Measuring and responding to gender-based violence in the Pacific: Action on gender inequality as a social determinant of health

Republic of Kiribati

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Executive Summary

As elsewhere, gender inequality is prevalent in the Pacific island nation of Kiribati, 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,” in addition to limiting access to health care services. A significant consequence of gender inequality is the high level of gender-based violence (GBV) women in Kiribati face, including sexual, emotional and/or physical violence perpetrated by intimate partners and non-partners.

Prior to 2008, the prevalence of GBV in Kiribati was unknown to health policymakers, as no nationally representative study on GBV had been conducted. With support from the Australian Government, UNFPA and the Secretariat of the Pacific Community (SPC), and drawing on the methodology of the WHO Multi-country Study on Women’s Health and Domestic Violence, the Kiribati Ministry of Internal and Social Affairs (MISA) conducted the Kiribati Family Health and Support Study (FHSS) in 2008. A Committee of Stakeholders (KFFSSC) was assembled to guide the research, support its planning and implementation, and provide a longitudinal sense of buy-in and ownership.

The FHSS project included a research phase for conducting the study followed by an intervention phase in which research findings were disseminated and, subsequently, translated into national policy responses (with ongoing support from SPC, AusAID, UNFPA and other UN agencies). The FHSS revealed an alarming prevalence of GBV in Kiribati: 68% of women aged 15-49 who had ever been in a relationship had experienced some form of violence (emotional, physical and/or sexual), from an intimate partner; 90% had experienced controlling behavior from a male partner; and 10% had faced violence from a non-partner. Survivors were more likely to report poorer health outcomes, including emotional distress, and were three times more likely to have attempted suicide. Qualitative research with men’s focus groups investigated the causes of GBV and attitudes towards women so as to inform later interventions.

Upon release of the draft report, members of the KFFSSC held stakeholder consultations to develop a strategy to disseminate the controversial findings. In an impressively visible show of government support for the project’s findings and action on the issue, the President of Kiribati accepted the results and
launched the initial findings of the FHSS. After six months of community-based awareness-raising on the findings, the Cabinet unanimously endorsed the draft report. With the continued support of UNFPA and other UN agencies, MISA began to develop a National Action Plan (NAP) to eliminate violence against women in the same highly consultative manner, actively engaging stakeholders and other ministries in the process.

Systematic stakeholder consultation, combined with visible promotion from the government, consistent technical support from UN agencies and experts with experience in GBV, conscientious adaptation of the research methodology and implementation plan to the Kiribati context resulted in successful completion of the FHSS. These same supporting factors further facilitated the dissemination of research findings to government officials, community leaders and the general population, winning broad-based support for the creation of two responsive policies on gender equality and GBV, guided by a 10-year national plan of action. Too little time has elapsed since the adoption of these policies to evaluate their full impact, but anecdotal evidence of social change related to the completion of FHSS, and the associated policy responses, indicates effectiveness.

The research methodology determined, in large part, the information collected and its potential uses. The Kiribati FHSS was able to inspire policy responses to both GBV and its key determinant, gender inequality, because it included gender-sensitive indicators and attempted to measure gender inequality itself. Also, the qualitative research sufficiently focused on men, validating, while attempting to understand, their perspectives so that men and boys may be involved as agents of social change.

As the Kiribati experience demonstrates, efforts to measure the extent of the problem can raise political awareness and thereby effectively trigger policy responses on a key social determinant of GBV, namely gender inequality, which are critical to reduce health inequities.
Problem

Following the WHO Multi-country Study on Women’s Health and Domestic Violence, a previously unevaluated but pervasive level of gender-based violence (GBV), stemming from gender inequality, was revealed by the Kiribati Family Health and Support Study (FHSS) in 2008, spurring national action.

GBV is defined as actions which result in “physical, sexual or psychological harm or suffering to women...[encompassing] but not limited to...physical, sexual and psychological violence occurring in the family...within the general community...perpetrated or condoned by the State, wherever it occurs.”  

Violence against women is “a manifestation of the historically unequal power relations between men and women,” fundamentally related to gender-based inequalities, which both lead to and result from violence against women, in a vicious cycle.

Prior to the Kiribati Family Health and Support Study, violence against women and children was “an accepted fact,” something that happened ‘behind closed doors’ – a reality of women’s lives, but not an issue of national public health concern. While sporadic donor-funded initiatives to counter GBV were implemented during and before the 2000s, Kiribati had no policies or laws related to GBV, gender equality or the status of women; police procedures related to GBV lacked clarity and accountability mechanisms; and no reliable national data were available on the prevalence of GBV, its causes or the resources available for victims. Government intervention had become imperative.

In this context of growing regional and global concerns about GBV, and as part of UNFPA’s Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia and Micronesia, the Kiribati government embarked on the FHSS, in collaboration with the Secretariat of the Pacific Community (SPC), and with support from the Government of Australia. Replicating the WHO multi-country study methodology, the FHSS aimed to (1) estimate the national prevalence of GBV, especially that committed by intimate partners, (2) analyze associations between GBV and health outcomes, (3) identify risk and protective factors, (4) assess coping strategies and services used by victims and (5) investigate associations between GBV and child abuse.
The FHSS revealed an alarming prevalence of GBV in Kiribati: 68% of women aged 15-49 who had ever been in a relationship had experienced some form of violence (emotional, physical and/or sexual), from an intimate partner (Figure 1); 90% had experienced controlling behavior from a male partner; and 10% had survived violence from a non-partner. Survivors were more likely to report poorer health outcomes, including emotional distress, and were three times more likely to have attempted suicide. Four main causes of GBV given by men in focus groups were: (1) jealousy, (2) alcohol, (3) acceptance of violence as a form of discipline, and (4) gender inequality. The FHSS was well implemented, with high adherence to the WHO multi-country study methodology. As such, it shares the WHO study limitations – primarily that, as a cross-sectional study, it cannot prove causality.

Figure 1. Percentage of women aged 15-49 who have ever been in a relationship reporting emotional, physical and sexual partner violence (N = 1527) (Kiribati Family Health and Support Study 2010)

Key actors involved in the completion of the FHSS—including the Kiribati Ministry of Internal and Social Affairs (MISA) and National Statistics Office (NSO), the SPC, UNFPA, AusAID, and actively engaged faith-based organizations and NGOs—needed to jointly determine an overall communication strategy for disseminating these findings and translating them into policy 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 with global advocacy efforts, punctuated by international declarations and agreements regarding gender equality and human rights, including the Vienna Declaration and Programme of Action, the Cairo Programme of Action and the Beijing Platform for Action. The Beijing Platform for Action in particular notes the need for adequate data on the prevalence, causes and consequences of violence and calls upon governments to build an international knowledge base on GBV.

Gender inequality evident in traditional I-Kiribati social structures such as the maneaba community council and unamane male elders has persisted, and unequal gender norms, roles and relations have multiple and additive effects on health across the lifespan. Unfair and discriminatory feeding practices, division of work and environmental exposures, lower opportunities for political participation and access to health services and, importantly, gender-based violence stem from gender inequality.

In Kiribati, GBV has been normalized and viewed as an acceptable or even deserved form of discipline for women who do not fulfil their prescribed gender roles. Excessive alcohol consumption, although widely recognized to ignite or exacerbate violence, is tolerated in the community for men and, increasingly, for women. In the event of violence, survivors have few options: police procedures for addressing violence can be unclear and the traditional practice of settling domestic disputes within the family or community preferred; reporting violence and/or pressing charges may be seen as attempts to end intimate partnerships; married women have no land or property rights and cannot stay on their husband’s family land in the event of divorce; help from outsiders is often unwelcome; and sociocultural barriers inhibit the utilization of shelters and other (limited) services for survivors.

While GBV fundamentally stems from gender inequality, it is fueled by other conditions and structures of daily life for I-Kiribati women (which may themselves be shaped by gender inequality). Primary education is universal and well attended by both girls and boys (although girls’ education is considered less important), but access to secondary school is limited for both women and men. The Education is of variable quality and lacks a comprehensive GBV prevention curriculum. With less than one job available for every four new entrants to the job market, 37 percent of the population is unemployed, and
laborers are pushed to the informal economy, shipping-based markets and overseas employment, perpetuating reliance on remittances and foreign aid.\textsuperscript{18} Without secure, decent employment, fair property rights,\textsuperscript{5} and formal social protection,\textsuperscript{13,15} survivors of GBV may have no choice but to stay in abusive relationships.\textsuperscript{4,6} Furthermore, in this context, gender inequality created a uniquely vulnerable population of women, \textit{ainen matawa}, who board foreign shipping vessels to exchange sex for money, food and other goods. \textit{Ainen matawa} experience stigma and discrimination, violence and/or social exclusion such that, although they are at higher risk for HIV and other STIs, stigma inhibits their use of sexual and reproductive health services.\textsuperscript{19} Finally, Kiribati has a history of colonial annexation, wartime occupation and religious settlement, which have contributed to its weak position in the global economic order,\textsuperscript{13} and which often served to reinforce gender inequality.\textsuperscript{6} The potential for foreign aid structures to exacerbate existing dimensions of gender inequality must also be considered.

Anecdotal evidence and community-based knowledge on the occurrence of GBV have existed for generations, but “politics [are] dominated by men, and decision-making is influenced by cultural identity and competition among different male-dominated interest groups...until recently, political leaders trivialized and denied the existence of [violence against women].”\textsuperscript{20} A ministerial Women’s Affairs Unit was established in 1995 (now under MISA), but even when GBV became an issue for the national umbrella women’s NGO, Aia Maea Ainen Kiribati (AMAK), following the Fourth World Conference on Women, no policies on gender equality, GBV or its elimination were enacted.\textsuperscript{6,9} Prior to FHSS, although Kiribati ratified CEDAW in 2004,\textsuperscript{21} the Constitution provided the only policy on violence: a guarantee of the “fundamental rights and freedoms of the individual...whatever his race, place of origin, political opinions, colour, creed or sex,”\textsuperscript{22} specifically stating that “no person shall be subjected to torture or to inhumane treatment or degrading punishment or other treatment.”\textsuperscript{23}

\textbf{Planning}

Persistent advocacy by civil society and faith-based organizations;\textsuperscript{6,8,20} attention to GBV from UN\textsuperscript{24} and donor agencies, with significant financial support from UNFPA and AusAID in particular;\textsuperscript{4,25} the lack of any reliable national data on GBV;\textsuperscript{6} as well as the recognition that GBV not only harms health but significantly impedes social and economic development\textsuperscript{26,27} collectively provided the impetus to conduct the FHSS.
The Kiribati Family Health and Support Study is the alias ‘safe name’ given to the UNFPA Socio-Cultural Research on Gender-Based Violence and Child Abuse in Melanesia and Micronesia in Kiribati, so as to encourage national participation and to protect its respondents and project team. The FHSS aimed to (1) estimate the national prevalence of GBV, especially that 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 and protective factors, (4) assess coping strategies and services available to survivors and (5) investigate associations between GBV and child abuse, so as to ultimately develop the most 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. These objectives were in line with the previously-validated WHO multi-country study methodology, which was therefore adapted for FHSS.

To provide country-level guidance and support to the national research team for the implementation and follow-up of FHSS, a Committee of Stakeholders was assembled, the Kiribati Family Health and Support Study Committee (KFFSSC), chaired by the Coordinator of the National Project Team, under MISA. In addition to giving support with planning and implementation, the KFFSSC provided a crucial, longitudinal sense of buy-in and ownership. It consisted of representatives from:

- Local and national government, including MISA; the Ministries of Education, Finance and Economic Development, Health and Medical Services; the police; and the Attorney General’s Office
- Ten NGOs, including women’s advocacy NGOs and associations, crisis centers, the Kiribati Association of Non-Governmental Organizations (KANGO), AMAK (a semi-governmental organization), Alcoholic Awareness and Family Recovery, the Kiribati Women’s Advocacy Network, Tetokatarawa Old Men Association and the Kiribati Family Health Association
- International organizations such as UNICEF, WHO, AusAID and SPC

A Regional Project Coordinator chaired the Regional Project Team, overseeing both the FHSS and an analogous project in Solomon Islands, the Solomon Islands Family Health and Safety Study. A Regional Project Advisory Committee (RPAC) chaired by the Regional Coordinator, was also assembled to support
research projects in both Kiribati and Solomon Islands through annual meetings. The RPAC included UNFPA and AusAID (the funders), the SPC implementing agency and two country representatives: the Secretary of MISA (also the National Project Coordinator) and the Secretary of the Ministry of Women, Youth and Children’s Affairs in Solomon Islands. The Regional Coordinator established a Technical Advisory Panel (TAP) consisting of experts in GBV and three core members of the WHO multi-country study team, who would be available for remote consultation on study implementation. An additional member of the WHO multi-country study team was recruited to train I-Kiribati interviewers who would actually conduct the study.

The RPAC, TAP and KFFSSC selected targets through careful analysis and adaptation of the WHO multi-country study and UNICEF child abuse materials, with the assistance of a consultant and a stakeholder workshop, and with the understanding that, to effectively measure a phenomenon inherently related to gender equality, gender-sensitive indicators relevant to the information wanted, with both qualitative and quantitative data appropriately disaggregated, must be used. Less than 10% of the original WHO questionnaire was adjusted prior to translation to Kiribati by a translation panel. Pre-tests and a pilot venture were conducted, after which final modifications were made to the questionnaire. By December 2007, recruitment of national country staff to implement the FHSS had been completed. MISA’s National Project Team, in collaboration with the National Statistics Office (NSO), completed the study in 2008.

Importantly, dissemination of research results was a key component of the UNFPA project, and planning for study follow-up started in the early stages of the project. As a result, national and regional coordinating teams were consistently mindful of study follow-up, from coordinating the dissemination of research findings with carefully crafted messages to supporting the development of policy responses, proactively engaging key stakeholders at every step. For example, when the RPAC came together in a meeting facilitated by UNFPA in early 2009, it focused on the process of transitioning from research to intervention, including working with service providers and policy development. By the summer of 2009, international consultants were in place to assist with developing national action plans for the elimination of violence against women.
Upon release of the draft report, members of the KFFSSC held stakeholder consultations to develop the communication strategy for dissemination of the controversial research findings, mindful that largely male community leaders were likely to initially reject the results. Key stakeholders in this process included local and national government, the police, women’s and other NGOs, the Crisis Centre, the Attorney General the Kiribati Protestant and Catholic churches and other faith-based organizations, legal staff and research project staff from MISA and the NSO.\(^7\)

The communication strategy aimed to:

- Provide government and community leaders with the research findings so as to inform policy and legislation to protect women and children from violence while promoting and protecting their human rights more generally
- Educate stakeholders, community leaders and the general public about the results, equipping them with the information needed to lead positive social change and action to discourage and reduce GBV
- Generate tolerance, acceptance and support of the findings from all government and community sectors by ensuring that the results are understood and “owned” by I-Kiribati, in order to ensure effective action against GBV and child abuse
- Inform and streamline advocacy and awareness messages of the media campaign from initial to later stages\(^9\)

Prior to dissemination, KFFSSC members would receive training on gender and preparation for research dissemination, including best practices for addressing sensitive questions. Draft information and fact sheets would be tested and evaluated.\(^7\) Observations from initial sharing of research findings would be further taken into account for subsequent policy development phases.\(^9\)

UNFPA committed to providing technical and financial support to MISA for the completion of the FHSS, dissemination of its findings and translation of the results into effective policy.\(^4,29\) UNFPA also planned to further address GBV through the health sector,\(^12\) and other UN partners provided or committed to providing additional programming and technical support. By September 2009, for example, UNIFEM committed to drafting GBV legislation in collaboration with the Regional Rights Resource Team (RRRT)
and would also work with MISA to compose a national policy for gender equality and development.\(^{29}\) Furthermore, UN Women would provide grants and capacity development through its “Pacific Fund to End Violence Against Women.”\(^ {30}\) UN agency involvement would be coordinated and streamlined through a UN Gender Group in Kiribati (GGK), established to address the “greater need to support the Government with its commitments toward gender equality.”\(^ {31}\)

In line with its domestic and international aid priorities, and in accordance with UN recommendations at a Parliamentary Roundtable,\(^ {20,30}\) AusAID committed to continue its support of UN and civil society initiatives to reduce the incidence of GBV while advancing care and justice for survivors,\(^ {25,25}\) recently announcing its renewed support for the elimination of GBV.\(^ {32,33}\)

**Implementation**

Time, effort and thoughtfulness put into the planning stages made for successful implementation of the FHSS and its follow-up. Under the alias of the Family Health and Support Study, recruitment of national and regional coordinating teams began in 2007. Despite planning measures, an eventual problem with capacity was encountered: no one candidate for the position of Regional Coordinator in particular had sufficient experience in research management as well as expert-level knowledge on gender equality, GBV and child abuse. Technical rigor was assured at the regional level, however, by establishing and utilizing a Technical Advisory Panel while calling upon additional expert consultants as needed throughout the study. In this way, the RPAC quickly filled gaps with external support while building research capacity within the country and region.\(^ {7}\)

Once national and regional coordinating teams were established, the project team began to recruit, select and train I-Kiribati women who would conduct the study interviews and focus groups. 250 applicants were recruited from newspaper and radio announcements. Screening, including some assessment of mathematical skill, yielded 60 women who would undergo three weeks of interviewer training. 34 interviewers were ultimately selected based on their competence in a pilot survey and were required to sign an oath of confidentiality; no interviewers dropped out. Women who were selected to be supervisors and field editors underwent additional, specialized training. Six field teams of 4-6 people were assembled, each with a supervisor, a field editor and 1-3 interviewers. Each interviewer completed
4 interviews on average per day for 8-9 weeks (May to July 2008), using planes, cars, motorbikes and boats as transportation.⁷

Challenges to implementation in the field were largely related to community integration and the sensitive nature of the study. For example, study teams were frequently expected to attend community social and religious events, which threatened to interfere with completion of the research. Regrettably, during the course of the study, despite efforts to protect respondents, one woman may have been subjected to violence as a result of her participation and unwillingness to share the study questions with her partner.⁷

As described above, the UNFPA-funded project taken on by Kiribati consisted not only of research planning and study administration, but included from its onset, the crucial steps of dissemination and follow-up responses including policy-making.⁷ As such, following data entry, data processing, weighting and tabulation, RPAC and KFFSSC worked to develop a communication strategy for sharing the research findings, oriented to community leaders/target groups or the communities themselves. This marked the transition between the research phase and the intervention phase of acting on research findings. UNFPA assisted in identifying and prioritizing the pertinent, key facts for various target groups, and proceeded to translate key findings into simple terms on accessible fact sheets and booklets for national and community-based stakeholders.⁷ Fact sheets on the research contained key findings of the research including the consequences of GBV, listed key messages for the community, encouraged action against GBV and identified the research as government-supported. These fact sheets were developed, tested and evaluated before use by dissemination teams.⁷

In an impressively visible show of government support for the project, its results and action on the issue, The President of Kiribati accepted the results and launched the initial findings of the FHSS on 3 December 2008, strategically during the global Sixteen Days of Activism Against Gender Violence. In an address to MPs and community and church leaders, the President committed to a “whole-of-government” approach to eliminating violence against women and children.⁷ Subsequently, teams composed of government officials and civil society representatives underwent training workshops on gender equality and results dissemination, the latter of which was opened by the MISA Minister.⁷ These teams would carry out the initial sharing of results according to the communication strategy, holding
“awareness workshops” with church and community leaders, starting first with non-sampled communities, to protect respondents.⁷,³⁴

When the draft results were presented to a stakeholders group that included conservative men and male provincial chiefs, they were initially skeptical of the results and defensive. A national statistician present at the workshop was able to verify the data and simplify the results. After a simplified explanation, the chiefs accepted the results. Given these and other experiences, it became clear early in the dissemination process that results must be broken down into simple key messages, as had been done for the fact sheets. In particular, it was not useful to express the results as superlative statements or country rankings; rankings were challenged, ultimately distracting workshop audiences from the results.⁷ The research team was found to be effective in disseminating the results of the FHSS, resulting jointly from their own training and status as peers to the MPs, the support and national endorsement by the President and greater government and the involvement of churches in research dissemination and community engagement through sermons and youth organizations.⁷

In June 2009, after six months of community-based awareness-raising activities, the gubernatorial Cabinet unanimously endorsed the draft report of research findings.⁷ With the continued support of UNFPA and other UN agencies, MISA began to develop a National Action Plan (NAP) to eliminate violence against women in the same highly-consultative manner, actively engaging stakeholders and other government ministries in the process (Appendix 1). The NAP would be costed and mapped to the budget, as well as the Kiribati Development Plan 2008-2011, on an implementation timeline from 2010-2020.⁹ Given the broad-based government support of action on the issue, from its receipt of study results to its engagement in the dissemination process, it was recognized that “a road-map for the full government [was] required, to be spearheaded and monitored under MISA, in order to have a wide and sustainable approach to eliminating [violence against women.]”⁹

In the policy-development phase, it is clear that MISA, with assistance from UNFPA and UNIFEM, recognized that, in order for “interventions...to make a significant difference both to inequities and to the global toll of death and disability, they need to act on upstream measures,” creating policies to act on root drivers of behaviors as opposed to “behavioral interventions directed towards individuals”
themselves, which “will further widen inequities.” This is evident in the planning for and ultimate development of two separate policies in response to the FHSS, namely:

- The National Policy on Gender Equality and Women Development (December 2010)

It was decided that the EVAW policy (and sections of the policy on gender equality) would be operationalized according to a ten-year NAP, which contains a detailed framework committing multiple government sectors to a budgeted implementation plan (Appendix 1). MISA’s Women’s Affairs Unit had been largely under-resourced since its establishment in 1995. The EVAW National Policy notes that reviving this unit with “qualified and experienced gender advisors” would be a logical step in acting on the government’s goal to “eliminate violence against women that is largely resultant from gender inequality.” This revitalized division would support MISA and other ministries to fulfil their parts of the NAP, while implementing the GBV and gender equality policies. A National Task Force (NTF) comprising all involved Ministerial Secretaries would guide the unit for a truly all-of-government approach.

Kiribati maintains a community-centred society, relying on collective social security and community-based management of domestic disputes, the *maneaba*. Despite initially negative reactions by community leaders, FHSS was successfully planned, conducted and translated into policy, largely because of the participatory process that engaged stakeholders at every step. Evidence of compromise from both sides is apparent in the progressive policy for Gender Equality and Women Development, which “[promotes] equal valuing of I-Kiribati women and men’s shared roles contributing to peace and socio-economic development of their own families, communities, islands and Kiribati as a whole. It also respects and aligns with island culture and the *maneaba* system, and the need to work within the current national and institutional frameworks.”
Evaluation of results and impacts, including on social determinants and health inequities

As detailed above, the planning and implementation for every step of this project – from assembling national and regional project coordination teams; to recruiting, training and evaluating potential interviewers with pilot interviews prior to conducting the research; to developing and testing strategies for the dissemination of results; to creating and piloting information fact sheets; and to drafting policy responses, were characterized by active engagement of stakeholders, pilot testing, assessment and adjustment before proceeding with implementation.4,7

This systematic stakeholder consultation, in combination with visible promotion from the government, consistent technical support from UN agencies and experts with experience in GBV, and conscientious adaptation of the research methodology and implementation plan to the Kiribati context, resulted in successful administration of the FHSS. These same supporting factors further facilitated the dissemination of research findings to government officials, community leaders and the general population, winning broad-based support for the creation and passage of two responsive policies on gender equality and GBV, guided by a 10-year national plan of action.7,9,32

Brief analysis of the targets and aims of the EVAW and Gender Equality policies reveals their complementarity and greater understanding that GBV is fundamentally both a cause and result of gender inequality. The National Policy on Gender Equality and Women Development is guided by a “fair amount of balance between advancing women’s development and culture,” recognizing the need for “phrasing, wordings and ideologies [which] show respect to culture.”36 It is complementary to the EVAW policy, aiming to “(1) [promote] gender equality, (2) [eliminate] violence against women and children, (3) [enhance] legal and human rights for women, (4) [improve] access to services for women, (5) build mechanisms to promote advancement of women, [and] (6) [improve] economic empowerment for women.”36 The EVAW policy emphasizes that “Violence against women and children and the broader problem of gender inequality is a significant constraint on development...ending violence against women and children is crucial, therefore, to achieving gender equality and delivering positive development outcomes,”9 demonstrating again the complementarity between policies. The key strategic areas of
EVAW are, appropriately, focused on preventing GBV and providing support for survivors, but also relate more broadly to gender equality in the areas of justice, community capacity and social services. Although too little time has elapsed since the adoption of these policies to evaluate their full impact, anecdotal evidence of social change related to the completion of FHSS and the associated policy responses indicates effectiveness. An independent assessment of the research planning and implementation process was conducted by a former member of the WHO multi-country study team, and the research dissemination process itself was assessed. Research dissemination efforts were found to have effectively raised public awareness of the report findings, and dissemination of the report has additionally resulted in:

- High levels of bi-partisan support within Parliament;
- Awareness and support of the report’s findings among national and outer island leaders;
- High awareness that GBV is a crime and of the services available at the Catholic Crisis Centre (no baseline);
- Establishment of domestic violence desks in four police stations in South Tarawa;
- Higher reporting of violence and sexual offenses;
- Stronger continuity of service delivery to survivors of GBV and child abuse; and
- A proposed Memorandum of Understanding on Standard Operating Procedures related to GBV for all relevant service providers.

MISA has additionally noted third party reporting of GBV in Eita Village, South Tarawa, sermons given by priests and ministers that discourage violence, and police awareness of possible actions that might be implemented, such as restraining orders. Other notable changes include the formation of the Kiribati Women’s Advocacy Network (K-WAN) by some stakeholders, police training curricula that include human rights and GBV, the creation of more GBV registers in police units, and increasingly positive comments about the police.

A final area of impact must be noted: whole research project teams and participating NGOs have benefited from immense capacity building throughout the process of research planning, implementation, sharing of results and policy development. Regional and national project teams have overcome
challenges associated with expansive geography; cultural diversity; communication with other staff members, consultants and stakeholders; data collection systems in atolls; and coordination of activities guided by two donor agencies, one implementation partner, two governments (since Solomon Islands also participated in RPAC) and numerous advisory/steering committees. On a personal level, female interviewers gained incredible experience suited for future positions with DHS and/or census bodies.7

As mentioned above, the EVAW Policy includes provisions and plans for reviving the Women’s Unit under MISA. The revitalized Women’s Unit will support all ministries engaged in the NAP on GBV, guided by its own NTF comprising all involved Ministerial Secretaries. This whole-of-government approach also stipulates that the NTF will have ultimate responsibility for effective, “participatory monitoring, evaluation, and reviews,” detailed in the NAP, and based on reporting from the Women’s Unit, of progress made on the EVAW Policy. Importantly, monitoring and evaluation processes will continue to involve stakeholders in decision-making.9

The NAP (Appendix 1) includes tables of targets mapped to their respective indicators, brief methods for collecting information on those indicators, responsible agencies/actors, an implementation timeline, cost and funding sources. The objectives and indicators are organized according to the NAP’s three main goals:

- Improving women’s access to justice,
- Increasing women and children’s access to support services, and
- Preventing violence against women and children.

The NAP expects cooperation from women, women’s and other NGOs, churches, police, the court system, crisis centres, UN agencies and government officials from multiple sectors to compile monitoring data. While the NAP provides a solid, costed, whole-of-government plan to address GBV, there is no specified plan for a follow-up FHSS and no current plan to assess men’s attitudes related to women or gender equality, even though “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.”37
Follow-up and lessons learned

That MISA was central to the initiation, coordination, planning and implementation of FHSS had immense value. Whereas organization and implementation by any of Kiribati’s women’s NGOs may have inadvertently caused the project to be branded as a “women’s project” or “for women only,” with low priority, MISA was seen as a neutral organizing party, respected as a government body and, by virtue of being a government body, always demonstrated to NGOs and community leaders that the government was taking GBV seriously. The acceptance of research findings and their subsequent translation into legislation was greatly facilitated by the inherent government approval in MISA as the primary coordinating body. Further, as discussed above, the consistently participatory process was immensely helpful for earning broad-based support for the research project and its associated policy responses.

The successful implementation of the FHSS with the subsequent development of responsive policies to tackle the problem of GBV in Kiribati demonstrate several key lessons for other problems to be addressed, perhaps in other contexts. First, data collection is a time-consuming and expensive process, but it is necessary to assess and understand health issues in order to develop responsive policies. Communities and municipalities/provinces should be informed of the study (with a safe name, if deemed necessary) prior to its initiation, so as to facilitate collaboration. If staff capacity and/or expertise is lacking, appropriate sources of support should be identified and utilized, not only to ensure a successful research project, but in order to build national capacity. It was important in Kiribati that government officials carried out the study and follow-up activities – and that they were publicly perceived to do so. Consistent (and appropriate) stakeholder engagement throughout the intervention was critical for credibility, successful implementation and acceptance of results.

The selection of the research methodology must also be considered and goal-oriented: the indicators included in an investigation (or not) will determine, in large part, the information collected and its potential uses. The WHO multi-country study offers a validated methodology for measuring GBV, which has proved to be replicable in the Pacific. The Kiribati FHSS was able to inspire policy responses to both GBV and its key determinant, gender inequality, because it included gender-sensitive indicators and metrics of gender inequality itself (qualitative in this instance). Additionally, the qualitative research sufficiently focused on men, validating while attempting to understand their perspectives so that men and boys may be involved as agents of social change.
Given the apparent recognition in Kiribati that gender inequality fuels its epidemic of GBV, monitoring and evaluation of its policies on EVAW and gender equality should include an assessment of gender inequality. The FHSS included some metrics of gender inequality, but as mentioned above, the NAP on EVAW will need to be supplemented by additional monitoring to adequately measure changes in gender inequality. As challenging as it was to accumulate sufficient political will and attention to GBV for completion of the FHSS, a more thorough assessment of gender equality should be conducted so as to provide a baseline against which the effects of the National Policies on Gender Equality and EVAW can be measured. While the determinants of GBV itself – largely gender equality, are more challenging to quantify than its incidence or prevalence, WHO’s Regional Office for the Western Pacific has identified some indicators of gender equity,\(^38\) and repeat focus groups could provide quantitative data.

Given the acceptable, feasible and successful administration of the 2009 FHSS with translation into policy, future efforts to measure and monitor GBV and gender equality – as well as other health inequities – will likely be successful, assuming 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 dollars in development aid to GBV with other funds allocated to health equity in the Pacific,\(^25,33\) the UN has assembled a Gender Group in Kiribati\(^31\) with plans to launch a regional UNiTE campaign against GBV in 2010-11,\(^12\) a regional reference group on GBV was formed,\(^30\) and there has been regional action on other determinants of GBV as well.\(^39\) International consequences primarily include further support for this research methodology while also demonstrating that effective policy against GBV requires targeted GBV policy with complementary action on its root causes.
References


22 The Constitution of Kiribati, Chapter 2, Section 3.

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34 Ministry of Internal and Social Affairs, “Kiribati Family Health and Support Study (The study on violence against women and children),” a presentation at a side event – VAW, SPC Triennial, Noumea, New Caledonia, 16-20 August 2010.


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