



Strengthening
Regional Work
on
Gender-Based
Violence

A meeting of activists, practitioners and researchers
from the Horn, East and Southern Africa,
Kampala, Uganda, November 8-9, 2006



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Strengthening Regional Work on Gender-Based Violence

A meeting of activists, practitioners and researchers from the Horn, East and Southern Africa, Kampala, Uganda, November 8-9, 2006



 On November 8 and 9, 2006, over 100 community activists, advocates, researchers, service providers, health care professionals and practitioners gathered in Kampala, Uganda for a unique, first-of-its-kind meeting on *Strengthening Regional Work on Gender-Based Violence (GBV)*. Participants came from Botswana, Eritrea, Ethiopia, Kenya, Malawi, Rwanda, Somalia, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zimbabwe, United States and Nicaragua. Together, they discussed innovative interventions, unexpected challenges and lessons learned from their collective experiences in the field.

The meeting was a collaborative initiative of Raising Voices, PATH, the Gender-Based Violence Prevention Network, the Interagency Gender Working Group (IGWG) and the East Africa Regional Office of the United States Agency for International Development (USAID/EA). The impetus for a regional dialogue came out of a technical update on gender-based violence convened by the Interagency Gender Working Group. The meeting highlighted the need to support collaboration and encourage an integrated response to gender-based violence, focusing especially on prevention. Raising Voices' pioneering work on violence against women, their strong partnerships with community-based organizations and their coordination of the Gender-Based Violence Prevention Network all presented as excellent vehicles for tapping into innovative work in the field.

While it is difficult to do justice to the creative energy that was evident in the room, this report attempts to synthesize the discussions and summarize the key lessons that emerged over the two days. It is intended to spark continued discussion, inspire innovation and encourage collaboration for advancing the work of preventing gender-based violence in the region.

THE INTERAGENCY GENDER WORKING GROUP (IGWG) is a network that includes nongovernmental organizations, the United States Agency for International Development (USAID), cooperating agencies and the Bureau for Global Health of USAID. Its goal is to foster gender equity in health programs and improve reproductive health and HIV/AIDS outcomes. The IGWG focuses on gender-based violence and the gender implications of HIV/AIDS as two of its priority areas—developing resource guides, sponsoring awareness-raising events and hosting technical update meetings for professionals in the field.

More information at www.igwg.org

RAISING VOICES, based in Kampala, Uganda, is a small, results-oriented organization that has been recognized regionally and internationally for its pioneering approach to preventing violence against women and children. Raising Voices works in partnership with community-based, nongovernmental organizations in developing tools to strengthen primary violence prevention programs and to advocate for a broader use of social change models. Raising Voices works to prevent violence against women by addressing its root causes, including traditional gender norms and the imbalance of power between women and men.

More information at www.raisingvoices.org

USAID EAST AFRICA REGIONAL OFFICE (USAID/EA), based in Nairobi, Kenya, coordinates USAID's efforts in 16 countries. Several United States Government (USG) agencies address aspects of GBV, such as male norms in regard to HIV and legislation supporting women's rights. USAID/EA supports these efforts with regional literature reviews, donor coordination, development of outcome measures and training in GBV programming. USAID/EA also develops programs for addressing GBV work with government bodies, nongovernmental organizations, faith-based organizations, organizations of religious leaders, European donors and others.

More information at eastafrica.usaid.gov

THE GENDER-BASED VIOLENCE (GBV) PREVENTION NETWORK grew out of a review of regional violence prevention efforts in the Horn, East and Southern Africa in 2003 and was born during a regional dialogue held in Kampala, Uganda in 2003, hosted by Raising Voices and UN-Habitat Safer Cities Programme. The GBV Prevention Network has over 150 individual and organizational members from across the region. The Network aims to provide member organizations with relevant information about and access to resources on violence prevention; to build solidarity between organizations working on violence; and to advocate for increased interest and investment in preventing violence against women in the region. Its website provides practitioners, researchers, funders and others in the region with global access to helpful resources on violence prevention.

More information at www.preventgbv africa.org

PATH is an international, nonprofit organization that partners with communities to break cycles of poor health. PATH promotes gender equity in health and in the efforts to prevent gender-based violence. PATH works with local and international partners in Asia, Africa, Latin America and Eastern Europe to carry out evidence-based advocacy and strengthen health systems. Its initiatives address gender-based violence from a human rights and public health perspective.

More information at www.path.org

TABLE OF CONTENTS

INTRODUCTION

Opening Remarks

I WHAT WE KNOW ABOUT GENDER-BASED VIOLENCE IN THE REGION 1

- Intimate Partner Violence and Non-Partner Sexual Violence 1
- GBV in Armed Conflict and Refugee Communities 10
- Harmful Traditional Practices 12

II INITIATIVES IN THE REGION TO PREVENT AND RESPOND TO GBV 15

- Mobilizing Communities Towards Positive Change 15
 - Facilitating Communication for Social Change 23
 - Men Joining Hands With Women 27
 - What are Some of the Challenges for Community Mobilization 31
- Strengthening Service Delivery for Survivors of GBV 32
- The Co-Pandemics of HIV/AIDS and GBV 39
- Addressing GBV in Armed Conflict and in Refugee Communities 46
- Advocacy for Improved Laws and Policies 49

III A NOTE ON MONITORING AND EVALUATION 57

IV THE WAY FORWARD: SOME CONCLUDING OBSERVATIONS 62

V APPENDICES 65

- Meeting Agenda
- Participant Contact List
- Meeting of the GBV Prevention Network
- Selective List of Useful Resources

INTRODUCTION

Gender-based violence¹ has been increasingly recognized around the world as a grave challenge for public health and development and as a violation of human rights. In Africa, as in other regions, gender-based violence perpetrated against women is an extremely complex issue resulting from and perpetuated by various societal, economic and cultural factors. As women's groups have galvanized attention and momentum for action, a wide range of initiatives across the region have directed their efforts towards mitigating, preventing and responding to such violence.

The Kampala meeting was both a recognition of the groundbreaking work in the region that challenges gender-based violence—much of it spearheaded by the women and men attending—and an opportunity to think collectively about the barriers that remain and how to overcome them. Participants highlighted that while significant progress has been made in recognizing gender-based violence as a serious public health problem and a grave human rights concern, the continued prevalence of such violence reveals that not enough progress has been made. They stressed the need for collaborative, holistic efforts that engage the community in challenging the discriminatory norms and stigmatizing attitudes that perpetuate violence and in responding meaningfully to survivors' immediate and long-term needs.

This report synthesizes two days of presentations, workshops and discussions, exploring a wide range of innovative initiatives encompassing research, community mobilization, advocacy and services. The meeting was an opportunity to foster dialogue, share experiences and develop networks among those working in the field. The report is intended to inspire increased collaboration and coordination, and through this, strengthen individual and organizational responses to gender-based violence.

DEFINITIONS

In 1993, the United Nations General Assembly adopted the *Declaration on the Elimination of Violence against Women*, defining violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”²

Intimate partner violence is defined by the Centers for Disease Control and Prevention as “actual or threatened physical or sexual violence or psychological or emotional abuse directed towards a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner.”³

Sexual violence is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.”⁴

The meeting focused primarily on intimate partner violence and sexual violence (within and outside of intimate relationships), because of their documented prevalence in the region. Studies indicate high rates of intimate partner physical and sexual violence in the region. Research also highlights widespread acceptance of violence in intimate partner relationships as punishment for a woman's perceived disobedience, unfaithfulness or failure to complete household chores.⁵ Sexual violence by strangers is less documented. Available data, usually from police or clinics, present just the tip of the iceberg. As with intimate partner violence, widespread attitudes and misconceptions about the nature of sexual violence fuel its continued prevalence. Many people do not view sexual violence, or any type of gender-based violence, in the context of asserting power over women. In addition to intimate partner and sexual violence, workshops also addressed the particular vulnerability and extreme violence faced by women in armed conflict and refugee situations.

Why does this violence continue? The *Declaration on the Elimination of Violence against Women*, (see box) highlights violence against women as “a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women.”⁶ Prevailing gender norms and attitudes about the acceptability of violence continue to fuel gender-based violence in the region, as in the rest of the world. The experiences of organizations such as PATH and Liverpool VCT, Care and Treatment (LVCT/Liverpool VCT), as well as the experiences of countless women in the region, point to the effect of such norms on the capacity of practitioners to provide appropriate care to survivors. Fear, shame and stigmatization can prevent women from seeking care or disclosing their situation to family, friends, service providers and other community members.

In light of this understanding, development workers, activists, researchers and practitioners increasingly emphasize primary prevention efforts, which address the underlying causes of gender-based violence and promote wide-scale, sustainable social change. Initiatives such as Raising Voices and CEDOVIP in Uganda and Kivulini in Tanzania challenge communities to examine and change the assumptions behind gender-based violence, mainly women's unequal status. Tools such as *Stepping Stones* and *African Transformation* help to facilitate and guide open communication among community members on issues related to gender equality. The *Be a Man Campaign*, the *Men to Men and Men as Partners* programs, and the *Malawi Bridge Project* all engage men as allies and role models in challenging traditional masculinity and promoting gender equality. They aim to inspire change—in the hearts and minds of community members—that will survive well beyond the initiatives themselves.

By working proactively to energize momentum against violence, initiatives for preventing GBV also empower women living with violence to speak out and seek assistance. This in turn can strengthen the capacity of health practitioners, especially in reproductive and HIV/AIDS services, to provide appropriate, holistic care to survivors. In response to findings from an evaluation of services, Liverpool VCT's *Post Rape Care Program* initiated system-wide change in policies, standards, coordination and delivery mechanisms for post rape care service in health facilities, to create a strengthened comprehensive response for victims. A system-wide response, such as this, also requires mobilizing coalitions and referral networks in the community so that women can access a range of services, including

medical care, shelter, counseling and legal and economic assistance. An integrated multi-sectoral approach in tandem with a multi-service initiative, like the Saartjie Baartman Centre, is critical for addressing the complexities of gender-based violence—meeting women’s immediate and long-term needs and ultimately empowering women to end cycles of violence in their lives.

Initiatives to prevent gender-based violence must be implemented along with sustained, collective advocacy to promote human rights, gender equality and women’s empowerment. Organizations such as CREAM, EWLA, Equality Now and COVAW spearheaded widespread, multipronged national and regional campaigns to lobby for the ratification and implementation of laws addressing gender-based violence, and to educate women about their rights under the law. SOAWR’s advocacy efforts for the *African Protocol on the Rights of Women* have been particularly successful in changing the policy frameworks in which we operate. However, additional work needs to be done to translate these policy frameworks into meaningful national laws and policies. Organizations such as SNV and AMWIK use innovative multimedia campaigns to advocate for domestication of policy frameworks and increased awareness of gender-based violence.

Gender-based violence remains a pervasive, hidden epidemic in the region. But the Kampala meeting was an important step in breaking the silence. The essence of the meeting was captured by two of the participants in the following comments:

“Sharing experiences from different parts of the region is most refreshing and strengthening because we get to know that we are not alone.”

—Participant from Uganda

“In my opinion, meetings of this nature play an important role in strengthening GBV work in the region, providing a platform for participants to share experiences and learn from one another. This serves to strengthen community mobilization strategies and advocacy work in the region.”

—Participant from South Africa

These participants were among many who were reinvigorated by the energy at the meeting and the recognition of how individual efforts could be strengthened through continued collaboration of efforts.

OPENING REMARKS

Ms. Margot Ellis, USAID Mission Director, Kampala, Uganda

In her opening remarks, Margot Ellis welcomed everyone and called attention to the “painful, awful and hidden subject” of gender-based violence. She noted that the “shroud of silence” is lifting, as gender-based violence is increasingly recognized as a critical health and development issue at national and international levels. Ms. Ellis highlighted USAID’s guidelines on gender-based violence for the health sector and the WHO Multi-country Study on Women’s Health and Domestic Violence against Women, which sheds light on the prevalence and nature of gender-based violence and found that women are most at risk for violence from intimate partners.

Ms. Ellis applauded initiatives in Uganda, including the Law Reform Commission and Demographic and Health Surveys, which strengthened understanding of the extent and type of violence women experience, as well as its consequences. She expressed her hope that these initiatives would inform concrete policies that would strengthen health care providers’ response to gender-based violence and lead to the passage of legislation on domestic violence and sexual offenses. She also stressed the need for a comprehensive response in providing services to women experiencing gender-based violence and for stopping violence perpetrated against women before it happens.

In closing, Ms. Ellis noted the groundbreaking and innovative work spearheaded by many of the participants in the room and the opportunity to share and learn from the wide range of experiences. She expressed her enthusiasm to hear about participants’ various collaborative strategies for addressing gender-based violence.

I WHAT WE KNOW ABOUT GENDER-BASED VIOLENCE IN THE REGION

● Intimate Partner Violence and Non-Partner Sexual Violence

A woman I know was recently killed by her live-in partner. Now I am very fearful and hardly sleep at night. I keep watch because when my partner is drunk or has smoked marijuana, he sharpens his knife before going to bed. He regularly warns me that he will kill me if I leave him, or do not please him in any way.

—Woman from Namibia, interviewed for the *WHO Multi-country Study on Women's Health and Domestic Violence against Women*⁷

Sobering findings from three separate studies conducted in the region on gender-based violence set the stage for the two-day discussion. In the first panel at the Kampala meeting, Jessie Mbwambo (Tanzania) presented the *WHO Multi-country Study on Women's Health and Domestic Violence*;⁸ Fredinah Namatovu (Uganda) presented a study on coerced first sex among young women in the Rakai District of Uganda⁹ and Shanaaz Matthews (South Africa) presented a study on intimate partner femicide in South Africa.¹⁰ While each study employed different methodologies, focused on different populations and addressed different forms of violence, all three provide insight into the prevalence and nature of gender-based violence in the region and areas for focused intervention. The findings draw attention to the devastating psychological and physical effects of such violence and the need for concerted prevention initiatives that challenge the underlying root causes.

What does the evidence show?

Physical, sexual and emotional violence is extremely common in women's lives. In East and Southern Africa, as in other regions of the world, a woman's greatest risk for violence is from an intimate partner. Findings from the *WHO Multi-country Study*, presented by Mbwambo, show that up to 36 percent of women in Namibia, 56 percent in Tanzania and 71 percent in Ethiopia experience physical or sexual violence or both during their lifetimes at the hands of an intimate partner. These findings are consistent with studies from a number of countries, which have found that on average, one third of women globally will experience some form of intimate partner violence in their lifetimes.¹¹ Recent data from Rwanda's National Institute of Statistics indicate that 31 percent of women are subjected to domestic violence after age 15, generally by a husband or intimate partner. In 10.2 percent of cases, the violence occurs during pregnancy.¹² Results from Kenya's Demographic and Health Survey in 2003 found that 44 percent of married, divorced or separated women aged 15–49 report they had been physically or sexually violated at least once by their husbands or partners.¹³

Sexual violence by strangers is less rigorously documented. Because of the shame and stigma associated with sexual violence, its incidence is largely underreported, and available data, mostly from crime records, are widely considered to be unreliable underestimates. What is known is alarming. Official data and independent studies from South Africa, Kenya and other countries in the region show that sexual violence is a widespread problem.¹⁴¹⁵ The Rakai study, presented by Namatovu, showed that 14 percent of women in Uganda experience coerced first sex; that is, 14 percent are raped the first time they have sex.¹⁶ And because of under-reporting, these numbers do not even begin to convey the full picture.

Official data and studies from countries in the region show that sexual violence is a widespread problem.

In its extreme, gender-based violence results in death. The study on femicide, presented by Matthews, found that in South Africa 50.3 percent of women murdered by a known perpetrator are killed by an intimate partner.¹⁷ A woman is killed by an intimate partner every six hours. Statistics on femicide are sparse, as many countries do not collect systematic homicide data regarding the relationship between the victim and perpetrator.

Gender-based violence is fueled by harmful notions of masculinity, including the need to control and dominate women. As part of an evaluation of the *Stepping Stones* program in South Africa, researchers found that “gang rape, often referred to as *istimela* (train) or *streamline*, is most commonly done by groups of friends. While sometimes practiced opportunistically against a randomly chosen woman, it is often committed as a way of ‘disciplining’ or humiliating a young woman known to them, often an (ex) girlfriend of one of the group, for perceived transgressions. Young men who participate often do not view their actions as part of the crime of ‘rape’ because they argue that they have sexual access to these women, that a woman’s silence entails ‘consent’, that it often involves trickery and subtle coercion rather than outright violence, and because drunk women are thought to be fair game.”¹⁸

In South Africa, 50.3% of women murdered by a known perpetrator were killed by an intimate partner... a woman is killed by an intimate partner every 6 hours.

A study in Malawi found that most women consider social and cultural norms to be the causal factors for violence, while most men attribute it to interpersonal dynamics.¹⁹ Such disparate perspectives on the legitimacy of violence highlight the need for strengthening understanding and communication in families and the community about gender-based violence. This effort needs to occur alongside the implementation of laws that hold perpetrators accountable.

Violence in women’s lives remains largely hidden. Informal networks including family, friends and neighbors often provide the first point of contact for abused women, if they disclose at all. In the *WHO Multi-country Study*, one fifth to two thirds of women across all settings had never told anyone about their partner’s violence prior to being interviewed. In Africa, 21 percent of women in Namibia, 30 percent in Tanzania

and 39 percent in Ethiopia had never told anyone about violence in their lives. Women who had already disclosed being abused had usually told family, friends or close neighbors—50 percent of women in Ethiopia had confided in family and friends and 61 percent in Namibia had told their families.

WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE (2006)

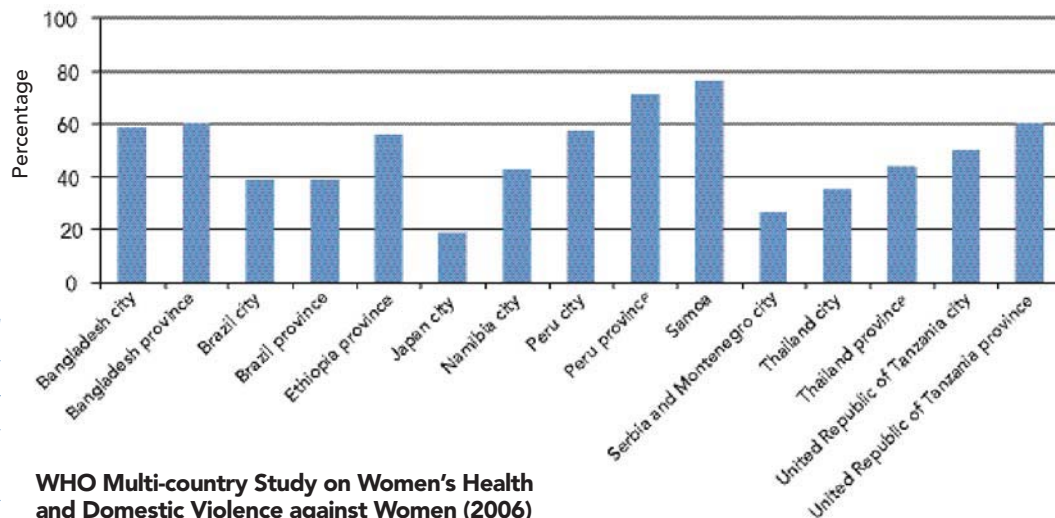
Over 24,000 women in ten mainly resource-poor countries were interviewed for the 2006 *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. In Africa, the study was conducted in Ethiopia, Namibia and Tanzania. Data was collected on women's experiences of intimate partner violence, including emotional violence, sexual assault and child sexual abuse. The study's robust, standardized methodology facilitated cross-culturally relevant comparison and analyses of findings across various settings. Specifically, it aimed to:

- Estimate the prevalence of violence against women, with particular emphasis on physical, sexual and emotional violence by male intimate partners;
- Assess the extent to which intimate partner violence is associated with a range of negative physical and mental health outcomes;
- Identify risks and protective factors for domestic violence against women, and compare them within and between settings; and,
- Explore and compare the strategies used by women who experience domestic violence.

More information at www.who.int/gender/violence/who_multicountry_study

Even when women tell someone about violence in their lives, they are not likely to seek or receive help. Mbwambo noted that even among those respondents to the WHO study who had told someone about the abuse, a much smaller proportion actually sought help—60 percent of women in Tanzania and 62 percent in Namibia never sought formal assistance from police, health care or other formal services, religious leaders, community leaders, other authority figures or nongovernmental organizations. Of those who did reach out for support, many remembered that no one tried to help them. Although 25 percent of women in Tanzania had talked with local leaders, only 7 percent said that these leaders had tried to help, and it is not clear whether this contact improved the situation.²⁰ In some cases, family members and local leaders may condone violence or prioritize the perceived well-being of the family and community over the woman's safety. Participants at the meeting highlighted that institutional discrimination and judgmental attitudes on the part of service providers have a chilling effect on service provision for survivors.

Prevalence of physical or sexual violence against women by anyone (partners and others), since age 15 years



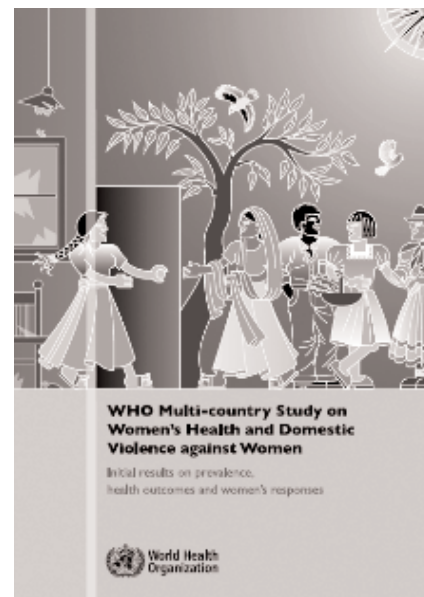
Although many respondents reported having told family and friends about their partner's violence, they were less likely to report that these people had tried to help. In the United Republic of Tanzania, although a quarter of women had talked with local leaders, only 7% said these leaders had tried to help. Overall, between 34% and 59% of physically abused women reported that no one had tried to help them.

WHO Multi-country Study on Women's Health and Domestic Violence against Women (2006)

The finding that more women choose to talk informally rather than seek formal support may suggest that an individual's response to violence takes time to develop. It may also be reflective of an unsupportive community environment. In some cases, it may take years before a woman challenges violence in her life, and even longer before she seeks help from others. In the WHO study, the respondents' reasons for not seeking help were often either that they considered the violence normal or not serious or that they feared consequences such as further violence, losing their children or bringing shame to their family. Some feared that they would not be believed or that disclosing would not improve their situation. Even in countries with relatively good access to services, barriers such as fear and stigma often stop women from seeking help.

Women may internalize social norms that justify abuse.

Over 60 percent of women in one province in Ethiopia believed that leaving housework unfinished, disobeying their husbands or being unfaithful would justify a husband's violence. In virtually all cases, acceptance of wife beating was higher among women who had experienced abuse than among those who had not. Those experiencing violence may come to accept it as normal. In Tanzania, 56 percent of women in violent relationships did not seek help because they perceived it as normal. However, it is important to recognize that



gender-based violence is normative across the world, in every region and within every culture.²¹ Strengthening women’s agency to leave violent relationships is thus critical.

COERCIVE FIRST SEX AMONG YOUNG WOMEN IN RAKAI, UGANDA

Fredinah Namatovu presented a community cohort study conducted by the Rakai Health Sciences Program aimed at strengthening understanding of the prevalence and consequences of coerced first sex for young women.²² Researchers interviewed sexually active adolescent women in Rakai District, Uganda about their experiences of sexual coercion as well as their current sexual practices and sexual health. Sexual coercion is defined as *compelling someone to have sex against her/his own will as the result of experiencing physical force, intimidation, threats, verbal insistence and/or deception*.

The Rakai Health Sciences Program was motivated by recent studies indicating that between 20 percent and 40 percent of women report having coerced first sexual experiences. While this in itself should galvanize action, the association between such coercion and a range of long-term negative health outcomes as well as elevated levels of sexually risky behavior provide even more compelling reasons for intensifying prevention and response on the part of all sectors.

The findings of the Rakai study highlighted a strong association between coercive first sex and unintended pregnancies as well as sexually risky behaviors, including inconsistent or non-use of contraceptives. The proportion of women reporting at least one genital tract problem was twice as high among those who had experienced coerced first sex in comparison to those who had not. The prevalence of symptoms such as abdominal pain or genital ulcers was consistently higher for this same group. Women who reported coerced first sex were also significantly more likely to report recent (past 12 months) coercion.

In response to the findings, the Rakai Program developed the SHARE (Safe Homes and Respect for Everyone) Project to outreach to adolescents in the community with positive prevention messages. (See section on mobilizing communities towards positive change.)

More information at www.jhsph.edu/rakai

Over 60% of women in one province in Ethiopia believe that a wife not completing her housework, disobeying her husband or being unfaithful are reasons that justify wife-beating. In virtually all cases and for all reasons, acceptance of wife-beating was higher among women who had experienced abuse than among those who had not.

There is a strong, documented relationship between gender-based violence, a range of poor physical and mental health outcomes for women, and risky sexual behavior by women. An association between recent ill health and lifetime experiences of violence suggests that the negative consequences of violence may persist long after the violence has ended. Mbwambo emphasized that women who had experienced violence suffer from increased pain, memory loss, dizziness, gynecological disorders, induced abortions, miscarriages, mental distress and suicide attempts. Namatovu noted that “women reporting coerced first sex were more likely than those not to report recent coercion.” Coerced first sex was also strongly associated with inconsistent use or failure to use contraception, unintended pregnancy and genital tract problems. Research has increasingly made the link between gender-based violence as a cause and consequence of HIV infection. Studies in Tanzania, South Africa and Kenya found that HIV-positive women are more likely than HIV-negative women to report intimate partner vio-

lence. Social, economic and biological factors combine to increase women's vulnerability to both these co-pandemics. (See section on the co-pandemics of GBV and HIV.)

GENDER-BASED VIOLENCE AND WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

Gender-based violence has been associated with a range of sexual and reproductive health issues, including unintended and early pregnancy, induced abortions, miscarriages, high number of births and unsafe sexual practices. These effects may occur as a direct consequence of violence, such as forced sexual intercourse, or through indirect pathways, such as when childhood sexual abuse leads to greater sexual risk-taking behavior in adolescence and adulthood.²³

The *WHO Multi-country Study* found that, in the majority of settings, ever-pregnant women who had experienced intimate partner violence were more likely to report induced abortions and miscarriages than women who had not experienced intimate partner violence. Further, in three sites including provinces in Ethiopia and Tanzania, ever-pregnant women who reported that their partner had been violent towards them were less likely to have attended antenatal services than other women. In a number of settings, intimate partner violence appeared to interfere with postnatal care, although the effect varied greatly by setting. Pregnancy is not necessarily a protected time for women. Between 1 and 28 percent of women who have ever been pregnant report being abused during at least one pregnancy. In over 90 percent of cases the abuser is the biological father of the child.

The WHO study also found across a broad range of settings that "men who are violent towards their partners are also more likely to have multiple sex partners . . . Because violent men are more likely to be unfaithful, they may have a greater chance of becoming infected with HIV and other STIs, potentially putting women in violent relationships at increased risk of infection . . . And in most sites, women whose current or most recent partners were violent were more likely to have asked their partner to use a condom and to report that their partner had refused to wear a condom."²⁴

Early marriage, a documented form of gender-based violence, has also been associated with a number of gynecological problems, including but not limited to obstetric fistula, pregnancy complications and death from hemorrhaging.

Coerced first sex was strongly associated with inconsistent use or failure to use contraceptive aids and condoms, unintended pregnancy and genital tract symptoms. Those who reported coerced first sex were significantly more likely than those who did not to report recent (past 12 months) sexual coercion.

INTIMATE PARTNER FEMICIDE IN SOUTH AFRICA

Intimate partner femicide, defined as *the intentional killing of a woman by an intimate partner (i.e., husband, boyfriend, cohabiting partner, same-sex partner or rejected lover)* is the most extreme manifestation of this type of death. The WHO estimates that between 40 and 70 percent of female murder victims worldwide are killed by an intimate partner. However, data in this area is sparse and not systematically collected. In countries lacking monitoring systems, routine data may not capture necessary information, such as the relationship between the perpetrators and victims.

Shanaaz Matthews of the Medical Research Council highlighted a study aimed at describing the prevalence of intimate partner femicide in South Africa, which identified factors associated with intimate femicide and assessed aspects of medico-legal investigation and case management for intimate and non-intimate femicide. Researchers gathered data on female homicide victims from mortuaries and then queried investigating officers on the relationship between the victims and perpetrators and the outcome of any legal cases pursued.²⁵

The findings were eye-opening and troubling. Approximately 50.3 percent of women murdered by a known perpetrator were killed by an intimate partner. One woman every six hours or four women every day are killed by an intimate partner in South Africa. The study also looked at various factors including race, relationship, age and employment status of victims and perpetrators. Matthews emphasized the importance of these factors in planning appropriate interventions. For example, she asked, “What does it mean that the average age for victims of intimate femicide is much younger (by about ten years) than for non-intimate femicide?”

The study also highlighted gaps in evidence gathering. For example, in intimate partner femicide cases medical examiners rarely visited the crime scene and DNA specimens were rarely collected. The lack of strong forensic evidence seriously impedes the prosecution and conviction of perpetrators—with many receiving light or no sentences. The findings were used to advocate for better monitoring and increased awareness of intimate partner femicide (see box).

More information at www.mrc.ac.za/gender

FROM RESEARCH TO ACTION: THE MEDICAL RESEARCH COUNCIL OF SOUTH AFRICA

Research on gender-based violence needs to be used to support action. The findings of a study on intimate partner femicide in South Africa, for example, were used as an advocacy tool at a number of levels. The study was spearheaded by the Gender and Health Research Unit of the Medical Research Council (MRC) of South Africa. The MRC worked with civil society groups to adopt a national campaign on femicide and lobby policy makers for a database to monitor intimate partner femicide cases. A partnership was formed with the Commission on Gender Equality, which used the *16 Days of Activism* campaign to raise awareness on intimate partner femicide.

The Gender and Health Research Unit focuses on research, training and advocacy to inform the development of policy, health services and health promotion, with an emphasis on gender-based violence and its impact on women’s health. The Unit partners with organizations to promote appropriate health sector responses to gender-based violence and is host to the *South African Gender-Based Violence and Health Initiative* and the *Sexual Violence Research Initiative*.

The *Sexual Violence Research Initiative* promotes research on sexual violence to support its recognition as a legitimate public health problem with severe health consequences. A network of activists, researchers and policy makers spearhead a range of projects, including an interactive website targeted at strengthening global, evidence-based responses to sexual violence.

More information at www.mrc.ac.za/gender and www.svri.org

Rigorous data is essential for designing appropriate interventions. Evidence that illuminates the full picture of gender-based violence can guide people to interventions that might not have been previously considered. Many participants at the meeting echoed concerns about the need to strengthen the quality and availability of data to inform the development of their programs and campaigns. For example, Matthews noted that over 50 percent of intimate partner femicides in South Africa are committed by common-law partners, 30 percent by boyfriends and 18 percent by husbands.²⁶ She emphasized that “we need to look at the many factors associated with intimate partner femicide to help identify appropriate entry points and strategies for intervention. For example, why are prevalence rates higher in common-law than in married relationships?”

The lack of rigorous forensic evidence hinders successful prosecution. Matthews stressed the importance of having rigorous evidence to effectively prosecute perpetrators of violence against women. The study on intimate partner femicide documented serious gaps in evidence gathering. For example, medical examiners rarely visited the crime scene, and DNA specimens were rarely collected in intimate partner femicide cases. The lack of strong forensic evidence is a key reason that over 75 percent of perpetrators are not convicted and a factor in the shorter sentences handed down in cases of intimate partner violence.²⁷ A subsequent presentation on the Liverpool VCT *Post Rape Care Program* (see section on strengthening service delivery for survivors) elaborated on the need for an integrated effort to collect forensic evidence for prosecuting sexual assault.

The lack of strong forensic evidence is a key reason over 75% of perpetrators are not convicted... in cases of intimate-partner violence.

What are some of the remaining challenges for collecting and using data on gender-based violence?

- There is considerable debate about whether health care providers who identify victims of violence should be obligated to report these cases. Many activists and health care providers consider this a breach of privacy and confidentiality that can result in fewer disclosures by women who fear reprisals and increased risk of violence. Health care providers have also raised ethical concerns about identifying women who may be experiencing violence and may need assistance, when the health sector is unable to provide appropriate services or referrals. Those collecting data and evidence, whether in the context of a survey or services, must prioritize women’s safety.
- Data can be a powerful tool, but it can also be misinterpreted and misused. Researchers of gender-based violence need to take responsibility for ensuring that studies are done in an ethical manner and that data made public is placed in its proper context. Data by itself, in particular purely quantitative data, may not reveal the multi-dimensional complexities of gender-based violence. Those charged with translating data into policies and interventions need to ensure they are working with an understanding of the full picture and not just the snapshot. The WHO’s *Ethical and Safety Recommendations for Research on Domestic*

Violence against Women provides guidance in these areas.²⁸

- A number of issues related to gender-based violence challenge researchers and service providers, such as dealing with stigmatizing attitudes they themselves may harbor, feeling unprepared to understand their own emotional responses when hearing women’s experiences and feeling powerless to help women change their situation. Ongoing training and counseling are essential components of any efforts to document experiences of gender-based violence.
- Rigorous data collection requires an investment in resources and capacity building, which in turn requires gender-based violence to be prioritized at the local and national level. The Secretary-General’s study on violence against women calls on governments to take responsibility for strengthening knowledge in this area through supporting systematic research, training professionals and setting standards and protocols for routine service sector data gathering. The study notes that progress has been made in quantifying prevalence rates of violence against women, but significant gaps remain.²⁹ Participants in the meeting repeatedly noted the scarcity of systematic, comparable data on particular aspects of gender-based violence, such as femicide, sexual coercion and the characteristics of perpetrators. This information is needed to empower communities in ending gender-based violence and to establish policies and mechanisms that prevent and respond to such violence.
- Monitoring and evaluation remain a continual challenge to advocates, practitioners and service providers. Strong evaluation models that can be adapted to prevention work are needed. In particular, participants noted the need for appropriate indicators that could be used for such evaluations. Service providers and practitioners may not have the capacity to conduct evaluations and may not prioritize evaluation in their work or as part of their mandate. Nevertheless, evaluation is essential to understanding whether women’s needs are being met. An evaluation of Liverpool VCT’s *Post Rape Care Program* highlighted major gaps in care for survivors of sexual violence. As a result, system-wide institutional changes were made to ensure that survivors’ immediate and long-term needs were being met. (See section on strengthening service delivery.) The assessment of the *Stepping Stones* initiative discussed later in the report as well as the recently published IMAGE study in South Africa also demonstrate the importance of continuous evaluation. (See section on monitoring and evaluation.)

RESEARCHING VIOLENCE AGAINST WOMEN: A PRACTICAL GUIDE FOR RESEARCHERS AND ACTIVISTS

Global understanding of the prevalence and nature of gender-based violence has increased substantially and has galvanized attention and calls for action. But serious gaps remain in the data and statistics available on gender-based violence and the methodology used to collect that information. The United Nations Secretary-General's in-depth study on all forms of violence against women highlights that "despite the progress in recent years, there is still an urgent need to strengthen the knowledge base on all forms of violence against women to inform policy and strategy development. Many countries still lack reliable data and much of the existing information cannot be meaningfully compared. Moreover, very few countries collect data on violence against women on a regular basis, which would allow changes over time to be measured." A wealth of anecdotal accounts and exploratory studies conducted with non-representative samples of women has been invaluable in galvanizing attention around gender-based violence, but is not useful for understanding the dimensions and characteristics of abuse across wider populations.³⁰

The manual *Researching Violence against Women: A Practical Guide for Researchers and Activists* was developed by WHO and PATH in response to the need to improve the quality, quantity and comparability of international data on physical and sexual abuse.³¹ It outlines methodological and ethical challenges of conducting research on violence against women and describes a range of innovative approaches that have been used around the world, in different environments and in different contexts to address these challenges. The manual is intended to guide researchers, activists, community workers, service providers and others who are interested in strengthening research on gender-based violence. It provides a step-by-step guide to conducting research, highlighting ethical concerns, developing research strategies and questions, interviewing in the field, analyzing data and turning findings into advocacy and action.

More information at www.who.int/gender or www.path.org

● GBV in Conflict Affected and Refugee Communities

They took K.M., who is 12 years old, in the open air. Her father was killed by the Janjaweed in Um Baru. The rest of the family ran away and she was captured by the Janjaweed who were on horseback. More than six people used her as a wife; she stayed with the Janjaweed and the military more than ten days. K., another woman who is married, aged 18, ran away but was captured by the Janjaweed who slept with her in the open place—all of them slept with her. She is still with them. A., a teacher, told me that they broke her (K.M.'s) leg after raping her.³²

—66 year old farmer from Kutum District, Darfur, Sudan

Participants in one workshop addressed the issue of gender-based violence in conflict-affected and refugee communities. The United Nations and other international bodies have recognized that civilians, particularly women and children, account for the vast majority of those affected by armed conflict, including as refugees and displaced persons. However, only recently has critical attention been focused on the gendered nature of violence and particular vulnerability of women in these situations. The use of sexual violence as a weapon of war galvanized world outrage with conflicts in Yugoslavia and Rwanda. But girls and women are also made to endure a myriad other forms of violence,

especially when forced to abandon their homes. In addition to escaping escalating conflict, whole communities may be forced to flee as an intentional strategy of war, as was the case in the Democratic Republic of Congo, Rwanda and Sudan. This is a particular concern for women who comprise over 80 percent of refugees in the world today.³³

As Rwanda emerged from the 1994 genocide, the world learned about the pervasive sexual violence that accompanied the brutal campaign of displacement, starvation and slaughter. It is estimated that between 250,000 and 500,000 women were raped, and approximately 70 percent of survivors were infected with HIV.³⁴ Parliamentary elections in 2003, with one third of the seats reserved for women, have propelled the country towards peace. But the traumatic consequences of violence for women are still being felt, especially because, until recently, discriminatory laws and practices prevented survivors from taking perpetrators to court. However, a nationwide campaign spearheaded by women parliamentarians led to changes in the penal code and the recognition of gender-based violence as a crime. (See box on SNV.)

It is estimated that between 250,000 and 500,000 women were raped and approximately 70 percent of survivors were infected with HIV, (during the early 1990s genocide in Rwanda).

Global attention has recently focused on the region of Darfur in southern Sudan, which has been embroiled in a deadly conflict since 2003. At least 400,000 people have been killed. More than 2 million civilians have been forced to flee their homes and now live in displaced persons camps in Sudan or refugee camps in Chad. More than 3.5 million rely on international aid for survival. The Darfur Peace Agreement, brokered in May 2006, has done little to end the violence. Fighting among factions has escalated and made it dangerous, if not impossible, for the millions of displaced persons to return to their homes. Humanitarian aid agencies face growing obstacles to bringing much needed relief.³⁵ It is in this environment that reports of pervasive rape, sexual violence, exploitation and slavery of thousands of girls and women have surfaced.

The actual prevalence of sexual and other gender-based violence in the Sudan region is very difficult to estimate. Reports from health care organizations, however, provide some sense of the scope of the problem. The medical activities of Médecins Sans Frontières (MSF) have uncovered a high incidence of sexual violence. In a survey in Murnei camp, West Darfur, for example, nearly 14 percent of the victims of violence treated by MSF from April to June 2004 were victims of sexual violence. Most of the violence occurred during attacks on their home villages. In almost all cases the assailants were armed men who forced their victims at gunpoint. Gang rapes and abductions have also been reported. Because of the sensitivity of this issue, the number of women reporting sexual violence in clinics is thought to greatly under-represent the scale of the problem. Many girls and women will not seek or have access to medical treatment.³⁶

The actual prevalence of sexual and other gender-based violence in the Sudan region is very difficult to estimate. Reports from health care organizations, however, provide some sense of the scope of the problem. Because of the sensitivity of this issue, the number of women reporting sexual violence in clinics is thought to greatly under-represent the scale of the problem.

A number of ongoing conflicts in Uganda, Ethiopia, Eritrea and the Democratic Republic of Congo have resulted in the deaths of millions of people. Rape, sexual violence and other forms of gender-based violence are pervasive in these situations.

● Harmful Traditional Practices

The reason infibulation is practiced is because the girl will be insulted and be looked at as something open and used. In our society, FGM takes place mainly to reduce high sexual desire of a woman and to develop high confidence during marriage. With the women who are circumcised and stitched together, it is like packing the confidential resource that will be opened by the owner.³⁷

—Response from a married woman during field interviews regarding child marriage, Ethiopia

You are becoming an obstacle to opportunity of the girls who have been asked for marriage. The government does not give them jobs. What will happen to them? Do you want them to go to the cities?³⁸

—Response from an elder during field interviews regarding child marriage, Ethiopia

The World Health Organization estimates that 6,000 girls a day, more than 2 million a year, are genitally mutilated. Over 150 million girls and women alive today have undergone the procedure.

Certain practices that are harmful to girls and women are often considered part of a community's tradition, the passing of its culture to the next generation. Female genital mutilation (FGM) and early marriage are two practices that have been documented in the region. The World Health Organization (WHO) estimates that 6,000 girls a day, more than 2 million a year, are genitally mutilated. Over 150 million girls and women alive today have undergone the procedure. FGM is practiced in over 28 countries, mostly in Africa, but also in immigrant communities around the world. Studies indicate significant geographic variations in prevalence rates, from over 90 percent in Guinea, Egypt, Mali and Sudan, over 80 percent in Ethiopia and Eritrea, 37 percent in Kenya and down to 5 percent in Benin and Niger.³⁹ Studies indicate that the practice may be declining in certain areas as opposition from women's groups increases.

The rationale for FGM is varied. For many, it is a rite of passage into womanhood and marriage. In some communities, uncircumcised girls are considered unmarriageable—as no man will want an uncircumcised wife. The practice is said to restrict women's sexuality, making them less promiscuous. FGM has also been closely identified with cultural identity, and has been supported in some communities as a practice that promotes cultural respect. For others, it is associated with religious practice.

The immediate and long-term psychological and health consequences of FGM are severe and traumatic. Immediate complications include hemorrhage, shock, extreme pain, ulceration of the genital region, urine retention and infections. In the long-term, FGM leads to chronic pain, scarring, abscesses, incontinence, cysts, painful intercourse, complications with pregnancies and death from infection.

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International norms promoted by the Commission on Human Rights and its Special Rapporteurs on Violence against Women and Harmful Traditional Practices call for the abolishment of FGM. The Special Rapporteur on Violence against Women urged governments not to invoke any custom or tradition to avoid their obligation to eradicate violence against women, to appropriately punish perpetrators and to support victims. However, the concern expressed by some that values are being externally imposed has led to a tension between international norms and respect for a community's identity and independence. Women's groups emphasize that women in the community need to lead the transformation, and that the international community needs to work closely with African women to effect change.

FGM has also been addressed at the regional level. A conference in Nairobi resulted in a declaration that “the practice of FGM is a violation of the rights of women and girls and an assault on their human dignity . . . Efforts for the abandonment of FGM should be undertaken so as to reinforce the fact that FGM is a human rights issue . . . there needs to be a common and integrated approach to addressing FGM and to finding solutions for combating the practice and to effect long-lasting behavioral changes in society.”⁴⁰ A conference in Cairo affirmed that the abandonment of FGM can only be achieved through comprehensive approaches promoting behavioral change and using legislative measures as a pivotal tool.⁴¹

Strong, local women’s movements aimed at eradicating FGM exist in many countries in the region. The practice has been challenged effectively through coordinated, community-based advocacy and awareness-raising campaigns that highlight its traumatic consequences, offer alternative rites that do not threaten the well-being of girls, support public declarations by community members and leaders against the practice, and promote legislation outlawing it as a human rights violation. The women’s movement in Africa has also been fundamental in advocating for laws against FGM. At least twelve countries have enacted laws criminalizing FGM, although prosecution rates remain low.

Early or child marriage is defined 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*. It may take place with or without formal registration, and under civil, religious or customary laws. There is often an element of coercion involved in child marriages: families may pressure, collude or force children into marriage. Many girls are socialized into accepting child marriage as the norm, and many give their consent as a duty and sign of respect.

It is very difficult to get accurate data on the true extent of child marriages. A new study by UNICEF, *Early Marriage: A Harmful Traditional Practice: A Statistical Exploration*, found that in Africa, 42 percent of 15–24 year olds were married before they reached 18. This number rises to over 60 percent in parts of East Africa.⁴² A study in the Amhara region of Ethiopia found that 15 percent of ever-married women were married before the age of 12. And 53 percent of rural ever-married women were first married between 12 and 15 years. More than half of the married women reported that they were pressured to marry, largely by their parents.⁴³

Deep-rooted traditions compel families to continue the practice of early marriage despite its consequences. In some communities, early marriage is seen as a way to improve the family’s status in the community, to strengthen ties between families, to ensure that girls are virgins when they marry and to avoid the possibility of a girl reaching an age where she is no longer desirable as a wife.

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The practice of early marriage is now understood to have very harmful, long-lasting effects on the socio-economic, psychological and physical well-being of young girls.

The practice of early marriage is now understood to have very harmful, long-lasting effects on the socio-economic, psychological and physical well-being of young girls. Among the many harmful physical consequences, child marriages create a multitude of conditions that make child brides vulnerable to violence. The wide age gap between child brides and their spouses makes them less able to negotiate. Girls who marry young tend to drop out of school and are more likely to bear children during adolescence, thus ensuring they will not return to school or develop work skills. They have limited social support networks, are economically dependent and have limited mobility. Younger child brides may also be at risk of sexual violence and abuse from older men in their spouses' families, and are known to be more likely to tolerate violence and less likely to leave abusive partners.⁴⁴

Because of their limited negotiating powers, young brides have limited access to and opportunity to use contraception and reproductive health services. Many are exposed to early, frequent sexual relations and repeated pregnancies before they are physically and psychologically ready. Many of these girls also suffer from tragic consequences, such as obstetric fistula and pregnancy-related deaths. Research by the Population Council shows that child brides are more vulnerable to contracting HIV because of frequent unprotected sexual activity, limited access to information and limited negotiation powers. The early marriage of girls impairs the realization of virtually all of their rights. The imposition of marriage on children deprives them of freedom, opportunities for personal development, health and well-being.⁴⁵

II. INITIATIVES IN THE REGION TO PREVENT AND RESPOND TO GBV

● Mobilizing Communities Towards Positive Change

Why is community mobilization critical in addressing gender-based violence?

Our conviction is that changes of harmful beliefs and practices must engage and occur in the hearts and minds of community members themselves, in that way momentum for change can live longer after specific projects end.

—Yassin Ally, coordinator of Kivulini

The studies presented at the Kampala meeting highlighted that preventing and ending gender-based violence will require transforming harmful norms about gender and the acceptability of such violence. Even when gender-based violence is not overtly supported, communities may still stigmatize and blame women for the abuse they endure. For many survivors, fear and shame prevent them from seeking care and treatment. Misconceptions about the nature and consequences of violence may lead to inappropriate or inadequate service provision for women. Prevailing norms can also translate into legal discrimination, a powerful barrier for survivors seeking justice.

Lori Michau of the Uganda based organization Raising Voices emphasized that “mobilizing communities is a long-term process that moves beyond awareness raising to facilitate positive change at the community level in the attitudes and behaviors that perpetuate violence against women.” Individual change is difficult to sustain in non-receptive environments. Prevention thus needs to move beyond individuals to influence the social climate of a community and build infrastructures that allow alternative values to grow. By challenging root issues, including gender inequality, community mobilization efforts foster an environment where gender-based violence is not tolerated. By energizing the community, these efforts ensure that changes are ultimately sustainable. By engaging men, they create positive role models and support male activism for gender equality.

Community mobilization efforts strengthen a community’s response to gender-based violence. By increasing understanding and challenging the stigma surrounding such violence, these efforts make it easier for survivors to seek assistance from family, friends and community members. By challenging norms, community mobilization efforts strengthen service providers’ capacity to provide appropriate care and assistance. By reaching out to various sectors of the community, they facilitate the collaboration and referral networks required for survivors’ long-term needs to be met.

Mobilizing communities is a long-term process that moves beyond awareness raising to facilitate positive change at the community level in the attitudes and behaviors that perpetuate violence against women.

—Michau

What initiatives are being implemented to mobilize communities in the region?

The second panel of the Kampala meeting and subsequent workshops highlighted activists working to inspire momentum in their communities to prevent gender-based violence. Their experiences highlight that change does not occur as the result of a single intervention, nor does it happen overnight. Preventing gender-based violence requires individuals and communities to understand and challenge the root causes of such violence, such as women's inequality and discriminatory gender norms. Michau introduced *Raising Voices' Resource Guide for Mobilizing Communities to Prevent Domestic Violence*, which emphasizes a process of social change. Initiatives based on the *Resource Guide*, such as *Kivulini* introduced by Yassin Ally (Tanzania), *CEDOVIP*, introduced by Tina Musuya (Uganda), and *SHARE*, introduced by Fredinah Namatovu (Uganda), all engage the participation, support and commitment of a wide cross-section of community members, institutions and leaders in promoting an end to violence. There are also several initiatives in the region targeting two critical aspects of community mobilization: the need to engage men and the importance of facilitating communication for social change.



The process of social change From the *Raising Voices Resource Guide for Mobilizing Communities*

What lessons were learned?

Recognize that changing community norms is a process, not a single event.

As the *Resource Guide* highlights, "Projects based on an understanding of how individuals and communities naturally go through a process of change can be more effective than those that thrust haphazard messages into the community. Thus, efforts to try to influence social change must be approached systematically with a long-term vision. Organizations that

attempt this work can become skilled facilitators of individual and collective change by working with, guiding, and supporting the community along a journey of change. Community members need to be engaged with regular and mutually reinforcing messages from a variety of sources over a sustained period of time. This contributes to changing the climate in the community and building momentum for change. For example, in one week a man may hear a sermon about family unity in church, see a mural questioning domestic violence on his walk to work, hear a radio program about human rights, and be invited by a neighbor to join a men’s group to discuss parenting skills. Repeated exposure to ideas from a variety of sources can significantly influence perception and affect behavior.”⁴⁶

Projects based on an understanding of how individuals and communities naturally go through a process of change can be more effective than those that thrust haphazard messages into the community.

—Raising Voices Resource Guide for Mobilizing Communities



From the Raising Voices Resource Guide for Mobilizing Communities

Begin with the community.

Prevention begins with respecting the community’s capacity to make positive change. Efforts need to be premised on understanding a community’s views on gender-based violence as a framework for strengthening its response to such violence. Prevention should recognize the multifaceted relationships between community members and institutions and acknowledge the complex history, culture and experiences that shape each community. For example, the *Stepping Stones* initiative (see section on facilitating communication for social change) depends on participants discussing their views, and raising their concerns about relationships and figuring out ways to address those concerns. Local context, culture and history play a large role in developing appropriate solutions.

Reach out to and engage all stakeholders in the community.

Preventing gender-based violence requires the long-term commitment and engagement of the entire community. Initiatives should seek input and participation from a cross-section of individuals, organizations and institutions in the community to galvanize momentum for action. Successful programs also recognize the influence of a community’s formal and informal leadership. Effective initiatives take the time to build relationships with gatekeepers and opinion-holders and to engage the leadership’s support in facilitating change. Musuya reflected that *CEDOVIP*’s “approach creates lasting activism. The communities are engaged and they feel that it is their responsibility to take the process of changing attitudes and behaviors that perpetuate domestic violence forward.”

[A community mobilization] approach creates lasting activism. The communities are engaged and they feel that it is their responsibility to take the process of changing attitudes and behaviors that perpetuate domestic violence forward.
—Musuya

Ensure community ownership of the process.

While NGOs and local authorities can play an important role in catalyzing support for action, the process must ultimately be spearheaded and sustained by community members. Initiatives aimed at challenging harmful beliefs and practices in a community must engage and be led by members of that community. Advocates should work closely with individuals, groups and institutions to strengthen their capacity to be agents of change. *CEDOVIP*, *Kivulini* and *SHARE* all engage community members in leading and mobilizing change.

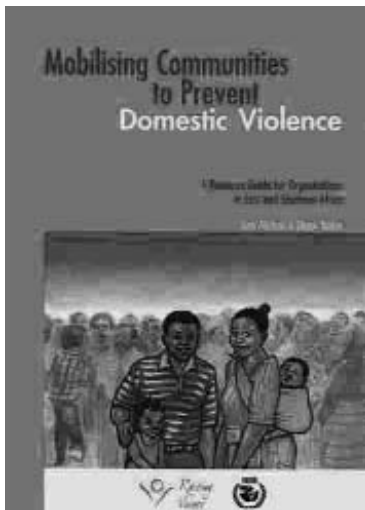
A RESOURCE GUIDE FOR MOBILIZING COMMUNITIES: RAISING VOICES

Raising Voices developed the *Resource Guide for Mobilizing Communities to Prevent Domestic Violence*—a tool for community-based organizations to plan, implement and monitor long-term, community-based approaches to preventing gender-based violence.⁴⁷ Lori Michau emphasized that “community mobilization moves beyond awareness raising....The goal is to build a critical mass and reach enough people at various levels to have an impact on the overall value system of a community.” Initiatives focusing on the prevention of domestic violence and reinforcing those messages at the community level are ultimately more sustainable.”

Behavior is a result of experiences and attitudes, and is deeply linked to the prevailing belief system of the community. Changing community norms involves a long process, not a single event. Projects that recognize how individuals and communities naturally go through a process of change, and support each step of that process, can be more effective than those that thrust ad-hoc, haphazard messages into the community. The Guide’s approach scales up the process of individual change into phases of community mobilization, which help organizations build community support and formalize change.

Different strategies are suggested in each phase to guide organizations in engaging a wide range of community members, including formal and informal leaders, to take action. The Guide also offers practical ideas for advocacy and capacity building activities. Originally published in 2003 for use in Southern and East Africa, the Resource Guide has been requested by organizations in over 65 countries from around the world. The approach has been highlighted as good practice by the UN Division for the Advancement of Women, USAID and Women and Cities International.

More information at www.raisingvoices.org



Focus on primary prevention based on a human rights framework.

Long-term change requires focusing on prevention and promoting human rights. Preventing gender-based violence involves addressing the root causes of such violence and challenging communities to examine the assumptions and norms that perpetuate it, including women's lower status and inequality within intimate relationships. The human rights framework empowers women by recognizing their inherent right to equality and dignity, allowing them to claim those rights and holding the community accountable for any violations.

It also empowers the community to make meaningful change to promote and protect women's rights without the need to appeal to the goodwill of others to keep women safe.

Create a comprehensive, multifaceted program.

Engaging the community requires using a variety of creative strategies to reach different stakeholders in different ways. Multifaceted programming is challenging but possible, and will ultimately enable prevention messages to seep into the community's collective value system. Ad hoc efforts involving isolated groups or sporadic activities have limited impact. Programs should aim for a systematic, comprehensive response using approaches that meet people's particular needs, reinforce the primary message and pave the way for widespread receptivity to that message. Efforts should also include introducing policies and structures that facilitate formalized institutional change. Many of the community mobilization, service provision and advocacy initiatives that were highlighted attribute their success to comprehensive, multifaceted and collaborative strategies. For example, to reach adolescents with prevention messages, the SHARE program conducts targeted outreach with in-school, out-of-school and married adolescents with a multifaceted program of capacity building, community outreach, counseling and referral services (see box p. 22). Planned Parenthood's Africa Regional Office's multipronged initiative stimulates community support for the eradication of female genital mutilation, with multimedia campaigns, alternative rites of passage for girls and assistance for circumcisers to find alternative income sources.

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CENTER FOR DOMESTIC VIOLENCE PREVENTION (CEDOVIP), UGANDA

The Center for Domestic Violence Prevention (*CEDOVIP*) partners with communities to inspire change in attitudes and behaviors that perpetuate domestic violence. *CEDOVIP* uses the approach articulated in the *Raising Voices Resource Guide* as a framework for its multifaceted activities designed to reach out and engage all community members. Over 70 community volunteers and counselors (equal number of women and men) spearhead local activism through booklet clubs, theatre, impromptu discussions and other forums for engaging in dialogue on ending gender-based violence.

CEDOVIP works with community gatekeepers and local institutions to promote recognition of a woman's right to safety and to support structural changes towards this end. Coordinator Tina Musuya highlighted that as a result of *CEDOVIP*'s work, domestic violence, once a hidden, private problem, is now talked about openly and publicly: "This kind of approach leads to reduced acceptance of violence against women as seen in the way people are increasingly talking about it. Community members, police, local councils and the community members are taking the issue seriously. There is less blame for the survivors, and the perpetrators are being held accountable for their actions."

Musuya noted that "as local leaders and institutions acknowledge the importance of addressing such violence, concrete mechanisms have been established in the community to help prevent it." The police and health care sectors have issued specific guidelines addressing domestic violence and formalizing mechanisms for responding to cases. Local leaders have pushed for the implementation of a domestic violence by-law in Kawempe. In addition, traditional marriage counselors, known as *Ssengas*, are challenging traditional gender norms, counseling women and men to view equality, respect and the absence of violence as the basis of healthy relationships.

More information at www.raisingvoices.org/cedovip.php

KIVULINI WOMEN'S RIGHTS ORGANIZATION, TANZANIA

In Kiswahili, *Kivulini* means "in the shade." The word implies a place under a tree where people discuss and support each other. *Kivulini* Women's Rights Organization was established in Mwanza, Tanzania in 1999 by six women who had a vision for creating a community free from domestic violence and one in which women's rights were respected. *Kivulini* remains committed to empowering women and ending gender-based violence. Community Action Groups, Community Volunteers and End Action Groups mobilize people to change the attitudes and behaviors that underlie violence against women.

Kivulini's initiatives address the links between women's unequal status, their vulnerability to HIV infection and the interconnection with gender-based violence. Through facilitating supportive dialogue in tandem with capacity building and advocacy, *Kivulini* confronts the stigma around gender-based violence and HIV and inspires action towards their prevention. A keystone in its activities is an economic empowerment program promoting understanding of the correlation between women's economic status and vulnerability to violence. Business management training helps women participate fully in the formal sector and reduce their economic dependency. Yassin Ally, *Kivulini*'s coordinator, stressed that "the economic factor locks many women into violence. So we are trying to empower them so they can contribute equally to the family's survival. It is not only about dishing out the money, but that people need to be helped with the skills to manage it . . . [Lending money without training] can actually add to violence in the home."

One village leader commented about *Kivulini*, "I never knew that this small group [Haki-Sawa] would ever bring such important training to discuss serious problems that face women and children in our village. I am happy and I will help the group to solve problems in our village."

More information at www.kivulini.org

Involve men integrally in prevention efforts, not just as add-ons.

Initiatives that engage men in challenging prevailing norms and attitudes are models of strong primary prevention efforts. For example, *CEDOVIP* and *Kivolini* both emphasize and prioritize engaging men in prevention efforts. Male facilitators called ‘kojas’ are critical in reaching out to men in Kawempe District and supporting men speaking out against gender-based violence and for gender equality. In these programs, men work alongside women in raising awareness and creating change in their communities, which avoids community members marginalizing violence as a women’s issue.

Reach out to men where they are most comfortable.

Garage advocacy, discussions in bars and male peer groups are some of the strategies used by community-based campaigns to reach out to men. Meeting on comfortable, familiar ground, in spaces where they might naturally congregate, eases what might have been an unnerving experience for men. Giving men space to voice their concerns and fears provides excellent entry points for other men to acknowledge, explore and assuage concerns. Community mobilization initiatives all look for ways to meet men “on their turf.”



CEDOVIP community drama
Photo by Heidi Jo Brady

Commit to a long-term, organic process.

Social change is an organic process that may not proceed according to a neat plan. Transforming a community’s fundamental belief system about women and their worth will not occur as the result of a single intervention and will not happen quickly. Effective programming requires an understanding of how people change and a commitment to supporting the community during each step of the transformation. Different ideas and concepts should be introduced systematically and carefully over time, with realistic objectives set at each stage. This approach encourages greater receptivity to the message of prevention and strengthens a community’s capacity to respond to violence against women in a way that is more likely to “stick.”

Social change is an organic process that may not proceed according to a neat plan. Transforming a community’s fundamental belief system about women... will not occur as the result of a single intervention and will not happen quickly.

SHARE (SAFE HOMES AND RESPECT FOR EVERYONE) PROJECT

The SHARE (Safe Homes and Respect for Everyone) project evolved from the Rakai Health Sciences Program (RHSP) research findings that established the presence of high levels of physical and sexual intimate partner violence, community attitudes that condone partner violence, and links between violence, HIV/AIDS and a broad range of negative reproductive health outcomes. These findings shed light on the need “to focus on primary prevention initiatives to reach community members with messages regarding reproductive health, HIV/AIDS and domestic violence.” The Rakai Health Sciences Program in Rakai District — Uganda, is a research and service provision collaborative that promotes reproductive health and prevention of HIV/AIDS and violence. SHARE focuses on primary prevention initiatives in partnership with community members and organizations including police, local leaders, professionals and health and community service offices.

Through a multifaceted program of capacity building, community outreach, counseling and referral services, SHARE raises awareness and inspires momentum for the prevention of gender-based violence and HIV/AIDS, the promotion of reproductive health and the respect for human rights. Recognizing the importance of reaching adolescents with prevention messages, SHARE conducts targeted outreach with in-school, out-of-school and married adolescents.

More information at www.jhsph.edu/rakai

A CAMPAIGN TO ERADICATE FEMALE GENITAL MUTILATION (FGM) IN KENYA

Planned Parenthood's Africa Regional Office in Kenya uses a multipronged initiative to galvanize community support for young girls to remain uncircumcised. Creative media strategies, including folk media, are used to sensitize community members and highlight the benefits of ending FGM. Radio Ariel, for example, broadcasts positive slogans for uncircumcised girls. Peer youth groups, “clitoris protection squads” and positive role models are critical in encouraging support for FGM eradication. Female circumcisers are offered assistance in developing alternative income sources. Alternative rites of passage allow young women to experience a tradition in a manner that does not harm their health.

Charity Koronya, program officer for Planned Parenthood, highlighted that the organization's efforts in Kenya have increased public discussion and action related to FGM. They have generated advocacy by men who support uncircumcised girls, alternative rites of passage for over 500 girls, the arrest and imprisonment of a female circumciser, the promise by others to lay down their tools, and the public support of community elders for the eradication of FGM.

More information at www.plannedparenthood.org/global

■ Facilitating Communication for Social Change

Why is communication for social change critical in addressing gender-based violence?

Opening up avenues for communication and understanding is essential to the process of social change. When husbands and wives can address their fears and concerns honestly, intimate partner violence can be greatly diminished. When young women and men can discuss sexuality comfortably, risky sexual behavior can be changed. Understanding the barriers, fear, stigma and discrimination that survivors face daily is critical to providing meaningful and appropriate care, addressing their needs holistically and empowering them to leave cycles of violence.

When husbands and wives can address their fears and concerns honestly, intimate partner violence can be greatly diminished. When young women and men can discuss sexuality comfortably, risky sexual behavior can be changed.

What tools have been developed to facilitate this communication?

A number of tools to facilitate communication and foster community receptivity to change were introduced, including *African Transformation*, presented by Donna Sherard (Uganda), and *Stepping Stones*, introduced by Mzikazi Nduna and Rachel Jewkes (both from South Africa). While neither tool focuses specifically on violence against women, both encourage communication on entrenched gender norms, barriers to communication and their impact on individual lives and health. Both tools promote open, supportive dialogue as a vehicle for increasing receptivity among community members to positive prevention messages.

The training game *In Her Shoes* and its Spanish language adaptation *Caminando en Sus Zapatos* were introduced by Margarita Quintanilla (Nicaragua). As the title suggests, *In Her Shoes* lets participants walk in the shoes of women struggling to leave violent relationships and to experience the barriers and challenges these women face as they navigate services such as shelters, police, health care and courts. By gaining insight into the day-to-day reality for these women, participants, usually practitioners and service providers, equip themselves to provide meaningful, holistic and empathetic assistance for these women in the future.

What lessons have been learned?

Promote messages that empower women and challenge harmful gender norms.

An integral part of prevention is changing gender norms which perpetuate women's unequal status into ones that empower women and promote equality in relationships. Basil Tushanbe, coordinator for *African Transformation*, emphasized that "*African Transformation* encourages increased couple communication, [which] creates better opportunities for joint planning, decision making in relation to family planning and sharing of roles." Facilitators guide discussions about the impact of harmful gender norms on people's lives and how such norms can be changed. Participants shared the following impressions: "I have learnt that if a woman works outside the home, it does not [necessarily]

lead to unfaithfulness.” “I have learnt the importance of sharing responsibilities with my wife.” “I have learnt that in case my husband dies, [I have the right] to safeguard our children’s property.”

Facilitate participatory and interactive dialogue that encourages understanding.

When women and men are able to discuss their fears and concerns openly, violence may be averted. In an interview, Rachel Jewkes noted that *Stepping Stones* encourages couples “to communicate their feelings in order to ward off violence. Violence is often used by men when they feel angry and powerless. By helping men and women talk about their relationship issues, we help reduce the use of violence. For example, a man may tell his partner, ‘I feel anxious when I come to your home and find you are not there, because I am worried. I feel jealous, and that’s why I’m angry. And the woman may say [something like], ‘I feel you are upsetting me when you get angry because I’m out when you come by. I am a child in the household, and if my grandmother asks me to buy bread, I must buy bread. I am not seeing other men.’”⁴⁸

Recognize the links between gender-based violence and sexual and reproductive health concerns, and support open communication regarding sexual and reproductive health issues.

Creating comfortable spaces for frank discussion about taboo subjects like sex and sexuality allows participants to identify risky behavior and reflect on ways to transform it. Participants provided the following feedback after attending a *Stepping Stones* program: “Women felt full of enthusiasm upon knowing that men who attended *Stepping Stones* began to see the importance of change in their sexual behavior and their outlook towards women.” “My relationship has improved because my husband no longer goes out to engage in extramarital sexual activities.”

Creating comfortable spaces for frank discussion about taboo subjects like sex and sexuality allows participants to identify risky behavior and reflect on ways to transform it.



Kivulini community mobilization, Tanzania

A *Stepping Stones* exercise called “Let's look deeper at why we behave as we do” encourages women and men to discuss their sexual expectations, within and outside of relationships. Young women in South Africa opened up about looking for the Triple C's, “CCC for car, cash and cell phones.” They also discussed men's attitudes towards casual sex. The typical encounters young women describe place them at greater risk for both HIV and violence. A “change chart,” for participants to identify risky behavior they have engaged in, is used to explore why they engage in such behavior and to think of steps they can take to change that behavior.

Employ a range of mass media initiatives with messages that reach and engage a wide audience.

Different people will respond to different media. Videos, pictures and stories used in *African Transformation* feature inspiring profiles of women from different backgrounds who have overcome adversity in their lives. Donna Sherard reflected that “*African Transformation* is an important innovation for addressing gender norms because it is multimedia but designed to facilitate discussion. The project actively involves men and is designed to be used by men and women together and encourage action.”

Link communication tools with complementary initiatives, such as community mobilization, health care and service provision.

In Her Shoes has won praise in the United States and been recommended as a training tool for health practitioners, police, court officials, community activists, service providers, advocates and others engaged in addressing gender-based violence. Such partnerships are essential in improving meaningful access to service and care and building support for normative and policy change. By engaging various sectors of the community in dialogue, communication tools foster an environment of support for women's rights and an understanding of the steps needed to support and promote those rights.

Partnerships between community mobilization and health care, police, counseling, advocacy and other service provision initiatives are essential in improving meaningful access to services and building support for normative and policy change.

Ensure that facilitators are given adequate, ongoing training and support.

Stepping Stones and *African Transformation* emphasize the importance of ongoing training for facilitators. Many participants at the meeting echoed the need for this emphasis. Some were concerned that inadequately trained facilitators would find it difficult to guide discussions on challenging or controversial issues. The concern was raised in the context of responding to community members who do not support change and who may actively steer discussion away from gender equality. Training is essential for learning how to guide such debates, hear and acknowledge people's underlying concerns and support dialogue that encourages participants to share their perspectives while listening to others. Also critical is ongoing support for facilitators to address their own concerns, fears and questions.

AFRICAN TRANSFORMATION

The *African Transformation* toolkit features inspiring profiles of women from low socioeconomic backgrounds who overcame gender barriers many considered insurmountable to achieve goals many considered unachievable. The profiles are used to spark dialogue and explore how traditional social roles operate in women and men's lives. *African Transformation* promotes a vision of a tolerant society in which women and men respect each other, examine and change gender-based inequities and participate in equitable decision making and resource allocation.

A specific module on intimate partner violence features Fortunata Mafaku, a woman from Tanzania who overcame domestic violence and co-founded a counseling assistance center for women and children. Deputy Regional Representative Donna Sherard reflected that "*African Transformation* is an important innovation for addressing gender norms because it is multimedia but designed to facilitate discussion at a community level. Most importantly, the project actively involves men and is designed to be used by women and men together, and to lead them to take action."

Coordinator Basil Tushanbe emphasized that "increased couple communication creates opportunities for joint planning and decision making and sharing of responsibilities. In addition, it offers an opportunity for members to discuss causes of domestic violence and discuss their own relevant initiatives on how to address such a problem."

Participants have noted about *African Transformation*: "I have learnt that if a woman works outside the home, it does not [necessarily] lead to unfaithfulness." "I have now learnt the importance of sharing responsibilities with my wife." "I have learnt that in case my husband dies, [I have the right] to safeguard our children's property." The approach emphasizes the process of fostering individual and community receptivity to positive prevention messages.

More information at www.cdfuug.co.ug

IN HER SHOES

Meeting survivors' immediate and long-term needs means being able to empathize with them and understand what they are going through. Health care practitioners, counselors, police, court officials and other service providers need to recognize the difficulties and barriers facing women attempting to leave abusive relationships and use that insight to provide compassionate, nonjudgmental assistance.

Margarita Quintanilla introduced *In Her Shoes*, a training game that brings to life the experiences of women struggling to escape violence in their lives. In it, participants assume and experience the roles of diverse women as they seek assistance from a variety of resources set up as stations. Each station represents an institution or service that women encounter when they attempt to escape a violent relationship, such as courts, doctors and shelters. And each station may be a resource or a barrier. *Caminando en sus Zapatos*, a Spanish language adaptation developed last year, focuses on the experiences of Latin American women. In focus groups, women in Latin America commented that they related to the women portrayed. The experiences, challenges and barriers faced as well as the successes gained were familiar to them. The women's stories were their stories.

In Her Shoes demonstrates that an individual woman's escape from abuse is fraught with complications and unpredictability. The experiential nature allows participants to understand the severe challenges faced by abused women and to answer for themselves questions such as, "Why doesn't she just leave?" By "walking in their shoes" service providers gain insight into the particular barriers women face, including stigmatization, discrimination, fear and lack of resources, allowing them to take the first steps in providing compassionate, holistic assistance.

More information at www.wscadv.org/Resources

STEPPING STONES

Stepping Stones is a training package on gender, HIV, communication and relationship skills designed to help women, men and youth explore their social, sexual and psychological needs, discuss sexual and reproductive health, and examine communication and relationship skills. First developed in Uganda in 1995, it has been widely adapted for use in a variety of contexts and countries in Africa, Asia and Latin America. Mzikazi Nduna, a researcher involved in introducing the *Stepping Stones* model in South Africa, highlighted how participants have used *Stepping Stones* in their communities: "In this community, facilitators believe it may not be easy for women and men to access voluntary counseling services because of the belief in 'coconut wireless, which is faster than lighting.' This widely used saying for gossip is applied to lack of confidentiality from service providers. Training participants discussed the importance of confidentiality in dealing with GBV and HIV and about ways of 'slipping the tongue.'"

Participants are guided through interactive discussions to identify risky behaviors, address issues and concerns and reflect on their actions. A "change chart" is used to brainstorm how harmful behaviors can be changed. Language familiar to the group and culture creates a comfort level for talking about taboo subjects such as sexuality and relationships. Participants reflected: "Women felt full of enthusiasm upon knowing that men began to see the importance of change in their sexual behavior and their outlook towards women. Men in the communities tended to empathize with women's situation and would do something in their personal capacity . . . to change the existing order." "Before the program, the men used to beat their wives all the time. But because of the knowledge gained, this has changed and you won't hear fighting now."

More information at www.stepsstonesfeedback.org

■ Men Joining Hands With Women to End Gender-Based Violence

What does it mean to engage men in prevention and why is their involvement critical?

Evidence suggests that one of the most promising ways to reduce a community's tolerance for gender-based violence is to promote nonviolence and gender equitable norms among boys and men. Participants at the meeting highlighted the importance of engaging men integrally and visibly in prevention efforts. While most men do not perpetrate violence against women, such violence is primarily committed by men. Violence rooted in gender inequality is compounded by notions of masculinity, including the need to dominate women. Vincent Kiwanuka from the *Be a Man Campaign* noted "there is a need to challenge male gender norms that threaten the health of men and their families."

Preventing violence requires community-wide social change, so men need to be an integral part of that process. Men who do not use or condone violence need to join women in speaking out and calling for accountability. Male peer groups are a powerful tool for transforming ideals of masculinity. As boys look up to the men, positive male role models are key to changing gender norms, including what it means to be "a real man."

Women are typically the focus of reproductive health interventions, yet men are central to sexual and reproductive health decision making. Traditional gender roles often prevent women from making their own reproductive health choices.

—EngenderHealth

The organization EngenderHealth also recognizes that “women are typically the focus of reproductive health interventions, yet men are central to sexual and reproductive health decision making. Traditional gender roles often prevent women from making their own reproductive health choices. In addition, the health of both men and women is compromised by risky male behaviors such as violence and seeking multiple sex partners.”⁴⁹

How are men getting involved in preventing gender-based violence in the region?

An increasing number of men are joining hands with women in efforts to end gender-based violence. In this region, promising initiatives such as the *Be a Man Campaign*, introduced by Vincent Kiwanuka (Uganda), the *Men as Partners* program, introduced by Fredrick Nyagah (Kenya) and Rita Ndegwa (Kenya), the *Men to Men* project, introduced by Kennedy Otina (Kenya), and the *Malawi Bridge Project*, introduced by Glory Mkandawire (Malawi), are inspiring examples of men raising their voices in support of women’s equality and violence-free communities.

The success of these initiatives is due to their efforts to engage men in open, supportive dialogue, focusing on the benefits of violence-free relationships while avoiding judgmental, negative stereotypes. Their approaches are based on encouraging receptivity to the messages, meeting men in familiar, comfortable locations and understanding their concerns. Engaged men can act as powerful roles models for other boys and men in the community. The voices of Kiwanuka, Otina, Nyagah, Ally and other men in the movement attest to the power of individuals to inspire widespread change.



Kivulini, Tanzania

should not be dismissed, mobilizing change should never rely on instilling a fear of sanctions, nor should it focus on negative portrayals or judgmental statements. Instead, it should begin with the premise that most men are good people and want healthy relationships. Women, men and youth should be encouraged to discuss, separately and together, their vision for strong, mutually nurturing relationships. Otina stressed that “for men to listen, you need to talk to them in a positive, proactive way. There is this fear that men have that women are taking over. But it is not about taking over. It is about the right way of life.”

What are the lessons learned?

Accentuate the positive through a benefits-based approach.

Initiatives should focus on promoting the benefits of violence-free relationships, homes and communities. While legal and punitive consequences for violent acts

Build support among men for gender equality and nonviolence and create opportunities for community-wide dialogue among women, men and youth about their concerns.

Men listen to other men. Initiatives should facilitate open supportive environments where men can talk freely, without fear of judgment, and feel encouraged to reach out to other men. This strategy fosters male activism and creates role models in the community, which can reduce backlash. A critical and common feature of the initiatives introduced at the meeting is their use of male activists to facilitate a space for frank discussion—discussion aimed at men supporting other men in speaking out against gender-based violence. A male participant of *Men to Men* reflected that: “I think I can now understand the way I violate women naively. I strongly believe the time for us to stop this is now. This violence doesn’t make us happy in the family.” And a participant in the *Be a Man Campaign* reflected that with regard to gender norms the only differences between women and men are biological, “otherwise both are capable and equally important.”

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BE A MAN CAMPAIGN, UGANDA

Research in Uganda indicates that prevailing gender norms encourage boys and men to exhibit certain behaviors, with grave consequences for their health. Studies also indicate that challenging inequitable gender norms is a necessary component of HIV prevention. However, the following quote from a man attending a training session highlights some of the obstacles: “You people want to put women above men and make them rebellious.”

Vincent Kiwanuka, coordinator of the *Be a Man Campaign*, noted “the need to challenge male gender norms that threaten the health of men and their families. This includes the norms that encourage men to have multiple sexual partners and the norm that discourages men from seeking advice, support and treatment from health providers, and thereby contributing to a reduction in the incidence of HIV and to improved health and well-being for themselves and those around them.” The Campaign’s public debates, TV, radio and other media events focus on helping young men adopt positive male attitudes that promote healthy behaviors and strong female/male relationships.

Ultimately, the Campaign aims to reduce the number of men with multiple sexual partners, improve communication between partners, increase disclosure of HIV status, nurture respectful and nonviolent means of resolving conflicts and promote responsible fatherhood.

There is a need to challenge male gender norms that threaten the health of men and their families.

—Kiwanuka

When we approach men as violent, as always beating up their wives, they tend to be defensive and resistive. At some point, it creates a barrier and you are not able to communicate . . . If you communicate effectively, I think you can make a breakthrough. —Otina

MEN TO MEN, (MEN FOR GENDER EQUALITY NOW) KENYA

Kennedy Otina's very personal account of his motivation for joining the *Men to Men (Men for Gender Equality Now)* project in Kenya speaks volumes about the need to engage men as an integral part of social change, as well as the transformative power of initiatives that seek to bring out the best in men. Otina recounted his perspective: "I am first of all doing this for my own good. I have managed to establish peace in my family because I decided not to violate my wife again. However looking at the world of my daughter I must keep on working hard to change my fellow men so that my daughter can live her life in the fullest void of oppression and violation."

Men for Gender Equality Now, which is a project of FEMNET (African Women's Development and Communication Network), has grown from a small group of men condemning gender-based violence to a powerful program of over 70 men walking hand-in-hand with women in support of survivors. Otina reflected that "when a battery or rape occurred, only the women were seen as talking about it, condemning it. We started feeling we were missing in action by not saying anything. So we started showing our faces. It created quite an impact with people wondering, 'who are these men condemning violence?'"

The project's philosophy is to open communication. Otina stressed that "when we approach men as violent, as always beating up their wives, they tend to be defensive and resistive. At some point, it creates a barrier and you are not able to communicate . . . If you communicate effectively, I think you can make a breakthrough."

More information at www.femnet.or.ke

ENGENDERHEALTH: MEN AS PARTNERS

"Women are typically the focus of reproductive health interventions, yet men are central to sexual and reproductive health decision making. Traditional gender roles often prevent women from making their own reproductive health choices. In addition, the health of both men and women is compromised by risky male behaviors such as violence and seeking multiple sex partners."⁵⁰ The above from EngenderHealth reflects the challenge and need to engage men in promoting gender equity in their health, families and communities.

In South Africa, EngenderHealth's multifaceted program *Men as Partners* engages men in reducing gender-based violence and in promoting men's role in HIV/AIDS prevention, care and support. The program challenges norms of masculinity through a range of community mobilization efforts, involving collaborations with civil society, health care providers, the national health system, and media campaigns promoting social change. The program also involves clinics, in an effort to increase men's use of HIV services.

More information at www.engenderhealth.org

What Are Some of the Challenges for Community Mobilization?

- Rigorous evaluation is a particular challenge for initiatives aimed at transforming norms and facilitating communication, due to the difficulty of measuring long-term change. There is a need for evaluation models and indicators adapted for measuring social change, and for initiatives to incorporate monitoring and evaluation as a critical part of their efforts.
- Programs may underestimate the long-term nature of social change. Transforming norms will not happen overnight. An investment needs to be made in sustained initiatives as opposed to short-term, ad-hoc campaigns. Donors also need to recognize the complex, long-term nature of community mobilization and work with organizations to develop meaningful expectations regarding outputs.
- One size does not fit all when it comes to social change. Different people respond to different strategies and messages. Community members need to be engaged in identifying and developing a range of strategies and messages that will resonate with the wider population. Initiatives should not focus on a single strategy that will reach a limited segment of the population.
- Facilitators (and trainers themselves) need ongoing training and support. This support needs to be an integral part of any community mobilization initiative and prioritized in the development of programs.
- While participants agreed with the need to involve men, they stressed that prevention efforts must always remain focused on women's needs and priorities and ensure that women's voices are at the fore. During community activities that engage both women and men on gender-based violence prevention, it is often useful to create the opportunity for single-sex groups, so women and men can explore attitudes and experiences in a safe space. Collaboration with women's organizations should be encouraged to ensure that women's priorities are always at the fore.
- Successful initiatives focus on challenging gender norms and inequality, and not just on the manifestations of violence. It is thus important to find and build on support from receptive community members. Many participants, however, highlighted the difficulty of finding receptive men and leaders to spearhead initiatives in their communities.

● Strengthening Service Delivery for Survivors of GBV

How can strengthening service delivery help in preventing and responding to GBV?

Early one evening in Nairobi, while waiting at a bus stop on her way home, Margaret was accosted, dragged behind a bush and gang raped by 10 men until dawn. When they finally left her, she made her way 400 meters to a petrol station where she was given a sweater to replace her tattered clothing and some money to get home. Filled with shame and blaming herself, she could not face her parents. Her sister accompanied her to one of the largest hospitals in Kenya. When she was finally seen by the doctor after hours of waiting, he instructed her to use her own fingers to remove the semen from her body and place it on a glass slide for analysis, since he did not have gloves and did not wish to go looking for them.⁵¹

—Story recounted by Ann Njogu, Executive Director, CREAM, at an OSI/ SHARP meeting

Because so many women come into contact with the health system at some point in their lives, the health sector has a unique opportunity to address the needs of survivors and prevent the perpetuation of violence in women's lives.

Practitioners who do not raise the issue of violence may misdiagnose problems, provide inadequate care or even put women at increased risk for further violence.

The public health importance of violence against women, and the role of the public health sector in addressing and preventing such violence has been given increasing recognition. Because so many women come into contact with the health system at some point in their lives, the health sector has a unique opportunity to address the needs of survivors and prevent the perpetuation of violence in women's lives. From a human rights perspective, the sector's role in protecting community health carries a responsibility to use its resources towards ending the epidemic of gender-based violence.

Health providers are often the first and only point of contact outside the home for survivors of gender-based violence. By addressing such violence with women, practitioners strengthen their ability to provide appropriate, holistic care. By counseling women and providing referrals, they empower women to leave cycles of violence, preventing further violence from occurring. Practitioners who do not raise the issue of violence may misdiagnose problems, provide inadequate care or even put women at increased risk for further violence.

The health sector has made considerable progress over the last two decades in improving access to services and treatment for survivors. Guidelines have been developed by a number of health care and other organizations on how health workers can better identify, support and refer victims of violence. A number of African countries have begun incorporating guidelines for addressing gender-based violence in their health sector policies, and some, including South Africa, have piloted projects that train health workers to identify and respond to abuse.

But Margaret's story, recounted by CREAM's (Centre for Rights Education and Awareness) Executive Director, highlights that survivors still face many challenges in accessing care and services. The health sector's progress to date has not been adequate, and health professionals face a number of barriers when confronting gender-based violence. The biggest challenges remain the stigma that surrounds gender-based violence and ensuring that women have access to quality, long-term, holistic care.

What efforts are being made to strengthen service delivery?

The third panel at the Kampala meeting turned the spotlight on strengthening services for survivors. Mary Ellsberg used the experiences of PATH to highlight some promising practices for promoting meaningful support for survivors of gender-based violence. Nduku Kilonzo from Liverpool VCT (Kenya) shared findings from an evaluation of post-rape care services and how they were used to catalyze change in the health sector's response. Irma Maharaj from the Saartjie Baartman Centre for Women and Children (South Africa) highlighted a model for providing survivors comprehensive care in a multi-service center.

Panelists emphasized that the response to violence in women's lives can be strengthened with a holistic approach that addresses women's immediate and long-term needs, recognizes the emotional trauma they may suffer and challenges the stigma that accompanies gender-based violence. The experiences of PATH and Liverpool VCT highlighted the importance of breaking the silence around gender-based violence and confronting discriminatory attitudes among providers. The experiences of the Saartjie Baartman Centre empower women to leave violent relationships, preventing further violence.

What are the lessons learned?

Break the silence!

Health care providers may lack the knowledge and confidence to address the issue of violence with women in their care or to recognize signs of violence. Many are afraid that asking about violence may offend women or raise issues that they, as service providers, may be unable to address. Ellsberg noted that "if health care providers are not asking about women's experiences with violence, they may be missing critical information about problems and may be providing inappropriate care. Practitioners need to realize they can make an important contribution to addressing violence through actions that are not time consuming and do not require additional skills. Giving women the opportunity to be heard and have their feelings acknowledged is critical to empowering them. Success may not necessarily mean ending violence, rather it may be giving women a sense of control, offering them alternatives and helping them deal with the stigma and shame associated with intimate partner violence."

Studies indicate that most women would welcome the opportunity to discuss the issue of violence, if asked in a private, empathetic and nonjudgmental manner.⁵² Because violence is such a serious threat to women's health, many experts encourage providers to ask about violence as a routine part of clinical history taking. Studies with practitioners have shown that the use of a screening tool or chart prompt can strengthen providers' capacity and comfort and increase identification rates for violence.⁵³

If health care providers are not asking about women's experiences with violence, they may be missing critical information about problems, and may be providing inappropriate care....Success may not necessarily mean ending violence, rather it may be giving women a sense of control, offering them alternatives and helping them deal with the stigma and shame associated with intimate partner violence. —Ellsberg

Studies indicate that most women would welcome the opportunity to discuss the issue of violence, if asked in a private, empathetic and nonjudgmental manner.

Responding meaningfully to gender-based violence also requires providers to challenge stigmatizing norms and attitudes about violence, within themselves, among their colleagues and within the community.

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Challenging norms and attitudes requires providers to examine their own prejudicial beliefs and for health sector training to include discussions about prevailing attitudes and the experiences that may have shaped them. Findings from the Liverpool VCT evaluation suggest that service providers' prejudicial attitudes regarding gender-based violence prevented women from accessing care. Misconceptions about the use of force as opposed to consent and about the belief that "women say 'no' when they mean 'yes'" continue to influence how a provider responds to survivors.⁵⁴

Kilonzo noted that "community stigma is also a challenge for addressing sexual violence. For instance, if a boy tells a girl that he can ruin her reputation in the community by saying that she was raped, fear may lead her to unwillingly have sex rather than face possible stigmatization associated with having been "raped." A 16-year-old girl from Thika explained how nuanced the line is between force and coercion: "Let's say I have a boyfriend and am against the act, but you can be forced. He will come at night when he knows I am there because he wants to do . . . and to make me give him . . . He knows if he rapes me, I will be disappointed and when the others get to know 'wataniepuka, na wataniciekea na watasema nilirepiwa' [they will reject and laugh at me saying I was raped], so I will give in."

Develop clearly defined policies that can provide a critical framework for addressing gender-based violence and a baseline for assessing the provision of care and services.

The Liverpool VCT assessment revealed serious gaps in the response to sexual violence. Service delivery was inconsistent across the sector. VCT counselors were unsure of how to deal with sexual violence cases. Emergency contraception was not routinely discussed or delivered. Practitioners unclear on protocols were unable to establish evidence chains for prosecuting cases. Records documenting "assaults" omitted references to the relationship between assailant and victim or to sexual violence. Establishing clear norms and protocols would provide practitioners guidance in supporting and empowering survivors.

Follow the cardinal principle for practitioners to "first do no harm."

In the context of gender-based violence, this means not re-victimizing, judging or humiliating women, or compromising their safety. Anyone who may come into contact with survivors should be sensitized to their particular needs and how to respond with compassionate, appropriate care. This type of response needs to be integrated across all existing health initiatives, with specific attention paid to how abuse and coercion are addressed within and outside clinic settings.

Ensure that information systems that document and give much needed visibility to the issue of gender-based violence are an integral component of health sector care.

The sector needs to assess the effectiveness of services and approaches, identifying whether women use the services, whether they benefit from them, and the impact of interventions including any unintended and unforeseen consequences. Tools are needed to assess women's well-being and satisfaction with services in order to inform the design of rigorous interventions and success indicators.

Develop system-wide procedures that promote adequate support and referrals for women who disclose violence.

In addition to increasing identification rates, the health sector should emphasize follow-up supervision and counseling, standardized procedures for patient flow and documentation, assistance with danger assessment and safety planning, providing information about rights, ensuring patient privacy and strengthening community referral networks.

Develop close collaborations and referral mechanisms across the spectrum of social care services and organizations, to ensure a meaningful response to women reporting violence.

The development of community-based networks greatly enhances the quality of care provided to survivors. Referral networks ensure that women receive holistic and comprehensive attention to their needs and do not fall through the cracks when interacting with different institutions. The Liverpool VCT evaluation brought to light the need to offer follow-up counseling for survivors, their partners and families. The study indicated high attrition rates for post-exposure prophylaxis (PEP) HIV prevention, especially among those not participating in post-treatment counseling.⁵⁵

Research conducted by the Gauteng (South Africa) Department of Health on the provision of PEP to survivors of sexual assault, confirms the findings of the LVCT assessment. Their study found that less than 27 percent of patients who took PEP after a sexual assault completed the regimen.⁵⁶ The study further indicated that "interagency referrals appeared to be largely nonexistent at some sites . . . four of the seven sites had no referral links to rape trauma counseling services . . . At most sites, it appeared as though health workers' primary focus was on providing the drugs, with less thought and time spent on the emotional needs of the survivor."⁵⁷

Recognize that women may find themselves unable to break free from vicious cycles of violence without meaningful access to a holistic, multifaceted range of support services.

Arranging for services in hard to reach locations may prove difficult and dangerous for already vulnerable women. The logistics involved in traveling safely from a shelter to a counseling center or a training program may prove to be serious obstacles. Irma Maharaj of the Saartjie Baartman Centre for Women and Children stressed that "a multifaceted

A multifaceted response is needed to deal with the complexity of gender-based violence and to meaningfully support women. Initiatives to address violence against women also need to remain flexible as women's needs change in relation to their changing environment.

—Maharaj

response is needed to deal with the complexity of gender-based violence and to meaningfully support women. Initiatives to address violence against women also need to remain flexible as women's needs change in relation to their changing environment." Centers like Saartjie Baartman provide a range of shelter, counseling and support services for survivors. Access to support in one safe location reduces vulnerability to further violence and empowers women to escape violent relationships.

LIVERPOOL VCT POST RAPE CARE PROGRAM

Motivated by alarming rates of sexual violence seen by health practitioners, Liverpool VCT initiated an assessment of post rape care service delivery at health care facilities, aimed at evaluating how well survivors' needs were being met. The assessment revealed a number of serious challenges to the health sector's response to sexual violence. Practitioners lacked the framework, standards, coordinating mechanism and procedures to guide their response. Service delivery was inconsistent across a sector dealing with limited resource capacities. And referral mechanisms were not in place for women to access critically needed resources.⁵⁸ Nduku Kilonzo, Director of Policy and Performance, noted that "a lot of VCT counselors are saying there is a need to address sexual violence with their clients, but they are unsure of how to deal with it. There is little coordination of services and clarity on the protocols that should be followed."

In response, the Liverpool VCT *Post Rape Care Program* partnered with the government to strengthen post rape care service in health facilities and to address barriers to response. Their efforts helped introduce a multisectoral, holistic approach to care—strengthening norms and protocols, integrating treatment with ongoing counseling and legal training, instituting evaluative mechanisms, and taking steps to address underlying attitudes regarding HIV/ AIDS and gender-based violence. A number of services for survivors are now provided free of charge in health facilities, including the following:

- Clinical evaluation and documentation (including comprehensive forensic examinations, evidence collection, specimen analysis and standardized legal evidence documentation);
- Clinical management of injuries, emergency contraception, PEP and STI treatment;
- Collection of epidemiological data on sexual violence; and
- Crisis prevention and trauma counseling services for survivors and their families (including ongoing HIV counseling and testing in the context of trauma, PEP adherence and preparation for the criminal justice process).

Liverpool VCT also promotes the development of national policies and strategies, collaborating with the government to produce standard-setting documents, including training manuals and curricula on how to provide clinical and counseling care for survivors of sexual violence. New guidelines include details for reporting rape and remove the requirement for police presence during an examination.

More information at www.liverpoolvct.org

SAARTJIE BAARTMAN CENTRE FOR WOMEN AND CHILDREN: ONE-STOP CENTRES FOR SURVIVORS OF VIOLENCE

The Saartjie Baartman Centre in Manenberg, South Africa, is recognized as a model site for providing holistic, integrated services to survivors of violence in a safe, accessible environment. Some of the services are managed directly by the Centre, including 24-hour crisis response, a residential shelter for abused women and their children, legal assistance and job skills training. Other services are provided by ten organizations working in partnership at the Centre, including an after-hours crisis response for children; specialized counseling services in rape/sexual assault, drug and alcohol abuse, trauma and domestic violence; job-skills training and job placement projects; primary health care and HIV/AIDS programs; community outreach; advocacy and lobbying; training and research.

Irma Maharaj, a researcher at Saartjie Baartman, stressed the need for a broad, multisectoral response to gender-based violence. The first multiservice centre of its kind in South Africa, the Centre's strong partnership with government, nongovernmental and private entities forms the core of its comprehensive services—allowing the Centre to address the full range of survivors' needs and to empower women in breaking the cycles of violence in their lives.

More information at www.saartjiebaartmancentre.org.za



Catering training course at the Saartjie Baartman Centre

Photo provided by Saartjie Baartman
Centre

What are some of the challenges facing service provision for survivors of gender-based violence?

- Institutional constraints continue to challenge the health sector's response to gender-based violence, including an absence of clearly articulated norms and protocols, limited resource capacities and inconsistent delivery of care across the health system.
- The lack of an integrated response and referral mechanisms across the spectrum of social care services and institutions means that survivors may not receive the holistic medical, psychological and social services and support they need to escape cycles of violence.

- Concerns have been raised regarding routine enquiries about gender-based violence in settings where women have little access to services and live with discriminatory laws. This is especially important within communities where stigmatizing attitudes about gender-based violence prevail. Policies need to be in place to ensure women's safety and confidentiality.
- Concerns have also been raised about the lack of training available to health professionals on gender-based violence. Long-term efforts are needed to sensitize and train health care practitioners and integrate gender-based violence into all aspects of health care services.
- Stigma, shame, fear and prejudice remain powerful barriers to care and services for women experiencing violence. Women may be reluctant to bring up violence in their lives, fearing blame, judgment or disbelief on the part of the provider, stigmatization from the community or reprisals on the part of the abuser—especially in settings where mandatory notification laws are enforced. Practitioners may share prevailing community perspectives, including stigmatizing attitudes about gender-based violence, such as the often-voiced belief that women are responsible for the violent acts they experience.
- The lack of rigorous evidence, evaluation and monitoring to guide the development of programs and policies remains a critical problem. Inadequate attention has been paid to evaluating health care interventions, especially in resource-poor settings. Interventions carried out in a vacuum may lead to wasting resources, providing inappropriate care or potentially subjecting survivors of violence to additional harm or violation of rights.

**ADDRESSING GENDER-BASED VIOLENCE THROUGH USAID'S HEALTH PROGRAMS:
A GUIDE FOR HEALTH SECTOR PROGRAM OFFICERS**

Researchers, health advocates, practitioners and service providers have increasingly stressed the unique role and responsibility of the health sector in addressing and responding to gender-based violence. Participants at the Kampala meeting also emphasized that preventing such violence requires an integrated, holistic and multisectoral approach. However, many service providers are unclear as to how gender-based violence can be meaningfully integrated into their work.

The USAID guide *Addressing Gender-Based Violence through USAID's Health Programs* was produced by the Interagency Gender Working Group to help program officers integrate gender-based violence into their health sector portfolios during project design, implementation, monitoring and evaluation.⁵⁹ The guide emphasizes a multisectoral approach to preventing and responding to gender-based violence, focusing on specific actions the health sector can take. It explores why programs—such as community mobilization, health policy, communication for social change, service delivery and humanitarian efforts—need to integrate gender-based violence into their work, and it provides concrete examples for each.

More information www.igwg.org

● The Co-Pandemics of HIV/AIDS and GBV

Why are HIV/AIDS and GBV considered co-pandemics?

*The toll on women and girls . . . presents Africa and the rest of the world with a practical and moral challenge, which places gender at the center of human condition. The practice of ignoring gender analysis has turned out to be lethal.*⁶⁰

—Stephen Lewis, 2002

All over the world, women are being infected with HIV at higher rates than men. On average, there are 13 women living with HIV for every 10 infected men, and this gap continues to widen, with women being infected with HIV at earlier ages than men. Furthermore, young girls are three times more likely to get HIV than boys.⁶¹ Women from sub-Saharan Africa are the most severely affected by HIV / AIDS. According to UNAIDS, three quarters of all the women in the world with HIV live in sub-Saharan Africa. And 59 percent of HIV-infected people in this region are women.⁶² It is also becoming clear that married women in the region are at very high risk for contracting HIV.

Research has confirmed a direct correlation between sexual and other forms of gender-based violence and vulnerability to HIV infection. A recent study in South Africa found that women who suffer intimate partner violence are nearly 50 percent more likely to become infected with HIV compared with women who live in nonviolent households.⁶³ Other studies from the region indicate that women who have experienced violence are up to three times more likely to get HIV than those who have not.⁶⁴ Once infected, women are at increased risk of violence from their partners, family or community when they reveal their positive status or seek treatment or services. Dr. Peter Piot, Executive Director of UNAIDS, makes the link very clearly in recognizing that “we must eliminate violence against women if we are to stop the spread of AIDS.”⁶⁵

A recent study in South Africa found that women who suffer intimate partner violence are nearly 50 percent more likely to become infected with HIV compared with women who live in nonviolent households.

At the heart of women’s vulnerability to violence and HIV / AIDS is the imbalance of power between women and men. Social, economic, religious, cultural and political realities and practices join forces with biology to make girls and women more vulnerable to HIV infection. Unequal gender roles further increase the extent to which girls and women are not only at greater risk of HIV infection but also of being subjected to violence and abuse. Thus, girls and women are disproportionately impacted by the co-pandemics of HIV and gender-based violence. Women are also at a disadvantage when it comes to information about HIV / AIDS—men in the region appear to have greater access to electronic media and print resources. Women, who are most affected, are unable to get the information they need to empower themselves in making healthy, life-saving choices.

Why exactly does the imbalance of power between women and men increase women’s vulnerability to both violence and HIV? There are a number of reasons. Forced sex, within and outside of marriage, is a leading cause of HIV infection among women.

Additionally, a forced or coerced sexual debut is associated with increased HIV risk-taking behaviors. The threat of violence or fear of violence may limit a woman's ability to negotiate for safe sex and prevent her from getting tested, seeking treatment or disclosing her status. Women who have experienced violence in their lives are more likely to engage in risk-taking behavior, including having transactional sex or sex with multiple partners. Women's economic vulnerability and dependence on men make it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection and less likely that they will leave a relationship that they perceive to be risky. Finally, women may also experience violence as a result of disclosing their status, including being abandoned or kicked out of their homes, losing their property or children and suffering physical abuse.

What initiatives are being implemented to address these co-pandemics?

A number of initiatives are challenging the linked factors that increase women's vulnerability to HIV/AIDS and gender-based violence. SAfAIDS's (Southern Africa AIDS Dissemination Service) *Women's Treatment Literacy Kit* and the training manual *Gender Violence: HIV and AIDS* developed by AIDS Legal Network guide practitioners and others in challenging stigma and shaping an environment where women are treated holistically. Raising Voices' multimedia activist kit *SASA!* makes the case for a synergistic approach to addressing both GBV and HIV/AIDS. Kivulini (see section on community mobilization) promotes women's economic empowerment and independence as a way of decreasing their dependence and vulnerability to both GBV and HIV.

What lessons have been learned?

Strengthen collaboration in prevention and service efforts addressing gender-based violence and HIV/AIDS, two of the most critical issues impacting communities in Africa and worldwide.

Organizations focused on violence prevention and those addressing HIV/AIDS need to make the link between these co-pandemics in meeting women's needs. Fundamental to this work is the need to address the underlying causes for women's increased vulnerability to violence and HIV/AIDS: the imbalance of power between women and men. *SASA!* is a powerful tool to help individuals and communities make this link, address the pandemics in tandem and improve outcomes for both. Of critical importance is challenging stigmatizing attitudes associated with violence and HIV/AIDS, including providers' attitudes, and ensuring that women are not revictimized when accessing treatment. Health initiatives should collaborate with community mobilization efforts that inspire change in norms and empower women, such as Kivulini in Tanzania. The *Women's Treatment Literacy Kit* and the manual *Gender Violence: HIV and AIDS* offer a range of creative resources and interactive activities to explore stigma and discrimination, which could help practitioners in responding holistically.

There is a need to address the underlying causes for women's increased vulnerability to both violence and HIV/AIDS: the imbalance of power between women and men.

Address the link between sexual violence and HIV as evidenced by the prevalence of rape and sexual violence and the increase in the number of women infected with HIV.

The challenges faced by survivors of sexual violence and women infected by HIV relate to prevailing gender norms and involve myths and stigmatizing attitudes. Both are linked to sex, often a taboo subject, and both have struggled for acknowledgement from communities and governments, resulting in inadequate attention and resources. Both suffer from a lack of understanding about the psychological and emotional impact on the people affected. The Liverpool VCT *Post Rape Care Program* has developed guidelines for health care practitioners to respond to survivors of sexual violence and address their immediate and long-term health and emotional needs. These guidelines include ongoing follow-up and counseling for women on PEP treatment.

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Strengthen capacity on the part of health sector practitioners and other service providers to give appropriate, holistic care and address the special treatment concerns of girls and women.

Health workers usually focus primarily on providing drugs, with less thought and time spent on the emotional needs of survivors. Health services for rape survivors should not stop with the provision of PEP. As SAfAIDS emphasizes regarding HIV treatment, “Rolling out ART [anti retroviral therapy] is not about unveiling antiretroviral drugs but a complex exercise whose planning should address special treatment concerns of girls and women . . . [including] rampant gender-based violence.”⁶⁶ The psychological impact of trauma should also be acknowledged, and treatment should be expanded to include referrals for trauma counseling at qualified rape counseling centers.

Health workers usually focus primarily on providing drugs, with less thought and time spent on the emotional needs of survivors.

Prioritize safety for girls and women.

Guidelines and protocols should be introduced to ensure women’s needs are met and safety is prioritized, along with continuous training, supervision and monitoring. Health service providers need to be especially aware of the potential risk of increased violence for women who disclose their HIV status or whose partners find out they are seeking testing or treatment—and to be prepared to assist and support women in their decision-making process. Liverpool VCT developed guidelines to address the concerns for women’s long-term health and safety.

What are the challenges for addressing HIV/AIDS and GBV?

The HIV epidemic has imposed new challenges on all human institutions, particularly the health sector:

- Fear of violence and the double stigmatization and discrimination that accompanies violence and HIV/AIDS continues to prevent women from seeking treatment, getting tested or disclosing their status. Women may be subjected to violence at the hands of partners because they have tested positive or negative, or merely because of getting tested. Lack of access to treatment in turn perpetuates stigma and discrimination and fuels continued violence.

Fear of violence and the double stigmatization and discrimination that accompanies violence and HIV/AIDS continues to prevent women from seeking treatment, getting tested or disclosing their status.

- The link between women's vulnerability to violence and HIV is not being made, and women are dying as a result. The director of a woman's organization in Kampala responded in a survey: "I know the issues are important, but how to talk about it, how to start raising the issues, we just don't know where to start." A program officer of an HIV organization said, "We don't have materials that would help us address the link, and our organization doesn't have the capacity to develop such things." Both their remarks reflect the reality that the link is being missed.
- HIV health and counseling services offer a unique entry point for addressing and preventing violence. In fact, women in South Africa have used VCT services as a useful part of the decision-making process regarding their violent relationships and possible options. However, institutions and individuals are often unprepared, unwilling or hesitant about tackling violence. Many do not view it as part of their specific mandate, and are not comfortable raising the issue. Treatment and advice for sexually transmitted diseases and pregnancy is often overlooked in favor of providing drugs. And inadequate attention is paid to the long-term medical and emotional needs of women.
- Gender-based violence needs to be integrated into training for all HIV / AIDS service providers and counselors to raise their comfort level and strengthen their capacity to meet women's needs. Trainings can introduce simple interventions such as asking the question, "Do you feel safe in your relationship?" combined with positive prevention messages and empowering women with alternatives and referrals.
- Studies reveal that disparate levels of training and knowledge among health care workers as well as staff shortages and limited resources, including drugs, place severe constraints on services. The Gauteng (South Africa) Department of Health found that many patients provided with post exposure prophylaxis (PEP) after a sexual assault failed to complete the treatment. Many failed to adhere to regimens because of a lack of clarity about medication and its side effects. Furthermore, judgmental attitudes towards sexual assault patients were also reported, aggravated by the lack of interagency referrals to rape counseling services at many sites. Factors influencing adherence seemed to depend largely on the skill, knowledge and attitudes of the health staff and the nature of support patients receive in their immediate environment. Failure to adhere is especially a concern in areas where there are no services and referrals.
- Survivors may be revictimized in the health delivery system. Women diagnosed as HIV-positive may be isolated in separate wards. Their HIV status may be disclosed to third parties without their consent, or test results may be disclosed in public, without counseling. Survivors who do not want to keep pregnancies may

not be offered meaningful counseling and assistance. Gender-based violence is also reinforced by institutional structures and oppressive customs that make it difficult for women to feel safe when seeking health care.

- The widely promoted ABC prevention strategy fails to respond to women’s needs and take into account gender inequalities, including high rates of abuse and sexual violence. Married, monogamous women are highly vulnerable to HIV infection due to their unequal status in marriage. They may have difficulty negotiating safe sex and escaping abuse. A woman’s risk of contracting HIV through sexual violence is not eliminated, even if she follows ABC. As long as the ABC strategy does not address the factors underlying violence, it can perpetuate the spread of HIV.
- HIV prevention strategies need to promote the fundamental human rights of equality and nondiscrimination. This includes the right to be free from violence, the right to make sexual and reproductive decisions and the right to security of one’s body. Many organizations are grappling with the dual issues of traditional norms around sexuality and restrictions imposed by funders on the kind of counseling and treatment that can be offered.
- A concern expressed by participants during a workshop on VCT was the thin line, with regard to HIV testing, between a women being coerced or giving informed consent to be tested. There is an existing potential for violating women’s rights—especially in the context of prenatal counseling. As prenatal services move towards provider-initiated testing and counseling, the risks may increase for women. Safety and confidentiality need to be the primary concern of all interventions and an integral part of organizational policy.
- In Tanzania, counseling and testing within health care settings has increased rates of reported gender-based violence, especially when there was no previous communication about HIV tests between a woman and her partner. As one participant noted, “We don’t know the outcome of disclosing for women. We don’t understand why, how or who women choose to disclose to and what pathways they will use. And this is particularly complex and risky for women who have come in for sexual violence.” Service providers need to support women in making decisions about disclosing HIV testing, HIV status or sexual violence in a way that empowers them and protects them. A project in Tanzania is studying the role of social support networks as a tool for helping with disclosure, including (a) who women go to for support; (b) whether women want social counselors to accompany them; and (c) to what extent social networks are an avenue for enhancing disclosure or ensuring that disclosure happens. Such social support networks are critical aspects of holistic support.

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Women who seek HIV testing may face violence from their partners because of getting tested or because of discordant results.

- Participants also grappled with the issue of discordance. Women who seek HIV testing may face violence from their partners because of getting tested or because of discordant results. Nduku Kilonzo noted the link between discordance and gender-based violence—provoked by shame, anger or suspicion, and fueled by stigmatizing beliefs. The mere act of getting tested has the potential for causing violence. If she is positive, then her partner’s feelings of anger, shame and suspicion may lead to violence and abandonment. If a woman is negative, forced, unprotected sex may make her vulnerable to infection. Some counseling centers are addressing this issue.

Over the past decade, the response to both HIV / AIDS and gender-based violence in the region has grown significantly. However, greater attention needs to be paid to addressing the factors that increase women’s vulnerability to these co-pandemics if progress is to be made in mitigating and preventing either one. This attention needs to be an integral part of all advocacy, service provision, health care, counseling and other initiatives.

SOUTHERN AFRICA AIDS DISSEMINATION SERVICE (SAFAIDS)

The Harare-based Southern Africa AIDS Dissemination Service (SAfAIDS) challenges stigma and discrimination associated with HIV/AIDS using online resources—including online information, interactive discussion forums and blogs—to help demystify the disease and debunk myths. A focus of its work has been empowering women by addressing gender inequality and gaps in knowledge regarding treatment options for HIV/AIDS.

SAfAIDS developed the *Women’s Treatment Literacy Toolkit* as a way to encourage women to begin and stay on antiretroviral treatment programs. The Toolkit’s information sheets, brochures, “Let’s Share” cards, posters and audio recording are available in English and three local languages. The kit addresses violence as a consequence of HIV and the factors that increase women’s vulnerability to violence and reinfection if on ART. These risk factors include the following:

- Male partners who do not wish to be tested or seen getting a supply of ART may force women to share their ART.
- Fear of violence or stigma may prevent women from disclosing their status to their partners, leading them to take ART in secret.
- Discriminatory social norms prevent women from making individual choices about their health. Those making independent decisions to be tested and to begin ART treatment may be at risk for violence at the hands of their partners.
- HIV-positive women on ART must practice safe sex, or they risk reinfection and developing drug-resistant strains of HIV.

To address these concerns, the toolkit addresses issues of adherence, emphasizes the importance of not sharing ART, encourages open discussion and testimony by women about their HIV status and ART needs, and promotes empowering an HIV-positive woman to demand safe sex even when she is on treatment (this is called “positive prevention”).

More information at www.saf aids.org.zw

AIDS LEGAL NETWORK (ALN): RESOURCE AND TRAINING MANUAL

The Capetown based AIDS Legal Network (ALN) serves as a resource, training and advocacy center for promoting holistic, human rights based responses to the public health co-pandemics of gender-based violence and HIV/AIDS. ALN's work addresses discriminatory practices and attitudes and promotes behavioral change. ALN also responds to legal and ethical challenges presented by GBV and HIV/AIDS.

To promote an integrated response, ALN and the KZN Network on Violence Against Women developed the resource and training manual *Gender Violence: HIV and AIDS*. The manual is an invaluable tool for strengthening organizational and individual capacity and promoting understanding of the links between gender-based violence and HIV/AIDS. Through a range of guided, interactive and participatory activities that explore the role of gender in treatment, support and care, this manual contributes to dialogue for changing the environments that foster both pandemics.

Johanna Kehler of ALN asks: "Ever wonder why there is little joy to be had for women while celebrating 10 years of constitutionally guaranteed dignity, equality, nondiscrimination and freedom? Ever wonder why we don't seem to be able to enjoy our freedom? Free to make choices, to make informed decisions about one's own body; free to choose whether or not to have sex, with whom, when and where; free to choose whether or not to test for HIV and to disclose one's HIV status; free to enjoy respect and protection from all forms of violence, be it at home, the bedroom, the workplace, or the many places where we want to access services for our own protection. What needs to be explored, done and challenged to create a society which is free of violence and free of HIV, is what this publication is all about."

More information at www.aln.or.za

SASA! AN ACTIVIST KIT FOR PREVENTING VIOLENCE AGAINST WOMEN AND HIV/AIDS

Violence prevention efforts are underway in many countries throughout East and Southern Africa. However, many do not focus on the link between gender-based violence and HIV/AIDS. Similarly, very few HIV/AIDS organizations are addressing violence within their prevention and outreach work. The results are deadly for women. Raising Voices conducted a survey of more than 20 prominent HIV/AIDS and violence organizations in Uganda to learn more about what prevents them from addressing these cross-cutting issues. The most common barriers cited by both HIV/AIDS and violence organizations were the lack of training, information, resources and funding.

In response, Raising Voices created *SASA!*, an activist toolkit for organizations in East and Southern Africa that traditionally address gender-based violence and/or HIV/AIDS. The kit aims to generate synergy and to demonstrate that in the African context addressing both pandemics in tandem will significantly improve outcomes in both areas. *SASA!* presents a fresh perspective—pushing boundaries, challenging organizations and individuals to rethink issues in a new light, avoiding old jargon in favor of a bold new analysis of power and activism.

In Kiswahili, *sasa* means "now." Now is the time to prevent violence against women and HIV/AIDS. *SASA!*'s multimedia activities are intended to reach a broad spectrum of stakeholders from community members and leaders, to journalists and police, to policy makers and service providers.

More information at www.raisingvoices.org

● Addressing GBV in Armed Conflict and Refugee Communities

What particular vulnerabilities do women in armed conflict and refugee communities face?

Many women are abused when fleeing to safety, by border guards, security officials, armed groups, even peacekeepers or other refugees.

Women refugees and asylum seekers may find themselves caught in inescapable cycles of violence. Fleeing from one dangerous situation, they may find themselves in another equally dangerous one. Many women are abused when fleeing to safety, by border guards, security officials, armed groups, even peacekeepers or other refugees. Faced with the challenge and burden of caring for family members in violently insecure environments, women are extremely vulnerable to abuse and exploitation. Searching for food and water or even private space to relieve themselves puts girls and women at risk, even after reaching the supposed safety of camps. In some conflict ridden areas, peacekeepers and humanitarian workers responsible for protecting and helping civilians have broken that trust in the most egregious manner, abusing girls and women or demanding sex in return for access to critical resources. And for those women affected by gender-based violence, accessing services may be difficult or impossible.

Patterns of violence in refugee settings often reflect the day-to-day violence that was prevalent in women's homes. The upheaval adds to the pressures on uprooted individuals and communities in refugee and resettlement camps. Community structures and traditional support networks, which might otherwise accord women a measure of protection, break down. Previously existing or new tensions can be exacerbated by the abrupt loss of economic and social context and the strains of camp life. The resulting pressures have a detrimental effect on both women and men, and in many cases, may lead to increased gender-based violence as men vent their frustration.

What efforts are being made to address GBV in these particular situations?

It is in this context that the particular vulnerabilities of women in armed conflict and refugee situations need to be addressed. As the organization mandated to coordinate prevention and care for survivors of gender-based violence in Darfur, the United Nations Population Fund (UNFPA) works with all responsible entities to ensure an integrated response that prioritizes the protection of refugees and displaced persons and appropriate services for survivors. Roselidah Ondeko introduced UNFPA's initiatives in the field. Ann Reiner introduced the American Refugee Committee International's (ARC) unique participatory video project that allows survivors to speak out and play an active role in promoting change in their community. Both initiatives address the specific challenges refugee and displaced women face.

What lessons have been learned?

Call on leaders at all levels to recognize, condemn and take action to end gender-based violence in refugee and armed conflict situations.

Women in armed conflict situations and those in refugee and displaced person camps are particularly vulnerable to violence and exploitation at the hands of armed forces, other refugees, security personnel, humanitarian aid workers and peacekeepers. However, as seen in Darfur, recognition by authorities of gender-based violence is often shamefully slow. While the global community increases calls for action, backed by UN resolutions, violence continues as politics fuels inaction.

Continue advocacy calling for zero tolerance policies, implementation of resolutions and international law and identification and prosecution of all perpetrators.

UN guidelines and regulations regarding sexual exploitation need to be strictly enforced in all situations involving armed conflict or humanitarian emergencies. Peacekeepers, humanitarian workers and all those working in conflict-affected and refugee communities need to be held accountable for acts of gender-based violence.

Prioritize protecting refugee and displaced women and meeting the particular needs of survivors through coordinated and integrated prevention and response efforts.

The recently released UN Guidelines on Gender-Based Violence Interventions in Humanitarian Settings emphasizes that “to save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a coordinated manner to prevent and respond to gender-based violence from the earliest stages of an emergency. Survivors of gender-based violence need assistance to cope with the harmful consequences, and may need health care, psychological and social support, security, and legal redress.” Providers of prevention activities must be knowledgeable, skilled and compassionate in order to help survivors and establish effective preventive measures. Prevention of and response to GBV requires coordinated action from all sectors and agencies. It is this response that UNFPA is responsible for coordinating in Darfur.

Recognition by authorities of gender-based violence is often shamefully slow. While the global community increases calls for action, backed by UN resolutions, violence continues as politics fuels inaction.

Coordinated and integrated prevention and response efforts need to prioritize protecting refugee and displaced women and meeting the particular needs of survivors.

THROUGH OUR EYES: A COMMUNITY VIDEO INITIATIVE ON GENDER-BASED VIOLENCE FOR CONFLICT-AFFECTED COMMUNITIES

The American Refugee Community International (ARC) and Communication for Change (C4C) have undertaken a unique community video collaboration that addresses the problem of gender-based violence in conflict-affected and displaced communities. The *Through Our Eyes* video teams were pioneered at a 2006 training workshop at Lainé refugee camp in Guinea. Community members use the videos, which focus on issues such as rape, wife beating, STDs and forced marriage to share experiences and offer ideas on how to address problems confronting them. They also gain firsthand information about ARC's services for survivors of violence including legal aid, counseling and skills-training programs that foster women's economic independence.

The participatory videos allow survivors of gender violence to play an active role in promoting change within their communities. Some survivors choose to speak out directly. The refugee woman featured in the team's first documentary on the consequences of forced/early marriage wanted to share her story on camera. In doing so, she was able to urge others to abandon a practice that had such a detrimental effect on her own life. Ann Reiner, Acting HIV/AIDS Program Manager, highlighted that the video scenarios may resonate with viewers in a way that lessens concerns about stigma, encouraging them to speak out and seek appropriate care. Prior to the implementation of video activities, most reports of rape involved assaults on children. Following the sessions, a greater number of adult women have come forward to report assaults and seek counseling. ARC is piloting the video project in the Sudan and other countries.

More information at www.arcrelief.org and www.c4c.org

THE UNITED NATIONS POPULATION FUND (UNFPA) RESPONSE TO SEXUAL AND OTHER GENDER-BASED VIOLENCE IN DARFUR, SUDAN

In October 2004, UNFPA, the United Nations Population Fund, was mandated by the UN Sudan Country Team to coordinate prevention and care for gender-based violence in Darfur. UNFPA implements this mandate through (1) the coordination of working groups at the federal and state levels; (2) advocacy for protection and change in service provision policies; (3) training for health care workers and medical supplies for the treatment of sexual violence cases; (4) the development of guidelines and protocols; and (5) capacity building for NGOs, UN agencies and the government.

UNFPA's advocacy has raised awareness at the highest levels and led to positive policy change. Roselidah Ondeko, GBV Program Manager at UNFPA, highlighted the organization's work with the Ministry of Health, which has greatly facilitated prevention of and response to gender-based violence. As she described, "rape survivors were required to fill out a specific police form—Form 8—before receiving any medical attention or services." Many survivors are understandably unable at that moment to recount the details of the assault, but they are in need of immediate care. UNFPA advocated for and briefed police on new policies allowing rape victims immediate access to care and raised awareness of the rights of the survivor in the process.

Ondeko emphasized that "data on gender-based violence in Sudan is political, but it is also critical." Despite widespread reports of sexual and other forms of gender-based violence in Darfur, the availability of quality data on the magnitude of the problem is very limited. UNFPA works with partners to strengthen knowledge on gender-based violence and to ensure that information is collected and disseminated in an ethical manner. She noted that journalists often included survivors' names and contact information in their reports, violating confidentiality and increasing their vulnerability. To address this, UNFPA worked with the media on guidelines for reporting on gender-based violence and ensuring confidentiality for survivors.

More information at www.unfpa.org

What are some of the challenges in addressing GBV in armed conflict and refugee communities?

- Gender-based violence may become politicized during civil conflicts, such as in Darfur. Women continue to suffer as negotiations stall, peace talks flounder and global and regional politics get in the way of action. The global community has recognized and expressed outrage about the abuse of girls and women in armed conflict and refugee communities, but the situation remains fatally static. Advocacy for an end to impunity for such violence needs to continue, and the international community needs to demand accountability and an end to its tolerance.
- Addressing women's needs is extremely challenging in violent, insecure environments. Access to refugee camps is restricted or prohibited. Victims of abuse are hard to reach. Resources and services are provided in an ad-hoc and sporadic basis, and survivors are unable to access long-term, holistic care. Different sectors involved in humanitarian relief and peacekeeping efforts may not prioritize prevention of gender-based violence in their work. The *Guidelines for Addressing Gender-Based Violence* are meant to assist organizations in responding to such violence. However these guidelines have not been meaningfully implemented, even in Darfur. UNFPA has taken the lead, but coordination and communication remain a challenge for the organizations in this area.
- Many individuals have expressed concern regarding research that is not coordinated with service provision, for example, surveying women affected by gender-based violence in conflict-affected areas without adequate referral mechanisms in place to meet their needs.

Addressing women's needs is extremely challenging in violent, insecure environments.... Advocacy for an end to impunity for such violence needs to continue, and the international community needs to demand accountability and an end to its tolerance.

● Advocating for Improved Laws and Policies

Why is continued advocacy essential for prevention and response efforts?

Preventing gender-based violence requires fostering an environment of respect for human rights, creating a framework for addressing violence as a violation of human rights and making a commitment to promoting and protecting those rights at all levels. The landmark *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, ratified in 2005 after years of advocacy and collaboration between women's groups and the African Union, provides the first explicit framework for women's rights in the region. Three articles specifically address gender-based violence: Article 3, which prohibits violence against women; Article 4, which focuses on the rights to life, integrity and security of the person, defining ways the State must act to protect women; and Article 5, which focuses on eliminating harmful traditional practices, including female genital mutilation.⁶⁸

Preventing gender-based violence requires fostering an environment of respect for human rights; creating a framework for addressing violence as a violation of human rights; and making a commitment to promoting and protecting those rights at all levels.

While statistics show that rape is prevalent in Kenya,⁶⁹ the legal framework has proved entirely insufficient for dealing with pervasive sexual violence, often handing offenders a proverbial “slap on the wrist.”

The Protocol is an important first step, but advocacy is still needed to bring national laws and policies in line with international and regional instruments. Elizabeth Njuguna of the Center for Rights, Education and Awareness (CREAW) highlighted a familiar concern among those working to prosecute sexual offenses: “The man convicted of raping my client was sentenced to spend one day in jail. I could hardly explain it to my client. There is a need to address all remaining holes, gaps and fallacies in the laws addressing rape.” While statistics show that rape is prevalent in Kenya,⁶⁹ the legal framework has proved entirely insufficient for dealing with pervasive sexual violence, often handing offenders a proverbial “slap on the wrist.”

Hundreds of thousands of women were estimated to have been raped and infected with HIV as a consequence of the 1994 genocide in Rwanda.⁷¹ Women were doubly victimized by the stigmatization and ostracism associated with sexual violence and the lack of meaningful legislation specific to such violence. The Rwandan Penal Code, for example, did not provide a legal definition of rape or sexual torture and offered no rape shield law to protect victims. Prior to 2004, the media frequently portrayed sexual stereotypes of Tutsi women as arrogant and desirable. Many women, traumatized and unsupported, were unwilling to report rape or to testify. Thus, a culture of silence enveloped the issue.

These examples are powerful reminders that preventing gender-based violence requires an environment that promotes and protects human rights and views violence as a violation of rights.

CAMPAIGNING FOR THE AFRICAN PROTOCOL ON WOMEN'S RIGHTS

On October 26, 2005, African women celebrated the coming into force of the landmark *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, known as the Protocol. The culmination of years of advocacy and collaboration between women's groups and the African Union, the Protocol provides the first explicit framework for women's rights in region. Three articles specifically address gender-based violence, including defining specific ways the State must act to protect women and eliminating harmful traditional practices, including female genital mutilation.⁷²

The final ratification was a hard-won victory. A full year after its adoption, only one country had ratified the Protocol. Recognizing the need for concerted advocacy, women's organizations around the region formed the Solidarity for African Women (SOAWR) coalition in 2004 to spearhead a campaign encouraging governments to ratify and domesticate the Protocol.

Caroline Muthoni Muriithi of Equality Now and Faith Kasiva of COVAW (Coalition on Violence Against Women) described SOAWR's widely popularized and innovative campaigns, which engaged the coordinated efforts of individuals and organizations across the region. A “Text Now 4 Women's Rights” mobile phone campaign urging people to text their support for the Protocol and petition for its ratification had thousands of people sending messages. SOAWR also spearheaded a colored card campaign, giving green cards to countries that had ratified the Protocol, yellow cards to those that had signed but not ratified it, and red cards to those who had neither signed nor ratified it. These campaigns were carried out in conjunction with ongoing dialogue with Member States to discuss progress towards ratification and any obstacles to that progress.

Largely due to SOAWR's tireless efforts, the Protocol became the fastest ratified human rights instrument in Africa, with ratifications by 20 countries to date. H.E. Alpha Oumar Konare, Chair of the African Union Commission, stated that “the speed with which the Protocol came into force on 25 November 2005 set a new record for the ratification of pan-African rights standards for the continent. It is a remarkable success for all of us that have campaigned at pan-African, national and local levels to make this a reality . . . In doing so; we give life to the vision of the African Union as people-driven and inclusive.”

More information at www.equalitynow.org/english/campaigns/african-protocol/african-protocol_en.html

EQUALITY NOW: GRASSROOTS NETWORKING FOR ACTION

Equality Now was founded in 1992 to work for the protection and promotion of the human rights of women around the world. Working with national human rights organizations and individual activists, Equality Now documents violence and discrimination against women and mobilizes international action to support their efforts to stop human rights abuses. Through its global Women's Action Network of concerned groups and individuals, Equality Now distributes information about human rights violations, takes action to protest these violations and brings public attention to human rights violations against women.

As the Secretariat for SOAWR, Equality Now's Kenya Office spearheaded the coalition's regional advocacy, calling on Member States to ratify and domesticate the *Protocol to the African Charter on Human and Peoples Rights on the Rights of Women*, including its widely popularized mobile phone text message and colored card campaigns. Their tireless energy, creative strategies and ability to galvanize broad-based support have fostered a receptive policy climate for preventing gender-based violence.

More information at www.equalitynow.org/english/campaigns/african-protocol/african-protocol_en.html

COALITION ON VIOLENCE AGAINST WOMEN (COVAW) KENYA

COVAW has worked for over ten years to break the silence surrounding gender-based violence in Kenya and strengthen the capacity of communities to respond to and prevent such violence. As the focal point for SOAWR in Kenya, COVAW spearheaded a national campaign to popularize the Protocol to the African Charter on Human and People's Rights on the Rights of Women and advocate for its ratification and domestication. COVAW's multipronged strategy included engaging the support of key policy makers and cabinet ministers, organizing meetings with magistrates and lawyer's groups, leading community advocacy and awareness raising on the Protocol's provisions and conducting extensive media and petition campaigns.

As Faith Kasiva stressed, "effective advocacy in getting this legislation passed involved working with those in leadership positions, members of parliament, the Ministry of Gender, the Attorney General and cabinet members to ensure successful passage of the bill. It also means following up with the same leaders to ensure its meaningful implementation and raising awareness about its provisions with women's groups. This is a gradual process and it will take time. Most of the international instruments are yet to be domesticated."

More information at www.covaw.or.ke

What advocacy campaigns are being conducted in the region?

The fourth panel and subsequent workshops highlighted inspiring work by organizations and coalitions to advocate for laws and policies that promote women's rights and an end to gender-based violence.

Caroline Muthoni Muriithi and Faith Kasiva highlighted SOAWR's innovative and widely popular campaign, responsible for the *African Protocol on Women's Rights* being the fastest ratified document on the continent. SOAWR will continue its efforts to popularize the Protocol across the continent and to advocate for its universal ratification and implementation at the national level.

Despite its ratification, discriminatory views about gender-based violence continue to impact women's human rights. Elizabeth Njgunu introduced CREAW's work with civil society organizations to draft and advocate for a bill that addresses the numerous gaps in the law hindering meaningful prosecution of perpetrators. The introduction of a Sexual Offenses Bill in Kenya's Parliament garnered initial, enthusiastic support from members. However, this support eroded quickly and dramatically as members became familiar with the Bill's provisions; they acted to have it withdrawn or to introduce amendments greatly diminishing its provisions. Predominant views on rape were summed up in one member's objections: "I am one of those people who have looked at the bill chapter by chapter. You know as well as I do that these creatures [women] are somehow shy. They are not as open as men are. When an African lady says "no" she means 'yes.'"

The list of objections appeared endless. Parliament members claimed that marital rape was a foreign concept that did not exist in the African context. After all, how could one rape one's property? Members objected to a sexual harassment clause claiming it was "intended to destroy the very basic tenets of our society and social life of courtship!" Perhaps the most egregiously unconstitutional amendment introduced was the so-called "Zuma clause," which stipulated that if a victim of rape reports the crime, and the perpetrator is not convicted of rape or defilement, the victim shall be charged with malicious prosecution and face a sentence similar to what the perpetrator would have received, if convicted. Victims of sexual assault would be considered criminals for the mere "crime" of telling someone they had been raped.

While not perfect, the new act, signed into law on July 14, 2006, toughens sanctions for rape and sex-related crimes, and broadens the range of sex crimes to include date rape, sexual harassment in institutions, child trafficking, sex tourism, rape and incest. Convicted rapists face a sentence of ten years to life, and the penalty for the deliberate transmission of HIV/ AIDS is a minimum fifteen years. Women's groups won a victory with the passage of the new law, but as Njuguna noted, serious gaps and loopholes need urgent redress.

Mahdere Paulos of the Ethiopian Women Lawyer's Association (EWLA) highlighted examples of gaps in Ethiopia's legal framework on gender-based violence. These included provisions allowing perpetrators to receive minimal sentences or avoid punishment altogether and the lack of specific provisions for addressing certain forms of violence, such as abduction for marriage and harmful traditional practices. EWLA undertook groundbreaking research in the country on a range of issues related to promoting and protecting women's rights, which were the key resource for legal reform advocacy, including influences on the new Ethiopia Penal Code and public education programs.

A number of other local and national campaigns in the region are galvanizing support for legislative and policy change (see boxes on AMWIK and SNV).

CENTRE FOR RIGHTS, EDUCATION AND AWARENESS (CREAW)

CREAW is a nongovernmental organization created to promote equality and justice and to enhance women's access to basic human rights through the elimination of all forms of discrimination and violence. In addition to providing legal aid for survivors of abuse, advocating for women's rights, and lobbying for progressive legislation around sexual abuse, domestic violence and affirmative action, CREAW's staff work on gender-based violence prevention at the community level through education, mobilization and awareness raising campaigns.

Executive Director Ann Njogu stresses that women have little to no control over their sexuality in Kenya and that sexual violence is rampant. CREAW's programs facilitate broad community engagement in addressing issues almost never discussed in Kenya and fostering a sense of accountability for gender-based violence. Njogu hopes that "if one woman tells 20 people what they have learned and each of them tells 20 more, the seeds they have planted will germinate, results will be achieved, and community paradigms will change."⁷³

Changes are already underway. CREAW's "Rape Red Spot" campaign identifies dangerous community zones that have been the sites of multiple assaults and raises awareness about these areas through billboards and media. The initiative has already led to a wider understanding of gender-based violence and galvanized the revitalization of risky locations, as stakeholders remove clutter, improve lighting and increase surveillance.

More information at www.creawkenya.org

ETHIOPIAN WOMEN LAWYER'S ASSOCIATION (EWLA)

The Ethiopian Women's Lawyer's Association has worked since 1996 to promote the economic, political, social and legal rights of women in Ethiopia, and to secure the full protection of those rights under the Constitution and relevant human rights conventions. EWLA's research, advocacy and legal aid initiatives prioritize the elimination of legally and traditionally sanctioned discrimination against women and ensure equal treatment and protection for women under the law.

EWLA's recent efforts contributed to the revision of discriminatory legislation, including the Penal Code, to address gaps in responding to gender-based violence. A new penal law, which came into force in July 2005, addresses sexual and physical violence against women by raising mandatory sentences and incorporating provisions for crimes previously justified as traditional practices—such as FGM, domestic violence, early marriage and abduction for marriage.

More information at www.etwla.org

What lessons were learned?

Build coalitions and networks.

The success of coalitions such as SOAWR, CREAM, COVAW and EWLA points to the strength of networks that engage a wide range of stakeholders, policy makers, advocacy groups and individuals.

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Their achievements speak to the power of uniting individual and organizational voices together to foster change, even when such change appears unreachable. Muriithi noted, in particular, SOAWR's strong relationships with key parliamentarians and decision makers, the strength and visibility of its membership, and its unique, concerted outreach efforts as crucial to its success. For example, the SOAWR coalition uses strategic opportunities, including African Union meetings, to hold governments accountable for meeting their commitments to women.

To counter numerous objections from male parliamentarians to the Sexual Offenses Bill, CREAM mobilized a nationwide campaign, in partnership with a taskforce of organizations and individuals, to advocate for the Bill's passage and the removal of amendments that would erode its intent. In a powerful show of solidarity for the eradication of sexual violence and support for the Bill, task force members rallied huge demonstrations and processions around parliament and remained a vigilant presence at parliament hearings. Members also convened press conferences, plastered the media with advertisements and articles, and held numerous meetings to secure the support of parliamentarians and other leaders.

Engage the support of those in key leadership positions.

Effective advocacy in getting legislation passed involves working with those in leadership positions, members of parliament, the Ministry of Gender, the Attorney General and cabinet members. It also means following up with the same leaders to ensure its meaningful implementation and raising awareness about its provisions with women's groups.

—Kasiva

Kasiva stressed that "effective advocacy in getting legislation passed involves working with those in leadership positions, members of parliament, the Ministry of Gender, the Attorney General and cabinet members. It also means following up with the same leaders to ensure its meaningful implementation and raising awareness about its provisions with women's groups."

Employ multipronged strategies, including mass media campaigns, workshops and community awareness-raising initiatives to ensure widespread publicity and meaningful implementation of those laws and policies throughout the community.

Laws are only meaningful if people understand them, respect them and actively promote them. Creative strategies should be used to bring laws to a wide segment of the population in ways that will resonate with them. For example, SNV campaigns for legislative change using TV and radio broadcasts, reaching a large segment of the population and AMWIK uses Information Communication Technology (ICT) in its campaigns to raise awareness about GBV. (See boxes)

The work is not over. Advocacy should not end with the passage of laws or policies. Numerous gaps and loopholes in the law still need to be addressed. However, as Njuguna stressed, the experiences of “CREAW have pointed to the biggest lesson of all: unless there is a critical mass of women in parliament and in all other decision-making bodies, the women’s agenda will remain a mirage.” For example, the Rwandan elections of 2003, which reserved one third of seats for women, were a catalyst for legislative change to criminalize gender-based violence. Paulos also stressed that “advocacy should be based on research which highlights specific legal and policy issues to be addressed. Legal reform should also be conducted in tandem with mechanisms for monitoring the implementation of the laws.”

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ASSOCIATION OF MEDIA WOMEN IN KENYA (AMWIK)

Jane Thuo, Programme Manager for the Association of Media Women in Kenya, highlighted AMWIK’s creative media campaigns to raise awareness about the harmful nature of female genital mutilation, including a website with personal stories, media reviews and a monthly newsletter, and an international conference on FGM that resulted in the seminal Nairobi Declaration promoting an end to the practice.

AMWIK works to build a cultural and social environment allowing and facilitating the choice of abandoning FGM at the community and individual level. It was involved in a popular signature campaign petitioning policy makers to pass laws against the practice and other regional campaigns advocating its abandonment. AMWIK also uses Information Communication Technology (ICT) to raise the issue of gender-based violence in a small, rural Kenyan community where domestic violence, rape and other forms of violence are rampant. AMWIK also partners with women’s media associations in Tanzania, Ethiopia, Zambia and Uganda for a South-to-South exchange program in which journalists share experiences and creative strategies about how the media can better address gender-based violence.

More information at www.amwik.org

**A CAMPAIGN TO ENACT LEGISLATION ON GENDER-BASED VIOLENCE
NETHERLANDS DEVELOPMENT ORGANIZATION OF RWANDA (SNV)**

As Rwanda emerged from the 1994 genocide, the world learned about the pervasive sexual violence that accompanied the brutal campaign of displacement, starvation and slaughter. With the seminal elections of 2003, women parliamentarians set an ambitious agenda to revise discriminatory laws and draft the *Law on Prevention, Protection and Punishment of Any Gender-Based Violence*. Parliamentarians directed an intensive consultation process with experts and organizations working on GBV and with parliamentarians to discuss the draft terms.

Shirley Randell, senior adviser to the Netherlands Development Organization of Rwanda, highlighted SNV's campaign to support GBV legislation. Conferences and discussions with lawmakers and experts, broadcast nationally on TV and radio, helped frame the issue. Live call-in debates were organized for citizens to ask questions and express concerns. MPs solicited opinions and recommendations and galvanized support during visits to their home districts, followed by letters to the President advocating legislative change.

The Bill's introduction in Parliament on August 2, 2006 stimulated intense debate. The President of the Female Parliamentarians fielded numerous questions about its terms, proposed penalties and other concerns, after which the Bill passed without objection to Committee. Randell noted that parliamentarians were confident their efforts would have a favorable reception because of the widespread support their campaigns and consultations had galvanized. Success came as a result of the political will fostered from all members of parliament and government and a collaborative model of leadership that included men as allies on this issue. The critical lesson was that criticism and opposition should not be feared. As one woman stated, "If you are drafting a law for the population, you must let them discuss it."

More information at www.snworld.org/rwanda

III A NOTE ON MONITORING AND EVALUATION

Why are monitoring and evaluation critical to prevention and response efforts?

Monitoring and evaluation remain a continual challenge to advocates, practitioners and service providers. Information on the effectiveness and impact of interventions is essential, but rarely meaningfully collected. Effectiveness and success are difficult concepts to measure, especially in the context of long-term, community-based prevention initiatives, and there remains a critical need for strong evaluation models that can be adapted to this work.

In the context of gender-based violence, participants stressed the importance of monitoring and evaluation in assessing the effectiveness of prevention and response interventions and their impact at the individual and community level. Evaluations are essential in ensuring that women's immediate and long-term needs are being met, and importantly, that interventions are not harming or re-victimizing women.

When discussing community mobilization work, Lori Michau of Raising Voices emphasized that "monitoring and evaluation of initiatives is challenging. The kind of transformation desired involves multiple dynamic influences at the individual, family and community level. It is a long-term, organic and messy process that does not fit neatly into donor timeframes and expectations. We need to be realistic about what we can expect. Change needs to be tracked at the individual and community level with meaningful, quantifiable indicators established at each phase." She suggested that, when possible, initiatives should team up with researchers to develop models for effective evaluations.

How should organizations evaluate the impact of their initiatives? A workshop focusing on monitoring and evaluation allowed participants to grapple with the challenges involved in meaningful monitoring and evaluation. To frame the discussion, Shanaaz Mathews from the Medical Research Council (MRC) provided the following working definitions:

- **Monitoring** is the routine process of collecting data and measuring the progress of a program based on its objectives. It involves counting what is being done and reviewing the quality of services provided.
- **Evaluation** is the systematic investigation of the effectiveness of a program or project. It requires rigorous study design and measurement over the long term.

Mathews echoed many participants in stressing the importance of monitoring and evaluation for:

- Ensuring that strategies are working;
- Improving the design and implementation of projects;
- Determining if resources are being used effectively and efficiently; and
- Assessing whether objectives are being met.

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—Michau

How are social change initiatives evaluating their impact and what tools are available?

While many groups and organizations use one-time pre and/or post intervention questionnaires for monitoring their work, most are not familiar with scientifically rigorous methods to assess whether a project is on track and what its impact has been. The evaluations of the South African *Stepping Stones* program (see box p. 60) and of post-rape care services at Liverpool VCT in Kenya are examples of scientifically rigorous studies. Both framed the research questions around the specific objectives of the interventions. The recent evaluation of the IMAGE (Intervention with Microfinance for AIDS and Gender Equity) program⁷⁵ is another good example of a participatory evaluation of social change initiatives. According to Julia Kim, a physician and researcher based at Rural AIDS and Development Action Research, University of the Witwatersrand, “the IMAGE study offers encouraging evidence that these realities are not untouchable, and that it is possible to address poverty, gender inequalities and gender-based violence as part of a broader HIV-prevention strategy.”⁷⁶

To evaluate the effectiveness of the *Stepping Stones* model in preventing HIV in South Africa, MRC looked at the program’s impact on HIV incidence and sexual behaviour, including experiences of intimate partner violence. In reference to the surprising findings, Rachel Jewkes stressed that “we should expect different outcomes from different interventions and should not only be asking: ‘Will this person be less likely to perpetrate violence against women after this intervention?’” Evaluations can strengthen our understanding of the process of change and how interventions can contribute to change.

As health workers began reporting increased levels of sexual violence, Liverpool VCT sought to evaluate its post-rape care services, including clinical care management, protocols and procedures and documentation. As Nduko Kilonzo highlighted, the evaluation brought to light stigmatization around gender-based violence, which she emphasized “can include institutional stigma, such as that reported with the police or health services.” It also shed light on the need for guidelines to aid health providers in addressing GBV. The evaluation led to systematic change in service provision and development of national standards for post rape care programs.

Participants highlighted a number of smaller scale evaluations in the region and the need for additional assessments. An upcoming Tanzanian study will look at the role of social support systems as a tool to help women disclose their HIV status and will evaluate the health sector’s understanding of these support systems. Participants also suggested specific ideas for regional evaluations, such as an evaluation following up with women who transitioned out of the Saartjie Baartman Centre to provide insight into the model’s long-term impact on women’s experiences with violence.

We should expect different outcomes from different interventions and should not only be asking: ‘Will this person be less likely to perpetrate violence against women after this intervention?’

—Jewkes

Mathews introduced a number of resources, including two tools for measuring attitudes related to gender norms: the Sexual Relationships Power Scale (SRPS) and the Gender Equitable Men (GEM) Scale. The SRPS measures control in relationships using statements such as: “My partner always wants to know where I am.” “My partner does what he wants, even if I don’t want him to.” And “My partner would get angry if I suggested condom use.” It also measures dominance in decision-making with statements such as: “Who usually has more say about whether you have sex?” and “Who usually has more say about important decisions?”

RESOURCES FOR MONITORING AND EVALUATION

A number of resources are available to guide the formation of research questions and the development of evaluation models:

- The WHO/ PATH publication *Researching Violence Against Women: A Practical Guide for Researchers and Activists* provides step-by-step guidance for those seeking to conduct research on violence against women. www.path.org and www.who.int/gender/en
- The WHO Multi-country Study looked at the prevalence of physical and sexual violence against women in several countries as well as the risk and protective factors associated with this violence. www.who.int/gender/violence/who_multicountry_study
- Measure DHS/ ORC Macro supports the DHS surveys and has a range of resources, including indicators, service provision assessments and other data options that can be adapted for specific evaluations. www.measuredhs.com
- Measure Evaluation has produced a CD-ROM of over 200 publications relating to monitoring and evaluation of population, nutrition, health, family planning, HIV/AIDS and many other topics. www.cpc.unc.edu/measure
- The International Planned Parenthood Federation has developed a range of tools related to reproductive and sexual health, including assessments of health programs. www.ippfwhr.org
- The Reproductive Health Response in Conflict Consortium (RHRC) developed the *Gender-based Violence Tools Manual for Assessment, Program Design, Monitoring and Evaluation in Conflict Affected Settings*. www.rhrc.org
- The SIDA manual *The Path to Equality: A Practical Guide for Evaluating Projects for Women’s Empowerment* provides descriptions of tools for participatory assessment and evaluation.
- Recent evaluations of the *Stepping Stones* and *IMAGE* programs in South Africa and *Puntos de Encuentro’s* edutainment program *Sexto Sentido* in Nicaragua are excellent examples of impact evaluations of behavior change initiatives.
- AIDSquest is a resource for developing HIV/AIDS-related data collection tools, including methodological tips on designing AIDS-related questions and a library of surveys. Behavioral theories used in HIV research are explained, as well as how those theories can be used to inform surveys. www.popcouncil.org/horizons/AIDSquest/description.html

The GEM Scale measures attitudes towards traditional norms with responses to statements such as: “Men are always ready to have sex.” “There are times when a woman deserves to be beaten.” “I would be outraged if my partner asked me to use a condom.” Egalitarian norms are measured with statements such as: “A man and woman should decide together what contraception to use.”

AN EVALUATION OF THE STEPPING STONES MODEL IN SOUTH AFRICA

Rachel Jewkes of the Medical Research Council (MRC) emphasized that “evaluation of initiatives seeking to effect change at the community level is really challenging and involves a lot of complex factors.” An evaluation of the *Stepping Stones* program in South Africa is an example of the importance of assessing programs. At its inception in Uganda, *Stepping Stones* had the advantage of experienced facilitators who were trusted by a motivated community. Participants reported some remarkable changes after the workshop. However, it was unclear whether the same model could be adapted for a different population in a different environment with similar success.

The study sought to determine the effectiveness of the model in preventing HIV infection among youth in rural South Africa, comparing the impact of the *Stepping Stones* intervention on HIV incidence and sexual behavior—including experiences of intimate partner violence. The study found that the program did not protect women from experiencing intimate partner violence. However, it did reduce the likelihood of men perpetrating such violence. Based on the findings, *Stepping Stones* appears to be a useful intervention for young men in preventing intimate partner violence.⁷⁷ However, Jewkes stressed that expected outcomes may differ for women. Since intimate partner violence is primarily male behavior, the finding that the program impacted men’s behavior but did not reduce women’s experiences with violence should not be surprising.

The evaluation highlighted: *Improvements in communication of both men and women with partners were prominent. Stepping Stones, we were told, had profoundly changed communication by teaching them to express their opinions and feelings clearly, listen to each other and to discuss issues rather than remaining quiet and keeping things inside. As a 17 year old Mthatha woman told us: “he listens to me, I just say ‘OK I do not like this and that, the reason is this and that’, ... now I am able to approach him and tell him “‘Sisa something like this and that is wrong, I do not like it” ... The improved communication was coupled with a new realization that violence against women was wrong. Some of the women had seen it as so normative before that they had not thought to act on it. Several of the men spoke of new awareness : “I saw that thing that it is not a right thing. I mean when I beat a girl now you see at my age that means I will beat my wife, if I continue beating girls this time, so I decided that I must stop it.”*

The MRC evaluation highlights the importance of evaluation in understanding how interventions might contribute to change. The results of the evaluation, for example, may prove a better indicator of the relationship between gender-based violence and poor health outcomes. They may also highlight unexpected benefits for women, such as a strengthened sense of agency and capacity to leave a relationship or an increased sense of importance in relation to their role in society.

What are some of the challenges with monitoring and evaluation?

- There is a need for a rigorous evaluation model that can be adapted for use with social change and community mobilization initiatives, particularly for organizations that might not have extensive research skills. Gender-based violence is a relatively new area of research. While progress has been made in measuring prevalence and severity, there is a need to improve and standardize indicators, research methods and data collection tools used to evaluate the impact of GBV interventions.
- As Mary Ellsberg noted (see services section), success can be viewed from a number of different perspectives. In the context of service delivery, for example, Ellsberg explains that “success may not necessarily mean ending violence; rather, it may be giving women a sense of control, offering alternatives and helping deal with the stigma and shame often associated with intimate partner violence.” There is a need to improve understanding of what constitutes “success” and how it can be measured. Interventions focused on decreasing community tolerance of GBV, for example, might look at changes in attitudes underlying such violence, using meaningful indicators to accompany the specific phases of change.
- All programs focusing on gender-based violence need to incorporate a strong monitoring and evaluation component from the design and inception of the intervention, not as an afterthought. Programs should identify results-oriented objectives, clarifying and capturing what success would look like. Indicators should be developed to match the objectives. Particular attention needs to be paid to measuring unintended consequences of interventions and ensuring women’s perspectives and interpretations, especially those of survivors, are taken into account.
- Finally, funders should recognize the complex nature of gender-based violence, and the long-term, nonlinear, organic nature of interventions seeking to transform attitudes and norms. The successes achieved by specific interventions may not fit neatly into standard reporting guidelines and the kinds of outputs expected. Funders should work with organizations in developing meaningful and realistic expectations and translating them into indicators.

There is a need for a rigorous evaluation model that can be adapted for use with social change and community mobilization initiatives, particularly for organizations that might not have extensive research skills.

Funders should recognize the complex nature of gender-based violence, and the long-term, nonlinear, organic nature of interventions seeking to transform attitudes and norms.

IV THE WAY FORWARD: SOME CONCLUDING OBSERVATIONS

The meeting in Kampala highlighted the wide range of groundbreaking research, community activism, service provision and advocacy initiatives in the region, which respond to and challenge gender-based violence. Participants emphasized the need for collaborative, holistic efforts that engage the community in promoting human rights; in challenging the discriminatory norms and stigmatizing attitudes that perpetuate violence; and in responding meaningfully to survivors' immediate and long-term needs. Eunice Njovana, former director of the Musasa Project in Zimbabwe, provided the following concluding observations.

Njovana noted that primary prevention efforts reach beyond the individual to facilitate community-wide social transformation. Pioneering community mobilization initiatives such as Raising Voices, SHARE, CEDOVIP and Kivulini target the root causes of violence by challenging traditional constructions of gender and women's unequal status. By using a human rights framework, they empower women to claim their rights and empower communities to hold all actors, including non-state actors, accountable. Successful initiatives are those that frame their work on an understanding of the causes and impact of gender-based violence. They are the initiatives that address the issue of gender-based violence holistically, taking into account the needs of women, men and young people and working to galvanize a critical mass of support and action.

Njovana highlighted that recent studies on gender-based violence in the region, including the *WHO Multi-country Study*, the Rakai sexual coercion study and the MRC study on femicide, underscore the importance of research to inform programming and advocacy efforts. The importance of rigorous data was summed up by one participant who stated that "if you cannot count it, it does not count." Critical areas of new knowledge helped frame the SHARE program for youth, shape an advocacy campaign on femicide in South Africa and highlight opportunities for new multisectoral approaches. Research into the nature of gender-based violence strengthens understanding of intersections with other issues, including HIV/AIDS. As was noted by several participants, a stronger link between research and programmatic development needs to be made. The evaluation of the *Stepping Stones* initiative underscored the need to integrate evaluation in programming to ensure efficiency and effectiveness.

Njovana also noted the importance of multi-pronged, targeted and community-based advocacy to promote legal change and policy development. To be effective, advocacy needs to reach a wide range of people using appropriate and creative multimedia methods to deliver clear, appropriately packaged messages. Advocacy efforts should be carried out in tandem with the development of strong national institutional mechanisms for supporting women's rights, such as domestication of international and regional laws and education programs that challenge stereotypical images of women.

Njovana wrapped up by drawing from the presentations and dialogue and sharing some implications for strengthening gender-based violence work in the region. In particular, Njovana emphasized that high-level GBV programming and policy reform calls for:

Sustained promotion of primary prevention work — Prevention efforts need to focus on changing the social norms that perpetuate violence, including discriminatory attitudes and behaviors held by women and men. Prevention programs need to focus on communities as a whole and recognize that a cross-section of women and men, professionals and leaders need to be systematically engaged over time in order to influence meaningful change. Transforming deeply embedded norms is not easy and will not happen overnight. Preventing gender-based violence requires the commitment and engagement of the entire community in addressing its root causes.

Engaging youth in prevention efforts — Prevention involves educating young people in the skills needed for handling conflict and engaging in healthy relationships. As Fredinah Namatovu from the Rakai Program emphasized, “it is important to focus on primary prevention initiatives and to reach adolescents with messages regarding reproductive health, domestic violence and HIV / AIDS.”

Comprehensive support services that focus on empowering women and protecting their human rights, including effective documentation and knowledge management systems and integrated service delivery mechanisms—Of primary importance is challenging the stigma surrounding gender-based violence and encouraging family, community and institutional support for women living with violence. Health practitioners need to develop their capacity to identify and provide appropriate services for women experiencing abuse, with a coordinated, holistic response addressing survivors’ physical as well as psychological needs. Prevention initiatives need to be integrated with a range of health care programs, such as those related to HIV / AIDS, reproductive health and adolescent health.

Harnessing political and community leadership and commitment — Gender-based violence is a violation of human rights that has serious and traumatic consequences. Political will, leadership and commitment from leaders at the community, national and regional levels is essential for promoting its prevention—ensuring a meaningful response, and ending impunity for perpetrators. Advocacy efforts need to continue to urge leaders to amend discriminatory legislation, enact and implement laws and policies that promote women’s rights and challenge discriminatory practices.

Strengthening knowledge about the nature, causes and consequences of all forms of gender-based violence in the region and the effectiveness of current initiatives—An overarching message is “the need for strategies to ensure greater visibility about the preva-

lence of such violence, especially through dissemination of information.” Information on all forms of gender-based violence needs to be systematically collected, properly documented and widely shared. In addition to raising visibility, rigorous evidence is needed to increase understanding on the nature of gender-based violence, inform the development of appropriate interventions and strengthen the capacity of advocates, care providers and the community to respond meaningfully. Studies highlighted at the meeting, and others in the region, provide examples of initiatives to strengthen data on gender-based violence. The 2006 *United Nations Secretary-General’s in-depth study on violence against women* provides an overview of data collected to date on violence against women, and highlights gaps and obstacles that remain.⁷⁸ A substantial amount of knowledge has been gathered, but as participants stressed, additional information is critically needed to prevent and respond to gender-based violence. The capacity of women’s organizations, government agencies, researchers and other entities to collect data needs to be strengthened.

**UNITED NATIONS SECRETARY-GENERAL’S IN-DEPTH STUDY
ON ALL FORMS OF VIOLENCE AGAINST WOMEN**

The Secretary-General’s in-depth study on all forms of violence against women was launched in the General Assembly on October 9 2006. The goals of the study were to highlight the persistence and unacceptability of all forms of violence against women in all parts of the world, strengthen political commitment and joint efforts of all stakeholders to prevent and eliminate violence against women, and identify ways to ensure effective implementation of State obligations and increase accountability.⁷⁹

The study gives an historical overview of the development of international awareness and action on male violence against women; sets out the context in which violence against women occurs and persists; synthesizes the knowledge regarding the extent and prevalence of its different forms and manifestations; discusses gaps in the availability of data, including methodologies for assessing its prevalence; highlights the responsibilities of States to address and prevent violence against women; gives examples of promising practices in law, service provision and prevention, and puts forward a blueprint for action by all stakeholders to make measurable progress in preventing and eliminating violence against women.

In December 2006, the General Assembly adopted resolution 61/143 urging Member States to take action to eliminate all forms of violence against women by means of a more systematic, comprehensive, multisectoral and sustained approach.⁸⁰

More information at www.un.org/womenwatch/daw/vaw

Evidence-based community-centered advocacy and activism — Research is a means to ending gender-based violence. Rigorous evidence should be the basis for designing programs aimed at strengthening a community’s capacity to understand and respond meaningfully to such violence and challenge the stigma surrounding it. Research needs to reach the people who will be able to translate it into advocacy, laws, policies, programs and interventions that address all aspects of gender-based violence, most importantly, the community of women whose experiences are quantified in the data.

V APPENDICES

● Meeting Agenda

Wednesday November 8th

Welcome and Introductions

Uganda USAID Mission, IGWG, EARO, PATH, Raising Voices, GBV Prevention Network

Presentations

Presenting the Evidence: Current Research on GBV in the Region

Moderator: Karusa Kiraga, PATH/Population Council

- WHO Multi-Country Study, Jessie Mbwambo, Muhimbili College of Medical Sciences, Tanzania
- Sexual Coercion, Fredinah Namatovu, Rakai Health Sciences Program / Share Project, Uganda
- National Femicide Study, Shanaaz Mathews, Medical Research Council, South Africa

Community Mobilization Approaches for Preventing GBV

Moderator: Monique Widyono, UN Division for the Advancement of Women

- Mobilizing Communities to Prevent Domestic Violence, Lori Michau, Raising Voices, Uganda
- Community Mobilization in Kawempe, Center for Domestic Violence Prevention (CEDOVIP), Tina Musuya, Uganda
- Stepping Stones, Rachel Jewkes, Medical Research Council, South Africa

Strengthening Services Delivery for Survivors of GBV

Moderator: Ann McCauley, EARO

- Health Sector Responses to GBV – Global Best Practices, Mary Ellsberg, PATH, Washington, DC
- Addressing Sexual Violence through VCT Programs Liverpool VCT, Nduku Kilonzo, Kenya
- One-Stop Centers, Saartje Baatman, Irma Maharaj, South Africa

Advocacy for Improved Policies and Laws on GBV

Moderator: Dora Byamukama, MP East African Legislative Assembly

- Advocating for the Women's Protocol, Coalition on Solidarity for African Women's Rights (SOAWR), Caroline Muthoni, Equality Now and Faith Kasiva, COVAW, Kenya
- Sexual Offences Bill in Kenya, Elizabeth Njuguna, Center for Rights, Education and Awareness (CREAW), Kenya
- Legal Reform in Ethiopia, Mahdere Paulos, Ethiopian Women Lawyer's Association, Ethiopia

Thursday November 9th

Review and Setting the Day's Agenda

Skill Building Mini-Workshops (first session)

Working with Men to Prevent GBV

- Men-to-Men Project, Kennedy Otina, Kenya
- Men as Partners / Engender Health, Rita Ndegwa, Kenya

Strengthening VCT to Respond to Violence

- Jessie Mbwambo, Muhimbili College of Medical Sciences, Tanzania\
- Nduku Kilonzo, Liverpool VCT, Kenya

Monitoring and Evaluation

- Karusa Kiragu, PATH/Horizons, Kenya
- Shanaaz Mathews, Medical Research Council, South Africa

Tools for Communication for Social Change on GBV

- *In Her Shoes*, Margarita Quintanilla, InterCambios/PATH, Nicaragua
- Creating a One-Stop Center, Irma Maharaj, Saartjie Baartman, South Africa

Skill Building Mini-Workshops (second session)

Tools for Communication for Social Change on GBV

- African Transformations, Thomson Ondoki, Donna Sherard, Uganda
- BRIDGE Project, Glory Mkandawire, Malawi
- Be a Man Campaign, Vincent Kiwanuka, Young Empowered and Healthy! (YEAH!), Uganda

Strengthening VCT to Respond to Violence

- Johanna Kelher, AIDS Legal Network, South Africa
- Rouzeh Eghtessadi, SAfAIDS, Zimbabwe

Mobilizing Communities to Prevent Domestic Violence

- Yassin Ally, Kivulini, Tanzania
- Christine Musuya, CEDOVIP, Uganda

Priorities for research on GBV (Strategy Session)

- Rachel Jewkes, Medical Research Council, South Africa
- Mary Ellsberg, PATH, Washington DC

Gallery Walk – posters and materials on organizations activities

Parallel Sessions (afternoon)

Launch of SASA! An Advocacy Film on VAW and HIV and Roundtable Discussion on VAW and HIV

- Lori Michau, Raising Voices, Uganda
- Yassin Ally, Kivulini, Tanzania

Traditional Practices/FGM: Roundtable Discussion

- Charity Koronya, Planned Parenthood Association, Kenya

Armed Conflict: Roundtable Discussion

- Roselidah Ondeko, UNFPA, Sudan
- Ann Reiner, ARC, Uganda

Media and Advocacy for Policy Change

- Jane Thuo, Association of Media Women in Kenya (AMWIK), Kenya
- Shirley Randall, SNV, Rwanda

Discussion on Opportunities, Challenges and Recommendations

Closure

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● Meeting of the Gender-based Violence Prevention Network

On November 10, 2006 members of the Gender-based Violence Prevention Network took the opportunity to hold a discussion in Kampala. The meeting was hosted by PATH and Raising Voices. The GBV Network is a coalition of over 130 organizations and individuals from the Horn, East and Southern Africa and around the world engaged in work to address, prevent and end gender-based violence. The meeting was an opportunity for members to learn from other networks about their successes and struggles, to discuss the current state of the Network and in particular, how members would like to see the network grow. Many emphasized that they would like to see the Network grow as a mechanism for inspiring collaborative, coordinated work in preventing gender-based violence. Information on the network can be found at www.preventgbvafrica.org.

Schedule

9:00 – 9:30	Background and current status of the GBV Prevention Network Lori Michau, Raising Voices
9:30 – 10:30	Presentations from other Networks South Africa GBV and Health Initiative (SAGBVHI) Rachel Jewkes Sexual Violence Research Initiative, Nduku Kilonzo Intercambios, Mary Ellsberg
10:30 – 11:00	Break
11:00 – 12:00	Small group discussions on the Network – objectives, structure, strategy
12:00 – 1:00	Group Discussion on Way Forward

This meeting was a wonderful opportunity to have face-to-face discussions about the Network. Many new ideas were shared. All members are encouraged to continue sharing ideas and thoughts about future directions for Network.

The following GBV Prevention Network members participated in the meeting:

- Angie Dawa, Margaret Wanzuu Foundation, Kenya
- Caroline Muthoni Muriithi, Equality Now, Kenya
- Charity Koronya, Planned Parenthood Association, Kenya
- Dolphine Okech, Kenya Female Advisory Organization, Kenya
- Elizabeth Njuguna, Center for Rights, Education and Awareness, Kenya
- Faith Kasiva, Coalition on Violence against Women, Kenya
- Fredinah Namatovu, Share Project, Uganda
- Jane Thuo, Association of Media Women in Kenya
- Janet Khumalo, Family Life Association, Swaziland
- Jennifer Kaahwa, ESCA, Tanzania
- Johanna Kehler, AIDS Legal Network, South Africa
- Kennedy Otina, Men for Gender Equality Now, Kenya
- Lori Michau, Raising Voices, Uganda
- Mzikazi Nduna, University of Wits, South Africa
- Natsnet Gebrebrhan, CHF International, Sudan
- Nduku Kilonzo, Liverpool VCT, Kenya
- Rita Ndegwa, EngenderHealth, Kenya
- Roselidah Ondeko, UNFPA, Sudan
- Rouzeh Eghtessadi, SAfAIDS, Zimbabwe
- Yassin Ally, Kivulini Women's Rights Organization, Tanzania

Those not participating in the network discussion had the opportunity to visit community mobilization initiatives spearheaded by CEDOVIP in Kawempe District, Uganda.

● Selective List of Useful Resources

- Ellsberg M., "Violence against women and the Millennium Development Goals: Facilitating women's access to support", *International Journal of Gynecology and Obstetrics*, vol. 94 (2006), pp. 325-332.
- Ellsberg M., and Heise L., *Researching Violence against Women: A Practical Guide for Researchers and Activists* (Washington DC: World Health Organization, Path; 2005).
- García-Moreno C., Jansen H., Ellsberg M., Heise L., and Watts C., *WHO Multi-country Study on Women's Health and Domestic Violence against Women* (Geneva: World Health Organization, 2005). and United Nations, Secretary-General's In-depth Study on All Forms of Violence against Women, General Assembly document A/61/122, Add.1 (New York: United Nations, 2006).
- Guedes, A., *Addressing Gender-based Violence from the Reproductive Health/ HIV Sector*. (Washington DC: IGWG/USAID, 2006).
- Interagency Gender Working Group, *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers* (Washington DC: IGWG/USAID, 2006).
- Jewkes R., Nduna M., Levin J., Jama N., Dunkle K., Wood K., Koss M., Puren A. and Duvvury N., *Evaluation of Stepping Stones: A gender transformative HIV prevention intervention*, Medical Research Council Policy Brief (Capetown, South Africa: Medical Research Council, 2007).
- Kilonzo N. et al., *Post Rape Services in Kenya: A Situational Analysis* (Nairobi: Liverpool VCT & Care, 2003).
- Michau L. and Naker D., *Mobilising Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and South Africa* (Kampala: Raising Voices, 2003).
- Pronyk P., Hargreaves J., Kim J., Morison L., Phetla G., Watts C., Busza J. and Porter J., "South African IMAGE Study on violence and HIV", *The Lancet*, vol, 368, (2006), pp. 1973-1983.
- Raising Voices and UN-HABITAT Safer Cities Programme, *Preventing Gender-based Violence in the Horn, East and Southern Africa: A Regional Dialogue* (Kampala, Nairobi: 2004).
- World Health Organization Ethical and Safety Recommendations for Domestic Violence Research (1999) available at www.who.int/gender/violence/firtseng/pdf
- Websites for all participating organizations are included in the participant list.**

Endnotes

¹ The terms *gender-based violence* and *violence against women* are often used interchangeably. In this report, *gender-based violence* refers to acts of violence perpetrated against women *because* they are women. When *violence against women* has been used by individuals or organizations, or in quoted text, the report keeps that terminology.

² United Nations General Assembly resolution 48/104, *Declaration on the Elimination of Violence against Women*, December 1993.

³ Centers for Disease Control and Prevention, Department of Health and Human Services, *Fact Sheet on Intimate Partner Violence* available at www.cdc.gov/ncipc/factsheets/ipvoverview.htm (last accessed 23 May 2007)

⁴ Jewkes R., Sen P. and Garcia-Moreno C., "Sexual Violence." World Report on Violence and Health. Krug E. G., Dahlberg L., Mercy J. A., Zwi, A., Lozano R. eds. (Geneva: World Health Organization, 2002).

- ⁵ See for example García-Moreno C., Jansen H., Ellsberg M., Heise L., and Watts C., *WHO Multi-country Study on Women's Health and Domestic Violence against Women* (Geneva: World Health Organization, 2005) and United Nations, *Secretary-General's In-depth Study on All Forms of Violence against Women*, General Assembly document A/61/122, Add.1 (New York: United Nations, 2006).
- ⁶ See United Nations General Assembly resolution 48/104.
- ⁷ See García-Moreno et al.
- ⁸ Ibid.
- ⁹ Koenig M., Zablotska I., Lutalo T., Nalugoda F., Wagman J., and Gray R., "Coerced first intercourse and reproductive health outcomes among adolescent women in Rakai, Uganda", *International Family Planning Perspectives*, vol. 30, No. 4 (2004), pp. 156-163.
- ¹⁰ Mathews S., Abrahams N., Martin L., Vetten L., van der Merwe L. and Jewkes R., *Every Six Hours a Woman is Killed by her Intimate Partner: A National Study of Female Homicide in South Africa*, Medical Research Council Policy Brief Number 5 (Capetown, South Africa: Medical Research Council, 2004).
- ¹¹ See United Nations, *Secretary-General's In-depth Study on All Forms of Violence against Women*.
- ¹² Rwanda National Institute of Statistics, Measure DHS (ORC Macro), *Rwanda Demographic and Health Survey* (Kigali; 2005).
- ¹³ Central Bureau of Statistics and Ministry of Health, Measure DHS (ORC Macro), *Kenya Demographic and Health Survey* (Nairobi; 2003).
- ¹⁴ Jewkes R., Dunkle K., Koss M.P., Levin J.B., Nduna M., Jama N. and Sikweyiya Y., "Rape perpetration by young, rural South African men: Prevalence, patterns and risk factors", *Social Science & Medicine*, vol. 63, (2006), pp. 2949-2961.
- ¹⁵ Amnesty International, *Kenya, Rape – The Invisible Crime* (Amnesty International Index: AFR 32/001/2002, 2002).
- ¹⁶ See Koenig et al.
- ¹⁷ See Mathews et al.
- ¹⁸ Jewkes R., Nduna M., Levin J., Jama N., Dunkle K., Wood K., Koss M., Puren A. and Duvvury N., *Evaluation of Stepping Stones: A gender transformative HIV prevention intervention*, Medical Research Council Policy Brief (Capetown, South Africa: Medical Research Council, 2007).
- ¹⁹ Pelsler E., Gondwe L., Mayamba C., Mhango T., Phiri W. and Burton P., *Intimate Partner Violence: Results From a National Gender-based Violence Study in Malawi* (Pretoria: Institute for Security Studies, 2005).
- ²⁰ See García-Moreno et al.
- ²¹ Ibid.
- ²² See Koenig et al.
- ²³ Interagency Gender Working Group of the United States Agency for International Development, *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers* (Washington DC:IGWG/USAID, 2006).
- ²⁴ See García-Moreno et al.
- ²⁵ See Mathews et al.
- ²⁶ Ibid.
- ²⁷ Ibid.
- ²⁸ World Health Organization Ethical and Safety Recommendations for Domestic Violence Research (1999) available at www.who.int/gender/violence/firtseng/pdf (last accessed on May 22 2007)
- ²⁹ See United Nations, *Secretary-General's In-depth Study on All Forms of Violence against Women*.
- ³⁰ Ibid.

- ³¹ Ellsberg M., and Heise L., *Researching Violence against Women: A Practical Guide for Researchers and Activists* (Washington DC: World Health Organization, Path; 2005).
- ³² Amnesty International, *Sudan: Darfur — Rape as a weapon of war: sexual violence and its consequences* (Amnesty International Index: AFR 54/076/2004, 2004), as quoted in Amnesty International, *Lives Blown Apart: Crimes against Women in Times of Conflict* (London: Amnesty International, 2004).
- ³³ United Nations, Fourth World Conference on Women (Beijing, September 1995), *Action for Equality, Development and Peace, Beijing Declaration and Platform for Action*, United Nations Document A/Conf.177/20.
- ³⁴ United Nations, *Report on the Situation of Human Rights in Rwanda*, submitted by Mr. René Degni-Segui, Special Rapporteur of the Commission on Human Rights, under paragraph 20 of the resolution S-3/1 of 25 May 1994, E/CN.4/1996/68, January 29, 1996, p. 7.
- ³⁵ Médecins Sans Frontières, *Persecution, Intimidation and Failure of Assistance in Darfur* (Amsterdam: MSF-Holland, 2004) and Save Darfur Coalition, Background paper. Available at www.savedarfur.org/pages/background (last accessed on May 22, 2007)
- ³⁶ See Médecins Sans Frontières.
- ³⁷ As cited in Feldman-Jacobs C. and Ryniak S., *Abandoning Female Genital Mutilation/Cutting: An In-depth Look at Promising Practices* (Washington DC: Population Reference Bureau, 2006).
- ³⁸ Ibid.
- ³⁹ UNICEF, *Female Genital Mutilation/Cutting: A Statistical Exploration* (New York: UNICEF, 2005); and UNICEF, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, UNICEF Innocenti Digest (Florence, UNICEF Innocenti Research Centre, 2005). Available at www.unicef-icdc.org/publications/pdf/fgm-gb-2005.pdf (last accessed May 24, 2007)
- ⁴⁰ Final Declaration from the *International Conference on FGM: Developing a Political, Legal and Social Environment to Implement the Maputo Protocol* (Nairobi, September 16-18, 2004). Available at www.emmabonino.it/campagne/stopfgm/nairobi/dec_eng.php (last accessed May 24, 2007)
- ⁴¹ Cairo Declaration for the Elimination of Female Genital Mutilation (Cairo, 23 June 2003). Available at www.stopfgm.org/stopfgm/doc/EN/216.rtf (last accessed May 24, 2007)
- ⁴² UNICEF, *Early Marriage: A Harmful Traditional Practice: A Statistical Exploration* (New York: UNICEF, 2005); Estimates are given in United Nations, *World Marriage Patterns* (New York: United Nations, 2000).
- ⁴³ The information on early marriage is from International Planned Parenthood Federation and Forum on Marriage and the Rights of Women and Girls, *Ending Child Marriage: A Guide for Global Policy Action* (London: IPPF, 2006) and Pathfinder International, *Report on Causes and Consequences of Early Marriage in Amhara Region* (Addis Ababa: Pathfinder International, 2006).
- ⁴⁴ Ibid.
- ⁴⁵ Ibid.
- ⁴⁶ Michau L. and Naker D., *Mobilising Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and South Africa* (Kampala: Raising Voices, 2003).
- ⁴⁷ Ibid.
- ⁴⁸ Interview with Rachel Jewkes by William Eagle, VOA News (November 20, 2006). Full interview and article available at www.voanews.com/english/archive/2006-11/2006-11-20-voa35.cfm?textmode=0 (last accessed on May 27, 2007)
- ⁴⁹ EngenderHealth, *Fact Sheet on Men as Partners in Reproductive Health*. Available at www.engenderhealth.org/ia/wmm/index.html (last accessed on May 24, 2007)
- ⁵⁰ Ibid.
- ⁵¹ Open Society Institute Sexual Rights and Health Project (SHARP) forum with Ann Njogu (New York, March 9, 2006). Available at www.soros.org/initiatives/health/focus/sharp/events/njogu_20060309 (last accessed May 24, 2007)

- ⁵² Ellsberg M., "Violence against women and the Millennium Development Goals: Facilitating women's access to support", *International Journal of Gynecology and Obstetrics*, vol. 94 (2006), pp. 325-332.
- ⁵³ Ibid.
- ⁵⁴ See Kilonzo N. et. al., *Post Rape Services in Kenya: A Situational Analysis* (Nairobi: Liverpool VCT & Care, 2003) and Kilonzo N., and Taegmeyer M., *Comprehensive Post-Rape Care Services in Resource-poor Settings: Lessons learnt from Kenya. Policy Briefings for Health Sector Reform 6* (Nairobi: Liverpool VCT & Care, 2005). (Findings to be published.)
- ⁵⁵ Ibid.
- ⁵⁶ See Haffajee S., "Post-exposure Prophylaxis Following Sexual Assault", (ALG, 2005) as cited in KZN Network on Violence against Women and AIDS Legal Network, *Gender Violence, HIV and AIDS: Break the Cycle, Break the Silence* (2006); and Vetten L. and Haffejee S., *Factors Affecting Adherence to Post-Exposure Prophylaxis in the Aftermath of Sexual Assault: Key findings from seven sites in Gauteng Province*. Paper prepared for the Gauteng Department of Health (2005).
- ⁵⁷ Ibid.
- ⁵⁸ Ibid.
- ⁵⁹ See Interagency Gender Working Group of the United States Agency for International Development.
- ⁶⁰ Press statement by Stephen Lewis, United Nations Secretary-General's Envoy on HIV / AIDS in Africa, United Nations media briefing (July 3, 2002). Full statement available at http://data.unaids.org/Media/Press-Statements01/lewis_press-statement_03jul02_en.doc (last accessed May 24, 2007)
- ⁶¹ UNAIDS Joint United Nations Program on HIV / AIDS, *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2006).
- ⁶² Ibid.
- ⁶³ Pettifor A. E., Measham D. et al, "Violence against Women and HIV / AIDS: Critical Intersections—Intimate Partner Violence and HIV / AIDS", *Information Bulletin Number 1* (Washington DC, Geneva: Global Coalition on Women and AIDS, World Health Organization, 2004).
- ⁶⁴ Mbwambo J., Hogan M., Kilonzo G., Maman S., Sweat M. and Weiss E., *HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania* (Washington, DC: Population Council/ Horizons, 2001).
- ⁶⁵ UNAIDS Joint United Nations Program on HIV / AIDS, Statement of the Executive Director, Human Rights Day (2004) and Statement of the Executive Director at the United Nations, *Commission on the Status of Women, Forty-third Session* (New York, March 3, 1999).
- ⁶⁶ SafAIDS website "A Treatment Literacy Toolkit" www.safaid.net/?CFID=12917827&CFTOKEN=66102379 (last accessed May 26, 2007)
- ⁶⁷ See Haffajee S., "Post-exposure Prophylaxis Following Sexual Assault."
- ⁶⁸ *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 11 July 2003. For full text of the Protocol see www.achpr.org/english/_info/women_en.html
- ⁶⁹ Amnesty International, *Kenya, Rape — The Invisible Crime* (Amnesty Index AFR 32/001/2002, 2002).
- ⁷⁰ Ibid.
- ⁷¹ See United Nations, *Report on the Situation of Human Rights in Rwanda*
- ⁷² See *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*.
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- ⁷⁵ Pronyk P., Hargreaves J., Kim J., Morison L., Phetla G., Watts C., Busza J. and Porter J., "South African IMAGE Study on violence and HIV", *The Lancet*, vol, 368, (2006), pp. 1973-1983.

⁷⁶ See Pronyk et al.

⁷⁷ See Jewkes R., et al., *Evaluation of Stepping Stones*.

⁷⁸ See United Nations, *Secretary-General's In-depth Study on All Forms of Violence against Women*.

⁷⁹ Ibid.

⁸⁰ United Nations General Assembly resolution 61/143, *Intensification of Efforts to Eliminate all Forms of Violence against Women*, December 2006.

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