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SCALING UP INTERVENTIONS TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE

AN ANALYTICAL REPORT

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This document was produced for review by the United States Agency for International Development. It was prepared by the Gender, Equity and Social Inclusion Practice of Development and Training Services (dTS), through the Transparency Accountability and Performance (TAP) IQC, Gender-based Violence Strategy Research Agenda Project.

USAID's Office of Gender Equality and Female Empowerment has several documents available on addressing GBV through USAID programming that can be accessed through the Development Experience Clearinghouse (http://dec.usaid.gov).

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SCALING UP INTERVENTIONS TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE

AN ANALYTICAL REPORT

CONTENTS

ACRONYMS

CBO	Community–Based Organization
CCSE	Combating Commercial Sexual Exploitation
CORO	Committee of Resources Organization for Literacy
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GE	Gender Equality
GEMS	Gender Equality Movement in Schools
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HTP	Harmful Traditional Practices
IJM	International Justice Mission
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
ICRW	International Center for Research on Women
IPV	Intimate Partner Violence
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
MAMTA	Health Institute for Mother and Child
MATI	MenEngage Africa Training Initiative
MFL	Micro Finance Loans
MOU	Memorandum of Understanding
MSI	Management Systems International
N.D.	Not dated
NGO	Non-Governmental Organization
NNVAW	National Network on Violence against Women
NPA	National Prosecuting Authority
OMC	One Man Can Campaign
OSC	One Stop Centers
PEP	Post-Exposure Prophylaxis
PPSA	Planned Parenthood of South Africa
RADAR	Rural Aids and Development Action Research
RCT	Randomized Control Trial
SAG	South Africa Government
SCIDHC	The Soul City Institute for Health and Development Communication
SC4	Soul City Series
SEF	Small Enterprise Foundation
SFL	Sisters for Life

SOCA	Sexual Offences and Community Affairs
SONKE	Sonke Gender Justice Network
STIs	Sexually Transmitted Infections
TISS	TATA Institute for Social Sciences
TCC	Thuthuleza Care Center
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WJEI	Women's Justice and Empowerment Initiative

EXECUTIVE SUMMARY

This report on scaling up interventions to prevent and respond to GBV was commissioned by the United States Agency for International Development (USAID) as part of its GBV Strategy Research Agenda to identify lessons learned from scaled-up GBV interventions to inform and to improve its global prevention and response mechanisms. The information presented in this report may be used to assist in the identification of GBV interventions that are scalable, or in designing GBV interventions with sound plans to bring them to scale and to maximize impact.

Scaling up refers to "*taking successful projects, programs, or policies and expanding, adapting, and sustaining them in different ways over time for greater development impact.*"[1] While scaling up is a common goal of international development donors and implementers alike, there is no universally accepted methodology that is employed. The three scale-up methodologies explored in this report are: expansion of scope, replication and expansion of geographic coverage. The objective of this report is to assist USAID staff in identifying and selecting scalable GBV interventions across four sectors: (1) health, (2) youth and education, (3) democracy and governance, and (4) economic growth.

It is a product of a three-pronged research methodology: (1) a literature review, (2) key informant interviews and focus group discussions conducted in Washington, D.C. and by telephone, and (3) data collected from site visits on scaled-up GBV interventions in India and South Africa. Eighteen scaled-up GBV interventions were analyzed in the literature review, eight interventions, which varied by sector and type of scale-up were chosen for further in-depth analysis during the site visits. The mixed-method research design was used to develop this analytical report in order to better understand scaled-up activities to address gender-based violence.

While best practices in the development context are important to know when considering any scale-up, further field research was needed to refine this knowledge in the context of GBV. The research team conducted field research on eight innovative, evaluated and scaled-up GBV interventions in the health, youth development and education, democracy and governance, and economic growth sectors. The best practices in scaling up focused on three key components: program actions, assessing the enabling environment and influencing factors, and ensuring institutional capacity.

The following best practice examples were selected to illustrate initiatives that provide evidence of success in contributing to the prevention of GBV:

- **Health:** One Man Can Campaign, Soul City, and Stepping Stones in South Africa
- **Youth and Education:** Yaari Dosti and Gender Equality Movement in Schools in India
- **Democracy and Governance:** South Africa's Thuthuleza Care Centers (TCCs) and the International Justice Mission (IJM) in India
- **Economic Growth:** The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in South Africa.

1. Brookings Institute "Scaling Up: A Path to Effective Development" (2007)

The interventions were selected based on an extensive literature review and interviews with key stakeholders. Based on findings from the site research and the literature review, the research team extrapolated six key lessons learned for designing scalable GBV interventions:

1. **Align GBV interventions with government commitments to end GBV;**
2. **Secure community ownership for the GBV intervention;**
3. **Provide proof of concept for the GBV intervention;**
4. **Build a GBV prevention and response community of practice;**
5. **Integrate GBV prevention and response into government structures and sectoral programs; and**
6. **Design the GBV interventions with scale in mind.**

Conversely, the greatest barriers to scale-up focused in three areas: lack of support, insufficient intervention design, and weak institutional capacity. Examples of these are:

- **Lack of Support**
    - Lack of large-scale, consistent and comprehensive funding sufficient for scaling; short funding cycles
    - Lack of political commitment, in part due to lack of belief by national level policymakers (and international level bodies) that GBV can be prevented or effectively addressed
- **Insufficient Intervention Design**
    - Demonstration model that was successful in one region may not work in other locations
    - Inappropriate mix of services planned
- **Weak Institutional Capacity**
    - Charismatic, dedicated leadership that was responsible for small-scale success cannot be replicated
    - Challenges in holding people accountable

Finally, the report concludes with a checklist tool to help USAID staff design GBV interventions for scale and to assess the scalability of GBV interventions. The checklist incorporates the best practices and six key lessons learned and will help USAID staff address barriers to scaling up. Corresponding instructions are also included.

GBV has a profoundly negative impact on the lives of thousands of women, girls, men and boys and is a barrier to international development goals, including healthy communities and sound economic growth. Interventions that help communities prevent and respond to gender-based violence have the potential to transform lives and support robust development outcomes. It is hoped that this report will be useful to USAID staff and partners in continuing to work toward gender equality and the empowerment of women and girls.

SECTION 1

INTRODUCTION

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INTRODUCTION

PURPOSE OF THE ANALYTICAL REPORT

This analytical report was commissioned by USAID to provide applicable lessons learned from the process of scaling up proven interventions that prevent and respond to GBV. Gender-based violence (GBV) is widespread and pervasive. It has profound impact on the lives of thousands of women, girls, men and boys and is a barrier to international development goals such as healthy communities and sound economic growth. This report is one of a number of resources that have and are being developed to help USAID staff address GBV by providing evidence, tips and tools on scaling up effective interventions into global and multi-country programming. The ultimate objective of this report is to assist USAID in identifying and selecting scalable GBV interventions across four sectors: (1) health, (2) youth and education, (3) democracy and governance, and (4) economic growth.

Three scale-up methodologies are delineated in this report:

- **Expansion of Scope:** Increasing the size of a particular intervention by adding resources to increase the number of beneficiaries served or adjusting an activity so that it offers additional services that allow it to more fully meet challenges and on-the-ground needs. The scope of work is expanded.
- **Replication:** Reaching greater numbers of beneficiaries geographically (locally, nationally, regionally, and internationally) through distinct adaptations of an intervention.
- **Expansion of Geographic Coverage:** Increasing the size of an intervention to bring quality benefits to more people over a wider geographic area quickly, equitably, and efficiently.

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HOW TO USE THIS REPORT

The information presented in this report may be used to assist in the identification of GBV interventions that are scalable, or in designing GBV interventions with sound plans to bring them to scale and to maximize impact. USAID staff can use the report as a guide when reviewing and assessing GBV interventions to determine the ideal scale-up approach that will assess institutional capacity and readiness for scaling up, and identify enabling factors that may improve scale-up potential.

To begin, the report defines scaling up and lays out methods for doing so, along with factors associated with scale-up successes and failures.

The report then guides the user from theory to practice. Phase 1 of the research elucidated best practices based on real world interventions in the health, youth and education, democracy and governance, and economic development sectors. During Phase 2, the research team collected lessons learned when applying these best practices in India and South Africa. Through case studies, six best practices in programming are explicitly tied to the field-based lessons learned so that USAID staff can clearly see their practical application.

A checklist tool based on the research in India and South Africa is included in Annex 1 that will help USAID staff apply the key lessons learned to designing scalable GBV interventions and assessing the scalability of GBV interventions.

The analytical report may be used in its entirety or the sections may be used as stand-alone resources. It will prepare USAID staff to ask the right questions and to get answers that will help them make choices on scaling up GBV interventions.

This report will provide resources to help answer the following questions:

- What are commonly used methods of scaling up?
- What are programmatic actions that may be taken to improve the success of scaling up?
- What are barriers to scaling up of GBV interventions?
- What enabling factors will improve the success of scaling up?
- What lessons can be learned from previous efforts to scale-up GBV interventions?

U.S. COMMITMENT TO ADDRESSING GBV

GBV is a gross violation of human rights and a pervasive manifestation of gender inequality throughout the world. The World Health Organization (WHO) estimates that at least one in every three women globally will be beaten, raped, or otherwise abused during her lifetime. In most cases, the abuser will be a member of her own family (WHO 2013). An estimated 133 million girls and women worldwide are currently living with the consequences of female genital mutilation/cutting (FGM/C) (UNICEF 2014). In countries where armed conflict is prevalent, there are reports of rape being used as a weapon of war. The impacts of such violence extend beyond the individuals affected, affecting households, communities and countries, and spans across multiple generations.

Global mandates and commitments toward eliminating GBV are articulated in numerous international and regional instruments, including the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)*, the *Convention on the Rights of the Child (CRC, 1988)*, the *Beijing Platform for Action (1995)*, the *Program of Action of the International Conference on Population and Development (ICPD, 2014)*, and United Nations Security Council Resolutions 1308, 1325, 1820, and 1888, among others.

On August 10, 2012, as part of its commitment to end GBV, the U.S. Government released it's first-ever whole-of-government *Strategy to Prevent and Respond to Gender-Based Violence Globally* (GBV Strategy). The GBV Strategy lays out a framework for strategically combatting forms of violence that include sexual abuse, domestic violence, female infanticide, sex trafficking and forced labor, elder abuse, and harmful traditional practices (HTP), such as early and forced marriage, "honor killings," and FGM. With a mandate of "do no harm," the objectives of the Strategy include: (1) to increase the coordination of GBV prevention and response efforts among USG agencies and other stakeholders; (2) to enhance integration of GBV efforts into existing USG work; (3) to improve collection, analysis and use of data and research, and; (4) to enhance or expand USG programming that addresses GBV.

With GBV now widely accepted as a major development constraint, part of the challenge in addressing it is understanding what constitutes a successful GBV intervention, including best practices and lessons learned in scale-up. As a relatively new area of strategic focus for many development institutions, there is a need to fill in the evidence base on GBV. This report is the product of research commissioned to contribute to closing this knowledge gap by identifying and documenting lessons learned on effective and scalable interventions

RESEARCH METHODOLOGY

This report is a product of a two-phase mixed-methods research approach that included: (i) a literature review, (ii) key informant interviews and focus group discussions and (iii) data collected from site visits on scaled-up GBV interventions in India and South Africa.

PHASE I

Literature Review

The research team conducted an extensive literature review that involved identifying and analyzing available literature on scaling-up development interventions and GBV interventions that have been successfully scaled up. This information was gathered through qualitative and quantitative program performance information for the health, youth and education, democracy and governance and economic growth sectors. Research was also conducted on interventions supported by organizations other than USAID.

The literature review included a synthesis of definitions and existing methodologies on scaling up in the development field more generally. After an initial desk-review, eighteen scaled-up GBV interventions were analyzed in the literature review, six of which were chosen for further in-depth analysis during the site visits. The following criteria applied to the selection of all eighteen programs:

- The intervention successfully prevented and/or addressed GBV;
- The intervention was evaluated and well documented; and
- The intervention was scaled-up, and adopted in other setting(s).

It is important to note that one of the key challenges for reducing or preventing GBV is the lack of supporting data on its prevalence making comparability of interventions difficult. In recognition of this, site visits were used to address informational gaps from the literature review.

PHASE II

Interviews and Focus Group Discussions (FGDs)

The team conducted FGDs and individual interviews with sixteen USAID staff representing the four sectors. Individuals were asked to provide information about evaluated interventions that have been successfully scaled up (GBV and other non-GBV specific interventions), stand-alone interventions to address gender-based violence, or interventions that have been adapted and integrated into existing USAID efforts.

The dTS team developed an interview protocol to guide researchers in Washington D.C. and in the field. It can be used as a guiding tool to address distinct dimensions of scaling up for general scale-up interventions during intervention-level research (See Annex B for the complete protocol).

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Site Visits

India and South Africa were identified as the sites for the field research based on feedback from interviewees as well as the sites' representation in documentation on successfully scaled-up GBV prevention interventions. Using the snowball method[2], the team conducted interviews with USAID mission staff and key NGOs implementing GBV interventions in the four aforementioned sectors, who then recommended other GBV prevention experts and professionals who should be consulted.

Key informant interviews were also conducted with staff members of selected implementing partners based on the interventions identified in the literature review. When appropriate, the open-ended interviews extended the discussion into topics to include other cross-cutting gender equality issues such as promoting women and girls leadership; creating public private partnerships; constructively engaging men and boys; addressing sector-specific needs of youth, LGBTI, and other vulnerable populations.

A total of 23 key informant interviews were conducted in India and 31 were conducted in South Africa. The research in South Africa took place over a 12-day period from January 7-18, 2013, and in India for five days, from February 11-15, 2013 (See Annex C for a complete list of key stakeholders interviewed).

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2. The snowball method is a sampling method through which informants recruit other informants from among colleagues and acquaintances.

LIMITATIONS

The research focused on examining scaled-up GBV interventions located in the global South and reviewing documentation produced in English that was accessible online. Limitations included:

Extremely small sample. There is a very small number of GBV interventions that have been scaled-up, and an even smaller number that have been evaluated to determine their effectiveness. This report utilizes a set of 18 interventions.

Lack of literature on scaling up. Documentation on scale-up processes and lessons learned is not widely available. It was particularly difficult to identify evaluated and scaled-up GBV interventions that were sector specific, particularly in the democracy and governance and economic growth sectors.

Limited time. The allotted window for conducting field research was short. Although the research team interviewed a number of key informants, some were not available during the brief country visits.

Lack of records. The team sought to drill down and collect implementation details on the scaled-up GBV interventions reviewed, but few informants interviewed could recall or provide this information.

Despite these limitations, the research yielded practical information that may be useful to apply to scaling up other GBV interventions. This will be explored in the following section.

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SECTION 2

SCALING UP METHODS, BEST PRACTICES AND CHALLENGES

STEPPING STONES

SCALING UP METHODS, BEST PRACTICES AND CHALLENGES

SCALE-UP METHODOLOGIES DEFINED

> *Scaling up is "expanding, adapting and sustaining successful policies, programs or projects in different places and over time to reach a greater number of people."*
> HARTMANN AND LINN 2008

A 2009 World Health Organization (WHO) study found that adapting service innovations to changing socio-cultural, economic, and institutional contexts is vital for scale-up success. Literature equates scale-up with adapting programming to expand impact by addressing programmatic effectiveness, efficiency, sustainability, and equity as well as increasing geographic coverage and including additional beneficiaries.

While scaling up is a common goal of international development donors and implementers alike, there is no universally accepted methodology that is employed. Depending on the context, there are usually three types of methodologies used: expansion of scope, replication, and expansion of geographic coverage. Often, elements of one or more types are used together and thus the methodologies are not mutually exclusive. All require the mindful adaptation of interventions to differing contexts. For the purposes of this report, the varying methodologies and definitions are synthesized into the three general types of methodologies used.

SCALING UP THROUGH EXPANSION OF SCOPE

Expansion of Scope is increasing the size of a particular intervention by adding resources to increase the number of beneficiaries served or adjusting a project or activity so that it offers additional services that allow it meet challenges as identified on the ground.

Definitions and explanations of scale-up as expansion of scope include:

- Picciotto (2004) similarly defined scale-up as a process of "moving to a higher plane, assembling resources to increase size or calibrating an activity so that it measures up to a given challenge."
- In the field of international health, scale-up is defined as "the ambition or process of expanding the coverage of health interventions" (Manghan and Hanson 2010), referring to increasing the financial, human, and capital resources required to expand reach.
- Uvin, Jain, and Brown (2000) define scaling-up as 'expanding impact' and not about becoming large, the latter being only one possible way to achieve the former."
- Management Systems International (MSI, 2006) similarly defines expansion scale-up as, "when a project or intervention increases its scope of operations. This can be accomplished through growth, restructuring, decentralization, franchising, or spin-off."

SCALING UP THROUGH REPLICATION

Replication: reaching greater numbers of beneficiaries geographically (locally, nationally, regionally, and internationally) through distinct adaptations of an intervention.

Definitions and explanations of scale-up as replication include:

- Hartman and Linn (2007) describe scale-up initiatives in the 1980s as attempts to replicate successful models, especially in connection with participatory and community development approaches. They note that replication scale-up may go beyond national borders by reproducing interventions across an entire region.
- MSI (2006) defines replication scale-up as having an element of adaptation, noting that "scale-up involves increasing the use of a particular process, technology or model of service delivery by getting others, including the public sector, to implement the model. Replication may be accomplished through policy adoption, grafting, diffusion, and spillover, or via the mass media. Often the scale-up involves adapting the original model in order to replicate it into specific cultural contexts, new geographic locations or to address constraints related to time, resources, or staff."
- Jowett (2010) discusses how governments can be key to nationwide replication of local interventions either through taking ownership or partnering with NGOs. In addition, she describes that the franchising definition of replication is the adaptation of an approach in compliance with certain performance standards and requirements. This model is most commonly known as a private sector business model.

SCALING UP THROUGH EXPANDING GEOGRAPHIC COVERAGE

Expansion of Geographic Coverage: increasing the size of an intervention to bring quality benefits to more people over a wider geographic area quickly, equitably, and efficiently.

Definitions and explanations of scale-up as geographic expansion include:

- Hartmann and Linn (2008) call this approach "scaling out."
- Uvin and Miller (1996) noted that the most commonly used definition of scaling up was the one used in a 1992 USAID evaluation (Core Group, 1992), which defined scaling up as reaching several times the actual number of beneficiaries in the country or location of focus.
- The CORE Group (2005) elaborates on this definition as "widespread achievement of impact at an affordable cost" (pp. 2), through "efforts to bring more quality benefits to more people over a wider geographical area more quickly, more equitably, and more lastingly" (pp. 3).
- A "going to scale workshop" hosted by the International Institute for Rural Development (IIRR) in 2000 has also used this conceptualization as their operational definition of scaling-up.
- Management Systems for Health defines a similar type of scale-up as "a process of systematically overcoming constraining factors such as demand potential, resource availability, and technological barriers." (2002)
- In rethinking notions of scaling-up for school reform initiatives, Coburn (2003) also rejects traditional conceptualizations of scale-up as replications. Rather, she states that "scaling-up, not only requires spread to additional sites, but also consequential change in classrooms" (pp. 4). To accomplish this, she proposes that there is a need to focus on: (1) the nature of change envisioned or enacted; (2) the degree to which the change is sustained; and (3) the degree to which school and teachers have the knowledge and authority to continue to grow the reform over time.

The purpose of scaling up is to expand successful programs in order to create greater impact. To summarize, **expansion of scope** deploys new resources to reach new beneficiaries or add new services; **replication** involves distinct adaptations to reach beneficiaries in new geographical areas; and **expansion of geographic coverage** involves increasing the existing geography to a wider area. Along with options for different types of scale-up, there are key factors to consider whether assessing a program for scale-up or designing an intervention with scale-up in mind.

CONSIDERATIONS IN SCALE-UP

The process of determining an intervention's potential for scale-up includes identifying and incorporating best practices in program design, assessing the enabling environment and factors that may influence the success of the scale-up and mitigating potential barriers.

Key factors to success and barriers to overcome are multiple and interrelated, as will be exemplified in this section. Of particular importance worth noting is institutional capacity. As noted in the literature review, there are interrelationships amongst the central elements and strategic choices involved in scale-up. Scaling up often involves institution-building, which requires a variety of specialized technical and managerial human resources, leadership, and financial inputs as well as longer timeframes than typical project cycles. Scaling up must therefore encompass sustainable policy and program development and the availability of sustained financial resources and institutional capacity. The level of institutional change required to adapt an intervention is positively correlated with the amount of technical support and time required for scale-up. MSI (2006) defines collaborative scale-up as an ideal mix of expansion and replication that can involve informal and formal partnerships, including joint ventures, strategic alliance, networks, coalitions, innovative structures, and governance arrangements.

BEST PRACTICES IN SCALING UP

Best practice examples from the literature review and field research were selected to illustrate evidence of success in scaling up GBV interventions. These are detailed in Table 1. In this context, best practices signify well-documented initiatives that contribute to the prevention of GBV.

TABLE 1: BEST PRACTICES IN SCALING UP

Components	Best Practices for Scale-up
Program Actions	• Align interventions with national commitments to end GBV. • Secure community ownership for the GBV intervention. • Provide Proof of Concept for the GBV intervention. • Build a GBV community of practice for the prevention of and response to GBV. • Integrate GBV into the social sector (e.g., the public health or education systems) and other targeted sectors (e.g., access to justice, economic development) in existing government or partner programming. • Design GBV interventions with scale in mind.
Enabling Environment and Influencing Factors	• Broad acceptability of the intervention, including favorable social and political climate and support (inclusive of existing national commitments). • Sound opportunity exists for extension of geographical coverage. • Sound opportunity exists for the introduction of a new service in an existing system. • Potential exists for integrating activities vertically (e.g., with government) or horizontally (e.g., with like-minded organizations). • Potential exists for 'explosive' introduction of new policies or strategies on a national scale.

TABLE 1: BEST PRACTICES IN SCALING UP

Components	Best Practices for Scale-up
Guiding Principles	• Aim for positive, long term, and observable results and impact in participants' lives (e.g., reduction in GBV prevalence or increased reporting of GBV incidence). • Focus on increasing access, equity, quality, acceptability, demand, and satisfaction of target groups. • Emphasize transformative interventions to advance social change (e.g., attitudinal and behavioral change) and change the paradigm of underlying causes. • Consider institutional capacity for scale-up (e.g., fiscal, asset, environmental, and social). • Replicate successful, evidence-based pilot programs after adapting as needed. • Invest in rigorous monitoring and evaluation (M&E) to ensure that results inform strategic adaptations and provide evidence of programmatic impact. • Identify cost-effective strategies, including cost sharing opportunities. • Collaborate with communities in design and implementation.
Institutional Capacity	• Staff has appropriate technical and managerial expertise. • Professional development opportunities for human resources. • Strong leadership, financial sustainability and longer planning timeframes. • Collaborative environment with formal and informal partnerships that include joint ventures, strategic alliances, and networks.

BARRIERS TO SCALING UP

While it is important to identify sound scale-up strategies, it is equally important to identify barriers in order to mitigate them and to assess the feasibility of going to scale. Moura (2012) highlights the need to understand the obstacles to scaling up as a contribution to organizational learning. Myers (1984) identifies the components of three overarching constraints: lack of support, insufficient design, and weak institutional capacity that can cause projects to "fail to go to scale." Specific examples include resource and financial constraints, a lack of political commitment at various levels, weak demand for services offered or an inappropriate mix of services provided; and management without clear direction or lines of communication and authority. A synthesized list of potential challenges is provided in Table 2.

TABLE 2: BARRIERS TO SCALING UP

Barriers	Main Barriers for Scale-up
Lack of Support	• Lack of large-scale, consistent and comprehensive funding sufficient for scaling; short funding cycles • Lack of political commitment, in part due to lack of belief by national level policymakers (and international level bodies) that GBV can be prevented or effectively addressed • Social organization and participation that helped make community-based pilot models work is not available or not considered realistic when contemplated on a larger scale

TABLE 2: BARRIERS TO SCALING UP

Barriers	Main Barriers for Scale-up
Insufficient Intervention Design	• Demonstration model that was successful in one region may not work in other locations • 'Mystique' associated with the original project may wane as the program grows • Information about pilot projects is not available at the proper time and in the proper form to the people designing the intervention and scale-up • Inappropriate mix of services planned
Weak Institutional Capacity	• Charismatic, dedicated leadership that was responsible for small-scale success cannot be replicated • Challenges in holding people accountable • Organizational base is inadequate to support large-scale programs, and expansion occurred too fast for the needed capacity to be built • Squabbles among regional partners or counterparts • Administrative controls are not in place • Bureaucratic territoriality and malaise undercut good intentions • Competition between interventions exists to prove which is successful or shows the most impact rather than a willingness to merge the best of each intervention • Weak social institutions increases the difficulty of raising sensitive topics

THEORY TO PRACTICE

While best practices in the development context are important to know when considering any scale-up, further field research was needed to refine this knowledge in the context of GBV. Table 3 and 4 present a list of eighteen scaled-up GBV interventions analyzed in the literature review, and includes an additional eight that were subject to further examination during field research in India and South Africa, as well as the corresponding scale-up methodology used.

Each intervention is further categorized into types of responses: (1) policy and legal responses, (2) program responses and (3) advocacy and community mobilization responses. Policy and legal responses include national family and domestic or sexual violence legislation, capacity building for government ministries and local government, regional and international conventions, international conferences and conventions and judicial reform. Program responses include health care services, domestic violence shelters, counseling and testing programs, men's behavioral change programs, legal rights and legal aid programs, training for protection and security service providers and GBV curriculum development for university health, justice and legal programs. Advocacy and community mobilization responses include media and information campaigns, public and community awareness and education programs, and community networks and interventions.

Over half (56 percent) of interventions used a geographic expansion scale-up methodology, sometimes including elements of replication or scope expansion, whereas 28 percent used scope of work expansion alone. Only one intervention used replication alone, and one other used a combination of replication and expansion. Since this sample only includes GBV interventions for which an evaluation was available, this distribution could point to a correlation between scaled programs that are able to demonstrate results across a broad geographic area and sound scale-up methodologies.

TABLE 3: SCALED UP GBV INTERVENTIONS REVIEWED - LITERATURE

GBV Project	Review Type	Sector	Response Type	Scale-up Method
Community Empowerment Program (Senegal)	Literature	Health	Advocacy & Community Mobilization	• Replication • Geographic expansion
Program H (Brazil)	Literature	Youth & Education	Advocacy & Community Mobilization	• Replication • Geographic expansion
Ishraq (Egypt)	Literature	Youth & Education	Program	• Scope of work expansion
Berhane Hewan (Ethiopia)	Literature	Youth & Education	Advocacy & Community Mobilization	• Scope of work expansion
Mobile Courts (Romania)	Literature	Democracy & Governance	Policy & Legal	• Geographic expansion
A Coordinated Institutional to Curb Domestic Violence & Serve Survivors (Romania)	Literature	Democracy & Governance	Policy & Legal	• Replication • Geographic expansion
Isange One Care Centers (Rwanda)	Literature	Democracy & Governance	Program	• Replication • Geographic expansion
Greater Rape Intervention Program (South Africa)	Literature	Democracy & Governance	Advocacy, Community Mobilization & Program	• Replication • Scope of work expansion
Apna Dhan (India)	Literature	Economic Growth	Program	• Scope of work expansion
Rescue Agriculture Program (Ghana)	Literature	Economic Growth	Program	• Scope of work expansion

TABLE 4: SCALED UP GBV INTERVENTIONS REVIEWED - FIELD

GBV Project	Review Type	Sector	Response Type	Scale-up Method
Stepping Stones (South Africa)	Field	Health	Program	• Replication • Geographic expansion
Soul City (South Africa)	Field	Health	Advocacy & Community Mobilization	• Replication • Geographic expansion • Scope of work expansion
One Man Can (South Africa)	Field	Health	Advocacy & Community Mobilization	• Replication • Geographic expansion
Gender Equality Movement in Schools (India)	Field	Youth & Education	Advocacy & Community Mobilization	• Scope of work expansion
Yaari Dosti (India)	Field	Youth & Education	Advocacy & Community Mobilization	• Replication • Geographic expansion
Combating Commercial Sexual Exploitation (India)	Field	Democracy & Governance	Policy & Legal	• Replication • Scope of work expansion
Thuthuzela Care Centers (South Africa)	Field	Democracy & Governance	Program	• Replication
IMAGE (South Africa)	Field	Economic Growth	Program	• Replication • Geographic expansion

SECTION 3

LESSONS LEARNED FROM SCALED-UP GBV INTERVENTIONS

SOUL CITY

LESSONS LEARNED FROM SCALED-UP GBV INTERVENTIONS

Based on an analysis of findings and conclusions generated by focus groups and key informant interviews in South Africa and India, there are six key lessons critical to scale-up when utilizing adaptation, replication, or expansion methodologies; these lessons are presented in Table 5. See Annex E for a complete listing of lessons learned by sector.

TABLE 5: GBV SCALE-UP LESSONS FROM INDIA AND SOUTH AFRICA

Scale-up Lessons	Sectors	Scale-up Methodology	Scaled-up GBV Interventions
1. **Align GBV Interventions with National Commitments to End GBV**	Health	• Replication & Geographic Expansion • Replication, Geographic Expansion & Scope of Work Expansion	• One Man Can, South Africa • Soul City, South Africa
	Democracy and Governance	• Replication	• TCCs, South Africa
2. **Secure Community Ownership**	Health	• Replication, Geographic Expansion & Scope of Work Expansion	• Soul City, South Africa
	Education	• Replication & Geographic Expansion	• Yaari Dosti, India
3. **Provide Proof of Concept**	Economic Development	• Replication & Geographic Expansion	• IMAGE, South Africa
	Health	• Replication, Geographic Expansion & Scope of Work Expansion	• Soul City, South Africa
4. **Build a GBV Prevention and Response Community of Practice**	Health	• Replication & Geographic Expansion	• Stepping Stones, South Africa
	Education	• Replication & Geographic Expansion	• Yaari Dosti, India
	Economic Development	• Replication & Geographic Expansion	• IMAGE, South Africa

TABLE 5: GBV SCALE-UP LESSONS FROM INDIA AND SOUTH AFRICA

Scale-up Lessons	Sectors	Scale-up Methodology	Scaled-up GBV Interventions
5. Integrate GBV Prevention and Response in Government Structures and Sectoral Programming	Economic Development	• Replication & Geographic Expansion	• IMAGE, South Africa
	Democracy and Governance	• Replication & Scope of Work Expansion • Replication	• Combating Commercial Sexual Exploitation, India • TCC, South Africa
6. Design with Scale in Mind	Health	• Replication & Geographic Expansion • Replication • Replication & Geographic Expansion • Replication, Geographic Expansion & Scope of Work Expansion	• Stepping Stones, South Africa • TCCs, South Africa • One Man Can, South Africa • Soul City, South Africa

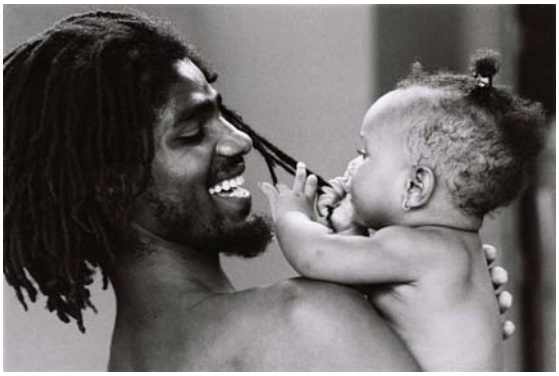
LESSON I: ALIGN INTERVENTIONS WITH NATIONAL COMMITMENTS TO END GBV

Staff and managers of three GBV interventions in South Africa stated that aligning their interventions with their government's commitment to end GBV was paramount to the success of their scale-ups. The favorable and supportive social and political climate allowed for easier development and application of blended scale-up methodologies inclusive of the types defined above. Linking existing commitments by South African Government leaders and other champions, including famous and respected individuals and institutions, to interventions brought attention to GBV.

USAID staff who are designing or implementing GBV interventions should take into consideration how well the scaled intervention is aligned with the national government and public commitment to end GBV.

The following questions can be considered:

- Does government policy exist on ending GBV? If so, to what extent does the intervention support the implementation of the policy?
- What current agendas, work plans or programs exist, owned by government ministries or departments, which explicitly aim to prevent and respond to GBV? If they exist how can the intervention can support and be supported by, such efforts?
- Do champions exist for ending GBV (e.g., government officials, famous and respected individuals, and religious or medical institutions)? If so, what opportunities can be leveraged to engage their public support and promotion of the intervention?



SONKE

CASE STUDY

THE ONE MAN CAN (OMC) CAMPAIGN

BACKGROUND

The Sonke Gender Justice Network (Sonke) is a non-partisan NGO established in 2006 in South Africa that aims to enable men, women, young people, and children to enjoy equitable, healthy, and happy relationships as well as to contribute to the development of just and democratic societies. Sonke applies a human rights framework to its work to build the capacity of government, civil society, and citizens to achieve gender equality, to prevent GBV, and to reduce the spread of HIV and the impact of AIDS across Southern Africa as a region.

GBV INTERVENTION

Launched in 2006, The OMC Campaign is an awareness-raising and community education multimedia campaign designed to reduce violence against women, as well as men's and women's risk of contracting HIV. The OMC Campaign's major objectives are to: (1) support men's advocacy for gender equality, including taking active stands against domestic and sexual violence; (2) promote and sustain change in

their personal lives to protect themselves and their partners from HIV/AIDS; and (3) change the gender norms driving the rapid spread of HIV. The OMC Campaign examines the links between gender, power, and health (alcohol use, violence, HIV/AIDS); reflects on masculinities as they are practiced in relationships with women, other men, children, and the broader community; and uses a rights-based approach to reducing violence against women and risks of HIV.[3]

The OMC Campaign works with men and boys and is based on the belief that all men can become advocates for gender equality and active participants in efforts to respond to HIV/AIDS. The OMC Campaign has been implemented in urban, peri-urban, and rural areas with a wide range of men and boys, including religious and traditional leaders; young and adult men in prisons and upon release; farm workers; miners; commercial fishermen; school children and their parents; health service providers; and policymakers at national, provincial, and local levels.

SCALE-UP: REPLICATION AND ADAPTATION

The OMC Campaign was scaled up nationally from the Western Cape Province through replication in eight of South Africa's nine provinces, as well as regionally in Southern Africa.

Sonke used existing "learning centers" or "centers for excellence" to cultivate and sustain scale-up. Sonke's deliberate investment in engagement with academic institutions and research centers, such as the Women's Health Research Unit at the University of Cape Town, resulted in formation of the MenEngage Africa Training Initiative (MATI). MATI is a 10-day residential course with the overall goal of increasing the leadership capacity and advocacy skills of men and women as gender justice advocates in Africa. The initiative is designed to build a network of future leaders who will engage men and boys for gender equality, HIV prevention and responding to sexual and gender-based violence, thereby continuing to scale-up Sonke's impact. This approach focuses on the professionalization of advocates in support of the technical institutionalization required for a field of study and professional advocacy practice on GBV.

The campaign was scaled-up by other organizations in South Africa utilizing an adaptation methodology. Each organization adapted and integrated OMC materials into their existing platforms in order to maximize impact of their work targeting specific population segments. The OMC Campaign has been featured as an example of a best practice by WHO, the United Nations Program on AIDS (UNAIDS), and the United Nations Population Fund (UNFPA), amongst others, and has been translated into nearly a dozen languages and implemented all across Sub-Saharan Africa. Adaptations that have been used within South Africa by other NGOs include:

1. Hope Worldwide is currently using campaign materials in the Western Cape to raise awareness amongst taxi drivers, encouraging them to play CDs produced by the OMC campaign on their routes and place the OMC Campaign stickers on their vehicles;

2. Planned Parenthood of South Africa is in the process of printing 5,000 OMC Campaign bumper stickers to integrate materials in their advocacy campaign that targets the trucking industry;

3. Artist Proof Studio is utilizing the OMC Campaign workshop materials with staff, apprentices, and art students who translated their commitment to address gender inequality through murals found across Johannesburg depicting men taking action to promote gender equality;

4. Mo Africa Ithlokomele adapted and implemented the OMC Campaign in juvenile prisons, running OMC workshops and linking young men leaving prisons with former inmates who serve as mentors.

3. Information obtained in email exchange with Dean Peacock (Executive Director, Sonke Gender Justice Network) on December 18, 2012.

LESSON 1 - ALIGNMENT WITH NATIONAL COMMITMENT

Sonke engaged actors at numerous levels to secure and align political and social commitment to ending GBV with the scaling-up of the OMC Campaign. Sonke partnered with the Government of South Africa to promote policy implementation, worked in communities to build capacity and skills, initiated dialogue, hosted community radio shows, worked with traditional leaders, and established networks regionally and internationally. By aligning its efforts within existing national efforts and commitment to end GBV, Sonke has been able to shape emerging laws and policies[4] on GBV to foster a more supportive environment for the scale-up of work on GBV interventions by:

- Actively participating in a number of national and regional task forces that influence key national and global GBV prevention initiatives, including the South Africa National GBV Council, the South African National AIDS Council, and the Task Force on Hate Crimes.
- Inserting strong language on gender transformation into South Africa's 2012-2016 National Strategic Plan on HIV and AIDS.[5]
- Addressing national social barriers to the effective engagement of men and boys in prevention of violence and promotion of gender equality.

Support of the national government and key public leaders and decision-makers enabled Sonke to more efficiently and effectively scale-up the OMC Campaign. It also provided the political space and forward momentum for other organizations to adapt the campaign to maximize its impact.

IMPACT OF SCALE-UP

Sonke reported that scale-up of OMC Campaign increased its impact by expanding its ability to influence and strengthen government systems, and involving a wide range of men and boys including policy makers and male public officials at the national, provincial, and local levels.

An impact evaluation of the scaled-up OMC Campaign workshops and community mobilization in South Africa found demonstrated impact on participants. For example, results of a survey of 256 participants found that in the weeks following participation in the OMC Campaign, 50 percent of all participants reported taking action to address acts of GBV in their community. Other behavioral factors often associated with GBV were also affected positively: After participation in the campaign, 25 percent of participants accessed voluntary counseling and testing (VCT) for HIV; 61 percent reported increasing condom use; and four out of five participants reported talking with friends or family members about HIV and AIDS, gender, GBV and human rights as a direct result of the campaign (Colvin et al. 2009).

4. For example, scale-up of the OMC Campaign provided Sonke with the platform to advocate for the inclusion of strong gender language in the South African Department of Social Development's draft white paper on families.

5. See, for instance: http://www.genderjustice.org.za/highlights/news/highlights/sonkes-work-featured-as-best-practice-in-global-aids-response-progress-report-2012.

LESSON 2: SECURE COMMUNITY OWNERSHIP FOR THE GBV INTERVENTION

Organizations in India and South Africa stated that scaling-up GBV intervention is both a community development initiative as well as a programmatic intervention. Organizations identified that adapting the interventions to their contexts was successful, in large part, due to favorable community support, involvement, and buy-in. Broad-based ownership increased the relevance and legitimacy local communities afforded interventions as well as the priority placed upon successful implementation. In addition, community assessments facilitated deeper engagement. They served as a platform for communities to articulate needs, opportunities, and constraints to scaling up. The organizations noted that engaging men and boys and acknowledging the roles they can play as supportive partners as well as their particular vulnerabilities as survivors of GBV is a key way to promote community ownership and sustainability at scale.

USAID staff who are designing or implementing GBV interventions to go to scale may consider how well the intervention is working to secure community ownership of the GBV intervention. The following questions can be considered:

- Does the community accept the GBV intervention broadly among different segments of the population, including women, men, youth, and the elderly?
- Are there existing social organizations that are active and effective? If so, how can they be leveraged to support scale-up of the intervention?
- What strategies are needed to ensure participation of a diverse range of stakeholders[6] and community members, including marginalized groups, in project design for GBV interventions to promote buy-in and local relevance of the GBV intervention to be scaled?
- What strategies are required to engage men and boys, including influential community leaders, as supportive partners in GBV prevention and response?

The example below focuses on the Indian adaptation of Instituto Promundo's Program H, *Yaari Dosti*, to explore its experience in securing community ownership.

6. Stakeholders may include local authorities, traditional leaders, the private sector, women's rights organizations, groups representing marginalized groups (e.g., indigenous populations, the elderly, children and youth, people with disabilities, and members of the LGBTI community) in planning and implementing scale-up.

CASE STUDY

PROGRAM H TO YAARI DOSTI

BACKGROUND

In 2005, the Instituto Promundo and the International Center for Research on Women (ICRW) started an initiative in India called Yaari Dosti that was a scale-up of the program first developed in Brazil called Program H. The aim of Program H and its replications is to increase awareness about the role that gender norms play in fostering partner violence among youth. The Population Council joined forces with ICRW and Instituto Promundo to strengthen learning and research on Yaari Dosti.

GBV INTERVENTION

Created in Brazil, Program H seeks to promote dialogue and reflection about gender norms for young men, including questioning of men's use of violence against women and promoting participation in caregiving and household tasks (Moura 2012).

The program attempts to stimulate critical thinking about gender norms that promote violent and risky health behaviors and creates support for young 'gender-equitable men' who promote care and communication. A gender-equitable man is defined as one who (1) supports relationships based on respect, equality, and intimacy rather than on sexual conquest, (2) is or seeks to be an involved domestic partner and father, both in terms of childcare and household activities, (3) assumes or shares with his partner the responsibility for sexual and reproductive health (SRH) and disease prevention, and (4) finally opposes intimate partner violence (IPV) and homophobia (Verma, et al. 2008).

SCALE-UP: REPLICATION

Thinking about spaces in which gender socialization occurs has consistently inspired scaling-up of Program H. Program H has been scaled through adaptation—tested, adapted, and implemented, and by project partners in more than 20 countries in South and Southeast Asia, the Balkans, parts of Latin America, the Caribbean, U.S., and in sub-Saharan Africa. The Program H curriculum has been translated into 10 languages. (See Annex D for a full list of Program H Replications as of this printing.)

Yaari Dosti is a replication of the Instituto Promundo's Program H within the Indian context. ICRW undertook extensive research and validation in rural and urban areas. In 2005, Promundo and ICRW began testing the approach in Indian schools. They adapted Program H's *Working with Young Men Series*[7] curriculum and piloted Yaari Dosti in rural and urban areas of Maharashtra and Uttar Pradesh, including urban slum communities in Mumbai. The exercises use participatory methods of learning with extensive

7. Available at: http://www.promundo.org.br/en/sem-categoria/program-h-materials

use of role-plays, discussions, and debates to cover themes including partner, family, and community violence; gender and sexuality; and reproductive health. Through these lessons, young men learn about positive aspects of masculinity, are encouraged to participate in sexual and reproductive health, learn to respect sexual diversity, as well as understand their body and sexuality.

ICRW and the Population Council utilized formative research, a week-long workshop, and two months of community consultations to adapt the design and implementation of Program H into Yaari Dosti. The team adapted the content, characters, storylines and examples in the curriculum to the appropriate context and pre-tested them.

Peer leaders, who were mainly drawn from the group that participated in the formative research, underwent a two-week training program to strengthen their knowledge and facilitation skills. Four groups of young men from the community were recruited to participate in the intervention. The 126 young men recruited[8] were from vocational training groups; political, cultural, and religious youth groups; youth on the street not part of a group; and a network of the peer leaders' friends. They were divided into four groups of 30 to 35 participants. The intervention began with an intensive week of group educational activities that were facilitated by peer leaders and adult gender specialists and were followed by 2-3 weekly hour sessions, also led by peer leaders, for duration of six months.

LESSON 2 - SECURING COMMUNITY OWNERSHIP

Yaari Dosti's work in the community and efforts to secure community ownership are representative of worldwide replications of the Program H approach (see Annex D). The involvement of grassroots organizations that utilize communication, training, and intervention research as their strategies for community development and building capacity of the tools and resources available to community leaders was a key strategy in the Yaari Dosti adaptation of Program H. Community men and women participated as a team to conduct research and implement program activities. They also worked to create and maintain networks and alliances, including collaboration with community-based organizations (the Committee of Resource Organizations for Literacy--CORO); academic institutions (Tata Institute for Social Sciences--TISS); foundations (Nike Foundation, MacArthur Foundation); and state and city government (the Brihanmumbai Municipal Corporation).

Additionally, program activities were piloted and tested with a group of young men from low-income communities. Selected peer leaders underwent an intensive two-week training program to strengthen their knowledge and facilitation skills. Afterwards, peer leaders recruited young men from the community to participate in the intervention. Yaari Dosti is an example of how scaling-up strategies that extend beyond the involvement of project staff members to youth, peer-leaders and community members from varying backgrounds and at different levels can inspire and maintain systemic social change in attitudes and behavior.

IMPACT OF SCALE-UP

The World Bank, UNICEF, UNDP, UNFPA, and the Pan American Health Organization (PAHO/WHO) have recognized Program H as a promising practice for promoting gender equality and for reducing GBV (Barker et al. 2012). Evaluations of its adaptation and implementation in countries outside of Brazil (e.g., the Balkan countries) highlight the positive impact of community involvement on increasing the number of men who self-reported decreased tolerance of GBV (Namy, Heilman, Stich and Edmeades 2014). Furthermore, an evaluation of Yaari Dosti indicates that the proportion of men who said that "it is okay

8. Of the 126 young men aged 18 to 29 who participated in the group educational activities, 107 completed the pre-test questionnaire. At baseline, the mean age of respondents was 21. About 72 percent were single, 19 percent had a current girlfriend, and 9 percent were married. A little more than half of the young men (56 percent) had completed 11 years or more of formal education. Most of the young men earned less than Rs. 2,000 (USD 45) per month.

for a man to hit his wife if she refuses sex with him" declined from 28 percent during the pre-test to 3 percent during the post-test. Similarly, the proportion of young men who reported that "a man should have the final word about decisions in his home" declined from 34 percent to 11 percent (Verma et al. 2005). Notably, self-reported harassment of girls significantly declined from 80 percent during the pre-test to 43 percent during the post-test (Verma et al. 2005).

Following the positive results from the Yaari Dosti experience, the Gender Equality in Schools (GEMS) project was adapted from it and launched to foster more equitable attitudes among male and female youth in attending public schools in Goa, Kota and Mumbai. In Goa and Kota, it was layered with ongoing school curricula, while in Mumbai, it was implemented as an independent pilot project in 45 schools. Following the success of the Mumbai pilot, the Maharashtra State Government integrated key elements of GEMS for all of its nearly 25,000 public schools.

LESSON 3: PROVIDE PROOF OF CONCEPT FOR THE GBV INTERVENTION

Site visits revealed the importance of providing "proof of concept," or evidence that their GBV interventions could demonstrate impact and directly improve their ability to garner support and funding for their scale-up initiatives. Implementers that grew a body of evidence reported that doing so helped gain the buy-in of funders and partners because it showed that the interventions redressed power disparities among women and men. They noted that while a good idea may be able to attract support for a pilot, donors and governments are more attracted by solid evidence that programs work and are effective prior to investing in scale-up of a program. Thus, obtaining proof of concept not only substantiated that their evidence-based initiative was transformational—it also paved the way for scale-up. IMAGE utilized blended scale-up methodologies that included elements of replication and geographic expansion, and also included the expansion of the scope of work.

USAID staff who are designing or implementing GBV interventions at scale may consider how well the intervention will provide proof of concept. The following questions may be considered, preferably during design:

- Does USAID and/or its implementing partner have the capacity to conduct formative research utilizing randomized control trials (RCT) or quasi-experimental design to provide an evidence base for impact?
    - Are there local organizations or academic institutions available to collaborate with the implementing partner to focus explicitly on conducting or supporting research activities?
- Is there adequate budget available and allocated specifically to conduct rigorous research, including a baseline, midterm and final evaluations?
    - If the programming has already begun, does quality baseline data already exist? If not, what strategies can be employed to construct retroactively a baseline against which to measure impact?
- Does a theory of change exist for the implementing partner that has been proven to prevent or respond to GBV effectively?
- Does the implementing partner have the capacity to utilize evaluation findings and lessons learned in order to adjust programming towards adaptive scale-up planning? If so, is there flexibility in work planning to do so?
- Is it feasible to plan for programming that begins with a research-intensive pilot project with planned adaptive scale-up based on evidence?

IMAGE, an NGO in South Africa, is explored in greater detail below to show staff experience in leveraging proof of concept to facilitate scale-up.

STEPPING STONES

CASE STUDY

INTERVENTION WITH MICROFINANCE FOR AIDS AND GENDER EQUITY (IMAGE)

BACKGROUND

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) is a multi-sectoral partnership addressing poverty and gender inequality to reduce women's risk of HIV and gender-based violence in South Africa.[9] In 2001, IMAGE began as a five-year randomized control trial by the Rural Aids and Development Action Research (RADAR), an initiative of the University of the Witswatersrand and the London School of Hygiene and Tropical Medicine. IMAGE is now a NGO receiving USAID support and is managed by the Wits Consortium at the University of Witwatersrand. IMAGE tools and materials are recognized as good practices in HIV prevention by the WHO and UNDP.

IMAGE aims to improve women's employment opportunities, increase their influence in household decisions and their ability to resolve marital conflicts, strengthen their social networks, and to reduce HIV transmission (Kim et al. 2009, National Prosecuting Authority and UNICEF n.d.). IMAGE targets women living in the poorest households in rural areas, and combines a microfinance program with awareness raising and skills-building training sessions on HIV prevention, gender norms, cultural beliefs, communication and intimate partner violence.[10] The program also encourages wider engagement of men and boys.

GBV INTERVENTION

IMAGE highlights the potential for partnerships between specialist organizations (Hargreaves et al. 2008). IMAGE developed a training program using the participatory Sisters For Life (SFL) curriculum for preventing HIV/AIDS and domestic violence, and builds leadership in community mobilization. It was implemented in partnership with a microfinance institution, the Small Enterprise Foundation (SEF), which targets vulnerable women using the Grameen model of solidarity group lending.

RADAR implemented IMAGE training modules with SEF's client base in the very poor and mainly rural state of Limpopo (Hargreaves et al. 2008). RADAR used a cross-sectoral intervention strategy with the belief that an integrated model may produce greater benefits than a single component.

SCALE-UP: REPLICATION, GEOGRAPHIC AND SCOPE OF WORK EXPANSION

9. In South Africa, intimate partner violence has been identified as an independent risk factor for HIV infection.

10. Stand-alone credit and rural development interventions such as the Grameen Bank and BRAC target women and appear to show some promise in reducing intimate partner violence (Forum on Global Violence Prevention 2011).

Replicative scale-up was part of IMAGE's initial design and was based on an explicit theory of change.[11] IMAGE was replicated in phases starting in 2001, with some gaps in programming due to a lack of funding. In its trial period (2001-2004), the intervention was delivered to 860 women in eight villages in rural Limpopo. By mid-2007 IMAGE was reaching 3,000 households in over 100 villages. IMAGE also has been replicated in additional provinces in South Africa and expanded into Tanzania.

After the impact evaluation was conducted in 2008, a new institutional structure was designed[12] to reach 15,000 households by 2011-2012 in areas surrounding proposed mining developments in South Africa's rural northeast (GVP n.d.). For each new area reached, IMAGE is adapted to take into account the cultural norms and traditions of different ethnic groups.

IMAGE became an independent NGO (the Small Enterprise Foundation) in 2012. From 2012-2015, with oversight from the Wits Consortium, IMAGE is receiving support from USAID and currently services 6,000 additional microfinance clients in three states: Gautang, North West, and the Kwa-Zulu Natal. In this new geographic expansion, the SFL training was reduced to six weeks with a focus on HIV/AIDS training (including GBV). As a result of this shift in focus and receipt of USAID funding, IMAGE is reporting on five PEPFAR indicators.[13]

Touching upon cost efficiencies, while the initial intervention cost approximately 25 USD per woman, that cost was reduced to 7 USD per woman by taking advantage of economies of scale.

LESSON 3 - PROOF OF CONCEPT

From the beginning, IMAGE instituted a rigorous M&E system, applying the gold standard of evaluation approaches: the randomized control trial (RCT).[14] The program also utilized process analysis and implemented wide dissemination of findings.[15]

The strong evidence base generated by IMAGE's research ultimately paved a way for adaptive scale-up to reach targeted audiences equitably, efficiently, and sustainably by its integration into national planning. For example, the South African Government further adapting the IMAGE model and incorporated it into the South African National AIDS Council's (SANAC) Strategic Plan for 2007-2011, as an urgent component of the HIV prevention agenda.

IMPACT OF SCALE-UP

IMAGE's impact on GBV was evaluated through a cluster randomized control trial of the initial pilot from 2001-2006. This evaluation showed great strides in changing attitudes toward GBV in the targeted villages. A six-year process evaluation that spanned the pilot and initial scale-up was used to assess scale-

11. The intervention's approach drew on ecological theories of disease causation and adopted the constructs of social capital, social networks, and community mobilization (Hargreaves et al. 2008). This approach was influenced by Paulo Freire's (1968) transformative approach to adult education and the notion of the development of critical consciousness.

12. As a result of the process evaluation, the intervention was redesigned and three components were delivered to the same clients by staff from the two specialist organizations: SEF delivered the microfinance; RADAR delivered the Gender and HIV training (Sisters for Life program) and the community mobilization; (Hargreaves et al. 2008).

13. The indicators are outlined in South Africa Strategic Information (SASI) Manual to provide Strategic Information (SI) guidance with a focus on results reporting for all United States Government (USG) partners implementing the President's Emergency Plan for AIDS Relief (PEPFAR) in South Africa.

14. The RCT was supported by funding from six donors.

15. IMAGE was heralded by the WHO as a best practice model for HIV prevention during the 15th ICASA conference held 3rd through 7th of December 2008 in Senegal, Dakar. IMAGE is also one of 10 global case studies for the Commission on the Social Determinants of Health. IMAGE has been profiled as a United Nations Development Program's (UNDP) good practice model toward achieving Millennium Development Goals (MDGs) and in 2009 was profiled as a best practice model for HIV prevention during PEPFAR's Technical Exchange (October 2009; JHB SA).

up. The process evaluation found that at a larger scale, the IMAGE interventions had high recruitment and repayment rates as well as low dropout rates. Clients found the training useful (Hargreaves et al. 2008).

LESSON 4: BUILD A GBV COMMUNITY OF PRACTICE[16]

Sites visited in India and South Africa revealed that building a community of practice for GBV prevention and response directly improved their ability to garner support and funding for their scale-up initiative. Communities of practice allowed for collaboration around learning, so that standards and technical approaches could be developed, disseminated and implemented. They found that by linking the GBV intervention to a community of practice they were able to secure the technical institutionalization and sustainability of their planned scale-up. The following questions may be considered, preferably during design:

- What opportunities exist to connect to a GBV learning center or GBV center of excellence?
- What is the potential for development and capacity strengthening for future GBV professionals through partnerships with academic institutions and other implementing partners' organizations to grow, sustain, and support scale-up of GBV interventions?
- What tools exist that may be used in the development of standards for the design, implementation, monitoring and evaluation of the GBV intervention?

An illustrative example of one GBV intervention, Stepping Stones in South Africa, is provided below to illustrate staff's experience in building a GBV-focused community of practice.

STEPPING STONES

CASE STUDY

STEPPING STONES

BACKGROUND

The Medical Research Council, South Africa (MRC) is a science, engineering and technology institution based in Pretoria. It was established in 1969 by the South African Medical Research Council Act (Act 19 of 1969). The purpose of the Council is to improve the health and quality of life of South Africans through relevant and responsive research, development and technology transfer.

GBV INTERVENTION

Stepping Stones is an HIV/AIDS prevention program that aims to improve sexual health by building stronger, more gender-equitable relationships that foster better communication between partners. It was originally developed in 1995 for use in Uganda and in 1998, MRC launched the program for South

16. A community of practice is a group of USAID staff who share a domain of interest (in this case GBV prevention and response) where members engage in joint activities and discussions, share information and learn from each other. Communities of practice often develop a repertoire of resources: evidence, experience, tools and approaches to addressing recurring problems.

African youth in the Eastern Cape Province through its partnership with the Planned Parenthood of South Africa (PPSA).

Stepping Stones sought to reduce HIV rates in the Eastern Cape and to increase young men's and women's knowledge of legal protections by reviewing South Africa's Domestic Violence Act, and exploring questions such as, "Why do men rape?" and "Why do men and women mistreat each other?" The program worked with youth over a period of 12 to 18 weeks[17] and used an HIV/AIDS prevention training package that employed participatory learning activities to increase knowledge about sexual health and risk-taking to improve communication skills, and to facilitate self-reflection on sexual behavior (ACORD 2007).[18]

SCALE-UP: REPLICATION AND GEOGRAPHIC EXPANSION

Over the last decade, Stepping Stones has been used in over 40 countries, adapted for at least 17 settings, and translated into at least 13 languages (Wallace 2006). Following the initial adaptation in South Africa, a subsequent replication of Stepping Stones took place in the Gauteng, North West, Western Cape, KwaZulu-Natal, and Limpopo provinces, increasing geographical coverage and numbers of beneficiaries reached.

Owing to the success of the program in reducing GBV in South Africa, Stepping Stones was scaled-up in The Gambia. The scale-up took place through a series of phases. In the first phase, from 2003 to 2005, Stepping Stones was implemented in 120 villages. In the second phase, in 2006, the program was implemented in an additional 225 villages, and in the third phase, it was expanded to include 300 more villages. This was achieved through effective mainstreaming and coordination with other actors from the local to the international level (ACORD 2007).

Scale-up in The Gambia was conducted by "blueprinting" a successful training and education process into a new context and adapting it by adding a GBV component. Specific GBV issues covered include identifying and responding to different types of violence, identifying formal and informal sources of help as well as legal protections against violence, among others.

LESSON 4 - BUILDING A GBV COMMUNITY OF PRACTICE

The scale-up of Stepping Stones in South Africa required the cooperation and inclusion of a large number of beneficiaries. Consequently, a large corps of trainers was needed to build skills. As such, MRC developed of a community of practice through extensive training and local capacity building of organizations, communities, and individuals. In partnership with PPSA, facilitators were recruited and trained[19] to provide needed technical capacity. Numerous training sites were established in order to carry out the scale-up. MRC's investment in building a community of specialized Stepping Stones trainers who reflected their trainees' demographic characteristics facilitated learning, established standards, and honed technical approaches, allowing for scale-up.

17. The time taken varies depending on the frequency of meetings and the number of sessions included.

18. This discussion seeks to raise awareness about legal rights and protection for violence against women, as well as violence against children and men. Throughout the training package, participants reflect upon and discuss male norms and behaviors that are harmful or beneficial for young men, young women, their families, and their communities. The session on gender-based violence raises awareness among the men about how violence affects women in general and their partners specifically, and also helps change perceptions among young women about how they should be valued and treated.

19. Rigorous interviews were conducted to assess each new trainer's knowledge in HIV, gender equality and GBV; trainers then went through the training manual themselves.

IMPACT OF SCALE-UP

Stepping Stones was the first HIV prevention and behavioral intervention that was subject to a rigorous level of evaluation in Africa. The program in South Africa was found to influence positively participants' attitudes and behavior on GBV after the workshops. A cluster randomized control trial of the scale-up in the Eastern Cape showed that men participating in the program reduced their use of violence; the proportion of men who disclosed perpetrating severe IPV (defined as more than one episode of physical or sexual IPV) was lower at 12 and 24 months. A significantly lower proportion of men reported perpetration of violence against a partner down from 14.5 percent to 9.6 percent after the intervention (Jewkes et al. 2007). Many of the participants became advisors to other youth on a range of issues, including avoiding the use of violence (Jewkes et al. 2007). As Uvin et al. (2000) note, success of capacity strengthening is tied to the diversity and composition of trainees and managers of the institutions, commitment to change, belief in the value of the change desired, and faith in both the organization and people conducting the training.

LESSON 5: INTEGRATE GBV INTO GOVERNMENT STRUCTURES AND SECTORAL PROGRAMMING

The integration of GBV prevention and response into sectoral programming, particularly those run by the government, was reported by the sites visited as directly translating into the scale-up of their initiatives. Integration required weaving the intervention into existing government structures (e.g., public health or education system) and via government planning, budgeting processes and service delivery. The incorporation of a GBV intervention into an existing government structure resulted in higher confidence in its potential to be sustained because the government absorbed it as an important priority warranting inclusion in the budget.

USAID staff who are designing or implementing GBV interventions to go to scale may consider the intervention's potential for integration into sectoral programming and/or existing government institutions or programs. The following questions may be considered:

- What opportunity exists for integration of a GBV intervention in existing government structures? Is the intervention aligned with existing government program priorities, objectives, or action plans?
- What opportunities exist to incorporate GBV interventions in existing government or program planning, budgeting and service delivery? What is the capacity of the implementing partner to develop sound budget and work plans to make the business case for inclusion of GBV interventions?
- What opportunities exist for integration of the GBV intervention in existing sector-focused projects (driven by government, NGOs, communities, or other partners)? What ability does the implementing partner possess in supporting or extending the sector program's goals?

Two illustrative examples of GBV interventions, Combating Commercial Sexual Exploitation (CCSE) in India and the Thuthuleza Care Centers (TCC) in South Africa, are provided below to demonstrate program staff experience in integrating GBV response into government sectors.

IJM

CASE STUDY

COMBATING COMMERCIAL SEXUAL EXPLOITATION (CCSE)

BACKGROUND

In 2000, the International Justice Mission (IJM) launched the Combating Commercial Sexual Exploitation (CCSE) program to combat commercial sex trafficking and commercial sexual exploitation of minors in India. IJM works to protect people from violent forms of injustice by securing rescue and restoration for victims and ensuring public justice systems work for the poor. IJM is headquartered in Washington, D.C. and works in a diverse range of countries including Bolivia, Guatemala, Kenya, Rwanda, Uganda, Zambia, India, Cambodia, the Philippines and Thailand.

GBV INTERVENTION

CCSE's first objective is to assist the legal system with effective law enforcement action against purveyors of commercial sex who rely on forced labor supply (IJM, 2004). The IJM's approach is to foster effective law enforcement that addresses sexual exploitation of minors as well as acts as a strong deterrent (preventative) effect.[20] CCSE supports aggressive prosecutions of traffickers, brothel keepers, and their agents to undermine profit incentives both for the criminals caught and other would-be traffickers (IJM, 2004). A secondary objective of the CCSE is to support aftercare homes by providing a minimum standard of care to rescued victims; offering recovery from abuse, vocational training, and rehabilitation away from prostitution.

SCALE-UP: GEOGRAPHIC AND SCOPE OF WORK EXPANSION

CCSE began its operations in Mumbai and scaled up via expansion within the city. Its operations evolved from individual case-work and one-on-one training of police and prosecutors to training for all new officers in the police academy (IJM, 2004).

CCSE was also extended to Kolkata in 2006. The IJM's program managers viewed this scale-up as a natural progression: both cities had large red-light areas and were connected to each other through a major trucking and trafficking network that ran across India.

However, this was not a matter of replication to a new area; rather, IJM expanded its scope of work to include catching and prosecuting sex traffickers. The IJM found that girls were being trafficked into Kolkata from Bangladesh and Nepal, before transiting to Mumbai. According to IJM's initial assessment in Kolkata, "hundreds" of minors appeared to reside in the Sonagachi red-light district and a significant number of adult victims of trafficking (as classified under the Immoral Trafficking Prevention Act) were also present. IJM scaled-up programming to address the challenge along the supply chain; working with a local to identify and to help the police to catch and prosecute sex traffickers at the source in Kolkata.

LESSON 5 - INTEGRATING GBV RESPONSE INTO THE DEMOCRACY AND GOVERNANCE SECTOR (CCSE)

A key element of CCSE was that it was directly woven into the government's justice sector. CCSE builds the capacity of the police, prosecutors, and judges to enforce current laws by: i) initiating investigations that identify victims of commercial sexual exploitation and trafficking; ii) securing the release of victims through coordination with local law enforcement; iii) utilizing the evidentiary materials gathered through brothel investigations and debriefings of rescued victims to initiate arrests and prosecutions of traffickers and brothel keepers; iv) facilitating placement of rescued victims in aftercare homes that provide recovery from abuse, vocational training, and rehabilitation to a life after prostitution, or repatriation to their home. This work is based on an explicit theory of change and the methodology underpinning the integration of the GBV intervention is called collaborative casework.

IJM began with one-on-one training for police officials, documenting and obtaining information of crimes, working with the police to make arrests, and looking for evidence that could be upheld in a court of law (IJM, 2004). The work continued through activities such as prosecutor buy-in, training, and support in court for those who did not have adequate training in the area of law related to trafficking. Senior level

20. Facts and Figures quoted in IJM Kolkata Newsletter, June 2012: "According to the National Human Rights Commission of India figures indicate that the average age of those who fall victim to human trafficking is between nine and 13 years. There has been a staggering rise in the number of persons involved in human trafficking in the country – the figure has increased 17 times in the past decade." "Human Trafficking victims inspire others with their courage tales." Reported by The Times of India. 6 April 2011.

police officers and judges have acted as champions and allies for IJM's work to build capacity within the police and judicial system for anti-trafficking work. [21]

IMPACT OF SCALE-UP

CCSE's successful work in Kolkata 2006-2012 resulted in multiple positive outcomes: 289 arrests of sex traffickers in and around Kolkata; 268 minors rescued from brothels; repatriation of 28 minors to Nepal and Bangladesh; reintegration of 39 minors into society; direct caseload of 87 in aftercare homes; the development of Mahima, a model aftercare home for minor survivors of sex trafficking in Kolkata; and a minimum standard of care in government aftercare homes with current service impacting 791 minors.[22] Although the number of traffickers arrested and convicted appears low, IJM staff in India maintain that the conviction and removal of even a small number of sex traffickers translates into the circumvention of potentially hundreds of girls from becoming future trafficking victims.[23]

According to IJM, one of the most critical results of the scale-up followed its first conviction of a sex trafficker in 2010, which resulted in a strengthened relationship between IJM and the police in Kolkata. Since then, the police increasingly request IJM's assistance when carrying out investigations and raiding brothels, making arrests in 77 percent of cases (up from 30 percent in 2010). This collaborative effort has increased the capacity of police, prosecutors, lawyers, and judges who were trained to enforce the anti-trafficking laws. Both Mumbai and Kolkata offices also have built strong linkages with other Indian NGOs who work on combating sex trafficking and train in alternative livelihoods. Together these organizations have formed an advocacy group that pressures the government to stop the sexual exploitation of minors.

21. IJM consider senior level police force, prosecutors and judges, important allies especially as they near retirement and are often looking to leave a useful professional and personal legacy.

22. These figures were presented in IJM Kolkata's power point presentation for the GBV research team during the field mission in February 2013.

23. To evaluate its work the IJM uses the indicator of minors who are no longer openly visible in red-light districts as a result stemming from raids on brothels where trafficked minors were often held. The IJM acknowledges that while the deterrent effect of raids and the conviction of sex traffickers, some of the trafficking of minors may simply have moved further underground. Another reason for the lower visibility of minors in the red-light districts is that the trade may be moving from more "traditional" areas of trade to regular housing areas.

TCC

CASE STUDY

THE THUTHULEZA CARE CENTERS

BACKGROUND

The Thuthuleza Care Centers (TCCs) are one-stop facilities that have been introduced as part of the South Africa Government's (SAG) strategy for the prevention, response, and support to rape survivors.[24] The South African Government (SAG) created the one-stop TCC network program under the Ministry of Justice and its National Prosecuting Authority (NPA) (SAG 2013).

The NPA's aim is to continue to increase the conviction rate, thereby putting an end to a culture of impunity often accorded to perpetrators of GBV crimes. The NPA's Sexual Offences and Community Affairs (SOCA) Unit handles cases of sexual violence, domestic violence, and violence against children, as well as the management of young offenders. Led by SOCA, the Inter Departmental Ministerial Team mechanism consists of justice, health, education, treasury, correctional services, safety and security, local government, home affairs, social development and designated civil society organizations (Muthien 2003). These multi-sectoral coordination mechanisms are present at national, provincial and district levels.[25]

Since 1999, USAID in South Africa has supported the SAG in the implementation of the TCCs through various implementing partners, including RTI International and the Foundation for Professional Development. The TCCs are also supported through a partnership with the Government of Denmark, which funds UNICEF as the implementing partner.

GBV INTERVENTION

The main goal of the TCCs is to increase conviction rates and to reduce offender impunity to GBV crimes, reduce the cycle time for finalizing cases and secondary victimization, and address the social needs of survivors (SAG 2013). Using a survivor-centered approach, the TCCs[26] are designed to address the legal, medical, and social needs of survivors of rape and sexual assault at one location (i.e., a one-

24. The TCC concept is recognized by USAID "as turning victims into survivors" and the UN General Assembly as a "world best-practice model" in the field of gender-violence management and response. A PEPFAR funded assessment of GBV in South Africa (USG 2011) identified the TCCs as a success story based on the government taking ownership of the TCCs, delivering services to respond to and treat victims of sexual violence. UNICEF has identified that five other countries wish to adopt the model. (UNICEF Undated).

25. The new ministry, the Department of Women, Children and Persons with Disabilities, hopes to take a leading role in SAG's GBV efforts by coordinating its internal GBV mechanism, the Inter-Departmental Management Team, and its arm for collaboration with civil society organizations (CSOs), the National Gender Machinery. It also hopes to pass a new Gender Equity Bill, which will address gaps in current legislation such as hate crimes based on sexual orientation, or human trafficking (USG 2011).

26. The analysis of the TCCs scale-up intervention is based on an extensive literature review, focus group discussions with USAID staff in Washington and Pretoria, interviews with TCC staff and NGO counselors at the Khayelitsha Hospital TCC in the Western Cape, outside Cape Town, and interviews with NGO stakeholders (Sonke Gender Justice Network in Cape Town, John Hopkins Health and Education in South Africa in Pretoria).

stop shop). Services provided include legal assistance in order to reduce secondary victimization reported at police stations, improve conviction rates of rape crimes, and reduce the cycle time for finalizing criminal cases; medical assistance\ such as the provision of post-exposure prophylaxis (PEP) and sexually transmitted infections (STI) testing; and social assistance in the form of psycho-social counseling through non-governmental organizations (NGOs) (NPA n.d.).

SCALE-UP: REPLICATION

The first pilot TCC opened in GF Jooste Hospital in Manenberg, Western Cape in June 2000. The pilot was based on input from a small (15) sample of women survivors of rape. The pilot had a single sector "silo" mentality with separate ministries providing services to rape victims independently of each other.

The passage of the long awaited Sexual Offenses Act of 2007 sped up the process of replicating TCCs[27] in other cities such as East London, Umtata and Soweto. A new integrated multi-sector model of TCC was presented at the first Sexual Offenses Indaba (Conference), a three-day joint planning session for the NPA, Ministries and Government Departments, stakeholders, and donors in preparation for the rollout of the TCCs (NPA-IDMT 2009).

The rollout of the TCCs was based on a comprehensive assessment of 70 hospitals and police stations, which recommended locations based on the demographic composition and priorities of each province. It also incorporated a timeline for implementation, monitoring and evaluation (M&E) tools, a timeline for absorption of the TCCs into the SAG's budget by the Sexual Offences and Community Affairs (SOCA), as well as support required from donors for the initial set-up of the TCCs, and (NPA-IDMT 2009). The strategy for the scale-up of the TCCs was later revisited, reassessed, revised, and reinforced at the Sexual Offences Indaba, held annually since 2008 (Skumisa 2011).

Supported through national budget allocations under the Ministry of Justice's SOCA-NAP budget and strong donor support, there are presently 52 TCCs across the nine provinces of South Africa, with a plan to roll out to a total of 80 TCCs to meet overwhelming demand.[28]

INTEGRATING GBV RESPONSE INTO THE HEALTH AND DEMOCRACY AND GOVERNANCE SECTORS (TCC) – LESSON 5

The TCC's integration into both the health and justice sectors is driven by the demand for coordinated services that reduce secondary victimization and allow access to justice and health related services in one location for victims and survivors of GBV. The one-stop-center model facilitates the provision of psycho-social counseling usually provided by a community service organization or a non-governmental organization (CSO/NGO) and the collection of forensic evidence to support convictions of offenders.

PEPFAR-supported post-exposure prophylaxis (PEP) and sexually transmitted infection (STI) testing are offered as well as psychosocial services (funded through the Department of Social Development's Victim Empowerment Program and delivered by CSOs/NGOs) in the same TCC facility or are referred to services off-site. Some limited outreach and awareness raising activities are also conducted within the community surrounding each TCC, depending capacity of local CSOs/NGOs.

27. The pilot in the rural areas took much longer than one in the urban areas.

28. South Africa is said to have the highest rate of reported rape in the world.

IMPACT OF SCALE-UP

There was a significant increase in reporting GBV crimes by survivors and community members, with 25 percent of all cases referred to the court for prosecution and an average conviction rate of 62 percent (NPA, 2012).[29] Conviction rates for perpetrators of GBV increased from an average of 7 percent to 60 percent among TCC clients who choose to open a case (USG 2011). The reporting of sexual offences has also increased. According to the South Africa Police Services (SAPS), in 2010-11, they recorded 56,272 rapes and 28,128 sexual offences against children younger than 18 years (an increase of 2.1 percent and 2.6 percent, respectively, from the previous year). The number of cases received at court, where case managers were appointed, also increased by almost 10 percent from 9,716 to 10,949 (NPA 2011-12). Similarly, the number of cases finalized by the courts increased from 1,761 to 2,180 (NPA 2011-12).

29. NPA Annual Report 2011/12, Pg. 38-41 and NPA Annual Performance Plan 2012/13, Pg. 13.

LESSON 6: DESIGN THE GBV INTERVENTION WITH SCALE IN MIND

The key to scale-up success for sites in South Africa was designing the GBV intervention with scale-up in mind. Early planning facilitated thoughtful adaptation, replication, and expansion. USAID staff who are designing or implementing GBV interventions should consider scale-up as a key design component. The following questions may be considered:

- What strategies should be employed to involve a broad range of stakeholders in scale-up planning and necessary preparatory steps?
- How can scale-up lessons learned highlighted in this document be integrated in the scale-up plan?
- What strategies for adaptation should be included in the scale-up plan?

An illustrative example of one GBV intervention, Soul City, is provided below to demonstrate program staff experience in designing with scale in mind in order to facilitate adaptive scale-up.

SOUL CITY

CASE STUDY

SOUL CITY INSTITUTE FOR HEALTH AND DEVELOPMENT COMMUNICATION (IDHC)

BACKGROUND

The Soul City Institute for Health and Development Communication (Soul City IDHC) is an NGO based in South Africa that has been using mass media for social change since 1992. Soul City IDHC integrates a number of existing models of behavioral change to create a supportive environment for change. Soul City IDHC employs the concept of integrated entertainment and education, known as "edutainment," the art of integrating social issues into popular high-quality entertainment formats, combined with a thorough research process. Through its multiple media formats, including prime-time television drama, radio drama, and print media, they reach more than 16 million South Africans.

GBV INTERVENTION

Soul City It's Real/Soul City 4 (SC4) is the Institute's flagship television show, which has become one of South Africa's most loved television shows over the past 17 years. Set in the fictional Soul City Township, the series mirrors the social and development challenges faced by poor communities across South Africa. It weaves real-life health and social issues into powerful stories for millions of viewers, who have grown to trust the powerful messages of this very popular program. The original series consisted of a 13-episode prime time television drama, a 45-episode radio drama in nine languages, and

three full-color informational brochures with a national distribution of one million copies each (Guedes, 2004). SC4 utilized a multi-media approach to leverage available resources as well as repeat exposure to gender transformative ideas.

> *"To scale-up effective 'edutainment' programs that foster social change in the area of women's rights, including addressing GBV, strategic partnerships and alliance building with partner organizations, stakeholders and other key civil society organizations are essential."*
> SOUL CITY, ONE MAN CAN

The story line presented in SC4 was based on extensive formative research conducted by the Soul City IDHC, comprised of literature review, focus group discussions, in-depth interviews, and stakeholder consultations. Research findings[30] informed project objectives, reinforced the need for an ecological approach,[31] and informed the content of the series and advocacy efforts on GBV. The public's perceptions of domestic violence—causes, impact, and solutions were incorporated into the story line (Usdin et al., 2005).

SCALE-UP: REPLICATION, GEOGRAPHIC EXPANSION, AND SCOPE OF WORK EXPANSION

The series has been scaled-up through expansion and replication to an additional 11 subsequent series. Beginning in 1999, Soul City IDHC scaled up by simultaneously developing communication programs in eight Southern African countries while building the skills and capacity of partner organizations across the region. Over 300 people have received training in key areas of edutainment methodology, research, print, television and radio production, and advocacy.

Soul City 4 (SC4) scaled-up across the African continent, including in Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia, and Zimbabwe. Each show applies context-specific and tailor-made "edutainment" strategies, combined with community mobilization strategies. This particular iteration of Soul City included a focus on violence against women.

Soul City IDHC also has included partnership building and utilization of prior experiences in scaling-up of the series programming in different countries (Soul City 2001b). For example, in South Africa, Soul City IDHC partnered with the National Network on Violence Against Women (NNVAW) to combine and leverage the experience, credibility, and strengths of the network.

The credibility of both of these organizations in public and government spheres was also key in gaining support to go to scale. For example, Soul City IDHC's reputation with the media as a credible source,

30. The formative research findings revealed a patriarchal society with high levels of tolerance of domestic violence. A major barrier to action was the pervasive belief that domestic violence is a 'private affair.' Women respondents revealed a frustration with existing legislation and police reluctance to assist (Usdin et al., 2005).

31. The ecological approach is a practice that involves addressing GBV holistically, emphasizing linkages between different levels, actors, and sectors of society (WHO 2010). The approach looks at GBV from different angles, generating an understanding of the situation based on the relevant context and cultural nuances. It provides an understanding of some of the key factors that contribute to women and girls' vulnerabilities to violence on four levels: individual, relationship, community and society. Ecological approaches highlight the importance of interaction between biological, psychological, social, cultural, economic and political factors that enhance women's and girls' risks of experiencing violence, and the likelihood of the perpetration of violence by men (UN Women, 2012 and Heise, 1998).

bolstered by relationships it cultivated with journalists covering health and development issues, generated extensive media coverage. This enabled Soul City IDHC to establish partnerships with print and electronic media and encouraged journalists to cover issues raised by the program. The NNVAW's community-based membership structure complimented this by facilitating a social mobilization campaign to scale-up (Soul City 2011b).

LESSON 6 - DESIGNING WITH SCALE IN MIND

Staff and managers interviewed at Soul City IDHC indicated that the organization's brand of "edutainment" and SC4 were designed with the goal of scaling up. It was designed to be a media vehicle that could address a variety of issues on an ongoing basis while reaching an increasing audience of consumers through a variety of techniques. Soul City aimed to become a commercially viable enterprise that partnered with media owners (CASE 1994). Scaling of television coverage area, partnerships, research and advocacy or policy change were all part of a larger theory of change and plan to transform national attitudes and behavior related to domestic violence and violence against women and to engender the passage of national domestic violence legislation. This design for scale from the beginning prioritized relationship-building, partnerships, and collaboration to make scale-up possible.

IMPACT OF SCALE-UP

A 2001 mixed-methods impact evaluation of SC4 identified a shift in individual knowledge and attitudes about domestic violence. For example, there was a 10 percent increase in the number of respondents who agreed that domestic violence was a public matter (Soul City 2001a).[32] Qualitative analysis suggested the enhancement of women's sense of efficacy in making decisions about health. The SC4 evaluation indicates a strong association between exposure to intervention components and a range of intermediary behaviors and attitudes necessary for the realization of positive social change.[33] In addition, the evaluation concluded that positive changes in policy were attributable to the increased reach of SC4, especially implementation of the Domestic Violence Act passed by the Government of South Africa in 1998.

32. The sample for the baseline survey was 1979 and the evaluation survey was completed by 1981 respondents.

33. To read volumes I and II of the evaluation and learn more about the methodology, see http://www.soulcity.org.za/research/evaluations/series/soul-city/soul-city-series-4

SECTION 4

KEY LESSONS AND APPLYING LESSONS LEARNED

SOUL CITY

KEY LESSONS AND APPLYING LESSONS LEARNED

To summarize, there are six key lessons for scaling-up GBV interventions and based on findings. The case studies in India and South Africa yielded findings that can be applied to scaling up GBV interventions across sectors. The key lessons learned gained from each site visit are detailed in Table 6:

TABLE 6: LESSONS LEARNED FROM PROJECT ACTIVITIES

Lesson Learned	Case Study	Sector
Align Interventions with National Commitments to End GBV	One Man Can Campaign South Africa	Health
Secure Community Ownership for the GBV Intervention	Yaari Dosti India	Youth
Provide Proof of Concept for the GBV Intervention	IMAGE, South Africa	Economic Growth
Build a GBV Community of Practice	Stepping Stones, South Africa	Health
Integrate GBV into Government structures and sectoral programming	Combating Commercial Sexual Exploitation (CCSE), India and The Thuthuleza Care Centers (TCC) South Africa	Democracy and Governance
Design the GBV Intervention with Scale in Mind	Soul City Institute for Health and Development Communication, South Africa	Education

KEY FINDINGS

Rigorous formative research and robust M&E systems are crucial in determining a nuanced understanding of what makes an intervention effective. The research suggests that GBV intervention scale-up processes should focus on 'learning through action' and incorporate lessons learned at the community level to strengthen scale-up efforts. The development of a community of practice is one important approach that helps to scale-up GBV interventions.

Building on and utilizing local traditions, customs and popular culture, as well as linking economic livelihoods models with GBV prevention are stepping stones to transformative scale-up of GBV interventions. Ensuring relevance and authenticity in a GBV scale-up effort is a necessary condition for effectiveness and success.

Successful scaling-up of interventions designed to address GBV is dependent on institutional structures with a high capacity for implementation and management that takes time and funds to build, including: governance and leadership; supportive policy frameworks; strategic plans and planning documents; financial management; mechanisms to support partnerships; and skilled and committed human resources.

ALTERNATIVES TO SCALING UP

In cases where USAID resources may not be available to fund a large scale-up of a GBV intervention, program managers seeking to identify cost-effective GBV prevention and response activities should take

into account activities such as institutional strengthening, collaboration and partnership development, and support for the creation of GBV communities of practice to encourage additional donor support.

- **Institutional Capacity Support**
    - Support for organizational strengthening and development of strong management structures for implementers to carry out large-scale GBV intervention scale-ups;
    - Support for organizational development and strengthening of technical capabilities of implementers of scaled-up GBV interventions in monitoring, evaluation and documentation of results.
- **Collaboration and Partnership Development Support**
    - Support learning and exchange activities, such as conferences, workshops, trainings and forums including support for individual participation in such vents to share resources and knowledge, results and experiences from successful scale-ups among like-minded USAID staff locally, regionally, and internationally;
    - Support networking and collaboration opportunities between organizational partners, by leveraging connections between non-state and government agencies and existing GBV networks.
- **Support for Creation of Communities of Practice**
    - Support investment in learning centers and centers of excellence to cultivate and sustain commitment to preventing GBV and replication of evaluated and proven models;
    - Promote and support investment in collaboration and involvement between implementers and academic and research institutions to carry out the research portion of a GBV scale-up;
    - Promote and support the generation of lessons, research finding and evaluation conclusions and wide dissemination of results and experiences from successful scale-up efforts.

ASSESSING AND DESIGNING FOR SCALE-UP

Annex A is a checklist tool that will help USAID staff design GBV interventions for scale and assess the scalability of GBV interventions. The checklist incorporates the best practices and six key lessons learned.

GBV SCALABILITY CHECKLIST TOOL

ANNEX A

The objective of this research task was the development of a tool to assist USAID in scaling up successful GBV interventions in health, youth and education, democracy and governance, and economic growth sectors. This checklist (see Table 7) was developed based on information gained during site visits to successfully scaled-up interventions in India and South Africa. The tool is accompanied by instructions on how to complete the checklist and how to interpret and use the results.

How to use the GBV Intervention Scalability Checklist

The *GBV Intervention Scalability Checklist* tool is designed to assist the user in assessing a GBV intervention's scalability. The tool is based on the six lessons for GBV intervention scale-up presented in this report. The tool allows the user to rate the GBV intervention by assessing the degree to which each indicator is present.

Scoring Instructions: For each lesson's indicator, select the rating category that most closely reflects the information you have on the given GBV intervention and the indicators detailed below:

- A basic understanding of the implementing organization's capacities and capabilities;
- Knowledge of the political and social environment as it relates to GBV;
- Knowledge of the implementer's formative research, monitoring and evaluation of the GBV intervention;
- The implementer's scale-up strategy; and
- The type of GBV intervention: integrated or stand-alone

Select "no" and insert the score "1" in the box if the indicator **is not present**. Select "somewhat" and insert the score "2" in the box if the indicator is **slightly or fairly present**. Select "yes" and insert "3" in the box if the indicator **is present**.

Tallying Guidance: Row totals provide a rating for each indicator while column totals provide a sum for each rating category. To obtain an intervention's scalability score, sum the subtotals for each lesson in the final row of the tool.

Interpretation of Scores: Row scores range from 1-3. A score of "1" is a low score indicating that the implementer's GBV interventions' lacks readiness for that specific indicator. A score of "2" indicates some readiness while a score of "3" indicates full readiness in that area. The combination row/column score ranges from "3" to "9" for each lesson. A score of "3" is a low rating indicating that the implementer's GBV intervention is not ready for scale-up in the lesson area while a score of 9 indicates readiness. The overall score may range from "18" to "54" with "18" being the lowest score possible, "36" delineating the midpoint, and "54" representing the highest score possible. An implementer's GBV intervention with a low rating is unlikely to be ready to go to scale while a GBV intervention with a high score is more likely to scale-up effectively.

TABLE 7: GBV INTERVENTIONS SCALABILITY CHECKLIST TOOL

Scale-up Lesson	Indicators	Rating and Scoring			
		No (1)	Possible (2)	Yes (3)	Total Score
Lesson 1 **Intervention is aligned with government commitments to end GBV**	1a. Government policy on ending GBV				
	1b. Government programs on preventing and responding to GBV				
	1c. Champions for ending GBV (including government, famous and respected individuals and institutions)				
	SUBTOTAL				
Lesson 2 **Community ownership of the intervention has been secured**	2a. Broad community acceptance of the GBV intervention				
	2b. Participation of a diverse range of community members including marginalized groups in community driven assessment and project design for GBV interventions				
	2c. Engagement of men and boys as supportive partners in GBV prevention and response				
	SUBTOTAL				
Lesson 3 **Proof of concept for the intervention is available and credible**	3a. Formative research including a comprehensive GBV analysis and an explicit theory of change				
	3b. Strong monitoring and evaluation including a baseline				
	3c. Ability to utilize evaluation findings and lessons learned to adjust programming				
	SUBTOTAL				
Lesson 4 **A GBV prevention and response Community of Practice built or in development**	4a. Connection to a GBV learning center or GBV center of excellence				
	4b. Development and capacity strengthening for future GBV professionals through partnerships with academic institutions and other implementing partner organizations				
	4c. Standards for design, implementation, monitoring and evaluation of the GBV intervention developed				
	SUBTOTAL				

TABLE 7: GBV INTERVENTIONS SCALABILITY CHECKLIST TOOL

Scale-up Lesson	Indicators	Rating and Scoring			
		No (1)	Possible (2)	Yes (3)	Total Score
Lesson 5 **A GBV prevention and response Community of Practice built or in development**	5a. Connection to a GBV learning center or GBV center of excellence				
	5b. Development and capacity strengthening for future GBV professionals through partnerships with academic institutions and other implementing partner organizations				
	5c. Standards for design, implementation, monitoring and evaluation of the GBV intervention developed				
	SUBTOTAL				
Lesson 6 **Intervention was designed with scale in mind**	**6a. Interventions lessons learned from this report**				
	6b. Intervention sustainability and cost effectiveness included in scale-up plan				
	6c. Strategies for adaptation and replication included in the scale-up plan				
	SUBTOTAL				
TOTAL SCORE					

KEY STAKEHOLDER INTERVIEW GUIDE

ANNEX B

TABLE 8: DIMENSIONS OF SCALING UP

Dimension	Interview Question
Scale-Up Method	• Define the scale-up: was it replication/adaptation, expansion, or collaboration?
Timing	• When did you consider scaling-up, how did you make the decision i.e. what was the right time to scale-up?
Capacity	• What technical or organizational management, technological and human competencies, capacities and capabilities were necessary to bring your intervention to scale?
Strategy	• What strategies produced the desired leap, what were the particular methodologies used to scale-up your intervention?
Impact	• How do (did) you measure the desired impact of your intervention; what M&E framework was in place, how was it used, how did the results inform or impact the scale-up?
Sustainability	• How do you maintain the gains of the expanded intervention, how do you maintain the quality and objective(s) of the original pilot project?
Coverage	• What kind of coverage is enough to qualify as scaled-up, what is the coverage of your scale-up?
Supply and Demand	• Which particular activities are being scaled-up, how was the decision to scale-up those activities made?
Cost	• How much did it cost to scale-up, was there any cost-analysis conducted prior the scale-up?
Resources	• What resources (financial, human resources, organizational or technical) are needed to scale-up your intervention, how were they mobilized, how are they being secured?

KEY STAKEHOLDER INTERVIEWS

ANNEX C

The research team conducted interviews with USAID Mission staff and key NGOs working to address gender-based violence in South Africa and India. A complete list of the experts that were interviewed as a component of this field research is detailed in Tables 9 and 10.

TABLE 9: KEY INFORMANTS INTERVIEWED IN INDIA (MEETINGS HELD IN MUMBAI, NEW DELHI, CALCUTTA)

Name	Program	Implementer	Location of Interview and Contact Information	Method of Contact
Ravi Verma	Yaari Dosti and Gender Equality Movement in Schools (GEMS)	International Center for Research on Women (New Delhi)	New Delhi, India rverma@icrw.org	Email and In-person
Nandita Bhatla	Gender Equality Movement in Schools (GEMS)	International Center for Research on Women (New Delhi)	New Delhi, India nbhatla@icrw.org	Email and In-person
Pranita Achyut	Gender Equality Movement in Schools (GEMS)	International Center for Research on Women (New Delhi)	New Delhi, India pachyut@icrw.org	Email and In-person
Shubhada Maitra	Gender Equality Movement in Schools (GEMS)	Tata Institute of Social Science	Mumbai, India shubhada@tiss.edu	In-person
Satish Singh	MASVAW/ Program H	Center for Health and Social Justice (New Delhi); Program Officer	New Delhi, India	Email and In-person
Abhijit Das	MASVAW	Center for Health and Social Justice (New Delhi); Director	New Delhi, India abhijitdas@chsj.org	Email and In-person
Sujata Khandekar	Yaari Dosti	CARO	Mumbai, India sujata55@hotmail.com	Email and In-person
Pallavi Palav	Yaari Dosti	CARO	Mumbai, India pallusimu77@yahoo.co.in	Email and In-person
Diya Nanda	General	UNWomen, Safe Cities Program	New Delhi diya.nanda@unwomen.org	Phone
Bharati Silwal	General	UNWomen, Safe Cities Program	New Delhi bharati.silwal@unwomen.org	Phone
Shailaja Bista	General	Political Officer, Global Issues Unit, Political Section	New Delhi Bistas@state.gov	In -person

TABLE 9: KEY INFORMANTS INTERVIEWED IN INDIA (MEETINGS HELD IN MUMBAI, NEW DELHI, CALCUTTA)

Name	Program	Implementer	Location of Interview and Contact Information	Method of Contact
Jennifer Gratez	General	USAID, Office of Program Support	Kolkata jgratez@usaid.gov	In -person
Eva D'Ambrosio	General	US Department of State, Vice Counsel for Economic Affairs	Mumbai dAmbrosioeh@state.gov	In-person
Anna E. O'Neill	General	Political and Economic Affairs Officer,	Kolkata Consulate General of the US oneillae@state.gov	In -person
Dean R. Thompson	General	US Counsel General, Kolkata	Kolkata Consulate General of the US	In-person
Sourabh Sen	General	Global Affairs Advisor	Kolkata Consulate General of the US SenSX@state.gov	In-person
Holly J. Burkhalter	Combating Sex Trafficking	International Justice Mission, Vice President, Government Relations	Washington, D.C hburkhalter@ijm.org	Email and Phone
Saju Mathew	Combating Sex Trafficking	International Justice Mission, HQs Program Manager	Washington, D.C. smathew@ijm.org	Email and Phone
Biju Mathew	Combating Sex Trafficking	International Justice Mission, Field Office Manager	Kolkata, India bmathew@ijm.org	In-person
Steven MacEwan	Combating Sex Trafficking	International Justice Mission, Field Office Manager	Mumbai, India smacwan@ijm.org	In-person
Gita Banerjee	Combating Sex Trafficking	Sanlaap (NGO), Founding member and Social Worker	Kolkata, India hq@sanlaapindia.org	In-person
Smita Singh	Combating Sex Trafficking	Mahima India (NGO), Director of Aftercare and Counseling	Kolkata, India smita.mahima@gmail.com	In-person
Sarah Lance	Combating Sex Trafficking	Sari Bari (NGO), Managing/Creative Director	Kolkata, India info@saribari.com	In-person

TABLE 10: KEY INFORMANTS INTERVIEWED IN SOUTH AFRICA (MEETINGS HELD IN PRETORIA, JOHANNESBURG AND CAPE TOWN)

Name	Program	Implementer	Location of Interview and Contact Information	Method of Contact
Dr. Mzikazi Nduna	Stepping Stones	University of the Witwatersrand, Visiting Lecturer at the University of Western Cape	Cape Town, South Africa Mzikazi.Nduna@wits.ac.za	In-person
Lindiwe Farlane	Stepping Stones	University of the Witwatersrand Reproductive Health and HIV Institute, Program Administrator	Johannesburg, South Africa lindiwefarlane@gmail.com	In-person
Dr. Nwabisa Shai	Stepping Stones	Medical Research Council of South Africa, Senior Researcher	Pretoria, South Africa nwabisa.shai@mrc.ac.za	Email and In-person
Dr. Rachel Jewkes	Stepping Stones	Medical Research Council of South Africa, Director, Gender & Health Research Unit	Pretoria, South Africa Rachel.Jewkes@mrc.ac.za	Email
Shereen Usdin	Soul City	Soul City, Program Director	Johannesburg, South Africa shereenu@soulcity.org.za	Email and In-person
Lebo Raafoko	Soul City	Soul City, Chief Executive Officer	Johannesburg, South Africa legor@soulcity.org.za	In-person
Sue Goldstein	Soul City	Soul City, Program Director	Johannesburg, South Africa sueg@soulcity.org.za	In-person
Dean Peacock	One Man Can Campaign	Sonke Gender Justice Network, Executive Director	Cape Town, South Africa dean@genderjustice.org.za	Email and In-person
Tim Shand	One Man Can Campaign	Sonke Gender Justice Network International, International Programs Coordinator	Cape Town, South Africa tim@genderjustice.org.za	Email and In-person
Aadielah Maker	One Man Can Campaign and Thuthuzela Care Centres	Sonke Gender Justice Network, Senior Programs Specialist	Cape Town, South Africa Aadielah@genderjustice.org.za	In-person

TABLE 10: KEY INFORMANTS INTERVIEWED IN SOUTH AFRICA (MEETINGS HELD IN PRETORIA, JOHANNESBURG AND CAPE TOWN)

Name	Program	Implementer	Location of Interview and Contact Information	Method of Contact
Maja Herstad	One Man Can Campaign	Sonke Gender Justice Network, International Programs and Networks Unit	Cape Town, South Africa maja@genderjustice.org.za	Email and In-person
Paula van Dyke	Thuthuzela Care Centres	USAID/South Africa, Program Management Specialist, Democracy and Governance	Pretoria, South Africa pvdyk@usaid.gov	In-person
Virginia Francis	Thuthuzela Care Centres	USAID/South Africa, Gender Advisor	Pretoria, South Africa vfrancis@usaid.gov	In-person
Richard Delate	Thuthuzela Care Centres	John Hopkins Health and Education in South Africa, Country Program Director, Communications	Pretoria, South Africa richard@jhuccp.co.za	In-person
Bronwyn Pearce	Thuthuzela Care Centres	John Hopkins Health and Education in South Africa, Deputy Country Program Director	Pretoria, South Africa bronwyn@jhuccp.co.za	In-person
Mandla Ndlovu	Thuthuzela Care Centre	John Hopkins Health and Education in South Africa, Program Manager, Communications	Pretoria, South Africa mandla@jhuccp.co.za	In-person
Boni Mogale	Thuthuzela Care Centre	Khayelitsha TCC, Site Coordinator	Cape Town, South Africa boni.mogale@gmail.com	In-person
Audry Ziervogel	Thuthuzela Care Centre	Khayelitsha TCC, Case Manager	Cape Town, South Africa audrytcc@gmail.com	In-person
Tabisa Gae	Thuthuzela Care Centre	Khayelitsha TCC, Victim Assistant Officer	Cape Town, South Africa matabie386@gmail.com	In-person
Genine A. Josias	Thuthuzela Care Centre	Khayelitsha TCC, Medical Coordinator	Cape Town, South Africa Genine.josias@westerncape.gov.za gajosias@mweb.co.za	In-person

TABLE 10: KEY INFORMANTS INTERVIEWED IN SOUTH AFRICA (MEETINGS HELD IN PRETORIA, JOHANNESBURG AND CAPE TOWN)

Name	Program	Implementer	Location of Interview and Contact Information	Method of Contact
Yumisa Lancia	Thuthuzela Care Centre	Mosaic, Psycho-social Counselor	Cape Town, South Africa	In-person
Busiswa Munwa	Thuthuzela Care Centre	Mosaic, Psycho-social Counselor	Cape Town, South Africa	In-person
Esther Olga Mashia	IMAGE	USAID/South Africa, Youth And Prevention Specialist, Health	Pretoria, South Africa omashia@usaid.gov	In-person
Lufuno Muvhango	IMAGE	IMAGE, Program Manager	Johannesburg, South Africa lufunok@gmail.com	In-person
Dr. Paul Pronyk	IMAGE	IMAGE, Technical Advisor	New York, USA paulpronyk@gmail.com	Skype
Dr. Charlotte Watts	IMAGE	IMAGE, Technical Advisor London School of Hygiene and Tropical Medicine, Health Policy Unit, Department of Public Health and Policy	London, UK Charlotte.Watts@lshtm.ac.uk	Skype
John De Wit	IMAGE	Small Enterprise Foundation, Managing Director	Tzaneen, Limpopo, South Africa	Skype

PROMUNDO PROGRAM H REPLICATIONS

ANNEX D

TABLE 11: PROGRAM H REPLICATIONS

Country	Implementer	Name of Adaptation
Belize	*N.A.*	Program H
Bolivia	World Vision	Program H
Bosnia and Herzegovina	CARE International	Budi muško
Brazil	Instituto Promundo, Instituto Papai, ECOS Comunicação em Sexualidade	Program H
Burundi*	CARE International	Abatangamucho
Canada	*N.A.*	*N.A.*
Chile	CulturaSalud	Program H
Colombia	Profamilia	Program H
Costa Rica	*N.A*	Program H
Croatia	CARE International	Budi muško
Democratic Republic of Congo*	Women for Women International	Kundi Ya Wababa Waponyaji
El Salvador	Secretaria de Inclusion Social	Program H
Ethiopia	Hiwot and Engender Health	Male Gender Norms Initiative
Guatemala	*N.A.*	Program H
Jamaica	Youth Now and the Family Planning Association	Program H
India	Population Council	Yaari Dosti
Ivory Coast	*N.A.*	*N.A.*
Kosovo	CARE International	Klubi Bonu Burre
Mexico**	Salud y Genero	Construyete
Mozambique	Men for Change Network (HOPEM)	Men for Change Campaign
Namibia	*N.A.*	Male Gender Norms Initiative
Nepal	*N.A.*	*N.A.*
Nicaragua	Asociación de los Municipios de Nicaragua (AMUNIC) and Centro de Estudios y Promoción Social (CEPS)	Program H
Pakistan	Rozan	Humqadam
Panama	*N.A.*	Program H
Peru	INNPARES and UNFPA	Program H
Rwanda	Rwanda Men's Resource Center	Bande Bereho
Serbia	CARE International	Budi Muško
Tanzania	FHI 360 FHI Tanzania	*N.A.*
Vietnam	*N.A.*	Kaka Wa Leo

** These implementations were partial adaptations of Living Peace, which is a combination of Program H and new therapeutic elements. Living Peace was integrated into ongoing programming. **This adaptation was integrated into Contruye Ti, which is a larger program.*

SECTOR LESSONS

ANNEX E

TABLE 12: SCALING UP OF GBV INTERVENTIONS

Sector	Sector Lessons For GBV Interventions
HEALTH	• Using a human rights learning approach adapted to local context and utilizing a holistic approach when scaling-up work with diverse communities can positively affect many aspects of program beneficiaries' lives, and contribute to the overall development of the community (*One Man Can, Community Empowerment Program*). • Scaling up on a large scale is beyond the scope of a single organization. Large scale-up efforts are possible through effective advocacy, networking and coordination of efforts so that the benefits are widely spread (*Stepping Stones*). • When scaling up programs that use group-education activities, matching the facilitator to the participants by age and sex is important so that they may feel free to communicate; continual training of fieldworkers and intervention facilitators is recommended (*Stepping Stones*). • Community mobilization is a process that requires resources, and should be prioritized while scaling-up. (*Stepping Stones*). • Community cooperation is central to scaling up. To ensure community support, the process must address issues of concern and value to them. Program coordinators scaling up GBV interventions must invest time and effort in explaining the proposed study to build strong community involvement (*Stepping Stones, Community Empowerment Program*). • Research instruments, program elements, and educational materials validated in other settings must have their validity established in local settings. Involving field workers in validating and translating instruments greatly increases their depth of understanding of the instrument and resultant data quality (*Stepping Stones, Community Empowerment Program*). • To scale-up effective 'edutainment' programs that foster social change in the area of women's rights, including SRHR and GBV, strategic partnerships and alliance building with partner organizations, stakeholders and other key civil society organizations, media broadcast industry and private sector are essential (*Soul City, One Man Can*). • Global collaboration and partnership building create a space for debate and learning and provide economies of scale, a global network to address common issues, coherence of approach, and opportunities to share and exchange ideas and information (*Soul City, One Man Can*). • It is important that scale-up does not compete with other national or regional efforts to address GBV, but complement and strengthen them (*Soul City, One Man Can, Community Empowerment Program*). • Sharing materials and individual program elements with others, and disseminating lessons learned, best practices, challenges and past experiences from scale-up is essential for successful scale-up elsewhere (*One Man Can, Soul City, Stepping Stones).*

TABLE 12: SCALING-UP OF GBV INTERVENTIONS

Sector	Sector Lessons For GBV Interventions
YOUTH AND EDUCATION	• When developing and implementing pilot programming, keep future expansion in mind–developing a scale-up plan during the project design phase can provide roadmap for future expansion (*Berhane Hewan*). • When scaling up programs centered on the use of training manuals, curricula, and workshops; it can be useful to change characters, modify story lines and examples, as well as alter the format and content of a few exercises to better fit local context (*Program H*). • Collaboratively designing and implementing activities as well as learning among concerned parties generates a sense of ownership, and enables scale-up to be widely accepted and supported (*Program H*). • Collaboration among partner organizations through the provision of resources facilitating the day-to-day activities of a scale-up, and collaboration with government agencies that implement, integrate, or coordinate programming can result in rapid scaling and the coverage of vast areas in relatively short periods of time (*Ishraq*). • It is strategic when scaling up to ensure inclusive decision making processes and strong partnerships with civil society in order to expand or replicate programs (*Ishraq*). • When expanding a program, it is strategic to develop a proposal for the scale-up as well as include scale-up coordinators (mentors) to oversee development, implementation, reporting, and all financial and program scale-up activities. Such designated program staff can recruit, mobilize, and sensitize community members (*Berhane Hewan*). • When scaling up, conduct additional analysis of survey data to identify any further community needs or project challenges in order to add new components to the program and to ensure program sustainability (*Berhane Hewan*). • When expanding programs systematically consider eliminating, retaining, or adding components to to reinforce its success (*Berhane Hewan*). • Involve youth through innovative and meaningful ways in program and scale-up design (*Program H, Yaari Dosti*). • Consider multi-session group educational activities that promotes a critical reflection among youth about gender norms related to GBV (*Stepping Stones, Program H*) as well as integrated interventions that combine group education with community-based or mass media campaigns (*Soul City, Program H).*

TABLE 12: SCALING-UP OF GBV INTERVENTIONS

Sector	Sector Lessons For GBV Interventions
DEMOCRACY AND GOVERNANCE	• Democracy and governance structures plays a significant role in addressing GBV, by implementing laws against GBV and institutionalizing and coordinating a multi-sector response to GBV. *(Mobile Courts, Isange, TCCs, GRIP, Romania project).* • Greater scale and institutional sustainability were more likely to be achieved when the government adopted the model into its own development plans and budgets, coordinating important police, legal and health services offered with different ministries at both the central and decentralized levels. *(TCCs, Isange, Romania project).* • Sustainability is often supported through Sector-Wide Approach Programs (SWAPs) or gender responsive budgeting processes targeting GBV programs. *(TCCs, Isange, Romania project).* • It was crucial that government structures be supported by NGOs with a direct outreach to communities that implement prevention activities and support victims to access government services. *(Mobile Courts, TCCs, Isange, GRIP, Romania project).* • Legal recourse to GBV victims in remote areas may be provided by scaling up mobile gender courts as a cost effective and efficient justice sector response. *(Mobile courts).* • NGOs, including volunteer based organizations, play an important role in building government capacity for services and help reduce costs in addressing GBV. Including small stipends for survivors and volunteers (for transportation, food, shelter) to enable them to attend court and follow through with prosecution increases the chances that a greater number of victims have access to legal redress. *(Mobile Courts, TCCs, GRIP).* • A long time frame is necessary for scaled-up interventions to address GBV as the institutions often reflect the society and sensitization to the change required in not accepting GBV crimes as an inevitable part of societies is often slow. *(TCCs, GRIP, Romania project)* Supporting gender champions inside and outside government is an important strategy for addressing GBV response and prevention activities. (*TCCs, Romania project*). • Investment in research, information and M&E systems produces long-term dividends and also allows cost-effective sharing of information and coordinating services across a range of stakeholders who support GBV victims *(TCCs, Isange, Romania project).* • Coordinating efforts with national government, other donor agencies, national and international organizations, and different programs within USAID builds a multiple change process (e.g. in South Africa, a program supports a judicial change process, another the TCCs and complementing it, PEPFAR supports the health inputs required for GBV survivors, following a systematic approach to scaling-up) *(Mobile courts, TCCs, Isange, Romania project).*

TABLE 12: SCALING-UP OF GBV INTERVENTIONS

Sector	Sector Lessons For GBV Interventions
ECONOMIC GROWTH	• Scaled-up economic livelihood interventions must include a specific objective to reduce GBV, a gender/GBV strategy based on an explicit Theory of Change, and specific output and outcome indicators to measure GBV results against a baseline. *(IMAGE, POWER/ISARO)*. • Programs aiming to empower women economically should be attentive to the issue that men who perceive themselves to be economically vulnerable are already, in some settings, more likely to commit gender-based violence, and must strategize to scale-up by additionally targeting poor men *(IMAGE, POWER/ISARO)*.[34] • In order to reduce conflict due to women's economic empowerment and changing power structures within households, a scale-up needs to include a two pronged strategy against GBV--women's empowerment coupled with engaging men as allies. *(IMAGE, POWER/ISARO)*. • Adding GBV prevention activities through group education and community-based campaign activism, can be relatively easily combined with women's economic empowerment activities when adequate resources and training for staff are available *(IMAGE, POWER/ISARO)*. • Innovative approaches and collaboration of various stakeholders may be required because organizations focused on livelihoods might not have the capacity to address GBV on a larger scale. *(IMAGE, POWER/ISARO)*. • Conditional cash transfers represent low cost GBV strategies especially when integrated into already established networks of health facilities such as the rural ICDS network in India. (*ABAD/Ladli*) • A rigorous monitoring and evaluation process is needed to capture the impact of economic livelihood interventions on the prevalence at different scales of GBV in areas such as domestic violence, early childhood marriage, and rape affecting vulnerable groups of women such as adolescents, female headed households and sex workers. *(IMAGE; ABAD/Ladli; POWER/ISARO)*. • Support action-oriented research at different scales to enable practical interventions to achieve lasting progress in reducing violence (*IMAGE; ABAD/Ladli; POWER/ISARO)*. • Research organizations are good candidates for high quality support for monitoring and evaluation and impact evaluation (*IMAGE)*. • Promote South-to-South collaboration for scaling up *(IMAGE; POWER/ISARO)*.

34. If economically marginalized men view their traditional roles as 'heads' of households being eroded by women's income-generating activities, there is a need to engage them in a deliberate questioning of such roles. An approach to women's economic empowerment would suggest that activities to engage men at the community level in questioning and ending gender-based violence should be part of all women-focused activities by building on those interventions that have shown evidence of changes in men's attitudes and behaviors related to gender-based violence.

RESOURCE GUIDE

ANNEX F

Detailed below is a selection of literature from the extensive literature review which was conducted to inform this toolkit. These resources may serve as a useful reference on scaling-up development interventions that address GBV.

General Resources for Scaling-up Interventions:

Bird, B., & Gray-Felder, D. 2001. Conceptual Framework-Planning Model. The Rockefeller Foundation, on Communication Initiative

Hartmann, A., & Linn, J. 2008. Scaling up: A Framework and Lessons for Development Effectiveness from Literature and Practice [Working paper]. Washington, DC: The Brookings Institution.

Hornick, R. 1990. Alternative models of behavior change. Annenburg School for Communication. Working Paper, 131, 3–4.

MSI. 2012. Scaling Up – From Vision to Large Scale Change – Tools and Techniques for Practioners. Coffey International.

United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). 2012. Key theoretical models for building a comprehensive approach.

Resources for Scaling-up Interventions in the Health Sector:

Barker, G., Ricardo, C., Nascimento, M., 2007. *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from Programme Interventions.* World Health Organization, Geneva

Central Bureau of Investigations (CBI). (2003) *Report on Human Trafficking*. By Anurag Garg, DIG, Central Bureau of Investigations, India.

CORE Group. 2005. "Scale" and "Scaling-Up" A CORE Group Background Paper on "Scaling-Up" Maternal, Newborn and Child Health Services. July 11, 2005.

Doyal L., Anderson, J., and Paparini. S. 2009. You are not yourself: exploring masculinities among heterosexual African men living with HIV in London. Soc Sci Med 68: 1901-1907.

Dunkle, K., Jewkes, R., Nduna, M., Levin, J., Jama, N., Khuzwayo, N., Koss, M., and Duvvury, N. 2006. *Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa*. *AIDS* 20*:* 2107-2114.

Dworkin, S., Christopher Colvin, Abbey Hatcher and Dean Peacock. 2012. Men's Perceptions of Women's Rights and Changing Gender Relations in South Africa: Lessons for Working with Men and Boys in HIV and Antiviolence Programs. Gender & Society 2012 26: 97.

Gilson L, Schneider H. 2010. Managing scaling up: what are the key issues? Health Policy Plan 25: 97–98.

Hargreaves, J., et al. 2008. *What happens after a trial? - Replicating a cross-sectoral intervention addressing the social determinants of health: the case of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE).* London: London School of Hygiene.

Hargreaves, J., Morison, L., Kim, J., Watts, C., Bonnel, C., Porter, J., Watts, C., Busza, J., Phetla, G., Pronyk, P., *J. Epidemiol. Community Health* 2008; 62;113-119.

Heise, L. 1998. Violence against Women: An Integrated, Ecological Framework. *Violence against Women* June 1998 4: 262-290.

IJM. 2004. *An Initiative to End Commercial Sexual Exploitation, A Plan for Expansion of our Operational Field Presence (OFP) in India, Technical Proposal.*

Jewkes, R. Nduna, J. Levin, N. Jama, K. Dunkle, A. Puren, and N. Duvvury. 2008. Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ 337: a506.

Jewkes, R., Sikweyiya, Y., Morrell, R., and Dunkle, K. 2009. *Understanding men's health and use of violence: interface of rape and HIV in South Africa.* Pretoria: Medical Research Council.

Management Sciences for Health. 2002. *Ten dimensions of scaling-up reproductive health programs: an introduction.* USAID.

NPA-IDMT. 2009. *Report on the Ist Sexual Offences Indaba, 21-23 April, 2008* held at Helderfontein Conference Centre, Bryanston, Johannesburg. Report prepared by Pumeza Mafani and Adv. Brandon Lawerence. Supported by NAP, UNICEF, USAID, and the Danish Government.

One Love. Talk. Respect. Protect. Preventing HIV in South Africa. Campaign Booklet, The Soul City Institute for Health and Development Communication: Information Brochure.

Rohrs, S. 2011. "I feel for rape survivors, but I don't have the time, I'm always running" – Barriers to Accessing Post Rape Health Care in South Africa. University of Cape Town: Gender Health and Justice Research Unit.

Rose, M.L. 2012. *Red Light City: Sex Workers Experiences in the City of Joy*.

Sonke Gender Justice Network. One Man Can: Working with Men and Boys to Reduce the Spread and Impact of HIV and AIDS. Manual. Sonke; Cape Town.

Soul City. 2001a. Soul City 4 Impact Evaluation: Violence Against Women – Vol I. Johannesburg.

Soul City. 2001b. Soul City 4 Impact Evaluation: Violence Against Women – Vol II. Johannesburg.

UNAIDS. 2010. *Report on the global AIDS epidemic.* Geneva: Joint United Nations Program on HIV/AIDS.

Verma R K, Mahendra VS, Pulerwitz J, Khandekar S, van Dam J, Flessenkaemper S, Rangaiyan G, Barker G; 2005. *From Research to action: Addressing Masculinity as a strategy to reduce HIV risk behavior: From Research to Action.* Indian Journal of Social Work (special issue); January.

WHO. 2009. Practical Guidance for Scaling Up Health Service Innovations. WHO Geneva.

World Health Organization/London School of Hygiene and Tropical Medicine. 2010. *Preventing intimate partner and sexual violence against women: taking action and generating evidence.* Geneva, World Health Organization.

Resources for Scaling-up Interventions in the Youth and Education Sector:

Achyut P., Bhatla N., Khandekar S., Maitra S. and Verma R.K. 2011. Building Support for Gender Equality among Young Adolescents in School: Findings from Mumbai, India. ICRW, New Delhi.

Bradshaw D, Bourne D, Nannan N. 2003. *What are the leading causes of death among South African children? MRC* Policy Brief, No. 3, December 2003.

Coburn, C., Rethinking Scale: Moving Beyond Numbers to Deep and Lasting Change, Educational Researcher, Vol. 32, No. 6, pp. 3–12, August/September 2003.

Friere, P. 1968. *Pedagogy of the Oppressed.*

ICRW. 2011. Gender Equality Movement in Schools. Training Manual for Facilitators. New Delhi: ICRW.

Jowett, A. 2010. Paths to Scaling-up through Replication: An Educational Perspective *POLIS Journal* 2010 4.

Namy, S., Heilman, B., Stich, S., Edmeades, J. 2014. Be a Man, Change the Rules! Findings and Lessons from Seven Years of CARE International Balkans' Young Men Initiative. Washington, D.C.: ICRW.

Resources for Scaling-up Interventions in the Democracy and Governance Sector:

Cooper C., Goodsmith, L., Lotter, E., Molony, T. 2010. Communication, Participation and Social Change: A review of communication initiatives addressing gender-based violence, gender norms, and harmful traditional practices in crisis-affected settings. American Refugee Committee, USAID, and Communication for Change; September 2010.

Skumisa. 2011. *The Sexual Offences Indaba 2011: What is the Department of Justice Working on?*

U.S. Department of State. 2002. *Human Rights Report.*

USAID/Zambia. 2010. *Gender – Based Violence Programming Evaluation*. Report prepared by DevTech Systems Inc. Lusaka, Zambia. http://transition.usaid.gov/our_work/cross-cutting_programs/wid/pubs/Zambia_GBV_Programming_Evaluation_Aug-2010.pdf

USAID: Summary of Gender-Based Violence Support to the Government of South Africa.

USAID and AIDSTAR-One

USAID. 2011 Gender Based Violence Assessment Report, South Africa. Washington, DC

Resources for Scaling-up Interventions in the Economic Growth Sector:

Ashe, J., Hirschland, M, Burnett, J. 1992. Access to Credit for Poor Women: A Scale-Up Study of project Carried Out by Freedom from Hunger in Mali and Ghana. USAID.

Hargreaves, J., Hatcher, A., Strange, V., Phetla, G., Busza, J., Kim, J., Watts, C., Morison, L., Porter, J., Pronyk, P., Bonnel, C. 2009. Group-microfinance and health promotion among the poor: six-year process evaluation of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in rural South Africa

Pronyk P, Kim J, Abramsky T, et al. (2008) A combined microfinance and training intervention can reduce HIV risk behaviour among young female participants: results from the IMAGE Study.

Simanowitz, A. 2008.Combining microfinance and training on gender and HIV – a proven approach to reduce poverty and halve violence against women. Brighton, UK: Institute of Development Studies.

Resources from the Case Studies:

Community Agency for Social Inquiry (CASE). 1994. *"Let the Sky To Be the Limit" Soul City Evaluation Report*. Johannesburg.

Colvin, C. Human, O. Peacock, D. 2009. Report on Formative Research Conducted for Sonke Gender Justice Network's "One Man Can" Campaign. Sonke Gender Justice Network.

NPA. 2012. *Annual Report 2011/12*. South Africa Government Pretoria, South Africa.

NPA. n.d.. *Thuthuleza Care Centres Brochure*.

Uvin, P. Jain, P & Brown, L. 2000. *Scaling Up NGO Programs in India: Strategies and Debates*. Institute for Development Research. Volume 16, Number 6; 2000.

Population Council, 2006. *Yaari Dosti Young Men Redefine Masculinity. A Training Manual.* New Delhi: Population Council.

Sideris, Tina. 2004. You have to change and you don't know how!: Contesting what it means to be a man in a rural area of South Africa. Journal of African Studies 63: 29-49.

Sonke Gender Justice Network. 2011. *The MenEngage Africa Network Regional Organizational Survey.* Sonke and MenEngage; South Africa, March 2011.

Usdin, S., Scheepers, E., Goldstein, S., Japhet, G. 2005. Achieving Social Change on Gender-Based Violence: A Report on the Impact Evaluation of Soul City's Fourth Series. *Soc Sci Med*. 2005; 61(11):2434-45.

Unpublished paper obtained through a personal email exchange with Sonke's staff members in December 2012: *Sonke's Reach, Impact and Sustainability Report.* November, 2012.

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