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Gender-based violence in Solomon Islands: Translating research into action on the social determinants of health

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Executive Summary

As elsewhere, gender inequality is prevalent in Solomon Islands, and impacts health through "discriminatory feeding patterns, violence against women, lack of decision-making power, and unfair divisions of work, leisure, and possibilities of improving one's life,"[1] in addition to limiting access to health care services. One of the most significant consequences of gender inequality for women in Solomon Islands is the high level of gender-based violence (GBV) they face, which ranges from sexual violence, coercion, emotional and/or physical violence perpetrated by intimate and non-partners. GBV "reflects and reinforces inequality between men and women…[compromising] the health, dignity, security and autonomy" of its survivors."[2]

The causes of GBV are multiple, but it primarily stems from gender inequality and its manifestations. In Solomon Islands, GBV has been largely normalized: 73% of men and 73% of women believe violence against women is justifiable, especially for infidelity and "disobedience," as when women do "not live up to the gender roles that society imposes." For example, women who believed they could occasionally refuse sex were four times more likely to experience GBV from an intimate partner. Men cited acceptability of violence and gender inequality as two main reasons for GBV, and almost all of them reported hitting their female partners as a "form of discipline," suggesting that women could improve the situation by "[learning] to obey [them]." Another manifestation and driver of gender inequality in Solomon Islands is the traditional practice of bride price. Although specific customs vary between communities, paying a bride price is considered similar to a property title, giving men ownership over women. Gender norms of masculinity tend to encourage men to "control" their wives, often through violence, while women felt that bride prices prevented them from leaving men.

Despite continued efforts by Solomon NGOs and faith-based organizations including the Voice Blong Mere (VBMSI), the Christian Care Centre, Family Support Centre and Solomon Islands Christian Association Federation of Women, "until recently political leaders trivialised and denied the existence of violence against women…the region has been very slow in developing relevant legislation, policies, programmes and budgets to address the issue." The first national study on GBV was conducted in 2007, as the result of growing regional and global attention to GBV; strong government leadership; growing advocacy from faith-based organizations and NGOs; attention, financial and technical support to GBV from UN and donor agencies [including AusAID, NZAID, UNFPA, UNIFEM (now UN-WOMEN) and WHO]; as well as the recognition that GBV harms health and significantly impedes social and economic development. The Solomon Islands Family Health and Safety Study (SIFHSS)

revealed extremely high prevalence of GBV: 64% of women aged 15-49 who had ever been in a relationship reported having experienced some form of violence (emotional, physical and/or sexual), from an intimate partner. 56% of women had experienced controlling behavior from a male partner, and 18% had survived violence from a non-partner. Survivors were more likely to report poorer health outcomes, including emotional distress, and were nearly four times more likely to have attempted suicide.

As part of the agreement with UNFPA and AusAID to undertake the SIFHSS, the Solomon Islands government committed to a year of work beyond conducting the research to disseminate results and work to develop responsive policies. Thus, based on SIFHSS findings, and capitalizing on political momentum, the government developed a national policy on the Elimination of Violence against Women (EVAW) as well as a 10-year National Action Plan to guide its implementation. Both were developed with continued support from UNFPA, AusAID and NZAID in a consultative, inclusive manner. In recognition that, "to make a significant difference both to inequities and to the global toll of death and disability, [interventions] need to act on upstream measures," the former National Women's Policy was revitalized into a new national policy on Gender Equality and Women's Development, linked to the EVAW policy, thereby acting on a major driver of GBV. In addition, steps were taken to initiate "interventions directed towards individuals." Consistent stakeholder engagement and ongoing support from the national government, UN and donor agencies enabled the successful implementation of SIFHSS and the uptake of its findings into policy development.

Problem

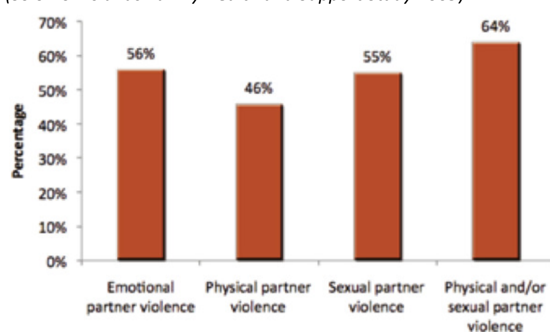
In light of anecdotal knowledge and regional attention[3] to gender inequality and consequent gender-based violence (GBV), Solomon Islands conducted the Solomon Islands Family Health and Safety Study (SIFHSS) in 2008, which revealed epidemic levels of GBV that demanded a national response.

GBV is defined as actions which result in "physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[4,5] Violence against women is "a manifestation of the historically unequal power relations between men and women,"[5] inherently related to gender-based inequalities, which both lead to and result from violence against women, in a vicious cycle.[5,6] Children who see or suffer violence are more likely to be violent as adults, having been 'taught' violent modes of conflict resolution.[7]

Traditionally, GBV was "the subject of continuous denial and suppression by society…[Solomon Islands] society has been slow in condemning violence against women and child abuse as crimes,"[2] although these have characterized women's and children's lives.[2] Most men and women consider violence is legitimate and justifiable way to discipline women for "transgressing their gender roles,"[2] disobedience or infidelity.[2, 8] A women's rights movement gathered strength in the 1990s: the Ministry for Women was established (1993), a National Plan for Women was made (1998) and efforts started to address GBV.[9] The achievements of this movement, however, were erased by the civil conflict that devastated Solomon Islands from 1998 to 2003, including a coup d'état in 2000. Despite prior progress on women's rights, this period saw a resurgence in GBV, particularly sexual violence.[9, 10] After the 2003 peace agreements, partner violence increased, survivors were stigmatized, perpetrators largely enjoyed impunity, and little action was taken on stated commitments to counter GBV.[10]

In 2007, with support from AusAID, UNFPA, and the Secretariat of the Pacific Community (SPC), Solomon Islands decided to participate in UNFPA's Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia and Micronesia. The Ministry of Women, Youth and Children's Affairs (MWYCA) and the National Statistics Office (NSO) proceeded with the SIFHSS. Drawing on the WHO Multi-country Study on Women's Health and Domestic Violence methodology, the SIFHSS aimed to (1) estimate national GBV prevalence, especially by intimate partners, (2) evaluate links between GBV and health, (3) identify risk and protecting factors, (4) note coping strategies and services used by survivors, and (5) assess links between GBV and child abuse.[2,11]

Figure 1: Percentage of women aged 15-49, who have ever been in a relationship, reporting different types of intimate partner violence (N=2618).
(Solomon Islands Family Health and Support Study 2009)



The study revealed an alarming prevalence of GBV: 64% of women aged 15-49 who had ever had an intimate partner had experienced some kind of violence by the partner (Figure 1), and when violence was experienced, it was more likely to be severe than moderate or mild. 18% of women had experienced non-partner violence, and 37% had been sexually abused before the age of 15. Survivors of violence were more likely to report poorer health outcomes and nearly four times more likely to have attempted suicide.[2]

The SIFHSS was implemented well, with high adherence to the WHO multi-country study methodology.[12] As such, it shares the WHO study limitations – primarily that, as a cross-sectional study, it cannot prove causality.[2,11] Key actors involved in the SIFHSS, including the MWYCA and NSO, SPC, UNFPA, AusAID, NGOs and faith-based organizations, needed to jointly devise a communication strategy to disseminate these results and encourage responsive policy-making, to protect women and children from violence and to promote the fulfillment of their human rights, including health.

Context

Recognition of GBV as a human rights violation with real consequences for health increased during the 1990s, as worldwide advocacy efforts spurred the creation of supportive international declarations and agreements regarding gender equality and human rights.[5,13,14] The Beijing Platform for Action in particular identifies the need for adequate data on the prevalence, causes and consequences of violence and calls upon governments to increase international knowledge on GBV (120 and 129a).[5] In addition to enabling GBV, gender inequality operates broadly to influence feeding and birth patterns, opportunities for education, divisions of labor, civil participation, legal rights, environmental exposures and access to health care, among other things, thereby exerting multiple effects on the health of women and men.[1]

The causes of GBV are multiple, but it primarily stems from gender inequality and its manifestations. In Solomon Islands, GBV has been largely normalized: 73% of men and 73% of women believe violence against women is justifiable, especially for infidelity and “disobedience,”[2,8] as when women do “not live up to the gender roles that society imposes.”[2] For example, women who believed they could occasionally refuse sex were four times more likely to experience GBV from an intimate partner. Men cited acceptability of violence and gender inequality as two main reasons for GBV, and almost all reported hitting their female partners as a “form of discipline,” suggesting that women

could improve the situation by "[learning] to obey [them]."[2] Another manifestation and driver of gender inequality in Solomon Islands is the traditional practice of bride price.[15] Although specific customs vary between communities, paying a bride price is considered similar to a property title,[10,16] giving men ownership over women.[9] Gender norms of masculinity tend to encourage men to "control" their wives, often through violence, while women felt that bride prices prevented them from leaving men.[2,10]

Other conditions and structures of daily life (themselves shaped by gender inequality) contribute to GBV as well. Primary education is not yet universal, and enrolment drops sharply in secondary school for boys and girls, largely because of fees, with less than 30% gross enrolment for girls.[8,17] Although recent data are lacking, 46% of young people were unemployed in 1999, [10,17, 18] and male unemployment was correlated with higher risk of GBV for women.[2] Women's participation in the formal economy has grown, but women hold just 6% of senior public service jobs.[19] Logging, the main export industry, has faced challenges including costly illicit logging, extensive deforestation by foreign companies[20] and sexual exploitation of girls by foreign loggers.[21] The civil conflict took an enormous toll on Solomon Islands' economic and social development, retarding education, employment, infrastructure and economic growth.[9,10] Infrastructure damaged during the tensions continues to limit economic growth, exacerbated by natural disasters[22] and high vulnerability to climate change, which is already showing an impact.[23,24] Without secure, decent employment; access to credit;[17] full social protection;[25] or support services in rural areas (where 80% of the population lives),[2,9,10] survivors of GBV may be constrained to stay in abusive relationships. In the absence of laws criminalizing GBV (including marital rape),[2,9] the largely male police force hesitated to honor restraining orders or penalize perpetrators, preferring to seek peace according to traditional, community-based justice methods.[2,9,10,16] Given women's lack of representation in parliament,[9,10,17,19] advancing women's rights within the legal system remained difficult.[9,10,17] Excessive alcohol consumption, the global political economy and the potential for foreign assistance to exacerbate existing dimensions of gender inequality are also relevant factors.[9,20]

Solomon Islands ratified CEDAW in 2002,[26] and the UN Economic and Social Council recommended that Solomon Islands enact legislation against GBV in the same year.[27] However, prior to the SIFHSS, it was only the Constitution that contained any protection from GBV, guaranteeing "life, liberty, security of the person and the protection of the law"[28] as well as protection from "torture or to inhuman or degrading punishment"[29] to "the individual…whatever his race, place of origin, political opinions, colour, creed or sex."[28] In 2003, women formed Voice Blong Mere (VBMSI, "Voice of the

Women"), an NGO advocating for women's rights, and the Women's Development Division of MWYCA was revitalized,[9] but plans to establish three counseling centers for victims of war-related and gender-based violence did not come to fruition,[10] and no CEDAW treaty body reports have been submitted to date.[10,26]

Planning

Despite continued efforts by Solomon NGOs and faith-based organizations, including the VBMSI, the Christian Care Centre (CCC), Family Support Centre (FSC) and Solomon Islands Christian Association Federation of Women (SICA FOW), "until recently political leaders trivialised and denied the existence of violence against women….[T]he region has been very slow in developing relevant legislation, policies, programmes and budgets to address the issue."[30] The first national study on GBV was conducted in 2007, as the result of growing regional[3] and global attention to GBV;[4] strong MWYCA and NSO leadership; persistent and growing advocacy from faith-based organizations and NGOs;[10] UN[31] and donor agency attention to GBV;[9] technical support from UN agencies; financial support from NZAID, AusAID, UNIFEM (now UN-WOMEN) and UNFPA;[9,10] as well as the recognition that GBV not only harms health but significantly impedes social and economic development.[2,4]

The Solomon Islands Family Health and Safety Study is the alias 'safe name' given to the UNFPA and AusAID-funded Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia and Micronesia in Solomon Islands, so as to encourage national participation and to protect all of its respondents and project team members.[12] The SIFHSS aimed to (1) estimate the national prevalence of GBV, with emphasis on violence committed by intimate partners, in a nationally-representative and internationally comparable way, (2) analyze associations between GBV and health outcomes, (3) identify country-specific risk factors for GBV as well as protective factors, (4) assess coping strategies and services used by GBV survivors, (5) investigate associations between GBV and child abuse, so as to ultimately develop effective policy responses and interventions to reduce the incidence and impact of GBV and child abuse, and (6) build regional and national capacity for research activities.[2,11,12] To effectively achieve these objectives, the SIFHSS would adapt the internationally validated methodology of the WHO Multi-Country Study on Women's Health and Domestic Violence to its own context.[2,12]

As part of the agreement between UNFPA, AusAID and Solomon Islands government to undertake the SIFHSS, Solomon Islands committed to a year of work beyond conducting the research to disseminate results and work to develop responsive policies.[12,19] To support and guide the national

project team in its administration and follow-up of the SIFHSS, a committee of stakeholders, the Solomon Islands Support Committee (SISC), was assembled. The SISC would be chaired by the Coordinator of the Country Research Team, under MWYCA, to provide country-level support.[12] As a result of its careful composition, the SISC not only supported the project with technical guidance, but provided a longitudinal sense of national and community buy-in and ownership. The SISC met quarterly and included approximately 50 members representing:

- Local and national government including MWYCA, NSO, the Ministry of Medical Services and Social Welfare, the Ministry of Education, the Department of Planning and National Aid Coordination, the office of the Prime Minister, the Attorney General's Chamber, the Public Solicitor's office, the Women Lawyer's Association, the Law Reform Commission, the RAMSI Law and Justice Programme, the Machinery of Government and the Solomon Islands Police Force (Community policing, Sexual Assault Unit and Family Violence Unit);
- NGOs such as the Community Sector Program, Development Services Exchange, SIPPA, the National Council of Women, VBMSI and World Vision;
- Faith-based organizations including the FSC, CCC, SICA FOW, SDA Dorcas, United Church, Catholic Women's League and Church of Melanesia (Anglican) Mother's Union;
- International organizations and UN agencies such as UNICEF, WHO, Save the Children; and
- The funding partners, UNFPA and AusAID.[12]

A Regional Project Coordinator chaired the Regional Project Team, overseeing both the SIFHSS and the analogous project in Kiribati, the Kiribati Family Health and Support Study. A Regional Project Advisory Committee (RPAC) chaired by the Regional Coordinator was also assembled to provide further support to the research projects ongoing in both Kiribati and Solomon Islands. The RPAC would meet annually and included representatives from UNFPA and AusAID (the funders), the SPC (implementing agency) and two country representatives: the Secretary of MWYCA and the Secretary of the Kiribati Ministry of Internal and Social Affairs. Early in the project, the Regional Coordinator established a Technical Advisory Panel (TAP) consisting of GBV experts as well as core members from the WHO multi-country study team, which would be available for consultation throughout study implementation. An additional member of the WHO multi-country study team with island-context experience was recruited to train interviewers who would actually conduct the study.[12]

The RPAC TAP and SISC collectively selected targets in a stakeholder workshop, with the implicit

understanding that, to effectively measure a phenomenon inherently related to gender equality, gender-sensitive indicators relevant to the topic of interest must be used, with both qualitative and quantitative data appropriately disaggregated.[12, 32] Through careful analysis and context-specific adaptation of the WHO multi-country study questionnaires, as well as consultant-supported inclusion of UNICEF-based questions related to child abuse, a draft version of a Solomon Islands questionnaire was developed in English; less than 10% of the original WHO questionnaire had been revised. The questionnaire was translated into Pidgin by a member of the Country Project Team, verified by independent back-translation by NSO. The finalized questions were reviewed and adjusted during interviewer training, and final modifications made after a pilot survey in the field. By November 2007, the Solomon Islands country research team had been assembled and was fully operational; the team completed the research in October 2008.[12]

While 2008 was a year for research, 2009 was a year for intervention, transforming research results into meaningful, acceptable and stakeholder-supported policy responses. The MWYCA Permanent Secretary anticipated and noted the following challenges to doing so: GBV continues to be a sensitive issue, not only because of the stigma experienced by survivors, but because of the entrenched acceptability of violence as “men’s right,” related to bride price and other manifestations of gender inequality described above.[9,12,19] Because dissemination of the research was stipulated from the start, stakeholder-informed planning for study follow-up began early in the project. In a meeting facilitated by UNFPA and SPC in early 2009, the RPAC focused on the process of transitioning from research to intervention, including work with service providers and policy development. UNFPA and AusAID supported supplementary activities including an assessment of currently available GBV support services and, importantly, the development of a communication strategy for disseminating research findings.[12]

Mindful of the potential reluctance of communities to accept and/or act on the results of the study, the country research team worked with UNFPA technical staff to identify key messages in the report best suited to each target group that would receive the information. Prior to dissemination, teams charged with dispersing the results underwent training on gender and data presentation for various audiences. The preliminary report was launched on 25 November 2008, and it received attention in Parliament: the Solomon Islands Government Cabinet approved the report for dissemination and pledged support for subsequent policy and legal work on GBV.[12] International consultants were recruited to assist with developing a national policy on the elimination of violence against women as well as a 10-year national action plan to guide its implementation, both to be completed in a

consultative manner, inclusive of all stakeholders.[12] An additional consultant would review the existing National Women's Policy for revitalization into a new national policy on women and gender equality.[12,19]

Consistent stakeholder engagement and sense of ownership, support from the national government (the Permanent Secretary of MWYCA in particular) as well as ongoing support from UN and donor agencies greatly facilitated the successful implementation of SIFHSS and its follow-up.[2,12] UN and donor agency support was secure and ongoing: UNFPA planned additional activities to address GBV in the health sector,[12] UN Women would provide grants and capacity development through its "Pacific Fund to End Violence Against Women,"[33] and, in line with UN recommendations,[31] domestic and international aid priorities,[34] AusAID remains committed to reducing GBV and advancing care and justice for survivors[35] through partnerships with the UN and civil society organizations.[16]

Implementation

An independent assessment of the Solomon Islands experience in planning and implementing the SIFHSS, raising national awareness of research findings and capturing that momentum for responsive policymaking was completed in late 2009. Despite some logistical challenges faced during the project's implementation, it was concluded that the RPAC and national project team "managed successfully to coordinate a difficult project," largely because of the way in which national and regional coordinating teams regularly and proactively engaged stakeholders throughout planning and implementation.[12]

Under the alias of the Family Health and Safety Study, recruitment of national and regional coordinating teams began in 2007. Early in the process, a capacity-related challenge was encountered: no one candidate for Regional Coordinator had sufficient experience in all of research project management, finances, and logistics as well as culturally-specific and expert-level knowledge on gender equality, GBV and child abuse. Technical rigor was assured in all aspects by establishing and utilizing the Technical Advisory Panel, calling upon internationally renowned experts on GBV research as needed and taking advantage of opportunities to learn throughout the study. In this way, the RPAC quickly filled gaps with external support while building research capacity within the country and region.[12]

Once project teams and coordinating committees were assembled at both national and regional levels, the country project team began to recruit, select and train Solomon Islander women who

would conduct the qualitative and quantitative research. 70 women were recruited to undergo three weeks of interviewer training according to the WHO methodology. They underwent the training, with elimination of inappropriate candidates during the first week. Final researcher selection was based on NSO test results and observations by the WHO-trained trainer to ensure that all selected researchers would be able to work with confidentiality and sufficient skill so as to fill out the lengthy questionnaire with respondents. 45 interviewers and five alternates were selected, and women who would become supervisors and field editors underwent additional, specialized training. Nine field teams of 4-6 people were formed, each with a supervisor/counselor, a field editor and 1-3 interviewers.[12]

Field implementation challenges were largely related to the logistics of conducting research across a large, topographically diverse geographic area with imperfect telecommunication infrastructure. Study teams began in the outer islands, traveling via boat, canoe, truck or by foot, with frequent transport delays. Teams contacted the country coordinating team every two days as possible, and the country team made occasional field visits to boost morale and fix errors. Letters to inform provincial governors of the study had been sent in advance, and teams met with community leaders upon arrival in a village to explain that a MWYCA study was being conducted. Village premiers, chiefs and leaders across Solomon Islands allowed the research (under its safe name) to be carried out in their provinces and communities,[2] and these authorities were thanked when work in their communities was completed.[12]

Study teams often had to be away from home for 4-8 weeks at a time, staying 1-3 days in any given village, with impacts on interviewers' families. *Per diem* and imprests were provided, but imprests for fieldworkers were considered insufficient for accommodation, although these costs were fully funded for all team members. In addition to the physical demands of travel, teams sometimes experienced theft, sexual harassment threats, verbal harassment and exposure to witchcraft and black magic, which prohibited teams' entry into one village (this was circumvented by having respondents travel to meet the team outside the village).[12] As a result of these challenges, and despite a "stress allowance" paid upon completion of the work, 10 interviewers dropped out before the fieldwork was finished. To finish the study, field editors (who had completed the required three weeks of training) acted as interviewers, and replacement field editors with NSO experience were recruited and trained.[12]

The research was completed successfully after six months with minimal complications: it was not a

problem to speak to women privately in their homes, and women respondents were given information on GBV resources, including CCC, FSC, police and social welfare, all of which were involved even if they were of limited use for women outside Honiara.[12] A counseling session was held for all researchers, and private counseling was available for anyone wishing to further discuss their experiences. Field workers returned home safely, and no respondents were known to have experienced violence as a result of their participation in the study. NSO assisted with budget calculations, data entry, transportation for field teams, finding and mapping target communities, and subsequently supported data processing efforts.[2,12]

As described above, the project consisted not only of research planning and administration, but also research dissemination and work to promote responsive policymaking.[2,12] Following completion of SIFHSS data entry, processing, weighting and tabulation, the SISC continued its active involvement. In two separate workshops, key study findings were presented to national teams, SISC and other stakeholders as a way to transition from the research to action phase. A draft report, written with intensive participation from the country research team, was presented in a stakeholders' workshop, where the research findings were discussed and recommendations modified in light of their feedback. UNFPA supported the development of a communication strategy for sharing research results with target populations in Solomon Islands, as described above. With UNFPA's assistance, complex findings and statistics from the study were broken down into simple, understandable messages, and fact sheets publicizing the state's support, key messages and recommended actions developed, again for a range of target groups. Fact sheets were tested and evaluated before use by dissemination teams.[2,12]

Regular and consistent stakeholder involvement proved to be crucial for successfully implementing the SIFHSS as well as moving forward with subsequent policy development. During the research phase, researchers, NSO, the MWYCA Permanent Secretary, other members of the government and additional stakeholders discussed updates and solved issues together every one to two weeks.[12] These partners were essential for supporting the study and dissemination of its findings.[2,12] High-level governmental support for the project, mainly from the MWYCA Permanent Secretary, was essential for the success and validity of the research, for ensuring consultation with SISC members (including NGOs, service agencies and donors) and for continuing collaboration. The preliminary report was launched on 25 November 2008, and when opposition in Parliament questioned the surprising findings, the Permanent Secretary held that, "even if report is not endorsed, it does not jeopardize the credibility of the research."[12] Ultimately, Parliament gave its full support for the report

and for acting on its recommendations.

As a result of SIFHSS findings, and capitalizing on political momentum, government officials worked with international consultants to develop a national policy on the Elimination of Violence Against Women (EVAW) as well as a 10-year National Action Plan (NAP) to guide its implementation. Both were developed with continued support from UNFPA, AusAID and NZAID in a consultative, inclusive manner, including a provincial level consultation.[12] In recognition that, "to make a significant difference both to inequities and to the global toll of death and disability, [interventions] need to act on upstream measures,"[36] MWYCA worked with an additional consultant to review and revitalize the former National Women's Policy into a new national policy on Gender Equality and Women's Development (GEWD), linked to the EVAW policy, [12,19] thereby acting on a major driver of GBV, in addition to initiating steps to introduce "interventions directed towards individuals."[36]

Implementation of the GEWD policy will follow a national Plan of Action (Appendix 1), to be overseen by the National Women's Machinery, a "public-public" body comprised of MWYCA and the Solomon Islands National Council on Women (SINCW), each to play the lead (but not exclusive) coordinating role in its respective governmental or civil society domain. GEWD implementation will build upon the experience of its predecessor policy, increasing partner coordination through a Development Partners' Coordination Group while cultivating dialogue with faith-based and civil society organizations through a forum to be convened quarterly by SINCW, the GEWD Civil Society Group.[19] The EVAW policy will be implemented in tandem, as a subsidiary to the GEWD policy, through a similarly participatory and whole-of-government approach, detailed in its National Action Plan (NAP) (Appendix 2), led by MWYCA. The NAP will be operationalized on a 3-year rolling basis with annual updates, to be as responsive and effective as possible. The EVAW National Task Force (NTF), chaired by the MWYCA Permanent Secretary, will consist of government representatives, NGOs and faith-based organizations, donors and media. The NTF will report its progress to the GEWD National Steering Committee (as described below).[37]

Evaluation of results and impacts, including on social determinants and health inequities

As detailed above, the active engagement of stakeholders at local, national and regional levels characterized the planning and implementation for every step of the SIFHSS – from assembling national and regional project coordination teams; to troubleshooting and conducting the research in the field; finalizing recommendations of the report; developing and testing strategies for the

dissemination of results; creating and piloting information fact sheets; and drafting responsive national policies.[2,9,12,19,37]

This systematic stakeholder involvement, in conjunction with visible promotion from the Permanent Secretary of MWYCA, consistent technical support from UN agencies and experts with experience in GBV as well as financial support from donor agencies, and conscientious adaptation of the research methodology and implementation plan to the Solomons' context, resulted in successful implementation of the SIFHSS. These same supporting factors further facilitated the dissemination of research findings to Parliamentary officials, community leaders and the general population. Contemporary Solomon Islands society prioritizes its traditional culture, including the community-based resolution of domestic disputes.[2,9,10] Despite the initial challenges in acknowledging GBV as a problem requiring action rather than an acceptable feature of heterosexual partnerships, results from the SIFHSS were presented to the community in a way that both valued and respected culture, while calling for social change. Rather than advocating change to an entrenched, accepted part of culture (GBV), it was noted that, "as a society that prides itself on its family kinship being tightly knitted, the health and well-being of our families is important to us," so that action on GBV would uphold this cultural value.[2,37] Unwavering government support, technical assistance from UN agencies and the active participation of stakeholders eventually won broad-based support for the creation and passage of two responsive national policies:

- The National Policy on Gender Equality and Women's Development: Partners in Development (GEWD), 2010-2012
- The National Policy on Eliminating Violence Against Women (EVAW), 2010-2013

Brief analysis of the rationale, targets and aims of the EVAW and GEWD policies reveals their complementarity and greater understanding that GBV is fundamentally both a cause and result of gender inequality. The GEWD "recognises that in order to redress gender inequalities it is necessary to invest in women's development while women and men work together to address attitudinal and institutional barriers to gender equality." It is truly complementary to the EVAW policy, aiming to achieve five priority policy objectives: "(1) Improved and equitable health and education for women, men, girls and boys; (2) Improved economic status of women, (3) Equal participation of women and men in decision making and leadership, (4) Elimination of violence against women, [and] (5) Increased capacity for gender mainstreaming.[19] Similarly, the EVAW policy emphasizes the need to prevent GBV, protect survivors and better prosecute perpetrators while recognizing "that effective

interventions must be based on well thought out strategies, activities and key ongoing processes designed to prevent and eliminate violence (including triggers to violence), advance gender equality and promote women's development," again demonstrating the complementarity of the policies.[37] Indeed, the four principles and values of the EVAW policy include: "(1) Zero tolerance of violence, (2) Recognition of women's rights, (3) Sharing responsibility for elimination of violence against women and (4) Achieving gender equality." [37] The seven key strategic areas of the policy, appropriately, focus on preventing GBV and providing support for survivors, but relate more broadly to gender equality in the areas of justice, public advocacy, working with men to end GBV and policy coordination.[37]

Although too little time has elapsed since the adoption of these policies to be able to evaluate their full impact, anecdotal evidence of responses to the completion of the SIFHSS, momentum for social change and the adoption of two responsive national policies indicates effectiveness. For example, during an interview in mid-2009, as part of an independent assessment of the SIFHSS conducted by a former member of the WHO multi-country study team,[12] the Permanent Secretary of MWYCA reported that the SIFHSS and its findings were already contributing to evidence-based legal reform, undertaken by the Law Reform Commission and the Regional Rights Resource Team (RRRT), to integrate GBV into the penal code and conduct informal shelter training for GBV survivors, in addition to policy development around GBV and gender equality. Also at that time, interviewers who had implemented the SIFHSS were establishing a new women's rights advocacy NGO, Raets Blong Uimi Network.[12]

An additional area of impact must be noted: research project teams and participating NGOs have benefited from considerable capacity building throughout the process of research planning, implementation, sharing of results and policy development.[2,12,19] Country and field teams overcame and learned from challenges associated with communication with other staff members; recruitment processes; logistically challenging field conditions; consultants and stakeholders; data collection systems across expansive geographical areas; and coordination of activities guided by two donor agencies, one implementation partner, two governments (as Kiribati also participated in RPAC) and advisory/steering committees. According to NSO, this was the first study to use only women interviewers, and these women gained valuable experience suited for future employment with NSO and/or census bodies.[12]

As mentioned above, the GEWD and EVAW policies will be implemented through their respective national action plans, each stipulating a whole-of-government approach and working with

stakeholders to ensure "inter-organizational linkages" and cooperation in policy implementation. Their monitoring processes are similarly participatory in nature, and are inextricably structurally inter-related.[19,37] While the National Women's Machinery will oversee GEWD's implementation, a separate entity–the GEWD National Steering Committee (GEWD-NSC)—will monitor progress toward its objectives. The GEWD-NSC will be composed of the Permanent Secretaries of all gubernatorial Ministries and other key stakeholders and report annually to Parliament via MWYCA. The GEWD-NSC will be informed by National Task Forces for each of its priority outcomes (for example, the EVAW NTF represents the GEWD priority outcome related to GBV, and will report to GEWD-NSC as described below). Additionally, MWYCA will work with other Ministries and agencies to ensure that their plans align with GEWD, a sort of 'gender policy mainstreaming.' MWYCA will additionally host a database to detail and monitor the situation of women and girls in Solomon Islands, conducting or coordinating necessary research on this topic. Through its reports and stakeholder forums, MWYCA will not only assess the progress and effectiveness of policy implementation, but it will inform the general public and policymakers alike.[19]

The EVAW NTF will ultimately report to the GEWD-NSC and undertake "participatory monitoring, evaluation and reviews" of the EVAW NAP. In other words, monitoring will be done in cooperation with stakeholders so as to enhance their understanding and commitment to the policy's implementation. For example, each year the Royal Solomon Islands Police Force, the Ministry of Health and Medical Services, VBMSI, FSC, CCC and other agencies will be invited to submit reports to the NTF, which will then submit a composite report to the GEWD-NSC. The NAP itself will be updated each year according to Ministries' corporate plans, and the NAP will undergo its first review by the NTF and GEWD-NSC after two years. Any identified gaps, areas where outcomes are not being met or "social changes that need other support if they are to occur" will be used to update the NAP and guide subsequent triennial evaluation of its effectiveness.[37]

MWYCA, in collaboration with the Ministry of Development Planning and Aid Coordination, will identify relevant "sectoral and cross-sectoral gender indicators" for evaluating GEWD and its priority outcomes, including GBV, and has already specified that data must be disaggregated by sex.[19] The GEWD Plan of Action (Appendix 1) and EVAW NAP (Appendix 2) include actions and outputs (targets) mapped to their respectively desired outcomes, but not methods for collecting information on those indicators, an implementation timeline, cost and funding sources.[19,37] While these plans identify a whole-of-government approach to address gender equality and GBV, there is no documented expectation for a follow-up SIFHSS, despite recognizing that "statistical data should be gathered at

regular intervals on the causes, consequences and frequency of all forms of violence against women, and on the effectiveness of measures to prevent and address such violence."[38]

Follow-Up and Lessons Learned

That MWYCA was central to the initiation, coordination, planning and implementation of the SIFHSS had immense value for securing stakeholder engagement, managing donor contributions and lending validity to the research in all stages. Despite MWYCA being a ministry devoted, in part, to women's affairs, it had the advantage of authority as a government body, whereas implementation by women's advocacy organizations may have inadvertently caused the project to be branded as a "women's project" with low priority. As discussed above, the eventual acceptance of research findings and subsequent transformation into legislation were facilitated not only by government leadership, but also the regular engagement and participation of stakeholders, which was essential for accumulating broad-based support for the research and cooperation in the implementation of resulting polices.[2,12,19]

The successful implementation of the SIFHSS with resultant policy development provides several key lessons for addressing other health inequities, perhaps in other contexts. First, data collection is a time-consuming and expensive process, but is necessary to effectively understand health issues for responsive policymaking. The selection of research methodology and indicators must be well-considered, comprehensive and goal-oriented: the indicators measured (or not) will significantly determine, the information collected and its potential uses. The WHO multi-country study provides a validated methodology for measuring GBV, replicable in all regions, including the Pacific.[2,11,12] The SIFHSS was able to catalyze policy responses to both GBV and its key determinant – gender inequality – because, building on WHO methodology, it included gender-sensitive indicators and metrics of gender inequality itself (qualitative in this instance).[2,11] Furthermore, the qualitative research sufficiently focused on men, at once validating and attempting to understand their perspectives so that men and boys may be meaningfully involved as agents of social change.[2,16,37]

Second, research implementation should be completed in a context-specific and respectful manner that allows for study rigor as well as the safety and well being of its research team. Recruitment, selection and training are important for the successful completion of the study, and applicants should be given detailed information of the work required and living situation during fieldwork, including time away from home. Positive attitudes and teamwork skills are invaluable. Communities should be informed of the study (with a safe name, if necessary) in advance so as to facilitate

collaboration and reduce study team harassment. Travel logistics, accommodation and board in research sites should be anticipated and pre-organized. If staff capacity and/or expertise is lacking, external sources of support should be identified and utilized to ensure a successful project while building national capacity.[12]

Given the recognition that gender inequality fuels the high levels of GBV in Solomon Islands, monitoring and evaluation of its GEWD and EVAW should include specific assessment of gender inequality. The SIFHSS included some measures of gender inequality, but GEWD and EVAW monitoring will require additional data to adequately measure progress towards gender equality. While the determinants of GBV, largely gender inequality, are more challenging to quantify than the incidence or prevalence of GBV, WHO's Regional Office for the Western Pacific has identified gender-equity indicators that might be used,[39] and quantitative data could be gleaned from repeat focus groups.

Successful administration of the 2009 SIFHSS with translation to policy suggests that future efforts to measure and monitor GBV and gender equality – as well as other health inequities and their determinants, will be successful, assuming continued support from donors, UN agencies and all levels of government (although political momentum for policymaking can never be guaranteed). The Australian government has committed 9.4 million aid dollars to GBV[40] and other funds to health equity in the Pacific,[34] the UN plans to launch a regional UNiTE campaign against GBV in 2010-11[41] and a regional reference group on GBV was formed.[33] Importantly, there has been regional action on determinants of GBV other than gender inequality as well.[42] Intersectoral actions on multiple determinants of GBV have the best chance to successfully and sustainably eliminate GBV. International consequences primarily include further support for this research methodology and a best practice example of policymaking targeted to preventing and addressing GBV while also acting on its root causes.

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