AFRICA HEALTH ORGANISATION

Policy and Strategy Proposal for Addressing SGBV in Africa

Prepared by: Sarah Helen Dick (*Msc Human Rights and International politics; BA Hons History and Politics and International Relations*)


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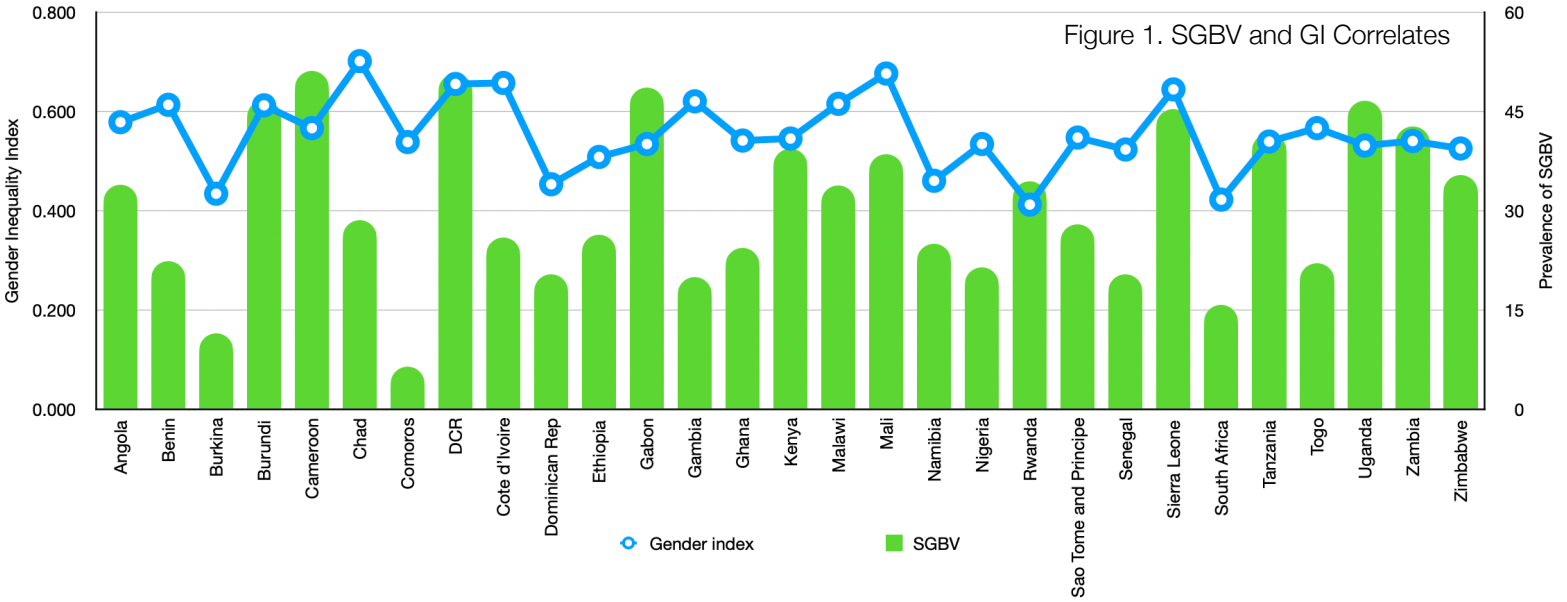
Table of contents

INTRODUCTION

The problem of sexual and gender based violence (SGBV) is a significant human rights issue that impacts the entire globe. Indeed, SBGV exists in every single country and occurs in every social, cultural, racial and ethnic group. While the occurrence of SGBV is omnipresent in every society world wide, its prevalence in Africa calls for further dedication and urgent policy and strategy development. According to the World Health Organization (WHO) the highest rates of SGBV were reported in the African region (WHO, 2005). Additionally, a plethora of studies have confirmed the high rate of SGBV in the African continent with the highest rates of violence concentrated in east and west Africa (Muluneh, Stulz, Francis, Agho, 2020). The graph below illustrates that the high prevalence of SGBV in Sub-Saharan Africa also correlates with high levels of gender inequality.



According to the UNHCR, SGBV refers to “any act that is perpetrated against a person’s will and is based on gender norms and unequal power relationships” (UNHCR, ‘Sexual and Gender Based Violence’). The Declaration on the Elimination of Violence Against Women issued by the UN General Assembly in 1993, 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 deprivation of liberty, whether occurring in public or in private life" (Article 1). SGBV is a broad term that encompasses many different forms of violence against women. SGBV can be conducted by an intimate partner, known as Intimate Partner Violence (IPV) or a non intimate partner such as a neighbour, a stranger, a relative, a friend, an employee, a colleague or a boss for example. The methods of violence are also multifaceted including physical, emotional, and sexual violence. SGBV also encompasses such practices as human trafficking, FGM and child marriage. In particular reference to sexual based violence, the prevalence rate is substantially higher in conflict and post-conflict countries such as Somalia and Rwanda. Rape and sexual violence are often used as tactics during warfare and can increase dramatically following the erosion of law and order, the increased availability of weapons and a general increase in violence, instability and insecurity (Murray, 2013; Wirtz, Perrin, Desgroppes et al, 2018).

SGBV violates several articles of the Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Declaration on the Elimination of Violence Against Women (1993), the Convention on the Rights of the Child (1991) and the International Covenant on Civil and Political Rights (1976). In particular it violates the right to life, the right to liberty, the right to autonomy and security of the person, the right to equality and non discrimination, the right to be free from torture and cruel, inhumane and degrading treatment or punishment, the right to privacy and the right to the highest attainable standard of health (WHO, 2010). Additionally, SGBV whether that be IPV or non IPV results in serious health issues. These health issues are listed in the table below.

Physical	Sexual	Psychological
Homicide	Unintended pregnancy	Suicide
Headaches	Induced and often unsafe abortion	Suicidal thoughts
Back pain	Gynaecological problems	Depression
Abdominal pain	STI (in particular HIV/AIDS)	PTSD
Fibromyalgia	Miscarriage	Sleep disorders
gastroenteril disorders	Stillbirth	Eating disorders

Physical	Sexual	Psychological
Cuts	Pelvic pain	Substance abuse
Bruises	Pelvic Inflammatory Disease	Anxiety
Lacerations	Vaginal Bleeding	
Welts	Fibroids	
Fractures	Urinary Tract Infections	
Broken bones and teeth	Infertility	
Thoracic injuries		

(Campbell, Jones, Dienemann et al, 2002; WHO, 2014; Krug, Dahlberg, Mercy, et al, 2002; WHO, 2010; WHO, 2013; WHO, 2016)

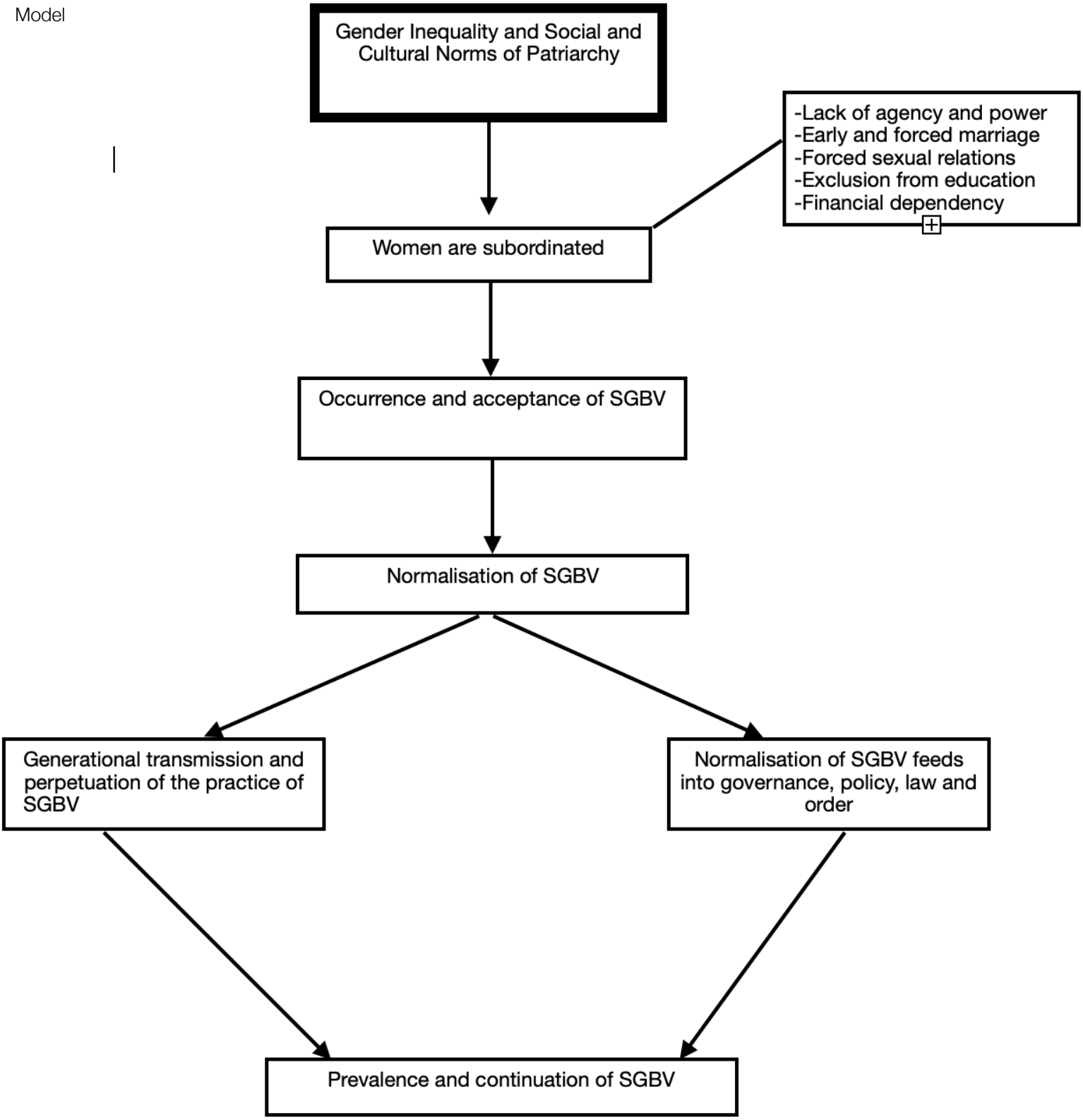
Problem identification

One of the main challenges in addressing SGBV is the complexity of the issue. The root causes of SGBV are multifaceted, interconnected and highly contingent on social context. For example, the context of war and conflict significantly exacerbates the issue of SGBV and makes it harder to combat in comparison to contexts of peace. One only has to recall the devastating spike in rape and SGBV during the Rwandan genocide, or the high prevalence of SGBV in Somalia (Wirtz, Perrin, Desgroppes et al, 2018). The causes of SGBV can be thought of as an interacting and intersecting web with one crucial problem at the centre. This crucial problem is gender inequality and social and cultural attitudes that centre around patriarchal ideals. This creates a culture of acceptance of violence towards women that perpetuates throughout generations. For example, studies have shown that witnessing violence against a women as a child, particularly in the family home, substantially increases the likelihood of that individual committing SGBV against a women in adulthood (Wirtz, Perrin, Desgroppes et al, 2018; Addo-Lartey et al, 2018; WHO,2012; WHO,2010). Thus, SGBV can be considered an inherited social action. Therefore, cultures of gender inequality and patriarchal ideals normalise and legitimise the use of violence against women.

In addition, cultures of gender inequality and patriarchal ideals allow for several practices that increase a women's vulnerability to experiencing SGBV. These practices include early

and forced marriage, forced sexual relations, exclusion from education and as a result the formal labour market. Education for girls is invaluable and provides resources, fosters abilities and creates networks that can help to navigate and reduce the occurrence of potentially violent situations and relationships (Murray, 2013; WHO, 2010). As Jewkes confirms, “having some education empowers women enough to challenge certain aspects of traditional sex roles” (2002, p. 1425). As a result, it is unsurprising that a large body of research has confirmed that in Africa, high rates of SGBV coincide with low levels of education (WHO, 2012; Uthman, Lawoko, Moradi, 2009; Adjah, Agbemafle, 2016; Gust et al, 2017; Addo-Lartey et al, 2018). Cultures of gender inequality also feed into systems of governance and law and order. When gender inequality and SGBV are social norms, these become reflected and entrenched in governance, legislation and policy. This leads to a lack of protection and a systematic inability to tackle SGBV. A model of the root causes of SGBV is demonstrated in figure 2 on the following page. Thus in combating SGBV, the health sector must seek to adopt a preventative model by eliminating the prevalence of cultures of gender inequality and patriarchal ideals that lead to the occurrence and acceptance of violence against women. As the following policy analysis will demonstrate, a commitment to education is essential if this goal is to be realised.

Figure 2- Root Cause Model



POLICY ANALYSIS

There are a multitude of policy options and strategies for dealing with SGBV, many of which are indeed already currently addressed in the AHO's Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women in Africa (AHO, 'Violence Against Women Must End Now', 2019). Strategies for addressing SGBV in Africa range from Microfinance, reformation of criminal justice and legal frameworks, media and advocacy campaigns, greater attention to the health issues and health warning signs of SGBV in the health sector, sensitising and training health professionals and improving the quality of care for survivors. While all of these policy and strategy options are useful for the health sector to better respond to SGBV, they have some pitfalls and drawbacks that limit their effectiveness in reducing the occurrence of SGBV. For example, Microfinance projects can increase pressure on women to repay loans and can increase the already heavy burden they carry. Additionally providing women with finance does not necessarily mean they will experience less violence, nor does it mean they will have control over its use (Kim et al, 2011). Reforming the criminal justice system by introducing new or harsher penalties for perpetrators of SGBV while on paper seems promising, has little impact in preventing violence if cases are not reported due to the continuation of sigma and cultures of fear (Bott, Morrison, Ellsberg, 2005). Further not only are legal fees expensive for victims, but if those who are in charge of enforcing these laws do not believe that SGBV is a serious crime, then implementation and enforcement is extremely difficult. As Manuh comments, "a major challenge hampering the effective implementation of laws and policies is the lack of political will and commitment to gender equality"(Manuh, UN Chronicle). Lastly, while training health professionals to identify signs of SGBV, sensitising and training them to improve care for survivors, and partaking in referral activities does provide help in terms of treating victims of SGBV, it unfortunately does little to prevent the occurrence of SGBV in the first place. As a result, current efforts to address SGBV, particularly in the health sector, predominantly concentrate on treatment rather than prevention.

What has been shown to be extremely effective in preventing the occurrence of SGBV, yet what is lacking in the AHO strategy more generally is the role of education. As has already been alluded to, one of the most fundamental root causes of SGBV is the existence and

continuation of cultures of discrimination against women, patriarchal norms that justify violence, and gender inequality. These are ideologically, socially and culturally rooted. One of the most effective ways of changing social norms is via education. For example, in the Kenyan context, one study has claimed that education tailored on “anti violence and personal, economic and sexual empowerment should be a major focus of public health” (Gust et al, 2017, p. 9). Similarly, in the context of Somalia educational “efforts to focus on primary prevention that seek to change social norms among men and women as they relate to GBV are critical to addressing violence” (Wirtz, Perrin, Desgroppes et al, 2018, p. 10). Not only is there strong evidence that education can change social norms and that it should be a major focus of public health, but there is a strong body of literature that illustrates its effectiveness in reducing SGBV. For instance, studies by Foshee et al (1996, 1998) have shown that education focused on changing dating violence norms, gender stereotyping and conflict management skills were effective at reducing perpetration of SGBV. Further, Avery-Leaf et al (1997) have found that when curriculum includes lessons highlighting the harmful effects of gender inequality, challenging the use of violence as an acceptable conflict resolution tactic and encouraging constructive communication, acceptance of aggression in the context of romantic and intimate relationships was reduced. Lastly, those such as Wolfe et al (2003) have found a significant reduction in physical and emotional abuse in the context of SGBV when learning curriculum incorporated education and awareness on abuse and power dynamics in close relationships, patriarchal values, skill development and social action.

Education not only reduces the occurrence and acceptance of SGBV among those directly receiving the education but can lead to a sustained reduction in SGBV (Cornelius, Resseguie, 2007). This is achieved by creating an increase in the non-acceptance of the current culture that is responsible for SGBV. In other words, education changes the values among those in society to align closer with gender equality. It changes norms surrounding patriarchal ideals and violence, and fosters a reconsideration of the way women are treated. As a result education renders SGBV unacceptable and intolerable. It is important to note that the benefits of education need to be considered in conjunction with other already active strategies in the health sector such as the provision of antenatal services, HIV testing, support and treatment for survivors of violence and referral systems, not instead of them.

For those currently facing SGBV, and considering that changing cultural norms does not happen overnight, the current policies adopted by the AHO are of paramount importance.

That educational initiatives target boys and men is crucial considering it is largely males who are perpetrators of SGBV. However, the inclusion of girls is equally important. It is important for females to understand and to learn that SGBV is not acceptable, is a crime and is a violation of their human rights. As a result, it is also important to note that the impacts of formal education will not be sufficiently realised if access to education for girls in Africa is not upheld and improved. As a result, this strategy and policy initiative must work closely with the work that the AHO is currently undertaking in regards to education for girls. Where girls have been excluded from education, and where boys and adult women have been excluded, community outreach programs can be used as a substitute. However admittedly, not only are these additional community outreach programs financially draining, implementation and attendance will be difficult, although partnership with NGOs will mitigate this burden slightly. While necessary in the early stages of this policy initiative, the reliance on community outreach should decrease as education rates improve, as more females enter the formal sector of employment and as parents, community leaders, activists and health care workers can pass on, and teach SGBV curricula to their children, relatives and communities more generally. Norm creation is a long process but it is essential and necessary for significant long lasting change. Unless this entrenched long lasting change is achieved, the health sector will be stuck responding to SGBV on a treatment level on a case by case basis, rather than helping to eliminate its root cause. Not only is this financially costly, but it is unacceptable for further generations of girls and women.

At this point in this policy analysis, it is relevant to point out that the AHO does not neglect the role of education in addressing SGBV. For example, AHO stresses the importance of incorporating issues of violence into medical and nursing circular as well as during service training (AHO, 'Violence Against Women Must End Now', 2019). Further, in strategic line 4, the AHO makes note that the public health community should raise awareness about violence against women as a public health program (AHO, 'Violence Against Women Must End Now', 2019). Indeed this line acknowledges the need to challenge social norms and attitudes that condone gender inequality and violence. However, what is lacking is a further

dedicated strategy to education and a solid and sustained commitment to this. Indeed, further emphasis is needed to be placed on prevention as opposed to treatment.

This document proposes that in order to reduce SGBV, the health sector must commit to a preventative model based on education. An increase in education surrounding SGBV will foster change in the cultural, social and ideological norms that are responsible for the occurrence of SGBV at its core. Through education for the health sector, through school curriculum and through community based projects, a reduction of SGBV may be achieved. In combating SGBV, changing social attitudes *towards* women via education and increasing education *for* women is essential. These two main policy initiatives will in turn foster the improvement of other correlated causes of SGBV. That is, if we refer back to the 'Root Cause Model' increasing education will reduce the patriarchal cultural norms responsible for the perpetration of SGBV in the first place and in turn will:

- reduce the exposure to violence as a child
- increase the empowerment of women
- reduce child and forced marriage
- decrease female financial dependency on men
- reduce the normalisation and acceptability of violence against women
- strengthen governance and legal structures to offer protection and ramification of SGBV against women.

An important caveat here is the context of conflict and instability, which will hinder policy implementation surrounding education and its ability to enact cultural change concerning gender norms.

GOALS AND OBJECTIVES

Goal 1-Strengthen health care providers understanding of SGBV

This goal largely builds off of the work already set out by AHO such as the incorporation of issues of violence into medical and nursing curriculum. It is essential that those providing immediate care to victims of SGBV have a great understanding of not only the medical signs and symptoms of SGBV but also the social determinants and underlying causes of SGBV more broadly. SGBV is a complex issue with a myriad of causes and effects. Some of which are hidden. Having a greater understanding of SGBV will not only aid in identifying vulnerable patients allowing early intervention, but will also allow health care professionals to combat SGBV in their own lives and workplace.

A study by Abeid et al (2016) has found that training on the management of sexual violence is feasible and their results indicate an improvement in healthcare workers' knowledge and practice.

Objectives

- Use evidence and discussion to continually educate and inform health care providers about SGBV, its causes, impacts and warning signs
- AHO (resources pending) could arrange for academics and other experts in the field of SGBV to hold workshops, training sessions and meetings to disseminate the newest information concerning SGBV in order to keep health care providers up to date
- AHO must ensure that staff themselves are educated in the causes of SGBV and provide them with a forum and an opportunity to further educate themselves, to ask questions and to learn how to better address specific areas of concern. This will only come via collaboration with experts, specialists and victims themselves through workshops, working groups, and training days with NGOs, universities and other experts.

For example, the Sexual Violence Research Initiative (SVRI) holds SGBV forums and is the key research conference in SGBV in middle and low income countries. Attendance at this would be greatly advantageous.
Examples of potential partners for the AHO from the NGO community:

- Coalition on Violence Against Women (COVAW) is based in Kenya. The organisation works on addressing the root causes of violence and breaking the cycle on domestic abuse through various means.
- Project Alert on Violence Against Women is based in Nigeria. It carries out research on the nature and prevalence of domestic violence in Nigeria.

Examples of experts and academics for the AHO to partner with:

- South African Medical Research Council currently has a substantially sized team that focus of SGBV
- The African Medical Research Council covers a wider geographical area but focus on SGBV is much more limited
- London School of Tropical Medicine is one of the leading schools in SGBV. Partnership here would be resource based as there would be a significantly larger financial cost involved in having on-the-ground workshops with this particular body.

Possible Indicators

- Number of workshops, conferences or training days held for health care providers addressing SGBV
- Number of those attending workshops, conferences or training days addressing SGBV
- What new issue areas concerning SGBV, if any, were health care providers informed about
- What new issues concerning SGBV were raised by health care providers

Goal 2-Health care professionals as a source of education (school based prevention programs)

This goal is directly dependent on Goal 1. If health care professionals are misinformed, not up to date or do not have a solid understanding of SGBV, their ability to aid prevention by educating others is hindered. Education reform could prevent SGBV by increasing school safety, by empowering women through education and promoting better attitudes and practices among students with regards to women rights.

Objectives

- As nurses and health care workers are trained, they themselves could provide workshops in schools both to students and to teachers. It is of paramount importance that teachers and adults in the school environment not only understand SGBV, but behave in a manner that does not foster SGBV.
- Health care providers can liaise with policy makers or school boards in the creation of school curriculum. Particularly in the context of “health classes” or “life skills classes”.
- Educate students and teachers on issues surrounding gender, violence and conflict resolution.
- Incorporation of lessons on problem solving, anger management, promotion of better attitudes and practices among students with regards to women’s rights.

Examples of school based programs both for teachers and pupils

- Safe Dates Project:
  - life skills based project that incorporated into curriculum lessons on violence norms, gender stereotyping, conflict management skills, and, particularly for those already involved in a violent relationship, altering the cognitive factors associated with help-seeking behaviour.
- Dating Violence Intervention Program (DVIP):
  - three educational sessions in the context of health classes , several school wide activities, educator and administrator education and a theatre presentation.
  - Curriculum focused on defining and identifying abuse in interpersonal relationships, exploring how power differentials may contribute to the manifestation of violence, how adherence to traditional gender roles may facilitate aggression, and suggestions for preventing violence.
  - Inclusion of training to improve proficiency of communication, negotiation and problem solving skills with the use of role playing, modelling and rehearsal.

Possible Indicators:

- Number of workshops held in schools to pupils
- Number of workshops held in schools for teachers and adults

Goal 3- Educate Communities.

For those not in schools, health care providers can aid the prevention of SGBV by engaging in community prevention projects. Just in the same way that pupils can receive education on SGBV, so too can communities where children and adults have not had the opportunity to enter or remain in education and therefore have missed this crucial part of education.

Community outreach programs, in addition to educating also foster an empowerment approach to challenging the foundations that lead to SGBV. Community outreach programs are utilised as an approach to help individuals and communities to identify their own problems and to develop, through participatory methods, the resources and skills and confidence needed to address them. Community outreach programs are designed to effect social change by creating a supportive environment for changing individual and community attitudes and behaviour (WHO, 2010; Jewkes, 2002; Bott, Morrison, Ellsberg, 2005). Indeed both the WHO and the UN have found community outreach programs to be an effective way of reducing IPV and SGBV (WHO,2010; WHO, 2016; Manuh, UN Chronicle).

Objectives:

**keeping in mind the low levels of educational attainment, programmes developed and delivered here need to be catered to the learning capabilities of the communities under consideration.

- Health care providers can hold discussion groups. These can operate as safe spaces for women to talk about their experiences or as mixed sessions where adults can discuss SGBV openly. Here, further resources and advice can be administered to those attending that will allow them to more easily seek help through official channels when needed.
- Provision of 'edutainment' such as plays demonstrating the causes and consequences of SGBV and other forms of visual learning that is engaging but informative.

Examples of current community outreach programs:

- Stepping stones:

- Gambia, Ghana, Kenya, South Africa, Tanzania, Uganda, Zambia. This program aims to encourage communities to question and rectify the gender inequalities that contribute to HIV/AIDS, SGBV and other health issues. This program uses workshops, community wide meetings, drama, peer group discussions and other strategies. Specifically this program reduced the social acceptability of wife beating at the community level (Bott, Morrison, Ellsberg, 2005; Stepping Stones).

- Men as Partners (MAP):
  - This is a program by EndenderedHealth in South Africa. It involves community based workshops with men and mixed sex audiences in settings such as workplaces, trade unions, prisons and faith based institutions. It promotes discussion about gender issues, power dynamics and gender stereotypes (Bott, Morrison, Ellsberg, 2005; EngedneredHealth).

The partnership with existing programs such as these or the creation of new additional ones run solely by health care professionals from AHO are two strategy options. Partnership would reduce the workload of AHO significantly as opposed to creating and running their own ones. However, health workers will need to be significantly involved with the delivery and creation of these partnered interventions in order to make sure these community outreach projects align with the education set out in Goal 1.

Possible Indicators:

- How many outreach programs were held
- How many attended community outreach

FINANCIAL IMPLICATIONS

As with any social health issue, this policy and strategy for reducing SGBV via education will require significant partnerships and inter-sector collaboration. Above all, this strategy requires commitment and endurance as results will not be immediate and optimism must be kept in the face of remaining cases of SGBV.

Of particular financial consideration will be:

- Training days for health care providers
- The creation of conferences and attendance to conferences
- The creation of resources for schools and communities
- The devotion of a proportion of the health sector to become educators for teachers, pupils and communities

A financial estimation for this policy is represented in the tables and graph on page the following page. The sources used for this estimation primarily come from the WHO-CHOICE database. The financial estimation covers a ten year period from 2020-2030. Each price estimate is for one singular unit. As a result, the actual financial cost of this policy will be considerably higher than the one represented. The financial estimation proposed operates under several assumptions:

- the AHO will utilise two separate educator teams, that is one team for school based education and a separate for community education; each with separate transport facilities.Costs could be reduced by fusing these two different goals together and having one team conducting both goals.
- The AHO will have office space to hold their training days

Further to this, there are some unknowns that inhibited a full financial estimation of this policy:

- Resources*. It is unknown how many resources will be needed for workshop trainings, that is how many will attend the training. Financially, resources could be used for free. The WHO has a SGBV training curriculum that could be used. The E-version is to be released by mid 2020. It is unknown how much it will cost to print resources.

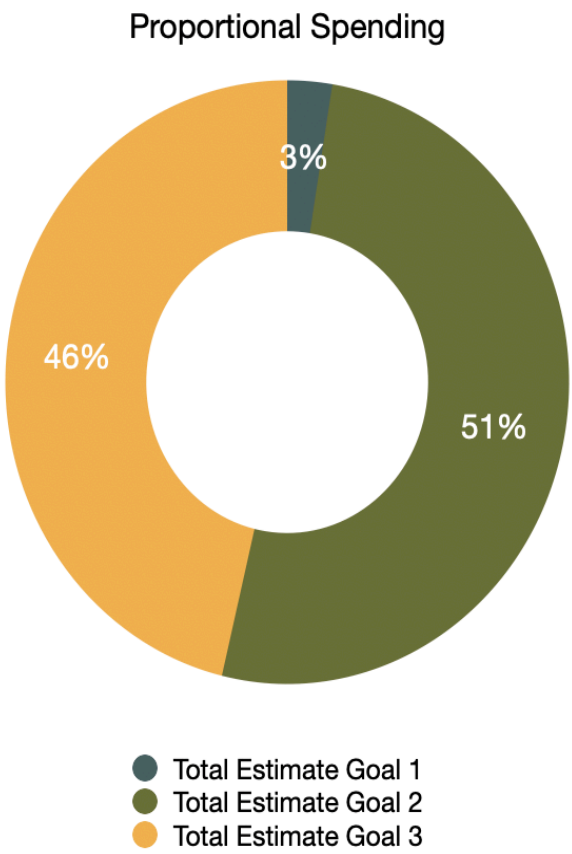
- Travel*. The cost of travel to international conferences is difficult to price without knowing how many will be attending conferences and where the destination is. The cost of attending conferences therefore will need to be priced when the conferences that the AHO wishes to attend are known. It is worth noting that in the current international health climate, many conferences are being broadcast online and for free due to COVID-19. This would allow the AHO to broaden participation and to save financially.
- Catering*. The cost of catering for the hosting of a conference is difficult to price without knowing how many to cater for and where the conference is taking place.
- Transport*. In Goal 3, transport could be omitted if the AHO wishes to only have one transport team working for both educating teams.

Goal 1- Educating health care providers		
Workshops (1 day per year)		
Resources*	US$	0
Trainer	US$	1,838
Attending Conferences (2-3 per year)		
Attending ticket (per person)	US$	11,532
Travel*	US$	0
Creating Conferences (1 per year)		
Panel of Experts	US$	6,548
Venue	US$	5,000
Resources	US$	5,000
Marketing and admin	US$	2,000
Catering*	US$	0
Total Estimate Goal 1	**US$**	**31,918**

Goal 2- Health care professionals as a source of school based education		
Transport driver salary (per driver)	US$	143,440
Transport operating costs (per KM per car)	US$	2
Resources	US$	246,940
Devotion of health workers to school education per educator (salary)	US$	246,940
Total Estimate Goal 2	**US$**	**637,322**

Goal 3- Community outreach		
Transport* driver salary (per driver)	US$	143,440
Resources	US$	187,050
Devotion of health workers to community education (salary per health worker)	US$	245,940
Total Estimate Goal 3	US$	576,430
Total Policy Estimate	US$ 1,245,669	

Figure 3-Financial Estimation



MONITORING AND EVALUATION

The strategy of reducing SGBV via education will need to be monitored and evaluated to elucidate any issues and problem areas, but also to uncover its strengths and progress. Monitoring and evaluation can potentially be indicated by:

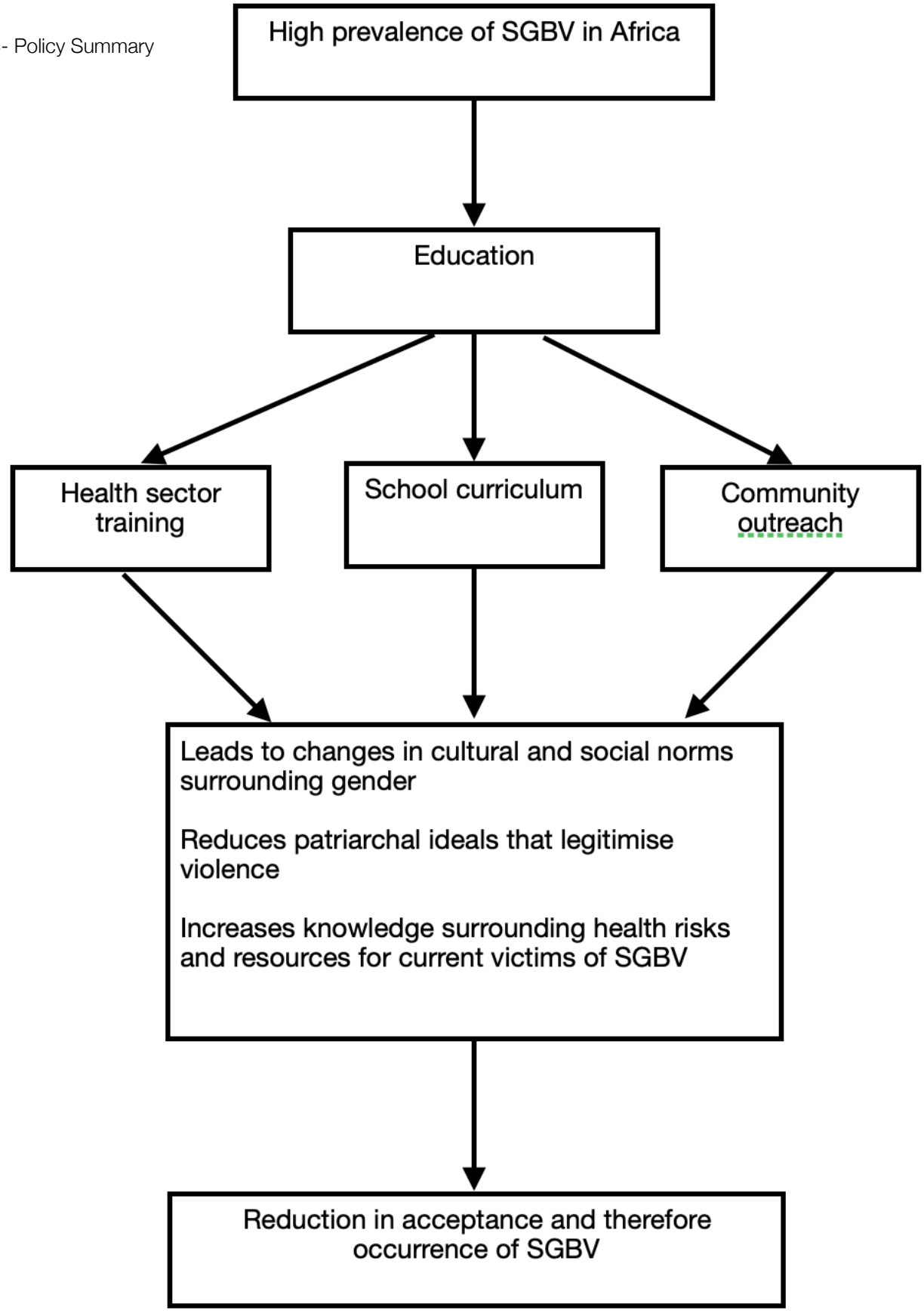
- Number of countries that are dedicated to continually training their health care providers in SGBV
    a. The number of countries holding workshops, training days and educational seminars for health care professionals
- The number of countries that have designated a proportion of their health care providers to educating the public on SGBV
    a. The number of countries that have incorporated SGBV education into school curriculum
    b. The number of countries that have incorporated SGBV training for teachers
- The number of countries that have active community outreach programs that liaise with health care providers
- The number of cases of SGBV occurring country wide. This data is particularly useful when using it to compare it to those countries that have a visible commitment to health education addressing SGBV, versus those that have not.

However, in regard to gathering and interpreting this data, particular caution needs to be held when dealing with SGBV. Firstly, cases of SGBV are notoriously underreported. Secondly, in measuring whether education has helped to change the patriarchal ideals, gender norms and propensity to violence that are responsible for the occurrence of SGBV, social desirability bias, attitudinal behavioural fallacy and stigma and fear will still impact these results. Additionally, it is also important to note that norm creation and therefore changes in attitude will have a lagged effect. That is they take time to engrain in society.

SUMMARY

In essence, in order to reduce SGBV, more emphasis needs to be placed on prevention. Using social norms theory as its basis, this policy seeks to increase education for both adolescents and adults, both within the setting of school based education and in the community. In doing so, this will reduce the underlying root cause responsible for the prevalence of SGBV. This can be seen visually in figure 4 on the following page. Because the occurrence of SGBV is rooted in cultural, contextual and socially constructed norms surrounding violence and gender, its true reduction must be rooted in removing these norms and the most effective way to instill this kind of social shift is via education and learning. This policy and strategy document largely focuses on addressing the causes of perpetration of SGBV. As was outlined at the beginning of this document, in further assisting victims or potential victims of SGBV educational opportunities need to be expanded for girls. This will allow them to attend health classes that inform them about the health issues related to SGBV, its causes, provide them with resources concerning where to seek help, and also inform them of their rights and where to seek redress for violation of these rights.

Figure 4- Policy Summary



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