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Gender-Based Violence: Focus on Africa

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Introduction

Experienced by an estimated one third of women worldwide (UNICEF, 2009), gender-based violence (GBV) is a global affront to human rights, a public health crisis, and a major barrier to development. Violence can happen to anyone, but some groups, such as minority women, indigenous women, refugee women, and children are especially vulnerable throughout the world to a range of violence. This literature review presents an introduction to the factors associated with GBV, its prevalence, consequences, and implications for program, policy, and practice, with a specific focus on Africa. With some of the highest cited rates of GBV, awareness is growing with respect to the relationship between GBV, human rights, health, and development in the various African regions. As public, private, and NGO sectors increasingly respond to GBV in Africa, it will be essential to address not only the consequences of GBV by attending to the needs of survivors, but also its causes and contributing factors. As with any complex social problem, GBV stems from and manifests itself at every level of society, from individual to societal, and in a wide array of forms, from private to public. Successful efforts will require coordinated, comprehensive, multi-sectoral responses.

Overview of Gender-Based Violence

Definitions

The term gender-based violence is widely used as a synonym for violence against women, as women are the most obvious victims and survivors of violence. The United Nations' 1993 *Declaration on the Elimination of Violence Against Women* defines 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 deprivations of liberty, whether occurring in public or private life." This declaration explicitly covers a broad range of acts, including marital rape, sexual abuse of female children, sexual harassment, trafficking in women, forced prostitution, and violence perpetrated by the state. The UN definition of violence against women is important because it recognizes the responsibility of the state to address the human rights of women, and recognizes that violence against women is gender-based, and that it goes beyond the private problems of individual victims (Levy, 2008: 4). GBV originates from power imbalances between men and women, and serves to maintain them among both groups and as individuals on the personal, household, community, and state levels (Terry & Hoare, 2007). In considering GBV and violence against women, in

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particular, it is important to recognize that not all women are subordinated in the same way, and it is not only men who perpetrate GBV. Women may take part in enforcing gender hierarchies for a variety of reasons, including culture, tradition, and self-preservation.

Although usually focused on violence against women, gender-based violence (GBV) is also prevalent against children of both sexes, and rates of GBV experienced by adult males are not insignificant. Expanding the scope, accordingly, the definition of GBV refers to the "physical, mental, or social abuse directed against a person because of his or her gender or gender role in a society or culture. In these cases, a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences" (IGWG, 2006). GBV includes a range of mechanisms that can be subtle or obvious, including but not limited to the following[1]:

- Physical violence: slapping, kicking, hitting, or use of weapons
- Emotional violence: systematic humiliation, controlling behavior, degrading treatment, threats
- Sexual violence: coerced sex, forced sexual activities considered degrading or humiliating
- Economic violence: restricting access to financial or other resources with the purpose of controlling a person (World Bank Gender and Development Group, as cited by the Population Council, 2008).

These closely interrelated and mutually reinforcing types of abuse may occur separately, in sequence, or in combination and essentially serve as mechanisms to perpetuate and promote hierarchical gender relations and to maintain control over resources and power (Maynard, 1996). GBV functions as a systematic wearing down of women's autonomy and self-esteem.

Patterns of GBV vary from place to place, as do cultural and legal understandings of its acceptability. At the community and societal levels, definitions of wrongdoing through violence vary according to shifting patterns of class, race, and gender relations rather than being founded on a universal notion of intrinsic harm (Green, 1999). GBV may also be experienced differently throughout the life cycle, from the prenatal phase to old age (Population Council, 2008; Heise, 1994).

Consequences

Worldwide, the range and magnitude of GBV has tremendous negative impact for both the individual and society. In addition to being a direct cause of injury, illness, and death, exposure to gender-based violence significantly increases other health risk factors for girls and women, including increased likelihood of early sexual debut, forced sex, transactional sex, and unprotected sex, (Population Council, 2008). Survivors of gender-based violence experience increased rates of morbidity, mortality, and higher rates of health conditions including HIV and other sexually transmitted diseases, health risks associated with unwanted pregnancies, and mental illness (Krug et al., 2002; Mugawe & Powell, 2006; IGWG of USAID, 2006; Terry & Hoare, 2007).

From an international development perspective, GBV is fundamentally at odds with the objectives such as the Millennium Development Goals, which include promoting gender equality and empowering women. GBV contributes to, and is exacerbated by, the economic and sociopolitical discrimination experienced by women in

[1] Human trafficking is a specific form of GBV, as the overwhelming majority of victims are women and children who are forced into labor, combatant roles, and sexual exploitation (UNIFEM, 2012). Like all forms of GBV, human trafficking is a complex problem worthy of serious consideration. However, particular factors associated with human trafficking extend beyond those of other forms of GBV, placing it outside the scope of this review.

many countries (Population Council, 2008). It is a major driver of individual women's poverty and poverty in general , as the threat of violence constrains women's choices, abilities, and productivity both within and beyond the household (Terry & Hoare, 2007). GBV hampers productivity, reduces human capital and undermines economic growth. Exposure to GBV exacerbates the problem of women's poverty and that poverty, in turn, makes women more vulnerable to GBV. Women's lack of economic empowerment is evident in lack of access to and control over resources such as land, personal property, wages, and credit (UN-GA, 2006 as cited by Population Council, 2008).

Causes and Associated Risk Factors

The causes of GBV are complex and occur at different levels of society: individual, relationship, and community. By examining the relationship between the individual and contextual factors that influence behavior, an ecological model illustrates the necessity of a comprehensive, multilevel approach to eliminating GBV; it cannot be eliminated by simply implementing interventions at one level of risk, as other levels will continue to support violent behavior if not simultaneously addressed. Table 1, below, provides an overview of well-documented risk factors for the perpetration and victimization of intimate partner violence and sexual violence at each ecological level. Table 1 is not intended to be exhaustive, as other risk factors specific to particular forms of GBV may exist at each level.

Individual level risk factors are elements of biological or personal history that influence a person's behaviors. These can include biological factors, demographic factors, psychological characteristics, and past experiences that increase the likelihood that a person will be a perpetrator or victim of violence. Risk factors common to both intimate partner violence and sexual violence include low levels of education, exposure to child maltreatment, witnessing parental violence, antisocial personality disorder, substance abuse, multiple partners/infidelity, and attitudes accepting of violence (WHO, 2011).

A key aspect of ecological models is that they illustrate the interrelated nature of the risk factors at various levels. Individual-level risk factors for intimate partner and sexual violence are personal characteristics, but they can also occur within families, communities, and the larger society. Many of these factors are associated with both perpetrators and victims of violence, but some are specific to one or the other, as shown in Table 1 (WHO, 2011). The relationship level of the ecological model explores how close relationships such as those between peers, family members, and intimate partners increase the risk for perpetrating or experiencing GBV. Proximal relationships typically involve repeated interactions on a daily or frequent basis, giving peers, intimate partners, and family members the ability to shape an individual's behavior and experiences (Krug et al., 2002).

At the broadest levels, communities and the larger society have characteristics that exert a great deal of influence over the behavior of those who live in them. For the purposes of this literature review, community and social factors are presented together in Table 1, although it is important to recognize that multiple communities within the same country or society can present unique combinations of risk factors and, therefore different rates of GBV.

Table 1: Risk Factors for Gender-based Violence

	Intimate Partner Violence Risk Factor	Sexual Violence Risk Factor	Perpetrator Risk Factor	Victim Risk Factor
Individual Level				
Young age	X	X	X	X
Low income	X	X	X	X
Low academic achievement	X	X	X	X
Involvement in aggressive or delinquent behavior as an adolescent	X		X	
Abuse of alcohol and/or drugs	X	X	X	X
Insecurity and/or low self-esteem	X		X	X
Depression	X		X	
Aggressive or antisocial personality disorders	X	X	X	
Lack of inhibitions to suppress associations between sex and aggression		X	X	
Attitudes and beliefs that are accepting of violence, including sexual violence and coercive sexual fantasies	X	X	X	X
Patterns of impulsive, anti-social, and hostile behavior toward women	X	X	X	
Association with sexually aggressive peers		X	X	
Exposure to child maltreatment	X	X	X	X
Childhood family environment of physical violence, lacking emotional support, and low economic resources	X	X	X	X
Having multiple partners or are suspected by their partners of infidelity	X	X	X	
Past history of violence as a perpetrator or victim	X	X	X	X
Relationship/Family Level				
History of violence in family	X		X	X
Family poverty	X		X	X
Discord or conflict in the marital relationship	X		X	X
Beliefs in family honor and sexual purity		X	X	X
Community/Society Level				
Marked inequalities between women and men	X	X	X	X
Rigid gender roles	X	X	X	X
Social/cultural norms that tolerate or justify violence against women	X	X	X	X
Weak community sanctions, laws, and policies against perpetrators	X	X	X	X
Poverty	X	X	X	X
Traditional gender norms that support male superiority and entitlement	X	X	X	X
High levels of crime, conflict, and other forms of violence in society more generally	X	X	X	X

Sources: Krug et al., 2002; WHO Factsheets on IPV and Sexual Violence, 2002; WHO, 2011

Prevalence

Given its range and magnitude, GBV is a form of human rights abuse that has few rivals. There is abundant evidence that GBV is endemic to communities around the world, affecting people of every class, race, age, religion, and national boundary, although to varying degrees and in different ways. While systematic data is not available in all countries, A WHO multi-country study found that between 15–71% of women reported experiencing physical and/or sexual violence by an intimate partner at some point in their lives (2011). GBV spans the lifecycle and begins early. Nearly one third of adolescent girls worldwide report that their first sexual experience was forced, and almost half of all sexual assaults are against girls 15 years or age of younger (UNICEF, 2009).

Socialized into the gender roles of their specific cultures, women and girls often hold beliefs that support their oppression through GBV. Approximately 40% of women across the 10 countries said they would have sex if their partner refused to use a condom, and a similar proportion did not think women have the right to refuse sex with their partner (CIET, 2007). More than 80% of women in Ethopia believe their husbands have the right to beat them (Womankind Worldwide, 2011).

Globally, rates of GBV are highest in developing countries, with some of the most extreme rates in African countries. Worldwide, approximately 100 to 140 million girls and women have experienced female genital mutilation/cutting, with more than 3 million girls in Africa annually at risk (UN Women, 2011). In Sub-Saharan Africa, 14.1 million girls are child brides, married before the age of 18 (UN Women, 2011). In a 2007 survey across eight countries (Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe) 18% of women aged 16-60 years had experienced intimate partner violence in the past 12 months; one in every five youths aged 12-17 years said they had been forced or coerced to have sex, and one in 10 said they had forced sex on someone else (CIET, 2007).

Although systematic data is not available in all African countries, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) maintains a current inventory of systematically collected data on violence against women. Table 2 is a summary of the most recent prevalence data from countries in each of the African regions.

Table 2: Violence Against Women Prevalence Data, Surveys By Country

Region	Country	Lifetime experience of physical and/or sexual violence from an intimate partner	Survey
Northern Africa			
	Egypt	34%	DHS 2005, National
	Morocco	(63%)*	Other 2010, National
Western Africa			
	Cape Verde	16%	DHS 2005, National
	Ivory Coast	(12%)*	DHS 2005, National
	Ghana	23%	DHS 2008, National
	Liberia	39%	DHS 2007, National
	Nigeria	18%	DHS 2008, National
Central Africa			
	Cameroon	42%	DHS 2004, National
	Democratic Republic of Congo	64%	DHS 2007, National
East Africa			
	Ethiopia	71%	WHO 2002, National
	Kenya	41%	DHS 2003, National
	Malawi	28%	DHS 2004, National
	Mozambique	40%	IVAWS 2004, National
	Rwanda	34%	DHS 2005, National
	Uganda	59%	DHS 2006, National
	Tanzania	41% City, 56% Province	WHO 2002, City and Province
	Zambia	50%	DHS 2007, National
	Zimbabwe	38%	DHS 2006, National
South Africa			
	Namibia	36%	WHO 2002, City of Windhoek
	South Africa	14% physical, 4% sexual (no combined measure available)	DHS 1998, National

*Available measure is past 12 months physical and/or sexual violence from an intimate partner or non-partner
Source: UN Women, March 2011. *Violence Against Women Prevalence Data: Surveys by Country.*

Specific Manifestations of Gender-Based Violence in Africa:

As evidenced by the prevalence data that has been presented in this review, there exists wide variation in the experience of GBV across the regions of Africa. This diversity of experience not only exists in terms of prevalence, but also in the specific types of GBV engendered by particular social and community contexts. A few manifestations of GBV and risk factors beyond those identified in Table 1 are worth noting in particular:

Wife battery: Studies suggest that physical intimate partner abuse is the most common form of gender violence committed not only in Africa but worldwide (UN Women, 2011; Green, 1999). In addition to risk factors noted in Table 1, the marriage rite of bride price, commonly practiced in many African and other countries, has

been identified as contributing to this behavior because it encourages women to be viewed as property, helping to justify violence against them, reducing women's decision-making abilities in the household, limiting women's independence, and perpetuating unequal gender relations (Green, 1999; Kaye et al., 2005; Hague et al., 2011).

Rape: A number of factors make rape a particularly acute problem in regions of Africa, including but not limited to the virgin cleansing myth that having sex with a virgin will cure a man of AIDS (Freeman, 2004), prevalence of sexual violence in schools (Wilson, 2008), corrective rape wielded against lesbians (Middleton, 2011), beliefs that forcing sex on a woman is not wrong, and the use of rape as a political weapon.

Female genital mutilation (FGM): A practice typically carried out by traditional circumcisers, FGM involves partial or total removal of the external female genitalia for non-medical reasons. FGM has no medical benefit whatsoever and harms girls and women in both immediate and long-term ways. The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities (WHO, 2012).

Child marriage and forced marriage: Widely recognized as a violation of human rights, forced marriage and child marriage deprive young girls of their rights to health, education, development, and equality. Contributing social and community factors include tradition and customary law, religion, poverty, bride price, and notions of morality and family honor associated with a girl's virginity (UNICEF, 2005).

Property grabbing: This practice whereby an individual, often upon the death of her husband, is forcibly evicted from her home by family members, neighbors, or traditional leaders and is often unable to take her possessions with her, disproportionately affects women. Occurring in areas of Southern and East Africa, the practice increases women's poverty and is often accompanied by other acts of extreme GBV. Women's weak inheritance and property rights, customary laws and practices, and high rates of HIV/AIDS mortality contribute to this form of GBV (Izumi, 2007).

GBV in Emergency Contexts: Some populations are especially vulnerable to GBV, including displaced persons and refugees. As noted by the UN, "In both emergency and post-conflict contexts, high rates of unemployment, lack of basic services, and the breakdown in community infrastructure and social structure limit economic opportunities and social protection" (UNICEF, 2009). During armed conflict, and in times of severe economic hardship, adolescent girls tend to be the first victimized, with women and children disproportionately impacted by GBV overall. In addition to lacking basic necessities, refugees who typically have language barriers, fear discrimination and corruption, and have little to no previous experience with justice systems may find it especially difficult to access legal assistance in asylum countries (UNICEF, 2009).

Survivor's Agency

While this literature review has focused primarily on GBV in terms of perpetration and victimization, it is critical to recognize that survivors of GBV worldwide are individuals with diverse experiences, beliefs, behaviors, and agency. "Women should not be considered as objects, powerless against family, community, or state violence. Women are social actors who may suffer, resist, and/or even take part in the oppression of women" (Green, 1999). Even where there exist high rates of GBV, tremendous variation exists in how that violence is experienced and managed. Women and other survivors of GBV do not all suffer equally, nor do they respond in the same way. Some suffer, some simply survive, some build invisible communities of support, some resist, and

some participate in the oppression. Effective responses to GBV take the agency of survivors into account in strengths-based approaches and avoid further marginalizing or re-traumatizing survivors by presenting them solely as powerless victims.

Promising Approaches

Given that GBV is caused by complex and inter-related factors at the individual, relationship, community, and societal levels, efforts to eliminate GBV must be coordinated, multi-sectoral responses. The development of meaningful and promising strategies should be informed by systematic data on prevalence of GBV, and on the effectiveness of previous interventions and responses. As noted by others in the literature, (UN,-GA, 2006; Population Council, 2008), there is much room for improvement in the collection of data and research on programs to address GBV, although with recent increasing awareness, there are a growing number of resources that identify promising approaches and emerging evidence-based strategies for under-developed communities.

Prevention: Whether working to reduce GBV in developed or developing nations, there needs to be an increased emphasis on stopping it from occurring in the first place - primary prevention. As noted by the World Health Organization, the strongest evidence of effectiveness for the primary prevention of GBV is with respect to school-based programs to prevent violence within adolescents' dating relationships. Such programs, however, have not been sufficiently evaluated in resource-poor settings and cannot be expected, in any case, to be effective as isolated strategies (WHO, 2011).

Additional promising primary prevention strategies are emerging, including microfinance combined with gender equality training; promotion of communication and relationship skills within communities; reducing access to alcohol; alcohol harm reduction; and changing cultural gender norms (WHO, 2011).

Secondary and Tertiary Prevention/Intervention: Preventing the recurrence of violence and mitigating its consequences are essential to any comprehensive effort to reduce GBV. Such responses must involve multiple sectors in the community, from law and justice to education and health. Figure 1 provides an example of specific strategies that a comprehensive multi-sectoral response may entail. Fear, victim-blaming, stigmatization, discrimination, and cultural taboos often keep survivors of GBV from seeking assistance, and efforts must be made to ensure that services are available and accessible. Medical, legal, and social services for survivors should be integrated and coordinated responses.

Figure 1: Seven Components for a Comprehensive Model of Care, Support, and Prevention of Sexual and Gender-Based Violence (Population Council, 2008).

1. Medical Management of sexual violence at point of first contact with the survivors
2. Psychological counseling of rape survivors
3. Sensitive approaches to managing child survivors of sexual violence (of both sexes), and to encouraging and enabling presentation by male survivors.
4. Collection of forensic evidence (at health facility during medical management and/or at police station) and creation of a chain of evidence that can be used during a prosecution.
5. Strong links between police and health facility to enable incidents to be referred in either direction so that, if desired, a prosecution can be initiated. Ensure prosecutions initiated by the police are sustained through the judiciary.
6. New or strengthened community-based prevention strategies that are relevant and appropriate for the local context and that are directly linked to the nearest medical/police structures.
7. Physical (and psychological/emotional) violence between domestic or intimate partners addressed through:
    a. Messages communicated during the prevention strategies;
    b. Screening for signs and symptoms of such violence during routine health consultations.

Legislation and policies must be developed and enforced to protect survivors of GBV, address gender discrimination, promote gender equity, and discourage violence (WHO, 2011). Even though legislation to prevent and address gender-based violence has been enacted on international and national levels, these laws are not uniformly enforced (UNICEF, 2009). Legal systems can be undermined by national and international conflicts, disregarded, or procedurally circumvented (UNICEF, 2009; WCRWC, 2006). On a state and community level, legal systems can sometimes serve to re-victimize survivors of GBV rather than helping them. As noted by UNICEF, many governments deny the existence of sexual violence, engage in extreme forms of victim blaming, force victims into the hands of their abusers, and block humanitarian efforts to provide services for survivors of abuse. Proving rape is extremely difficult in some legal systems, resulting in stigmatization and further harm to survivors while perpetrators go unpunished (UNICEF, 2009). Continuing advocacy, monitoring, and accountability by the international community is important to encourage governments worldwide to enforce the laws that protect human rights, the health and wellbeing of their populations, and promote positive development.

Conclusion

While not exhaustive, this literature review has provided an overview of the complex and inter-related factors that contribute to GBV in Africa and worldwide, and briefly addressed its consequences and approaches to prevention. GBV is complicated, multi-dimensional, grounded in social structures, culture and history, and difficult to eradicate. But activists worldwide have made tremendous strides against GBV in recent decades, increasing its visibility and making resources available for prevention and intervention, alongside the passage of

national and international laws, treaties, and policies. As a human rights issue, public health issue, and development issue, we must continue to strive for the eradication of GBV, the damaging effects of which are experienced not only by individual survivors, but by their communities and by the women, men, and children who care about them.

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