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Conflicts in Africa: Intersectionality of GBV and HIV/AIDS

by
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Introduction

This study aimed to understand the experiences of African women in conflict-affected situations. The research intends to foster links and partnerships between People Opposing Women Abuse (POWA) and other African NGO's and CBO's working in the field of GBV by sharing information and negotiating strategies for dealing with and alleviating GBV in this specific context. The vision to work with other African NGO's is part of President Thabo Mbeki's vision for an African Renaissance by which African countries determine African solutions for African problems.

POWA was established in 1979 in a climate of conflict, during the apartheid era, with white men superior to black men and women. Black women were subordinates to both black and white men as well as white women. This hierarchy of white men over black men and women created a cycle of state violence. The intersectionality[1] of state violence and gender-based violence (GBV) highlights the hierarchy of subjugation of men by other men through racial, class and religious discursive practices perpetuating the vulnerability of women and children. It was in this light that women found themselves excluded from policy-making processes and as autonomous self-determined members of a citizenry. The insidious denouement in post-apartheid South Africa has ramifications for the perpetuation of GBV. Under this backdrop of the South African experience, POWA serves as a resource in mapping out the transitioning of an NGO from a conflict to post-conflict response organisation dealing with GBV.

POWA's position regarding this research is based on fostering a partnership, networking and sharing of information around GBV with NGOs and CBOs in countries that are conflict-affected. POWA is concerned with alleviating GBV in Gauteng but also in

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[1] Intersectionality is a method of analysis, looking specifically at how various factors impact and integrate with each other.

assisting and increasing knowledge about GBV in various other situations. POWA is aware of the sensitivities around GBV and conducts research on this basis with a strong ethical research code. The results yielded from this research would contribute to a collaborative approach towards dealing with gender issues related to armed conflicts which affect Africa as a continent. In terms of collaborative efforts amongst NGOs throughout Africa, a contribution towards meeting Thabo Mbeki's vision for an African Renaissance could be achieved.

Methodology

Defining quantitative and qualitative research
This is a qualitative and quantitative study. Sixteen African countries were initially identified in a desktop study as key countries facing conflict or post-conflict challenges related to GBV. The rationale for selection of these countries was based on their meeting the criterion of having been affected by conflict within the past 25 years. These countries therefore include both conflict and post-conflict settings. An initial questionnaire[2] was designed to survey prevention and response strategies adopted by various organisations in targeting GBV on psychosocial, legal and health levels. Adopting a multi-sectoral model[3], the format and content of the questions of the *Assessment of Existing Multi-sectoral Prevention & Response* questionnaire designed by the Reproductive Health Response in Conflict (2004) were closely adhered to but summarised to a large extent based on the selection of questions relevant to the present investigation. For the purpose of conciseness, questions were restricted to NGO activities in psychosocial, legal and medical areas[4], while questions pertaining to the security sector were excluded from the design of the initial questionnaire.

The questionnaire was widely distributed via e-mail to various organisations throughout

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[2] See Appendix A (1) for the initial questionnaire.
[3] The multi-sectoral model forms the "best practice" for prevention of and response to GBV in refugee, IDP, and post-conflict settings. The underlying principle of the multi-sectoral model recognises the rights and needs of survivors as pre-eminent, in terms of access to respectful and supportive services, guarantees of confidentiality and safety, and the ability to determine a course of action for addressing the GBV incident. Key characteristics of the multi-sectoral model include full engagement of the refugee community, interdisciplinary and inter-organisational cooperation, and collaboration and coordination among health, psychosocial, legal and security sectors (Reproductive Health Response in Conflict (2004). *Gender-Based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation in Conflict-Affected Settings*, p. 37).
[4] Nongovernmental and community-based organisations – initial target organisations – were mainly involved in psychosocial, legal or health-related work, or a combination of these.

Africa (see *data collection process*). Despite this, a low response rate was yielded. As a result, a number of revisions were made to the format of the original questionnaire and a subsequent questionnaire was devised[5]. Apart from questions assessing prevention and response strategies of organisations, the revised questionnaire contains items on general organisational profile (specifically, the date of inception, mission and objectives and core GBV focus), as well as questions relating to the respondent organisation's conceptualisation of GBV in conflict-affected areas. While preserving the qualitative content of the items assessing prevention and response strategies, additional items pertinent to understanding organisational strategies in relation to GBV in the context of conflict-affected situations were addressed. These additional items include: *prevention strategies* (creating public awareness on GBV issues, supporting empowerment activities and establishing and enforcing standards of behaviour for staff) and *response strategies* (providing material support, ensuring availability of emergency contraception (EC) and post-exposure prophylaxis (PEP), and collaboration with traditional healing practitioners. The revised questionnaire is considerably shorter in length, comparatively more concise and less verbose in quality. Moreover, questions are more sharply tuned to addressing the correlation between GBV and conflict/post-conflict settings. Although it relies largely on a structured ticked-response format, room for additional comment is also provided. The questionnaire was distributed for proof-reading purposes to two humanitarian aid workers who have worked in a number of conflict areas on the African continent - Lynn Heinisch of CARE International, and David Synder of Catholic Relief Services. Lori Michau, Co-Director of Raising Voices (Uganda) further provided input in terms of revisions to the structure and content of the questionnaire. The revised questionnaire was redistributed to the various NGOs and CBOs and international aid agencies on the list.

Taking these considerations into account, both the revised questionnaires (N=23) and the initial questionnaire (N=1) were subjected to quantitative and qualitative analysis[6].

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[5] See Appendix A (2) for the revised questionnaire.

[6] Responses were received from two organisations (Nagaad Umbrella Organisation and Somaliland Young Women Association) based on the initial questionnaire. The 'follow-up' revised questionnaire was subsequently sent to the two organisations, of which only the former responded. Subsequently analysis was based on responses from the revised version for this organisation. Responses from the latter organisation were not excluded from the research but were limited to the category entitled: "Strategies employed by organisations to address GBV" (See section 7 for *Research Findings and Outcomes*). In addition, one completed questionnaire (revised) from Miller du Toit Inc., a South African based legal practice, was received. However, this was excluded from analysis as the company profile description was not relevant to the purposes of the present research (see *Data Collection Process*). In total responses from 24 organisations were utilised in the analysis (23 and 1 based on the revised an initial versions respectively).

Quantitatively, descriptive statistics was performed. Descriptive statistics forms the basis of quantitative analysis of data. It is a branch of statistics which has the aim of simply describing what the data shows by summarising information using methods such as graphical description (using graphs to summarise data), tabular description (using tables to summarise data) or parametric description (estimating the values of certain parameters which are assumed to complete the description of the set of data) (Trochim, 2002; http://encyclopedia.laborlawtalk.com/Descriptive_statistics). The small sample size (N=24), however, did not warrant the use of more meaningful statistical analyses, such as correlations. The data from the questionnaires were statistically interpreted to reflect patterns of GBV occurrence.

In instances where comments were made, the comments were interpreted qualitatively. Discourse analysis was employed as the dominant framework within which other theories and methods of analysis are located. For the purposes of this study, the methods of analyses included intersectionality, psychoanalysis, representation and ethnomethodology where questionnaires were completed with comments. The reason for employing discourse analysis is because discourse analysis relies on psychoanalytic theory for locating GBV.

Psychoanalysis frames GBV around discourses of power, dominance and violence. Ethnomethodology attempts to locate the socio-cultural context of a specific group of people and how they define their particular environment. Discourses on GBV intersect with discourses around self and other. As a result, it is crucial to understand how the subject is negotiated in a displaced environment and how the subject makes sense of the abuse experienced and, the ways in which the subject copes with his/her particular abuse. Representation then is about how cultural codes impact on the subject and vice versa. Therefore, the way in which comments were analysed relied on the usage of language. Breaking the silence for many women and victims of sexual violence is about challenging traditions and subverting the norm to create a new and alternate space for new representations, which is how representation becomes a method of analysis. Thus, qualitative analysis was used to understand the comments and to draw on general conclusions based on the information contained in the questionnaires.

The questionnaires were coded into categories, namely into themes which manifest on a continental level and on a case by case basis (i.e. organisational level). The context of the violence as well as the history of the conflict was used to determine the rationale for the

comments. HIV/AIDS prevalence rates were not given as fact but were commented on as challenges faced amongst the many.

Research Design

POWA had been funded by the Centre for Civil Society, University of KwaZulu Natal to do a desktop study. The aim of our current research is two-fold:

1. to investigate the relationship between GBV and conflict-affected settings in Africa by identifying emergent patterns in the data relating to the various forms of GBV in specific conflict-affected settings;
2. to survey prevention and response strategies as a basis for identifying existing gaps in assisting survivors of GBV;

Data Collection Process

As part of the data collection process, 16 African countries were identified in a desktop study as key countries facing conflict or post-conflict challenges related to GBV. The rationale for selection of these countries was based on a timeframe of 25 years of having been affected by conflict. A list of targeted NGOs based in these countries totalled seventy-eight. These countries included Angola (4), Chad (1), Democratic Republic of Congo (DRC) (3), Eritrea (3), Guinea (3), Ivory Coast (1), Liberia (5), Mozambique (3), Namibia (6), Rwanda 5), Sierra Leone (3), Sudan (7), Uganda (13), Zambia (8) and Zimbabwe (13). The number of organisations represented in each country was based on a selection of organisations that dealt with women's issues, particularly GBV.

The initial questionnaire was distributed largely via e-mail to the various organisations. Given the difficulties with direct access to some of the local NGOs and CBOs without such facilities, nine international aid agencies and humanitarian organisations operating within the selected regions were targeted as potential facilitators in the distribution of the questionnaire to local organisations within their country of operation. Questionnaires were sent to their representative countries or regional offices. Of the international bodies contacted, feedback was obtained from UNIFEM in Eritrea and Zimbabwe and CARE International, in which consent was provided in assisting with the dissemination of questionnaires to key individuals at UN country level and at country offices in East, West and Southern Africa respectively.

As noted, two responses based on the initial questionnaire were received. Following content and format revision, the questionnaire was redistributed to these organisations via

email. From NGOs, responses were obtained from 'co-ordination' or network organisations, in which agreement was reached to have the questionnaire publicised on various NGO network websites, such as Kubatana NGO Network Alliance Project (www.kubatana.net) and GBV Prevention Network (www.preventgbvafrica.org). Given the large measure of co-operation obtained from these organisations, the revised questionnaire was widely distributed throughout the various countries in Africa. Subsequently, responses from organisations stationed outside of the 16 countries originally targeted for the current research were received. Thus, given their potential value to the research, these organisations were added onto the list of NGOs and CBOs dealing with GBV. These organisations were from Kenya (The Cradle – The Children's Foundation), Mali (Association pour le Progrès et la Défense des Droits des Femmes (APDF)), Mauritius (Mauritius Family Planning Association, Mauritius Union of Journalists), Nigeria (Women Information Network, International Community Education Association) and the Somaliland region (Nagaad Umbrella Organisation). Response from a legal practice based in South Africa (Miller du Toit Inc.) addressing issues related to family law was deemed irrelevant for the purposes of this study and was therefore excluded from the analysis.

Although the international bodies were initially targeted merely as facilitators in the distribution of the questionnaire at the local NGO and CBO level, two such organisations, namely CARE International (DRC) and the International Rescue Committee (Liberia) completed the questionnaire based on their work on GBV. Their input was subsequently included in the data analysis. Overall, the response rate increased following distribution of the revised questionnaire, with 8 responses from the initially targeted 78 NGOs (based in the 16 countries) and 14 from organisations other than from the pre-selected list (including two international organisations).

A number of explanations are put forward to account for the lack of responses from the targeted organisations, and these can be subsumed under the categories, lack of time and shortage of resources. A number of targeted organisations which failed to respond, at present, may be directly involved in interventions in crisis situations. Therefore, rendering emergency assistance in such areas is given a much higher priority. Of the organisations that did respond, 90% were involved in some form of programmatic work, such as development of networks, empowerment/education and raising awareness, lobbying and advocacy. In contrast to organisations more directly involved in frontline services, they may have greater resources in terms of time, staff and technology.

Moreover, due to lack of technological capabilities and resources, grassroots' organisations may have limited access to email facilities in order to access the questionnaires. A number of questionnaires sent out electronically were automatically returned with delivery failures. Thus, some organisations may have been previously established as temporary relief agencies rendering assistance to the particular needs of a community at a particular time and may have subsequently dissolved over time, perhaps due to a lack of funding or lack of immediate demand for their services. Given these factors, direct entry via network agencies (with whom contact has been established) into areas where such organisations operate becomes pertinent for the second phase of this research.

Feedback was received from the following 24 organisations:

1. CARE International (DRC)
2. Fontaine d'Espoir Filles et Femmes (DRC)
3. The CRADLE – The Children's Foundation (Kenya)
4. Amazonian Initiative (Guinea)
5. International Rescue Committee (Liberia)
6. Association pour le Progres et la Defense des Droits des Femmes (APDF) (Mali)
7. Mauritius Family Planning Association (Mauritius)
8. Mauritius Union of Journalists (Mauritius)
9. Women Information Network (Nigeria)
10. International Community Education Association (Nigeria)
11. Rwanda Women's Network (Rwanda)
12. Entishar Charity Society (Sudan)
13. Sudan National Committee on Traditional Practices (Sudan)
14. Choices Centre (South Africa)
15. Oil (South Africa)
16. Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) (South Africa)
17. Association of Human Rights Organisations (Uganda)
18. Raising Voices (Uganda)
19. Movement of Community Action for the Prevention of Young People Against Poverty, Destitution, Diseases and Exploitation (MAPODE) (Zambia)
20. Women, Coalition of Zimbabwe (Zimbabwe)
21. Connect (ZIST) (Zimbabwe)

22. Girl Child Network (Zimbabwe)
23. Nagaad Umbrella Organisation (Somaliland)
24. Somaliland Young Women Association (SOYWA) (Somaliland)[7]

The questionnaires were 'coded' into categories for analytical purposes. These categories are listed as follows:

A. Organisational profile
   1. Date of inception: organisations involved in GBV work
   2. Conflict and post-conflict countries
   3. Organisational mission and objectives
   4. Core focus of GBV work

B. Organisations' conceptualisation of GBV in conflict-affected settings
   1. Most prevalent forms of GBV in conflict-affected settings
   2. Contexts in which GBV occurs
   3. Phases of conflict during which survivors most likely seek help
   4. Perceptions of HIV/AIDS infection rates in conflict-affected settings
   5. GBV prevalence: conflict or post-conflict?

C. Strategies employed by organisations to address GBV
   6. Prevention strategies employed to address GBV
   7. Response strategies employed to address GBV
   8. Collaboration with NGOs/CBOs in various sectors

Discussion and Critique

The aim of the research was to investigate the relationship between GBV in conflict-affected settings by identifying patterns and trends of GBV and organisational strategies for intervention. The method of sample selection was initially based on a non-random purposive sampling method. This involves selecting a convenience sample from a population with a specific set of characteristics for the research (http://www.audiencedialogue.org/gloss-quant.html). The criteria specified for the research was African countries that have been affected by conflict(s) within the past 25 years and, NGOs and CBOs operating in those countries that engage in GBV work.

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[7] Responses based on initial questionnaire.

Criticism, however, is targeted at this method due to its non-random nature and subsequent bias that is introduced[8]. Due to the unrepresentative nature of the sample, drawing conclusions about the population based on the information derived from the sample becomes difficult (Australian Bureau of Statistics, 2004). The choice of this method is justified on the basis that "small numbers of individuals/groups may well be sufficient for understanding human perceptions, problems, needs, behaviours and contexts" of GBV on a qualitative level (Commonwealth Educational Media Centre for Asia: http://www.cema.org/books/index.html).

However, a low response rate generated from this sample subsequently directed the study towards a 'chain/snowball' method of sample selection. This involved soliciting assistance from 'participant' respondent organisations[9] in distributing the questionnaire to other organisations within their GBV network. Although this method of data collection generated responses from organisations in countries not initially selected, certain organisations in specifically targeted countries with a known history of war-time gender abuses (e.g. Angola, Chad, Eritrea, Guinea, Ivory Coast, Mozambique and Sierra Leone), as a result of non-response, failed to provide potentially valuable insight to the research. The possible reasons for lack of response have been discussed at length in the previous section. While 24 completed questionnaires in total were utilised, only 14 African countries were 'represented'. Given this non-response bias, the results yielded are not truly reflective of GBV as experienced in conflict-affected settings in Africa as a whole but are limited to specific areas. Moreover, organisations from certain countries that did respond (e.g. Mauritius) did not have a history of conflict and documented GBV occurrences associated with such contexts.

The results of the current study provide a mere backdrop of patterns of GBV in conflict-affected settings in certain regions in Africa and provide a survey of the organisational prevention and response strategies to tackle GBV within these settings. Subsequently, the results yielded from this investigation, at best, represent an overview of challenges

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[8] A sample is said to be biased if "not all outcomes have a known chance of occurring or if some outcomes have a zero chance of occurring" (Australian Bureau of Statistics, 2004). With random sampling methods, every subject has an equal opportunity to be selected, thereby enabling the sample to be representative of the population (Rosenthal & Rosnow, 1991).

[9] These organisations involved international aid/humanitarian organisations as well as NGOs based in Africa which were linked to GBV networks (namely, *Raising Voices* (Uganda)).

and gaps in intervention strategies to alleviate GBV in specific settings. Compared to domestic violence, sexual violence, physical violence and harmful traditional practices, conflict-related violence as a category did not feature prominently in terms of being one of the core foci addressed by the surveyed organisations. It is acknowledged that the category 'conflict-related violence' is particularly ambiguous within the context of GBV. While its purpose in the questionnaire was to distinguish between the work of organisations specifically focused on GBV within a conflict setting and GBV on a more interpersonal level, the difficulty in making such a distinction became apparent in subsequent analyses of responses. Child sexual violence and domestic violence, for instance, according to respondents featured prominently in conflict-affected settings, thereby making apparent the intersections of violence on a public level (i.e. the socio-economic and political) with that on a personal level (i.e. the domestic/familial and interpersonal).

The results of this study pertain to both conflict and post-conflict settings. Given that no clear-cut definition exists, enabling thorough distinction between these terms[10], research into prevalence and nature of GBV unique to each setting becomes complex. While GBV may occur on a mass scale during times of conflict, the repercussions are evident in the post-conflict period. This picture of GBV is further complicated by increased awareness and dissipating fears following conflict which potentially inflates numerical representations of the phenomenon as a result of increased reportings. Further research which establishes well-grounded criteria for classification of countries as 'conflict' or 'post-conflict' would prove beneficial in terms of establishing a baseline for comparisons. Select focus on a limited number of countries would allow for in-depth analysis and more effective intervention methods 'tailor-made' for particular contexts.

Interrelations between GBV, HIV/AIDS and poverty are acknowledged in this study. However, further investigation into the interplay between these contextual factors would enable more effective strategies for intervention to be devised, thereby increasing survivors' accessibility to critical institutions during and after conflict.

Locating Conflicts in Africa

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[10] See discussion : 'Defining conflict and post-conflict' in Literature Review.

Defining violence and conflict

Violence is usually categorised into self directed violence, interpersonal violence and collective violence. Interpersonal violence includes partner violence and GBV. Collective violence refers to violence used by members of one group against another group to achieve political, economic or social objectives (Krug, et al., 2002, Phinney & De Movre, 2003). For the purposes of this study the term conflict will be used as a synonym for collective violence and will exclude interpersonal violence. Jessica Benjamin (1995) associates violence with issues of dominance. For Benjamin the intersection of dominance and violence relies on the Hegelian understanding of the master/slave dialectic. She purports that ego psychology or object-relations theory is based on the premise of recognition. Psychoanalysis borrows from this idea of recognition because it claims that the master/slave dialectic is only initiated when the master is recognised by the slave as the master and that the slave understands his/her position as the slave. The master/slave dialectic is inoperable if there is misrecognition. To relate the theory to a day-to-day experience of women in conflict-affected situations in Africa, it is important to understand the value of tradition and culture and how that translates into daily practice in a paternalistic and patriarchal society; recognition by both men and women of the value system that is culturally coded is the foundation for perpetuating and ensuring women's subordination and vulnerability to violence.

Interpersonal violence

Interpersonal violence intersects with other forms of conflict, as described above (Begic & Jokic-Begic, 2001, Pickup. e*t al.,* 2001), and is exacerbated through rapid social changes (Phinney & De Hovre, 2003). The ecological model explains how different systems influence violence on an individual, historical and biological level. Other levels include proximal social relationships, characteristics of the community and societal factors and, policies and social norms. To understand, reduce and prevent violence it is very important to include all levels of intervention (Phinney & De Hovre, 2003, Krug, 2002). However, this study focuses on the influence of community and socio-cultural factors that contribute, enhance and sustain conflict situations.

It is an aphorism that interpersonal violence is directed mostly at women and to a lesser extent towards vulnerable children. Conflict situations can therefore be seen as intersecting and affecting the incidence of GBV. Conflicts are constantly evolving and changing due to socio-cultural aspects and should be seen in context (Krug, 2002).

The psychosocial affects of the wars have had a direct effect on the level of GBV (De

Abreu, 1998). Due to impunity for rapist during wars, many women have not seen justice meted-out, resulting in gender biases being perpetuated. It is critical to restore the dignity of victims of abuse. Social awareness is a strategic attempt in reducing high levels of GBV.

Poverty alleviation is a necessary component for the empowerment of women because it allows them to be economically independent thereby allowing them to challenge social and cultural gender-biases.

Conflict

The term conflict (collective violence) induces a range of political tensions emerging from limited resources or a difference in values. Klaus Theweleit (1989) comments on how wars are a masculine construction that represses one's desires and feelings by inducing the desire to control others through force and cruelty. In conflict situations, the lack of resolution often leads to grave human rights injustices such as the Rwandan genocide and various other forms of civil strife. It is in this vacuum for a lack of resolution that Africa's greatest challenge lies, albeit in eliminating armed conflicts intrastate to interstates, genocide, repression and other human rights abuses, terrorism and organised crime (Krug, et al., 2002, Phinney & De Movre, 2003). In Africa, tensions around resources and rampant poverty are contributing factors in the repression of goodwill in order to have control over resources. In the Balkans people are now establishing and entering into a process of cultural and interethnic exchange because they realise that the twelve-year war was "senseless" (The Sunday Independent, July 25, 2004).

Africa's historical context

Written African history is riddled with various types of conflict. Two common examples are slavery and colonialism (1650 – 1900). Former colonial powers in Africa were Portugal, Germany, Great Britain, Belgium, France, Italy and Spain. Colonialism was met with resistance. Political organisations and underground resistance movements such as Mkhonto weSizwe fought for the establishment of independent states on the continent. Once countries gained independence various political organisations such as South Africa's African National Congress (ANC) transitioned from political organisations into political parties and many remain within the current governing systems. Many of these political parties with their struggle ideologies influenced not only the political machinery of the country but also various trajectories within the economy with an emphasis on

Black empowerment and affirmative action policies, redressing the injustices of the past. Nonetheless, with the eradication of colonialism and oppression, conflict remains still an ever-present African reality, manifesting through civil unrest, one party states, coup attempts and refugee problems (Gersony, 1988, http://www.lonelyplanet.com/destinations/africa/).

South Africa as a post-conflict country

South Africa is a post-conflict nation-state. The South African experience serves as a reference point when evaluating and understanding conflicts on the continent. Post-apartheid South Africa has high levels of GBV. During apartheid, GBV was not discussed publicly. However, the Truth and Reconciliation Commission (TRC) hearings, made public men's abuse at the hands of the security police, revealing incidents of sodomy in breaking down detainees' resistance. Yet, women were never given the platform to reveal their abuse whilst in detention as well as in the camps including obligatory sex work to serve the cadres[11]. Due to amnesty for atrocities perpetrated during apartheid, women would not have had justice meted-out for their abuses. Instead they would be facing their perpetrators publicly without their perpetrators being censured.[12] The denial of women's abuse on a public scale reinforced the notion of GBV as a private and domestic issue that should not be made public. However, the high numbers of police reports on GBV contradict the maintenance of silence around GBV. More women are reporting GBV in South Africa and public personalities such as Nomboniso Gasa and Charlene Smith have paved the way for women to break the silence. However, this is not sufficient as GBV is still rampant in post-apartheid South Africa. Law reform such as the Domestic Violence Act and discussions on the Sexual Offences Bill indicate progress that is made on policy level but often does not translate into practical implementation of women's rights issues. Therefore, more significant public dialogue around GBV is needed as well as streamlining the criminal justice system to penalise perpetrators of these crimes.

Case Studies:

Table 1: Brief histories of some African countries

Country	Highlights	Gender-based Violence
Angola	Former Portuguese colony. 20 years of civil war. In 2002 a ceasefire	High numbers of displaced people still living in

[11] Louise du Toit (2005: 8) quotes Antjie Krog (1998: 182).
[12] The question arises that if women were to make public their testimonies of abuse would South Africa be breaking the silence on GBV or would we leave women vulnerable to abuse by not censuring these crimes?

	was declared and a peace agreement was signed, however, crime is still widespread. Home to refugees fleeing from DRC .	camps. Sex work, forced sex and forced marriage are prevalent features, exacerbating GBV and spread of HIV/AIDS.
Chad	French colony. Gained independence in 1960. Civil war from 1979 – 1982 destroyed the fabric of society and forced women to the forefront of the struggle. Fragile peace due to ethnic and political tensions.	Women exposed to torture, abuse, arbitrary killings and detentions as a result of the struggle between warlords and government forces. Gang rapes, forced sex in front of family and collective rapes are part of the genoicidal strategy used by warlords.
Democratic Republic of Congo (DRC)	Former Belgium colony. Security situation is unstable after years of bloodshed during the civil war. An estimated 2.5 million people died and the situation is still currently unstable.	Sexual violence a war tactic for ethnic cleansing and diminishing the dignity of a people. Men have also been victims. Crimes committed with impunity.
Guinea	Host to half-a-million refugees from Liberia and Sierra Leone. Sierra Leoneans have been repatriating to their country, but Liberians are continuing to flee from conflict.	Refugees from Liberia & Sierra Leone subjected to torture, sexual slavery, sexual violence, amputations. Genital mutilations emerge in camps.
Ivory Coast	France took interest in the 1840's. War broke out in the 1890's. Independence gained in 1960. Strikes, unrest and protests began in 1990. Since then, no elections, peaceful or democratic and many attempted coups.	Older women subjected to domestic slavery by rebels. Rape is normalised due to high prevalence. Forced marriage, labour exploitation, domestic violence are prevalent features.
Kenya	Former British colony. Mau Mau uprising (1952-26), an 'independence' and civil war, resulted in Kenyan independence in 1963. Jomo Kenyatta heads Kenya as Prime Minister.	Refugee women most susceptible to violence. Nairobi refugees denied basic human rights, including right to security, protection from torture and mistreatment. Police/government agents often perpetrators of abuse.
Liberia	Colonized in the early 19th century by African-American slave descendents. Declared an independent republic in 1847. Centralized republic dominated by a strong presidency. A seven-year long civil war ended in 1996. Elections thereafter said to be administratively free and transparent, though conducted in an atmosphere of intimidation. 1997 saw President Charles Taylor winning presidency.	Girls/women have been raped, tortured, kidnapped and killed. Older women targeted as victims of sexual violence, as younger women are more capable of fleeing to places of safety. Socio-cultural context of rape of the 'elderly': older women view younger men as sons who are also perpetrators of abuse.
Mali	Following dissolution in 1960, the Mali Federation was renamed the Republic of Mali, a fully independent region. Democracy reigned in 1992 with the election of Alpha Konare in 1992 subsequent to periods of marked instability and internal and external conflicts. Subsequent conflict between Malians and the Tuareg ethnic groups arose. Peace deal signed in 1995.	Violence against women reportedly widespread. Traditional harmful practices (e.g. female genital mutilation) are sanctioned by culture. Site of internal and cross-border trafficking.
Mauritius	Gained independence in 1968 as a constitutional monarchy. Successful containment of conflicts, despite tensions between the Creole and Indian communities. Mauritius became a republic in 1992.	Compared to other African countries, no large-scale acts of GBV documented. Reportedly "one of the best laws on GBV in the SADC region", (Virahsawmy, 2003).
Mozambique	Former Portuguese colony. Fascist regime overthrown in 1974 after 10 years of war. Portugal withdrew overnight. Frelimo and Renamo peace treaty was signed in 1992. Elections were held in 1994. Currently, the country is in the process of rebuilding itself.	During civil war, women were raped at gunpoint. Women and children displaced. Women taken as sexual amusement for men and made to do domestic chores for men in camps (bandits).
Namibia	Annexed by Germany (end of 19th century), Rebellion by Herero people, which was brutally suppressed (1904). German rule came to an end after WWII. SA mandated to rule. War of independence over	Women were active in SWAPO's work. Girls and women subjected to rape and sexual violence by SA soldiers, SWAPO chiefs and the SWATF. Women

	in 1989 and SWAPO wins first election in 1995.	placed in contradictory position - rapes not reported due to shame, as well as their loyalty to SWAPO.
Nigeria	Achieved independence in 1961 from British rule. Nigerian Civil War (1967-1970) was an ethnic and political war due to attempted secession of Nigeria's South-eastern provinces as an independent republic of Biafra. Political liberalisation initiated a return to civilian rule, resulting in increased expression of frustrations and violence between religious and ethnic groups.	Two thirds of women in Lagos State communities experience physical, sexual and psychological violence in the family. Abusive acts go unchecked and sometimes condoned by government in some instances (Amnesty International, 2005).
Rwanda	German colonialism ended after WWI and "given" to Belgium. Gained independence in 1962. Ruled by a Tutsi minority leadership. Faction fighting between Hutus and Tutsi majority lead to the Rwandan genocide, an estimated 1 million people are reported to have been killed. Over the past few years the situation has improved including resettlement of refugees.	Sexual violence rampant. Women targeted for their ethnicity. Honour rapes committed as revenge for rapes of women on either Hutu or Tutsi sides. Rape used as a strategy for ethnic cleansing. Children born out of rape referred to as "devil's children and are ostracised.
Sierra Leone	Recently ended a 10-year civil war and is in the process of rebuilding the country. Half of the population was displaced and the conflict was defined by grave human rights violations against civilians.	High incidence of sexual violence. Domestic violence sanctioned in culture and accepted as part of the context of marriage. Rape of girls as a tactic employed to eradicate dignity and demoralise the community.
Somaliland	A former British territory self-proclaimed as an independent republic in 1991. Sub-clan rivalries within the Isaaq clan arose subsequently with fighting between the Somaliland National Movement (SNM) and its rival factions ensuing. Peace talks led to an end of conflicts	350 000 IDPs in Somalia and Somaliland region. Violence and human rights abuses problematic in Somalia, but peace and stability characterise the Somaliland region.
South Africa	Former Dutch and British colony. Difaqane and Mfoqane (Zulu terror campaigns). Great trek of Boers away from British rule. Zulu and Boer clash, resulting in concentration camps. 1910 racist legislations emerge (foundation of apartheid). Homelands to restrict blacks with widespread suffering. Black resistance with strikes and protest marches. British Commonwealth withdrew in 1961. Isolation followed. SA military responded with war tactics ranging from limited strikes (Lesotho, Mozambique) to full-scale assault (Angola). Revolutionary struggle. Third force activity, resulting in black-on-black violence. 1994 saw the first free and democratic elections. Redressing historical injustices.	Women suffered directly from Apartheid policies and affected by the loss and torture of family members. Women sexually violated in detention; raped or forced to have sex with other prisoners; pregnant women subjected to electric shocks. Bestiality with rats used as a form of rape to degrade victims. Sexual violence used as strategy to undermine resistance, political will and self-determination.
Sudan	British colony. Joint rule between Britain and Egypt. Independence in 1956. Longest civil war between the Arab-speaking north and the Black Christian and animist south.	Sudanese War conceptualised as genocide (Northerners rape/impregnate women from the South to eradicate their culture). Women, who are the honour of the enemy, are captured, abused and enslaved by their captors; used for comfort and a source of sexual release in order for men to perform well in war.
Uganda	British protectorate. Gained independence in 1962. Dictatorial rule with a reign of terror. War with Tanzania and guerrilla warfare. On the road to recovery. Still inter-tribal conflicts present.	Militarised rapes are routine and encouraged by commanders as a form of ethnic cleansing and to destroy the dignity of the community. Children born out of these atrocities carry the rapist's ethnicity and are stigmatised. Women abducted and used as sex

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		slaves.
Zambia	Under British control from 1924-63 (Northern Zimbabwe). Gained independence in 1964. One legal party till 1991, but the subsequent vote in 1996 saw blatant harassment of opposition parties.	Rape, abduction, forced marriages and domestic violence rampant in camps. Women exploited by fellow refugees and aid workers.
Zimbabwe	British colony. War of Liberation. Was formerly known as Rhodesia. Racial conflict between Black and White. Guerrilla warfare. One-party state. Dictatorship.	Women served as freedom fighters. Militias routinely torture and rape women in front of families as a means of instilling fear, oppression and humiliation. Women taken as wives for soldiers and used as domestic labourers.

Literature Review

DEFINTION OF TERMS:

Gender-based violence (GBV)

The World Health Organisation (WHO) uses the term gender-based violence synonymously with violence against women (VAW)[13]. Two areas of priority are highlighted, namely (1) "violence against women by an intimate male partner or ex-partner, which is known as domestic violence against women (DVAW) or intimate partner violence (IPV), including physical and sexual violence, emotional abuse, and a range of coercive and/or controlling behaviours; and (2) sexual violence, which includes rape and other forms of sexual coercion, either by partners or by others" (http://www.who.int/gender/violence/en/).

Similarly, the United Nations (UN) Declaration on Violence Against Women, adopted by the UN General Assembly in 1993, defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life." (http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument).

Article 2 of the document presents what the international community recognises as

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[13] GBV is not necessarily VAW. Implying that GBV is synonymous with VAW places GBV in a hetero-normative framework and biases acts committed within a homosexual context (as in the case of the TRC hearings of male-on-male abuse).

generic forms of violence against women, which encompasses, but is not limited to:

a. "Physical, sexual and psychological violence occurring in the family, including battery, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs"
(http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Op endocument).

The United Nations Declaration on Violence Against Women provides a basis for defining GBV. Violence against women (VAW) is therefore understood as a form of GBV. It affects women disproportionately or is directed against a woman because of the fact that she is a woman (Amnesty International 2004). In order to mobilise policy and programming efforts to deal with violence, it is necessary to highlight the social dimensions and root causes of violence against women. For the purposes of the current research, GBV as defined by the United Nations Population Fund (UNFPA) is adopted (http://www.unfpa.org/intercenter/violence/intro.htm):

"… Violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women… It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community). It includes that violence which is perpetrated or condoned by the State" (UNFPA Gender Theme Group, 1998).

GBV in the context of conflict and displacement
In locating this definition of GBV within the context of conflict and displacement, which forms the basis of the present study, it is necessary to understand this relationship. According to Forced Migration Online (FMO), common acts of GBV committed against

women and girls during armed conflict as well as during the consequent social disruption phases, include "sexual assault, often associated with violent physical assault; mass, multiple and gang rapes; early or forced marriage and forced pregnancies; enforced sterilization; forced or coerced prostitution; military sexual slavery; human trafficking; and domestic violence". While it is acknowledged that men and boys suffer from sexual abuse and rape as well as forced conscription, forms of violence said to affect women and girls particularly during conflict include female infanticide, female genital mutilation and honour killing.

According to Amnesty International (2004, December), women abuse in conflict is part of the wide-ranging acts of violence against women entrenched in a "global culture of discrimination that denies women equal status with men and legitimizes the violent appropriation of women's bodies for individual gratification or political ends". Social, political and certain religious institutions instil the notion of women as possessions of men, conflate chastity of women with family honour and ethnic identity, and sanction the "bodily   appropriation"   of   women (http://takeaction.amnestyusa.org/ctt.asp?u=677819&1=11483).

One of the most visible consequences of armed conflict is forced migration, which is defined as "movements of refugees and internally displaced people (those displaced by conflicts within their country of origin) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects" (International Association for the Study of Forced Migration, cited in Loughna, 2004). Refugees and internally displaced persons (IDPs), of which women and children constitute a large majority (Women's Commission for Refugee Women and Children, 2004) are therefore forced migrants in the category of conflict-induced displacement. Reports have documented women and girls' increased vulnerability to GBV within the context of forced displacement (Amnesty International, 2004, May; Torres, 2002; International Rescue Committee, 2004; Jack, 2003; Mooney, 1998), and arguably in all conflict settings (Machel: http://www.un.org/rights/impact.htm), during which gender-based discrimination practices existing prior to conflict are repeated and even exacerbated (Torres, 2002; Women's Commission for Refugee Women and Children, 2004). It is acknowledged, however, that in conflict situations, many women face gender-based abuses, whether as refugees or internally displaced persons, as civilians or combatants (Amnesty International, 2004). In many societies, women do not enjoy legal majority status and continue to experience discrimination in the family. Where the rights

of women are not affirmed in non-conflict settings, safeguarding women against abuse is not accorded priority during or after a conflict (Women's Commission for Refugee Women and Children, 2004). Moreover, given that refugees and IDPs do not enjoy protection by their governments, they are among those most vulnerable to acts of violence, including sexual and gender-base violence (United Nations High Commissioner for Refugees, 2003).

Women Refugees

The legal definition of a refugee, which is enshrined in the 1951 United Nations Convention Relating to the Status of Refugees, defines refugees persons residing outside their country of nationality, who are unable or unwilling to return because of a 'well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion'. Those recognized as refugees have a clear international legal status and are afforded the protection of the United Nations High Commissioner for Refugees (UNHCR) (Loughna, 2004). Women and girls being subjected to sexual and other types of GBV (e.g. rape, early pregnancies, kidnapping, forced marriage) in refugee/IDP camps, by male refugees/IDPs. This is largely owed to the design of camps which cater for only communal living and sleeping spaces, communal washing facilities, as well as conditions such as poor lighting and overcrowding (Coomaraswamy, 1995; Interagency Coalition on AIDS and Development (ICAD), 2002). Sexual violence against women by security personnel, camp officials or humanitarian aid workers and members of peacekeeping forces has also been extensively documented (Amnesty International, 2004; Callamard, Bedont, Brunet, Mazurana & Rees, 2001; Chinkin, 1994; "U.N. Peacekeepers", 2004; Coomaraswamy, 1995; Jack, 2003; Pickup, Williams & Sweetman, 2001; Torres, 2003; World Health Organisation (WHO), 2002, May[2]).

Internally Displaced Women

The Guiding Principles (1998) definition is generally recognized as the UN definition of internally displaced persons and is defined as: "…persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border" (http://www.unhchr.ch/html/menu2/7/b/principles.htm).

The predicaments faced by IDPs are said to be greater than those of refugees, for the reason that they remain within the borders of their own country under the jurisdiction of a government, who perhaps is the cause of the displacement, or in the least failed in its obligations to protect them (Roberts, 2004; Torres, 2003). Unlike refugees, IDPs are granted less international protection and assistance than refugees who traverse country boundaries. Although a representative of the UN Secretary-General on Internally Displaced People was appointed in 1992, and the Guiding Principles on Internal Displacement were introduced in 1998, these are not legally binding (Phuong, 2005; Torres, 2003). Similar to refugee women, internally displaced women are more vulnerable to sexual and other types of GBV. Moreover, break in social and cultural contacts, disruptions to family and social life result in increased risk of sexual abuse and violence as well as domestic violence (Torres, 2003).

GBV as a Strategy of War
Gender-based violence, particularly the systematic and rampant use of rape and sexual violence in conflict situations, is acknowledged widely as a deliberate instrument of war (Amnesty International, 2004a; Callamard et al., 2001; Chelala, 2004; Chinkin, 1994; Human Rights Watch, 2000(b); Martin, 2004; Narayanaswamy, 2003:13; Pilch, 1999; Sideris, 2001; Swiss & Giller, 1993; Twagiramariya & Turshen, 2001; Weise, 2002).

The Reproductive Health Response in Conflict Consortium claims that GBV is used as a tactic to eradicate the dignity of a group of people:

> Sexual and gender violence is endemic in conflict situations, where rape and other forms of violent sexual assault are increasingly used as weapons of war. In the former Yugoslavia, rape was deliberately employed to demoralise men and women held in captivity. In Rwanda, and other countries where the ethnicity of the child is determined by the father's ethnicity, rape has been used to alter the ethnic composition of the population. (www.rhrc.org/pdf/gbv.pdf)

Nordstrom (1991, cited in Sideris, 2001, p. 147) emphasizes that sexual attacks are "tactics of intimidation and instruments of social destruction", which have as their aim the crippling of socio-political processes and represents an attack against personal identity and cultural integrity. As a tool of intimidation, it is used to dominate, humiliate and control behaviour (Herman, 1992), as well as to instil fear, terrorise civilian

populations and demonstrate the power of invading forces (Agger, 1992). As a tactic of social destruction, GBV is employed to disable the enemy by destroying bonds of families, communities, cultures and society (Amnesty International, 2004a; Mooney, 1998; Pilch, 1999). Most often GBV is carried out in the presence of family and compatriots (Granados, 2004; Sideris, 2004; Turshen, 1998; UN Office for the Coordination of Humanitarian Affairs, 2004; Weise, 1992), rape yields destructive consequences of humiliation, shame, stigma, ostracism and social rejection for the victim by the family and community (Amnesty International, 2004a). As an expression of ethnic group hatred (Swiss, 1993), the public raping of women by military forces destabilises communities, systematically forcing them into flight, displacement and disintegration, thereby achieving the goal of "ethnic cleansing" (Swiss & Giller, 1993). Rape, in the context of conflict, therefore is an assault on the individual, her family and her community. Being a tactic of war, it is often perpetrated on a mass scale (particularly against women and children) (Inter-Agency Standing Committee (IASC), 2004, Sideris, 2001), but can take on other forms, such as sexual slavery (Amnesty International 2004). Investigations by the UN Commission on Human Rights and the Security Council's Commission of Experts into allegations of widespread sexual violence in former Yugoslavia revealed mass scale rapes falling into several "patterns" of abuse: rape as a policy of terror, "rape camps" where forcible impregnation was the explicit goal, rape as a spectacle, and rape in conjunction with mutilation (Pilch, 1999, p. 2). It is necessary to acknowledge, however, that apart from sexual violence, forced displacement and GBV too are strategies of war that destabilise families and communities (Amnesty International, 2004; Machel:http://www.un.org/rights/concerns.htm), that - as demonstrated in Kosovo - (Human Rights Watch, 2000, cited in Narayanaswamy, 2003:13) the threat of rape alone would suffice to force women and families into flight.

GBV, Conflict and HIV/AIDS
The relationship between conflict and HIV/AIDS is complex and is mutually reinforcing. On the one hand, the brutalities of war aggravate the conditions of poverty, powerlessness and social instability, which fuel the HIV/AIDS crisis (ICAD, 2002; Machel, 2001; Sarup, 2004). In the context of long-running conflicts, critical institutions in affected communities become crippled as a result of reduced numbers of qualified staff, damage to social infrastructures and health care facilities as well as the collapse of educational systems, threats to life due to instability and the breakdown of implementation capacity between different sectors. In addition, the local and national systems that maintain the rule of law protect human rights and aim to reduce poverty

collapse (Machel, 2001; Nebarro, 2004; Sarup, 2004).

The lack of accessibility to public services, shortages of emergency contraception (EC), anti-retrovirals (ARVs), post-exposure prophylaxis (PEP) together with the lack of diagnostic tests, equipment and medicines essential to address sexual trauma are other factors which compound the problem in such crises settings (Nebarro. 2004). In some settings, it is evident that services are not equipped to meaningfully deal with trauma, diseases and physical ailments[14] that emerge as a result of GBV (Amnesty International, 2004, April). Moreover, the notion of 'accessibility' to health care and treatment and the feasibility of expensive drugs (such as ARVs) in the context of resource constraints presents as problematic in situations where essential survival and nutritional needs are not satisfied (Muthein, 2003). Accessibility to support organisations is limited as a result of forced displacement, and support becomes a less urgent need than pure survival.

Poverty is furthermore identified as a critical reason for the gender gap in HIV care and access to treatment. HIV disproportionately affects the socially and economically marginalised. Women and girls, who are generally disproportionately sexually vulnerable to HIV infection and often economically dependent on men, occupy this marginal space and therefore lack the decision making power to access female-controlled HIV prevention methods, as well as to negotiate safer sex practices (Muthein, 2003; WE-ACTx, 2004). Alongside factors of economic deprivation, stigma and fear of social ostracism and discrimination present obstacles to testing, treatment and prevention (WE-ACTx, 2004). Instances of rejection by spouses and family, homelessness, emotional abuse, violence and even death have been reported in cases where women disclosed their HIV status (Muthein, 2003; Vetten & Bhana, 2003; WE-ACTx, 2004).

Due to political instability and socio-economic vulnerability, women and orphaned girls in contexts of displacement are at a greater risk of being attacked or being sexually exploited for example through prostitution or "survival sex" (sex in exchange for food, clothing, etc) all of which greatly increase the risk and accelerate the spread of HIV infection (Amnesty International, 2004; Sarup, 2004; WE-ACTx, 2004; http://www.un.org/apps/news/story.asp?NewsID=13900&Cr=hiv&Cr1=aids).

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[14] Physical ailments include sexually transmitted infections (STIs), such as HIV/AIDS, urinary tract infections, cervical infections, vesico-vaginal fistula, trauma mutilation, complications from botched abortions, scarring of the vagina, birth complications and problems associated with engaging in normal sexual activity (Callamard et al., 2001).

On the other hand, the planned and purposeful transmission of HIV infection in certain conflicts, namely in the Rwandan genocide, has been used as a tool of ethnic warfare (Chatterjee, 2004; Nathanson, 2000 as cited in ICAD, 2002). Similarly, during the "ethnic cleansing" campaign in Uganda in the 1970s, mass rape is believed to have resulted in pervasive HIV infection rates in the region (Berkely, 1994; Martin, 2004). In the case of Darfur, where rape is employed as a weapon of war, mass-scale rape threatens to potentially "skyrocket" the spread of HIV and halt all ongoing prevention efforts in and around neighbouring countries in Sudan (Martin, 2004, p. 2). The spread of HIV is not only limited to Darfur women and their Janjaweed rapists, but a 'spill-over' effect into the refugee camps of neighbouring Chad is postulated (Garrett, 2004). While the intentional transmission of HIV via the systematic mass rape in these regions has not been formally ascertained in these instances, arguments purporting HIV/AIDS to be a "genocidal strategy" have been proposed in other contexts. In West Papau, the Indonesian military have been accused of "knowingly" introducing infected prostitutes into the region as a deliberate offering of favours to local tribal leaders as a means of wiping out the indigenous people (Flanagan, 2002).

Sexual violence recognized as a war crime
In the past, rape and acts of sexual violence during conflict were either silently acknowledged as 'fringe benefits' of war (Scheffer, 1999), or consistently marginalized or dismissed as side effects or natural consequences of war (Bideke, 2002; Granados, 2004). Rape of women during war first attracted international attention in Hugo Grotius' (1623, cited in Granados, 2004) publication, *De Jure Belli ac Pacis* which represented a breakthrough in the "growing recognition on the Middle Ages that wartime gender based violence is a crime" (Mertus, p. 73, 2000 cited in Granados, 2004). Subsequently, rape was classified as a war crime in the post World War I Versailles Commission (Parker, 1995). Control Council Law No. 10, Punishment of Persons Guilty of War Crimes, Crimes Against Peace and Against Humanity (1945) (http://www1.umn.edu/humanrts/instree/ccno10.htm), defines war crimes and lists crimes against humanity for the Nuremberg and Tokyo Charters, includes war rape in the category of 'crimes against humanity' (Parker, 1995). In 1993 and 1994, rape and sexual violence was recognized, for the first time, as an independent crime within the statutes of International Criminal Tribunals for the Former Yugoslavia (ICTY) and for Rwanda (ICTR) (Scheffer, 1999). Due to a landmark decision by the ICTR, rape and acts of sexual violence were, for the first time, granted equal status as other offences. In the

Akayesu judgement delivered by the ICTR on September 2, 1998, rape was linked with the crime of genocide and is recognised as such if there is evidence to prove that it is employed with the intent to destroy a group, whole or in part, psychologically or physically (Pilch, 1999**;** Scheffer, 1999).

Like torture, rape is employed for purposes such as intimidation, degradation, humiliation, discrimination, punishment, coercion, control or destruction of the person (Human Rights Watch, 2000 (May); Scheffer, 1999). Rape represents a violation of personal dignity and "constitutes torture when it is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" (Prosecutor v. Jean-Paul Akayesu 1998 ICTR, cited in Scheffer, 1999, p. 2).

Rape was further recognised in 1998 by the ICTY as a violation of the Laws and Customs of War and as a basis of torture under the Geneva Conventions (Scheffer, 1999). The ICTY Trial Chamber further acknowledged rape to be "a despicable act which strikes at the core of human dignity and physical integrity" (www.i**cc**women.org/ar**c**hive/resour**c**es/ex**c**erpts.htm).

The *Furundzija* judgement decided by the ICTY in 1998, based on common article 3 of the Geneva Conventions dealing with internal armed conflicts, confirmed the status of rape as a war crime (www.shanland.org/HR/Publication/LtoR/sexual_violence_as_a_war_crime.htm). Based on international humanitarian law (http://www.redcross.lv/en/conventions.htm), common Article 3 of the Geneva Conventions prohibits "violence to life and person," "cruel treatment," "torture" or "other outrages upon personal dignity." (http://www.genevaconventions.org/). Article 4(2)(e) of Protocol II to the Geneva Conventions, governing the protection of civilians in internal armed conflicts, explicitly outlaws "outrages upon personal dignity, in particular humiliating and degrading treatment, rape, enforced prostitution and any form of indecent assault." (http://www.genevaconventions.org/).

Based on the landmark developments in international jurisprudence on sexual and gender-based violence, international human rights instruments prohibit cruel, inhuman or degrading treatment or punishment. Rape, forced pregnancy and sexual torture are now recognised as war crimes and crimes against humanity (Loughna, 2004). Rape is considered as either a *war crime*, when committed in time of international or internal

armed conflict, or a *crime against humanity* (whether carried out in time of war or peace), if it is part of a widespread or systematic attack on civilians. In addition to rape, international law further prohibits and criminalises, as either a war crime or crime against humanity, any serious act of *gender violence* "causing the victim to engage in an act of sexual nature by force, or by threat of force or coercion against the victim or another person, or by taking advantage of a coercive environment". While acts of gender violence may not necessarily take the form of forced penetration of the human body, they nevertheless "constitute an extreme form of humiliation and debasement for the victim, contrary to the most elementary principles of respect for human dignity", and are therefore criminalised ("Report of the International Commission of Inquiry", 2005, p.95).

Defining conflict and post-conflict
Conflict is defined as the "fighting between two groups of people or countries" (Cambridge Advanced Learner's Dictionary, 2004). Nana-Sinkam (2000) acknowledges the difficulty in precisely defining 'conflict' given the ambiguous nature of the term. Listing instability and insecurity as key characteristics, he accedes to a definition of conflict as "a violent, extremely destructive reciprocal engagement between two states or groups of people within a discernible political space against each other" (p. 4). Many complex discourses abound as to the 'root causes' of conflicts in Africa. Ethnic competition for control of the state, regional or secessionist rebellions, border disputes (Lodge, 1999), competition for land, resources or state power (Majavu, 2004) are some of the theories put forward to understand the origins of African conflicts.

Post-conflict is defined as the transition phase to peace following conflict. Even though relative peace may be established in certain parts of a country, other areas may continue to be ravaged by war (and for long periods of time), thus, the use of the term is not a clear-cut one. Great instability marks the post-conflict phase with the constant possibility of a return to open conflict (WHO, 2000). In the case of Uganda, which is in a post-conflict setting but nonetheless is ravaged with conflict in the north, Northern Uganda would then be considered as a conflict-affected area. Similarly, Sudan is said to have very recently emerged from a 21 year civil war between the predominantly Muslim north and the Animist and Christian south following a comprehensive peace deal signed in January 2005 (http://news.bbc.co.uk/1/hi/world/middle_east/country_profiles/820864.stm). Despite this, conflict is reportedly resurfacing with the threat of intense violence occurring in oil-rich areas outside the Darfur region, namely Western Kordofan (http://www.politinfo.com/articles/article_2005_01_12_4237.html). Moreover, a 'tribal

conflict' between "Darfur's myriad groups", particularly in the western region of Darfur, is said to have overshadowed the political conflict (Agence France-Presse [AFP], 2005).

Despite transitioning into the post-conflict phase, women may continue to suffer gender-based violence during post-war reconstruction, particularly as sexual violence shifts from the public to the private home space (Netherlands Institute of International Relations, 2003). Perry (2004) makes reference to violence against women being on the increase in 1998 and 1999 in Yugoslavia, despite a signed ceasefire agreement in 2001. GBV is also reported to be a persistent feature during post-war insurgencies in Rwanda and the Democratic Republic of Congo (DRC) (Amnesty International, 2004, April). Amnesty International (2004, April) reports that the phenomenon of rape neither began nor ended after the Rwandan genocide in 1994; sexual violence and forced marriages continue to be carried out by Rwandese military and security forces.

Defining conflict-related violence
For the purposes of the research, conflict-related violence is understood as violence carried out within the context of conflict between opposing groups on an interstate or intrastate level, and can include emotional or economic force, coercion, pressure as well as physical harm. This includes, but is not limited to, physical assault, sexual assault, mass rape, military sexual slavery, coercive sex for protection or survival or in exchange for basic needs, forced prostitution, force marriages and forced pregnancies.

While this definition includes forms of GBV, such as physical violence, sexual violence, harmful traditional practices etc, it is listed as a specific category in the revised questionnaire[15]. The purpose was to ascertain whether the respondent organisations were directly involved in GBV work within conflict settings.

Rationale for Research

Violence against women has only in the past decade been given place on the international agenda. In 1993, the International Conference on Human Rights acknowledged that women's rights were subsumed under the category of human rights, that violence against women was a violation of women's human rights (Jansen, 2005). The Declaration for the

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[15] See Appendix A(2), Question 3.

Elimination of Violence Against Women (CEDAW), approved by the UN General Assembly in 1993, identified gender inequality and discrimination as the basis of violence against women. Governments and NGOs are urged to engage in collaborative efforts (whereby knowledge and information gained by NGOs are used to inform the work of governments) to develop long-term measures to eliminate all forms of discrimination against women (Chiongson, 2004; Jansen, 2005; http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument). During the 4th World Conference on Women in Beijing, China, 1995, Violence against women was identified as one of the twelve critical areas of concern deserving urgent attention and an action plan by governments, nongovernmental organisations and individuals (Beijing Declaration and Plan for Action, Fourth World Conference on Women, 15 September 1995). In 1996, during the Forty-Ninth World Health Assembly Resolution WHA49.25 was adopted, GBV gained recognition by the World Health Organisation as a priority global public health and human rights problem throughout the world (Dahlberg & Krug, 1996; Fatusi & Oyeledun 2002).

Although the focus of the research is based on the experiences of women in conflict-affected settings, the current investigation nevertheless attempts to address some of the gaps highlighted. The study attempts to highlight the link between GBV within conflict-affected situations, looking at the behavioural patterns that emerge or are perpetuated. Much information has been reported by various organisations such as the ICTR and ICTY about grave human rights abuses and sexual violence occurring within conflict situations. However, there is not much research that links the effects of conflict and post-conflict behaviour on GBV.
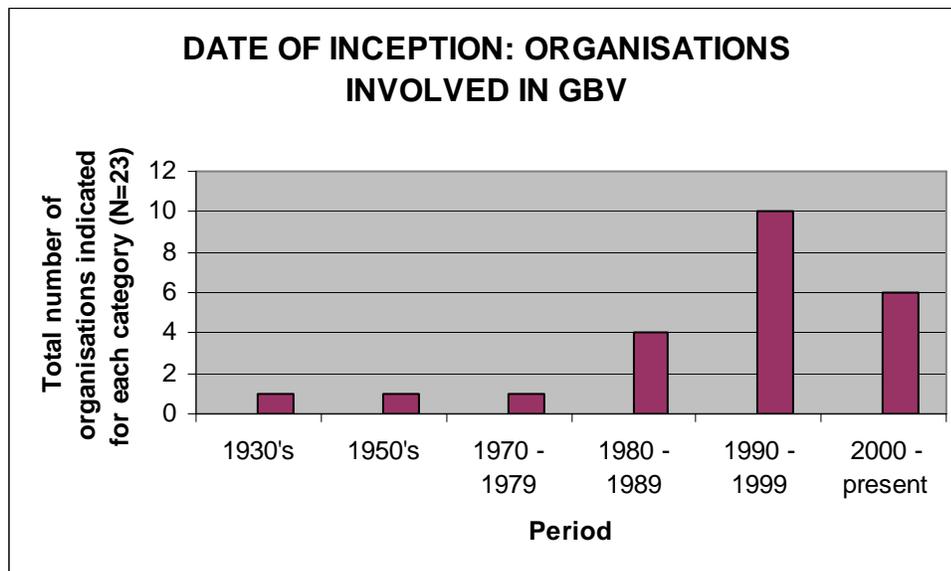
Research Findings and Outcomes
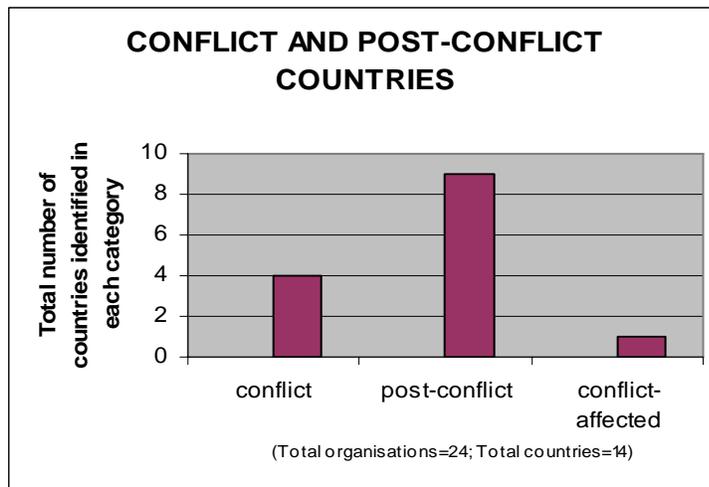
DESCRIPTIVE STATISTICS:

A. ORGANISATIONAL PROFILE[16]

Date of inception of organisations involved in GBV work

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[16] Analysis of data is based on the 23 revised questionnaires (see footnote 6).

DATE OF INCEPTION: ORGANISATIONS INVOLVED IN GBV

Of the 23 organisations which responded, 13% were established prior to 1975 and 17% were formed during the 1980s. The oldest established organisation, the International Rescue Committee (IRC, Liberia), although founded in 1933, began initiating emergency programmes in Liberia only in 1996 which aimed at providing emergency assistance to those displaced by violence (IRC, 2004). The majority were established post 1990 to 1999 (43%), while 26% were formed between 2000 and 2002. The emergence of the majority of organisations addressing gender issues in the 1990s perhaps reflects the increasing awareness of gender-related issues on an international level, particularly the reproductive health needs of women and girls in conflict settings. Krause (2004), in this regard, notes that prior to the mid 1990s, very little was done to address the critical reproductive health (of which GBV is an aspect) needs of refugees and internally displaced persons. 1995 saw the establishment of the Inter-Agency Working Group (IWAG) on Reproductive Health in Refugee Situations, following the collaborative efforts of the United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), World Health Organisation (WHO) and more than 50 United Nations, governmental and nongovernmental organisations. Subsequently, a significant effort to raise awareness and advance reproductive health in conflict settings had arisen due to collaboration and exchange among organisations involved in such work (Krause, 2004). It is acknowledged, however, that our sample size may not necessarily be a fair reflection of this general international trend.

Conflict and Post-conflict Countries

CONFLICT AND POST-CONFLICT COUNTRIES

Total number of countries identified in each category

10
8
6
4
2
0

conflict   post-conflict   conflict-affected

(Total organisations=24; Total countries=14)

From the 23 organisations, 14 countries were identified. Of these, 64.2% were identified as post-conflict countries and included: Kenya, Guinea, Liberia, Mali, Rwanda, Somaliland, Zambia, Mauritius and South Africa. Sudan was included in this category and was identified as very recently post-conflict. Uganda, although considered a post-conflict setting, is still torn by war in the northern areas, and is therefore identified as a conflict-affected area. The remaining 28.5% were identified as being involved in present conflict, and these included: Democratic Republic of Congo, Nigeria and Zimbabwe.

Mission and Objectives

MISSION & OBJECTIVES OF ORGANISATIONS

Total number of organisations indicating response in each category (N=23)

15
12
9
6
3
0

Objective areas
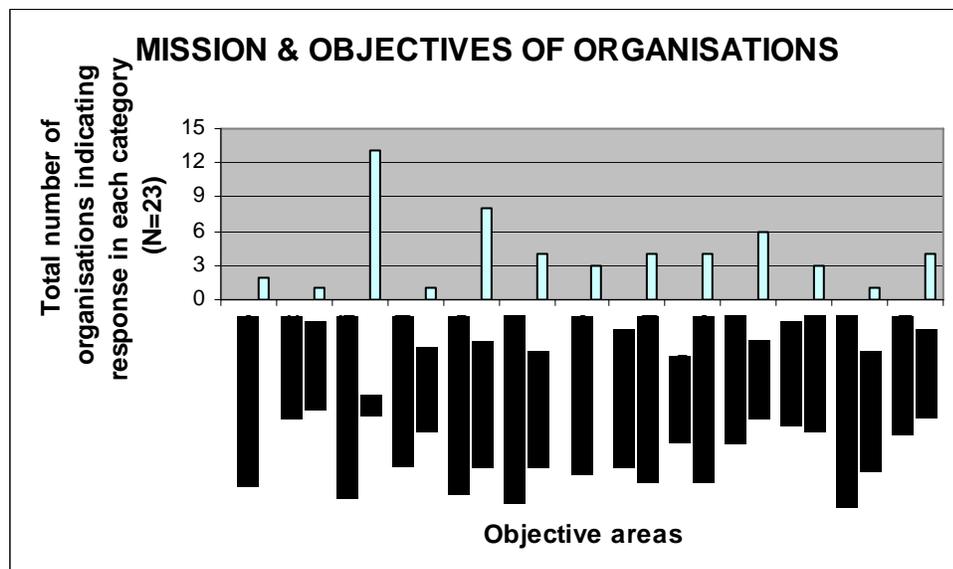
In terms of mission and objectives, the empowerment and education of women/girls/youth (56.5%) featured most frequently among respondents. This was followed by other organisational objectives based on the following frequencies: the promotion/protection of human rights (34.8%); the development of governmental or nongovernmental networks (26.1%); providing counselling/psychological assistance, lobbying against harmful traditional practices, promotion of sexual/reproductive health rights and family planning assistance (17.3%); providing material assistance, resolution of conflict/promotion of peace (13%); emergency response/humanitarian relief (8.6%); resettlement assistance, sheltering/physical protection and raising awareness on child abuse/neglect (4.3%). Given that a number of organisational objectives are employed in each organisation, the data indicated does not reflect mutually exclusive categories.

From this analysis, it is apparent that the majority of organisations surveyed were involved in programmatic work of some form related to GBV, such as empowerment, network co-ordination, advocacy and lobbying. Direct frontline work, such as rendering humanitarian aid, resettlement assistance and providing sheltering/physical protection was not highly represented in the sample.

Core focus of GBV work
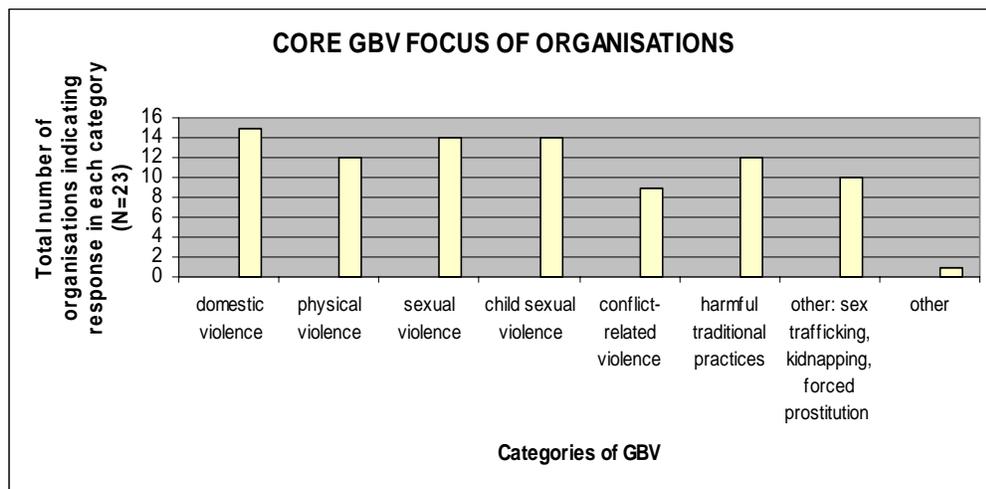
Of the 23 organisations, 83% reported working directly within the GBV field. Of these organisations, 78% reported having more than one area of focus in terms of dealing with specific forms of GBV (i.e. domestic violence, physical violence, sexual violence, child sexual violence, conflict-related violence, harmful traditional practices and other forms of

GBV such as sex trafficking, kidnapping and forced prostitution). Only 13% of these organisations reported having only one core GBV focus, namely child sexual violence (Mauritius Family Planning Association), unplanned pregnancy (Choices Centre) and peer education (Oil). The remaining 9% failed to indicate their response. While GBV issues are reportedly addressed by these organisations, their core activity involves raising awareness of GBV issues in general by fostering partners, networking and providing technical support (Raising Voices) and journalism (Mauritius Union of Journalists).

Based on the responses of the 18 organisations which reported having more than one GBV focus, domestic violence ranked highest (65.2%) in terms of being allocated as one of the many forms of GBV foci. This was followed by sexual violence (60.8%), child sexual violence (60.8%), physical violence (52.1%), harmful traditional practices (52.1%), other forms of GBV (e.g. sex trafficking, kidnapping, forced prostitution) (43.4%), followed by conflict-related violence (39.1%) and 4% in the other category. In other words, a large majority of the organisations surveyed appeared to deal with more than one area of GBV.

In differentiating among these organisations, it appears that most deal with domestic violence, sexual violence, child sexual violence and physical violence, harmful traditional practices, as compared to conflict-related violence and other forms of GBV. Of the 23 organisations, those which focused on domestic violence, physical violence, sexual violence and child sexual violence together as a composite whole totalled 9 (39.1%). Of these 9 organisations, 6 further reported conflict-related violence to be their core focus, whereas 4 further reported conflict-related violence and harmful traditional practices to be their core foci. Other forms of GBV (e.g. sex trafficking, kidnapping, forced prostitution) were listed as a core concentration among 5 organisations which also had domestic, physical, sexual and child sexual violence as their core foci.

While respondents indicated that they addressed wide-ranging forms of GBV, it is unclear at this stage whether individual cases of GBV were related specifically to violence carried out in the context of conflict, or whether they had been isolated incidents that took place in other contexts, or both. While 39% of the organisations revealed that 'conflict-related violence' was one of their core foci, it is acknowledged that this category is not a discrete one, as it is inclusive of forms of GBV listed in other categories[17].

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[17] See definition of 'conflict-related violence' in section 3: 'Definition of Terms'.

B. ORGANISATIONS' CONCEPTUALISATION OF GBV IN CONFLICT–AFFECTED SETTINGS[18]

Most prevalent form(s) of GBV in conflict-affected settings
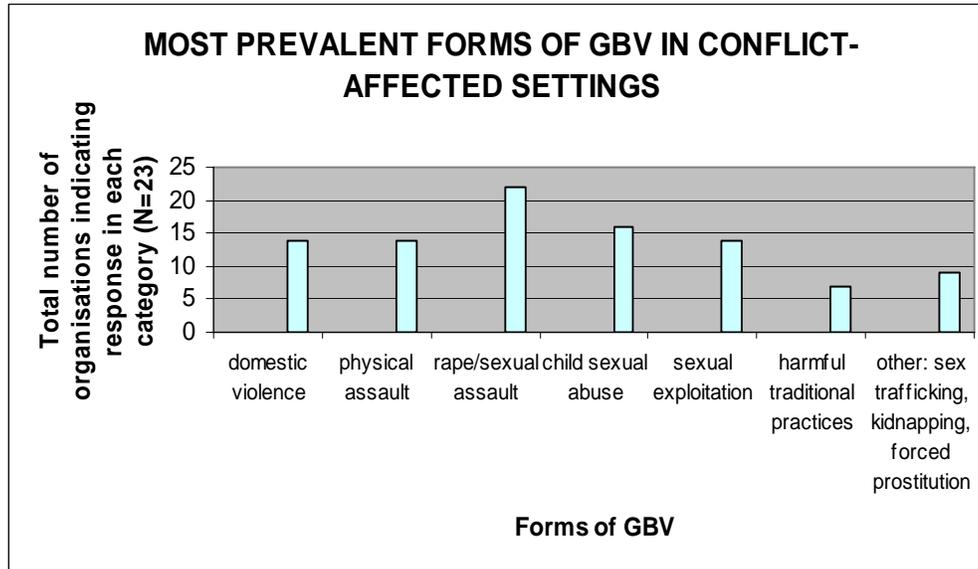
In terms of indicating the most prevalent forms of GBV in a conflict-affected setting, rape/sexual assault was most frequently identified (95.6%), followed by child sexual abuse (69.5%), physical assault (60.8%), domestic violence (60.8%), sexual exploitation (60.8%), other forms of GBV (e.g. sex trafficking, kidnapping, prostitution) (39.1%) and harmful traditional practices (30.4%)[19]. The categories of GBV yielding the highest frequencies were grouped to reveal the following statistics:

(1)   rape/sexual assault, sexual exploitation (e.g. 'survival' sex) and child sexual abuse were together identified as most prevalent in conflict-affected settings by 47.8% of the respondent organisations;

(2)   rape/sexual assault and domestic violence were jointly identified as most prevalent in conflict-affected settings by 56.5% of the respondent organisations;

(3)   rape/sexual assault and physical assault were jointly identified as most prevalent in conflict-affected settings by 56.5% of the respondent organisations;

(4)   rape/sexual assault and child sexual abuse were jointly identified as most prevalent in conflict-affected settings by 69.5% of the respondent organizations.

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[18] Analysis of data is based on the 23 revised questionnaires (see footnote 6).

[19] The percentages indicated do not reflect forms of GBV as discrete categories. Given that the majority of organisations focus on multiple forms of GBV, there is an overlap in terms of areas of focus.

While it is acknowledged that rape is pervasive throughout all phases of conflict, authorities in GBV suggest that GBV takes on forms of a different nature and scale during the various phases (WHO, 2000, May [2]), ranging from random acts of sexual assault by border guards, bandits, members of security forces or other refugees, to rape as a deliberate strategy of war aimed at destabilizing communities, instilling fear and terrorizing civilian populations (Coomaraswamy, 1995; WHO, 2000, May [2]). While domestic violence is reportedly exacerbated during the armed conflict and displacement phases of conflict, female genital mutilation is said to resurge among refugees and displaced persons as a means of reinforcing cultural identity and a sense of belongingness (WHO, 2000) (http://www.who.int/reproductive-health/publications/RHR_00_13_RH_conflict_and_displacement/PDF_RHR_00_13/conflict_dis placement.pdf).

Whilst 78% of the organisations indicated GBV as being most prevalent in more than one phase of conflict (i.e. during armed conflict, during flight/displacement, whilst in refuge, during return phase and during post-conflict phase)[20], the forms of GBV listed in the research were most frequently identified as occurring during the armed conflict and flight/displacement phases of conflict (74%). This was followed by the refuge stage (52%), post-conflict stage (48%) and the return phase (13%). While no conclusions relating to patterns of GBV across various conflict stages can be directly inferred from the data, previous investigations have yielded the following trends:

(a) Rape and sexual violence in the context of attacks on villages
Numerous investigations have documented rape in the context of attacks on villages, with women invariably being the primary targets of violence. Compared to men who tend to herd cattle, women stay within close vicinity to the village, subsequently this eases their accessibility to aggressors (Amnesty International, 2004, May). Abductions and sexual slavery are often reported in the context of attacks. According to several testimonies collected by Amnesty International in Darfur, Sudan, sexual slavery and torture in this context appears to be a strategy to prevent the escape of women held as sex slaves (WHO, 2000, May [2]; Amnesty International, 2004, May).

(b) Rape and sexual violence during flight

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[20] Subsequently the data do not reflect mutually exclusive categories.

Women in flight are typically the main providers of food, shelter and care for children as a result of being widowed or separated from male relatives who are engaged in conflict. Women face increased risk of being sexually victimised or raped whilst fleeing to places of safety without protection of male companionship (Amnesty International, 2004). Following flight from attacked villages reports of rape and abductions are rife with Sudanese women and girls being violated at roadblocks and checkpoints by the Janjaweed militia (Amnesty International, 2004, May). Those seeking refuge in cities face the peril of being trafficked, exploited and abused sexually.

(c) Sexual and domestic violence during the refuge stage

As stipulated by previous research (Clark, 2003; Human Rights Watch, 2000), GBV could take on different forms in various conflict settings. Thus, in refugee and IDP camps, domestic violence (DV) may emerge in relation to socio-economic difficulties introduced by armed conflicts and flight. Whilst DV may have preceded displacement, it is reportedly exacerbated by the instability of a conflict (i.e. uncertainties, loss of power/dignity associated with displacement, food and housing shortages as well as lack of security). This context of deprivation means that women take greater risks to provide for their families' survival needs and, out of pressure or necessity, are forced to 'submit' to non-consensual sexual relations (Callamard et al., 2001). Disempowered men are stripped of their traditional family role and ability to provide (e.g. the man's role as provider is usurped by humanitarian aid agencies that provide housing, food and clothing) thus resulting in feelings of helplessness, powerlessness and frustration, which can translate into violence against women (Human Rights Watch, 2000).

Refugee women are also known to be targeted by male refugees within camps, but also by members of the non-refugee community who perceive them as a threat to their own security. Women in African societies are attacked whilst fulfilling traditionally-allocated chores, such as collecting firewood and water as well as while engaging in farming activities or seeking employment from local villagers (Adanje, 2002; Amnesty International, 2004; Human Rights Watch, 2005). In March 2004, the UN received reports that in the camp for IDPs in Mornei, Western Darfur, up to 16 women were raped every day as they went to collect water (Amnesty International, 2004, May).

Refugee women have little or no legal remedies against sexual and DV as a result of fear of reporting or mistrust of local police or judicial authorities as well as a lack of proactive, timely and sensitive intervention by authorities. Moreover there may be a lack

of applicable mechanisms within these camps to punish perpetrators. While local councils ('abashingatahe' in Tanzanian camps) may exist in refugee camps, these are run by male refugee elders who have no jurisdiction to rule over criminal matters, and whose standards are not in line with international human rights law (Human Rights Watch, 2000). Subsequently, high rates of sexual abuse and DV characterise life in refugee camps.

(d) GBV in post-conflict settings

As documented previously, women's vulnerability to GBV persists particularly in areas where security is lacking. Despite this, however, women are continually discriminated against (e.g. in resettlement and return policies or compensation packages) or their human rights remain largely ignored (e.g. independent property rights) (Torres, 2002).

However, many issues which confront women in post-conflict situations are consequences of their experiences during conflict. A complex dynamic of physical, psychological, political, economic and cultural repercussions transpire and persist long after the conflict phase, often pervading an entire lifetime (Callamard et al., 2001). A statement by Amnesty International (2004, April, p. 1) on the plight of the Rwandese following the "One Hundred Days of Violence Campaign" aimed at the Tutsi and moderate Hutu population, explicates this dynamic:

> "Ten years later…survivors of violence still cry out for medical care; survivors and families of victims clamour for justice that is slow in coming. Women continue to die from diseases related to HIV/AIDS, which some of them contracted as a result of rape during the 1994 genocide and armed conflict. Survivors of rape and their families face human rights violations that themselves lead to further and overlapping violations: survivors of sexual violence may have contracted HIV/AIDS, as a result of which they and their families often face stigma, which can in turn lead to loss of employment, difficulty in asserting property rights, and a loss of civil and political rights."

Contexts in which GBV occurs

CONTEXTS IN WHICH GBV OCCURS

Total number of organisations indicating response in each category (N=23)

unemployment	economic insecurity	housing shortage	food scarcity	lack of health care	lack of education	political unrest	other

Contextual factors
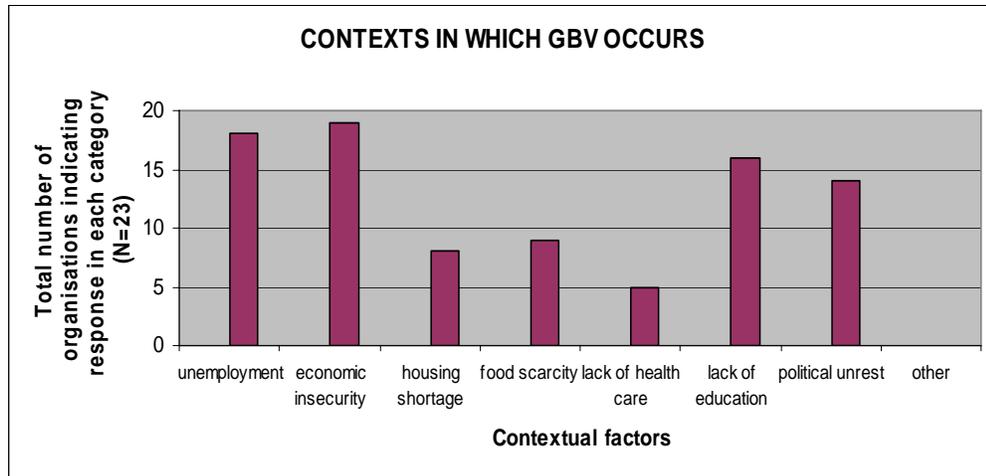
Previous research has identified specific contexts in which GBV is likely to be perpetuated and experienced, namely unemployment, economic insecurity, housing shortage, food scarcity, lack of health care, lack of education and political unrest (Clark, 2003). Findings from the present research indicate that economic insecurity was most frequently identified as a context in which GBV is most likely to occur (82.6%), followed by unemployment (78.2%), lack of education (69.5%), political unrest (60.8%), food scarcity (39.1%), housing shortage (34.7%) and lack of health care (21.7%)[21].

Phases of conflict during which survivors most likely seek assistance

PHASE OF CONFLICT DURING WHICH SURVIVORS SEEK ASSISTANCE

Total number of organisations indicating response in each category (N=23)

armed conflict	flight/displacement	refuge stage	return phase	post-conflict phase
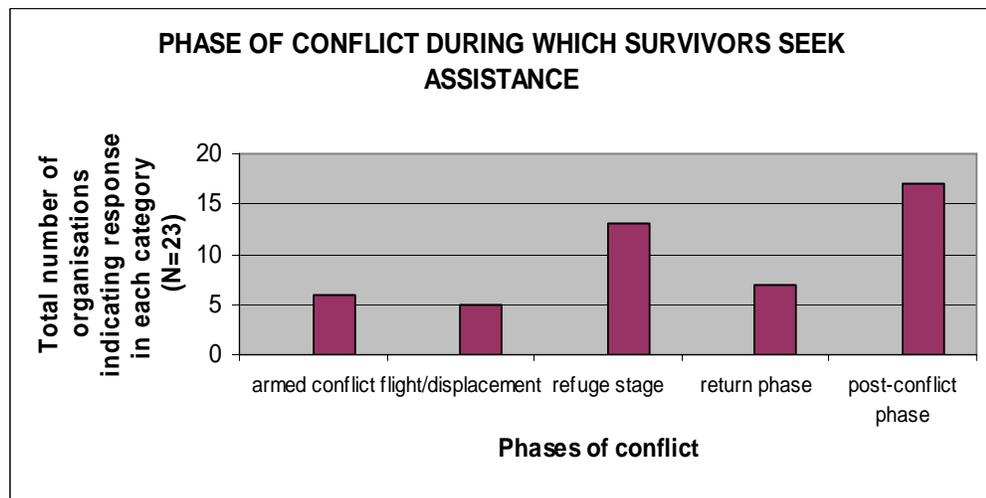
Phases of conflict

In identifying the phases of conflict during which survivors most likely seek assistance,

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[21] GBV occurs within the context of a myriad of interrelating factors. Subsequently the data do not reflect discrete categories.

the post-conflict phase was most often selected (73.9%). This was followed by the refuge stage (56.5%), the return phase (30.4%), the armed conflict phase (26%) and the flight/displacement phase (21.7%)[22].

Perceptions of HIV/AIDS in conflict settings
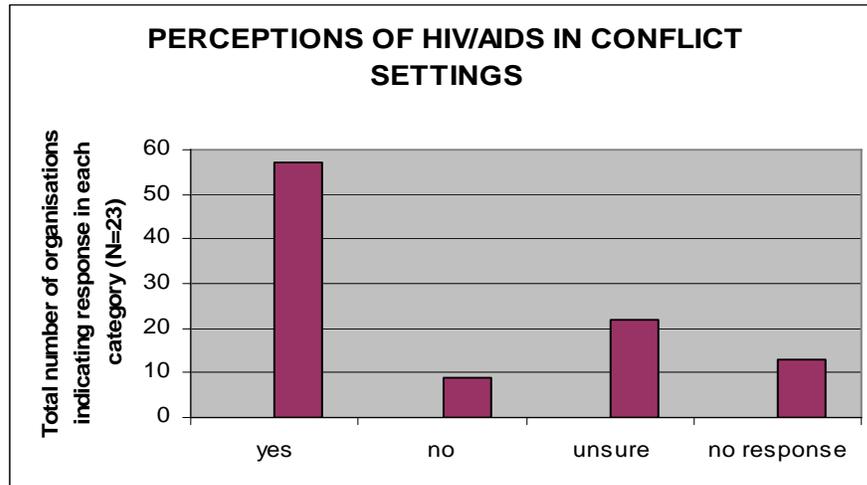
Approximately fifty two percent (12) of the surveyed organisations indicated that there was an increase in HIV/AIDS infection rates among war-affected populations (i.e. among refugees, internally displaced persons and those living in war zones), while 8.6% (2) indicated the opposite to be true. Approximately twenty two percent (5) expressed reluctance to comment on this association without having supporting data, whilst the remaining 17.3% (4) did not provide a response.

GBV prevalence: conflict or post-conflict?

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[22] Data do not reflect mutually exclusive categories.

CONFLICT OR POST-CONFLICT: GBV PREVALENCE
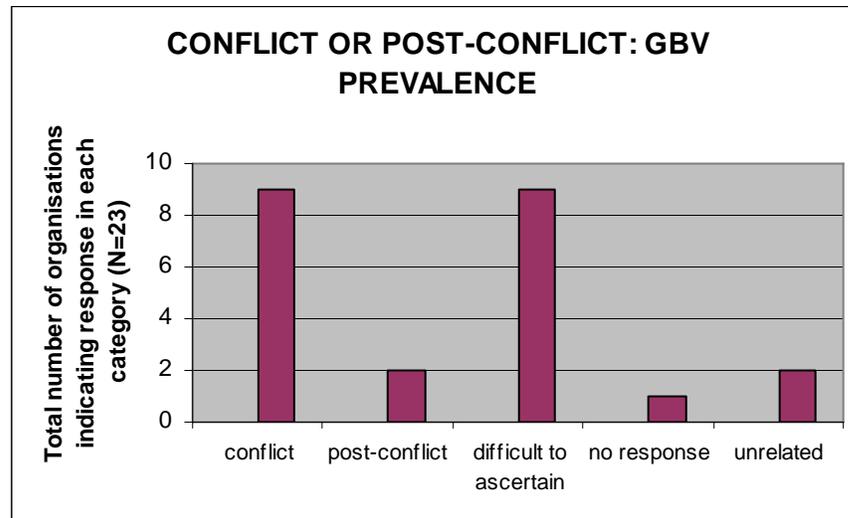
Of the 23 organisations, 39.1% indicated that GBV increases during the conflict phase, while 8.6% indicated that GBV is more prevalent during the post-conflict phase. Thirty nine percent expressed uncertainty in making such a comparison, alluding to greater public awareness of GBV issues post-conflict as well as a greater willingness of survivors to disclose without fear of reprisal. This potentially increases the number of reports and the likelihood that survivors would seek help following conflict and is thus not a fair reflection of prevalence in either setting. Approximately nine percent made reference to other unrelated factors, while 4.3% did not indicate a response.

C. STRATEGIES EMPLOYED BY ORGANISATIONS TO ADDRESS GBV[23]

1. Prevention strategies employed to address GBV

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[23] Analysis of data in this category is based on responses from 24 organisations (see footnote 6).

PPREVENTION STRATEGIES TO ADDRESS GBV

(Chart: Total number of organisations indicating response in each category (N=24) vs. Areas of intervention (Prevention))

Categories: create public awareness, community training on GBV, facilitate peer support groups, support empowerment activities, GBV sensitisation to staff, enforce standards of behaviour (staff), continuous programme evaluation, compile data:GBV incident reports, other

An analysis of the data on responses to prevention and response strategies to address GBV revealed a number of trends. In terms of prevention strategies of these organisations, intervention appears to be largely focused on creating public awareness on GBV issues (87.5%). Whilst providing community training (75%) and providing GBV sensitisation and gender-awareness training to staff (66.6%) featured prominently among prevention strategies; establishing and enforcing standards of behaviour for staff (45.8%), supporting/providing empowerment activities (e.g. income-generating activities, literacy programmes) (45.8%) and supporting/facilitating peer groups (45.8%) and, compiling and analysing data from GBV incident reports (37.5%) were accorded less significance. Engaging in continuous programme monitoring and evaluation (29.1%) were least frequently employed as prevention strategies by the organisations surveyed[24].

2. Response strategies employed to address GBV

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[24] The majority of organizations indicated employing multiple prevention strategies. Subsequently the data does not reflect mutually exclusive categories.

RESPONSE STRATEGIES TO ASSIST GBV SURVIVORS
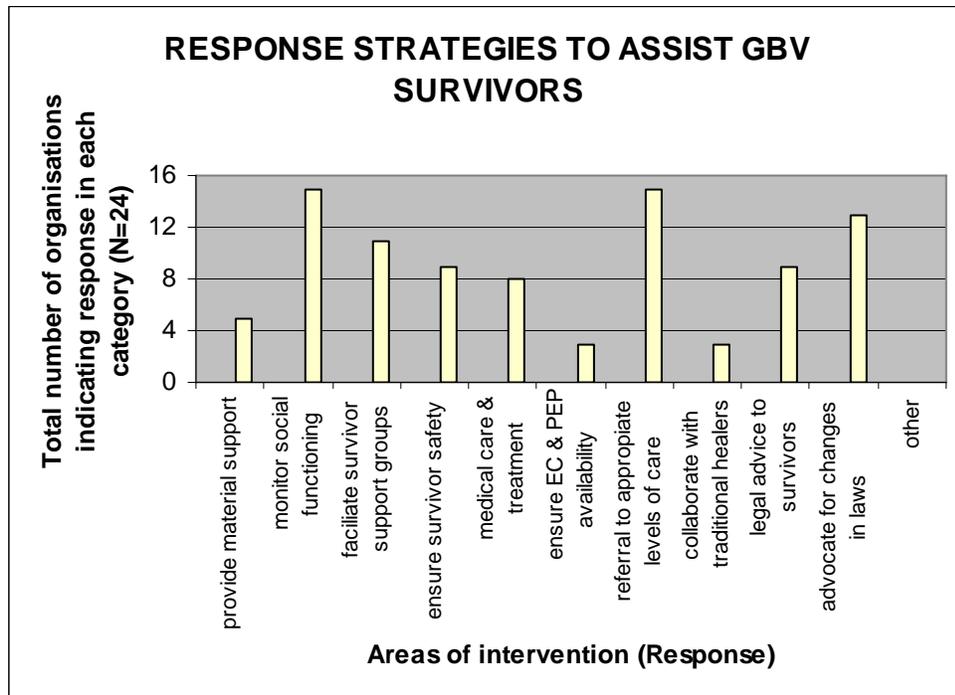
Based on the data identifying specific response strategies in assisting GBV survivors, monitoring the survivor's social functioning (providing counselling and assistance) (62.5%) and providing referral (and transport) to appropriate levels of care (62.5%) were most frequently identified as response strategies. This was followed by strategies such as advocating on behalf of survivors for protection and safety or for changes in laws/policies (54.1%), facilitating survivor support groups (45.8%), ensuring survivor safety (e.g. through safe houses and shelters) (37.5%), providing legal advice to survivors and witnesses (37.5%), providing medical treatment (33.3%) and providing material support (e.g. food, clothing and non-food items) (20.8%). Response strategies accorded least significance was collaborating with traditional healing practitioners (12.5%) and ensuring the availability of emergency contraception (EC) and post-exposure prophylaxis (PEP) (12.5%)[25].

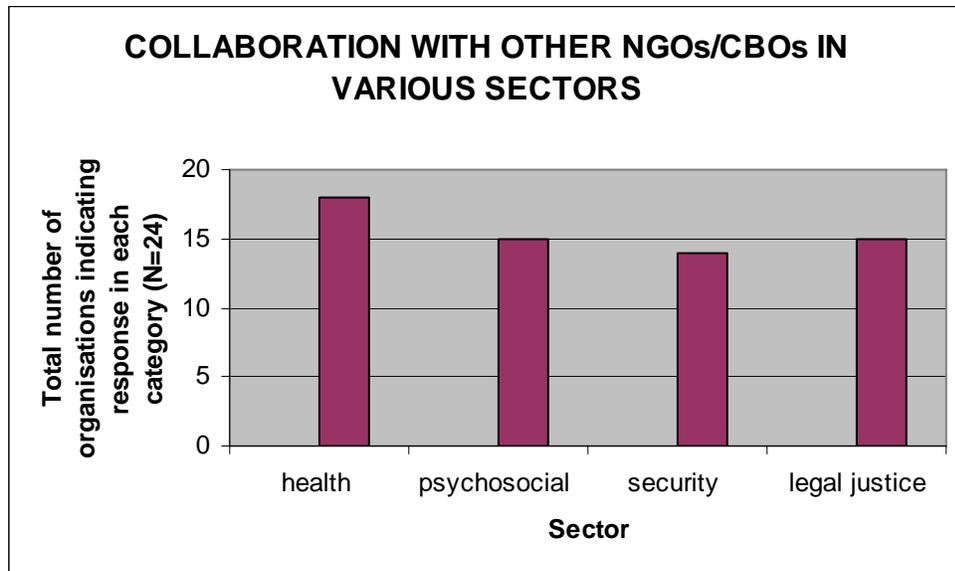**3. Collaboration with other organisations in various sectors**

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[25] The majority of organizations indicated employing multiple response strategies. Subsequently the data does not reflect mutually exclusive categories.

COLLABORATION WITH OTHER NGOs/CBOs IN VARIOUS SECTORS

Total number of organisations indicating response in each category (N=24)

A bar chart showing the total number of organisations by sector: health = 18, psychosocial = 15, security = 14, legal justice = 15. The vertical axis ranges from 0 to 20.

Sector

In terms of collaboration with other NGOs and CBOs in various health sectors, the health sector was most frequently identified (75%), followed by the psychosocial and security sectors (62.5%) and the legal justice sector (58.3%). The results further indicate that the organisations surveyed in this research most frequently identified collaboration with local NGOs and CBOs for referral purposes (75%). Collaboration on monitoring, evaluation and programme planning and development (50%) followed subsequent to discussing prevention and response activities (70.8%) and sharing information about GBV incident data (66.6%)[26].

Of the total 24 organisations surveyed, 87.5% (21) expressed interest in collaborating with POWA on the current research in the form of sharing resources and strategies on tackling GBV in conflict-affected settings. The remaining 12.5% (3) required further information prior to providing consent in this regard.

OUTCOMES:

- Rapes are most prevalent during armed conflict where there is no rule of law.
- Rape is used as a machine of genocide in eradicating the dignity of a people.
- Various forms of GBV are prevalent during conflicts, internally displaced persons

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[26] The majority of organizations indicated collaboration with more than one sector. Subsequently the data does not reflect mutually exclusive categories.

(IDPs) stage (i.e. during flight and displacement) and refuge stage.

- Many refugees experience GBV at the hands of humanitarian aid workers, peacekeepers and police.
- GBV is heightened during conflicts because of stressful conditions.
- Increase in GBV during conflict may be owing to the fact that there is no reprisal for the violence during conflict stage.
- Violence during war is often sanctioned, tolerated or ordered by military or governmental actors. GBV has been consistently marginalized or dismissed as a natural consequence of war.
- Services are often not equipped to deal with the trauma and diseases caused by GBV.
- GBV is vehicle for the transmission of HIV.
- Incubation periods for HIV are decreased in conflict settings due to psychosocial trauma and malnutrition.
- There is very little scientific evidence confirming or denying a rising increase in the rate of HIV infection. However, popular belief amongst NGO's working in conflict-affected areas supports the fact that the HIV rate is on the increase. This is a **GAP** in the findings and requires further empirical data.
- Stigmatisation of people living with HIV/AIDS (PLWHA) does not allow for open disclosure of one's status.
- Lack of emergency relief services during armed conflict increases the possibility for unwanted pregnancies and HIV/AIDS because of lack of emergency contraception (EC) and post-exposure prophlyaxis (PEP).
- Existing support organisations' capacities are challenged to meaningfully assist survivors with profound psychological trauma e.g. survivors still needing medical care and demanding justice, women dying from AIDS-related illnesses, survivors of sexual violence facing stigmatisation for their abuse and HIV+ status resulting in potential loss of employment etc.
- HIV/AIDS statistics underline the imperative to include HIV/AIDS prevention and counselling in all programmes related to the reintegration of war-affected young people, especially ex-combatants and refugee children. (see Machel, Graca article: Conflict fuels HIV/AIDS crisis)
- Some of the social consequences of conflicts are: orphaned widow as sole breadwinner, girls pressured into "opportune" marriages for survival, survivors caring for sick/injured/disabled orphans, orphaned children deprived of education, child-headed households, "survival sex" (in exchange for food, clothing, school

fees etc) (Amnesty International, 2004)

- GBV is a crime against humanity however destroying emergency response service nodules further hinders efforts to provide adequate aid to victims.
- People living in war zones are most vulnerable because of lack of emergency relief services.
- The context of conflict affects the level or lack thereof of rule of law, meaning that in some instances the conflicts can be contained outside civilian targets.
- Our data yielded from this research suggests that various forms of GBV such as rape and child sexual abuse are more prevalent during armed conflict and may be confounded by a number of factors:
  - while large scale GBV may occur in the conflict situation, the consequences may only be evidenced post-conflict.
  - GBV could take on different forms in different types of environments. During conflict, certain forms of sexual violence increase, such as gang rape by soldiers, abduction and sexual slavery. However, once populations are in IDP, refugee or return settings, reports of domestic violence and harmful traditional practices increase.
  - During the post-conflict phase, survivors may have a greater awareness of GBV and may be more willing to disclose and report incidents without fear of reprisal
- GBV exists during socio-economic and politically instability. Poverty, lack of housing and unemployment are some of the factors that contribute towards GBV and conflict.
- GBV increases during conflicts but the consequences are felt post-conflict.
- Most victims/survivors of GBV seek help during refugee, returnee or post-conflict stage.
- Harmful traditional practices such as Female Genital Mutilation (FGM) are resurging within refugee camps as a result of reverting to former concepts of belonging and community.
- Due to impunity for rapist during wars, many women have not seen justice meted-out, resulting in gender biases being perpetuated. Establishing and addressing gender equity issues may restore faith in the social and judicial systems.

Conclusion

The aetiology of conflicts in Africa are due to competition for resources; whether that competition plays out in the form of control for land by controlling rights to minerals, water or for agricultural or pastoral reasons. The point is that when there is a competition for resources, it is fertile ground for the creation of an "us" and "them" divide. Many of the conflicts in Africa can be traced to issues of identity and belonging – whom is the rightful custodians of what? The Rwandan genocide, the Burundi conflict, the South African apartheid state and the Sudanese battle for control of land through an artificially imagined lineage are some of the "us" and "them" divides that have maintained one group in power over others. GBV in relation to this divide plays out in various forms such as miscegenation – genocide by eliminating the eugenics of a community or tribe and the spread of HIV/AIDS. It is no accident that GBV is considered a war crime, it is used systematically as a strategy to further the purposes of the "us" and "them" divide, to maintain control and power over others but it is also important to note that GBV should never occur without censure. The South African lesson to share with our continental neighbours is that GBV with impunity causes huge problems in the post-conflict stage. It allows for GBV to perpetuate as a private violence that is silenced and in part accepted as a "cultural specific violence". GBV must be tried as a war crime and it must serve as a lesson to others that GBV will not carry with it the impunities of a war.

GBV is the vehicle for the transmission of HIV/AIDS. During conflicts most people are infected through GBV. Given that survivors of GBV tend to seek help during the refuge and post-conflict stages meeting their health, psychosocial and legal needs becomes pertinent. In the post-conflict stage, lack of resources together with economic and politically fragile stability places huge challenges for nations that are busy with rehabilitation and restoration. People who are HIV+ and are affected by GBV suffer psychosocial trauma that decreases their incubation period for the virus thus lowering their CD4 count. Post-conflict challenges mean that these people are in dire need of ARV treatment. With tentative political and economic stability, ARV treatment is not easily accessible and thus people die due to lack of treatment. One of the main focuses for dealing with survivors of GBV is to ensure that they can have access to ARV programmes but this entails a commitment from the international community to ensure that treatment is available during the post-conflict stage. Spreading the AIDS pandemic during wars should be a consideration for censure and sentencing for war tribunals.

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Assessment of Existing NGO/CBO Prevention & Response to Gender-Based Violence in Conflict and Post-Conflict Settings

The following is a set of questions that aims to survey the type and level of prevention and response strategies implemented by your organisation in order to address gender-based violence in conflict and post-conflict settings. The questionnaire is comprised of 4 sections. The first section deals with personal identifying information of your organisation, and the three remaining sections focus on intervention strategies in the psychosocial, legal and health sectors. Depending on the focal objectives of your organisation, not all the questions pertaining to each sector may apply directly to you. Kindly complete all sections of the questionnaire as they best pertain to your organisation. Any information provided will be treated with utmost confidentiality. Your cooperation is most appreciated and highly valued.

II.   Personal Identifying Information

Name of organisation:

_____

Country of operation:

_____

Address: _____

_____

Telephone: (code) _____   (office) _____
Contact person: _____
Email address: _____

III.   Psychosocial sector

A. Administration
1. Does your organisation have a policy/mandate/protocol for the provision of counselling, advocacy, and referral for survivors of GBV addressing: sexual assault, harassment, physical assault, domestic violence, survivors of child sex abuse, other forms of GBV, e.g. female genital cutting, forced marriage, kidnapping, prostitution?

Yes _____ No _____

Comment: _____

_____

2. Does your organisation have and maintain directory of organisations providing GBV and collateral services?   Yes _____ No _____

Comment: _____

3. Does your organisation have a policy/mandate/protocol for survivor response, including intake, counselling, safety planning, and secondary trauma/stress?

Yes _____ No _____

Comment: _____

4. Does your organisation have a policy/mandate/protocol for the care and safety of counsellors and service providers?   Yes _____ No _____

Comment: _____

5. Does your organisation have a policy/mandate/protocol for record keeping that ensures safety and confidentiality of survivors?   Yes _____ No _____

B. Prevention
1. Are all psychosocial workers in the setting sensitised to GBV?
                                                                    Yes _____ No _____
    Comment: _____
2. Does your organisation support community engagement in information education campaigns (IEC) (e.g., through religious groups, market groups, men's groups, etc)
                                                                    Yes _____ No _____
    Comment: _____

3. Does your organisation support/facilitate peer groups for:
    Women   Yes _____ No _____
    Adolescents   Yes _____ No _____
    Men   Yes _____ No _____
    Comment: _____

C. Response
1. Does your organisation have 24-hour (on call) services?   Yes _____ No _____

2. Is intake or assessment conducted using a standard incident report form?
                                                                    Yes _____ No _____
3. Does your organisation provide counselling and case management for the survivor?
                                                                    Yes _____ No _____
    Comment: _____

4. Does your organisation provide referrals: maintain and utilize directory of organisations offering GBV-related services?   Yes _____ No _____
    Comment: _____

5. Does your organisation assist the survivor to interact with other sectors as s/he desires by initiating contact, making phone calls, etc.   Yes _____ No _____
    Comment: _____

6. If the survivor is raped or injured, does your organisation provide escort to health services?   Yes _____ No _____
    Comment: _____

7. If the survivor requests, does your organisation provide escort to police/security services?
                                                                    Yes _____ No _____
    Comment: _____

8. Does your organisation facilitate survivor support groups?   Yes _____ No _____
    Comment: _____

9. Does your organisation provide ongoing supervision to GBV counsellors?
                                                                    Yes _____ No _____
    Comment: _____

10. Does your organisation assure care and safety of counsellors and other program employees? Yes _____ No _____
    Comment: _____

11. Does your organisation facilitate community action to establish "safe houses" or other methods to ensure survivor safety? Yes _____ No _____
    Comment: _____

12. Does your organisation maintain confidential files? Yes _____ No _____
    Comment:_____

13. Does your organisation compile and analyse monthly incident reports to use for programme improvement? Yes _____ No _____
    Comment: _____

IV. Legal/Justice

A. Administrative
1. Does your organisation have a policy/protocol for GBV survivor protection, assistance and advocacy through judicial proceedings? Yes _____ No _____
   Comment: _____

2. Does your organisation have guidelines for traditional courts, including refugee tribunals, for types of GBV cases these courts can and cannot judge; sentencing is appropriate for types of crimes and respects/reinforces human rights of survivors?
   Yes _____ No _____
   Comment: _____

B. Prevention
1. Does your organisation have human rights education/training for community, police, courts, and humanitarian actors (national and international)?
   Yes _____ No _____
   Comment: _____

C. Response
1. Does your organisation assess each case using a standard incident report form?
   Yes _____ No _____
   Comment: _____

2. Does your organisation provide referrals using directory of organisations providing GBV and collateral services? Yes _____ No _____
   Comment: _____

3. Does your organisation assist with monitoring police action for investigation and arrest of perpetrators? Yes _____ No _____
   Comment: _____

4. Does your organisation provide legal advice and information to survivors?
   Yes _____ No _____
   Comment: _____

5. Does your organisation monitor court proceedings and advocate for the survivor as necessary? Yes _____ No _____

Comment: _____

6. Does your organisation escort the survivor and witnesses to court and advocate for protection as necessary? Yes _____ No _____
Comment: _____

7. Does your organisation compile and analyse monthly incident reports?
Yes _____ No _____
Comment: _____

V. Health

A. Administration
1. Does your organisation operate a health clinic to assist GBV survivors in medical examination and treatment? Yes _____ No _____
(If 'No', please ignore remaining questions)
Comment: _____

2. Does your clinic have a policy/protocol for medical management of GBV that includes: medical history, examination, treatment (emergency contraception, STI/HIV prevention/treatment) referral (surgeon, OB-GYN, psychologist, psychiatrist, other), pregnancy counselling, record keeping that ensures confidentiality, and coordination with other sectors and actors)?
Yes _____ No _____
Comment: _____

3. Does your clinic have a directory of organisations providing GBV and collateral services maintained and up-to-date? Yes _____ No _____
Comment: _____

B. Prevention
1. Do all the health staff at the clinic receive GBV sensitisation training?
Yes _____ No_____
Comment: _____

2. Do select staff receive training on medical management of GBV, including ability to screen for GBV? Yes _____ No _____
Comment: _____

C. Response
1. Are there 24-hour (on call) services with same-sex medical provider (nurse and/or doctor) trained in GBV response? Yes _____ No _____
Comment: _____

2. Is there an in-take/assessment procedure using standard incident-report form?
Yes _____ No _____
Comment: _____

3. Does the clinic take a medical history? Yes _____ No _____
Comment: _____

4. Does the clinic conduct a medical exam? Yes _____ No _____
Comment: _____

5. Does the clinic provide medical treatment? Yes _____ No _____
   Comment: _____
6. Does the clinic provide referrals using directory of organisations providing GBV and
   collateral services? Yes _____ No _____
   Comment: _____

7. Does the clinic maintain confidential files? Yes _____ No _____
   Comment: _____

Gender-Based Violence in Conflict/Post-Conflict Settings

People Opposing Women Abuse (POWA), an NGO based in South Africa, is undertaking research into gender-based violence (GBV) in Africa. The following is a set of questions that aims to investigate the correlation between the incidence of GBV and conflict/post-conflict settings in your country of operation. Please feel free to further comment on any of the following questions. With this research, we intend to foster links and partnerships with NGO's and CBO's working in the field of GBV by sharing information and negotiating strategies for dealing with and alleviating GBV in this specific context. Through participation, your organisation will be mentioned in a publication and our research findings will be made available to you. **We value your input.**

The questionnaire can be sent to us via e-mail at nadira@powa.co.za. Alternatively, it can be returned via fax (+2711 484 3195) or posted to: Research Manager, 64 Mitchell Street, Berea, 2090, Johannesburg, Gauteng, South Africa, before **28 February 2005**. *Thank you for your time.*

Name of organisation: _____

Country of operation: _____   Address: _____

Telephone: (code) _____   (office) _____ Contact person: _____

Email address: _____   Website: _____

1.   When was your organisation first established?

2.   Briefly state the mission and main objectives of your organisation.

3.   Does your organisation address any of the following issues as its **core focus**? (Please indicate).

____ domestic violence   ____ physical violence   ____ sexual violence

____ child sexual violence   ____ conflict-related violence

____ harmful traditional practices (e.g., female genital cutting, forced marriage, infanticide of girl children)

____ other forms of GBV (e.g. sex trafficking, kidnapping, forced prostitution)

____ other, please specify:

4.   Based on your work with GBV, which type(s) of GBV is most likely to prevail in conflict-affected settings?

____ domestic violence   ____ physical assault   ____ rape/sexual assault

____ child sexual abuse

____ sexual exploitation (e.g., provision of assistance in exchange for sexual acts, sexual slavery)

____ harmful traditional practices (e.g., female genital cutting, forced marriage, infanticide of girl children)

____ other forms of GBV (e.g. sex trafficking, kidnapping, forced prostitution)

____ other, please specify:

5.   Based on your response to question 4, in which phase of conflict are these type(s) of violence most prevalent?

____ during armed conflict phase   ____ during flight/displacement phase

____ whilst in refuge (e.g, refugee camps, shelters, 'safe houses')

    ____ during the return phase   ____ during post-conflict phase

6.   Based on your work with GBV, in which context(s) are GBV most likely to occur?

    ____ unemployment   ____ economic insecurity

    ____ housing shortage   ____ food scarcity

    ____ lack of health care   ____ lack of education

    ____ political unrest

    ____ other, please specify:

7.   Based on your work with GBV, during which phase of conflict are victims most likely to seek help?

    ____ during armed conflict phase   ____ during flight/displacement phase

    ____ whilst in refuge (e.g., refugee camps, shelters, 'safe houses')

    ____ during the return phase   ____ during post-conflict phase

8.   Among the populations affected by armed conflict, which group(s) of individuals are at an increased risk for GBV?

    ____ refugees   ____ internally displaced persons

    ____ returnees   ____ those living in war-zones

9.   Based on your work with GBV, have you seen an increase in HIV/AIDS infection rates among war-affected populations? (yes/no)

10.   What *prevention* strategies does your organisation have in place to address GBV?

    ____ create public awareness on GBV issues

    ____ provide community training on GBV issues

    ____ support/facilitate peer groups (for women, adolescents or men)

    ____ support/provide empowerment activities (e.g., income-generating activities, literacy programmes, vocational training, civil-society building)

    ____ provide GBV sensitisation and gender-awareness training for staff

    ____ establish and enforce standards of behaviour for staff (i.e., codes of conduct, accountability systems, consequences for violations)

    ____ engage in continuous programme monitoring and evaluation

    ____ compile and analyse data from GBV incident reports

    ____ other, please specify:

    ____ none

11.   What *response* strategies does your organisation have in place to assist GBV survivors?

    ____ provide material support (e.g., food, clothing, non-food items)

    ____ monitor survivor's social functioning (e.g., provide counselling and assistance)

    ____ facilitate survivor support groups

    ____ ensure survivor safety (e.g., through 'safe houses' or shelters)

    ____ provide medical care and treatment

    ____ ensure availability of emergency contraception and post-exposure prophylaxis (PEP)

    ____ provide referral (and transport) to appropriate levels of care

    ____ collaborate and co-ordinate with traditional healing practitioners

_____ provide legal advice to survivors and witnesses

_____ advocate on behalf of survivors for protection and safety or for changes in laws/policies

_____ other, please specify:

_____ none

12. Does your organisation collaborate with other NGOs/CBOs within the various sectors in order to combat GBV? (yes/no). Please indicate:
   _____ the health sector

   _____ the psychosocial sector

   _____ the security sector

   _____ the legal justice sector

13. Does your organisation collaborate with other NGOs/CBOs within your country

   _____ for referral purposes (survivor assistance)
   _____ to share information about GBV incident data
   _____ to discuss prevention and response activities
   _____ to collaborate on monitoring, evaluation and programme planning and development
   _____ other, please specify
   _____ none

14. Based on your work with GBV, in which setting (i.e., conflict or post-conflict) have you seen an increase in GBV? Please explain.

13. Would your organisation be willing to work in close collaboration with POWA on the current research by sharing resources and strategies on tackling GBV in conflict and/or post-conflict settings? (yes/no).

Thank you!

We appreciate your participation.

- **For more information about POWA, please access our website at www.powa.co.za**