Promoting positive social norms in support of zero tolerance for gender-based violence in rural Zambia

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Challenge

- Gender-based violence (GBV) is a human rights abuse and a serious public health problem, with wide-ranging mental, physical, social and economic impacts.
- 2014 WHO Resolution on Violence Against Women calls for a global plan of action to strengthen the role of health systems in addressing GBV.
- As yet, the evidence base on how to intervene effectively is limited.

Background and Context

- MORE MAMaZ (More Mobilising Access to Maternal Health Services in Zambia Programme), worked with the Ministry of Health, district health teams and communities to address the range of demand-side barriers preventing timely use of maternal and newborn health services.
- The intervention covered between 61% and 94% of the population of five rural districts.
- Funded by Comic Relief, the programme was operational from 2014 to 2016.
- Baseline studies highlighted that:
  - GBV was a 'silent' issue
  - It was often associated with heavy drinking
  - There was widespread reticence to intervene
  - The prevailing social norm was "whatever happens in the household stays within the household"
- In 2011 Zambia introduced supportive legislation in form of Anti-Gender Based Violence Act.
- GBV statistics in the 2014 Demographic and Health Survey show little change from 2007.
- In response, MORE MAMaZ integrated focus on GBV into a broad-based demand-side maternal and newborn health intervention.
- Community health volunteers called Safe Motherhood Action Group volunteers (SMAGs) were trained to work on GBV in five rural districts in Central, Western and Muchinga Provinces.

GBV rates in Zambia

43% *Women and girls who have experienced violence at some point in their lives*

37% *Women and girls who have experienced violence in previous 12 months*

17% *Women and girls who have experienced sexual violence*

10% *Women who have experienced violence when pregnant*

Source: *2014 Zambia Demographic and Health Survey*

Approach

Community discussion groups

- Facilitated by SMAG volunteers, these provided space for men and women of all ages to reflect on how to support women in pregnancy.
- Safe pregnancy and delivery served as a non-confrontational entry point for addressing GBV.
- Discussions focused on the steps men could take to lighten women's work burden and help them take care of their health and nutrition.
- Many disagreements in the household were linked to perceptions that women not working hard enough during pregnancy.
- Hence discussions about women's well-being led to discussions about GBV.
- Discussion groups focused on 'sad memories' – instances where women or babies had been injured.
- This led to reflection on steps communities could take to avoid these situations in future.

Focus on peer education

- This was adopted as a key programme strategy.
- Male SMAGs shared their own stories about GBV during discussion groups and home visits.
- Men who were violent were not judged – they were friends, neighbours, family.
- The constructive approach created space for men to change while retaining their pride and self-esteem.

Use of song

- Song was used as a medium to spread anti-GBV messages.
- Songs made it easier for communities to talk about the relationship between care during pregnancy and GBV.
- Songs challenged GBV's taboo status, allowing communities to discuss the subject openly.

Training of health providers

- Front-line health providers were given training on communication and social exclusion.
- This built their capacity to identify, counsel and support least-supported women, including those affected by GBV.

Emphasis on community-wide responsibility for GBV

- Community members were encouraged to report GBV.
- SMAGs also organised themselves so they could intervene.
- The support of traditional leaders was sought to reinforce the importance of the campaign.

Results

- GBV interventions resulted in transformative change.
- Intervention communities reported a very significant reduction in GBV.
- 89% of men and 88% of women reported that GBV had declined (17% and 12% higher than in control sites) (Fig 1).
- GBV-related changes were more likely to be attributed to the work of the SMAG volunteers in intervention sites (Fig 2).
- This provides evidence of the added value of the SMAGs in addressing GBV.

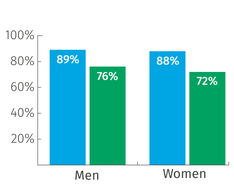

Figure 1: *Perceived reduction in GBV by community members*

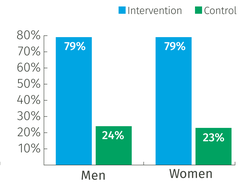

Figure 2: *% attributing reduction in GBV to SMAGs*

Source: *MORE MAMaZ endline survey, 2016*

- Traditional leaders readily embraced the anti-GBV campaign. Government legislation legitimised their efforts and gave them confidence.
- They cautioned or fined perpetrators and made clear their resolve to involve the police if necessary.
- SMAG volunteers more willing to intervene to address / prevent cases.
- Greater willingness on part of victims to report GBV and seek justice, including through traditional governance system.
- Community members reported greater harmony in the home.
- Health providers reported that increased probing encouraged female clients to talk about GBV.
- After training, health providers spent more time counselling women, in some cases interviewing domestic partners, and suggesting different types of community support.

"The men learnt that the wife should not be beaten, that they should talk and discuss rather than fight. Men are starting to discuss more. If something annoyed them in the past, men would just come back and hit their wife. Now they sit down and talk."
FEMALE COMMUNITY MEMBER, MONGU

Lessons Learned

MORE MAMaZ demonstrated that:

GBV mainstreaming is feasible:

- It is feasible to integrate a focus on GBV into the work of community health volunteers in Zambia, and at low cost.
- Once community health volunteers have received basic training and understand their role as facilitators, new topics can be easily be added to their portfolio.

Need for culturally appropriate approaches:

- It is important to tackle GBV sensitively, in ways acceptable to affected communities.
- In rural Zambian districts, care during pregnancy provided a non-confrontational entry point.
- A non-judgemental approach provided space for change.
- The 'whole community approach' resulted in a rapid shift in GBV-related social norms.

Reaching adolescents:

- In some sites SMAGs targeted young men in drinking places, focusing on links between heavy alcohol consumption and GBV.
- Efforts to reach out to young people were inconsistent, leading to missed opportunities for primary prevention.

Addressing all aspects of GBV:

- MORE MAMaZ did not explicitly address sexual violence.
- However, the emphasis on addressing the root causes of GBV, including the links between alcohol consumption and violence likely had a positive knock-on effect.
- In future, SMAGs should be trained to address all aspects of GBV.

Complementarity of supply- and demand-side interventions:

- MORE MAMaZ's work with health providers complemented and reinforced the demand-side GBV activities.

Policy Implications

- MORE MAMaZ identified practical yet transformative entry points for addressing GBV at community level and in the wider health system and intervened in both areas simultaneously. There is significant scope to scale up the GBV intervention further through the national Safe Motherhood Action Group initiative, thereby maximising transformative impact for women and girls in Zambia.
- Activities that promote inter-sectoral collaboration to counter GBV will be important in future GBV-related programming in Zambia. This will involve promoting linkages between health workers, the police, justice system, and social welfare services. This is an area that would benefit from further research.
- Government monitoring and evaluation systems can be modified so that they measure transformative impact in relation to GBV. To this end, there may be opportunities to include GBV indicators in the national Health Management Information System, and to monitor progress with GBV prevention through routine performance assessment processes in the health sector. This, too, is a priority area for intervention and research.

MORE MAMaZ was implemented by a consortium comprising Transaid, Health Partners International, Development Data and Disacare in partnership with the Ministry of Health and District Health Teams. Health Partners International was lead implementation partner for the programme.

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Further information and MORE MAMaZ resources can be obtained at: **www.healthpartners-int.co.uk**

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