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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

SEPTEMBER 2010

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EXECUTIVE SUMMARY

The USAID | Health Policy Initiative, Task Order 1 carried out the "Proyecto *Avances de Paz"* (Advances toward Peace Project)*:* Policy Implementation Model to Address and Prevent Gender-based Violence in Municipalities in Bolivia during 2006–2008. This report primarily presents the results of an assessment that sought to understand whether, how, and to what extent gender-based violence (GBV) affects women's use of family planning/reproductive health (FP/RH) services. The methodology and specific project results are presented in complementary documents.[1]

Previous studies in Bolivia have demonstrated that many cultural, economic, and social factors influence women's decision to use contraception or visit facilities for other RH services (Camacho et al., 1997; Quiroga et al., 1997; and Schuler et al., 1994). Many of the same factors contribute to the high incidence of GBV in Bolivia, including gender-based power imbalances between men and women, socioeconomic discrimination, inadequate access to FP/RH services, and poverty.

The project sought guidance and technical input from a group of experts in the field who reviewed the methodological guides prior to each phase and provided feedback on results at the end of phases I and II. They convened a final time to reflect on overall results and discuss a model for replication and scale-up of the methodology.

The purpose of this assessment is to ascertain whether GBV presents a barrier to the demand/use of FP/RH services and to explore whether stand-alone GBV interventions such as Avances de Paz have the potential to increase uptake of FP/RH services by addressing the common root causes of GBV and low FP/RH use. The assessment increased knowledge about how GBV prevents women's full access to services. This assessment draws on both quantitative and qualitative methods. While the assessment aimed to increase knowledge about GBV, it was not possible to carry out an impact evaluation of the project, as data were not collected as a baseline to compare with intermediate and long-term results.

Quantitative analysis of the 2003 Bolivian Demographic and Health Survey (DHS 2003) informs the first part of this report, which evaluates the relationship between GBV and use of FP/RH services variables at the population level through logistic regression models. The second part of the report is a qualitative analysis based on focus group discussions and in-depth interviews conducted with project participants and other key stakeholders in the four intervention municipalities (El Alto, Machareti, Oruro, and Quillacas). The qualitative analysis explored different stakeholders' perspectives on the relationship between certain forms of GBV and the use of FP/RH services to add depth to our understanding of the regression results.

The results of both the quantitative and qualitative analyses indicate that a reduction in the incidence of GBV is likely to increase women's demand for and use of FP/RH services. Quantitative findings yielded a strong and significant negative relationship between GBV and use of FP/RH services. For instance, the quantitative analysis found a 33 percent reduction in the use of FP services and a 36 percent reduction in use of RH services for women who reported physical abuse. Similarly, analysis of group and individual interviews revealed that both men and women believe that women's experience with and fear of GBV suppress their use of FP and other RH services.

[1] Go to www.healthpolicyinitiative.com for the overview report, *Strengthening Implementation of Gender-Based Violence Policies in Bolivia: Critical Analysis and Implementation Advocacy in the Avances de Paz Project*; "Stories from the Field: Bolivian Communities Take Action against GBV"; and Phase I and II methodological guides forthcoming in Spanish, (1) *Hablando sobre nosotros: autodiagnóstico comunitario—Modelo de intervención para implementar políticas de atención y prevención de la violencia basada en género* and (2) *Construyendo los avances de paz: análisis y planificación—Modelo de intervención para implementar políticas de atención y prevención de la violencia basada en género*.

Through the experience of the intervention model, *Avances de Paz*, participants reported that their perceptions and views on the relationships between GBV and FP/RH use were affected. As captured by the focus groups sessions and in-depth interviews, participants indicated that the project raised awareness of the effects of GBV on women and girls, men and boys, and their communities, including behaviors and beliefs related to reproductive health, gender inequality, gender roles, discrimination, and gender-based violence.

Global recommendations. The quantitative and qualitative findings of this study on the link between GBV and FP/RH services have far-reaching implications for programs and future research. They demonstrate how reductions in GBV are likely to increase uptake of FP/RH services for women, men, and young adults of both sexes.

The findings provide strong support for continuing stand-alone GBV programs as part of a comprehensive approach to increasing family planning use, as well as for integrating GBV programs and services within FP/RH services. The Bolivia data show that GBV reduces women's demand for FP/RH services. Addressing GBV and the power imbalances and gender inequity that are among its root causes will likely allow Bolivia to better achieve its FP goals.

ABBREVIATIONS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DHS	Demographic of Health Survey
FGD	focus group discussion
FHI	Family Health International
FP	family planning
GBV	gender-based violence
INE	Bolivian National Institute of Statistics
IPV	intimate partner violence
OR	operations research
RH	reproductive health
SEDES	Bolivian Department of Health Services
SERES	Bolivian Regional Health Services
STI	sexually transmitted infection

1. INTRODUCTION

1.1 Background

Gender-based violence (GBV) is increasingly recognized as a public health threat and a serious social problem undermining women's human and reproductive rights. Beginning in 2006, the USAID | Health Policy Initiative, Task Order 1 developed the "Proyecto de *Avances de Paz"* (Advances toward Peace Project): a Policy Implementation Model to Address and Prevent Gender-based Violence in Bolivia Project. In the end, working in close partnership with service provider organizations and community outreach workers, the Health Policy Initiative supported the design and implementation of a participatory methodology to identify barriers that impede communities and municipal organizations from preventing and adequately responding to gender-based violence (e.g., intimate partner violence [IPV], domestic violence, sexual harassment and violence, and gender-based political harassment).

The project developed a package of adaptable interventions and approaches to support the implementation of GBV-related policies and programs in municipalities, in the context of enhancing FP/RH services and outcomes. The core package of participatory activities contributed to stakeholders' understanding of the causes, prevalence, and consequences of GBV, including consequences for reproductive health-related behaviors. The activities also raised awareness about what interventions or additional policies are needed to prevent GBV, and how to make health services more responsive to survivors' needs, increasing demand and use of these services. These activities also revealed the importance of involving men and youth in FP/RH education and services and GBV prevention.

The purpose of this activity was to use empirical data to explore the untested experiential indications that GBV reduces access to FP/RH services. This type of analysis is needed to make a more persuasive case to donors and national policymakers that investments in reducing GBV are crucial for more effective and comprehensive reproductive health programs and policies.

This assessment examines the relationship between GBV and women's use of FP/RH services through both a quantitative re-analysis of the DHS data and a qualitative analysis of the project stakeholders' perspectives on the issue. The quantitative analysis focused on an econometric modeling of the relationship between GBV and the uptake of FP/RH services in Bolivia. This report presents the results of this analysis. In addition, a delay in undertaking the analysis provided an unexpected and welcome opportunity to complement the quantitative findings with a qualitative exploration of how GBV affects women's decisions to use FP and other RH services. Together, the two types of evidence—quantitative and qualitative—provide a compelling narrative of the negative impact of GBV on use of health services by women, men, and children.

1.2 Scope of the Assessment

The objective of this assessment was to ascertain whether GBV presents a barrier to the demand/use of FP/RH services. The quantitative analysis of the DHS data explored associations among women's reported experiences with GBV, socioeconomic and demographic variables, and use of family planning and/or other reproductive health services. To gain a better understanding of these associative patterns from both users' and health providers' perspectives, the qualitative analysis included focus group discussions (FGDs) with community participants in the pilot intervention sites, which are not representative of the general Bolivian population. FGDs explored their perceptions of

- Accessibility of FP/RH services;
- Prevalence of GBV—women's and men's experiences of GBV in their households and communities;

- The relationship between GBV and family planning/reproductive health and the nature of that association;
- The response to cases of GBV (identification, treatment, and prevention) by the health services in general and by FP/RH services in particular; and
- The impact of the project in responding to GBV and overcoming barriers to FP/RH.

A separate series of in-depth interviews, in the same pilot sites, with health service providers, police, educators, indigenous and municipal authorities, and judges explored their perceptions of

- Women's experiences of GBV and accessibility to health services;
- The relationship between GBV and family planning/reproductive health and the nature of that association;
- The capacity and responsiveness of FP/RH services to manage and prevent GBV within the municipality; and
- The impact of the project in responding to GBV and overcoming barriers to FP/RH.

1.3 Conceptual Framework

The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defines Gender-based Violence as "violence that targets individuals or groups of individuals on the basis of their gender." GBV includes any act that results in, or is likely to result in, physical, sexual, or psychological harm. GBV includes violent acts, such as rape, torture, mutilation, sexual slavery, forced impregnation, and murder. It also defines threats of these acts as a form of violence. GBV is both a consequence of, and a barrier to, women and men realizing full and equal citizenship, economic opportunities, and health outcomes. The experience of GBV, whether early in life, in adolescence, or as an adult, severely constrains women's ability to earn a living, fully participate in the political processes, or enjoy good health by limiting their capacity to make informed decisions about their sexuality and reproduction. Women and girls who have experienced sexual, physical, and/or emotional abuse tend to have poorer health, suffer more injuries, and use or need more medical resources.

The roots of GBV lie in unequal power relations and discrimination within society that reinforce subordinate roles for women within the household and community. For poor and indigenous women, gender inequality is also experienced in the context of economic and ethnic discrimination. GBV within an intimate relationship is also known as domestic violence or intimate partner violence (IPV), which can take various forms: physical assault, such as hits, slaps, kicks and beatings; psychological abuse, such as belittling, intimidation and humiliation; and sexual abuse and violence, compelling women and girls to engage in sex against their will. However, GBV also includes gender and sexual harassment in the workplace, on the street, or in government (such as violence experienced by women holding political office in Bolivia).

Cultures can sometimes reinforce GBV through institutionalized beliefs and social practices about the responsibilities and roles of women and men that normalize and legitimize psychological and physical abuse against women. At the societal level, cultural norms define and enforce gender roles around masculinity, which often are closely associated with male honor, toughness, and dominance over women and children. Such cultural constructions of masculinity also legitimize punishment of women and children and the use of violence as a way to resolve conflicts (Heise et al., 1999). Additionally, poverty and economic stress contribute to GBV, especially IPV. Within households, men's autonomous control of decisionmaking and wealth is highly associated with abuse, as is marital conflict (Heise et al., 1999).

In Bolivia, it not unusual for men to act violently against their intimate female partners when women contravene gender norms by disagreeing with or challenging them, expressing suspicions of their infidelity, refusing sexual intercourse, questioning them about money, or seeming to fail in performing

expected roles as principal caretakers of children and domestic work. According to a study carried out by Family Health International (FHI) in Bolivia in 1997 (Camacho et al., 1997), about 50 percent of women had been physically battered by their intimate partners, and nearly a third of them had been forced to have intercourse against their will.

IPV considerably reduces women's sexual and reproductive autonomy and exercise of their rights, but recent research shows that the relationship between IPV and use of FP/RH services is not constant and its direction might change according to circumstances, type of violence, and services demanded.

Some authors observe that IPV increases women's risk of having many children by reducing their ability to control the timing of sexual intercourse and use of contraception (Heise et al., 2002), suggesting that violence might constrain their access to FP services. Others report that women subject to IPV are more likely to use FP/RH services clandestinely for fear of retaliation from their intimate partners (Moreno-Garcia et al., 2002). When men consistently use coercion or violence to prevent women from using condoms to prevent diseases and other forms of contraception to prevent unintended pregnancies, women may seek contraception through FP services without knowledge of their casual or permanent partners.

Women who experience IPV are more likely to have gynecological problems, such as chronic pelvic pain, vaginal discharge or bleeding, vaginal infection, painful menstruation, urinary tract infection, painful intercourse, and infertility. Sexual abuse can cause physical injuries and mental trauma and may result in sexually transmitted infections (STIs), including HIV (Campbell et al., 2002).

Early childbearing as a result of rape and/or forced marriage can result in various health problems, including unsafe abortion. Women subject to IPV are more likely to have high-risk pregnancies, which can result in maternal mortality or prolonged and obstructed labor.

Gender-based abuse also produces chronic health problems, such as chronic pain (back pain, headaches, etc.), fainting and seizures, gastrointestinal disorders, depression, mental health problems, and cardiac problems. It also increases negative behavior risks, such as suicide, murder, and alcohol and substance abuse (Heise et al., 1995).

The use of FP/RH services also can increase men's abuse of women. Women who decide to use contraceptive methods may face violence from their partners; and in fact, using contraception may be one of the many factors triggering patterns of abusive behavior. In a Bolivian study by FHI in La Paz, Santa Cruz, and El Alto, the project team found that 5 percent of the women interviewed had been physically abused and 15 percent verbally abused because they were using contraceptive methods (Quiroga et al., 1997). In cases like this, suspicion of infidelity and perceptions linked to the use of contraception in Bolivia (see qualitative analysis below) can trigger violence (Heise, 1998).

Even when physical abuse is not used at all, fear of violence can greatly influence women's behavior and their sexual and reproductive decisionmaking. Women commonly identify fear of violence as a barrier to using condoms with their partners to prevent pregnancy and STIs.

Abused women have special needs, which include medical, psychological, and legal support. It is clear that these women need RH services designed for their particular situations. This is true of emergency contraception and testing for STIs and HIV, especially for those living in violent relationships.

All of this research indicates that the effects of violence on women's reproductive and sexual health are serious and intertwined. Lack of priority placed on GBV (and IPV) and its health consequences within a comprehensive FP/RH service delivery model makes reproductive healthcare less accessible and more ineffective, in addition to putting women's lives and health at risk.

2. RESEARCH METHODOLOGY

The review used both quantitative and qualitative methods. The quantitative method involved analysis of data from DHS 2003, available from the Bolivian National Institute of Statistics (INE). The project used these data to evaluate the relationship between IPV variables and use of FP/RH services variables at the population level. The project used qualitative instruments—focus groups and in-depth interviews—to provide a contextual background for peoples' attitudes and behaviors toward certain forms of IPV and the relationship with FP/RH service use.

2.1 Quantitative Analysis

The quantitative analysis was based on cross-sectional data from the 2003 Demographic Health Survey for Bolivia. The DHS dataset provides information for examining linkages between GBV and health outcomes. The DHS women's questionnaire gathers data for women ages 15–49 on various individual characteristics, such as age; parity; marital status; use of FP services and practices; employment; reproductive health; maternal anthropological measures; reproductive and sexual history; and partner's education, employment, and alcohol consumption.

A supplemental module collected information on respondents' experiences with psychological and physical violence. Of the 17,654 women surveyed, 14,650 answered a series of questions related to intimate partner violence. This subgroup makes up the sample for the analysis. The remaining 3,000 women reported never having been in an intimate relationship (never had a boyfriend or fiancé) and thus could not have ever experienced abuse by an intimate partner, defined as a legal spouse, cohabitating partner, or a steady boyfriend or fiancé. However, the sample was reduced to around 3,000 cases when regressors about husband behavior and women's use of health services in the last 12 months were accounted for.

2.1.1 Modeling Strategy

Since our goal is to examine the relationship between use of FP/RH services and domestic violence, after controlling for other factors associated with the outcomes of interest, the underlying theoretical model suggests that the empirical model should be specified through the following logistic regression equation:

$$log(\frac{USE}{1-USE}) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + ... + \beta_k X_k + \varepsilon$$

Where the ratio (USE/ 1–USE) is called the "odds ratio" of using FP/RH services, and the left-hand expression is denominated log odds or logit. Dependent and explanatory regressors are defined in the following sections. Thus, multivariate logistic regression models are used to explore the relationship between IPV and FP/RH in a population-based sample of Bolivian women.

In the logistic regressions only the sign and significance of coefficients can be interpreted. If we are interested in the size effect, coefficients must be transformed into odds ratios (ORs). Odds ratios are simply exponentiated regression coefficients, that is, exp (b), where b is the estimate of β.[2] Values of OR larger than 1 indicate that the variable in question increases the odds of the dependent event occurring (e.g., using FP/RH services) when other factors in the model are held constant; thus, there is a positive effect. Values of OR smaller than 1 indicate a decrease in the odds, in which case the effect is negative if other factors in the model are held constant. For example, an OR value of 1.34 for women with primary education (Annex 1,Table 1, model 1) indicates that having elementary education leads to an

[2] The expression exp (b) is equal to (3.8182…) to the power b.

approximately 34 percent increase in the odds of using FP services, holding constant all other factors in the model. In this case, the odds can be understood as the likelihood of using FP services compared with not using them.

2.1.2 Use of FP/RH services variables

Two aggregate categories are used to create binary or dichotomous dependent variables, using questions on (1) current use of contraceptive methods, and (2) use of prenatal care and Pap smear (reproductive health services) to create variables on the "use of FP/RH services." The first binary variable was coded either as one for "women who reported currently using any contraceptive method, either modern or traditional" or zero otherwise. The second variable accounts for the use of RH services and was coded as either one when "women was using prenatal care and/or Pap smear" or zero otherwise.

2.1.3 Violence variables

This assessment categorized a particular woman as having experienced physical or verbal abuse if she answered affirmatively when asked if her partner had hit her with his hand or kicked her, hit her with a hard object, tried to choke or strangle her, forced her to have sex, or told her that "you are good for nothing," either sometimes or frequently.

This information was pooled to create two aggregate measures (1) physical violence (which includes sexual violence) and (2) violence (which includes both physical and verbal). The first binary regressor was coded equal to 1 for all women who reported physical abuse and 0 otherwise, while the second regressor is coded to be equal to 1 for reports of physical *and/or* psychological violence at any frequency and 0 otherwise. Verbal abuse was not considered as a separate category because most of the verbally abused women also had been physically abused. It is important to highlight that women were asked about their experience of abuse in their current or most recent intimate relationship and not over their lifetime. This constraint may result in showing a weaker relationship between violence and use of FP/RH services.

2.1.4 Explanatory variables

Demographic variables included are woman's age: young (15–24), middle-aged (25–39), old (40–49); number of children (number of children ever born); respondent's education level (none, primary, secondary, or higher than secondary); and partner's education (none, primary, secondary, or higher than secondary). To measure socioeconomic status, DHS used a wealth index, which divides households into five groups: poorest, poorer, middle, wealthier, and wealthiest, according to the number of goods owned by the women's household.[3]

Other control variables were included:

- Woman is afraid of partner/husband as result of violence against her
- Woman has discussed FP methods with partner
- Partner/husband was drunk when women was battered
- Woman was visited by a family planning worker
- Woman is using FP services to limit number of children
- Woman was told about family planning at a health facility
- As a result of violence, woman has bruises, injury or broken bones, abortion, and temporary/permanent loss of body parts
- Respondent is currently working; partner/husband works
- Partner/husband decides on health issues
- Partner/husband decides on household expenses
- Woman belongs to an ethnic group

[3] This may underestimate the number of poor women, as women may not have access to and decisionmaking power over the wealth of their households, even when resources are available.

Some of these control variables are associated with attitudes and values that legitimate men's control over women. They also may reflect women's lack of empowerment, since disempowerment can often inhibit women from leaving abusive relationships. On the other hand, women's labor force participation and increased earnings may diminish violence, but only up to a point. A partner's low educational and socioeconomic status may create more stress between spouses and increase violence episodes against women. A woman also may be at risk of violence if her partner/husband uses alcohol.

2.2 Qualitative Analysis

The qualitative analysis in this assessment is based on information gathered in four intervention sites, the municipalities of El Alto, Oruro, Machareti, and Quillacas. At each site, the review team conducted FGDs and interviews with project participants and other stakeholders (adult women and men, adolescent girls and boys, and local authorities). Each focus group included an average of 5–8 people who participated in a guided discussion for up to two hours—although focus groups with young people were somewhat shorter in length.

Focus group participants were selected based on their participation in the *Avances de Paz* Project. The project also conducted individual interviews with decisionmakers and other stakeholders at the municipal level—some of whom had participated in project activities, while others had not. Across the project sites, 71 people participated in the focus group discussions and 31 people were interviewed individually. Most of the focus groups were single-sex discussion groups (6 groups), although focus groups with young people were mixed sex groups (4 groups) of high school students ranging in age from 13 to 22 years. These participants did not represent any meaningful population in the statistical sense, but provided additional views on the linkage between GBV and FP/RH services. An experienced facilitator led the focus group discussions and conducted the interviews using a topical list of questions.

The coordinator/moderator of the data collection process transcribed recordings of the individual and group interviews into computerized matrix text files, reproducing verbatim what was recorded in cassettes.

3. QUANTITATIVE FINDINGS: AT THE POPULATION LEVEL

Relatively little is known about the relationship between IPV and the uptake of FP/RH services at the population level. This analysis explores the direction and strength of this relationship by using a Bolivian population-based sample for 2003.

In a context of increasing awareness of the problem of IPV, especially violence against women and its association with adverse health outcomes, the dearth of representative data has become a deterrent to evaluating the relationship between IPV and FP/RH services uptake at the population level. However, there are ample data available from the DHS data sets, which collect information on the prevalence of domestic and other forms of violence against women in the household environment, as well as data on bio-demographic variables, health characteristics, and socioeconomic factors in developing countries.

The purpose of this section is to provide evidence on the relationship between IPV and the use of FP/RH services. Although this linkage has not undergone much close quantitative examination, it is theorized to be important for a more complete understanding of health outcomes for a significant number of women worldwide.

3.1 Distribution of FP/RH Services among Women who Reported IPV

Table 1 shows how users of FP/RH services for this population are distributed for each category of IPV. Among users of family planning, 56.5 percent do not report experiencing physical violence; 43.5 percent of users of family planning do report violence. Thus,women who experienced physical violence were less likely to be using family planning compared with women who reported none (about 44% and 57%, respectively). Women who reported physical violence were less likely to use RH services than women who reported no physical violence (about 41% and 59%, respectively). The response to physical and verbal violence combined was less clear—about 53 percent who had experienced violence used family planning, compared with about 47 percent who had not; but women who had experienced both physical and verbal violence were slightly less likely to use RH services compared with women who had not (49% and 51%, respectively).

Table 1. Percentage Distribution of Users of FP/RH Services by Type of IPV

	Use of Family Planning	Use of Reproductive Health Services[4]
Physical Violence (including Sexual Violence)		
Yes	43.5	40.8
No	56.5	59.2
Total	100.0	100.0
Violence (Physical and Verbal)		
Yes	52.9	49.0
No	47.2	51.0
Total	100.0	100.0

The table shows that 49 percent of the women who reported using RH services had experienced physical and verbal abuse. These unadjusted results suggest that women tend to use more of these services when they are not subject to violence. At the same time, these results also point to high levels of violence experienced by women who report accessing RH services.

3.2 Regression Analysis

This report uses multiple logistic regression models to determine whether there is a relationship between different types of IPV (physical abuse and verbal plus physical abuse) and use of FP/RH services. Control variables include various socioeconomic gradients as well as fertility desires and attitudes toward FP services.

Annex 1 includes two tables showing both regression coefficients and odds ratios (OR) for four regression models. The dependent variables are "use of family planning services" and "use of reproductive health services." To test the effect of IPV on the uptake of FP/RH services, two violence variables are introduced in the models separately as independent variables. The first model tests the net effect of physical violence on the use of FP services, while the second model tests the net effect of violence (physical and verbal) on FP services. Models three and four test the same violence variables but consider "use of reproductive health services" as the dependent variable.

[4] Reproductive health services included use of prenatal care and a pap smear.

It is clear in all four models that the net effects of IPV on the use of FP/RH services are statistically significant and in the expected direction. All four models show that the use of FP/RH services is significantly and negatively associated with IPV, after controlling for other relevant factors.

In model 1 (net effect of physical violence on the use of FP services), the regression coefficient for physical violence is -0.3968 and highly significant (p=0.009), which means that women subject to physical violence are less likely to use FP services (any contraceptive method at all), holding constant all other variables included in the model. The OR for this coefficient is 0.6724; that is, being subject to physical violence, compared to not being abused, leads to an approximately 33 percent reduction in the chances of using FP services, controlling for all other variables.

In model 2, the coefficient for violence (physical plus verbal) increases slightly to -0.3277 but remains significant at a 5 percent level. This value means that women suffering both physical and verbal violence also are less likely to use FP services, holding constant all other variables in the model. This indicates a reduction in the odds of using FP services of about 27.4 percent.

In model 3 (net effect of physical violence on use of RH services), the difference is the dependent variable. Models 3 and 4 have "use of reproductive health services" as dependent variables. For both models, the net effect of IPV on use of RH services is negative and the estimated coefficients are -0.4526 and -0.5301, respectively. These values can be interpreted as follows: women being abused are significantly less likely to use RH services (prenatal care and/or Pap smear), controlling for other variables in the model. Both coefficients are statistically significant, p=0.003 in the first model and p=0.001 in the second model.

The OR analysis presented in model 3 shows that women who report being subject to violence (physical and/or psychological) have a 36 percent reduction in the chances of using RH services, compared with women who do not report abuse, if other factors are equal**.** For physical violence, this percentage is about the same, that is, 36 percent.

Across models, we also can see the following trends: (1) as socioeconomic status increases, use of FP/RH services also increases significantly; (2) women self-identifying as members of an indigenous group are less likely to use those services; (3) there is a curvilinear relationship between a woman's age and use of FP/RH services; (4) working women are more likely to use FP services and less likely to use RH services (prenatal care and/or Pap smear); (5) as women's education increases, the likelihood of using FP/RH services also increases; (6) when FP methods are discussed with partner/husband, women are more likely to use FP services; (7) similarly, as husband's education increases, women are more likely to use services.

The regressor "afraid of husband" is expected to reduce the use of FP/RH services; however, in all models, the coefficients show signs in opposite directions. In this case, we are unable to ascertain which sign is the correct one since in all four models the net effect of the regressor "afraid of husband" is not statistically significant, which must be due to the fact "afraid of husband" is correlated to the regressors accounting for violence against women.

3.3 Conclusions

We found a strong negative relationship between IPV (proxy for GBV) and use of FP/RH services at the population level, even after we adjusted for respondents' individual and household characteristics. By gaining a greater understanding of this relationship, national and local efforts can more effectively address women's risk of violence and promotion of health services to improve their health and welfare.

The finding also has important policy implications. It argues for greater attention to GBV in the Ministry of Health's national program on sexual and reproductive health. Furthermore, the negative relationship between GBV and use of FP services may be behind the slow growth of contraceptive use rates during the last 10 years despite the impressive participation of various institutions in the effort to promote contraception. The findings demonstrate that the prevention of and vigorous response to GBV is crucial to increasing Bolivian women's uptake of FP/RH services.

4. QUALITATIVE FINDINGS: AT THE MUNICIPAL LEVEL

The project held focus group discussions and in-depth interviews in the municipalities that participated in *Avances de Paz.* Seventy-one people participated in 10 focus group discussions, and 31 people were interviewed individually. Most of the focus group participants had been involved in the project for more than nine months. Individual interviews included other key stakeholders, many of whom participated in the project's parallel process conducted with healthcare providers, teachers and school administrators, justices of the peace, municipal government representatives, and indigenous leaders. Participants' socioeconomic status varied. There were 20 housemakers, 36 high school students, 3 farmers, 1 driver, 1 seamstress, 1 musician, 1 nurse, 1 community leader, 1 social promoter, and 6 persons who did not want to identify their social status. Among participants, 62 percent were females and 38 percent males. Most of the participants were from the Municipality of Quillacas (28 participants), followed by Machareti (20 participants), Oruro (15 participants), and Oruro (8 participants).

4.1 Perceptions about Accessibility of Services for FP/RH, Related to the Role of GBV

There was wide consensus among the women, men, and youth of both genders as to the obstacles to accessing and using FP/RH services. Participants identified several obstacles directly related to male control issues and the potential for GBV perpetrated by male partners. One of the most important barriers for practicing family planning is the opposition to FP use exerted by women's partners or other influential persons in women's live (mother in law, community elders, etc.). In communities where family planning is not yet socially acceptable, women and adolescent girls who openly admit using contraception may face severe consequences, such as community disapproval, derision from relatives and friends, divorce, abandonment, and even abuse by their intimate partners.

Focus group participants revealed that healthcare providers' mistreatment and aggressive attitudes toward patients also acted as a barrier to women's use of services and sometimes encouraged men's disapproval of FP/RH services.

The intimate nature of RH visits can also act as a deterrent. Women are often afraid and embarrassed of disrobing and being touched by doctors during gynecological and obstetric visits. Participants felt that in some cases, men tended to sexualize the doctor-client relationship in their mind, fearing that doctors would tempt women into infidelity or perpetrate sexual abuse on their female patients, leading men to feel justified in restricting their partner's use of FP/RH services.[5]

[5] There are many factors at work that merit explanation. In many rural areas of Bolivia, a doctor may be the only healthcare provider around or at least on duty in the health center. It is neither practical nor feasible to follow protocols of having a female nurse present during gynecological exams. An alternative would be to allow a female relative or the woman's partner to accompany her. This is also not always feasible, as others often are not available to accompany her. Throughout the country, biomedical examination techniques also contrast greatly with procedures followed by traditional birth attendants and indigenous healers who only gently touch women who are fully clothed and only on parts of their body not considered intimate. Unfortunately, there also are some healthcare providers who do cross the line of patient-client ethical behavior and others who treat women disrespectfully by scolding them, talking to them as if they were children and even yelling at and insulting them. This type of behavior by medical professionals is based on deeply ingrained discrimination and racism.

Community members felt that many health facilities reinforce men's controlling behavior and support power imbalances by requiring the husband's presence or prior consent for women's use of some services, especially for family planning.

This lack of confidentiality limits women's freedom to choose to use FP and impedes access for those whose partners do not support them. Participants reported that in some cases, men divorce, abandon, or eventually hit or verbally abuse partners whom they discover using family planning secretly. They reported that beatings may occur after women visit health centers, and things may become worse when husbands are drunk because they also force women to have sex. When husbands find out their wives are hiding contraceptive use, the women are more likely to suffer violence.

When a woman wants to use a contraceptive method, the hospital doctor asks for her husband to accompany her. There are cases where the request leads the husband to discover his wife has been using a FP method without his consent and it causes a big problem for the doctor (Adult female, El Alto.)

Often, men oppose use of FP because of their lack of knowledge about its broader uses and benefits. A young female in El Alto said of men, "They are very closed-minded; all they do is work and they don't understand that women can get sick from having so many children…There is so much sexism in society. Others get very somber and scare women into not going." A comment made by one male participant reflected the views of many: "Women want to use contraception to misbehave or get involved sexually with other men." Because of these misconceptions, women must continually weigh the risks and benefits of deciding to use contraception against the potentially negative consequences from their male partners, including use of violence.

> *[The man] becomes restless, insecure, and thinks that it [contraception] is for another man. If men had information about what they [contraceptives] are good for, they would understand, or some would accept their use. We forget the pleasure of women in order to satisfy our own.*
>
> ~Male participant

Participants did note that when partners agree on the use of contraception or other RH services, men often accompany their partners to FP/RH consultations. Participants recommended that RH education be conducted for couples rather than just for women.

There was considerable similarity in the attitudes expressed by local authorities, service providers, and other stakeholders interviewed for the assessment.

4.2 Perceptions about the Connection between GBV and FP/RH Services

When asked explicitly about the relationship between GBV and FP/RH services, participants' opinions were clearly divided. However, most participants did identify that GBV impedes women's use of FP/RH services.

When men in the community were asked whether a reduction in violence against women would increase use of FP/RH services, the answer was a unanimous "no." When they were asked about barriers and obstacles for using FP/RH services, however, they mentioned that women did not use them because of fear of being mistreated by men and that clandestine use of contraception justifies beating and verbal violence. When the question was recast or rephrased after it was pointed out that violence does occur when women use or try to use contraceptive methods, male participants often became silent or seemed confused.

Female participants had a clear picture about the connection between GBV and FP/RH service use. Most women 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 attending FP/RH services is often due to fear of their husbands' violent reactions and subsequent verbal or physical abuse. Another barrier to using services mentioned by participants was costs and lack of access to economic resources.

Young female and male participants expressed unanimously that there is a negative relationship between violence and access to FP/RH services. They believed that a reduction in GBV would lead to increased use of FP/RH services. Many have witnessed the relationship at home and/or in friends' homes. Like adult participants, they noted that women often do not seek FP/RH services because they fear men's violent reactions, especially when men do not understand how important the services are for women's lives and families.

4.3 Perceptions about Broader RH, Health, and Development Consequences of GBV

Most participants seemed well aware of the negative effects of GBV on women's physical and mental health, in addition to its deterrent effect on women's use of FP/RH services. Among men, however, this awareness does not necessarily impact their behaviors and actions regarding GBV. Most men, women, and youth indicated that sexual violence may result in unintended pregnancy, STIs, internal trauma, and psychological damage and negative impacts on children and the family.

In addition to the outcomes mentioned above, most men perceived cancer to be one of the main consequences of physical violence against women, which they associated with repeated beatings. They were unable to identify which type of cancer affects women who are continually abused.

Women also mentioned HIV, miscarriage and damage to their reproductive tract as health-related impacts. Interestingly, they also noted that violence against them could result in low self-esteem and may foster a hate of men (Adult female, Oruro).

Young participants listed even more emotionally based responses to violence, such as women starting to shake at the time when their husbands are expected home from work, alcoholism, suicide, and even homicide.

It was clear that participants, especially youth, were aware that when children experience violence at home, they end up believing that abuse against women and children is something natural and a part of women's lives. Participants agreed that when boys become men, they often repeat the pattern of violence in their adult households, and that daughters believe they have to put up with violence as their mothers did.

An official of the departmental government (Prefectura) expressed the effect that violence has on women's mental health as follows:

> *When there are punches, the women stop attending meetings for fear of what they [their husbands] will say. They stop participating actively and lose their dignity. When an abused woman speaks to another who is not, she feels inferior, shy, and has a [inferiority] complex. The woman stops fulfilling her role in society and in her family* (Adult male, Oruro.)

4.4 Perceptions about the Response to GBV Cases by FP/RH and Other Services

4.4.1 Adult community members

There is a general consensus among community members 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. Just two women out of 100 visit health facilities and complain about physical, verbal, or sexual abuse.

Women stated that they preferred to settle things at home with their partners either because they have come to accept the abuse as part of their duty or the man's role, or for fear of angering their partner further and escalating the violence. Others said that their partners will change, or that they put up with the abuse in the interest of keeping the family together for the children (El Alto).

Although many women fear seeking help, some mentioned that when the nurses make home visits at a time when a husband is not home, it is a good opportunity to share information about their situation. Similarly, a woman from Machareti suggested that, rather than covering up the violence because of fear of men's threats, nurses should support community health promoters who investigate instances of violence.

> *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.*
>
> ~ Adult women, Quillacas

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 noted appropriate responses by health sector workers. Participants explained that nurses and doctors are not interested in finding out the causes of violence or talking to perpetrators. Several examples were given of healthcare personnel telling women that they are obligated to return home to their husbands, being turned away from services because they are too young or unaccompanied, or ignored because they did not display outward signs of abuse like bruising and heavy bleeding.

On the other hand, some women in the focus groups agreed that there are health personnel, especially physicians, who are able to identify different symptoms of violence, even from the way battered women express themselves. They repeated, however, that health providers can recognize violence more easily when a woman's body is severely hurt, with injuries such as deep wounds, black eyes, broken bones, or profuse bleeding; the implication was that without these overt signs, health personnel are less likely to respond. However, in the centers visited, there are no mental assessments being done to trace the consequences of GBV on women's mental health.

Focus group participants stated that when women do not receive attention for GBV at health facilities, they recover on their own at home—often staying home for a few days to avoid problems that could be triggered by seeking services. Men recognize that abused women go to health services when they receive punches that are too strong. There is a common perception that many women go to health services to obtain health certificates for separating from their partners, to cause problems, or to set traps for the partners.

4.4.2 Community youth

Young participants agreed that abused women tend to go to health services only in extreme cases, such as after being badly beaten. They also felt that women seek advice from their godparents, who almost always

counsel them not to separate and to reconcile their differences.[6] Younger participants, however, were more divided than adults in their opinions on whether health providers have the ability to recognize signs of violence. They concurred with some adult participants who felt that most health centers are not interested in recognizing or responding to violence. They told a story about a 13-year-old youth who was raped by her father when he was drunk. The girl never received medical attention and later had a child. Recently, she had escaped with her younger sister and her child (now 4 years old) (Machareti). This story, and others like it, point to women who do not get the care they need at clinics either because the healthcare personnel do not recognize signs of violence or choose to ignore them.

All 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 their aggressor or fear that the medical providers would inform on him. They also said that things are changing, and that some men are starting to recognize that it is a good thing for their partners not to have any more children.

4.4.3 Health personnel and authorities

Health personnel and authorities often presented contradictory information, indicating that their personal views may be more influenced by culture than the official line they are meant to take procedurally. Comments indicated that people in positions of authority often do not respond to abuse situations either because they condone the abuse, have become conditioned to accept it as the way things are, or because while women should be able to report abuse, it often puts them at risk for additional abuse.

Health personnel who were interviewed commented that sexual violence occurring between intimate partners is rarely reported, which makes it difficult for the Integrated Justice Center in District 6 of El Alto to serve women who have experienced sexual/physical violence. The coordinator of the Integrated Justice Center in El Alto stated emphatically that sex without mutual consent in marriage is an act of violence not sanctioned by law, but she went on to comment that a woman's refusal to have sex with her husband often puts her at greater risk of other types of physical and psychological violence as well.

Health personnel described standard procedure as follows: when an abused women arrives at the center, she is given legal advice, assigned a lawyer without any cost, counseled to request a forensic medical certificate from a health services, and then is referred to a health center. The center does not operate under any special protocol. Center personnel follow Law 1670 and report the case on a special form to the court and the Ministry of Justice.[7]

The reluctance to deal with intimate partner and sexual violence is not exclusive to the health sector but extends to local authorities. Local authorities also do not always provide effective responses when women are mistreated. They view themselves as state functionaries whose role is keeping the family together rather than separating the couple, even if separation is in the interest of the woman's safety. One authority commented, "We have become accustomed to view violence from husbands as natural."

Interviews with decisionmakers and stakeholders revealed a strong tendency to both deny and acknowledge the existence of the violence at the same time, especially among those interviewed who had not participated in the project. For instance, a teacher in Sevaruyo (Quillacas) stated: "in the community there is almost no violence; respect within the couple is inherited from the ancestors." But he said machismo (male chauvinism) is also inherited and that it does exist in large measure. The president of the Vigilance Committee in Machareti reported there had not been a single case of violence during his two months on the job, but admitted it does happen. He offered, by way of explanation, that

[6] In much of Bolivia, matrimonial godparents fill the role of impartial mediators between the couple when disputes arise.
[7] The Integrated Justice Centers are funded by USAID.

We should investigate how it happens. Maybe the women received a hit for a justifiable reason, when the man told her to do something and she raised her voice, for example, because she is provoking him (Adult male, Machareti).

The municipal magistrate (Corregidor) stated that, in the time he had served, he never had a case of violence in the community and had never heard of such a case. As a legal authority, his duty is to deal with violent situations, commonly understood as negotiation of an agreement between two parties. However, when violence occurs frequently and appears to be unjustified, then his duty is to refer the case to other authorities, such as the public defender or other legal services. For example, he stated his belief in the following way:

It is not violence for a husband to force his wife to have sex: she doesn't have the right to refuse him because it is a marriage.

His opinion ran contrary to those of other authorities in the four municipalities, who said that they considered forced sex within marriage to be a form of violence. A Departmental Health Services (SEDES) official commented that its personnel are trained to identify signs of violence and intervene appropriately. She described counseling a woman, recommending that she must try to denounce the perpetrator, advised the woman about her rights, possible sanctions against the perpetrator, and legal process available to deal with domestic violence issues.

These contradictions demonstrate that cultural beliefs are not homogenous and also are subject to change over time. In general, interviewees and participants who had not participated in the project expressed a much higher tolerance and acceptance of violence as the norm than those who had participated.

4.5 Participant Reports of Project Impact

4.5.1 Community adults

Without exception, all community respondents who participated in the project on GBV agreed that they perceived positive changes, such as increasing their awareness of GBV, its negative effect on women's reproductive health, and their ability to take concrete actions to promote peace and improved health.

> *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*
>
> ~Young male, El Alto

Most adult men interviewed declared that *Avances de Paz* had influenced their lives and the community positively. They believe a change has occurred, as they now realize that abusing women is wrong for them and their wives' health. Many of them said they learned that GBV should not be passed on from father to children: fathers usually teach their sons to beat women and that should not be so.

Women also felt that *Avances de Paz* and its workshops have improved their lives. The process followed to identify violence proved to be an important step in changing their husbands' attitudes, beliefs, and practices of violence.[8] The participants from a community in the Municipality of Machareti noted that a concrete example of the result of the *Avances de Paz* Project is the establishment of a new public defender's office (Defensoría de la Mujer.)

[8] The project starts with a module whereby the participants identified different types of violence and how it affects their lives. In almost all instances, this process of identification also was a process of discovery or "uncovering" of a condition that was viewed as normal and natural and thus was invisible.

Improved communications between men and women was identified by many community members:

> *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* (Adult male, Machareti.)

> *If there is less violence, there can be more communication, and then we can go together to family planning* (Adult female, El Alto.)

While both women and men commented that communications were improved, women community members did note that men's involvement in workshops should increase to "lose their shame," and receive orientation for themselves and to pass onto their sons.

Participants reported that women's knowledge about violence and its consequences has increased, resulting in a new confidence to access services, and they become advocates for the cause:

> *It seems that some women are able now to attend health facilities without regret or fear. They believe reductions in violence will help to increase recognition of the value of women—they [men] bring in money and have power, a woman is like a maid, and it's not true* (Adult male, 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, and now if anyone asks what we can do, I now say "Report them and go to other institutions." Now we go to the health centers more, I, for example* (Adult female, Oruro.)

4.5.2 Community youth

Young participants also praised the *Avances de Paz* Project and reported increased knowledge and changed attitudes, to an extent, toward GBV. They said, for example:

> *In the past, we didn't know that forced sex within the marriage was an act of GBV. Now we will not hit our women, only when it is necessary, when we believe they are unfaithful, when they drink and go off with others* (Young male, El Alto).

> *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 female,* Machareti).

Another positive impact of the project was the inclusion of adolescents in community activities, especially those in support of the offices of Public Defender (Defensoría) and Justice of the Peace (Fiscalia).

4.5.3 Authorities

The project helped some authorities to see the realities of GBV in their communities and the positive effects that decreasing GBV and increasing access to services would have. An official of the SEDES confirmed that a reduction in violence would permit women more freedom to use FP/RH services, as well as greater power of decisionmaking over their bodies as a fundamental right. The doctor said that the project staff had helped her to see women's reality, risks, and responsibilities. Now she can envision a more just and equitable society, not just in terms of health, but also in an integrated manner. Another doctor from the Regional Health Services (SERES) in El Alto concurred, saying, "*Once security*

improves, they [women] will have greater self-worth and greater access to information; they will know their rights and exercise them" (Adult male, El Alto).

Many respondents noted that the project had increased the attention that GBV was receiving from authorities and that they perceived an increased commitment to working with communities to end GBV.

> *Now we have network [against violence] meetings and you can see [more interest] in the national days against violence. In addition, on account of the effort of the national government in the departments [states], there is budgetary and level of effort support* (Adult female, Oruro).

The President of the Vigilance Committee commented:

> *Personally, I always thought that violence could change. Now that we have seen the way to work on it [provided by the Avances de Paz* Project*], we know that it is very positive and it appears very interesting to us that they made us participate and collaborate together* (Adult male, Machareti.)

Hospital Directors and staff stated their commitment to fighting against violence and working within the system to train staff and improve detection. An official of the Oruro departmental government confirmed that the governor has made 8,000 Bolivianos (a little more than US $1,000) available to the organization CIES for its GBV program.

The program seems to have started the process for change within the system, and at the personal level, as evidenced by a representative of the District Department of Education in El Alto who 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!*

In general, most participants felt that the *Avances de Paz* Project on GBV made them think about violence more seriously. They reported that it changed some of their views on relationships between men and women and violence, helping them to realize how GBV adversely affects individuals, communities, and society as a whole.

5. CONCLUSIONS

Both the quantitative and qualitative evidence presented in this assessment support the conclusion that reducing GBV will overcome one of the major obstacles to women's use of FP/RH services in Bolivia.

Quantitative analysis of 2003 DHS data demonstrated a strong and significant negative relationship between IPV (proxy for GBV) and use of FP/RH services. The qualitative analysis of responses from focus group discussions and in-depth interviews revealed that the participants also perceived a negative association between women's experiences and fear of IPV and their access to and use of FP/RH services.

Furthermore, the findings from this study (quantitative and qualitative) have far-reaching implications for FP/RH programs and future research on the link between GBV and FP/RH services in other parts of the world. For instance, from these results it can be inferred that policy changes that help to mitigate GBV could greatly improve women's use of FP/RH services.

The qualitative analysis also provides information on participant views on how the *Avances de Paz* Project has affected perceptions and views on GBV, FP/RH, and their interconnections. The intervention model was designed to partner with FP/RH service organizations with longstanding relationships in the project communities. Participants were guided through a process to investigate, analyze, and question hegemonic cultural beliefs, norms, and values underlying institutionalized social, political, and economic practices that justify and reinforce gender-based unequal power relations and violence. The project appears to have (1) stimulated communities to become aware of the impact of gender inequality and GBV on individuals (men and women, boys and girls) and the community, including RH-related practices; and (2) helped diverse stakeholders to identify, develop, and implement actions to address and prevent violence by changing traditional power structures, beliefs, practices, and attitudes about gender inequality, gender roles, discrimination, and GBV.

Avances de Paz actively integrated men, local decisionmakers, and young people as participants in the project, recognizing that a more diverse participation is crucial for preventing and eliminating GBV and achieving healthy sexual and reproductive behaviors for all. The project's methodological approach appears to have stimulated participant communities to question entrenched GBV attitudes; qualitative research findings show that many participants became committed to viewing GBV as a social problem, with both men and women sharing equally in the responsibility to end it.

Qualitative research supports the finding that the project changed women's and men's *shared* perceptions of the effect of GBV on women's lives. Both female and male participants in the focus groups and interviews agree that GBV limits women's choices, affects their health, restricts the scope of their activities, and undermines their self-confidence and self-esteem. The project also helped men and boys to understand how they are adversely affected by constructions of masculinity that perpetuate GBV. During the project workshops, young men in particular revealed how they had been victimized by violence from their peers for not being "macho" enough. Older men tapped into their experiences with violence as a result of ethnic and class discrimination, something they share in common with their female partners who are triply victimized by class, ethnicity, and gender.

On a broader scale, implementing policies to address GBV requires actions to alter the social norms and institutions that perpetuate gender inequalities and GBV. First, there is a need to find ways to deconstruct traditional power structures and underlying cultural beliefs and practices that sustain GBV. Second, through social action and advocacy, it is crucial that activists exert pressure on different levels of government; organizations (e.g., communities, non-profit organizations, religious organizations, and citizen groups); and services (healthcare facilities, schools, and courts) to assume responsibility for eliminating GBV and hold them accountable if they do not. Third, an adequate response to GBV requires that stakeholders craft multifaceted efforts and coordinate various sectors to maximize resources and actions. Finally, it is necessary to ensure that programs aimed at promoting development include attention to gender inequalities as part of their design and implementation.

6. RECOMMENDATIONS

Communities in Bolivia need intervention models and mechanisms for dealing with GBV and its impact on the use of FP/RH services. Shared social responsibility requires strong and enduring community-based, municipal, departmental, and national organizations. Development strategies should reinforce structures, control mechanisms, or associations capable of delegitimizing GBV as a means of conflict resolution in the family or the community.

Attitudes and behaviors shift over time, and it will take time to develop social mechanisms that strongly disapprove of GBV and challenge unequal power structures and roles that affect women and men

differently in terms of health needs, access to information, and access to FP/RH services. To instigate such monumental change, stakeholders and their allies must invest resources in informal education, effective use of media, and commitment from the private sector and local, regional, and national governments to ensure that existing legislation on GBV is enforced.

Global recommendations. The quantitative and qualitative findings of this study on the link between GBV and FP/RH services have far-reaching implications for programs and future research. They demonstrate how reductions in GBV are likely to increase uptake of FP/RH services for women, men, and young adults of both sexes.

The findings provide strong support for continuing stand-alone GBV programs as part of a comprehensive approach to increasing family planning use, as well as for integrating GBV programs and services within FP/RH services. The Bolivia data show that GBV reduces women's demand for FP/RH services. Addressing GBV and the power imbalances and gender inequity that are among its root causes will likely allow Bolivia to better achieve its FP goals.

ANNEX 1. REGRESSION TABLES

Table 1. Regression coefficients and odds ratios from multivariate logistic regression assessing the association of IPV and use of FP services

Use of Family Planning Services	**Model 1** (net effect of physical violence on the use of FP services)			**Model 2** (net effect of physical plus verbal violence on use of FP services)		
	Coefficient	**Odds ratio**	**p-value**	**Coefficient**	**Odds ratio**	**p-value**
Physical violence	-0.3968**	0.6724	0.009			
Violence (physical and verbal)	--	--	--	-0.3277*	0.7206	0.059
Afraid of husband	0.0729	1.0757	0.580	0.0397	1.0405	0.761
Primary education	0.2953	1.3435	0.066	0.3093*	1.3625	0.053
Secondary education	0.6668**	1.9479	0.001	0.6465**	1.9088	0.001
Higher education	0.6195**	1.8579	0.012	0.7433**	2.1029	0.002
Poor	0.2421	1.2739	0.081	0.2595*	1.2963	0.059
Middle	0.3721**	1.4506	0.010	0.3213*	1.3789	0.023
Wealthier	0.6577**	1.9303	0.000	0.6499**	1.9154	0.000
Wealthiest	0.5072**	1.6606	0.004	0.4857**	1.6253	0.004
Discussed FP with husband	0.5437**	1.7223	0.000	0.5587**	1.7484	0.000
Children ever born	-0.0921**	0.9119	0.000	-0.0939**	0.9103	0.000
Husband drunk	-0.0752	0.9276	0.418	-0.0483	0.9528	0.590
Young women	0.5049**	1.6568	0.000	0.4574**	1.5799	0.001
Middle-aged women	0.3689**	1.4463	0.000	0.4107**	1.5078	0.000
Visit of FP worker	0.1013	1.1067	0.366	0.0699	1.0725	0.524
Want no more children	2.0994**	8.161	0.000	2.1149**	8.2896	0.000
Primary education (husband)	0.8828**	2.4175	0.000	0.9642**	2.6228	0.000
Secondary education (husband)	0.8247**	2.2813	0.000	0.9074**	2.4779	0.000
Higher education (husband)	1.2522**	3.4982	0.000	1.2487**	3.4859	0.000
Told about FP at health facility	0.4442**	1.5593	0.000	0.4669**	1.5951	0.000
Woman is hurt	0.0776	1.0807	0.450	0.0319	1.0324	0.742
Respondent works	0.2459**	1.2788	0.010	0.2324**	1.2616	0.012
Husband decides on health issues	0.3917	1.4795	0.013	0.3786*	1.4602	0.016
Husband decides on expenses	0.2214*	1.2479	0.052	0.2163*	1.2415	0.058
Ethnic (indigenous women)	-0.5111**	0.5998	0.000	-0.5383**	0.5837	0.000
Constant	-2.8895		0.000	-2.2479		0.000

** Significant at the 1% level * Significant at the 5% level

Table 2. Regression coefficients and odds ratios from multivariate logistic regression assessing the association of IPV and use of RH services

Use of Reproductive Health Services	**Model 3** (net effect of physical violence on the use of RH services)			**Model 4** [net effect of violence (physical and verbal) on use of RH services]		
	Coefficient	**Odds ratio**	**p-value**	**Coefficient**	**Odds ratio**	**p-value**
Physical violence	-0.4526**	0.6359	0.001	--	--	--
Violence (physical & verbal)	--	--	--	-0.5301**	0.5886	0.003
Afraid of husband	-0.0781	0.9249	0.507	-0.0788	0.9242	0.503
Primary education	-0.2071	0.8129	0.167	-0.2133	0.8079	0.155
Secondary education	0.0922	1.0966	0.603	0.0888	1.0929	0.616
Higher education	0.2174	1.2428	0.365	0.2198	1.2458	0.359
Poor	0.4676**	1.5962	0.000	0.4656**	1.5929	0.000
Middle	0.6085**	1.8375	0.000	0.6072**	1.8353	0.000
Wealthier	0.8032**	2.2326	0.000	0.8129**	2.2546	0.000
Wealthiest	1.2596**	3.5242	0.000	1.2674**	3.5516	0.000
Discussed FP with husband	0.1779	1.1948	0.150	0.1926	1.2124	0.119
Children ever born	0.0006	1.0006	0.978	0.0019	1.0019	0.924
Husband drunk	0.0429	1.0439	0.614	0.0406	1.0415	0.633
Young women	0.6081**	1.8369	0.000	0.6071**	1.8352	0.000
Middle-aged women	0.5731**	1.7738	0.000	0.5754**	1.7778	0.000
Visit of FP worker	0.0947	1.0993	0.354	0.0972	1.1021	0.342
Want no more children	0.1939*	1.2141	0.022	0.1928*	1.2126	0.022
Primary education (husband)	0.0937	1.0982	0.623	0.0874	1.0913	0.647
Secondary education (husband)	0.1235	1.1315	0.539	0.1129	1.1196	0.575
Higher education (husband)	0.5631*	1.756	0.020	0.5481*	1.7299	0.024
Told about FP at health facility	0.6535**	1.9223	0.000	0.6508**	1.9171	0.000
Woman is hurt	0.0433	1.0442	0.645	0.0055	1.0055	0.952
Respondent works	-0.1447	0.8653	0.099	-0.155	0.8564	0.077
Husband works	0.0766	1.0797	0.752	0.0707	1.0732	0.770
Husband decides on health issues	-0.1329	0.8755	0.323	-0.1437	0.8661	0.285
Husband decides on expenses	-0.2174*	0.8046	0.029	-0.2289*	0.7954	0.021
Ethnic (indigenous women)	-0.1817*	0.8339	0.021	-0.1875*	0.8289	0.017
Constant	-0.4347	--	0.279	-0.2887	--	0.490

** Significant at the 1% level
* Significant at the 5% level

ANNEX 2. FOCUS GROUP DISCUSSION AND IN-DEPTH INTERVIEW PARTICIPANTS

Participants' Characteristics during the External Assessment of the Advance Process toward Peace

Focus Groups

El Alto

Focus Groups	Number of Participants	Age	Educational Level	Occupation	Marital Status	
					Single	Married
Women	3	17, 19, 35	Secondary	Housemakers	2	1
Young people	5	16/22	Secondary	Students	5	0

Quillacas

Focus Groups	Number of Participants	Age	Educational Level	Occupation	Marital Status	
					Single	Married
Men	7	35/70	3 Elementary 4 Secondary	3 Farmers 1 Drivers 1 Musician 1 Promoter 1 Leader	0	7
Women	12	28/75	12 Elementary	11 Housemakers 1 dk/da	3	9
Young people	9	14/18	9 Secondary	Students	9	0

Machareti

Focus Groups	Number of Participants	Age	Educational Level	Occupation	Marital Status	
					Single	Married
Men	5	27/48	5 Secondary	5 dk/da	0	5
Women	7	27/55	6 Elementary 1 Technical	6 Housemakers 1 Nurse	0	7
Young people	8	13/17	7 Secondary 1 Elementary	Students	8	0

Oruro

Focus Groups	Number of Participants	Age	Educational Level	Occupation	Marital Status	
					Single	Married
Women	5	18/42	3 Secondary 2 University	4 Students 1 Seamstress	3	2
Young people	10	14/16	10 Secondary	Students	10	0

In-Depth Interviews

El Alto

Health Sector	Lic. Sandra del Carpio
	Chief, Unit of Health Promotion and Social Communication, SERES El Alto
Education	Lic. Edson Montaño Ortiz
	Coordinator, Center for Pedagogical Resources, CEMSE CRP
Justice	Dra. Nancy Michael
	Coordinator, Center of Intergral Justice, District 6
Authorities	Lic. Marilin Lara
	President, Network against Violence, El Alto, and Responsible of the Adolescent and Youth Division at CIES

Quillacas

Health Sector	Enfermero Dadeo Jallasa Mamani
	Technician, Hospital of Sevaruyo
Education	Profesor Wálter Amilkar Ríos Mamani
	Director (a.i.), Public School of Sevaruyo
Justice	Policarpio Callahuara Calani
	Corregidor (local authority), Sevaruyo County
Authorities	Fernando Espinosa
	Major of Quillacas

Macharetí

Health Sector	Dr. Eusebio Mamani
	Chief Physician, Municipality of Macharetí
Education	
Justice	Limberth Perales
	Responsible, SLIM and Youth and Children's Ombudsman
	Dr. Remberto Prieto (abogado)
	District Attorney
Authorities	Sofía Chambaye
	Second Police Officer in Macharetí

Oruro

Health Sector	Dr. Víctor Aráoz
	Responsible, Sexual and Reproductive Health Strategic Planning, SEDES Oruro.
Education	Lic. Rosa Velásquez
	Specialist, Monitoring and Supervision, High School Level, Eduation District
Justice	Dra. Centellas

Authorities	Lic. Miriam Omonte
	Director, Unit of Gender and Family, Municipality of Oruro

ANNEX 3. ASSESSMENT INSTRUMENTS

Jóvenes

Grupo focal
Guía de preguntas
Fecha:_____ **Lugar: _____**
Moderador/a:_____ **Nota:** Adjuntar lista de participantes

1. Cuando necesitan orientación o atención de salud sexual y reproductiva, especialmente en planificación familiar, ¿dónde acuden?
2. ¿Qué obstáculos tienen los y las jóvenes para acceder a servicios de salud sexual y reproductiva, especialmente en planificación familiar?
3. ¿Qué piensan las personas adultas sobre las personas jóvenes que buscan y utilizan servicios de salud sexual y reproductiva, especialmente en planificación familiar?
4. ¿En qué ocasiones las mujeres maltratadas o golpeadas buscan ayuda en los servicios de salud? ¿Por qué no buscan ayuda?
5. En el centro de salud de la localidad, ¿creen que el personal puede reconocer las señales de violencia que presentan las mujeres maltratadas y abusadas, aunque ellas no lo digan o lo quieran ocultar?
6. ¿Conocen casos de mujeres maltratadas o abusadas que no recibieron atención? ¿Qué pasó con ellas?
7. ¿Cuáles piensan que son las consecuencias del maltrato o abuso sobre la salud de las mujeres?
8. ¿Por qué las mujeres que quieren utilizar servicios de planificación familiar, no los usan?
9. ¿Qué hacen los hombres cuando descubren que sus mujeres utilizan métodos anticonceptivos sin que ellos sepan (píldoras, DIU, inyecciones, etc.)? ¿Por qué?
10. ¿Qué puede suceder cuando una mujer casada o no casada tiene relaciones sexuales contra su voluntad? ¿Cuáles son las consecuencias para su salud?
11. ¿Creen que las mujeres no usan servicios de salud sexual y reproductiva, especialmente en planificación familiar, por temor a la violencia? ¿Por qué?
12. ¿Piensan que su participación en el Proyecto tuvo algún impacto en su vida?, ¿en su comunidad? ¿Por qué?

Mujeres

Grupo focal
Guía de preguntas
Fecha:_____ **Lugar: _____**
Moderador/a: _____ **Nota:** Adjuntar lista de participantes

1. Cuando necesitan orientación o atención de salud sexual y reproductiva, especialmente en planificación familiar, ¿dónde acuden?
2. ¿Qué obstáculos tienen las mujeres para acceder a servicios de salud sexual y reproductiva, especialmente en planificación familiar?
3. ¿Qué piensan sobre las personas jóvenes que buscan y utilizan servicios de salud sexual y reproductiva, especialmente en planificación familiar?
4. ¿Qué creen que los hombres opinan de las mujeres que buscan servicios de planificación familiar?
5. ¿En qué ocasiones las mujeres maltratadas o golpeadas buscan ayuda en los servicios de salud o salud reproductiva? ¿Por qué no buscan ayuda?
6. En el centro de salud de la localidad, ¿creen que el personal puede reconocer las señales de violencia que presentan las mujeres maltratadas y abusadas, aunque no lo digan o lo quieran ocultar?
7. ¿Conocen casos de mujeres maltratadas o abusadas que no recibieron atención? ¿Qué pasó con ellas?
8. ¿Cuáles piensan que son las consecuencias del maltrato o abuso sobre la salud de las mujeres?
9. ¿Por qué las mujeres que quieren utilizar servicios de planificación familiar, no los usan?
10. ¿Qué hacen los hombres cuando descubren que sus mujeres utilizan métodos anticonceptivos sin que ellos sepan (píldoras, DIU, inyecciones, etc.)? ¿Por qué?
11. ¿Qué puede suceder cuando una mujer casada o no casada tiene relaciones sexuales contra su voluntad? ¿Cuáles son las consecuencias para su salud?
12. ¿Creen que las mujeres no usan servicios de salud sexual y reproductiva, especialmente en planificación familiar, por temor a la violencia? ¿Por qué?
13. ¿Piensan que su participación en el Proyecto tuvo algún impacto en su vida?, ¿en su comunidad? ¿Por qué?

Hombres

Grupo focal
Guía de preguntas
Fecha:_____ **Lugar: _____**
Moderador/a _____ **Nota:** Adjuntar lista de participantes

1. Cuando necesitan orientación o atención de salud sexual y reproductiva, especialmente en planificación familiar, ¿dónde acuden?
2. ¿Qué obstáculos tienen los hombres para acceder a servicios de salud sexual y reproductiva, especialmente en planificación familiar?
3. ¿Qué piensan sobre las personas jóvenes que buscan y utilizan servicios de salud sexual y reproductiva, especialmente en planificación familiar?
4. ¿En qué ocasiones las mujeres maltratadas o golpeadas buscan ayuda en los servicios de salud o salud reproductiva? ¿Por qué no buscan ayuda?
5. En el centro de salud de la localidad, ¿creen que el personal puede reconocer las señales de violencia que presentan las mujeres maltratadas y abusadas, aunque no lo digan o lo quieran ocultar?
6. ¿Conocen casos de mujeres maltratadas o abusadas que no recibieron atención? ¿Qué pasó con ellas?
7. ¿Cuáles piensan que son las consecuencias del maltrato o abuso sobre la salud de las mujeres?
8. ¿Por qué los hombres que quieren utilizar servicios de planificación familiar, no los usan?
9. ¿Qué hacen los hombres cuando descubren que sus mujeres utilizan métodos anticonceptivos sin que ellos sepan (píldoras, DIU, inyecciones, etc.)? ¿Por qué?
10. ¿Qué puede suceder cuando una mujer casada o no casada tiene relaciones sexuales contra su voluntad? ¿Cuáles son las consecuencias para su salud?
11. ¿Creen que las mujeres no usan servicios de salud sexual y reproductiva, especialmente en planificación familiar, por temor a la violencia? ¿Por qué?
12. ¿Piensan que su participación en el Proyecto tuvo algún impacto en su vida?, ¿en su comunidad? ¿Por qué?

Entrevista a Autoridades

Nombre _____ Cargo _____
Lugar _____ Fecha _____

1. ¿Qué servicios de salud sexual y reproductiva, especialmente de planificación familiar, existen en esta localidad? ¿Estos servicios están al alcance de las personas adolescentes?, ¿de las mujeres?, ¿de los hombres?
2. ¿Qué obstáculos tienen las personas adolescentes?, ¿las mujeres?, ¿los hombres? para acceder a servicios de salud sexual y reproductiva, especialmente de planificación familiar?
3. ¿Qué piensan las personas adultas de la comunidad sobre jóvenes que buscan y utilizan servicios de salud sexual y reproductiva, especialmente de planificación familiar? ¿Qué piensan los hombres sobre las mujeres que buscan y utilizan estos servicios?
4. ¿Qué tipos de abuso o maltrato contra las mujeres se aborda con mayor frecuencia en la Institución?
5. ¿Cree que algunas mujeres provocan violencia y abuso sexual a través de sus actitudes o comportamientos?
6. Cuando el esposo obliga a su mujer a tener relaciones sexuales, ¿considera usted que éste es un acto de violencia? ¿Por qué? ¿La mujer tiene derecho a rechazarlo?
7. ¿Conocen algún caso en el que alguna mujer víctima de violencia haya fallecido sin recibir atención médica?
8. ¿El personal de la Institución tiene posibilidades de reconocer señales de violencia en mujeres maltratadas? ¿Qué hace en esos casos?
9. ¿Cree que los hombres que ejercen violencia necesitan atención? ¿Qué tipo de atención?
10. ¿Qué hacen los hombres cuando descubren que sus mujeres utilizan métodos anticonceptivos sin que ellos sepan (píldoras, DIU, inyecciones, etc.)? ¿Por qué?
11. ¿Cuáles son las consecuencias del maltrato o abuso sobre la salud de las mujeres?
12. ¿Qué sucede cuando una mujer tiene relaciones sexuales contra su voluntad y sin protección? ¿Esto puede tener consecuencias sobre su salud? ¿Cuáles?
13. ¿Creen que una disminución de la violencia contra las mujeres podría aumentar la demanda de servicios de planificación familiar y salud sexual y reproductiva? ¿Por qué?
14. ¿Piensa que el Proyecto ha podido estimular a las autoridades para que inviertan tiempo, esfuerzo y presupuesto en la prevención y atención de la violencia basada en género? ¿Cómo?
15. ¿Cuál cree que es la responsabilidad que tiene la institución que usted representa en este tema?
16. ¿Piensa que el sentido del Proyecto influyó de alguna manera en su trabajo? ¿Por qué?

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