



GENDER-BASED VIOLENCE PREVENTION AND RESPONSE PHASE II PROJECT (GBVPR II): MIDLINE STUDY BRIEF

March 20224

Background

Gender-based violence (GBV) is widespread in Nepal despite political commitment and a supportive legal framework. Women and girls continue to face various forms of violence throughout their lives, ranging from pre-natal sex selection and child marriage to intimate partner violence (IPV) and widow abuse. GBV remains shrouded in a culture of silence, deeply rooted in discriminatory social and gender norms.

To end the scourge of GBV, UNFPA is implementing the Gender-Based Violence Prevention and Response Phase II (2020-2026) project, in partnership with the Swiss Agency for Development and Cooperation (SDC) and the Royal Norwegian Embassy (RNE) in Nepal.

The project seeks to reduce all forms of GBV and discrimination against women and girls in 19 municipalities in Koshi Province and Sudurpaschim Province through: (1) primary prevention to change harmful social and gender norms; (2) investment in multi-sectoral response services to increase access to survivor-centered care for survivors; and (3) advocacy and policy dialogue to strengthen gender-responsive policies and budgeting.

The midline study aimed to assess the effectiveness of the project's prevention and response interventions across six areas of inquiry identified from the project's logical framework, providing crucial evidence to track progress and inform adaptations towards the achievement of the project's intended outcomes.

1. Experience of different forms of violence by women and girls.
2. Help-seeking behavior among women and girls subjected to violence.
3. Awareness/knowledge of GBV forms and available services for GBV survivors.
4. Attitudes and beliefs about gender roles, relationships and behaviors.
5. Acceptability of GBV and help-seeking.
6. Delivery of survivor-centered, quality services for GBV survivors.

Methodology

The midline study served as a midpoint observation in the longitudinal research design adopted for the project. It used a mixed-method approach to collect data on key indicators and mediators measured during the project's baseline study for which field work was conducted in April-May 2022. The study followed up with a sub-sample of adolescents, married men and women, service providers and female survivors benefiting from prevention and response interventions to assess change over time. It also included a sample of newly recruited survivors served at one-stop crisis management centers (OCMCs) and shelters. Field work was completed in August-September 2023.

The scope of the study was limited to the project's main prevention interventions: the 10-session discussion program for married couples and the 16-session Rupantaran life skills program for adolescents in school.

As part of the response interventions, the study covered 8 types of training and quarterly supportive supervision visits for multi-sectoral service providers (health care, psychosocial support, shelter and justice).

Surveys (Total: 715)

- 322 Married men & women
- 136 Adolescent boys & girls
- 182 Women survivors
- 75 Service providers

Interviews (Total: 95)

- 23 Married men & women
- 24 Adolescent boys & girls
- 21 Women survivors
- 27 Service providers

Municipalities (Total: 9)

With varying project performance across Koshi and Sudurpaschim

Program Participation

As not all the beneficiaries received programming as planned, the study used the level of participation in programming as a proxy for a control group in the analysis of the prevention interventions with couples and adolescents and the response interventions with service providers.

Participation for couples and adolescents targeted through prevention interventions was defined as high (attended more than 50% of sessions), low (attended 50% or less of the sessions, but at least one), or no participation. More adolescent boys (74%) and girls (71%) participated compared to married men (54%) and women (58%) (Figure 1).

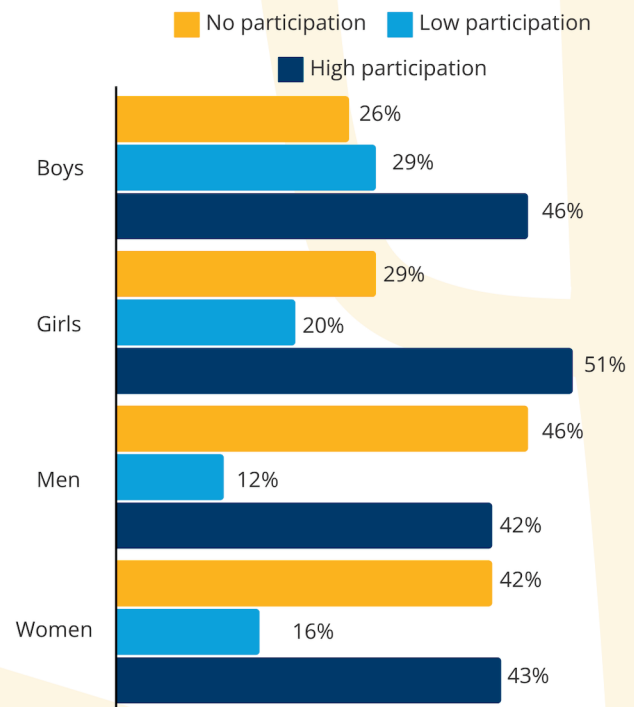


Figure 1. Level of participation in prevention interventions, by type of beneficiary.

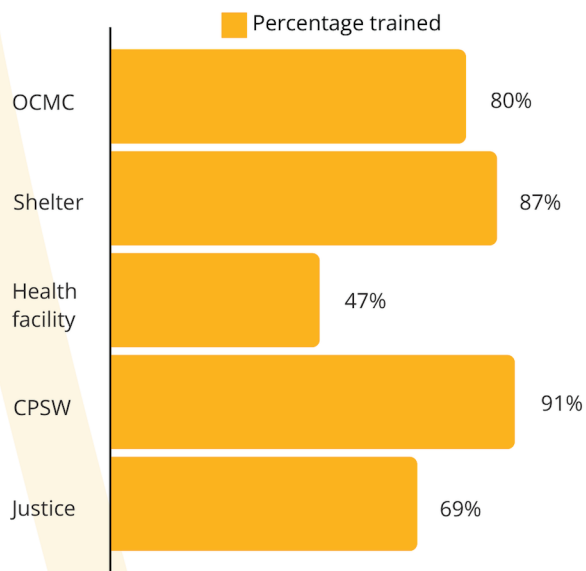


Figure 2. Level of participation in response interventions, by type of service provider.

Participation for service providers in response interventions was defined by service provider role, which was categorized as follows: (1) OCMC staff including psychosocial counselors, case managers, doctors, and nurses; (2) shelter staff including shelter in-charges and psychosocial counselors; (3) community psychosocial workers (CPSWs); (4) peripheral health facility personnel including health post in-charges and female community health volunteers (FCHVs); and (5) justice service providers including judicial committee members and community mediators. Overall, the amount of training differed by service provider type (Figure 2), which also applies for supportive supervision. OCMC staff and CPSWs had the highest average number of supportive supervision visits (8 and 4 visits, respectively), while shelter and peripheral health facility staff reported the lowest (3 and 2 visits, respectively). Justice service providers did not report any supportive supervision visits.

Key Highlights

- 1 IPV decreased in the sample of married women. This decline was concentrated among women with high participation in the couple discussion program (18% reduction, adjusting for baseline differences between the three prevention participation groups). However, the lack of other programmatically relevant and statistically significant changes described below suggests that the decline in IPV may be the result of social desirability bias due to reductions in the acceptability of wife beating, although an actual decrease in IPV cannot be ruled out.
- 2 Help-seeking among married women and adolescent girls was extremely low, but service providers reported that help-seeking was increasing. Most service providers observed a greater willingness among women to seek help, often attributed to their work and visibility in the community, which resulted in higher caseloads. On average, OCMC staff reported a modest increase of 2 additional cases per week. The reported increase in help-seeking is supported by administrative data collected through regular project monitoring, showing a positive trend in the number of survivors served in the OCMCs.
- 3 Gains in knowledge of GBV forms and help options were minimal except among men and boys with high participation in prevention programming, and only after being prompted. This finding was confirmed by the qualitative interviews. After prompting in the survey, men and boys with high participation recalled approximately 3 additional GBV forms and 3 additional help-options for survivors. Recognition of OCMC and shelter services increased specifically among adolescents and couples with high participation, from 21% at baseline to 36% at midline (Figure 3). Accounting for baseline differences in the three prevention participation groups, a 12% increase in the knowledge of OCMCs and safe houses/shelter homes was measured. The qualitative data, however, did not suggest greater recall among adolescents and couples. There were no significant changes in knowledge of CPSWs as a help option.

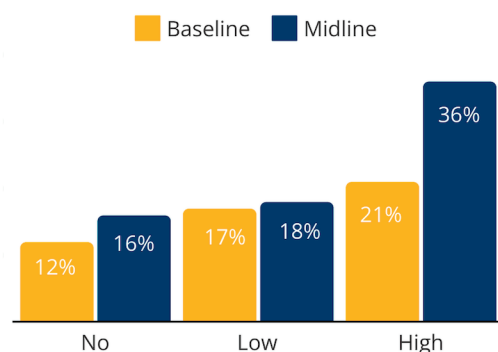


Figure 3. Proportion of adolescents and couples identifying OCMCs or safe houses/shelter homes as help options for survivors, by time point and participation level.



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There was limited change in gender-equitable attitudes and behaviors. Small improvements were observed in married women's household decision-making (10%), sexual and reproductive health decision-making (5%) and overall agency (+0.5 points on a 5-point scale), adjusting for baseline differences between the three prevention participation groups. However, these improvements were not attributable to the couple discussion program. Women and girls with high participation in prevention programming reported a lower percentage of their day spent on unpaid domestic and care work at midline (14%) than at baseline (19%). Boys' and men's contribution to domestic and care work remained unchanged at 6% from baseline to midline, except for a few couples in qualitative interviews reporting increased engagement of men in household chores. There was also no change in male engagement by participation level (Figure 4).

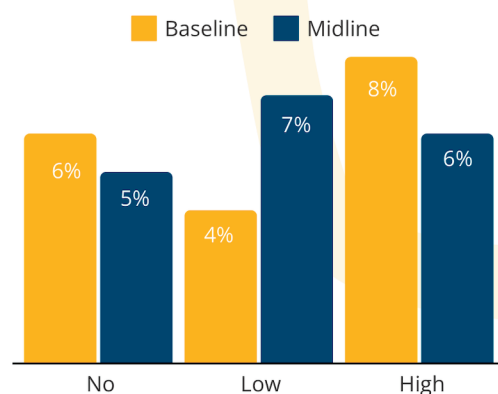


Figure 4. Proportion of time (% of 24-hour day) spent on unpaid domestic and care work by men and boys, by time point and participation level.

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The acceptability of wife beating decreased among adolescents and couples, especially those with high participation in prevention programming, declining from 32% at baseline to 13% at midline (Figure 5). When adjusting for baseline differences across the three prevention participation groups, this decrease reflects a 14% reduction in acceptability of IPV. However, the acceptability of help-seeking did not change substantially (an adjusted increase of 0.2 points on a 4-point scale) and was not attributable to participation in prevention programming. Nevertheless, most survivors reported minimal or no social consequences for seeking help and reduced feelings of stigma (-0.5 points on a 4-point scale). Several service providers also reported that help-seeking has become more acceptable.

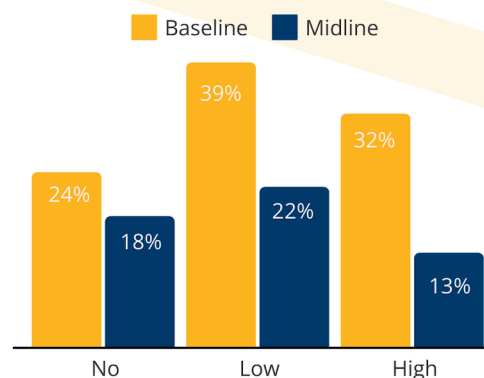


Figure 5. Proportion of adolescents and couples who agree that a husband is justified in hitting or beating his wife for specific reasons, by time point and participation level.

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It has a positive social consequence. After few people in the community received the services, now people are scared and realized that GBV has legal consequences. As perpetrators are scared, the survivors have become self-assured that they are protected and there are places where they can receive services. Now survivors have become optimistic and do not think that suicide is the only way out from GBV. Many women come to us saying that their husband beats them and that they feel that their life is worthless. Now, because of the project, those women have a new life...

(CPSW Coordinator, Surdurpaschim Province)

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Evidence for the provision of survivor-centered GBV response services suggests minimal benefit from programming.

CPSWs, OCMC and shelter staff received the majority of the training and supportive supervision (Figure 2). Among those who were trained or supervised, there was mixed evidence of changes in attitudes towards gender-equitable norms or knowledge of GBV. There were also no significant changes in feelings of GBV case preparedness (-0.2 points on a 7-point scale), the number of strong multi-sectoral relationships (-0.5 additional relationships), and survivor-centered elements in the workplace (+0.4 additional elements).

Similarly, service providers made few references to survivor-centered practices beyond confidentiality, privacy, and the provision of information about available services in qualitative interviews.

Despite limitations in survivor-centered care, survivors served in OCMCs and shelters reported high satisfaction (98% at baseline and 100% at midline) and a continued willingness to refer others to these services. However, they commonly misunderstood their rights. In addition, empowerment scores of survivors utilizing OCMC services increased at midline (+0.4-points on a 5-point scale), while those of survivors served in shelters remained nearly stable (+0.1-points on a 5-point scale).

Importantly, violence cessation (57%) or reduction (35%) were the most common outcomes for help-seeking survivors.

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I have filed for divorce, but people who don't understand say, you got married by yourself; you brought this pain on yourself, and now you have to suffer. In the village, all my relatives say, what have you achieved by filing for divorce? You will have to return to your own husband finally.”

(Survivor served at OCMC, Koshi Province)

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Survivors provided with accommodation in the safe houses/shelter homes lived separately from their abuser as lodging was provided for them and their children. Although the shelter homes allowed for long-term stay, some survivors expressed safety concerns as to what would happen after they returned home.

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After we learn new skills and go out to start working, there is the fear of safety. My husband has threatened me saying that wherever I go, he will find me and beat me. So, I have a fear...what if he finds me? How can I be safe from him?

(Survivor served at shelter, Sudurpaschim Province)

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Other obstacles to help-seeking identified by both survivors and service providers were transportation challenges and financial insecurity for survivors. In addition, service providers highlighted that several challenges to survivor-centered care persist, including low budgets despite increasing caseloads, facility limitations such as lack of private space and computers, staffing shortages and high staff turnover, as well as blame and threats from the perpetrator's family members.

Overall, the study results provide minimal evidence of success against outcomes across the six areas of inquiry encompassing the prevention and response interventions of the project.

Recommendations

Prevention

1. Deploy evidence-based prevention programs tailored for adolescents, men and women to increase the likelihood of achieving positive outcomes and generate evidence on what works before large-scale deployment.
2. Revise the couple discussion program and the Rupantaran life skills program for adolescents based on global best practices and lessons drawn from implementation in Nepal, and thoroughly pilot test the programs to assess their feasibility and effectiveness prior to further deployment.
3. Increase the intensity and duration of prevention programs targeting adolescents, men and women to effectively challenge social and gender norms that underpin gender inequality and GBV.
4. Prioritize the selection of prevention facilitators with gender-equitable attitudes and strong facilitation skills, provide them with adequate training and refresher training and conduct frequent quality control to maintain fidelity to the curricula.
5. Incorporate discussions to reflect on the acceptability of seeking help to stop violence into the prevention programming with adolescents, men, and women for increased reporting of GBV incidents.

Response

6. Reassess the scope of the service providers involved in the project to ensure that adequate training and supervision can be provided to improve survivor-centered care.
7. Assess the quality and quantity of the training provided to master trainers and cascaded down to others to identify limitations in the design and delivery of the training, and consider the use of MHealth for more standardization.
8. Conduct refresher training of service providers, increase the frequency of supportive supervision and foster learning visits of service providers across project sites to address persistent gaps in knowledge, attitudes, and practice to achieve more survivor-centered care.
9. Conduct needs assessments of the multi-sectoral service providers covered by the project to tailor training and supportive supervision to specific knowledge and skill gaps.
10. Advocate with relevant ministries, health professional education institutions and accreditation bodies to incorporate GBV training in pre-service education programs for health service providers at national and provincial levels.
11. Assess the current interventions to strengthen the health sector response to GBV against the WHO model of a comprehensive health-system approach to address GBV.
12. Intensify advocacy for investment in improved facilities, accessible subsidies for transportation and increased economic empowerment opportunities for survivors to ensure more survivor-centered care.

Integrated

13. Assess the study's data collection tools against the contents of the prevention and response interventions and conduct measurement analyses to determine the tools' reliability and their sensitivity to detecting change over time.
14. Plan and budget for formative research during the design of future projects and conduct more in-depth formative research for more locally contextualized, sustainable and effective interventions to prevent and respond to GBV.
15. Integrate operational research components in routine monitoring to identify and solve implementation challenges and explore further research on adapted project interventions.



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