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Sexual and Gender-based Violence: Road Map for Prevention and Response in Latin America and the Caribbean

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Gender and Diversity Division

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ROAD MAP FOR PREVENTION AND RESPONSE IN LATIN AMERICA AND THE CARIBBEAN

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List of acronyms

AI	Artificial intelligence
CAF	Development Bank of Latin America
CBT	Cognitive-behavioral therapy
CMC	*Ciudad Mujer Center*
DHS	Demographic and Health Surveys
DV	Domestic violence
ECLAC	Economic Commission for Latin America and the Caribbean
GBV	Gender-based violence
GDP	Gross domestic product
HIV	Human immunodeficiency virus
IACHR	Inter-American Commission of Human Rights
ICTs	Information and communication technologies
IDB	Inter-American Development Bank
INAM	National Institute of Women *(Instituto Nacional de la Mujer)* of Honduras
INAMU	National Institute of Women *(Instituto Nacional de la Mujer)* of Panama
IPV	Intimate partner violence
ISDEMU	Salvadoran Institute for Women's Development
LAC	Latin America and the Caribbean
LGBTQ+	Lesbian, gay, bisexual, transgender, *queer*
MAW	National Mechanisms for the Advancement of Women
RHS	Reproductive Health Survey
SGBV	Sexual and gender-based violence
STD	Sexually transmitted disease
UN	United Nations
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
VACS	Violence Against Children and Youth Surveys
VAW	Violence against women
VAWG	Violence against women and girls
WHO	World Health Organization

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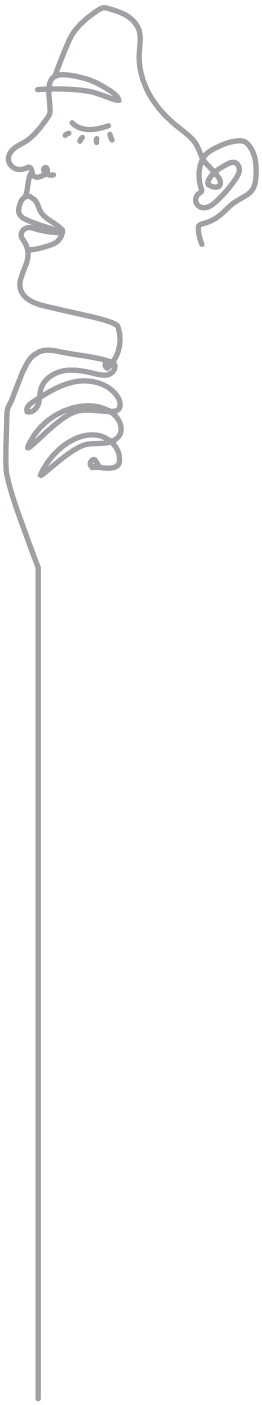
Introduction

Sexual and gender-based violence (SGBV) is a human rights violation that continues to affect the lives of millions of women and girls worldwide. In fact**,** SGBV, particularly against women and girls, has been called the shadow pandemic, because statistics show that the scale of the problem is chilling (UN Women, 2020a). In the Latin America and Caribbean (LAC) region alone, 34% of women between ages 15 and 49 have suffered physical or sexual violence at some time in their lives, compared to 31% of women worldwide (WHO, 2021; Bott *et al.*, 2019). The various dimensions in which this is manifested, or the mere threat of suffering it, make it impossible to thrive and are also obstacles to the development of safe, equitable and productive societies.

The prevalence of SGBV in the region demands a multifaceted approach based on public policies and programs that respond to the interests and needs of people in all their diversity. The purpose of this document is to create a road map that contributes to the design, implementation and evaluation of policies and programs based on available evidence about the prevention of and response to ESGBV. It is aimed at those who are involved in their design, implementation and evaluation in Latin America and the Caribbean (LAC). The map is guided by a theory of change that combines a series of components: analysis of the problem, barriers to preventing and addressing SGBV, and the evidence available about interventions that have been carried out, resulting from experimental or quasi-experimental evaluations considered in this analysis.

This document is divided into five sections. The first section describes the scope of the problem, presenting data about the prevalence of SGBV in LAC. The second provides a conceptual review of the various terms used in addressing SGBV. The third presents the theory of change that guides and provides the rationale for the work. The fourth section contains an inventory of some of the most recent interventions and actions that the Inter-American Development Bank (IDB) has supported in countries in the region in 2016-2021. The document concludes with final reflections and considerations about the overall exercise.

Prevalence of SGBV in Latin America and the Caribbean



All women and girls are at risk of suffering some type of gender-related violence at some point in their lives. In LAC, 34% of women between ages 15 and 49 have suffered, at some time, physical or sexual violence from a husband, ex-husband, partner or former partner, or sexual violence from a stranger, compared to 31% of women globally (WHO, 2021; Bott *et al.*, 2019). In addition, intimate partner violence (IPV) or violence by a former partner has been recognized as the most widespread form of gender-based violence (GBV) against women. The most recent estimates put the average in the LAC region at 25%, below the global average of 27% (WHO, 2021). The prevalence in LAC varies between 42% and 16%, depending on the country. Those exceeding the global average are Bolivia (42%), Peru (38%), Ecuador (33%), Guyana (31%), Colombia (30%), Trinidad and Tobago (30.2%), Suriname (28%) and Jamaica (28%), while Uruguay (18%) and Panama (16%) are the countries with the lowest rates (WHO, 2021).

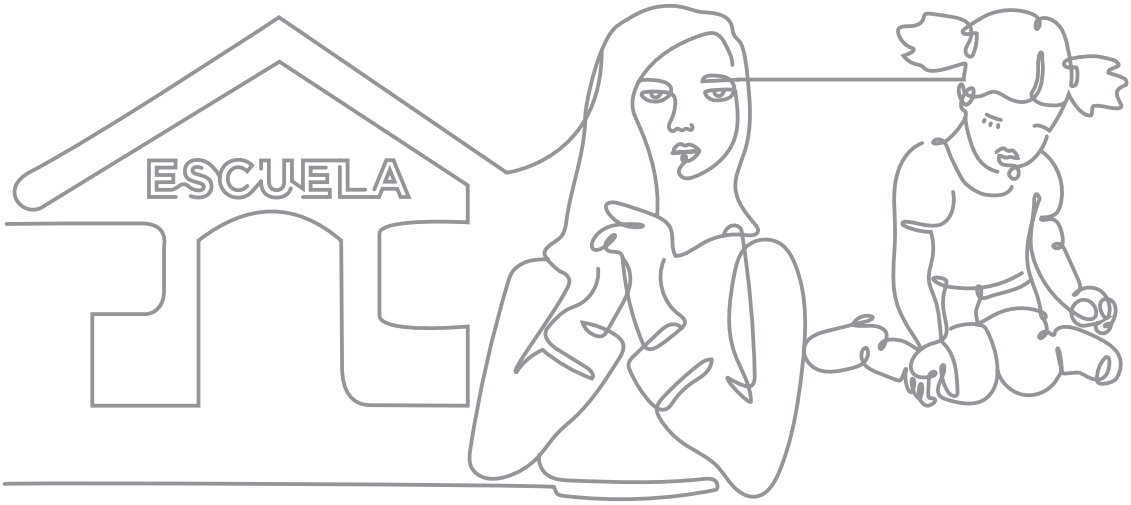
In LAC, the rate of sexual violence committed by a third party — that is, by a person who is not a current or former partner or husband — is among the highest in the world. The most recent estimates place the prevalence of this for women ages 15 or over who have suffered violence at least once in their lives at 12% in the LAC region, compared with the global average of 6% (WHO, 2021; Bott *et al.*, 2019). Nevertheless, the limited availability of data, because of stigmatization, shame or fear of repercussions from a complaint, suggest that these figures could underestimate the real scale of this form of violence.

Psychological or emotional violence is one of the most common forms of GBV in the region, and one of the types most difficult to measure and understand. Some countries have made efforts to measure it**,** but this requires a better understanding, given the complexity of comprehending what the trauma, emotional harm, relationship between psychological violence and other forms of discrimination, and overcoming of it in the short, medium and long term represent for a woman or girl. This violence takes the form of insults, disparaging remarks, emotional manipulation, isolation, humiliation, threats, among others, and occurs in both the private and public spheres. In Chile, 38.3% of surveyed women between ages 16 and 65 said they had suffered psychological violence at home at some time in their lives. In addition, 73.7% of the cases reported were perpetrated by a partner or former partner (MISP, 2020). In Mexico, 40.1% of women ages 15 or over said they had suffered emotional violence from a partner or former partner at some time in their lives; 23.2% said they had been subjected to it in the past year (INEGI, 2016). In Uruguay and Ecuador, psychological violence by a partner or former partner is the type most reported, both in the past year (18.4% and 25.2%, respectively) and throughout the woman's lifetime (44.6% and 31.6%, respectively) (INE, 2020; INEC, 2019). In the Caribbean, 35%, 28.8% and 35% of women surveyed in Trinidad and Tobago, Jamaica and Suriname, respectively, have suffered psychological violence by a partner at some time in their lives (Pemberton and Joseph, 2018; Watson Williams, 2018; Joseph *et al.,* 2019).

Twelve women die every day in LAC as a result of feminicide, the most extreme form of SGBV. The region includes 14 of the 25 countries with the highest number of feminicides in the world. A global study of homicide conducted by UNODC (2019) ranks the Americas as the second most lethal region for women, after Africa. This data refers to the risk of being murdered by a family member or a partner or former partner (1.6 per 100,000 inhabitants in LAC). Nevertheless, the figures for the total number of feminicides in 2019, which include violence perpetrated by a third party, suggest that in LAC, there were 4.6 such murders per 100,000 inhabitants, when the global average is 2.2 (ECLAC, 2019a). Figures from the Gender Equality Observatory for LAC report at least 4,640 cases of feminicide for 18 countries in Latin America and six in the Caribbean in 2019. The highest rates were recorded in Honduras (6.2 per 100,000 women), El Salvador (3.3), the Dominican Republic (2.7) and

Bolivia (2.1). Another issue worth mentioning is that, according to the most recent data indicated by the Gender Equality Observatory for LAC, in Ecuador and Paraguay, intimate feminicide — in which the perpetrator is or was in a conjugal relationship or one of cohabitation, courtship or an occasional affective relationship with the victim — constitutes more than 90% of all feminicides, while that trend is nearly reversed in countries such as El Salvador and Honduras, where intimate feminicides represent less than 20% of the total and the perpetrator is more often a person with whom the victim had no affective ties or was simply a stranger (UNODC, 2019; ECLAC, 2019a). The data also indicate that adolescent and young women are at greater risk of being murdered for being women. In 2019, seven countries in the region reported 80 feminicides of young women ages 25 to 29 years, 61 feminicides of adolescents ages 15 to 19 and 25 feminicides of girls ages 0 to 14 years (ECLAC, 2020a). The Inter-American Commission on Human Rights has also observed that feminicides more often affect groups of women who are in situations of particular vulnerability or those who identify as being of African descent, indigenous, lesbian or transgender. Nevertheless, very few countries in the region have these data broken down by these groups (IACHR, 2019).

Violence and harassment in school, including physical, psychological and sexual violence, is a global problem that mainly affects children and adolescents. Most violent acts are committed between peers, but in some cases the perpetrator is a teacher or non-teaching staff member (UNESCO and UN Women, 2021). This type of violence takes the form of corporal punishment, bullying, extortion, verbal and sexual harassment, intimidation or rape, among others. The proportion of students who say they have been subjected to harassment is 30.2% in South America, 25% in the Caribbean and 22.8% in Central America, figures that are below the global average of 32%. Girls are more likely to report sexual harassment in the Caribbean, while boys are more likely to suffer this type of harassment in Central America and South America (UNESCO and UN Women, 2021). There is little exhaustive data at the global level about sexual violence in schools, but the Violence Against Children and Youth Surveys (VACS) have begun to shed light on the situation in LAC. In Ecuador, 19 out of every 100 women over age 15 say they have suffered some type of school-related violence at some time in their lives. The highest figures are for psychological violence (13.7%), followed by sexual (7%) and physical (6.8%) violence (INEC, 2019). In Uruguay, 13.4% of women age 15 or over report having suffered school-related GBV situations during their lives. Women of African descent experience higher levels (10%) than women who are not of African descent (8.8%) (INE, 2020). In Mexico, it is estimated that nationwide, 10.9% of women age 15 or over have suffered some form of school-related sexual violence. The main aggressors are male classmates (39.9%), female classmates (20.1%) or teachers (14.4%) (INEGI, 2016).



In Guatemala, 15.7% of primary school students and 19.7% of middle schoolers have suffered various types of sexual harassment at school. It is worth noting that boys and male adolescents reported having suffered more cases of the various forms of harassment evaluated in the study (Espinoza Sandoval and Palala Martínez, 2015).[1]

Workplace violence and harassment, particularly sexual harassment and psychological violence, more commonly affect women. Studies indicate that women suffer the most sexual harassment in the workplace, and the most vulnerable are young women; those who are economically dependent, single or divorced; or those in an irregular migratory situation or other situation of vulnerability (ILO, 2007). Men may also be the object of these practices. Those most often harassed are young men, homosexual men and people of diverse ethno-racial backgrounds (ILO, 2007). There is little comparative data about the prevalence of workplace sexual harassment in LAC. In Colombia, according to official figures from the Attorney General's Office, between 2008 and 2020, of a total of 16,307 victims, 84% were women. In a survey conducted in 12 cities in Brazil, 52% of women said they had experienced some form of sexual harassment at work (DeSouza and Cerqueira, 2008). In Ecuador, 20.1% of women ages 15 or over experienced some type of workplace violence at some point in their lives; of these, 17.2% suffered psychological violence, 6.8% sexual violence and 1.2% physical violence (INEC, 2019). In Mexico, 11.2% of women age 15 or over who have worked were victims of sexual violence at some point in their lives; 10.6% suffered emotional violence and 1.6% physical violence (INEGI, 2016). In Uruguay, 17.9% of women experienced situations of GBV in the workplace during their lives (INE, 2020). Sexual harassment also is prevalent among domestic workers, with 26% of domestic workers in Porto Alegre, Brazil, and 33% in Guatemala reporting having suffered sexual harassment at work (DeSouza and Cerqueira, 2008; Human Rights Watch, 2006). Workplace sexual harassment continues to be a taboo issue, and victims often do not report it, either out of fear or because they do not know how to do so. In Ecuador, 97% of victims of psychological or sexual violence did not report the act, nor did 88% of victims of physical violence (INEC, 2019). In addition, women, more than men,

[1] The study explored the existence of three types of sexual harassment: unwanted physical contact, sexual comments or insinuations, and sexual demands. The differences between males and females are statistically significant for students in the third year of primary school and diversified fifth grade.

are victims of psychological violence in the workplace. In countries such as Argentina, national surveys have shown that the incidence of psychological harassment or abuse in the workplace is more than two percentage points higher for women than for men: 11.6% compared to 9.5%. There also is a gender gap in the incidence of aggression by a boss or supervisor, which is 1.4 percentage points higher for women than for men (ECTSS, 2020). In Chile, in the results of the Araucaria Survey (2011), significant differences are seen between men and women in the frequency of psychological violence (10% vs. 12%), physical violence (11% vs. 15%) and sexual violence (1% vs. 2.6%) (Ansoleaga *et al.,* 2015).

Women are more exposed to violence and to sexual aggression in public spaces, such as on transportation and in plazas, parks, streets and places of recreation. In a survey that included 16 cities worldwide, the three most unsafe capital cities for women in public places were Bogotá, Mexico City and Lima[2] (Thompson Reuters Foundation, 2014). Another study, by the United Nations, of cities and safe public places, with a sample of 27 countries, showed that in the city of Quito, 84% of women in the study identified public transportation as unsafe, both because of their own experience of sexual violence and because of the threat that it could occur. Results of a survey conducted in four neighborhoods indicated that, of women who reported having been victims of sexual violence, 77.6% suffered sexual abuse, 21% sexual harassment and 1.5% rape (Rodríguez Yánez *et al.,* 2021). The vast majority of these cases (93.4%) occurred during the use of public transportation and the rest (6.6%) in public spaces. In Mexico, 54.4% of women felt very unsafe on public transportation, while 69.1% felt unsafe in streets and public spaces (UN Women, 2017; UN Women, 2018a; OCLAC, 2014; USAID, 2020b). Also in Mexico, 34.3% of women ages 15 or over have experienced sexual violence in public spaces during their lives and 20.2% in the past 12 months. This occurred in the street and in parks (65.3%), and to a lesser degree on buses (13.2%) and in the metro (6.5%), among other places (INEGI, 2016). In Uruguay, 54.4% of women have experienced situations of GBV in public spaces during their lives (INE, 2020).

[2] Buenos Aires is also among the 16 most unsafe Latin American capitals. It ranks sixth.

Digital violence, or cyberviolence, against women and girls has become increasingly common, particularly with the daily and generalized use of the internet, social networks and other technological applications (UN, 2018c). Worldwide, 23% of women said they had suffered abuse or harassment online at least once in their lives, and one out of every 10 women age 15 or over has been the victim of some form of digital violence (UN Women, 2020b). Women ages 18-24 have a high probability of suffering sexual harassment as well as physical threats via the internet (Broad Band Commission, 2015). Data are still very scarce in LAC. Nevertheless, in Mexico, according to the results of the National Survey of Availability and Use of Information Technologies in Households *(Encuesta Nacional sobre Disponibilidad y Uso de las Tecnologías de la Información en los Hogares)* (ENDUTIH, 2020), 75% of the population age 12 or over reported having used the internet between July and November 2020. Of that group, 21%, or 16.1 million people, said they had been victims of digital harassment (22.5% women and 19.3% men). In all age groups, women reported more cyber harassment, especially young women ages 12-19 (29.2%) and 20-29 (29%). The situations experienced with greater frequency by the women surveyed were receiving sexual insinuations or propositions (35.9%), being the recipients of sexual content (31.3%), contacts via false identities (33.4%) and being the object of offensive messages (32.8%). Finally, accelerated digitalization during the COVID-19 pandemic was accompanied by a 74% increase in cybercrimes in Latin America, which exposed women and girls to greater risk of being victims of sextortion, receiving unsolicited pornographic videos or being recruited by trafficking networks (Vera Morales, 2021; UN Women, 2020b).

All forms of trafficking, especially that aimed at sexual exploitation, constitute one of the most extreme expressions of violence against women (VAW). Because of its strategic location, the region stands out as a point of origin, transit and destination of victims of human trafficking and related crimes (Contreras *et al.,* 2010). In North America,[3] Central America and the Caribbean, sexual exploitation is the most commonly detected form of trafficking (more than 70%). It is also one of the highest worldwide. In Central America and the Caribbean, most of the victims detected in 2018 were girls and women, representing 79% of all trafficking victims detected in this subregion.

[3] The report includes Canada, the United States and Mexico in the North American region.

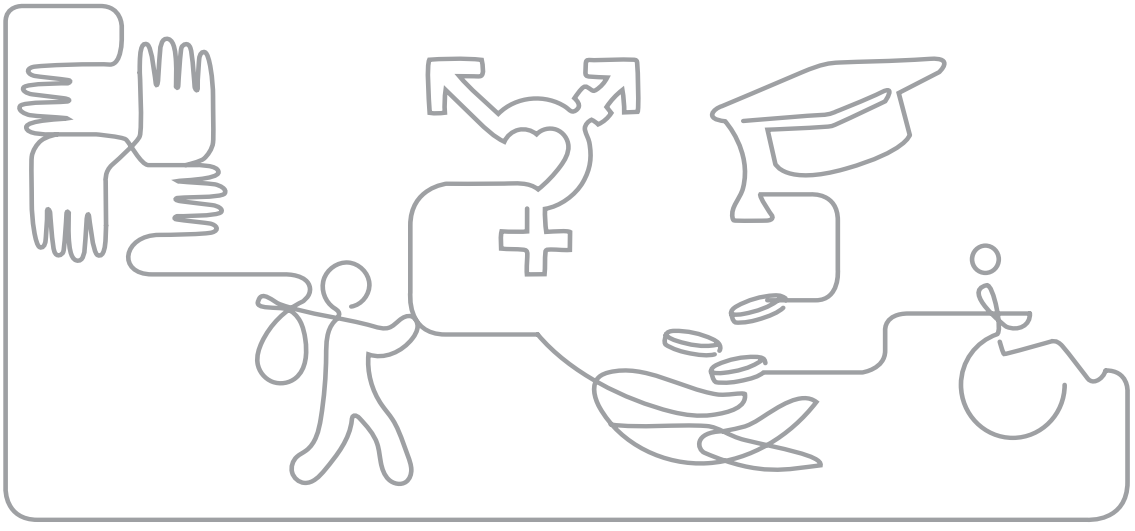
In particular, the share of girls as a proportion of the total detected victims (40%) remains one of the highest in the world.[4] Trafficking for labor exploitation and forced labor is reported in Central America and the Caribbean (13%) and in South America (35%) by victims who have been rescued (UNODC, 2020a). In South America, women represent the majority of trafficking victims: three out of four. The majority of people are victims of trafficking for sexual exploitation (a figure that has increased from 58% in 2016 to 64% in 2018), while more than one-third are victims of trafficking for forced labor. Data from 10 countries that report this information in the subregion[5] of the Southern Cone and the Andean region show that the immense majority of these victims (96%) are women (UNODC, 2020a). In general, people who come from sectors that are more excluded socially or in a situation of vulnerability, such as orphaned children or people without family networks, have a greater probability of being captured as victims of trafficking(Contreras *et al.*, 2010).

Contexts of economic crisis, natural disasters, conflicts or complex emergencies increase the situation of vulnerability and violence against women and girls. The first systematic review of the link between natural disasters and VAWG shows an association between exposure to catastrophes and an increase in VAWG, or at least connections with some types of violence (Thurston *et al.*, 2021). Despite being the region second most prone to natural disasters (OCHA, 2020), statistical information for LAC is limited. It should be noted that in Haiti, some studies show an increase in VAWG after the 2010 earthquake (Weitzman and Behrman, 2016; Kolbe *et al.*, 2010). Another study shows very similar levels of violence before (71.2%) and after (75%) the earthquake, although it notes that abused women reported a significantly greater number of mental and physical health problems than those who were not abused (Campbell *et al.*, 2016). In addition, a study that examined the long-term effect of internal displacement did not detect changes in physical, emotional and sexual violence against children two years after the earthquake in the last 12 months of the study (Cerna-Turoff *et al.*, 2020). Also, during epidemic outbreaks in which lockdown measures were adopted, as was

[4] In 2018, of every 10 victims detected worldwide, five were adult women and two were girls. Approximately one-third of all victims detected were minors, both girls (19%) and boys (15%), while 20% were adult men (UNODC, 2019).
[5] Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela.

the case during the Ebola crisis of 2014-2016 in Western Africa, women and girls suffered more violence and sexual exploitation (Onyango *et al.,* 2019), and currently, during the COVID-19 pandemic, levels of IPV have increased (Perez-Vincent *et al.,* 2021).

Although women and girls make up the majority of victims, conflict situations can also lead to sexual violence against men and boys (Chynoweth, 2017). The most common types of sexual violence experienced by men are individual or gang rape, genital mutilation and electric shocks to the genitals, and sexual torture or humiliation. There are few studies of prevalence but reports and studies confirm that men and boys have been victims of conflict-related sexual violence in various countries, such as the former Yugoslavia, Democratic Republic of Congo, Liberia, Burundi and Colombia, among others (UN, 2019; Johnson *et al.,* 2010; Mudrovcic, 2001). In Colombia, the National Victims Unit recorded 103 cases of conflict-related sexual violence in 2015, in which 3% of the victims were men (UN, 2016). More recently, 60 men who were victims of violence during the armed conflict reported the crime to authorities (UIA, 2021). Nevertheless, prevalence data could be underestimating cases, given that male victims of violence could be less prone to seeking assistance because of a series of specific factors related to the context and the culture, such as shame, fear of being discovered by the community and consequent social stigma, fear of reprisals, and fear of been arrested in situations in which relations between people of the same sex are penalized (Young *et al.,* 2016).



SGBV is aggravated when more than one dimension coincide, such as race, ethnicity, disability, migratory status, sexual orientation, gender identity, geography and age, among others. Although women are half the population, they are far from a homogeneous group, and therefore it is necessary to analyze SGBV from an intersectional standpoint (Crenshaw, 1991; ECLAC, 2018; Guedes *et al.,* 2019). Intersectionality describes a phenomenon by which each individual suffers oppression or has certain privileges based on their membership in multiple social categories (Crenshaw, 1989). It is an analytical framework for understanding a complex system of identity structures that are multiple and simultaneous, and which result in discrimination against a particular person or an entire human group (AWID, 2004). In this light, the prevalence of SGBV must be addressed through an intersectional lens. However, there also is a lack of official data broken down by different populations and ethnic-racial identity, age, diverse gender identities or other groups. The following are data available for some diverse groups:

- **Women with disabilities.**[6] Women with disabilities experience higher levels of violence than their peers without disabilities. Those most affected are young women and those with psychological disabilities.[7] Although disabilities affect older people more,[8] violence tends to be aimed more at younger people (Marques García *et al.,* 2019). Thus, according to a study by UNFPA (2018), for young women and girls with disabilities, the risk of facing violence is as much as 10 times that of those without disabilities.

[6] Around 12.5% of the population in LAC lives with some type of disability, whether visible or not visible, physical or psychosocial. This would represent at least 70 million people in the region (ECLAC, 2013; WHO, 2011; Marques García *et al.,* 2019). Persons with disabilities include those who have long-term physical, mental, intellectual or sensory deficiencies that, upon interacting with various barriers, can impede their full and effective participation in society, under equal conditions with others (Convention on the Rights of Persons with Disabilities, Art. 1).

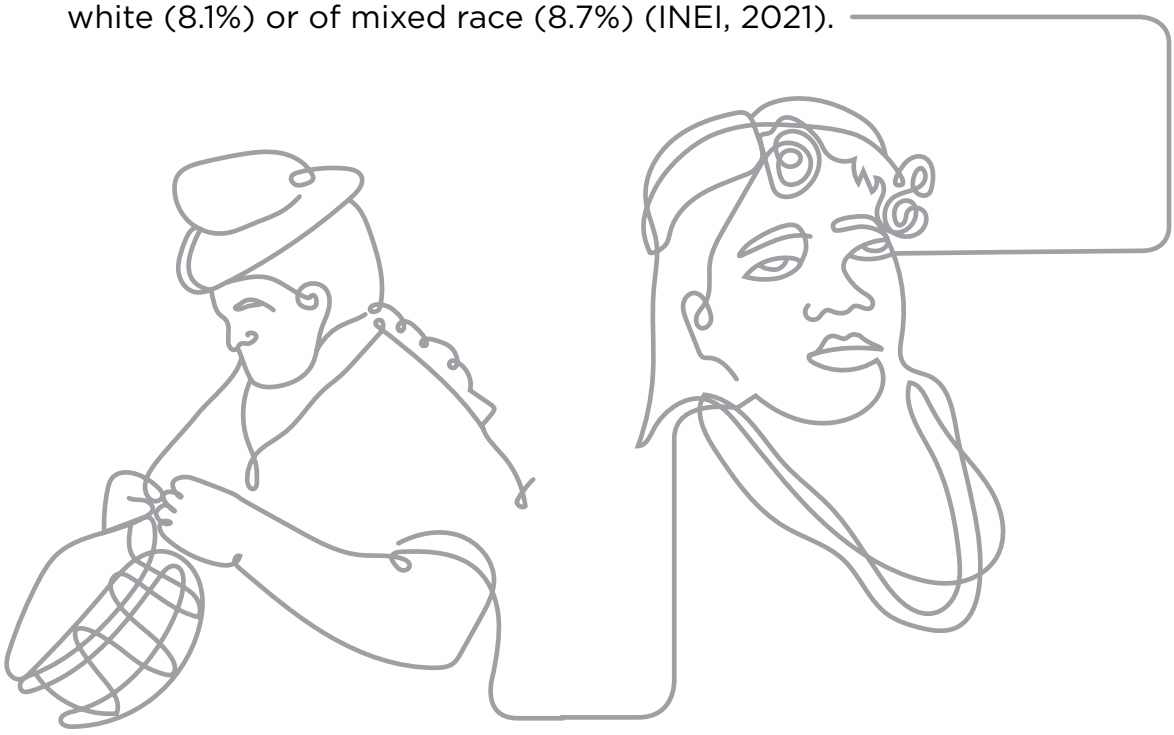
[7] In general, the risk of suffering violence is greater for women with disabilities because of various factors, including the following: fewer years of study because of stigmatization or a lack of resources or support that make it difficult to finish; greater workplace discrimination because of biases or lack of a workplace and business focus on inclusion and accessibility; greater dependence on care and the expense of medical needs and medications, including for their partners or families; forced marriage or sterilization; and discrimination because of gender, sex and affectivity roles related to their disability (UNFPA, 2018; WHO, 2011). In addition, social isolation and the lack of credibility that women with disabilities must face on the part of institutions contribute to increasing the aggressor's degree of power, control and impunity.

[8] Throughout the region, the prevalence rate of disability is four to six times higher in people between ages 60-69, compared to those in their 20s, and the prevalence in the population age 60 and over exceeds 40% in many countries (Duryea *et al.,* 2019).

It is also estimated that intimate partner violence is twice as frequent among women with disabilities than among their peers without disabilities (UN, 2012). In LAC, despite specific surveys about disabilities or others that ask about this situation, most do not formulate questions about violence against this group (Marques García *et al.,* 2019). The exceptions are Colombia, Uruguay and Costa Rica.[9] In Colombia, 72% of women with disabilities who have been married or have lived with a partner have suffered at least one type of violence (psychological, physical, sexual or economic) from their partner during their lives, compared with 67% of women without disabilities (Marques García *et al.,* 2019). In Costa Rica, the results of the National Disabilities Survey *(Encuesta Nacional de Discapacidades)* (END, 2018) indicate that while 5.9% of men with disabilities said they had been the object of a violent act of a sexual nature, for women that figure rises to 20.5%. In addition, 11.1% of women with disabilities suffer coercion in the management of their assets, 8.1% have been refused some medical service, and 4.4% have been denied general services such as health or food (UNFPA, 2021). These data show that the violence to which women with disabilities are subject is manifested in multiple ways in their nuclear and extended family and in the wider community, a situation that is exacerbated by the extremely limited opportunities for obtaining assistance (UNFPA, 2018; UN, 2017; Hughes *et al.,* 2012; Marques García *et al.,* 2019). It is also important to keep in mind the cycle of violence itself, because its effects could cause a new disability or exacerbate a pre-existing disability, especially in mental health cases (Dunkle *et al.,* 2018).

[9] In Uruguay, the Second National GBV Prevalence and Generations Survey generated information about how GBV affects women with disabilities (INE, 2020). Guatemala, Mexico, Peru and Chile have specific surveys about disabilities, but they do not include questions related to VAW (Marques García, 2019).

- **Indigenous women.**[10] A few national studies make it possible to understand the scope of the problem of SGBV in this group of women. In Mexico, 59% of indigenous women have experienced some type of violence (emotional, physical, sexual, economic, patrimonial or workplace discrimination) during their lives (INPI, 2017). In Peru, around 38% of indigenous women have suffered physical or sexual violence perpetrated by a partner at some time.[11] This is also the case for 24% of indigenous women in Guatemala and 20% in Paraguay (ECLAC, 2013). In Ecuador, the prevalence of violence during the life of indigenous women age 15 or over is 64%. This is the group with the third-highest rate after Afro-Ecuadorian women (71.8%) and mixed-race women (65.1%). In the family sphere, however, indigenous women show higher figures (25.1%), 4.8 percentage points more than for women who self-identify as being of mixed race (INEC, 2019). In Peru, physical or sexual violence within the past 12 months was mentioned by a higher percentage of women who self-identified as indigenous (9.6%) and by a lower percentage of women who identified as Black, morena, zamba, mulatta, Afro-Peruvian or of African descent (7.4%), white (8.1%) or of mixed race (8.7%) (INEI, 2021).



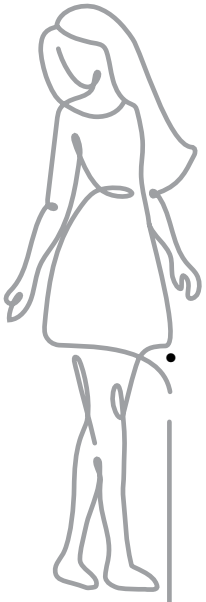
[10] In LAC there are around 54 million indigenous people, representing about 9.8% of the total population. An estimated 26 million are women (IDB, 2019; IACHR, 2017).
[11] See Agüero (2018), whose study sought to understand the evolution of violence and its intersection with ethnicity, analyzing the Family Health and Demographics Surveys *(Encuestas Demográficas y de Salud Familiar, ENDES)* in Peru in 2000-2012. It uses the spoken language to identify ethnic groups (indigenous, recent Spanish and old Spanish).

- **Women of African descent.**[12] Racial discrimination combines with gender violence and accentuates experiences of violence toward women of African descent.[13] In Ecuador, the percentage of Afro-Ecuadorian women who report having suffered some type of gender violence at some time in their lives is as much as 6.7 and 7.8 percentage points higher than for their mixed-race or indigenous peers, respectively (INEC, 2019). In Uruguay, 86.1% of women of African descent age 15 or over have experienced situations of GBV during their lives, compared to 75.1% of women not of African descent. The type of violence with the greatest prevalence is psychological (44.6%) and the proportion of women who reported having suffered it is 15.5 percentage points higher for women of African descent than for those not of African descent[14] (INE, 2020). In Brazil, the percentage of women who define themselves as brown *(parda)* and report having suffered levels of physical violence (76%) is higher than for women who self-identify as black *(preta)* (65%) or white *(blanca)* (57%). This phenomenon is repeated with sexual violence, where brown (17%) and black (27%) women suffer higher rates compared to white women (11%) (DataSenado and OMV, 2017). In Suriname, the experience of physical IPV at some time in a woman's life was greater among women who identified as Creole/African (34%) compared to women of any other ethnic group, including mixed (30%), Hindustani (28%), Maroon/Boslandcreeol (26%) and Javanese (20%) (Joseph *et al.,* 2019).

- **LGBTQ+ people.**[15] Although there have been advances in the situation of LGBTQ+ people in LAC in terms of legislation and recognition, there is still victimization and generalized discrimination, which make them more vulnerable to violence (IDB, 2017). According to the Trans Murder Monitoring Project *(Observatorio de Personas Trans Asesinadas)*, nearly 80% of crimes against trans persons reported

[12] It is calculated that of the 150 million people of African descent in LAC, half are women, a population that oscillates between 10% in Central America and some 50% in Brazil and the Caribbean (ECLAC, 2018; IDB, 2019).
[13] For example, in Brazil in 2006-2016, the homicide rate for women of African descent was 71% greater than for women who were not of that ethnic-racial origin. In addition, the proportion of women of African descent among all women who died from violence increased from 54.8% in 2005 to 65.3% in 2015 (ECLAC, 2017b).
[14] The proportion of Afro-Uruguayan women who experienced GBV was also greater than for women not of African descent in all spheres studied: public places, 43.7% vs. 35.3%; workplace, 18.2% vs. 14.1%; and schools, 16% vs. 7.5% (INE, 2013).
[15] Estimates for LGBTQ+ persons are very limited in LAC, even for the approximate percentage of the total in the region, which falls between 2.4% and 7% of the population (IDB, 2019; IDB, 2017).

worldwide between 2008 and 2019 — 2,608 deaths out of a total of 3,314 murders of trans and gender-diverse persons — were perpetrated in Latin American countries (ILGALAC, 2020). In addition, a report published by a regional observatory on violence about LGBTI persons, the *Observatorio Latinoamericano Sin Violencia* LGBTI[16] (2019), with data from nine countries, reported that the countries registering the most murders of LGBTI persons between January 2014 and June 2019 were Colombia (542), Mexico (402) and Honduras (164). In Chile, 18.5% of LGBTIQ+ people age 15 or over have been attacked sexually at some time in their lives for being perceived as an LGBTIQ+ person (MISP, 2021). The personal experiences of victimization of LGBTIQ+ persons in Chile mainly occur in public spaces, such as streets, parks or transportation (20.6%), social networks (17.2%), and in the home (12.5%) (MISP, 2021). In Uruguay, 92.5% of non-heterosexual women age 15 or over have experienced a situation of GBV during their lives, compared with 76.3% of heterosexual women (INE, 2020). A study reporting the results of interviews with 278 sex workers, gay men and transgender women in Barbados, El Salvador, Trinidad and Tobago, and Haiti indicated that nearly all experienced some form of SGBV. Psychological and economic violence were the most frequent forms, although approximately three-quarters of those interviewed reported sexual and physical violence (Evens *et al.,* 2019).



- **Children and adolescent**.[17] Severe physical punishment of children is a common phenomenon in LAC. The prevalence of violence against children and adolescents (up to age 19) in LAC ranges between 30% and 60% and decreases with age (Devries *et al.,* 2019). In Haiti, however, the figures exceed that range, showing that 67% of children have suffered physical violence at the hands of an adult responsible for their care or a public authority. It is also worth noting that the prevalence does not differ between boys and girls (Flynn-O'Brien, 2016). In four countries (Belize, Bolivia, Jamaica and St. Lucia), the incidence of corporal punishment is 40% or more (Berlinsky and Schady, 2015).

[16] This study took into consideration the homicide information reported by nine of the 10 countries that are part of the network (Colombia, Mexico, Honduras, Peru, El Salvador, Dominican Republic, Guatemala, Paraguay, Bolivia). Brazil will be included in the next report, given the possibility that it could rank first in violence-related deaths of LGBTI people, based on estimates from unofficial sources (ILGALAC, 2020).

[17] Children from age 0-14 represent 24% of the population of LAC, with girls representing 49% of that total (World Bank, 2020). The age ranges for early childhood, childhood and adolescence vary from country to country. This document follows WHO guidelines, which consider early childhood to be 0-4 years, childhood 5-9 years and adolescence 10-19 years. The latter is divided into two stages: early adolescence (10-14 years) and late adolescence (15-19 years).

Children and adolescents also suffer from sexual abuse, and although the data about prevalence are limited, statistical information from the VACS in different countries shows that in Honduras, 16% of girls and 10% of boys experienced sexual violence before age 18. The same is reported in Colombia and El Salvador, with 15% and 14% of girls, respectively, and 8% and 3% of Colombian and Salvadoran boys, respectively, having suffered sexual abuse before age 18 (PAHO, 2020). Several studies in the Caribbean have found relatively high rates of sexual violence against adolescents and young adults. For example, one study found that 39.6%, 57.3% and 52.5% of males between ages 15 and 30 in Barbados, Jamaica, and Trinidad and Tobago, respectively, had suffered sexual abuse at some point in their lives (Le Franc *et al.,* 2008). The aggressors tend to be people known to the victim, often trusted caregivers, such as parents, stepparents, relatives, friends or neighbors (Speizer *et al.,* 2008; Jewkes *et al.,* 2002; WHO, 2018b).

- **Older women.**[18] The prevalence of abuse and violence against this population in a situation of high vulnerability is virtually invisible. Besides the lack of data,[19] it is treated as a homogeneous group, classified as "elder abuse." Countries such as Argentina, Chile and Costa Rica have approved laws for protection of older adults or have adapted judiciary services to their particular needs and with a gender perspective (IACHR, 2019). In Uruguay, the percentage of women age 65 or over who experienced situations of GBV increased slightly, from 9.5% in 2013 to 9.8% in 2019 (INE, 2020). In Ecuador, the prevalence of violence in the past 12 months against women age 65 or over was 16.6% (INEC, 2019). In Chile, older adult women reported having suffered psychological violence (9.3%), physical violence (0.9%) and sexual violence (0.6%) in the past year (MISP, 2020). In Mexico, 17.3% of women age 60 or over had suffered emotional violence (15.2%), economic violence (6.3%) or physical violence (1.2%) (INEGI, 2016). A report from the 144 hotline in the province of Buenos Aires, Argentina, showed that during 2020, a total of 1,581 calls were reported for the over age 60 group.

[18] LAC is the region with the second-fastest rate of aging of its population. The population age 65 and over represents 9% of the total population, with 56% women, and by 2050, in just 35 years, it is estimated that one out of every four inhabitants of LAC will be over age 60.
[19] USAID's DHS and the CDC's RHS include women ages 15-49 and omit this part of the population.

These represented 9% of all calls about gender violence received by Line 144 in that province that year. It should be noted that 99.9% of the callers were women. That same year, women over age 60 represented 5.6% (16 of 287) of feminicide victims (MMPGDS, 2020).

- **Women in poverty.**[20] Studies in different regions of the world show that women who live in a situation of poverty have a greater probability of being affected by partner violence and sexual violence (Ellsberg and Heise, 2005; ECLAC-UNIFEM, 2004). In addition, the normalization of IPV situations is greater among women and people in rural areas or in socioeconomically disadvantaged situations (Bucheli and Rossi, 2019). Although violence occurs in all socioeconomic strata, women and girls in the two lowest quintiles of income distribution have a greater probability of having had unwanted sexual relations (Baker *et al.,* 2021). For example, in Uruguay, 24.1% of women ages 15 or over of a low socioeconomic level report GBV situations in their current family, a figure that drops to 18.3% for women at a medium level and 14.9% for the highest income level (INE, 2020).

- **Educational level.** Evidence shows that the level of education conditions the risk of being a victim of violence. Generally, the higher the educational level, the lower the risk of being a victim (Contreras *et al.,* 2010). Women's education also is positively associated with greater participation in decisions related to reproductive health and sexual relations with husbands or partners (Baker *et al.,* 2021). In some situations, however, women who have completed primary education report more violence, which could be because they begin to seek other educational and labor opportunities and therefore question traditional roles (Jewkes *et al.,* 2002 in Contreras *et al.,* 2010). For example, surveys in Bolivia, Colombia and Peru show that the risk of suffering sexual violence decreases as the woman's educational level increases; in Haiti and the Dominican Republic, however, the rate of sexual IPV is greater among women who have some primary education than those who have no education (Hindin *et al.,* 2008; Contreras *et al.,* 2010).

[20] In 2019, for every 100 men living in poor households in the region, there were 112.7 women in a similar situation (ECLAC, 2019). It is estimated that the crisis caused by COVID-19 will leave 118 million women in Latin America in a situation of poverty, 23 million more than in 2019 (ECLAC, 2021). Poverty does not affect urban and rural women in the same way, because in rural areas, access to income and basic services is limited (World Bank, 2015).

Finally, the woman's educational level in relation to that of her husband or partner also influences the probability of experiencing SGBV. Data indicate that a woman with a lower educational level than that of her husband or partner has a greater probability of suffering sexual violence than a woman whose educational level is similar to or higher than that of her husband (Baker *et al.,* 2021; Agüero, 2018).

- **Migrant or refugee women.**[21] Difficulties along the migratory route can increase the risk of suffering SGBV because of misinformation, lack of income, scant availability of safe refuges, absence of protective services, fear of reporting to institutions or the presence of human trafficking networks, among other things (UN Women, 2018a; SICA, 2016). In a context of high vulnerability, sexual violence and transactional sex in exchange for refuge, protection or money can affect the journey for many people. It is estimated that six out of every 10 women who are transiting the world's migration corridors suffer some type of sexual violence. One example in the region is the Northern Triangle of Central America — Guatemala, Honduras and El Salvador — on the way to Mexico, which is especially dangerous for women (Herrera Sánchez, 2014 in UN Women, 2018a; Granada *et al.,* 2021). Considering only rape and other forms of direct sexual violence, of the 429 migrants and refugees who responded to the survey, 10.7% of women and 4.4% of men were victims during their transit through Mexico (Médecins Sans Frontiéres, 2017). Nevertheless, violence is encountered not only on the journey, but also at the destination; for example, in Uruguay, a greater proportion of migrant women age 15 or over have suffered some GBV situation in the past 12 months, compared to Uruguayan women, in both the social sphere (59.6% of migrant women vs. 54.2% of Uruguayan women) and the workplace (21.4% of migrant women vs. 17.8% of Uruguayan women) (INE, 2020).

[21] In LAC, the proportion of international migrant women (50.7%) slightly exceeds that of men in the same situation (49.3%), a percentage similar to that of migrant women globally, who represent nearly half of the 272 million international migrants (IOM, 2020).

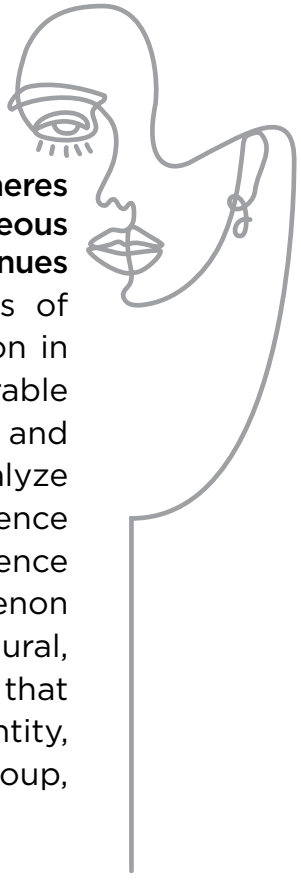
Box 1. Did you know that ...

... intimate partner violence increases during major sporting events? This phenomenon has been observed worldwide and has been documented in different countries, including England, the United States, Belgium, South Africa and several countries in Latin America (Economist, 2021). In Costa Rica, complaints of episodes of attacks against women increased by 75% on the last day of the national first-division soccer championship in 2018 (Observatorio de Violencia, 2018), and in El Salvador they increased by 30% when there were soccer games in which the national team or the most popular teams played (Fundación Justicia y Género, 2019). In Colombia, according to figures from the National Institute of Legal Medicine *(Instituto Nacional de Medicina Legal),* cases of IPV against women increased, on average, by 38% and 25% on days of a World Cup game featuring the Colombian national team in 2014 and 2018, respectively. They also increased by nearly 50% during the Americas Cup in 2015, in comparison with days on which the national team did not play. In a study of triggers of violence related to sporting events in England, the increase in violence was attributed to excessive alcohol consumption by the perpetrators (Ivandic *et al.,* 2021). The authors analyzed 523,546 cases of IPV reported to police in Manchester between 2012 and 2019 and found that cases of IPV decreased by 5% during the game, but increased after the game ended, reaching a peak 10 to 12 hours afterward, regardless of whether England had won or lost. Another study in England found that IPV increased by 26% when the national team won and by 38% when it lost (Kirby *et al.,* 2014). In the United States, IPV increased by 10% after the Super Bowl when the U.S. football team that was expected to win had lost, while there was no significant change related to whether the team that was expected to lose won or lost (Card and Dahl, 2011).

... domestic violence is related to increases in the real exchange rate? One study found that an increase in the exchange rate, by increasing the value of tradable goods, reduces the relative wage power of women (compared to men), who are underrepresented in the non-tradable sector, and their negotiating power in the household. As a consequence, this causes increases in the frequency of partner violence, understood as physical, sexual, economic and emotional, in high- and low-income areas in Montevideo, Uruguay (Munyo and Rossi, 2015).

... violence against women skyrocketed during the lockdowns caused by the COVID-19 pandemic? The measures taken to contain the propagation of the virus — quarantine lockdowns, social distancing, school and office closures, or reducing capacity in women's shelters — have had negative effects on the ability to respond to and prevent SGBV and have exposed millions of women and girls to riskier situations and to more time living with their aggressors. Although complaints decreased at the start of the pandemic, this was due to the difficulty of seeking assistance and not to a reduction in the prevalence of violence (Evans *et al.,* 2020; ECLAC, 2020a). Many countries and organizations responded to this situation by expanding hotline capacity. Data indicate an increase in complaints and cases of violence, whose magnitude rates from 10-15% in Paraguay, to 60% in Mexico and as much as 70% in Chile (López-Calva, 2020; Polischuk and Fay, 2020, in Aguayo *et al.,* 2021; Bustelo *et al.,* 2020). In the city of Buenos Aires, calls to the hotline for victims of domestic violence increased by 32% after the introduction of restrictions on movement (Perez-Vincent *et al.,* 2021). The same study compared women whose partners were exempt from the quarantine with those whose partners were required to comply and found a positive relationship between the obligation to comply with the quarantine and partner violence.

Conceptual elements for addressing SGBV



SGBV is a phenomenon that manifests itself in multiple spheres of public and private life, which does not have a homogeneous impact on all people and about which knowledge continues to increase. The fact that there are diverse conceptions of terms related to gender-based violence implies a limitation in establishing operational definitions, consistent and comparable measurements, or consensus about best practices (Ellsberg and Heise, 2005; Contreras *et al.,* 2010). This section will analyze the different terminologies referring to gender-based violence and will propose the use of sexual and gender-based violence (SGBV) as an umbrella concept, as it describes the phenomenon in a broad way that includes the series of dimensions (structural, political, institutional, regulatory, symbolic and subjective) that differentiate people by their biological sex and gender identity, and which can intersect with social class, age, ethnic group, migratory status, disability or sexual orientation.

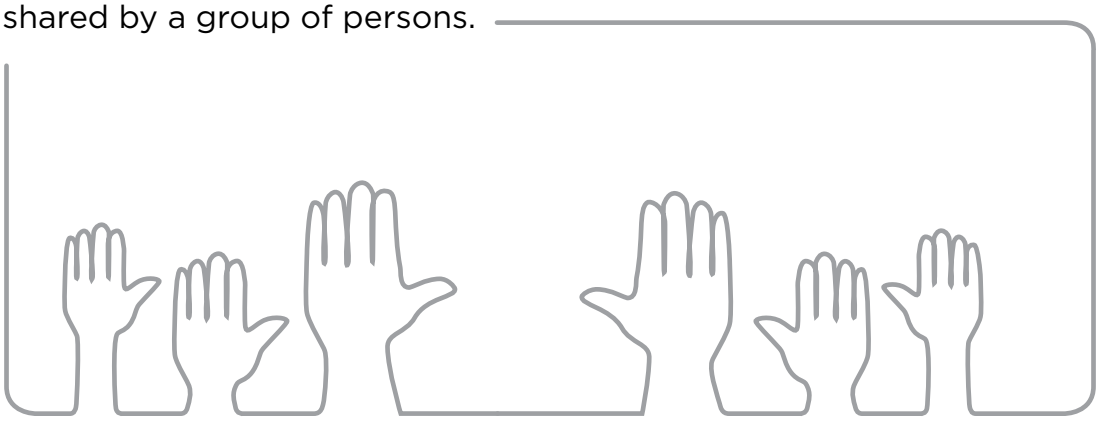
What is understood by sexual and gender-based violence (SGBV)?

- **SGBV refers to any harmful act based on unequal power relations aimed at persons or groups of persons because of their gender, particularly against women and girls.** These acts of violence may be perpetrated by any person, regardless of the relationship the aggressor may have with the victim, and in any sphere or context, whether public, private or virtual.

- **This violence has its origins in a social order that discriminates against women because they are women and which devalues patterns of behavior and roles associated with femininity.** This social structure

creates social inequalities between men and women. SGBV is thus exercised against women as a population group, but also against any collective that violates traditional norms related to sexual orientation and gender identity in society.

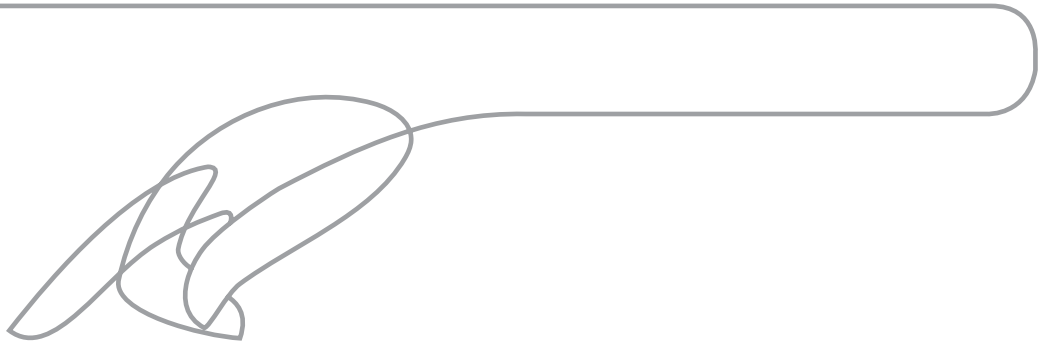
- **The term embraces different types of violence, because it is manifested in various ways and in different spaces.** Examples include physical, psychological, sexual, digital,[22], political,[23] obstetric,[24] institutional,[25] economic,[26] patrimonial,[27] vicarious,[28] social[29] and media[30] violence and trafficking.[31] It is important to note that, in general, these categories do not occur independently, nor are they easily distinguished from one another. This is because the acts of violence, on various levels, influence one another and intersect with individual and social aspects that give rise to experiences of violence shared by a group of persons.



[22] Violence committed or aggravated through the total or partial use of ICTs, such as telephones, internet, social networks, mobile apps, electronic mail, etc. It is manifested in acts of harassment; threats; hate messages; distribution of information, photos or videos without consent; and the use of these media to capture victims of human trafficking.
[23] Violence against women who are candidates, elected, appointed or exercising a public-political function, or against their families, with the purpose of influencing, cutting off, suspending, impeding or constraining the functions inherent to their position.
[24] Violence exercised by healthcare professionals (predominantly doctors and nursing personnel) toward women who are pregnant, in labor or post-partum.
[25] Violence exercised by the State, community member or family member that prevents women from exercising their political rights, including the right to vote and hold public office, to freely campaign, to associate and assemble, and to enjoy freedom of expression.
[26] Violence exercised through the impediment, limitation or control of income or wage autonomy or job performance.
[27] Appropriation, denial or destruction of goods, objects or property. Removal, transformation, control or illegitimate concealment of documents or property-related economic resources.
[28] Instrumental violence to intimidate and harm a victim by exercising physical, psychological or other violence against the person's children, animals or other people important to the victim, with the goal of making her suffer more.
[29] Violence exercised by controlling the victim and inducing her to social isolation through separation from her customary environment, family, friends or situation of trust and security.
[30] Violence exercised through stereotypes, messages, values or any role of subordination or objectification of women and other gender identities in mass communication media or publicity.
[31] Violence exercised through the capture and exploitation of persons by means of force, fraud, coercion or deception. Trafficking can be for sexual or labor purposes.

Why use SGBV as a conceptual umbrella?

The use of SGBV makes it possible to adopt an inclusive approach to the diversity of gender identity, sexual orientation and gender expression. Gender-based violence is not limited only to women and girls as victims of violence, although statistics show that they represent the great majority of those who suffer discrimination and violence based on their gender and associated roles. Nevertheless, the term SGBV makes visible the fact that men and boys can also be victims of violence, and other forms of discrimination because of their associated roles, although above all it considers the realities of victimization and violence aimed at persons with diverse and non-binary gender identities and expressions. The term also makes it possible to adopt a broader approach to the multiple types of violence that are perpetrated, including those of a sexual, physical, economic, psychological or other nature.

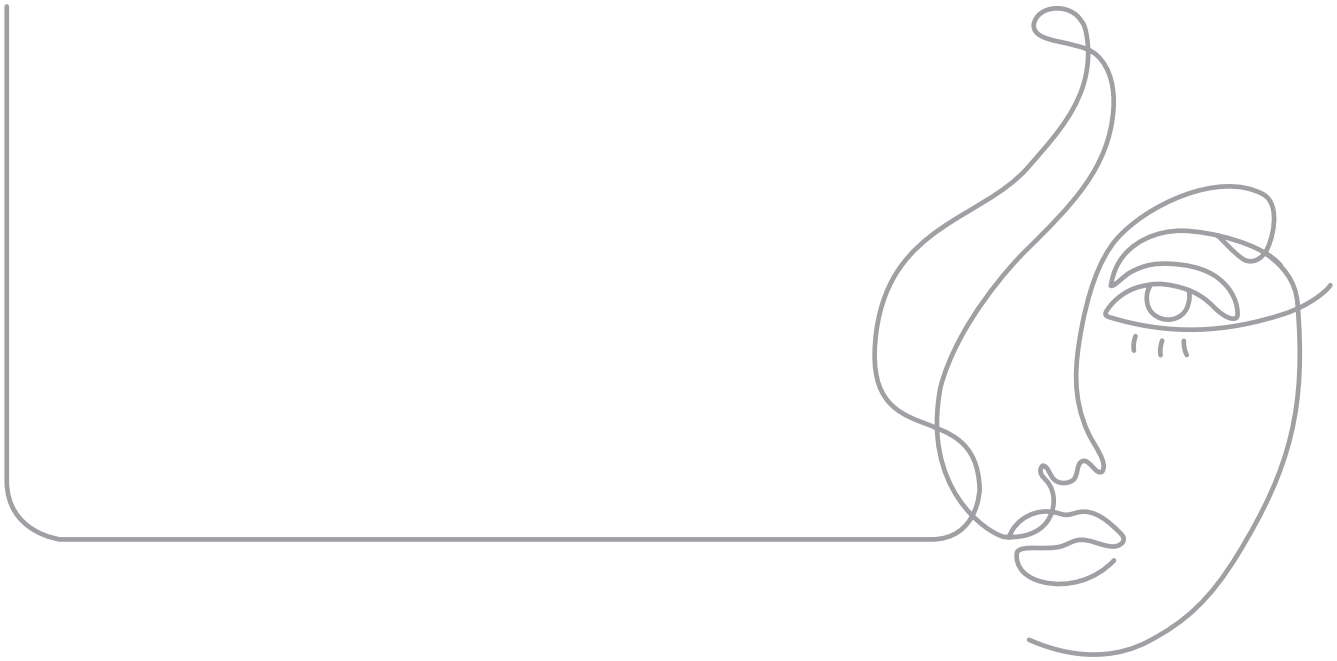


In saying that the concept of SGBV is an umbrella concept, we mean that it includes the following terms:

Violence against women (VAW)	**VAW is any type of violence exercised against a woman because she is a woman.** According to the Declaration on the Elimination of Violence Against Women, adopted by the UN in 1993, *violence against women* is understood as any act of violence based on belonging to the feminine sex, which results or could result in physical, sexual or psychological suffering or harm to the woman, as well as the threat of such acts, coercion or arbitrary deprivation of liberty, whether in public or private life.
Gender-based violence/Gender violence (GBV)	**GBV allows a broader view of who suffers this type of violence and why.** Besides recognizing that this is mainly violence aimed by men against women, it makes it possible to take into account other situations of gender-based violence against persons who do not fit into the binary sex/gender scheme.
Intrafamily violence (IV)/Domestic violence[32]	**This is violence that occurs between members of a family, which can take place within or outside of the domestic sphere.** This occurs when there are situations of abuse or mistreatment among people who are related by blood or affinity. It includes abusive relationships that cause physical, sexual or psychological harm, including physical aggression, intimate partner violence, sexual coercion, psychological abuse and controlling behaviors in the household. It can be exercised against women, men, girls, boys or older adults, as well as against persons with disabilities or with diverse sexual orientations and identities and gender expressions.
Sexual violence	**Sexual violence mainly refers to acts of sexualized violence,** that is, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (WHO, 2013). Emphasized are rape — within or outside of a couple relationship — as well as sexual aggression, forced pregnancy, sterilization, trafficking and sexual exploitation, among other forms.
Femicide/Feminicide[33]	**Violent death of women for gender reasons,** that is, because of being a woman. This can occur within the couple or family, in the street, at work, in the community, and by anyone. It may be intimate femicide — that is, murder committed by a current or former husband, partner or boyfriend — or it could be non-intimate femicide or murder committed by a stranger against a woman because of the simple fact that she is a woman (OAS, 2008).

[32] Not all domestic or intrafamily violence is gender based. It could have other conditioning factors or elements of analysis.
[33] In Latin American feminist literature, there is a rich debate about these two terms. In general, there are two schools of thought: one in which femicide refers to the murder of a woman because she is a woman, which emerges as an alternative to the neutral term "homicide" (Russell, 2008), and a second, in which feminicide aims to emphasize the role of the State in its responsibility for preventing, addressing and prosecuting femicide (Largarde, 2006). In this document, the choice has been made to use the term feminicide.

Homophobic, transphobic (or LGBTI-phobic) violence[34]	**This is violence against persons because of their sexual orientation or their gender identity, including violence against lesbian, gay, bisexual and transgender persons.** These acts of violence range from aggressive and ongoing psychological intimidation to sexual or physical aggression, torture, kidnapping and selective murder. The violence occurs in a variety of spheres: in the street, public parks, schools, workplaces, private homes, prisons and police detention cells (ICJ, 2007).

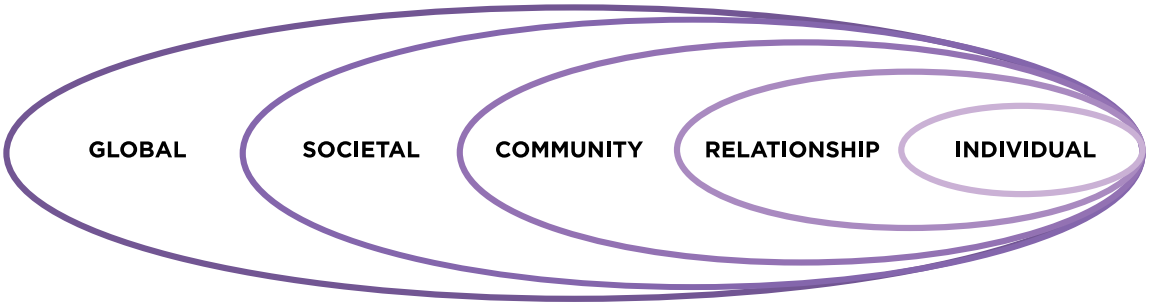


Conceptual framework for analysis of the causes of SGBV

The ecological model offers a conceptual framework to better understand the multiple causes of violence and the interaction among risk factors at the individual and relationship levels and in social, institutional and global spheres (Heise, 1998; Fulu and Miedema, 2015). The model is based on the assumption that every person is immersed daily in various relational levels, and abuse is a product of the interplay of multiple factors in which different expressions and dynamics of violence are produced. These relationships are expressed graphically in concentric structures that represent the most significant contexts for human beings and illustrate how the factors at one level influence the

[34] Not all LGBTI-phobic violence is gender based. It could have other conditioning factors and elements of analysis.

factors at another. Thus, the individual level is related to the person's biological history. This takes into consideration the background of the person's psychological state or self-esteem. At a second level, there is the immediate or family context, friendships and partners, where there is the risk of promoting or accepting aggressive behaviors, addictions or unstable environments for the person. At a third level, the community or surrounding environment is analyzed, where neighbors, the school, the workplace and other spaces of habitual interchange are analyzed to evaluate factors such as insecurity, abandoning formal education, access to basic services or income generation. A fourth level, the societal or institutional, considers structural elements that encompass the acceptance of cultural patterns harmful to women, weak institutions, the lack of services for preventing and addressing violence, and lack of trust in the State, among others. Finally, there is a global level, which responds to the historical moment in which the person lives, along with conditioning factors such as armed conflict, a natural disaster, high inflation or structural elements.



Ecological Model

The gender perspective is a theory of analysis that aids an understanding that society is structured by gender, as this cuts across the systems of the ecological model through socialization and cultural norms. Violence is a highly complex phenomenon, and the combination of the ecological model approach and the gender perspective provide a better understanding of SGBV (Alencar- Rodrigues and Cantera, 2012).

A road map for preventing and responding to SGBV

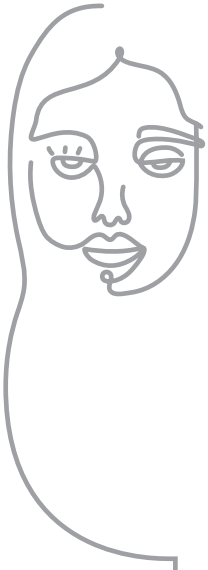
To contribute to the reduction of SGBV in LAC, it is necessary to begin with a conceptual framework that describes how to move from the current situation to the desired impact. The theory of change presented in **Table 1** is based on an analysis of the effect of SGBV on individuals, society and the economy, and the barriers to its prevention and response. To address the barriers, strategic interventions have been identified, based on a review of policies and programs that have rigorous evidence of their effectiveness. These interventions point to achieving results that will contribute to the desired impact — that is, fewer people, particularly women and girls, exposed to SGBV.

Table 1. Theory of change

Impact	Fewer people, particularly women and girls, exposed to SGBV.	
Results	• Greater knowledge and evidence to inform interventions for SGBV prevention and response. • Less acceptance of and greater awareness of SGBV in communities, institutions and society in general. • More women and girls gain access to preventive services and appropriate responses (judicial, economic, medical, psychological, safety, shelter), and have autonomy for accessing these services. • Institutions improve access to and the quality, coverage and multisectoral coordination of violence prevention, as well as mechanisms for filing complaints and services for responding.	
Products	**Policies**	Greater capacity for multisectoral planning and coordination, and greater will and resources allocated to interventions for SGBV prevention and response.
	Institutional	Institutions' capacity to prevent and respond to SGBV is strengthened (training of personnel, provision of services, awareness-raising programs, information systems, action plans, etc.).

	Legal	Judicial system prevents, detects and responds to SGBV with an intercultural and gender focus.
	Socioeconomic	Women, children and adolescents achieve better and greater access to educational services, life skills and opportunities, as well as programs for SGBV prevention and response..
	Knowledge	Data-gathering systems strengthened and more evidence generated about SGBV prevention and response , and scalable strategies developed.
Strategic interventions	Multisectoral and coordinated actions	Promotion of policies, plans and dialogues that foster coordination among parties involved in the design and implementation of policies and programs for addressing SGBV.
	Strengthening of institutions and capacities	Reinforcement of human resources and design of processes for providing preventive services and efficient, high-quality and culturally appropriate responses in the sectors of security, justice, health, psychosocial care, etc.
	Access to and quality of services	Increased access by women and girls to education, health, justice, security and psychosocial assistance services, and consideration of the use of new technologies to maximize access to and quality of provision of services.
	Awareness-raising and behavioral change	Awareness-raising among the population as a whole through the media, networks and communication campaigns, and through educational pedagogies for change. Involvement of men and boys in awareness-raising and behavioral change initiatives related to SGBV.
	Economic, social and political empowerment	Information and training for women and girls about their rights. Promotion of their leadership and provision of job and educational resources for income generation.
	Generation of evidence, data and accountability	Generation of evidence about interventions that work for preventing and responding to SGBV. Reinforcement of national and subnational data-gathering systems. Evaluation of the impact of the programs and policies implemented.
Barriers	Policies	Lack of political will and scant priority given to SGBV as a public problem; limited budgetary resources; underrepresentation of women in decision-making spaces.
	Institutional	Limited, non-existent, ineffective or inadequate access to educational, health, judicial, security and social welfare services aimed at preventing and responding to SGBV.
	Legal	Lack of consistency between regulations and effective implementation of policies, plans or programs that contribute to the elimination of SGBV.
	Socioeconomic	Insufficient economic and decision-making autonomy on the part of women and girls, which increases their vulnerability to violence and decreases their ability to respond.
	Cultural	Social norms and gender roles that perpetuate, support and promote SGBV.
Problem	SGBV and the threat of suffering it in all its forms violates the human right to live a life free of violence and has a negative impact on people's ability to participate in, contribute to and benefit from development. It especially affects women and girls.	

Impact of SGBV on individuals, society and the economy



SGBV has a negative impact on people's ability to participate in, contribute to and benefit from development. Being the victim of violence has negative physical and psychological consequences for the health of women survivors, such as depression, anxiety, suicide and a greater probability of experiencing unwanted pregnancies or consuming drugs and alcohol (Bott *et al.,* 2012; Ellsberg *et al.,* 2015; WHO, 2013, 2021). Women who have suffered physical or sexual abuse also are 1.5 times more likely to suffer from sexually transmitted illnesses, including HIV, than their peers who have not experienced such violence (WHO, 2013). Violence during pregnancy causes a 16% greater likelihood of premature delivery, and 42% of women who have experienced physical or sexual violence from a partner or former partner have had injuries as a result of this violence (WHO, 2021). Data from Central America, the Dominican Republic and Haiti indicate that violence has a negative impact on women's health, as the victims are more likely to use tobacco, report a sexually transmitted illness, have more children (except in Haiti and Guatemala), suffer higher levels of involuntary interruption of pregnancy and have more children die than non-victims (Anglade and Escobar, 2021). It should be noted that it is not only violence that is consummated, but also the risk of suffering violence in the private or public sphere that contributes to sociopsychological impacts that affect people, their patterns of movement, and their educational and job aspirations, among other things (Heise *et al.,* 2002; UN Women, 2017).

There is high intergenerational transmission of violence. Girls who witness violence against their mothers are twice as likely to be victims of violence in their households, and boys are six times as likely to abuse their partner when they are adults (Agüero, 2013; Vargas *et al.,* 2005; Jewkes *et al.,* 2002; Contreras *et al.,* 2010; WHO, 2021). There is also a close relationship between partner violence and violence against children. There is a greater probability that men who are violent with their partners will also be violent with their children (Bott *et al.,* 2012; Holt *et al.,* 2008; Moffitt and Caspi, 2003; Guedes *et al.,* 2016) or that the children will be exposed to neglect or dysfunctional care (Holt *et al.,* 2008; Arcos *et al.,* 2003). Women who suffer violence have a greater probability of engaging in violent child-rearing practices (Fulu *et al.,* 2017). Witnessing violence, even for minors who do not suffer it directly, has emotional and psychological consequences in the short, medium and long term (ECLAC, 2020a; Guedes *et al.,* 2016). Risk factors for children who have experienced violence include tolerance of violence and not aiding those who suffer it, depression, low self-esteem and anxiety, and multiple forms of perpetuation of violence or victimization once they are adults (Stith *et al.,* 2000). In Peru, for example, the children of women who suffer IPV are more vulnerable to illnesses and malnutrition, experience higher levels of diarrhea and anemia, and are shorter than other children (Agüero, 2013). Data from the above-mentioned study in Central America, the Dominican Republic and Haiti also show that the children of victims of violence have a greater probability of suffering anemia and not advancing in school than other children (Anglade and Escobar, 2021). Finally, there are other consequences that can manifest themselves in poor school performance, difficulty in interacting with others and establishing healthy affective bonds, and a predisposition to irresponsible sexual behaviors and chronic mental illnesses (UNICEF, 2016; ECLAC, 2020b).

SGBV not only has costs in human lives, but it also has a high economic cost for the women affected, businesses and the country's overall economy. This takes into account the tangible costs of violence, such as the loss of productivity, failure to comply with work hours and absenteeism for the victim, as well as related costs in health care and legal or psychological assistance, which often are assumed by the victims themselves, who must devote income and time to them (McLaughlin *et al.,* 2017). Studies show that women assume a greater part of the costs of SGBV. For example, one study estimates that the cost of VAW in Ecuador is equivalent to 4.3% of gross domestic product (GDP), of which

49.9% is assumed by the women themselves, their households and their microenterprises; 38.8% is assumed by medium and large enterprises; and 11.3% is assumed by the State (Vara-Horna, 2020). These results are practically identical to those from a study in Paraguay, where 48% was assumed by the women themselves, their households and their microenterprises; 38% by private enterprises; and 13.7%, by the State (Vara-Horna, 2018). Comparatively, the State is the party that assumes the least cost, but its indirect losses are much greater, if the opportunity cost of fiscal revenue, which in Ecuador is estimated at 0.41% of GDP, is considered (Vara-Horna, 2020). Finally, the economic cost of violence against women as a percentage of GDP varies among countries: Bolivia (6.46%), Ecuador (4.3%), Paraguay (5.2%), El Salvador (11.5%), Guatemala (7.5%) or Colombia (4.2%) (Vara-Horna, 2015, 2020, 2018; UNDP, 2006; Ribero and Sánchez, 2005).

Barriers to preventing and responding to SGBV

Barriers of access and quality in the supply of services for addressing SGBV are among the main reasons why many women do not seek assistance or file a complaint about an SGBV situation. As a result, worldwide less than 40% of women who experience violence receive some type of assistance (UN, 2015). Evidence suggests that women seek aid from people they know, relatives and friends instead of from institutions, because of the lack of trust or because they do not know how to access assistance, among other reasons (Bott *et al.,* 2012). In Colombia, the 2015 DHS indicates that only 20% of women who were victims of violence filed a complaint with an institution (Marques García *et al.,* 2019). In Argentina, 37.4% of the incidents of violence perpetrated by former or current partners resulted in formal complaints to the police or judicial authorities in 2018 (MJDH, 2019). In Peru, only 15% of victims age 18 or older turned to some institution to request assistance in 2015 (INEI, 2016). In Jamaica and in Trinidad and Tobago, 63% and 69%, respectively, of victims of sexual or physical partner violence did not seek assistance from an institution or aid agency (Pemberton and Joseph, 2018; Watson Williams, 2018). Studies also show that few people who identify as LGBTQ+ file formal complaints or seek assistance from public services because of discrimination and stigmatization by public employees (Evans *et al.,* 2020). For example, in Chile, only 9.2% of LGBTIQ+ persons filed a formal complaint about the most recent episode of victimization by crime, and among the main reasons for not doing so were shame (28.4%), not knowing what a complaint could contain or where to file it (16.9%), and fear of suffering discrimination (7.7%) (MISP, 2021).

Box 2. Why do survivors of SGBV not seek assistance?

Most victims of SGBV do not request support from any institution or file a complaint or accusation with a State authority. Surveys indicate that there are multiple factors (psychological, social, environmental and cognitive) that influence this decision. In some cases, the women believe they can resolve the problem themselves, because they believe that violence is "normal" or that assistance is unnecessary, while others are afraid of the consequences, are embarrassed, think no one will believe them, do not know where or how to denounce the violence, think that the violence will not be repeated, or fear losing their children or ruining their family's reputation (Bott *et al.,* 2012). Some examples:

Mexico: 88.4% of women who experienced physical or sexual violence from an aggressor other than their partner did not seek support from any institution and did not file a complaint or accusation with any authority (INEGI, 2016). Among the main reasons, according to the environment where the violence was perpetrated, were:

- Considered it something that was not important and did not affect her (varies from 34.1% of victims of domestic violence to 49.3% of victims of school-related violence).
- Fear of consequences or threats (varies from 11% of victims of school-related violence to 23.9% of victims of workplace violence).
- Did not know how or where to denounce the violence (varies from 9.1% of victims of domestic violence to 20% of victims of workplace violence).

Suriname: 67% of women who suffered physical or sexual violence did not seek assistance from any institution or aid agency (Joseph *et al.,* 2019).

- 50% said they did not seek assistance for another, unspecified reason.
- 30% did not seek assistance because they see violence as normal or not serious.
- 8% feared threats, consequences or more violence.
- 7% said they were not aware of their options.

Uruguay: Of women who reported GBV perpetrated by their current or most recent partner, 33.7% did not talk to anyone close to them about the situations they experienced (INE, 2020).

- 60.8% considered it unimportant.
- 16.8% did not think it would have consequences.
- 8.5% were embarrassed.
- 7.7% feared the consequences.

Trinidad and Tobago: 69% of women who suffered physical or sexual violence from their partner did not seek assistance from an institution or aid agency (Pemberton and Joseph, 2018).

- 33% did not know why they made that decision or did not respond.
- 17% said the violence was normal or was not serious enough to justify an intervention.
- 9% felt ashamed or thought they would be blamed or would not be believed.

The barriers to the prevention of and response to SGBV can be grouped into five main areas: political, institutional, socioeconomic, legal and cultural. The different categories respond to the difficulties that people face in breaking and escaping the cycle of violence; nevertheless, they are related and interconnected. As the ecological model explains, it is necessary to consider risk factors that operate on different levels — individual, relational, community, societal and global — to examine their combination, the barriers that each pose and how this affects SGBV in a particular context (Heise, 1998; Morrison *et al.,* 2007).

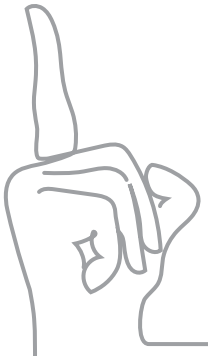
1. **Political barriers.** Taken together, these limit the priority placed on SGBV as a public and State problem, which contributes to the lack of coordinated, multisectoral and multiactor action by the agencies responsible, as well as insufficient allocation of budget resources and a lack of women in decision-making spaces.

    - **Weakness of national and sectoral plans or policies aimed at eliminating SGBV.** National plans and policies are rarely accompanied by formal mechanisms for follow-up, monitoring and the preparation of impact reports that identify the real extent and quality of their coverage. These instruments lack actions that are interconnected with other state and institutional regulations, inclusion in sectoral plans for eliminating SGBV and ongoing measurement of indicators and impacts related to their implementation and scope (OAS, 2021).

    - **Lack of political leadership for mechanisms for women's progress, ministries or other institutions responsible for preventing and responding to SGBV.** High turnover among authorities in charge of ministries, mechanisms or other entities related to SGBV is generalized. This situation contrasts with the fact that the goal of eradicating gender violence should be independent of partisan politics and should be positioned as a State matter (Essayag, 2017). Combating SGBV also requires political will to convert measures, programs and policies into State matters (Essayag, 2017; ECLAC, 2019), as well as a greater number of women in decision-making spaces, to increase the probability that these issues will be on the agenda (Schwindt-Bayer, 2006).

- **Insufficient budget resources for the implementation of national policies or plans for addressing SGBV.** Funding sources continue to allocate inadequate amounts to the bodies that provide direction or, in some isolated cases, to the entities that participate in the critical route of implementation. Some countries report on the resources they allocate to combat SGBV, but do not specify the percentage of public spending this represents; how the resources are distributed; whether the percentage of resources is proportionate to the demand by women for specialized health, judicial and other services; or the impact these resources have on the incidence of SGBV and the State's response (OAS, 2021). There is also a lack of budget programs with clear and transparent line items related to plans or policies for addressing SGBV (Essayag, 2017; ECLAC, 2017, 2019).

- **Lack of linkage between the demands of women and society as a whole and regulatory and institutional progress.** The absence of partnerships and dialogue between the State, academia and civil society limits the opportunity to address in a collaborative and coordinated manner the configuration of new analytical frameworks or the implementation of actions that contribute to the effectiveness and efficiency of public policy (Ellsberg *et al.,* 2015).



Box 3. Mechanisms for the Advancement of Women (MAW)

All countries in LAC have created a Mechanism for the Advancement of Women that includes, as part of its institutional mission, guiding gender policies and policies for equal opportunity and equal treatment of men and women, and the function of developing national plans or policies for addressing violence against women. Their performance and institutional capacities, however, vary from country to country.

Responsibility for the effective implementation of SGBV legislation and policies rests not only with the MAW, but with all State institutions. Nevertheless, MAWs with a legitimate and institutional robustness (or high institutional hierarchy) help interconnect the sectoral responses that fall under the responsibility of different institutions and open channels of dialogue with civil society, especially women's organizations, to share innovations and best practices or consider proposals.

Source: ECLAC, Gender Equality Observatory, 2016, https://oig.cepal.org/en/indicators/level-within-governmental-hierarchy-national-machineries-advancement-women

2. **Institutional barriers.** These refer to limited, non-existent, ineffective or inadequate access to State services for preventing and responding to SGBV, whether individually or as a whole, which constitute a lack of cooperation and interconnection among the institutions themselves. The institutional response is also affected by weak information and measurement systems.

   The main services for prevention of and response to SGBV are provided through (i) health care and psychosocial assistance; (ii) security or police services for protection, care, filing complaints and referral; (iii) legal and judicial assistance; and (iv) primary, secondary and tertiary education. Each of these services has its own particular barriers because of the idiosyncrasies of its functioning. Nevertheless, some of the barriers that interconnect across all four services can be characterized from the standpoint of access and quality (IACHR, n. d.; Contreras *et al.,* 2010; Morrison *et al.,* 2005; Jewkes *et al.,* 2002; Ellsberg and Heise, 2005; Rodríguez-Bolaños *et al.,* 2005).

   - **Factors that limit or impede access to services:** (i) low level of awareness of the seriousness of abuse and fear of reprisals from the perpetrator; (ii) stigma, shame and fear of suffering discrimination; (iii) lack of knowledge of available services; (iv) direct and indirect costs for women who seek services or use judicial processes; (v) difficulties with physical and geographic accessibility; (vi) absence of adaptations for universal accessibility; (vii) the complexity of reporting a crime; (viii) lack of trust in the ability of institutional services to resolve cases or that they will have zero tolerance for all forms of violence; (ix) deficiencies in basic infrastructure; (x) dearth of public providers in the health, judicial or security systems who speak the languages of women who seek assistance.

   - **Factors that affect the quality of services:** (i) those responsible for the formulation of policy and service providers lack precise and useful data, which hinders an effective response; (ii) insufficient knowledge of technical guidelines for integral attention to all forms of violence by service providers; (iii) complaint processes that require victims to repeat their account multiple times, thus revictimizing the survivor; (iv) service providers' beliefs about SGBV, which keep them from addressing it appropriately and result in underdetection of cases; (v) lack of coordination among entitles and non-existent or inadequate referral protocols; (vi) loopholes,

irregularities and deficiencies in the investigation, judicialization and punishment of cases of SGBV, which contribute to impunity; (vii) inadequate treatment of victims when they seek assistance from judicial services charged with ensuring protection; (viii) deficiencies in spaces and infrastructure that prevent the provision of confidential, user-friendly and appropriate assistance to victims; (ix) dearth of specific services for the LGBTQ+ community, migrants or persons with disabilities, and of socioculturally appropriate services for indigenous women and those of African descent.

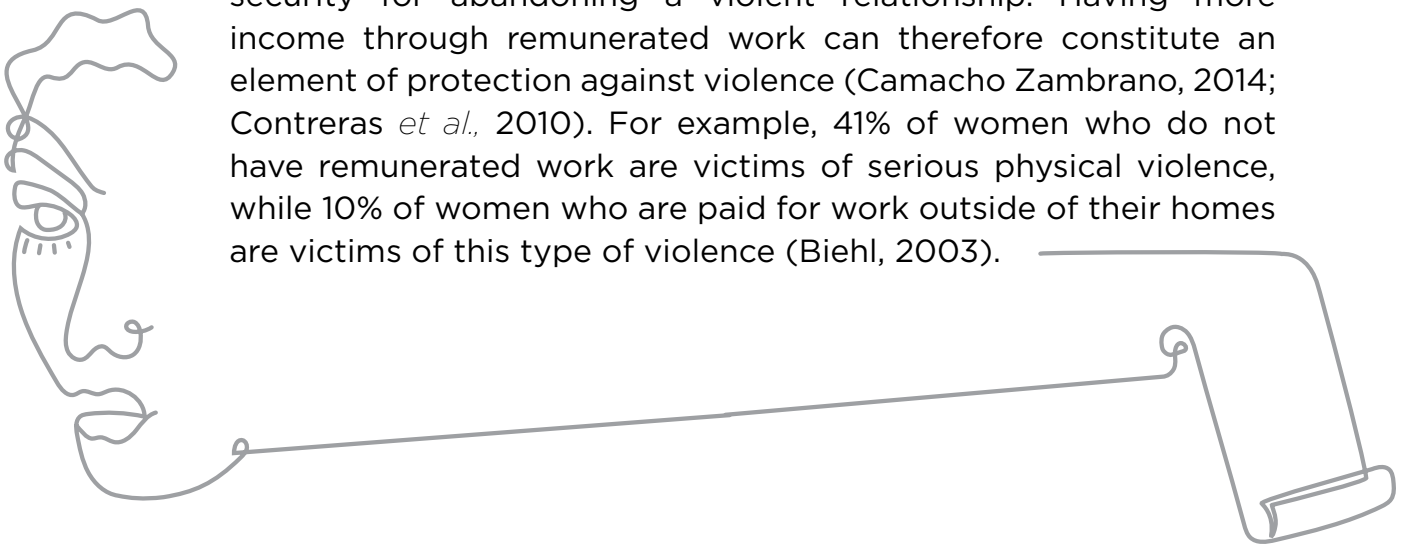
- **Lack of coordination and interoperability among key sectors, levels and actors in public administration.** The lack of intersectoral mechanisms and interconnected protocols that coordinate the various levels of government (national, provincial and local), along with the lack of unified and interoperable information systems, make effective, coordinated action for preventing and addressing SGBV impossible (Daverio, 2020).

- **Absence or weakness of permanent information, measurement, monitoring and evaluation systems with consistent indicators related to SGBV.** The lack of reliable, systematic and periodic measurement of the prevalence of violence, with consistency and international comparability, and the absence of measurements with an intersectional approach contribute to the lack of information and analysis of public policies. Despite progress in the region and national efforts, greater coordination and resources are needed to understand the real scope of the phenomenon beyond administrative records or the relevant module in demographic and health surveys (Bott *et al.,* 2019; ECLAC, 2017; WHO, 2021).

3. **Socioeconomic barriers.** Low socioeconomic levels and the lack of autonomy, both economic and in decision-making, for women and girls increases their vulnerability to violence and decreases their ability to respond to SGBV.

    - **Gender inequality increases the risk of SGBV, and SGBV, in turn, increases inequality.** Poverty constitutes a risk factor that limits women's agency and autonomy for gaining access to the market (Buvinic *et al.,* 2005; Buvinic *et al.,* 1999; Gonzales de Olarte and Llosa, 1999). In addition, women who are in the labor market not only earn less money, but they also have fewer labor benefits than men, which gives them less economic autonomy and decision-making power in the home, a factor that may contribute to the high rates of SGBV in the

region.[35] Meanwhile, women who suffer violence pay an emotional and economic price for SGBV that has repercussions for their health, welfare and labor productivity. Abused women have fewer possibilities of getting a job (Bowlus and Seitz, 2006), and those who suffer serious violence earn some 40% less in monthly income than women who are not abused (Ribero and Sánchez, 2005). Women who are in a situation of violence or economic vulnerability and are more dependent on their partners therefore have a greater probability of suffering or remaining in a complex situation of violence with the aggressor (Fulu and Kerr-Wilson, 2015; Bourgault *et al.,* 2021; Ellsberg *et al.,* 2015). The lack of economic autonomy and decision-making power in the home, the community and politics, as well as the psychological dependence characteristic of women who are victims of SGBV in relation to their aggressor, limit the woman's ability to make her own decisions, take action as a result and transform her situation. In this sense, financial autonomy offers a greater opportunity, greater negotiating power or more security for abandoning a violent relationship. Having more income through remunerated work can therefore constitute an element of protection against violence (Camacho Zambrano, 2014; Contreras *et al.,* 2010). For example, 41% of women who do not have remunerated work are victims of serious physical violence, while 10% of women who are paid for work outside of their homes are victims of this type of violence (Biehl, 2003).



[35] This inequality is reflected in the following data: (i) women's labor participation remains 25 percentage points below that of men, a figure that rises to 40 percentage points in cases of men and women with minor children (ILO, 2019; Bustelo *et al.,* 2019); (ii) greater unemployment, reflected in an unemployment rate of 10.2% for women compared to 7.3% for men during the first three quarters of 2019 (ILO, 2020a); (iii) a gender wage gap of 17% (ECLAC and ILO, 2019; Artza *et al.,* 2019); (iv) fewer high-quality jobs, compared with those of men, according to the IDB's Better Jobs Index; and (v) lack of shared responsibility for care, which contributes to the fact that women devote three times as much time as men to unremunerated work (ECLAC, 2021).

4. **Legal barriers.** Refers to the lack of consistency between regulations and the effective implementation of policies, plans and programs that contribute to the elimination of SGBV.

    - **Loopholes in legislation and lack of consistency between regulatory or legislative frameworks and policies for addressing SGBV.** Several countries in the region still do not address various types of SGBV (physical, psychological, sexual, economic, etc.) or contexts in which they occur, outside of the family (workplace, school, social, etc.) (IACHR, 2007). Some countries' criminal codes still do not include rape within marriage or a common-law relationship or aggravated homicide against women. Some countries that have classified feminicide as a crime lack comprehensive laws and national plans for addressing violence against women and gender violence; they therefore address only one aspect of the response to such violence — punishment — but they lack provisions for prevention, care for victims, investigation or protection of victims (UN Women, 2018).

    - **Deficiencies in the application and interpretation of laws.** Among the most important factors are the lack of regulations, the absence of clear procedures, an excessive workload in entities responsible for implementing laws, insufficient budget allocations for effective implementation of the existing juridical framework, and lack of public awareness of the existence and scope of relevant norms (IACHR, 2007; Ellsberg *et al.,* 2015; Essayag, 2017).

    - **Shortcomings in investigation, prosecution, trial and punishment of cases of SGBV.** The IACHR notes that the investigation of cases of violence against women is negatively affected by a diversity of factors, including unjustified delays by entities responsible for investigating and loopholes and irregularities in investigations, which create obstacles to the trial of cases and eventual punishment of perpetrators. This translates into a low number of cases that are investigated and that undergo the judicial process, which does not correspond to the high number of official complaints received (IACHR, 2007).

5. **Cultural barriers.** This refers to the social norms and gender roles that perpetuate and promote SGBV in society, in the community and in individuals. They are manifested in explicit and implicit ways.

    - **Persistence of patriarchal cultural patterns that perpetuate gender violence and naturalize violence against women in all spheres, such as school, transportation and the sexual division of labor.** Relationships of inequality between men and women are historically rooted in belief systems and symbolic constructions, as well as in traditions that define a society's collective imaginary. These are manifested in music, publicity, the sexual division of labor, relationships of subordination and domination beginning in childhood, harassment in the street and objectification of women, among other things (Contreras *et al.,* 2010; UN Women, 2017; UN Women, 2018).

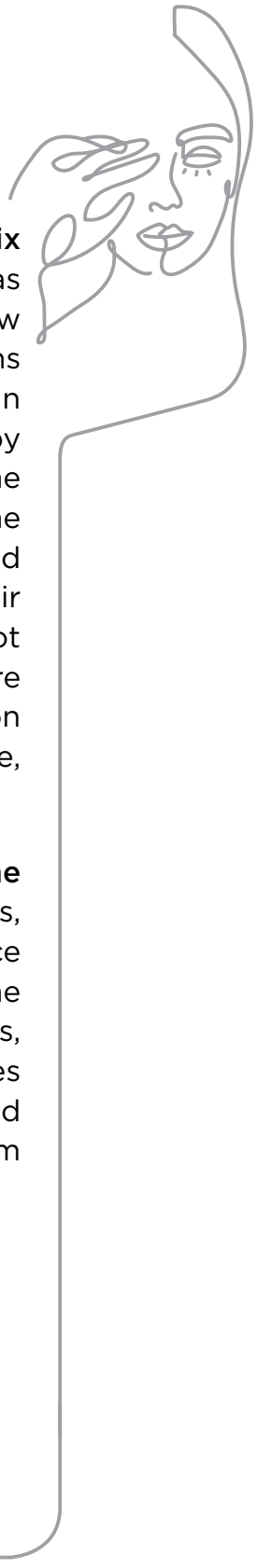
    - **Gender attitudes that "justify" violence.** The legitimization of control, domination, abuse and the low value placed on women are gender norms that are still very present in the region. There is a correlation between acceptance of *machista* gender norms and the exercise of violence that has been self-reported by men (Barker *et al.,* 2011; Levtov *et al.,* 2014; Fleming *et al.,* 2015). In the region, as many as 16.6% of women believe that their spouses are justified in hitting them, and 36% agree with corporal punishment in child rearing (Bott *et al.,* 2019). In Jamaica, 16% of men believe a man is justified in beating his wife if he discovers she has been unfaithful; 4% of women also agree with this statement. Hitting a woman is also considered justified when she has disobeyed her husband (10.8% of men, compared to 1.5% of women) (Reproductive Health Survey, 2008). In Guatemala, 11.9% of men believe that there are situations in which a man has the right to hit his spouse or partner (MSPAS, 2011). In addition, a woman's obligation to have sexual relations even if she does not want to is justified by 27.2% of men ages 15-24 in Jamaica, as well as 20.7% in Guatemala, without specification of age group. False ideas about romantic love are also a harmful recourse used to justify controlling behaviors that restrict a partner's freedom and autonomy (for example, the lack of privacy to know with whom, how and where one relates with others, on the pretext of protection). In addition, the stigma of a couple breaking up because the woman has not been a sufficiently

good mother, wife or partner, or because the relationship "is forever," and the self-imposed responsibility that the woman is guilty and that the partner or husband "will change; he just needs time," or even that she herself is responsible for his change are among the fallacies that contribute to a cultural perpetuation of gender violence. Outside of the couple relationship, shame and revictimization of rape by phrases like "What were you wearing?," "A woman shouldn't be out at that hour" or "She was asking for it" continue to appear in media headlines and the pages of court documents (Lagarde, 2005; Jewkes *et al.,* 2014).

- **Men's socialization based on machista and violent masculinities.** Masculinity is the psychological, sociocultural, and societal expression of the understanding that men have of themselves and of their relationships with women or the way in which they relate with other men, how they seek approval, recognition, respect, honor or the subordination of others (Lewis, 2002; Levtov and Telson, 2021; Ellsberg *et al.,* 2015; Jewkes *et al.,* 2014). The pillars[36] on which the ideals of masculinity are constructed are related to the fact that men and boys have a greater likelihood of exercising physical and psychological violence, as well as dying by homicide or suicide (Heilman and Barker, 2018; Heilman *et al.,* 2019). Other factors that are associated with the violence exercised by men against women are excessive consumption of alcohol (PAHO, 2007), depression and having participated in fights with weapons (Fleming *et al.,* 2015). In the region alone, 79% of recorded suicides are men (PAHO, 2014, in Aguayo *et al.,* 2021). Fewer than 10% of the world's adolescents live in LAC, but nearly 50% of adolescent homicides (10-19 years) occur in the region. The homicide rate for adolescent males (38.5 per 100,000) is nearly eight times that of the rate for women (5.1 per 100,000) (UNICEF, 2017; Save the Children, n. d.).

[36] Gender roles according to an analysis of masculinities are part of the "man box," where the masculine ideal is constructed and affects children based on seven pillars, in which self-sufficiency; physical strength; attractiveness; domination by masculine roles in the household; heterosexuality and homophobia; hypersexuality; and aggression, control and violence are common denominators (Heilman *et al.,* 2017; Levtov and Telson, 2021).

Strategic interventions

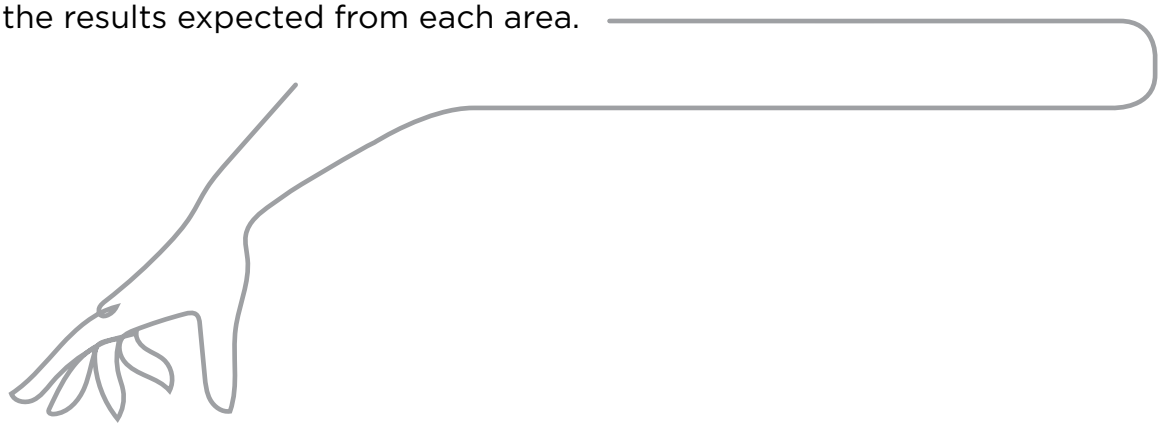


To respond to the barriers presented in the preceding section, six areas of strategic interventions have been identified. These areas were defined after an extensive literature review. The literature review focused on experimental or quasi-experimental impact evaluations conducted in developing countries, particularly in the region. In an initial exercise, a review of the literature already analyzed by other authors was conducted (**Annex 2**). In cases in which the intervention evaluated was not in a developing country or in the region, a search was conducted to find evidence from developed countries. The interventions were also classified according to their degree of effectiveness (effective, promising, with mixed results, not effective and insufficient evidence), and the classification criteria are presented in **Annex 3**. The interventions reviewed had impacts on different variables, such as victimization, perpetration of violence, and attitudes and social norms, among others.

The study and analysis include interventions aimed at both the prevention of and response to SGBV. Prevention includes actions, programs or regulations aimed at avoiding the occurrence of violence acts. It promotes changes in the unequal power relationships and the social patterns that naturalize SGBV. Response refers to the actions, programs or mechanisms aimed at providing timely responses when violence has occurred, through safe, efficient, relevant and coordinated services to protect and offer immediate and long-term solutions to victims of SGBV.

The literature review conducted for this study has limitations. It is not a systematic review, so it does not include all possible databases or social science, economics or health journals. It is possible that the search strategy may have omitted some impact evaluations, despite the effort to conduct an exhaustive search of interventions evaluated between 1999 and 2021. The languages of the publications reviewed are English and Spanish, so studies in other languages may have been omitted.

Next, we present the interventions for preventing and addressing SGBV according to the six areas of strategic interventions identified in the theory of change, as well as the results expected from each area.



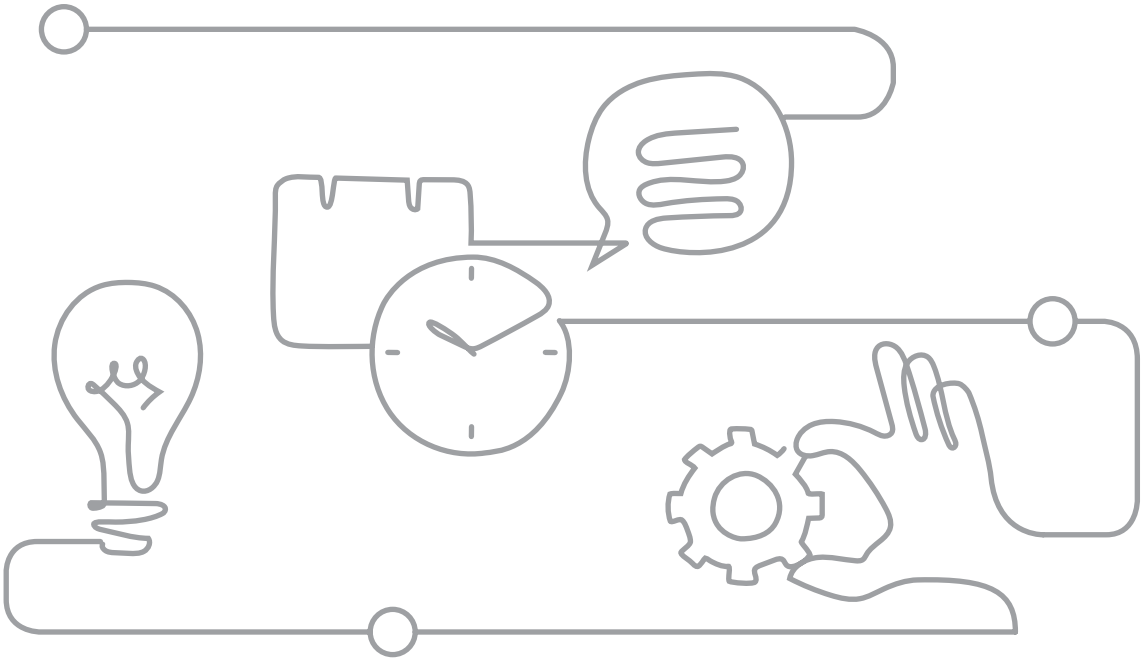
Strategic intervention 1. Multisectoral and coordinated actions

Description
Programs or interventions whose goal is to support the design and implementation of policies, action plans and strategies that foster commitment, political dialogue and coordination among the parties responsible for preventing and addressing SGBV

Expected results

- Institutions have improved access to and quality, coverage and multisectoral coordination of the prevention of violence, as well as mechanisms for filing formal complaints and services for responding.
- More women and girls gain access to services for prevention and appropriate response.

Effectiveness	Prevention	Response
Promising	• Legislative reforms and budget allocations	
		• Centers for integrated service delivery • Shelters
Insufficient evidence	• National action plans for combating SGBV • Protocols for prevention and attention in the health sector	
		• Women's police stations • Women's justice centers



Preventing and addressing SGBV requires an integral, multidisciplinary response characterized by collaboration and coordination among the institutions involved. A multisectoral approach will contribute to the implementation of interconnected policy instruments and the sustainability of resources and commitments for greater relevance, effectiveness and efficiency in access to and quality of provision of services (UN Women, 2015). Coordinated and multilevel responses also make it possible to identify the needs of victims/survivors from multiple standpoints and, as a result, offer consistent and integral services and responses (Arango *et al.,* 2014; UN Women, 2015). This does not imply agglomerating institutions and sectors, but rather harmonizing guidelines, budgets, personnel and actions with a common action plan, political will, budget allocations and institutional capacity. The following is a description of multisectoral actions and the existing evidence about this type of intervention:

- **National action plans for combating SGBV.** These are strategic programs or public policy instruments structured on the basis of an assessment of types of violence in the country, specific activities, quantifiable results and budgets aimed at carrying out short-, medium- and long-range actions to address SGBV or VAW in diverse spheres (political, family, institutional, etc.). In various countries in the region, they are addressed differently

or have different names.[37] Several countries have created national commissions to improve intersectoral coordination and oversee progress in the implementation of plans, and others have advanced in orienting their efforts toward the need for quantifiable results, as well as budgets tied to their effective implementation and rigorous assessment. Methodologically, it is nearly impossible to conduct a rigorous evaluation of a national plan, considering that the plans are national and there can therefore be no control group. Nevertheless, there is qualitative evidence that national plans, if well designed, can make a difference (Essayag, 2017). Follow-up reports that have been done about these plans suggest that creating a political space for dialogue between civil society and the State commits the government to place public demands on the agenda, which promotes sanctions and commitment to combating violence (Our Watch, 2019; Macuer *et al.,* 2017; Herrera *et al.,* 2012; López Mayher, 2019).

- **Legislative reforms and budget allocations.** The adoption of laws and policies that reinforce women's rights and offer protection against SGBV represent an important tool in the fight against violence. There is documentation about the positive impact of national legislation on intermediate results, such as an increase in formal complaints filed, an increase in the number of convictions and an improvement in the quality of the response from police and the judiciary; nevertheless, there is little evidence about the impact of legislation on the reduction of SGBV (Morrison *et al.,* 2007). In this area, there is one evaluation that shows that reforms that guarantee women and men the same rights in matters of inheritance have an impact on the reduction of violence against women. Granting equal conditions for inheritance to men and women, reduced recorded levels of violence by 36% in states in India where those rights were made equal during a 28-year period. In addition, women who married after the amendments

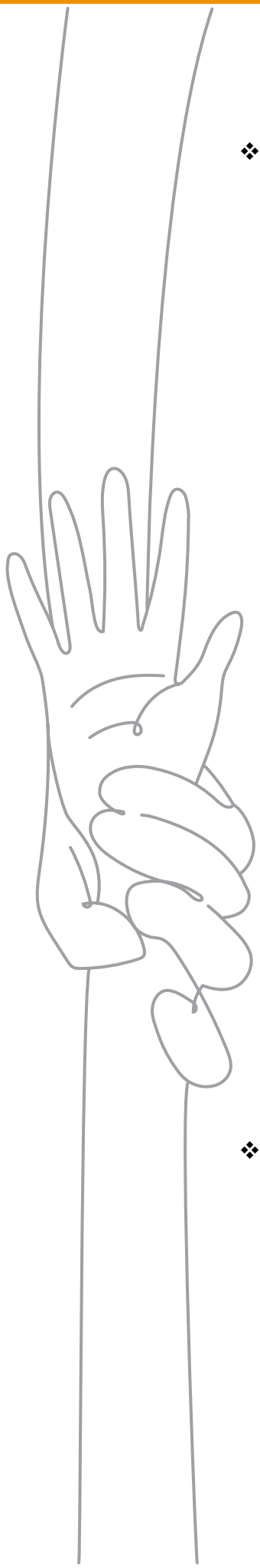
[37] Of the 33 countries in LAC analyzed by Essayag (2017) in 2016, 15 countries had national action plans on VAW, two had national action plans on domestic violence, eight had national action plans on gender violence, six had policies or plans that included a specific component for addressing violence in a broad sense, and two did not have national action plans on gender violence or violence against women. These two countries were St. Lucia and Trinidad and Tobago, whose plan had been drafted but not approved. As of 2021, according to a search, these latter two countries continued in the same situation.

had 17% less likelihood of experiencing IPV (Amaral, 2017). The impact of grant funding set by SGBV laws has also been evaluated. Jurisdictions in the United States that received funding under the Violence against Women Act had significant reductions in the number of rapes and aggravated assaults compared to those that did not receive funding (Boba and Liley, 2009).

- **One-stop centers.** One promising approach is the creation of stand-alone centers that provide integrated services to survivors of violence. In some cases, these centers limit their services to those related to police, justice and immediate response, while others include health care and services for promoting economic independence. Nevertheless, there is still a lack of solid evidence about the effectiveness of these interventions in reducing violence or mitigating its negative consequences (Ellsberg *et al.,* 2015; Fulu *et al.,* 2014). The following is a summary of the available evidence about the different types of integrated service programs:

  - **Centers for integrated service delivery.** These offer, in a single location, public services such as orientation, psychological and legal assistance, police intervention or requests for access to justice, with the goal of reducing the monetary cost and the time required of women for their use. *Ciudad Mujer Centers* (CMC) operate in four countries in LAC[38] and one of its modules provides orientation, psychological and legal assistance, police intervention and assistance with access to justice for preventing and addressing VAW. There is an experimental evaluation of the short-term impact of the *Ciudad Mujer Centers* in El Salvador focusing on the use of these services. It concluded that women who attended the CMCs used 43% more specialized public services in sexual and reproductive health, economic empowerment and support related to SGBV than women who did not attend the centers[39] (Bustelo *et al.,* 2016).

[38] The CMCs operate in El Salvador, Honduras, Mexico and Paraguay, and are in the design stage in the Dominican Republic.
[39] The CMC program operates under an "open door" policy, meaning that any woman can approach the CMC to use its services. In this context there is a natural comparison group, because women who decided to go to a CMC are likely to be different from women who decided not to go (Bustelo *et al.,* 2016)



- **Women's police stations.** In general, these are police units that principally serve women. They are mainly made up of female police personnel in multidisciplinary teams (lawyers, social workers, psychologists and other professionals) and they provide specialized services to women survivors of sexual or domestic violence (UN Women, 2011). Their main actions are aimed at raising awareness and receiving complaints; they provide support for accessing health and economic assistance and advice, and they help begin legal actions, such as obtaining protection orders. The women's police stations play a role in empowering victims, improving their access to justice, reducing victimization and increasing the representation of women in the police. Although there are studies that have documented the benefits of the women's police stations, for example in the filing of formal complaints about crimes and the reduction of homicide rates in the districts where they are established, there is little rigorous proof of their effectiveness in reducing the recurrence of violence in the lives of women who use their services (Perova *et al.,* 2015; Natarajan *et al.,* 2020; Jubb *et al.,* 2008; Ellsberg *et al.,* 2015; Fulu *et al.,* 2014). In addition, studies have documented important elements to consider: female police personnel have not demonstrated a better attitude toward victims of violence simply by virtue of their sex, and the special stations tend to lack sufficient funds, equipment, transportation and other key resources. Even when the stations function well, their efforts often are undermined by other parts of the judicial system, which cannot or will not enforce the law. Finally, women's police stations have been criticized for encouraging the regular police to abdicate their responsibility to respond to crimes against women (Jubb and Izumino, 2003, and World Bank, 2006, in Morrison, 2007).

- **Women's justice centers (WJC).** WJCs are the result of the joining of efforts and resources among various levels of the judicial system to create spaces that concentrate, under one roof, multidisciplinary services such as psychological, legal and medical assistance; temporary shelters; a play area with child development experts; and social and economic empowerment workshops to help women escape the circle of violence. No impact evaluations of WJCs were found (USAID, 2020a), but there are case studies, such as the one for the WJC in Hidalgo, Mexico (Cervantes *et al.,* 2018).

- ❖ **Shelters.** These are spaces that provide temporary protection to women and their children whose lives or physical or mental integrity are endangered by violence from a partner or former partner. They allow integral attention that includes psychological counseling, legal aid and a place to stay, so women are able to overcome the violence they have suffered. Shelters mainly have been evaluated in developed countries; for example, in a metanalysis of 10 experimental and quasi-experimental evaluations, it was demonstrated that interventions such as group counseling to improve emotion-management skills, classes for parents and children, individual therapy and advisory services provided during and after a woman's stay in a shelter improved mental health and reduced the rate of re- abuse (Jonker *et al.,* 2015). None of the studies, however, explored long-term effects. There are few rigorous assessments of the effectiveness of shelters in developing countries. One qualitative evaluation in Medellín, Colombia, showed that receiving aid from shelters increased the likelihood that women would file a formal complaint about the violence, and women also reported greater psychological well-being compared to those who received ambulatory services, although this effect diminished over time (Peñaranda and Armbrister, 2017).

- **Health sector protocols for prevention and response.** Health systems have a crucial role in identifying and addressing cases of SGBV, so coordination within the healthcare system and between the health system and other sectors is crucial for providing comprehensive services[40] (García-Moreno *et al.,* 2015). In the majority of countries in the region, institutions coordinate among themselves to combat and prevent SGBV, and have developed health sector guidelines or protocols that support a multisectoral response to SGBV. Nevertheless, there still is no solid evidence of their effectiveness (García-Moreno *et al.,* 2015).

[40] In 2016, in the update to the 69th World Health Assembly, agreement was reached on a World Action Plan to reinforce the role of the health system in providing a national multisectoral response to interpersonal violence. It includes four strategic areas: (i) reinforcing health system leadership and governance; (ii) improving the provision of health services and the ability of health workers and providers to respond to the needs of persons who have suffered violence; (iii) promoting programming for the prevention of interpersonal violence; and (iv) improving information and evidence (WHO, 2016).

Strategic intervention 2. Institutional strengthening and capacity building

Description
Programs or interventions that strengthen the capacity of institutions and sectors, as well as their personnel, or which reform the provision of services to improve their quality, efficiency and cultural appropriateness.

Expected results
• Institutions improve access to and quality, coverage and multisectoral coordination of violence prevention, as well as mechanisms for filing formal complaints and response services. • More women and girls gain access to services for prevention and appropriate response.

Effectiveness	Prevention	Response
Effective	———	Training programs for police
Promising	———	Training programs for personnel of women's police stations
Mixed	Areas reserved for women on public transportation	———
Insufficient evidence	Improvement of public infrastructure to increase women's safety	Training programs for: • Judicial system personnel • Health service personnel • All public sector personnel

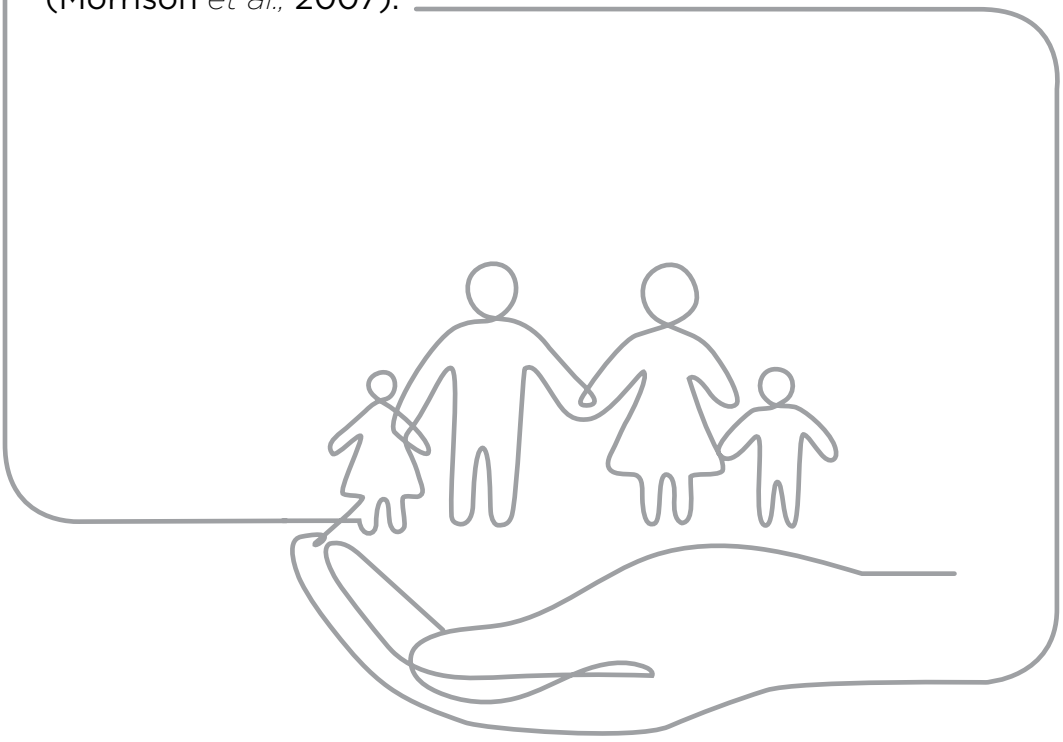
For efficient management of policies, programs and actions for preventing and responding to SGBV, the State needs adequate and trained human, technical, financial and organizational resources. Efforts and resources must be directed toward the training and strengthening of actors at different levels of responsibility and administrative management. This, however, cannot be reduced only to the health, justice, security or education sectors, and for that reason more and more public institutions are gradually adopting SGBV policies and programs and are training their personnel for their efficient implementation. This is the case, for example, in the infrastructure and public transportation sectors (Daverio, 2020). The following is a description of interventions for strengthening institutions:

- **Capacity building**. One of the most common interventions for improving the institutional response to SGBV in developing countries is training with a gender and human rights focus, to reinforce the technical capabilities of personnel in the health, justice and public security sectors, among others (Darak *et al.,* 2017). This can be done through workshops and courses or can be designed with a behavioral-change approach (Bustelo *et al.,* 2020). Evaluations of training programs suggest that they are more effective when aimed at all personnel (including authorities) and when accompanied by changes throughout the institutions — that is, in policies, procedures, resources, monitoring and evaluation (Rashid, 2001 and Villanueva, 1999, in Morrison *et al.,* 2007). The following are some of the interventions analyzed:

  - **Training for personnel of women's police stations.** There is one assessment of the impact of personnel training on the quality of services received by women who have been victims of IPV. The intervention trained personnel of Family Police Stations in Colombia to standardize procedures for receiving VAW cases so as to increase user satisfaction, avoid revictimization and increase the filing of formal complaints. The evaluation shows that being assisted by a trained employee increases the rates of formal complaints of VAW and the perception of having been assisted with confidentiality, compared to a control group that was not trained (Romero *et al.,* 2017). The study did not find impacts of training on the incidence of physical or psychological violence. The success of the trained police station personnel in encouraging women who were victims to file formal complaints suggests that the women's police stations could play a role not only in conciliation, but also in providing guidance for women to denounce their aggressors (Romero *et al.,* 2017).

  - **Training for the police.** The main goal of training and capacity-building interventions for police and security personnel is to develop knowledge, skills and capabilities for improving prevention of and response to violence against women and girls (Jewkes *et al.,* 2015). The evidence suggests that these programs can help the police control their own reactions in high-stress situations (Berking *et al.,* 2010), as well as produce

positive changes in the attitudes and behavior of police and security personnel toward women and girls who are survivors of violence. As a result, they have greater credibility among the survivors (Rao *et al.,* 2011; Khalique *et al.,* 2011). Training of police in issues related to legislation and HIV and raising their awareness about the circumstances of sex workers' lives are effective for reducing violence against this group, and particularly for reducing police arrests and improving fair treatment (Beattie *et al.,* 2015; Punyam *et al.,* 2012). In LAC, an impact evaluation with a quasi-experimental design was carried out of a training program on gender and sexual and domestic violence for police in Metropolitan Lima and Callao, Peru.[41] In the intervention group, there was an increase in knowledge about assistance, as well as positive changes in attitudes regarding gender- and SGBV-related issues. The training also had an impact on the police officers' family relationships, with a decrease in the use of violence and authoritarian attitudes (Mendoza and Díaz, 2007). There are, however, no evaluations that measure the impact of the training on the prevalence of violence, mainly because it was not part of the original objective of the intervention; nor is there sufficient evidence from developed or developing countries (Morrison *et al.,* 2007).



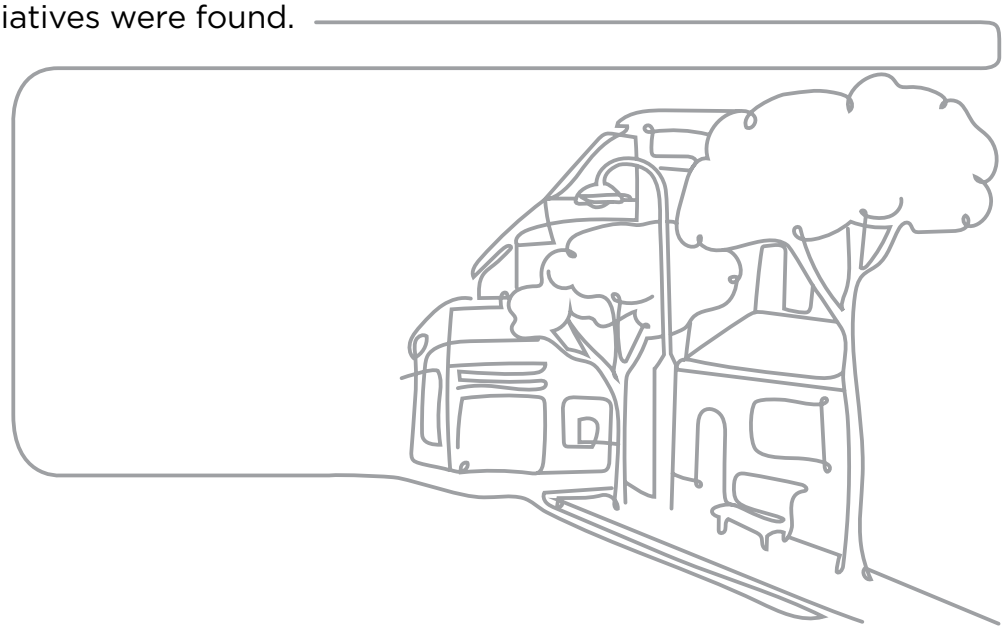
[41] There is also a training program for the police in Honduras that is considered a best practice by the UNFPA, but it lacks an evaluation using experimental or quasi-experimental methods (UNFPA, 2009).

- **Training for judicial system personnel.** Judicial training traditionally has focused on the interpretation and application of national legislation and the use of international conventions on SGBV. This training is aimed at judges, prosecutors, forensic medicine specialists, defenders and legal assistants in the justice sector (Villanueva, 1999). No experimental or quasi-experimental evaluations from developed or developing countries were found.

- **Training for healthcare service providers.** The goal of training is to reinforce the knowledge and skills of healthcare providers, mainly in primary care, to respond to the needs of women who experience violence (Kalra *et al.,* 2021). Most of the evidence comes from developed countries, and the few evaluations conducted in developing countries suffer from methodological limitations. No evidence was found of the impact of training on the incidence of IPV, but studies in developed countries do show an improvement in the knowledge and behavior of providers after the intervention (Wong *et al.,* 2006; Feder *et al.,* 2011; Jewkes *et al.,* 2015; Campbell *et al.,* 2001). Nevertheless, the evidence indicates that training and dissemination of information alone do not produce ongoing or sustainable changes, which suggests the need for an integral approach (Fixsen *et al.,* 2005; Feder *et al.,* 2011; Campbell *et al.,* 2001; Fanslow *et al.,* 1999). Finally, it should be noted that there also is insufficient evidence to determine whether training aimed at raising awareness among healthcare personnel about gender inequities in health, stigma and discrimination is effective. One systematic review found that only 37% of 29 studies showed a significant improvement in gender-related knowledge, attitudes or practice after the training (Lindsay *et al.,* 2019).

- ❖ **Training for all public sector personnel.** Several countries in the region offer training workshops to strengthen the technical capacities of public servants in State institutions with specific responsibilities in the area of prevention, assistance, investigation and punishment of SGBV (UNODC, 2018; COOPI, 2021). No rigorous evaluations of such training were found. One initiative that needs to be evaluated is Law No. 27499, the Micaela Law on mandatory gender training for all persons in the three branches of government in Argentina, which was signed into law in 2019. This measure requires "mandatory training in the area of gender and violence against women for all persons who work in public positions at all levels and in all hierarchies of the executive, legislative and judicial branches of the nation's government" (Art. 1). In 2020, agents and personnel of 121 entities in the executive and legislative branches received training, along with 4,461 top officials. In addition, 67 awareness-raising sessions were held with the participation of all provinces, and approximately 500 municipalities (MMGD, 2021).

- **Improvement of infrastructure and public spaces.** The studies suggest that improving public infrastructure, such as illumination and the appearance of transportation stations and adjacent streets, as well as increasing visibility within the stations and expanding security, helps women feel safer and can reduce the frequency of all types of crime, including SGBV (Taylor, 2011; OECD and ITF, 2018; Gishler *et al.,* 2016). Nevertheless, no rigorous evaluations of these initiatives were found.



- **Public transportation.** There are different institutional responses to the problem of victimization and insecurity for women who use public transportation systems in urban areas. The main strategy for preventing SGBV is the creation of safe spaces for women through buses or train cars, routes or hours exclusively for women (USAID, 2020a). The available evidence casts doubt on whether transportation adaptations exclusively for women are a long-term solution to sexual harassment in public transportation systems. An assessment of public transportation reserved for women in Rio de Janeiro, Brazil, found it was safer because it reduced cases of sexual harassment. The positive impact is even greater when the sexual segregation model is mandatory. Implicit association tests, however, reveal that travelers associate women who travel in unreserved public spaces as being more open to sexual advances (Kondylis, 2019). And an evaluation of *Viajemos Seguras* ("Let's Travel Safely") in Mexico shows that although the program is effective in eradicating sexual violence against women on public transportation, levels of physical violence increase in women's cars as a result of overcrowding (Soto Villagrán *et al.,* 2017). Another strategy for preventing SGBV is to have more security personnel and more employees of both sexes acting as transportation officers (Soto Villagrán *et al.,* 2017). Tactics include increasing the visibility of women security agents and using plainclothes agents to surprise and detain criminals (USAID, 2020a). Nevertheless, increasing the presence of security personnel in transit areas alone does not guarantee more safety for women, because transportation personnel may also perpetrate sexual harassment against women and create new vulnerabilities (Alam, 2018, in USAID, 2020a).

Strategic intervention 3. Access to and quality of service

Description
Programs or interventions that seek to ensure adequate access to services by users, as well as an ongoing improvement in quality.

Expected results
• More women and girls gain access to high-quality services for prevention and appropriate response.

Effectiveness	Prevention	Response
Effective	———	• Referral tools for victims of SGBV
Promising	———	• Technology for SGBV screening • Telephone hotline • Legal assistance • Online psychological attention • Use of social media to promote knowledge of and access to services • Courts and tribunals specializing in SGBV
Mixed	———	• Instruments for SGBV screening
Insufficient evidence	———	• Online and telephone legal services
	• Mobile apps	

Providing high-quality integral services that users can access without barriers is one of the maxims for any administration in any country. The adequate, timely and interconnected provision of services for preventing and responding to SGBV will help build trust in the state response and help break the cycle of violence. Well-targeted services with budget allocations for preventing, addressing and not tolerating any form of violence reflect solid institutions and a safer society. The following are interventions that provide services for prevention and response:

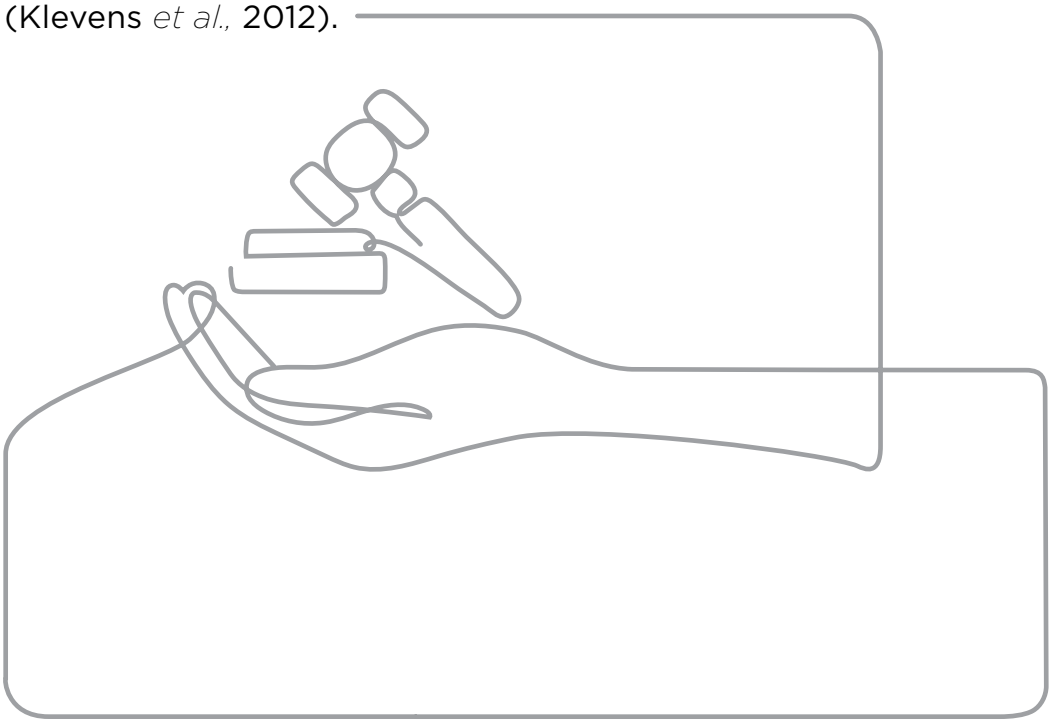
- **Instruments for screening SGBV.** The identification of women who are experiencing or have had a recent experience of SGBV — mainly IPV — when they seek healthcare services is done using a range of validated tools and instruments that can be administered through an in-person interview or a printed or computerized questionnaire.

Detection is generally followed by another intervention or referral to other entities that provide protection and services to the person who has been assisted (Jewkes *et al.,* 2015). The majority of evidence comes from developed countries, and almost all the studies conclude that the use of a screening instrument, particularly those that take an integral approach with multiple components, improves the identification of women who are experiencing violence (O'Campo *et al.,* 2011; Jewkes *et al.,* 2015). Nevertheless, studies using experimental or quasi-experimental methods have not found relevant evidence that referrals to other services have increased as a result of the screening or that they have reduced IPV, and there is insufficient proof that screening increases the use of specialized services (Doherty *et al.,* 2015; Taft *et al.,* 2013). Given the lack of evidence, questions have been raised about the suitability of the universal use of screening instruments in contexts of high prevalence, limited referral services, and overloaded and understaffed healthcare services (WHO, 2013a).[42] Finally, there is little evidence about the effectiveness of screening instruments for other groups or populations. Evidence from developed countries suggests that standard screening instruments could be ineffective for LGBTQ+ persons (Chan and Cavacuiti, 2008).

- **Instruments for referral of SGBV victims.** Most institutions that provide care for women survivors of violence are designed to work in an interconnected way, referring some users to a different institution where they can access specialized services (Luciano and Hidalgo, 2021). There is little evidence about the effectiveness of referral instruments, particularly in developing countries, partly because evaluation may be complex, given that referrals are made on the basis of different types of services, which in turn could have multiple components, some with positive results and some without (Luciano and Hidalgo, 2021). Of the studies reviewed, three stand out that demonstrate a positive impact of the use of referral instruments, while the other did not find an impact. The three studies with positive results found that (i) in the United States, women who reported partner violence and who received printed materials or direct referrals made more visits to social work and

[42] The WHO (2013a) does not recommend universal screening; rather, it recommends that healthcare providers be trained to respond and to be aware of mental and physical health indicators associated with violence, and that they ask about violence when those indicators are present.

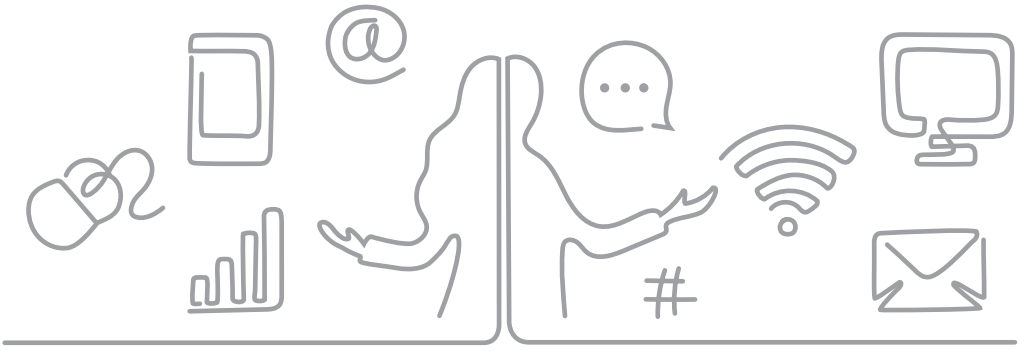
behavioral health services than women who declined both types of support (Clark *et al.,* 2019); (ii) victims who received an enhanced referral instrument, compared to a basic instrument, were more likely to use the suggested services in the United States (Wolff *et al.,* 2017); and (iii) an intervention that included screening, a brief activity and referrals for receiving treatment for women addicted to drugs and with problems of harmful alcohol consumption in Kyrgyzstan found that more than half of the participants reported having experienced fewer incidents of physical violence, a reduction in consumption of illicit drugs and an increase in access to SGBV-related services (Gilbert *et al.,* 2017). In other interventions in which the impact of referral instruments was compared with counseling sessions with nurses, the two types of actions were found to be equally effective for decreasing the threat of abuse, assaults (MCFarlane *et al.,* 2006) and IPV, but women who received the counseling session reported significant improvements in their mental health compared to those who received only screening and referral (Gupa *et al.,* 2017). Meanwhile, an evaluation conducted in the United States 12 months after the intervention found no difference in quality of life measurements (physical and mental health components) or recurrence of partner violence between the two groups that received the treatments (screening of IPV plus referral for women who were positive in detection of IPV, and referral only, without IPV screening) and the control group (no screening or referral) (Klevens *et al.,* 2012).



- **Specialized SGBV courts.** The objective of these courts is to improve the conviction rate, as well as the experience of survivors and their families, the judicial system's effectiveness in protecting women, coordination with other justice entities, reduction of delays and rates of victimization. In general, specialized courts have not been evaluated with rigorous methods and the evidence is very limited. Nevertheless, there are indications of a positive impact on survivors' access to justice (Jewkes *et al.,* 2015). One metanalysis of 20 studies found that specialized courts reduced the rates of recurrence of domestic violence; the results, however, became non-significant when considering only studies with solid, high-quality methodologies (Gutierrez *et al.,* 2016). In the United States, a recent study found that, compared with traditional courts, defendants assigned to a specialized court have less likelihood of being convicted, but are no more likely of being charged with a crime in the next three years (Golestani *et al.,* 2021). In addition, the victims had less likelihood of being involved in a future domestic incident.

- **Legal assistance.** Defenders and legal assistants help victims of SGBV gain access to and navigate the legal system. Rigorous assessments of the impact of such assistance on the reduction of abuse in the short term or an increase in access to the legal system were not found. Nevertheless, one pilot study conducted in the United States showed that abused women who received intense accompaniment by law students to obtain restraining orders for protection reported less recurring physical and psychological abuse and greater emotional support than women who received standard judicial services (Bell and Goodman, 2001).

- **Information and communication technologies (ICTs).** ICTs are tools that are increasingly being used in the fight against SGBV. Broad coverage of and access to the internet, mobile telephones and smartphones allow promising solutions for preventing and providing services to victims of SGBV. The following are some of the tools available:



- **Mobile apps.** There is a multitude of free apps, including for channeling complaints, emergency calls, legal advice and pedagogical assistance. A systematic review of 171 apps designed to address VAW found that they are used more for emergency solutions and less for prevention (Eisenhut *et al.,* 2020). The authors concluded that technological interventions must better address the range of factors (individual, relationship, community and societal) that contribute to VAW, connect with existing assistance groups and be complemented with more traditional approaches. It is also important that they be designed from a standpoint of universal accessibility, sensitive to ethnic-racial or connectivity aspects, and appropriate for the various situations of the people for whom the service is intended. Finally, it is recommended that they be included not as an end in themselves, but as tools complementary to other types of programs (El Morr and Layal, 2020).

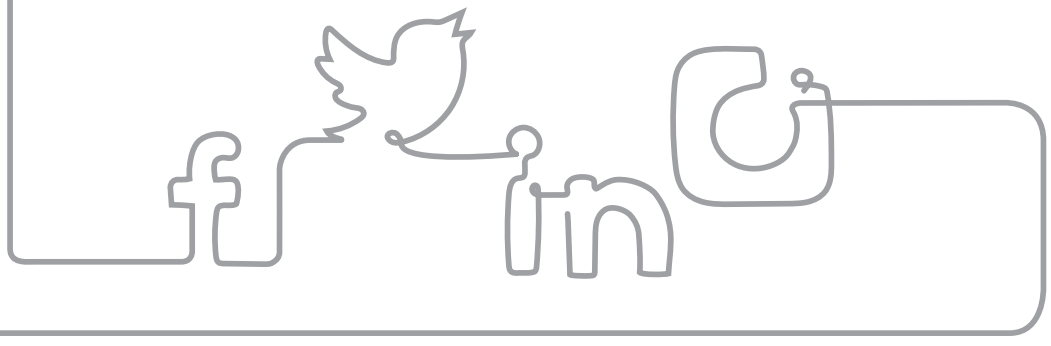
- **Telephone hotlines.** Telephone hotlines are staffed by lawyers, social workers and psychologists who provide specialized support to victims of SGBV and advise them about other available services. There is very little solid evidence about their effectiveness in preventing violence, and the literature review yielded only one impact evaluation. The evaluation of Line 123 in Medellín, Colombia, showed that providing immediate attention within 12 hours after an emergency call reduced the probability that the users would experience partner violence in the future (Romero *et al.,* 2017).

- **Online psychological assistance.** Evidence from developed countries shows that online psychological assistance for survivors of intimate partner violence (Constantino *et al.,* 2015) or sexual violence (Littleton and Grills, 2019) improves victims' mental health. For example, in the Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred (HELPP) intervention for intimate partner violence, participants were assigned at random to one of three study groups: online, face to face and waitlisted (control group). The results show that the intervention decreased anxiety, depression and anger in the face-to-face and online groups, and increased personal and social support for those in the online group (Constantino *et al.,* 2015).

- **Online and telephone legal services.** These offer orientation, guidance and technical-legal representation to women who suffer some form of SGBV and cannot afford a private lawyer. No robust evaluations were found of online or telephone legal services, but various resources refer to the importance of having such services, particularly in response to cases of IPV, which increased during the COVID-19 pandemic (see, for example, NCA and LAW, 2020; UNODC, 2020b; Gordon, 2002).

- **Technology for SGBV screening.** To screen for SGBV, healthcare service providers can ask questions in person or through printed or computerized questionnaires. Evidence from developed countries shows that the detection of SGBV using computerized questionnaires is as effective as or more effective than asking questions in person or using printed questionnaires (Chang *et al.,* 2012; Ahmad *et al.,* 2009; Trautman *et al.,* 2007), although printed questionnaires tend to have less missing information than personal interviews or computerized questionnaires (MacMillan, 2006). Nevertheless, one study that included low-income Afro-American women participants in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) found that they were less likely to disclose IPV using a computer-assisted self-interview compared to a face-to-face interview (Fincher *et al.,* 2015). Because face-to-face screening makes it possible to ask individualized questions and make a better emotional connection with the provider, the studies suggests that these methods be used in a complementary way.

- **Social media.** Social media can be used to promote awareness of available services. An evaluation tested the effectiveness of different behaviorally-informed Facebook ads on women's likelihood of seeking information about support services and obtaining assistance in cases of violence. The results of the randomized controlled trial showed a significant positive effect on the probability that women would seek assistance, as well as a significant and positive increase in the number of women who clicked on contact channels for *Ciudad Mujer* Honduras to ask about guidance and support services offered in the country's *Ciudad Mujer* Center (Bellatin *et al.,* 2020).



Box 4. Behavioral science as a public policy tool

Public innovation is essential for improving access to and the quality of services provided by the State. To this end, policy makers are increasingly applying ideas from the behavioral sciences to address public policy challenges, from encouraging savings for old age to improving services provided to victims of SGBV. Behavioral sciences seek to understand human behavior from different perspectives and take advantage of what is already known about how people make decisions, to prompt them toward better outcomes for themselves and for society as a whole (Garnelo *et al.,* 2019).

Although evidence about what works remains scarce, there are many opportunities to apply behavioral sciences to SGBV services. For example, the publication by Garnelo *et al.* (2019) provides practical recommendations and ideas for interventions that can be implemented and evaluated within the framework of existing services, both for public policy makers and for service providers, with an eye toward strengthening the response by LAC governments to survivors of IPV. It also offers an example of using social media to publicize and promote the use of services for victims of SGBV in *Ciudad Mujer* Honduras (see p. 67).

Strategic intervention 4. Awareness raising and behavioral changes

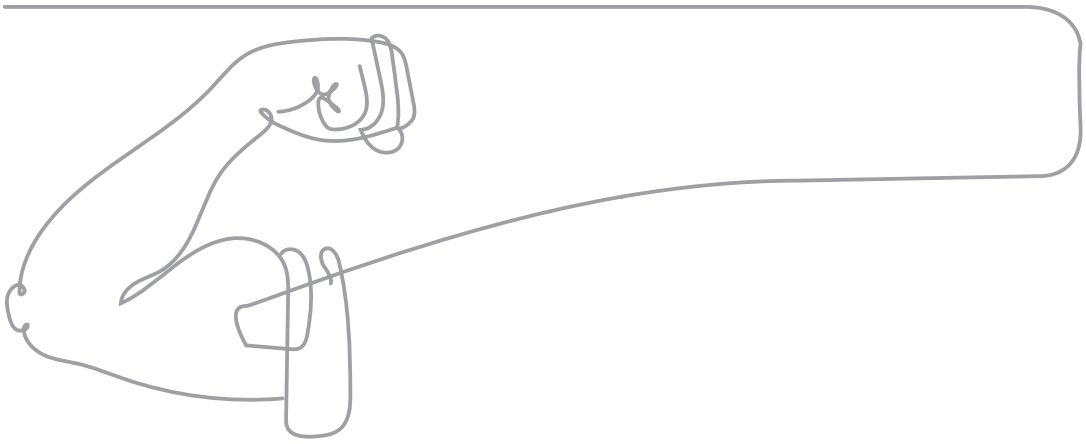
Description
Programs or interventions that seek to promote changes in behavior related to SGBV in women, men and children through psychoeducational programs and awareness-raising initiatives. These include efforts to raise public awareness about SGBV through the media, social media, communication campaigns and educational pedagogies.

Expected results

- Less acceptance and greater awareness of SGBV in communities, institutions and society as a whole.
- More women and girls gain access to adequate services for prevention and response.
- Women, girls, boys and adolescents gain better and greater access to educational services, life skills and livelihood opportunities.

Effectiveness	Prevention
Effective	• Community mobilization programs • Awareness-raising campaigns combined with workshops for social change • Public awareness-raising campaigns • Psychoeducational programs: ❖ for victims and survivors ❖ about non-violent child rearing ❖ for couples ❖ for adolescents, including school-related interventions ❖ pre- and post-natal
Promising	• Psychoeducational programs for women with disabilities • Bystander training programs for men
Mixed	• Sexual harassment prevention training in the workplace • Batterer's treatment programs

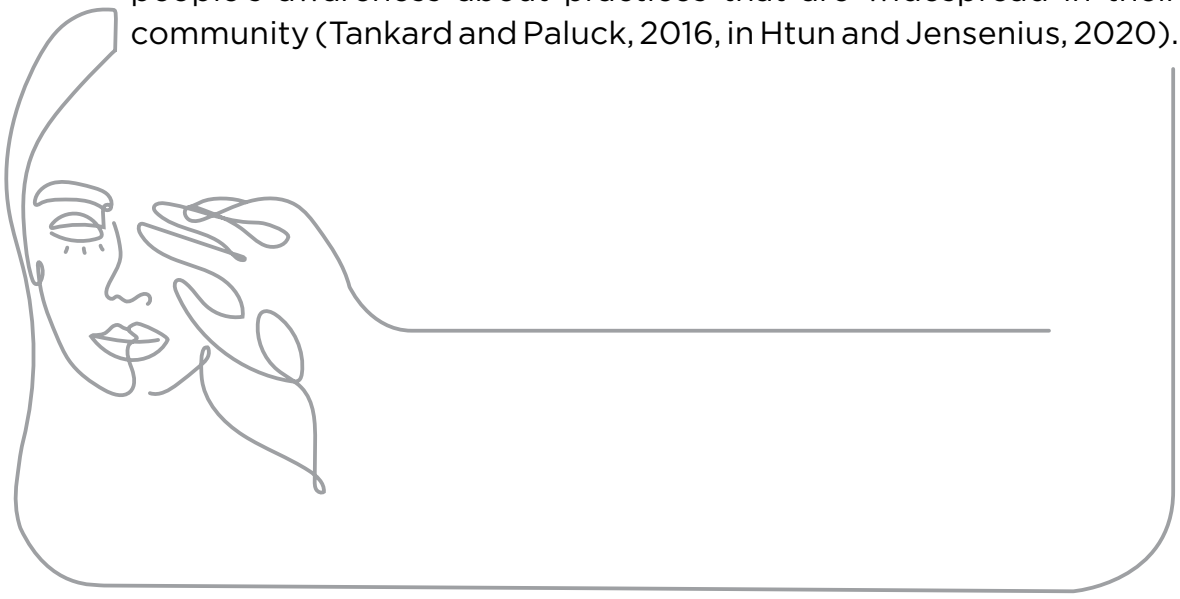
Unequal power relations between men and women are often justified on the basis of biological differences, rather than as socio-cultural patterns that have been constructed and which can be changed. Preventing and responding to SGBV require addressing multiple causes of gender inequality to produce the changes needed in social norms and behaviors (Arango *et al.*, 2014; Our Watch, 2019). Society as a whole must be part of the paradigm shift that questions and deconstructs conscious and unconscious gender norms. The following are some interventions that seek to promote behavioral changes and transform gender relations:



- **Community mobilization programs.** These are preventive interventions that seek to mobilize the community to reduce violence by questioning social norms and practices derived from gender roles. They may include community workshops and training sessions for peers and groups, aimed at changing attitudes and behavior; these often are accompanied by local campaigns and mobilization activities that include the use of video, radio or theater.[43] They may also include components that contribute to women's economic autonomy.[44] Most of the studies analyze the impact on direct beneficiaries of the intervention and not at the community level (for an exception, see Abramsky *et al.,* 2014). In one analysis of five interventions with rigorous evaluations, which were implemented in developed countries, six key elements were identified in the interventions that reduced violence: (i) inclusion of community groups, rather than including only community members as individuals; (ii) use of participatory methods in workshops to promote reflection about gender relations; (iii) development of manuals and materials to support implementation; (iv) gain commitment from and include women or couples who suffer violence and support survivors; (v) need for a significant contingent of personnel in the field and a minimum duration of 18 months for the activities; (vi) recognition of personnel selected for having the desired attitudes and modeling the expected behavior before being trained; and (vii) ongoing support for personnel after the training (Jewkes *et al.,* 2020).

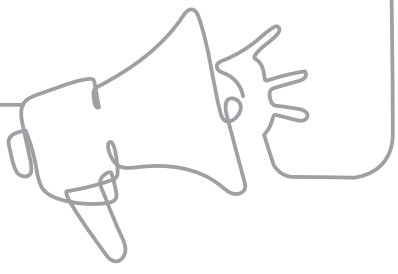
[43] For an example of an intervention that did not reduce physical or sexual partner violence because of a lack of sociocultural adaptation in Rwanda, see Dunkle *et al.,* (2020). For an example of an intervention that did reduce physical and sexual violence in Uganda, see Wegman *et al.* (2014).
[44] Community mobilization programs that combine group microfinance with additional participatory training on gender, violence and HIV risk reduce the probability that women will experience physical or sexual violence from their partners in South Africa (Kim *et al.,* 2007, 2009).

- **Public awareness raising campaigns.**[45] There is a lack of solid evidence that social awareness-raising campaigns or educational entertainment alone are effective for reducing VAW (Ellsberg *et al.,* 2015; Kerr-Wilson *et al.,* 2020; WHO *et al.,* 2010; Clark *et al.,* 2020). Nevertheless, campaigns have been shown to have an impact on raising awareness of SGBV. For example, one public information campaign increased awareness about gender violence among users of public transportation in Mexico City (Soto Villagrán, 2017; World Bank, 2017), although there is not yet solid evidence of its contribution to reducing violence. In addition, a marketing campaign about the prevention of sexual violence between 2010 and 2014 in a university in the United States asked 4,158 men about their attitudes, beliefs and behaviors, as well as their perceptions of those of their classmates. The results indicated that both their own attitudes and beliefs and their perception of those of their classmates improved over time, and the discrepancy between the two was reduced (Mennicke *et al.,* 2018; Kerr-Wilson *et al.,* 2020). It is important to note that campaigns against gender violence usually focus on the prevalence of rape — for example, with billboards stating that half of women are victims of partner violence — to cause indignation and mobilize commitment to change. Nevertheless, studies by social psychologists indicate that such campaigns may promote complicity with existing tendencies by increasing people's awareness about practices that are widespread in their community (Tankard and Paluck, 2016, in Htun and Jensenius, 2020).



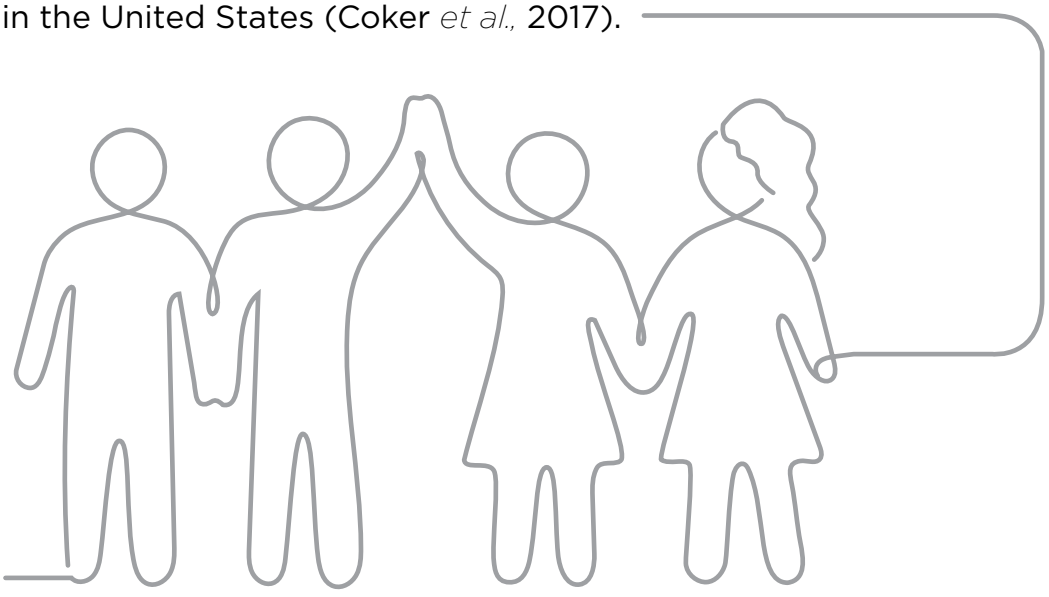
[46] It is important to mention that these campaigns have been classified as promising because of the result they seek to achieve, that is, not reducing SGBV, but affecting perceptions of or attitudes about it.

- **Awareness raising campaigns combined with workshops for social change.** If the information campaigns via television, radio, newspapers and other communication channels are complemented with actions at the community or individual level, such as socio-educational sessions or workshops, these campaigns may be effective in changing attitudes toward gender norms and reducing violence (WHO, 2010; Aguayo *et al.,* 2016). Some programs using this combination target men specifically and report promising results, such as positive changes in attitudes toward violence against women and a decrease in the self-reported use of physical violence against a partner in Brazil (Promundo, 2012); greater acceptance of housework as a responsibility of men; greater rates of condom use and lower rates of self-reported sexual harassment and violence against women in Brazil and India (Ricardo *et al.,* 2010); greater acceptance by men that they can avoid VAW and recognition that its effects go beyond the family unit and also affect their communities in Nicaragua (Solórzano *et al.,* 2000); greater probability of knowing about and having gone to a domestic violence center and of having talked with someone about the issue in Nicaragua (Solórzano *et al.,* 2008); and lower rates of physical and sexual violence, greater use of condoms, greater acceptance of equitable gender norms, better communication with partners and better attitudes toward sex in India (Verma *et al.,* 2008).



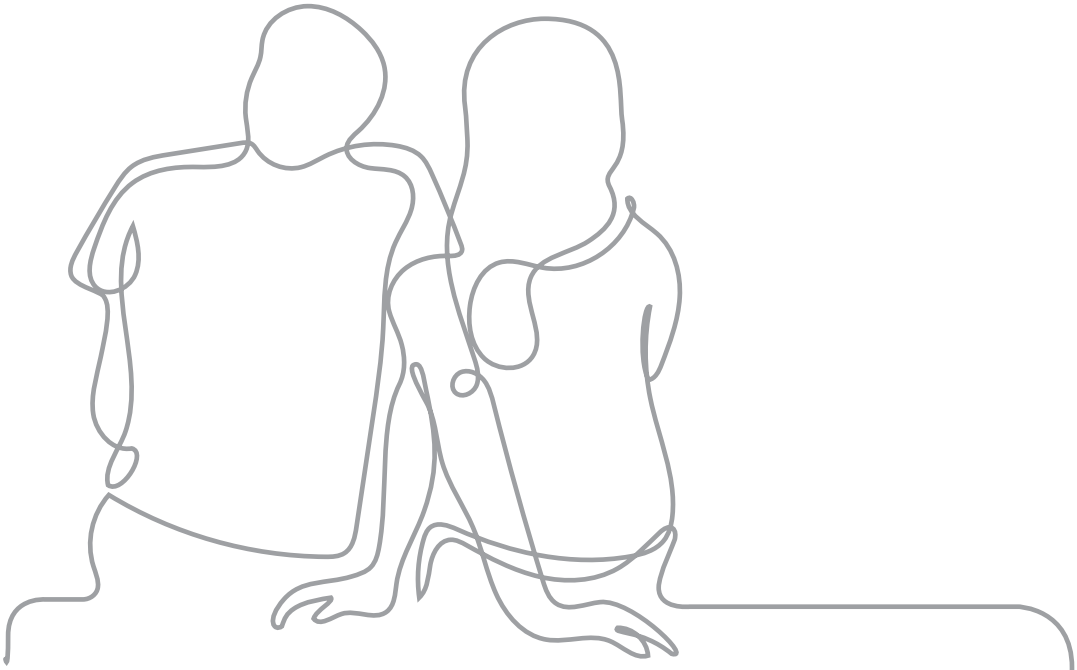
- **Bystander intervention training programs for men.** These focus on the ability of a person who witnesses an act of violence, mainly sexual, to identify such a situation as unacceptable and take responsibility and action to prevent it (Fenton *et al.,* 2016). Through awareness-raising interventions, this approach seeks to include men as allies who will intervene immediately if they witness an act of SGBV (Ricardo *et al.,* 2011). These programs are concentrated in university settings and have mainly been implemented in countries such as the United

States or Great Britain. Programs that have been designed with short sessions of one or two hours show no impact on reducing violence or other associated results (Gidycz *et al.,* 2011; DeGue, 2014; Jewkes *et al.,* 2014; Fulu and Kerr-Wilson, 2015). Interventions such as The Green Dot or Bringing in the Bystander, which have longer implementation times and more robust curricula, and which are designed to be led by student peers who are not professionals, but who are qualified and trained, seem to bring about positive changes in attitude on the following points: (i) not tolerating acts of violence; (ii) reducing sexist stereotypes; (iii) deconstructing myths about rape; (iv) increasing empathy about the consequences of rape; and (v) improving perceptions of the ability to intervene and its efficacy, among others (Cissner, 2009; Banyard *et al.,* 2014, Coker *et al.,* 2011, 2014, 2016; Amar *et al.,* 2012). Including women witnesses as allies for avoiding acts of violence also shows positive results (Banyard *et al.,* 2007). Finally, a randomized controlled trial in 26 secondary schools over five years shows positive results in the effectiveness of replicating the methodology of The Green Dot in the United States (Coker *et al.,* 2017).



- **Psychoeducational programs.** These contribute to making visible the unequal power relations between men and women and can help prevent or decrease the intensity and frequency of violence.

  - ❖ **Programs for victims and survivors.** Cognitive-behavioral therapy (CBT) encompasses a series of short-term treatments that include cognitive techniques related to learning to think differently about something, silencing self-criticism and revictimization, as well as behavioral components related to non-formal educational processes and development of skills for putting into practice new concepts and skills (Warshaw *et al.,* 2013; Kerr-Wilson *et al.,* 2020). Evidence that comes mainly from developed countries shows that psychoeducational programs help women who are victims of violence identify situations that are under their control and teach them empowerment skills to help establish agency and autonomy, make informed decisions and access resources, and reduce levels of post-traumatic stress and depression (Warshaw *et al.,* 2013; Johnson *et al.,* 2011; Johnson *et al.,* 2016; Santandreu and Ferrer, 2014). One cultural adaptation of a CBT-focused intervention for women refugees from Syria in Turkey showed high effectiveness in reducing post-traumatic stress symptoms, depression and anxiety, as well as the potential to be scalable by being reproduced in seven group sessions by trained, non-professional personnel (Eskici *et al.,* 2021). In Kenya, a program for women visiting an HIV treatment clinic, who were affected by GBV and were diagnosed with major depressive syndrome and post-traumatic stress syndrome, found that the women who received 12 CBT sessions along with the usual treatment had a significant reduction in post-traumatic stress, serious depression and IPV, compared to women who received the usual treatment. These sessions were conducted by trained, non-professional personnel (Meffert *et al.,* 2021). Finally, it should be noted that according to a literature review by Kiss et al. (2020), there are no physical and psychosocial health interventions aimed specifically at men and LGBT persons who are survivors of conflict-related sexual violence in low- and middle-income countries.



- **Programs for couples.** Initiatives evaluated in developing countries that focus on transforming gender relations within the couple or addressing alcohol and violence in relationships have proven effective for preventing and reducing violence in heterosexual couples (Kerr-Wilson *et al.,* 2020). The intervention may be aimed at same-sex groups or the couple, and effective interventions tend to be imparted by trained facilitators using participatory methods. Six of the 10 interventions analyzed had a positive impact on the reduction of SGBV (Kerr- Wilson *et al.,* 2020). The evidence comes mainly from countries in Africa and Asia, and no evaluations were found of programs in LAC. There also is little evidence focusing specifically on homosexual couples or those with disabilities. Nevertheless, the assessment of an intervention designed for couples in general found that couples with a disability obtained benefits similar to those of couples without a disability (Dunkle *et al.,* 2019). Research from developed countries suggests that the programs for LGBTQ+ couples require approaches that take into account their needs and realities (Rolle *et al.,* 2018; Merrill and Wolfe, 2000; Coleman, 2003).

- **Batterers' treatment programs.** These are court-ordered group interventions for male perpetrators that use cognitive-behavioral therapy approaches to reduce repeat incidences

of violence. Evidence about their effectiveness is mixed and comes from developed countries.[46] No assessments were found of the impact of those programs on LGBTQ+ persons (Rolle *et al.,* 2018). A review of 11 experimental and quasi-experimental studies in the United States, Canada and Australia concluded that the evaluations did not support the effectiveness of those programs, but there also is a lack of sufficient proof to conclude that they do not work (Wilson *et al.,* 2021). Another recent metanalysis found a significant reduction in IPV when all of the interventions were combined; nevertheless, analysis of the subgroups found that the interventions that incorporated a component on abuse of illicit substances or trauma were more effective than those that did not. Those that incorporated a component about gender relationships yielded mixed results (Karakurt *et al.,* 2019). The results point to the importance of applying strategies that adapt treatments to the situation of each individual (mental health, type of violence perpetrated, openness to change, etc.).[47]

- **Programs about non-violent child rearing.** The goal of these programs is to improve parent-child relationships and strengthen parenting skills. They consist of home visits but can also be implemented in clinics or at the community level. Evidence, mainly from developed countries, indicates that these interventions are effective for preventing the exposure of children to their parents' violence, reducing child abuse and breaking the cycle of intergenerational violence (McCloskey, 2011). Studies of child-rearing programs that include handling discipline without violence in developing countries (Chile [Aracena *et al.,* 2009], Iran [Oveisi *et al.,* 2010], South Africa [Cooper *et al.,* 2009] and

[46] One study from a Spanish-speaking country was found. The batterer's program in Spain seeks to eradicate abusive behavior toward a partner and decrease sexist beliefs used to justify such behavior. The evaluation found that the program produced in the subjects the expected cognitive therapeutic change in all variables related to abusive behavior that constituted the objectives of the intervention (Ramírez, 2010).

[47] There is a new generation of programs that have incorporated new elements, such as motivational interviews. Metanalyses have established that the motivational interviews improved outcomes within the program (for example, attendance and other indicators of compliance); nevertheless, there is insufficient proof to establish whether this new generation of programs reduces partner violence once the program ends (Santirso *et al.,* 2020, cited in Wilson *et al.,* 2021). In addition, most interventions for men who have acted violently toward their partner have been carried out as group interventions in the context of criminal justice. Few studies, therefore, have examined individual psychotherapy and how such interventions could reduce IPV. The findings of one exploratory study in Norway suggested that psychotherapy could be a promising intervention for reducing IPV (Askeland *et al.,* 2021).

Turkey [Kagitcibasi *et al.,* 2001]) also provide evidence of improvement in child-rearing practices and in parent-child relationships. In addition, the most recent interventions begin to combine approaches for preventing both IPV and violence against children. Two interventions evaluated with this approach, one in Rwanda and the other in the United States, yielded a positive impact on the reduction of IPV and of physical abuse of children (Doyle *et al.,* 2018; Feinberg *et al.,* 2018). The LAC region, however, has very few programs for strengthening parenting skills that focus on handling discipline without violence, include men and focus on prevention of violence against women and child abuse, and those that exist have not been subject to rigorous evaluations (Bustelo *et al.,* 2020; McCloskey, 2011). Nevertheless, it should be noted that there is a range of parenting programs in LAC that focus on improving child development and which have had positive effects on discipline. For example, a home visiting program that sought to improve child development through peer counseling for mothers in rural areas of Peru improved child development and changed child-rearing practices in the households: parents were less likely to adopt punitive child-rearing practices (Araujo *et al.,* 2021). In Jamaica, a home visiting program that sought to improve nutrition and stimulation of children with retarded growth found that 20 years later, the participants reported less involvement in fights and violent behavior (Walker *et al.,* 2011). Finally, another assessment of a home visiting program that offered guidance and counseling on child rearing and early stimulation, focusing on changing parents' behavior, found that the program did not affect the use of violent disciplinary practices in Bolivia (Johannsen *et al.,* 2019).

- **Programs for adolescents.** There are few studies and interventions in LAC that address violence among adolescents. As a result, many of the programs aimed at eradicating violence against women omit adolescence, a stage of life in which violent behaviors begin to manifest themselves, sexual initiation occurs and couple relationships begin. They therefore lose an opportunity to promote non-violent relationships throughout life (Bustelo *et al.,* 2020; Taylor *et al.,* 2017; McCloskey, 2011a). One study, which summarizes the evidence from six interventions with impact evaluations (five in developed countries and one in South Africa) aimed at reducing levels of IPV perpetration and victimization among adolescents, concluded that those interventions could be effective for preventing and reducing violence and obtain better results when implemented in multiple venues (schools, youth centers, multi-sport centers, among others), when they have a long-term duration or projection, and when they include people who play key roles in the adolescent's life (Koker *et al.,* 2014).

- **School-related programs for preventing SGBV.**[48] Assessments of interventions in school environments show that they are promising for modifying attitudes about gender roles among young people and lead to healthy dating relationships, better school environments and less physical and sexual violence during courtship (Kerr-Wilson *et al.,* 2020). Intervention success factors include incorporating multiple sessions over time that seek to change attitudes and norms, rather than just providing information. In the educational sphere, programs aimed at boys are more effective when they work with mixed groups (Russell, 2021). Most evidence comes from developed countries,[49] and the four impact evaluations found that were conducted in Latin America indicated that the interventions led to changes

[48] Other types of violence that occur in schools and which have not been included in the literature review are violence between peers, corporal punishment, violence perpetrated by a student against a teacher, and violence perpetrated by a teacher against a student. A study that summarizes evidence about these types of violence indicates that the majority of the interventions evaluated have been conducted in the United States and few have been identified as effective (Lester *et al.,* 2017). The authors indicated that cognitive-behavioral, socioemotional and peer counseling/mediation interventions were the most promising for reducing levels of perpetration of aggression between peers.
[49] Of 12 interventions with rigorous evaluations, nine are from the United States or Canada, two from South Africa and one from Mexico (Kerr-Wilson *et al.,* 2020). For another worldwide review of school interventions, see also Parkes et al. (2016).

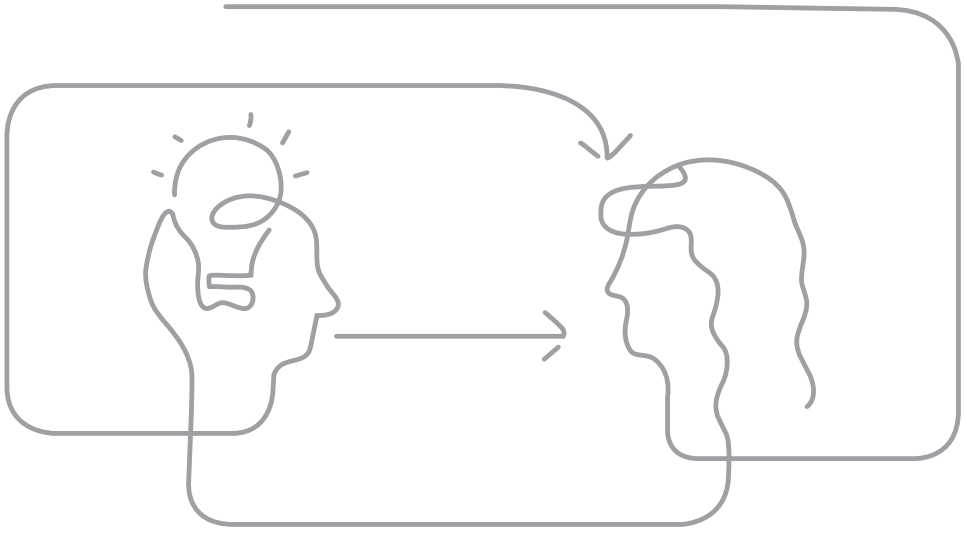
in violent psychological behaviors and attitudes but did not detect a reduction in physical or sexual violence. The first is of a program to reduce courtship violence among adolescents in Mexico (*Amor, pero del bueno*), which reduced the prevalence of psychological violence in adolescent dating and the likelihood that young people would accept violent and sexist attitudes, and increased students' knowledge of support resources available. No impact, however, was detected in victimization or perpetration of physical or sexual violence reported by adolescents (Sosa-Rubi *et al.,* 2017). The second, a program aimed at enhancing young people's life skills implemented in secondary schools in El Salvador, improved knowledge about gender among boys, promoted conversations and shifts toward attitudes more favorable to gender equality in women, and led to changes in reports about sexual behaviors for both sexes (Bando *et al.,* 2018). The third, a prevention program in Chile where young men participated in socioeducational workshops facilitated by trained health personnel, found a significant impact on attitudes related to gender and violence (Obach *et al.,* 2011). And the fourth, a training program in schools in two states in Brazil, aimed at young men and fathers, increased equitable attitudes about gender, decreased self-reporting of STD symptoms and increased condom use (Pulerwitz *et al.,* 2006). Other studies from developing countries outside of the region also have shown that interventions in schools modify knowledge about gender-based violence, increase awareness of rights and reduce the acceptance of violence among young men and women (Das *et al.,* 2012; Achyut *et al.,* 2011), even two years after the intervention (Dhar *et al.,* 2020).

- **Pre- and post-natal programs.** In general, interventions aimed at women in the pre- and post-partum stages can be divided into two types. The first targets women at high risk or victims of SGBV with a psychobehavioral approach and offers support for reflection and development of concrete strategies, including safety plans to minimize the risk of falling back into the cycle of violence. These focus on providing guidance for planning safety and financial support, as well as facilitating access to other services, such as shelters. Evidence that comes

mainly from the United States indicates that multiple-session cognitive-behavioral therapy interventions are effective in reducing IPV (Kerr-Wilson *et al.,* 2020). It also has been shown that multiple sessions of individual counseling for pregnant Afro-American women with a history of IPV are effective for reducing revictimization rates (Kiely *et al.,* 2010). Evidence also shows that brief counseling sessions have no impact (Kerr-Wilson *et al.,* 2020). The second type of intervention is home visits by health professionals or non-professional mentors during pre- and post-natal periods to women who are at risk or are victims of SGBV. The programs cover topics beyond counseling on IPV, including child nutrition, family relationships, safety planning and overall welfare. Evidence from developed countries shows that intensive and frequent home visits from health professionals or non-professional mentors to pregnant women at risk of SGBV during the pre- and post-natal periods reduced IPV, particularly when the visits continued for a year or more, were made before and after pregnancy, and involved the mother's partner (Bair-Merritt *et al.,* 2010; Mejdoubi *et al.,* 2013; Taft *et al.,* 2011; Dugan *et al.,* 1999). In LAC, an assessment of a home visiting program for pregnant adolescents detected no differences in abuse and child neglect between women who received the intervention and a control group using a health center in Chile (Aracena *et al.,* 2009).

- **Program for women with disabilities.** There are very few psychoeducational programs aimed specifically at women with disabilities. Indeed, there is a scarcity of interventions for women in general that incorporate a differentiated approach for this segment of the population. Nevertheless, one eight-week psychoeducational program in the United States, which educates and trains professionals who provide services to persons with disabilities, resulted in an improvement in protection factors, including greater awareness about abuse, skills and self-efficacy in the areas of safety, social support and behaviors that promote safety in women with disabilities, compared to a control group that received the standard service (Robinson-Whelen *et al.,* 2014).

- **Sexual harassment prevention training in the workplace.** The goal is to raise employees' awareness about sexual harassment at work: from increasing the ability to recognize it to informing about the organization's procedures for receiving, handling and resolving complaints. The little solid evidence that exists about the effectiveness of these programs, which comes from developed countries and mainly from university environments, indicates that training alone is unlikely to reduce sexual harassment in the workplace[50] (Roehling and Huang, 2018). In the United States, studies indicate that traditional training programs are ineffective because: they do not address the cultural change necessary within the organization, are focused merely on compliance with regulations,[51] people expect immediate results after a single training session, employees have negative attitudes before the training, and there is no effective measurement for determining whether the training has met its objectives (Zelin and Magley, 2020; Perry *et al.,* 2019).[52]



[50] Evaluations have yielded mixed, and in some cases unexpected, results. For example, one study suggests that training on sexual harassment can reduce the number of women managers, possibly as a result of threats against the group and the reaction from men (Dobbin and Kalev, 2019). In addition, an intervention aimed at university faculty in the United States found that participants demonstrated greater knowledge of sexual harassment in the workplace compared to those who did not participate in the program, but men were less likely than other groups to perceive coercive sexual harassment, less willing to file complaints about sexual harassment and more likely to blame the victim (Bingham and Scherer, 2001). Finally, a laboratory experiment in a university found that the training on sexual harassment can worsen men's attitudes about harassment by amplifying pre-existing gender biases (Robb and Doverspike, 2001).

[51] In several states in the United States, it is mandatory to provide training for employees about sexual harassment in the workplace.

[52] Current recommendations (not supported by impact evaluations) focus on promoting cultural change within the organization, adapting interventions that include, but are not limited to, training, and which simultaneously target both individuals within the organization and the organization itself (Perry *et al.,* 2019; Zelin and Magely, 2020; Cheung *et al.,* 2018). In addition, it is recommended that more women be contracted and promoted in companies (Dobbin and Kalev, 2019), that training be conducted according to evidence-based training principles (Eatough *et al.,* 2019) and that an organizational context be developed that supports training efforts (Roehling and Huang, 2018).

Strategic intervention 5. Economic, social and political empowerment

Description
Interventions aimed at informing and educating women and girls about their rights, promoting their leadership and providing tools and formative, work-related and educational resources, as well as opportunities for income generation. Also, empowerment programs or interventions that include men and boys.

Expected results

- Women, children and adolescents achieve greater and better access to educational services, life skills and livelihood opportunities.
- Less acceptance and greater awareness of SGBV in communities, institutions and society as a whole.

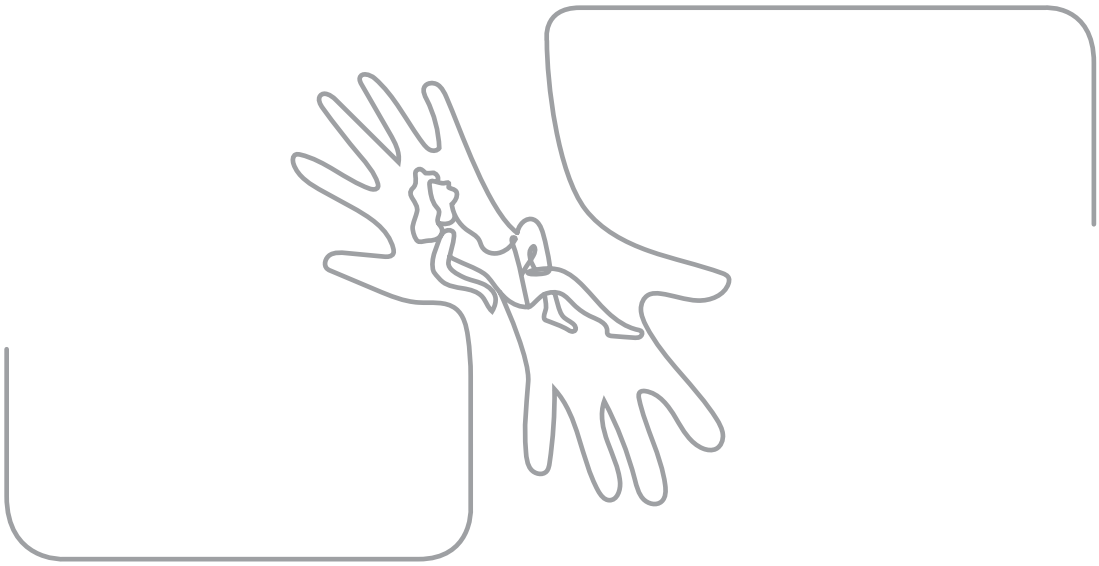
Effectiveness	Prevention
Effective	• Economic and social empowerment • Empowerment programs for sex workers • Empowerment and self-defense to prevent sexual violence in universities and secondary schools • Quotas for the inclusion of women and other groups in decision-making spaces
Promising	• Digital tools for safety • Promoting women's and girls' voice and agency
Mixed	• Cash transfer programs
Ineffective	• Stand-alone microfinance programs

Situations of marginalization, economic vulnerability or lack of access to livelihood opportunities increase the likelihood of suffering, witnessing or perpetrating SGBV (Ellsberg and Heise, 2005; Nieuwenhuis *et al.,* 2019; Hindin *et al.,* 2008). For men, living in poverty can create stress and frustration over not having fulfilled their role as provider (at least, that which is culturally expected), which contributes to perpetuating the cycle of violence and can be a cause of the high number of suicides (Heilman and Barker, 2018; WHO *et al.,* 2010, cited in Morrison *et al.,* 2007). Increasing women and men's economic opportunities and empowerment could therefore be a strategy for reducing violence. Interventions for promoting economic and social empowerment include:

- **Cash transfer programs.** In general, cash transfers are effective for reducing women's experiences of sexual or physical violence. Of a sample of 22 economic transfer interventions, 16 studies (73%) provided evidence that the cash transfer programs reduced intimate partner violence, two showed mixed results (9%) and four showed no effects (18%) (Buller *et al.,* 2018). In Latin America, however, various evaluations of cash transfer programs have shown that the impact on reducing SGBV has been mixed. On the one hand, there are two studies with a positive impact on the reduction of SGBV in Ecuador [53] (Hidrobo *et al.,* 2016) and in Peru[54] (Perova, 2010). On the other hand, other studies conducted in Latin America indicate that the magnitude of the effect and the results vary depending on the amount of the transfer[55] (Angelucci, 2008), the beneficiaries' educational level[56] (Hidrobo and Fernand, 2013), time in the program[57] (Bobonis *et al.,* 2015), poverty levels and geographic region[58] (Rodríguez, 2015), all of which could possibly increase aggressiveness and violence perpetrated by the husband or partner. The mixed results indicate the need to conduct more studies to understand: (i) if interventions with social components (workshops, group presentations or other conditionalities) have greater impacts on violence reduction within the couple than cash transfers alone; (ii) if the impact on SGBV continues once the cash transfers end; (iii) if women must be chosen directly to receive the transfer or if targeting the head of household (often a man) achieves the same

[53] In Ecuador, a program of cash transfers, food and coupons for women reduced sexual and physical violence and controlling behaviors, regardless of the mode of transfer.
[54] In Peru, a cash transfer program conditioned on the education and health of the beneficiaries' children significantly reduced the physical violence experienced by women in the couple, but not sexual violence within the couple relationship.
[55] Small conditional cash transfers reduce domestic violence associated with alcohol in rural households in Mexico; large transfers, however, increased aggressive behavior by husbands who had traditional views of gender roles (Angelucci, 2008).
[56] Cash transfers significantly decrease psychological violence in the couple for women with education beyond primary school; in the case of women with primary studies or less however, the cash transfer significantly increases emotional violence in households in which the woman's education is equal to or higher than that of her partner (Hidrobo and Fernand, 2013).
[57] Unlike short-term estimations, long-term rates of physical and psychological abuse among beneficiaries of conditional transfers in rural areas of Mexico do not differ significantly between beneficiary and non-beneficiary couples (Bobonis *et al.,* 2015).
[58] Conditional transfers in Colombia reduce intrafamily violence in beneficiary households in the wealthiest municipalities in the short term, but the effects disappear in the medium and long term, while in the poorest municipalities, the effect disappears and in some cases the situations of violence even worsen. The study also found that the reduction in intrafamily violence is lower when an unexpected payment is received and that, in contrast, when an expected payment does not occur, intrafamily violence increases (Rodríguez, 2015)..

positive results; (iv) if the impacts vary substantially depending on the initial position of the woman in relation to her husband or partner; (v) if there are direct or indirect impacts on violence against children or adolescents or other types of intrafamily violence; (vi) if there are impacts on emotional violence and controlling behavior by the partner; and (vii) beyond the impact, ways in which economic transfers affect IPV (Kerr-Wilson *et al.,* 2020).



- **Economic and social empowerment.** In general, evidence from interventions that combine critical reflection on gender roles, norms, and power relations between men and women with an economic empowerment component, for example, through microfinance, demonstrate that such interventions improve economic outcomes and reduce SGBV (Jewkes *et al.,* 2013, 2020). An analysis of five interventions with rigorous evaluations implemented in African countries, shows that the interventions were successful in reducing violence when they incorporated five key elements: (i) economic empowerment, providing funds for food and placing these resources under the women's control; (ii) inclusion of men and extended families, particularly in highly patriarchal environments; (iii) weekly two- or three-hour training sessions, with a total duration of 40 to 50 hours over the course of the intervention; (iv) personnel carefully selected, trained and supported throughout the intervention; and (v) a theory of change based on an analysis of the context (Jewkes *et al.,* 2020).[59]

[59] Kerr-Wilson et al. (2020) included six additional interventions that did not have an impact.

Another noteworthy aspect is that the short-term interventions had a greater impact on women over age 30, while adolescents experienced better outcomes with longer-term interventions. Although interventions with economic and social empowerment components tend to be effective, that is not always the case. For example, an educational training program focusing on human rights and VAW, which also included children and targeted women in rural areas of Peru who were already participating in a microcredit program, did not reduce IPV (Agüero and Frisancho, 2018). Nevertheless, women did achieve greater awareness and probability of perceiving controlling behaviors, as well increased knowledge of available SGBV resources and more openness to speaking publicly about family relationships.

- **Stand-alone microfinance programs.** The evidence indicates that stand-alone microfinance or savings interventions, which do not include additional components aimed at raising awareness or reducing the incidence of SGBV, do not reduce SGBV (Green *et al.,* 2015; Kerr-Wilson *et al.,* 2020).

- **Empowerment programs for sex workers.** The goal of these programs is to reduce the violence exercised by clients, police or strangers, and by the sex workers' partners. The interventions are aimed at empowerment and the creation of networks, and they promote the use of condoms and the reduction of consumption of alcohol and illicit substances. The evidence, which comes mainly from Africa and Asia, indicates that these interventions are effective in reducing violence when they promote collectivization[60] and operate during an extended period, or when, although short-term, they seek to reduce abuse of illicit substances[61] (Kerr-Wilson *et al.,* 2020). Sex workers in the LGBTQ+ community, mainly transgender women, face additional vulnerabilities; studies of interventions that included this group, however, were not identified.

- **Empowerment and self-defense.** These interventions include a personal defense component to fight aggressors and a strong emphasis on speaking about consent and pressure, risk assessment and other non-physical strategies for reducing risk and for avoiding or dissuading attacks. There is promising evidence from Canada and the United States that shows that such interventions with university students can be effective in reducing cases of sexual aggression (Hollander, 2014; Senn *et al.,* 2015, 2017; Kerr- Wilson *et al.,* 2020). Most evidence about the impact of the intervention on adolescents comes from developed countries, and the evidence from developing countries is from Africa. This evidence, from Kenya, shows a reduction in rates of sexual assaults and an increase in the reporting of sexual aggression by adolescents in secondary school (Baiocchi *et al.,* 2017; Sarnquist *et al.,* 2014), as well as a significant reduction in rapes of adolescents (Sinclair *et al.,* 2013). Evidence from Uganda shows significant improvements in knowledge and behavior in the treatment group in the area of sexual and reproductive health, and a marked reduction in forced sexual relations (Bandiera *et al.,* 2020). Finally, in the United States, the first study of a self-defense

[60] A program in southern India that combined joining workers together in a collective, promoting the supply and use of condoms, and promoting tests for the detection and treatment of HIV, with mechanisms for responding to violence suffered by the sex workers, including a 24-hour help line and legal responses, found that the workers suffered significantly less violence from clients and police (Beattie *et al.*, 2015).
[61] A program for sex workers in South Africa to address substance consumption and violence and promote condom use and the design of personal life plans, resulted in a biochemically verified reduction in drug consumption, as well as a reduction in physical violence and sexual abuse from partners (Wechsberg *et al.,* 2011).

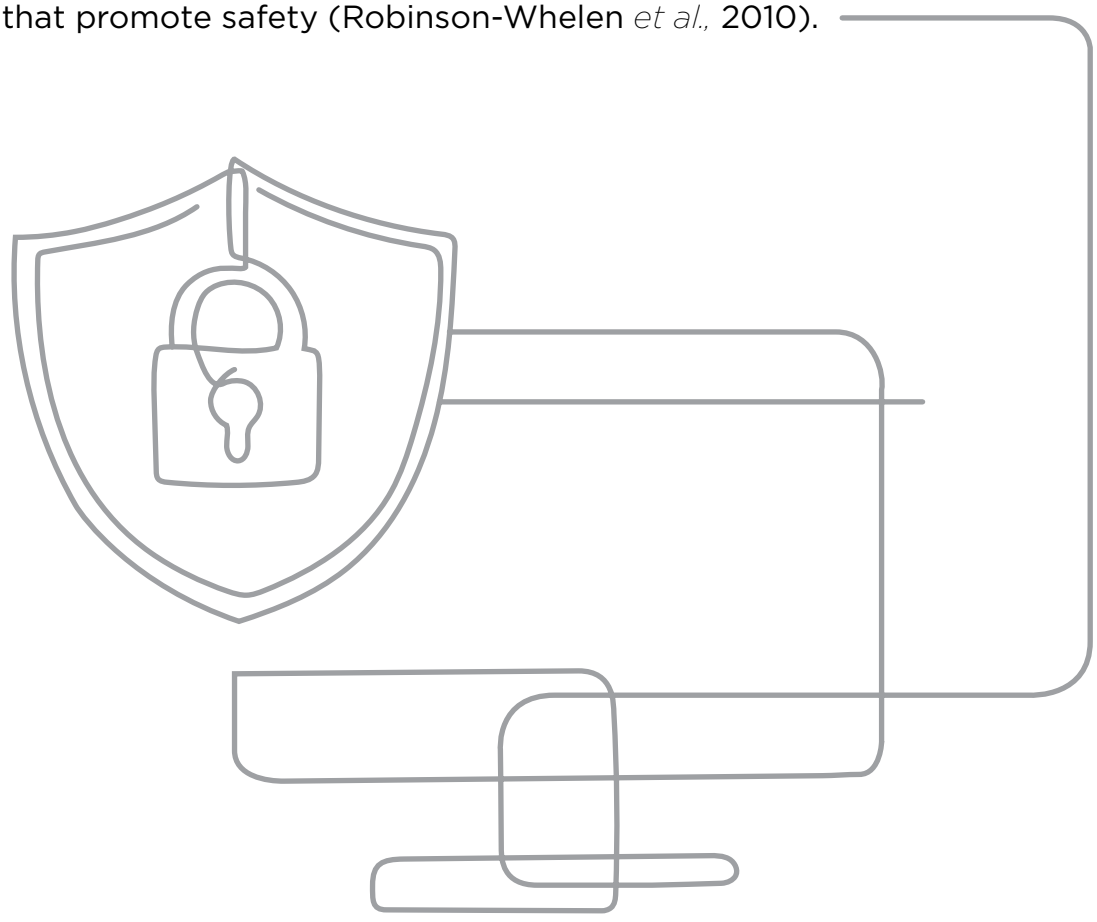
and empowerment program to prevent sexual assault among American Indian girls was conducted. The study evaluated the effectiveness of a six-session (12 hours) self-defense classroom delivered curriculum (Impower) among girls in an Indian Reservation and found a significant increase in efficacy in resisting a sexual assault and knowledge of resistance strategies. Follow-up analysis also suggested that girls who received this training reported less sexual assault and harassment compared to their peers in the control group (Edwards *et al.,* 2021).

- **Promoting women's and girls' voice and agency.** Programs that strengthen women's decision-making power and advocacy capabilities can contribute to a decrease in SGBV. For example, an intervention aimed at low-income Latin American migrant and refugee women in the United States that included leadership training to advocate for the interests of their community, among other activities, achieved a decrease in incidents of coercive or violent behavior from the participants' partners (Gómez *et al.,* 1999). Nevertheless, an evaluated intervention aimed at empowering indigenous girls in Mexico did not detect an impact on SGBV. The intervention operated through mentoring groups in which the girls could feel safe about expressing their opinions and demands and could receive information about a wide array of subjects, such as health, financial education, social capital, STD prevention and contraceptive use, as well as work aimed at preventing early marriage and school abandonment. No impact was detected in longer-term outcomes such as exposure to violence, adolescent pregnancy and upward social mobility (Larrea, 2020).

- **Quotas for the inclusion of women and other groups in decision-making spaces.** Promoting women's increased participation in decision-making spaces can contribute to greater representation of their interests, specifically on matters related to SGBV. In Latin America, greater representation of women in the legislative branch of government is associated with a larger number of laws that address SGBV, discrimination and sexual and reproductive rights, among other priority issues for women (Schwindt-Bayer, 2006). Evidence from other parts of the world also show that when people from diverse groups are included in the legislature, there is greater representation and adoption of policies benefiting those groups, such as persons with disabilities (Reher, 2021), LGBTQ+ persons (Reynolds, 2013), those of African descent (Grose, 2005) and Latinos in the United States (Hero and Preuhs, 2010). Quotas, when they are well designed and achieve a critical mass of women who participate actively, are an effective instrument for increasing women's participation in decision-making spaces (Franceshet *et al.,* 2012). In fact, there is a positive relationship between countries with well-designed quota laws and the presence of women in power with the existence of strong legislation against SGBV (rape, IPV and sexual harassment) (Hanks, 2015).

- **Digital tools for safety.** ICTs have been used to empower women, enabling them to create action and safety plans and providing them with tools for better decision making and self-efficacy (Luciano and Hidalgo, 2021a). This is an incipient area, but one that is increasingly included in interventions and evaluations. The available evidence comes from developed countries. There are interventions with positive results and others with mixed results. Among the studies showing positive impacts are two programs for victims of IPV in the United States that incorporated an online tool to facilitate the process of making decisions about safety. The interventions significantly improved the victims' decision-making capability and promoted the creation of a safety plan (Eden *et al.,* 2015; Glass *et al.*, 2010). Another intervention in Canada for victims of IPV used a digital intervention that helped participants with their symptoms of depression and their degree of confidence in safety planning, among other positive results (Ford-Gilboe *et al.,* 2020). Meanwhile, the evaluation of a program to help women IPV victims make safety decisions, which compared an interactive and individualized internet tool with a tool that was interactive but not individualized, found a non-significant reduction in

IPV for the group that received the individualized tool. Nevertheless, an analysis of the subgroups found a significant reduction in IPV in indigenous Maori women in New Zealand, while it did not detect an effect in non-Maori women (Koziol-McLain *et al.,* 2018). Another empowerment program aimed at women with disabilities in the United States used an online assessment tool that enabled women with disabilities to self-evaluate and detect IPV. The impact evaluation of this program showed that it significantly increased awareness of abuse among women who had not previously reported abuse (and did not have an impact on those who had previously reported abuse). It found no measurable effect on safety self-efficacy or in behaviors that promote safety (Robinson-Whelen *et al.,* 2010).



Strategic intervention 6. Data and evidence

Description

Programs and initiatives that generate evidence about what works in the prevention of and response to SGBV, efforts to reinforce national and subnational data-gathering systems and impact evaluations of interventions and policies.

Expected results

- Greater knowledge and evidence to inform interventions for preventing and responding to SGBV.

It is important to have rigorous data and evidence that measure the causes and effects of the different forms of SGBV, the tangible and intangible costs and losses due to this social problem, and the cost-effectiveness of interventions aimed at preventing it and supporting victims. These will make it possible, in a generalized way, to (i) understand the magnitude of the problem; (ii) formulate policies, programs and interventions that make it possible to offer solutions to problems and distribute resources; (iii) understand and quantify the quality of services; (iv) monitor progress and effectiveness of interventions; (v) adjust and adapt solutions to the differentiated realities and needs of diverse segments of society; and (vi) scale up the most cost-effective interventions.

In recent years, important progress has been made in generating evidence and data about SGBV. Information has been produced about the prevalence of violence, and there is greater knowledge about risk and perpetuation factors, preventive measures and response actions. Nevertheless, according to the literature reviewed for this study, most of the evaluations are from developed countries, and the most frequent ones from developing countries are from Africa or Southeast Asia. The lack of impact evaluations in LAC is generalized, but it is even more pronounced in the English-speaking Caribbean.

In the case of LAC, there are more effective interventions that have been evaluated in the area of prevention than in response. Of the 44 types of interventions analyzed for this study, there is more evidence of effective interventions for prevention of (12) than for response to SGBV (2) **(Table 2)**. The interventions that have been classified as effective for prevention are concentrated in the strategic areas of *Awareness raising and behavioral changes* and *Economic, social and political empowerment*, while there are none in the areas of *Multisectoral and coordinated actions, Institutional strengthening and capacity building* and *Access to and quality of services.* In the category of promising interventions, the opposite is true: there are more promising interventions for response (9) than prevention (4) of SGBV, and one of them addresses both areas. In addition, most of the evidence is aimed at interventions focusing on physical and sexual violence, and to a lesser extent on other forms of SGBV, such as psychological or economic violence or trafficking, among others. Finally, few studies have evaluated whether the changes achieved in the short term were maintained over time.[62]

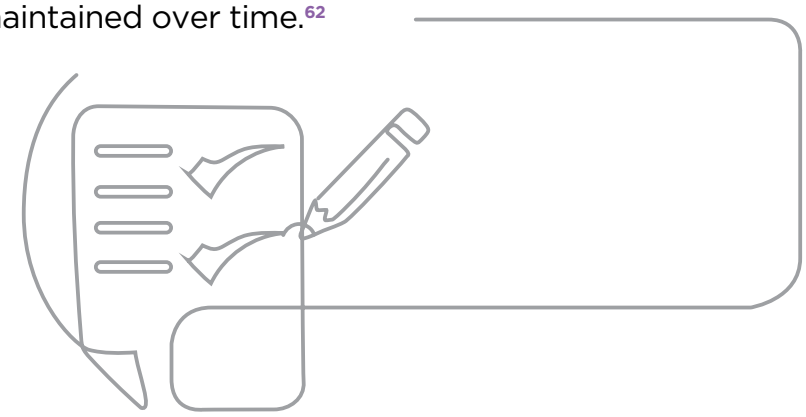


Table 2. Tabulation of interventions reviewed, by degree of effectiveness

	Prevention	Response	Prevention and response	Total
Effective	12	2	0	**14**
Promising	4	9	1	**14**
Mixed	4	1	0	**5**
Insufficient evidence	1	6	3	**10**
Not effective	1	0	0	**1**
Total	**22**	**18**	**4**	**44**

[62] Getting out of violence is a long-term process. In the short term, women may experience a greater risk of violence when they try to leave an abusive situation. This has important implications for the timing of impact evaluations, but also for the design and implementation of interventions (Morrison *et al.*, 2007).

Very few interventions that have been assessed using rigorous methods incorporate an intersectional approach. There is a lack of interventions that take an intersectional approach, but there are also few interventions aimed specifically at women and girls who suffer multiple forms of discrimination based on different social dimensions of their identity. Thus, a small number of evaluations measure differentiated impacts based on the participants' age, race, ethnic group, sexual orientation, poverty level, migratory status or disability (Crooks *et al.,* 2019). Nevertheless, some studies have begun to address this gap. For example, an analysis of four rigorous evaluations conducted in developing countries found that young and older women responded in differentiated ways to interventions for preventing IPV (Corboz *et al.,* 2020)[63]. Two metanalyses of evaluated interventions for preventing physical or sexual partner violence in developing countries found that women with disabilities reported the same results as their peers without disabilities, whether that was a comparable reduction or no effect. This suggests that women with disabilities were not affected differently by these programs for preventing SGBV (Dunkle *et al.,* 2020; Stern *et al.,* 2019).

There is very limited evidence about what interventions are effective at scale and what variables must be taken into account for scaling up and adaptation. There also are few interventions that have been implemented and assessed in one region of the world and later adapted in another.[64] In the case of LAC, we identified six interventions that have been adapted and reproduced in the region **(Annex 4)**. One example of innovative programs that seek scalability with cultural relevance are Promundo's Program H and M, which are adapted to the country's particular cultural characteristics. Program H has been adapted as Program Ra and Manhood 2.0 in the Middle East and the United States, respectively. In addition, the methodologies used by these programs have been adapted to numerous countries, some of them in Latin America (Aguayo *et al.,* 2016). On the other hand, an example of a failed adaptation is the community mobilization program "SASA!" which sought

[64] Workshop-based interventions resulted in a greater reduction of sexual and economic violence in young women, compared to older women, but no discernable age patterns were detected with regard to physical and emotional violence (Corboz *et al.,* 2020).
[65] Interventions can be adapted in different ways: (i) a program that is adapted to be administered in another country; (ii) programs that are scaled up or expand their coverage at the national level; and (iii) particular methodologies or curricula that, because of their effectiveness, are reproduced by diverse actors and in different contexts.

to apply the successful formula of a program from Uganda to a rural context in Rwanda without conducting a sociocultural analysis (Dunkle *et al.,* 2020).

There is still a lack of data about the cost and cost-effectiveness of interventions for preventing and responding to SGBV, and most comes from developed countries (Remme *et al.,* 2014). Evidence about the costs of prevention of and response to SGBV is fundamental for supporting the economic analyses necessary to justify the expansion of any intervention. Although there are several studies in the gray literature that analyze the cost and cost-effectiveness of interventions in developing countries,[65] to date only two of them have been published (Torres-Rueda *et al.,* 2020). The first case is the IMAGE program, an intervention that combines microfinance and gender training to prevent IPV in rural areas of South Africa (Jan *et al.,* 2011), which was potentially cost-effective, especially at scale (Torres- Rueda *et al.,* 2020), although it is important to note that when the program was adapted to and evaluated in Peru, no significant effects on the reduction of violence were detected (Agüero and Frisancho, 2018). The second case is SASA!, a community mobilization intervention in urban areas of Uganda (Michaels-Igbokwe *et al.,* 2016), which had a cost per person free of IPV per year of approximately US$460 in 2011 (Torres-Rueda *et al.,* 2020). As mentioned above, it was reproduced unsuccessfully in Rwanda (Dunkle *et al.,* 2020).

In recent years, however, there has been progress in measuring the cost-effectiveness of interventions for preventing SGBV. Torres-Rueda *et al.* (2020) created the first database of the costs of preventing VAW, applying a method based on the cost of health issues. In the six interventions analyzed from Pakistan and five countries in Africa, the cost per beneficiary varied widely, from US$4 in a community intervention in Ghana to US$1,324 for individualized counseling sessions in Zambia. When expanded to the national level, total costs varied from US$32 million in Ghana to US$168 million in Pakistan. The authors clarified that, according to cost modeling, unit costs could decrease in the community-based and workshop-based interventions, but unit costs could increase in interventions with fixed platforms, such as schools, when the average proportion of students per school is lower at the national level than in the pilot

[65] See summary in Remme *et al.,* (2014).

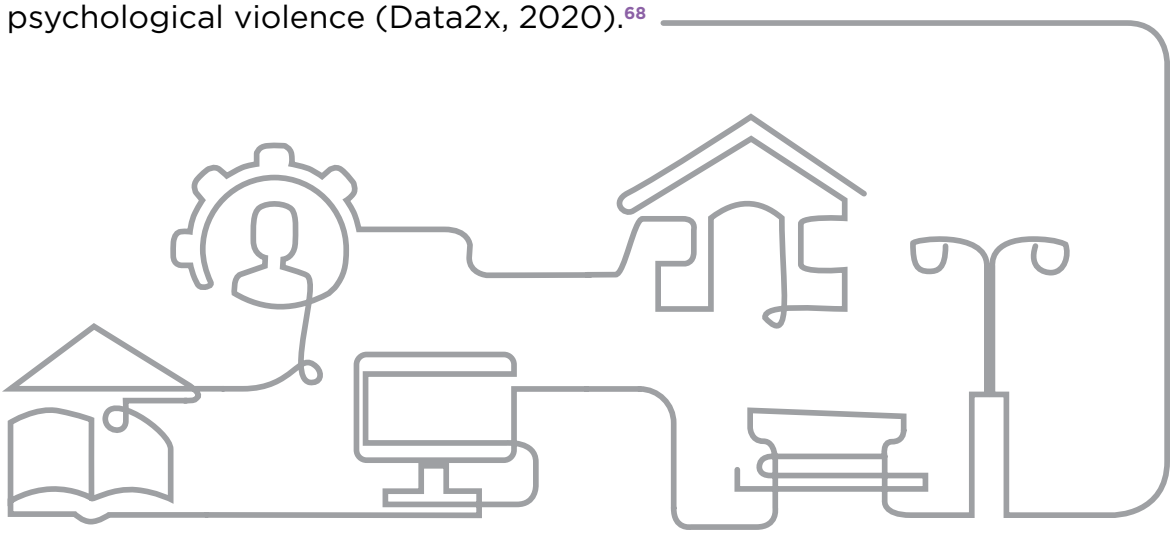
(because of high fixed costs at the delivery site). More empirical work is needed to better understand the balance between the reduction of costs in program execution and the sustained effectiveness in interventions for prevention of SGBV. It is also necessary to conduct a cost-effectiveness analysis to determine if the interventions that require more resources generate a better quality-price relationship. In this regard, it should be noted that the UNDP and CAF developed a methodological guide for cost estimation that makes it possible to determine the magnitude of the financial resources that a country must invest to comprehensively address the prevention of, response to and reparation for violence against women and girls (Curcio and Frenkel, 2020).

The lack of specific protocols for recording violence periodically and with standardized data broken down by gender, age, marital status, ethnic origin, type of violence and place of violence results in underreporting and, as a consequence, means that certain populations are not considered in the design of public policies. In addition, the lack of updated information about the scope of the problem, combined with the lack of consistency and standardization in administrative records, impedes countries from having monitoring systems for following up cases of SGBV. Several countries have recent national surveys, while others have data gathered more than a decade ago, or, as in the case of the Bahamas and Barbados, do not have national SGBV surveys conducted by the government **(Table 3)**. In addition, not all countries in the region produce these statistics in a reliable and comparable way, despite progress in measuring indicators of SGBV prevalence.[66] For example, the methodology applied in the multinational study by the World Health Organization (WHO) or the Domestic Violence Module of USAID's Demographic and Health Surveys (DHS) Program are considered best practices for measuring the prevalence of SGBV (Marques García *et al.,* 2019). In LAC, very few countries have applied the WHO methodology, as the majority

[66] Other examples of data or instruments for measuring violence include the Reproductive Health Surveys of the Center for Disease Control and Prevention (CDC), UNICEF surveys of groups of multiple indicators, and United Nations guidelines for the development of statistics about violence against women — Statistical surveys, 2014. The latter were used in surveys in Ecuador (2011), Mexico (2011) and Uruguay (2013).

have incorporated questions about SGBV into the DHS module, thus excluding the experiences of older women and men, since these surveys are directed at people between ages 15 and 49 (Marques García *et al.,* 2019).

The best estimates of the incidence of SGBV come from household surveys. The most sophisticated are those that ask about experiences with different types of violence and in multiple spheres, such as the home, the workplace, the street, with relatives and strangers, and with regard to different reference periods (for example, in the past year or during one's life).[67] Nevertheless, there are also challenges with these data: they often are not comparable between countries, because of differences in the definitions of violence, the questions formulated and the survey methodology and protocols (Htun and Jensenius, 2020). Another difficulty is that capturing self-reported information can conceal biases and underestimate the true prevalence, especially for certain population groups. In this regard, there are efforts to find alternatives to traditional data-gathering methods based on surveys with direct questions (see, for example, Agüero and Frisancho, 2017). Finally, although international standards and surveys exist for measuring prevalence and attitudes toward physical and sexual violence, there are none for measuring psychological violence (Data2x, 2020).[68]



[67] Only seven countries in the region have specific surveys about disability (Guatemala, Mexico, Peru, Chile, Colombia, Costa Rica and Haiti), and of these, three include questions related to violence against women (Colombia, Costa Rica and Haiti). For two (Colombia and Costa Rica), the sample size allows for cross-tabulation of variables about disability and violence against women (Marques García *et al*., 2019; UNFPA, 2021).
[68] The Conflict Tactics Scale (CTS) includes a measurement of psychological violence, but it has been used mainly the United States, and its international use is limited (Data2X, 2020).

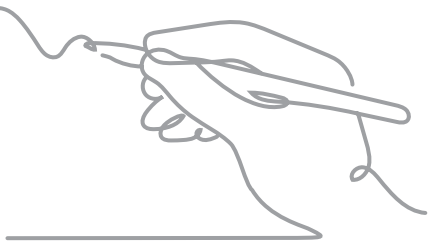


Table 3. National surveys that address SGBV in LAC [69]

Country	National SGBV survey	Domestic Violence Module of the USAID Demographic and Health Surveys (DHS) / years available	Reproductive Health Surveys (RHS) of the Centers for Disease Control and Prevention (CDC) / years available	CDC Violence Against Children and Youth Surveys (VACS) and Together *for Girls* / years available
Argentina	National Survey of Violence Against Women, 2015, 2018. (MJDH, 2017, 2019).			
Bahamas [70]	Has no national survey. For an approximation, see Domestic Violence in the Homes of College Students, 2009, 2010 (Plumridge and Fielding, 2009; Brennen *et al.,* 2010). For a summary of available data, see Sutton, 2016.			
Barbados	Has no national survey. For a summary of available data, see Bailey, 2016.			
Belize	National public health survey, 2015. (Young *et al.,* 2016).			

[70] Various countries have DHS conducted before 1990 and RHS conducted before 1995; these, however, were not included in the table, because only after those years did the surveys begin to include questions about SGBV. For an analysis of how data in the Domestic Violence Module of USAID's Demographic and Health Survey Program differ from those of the CDC's Reproductive Health Surveys, see Bott *et al.* (2012).
[71] The Bahamas does not have a national SGBV survey. There are four surveys that included questions about IPV and intrafamily violence: (i) two, one in 2009 and another in 2010, that used the same survey about domestic violence in the homes of college students, conducted by the Plumridge and Fielding (2009) and Brennen *et al.* (2010), respectively; (ii) one conducted in 2011 by the National Anti-Drug Secretariat and the Ministry of National Security about the prevalence of drugs in secondary schools; and (iii) one conducted by the Ministry of Education about bullying in primary schools.

Bolivia	Prevalence and characteristics of violence against women survey, 2016. (INE, 2016).	2003-2004, 2008	———	———
Brazil	Domestic and family violence against women survey, 2017, 2015. (DataSenado/ OMV, 2017). National health study, 2019. (IBGE, 2020).	2000-2001	———	———
Chile	National intrafamily violence and sex crimes victimization survey, 2008, 2012, 2017, 2019/2020. (MISP, 2020).	———	———	———
Colombia		1990, 1995, 2000, 2005, 2010, 2015, 2018	———	2018
Costa Rica	National violence against women survey, 2003. (Sagot and Guzmán, 2004).	———	———	———
Ecuador	National family relationships and gender violence survey, 2011, 2019. (INEC, 2019).	———	1999, 2004	———
El Salvador	National violence against women survey, 2017. (DIGESTYC, 2018).	———	2002-03, 2008	2017
Guatemala	National school-related violence survey, 2015. (Espinoza Sandoval and Palala Martínez, 2015).	2002, 2014-2015	2002, 2008-09	———
Guyana	Women's health and life experiences survey, 2018. (Contreras-Urbina *et al.*, 2019).	———	———	———
Haiti	———	2000, 2005-06, 2012, 2016-17	———	2012
Honduras	———	2005-06, 2011-12	2001	2017
Jamaica	Women's health survey, 2016. (Watson Williams, 2018).	———	1997, 2002-03, 2008-09	In process

Mexico	National survey of household relationship dynamics. (ENDIREH), 2003, 2006, 2011, 2016 (INEGI, 2003, 2006, 2011, 2016). National dating violence survey. (ENVIN), 2007 (INEGI, 2007). National violence against women survey. (ENVIM), 2003, 2006 (INEGI, 2003, 2006). National violence against women survey (ENVIM) of women users of health services, 2006. (CNEGSR, 2009). Intrafamily violence survey. (ENVIF), 1999 (INEGI, 1999).	———	———	———
Nicaragua	———	1998, 2011-12	2006-07	———
Panama	National sexual and reproductive health survey, 2009. (De León Richardson *et al.*, 2011)..	———	———	———
Paraguay	———		1995-96, 1998, 2004, 2008	
Peru	National social relationships survey (ENARES), 2013, 2015, 2019. (INEI, 2016, 2021). Demographic and family health survey (ENDES), 2000-2020 (INEI, 2021).	2000, 2004-05, 2007-08, 2009, 2010, 2011, 2012, 2013, 2014	———	———
Dominican Republic	———	1999, 2002, 2007, 2013	———	———
Suriname	National women's health survey. (Joseph *et al.*, 2019).	———	———	———
Trinidad & Tobago	National women's health survey, 2017. (Pemberton and Joseph, 2018).	———	———	———

Uruguay	National gender violence prevalence survey, 2013, 2019. (INE, 2013, 2020).			
Venezuela	Venezuela demographic survey. (ENDEVE), 2010 (INE, 2013a).			

Source: USAID, USAID, Demographic and Health Surveys Dataset; CDC, Reproductive Health Survey; CDC, Violence Against Children, Girls and Adolescents Survey.

In the future, the inclusion of new technologies, such as big data and artificial intelligence (AI), could be effective for predicting, preventing and responding to SGBV. The goal of integrating big data into programs and policies is to identify innovative solutions that have a lower cost and greater impact in different sectors. The technological and data revolutions contribute to the quest for new sources of information (internet, social networks, use of mobile apps, etc.), and, along with traditional data (such as censuses and household surveys), have the potential to produce information that is of higher quality, more detailed, up-to-date, timely and relevant (UN Women, 2018b). One example of the use of big data is the prediction of the number of complaints about gender violence filed in a court over a six-month predictive horizon with a precision of 0.17 court-filed complaints per 10,000 inhabitants in all of Spain (Rodríguez-Rodríguez *et al.,* 2020). Another example is an app that uses methodologies for processing natural language and emotion analysis to identify gender violence in Twitter messages in Mexico. The results reported show that the app has a high degree of precision in the

classification and identification of GBV-related messages, about 80% of the area under the curve (AUC) (Castoren *et al.,* 2021). Another promising tool is the use of machine learning to enhance protection of SGBV victims against reabuse. For example, there is a system that weights information reported by the victim in a survey and uses that to assign the person a risk level and type of protection. The results point to an improvement of 10-15% in the prediction of recidivism (González-Prieto *et al.,* 2021). Another example is the digital tool ELSA, an integral diagnostic and intervention system that, using algorithms and artificial intelligence, seeks to construct spaces free of sexual harassment in businesses and organizations in Bolivia, Colombia and Peru. Finally, it is important to note that, despite the multiple benefits and the potential of big data and AI, there are unknowns and risks related to privacy, control, algorithmic biases or connectivity gaps that must be analyzed, considered and included in the process (UN Women, 2018b).

IDB-supported interventions for preventing and responding to SGBV

The complex factors that reinforce SGBV require an integral, interconnected, multisectoral and ongoing response. In this regard, the IDB Group has supported multiple efforts in the region to prevent and respond to SGBV through its operations in various sectors: Education, Energy, Labor Markets, Migration, Science, Technology and Innovation, Citizen Security, Transportation, Social Protection, Health, Housing and Urban Development.[71] The Gender and Diversity Division provides technical support to all divisions, but also implements direct investment projects in the region. The instruments used by the IDB Group to address the issue include loans for development projects and programs; technical cooperation for the international transfer of knowledge and skills; support for the private sector through private resources and technical assistance; and non-financial products, such as research and regional policy dialogues to contribute to knowledge and promote the exchange of experiences and best practices in the region.

The prevention of and response to SGBV is one of the IDB Group's priorities. It is set out in the Operational Policy on Gender Equality (OP-761) and the Performance Standard on Gender Equality (ESPF 9) in the Environmental and Social Policy Framework[72]. The Gender Action Plans support the implementation of the Operational Policy.

[71] The IDB's Environmental and Social Safeguards (ESG) Unit evaluates risks that could be caused in IDB operations and its contracting in the area of SGBV and other issues through Environmental and Social Impact Assessments (EIAs). It also supports executing counterparts through guidelines and mitigation plans (code of conduct for contract workers, training and awareness raising, mapping of services in the project area, among others) to address risks in violence that could be generated. Through IDB Invest, the Environmental, Social and Corporate Governance (SEG) Division focuses on ensuring that its clients adopt practices that respect human rights and promote social values, among other priorities. It has a *Gender Risk Assessment Tool* that is used to identify, measure and mitigate gender risks in projects, including SGBV, and which also helps build clients' capabilities for mitigating and preventing SGBV.
[72] These were updated in 2020.

In the most recent update (2020-2021), it was shown that 13% of loans with sovereign guarantee approved in 2020 addressed strategic issues for preventing or addressing violence against women and girls, and 2% incorporated actions related to masculinity and inclusion of men and boys (IDB, 2020a). In 2019, the first IDB Diversity Action Plan (2019-2021) was approved to accompany and increase the relevance of operations targeting people with disabilities, indigenous peoples, people of African descent and members of the LGBTQ+ collective. In 2022, the IDB Group will develop a Gender and Diversity Action Plan 2022-2025, which will channel efforts toward a more intersectional approach in IDB operations and analytical products.

Box 5. IDB loans for gender equality

The IDB has invested in actions to prevent and address SGBV in the region through the following investment loans and policy-based loans (PBL),[73] which focus exclusively on gender equality:

Argentina. Program to Support Gender Equality Policies (AR L1298, 2018) was the first gender PBL financed by the IDB. The goal of the program is to reduce gender inequality by strengthening the regulatory and institutional framework to promote women's physical and economic autonomy and the institutional framework for a life free of violence against women, as well as improving government capacity to mainstream gender policies. Actions in the area of SGBV include: (i) publication of the Results of the Unified Registry of Cases of VAW from data of public agencies that responded to formal complaints between 2013 and 2017, and (ii) strengthening of the police forces' competencies for identification, action and investigation of feminicide cases.

Uruguay. Program for Gender Equality and the Empowerment of Women (ProMujeres) (UR-L1178/UR-J0002, 2021). This is the first investment loan approved by the IDB that focuses exclusively on promoting a life free of SGBV against women. ProMujeres seeks to increase the capacity of the GBV Response System (GBVRS) of the National Institute of Women (INMUJERES), including, among other things: (i) psychosocial and legal assistance for women age 18 or over; (ii) guidance and telephone consultations; (iii) temporary shelter for women and their children; and (iv) assistance and protection for women in trafficking situations. The program will also strengthen interventions that promote violence-free relationships in schools and will improve the quality and use of GBV data by strengthening the GBV Observatory and the third National GBV Prevalence Survey. The program will focus on the intersectionality of gender and diversity, ensuring benefits for women from diverse population groups, including women with disabilities, migrants, LBT (lesbian, bisexual or transgender) women, women of African descent and survivors of trafficking.

[73] These loans provide flexible, liquid (fungible) financing to member countries that are IDB borrowers to support policy reforms or institutional change in a certain sector or subsector.

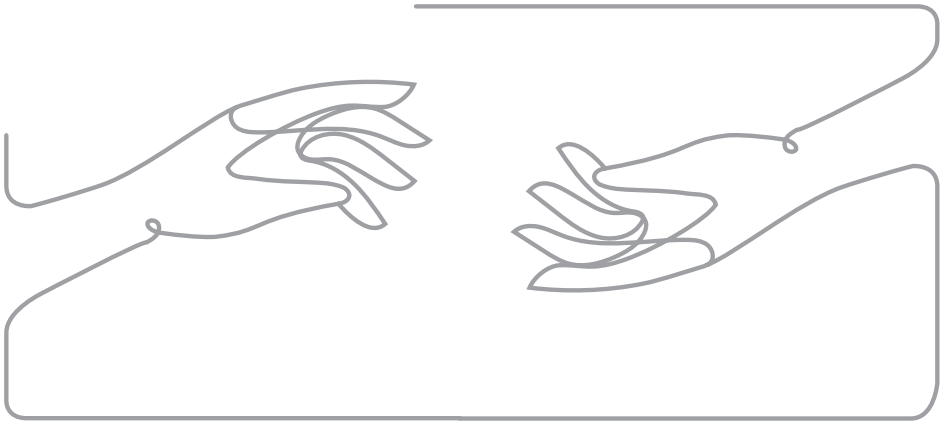
The IDB has also included SGBV as a cross-cutting issue in loans from various sectors, of which the following are noteworthy examples:

Honduras. Civic Coexistence and Neighborhood Improvement Program (HO-L1187, 2017). Supports actions to reduce feminicide and sexual and domestic violence and increase the effectiveness of the police response to cases of violence against women. These actions include the development of a protocol that standardizes first response to victims with a gender approach, training and the establishment of a minimum number of women police graduates of the Police Academy to work the target areas.

Bahamas. Reconstruction with resilience in the energy sector in the Bahamas (BHL1048, 2018). Supports training actions to prevent sexual harassment and GBV for personnel of all contracting companies participating in the ecosystem of the new renewable energy sector, which the project and the project's execution unit seek to create. This training aims to provide knowledge, techniques and tools for developing skills and promoting an organizational culture that integrates gender equality values.

Paraguay. Rehabilitation and Housing Program of the Bañado Sur in Asunción (Barrio Tacumbú) (PR-L1152, 2020). The *Barrio sin Violencia* (Neighborhood Without Violence) program supports a series of actions to address SGBV, including workshops and activities for the prevention of partner violence and violence in the community. These include issues of women's leadership, crime prevention, civic rights of men and women, intrafamily violence, existing prevention measures, and sexual and reproductive health, among others.

Table 4 presents some of the initiatives that have been supported by the IDB Group in the area of SGBV in the past five years (2017-2021).[74] This list of interventions includes not only operational activities, but also analytical work. **Annex 1** includes a list of IDB publications related to SGBV in the 2016-2021 period.



[74] In July 2020, a task force was formed of members of the Gender and Diversity (GDI), Innovation in Citizens Services (ICS), Education (EDU), Social Protection and Health (SPH), Labor Markets (LMK), Migration (MIG), Transportation (TSP) and Housing and Urban Development (HUD) divisions. This task force's goal was to understand the operational and analytical work being done by IDB and consider existing evidence about those operations to develop a road map that would enable the Bank to address the prevention of and response to SGBV in a coordinated way. It should be noted that this exercise does not include all of the Bank's work in the area of SGBV.

Table 4. IDB-supported interventions against SGBV

SECTOR/AREA	FOCUS AND INTERVENTION
Gender and diversity	
	PREVENTION AND RESPONSE
	1. **Models for providing integrated services for women** in various countries (Ciudad Mujer Centers, CMC). 2. **Assistance in the preparation and implementation of policies, regulations or national plans on SGBV,** accompanied by inter-ministerial coordination for an integral approach to SGBV. 3. **Campaigns to promote integrated services for assistance or prevention using behavioral sciences.** 4. **Strengthening of institutional and community capacities** for prevention of SGBV and assistance to and protection of women in situations of violence, with an emphasis on prevention of feminicide in Honduras.
	PREVENTION
	5. **Use of technology for the prevention of SGBV:** panic buttons, use of WhatsApp or other apps or digital technologies for prevention. 6. **Workplaces free of harassment** (ELSA , for the Spanish initials). A diagnostic and intervention tool that helps companies design a strategy for preventing workplace sexual harassment. 7. **Analysis of the SGBV situation from an intergenerational perspective** (children and adolescents), to provide specificity to programs and action plans with this focus. 8. **Research and evidence about masculinities, to include on the public policy agenda in the Caribbean.** 9. Strengthening institutional capacities to prevent and punish feminicide in El Salvador through the **development of tools for the detection, follow-up and protection of women at high risk.**
	RESPONSE
	10. Creation of and support for **digital social service platforms** for virtual assistance and training of personnel for remote assistance (ISDEMU, El Salvador; Ciudad Mujer and INAM, Honduras). 11. **Development of programs that offer training and labor counseling** for survivors of violence, including a model of assistance for indigenous women (INAMU, Panama). 12. **Production of knowledge and evidence about human trafficking** in LAC to provide work guidelines and to create venues for regional dialogue about best practices for intersectoral coordination of detection of cases and assistance to and protection of victims of human trafficking.
	DATA
	13. **Development of secure and ethical data-gathering systems** for monitoring the prevalence of SGBV. 14. **Gender and Diversity Laboratory (GDLab).** Research to inform policy design.

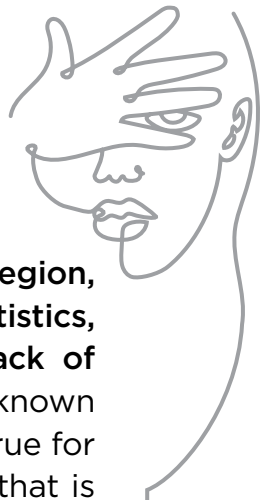
SECTOR/AREA	FOCUS AND INTERVENTION
Education	
	PREVENTION
	1. Integration of gender equality and unconscious bias issues into **teacher training.** 2. **Development of socioemotional skills curriculum and work for gender equality** in pre-school, primary and secondary schools.
	DATA
	3. **Collection of distance education data** during the COVID-19 pandemic, through Early Childhood Development surveys that include questions about intrafamily violence.
Labor markets	
	PREVENTION
	1. **Creation of action plans and guidelines for respect in the workplace.** 2. **Information campaigns about prevention and response, aimed at the public** (workplace harassment, among other topics). 3. **Technical training** to reduce occupational gender segregation and for **the elimination of barriers** that limit women's access to active policies and the certification of labor skills with a differentiated approach for migrant women.
	DATA
	4. **Collection of data** about crimes of sexual violence or harassment, exploitation or human trafficking in the area of formal and non-formal work.
Migration	
	PREVENTION
	5. **Protocols** for attention to the migrant population for the prevention of human trafficking and violence against women. 6. **Training for border agents** and associated assistance centers to prevent, detect and address cases of SGBV.
	RESPONSE
	7. **Temporary shelters for vulnerable migrants.** Includes priority attention for women and unaccompanied minors. 8. **Educational workshop program for technical training and certification of labor skills for the migrant population,** with particular emphasis on women migrants. 9. **Support for entry and employment of the migrant population,** with an emphasis on women heads of families affected by the pandemic.
	DATA
	10. **Identification and collection of data related** to registration, regularization, protection of migrants and their links with other sectors in the area of SGBV**.**

SECTOR/AREA	FOCUS AND INTERVENTION
Science, technology and innovation	
	PREVENTION
	1. Support for the development and implementation of **innovative mechanisms and devices for preventing, detecting and addressing SGBV** (emergency hotlines, social networks). 2. Awareness-raising **campaigns about SGBV** in business development centers. 3. **Awareness-raising for families of workers** on electricity infrastructure expansion projects to improve treatment of children and prevent violence against women and children.
Citizen security	
	PREVENTION
	1. **Infrastructure for police services for prevention** of and response to types of violence, specifically SGBV. 2. **Positive masculinities.** Interventions for the social prevention of violence, focusing on work with men. 3. **Generating data and evidence of violence against children and adolescents** to inform public policy. 4. **Tool for identifying the risk of revictimization.** 5. **Capacity building and economic empowerment for women deprived of liberty** at risk of suffering or returning to cycles of violence, for their social and economic reinsertion. 6. Improving the effectiveness of services for prevention of SGBV-related crime through **community prevention programs, police training for detection and prosecution, and improvement of the criminal justice system** with a focus on SGBV.
	RESPONSE
	7. **Academic curriculum for police commanders,** including training for assistance to SGBV victims. 8. **Capacity-building and training in criminal investigation** for police, treatment of evidence and use of technology to improve assistance in SGBV cases. 9. **Technological innovations** to motivate victims of SGBV to file formal complaints. 10. **Strengthening capacities of public, private and civil society institutions to prevent and address the trafficking of women in border areas.**
	DATA
	11. **Standardization of feminicide data** so it is comparable in the region, and comparative analysis of the different legal definitions in the region. 12. **Funding of surveys** of SGBV prevalence. 13. **Estimation of SGBV costs in public spending,** to propose improvements in the allocation and use of these resources.

SECTOR/AREA	FOCUS AND INTERVENTION
Transport	
	PREVENTION 1. **Training for personnel and contractors** on gender equality at work, including prevention of SGBV. 2. **Adaptation of infrastructure and design of urban transportation to reduce the risk of SGBV,** for example, through street lighting, visibility in parks/open areas, panic buttons in buses, and prevention of trafficking and child prostitution. 3. **SGBV campaigns, manuals and protocols** on transportation and in public spaces. 4. **Strengthening of women's safety in work camps,** through development of a manual for coexistence. 5. **Campaigns for public transportation** users to reduce harassment and inform about mechanisms for filing formal complaints and the consequences of harassing women. **RESPONSE** 6. **Mechanisms for reporting harassment in work camps,** for both people working on the site and members of nearby communities. 7. **Development of protocols for assistance, filing of formal complaints and referral related to SGBV** eat stations and stops and on urban transportation vehicles. **DATA** 8. **Collection of SGBV data** in the area of transportation, including perceptions of lack of safety.
Energy	
	PREVENTION 1. **Training for personnel and contractors** on gender equality at work, including specific courses on prevention of SGBV. 2. **Signing of a code of conduct and ethical guide** for personnel and contractors.
Social protection and health	
	PREVENTION 1. **Cash transfer programs** conditioned on educational activities for prevention of SGBV. 2. **Development and promotion of health guidelines** for prevention and assistance in cases of violence in healthcare institutions or centers. 3. **Campaigns focusing on child abuse prevention** for early detection by health and social protection institutions 4. **Strengthening of institutional guidelines** aimed at increasing public sector capacity to mainstream gender policies with an intersectional perspective focused on women with disabilities. 5. Operations that contribute to **sustainability, monitoring and improvement in the effectiveness of social protection** programs aimed at women or with a gender focus.

SECTOR/AREA	FOCUS AND INTERVENTION
	RESPONSE
	6. **Recognition and referral** of cases in the area of sexual and reproductive health services. 7. **Capacity-building and training curriculum** for health personnel to improve the quality of assistance to victims. 8. **Protocols for detection, response and coordination** between the health sectors and entities that handle formal complaints in SGBV cases. 9. **Support for primary health care units** to ensure timeliness and continuity in assistance to women, pregnant women, post-partum women, boys and girls.
Housing and urban development	
	PREVENTION
	1. **Reorientation services or referral of cases to structures more specialized in addressing cases of SGBV** and improved access to basic services infrastructure in vulnerable neighborhoods or communities. 2. **Training for architects and urbanists** for the design of public spaces that take into account SGBV prevention. 3. **Strengthening a gender approach in "security in urban planning," through the design of operations,** including the terms of reference, budgets, indicators or recommendations and analysis so the prevention of SGBV is included beginning with the design phase. 4. **Gender-sensitive analysis of urban space: settlement patterns, urban productivity patterns, urban mobility patterns.** 5. **Prevention of patrimonial violence,** to keep women from losing their homes. Also, juridical security for victims of SGBV, for example, with titling.

Final reflections



The high prevalence of SGBV persists in all countries in the region, supported, among other factors, by its invisibility in national statistics, discrimination in communities and public services, and the lack of funding for prevention and response programs. Little is still known about what works, for whom and under what conditions. This is true for both prevention and response to victims. Much of the evidence that is available comes from outside the region or from very different contexts; as a result, there is much to be done in this area in LAC. The case of the English-speaking Caribbean countries is particularly important, because in the preparation of this document, not a single impact evaluation of interventions related to SGBV in that subregion was found. It is also important to learn not only about initiatives that have been effective at a pilot scale, but also about how to scale them up and maintain their effectiveness at a cost that ensures their sustainability. Another dimension in which important knowledge gaps persist has to do with the temporal dimension of the changes produced by such programs. Do their short term impacts persist over time? Is it possible that some interventions require medium- and long-term evaluations for a complete characterization of their impacts? Finally, although we know that this is a problem that must be addressed by multiple sectors, little is known about the marginal benefit of specific actions by each.

When we speak of SGBV prevention and response and designing interventions in this area, it is essential not only to address the different forms of violence, but also to understand the causes underlying this phenomenon. This exercise requires identifying and understanding the intersectionalities related to socioeconomic situation, ethnic group, race, class, disability, sexual orientation, gender identity, age, migratory status, etc. It is also necessary to include the male population and the business sector much more actively as agents of change to take a qualitative leap toward a culture that is not tolerant of SGBV.

The IDB Group is committed to accompanying governments, businesses and society as a whole in preventing and responding to SGBV. This effort demands political commitments that translate into budget allocations. It also requires ongoing investment in data collection and analytical work that contribute to compiling rigorous evidence about the effectiveness of interventions, mechanisms by which these impacts are achieved and heterogeneity in the effects observed among different groups of people. It also aims to continue innovations to scale up and maximize the impact of interventions that seek to reduce SGBV in our region.

Annex 1. IDB publications related to prevention of and response to SGBV (2016-2021)

YEAR	PUBLICATION	TYPE
2021	Anglade, B. y J. Escobar. Effect of Violence Against Women on Victims and their Children: Evidence from Central America, the Dominican Republic and Haiti	Technical note
2021	Rodríguez Yánez, M.E., J.F. Redobrán Herrera, G. Cervallos *et al.,* Quito: La movilidad de las mujeres en las zonas noroccidentales.	Brochure
2021	Montoya Robledo, V., V. Bernal Carvajal, L. Montes Calero, J.R. Rendón, C.G. Lozano *et al.,* Género y Transporte: San Salvador. Transport Gender Lab member cities.	Brochure
2021	Levtov, R. and L. Telson. Man-Box: Men and Masculinity in Jamaica	Technical note
2021	Piras, C., N. Hidalgo, V. Roza y A. Monje. Violence against women in the context of COVID-19. Lessons and tools for Latin America and the Caribbean.	Brochure
2021	Perez-Vincent, S., E. Carreras, M. A. Gibbons, T. Murphy and M. Rossi. Los confinamientos de la COVID-19 y la violencia doméstica: evidencia de dos estudios en Argentina.	Technical note
2021	Luciano, D. and N. Hidalgo. Technical tool. Planes de seguridad para mujeres sobrevivientes o en riesgo de violencia sexual y basada en género.	Technical tool
2021	Luciano, D. and N. Hidalgo. Technical tool. Servicio en linea para la atención de mujeres sobrevivientes de violencia sexual y basada en género.	Technical tool
2021	Luciano, D. and N. Hidalgo. Technical tool. Sistemas de referencia para la atención de mujeres sobrevivientes de violencia sexual y basada en género.	Technical tool
2021	Granada, I., P. Ortiz and F. Muñoz La migración desde una perspectiva de género: ideas operativas para su integración en proyectos de desarrollo.	Technical note
2020	Urban, A., M. J. Flor Ágreda, A. Ramos Moreno and D. Ortiz. Hacia un mejor entendimiento de la discriminación por orientación sexual e identidad de género	Technical note
2020	Bellatin, P., M. Wills Silva, C. Bustin, M. Bustelo and N. Hidalgo. Encouraging survivors of violence against women to seek help. Behavioral Economics Group.	Web site
2020	Bustelo, M., V. Frishancho and M. Viollaz. What policies are effective at eradicating violence against women?	Brochure
2020	Agüero, J. and V. Frishancho. Perspectivas de investigación: Can greater privacy yield more accurate measurements of violence against women?	Brochure
2020	Piras, C. and M. Bustelo. Políticas sociales en respuesta al coronavirus. Grupo de mayor riesgo: Mujeres	Brochure

2019	López Mayher, C. Plan nacional de acción para la prevención, asistencia y erradicación de la violencia contra las mujeres 2017-2019 (Ley 26:485: Primer informe de monitoreo).	Technical note
2019	Joseph, J., C. Pemberton and U. Phillip. National Women's Health Survey for Suriname.	Monograph
2019	Garnelo, M., C. Bustin, S. Duryea and A. Morrison. Applying Behavioral Insights to Intimate Partner Violence: Improving Services for Survivors in Latin America and the Caribbean.	Monograph
2019	Marques García, L., D. Ortiz and A. M. Urban. Violence against women and girls with disabilities: Latin America and the Caribbean.	Technical note
2018	Alemann., C., M. Bustelo, J. Franco, S. Martinez and A. Suaya. Evaluación de impacto del Programa P Bolivia. Padres y madres por una crianza positiva, compartida y sin violencia. Informe de línea de base.	Technical note
2018	Bando, R., N. Hidalgo and L. Austin. El efecto de la educación en las actitudes de género: Evidencia experimental en educación secundaria en El Salvador	Working paper
2018	Augero, J and V. Frisancho. Sumaq Warmi: Reducing Violence against Women in Microfinance	Technical note
2018	Richard, P., S. Siebert, J. Ovince, A. Blackwell and M. Contreras-Urbana. A Community-Based Intervention to Prevent Violence against Women and Girls in Haiti: Lessons Learned	Discussion paper
2018	Cervantes, C. and A. Veraza López. Documentación de la experiencia en la implementación de los Centros de Justicia para las Mujeres. Un estudio de caso	Discussion paper
2018	Agüero, J. Prevalencia de la violencia contra la mujer entre diferentes grupos étnicos en Perú	Technical note
2018	Pemberton, C and J. Joseph. National Women´s Health Survey for Trinidad and Tobago. Final Report	Technical note
2018	Safranoff, A. and A. Tiravassi. The Intergenerational Transmission of Violence: Testimonials from Prison.	Technical note
2017	Romero, O., C. Penaranda, M. Pareces and A. Armbrister. Como marcar tres dígitos reduce la violencia intima de pareja en Medellín, Colombia. Evaluación del impacto de la línea de emergencia 123-Mujer, 2013-2014	Technical note
2017	Navarro Mantas, L. and L. Marquez Garcia. Experiencia de investigación de la violencia contra las mujeres en poblaciones indígenas: Desafíos y recomendaciones. Caso Toribió, Cauca (Colombia)	Monograph
2017	Peñaranda, C., O. Romero and A. Armbrister. Hogares de acogida para mujeres víctimas de la violencia intima de pareja en Medellín, Colombia. Resultados de un estudio de caso cualitativo, 2014	Technical note
2017	Taylor, A., G. Lauro, E. Murphy-Graham, T. Pacheco, D. Pacheco Montoya, and D. Araujo. Adolescent relationship violence in Brazil and Honduras.	Monograph

2017	Agüero, J. and V. Frisancho. Misreporting in sensitive health behaviors and its impact on treatment effects: an application to intimate partner violence	Working paper
2017	BID and PLENUS. Herramienta 1: Localización de los Centros de Servicios Integrados para el Empoderamiento de la Mujer. Serie: Servicios Integrados para el Empoderamiento de la Mujer	Technical Tool
2017	Soto Villagrán, P., A. Aguilar Esteva, E. Gutiérrez Fernández and C. Castro Reséndiz. Evaluación de impacto del programa "Viajemos Seguras en el Transporte Público en la Ciudad de México". Aportes al diseño e implementación de políticas de prevención de la violencia de género en espacios públicos	Technical note
2016	Sosa-Rubi, S., B. Saavedra, C. Piras, J. Van Buren, S. Bautista-Arredondo. Amor pero del bueno	Fact sheet
2016	Bustelo, M., S. Martínez, M. Perez, J. Rodriguez Silva. Evaluación de impacto del Proyecto de Ciudad Mujer El Salvador	Technical note
2016	Granada, I., A. M. Urban, A. Monje, P. Ortiz *et al*. The relationship between gender and transport.	Brochure
2016	Sutton, H. and L. Alvarez. How Safe are Caribbean homes for women and children? Attitudes toward Intimate Partner Violence and Corporal Punishment	Policy summary
2016	Galiani, S. and L. Jaitman. El transporte público desde una perspectiva de género. Percepción de inseguridad y victimización en Asunción y Lima.	Technical note

Annex 2. Publications summarizing evidence of the effectiveness of interventions

Prevention[75]

Darak, S., N. S. Nair, T. V. Bhumika, T. Darak, M. Mathews, V. Ratheebhai and A. Dave (2017). Gender-responsive policing initiatives designed to enhance confidence, satisfaction in policing services and reduce risk of violence against women in low and middle-income countries — A systematic review. Implications of evidence for South Asia. England: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

Ellsberg, M., D. Arango, M. Morton, F. Gennari, S. Kiplesund, M. Contreras and C. Watts (2015). Prevention of violence against women and girls: What does the evidence say? Violence against women and girls 1. *The Lancet*, 385: 1555-66.

Fulu, E., A. Kerr-Wilson and J. Lang (2014). What works to prevent violence against women and girls? Evidence Review of interventions to prevent violence against women and girls. Medical Research Council.

Fulu, E. and A. Kerr-Wilson (2015). What works to prevent violence against women and girls evidence reviews. Paper 2. Interventions to prevent violence against women and girls. What Works to Prevent Violence and UK DFID.

Fulu, E. and L. Heise (2015). What do we know about violence against women and girls and what more do we need to know to prevent it? A summary of the evidence. What Works to Prevent Violence and UK DFID.

Fulu, E. and L. Heise (2015). What Works to Prevent Violence Against Women and Girls Evidence Reviews. Paper 1: State of The Field of Research On Violence Against Women And Girls. What Works to Prevent Violence and UK DFID.

Fulu, E., A. Kerr-Wilson and J. Lang (2015). Effectiveness of interventions to prevent violence against women and girls: A summary of the evidence. What works to Prevent violence and UK DFID.

[75] Some publications included in the Prevention section include examples of interventions aimed at both SGBV prevention and response.

Gibbs, A., N. Duvvury and S. Scriver (2017). What Works Evidence Review – The Relationship between Poverty and Intimate Partner Violence. What Works to Prevent Violence and South African Medical Research Council.

Global Women's Institute (n. d.). Evidence Brief. School-based interventions to prevent violence against women and girls. George Washington University and Australian Government.

Jewkes, R., L. McLean Hilker, S. Khan, E. Fulu, F. Busiello and E. Fraser (2015). What Works to prevent violence against women and girls. Paper 3. Response mechanisms to prevent violence against women and girls. What Works to Prevent Violence and UK DFID.

Jewkes, R., S. Willan, L. Heise, L. Washington, N. Shai., A. Kerr-Wilson and N. Christofides (2020). Effective design and implementation elements in interventions to prevent violence against women and girls. What Works To Prevent VAWG? Global Programme Synthesis Product Series. South African Medical Research Council.

Kerr-Wilson, A., A. Gibbs, E. McAslan Fraser, L. Ramsoomar, A. Parke, HMA Khuwaja and R. Jewkes (2020). A rigorous global evidence review of interventions to prevent violence against women and girls. What Works to Prevent Violence Against Women and Girls Global Programme.

Koker, P., C. Mathews, M. Zuch, S. Bastien and A. Mason-Jones (2014). A systematic review of interventions for preventing adolescent intimate partner violence. *Journal of Adolescent Health.* 54(1):3-13.

Lester, S., C. Lawrence and C. Ward (2017). What do we know about preventing school violence? A Systematic review of Systematic reviews. *Psychol Health Med*. 22(sup1):187-223.

Ligiero, D., C. Hart, E. Fulu, A. Thomas. and L. Radford (2019). Lo que funciona para prevenir la violencia sexual contra las niñas y los niños. Resumen ejecutivo. Together for Girls.

McCloskey, L. (2011). A systematic review of parenting interventions to prevent child abuse tested with RCT designs in high income countries. South Africa: Sexual Violence Research Initiative. Medical Research Council, South Africa.

Parkes, J., J. Heslop, F. Johnson Ross, R. Westerveld and E. Unterhalter (2016). A Rigorous review of global research evidence on policy and practice on school-related gender-based violence. England: University College London.

Ricardo, C., M. Eads and G. Barker (2011). Engaging Boys and Young Men in the Prevention of Sexual Violence: A systematic and global review of evaluated interventions Sexual Violence Research Initiative and Promundo.

Russell, K. (2021). What Works to Prevent Youth violence: A summary of the Evidence. Social Research. Crime and Justice. Scottish Violence Reduction Unit.

The Prevention Collaborative (2019). Evidence brief cash transfers and intimate partner violence: findings from a review of quantitative and qualitative studies in low- and middle-income countries.

USAID (2020). Gender-based violence on public transportation a review of evidence and existing solutions.

WHO (2010). Violence prevention. The Evidence. Changing cultural and social norms that support violence. Organización Mundial de la Salud y Center for Public Health.

Prevention and response

Brown, J., J. Smith and B. Crookstone (2021). Evidence Review on Violence against women and girls and its relationship with Women's economic empowerment. Grameen Foundation.

El Morr, C. and M. Layal (2020). Effectiveness of ICT-based intimate partner violence interventions: a systematic review. *BMC Public Health* 20 (1372).

Gierman, T., A. Liska and J. Reimer (2011). Shelter for Women and Girls at Risk of or Survivors of Violence. Canadian Network of Women's Shelters and Transitions Houses.

IACHR (2019). Violencia y discriminación contra mujeres, niñas y adolescentes: Buenas prácticas y desafíos en América Latina y en el Caribe. Inter-American Commission on Human Rights. OAS/Ser.L/V/II. Doc.233/19.

Morrison, A., M. Ellsberg and S. Bott (2007). Addressing gender-based violence: A critical review of interventions. *The World Bank Observer,* 22(1):25-51.

Murphy, M., D. Arango, A. Hill, M. Contreras, M. MacRae and M. Ellsberg (2016). What works to prevent and respond to violence against women and girls in conflict and humanitarian settings? What works to Prevent violence.

Stark, L., I. Seff and C. Reis (2021). Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence. The Lancet, 5(3): 210-222

UNFPA, UN Women, EME, Promundo, Men Engage América Latina. Hacia la incorporación de los hombres en las políticas públicas de prevención de la violencia contra las mujeres y las niñas. Santiago: EME/CulturaSalud. Washington, D. C.: Promundo-US. Panama City: UN Women and UNFPA.

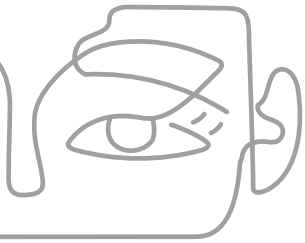
USAID (2020). Select gender-based violence literature reviews the effectiveness of one-stop GBV resource centers.

Annex 3. Criteria for classifying interventions by degree of effectiveness

To classify different types of interventions according to their effectiveness, classification criteria were defined as follows:

Classification	Criteria
Effective intervention	• There are at least two experimental or quasi-experimental impact evaluations with evidence indicating that the interventions are effective for SGBV prevention or response, and at least one of the interventions was conducted in a developing country. • An intervention is considered effective based on a high-quality metanalysis and systematic reviews of the findings based on evaluations of multiple interventions.
Promising intervention	• There is an experimental or quasi-experimental impact evaluation with evidence that indicates that the intervention is effective for preventing or responding to SGBV, in either a developed or a developing country. • Impact evaluations have shown positive results, but they were not significant. • The only experimental or quasi-experimental impact evaluations that exist have been conducted in developed countries, but they could be adapted to developing countries.
Intervention with mixed results	Impact evaluations present contradictory evidence because there may be mixed results in the same intervention.
Ineffective intervention	Evidence indicates that the intervention is not effective for changing attitudes or social norms or reducing SGBV.
Intervention with insufficient evidence	There is not enough evidence to establish whether the intervention is effective or not. No RCT/quasi-experimental studies have been found for these intervention categories.

Annex 4. Summary of interventions evaluated as effective and scaled up.



Name of intervention

Sixth Sense (We are Different, We are Equal)

(Solórzano *et al.,* 2008)

Evaluation design

Quantitative:

- Longitudinal panel study in three cities.
- Surveys: pre-, mid- and post-intervention.

Qualitative:

- Focus groups, group interviews and in-depth interviews in three cities.

Type of intervention

Communication campaigns for social change.
Edutainment (social soap opera + radio program) and workshops for social change.

Objective of the intervention

Change attitudes, norms and behaviors regarding gender, violence and HIV.

Target population

Adolescents and young adults ages 13-24.

Results related to SGBV

More equitable attitudes toward gender, greater knowledge and use of social and healthcare services (for example, assistance centers for VAW), greater interpersonal communication about SGBV and HIV.

Countries

Original: Nicaragua
The soap opera *Sexto Sentido (Sixth Sense)* was reproduced in Costa Rica, Guatemala, Honduras and Mexico.

Cost

Cost per adolescent: US$0.04 per episode, US$0.60 per season and US$1.80 for the three seasons.

Name of intervention

Ciudad Mujer
(Bustelo *et al.,* 2016)

Evaluation design

Quantitative: RCT, randomized at the level of the woman
Baseline survey before becoming a beneficiary and follow-up a year later

- T1: Treatment group: Beneficiaries of the program who received incentives.
- T2a: Control Group: Women who did not receive incentives.
- T2b: Placebo control group: Women who received incentives to use a traditional public service.

Type of intervention

Integrated service center

Objective of the intervention

Improve women's living conditions by offering specialized integrated services, all under one roof. The module to support cases of SGBV includes assistance and advisory services with police, legal investigations and forensic medicine.

Target population

Women in CM's area of influence

Results related to SGBV

The women who visited CM used 43% more public services than women who did not attend. Among the services most used are those related to legal processes involving economic empowerment and support in situations of gender violence.

Countries

Original: El Salvador
Adapted in Honduras, Mexico and Paraguay

Cost

n. a.

Name of intervention

Stepping Stones
(Jewkes *et al.,* 2008)

Evaluation design

Quantitative: CRCT, randomized at the community level
Surveys and blood tests before the intervention and after one and two years

- T1. Treatment group: Beneficiaries of the intervention
- T2. Control group: Beneficiaries of a traditional three-hour session about HIV and safe sex

Qualitative: in-depth interviews and focus groups

Type of intervention

Community mobilization

Objective of the intervention

Develop knowledge, awareness of risks and communication skills related to gender, HIV, violence and relationships through educational group sessions of 50 hours and awareness raising with local leaders.

Target population

Male and female youths and young adults, ages 15-26

Results related to SGBV

Smaller proportion of men who report IPV and increased awareness about violence against women as being incorrect. Did not decrease the incidence of HIV.

Countries

Original: South Africa
The model has been adapted for children ages 5-14 and has been reproduced in 40 countries since the mid-1990s. For example, in LAC it has been adapted to countries such as Honduras, Guatemala, Ecuador, Mexico and El Salvador.

Cost

n. a

Name of intervention

Programa H
(Pulerwitz *et al.,* 2006)

Evaluation design

Quantitative: Quasi-experimental
Surveys before the intervention and six and 12 months later in three communities

- T1. Treatment group: Beneficiaries of group educational sessions
- T2. Treatment group: Beneficiaries of group educational sessions and an awareness-raising campaign
- T3. Control group: Community with delayed intervention

Qualitative: Individual and couple interviews

Type of intervention

Communication campaign for social change

Objective of the intervention

Helping young men question traditional norms related to manhood and promoting their skills for talking about the "costs" of traditional masculinity and the advantages of more gender-equitable behaviors.

Target population

Adolescents and young adult men ages 14-25 in shantytowns in Río de Janeiro.

Results related to SGBV

More gender-equitable attitudes in the two communities that received the intervention; the changes in attitude were corroborated by the couples through interviews. Changes in gender norms did not appear to be significantly greater in the combined model, but informed behaviors about HIV/STDs were.

Countries

Original: Brazil
Reproduced in Mexico, Chile, India, Ethiopia, Rwanda, Tanzania, Croatia, Vietnam.

There are eight quasi-experimental evaluations that demonstrate significant positive changes related to gender issues, couple communication and partner violence.

Cost

Group education model: US$108 per participant (US$26,938 total).
Combined model: US$161 per participant (US$45,865 total) (Remme *et al.,* 2014).

Name of intervention

Sasa!
(Abramsky *et al.,* 2014)

Evaluation design

Quantitative: CRCT, randomized controlled trial, randomized by groups belonging to eight communities (four intervention and four control).

Cross-sectional survey before the intervention and four years after, with random samples.

Type of intervention

Community mobilization

Objective of the intervention

Positively alter traditional gender roles in the community and modify knowledge, attitudes, and behavior with the goal of correcting the imbalance of power between men and women.

Target population

Women ages 15-49

Results related to SGBV

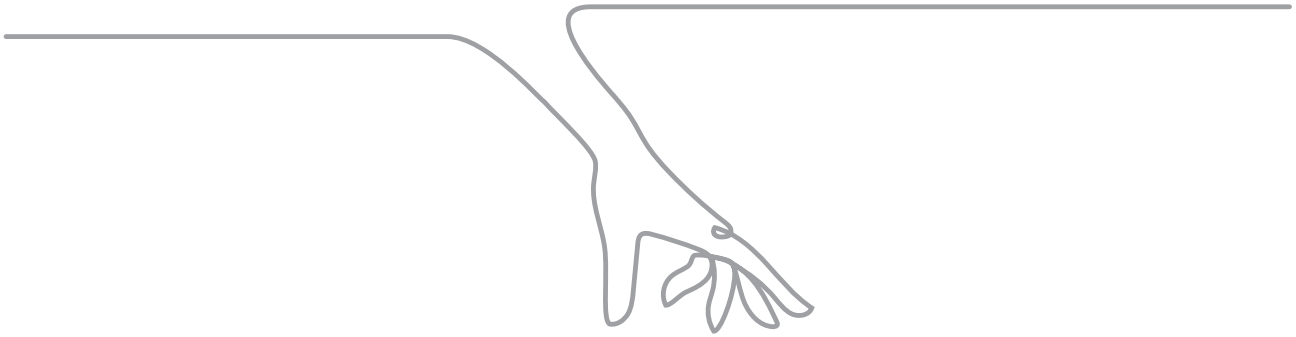
Less social acceptance of VAW among women and men, greater acceptance among men and women that a woman can reject sex, and lower levels of having experienced physical and sexual partner violence.

Countries

Original: Uganda
Expanded to 80 sites in Uganda and replicated in 20 countries, including Haiti, the first country outside of Africa to adapt the initiative.

Cost

The total cost of implementation was US$559,574, that is, US$137,605 annually. During the four years of implementation (2008-2011), this resulted in a cost of US$392 annually per activist supported (Remme *et al.*, 2014).



Name of intervention

Empower Self-defense curriculum (ESD)
(Sarnquist, 2014)

Evaluation design

Quantitative: Surveys. Baseline and 10.5 months after the intervention.

- T 1. Treatment group: Adolescents from four neighborhoods near Nairobi received training in empowerment and self-defense skills in six two-hour sessions.
- T 2. Control group: Received life skills classes.

Type of intervention

Empowerment self-defense curriculum

Objective of the intervention

Interventions that include an empowerment module for women through personal defense techniques for responding to rape attempts, as well as other non-physical response strategies to reduce risk and avoid and dissuade attacks.

Target population

Women ages 13-20
(80% between ages 15 and 18)

Results related to SGBV

Annual rates of sexual aggression decreased from 17.9/100 person-years at the beginning of the study to 11.1 in the follow-up; there were no significant changes in the control group.

In addition, 52% of adolescents in the intervention group said they had used the skills learned to stop an aggression.

Countries

Original: United States
Reproduced in: Canada, Kenya, Malawi, India, Costa Rica, Mexico, Chile, Brazil.

Cost

The cost of standard hospital services after an assault in Nairobi is estimated at around US$86 just for the initial visit.

The total cost of the intervention was US$1.75 per sexual aggression avoided.

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