

**USAID/Eastern and Central Africa,
UNICEF/East and Southern Africa
Regional Office's**

**Strategic Framework
for the Prevention of
and Response to
Gender-based Violence
in Eastern, Southern
and Central Africa**



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Strategic Framework for the Prevention of and Response to Gender-based Violence in Eastern, Central, and Southern Africa

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Executive Summary

Gender-based violence (GBV) is emerging as a serious global health, human rights, and development issue. It is a symptom of underlying gender inequalities and power imbalances, and it is a worldwide phenomenon—one that transcends the bounds of geography, race, culture, class, and religion, touching virtually every community in every corner of the globe. Too often condoned by custom and reinforced by institutions, GBV thrives on impunity. Today, as in history, violence against women may constitute one of the “most universal and unpunished crimes of all.”¹ According to the 1993 World Development Report, violence is as serious a cause of death and incapacity among women of reproductive age as cancer, and a greater cause of ill health than traffic accidents and malaria combined.²

GBV is defined by the Interagency Standing Committee Task Force on Gender and Humanitarian Assistance as a

...term for any harmful act that is perpetuated against a person’s will and that is based on socially ascribed (gender) differences between males and females.³

Purpose of the Strategic framework

The purpose of the strategic framework is to assist the United States Agency for International Development Office for Eastern and Central Africa (USAID/ECA) and the United Nations Children’s Fund East and Southern Africa Regional Office (UNICEF/ESAR), along with governments and civil society in the eastern, central, and southern Africa region (referred to in this document as ECA/ESA in order to include all areas of operation of both UNICEF and USAID), to improve and expand their programmatic efforts to prevent and respond to GBV. The Strategic Framework provides a “road map” for developing comprehensive programming to address the needs of survivors of GBV, as well as to address prevention efforts, in the five key sectors and at multiple levels. The strategic framework also can serve as a tool to advocate for more broad-based initiatives.

This strategic framework has been reviewed by USAID, UNICEF, United Nations Fund for Population (UNFPA), and United Nations Development Fund for Women (UNIFEM) representatives as well as key local partners and bilateral missions.

Process

The strategic framework builds on an extensive literature review covering 21 countries in the ECA/ESA region. The review identified current GBV-related data and examined existing and promising interventions. A survey was also disseminated to field staff of key partners to ascertain the level of current GBV programming and perceived gaps in programming. To facilitate the collection of more in-depth data, three countries (Angola, Ethiopia, and Tanzania) were selected for field-based assessments.

Scope of the Problem

GBV encompasses a wide range of violent actions. While men and boys may be subject to certain forms of GBV, the term is often used to refer specifically to violence against women and girls because their socially unequal positions in society mean they are the primary victims of GBV. Recognizing their special vulnerability, this strategic framework focuses on GBV as it affects girls and women.

Types of GBV that have been investigated for the strategic framework include:

- Intimate partner violence, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behavior in the context of marriage or other intimate relationships
- Rape and sexual assault
- Sexual coercion and harassment
- Sexual violence and exploitation in the context of armed conflict
- Child marriage
- Female genital mutilation/cutting
- Trafficking and sexual exploitation

There are significant costs to individuals from the consequences of GBV. Survivors of GBV often face acute and chronic physical and mental health problems. There are also costs to societies. Violence against women drains a country's existing resources and handicaps women's ability to contribute to social and economic progress. In the words of the United Nations Secretary-General, any society that fails to take measures to protect the safety and well-being of half its members "cannot claim to be making real progress."⁴

The Political and Legal Challenges of GBV

The existence and/or enforcement of anti-GBV measures vary widely across the region. Even comprehensive laws cannot prevent GBV or protect GBV survivors if they are not enforced and perpetrators are not convicted. Small budgets, lack of political commitment, women's low awareness of their legal rights, and general public resistance to improving women's rights are all obstacles to addressing GBV.

These obstacles are exacerbated in countries subject to chronic conflict and government instability. In the ECA/ESA region, conflict is concentrated in the Great Lakes and the Horn of Africa. USAID's Fragile States Strategy states that "data show a strong correlation between state fragility and inequitable treatment of women." Further, the conditions of fragility both increase the prevalence of GBV and make addressing it more difficult.

Strategic Programming Framework

For donors, governments, and civil society programs to contribute to the reduction of GBV among affected populations in the region, the following approaches to programming are recommended:

- Implement a multilevel approach to address GBV by (1) writing, adopting, and enforcing protective laws and policies; (2) improving health, legal/justice, security, education, and social welfare systems to monitor and respond to GBV; and (3) ensuring prompt and compassionate services to survivors;
- Implement a coordinated multisectoral approach among donors and other organizations and across sectors; and
- Mobilize communities to create and maintain social norms to change GBV behaviors.

Strategic Priorities

Any sustained effort to reduce GBV must work to transform the unequal relations of power that perpetuate it. Strategies should also include:

- Engaging all stakeholders—from the community level to the national government level—to ensure widespread commitment to eliminating GBV;
- Working with men, especially male youth, to change attitudes and behaviors;
- Filling research gaps on the pervasiveness and character of GBV in different ethnic, religious, class, and institutional contexts to better inform advocacy efforts and program design; and
- Developing better indicators and collecting better service delivery data for monitoring and evaluation, ongoing program assessment, and ongoing program improvement.

Next Steps

Reducing GBV requires long-term, holistic and coordinated efforts of multiple stakeholders and sectors. Too often, GBV projects are short-term, driven by donor interest in a particular issue or sectoral response and are not strategically designed to ensure comprehensive programming. This strategic framework is an attempt to encourage donors and programmers to recognize that effective programming must be broad-based and informed by an analysis of gaps and priorities in the target community. Taking into account the strategic advantage of individual donor organizations, the proposed interventions will need to be implemented in concert, with ongoing coordination and strategic planning among all partners involved.

Abbreviations

AIDS	acquired immune deficiency syndrome
CEDAW	Children Convention on the Elimination of all Forms of Discrimination against Women
CRC	UN Convention on the Rights of the Child
DRC	Democratic Republic of the Congo
ECA/ESA	eastern, central, and southern regions of Africa
FGM/C	female genital mutilation/cutting
GBV	gender-based violence
GHAJ	USAID Greater Horn of Africa Initiative
HIV	human immunodeficiency virus
IAC	Inter-African Committee on Traditional Practices Affecting the Health of Women
IASC	Inter-Agency Standing Committee of the United Nations
ICPD	International Conference on Population and Development
IDP	internally displaced person
MTSP	UNICEF Medium Term Strategic Plan
NGO	nongovernmental organization
OCHA/IRIN	United Nations Office for the Coordination of Humanitarian Affairs/Integrated Regional Information Networks
PEPFAR	President's Emergency Plan for AIDS Relief
SFA	Strategic Framework for Africa
STI	sexually transmitted infection
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Fund for Population
UNHCR	United Nations High Commissioner for Refugees
UNICEF/ESAR	United Nations Children's Fund/East and Southern Africa Regional Office
UNIFEM	United Nations Development Fund for Women
USAID/ECA	United States Agency for International Development/Office for Eastern and Central Africa
WHO	World Health Organization

I. Rationale for the Regional Gender-based Violence Strategic framework

Over the past year, the United Nations Children’s Fund/East and Southern Africa Regional Office (UNICEF/ESA)—in collaboration with the United Nations Development Fund for Women (UNIFEM)—and the United States Agency for International Development/Office for Eastern and Central Africa (USAID/ECA) have independently held meetings during which regional representatives called for an expansion of efforts within their respective agencies aimed at combating gender-based violence (GBV) at the local, national, and regional levels. As a result, UNICEF/ESA and USAID/ECA agreed to jointly conduct a literature review and undertake country assessments across the eastern, central, and southern Africa regions to identify and build on best practices related to addressing GBV. The aim of these activities was to develop a regional GBV strategic framework that can be used by their agencies to inform future action. Although UNIFEM already has a GBV strategy for Africa, it nevertheless agreed to contribute resources and expertise to the USAID/UNICEF strategic framework development process. UNFPA also agreed to support the design of the strategic framework by facilitating collaboration with UNFPA field offices in the region. These activities have culminated in the development of this *Strategic framework for the Prevention of and Response to Gender-based Violence in Eastern, Central, and Southern Africa*.

II. Purpose of the Strategic framework

The purpose of the strategic framework is to improve donor, government, and civil society efforts to prevent and respond to gender-based violence in the eastern, central, and southern regions of Africa (ECA/ESA). The partners collaborating on this effort recognize that neither human rights nor economic and social development goals can be reached in societies where gender inequality is both an accepted norm and a frequent excuse for interpersonal violence and discrimination. The partners further recognize that violence based on inequitable gender norms is most often directed toward girls and women. To address this situation, this proposed strategic framework promotes implementing activities that confront factors that deny girls and women safety from violence.

III. Background

A. Conceptual Framework

Over the last 20 years, gender-based violence has been increasingly recognized as a serious global health, human rights, and development issue. A growing body of research confirms that GBV has significant consequences, especially for girls and women’s physical, sexual, and mental health, as well as implications for the health and well-being of families and communities.

The definition of gender-based violence used in this strategic framework paper is from the Interagency Standing Committee Task Force on Gender and Humanitarian Assistance:

“Gender-based violence is an umbrella term for any harmful act that is perpetuated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/child marriage; and harmful traditional practices such as female genital mutilation, honour killings, widow inheritance, and others.”⁵

While GBV may take many forms, around the world it disproportionately impacts women and girls because of their subordinate status *vis-à-vis* men and boys. Both tacit and explicit acceptance of violence against women within laws, institutions, families, and communities is a manifestation of and an enforcing factor of gender inequality.⁶ Inequalities of power between women and men “contribute to an environment that accepts, excuses, and even expects violence against women.”⁷

The social mechanisms that contribute to violence against any person on the basis of his or her gendered identity also entrap men and boys in harmful and constricting roles and identities that are being played out in abusive ways.⁸ Men and boys not only feel pressured by their male peers to express their masculinity through acts of violence against women and girls, but also against other boys and/or men. Gender roles further contribute to the fact that men are much more likely to be attacked by a male stranger or acquaintance and women are much more likely to be attacked by a husband, male partner, or other family member.⁹

...[T]he use of sexual coercion and violence against women, unsafe sexual behavior and participation in violence or local insurgencies are often efforts by young men to publicly define or affirm themselves as men. The cultural imperatives of achieving manhood in sub-Saharan Africa (and much of the world) include getting married or forming a family (or being sexual active), and becoming a provider or working.¹⁰

Existing data suggest that gender-based violence is a pervasive human rights, social, and economic development problem in eastern, central, and southern Africa. The type and incidence of GBV, as well as the capacity to prevent its occurrence and to respond to the needs of survivors/victims, vary across the region, as does the availability of studies evaluating the impact of interventions. The scale of GBV, however, suggests that programming is not sufficient to adequately address the problem.

B. Methodology of Strategic Framework Development

The strategic framework is based on a review of existing literature that summarized research findings and gaps, identified priority issues, and examined promising interventions for GBV prevention and responses in the 21 countries constituting the region.¹¹ USAID and United Nations’ strategy documents and position papers on the region and related topics also informed the literature review. To ascertain the current needs and level of response, the strategic framework development team also distributed a questionnaire to field staff in USAID, UNICEF, UNFPA, and UNIFEM offices throughout the region. The questionnaire probed for GBV risk factors, best practices for prevention and mitigation, and suggestions on local and regional GBV programming. In three countries—Angola, Ethiopia, and Tanzania—the team

conducted field-based situational analyses that included focus group discussions and key informant interviews. The outcomes of all these efforts contributed to defining the strategic framework outlined below.

IV. Nature and Scope of GBV in the ECA/ESA Region

Gender-based violence takes many forms in the region, including physical, sexual, psychological, and economic violence. However, variations in definitions of different types of GBV and the ways they are measured make it difficult to analyze prevalence data, especially in the aggregate across the region. Definitions used in this strategic framework and a brief summary of select data are presented below.

Intimate partner violence. “Any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Such behavior includes:

- Acts of physical aggression—slapping, hitting, kicking, and beating.
- Psychological abuse—intimidation, constant belittling, and humiliation.
- Sexual violence to include forced and/or coerced sexual activity and sexual harassment.
- Various controlling behaviors—isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance,¹² which includes access to money, nutrition, income-generation activities, and medical care.

Country-level population-based studies indicate that prevalence rates of physical intimate partner violence vary from 13 percent in South Africa¹³ to as high as 49 percent in Ethiopia.¹⁴ Levels of sexual violence in intimate partnerships are even higher, varying from 7 percent in South Africa¹⁵ to as high as 59 percent in Ethiopia,¹⁶ with other countries’ rates between 15 percent and 31 percent.¹⁷ Research has demonstrated that throughout the region, it is common for both men and women to view sexual violence in intimate partner relationships as an acceptable way for men to punish women for perceived disobedience, not performing household tasks, or refusing sex.¹⁸

Rape and sexual assault. “Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.”¹⁹ Sexual violence is primarily perpetuated by men against women and girls; however, men and boys are also vulnerable to sexual violence, particularly in conflict situations, as victims of torture, or when segregated in same-sex environments such as prisons or mines.

Popular myths in parts of the ECA/ESA region—as in the rest of the world—include that most rape occurs between strangers, takes place in dark alleys or other remote locations, involves physical brutality, and is provoked by women who, for example, are perceived as acting promiscuously, who dress in a particular style of clothing, or walk alone at night.²⁰ However, studies from countries around the globe show that most sexual violence is perpetrated by someone known to the victim, from casual acquaintances to dating and marriage contexts.²¹ Indeed, research from South Africa suggests that many men see sex with their wives and girlfriends as their right and consider use of force as an acceptable means of initiating sexual activity.²²

Sexual coercion and harassment. “Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail, or other threats—for instance, the threat of physical harm, of being dismissed from a job, or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent—for instance, while drunk, drugged, asleep, or mentally incapable of understanding the situation. It may also occur when a person is legally too young to consent.²³ It may also occur in the context of economic need; a study of adolescents in Zambia found that many girls have sex with their male peers in exchange for money or goods. While the girls acknowledged that poverty is their prime motivator, the boys explained that “having sex with girls is a way of proving that one is a man and it is a means of gaining popularity.”²⁴ In qualitative research undertaken in Zimbabwe, young women acknowledged their powerlessness in sexual relationships: “A woman can refuse but then this woman will run the risk that she will be forced into sex. I would like to change it, but it cannot be done because a woman needs to follow the man.”²⁵

GBV in Schools

The Secretary General’s Study on Violence against Children has drawn international attention to the problem of violence in schools, including GBV. Though education by and large appears to protect girls from GBV, particularly harmful traditional practices, it is not uncommon in the ECA/ESA region for sexual harassment and coercion to take place within the context of schools. GBV in schools can include bullying, sexual harassment, excessive corporal punishment, and/or sexual abuse. It occurs in and around school, as well as on the way to and from school. It may be condoned by parents and teachers alike. A safe schools program in Malawi, for example, found that parents supported sexual exploitation of their daughters by male teachers as a way of generating additional income for the family. In a 2001 study in Uganda, girls felt that women teachers ignored the issue of physical and sexual harassment by boys and male teachers in the school: “The [women] teachers themselves do not challenge sexual harassment in school but just choose to tolerate it, thereby giving a helpless situation to the girls.”²⁶ In a 2001 survey of 560 secondary-school students in Botswana, 67 percent said that they had experienced unwanted touching, pressure for dates, and other forms of sexual harassment. For 25 percent of them, this was a regular occurrence.²⁷

Sexual violence and exploitation in the context of armed conflict. The ECA/ESA region has a long history of conflict, much of it concentrated in the Great Lakes and the Horn of Africa. Although overall more men than women continue to die as a result of conflict, girls and women suffer a myriad of debilitating consequences of war.²⁸ So much so, according to a 2002 report of the Secretary-General of the United Nations, that “women and children are disproportionately targets” and “constitute the majority of all victims” of contemporary armed conflicts.²⁹

Sexual violence has become a common weapon of war throughout the world. Although the analysis of the nature and scope of sexual violence in conflict is incipient, the little data that have been collected are disturbing. Of a sample of Rwandan women surveyed in 1999, 39 percent reported being raped during the 1994 genocide, and 72 percent said they knew someone who had been raped.³⁰ In 2004, UNFPA estimated that 40,000 women had been raped by fighters in the Democratic Republic of the Congo (DRC) over the preceding six years.

About 5,000 cases of rape, corresponding to an average of 40 per day, were recorded in Uvira in 2002.³¹ In recent research in South Kivu, DRC, interviews with 492 women who were sexually assaulted revealed that 79 percent of them had been sexually assaulted by between two and 20 attackers.³² Data from a survey conducted by UNFPA with displaced and repatriated residents of Rumonge, Nyanza-Lac, Kayogoro, Burambi, Buyengero, Buckeye, and Ruhororo, Burundi, show that of 1,575 women surveyed, 19 percent (300 women) were violated or had been raped once and 39.6 percent surveyed had heard of or had witnessed the rape of a minor; 22 percent knew of incidences of forced marriage; 22.6 percent of married women reported they have children from unwanted pregnancies; and 20.5 percent of women were not allowed by their partners to use contraceptives.³³ Women in conflict areas are also subject to higher levels of forced pregnancy, coerced sex, and trafficking.

Girls and women are also at risk for GBV in humanitarian settings. Camps for internally displaced persons (IDPs) or refugees may offer only limited protection from sexual violence. Research undertaken almost 10 years ago among refugees living in camps in Dadaab, Kenya, found that more than 90 percent of those who had been sexually assaulted reported that the rapes had occurred outside the confines of camps when they went in search of firewood and other staples not available in the camps.³⁴ In a study undertaken in Northern Uganda in 2004, a woman living in one of the many IDP camps in the region told investigators “rape is rampant here...A woman was recently harassed by two men who held her legs wide open to observe her private parts and allowed another man to rape her while they observed.”³⁵ Girls and women in these settings are not only at risk from assault by men in and outside of the camps, but also by those charged with their protection. A 2002 report jointly published by Save the Children (United Kingdom) and the United Nations High Commissioner for Refugees (UNHCR) documented allegations against 67 individuals working in 40 aid agencies serving refugees in three countries in West Africa. One young refugee mother told researchers “I have to sleep with so many men to make 1,500 GNF (37 cents) so that I can feed myself and my child. [The locals] pay me 300 (7 cents) each time, but if I am lucky and I get [an aid] worker, he can pay me 1,500.”³⁶



Due to the unending insecurity in northern Uganda, over 1.6 million people currently are living in over 200 camps for IDPs. Residents at the camps report that IDP life has had a disastrous effect on their society. Signs of social breakdown include high levels of promiscuity, substance abuse, unprotected sex, and increased numbers of child mothers. For households headed by women, the difficulties are heightened, leaving them especially vulnerable to sexual abuse and exploitation by men in the camp and in the surrounding community.

Image and text from *Broken bodies—broken dreams: violence against women exposed*, UN Office for the Coordination of Humanitarian Affairs/Integrated Regional Information Networks (OCHA/IRIN), 2005. Aven Torfinn, photographer.

Child marriage. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) defines child marriage as “any marriage carried out below the age of 18 years, before the girl is physically, physiologically, and psychologically ready to shoulder the responsibilities of marriage and childbearing.”³⁷ Many married children and adolescents have been forced into marriage, or may be “too young to make an informed decision about their marriage partner or the implications of the marriage itself.”³⁸ Child marriage constitutes a form of GBV because of (1) the absence of informed consent; (2) the violation of legal age of marriage; and (3) the negative health implications of girls who are married and engage in sexual activity before they are physically and emotionally mature.

On average, one in every three girls between the ages of 15 and 19 is already married in the region, compared with five percent of boys.³⁹ Two out of every three girls in Mozambique will be married before age 18.⁴⁰ In Ethiopia, more than half of all girls are married before age 18 and medical problems associated with early childbearing are rife, including obstetric fistula and an increased risk of contracting HIV. Girls under 15 years of age are five times more likely to die in childbirth than women in their twenties. They also are at a higher risk for obstetric fistula, which can result from prolonged and obstructed labor.⁴¹

Female genital mutilation/cutting (FGM/C). FGM/C includes “full or partial removal of girls’ external genitals, often performed in dangerous, unsanitary conditions and without anesthesia, for cultural or non-therapeutic reasons.”⁴² According to a World Health Organization (WHO) estimate, between 100 and 140 million women and girls in the world have undergone some form of FGM/C.⁴³ Recent analyses reveal that close to 3 million girls and women are cut each year on the African continent, and nearly half are from Ethiopia and Egypt.⁴⁴ FGM/C is practiced in the ECA/ESA region in the DRC, Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, Tanzania, and Uganda. In Eritrea, Ethiopia, and Sudan, FGM/C prevalence ranges from 80 to 97 percent, while in Kenya and Tanzania, it is markedly lower and ranges from 18 to 32 percent.⁴⁵ Care is required, however, when interpreting these figures, since they represent national averages and do not reflect the often marked variation in prevalence among different ethnic groups.

Trafficking. The United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children defines trafficking as “the recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, or the removal of organs.”⁴⁶

The forces of political instability, poverty, and gender-based discrimination place children and women at particular risk for being trafficked for labor and for sex.⁴⁷ The latest edition of the United States’ Department of State Report on Trafficking estimates that 600,000 to 800,000 human beings are trafficked across international borders each year—and these figures do not account for those who are trafficked “internally” from one destination to another within their own countries or communities. The report further estimates that 80 percent of transnational victims are women and girls, and most of them are trafficked into the commercial sex industry.⁴⁸ In many parts of the world, girls 12–15 years old are the most vulnerable to being trafficked.⁴⁹ Epidemics of sexually transmitted infections (STIs), including HIV, have increased the demand

for child prostitutes, who are believed to be less likely to be infected than adult prostitutes. Trafficking in children in the region, especially the Great Lakes region, is of special concern, where girls and boys have been abducted into internal and external conflicts, forced labor, and sexual servitude.⁵⁰

V. Factors Associated with GBV in ECA/ESA Region

A. General Risk Factors

Research on GBV in the ECA/ESA region has only been conducted in a handful of countries and, for the most part, on specific populations within those countries. Although there is little definitive evidence of a direct cause and effect relationship between GBV and particular demographic characteristics (e.g., age or level of education), behavioral factors (e.g., use of alcohol), or socioeconomic factors, there are some associations among a number of these factors and different types of GBV.⁵¹ Leading researchers in the region argue that the two essential factors underlying intimate partner violence are the subordinate status of women and the widespread acceptance of interpersonal violence in society.⁵² Young age, low educational levels, and a dependent economic status impede women's ability to confront the unequal sets of relationships and conditions that allow some men to use violence as a public and private expression of power.

Though poverty does not cause GBV, it may lead girls and women to make choices that put them at higher risk. Many girls and women living in poverty feel they have no choice but to remain in families where they are being abused. Living on the streets or in informal settlements, pursuing domestic work, and engaging in petty trading or sex increases girls' and women's vulnerability to GBV.

Simply being a child can be a risk factor for certain types of GBV and being a girl child elevates that risk significantly. Based on available data, the WHO estimates that approximately 25 percent of girls and 8 percent of boys around the globe have been subjected to some form of child sexual abuse.⁵³ Police statistics from South Africa show that the majority of all reported rapes are committed against girls, a sizeable proportion of whom are under age 12.⁵⁴ In addition, global research indicates that girls are at a much greater risk of incest than boys.



"Rose," age 10, was playing with three girlfriends by the road in her home in Nairobi, Kenya, when she and her girlfriends were seduced inside the house of a local vendor. After raping her three girlfriends, the man turned to Rose, who remembers, "When my turn came, I started feeling scared. I refused to take off my clothes. When he said he would stab me I was scared...He used force with the last girl. Afterwards, he opened the door and warned us that if he heard about what had happened from anyone in the community, he would kill us."

In this photo, Rose holds the syringe she uses to take antiretroviral medication to reduce her chances of contracting HIV from the rape. The treatment will last four months. Before the assaults, one of the four girls already was enrolled in a community health program for children who are HIV-positive.

Cross-culturally, 40 to 60 percent of sexual abuse in families involves girls under the age of 15.⁵⁵ Both boys and girls with physical and/or learning disabilities are particularly vulnerable.⁵⁶

Women with disabilities are also at higher risk for GBV. Research from the United States, for example, indicates they are at a 1.5 times greater risk of sexual victimization than women without disabilities.⁵⁷

As mentioned previously, armed conflict presents a high level of risk for GBV. Girls and women are deliberately targeted for rape, torture, sexual slavery, trafficking, and forced marriages in conflict zones. They may also be abducted by armed militia groups to serve as porters, cooks, “bush wives,” and combatants.⁵⁸

B. Risk Factors Associated with Traditional Practices in ECA/ESA

Several local practices and beliefs further increase women’s and girls’ vulnerability to violence and its negative consequences. Early age of marriage and brideprice abuse, for example, are two forms of GBV that may also increase risk for other types of GBV; both practices have been associated with increased levels of intimate partner violence. Research suggests that sexual assault in marriage may be more common among wives who marry young in part because of power inequities between older husbands and younger wives.⁵⁹ Where brideprice is exchanged in marriage, young girls may be pressured by impoverished family members to marry. In some communities in the region, recent practices put a premium on large brideprice payments for very young girls who are believed to be free of HIV/AIDS and other sexually transmitted infections, unlike older marriage partners.⁶⁰

The tradition of brideprice may also contribute to social norms that excuse violence against women, as husbands may feel entitled to beat or rape their wives because they paid for them. Female participants in focus group discussions in South Africa maintained that the practice of brideprice upholds the belief that women are property and can be bought and sold.⁶¹

Other traditional practices that both reinforce and exacerbate GBV in the region include polygamy, wife inheritance, widow cleansing (where new widows are forced to have sex with a member of their last husband’s family as a cleansing rite after the death), initiation practices, and property rights.

Challenges by women to the existing patriarchal hierarchy may also provoke some men to react with violence against women. The vicious cycle is hard to break, even when women achieve some modicum of economic independence, as sociocultural norms and laws may constrain women’s decisions and actions to leave their violent partners.

VI. Consequences of GBV

GBV is a major cause of morbidity and mortality among girls and women, and violence against women also increases their future vulnerability to ill health. Women’s reproductive, mental, and physical health are clearly affected by GBV. Reproductive health problems may include chronic pelvic pain, vaginal bleeding or discharge, vaginal infection, painful menstruation, sexual

dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infections, STIs, HIV/AIDS, pregnancy complications, unintended pregnancy, abortion, and infertility. Overall physical health problems may include gastrointestinal disorders, acute injuries, and chronic health problems. Mental health consequences may include stress, anxiety, substance abuse, depression, sexual risk-taking, and suicide.⁶² Moreover, there is increasing evidence that children of women who experience violence are at an increased risk of dying before the age of five or suffering long-term physical and emotional disability.⁶³

GBV further incurs considerable social and economic costs to individuals, such as personal insecurity, lost income, and productivity. GBV also has significant costs for the economies of developing countries because of its strain on healthcare and judicial systems, lower worker productivity and incomes, and lower rates of accumulation of human and social capital. Although studies measuring economic costs of GBV have not been conducted in the ECA/ESA region, the Centers for Disease Control and Prevention in the United States estimated expenditures on medical and mental healthcare services for the 5.3 million incidents of domestic violence reported in 1995 to be US\$5.1 billion.⁶⁴

Indirect costs such as the value of foregone earnings in both paid and unpaid work as a result of absenteeism related to GBV may also be significant.⁶⁵ Again data are limited, but in Nicaragua, for example, estimated indirect costs due to interpersonal violence were said to reduce gross domestic product by 1.6 percent or US\$32.7 million.⁶⁶ Few studies have measured costs of sexual violence outside of intimate partnerships in developing countries, but studies from the United States have found the cost of sexual violence to be from \$85,000 per rape in both direct and indirect costs⁶⁷ to \$159 billion in direct, indirect, and non-monetary costs for more than 100,000 jury decisions.⁶⁸

HIV as both a Consequence of and Risk Factor for GBV

Linkages between HIV and GBV are a global concern, but given the particularly high prevalence of HIV and its disproportionate impact on African girls and women, it is an area of critical concern in ECA/ESA. Different forms of GBV, whether perpetrated by intimate partners, family members, acquaintances, or strangers, put survivors at risk of HIV transmission.⁶⁹ Forced sex often results in trauma and tissue tearing that facilitates infection, and threats of force can discourage women from using condoms and/or trying to refuse sex.⁷⁰ Experiencing forced sex also increases the likelihood of future unprotected sex, multiple partners, substance use, and sex work.

Child marriage is another risk factor for HIV. In a recent study undertaken in Rwanda and cited in UNICEF's report on child marriages, 25 percent of girls who became pregnant at age 17 or younger were infected with HIV, even though many reported having sex only with their husbands. According to the study, the younger the age at sexual intercourse and first pregnancy, the higher was the incidence of HIV infection.⁷¹ In rural Uganda, girls 13 to 19 years old who were HIV positive were twice as likely to be married as girls who were HIV negative. For young wives, "abstinence is not an option—those who try to negotiate condom use commonly face violence and rejection."⁷²

Increased HIV rates can also be a contributor to GBV: it is widely felt that as rates of HIV/AIDS in a community rise, GBV increases—stressed and traumatized caregivers are more likely to abuse or neglect their children, and community and government initiatives to prevent GBV and protect girls and women weaken as human and financial resources are drained by the AIDS crisis and as the cultural values and systems that keep vulnerable members of society safe begin to erode. Children orphaned and made vulnerable by AIDS are at an especially high risk. For example, orphaned children may feel that support from a caregiver is conditional on providing sex and not telling anyone about the abuse.⁷³ HIV positive status is also associated with increased incidence of GBV due to violence against women by their partners related to disclosure.

VII. GBV as a Political and Legal Challenge

All of the countries in the ECA/ESA region are signatories to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). In addition, 15 of these 21 countries are signatories to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Article 4 of the protocol states that every woman is entitled to respect for her life and the integrity and security of her person and that all forms of exploitation and cruel, inhuman, or degrading punishment and treatment shall be prohibited. The protocol outlines specific protections for states to take, such as enacting and enforcing laws to prohibit all forms of violence against women, including forced or unwanted sex; adopting legislative, administrative, social, and economic measures as necessary to ensure the prevention, punishment, and eradication of all forms of violence against women; punishing perpetrators of GBV; preventing and condemning trafficking in women and prosecuting perpetrators of trafficking; identifying the causes and consequences of GBV and taking appropriate measures to prevent and eliminate such violence; and providing accessible services for survivors of GBV.

Furthermore, the UN Convention on the Rights of the Child (CRC), to which all countries in the region are party, forbids all forms of violence against children, including child abuse and exploitation, as well as discrimination based on gender. The Optional Protocol on the sale of children, child prostitution, and child pornography also asserts additional government obligations directly relevant to preventing and responding to GBV as it affects those under the age of 18.

However, few countries in the ECA/ESA region have comprehensive legislation protecting girls and women from GBV. Moreover, many countries recognize both constitutional and customary legal systems that are often at odds with statutory laws designed to protect the rights of women.⁷⁴ As a result, the interplay of international accords, national laws, and customary laws creates a paradoxical policy environment.

National laws and policies regulating inheritance rights, marriage and divorce, domestic violence, sexual violence, and harmful traditional practices such as FGM/C and child marriage, vary widely throughout the region. South Africa's Gender-based Violence Policy and Zambia's National Gender Policy are some of the world's most progressive policies; however, in many countries throughout the region there are no provisions pertaining to domestic violence, especially for rape in marriage. Other national laws reinforce discriminatory traditional

practices. Tanzania's laws, for example, permit girls as young as 12 years old to legally marry.⁷⁵

In the absence of enforcement, even the best laws do not prevent GBV or protect survivors. Globally, rape is among the least convicted of all crimes. On average, only 10 percent of all rapists will ever serve a jail sentence, and in many settings, that number is likely to be even lower.⁷⁶ The conviction rate for all rapes reported to the police, whether of a child or an adult, is approximately 7 percent in South Africa.⁷⁷ Research in Zambia has similarly shown that judicial processes rarely result in conviction of alleged rapists. Instead, courts may uphold the rights of the perpetrator and blame the victim.⁷⁸

Where there are laws against intimate partner violence, they often go largely unrecognized, carry light sentences—of which just the minimum is often applied—or are compromised by customary law, which often dictates that husbands may use a certain degree of violence against their wives to discipline them.⁷⁹ Such is the case in Ethiopia, Kenya, South Africa, Tanzania, and Zimbabwe. In some cases, as in Zimbabwe, customary law allows perpetrators of domestic or sexual violence to pay “peace bonds” or a fee to the victim’s family in lieu of other punishment. Families often favor this option, undermining the safety and needs of the victim.⁸⁰

Budgetary constraints, low political commitment, and/or limited popular support of women’s rights and a lack of training for lawyers and judges in the application of relevant laws, policies, and protocols also undermine the implementation of protective legislation. Furthermore, many women have little access to information about their rights and how to negotiate the legal system when their rights are violated.

Working in Settings of Armed Conflict

Over the past decade, there has been an acknowledgment of the extent and impact of GBV during armed conflict and an appreciation that any efforts at post-conflict reconstruction must include programming and policy development aimed at redressing and reducing violence against women and girls. According to USAID’s Fragile States Strategy, “data show a strong correlation between state fragility and inequitable treatment of women.”⁸¹ However, the circumstances of war—indiscriminate violence, population displacement, and non-existent or weakened governments—may not only increase the prevalence of certain forms of GBV but may also make addressing GBV all the more challenging.

In recognition of the special vulnerabilities of girls and women during periods of armed conflict, the United Nations Security Council adopted in 2000 the historic Resolution 1325, which “calls upon all parties to armed conflict to take specific measures to protect women and girls from gender-based violence, particularly rape and sexual violence.” Since that time, the United Nations Secretary-General has submitted two reports to the United Nations Security Council on the implementation of Resolution 1325. While these reports concede that much remains to be done, especially in terms of holding states accountable for the actions of fighting forces and in increasing the level of participation of women in all stages of peace building, they also note that major advances have been made in introducing codes of conduct that establish “zero tolerance” for all United

Nations personnel, including peacekeepers, who might sexually exploit those they are meant to serve.⁸²

Even with Resolution 1325 and other international and agency mandates—such as UNICEF’s Core Commitments for Children in Emergencies—that reinforce international responsibility to prevent and respond to GBV, programming in humanitarian settings is not consistently in place—not because of a lack of strategies but rather a lack of political will and financial and technical support to the populations served. Often, women themselves will create informal networks to provide support to survivors. However, without sufficient resources, these networks are limited in their capacities.

To promote efforts to address GBV in situations affected by armed conflict, the Interagency Standing Committee of the United Nations (IASC) has recently released guidelines for programming from the preparedness stage of an emergency to a stabilized phase. According to the guidelines, “although intervention in the early stages of an emergency should focus on sexual violence, each situation is unique and other forms of GBV should not necessarily be ignored.” In general, however, emergency response involves implementing the most basic services to ensure survivors receive immediate and comprehensive care, as well as implementing basic preventive measures, such as data collection for the purposes of monitoring the problem and advocating for increased levels of protection.

VIII. Key Elements for Prevention and Response to GBV

The strategic framework presented below provided guidance for GBV programming and elaborates on several key areas of attention when addressing GBV. The purpose of the strategic framework is to provide guidelines for introducing and expanding GBV-related prevention and response activities, with the ultimate goal of ending GBV in the ECA/ESA region.

A. Strategic Programming Framework

The factors that contribute to the high prevalence of multiple forms of GBV in the region require responses that target various levels of prevention related to GBV: the first and primary level of prevention is ensuring the adoption and implementation of protective **laws and policies**; the second level of prevention is capacity building in health, legal/justice, security, education, and social welfare **systems** to help prevent, detect, monitor, and address GBV; and the third and lowest level of prevention is ensuring that survivors receive **immediate and comprehensive care** that will reduce the likelihood of long-term negative effects related to GBV, as well as survivors’ vulnerabilities to future incidents of GBV. Implementing simultaneous strategies against GBV across all levels of prevention is critical to any lasting effort toward its eradication.⁸³

In addition to addressing GBV at these multiple levels of prevention, it is also important to institute **multisectoral** approaches. Programming experiences from the field have revealed that no one sector or agency working in isolation can make an impact with its GBV prevention and response activities. The UN and other lead agencies recognize that “at minimum, [services to address GBV must] be the outcome of coordinated activities between the constituent community, health and social services, and legal and security sectors.”⁸⁴ The multisectoral

model calls for holistic inter-organizational and inter-agency efforts across multiple sectors. It is characterized by the full engagement of the local community and interdisciplinary and inter-organizational cooperation, collaboration, and coordination. The goal of collaborative efforts is to create synergy among all stakeholders and to avoid the duplication of efforts.

Community mobilization is another critical area of programming. All members and strata of the community should be engaged in developing and enforcing preventative measures and in recognizing the rights and needs of victims. Individual behavior change is only possible when it is supported and reinforced by social norms.

Primary building blocks of the programming framework are:

1. Laws and Policies: Includes measures at the broadest level to ensure rights are recognized and protected through international, statutory, and traditional laws and policies. Examples include:
 - Substantive and procedural law reform
 - Supporting policy development within ministries of health, social welfare, education, labor, women's affairs, youth, justice, and security
 - Human rights education with policy implementers and traditional and community leaders
2. Systems: Includes systems and strategies to monitor and respond when rights are breached. Intervention at this level includes developing and building the capacity of statutory and traditional legal/ justice systems, health care systems, social welfare systems, and community mechanisms to prevent and respond to GBV. Examples include:
 - Education and training for government and nongovernmental organizations (NGOs) providing health, security, and social welfare services to women and girls
 - Support for national and local-level programs for capacity building, especially to judicial institutions and civil society
 - Technical assistance to government departments
 - Assessment of vulnerabilities of target beneficiaries
 - Coordination of multisectoral and inter-agency efforts
 - Generation of knowledge and information for advocacy
3. Service Delivery: Includes response at the individual level through direct services to meet the needs of women and girls who have been subjected to GBV. Examples include:
 - Community and school-based education and information campaigns about the availability of services
 - Case management, referral, and advocacy
 - Counseling and support
 - Medical forensic examination, treatment, and follow-up
 - Linkage with police and courts
 - Court support through the judicial process

4. Community Mobilization and Individual Behavior Change: Includes raising overall community awareness, mobilizing community-based efforts, providing support for evidence-based advocacy; and conducting mass media campaigns that improve knowledge, attitudes, and practices of community members. Examples include:

- Behavior change programs addressing GBV and gender relations that focus on men
- Use of educational entertainment or ‘edutainment’ programs (radio, television soap operas) to share key GBV messages with the audience
- Use of community-wide meetings, knowledge-building workshops, peer group discussions, and drama to challenge gender inequities related to GBV
- Awareness raising through seminars and workshops with students, their parents, teachers, government officials, and NGOs in relation to GBV in schools

B. Strategic Priorities

Several areas of special consideration when developing programs are outlined below. These areas should be incorporated into all GBV prevention and response strategies, as part of implementing the strategic programming framework.

Promoting and protecting human rights. Violence against girls and women must be recognized as a fundamental violation of their human rights. GBV violates a number of human rights, including the obvious, such as rights to life and security of person and the right to enter into marriage only with full consent, as well as rights indirectly violated, such as the right to a standard of living adequate for health and well-being of oneself and one’s family, the right to be free from discrimination and the right to equal protection before the law.⁸⁵ As signatories to various international conventions such as Convention to End Discrimination Against Women (CEDAW), Convention on the Rights of the Child, Human Rights Committee General Comment #28, the Convention Relative to the Protection of Civilian Persons in the Time of War, etc., countries are obligated to protect girls and women from all forms of GBV such as rape, sexual exploitation and abuse, forced prostitution, etc. By placing GBV in a human rights framework, we can pressure governments to fulfill their obligations and take active measures to punish and prevent such violence.⁸⁶ [Please see Annex 3 for a summary of relevant human rights treaties to which ECA/ESA countries are signatories.]

The foundation of all promising interventions to prevent GBV is attention to gender inequity and an increased understanding of GBV as a human rights problem that is detrimental to the community as a whole.

“True and lasting changes in gender norms will only be achieved when it is widely recognized that gender is relational, that it is short-sighted to seek to empower women without engaging men, and that it is difficult if not impossible to change what manhood means without also engaging young women.”⁸⁷

A programmatic and policy focus on gender equality at different levels of social interaction is essential to reducing the incidence of GBV in the region. To avoid responses that focus initiatives on girls and women solely as “victims,” it is essential to focus on gender relations between men and women and boys and girls and to address patriarchal attitudes and behaviors that reinforce the notion that GBV is acceptable.

Promoting participatory processes that engage all stakeholders. Widespread reform must be instituted from both the *top down as well as bottom up*. Activities that mobilize citizens of communities *and* engage leaders in the community and in institutions are especially successful in changing attitudes and, at least according to preliminary findings, behavior. All planning and implementation of GBV programming and advocacy must include participatory processes that engage communities, including survivors. Without support from the public sector and/or community leaders, interventions may not be taken seriously, and at times, not fully carried out. It also is important to ensure that strong alliances are formed with community-based organizations, tapping into the wealth of knowledge they have gained working against GBV.



Image and text from *broken bodies—broken dreams: violence against women exposed*, OCHA/IRIN, 2005. Brent Stirton, photographer.

Working with men. Working with men is an important factor in preventing GBV. Behavior change strategies in the health sector have shown that gender inequitable attitudes can be unlearned and thereby contribute to healthier relationships. Throughout society and the community in general, men are seen as leaders and are a major force for change. Evidence suggests that coalition building and advocacy are also successful strategies for working with men.

Targeting youth. Programs that work with young men and women have demonstrated more dramatic and sustainable changes in attitudes about the acceptability of gender-based violence. Evidence suggests that youth are more open to change, including their attitudes and behavior regarding violence⁸⁸, gender roles, and masculinity norms. These strategies are most successful when they also engage older community members and leaders.

Research promising programming approaches. There are many gaps in our understanding of the pervasiveness and character of GBV in the region. Research is needed to better understand the relationship of culture, politics, health, conflict, and personal insecurity with the perpetuation and impact of GBV. There is also an urgent need to undertake operations research to assess the effect of different programmatic approaches on preventing and reducing GBV and on changing social norms that are tolerant of violence within relationships and in the society. The emerging evidence on the relationship between GBV and women's risk of HIV also indicates that this is a critical area for more focused research.

Monitoring GBV in the region. Without better national and local data on the impact of GBV prevention efforts and support services, it will be difficult to achieve donor and government commitment to addressing GBV. The priorities for GBV monitoring and evaluation are to (1) gain consensus on definitions of different types of GBV; (2) develop consistent standards across funding agencies in the region for quantitative measurement; (3) create standard indicators; (4) formulate qualitative methods to capture local variation and nuanced differences in contributing factors, experience, and response to GBV; and (5) finance impact evaluations of past and ongoing projects/programs on GBV to identify successful interventions.

Investing in GBV programs and policies over the long term. Policy reform, systems change, behavior change, and community mobilization are complex and lengthy processes that are influenced by many other factors that are difficult to control in the short term. Additionally, helping individuals think through alternatives to violence and creating informal and formal systems of accountability and support are essential for individuals to sustain a change in attitude and behavior.⁸⁹

IX. From Vision to Action

Implementing the strategic framework includes developing multisectoral policies, systems, and services, as well as community support mechanisms to prevent and respond to GBV. This section presents key actions by sector and the level of preventive intervention. Below are some examples of priority actions for ensuring that policies, systems, and services, as well as community mobilization initiatives, are in place to achieve the goal of ending GBV. While recognizing the strategic advantage of individual donor organizations, the proposed interventions will need to be implemented with ongoing coordination and strategic planning among all partners involved.

1. Health (to include mental health response)

Laws and Policies. (1) Create policies that ensure appropriate and consistent health response to survivors of GBV and that ensure access to reproductive health services and HIV testing for everyone, including those under the age of 18; (2) formulate policies to ensure training on GBV and child rights in all medical schools and other educational programs for health professionals; (3) draft policies that ensure a higher number of female doctors and nurses; and (4) develop policies to ensure the support, recognition, and regulation of professionals and paraprofessionals providing mental health services.

Systems. (1) Create and implement training for all health providers on GBV screening, treatment, danger assessment and safety planning, and emotional support, including with children; (2) create standards for upgrading infrastructure to ensure confidentiality and privacy;

(3) ensure adequate funding of services, especially in resource-poor settings; 4) prepare protocols and develop and implement training on victim-friendly forensic examination; and (5) increase the number of accredited professionals and paraprofessionals providing mental health services.

Services. (1) Guarantee access to psychological support services, STI treatment, post-exposure prophylaxis, and emergency contraception; (2) ensure staff have adequate resources, such as screening tools and directories to refer victims to other services, including legal or counseling services; (3) integrate GBV services into antenatal, postabortion, STI, HIV/AIDS and family planning services; (4) guarantee free access to health services for survivors; and (5) ensure that children and adolescents have equal access to child and youth friendly health services.

Community Mobilization. (1) Develop strategies to improve the community response to violence and enlist community groups in efforts to provide sensitive community-based responses to victims and promptly refer them to health services; and (2) integrate GBV and gender activities into HIV/AIDS and reproductive health community-based education and behavior change communication efforts.

2. Legal/Justice

Laws and Policies. (1) Assess all laws for gender equality and compliance with CEDAW and the UN Convention on the Rights of the Child, especially those that affect the capacity of girls and women to extricate themselves and their children from abusive situations. These include laws regulating domestic relations (marriage, divorce, child custody, and inheritance), the criminal code and its treatment of both perpetrators and victims/survivors, property laws, and laws regulating access to financial services; (2) initiate processes to harmonize national and customary laws and practices; (3) support efforts to reform laws that have inadequate or negative impacts on victims/survivors and that tolerate continued acts of violence on the part of perpetrators; (4) support policy reform and advocacy efforts of policymakers who are committed to GBV prevention and response; and (5) support reforms to evidentiary requirements in judicial processes.

Systems. (1) Decrease operational and procedural barriers to women accessing the judicial system; (2) institute reforms to reduce re-victimization of girls and women by the judicial system and, in particular, institute procedures to optimize the credibility of children's testimony; (3) develop curricula to sensitize and train lawyers and judges on GBV and on working with child victims; and (4) improve and monitor the time it takes for the justice system to adjudicate cases.

Services. (1) Upgrade infrastructure and judicial procedures to ensure privacy, personal safety, and confidentiality; (2) improve access to legal services including providing legal aid; and (3) ensure victims advocates are available to assist girls and women through judicial proceedings.

Community Mobilization. (1) Strengthen advocacy and support coalitions to garner civil society and policymaker support for reform of laws, policies, and services in the justice sector; (2) educate women and men on their rights to be free of GBV, their legal entitlements, and how to access legal services; and (3) engage community members and leaders in discussions about the issues surrounding GBV and gaps between local customary and national legal practices.

3. Education

Laws and Policies. (1) Make it mandatory for educators to report child abuse and sexual violence against girls; (2) reform/develop and implement laws and policies on sexual harassment in schools that include stiff sentences and dismissal for teachers who are perpetrators; (3) incorporate into law protections for teachers, students, parents, and others who report GBV; and (4) support policies to ensure universal primary education, gender parity in school enrollment, secondary education for girls, and increased livelihood skills and opportunities for girls.

Systems. (1) Incorporate efforts to prevent and respond to GBV in life-skills curricula and make it mandatory; (2) ensure that all school and teacher training curricula promotes respect for girls' and women's rights; (3) establish standards and procedures for increasing the safety in schools, especially for girls, including codes of conduct for teachers that explicitly prohibit sexual harassment and abuse; and (4) establish a "whole school" approach to addressing GBV—sensitize and train school leaders, teachers, parents, and students as part of this whole school approach.

Services. (1) Establish mechanisms for students, parents, and teachers to report abuse; (2) provide appropriate protection and counseling for survivors without re-victimizing girls; (3) provide life-skills training for boys and girls; (4) use peer group interventions for youth to become sensitized and act as advocates for preventing GBV; and (5) provide support and services to ensure that girls enroll in and stay in school.

Community Mobilization. (1) Raise awareness about GBV and its consequences through seminars, workshops, theatre, radio, and film with students, their parents, teachers, government officials, and NGOs; and (2) conduct community education campaigns on the negative effects of child marriage and importance of girls' successful completion of school.

4. Security

Laws and Policies. (1) Institute legal protections, such as restraining orders, and develop policies for police in responding to GBV; and (2) prepare codes of conduct for military relating to GBV and policies for addressing any breach in those codes.

Systems. (1) Integrate GBV response into all levels of law enforcement, for example by creating special police units for monitoring and responding to various types of GBV incidents; (2) develop protocols for the collection and storage of forensic evidence; (3) create curricula for training police on legislation, how to respond to reported incidents of GBV, and processing victims'/survivors' cases; and (4) institute courses at police training colleges to sensitize and train all police on gender, GBV, and how to work with child victims.

Services. (1) Upgrade infrastructure and processing procedures to ensure privacy, personal safety, and confidentiality; (2) establish protective services, such as the enforcement of restraining orders and referrals to safe houses, health services, and legal services; and (3) improve and monitor the time it takes for police to respond to victims and survivors and to arrest perpetrators.

Community Mobilization. (1) Increase community members' awareness of where and how to report GBV; (2) establish community liaisons with police, as well as civil oversight of police; and (3) advocate for the development of community policing initiatives.

5. Social Welfare

Laws and Policies. (1) Establish laws and policies that ensure the social welfare of girls and women, including inheritance rights, child support, equal rights in marriage, and labor rights; (2) formulate policies that promote women's and girls' access to literacy programs, income-generation opportunities, and services for those who are identified as especially vulnerable, such as child- and female-headed households; (3) formulate policies that ensure that social welfare services targeted for survivors are adequately funded and widely available, such as safe houses, emergency financial support, and childcare assistance; (4) ensure adequate care, support, and protection from additional violence for children who are orphaned and have to leave their families because of violence; and (5) ensure that children and adolescents have equal access to social welfare provisions, particularly income support.

Systems. (1) Build the capacity of social welfare agencies to identify risks to women and girls particularly through increasing the number of accredited social welfare staff and providing services to reduce those risks; (2) build the capacity of social welfare agencies to meet the needs of survivors; (3) establish data collection for and monitoring of social welfare agencies; and (4) create widespread literacy and income-generation programs for women and girls at risk.

Direct Services. (1) Provide supportive counseling and case management through social welfare agencies; (2) create shelters or other housing opportunities for survivors and their children; (3) implement income-generation activities; and (4) facilitate literacy programs.

Community Mobilization. (1) Increase community members' awareness of where and how to access social welfare assistance; and (2) advocate for community members' involvement in the development and expansion of social welfare services for at-risk women and girls and for survivors of GBV.

6. Coordination Within and Across Sectors

Laws and Policies. (1) Ensure respect for the rights of survivors in laws across sectors, including property, inheritance, custody of children, social welfare, financial services, etc., and for those protected by international agreements signed by governments in the region; (2) conduct assessment of how customary laws influence the development, application, and enforcement of national laws that protect GBV survivors or treat perpetrators; and (3) integrate measures to address GBV into workplace policies.

Systems. (1) Promote and support networks that allow civil society and government organizations involved in the prevention and response to GBV to share information and work together to change laws and policies; and (2) integrate GBV awareness and prevention into food security programs, especially in areas of conflict.

Services. (1) Coordinate health, legal, psychosocial, economic, and financial support services for survivors or create integrated service delivery centers; and (2) integrate microfinance programs into survivor services.

Community Mobilization. (1) Integrate GBV awareness activities into economic growth and environmental programs where men's participation is high, e.g., integrate GBV activities into Regional Commodity Networks Training for pastoralists and farmers; (2) engage community members and leaders in advocacy efforts for local services and prevention efforts; and (3) support community-based initiatives to strengthen the social support networks of girls and women.

7. Settings Affected by Armed Conflict

Laws and Policies. (1) Follow international guidelines to address GBV in conflict-affected or refugee settings; (2) create programs that support legal redress and legal reform; (3) develop and implement advocacy action plans based on international law to advocate for local governments and armed groups to protect women, girls, and boys from gender-based violence in conflict-affected settings; and (4) use the opportunity of security sector reform and constitutional reform processes in post-conflict countries to influence policy and legal reforms, working with local partners.

Systems. (1) Integrate GBV prevention into all humanitarian programming, from food distribution to refugee camp design; and (2) form a coordinated network of governments, NGOs, and donor representatives to ensure prompt and appropriate services for survivors of GBV and to develop and monitor comprehensive cross-sectoral programs.

Services. (1) Provide healthcare and psychological and social support for victims; (2) institute community education programs to inform victims about the availability of services; and (3) target vulnerable groups (e.g., unaccompanied children, female-headed households, and child soldiers) for assistance to reduce their risk of sexual abuse and exploitation.

Community Mobilization. (1) Institute widespread community education about the availability of GBV services from the outset of an emergency intervention; and (2) focus on behavior change, such as demobilization and reintegration activities that include orientation and psycho-social support to ex-combatants (and their dependents) that allow for discussions and reflections on reasons for conflict as it relates to gender and men, and (3) develop a network of "peace builders," both male and female ex-combatants, to conduct community conversations and community mobilization activities to change the norms around GBV in their communities.

X. Suggested Regional and Local Implementing Partners

It is important that regional organizations which partners are working with be involved in the implementation of this strategic framework. Their capacity to develop and implement suggested interventions should be strengthened. Existing partners, as well as new partners can be involved in the development and implementation of GBV interventions. Current partners include:

Centre for African Family Studies CAFS)
Regional Centre for Quality of Health Care (RCQHC)
Commonwealth of Regional Health Community Secretariat (CHRCS)
Common Market for Eastern and Southern Africa (COMESA)
Association for Strengthening Agricultural Research in Eastern and Southern Africa (ASARECA)

Raising Voices
Solidarity Centre

Annex 1. USAID/ECA Programming Framework: Gender-based Violence Activities for Transformational and Fragile States

	Economic Growth	Democracy and Governance	Health and HIV/AIDS
Transformational states and areas	<ul style="list-style-type: none"> • Introduce GBV into Regional Commodity Network Training curricula • Develop an early warning system for reporting GBV 	<ul style="list-style-type: none"> • Integrate GBV into vocational training for former military, child soldiers • Build a network of community peace builders • Work with military, police 	<ul style="list-style-type: none"> • Train health providers to recognize and treat GBV • Engage men in preventing GBV • Identify and build the capacity of policy champions to support elimination of GBV • Integrate GBV into survivor services for poor women and orphans
Fragile states and areas	<ul style="list-style-type: none"> • Integrate GBV prevention activities into food security and refugee programs • Train community police and judicial structures to recognize and prevent GBV • Form networks of governments, NGOs, and donors to ensure services for survivors of GBV • Train health workers to identify and treat GBV 		
Holistic strategies for the region	<ul style="list-style-type: none"> • Develop high-level policies/legislation prohibiting GBV • Train journalists to recognize and report on GBV as illegal and against human rights • Support a regional film festival • Collect and analyze data on the prevalence, magnitude, and locations of different kinds of GBV • Form a regional network to prohibit trafficking in the region 		

Annex 2. UNICEF Programming Framework for Gender-based Violence Activities According to Key Programming Areas *

Minimum Response in Emergency Setting	<p>Health and Nutrition</p> <ul style="list-style-type: none"> • Ensure women's access to basic health services • Ensure women's access to treatment for sexual violence, including emergency contraception • Provide community-based psychological support • Implement safe food security and nutrition programs 	<p>HIV/AIDS</p> <ul style="list-style-type: none"> • Provide condoms and ensure condom supply • Manage the consequences of sexual violence, including providing post-exposure prophylaxis • Ensure safe blood supply • Undertake HIV surveillance and identify at-risk populations • Distribute UNAIDS awareness card to local community and international staff, including peacekeepers 	<p>Child Protection</p> <ul style="list-style-type: none"> • Conduct rapid situational analysis on the risks to children and women of exposure to GBV and define protection strategy • Establish coordination mechanisms for monitoring of GBV incidents and ensuring rapid response • Inform community about GBV and the availability of services • Support safe spaces for children and women 	<p>Education</p> <ul style="list-style-type: none"> • Ensure girls' and boys' access to safe education • Establish mechanisms for the prevention of and response to SEA in all education settings
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Holistic Response Transition/Development Settings

- Expand or improve protocols for medico-legal evidence collection
- Integrate GBV medical management into existing health system structures, national policies, programs, and curricula
- Conduct ongoing training and supervision of health staff
- Conduct regular assessments on the quality of care
- Conduct education with peacekeepers, humanitarian staff, and national uniformed personnel about sexual abuse and exploitation
- Conduct active screening in voluntary counseling and testing centers for GBV exposure
- Conduct community education on safe sex
- Provide technical assistance to judicial and criminal justice systems for reforms and effective implementation of laws in accordance with international standards, particularly the CRC and CEDAW
- Ensure that programs for demobilization, reintegration, and rehabilitation include women and children affiliated with warring factions
- Ensure programs for reintegration and rehabilitation include survivors/victims of GBV and children born of rape
- Provide training to relevant sectors including security forces, judges, and lawyers
- Include GBV life skills in the training for teachers, girls, and boys in all educational settings
- Support non-formal education/vocational training programs targeting those most vulnerable to GBV
- Identify and address traditional practices that may limit girls' school attendance, such as child marriage
- Conduct community education campaigns on the importance of girls' education

Holistic Strategies for the Region

- Train staff on gender equality issues, GBV and guiding principles, and international legal standards
- Disseminate and inform all partners of codes of conduct
- Establish intra-country coordination
- Advocate and raise funds to support GBV programming
- Facilitate inter- and intra-country monitoring and evaluation of GBV activities
- Facilitate standardized cross-country qualitative and quantitative research on the nature and scope of GBV

* Recommendations adapted from IASC Guidelines for Gender-based Violence in Humanitarian Settings; IASC Guidelines for HIV Interventions in Emergency Settings; and Checklist for Action: Prevention and Response to Gender-based Violence in Displaced Settings.

ANNEX 3. Background Documents for the GBV Strategic framework

Several Africa-wide and global initiatives, strategies, and treaties affect how USAID/ESA, UNICEF, UNIFEM, and UNFPA do business. Among the various initiatives, the following have particular relevance for addressing GBV:

1. International Human Rights Treaties: Most countries in the region are signatories to the Universal Declaration of Human Rights, Convention to End Discrimination Against Women (CEDAW), Convention on the Rights of the Child, ILO Convention #182, the International Conference on Population and Development (ICPD), Human Rights Committee General Comment #28, the Convention Relative to the Protection of Civilian Persons in the Time of War, and the International Covenant on Civil and Political Rights. These treaties contain language relevant to GBV, including forbidding sex discrimination, forbidding child labor and trafficking, requiring consent for marriage, asserting the right to be free from torture or mistreatment, forbidding rape, condemning forced prostitution or indecent assault on women, and so forth.

2. USAID Strategic Framework for Africa (SFA): The SFA addresses transformational development and fragile states. It discusses violence against women, including trafficking and violence in conflict settings, and requires gender integration in country and regional strategies and documents. Among the sub-goals of the SFA are 1. 3 Enhanced protection of individuals from physical violence, and 2.1 Reintegrate persons affected by crises. The SFA also calls on USAID programs to address the human toll of violence, including “the increased use of rape as a tool of war, civilian casualty and disability, the increased vulnerability of displaced populations to abuse and abduction of children into soldiering and slavery, and the long-lasting psychological trauma.” Specifically, the strategy states, “USAID seeks to enhance multisectoral, gender appropriate protection and care mechanisms for those affected by violence. This will include human rights monitoring, justice sector reform to end impunity and increase access, and training in civilian oversight of security forces and community policing.”

3. USAID Greater Horn of Africa Initiative (GHAI). GHAI, launched in 1994, focuses on 10 countries within the ESA which have been particularly affected by conflict during the post-Cold War era and face problems stemming from the link between food security and conflict. The strategy “is guided by the principles of African ownership, strategic coordination, linking relief to development, a regional perspective, and promoting stability.” (REDSO/ESA Strategic Plan 2001–2005)

4. President’s Emergency Plan For AIDS Relief (PEPFAR). The Emergency Plan supports activities to change social norms and male violence against women; prevent violence resulting from HIV status disclosure, link HIV programs with community and social services, and strengthen policy and legal frameworks outlawing GBV.

5. Inter-Agency Standing Committee Gender-based Violence Guidelines. The primary purpose of these guidelines is to enable communities, governments and humanitarian organizations, including UN agencies, NGOs, and CBOs, to establish and coordinate a set of minimum multi-sectoral interventions to prevent and respond to sexual violence during the early phase of an emergency.

6. Inter-Agency Standing Committee Guidelines for HIV in Emergencies. The IASC *Guidelines for HIV/AIDS interventions in Emergency Settings* helps individuals and organizations in their efforts to address the special needs of HIV-infected and HIV-affected people living in emergency situations. The *Guidelines* are based on the experiences of organizations of the UN system and their NGO partners,

and reflect the shared vision that success can be achieved when resources are pooled and when all concerned work together.

7. UNICEF's Core Commitments for Children in Emergencies. This document builds on UNICEF's experience in recent crises and outlines their initial response in protecting and caring for children and women in humanitarian crises.

8. UNICEF Medium Term Strategic Plan (MTSP) 2006-2009. "Investing in Children: The UNICEF contribution to poverty reduction and the Millennium Summit Agenda." The overall objective of the MTSP for 2006–2009 is to focus the capacities and organize the work of UNICEF in support of national and international implementation of the Millennium Summit Declaration and pursuit of the millennium development goals and to ensure an effective UNICEF contribution to poverty reduction through advocacy and partnership for sustained investments in children. Key results relevant to GBV include the reduction of harmful traditional practices, such as child marriage and FGM/C; the protection of children from all forms of abuse, exploitation, and violence, including those that are gender-based; the prevention of sexual abuse and exploitation of children and women in emergency-affected countries; and the reduction of gender disparity in schools.

9. UNHCR Guidelines for the Prevention and Response of Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons. This includes detailed guidance for developing community-based, multisectoral and interagency prevention and response plans. It describes the minimum recommended standards for survivor assistance services and prevention activities.

10. UNFPA's A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers. This publication contains practical steps needed to integrate measures on gender based violence into reproductive health facilities. It is also meant to help a wider range of readers to understand the connections between reproductive and sexual health and violence. While the Programme Guide is targeting primarily health service providers, it can also be used as a reference guide for advocacy purposes or to undertake other activities in this area.

11. UNIFEM's Not a Minute More: Ending Violence Against Women. This document provides strategies from the UNIFEM Trust Fund to eliminate gender-based violence.

12. UNIFEM's Picturing a Life Free of Violence: Media and Communications Strategies to End Violence Against Women. This document provides examples from around the world of specific media campaigns and community mobilization efforts aimed at reducing GBV.

13. USAID Bureau for Global Health Strategy for Female Genital Cutting: Working in conjunction with other donors and international partners, USAID Global Health Bureau will work to (1) Increase donor support for FGC abandonment programs; (2) improve collaboration among organizations working in this area; (3) enhance advocacy, leadership, and policy development through its leading role in the global community of FGC abandonment; (4) improve the community-level environment to reduce FGC practices; (5) mainstream anti-FGC activities into global health portfolios, USAID missions, and national programs; and (6) involve other NGOs and donors to adopt and implement successful models and best practices of FGC abandonment.

14. U.S. State Department Strategy on Trafficking of Women and Children: Components of the strategy include (1) activities focused on prevention of trafficking, protection of victims, and reform and implementation of anti-trafficking legislation; (2) a platform of development efforts that support and reinforce direct anti-trafficking activities, e.g., girls' education, reduction of violence against women and

promotion of their rights, poverty reduction, administration of justice, and refugee assistance; (3) partnerships with other organizations such as NGOs and faith-based organizations that are fighting trafficking and assisting victims of prostitution, child labor, and other forms of slavery; and (4) coordination with other donors.

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