants focus on building a society that seeks peace and is willing to change those patriarchal society values that generate gender-based violence. It required participants to look at the causes, and the structural causes in particular, of GBV. Many of the lessons learned from this project, and some of the most vivid images from it, have to do with this analysis of the root causes of violence and the links between gender, power, violence, and health.

- The foundation of the project is the participatory approach that entrusts all community-level activities to local partners and trained local facilitators. The project’s exercises push community participants through a self-analysis of GBV as it exists in their areas and help them analyze the contributing reasons for GBV and the barriers to access of FP/RH services, formulate their own strategies in response, and seek funding from local sources. As such, the process builds local ownership—which is particularly critical to the analysis of structural relationships and social organization within the community itself.
- *Avances de Paz* puts the onus on participants to discover GBV in their own community: no external agent or facilitator points out the existence of violence in the community. Participants identify violence in their communities through mapping exercises, in which they recognize GBV as a problem and discuss the harm it produces in society. Having acknowledged the issues in their own communities, participants then can commit to promoting the implementation of policies to address it and demand programs for prevention and care.
- A central tenet of the project was to transform GBV from a “women’s issue” to a community issue that becomes a social and developmental concern of the entire community. The participants themselves engaged in the process of changing beliefs, practices, and attitudes around their relationship and participation in community norms that tacitly accept GBV. When GBV no longer was seen as solely a women’s issue, the door opened to support from municipal leaders and the broader community. This approach brought men into the discussion of the problem, identification of solutions, and implementation of selected activities; men’s participation was considered crucial to preventing and eradicating GBV.
- Recognizing that addressing GBV is about changing power relations, *Avances de Paz* puts power at the center of the diagnostic and analytical process. The community analysis determined that many institutions providing GBV-related services (police, judiciary, health services) do so without a full understanding of gender relations and power imbalances. This lack of



“For me it is one of the most important projects. There were important changes within me that allow me to help the community learn and confront the causes of violence. We worked in a very committed way and now we have an action plan to change, beginning in the home we know the importance and can teach our mother, our sister, and friends.” (young man in Machareti)



understanding impedes the ability of service providers to respond effectively to women and men experiencing GBV, as they tend to focus on the effects of violence without helping to address the causes.

- The decision to include youth as active participants in the process was both challenging and valuable. It created some complications due to different scheduling and obligations of the youth (in terms of school schedules, vacation schedules, homework obligations). Yet, the youth clearly were interested in participating, and they indicated in the qualitative research that their inclusion had a wide range of positive effects in terms of prompting them to re-examine their own experience with GBV and to determine how to change their own futures and the future of their communities.
- Tools have to be validated in each local context to ensure they meet the needs of the local populace. The tools are meant to guide critical reflection and learning rather than teaching or lecturing.
- Similarly, facilitators need to use active listening techniques during sessions. A participatory process means respecting conclusions, proposals, plans, and reflections that come from participants. Facilitators can orient the process but should not decide nor define anything, as they cannot impose their ideas. Local facilitators for *Avances de Paz* were trained to “hear” more and “talk” less.
- Strategies to engage local partners should first engage local leadership and then engage diverse members/groups of local communities. A crucial part of the project was putting together the parallel but linked process with local authorities and service providers across all sectors, as this increased the chances of funding and implementing the action plans.
- Addressing the root causes of GBV (gender, power, broader societal violence) through a participatory approach requires strong facilitation skills, the trust of the community you are engaging, and intensive and supportive supervision. Initially, the terms of reference for the local facilitators stressed technical abilities. It soon became clear that it made more sense to hire local people and provide them with intensive training and support (one full week prior and after each phase and technical assistance and individual training during the whole process). The approach proved successful and efficient: while the training focused on the process and content, facilitators brought invaluable relations to the table. They already knew the people in the community and established empathy and trust that allowed them to work on the sensitive issues of GBV and power relations. To be able to work in this process, each person has to work on his or herself to address their own prejudices and weaknesses.
- During the implementation process, a strong message emerged that emphasis on GBV has to be on “prevention” at the community level, even if existing policies lean heavily toward treatment and response. Improving services for those who have experienced GBV should be accompanied by a community-led process of structural change that makes GBV less acceptable in society.

## Findings of the Quantitative Research<sup>2</sup>

The findings of the quantitative research were intended to further strengthen future evidence-based advocacy at the local level, providing information on the relationship between GBV and demand for

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<sup>2</sup> This section is excerpted from Pinto Aguirre, G., M. Kincaid, and B. Murillo. 2010. The Relationship between Domestic Violence and Reproductive Health and Family Planning Services in Bolivia, 2003. *Población y Salud en Mesoamérica* 7(2): article 4.

FP/RH services. Understanding that violence dampens the demand for FP/RH services should prompt discussion among service providers and decisionmakers about GBV's long-term impacts on population health and the importance of both integrated GBV-FP/RH programming as well as stand-alone GBV prevention programs. Research findings from a secondary analysis of DHS data showed a strong negative relationship between GBV and use of FP/RH services variables at the population level, even after adjusting for the respondents' individual and household characteristics. Comparing women subject to domestic violence (either physical and/or emotional) with women not being abused, the analysis provided the following results:

1. Women subject to physical and emotional violence were **36 percent less likely to use RH services** (prenatal care or Pap smear), other things being equal. For physical violence alone, the result was comparable, at 36 percent.
2. Women suffering both physical and emotional violence were **27 percent less likely to use FP methods** (any modern or traditional method), controlling for everything else in the model. For physical violence alone, abused women were 33 percent less likely to use FP methods than women who were not being abused.

At least three mechanisms can be entertained to explain the association between domestic violence and use of FP/RH services. First, physical and emotional abuse may increase a woman's lack of power and autonomy, thus reducing her ability to negotiate the use of reproductive health care and fertility regulation services (Heise et al., 1995). This mechanism reflects the fact that abuse against women is driven by power and gender inequalities.

A second mechanism, related to the previous one, is that in many countries women fear retaliation for certain behaviors and practices that can be considered as socially deviant by men (and women, including female relatives and in-laws), such as covert use of contraceptive methods or visiting health facilities alone during early stages of pregnancy. Thus, fear of violence may be affecting women's decisionmaking related to FP/RH services (Heise et al, 1995; Blanc et al., 1996; Bawah et al., 1999).

Third, women may avoid, of their own initiative, using FP/RH services as a strategy to reduce the likelihood of violence. Thus, for abused women what appears to be a lack of response to a violent environment might rather be a behavior to protect themselves and their children and not an act of surrendering to the demands of their husband/partner, given the restricted options available to them.

### **Findings of the Qualitative Research<sup>3</sup>**

During the focus group discussions and in-depth interviews, women, men, and youth participants discussed how GBV limits women's choices, affects their health, restricts the scope of their activities, and undermines their self-confidence and self-esteem. They also discussed how men are adversely affected by constructions of masculinity that perpetuate GBV. With GBV and gender norms as the backdrop, participants were encouraged to discuss the relationship between GBV and FP/RH services. Participants identified a range of obstacles to access and use of FP/RH services, including (1) opposition to practicing FP from the women's partners or extended family; (2) healthcare providers' (doctors and nurses) mistreatment and aggressive attitudes toward patients in general; and (3) clandestine use of FP methods as a reason for men to abuse partners.

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<sup>3</sup> This section is excerpted and adapted from Pinto Aguirre, G. 2010. Gender-Based Violence and Family Planning Services in Bolivia: A Review of the Evidence Through the Lens of the Demographic Health Survey and the Health Policy Initiative Avances de Paz Project. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Highlights of findings related to GBV and the use of FP/RH services are presented below, followed by highlights about the impact of *Avances de Paz* on participants' attitudes and beliefs about violence, sexuality, and masculinity.

### Highlights of findings on GBV and use of FP/RH services

- One of the most revealing findings of the focus group discussions was that men's lack of information about FP/RH is a major reason they use coercion to discourage women from using FP/RH services. *[The man] becomes restless, insecure, and thinks that it [contraception] is for another man. If men had had information about what they [contraceptives] are good for, they would understand, or some would accept their use (young man, Machareti) If a woman uses family planning secretly, blood will accumulate and the woman could die. That's what my husband who has studied told me. (Quillacas)*
- A key barrier to access and use is opposition to practicing family planning from women's partners or extended family members. In communities where FP is not yet socially acceptable, women and adolescent girls who openly admit to using contraception may face severe consequences, such as community disapproval, derision from relatives and friends, divorce, abandonment, and abuse by their intimate partners. *They [men] think the aim is not to have any more children. They say, "Why construct schools if in 10 years there won't be any more children." For this reason it is necessary to give more and better information to them about what it means to plan a family and that it is not so that women walk around like crazies from one man to the next (Machareti). There are many myths and taboos. Andean religion has many beliefs about women's sexuality and rights which conspire against the use of gynecological services (Oruro).*
- Another barrier to women's use and a reason for men's disapproval of FP/RH services is healthcare providers' (doctors and nurses) mistreatment and aggressive attitudes toward patients, particularly in gynecological services. Participants reported that health personnel treat clients disrespectfully, and this acts as a deterrent to seeking FP/RH services. Participants also expressed a lack of confidence in health personnel's capacity to identify and respond appropriately to signs of psychological abuse and physical violence, although some appropriate responses by health sector workers were noted. Participants explained that nurses and doctors are not interested in finding out the causes of violence or in talking to perpetrators. *"I want to see blood or black and blue before paying attention," they say. They don't care, they just give us a little pill. If one goes to the health center and one has children, they tell us we are obligated to return [home] (Quillacas).*
- Participants described cases where men divorce, abandon, or hit or verbally abuse partners whom they discover secretly using FP methods. They report beatings may occur after women visit health centers; when husbands find out their wives secretly are using contraceptives, the wives are more likely to suffer violence. *If I catch her I will hit her, because it is so that she can be with another man (El Alto).*
- Most participants agreed that GBV impedes women's use of FP/RH services. Women participants had a clear picture about this connection. Most of them said that if violence against women were eliminated, they would have freedom to look for and use FP/RH services to improve their health and quality of life. Women agreed that not using these services is caused by fear of their husbands' violent reactions and subsequent verbal or physical abuse. Other women mentioned that key barriers to using these services are cost and lack of access to economic resources.

- Youth participants (ages 15–19) unanimously agreed that there is a negative relationship between violence and access to FP/RH services. In El Alto, every one of the adolescent participants in the focus groups stated that they know of cases of abused women who decided not to seek medical attention out of fear of her aggressor and fear that the medical providers would tell him. They also said that things are changing and that some men are starting to recognize that it's a good thing for their partners not to have any more children (El Alto). Many had witnessed violent relationships at home and/or in friends' homes. They also voiced opinions similar to adults, that often women do not seek FP/RH services because of men's violent reactions, especially when men do not understand how important the services are for women's lives and their families.
- All participants were aware of the negative effects of GBV on women's physical and mental health, in addition to its effect as a barrier to women's use of FP/RH. There was a general consensus that abused women face many barriers in looking for and accessing help—and that such action may in fact provoke more violence. Participants were nearly unanimous in noting that abused women look for medical attention only when they are severely beaten or when relatives/friends report the attack to local authorities. *Out of habit, we put up with it, for our children, so that our husband doesn't leave us. As a woman, I can't leave my home, there inside, we settle things. If you are married you put up with it (Quillacas).*

### **Highlights of findings from participant reports on how *Avances de Paz* affected participants' attitudes and beliefs about violence, sexuality and masculinity**

- In general, participants felt *Avances de Paz* made them think about violence more seriously. *Sometimes we couldn't see beyond our noses, and now we know that a great many of women and children suffer violence. The learning and the culture to live well without violence stays within you (Machareti).* Participants reported that the program changed some of their views on relationships between men and women and violence, and made them realize GBV adversely affects individuals, communities, and the society as a whole. *For me, it is one of the most important projects. There were important changes within me that allow me to help the community learn and confront the causes of violence. We worked in a very committed way and now we have an action plan to change, beginning in the home we know the importance and we can teach our mother, our sister, and friends (young man in Machareti).*
- Women discussed how the Phase 1 exercise (mapping) to identify violence in their communities was an important step to change their husbands' attitudes, beliefs, and practices toward violence. *If there is less violence, there can be more communication, and then we can go together to family planning (El Alto).* Now, women and men talk more openly about violence and sexuality. *We didn't always talk about how to prevent violence. When communicating about domestic violence, we were always too shy, too timid or too afraid to broach the subject with our partners. Now we talk about GBV even with our siblings and children (Machareti). It seems that some women are able now to attend health facilities without regret or fear (El Alto).*
- Respondents noted that the project had a positive impact in their lives, including the majority of adult men. *[Men] now realize that abusing women is wrong for them and their wives' health (paraphrased, young man, Machareti). Fathers usually teach their sons to beat women and that shouldn't be so (paraphrased, adult man, Machareti). I have changed; I am experiencing a different stage [in my life]. When I was growing up there was a lot of violence in my house. Now, I am different. I am very grateful to the project (El Alto). We helped other women because we are trained and now if someone asks me about the topic [GBV] I can respond. We also have become conscious of our rights. It helps us to reflect... Now we go to the health centers more, I for example (Oruro).* One woman confessed: *It has been 20 years that I have lived with sexual,*

*physical, psychological and economic abuse and I thought that was the way it had to be. But I have broken this blindfold and we all have to do it. This work [against GBV] has served as therapy and a profession. Fight for your rights! (El Alto)*

- Participants noted that, along with women’s empowerment activities, men’s participation is an important part of a strategy for changing beliefs, practices, and unequal relations of power that legitimize GBV. [Participants] requested that men should be called to come to the workshops—“they need to lose their shame”—so they can receive orientation and advise their sons (paraphrased, adult woman, Machareti). Men’s participation in the process was seen as a requirement for successful reduction and elimination of GBV and all forms of discrimination.

Both the quantitative and qualitative evidence presented in this assessment supports the conclusion that a reduction in GBV will overcome one of the major obstacles to women’s use of FP/RH services in Bolivia. Quantitative analysis of the DHS data demonstrated a strong and significant negative relationship between GBV and use of FP/RH services. The qualitative analysis of the responses from focus groups and in-depth interviews revealed that the participants also perceive a negative association between women’s experience and fear of GBV and their access to reproductive health services and use of family planning.

## **V. RESULTS**

Initial results from the project suggest that it has had an influence in Bolivia. During the focus group discussions in 2008, participants from Machareti cited the establishment and funding of a new public defender’s office for GBV (Defensoria de la Mujer) as a concrete result of the project. In El Alto, participants from *Avances de Paz* formed a new youth network dedicated to reducing GBV: *Movimiento Ciudadano para Vivir con Armonía*” (Citizen’s Movement on Living in Harmony). In Oruro, the local partner, CIES-Oruro, has carried out advocacy, education, and training activities since 2008, in line with the community action plan it helped develop under *Avances de Paz*. And in Quillacas, APROSAR adapted the methodology for projects in eight municipalities and applied it in its entirety in several small municipalities in the Amazonian region of Beni.

The impact of the project, including the results noted above, can be categorized into three main areas: increased resources allocated to GBV; knowledge generated and disseminated; and replication of the *Avances de Paz* methodology.

### **Evidence of Increased Funding for GBV**

There is evidence of increased funding for GBV in the municipalities that participated in the project, primarily through

- New funding from municipalities to carry out action plans and support ongoing work in GBV;
- Commitment from local partner agencies to fund and support the program and its expansion; and
- Funding from donors and agencies to support further expansion of the methodology.

Funds for implementation of the participatory diagnosis and planning methodology were leveraged from the Kellogg Foundation (PROCOSI) and USAID/Bolivia (CIES and APROSAR). All four municipalities involved in the project designed and funded local government action plans; activities included organizing or strengthening networks against GBV, improving health and legal services available to people affected by GBV, and conducting awareness-raising activities about other forms of gender-related discrimination and oppression. In two municipalities, the participants were successful in obtaining commitments from local governments: the municipal governments of Quillacas and Machareti made funds available in the government operational plan for GBV activities, while funds for action plan activities in Oruro and El Alto

came from other sources. In Oruro, additional funds were made available through the public defender's office to establish a telephone hotline (dial 156) for victims of violence.

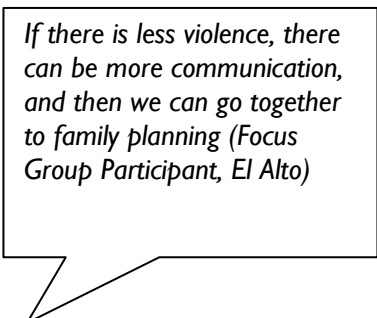
All of the partner organizations made institutional commitments to continue supporting the process in the original four municipalities and to replicate the methodology in new municipalities. According to the directors of the four implementing partners [CIES Oruro, CIES Camiri (Machareti), APROSAR (Quillacas), and PROCOSI (El Alto)], the project positioned the organizations as leaders in preventing and responding to GBV and increased their interactions with other institutions in the four municipalities where the project was operational. An official of the Oruro departmental government confirmed that the Governor made 8,000 Bolivianos (a little more than US\$1,000) available to CIES for their GBV program. PROCOSI received additional funding to work with youth on GBV issues to replicate the methodology beyond District 6 in El Alto. The new director of the PROCOSI community health project expressed interest in the process. APROSAR obtained funding from a Canadian donor (FLSS Canada) to replicate *Avances de Paz* during 2009–2010 in the municipalities of Ballivián Province in the Department of Beni. USAID/Bolivia encouraged partner organizations to incorporate the tools into their bilaterally funded programs.

The funding for implementing the action plans also came from other parts of USAID and other donor funding. As a result of the program, the USAID/Bolivia Democracy Team approved funding of national data collection and reporting on GBV by CIDEM, one of the CCCV members. In addition, the municipality of Machareti obtained additional funding from the German Agency for Technical Support (GTZ) and United Nations Children's Fund (UNICEF). The following donor agencies expressed interest in replicating the methodology in other regions of Bolivia: GTZ, UNICEF, Christian Children's Fund, and the United Nations Population Fund.

## Knowledge Generated and Disseminated through Participatory Process

The pilot intervention and methodological guides provide a model for future expansion of interventions to address GBV by working at the community level to understand and address the root causes of violence. *Avances de Paz* made important contributions in the four pilot communities by helping participants

- Discover GBV;
- Shift the perception of GBV from a “women's issue” to a community, social, and development issue; and
- Bring men into the process of changing community norms about GBV, sexuality, and power.



*If there is less violence, there can be more communication, and then we can go together to family planning (Focus Group Participant, El Alto)*

Most participants interviewed in the focus groups and in-depth interviews reported that they now realize that GBV has negative consequences for its victims and perpetrators, as well as for households and communities. The methodology developed in the project seemed to help participants from the participatory community process and the parallel process with local leaders to see the links among GBV, socioeconomic discrimination, inadequate access to FP/RH services and information, gender inequality, and poverty, which are all issues that must be addressed to increase prevention and care for GBV, particularly access to and use of contraception in Bolivia.

*Avances de Paz* achieved institutional changes in several instances. In Machareti, the project prompted the director of the local hospital to stand firmly and publicly in favor of an improved response to GBV within the health services sector: *The director confirmed that health workers have an obligation to report and work on violence: they have to apply the norms and protocols of care and get involved in activities for*

*men and women victims of violence who need help. The director said he is very committed to the fight against violence and will introduce education and training of all hospital staff (Machareti). Also in Machareti, a councilwoman reported that that the project stimulated local authorities to invest more effort in the struggle against violence. Students are even coming to ask for more workshops and they are asking questions. There is demand for the institutions and for teachers [to teach the workshops] (Machareti).*

## **Replication of the Methodology: Examples**

The influence of *Avances de Paz* is evident by commitment from USAID and implementing partners to adopt the methodology and replicate the models in other areas of Bolivia. USAID/Bolivia implementing partners—PROCOSI, including member organizations APROSAR, CIES, PROSALUD, Project Concern, Centro de Servicios Multieducativos (Center for Educational Services), Sociedad de Investigación Educativa Peruana, and PROMUJER—adopted the participatory diagnostic and planning methodology to engage municipal governments to improve their response to GBV within the context of FP/RH services and in collaboration with other sectors such as the police, the judiciary, schools, and other social services.

Some examples of replication by implementing partner member organizations include the following:

- **PROCOSI** promoted the methodology among its 34 member organizations (6 participated in the project). PROCOSI negotiated with the municipality of El Alto to obtain a commitment of funds for scaling up the project in that city, where the youth-focus was most intense. The sites involved are two large cities, a Department (equivalent to a state in the United States), and many rural municipalities. Also in **El Alto**, the Director of the Ministry of Health Los Andes Health Network requested technical support and orientation on the implementation of GBV activities in the public health services.
- **CIES** adopted the approach as an organization and planned to apply the methodology throughout the country; the institutional commitment also included integrating attention to GBV into its FP/RH services. The national director of CIES said the organization would replicate the methodology in all nine of the agency’s departmental affiliates throughout Bolivia (3 participated in the project). As a result of the project activity in El Alto, a CIES representative is now chair of the directorate for the network against violence in El Alto. CIES UMOSAS (mobile services located in the Chaco) will expand the methodology to four additional municipalities in Chaco (Chuquisaca).
- **APROSAR** integrated attention to GBV into its gender project, which the organization started as part of its participation in the PROCOSI initiative to make FP/RH services gender sensitive. The coordinator of APROSAR’s gender component participated in the process as an additional facilitator supported wholly by APROSAR. As a result, the methodology was applied in other municipalities in addition to the project-supported activities in Quillacas. APROSAR decided to apply the methodology throughout the Department of Oruro and received funding from the Prefecture (Department-level government) to do so. APROSAR expanded the methodology to all municipalities in the Department of Oruro and to municipalities where they work in the Department of the Beni under the USAID-funded PROCOSI Community Health Program. APROSAR reported similar advances in the municipality of Quillacas.
- **Project Concern International (PCI)** raised funds for the project “Youth building harmony” (*Jóvenes Construyendo Armonía*) in the municipality of Villa Rivero in the High Valley of Cochabamba, from Taylor Private Funds and the local Municipal Government of Villa Rivero. The project was implemented from March 23 to December of 2009, as a pilot Project to promote community mobilization toward “No to violence” among young women and men of the rural area as a contribution to national policies. The general objective was to “Contribute to decreased GBV rates in rural areas of Bolivia,” through “developing in Villa Rivero’s youth, more capacities to

recognize signs of GBV and seek institutional help.” Specifically, the project aimed to fight existing social barriers to preventing GBV, implementing effective responses proposed by young people and adolescents; develop shared leadership in the youth organizations to contribute to the reduction of GBV; and promote the creation of an institutional network of prevention and care. PCI replicated the *Avances de Paz* methodology together with others that had proven to be successful in similar projects like “Yuyay Thinku,” “Calidad y calidez concertada entre la comunidad y los servicios,” and “Social Capital.” The target populations included young men and women between 14 and 19 years old, youth organizations, women’s organizations, community leaders, Social Vigilance Committee, Territorial Organization, health personnel, and partner organizations including the municipal government, the Defensoría, Education, Police and Penal System. A total of 120 adolescents (43 males and 66 females) benefitted from the project, while 353 school teachers, health providers, police, judiciary personnel, defensoría de la niñez, and parents participated in the process.

- **CARE Bolivia** has incorporated the methodology into a project on adolescent reproductive health and GBV prevention. Cynthia Davalos, the *Avances de Paz* Technical Coordinator, is serving as the CARE project director. The project is titled “From local capacity building to national advocacy against GBV.” CARE is coordinating with CIES and influence change in attitudes and behavior of people, strengthen their knowledge and abilities to respond to GBV, and defend sexual and reproductive rights. Through coordination with diverse institutions (school committees, defensorías, youth health service brigades, others), students, teachers, parents, and health providers are expected to organize responses to GBV and advocacy in favor of the creation of GBV-related laws and programs and improved services from local and national institutions. The general objective of the project is to strengthen capacity of key state institutions and civil society to address GBV. It aims to build evidence for advocacy against GBV and promotion of policy changes. The project will last 24 months starting in October 2010 and operate with CARE, CIES, and U.S. State Department funding in Cotahuma-La Paz and the mining district of Potosí. It intends to reach 1,500 adolescents boys and girls between 13 and 18-years old in 10 educational units; 110 teachers; national and local authorities from educational, health, and legal services; 1,000 parents and members of grassroot organizations; 200 health providers from 9 health establishments; and men and women that attend health facilities and self-help groups.
- The Vice Minister of Intercultural and Traditional Health expressed interest in the methodology and the guides. She is a member of the Consultative Committee against Violence, the project’s technical advisory committee.
- Elements of the methodology were used by Congresswoman Elizabeth Salguero, a member of the CCCV, to engage different constituencies and other representatives in debate on national GBV legislation. Working with other legislators and civil society organizations from 2007 to the present, Congresswoman Salguero has spearheaded a legislative agenda (more than 14 laws and proposals) to further strengthen the legal framework around GBV and women’s status in Bolivia. She has put particular emphasis on laws that apply at the municipal level, where the legal response to GBV is deemed weakest.
- The Dean of the Universidad de la Cordillera agreed to develop a certificate program for the facilitators of the Health Policy Initiative methodology to provide them with an academic credential in recognition of the very intense learning process they went through during the project.



## VI. RECOMMENDATIONS

**Men's involvement is key to changing attitudes about GBV.** Engage men in the fight against GBV, as their involvement is central to changing attitudes and practices around violence, sexuality, and masculinity. Although men were involved in *Avances de Paz*, there is a need to develop more effective outreach and ways to engage them in greater numbers and over time. Likewise, more research is needed on how GBV affects men's lives (men as perpetrators) and what social and psychological supports are most effective at helping them break the cycle of violence, particularly from one generation to the next. It is important to think about men as an integral part of the implementation of GBV interventions. At the same time, however, programs must allow the time necessary for fundamentally changing beliefs, attitudes, and practices related to GBV, taking into account that these changes do not occur quickly or automatically.

**A multisectoral approach is promising and should be supported.** Promote a multisectoral approach to a multifaceted problem: recognize that GBV affects an entire community. Build critical consciousness from within communities, with stakeholders from various sectors, through an analysis of the role of power and gender-based inequalities in their communities—and the links to the root causes of GBV and barriers to adequate responses. The parallel process means that we go through the whole process with the other sectors and with authorities as we develop the communitarian participatory process. That is why when a community is working on its action plan, authorities and key sectors are already part of the process. In fact, the processes were launched by local authorities in every case, taking ownership for what was about to happen. This provides important opportunities for reinforcement of the prevention approach and responsiveness in sectors such as education, health, law enforcement, and justice. It also brings in community leaders, such as members of municipal leadership and indigenous leadership. This creates a more comprehensive approach that has potential for even greater impact. Such a multifaceted effort is required at the municipal, departmental, and national levels to ensure collaboration among key social sectors such as health, education, justice, and gender to maximize resources and develop more effective actions on GBV. In fostering program expansion, this multisectoral approach should be further developed and supported.

**Do not stop at analysis.** Help communities and other key actors/leaders to go deep and develop consciousness about the roots of GBV and the inequalities and social norms that sustain these and then link these to interventions and have them reflected in advocacy and policy action. Having built support for change, include as a target of change “going up the ladder” into budget, advocacy, and public decisionmaking processes at a policy level. *Avances de Paz* provides a concrete actionable methodology to achieve these goals.

**Addressing healthcare needs of victims of GBV is also essential.** While a multisectoral approach is important, it is also important to link intervention approaches closely with the health sector. Integrate GBV prevention and care services into health services, especially into FP/RH services, to improve screening and services for women experiencing GBV. Pay special care improving the quality of such services, especially for indigenous and rural women, as a means of increasing demand. This is relevant to efforts to expand access to FP services to achieve Millennium Development Goals, particularly within indigenous populations. Further, attention is needed to improving the quality of provider services by ensuring providers respect patient rights, and treat patients in a more attentive, less aggressive manner.

**Information and education is needed in the community on FP/RH health.** Clearly, broader education is needed on the importance of and potential benefits from healthy spacing of pregnancies, and use of FP/RH services for the health of children, mothers, families, and communities. Lack of information and education about family planning was a prime reason that men were unwilling to allow their wives to use services, and this lack of information is also a factor in the broader community. Programs that address

these factors would have to be carefully tailored to the local context, and based on research to inform program design and implementation.

**To improve understanding of programs and policies that work, it is important to support evaluation of GBV programs.** Greater attention to and resources for systematic impact evaluation and assessment could provide a means of determining program impact, specifically to follow-up on the earlier assessment in the four municipalities and to measure changes over time in

- Use of FP/RH services;
- GBV prevalence, attitudes, and community responses; and
- Accountability/citizen monitoring and vigilance of policy/program/budget implementation (this one seems especially germane to the Health Policy Initiative's focus). Citizen monitoring is key but needs dedicated time (and sufficient timeline) to implement. Another focus of the evaluation could examine project impact on the youth who participate, with attention to how the project affects their attitudes and actions over time.

**There are lessons for other countries in the region in identifying and sharing promising approaches.** Lessons from this experience might be of interest to other Latin American countries and other regions as well. The *Avances de Paz* methodology supports GBV policy implementation and does so in the context of FP/RH services. (Translation of materials into English could potentially be incorporated into follow-on work.) It offers a practical, actionable way to get to some of the root gender and power imbalances as a core part of making policy implementation work in other countries. Strong technical support should be offered to develop a comprehensive approach to cultural and social traditions to address GBV. This appears to be a promising approach.

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