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Common Cause, Collaborative Response:

VIOLENCE AGAINST WOMEN AND GIRLS AND
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Foreword

Globally, ActionAid stands with women and girls from all walks of life to ensure that their hard-won rights are respected and expanded upon. Women's rights activists have worked hard to advance gender equality, and a raft of international conventions – accompanied by hard evidence of progress on the ground – is testament to their work. Yet now many of the gains that have been secured over the last few decades now risk being undermined, not least in the area of sexual and reproductive health and rights, as it increasingly becomes a key issue of contention on the global stage.

I've spent many years working with women at the grassroots – as individuals, as community mobilisers, as activists and as human rights defenders. I know how brave and steadfast they are and how important their role is in reaching development goals and building a better world. And with the launch of ActionAid UK's new strategy 'Together, with women and girls', I'm proud that we are committed to standing with the women's movement to defend its achievements. We are now bound to marshal our resources behind advancing women's rights further in the coming decade.

ActionAid takes the side of those courageous enough to advocate for women's rights and challenge the social licence that allows abuse of women and girls as well as members of the LGBTI community to continue. Using our global reach and our rootedness in local communities, networks and partnerships, ActionAid will support diverse, broad-based movements for change. ActionAid will bring to bear authentic testimony, evidence and advocacy, amplifying the voices of women activists in places and with decision-makers who would otherwise not hear them.

Our aim is to make a distinctive contribution in the fight for gender equality, from the foundation of our human rights-based approach to development. We

will work tirelessly to ensure women and girls have a voice, choice and control over their own bodies.

This report is being released on the occasion of the second Family Planning Summit in London, a follow-up to that held in 2012. ActionAid welcomes this Summit as another step in the road to the realization of SRHR, a cause dear to our hearts for many decades. We reiterate our 2012 commitmentⁱ, and will strive to continue to work towards and beyond it in our next strategy period and beyond.

We hope that the following report will provide all actors – international institutions, governments and civil society itself – with food for thought in how we move forward to not only meet the ambitious targets set out in through the FP2020 initiative, but also in other policy processes, including the Sustainable Development Goals.

In solidarity,



Girish Menon
Chief Executive, ActionAid UK

ⁱ In 2012, ActionAid committed to: "promoting a transformative understanding of the sexual and reproductive health of women as central to development and poverty reduction. ActionAid will promote a discourse that reflects the importance of women's sexual health, sexuality and control over their bodies, to eradicating violence against women and women's social, economic and political exclusion. With the goal of fulfilling its commitments by 2017, ActionAid pledges to organize women and girls in rural areas to challenge and reject gender-based violence that denies them control over their bodies; secure improvements in the quality, equity and gender responsiveness of public services, including reproductive health services; support women to build and advocate gender-responsive economic alternatives at all levels; convince governments and influential agencies that violence against women is a pivotal barrier to gender equality; and convince governments to enact policies, programs and legislative frameworks to guarantee women full enjoyment of their rights, including the right to sexual and reproductive health."

Executive summary

The right to choose where you go, what you wear, when and with whom you have sex, who you marry and if and when you have children: these are choices that many people reading this paper will assume are theirs to take. But the reality is that for the vast majority of women and girls, it is simply not the case.

This report is released on the occasion of the international Family Planning summit, to be held on 11th July 2017, a follow up to the 2012 summit on the same theme. As a result of the commitments in 2012, 538,000 maternal deaths have been averted through modern contraception use. However, the most ambitious goal – for 120 million additional women and girls to be using modern contraception by 2020 – still appears out of reach, with just 25% of that target met.

The slower than planned progress towards the summit's major target is at least partially due to the lack of incorporation of Violence Against Women and Girls (VAWG) prevention and response into Sexual and Reproductive Health and Rights (SRHR) work, including family planning. The evidence presented in Section 1 of this report – ‘Common Cause’ – makes the case that **without addressing VAWG and its root causes, progress on SRHR – including family planning – will be slow, unsustainable and will leave women and adolescent girls who experience violence behind.** The report sets out how intimate partner violence (IPV) limits women's voice, choice and control over their bodies, and the exacerbating effect of child marriage and female genital mutilation, especially on

adolescent girls. We reiterate the case for comprehensive SRHR policy and practice to take into account the impact that coercion, control and VAWG has on SRHR issues.

Our research finds that, of the estimated 212.5 million unintended pregnancies which have occurred within the 69 FP2020 focus countries over the past 5 years, at least 31.8 million will have involved a woman who has experienced physical or sexual intimate partner violence.ⁱⁱ

Further, ActionAid estimates that by reducing intimate partner violence, 8.4 million unsafe abortions could be prevented - saving an estimated 14,100 women's lives - the majority in sub-Saharan Africa.

On the occasion of the Family Planning Summit there is a real opportunity to galvanize renewed political commitment and financial resources to enable more women and girls to use contraceptives by 2020. This will lead to fewer unintended pregnancies and unsafe abortions, and prevent needless deaths. But this can only be achieved if policy-makers address the underlying cause of gender inequality, namely patriarchy.

Section 2 on ‘Collaborative Responses’ concludes the paper with a comprehensive set of recommendations to policy makers, governments and programmers. Whilst ActionAid commends many major donors and governments in their work on VAWG

and SRHR, there is still much to do. Our key recommendations to donors and governments for this summit and beyond are:

- to engage in international influencing to increase awareness about the links between VAWG and SRHR with world leaders;
- to apply an intersectional gender-impact analysis to all strategies, programmes and projects – whether explicitly gender-related or not;
- to increase sustainable, long-term funding for intersectional grassroots feminist and women's rights organisations, coalitions, campaigns and programming consortiums at the forefront of the struggle for ending VAWG, realising SRHR and achieving gender equality;
- to implement individual and institutional norms change work regularly and consistently, and seek to end policy related barriers that prevent unmarried women and adolescent girls from receiving comprehensive SRHR services;
- to provide funding that supports tackling the spectrum of VAWG and SRHR – rather than focusing on single issues in isolation and without recognition that each form of VAWG is interlinked with others, that SRHR is linked to VAWG and that the root cause of both is gender inequality.



Providence (13), Uwasa (12) and Jeanne (14) stand outside the safe room at Kibaga Primary School in Nyanza, Rwanda. This safe space provides girls with information and is equipped with pads enabling them to stay in school.

ⁱⁱ This figure does not encompass emotional abuse, coercion, control and economic factors that might mean that a woman or adolescent girl is unable to decide for herself whether or not to have a child.

Background

"No woman can call herself free until she can control her own body."

Margaret Sangerⁱⁱⁱ

Over the last century, as the global feminist movement has gained strength and momentum, women's SRHR have emerged as a key priority issue for campaigners. As a result of their efforts, global declarations and conventions have increasingly acknowledged women's rights to control over fertility, their bodies and to freedom from all forms of violence (see page 8).

In recent years, this issue has once again attracted the attention of the international community. The first Family Planning Summit was held in July 2012 and was hosted by the UK Government and the Bill & Melinda Gates Foundation. The summit was a milestone in the international community's growing awareness on the importance of addressing women's and girls' rights. It launched a unique multilateral effort to ensure that 120 million women and girls, in some of the world's poorest countries, were able to access lifesaving family planning information, services, commodities – without coercion, discrimination or violence – by 2020. The summit was timely. Although there had been improvements in meeting family planning needs globally, by 2012, forty nine per cent of the demand for family planning in sub-Saharan Africa was still unmet,ⁱ contributing to countries in the region having the highest share of the world's 22 million unsafe abortions² and the highest rate of maternal mortality.³

In terms of mobilising resources, the summit proved successful. The Kaiser Family Foundation's annual analysis of donor government funding for family planning, released in 2016, found that of the eight donor governments^v who made commitments at the 2012 summit, all – except for Australia – were on course to meet those commitments by 2020.⁵ In 2015, members of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC),

contributed US\$392 billion to bilateral family planning programmes and to the United Nations Population Fund's (UNFPA) core resources.⁶ By March 2015, programming funded by the UK Department for International Development (DFID) alone had ensured that 9.9 million women were using modern methods of family planning⁷ and had also made a commitment to reach 24 million additional women with voluntary modern contraception by 2020. Further, DFID had either exceeded or met their financial commitment to spend £180 million per annum on family planning programming since 2012.⁸

"We're here for a very simple reason: women should be able to decide freely, and for themselves, whether, when and how many children they have"⁴

Former British Prime Minister, David Cameron's speech on Family Planning, July 2012

This funding, focus and support has helped to avert an estimated 538,000 maternal deaths through modern contraceptive use over the past five years for the 69 Family Planning 2020 (FP2020) focus countries.^v It is estimated that 344.6 million pregnancies have been averted in the past five years in FP2020 commitment-making countries, by the use of modern contraception.

However, despite the steps forward we have collectively taken on SRHR in the past years, there are issues which have seen slower change. Notably, the number of estimated unintended pregnancies has increased year-on-year for all 69 FP2020 focus countries, and for those countries who have made specific commitments in this area. Whilst this could be due to increased reporting and other variables, it is still notable that there have been an estimated 187.9 million unintended pregnancies between 2012 and 2016 in commitment-making countries and that in the 44 countries reporting, the birth rate is still close to one in ten for adolescent girls.^{vi}



Felicite attends a women's cooperative where she has received information about contraceptive use. She now uses contraception and was encouraged to do so by the cooperative, despite not having a husband or a boyfriend.

By FP2020's midpoint review, published in July 2016, only 30.2 million additional women and girls were using modern contraception compared to figures from 2012.⁹ This leaves 75% of the target still to be achieved by 2020, which is a formidable challenge.

What could explain the slower rate of change? And what can be done to accelerate it? This policy paper reflects and builds upon ActionAid's 2012 report, *Sex, Choice and Control: The Reality of Family Planning for Women and Girls Today*.¹⁰ It makes the case, again, for comprehensive SRHR policy and practice to take into account the impact that coercion, control and VAWG has on SRHR issues - including family planning. It sets out recommendations to policy makers, governments and programmers to work towards a more sustainable shift in family planning.

BOX 1: A NOTE ON BODILY INTEGRITY

Constructed differently in different contexts, the female body acts as a site where power is played out. The way in which female bodies are shaped and viewed are influenced by location, date, class, sexual orientation, gender, age, ethnicity – to name a few. Our relationship to our body is something which is deeply personal and yet, socially constructed. Bodily integrity encompasses freedom from violence, freedom of movement, sexual satisfaction and reproductive choice. Bodily integrity can be blocked, impaired or impeded by anyone, or any collective group at any time. The construction of the female body and femininity deny women and girls the right to bodily integrity. It influences the social norms of women and girls. This in turn influences not only the way they see themselves, but also the way they see other women and girls.

The state, the legal system and social norms confirm and constitute who has full access to bodily integrity and who does not. Those who benefit from patriarchy, with power and privilege, often have access to more aspects of bodily integrity than others. Women's and girls' bodies, broadly, are less likely to be confirmed and constituted as being human, and therefore are unable to access their full suite of human rights. Men and boys not only benefit from patriarchy, but also abuse the inequality that women and girls face by further penetrating women's and girls' bodily integrity in multiple implicit and explicit ways.

Within this paper, however, we use the language of development. We talk about VAWG, SRHR and family planning – terms we believe that many within the programmatic and policy world will recognise and understand. However, ActionAid hopes to move towards the increased use of the term bodily integrity – as it encapsulates the essence of the inequality women and girls face in a holistic way.

ⁱⁱⁱ Sanger (1879 – 1966) was an American birth control activist who opened the first birth control clinics in the USA, and established organisations that evolved into the Planned Parenthood Federation of America.

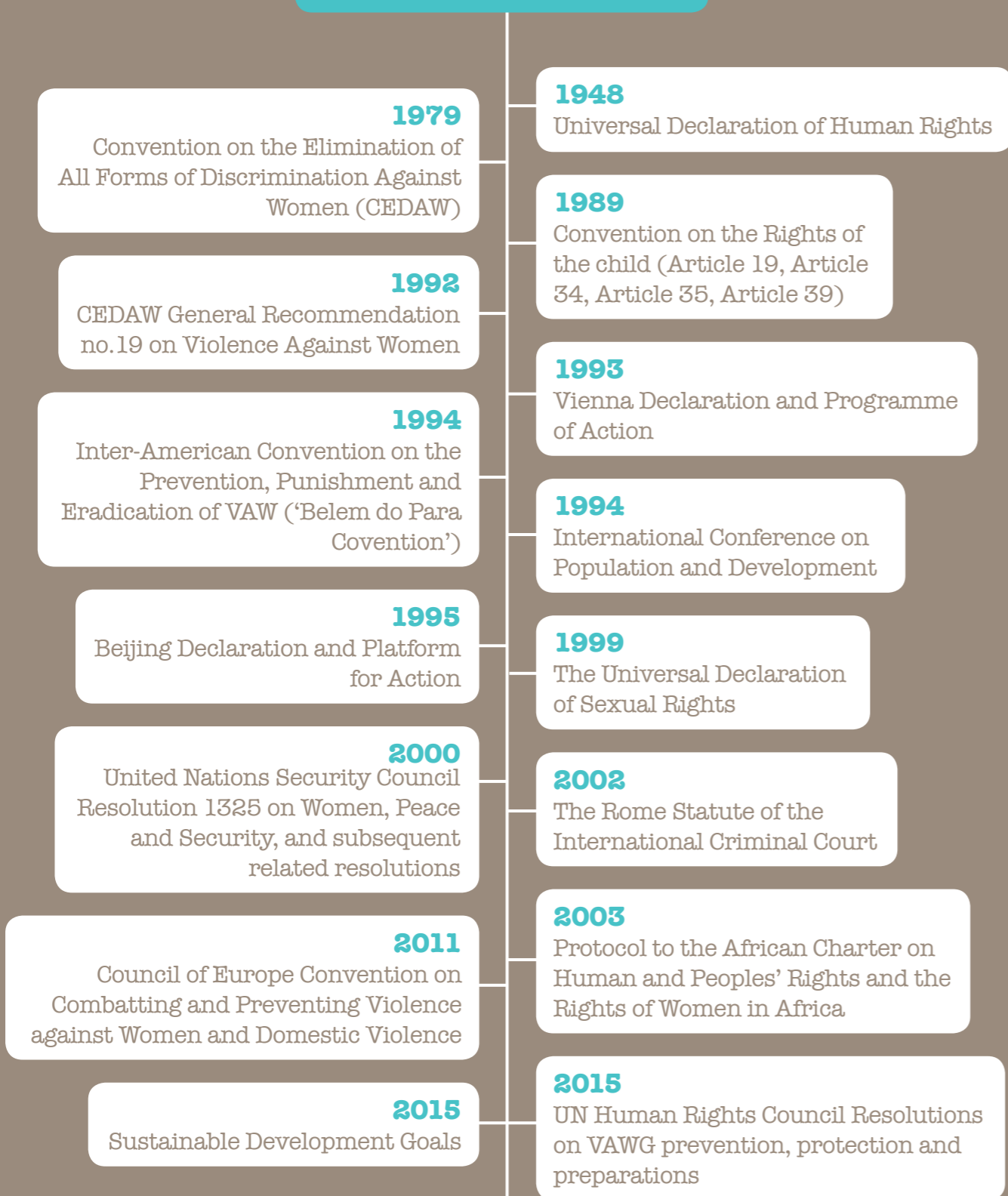
^{iv} Australia, Denmark, France, Germany, the Netherlands, Norway, Sweden, and the U.K.

^v For a list of the 69 FP2020 focus countries, and for access to data used by ActionAid to generate figures for this report, go to: <http://www.familyplanning2020.org/entities>

^{vi} Reported for year with most recent national survey data, from 2012 to present

Government commitments to eliminating VAWG and fulfilling women's sexual reproductive health and rights

Examples include:



CASE NOT CLOSED: THE ENDURING NEED TO CONNECT VAWG AND SRHR

"Like it or not, the intersection of violence and reproductive decision-making is showing up in the realities of women's lives. Both movements had better organize to confront it"

Heise L, Ellsberg M and Gottemoeller M, *Ending violence against women, Population Reports, 1999, Series L, No. 1*

Advocates and activists have been drawing attention to the urgent need for cross-movement building in women's rights in development and humanitarian contexts, for at least 20 years. One key area of need – and the one most pertinent to this paper – is to address the intersections between VAWG and SRHR. Despite the large body of evidence connecting them, at donor and national policy level, violence against women and reproductive health remain distinct. Programmatically, the same picture emerges: a continued approach to SRHR and Family Planning which focuses largely on the dissemination of information and provision of services, but which does not address the significant barriers that VAWG and gender inequity at the individual, family, community and structural levels create. There are exceptions, of course, such as the roll out of the World Health Organisation's *Clinical Management of Rape Survivors*, and their clinical and policy guidelines: *Responding to intimate partner violence and sexual violence against women* released in 2013.¹¹ While this is a welcome development, much more work remains to be done at a policy level.

ActionAid believes that in order to see a more sustainable shift in women's access to SRHR, understanding and addressing the links between VAWG and SRHR is vital.

At ActionAid we understand that all forms of oppression, domination, discrimination, abuse and VAWG are inherently linked. They are grounded in patriarchy and continued gender inequality. SDG5 (see BOX 2) was created to include multiple forms of discrimination and oppression of women and girls and recognizes that they are all linked by the same root cause. Yet all too often, in VAWG and SRHR

BOX 2: UNITED NATIONS SUSTAINABLE DEVELOPMENT GOAL 5

Sustainable Development Goal 5, aims to: achieve gender equality and empower all women and girls. Under the umbrella of SDG 5, multiple forms of discrimination and oppression of women are explicitly named, such as (but not limited to): Violence Against Women and Girls, Child Early and Forced Marriage, Female Genital Mutilation, access to Sexual and Reproductive Health and Rights and Unpaid Care Work.¹²

BOX 3: WHAT IS 'PATRIARCHY'?

Patriarchy is a system of power which influences everything that we do. Within this universal system, men dominate women physically, socially, culturally and economically. Patriarchy plays out in the economy, society, government, community and family. It is apparent in every sphere of life, giving rise to accepted discriminatory behaviours, attitudes and practices also known as 'patriarchal norms'.

The way patriarchy manifests itself in relationships, the family, community and society changes over time and "by location and cultural context".

BOX 4: WHAT DOES 'SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS' MEAN?

SRHR can be understood as the right for all, regardless of gender, age, ethnicity, sexual orientation, HIV status or other aspects of identity, to make choices regarding their own sexuality and reproduction. It also includes the right to access non-judgemental information and services needed to support these choices and optimise health.

BOX 5: WHAT IS 'VIOLENCE AGAINST WOMEN AND GIRLS?'

Any act of gender-based violence that results in, or is likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.¹³ VAWG also impacts negatively upon women's opportunities to achieve legal, social, political and economic equality in society.

programming, donors and international agencies work in siloes and lose sight of the root cause of the issues.

This report explores the ways in which VAWG and SRHR are linked – by their root causes and their

replication of each other. It highlights the way in which other interlinked issues, such as: unpaid care work, child marriage, female genital mutilation (FGM), economic inequality – play a part in the complex relationship between violence perpetrated by an intimate partner and women's and adolescent girls' ability to access SRHR services related to family planning. **It does this through the presentation of women's lived experience focusing on three in-depth case studies and other examples from ActionAid's programmes. It is supported by evidence from academic literature and literature from other non-academic sources.**



Photo: Fati Abubakar/ActionAid

As a girl, Asimawo Abullahi grew up with 16 siblings. Despite dreaming of being a lawyer and doing well at primary school, three of her brothers were given priority to attend secondary school. ActionAid has supported Asimawo to become a paralegal and to change community laws and practices related to women's rights.

Common Cause

INDIVISIBLY LINKED: INTIMATE PARTNER VIOLENCE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Evelyn Flomo featured in ActionAid's 2012 report, *Sex, Choice and Control: The Reality of Family Planning for Women and Girls Today*. This year, we were able to interview Evelyn again, to see what, if anything, had changed in her life since then in relation to VAWG and SRHR. What follows is an analysis of information from 2012 and 2017.

BOX 6: ACTIONAID'S HUMAN RIGHTS BASED APPROACH

Our Human Rights Based Approach (HRBA) is an approach to development that centres on supporting people to organise and claim their rights and to hold those responsible for protecting and upholding their rights to account. Our HRBA flows from our politics and our strategy. We analyse and confront power imbalances.

Evelyn is a 39-year-old farmer from Grand Gedeh County, Liberia. In 2012, Evelyn had one child and had decided from a young age that she only wanted two children. Her husband, however, wanted 10.

In 2012, Evelyn reported that her husband had perpetrated multiple forms of intimate partner violence against her. He had raped her, beaten her before and during pregnancy (causing miscarriage) and had locked her up in her home. He controlled her fertility. When ActionAid Liberia first came to her county - to provide information and work with grassroots women's rights organisations on SRHR - it was the first time she had had access to information and training on contraception. Due to her husband's controlling and coercive behaviour, she took contraception in secret, travelling to her friend's home each evening to do so. She had to attend a health centre in secret - as many

providers demanded that women could only receive contraception with their husbands present.

"Most of the time when we refuse they can force us and it can be hard for us to report. My husband can force me to have sex even when I am sick."

Evelyn, 2012

Since then, Evelyn has had a further two children and has agreed with her husband to have one more. Evelyn is now planning for four children altogether - two more than she had initially intended, but nowhere near the 10 that her husband desired. She notes that after years of work in her community, there has been a change in attitudes to the use of contraception. Her involvement in her own community - discussing issues around women's rights and SRHR - has had an impact on her own relationship as well.

"We can now go to the hospital freely to get family planning services. Nurses are no longer requesting our partners before they can give us treatment. Our men also understand, even my man he now understands and agrees for us to have 4 children instead of the 10. Though things have changed but we still have more to do."

Evelyn, 2017

Of her role in the change to her community's attitudes, she says: *"It was not an easy thing. We struggled with the awareness and sensitization, we went door to door, village to village, trying to convince men about the family planning services."*

Back in 2012, Evelyn's husband had control over her life, almost completely. Her daily existence consisted of unpaid care work – in the form of cooking, cleaning, washing, collecting resources for the home and looking after her child - and agricultural work. Part of her reservations around increasing the number of children in her family, were her concerns



Evelyn in 2012

about the way in which her life would be affected by increased labour as a result.

"Having too many children can make women fall behind. When you have many children you have to spend more time working hard to support the children; you can't spend time with your friends. If I have many children I would not be able to help women resolve their problems and participate in community work... The men leave all the burden on us yet they want plenty of children."

Evelyn, 2012

Despite her growing family, Evelyn was able to join a women's group, who farm collectively as a means of income generation. Part of the proceeds go to a women's rights group in her community who deliver women's protection services (in lieu of the State meeting its responsibility as duty bearer).^{vii} The income she generates from farming has helped her to redistribute some of the unpaid care work in the home, especially when out on awareness sessions. However, Evelyn and her husband still see this as his 'helping her' indicating that unpaid care work is still considered to be Evelyn's responsibility and highlighting that power within the home still very much lies with Evelyn's husband. She noted in her interview, on a number of occasions, that men in her community require convincing and that contraceptive use still needs to be negotiated. While there seems to be big improvements in Evelyn's access to her own rights, she still does not have full autonomy over her life, or her body.

Sadly, Evelyn's story is not unique. It demonstrates the way in which intimate partner violence, economic inequality and unpaid care work intersect and reinforce one another, thus limiting women's right to bodily integrity. Her story further demonstrates the role that wider society plays in reinforcing control and male power over women, for example the hospital staff clearly reinforced the notion that Evelyn should be submissive and comply with her husband's

instructions. It further reinforced shame and stigma around the use of contraception. Evelyn's situation may not be as dire as before, and she has displayed courage in ensuring that she is able to: **voice** her opinion and ensure it is heard; **choose** (to a certain extent) to use contraceptives; and gain some **control** of her movements and her bodily integrity as a result. Yet, Evelyn still does not have full access to her human rights.

Around one third of all women report having experienced physical and/or sexual violence – most frequently at the hand of an intimate partner.¹⁷ However, under-reporting means that this figure is likely to be much higher, especially taking into consideration the incidence of emotional and psychological abuse. Worryingly, men's own accounts of their actions suggest the same. Research published in 2013 analysed male perpetrators' perception of how much they engage in violence against their intimate partners across Asia and the Pacific. The authors found that:

"[...] men reported higher rates of physical partner violence perpetration than women reported victimization... compared with other equivalent studies [including the study which generated the '1 third of all women statistic], men's reports of physical violence were greater than the corresponding women's reports."¹⁸

This indicates that not only is violence normalised, but that the social norm of shame and stigma associated with being a survivor of violence limits women's and girls' access to reporting mechanisms. The manifestation of patriarchal attitudes and behaviours within those services such as: re-traumatisation, judgement, difficult bureaucratic processes and domination and control of women who report are well known and contribute greatly to lower reporting rates – as does the state's denial of appropriate, functional services simply through lack of investment.

IPV is by far the most prevalent form of VAWG. In the most extreme cases, IPV can lead to homicide, and it accounts for 38% of all murdered women (in contrast to 6% of all murdered men).¹⁹ Whilst rates of perpetration differ from context to context, the kind of intimate partner violence experienced by Evelyn

BOX 7: WHAT IS INTIMATE PARTNER VIOLENCE?

Violence by an intimate partner is manifested by physical, sexual or emotional abusive acts as well as controlling behaviours perpetrated by a current or former partner.¹⁴ It can happen within the context of marriage or in other relationships.¹⁵ This includes (but is not limited to):

- Rape: non-consensual penetration of the vagina, anus or mouth with a penis or other body part – or non-consensual penetration of the vagina or anus with an object.
- Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks.
- Physical assault: physical violence which is not sexual in nature. Examples include: kicking, biting, shoving, hitting with a fist, object or other body part, strangulation, suffocation, burning, scalding, attack with a weapon or object, acid attacks or any other act that results in pain, discomfort or injury.
- Denial of resources, opportunities and services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include: earnings forcibly take from an intimate partner, prevention of contraception use.
- Psychological/Emotional Abuse: Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, remarks, gestures, written works of a sexual and/or menacing nature, destruction of cherished things.¹⁶

IPV can affect men and women, but most frequently it is perpetrated by men. A survivor of IPV often experiences multiple forms of violence as a part of one incident and can experience multiple incidents across the lifetime of a relationship.

^{vii} ActionAid Liberia and partners demanded women adequate state supply and provision of services. Strategically, support was provided which addressed critical gaps in service provision. The proceeds from the agriculture project provide transportation for survivors who choose to report and/or seek health care in order to increase uptake of services, which are often inaccessible for a number of reasons, including – most basically – few services existing and long travel times.

is universal.²⁰ It is an expression of male dominance over women, it is both a cause and a consequence of women's serious disadvantage and unequal position in comparison to men, and its impact is felt throughout every layer of society.

IPV can manifest in a number of ways which impact on the reproductive health and rights of women and girls and it is notable that it is most likely perpetrated against women and girls of reproductive age.^{viii 21}

HOW IPV AND SRHR ARE LINKED

Unintended Pregnancy

Evelyn's story illustrates the way in which male intimate partners use violence and coercive practice to dominate their relationships **economically, physically, psychologically and sexually**. This has a profound effect on women's ability to prevent unintended pregnancies (as well as other areas of SRHR). Because IPV is a global phenomenon, it can be inferred that the impacts of IPV on all aspects of SRHR are global as well.

"He used to slap me in the streets at night or at his place. I didn't report anything I just let things be. Anyway what's the point of reporting someone who is feeding you? I really don't see the point."

Grace^{ix}, Accra, Ghana ²²

Rape, fear of violence when/if women refuse sex, and difficulties negotiating contraception and condom use in the context of an abusive relationship, all contribute to increased risk for unintended pregnancy as well as for sexually transmitted infections, including HIV.^x

In India, Ghana and South Africa, ActionAid's Young Urban Women's programme addresses young women's economic rights and SRHR. At its centre is a commitment to building the active

BOX 8: GENERAL HEALTH IMPACTS OF IPV

Injury; gastrointestinal problems; chronic pain; depression; suicide and suicide attempts/ideation; post-traumatic stress disorder; neurological disorders; chronic pain; disability; anxiety; non-communicable diseases (such as hypertension); cancer; cardiovascular disease; alcohol and substance abuse; death from homicide; and death from secondary results of IPV.

There is behavioural evidence that men who use violence against their female partners are more likely than non-violent men to have a number of HIV-risk behaviours, including having multiple sexual partners, frequent alcohol abuse, visiting sex workers, and having an STI - all of which can increase women's risk of HIV. Women who experience IPV are 1.5 times more likely to become HIV positive.

BOX 9: HEALTH IMPACTS OF IPV AGAINST WOMEN ON CHILDREN AND INFANTS

Women in violent relationships are less likely to receive adequate prenatal care and more likely to have a preterm birth or low birth-weight baby. Children of women who experience IPV are less likely to receive immunizations and may be at increased risk of additional health developmental and behavioural problems later in life. Moreover, children who witness violence in their home are significantly more likely to perpetrate or experience violence themselves later in life.

agency of young women living in poverty, through empowerment, campaigning and solidarity. One of the key findings from the evaluation of the first phase of the project is that to ensure that the impact of the project is sustainable, there is a need to address IPV and other forms of VAWG. In common with Evelyn, the experiences of the women who took part in this project highlighted that women's economic inequality increased their susceptibility to intimate partner violence. The reality is that, in all three countries, the women struggled with economic security and relied on their combined incomes with other family members or husbands in order to make ends meet.²³ Grace's statement, which acts as a sub-heading to this section, highlights the way in which economic inequality can act as facilitator of control and domination, and can force women and girls into a situation whereby they have to suffer through abuse, or they face hunger or destitution.

Across all project sites, increasing the capacity of women to earn independent incomes has improved their ability to afford contraceptives.²⁴ However, control is still imposed by some intimate partners who demand that women account for their income and expenditure.

"Since I started working I have the money to buy the contraceptive because I am self-employed. I can now refuse my husband when he demands sex if I am not in the mood. My husband has never advised me to use contraceptives but I haven't told him that I have been using it already. I haven't told my parents either."

Beatrice^{xi}, Accra, Ghana ²⁵

As we can see from Beatrice's comment – even where women are able to address some power imbalances and violence within their relationship, there is still fear of reprisal when it comes to speaking about contraception with their partner and family. Simply put, empowering women economically alone, is not enough to address IPV and the power imbalances in relationships which are at the heart of the issue.

"I am not able to refuse my partner sex. He is always persuasive and sometimes angry, so I try to satisfy him."

Priscilla^{xii}, Accra, Ghana ²⁶

There is now a large body of evidence linking compromised decision making for women within violent relationships with unintended pregnancy.²⁷ Rape (through coercion, exploitative methods, fear of violence if she refuses or use of physical force) and difficulties in negotiating contraceptive use and condom use, contribute to increased risk of unintended pregnancy as well as STIs.²⁸ As we see from Evelyn's story, her husband restricted her movements and it was only because she had a friend close by that she could go to for help that she was able to access contraception. Many women are in even more dire situations as violent intimate partners control their movements, who they speak to and where they go. This limits women and adolescent girls' ability to access SRHR services even further. In addition, men who are violent towards their partner, are also more likely to take part in reproductive coercion.²⁹

Reproductive coercion can take the form of tampering with contraception, removing a condom during intercourse without a partners consent, physical and sexual threats, and psychological forms of coercion - such as threatening to leave a woman if she doesn't get pregnant. One study showed that reproductive coercion, combined with intimate partner violence, **doubles the risk of unintended pregnancy**.³⁰

According to a ground breaking analysis conducted by Pallitto, et.al³¹ in 2012:

1. Unintended pregnancy is more common among women and adolescent girls who have experienced IPV compared to those who have not;
2. Reducing IPV by 50% could potentially reduce unintended pregnancy by up to 40%;
3. Women and adolescent girls reporting physical and/or sexual partner violence had almost twice the odds of having an unintended pregnancy; *and*
4. Overall, the proportion of unintended pregnancy that can be attributed to IPV is 15%.

^{viii} Although, it continues to be perpetrated against older women as well

^{ix} Not her real name

^x Although this paper does not focus on HIV/AIDs it is notable that globally, in 2015, there were an estimated 2.3 million adolescent girls and young women living with HIV, constituting 60% of all young people (aged 15 -24) living with HIV. 58% of new HIV infections among young persons occurred among adolescent girls and young women. For further information on the way in which IPV and HIV intersect and how to address it, please see: <http://raisingvoices.org/sasa/>

^{xi, xii} Not her real name

Accurate, global prevalence rates of IPV are, for the foreseeable future, impossible to generate. Lack of services, low levels of reporting due to stigma and fear, and differing legal frameworks and definitions, make it difficult to quantify intimate partner violence. However, based on the statistics above, and taking into account national statistics on unintended pregnancy and other global studies, it is possible to state:^{32 33}

Of the estimated 212.5 million unintended pregnancies which have occurred within the 69 FP2020 focus countries over the past 5 years, ActionAid estimate that: at least 31.8 million will have involved a woman who has experienced physical or sexual intimate partner violence.

It is important to note, that this estimate includes women who have ever experienced intimate partner violence. This is due to the far-reaching effects of IPV on a survivor's physical and mental health, which are listed in Box 7.

We should also note here that some studies have found that women who report IPV are more likely to use contraceptives, than women who don't.³⁴ Other studies suggest that women who are survivors of IPV are:

1. More likely to have used contraception at some point;
2. More likely to stop using contraception; and
3. Less likely to use their preferred method.³⁵

This suggests: "[...] that IPV interferes with women's ability to consistently use their preferred method over time".^{36 37}

Spontaneous and Induced Abortion

"The denial of the right to abortion enforces the kind of splitting that inevitably and continuously undermines a woman's sense of self. Her womb and body are no longer hers to imagine. They have been turned over to the imagination of others, and those imaginings are then allowed to reign over her body as law."³⁸

ActionAid firmly believes that women should have access to their full range of sexual and reproductive rights, and this includes access to information and safe abortions.³⁹

Violence perpetrated by a partner also contributes to the incidence of both spontaneous and induced abortions. WHO analysis of data from 31 studies has found higher rates of induced abortion among women with a history of IPV. According to one New Zealand study, women who have ever experienced IPV were 1.4 times more likely to report that they had had a miscarriage, and 2.5 times more likely to report that they had ever had an induced abortion.⁴⁰ This increased level of spontaneous abortion/miscarriage in women who have experienced IPV may be due to some of the overall health impacts of IPV (see Box 8). In addition, it is also worth noting that IPV can be common during pregnancy itself:

"for some who experience violence during pregnancy, the abuse is a continuation or intensification of previous abuse, whereas for others, the violence starts after they become pregnant. Ten percent of ever-pregnant women in Zimbabwe and at least 7% in South Africa have even been physically assaulted during pregnancy. In Butajira, Ethiopia, 77% of currently pregnant women report physical abuse during pregnancy; 28% have been punched or kicked in the abdomen. In the great majority of the cases, the perpetrator is the father of the child."⁴¹

When all 15 of their research sites were combined, Pallitto et. al attributed an average of 30% of abortions to Intimate Partner Violence. Women who had ever experienced physical and/or sexual partner violence had almost 3 times the odds of having an abortion.

Drawing on these figures and supporting studies, it is possible to estimate that by reducing IPV, 8.4 million unsafe abortions could

be prevented - saving an estimated 14,100 women's lives each year.

Sex-selective Abortion

The marginalisation of women and girls has multiple manifestations of violence, abuse and discrimination which link to SRHR. The complexity of the relationship between VAWG and SRHR is evident when analysing the issue of sex-selective abortion. Patrilineal and patrilocal household structures fuel

BOX 10: INDUCED ABORTION: FACTS FROM AROUND THE WORLD

- During 2010-2014, there were an estimated 56 million induced abortions each year worldwide.⁴²
- Countries in the Global South have a higher rate of induced abortion than those in the Global North, with abortion rates at 37 per 1,000 women and 27 per 1,000 women respectively.⁴³
- An estimated 225 million women in developing regions have an unmet need for modern contraceptives.⁴⁴
- At least half of all unintended pregnancies, globally, are terminated through induced abortion and nearly half of those take place in unsafe conditions.⁴⁵
- Around 13% of all maternal deaths globally are due to unsafe abortion.⁴⁶
- 21.6 million women experience an unsafe abortion worldwide each year; 18.5 million of these live in the Global South.⁴⁷
- Restrictive abortion laws have a negligible impact on the number of abortions taking place and countries with restrictive or prohibitive laws on abortion usually also have high levels of unmet need for contraception.⁴⁸ Restrictive abortion laws and stigma surrounding abortion mean that global abortion rates are expected to be much higher than reported.

boy child preference.⁴⁹ These customs are patriarchal in nature and also feed off and feed into women's economic injustice. For example, parents may prefer a boy child, as it is thought that they will be able to earn more money than girls and will therefore be able to support parents in old-age. Since 1990, with the advent of prenatal sex determination, there has been an increase in sex-selective abortions. The United Nations Population Division in 2010, estimated the current number of missing women at 117 million, most of them in China and India.

Six countries out of the 69 FP2020 focus countries^{xiii} have a high prevalence rate of sex-selective abortion – high enough to see changes in the gender balance of the population. Of these 6 countries, Afghanistan and India has the largest gender gap with an additional 7.2% and 7.3% of the population made up by males respectively.⁵⁰ The practice of aborting girls is widespread in India – the 2011 census of India revealed there were only 919 girls to every 1,000 boys. In effect, this means there are around 60 million women who are "missing". India has laws in place against this practice, however conviction rates are very low at just 2%. Under the law, anyone who carries out or attends a sex-selective ultrasound test – now illegal - can be prosecuted.

Padma (not her real name), is a community worker for Action India, an ActionAid partner trying to prevent girls being aborted. She spoke to us anonymously, after receiving threats from the clinics who perform the services required to abort girls.

"First of all when I go into the community, I share with them about the drop in the numbers of girls being born. I also share about the severity of this issue in Delhi, that has left only 914 girls per 1,000 boys and if we see this in comparison to the national population, millions of girls are going missing each year. If the numbers keep dropping that way, then the very existence of women will be at risk. People want a wife, a mother but not a daughter, but is it possible to get a wife and mother without a daughter?"

Secondly we gather their own experiences of what happened when a child was born in their family, how was it different when they had a son or if it was a daughter. Women tell us that when a son is born, it's a different atmosphere, there is a lot of happiness and celebration, people unknown to them come to congratulate them. But when a daughter is born, it's not even considered important to share the news that a girl is born.

^{xiii} Afghanistan, Bangladesh, India, Nepal, Pakistan and Viet Nam alone,

So we thought - why not turn this around? We did a house-to-house survey to identify girls between one and three months old and asked the parents of baby girls if they would like to be part of a celebration for their daughters. We went to people's homes to sing songs, play drums and give presents – just like when a boy is born.

Recently when I was with a community group, one woman said she had taken her daughter-in-law to undergo a sex-selective test. But when she started coming to our meeting and heard about the importance of girls, she dissuaded her daughter-in-law and son from going ahead with the abortion. When the girl was born she asked us to come to her house and celebrate. Women want this kind of change in Indian society.

I experience threats because of my work so I have to be careful. Doctors are lobbying to change the law so that women who get sex-selective abortions are prosecuted, rather than those who perform the abortions. They are very powerful."

Sex selective abortions are just one example of the extreme inequality which exists globally. Even before birth, girls are devalued. Restricting a woman's right to choose whether or not to have an abortion, whether to have a child, whether to use contraception is all part of the same patriarchal control and denial of women's rights that ActionAid strives to end.

Girls are often seen as a burden to families. Sex-selective abortions highlight the way in which gender inequality plays out throughout women's lives. The way in which families and communities view girls leads to the way they are treated in their intimate relationships and by the families of their partners.

ONLY YOUNG ONCE: THE PARTICULAR ISSUES FACED BY ADOLESCENT GIRLS

"I was a girl in a land where rifles are fired in celebration of a son, while daughters are hidden away behind a curtain, their role in life simply to prepare food and give birth to children."⁵¹

Malala Yousafzai



Christine, 14, lives in a village in Kongolai, West Pokot.

Christine was just 12 when she experienced female genital mutilation (FGM). Despite losing a lot of blood during the procedure, she wasn't taken to hospital because FGM has been illegal in Kenya since 2011. Instead, Christine was taken deeper into the bush. Three out of four girls and women in Kongelai, West Pokot, have undergone FGM.

"There was excessive bleeding and then because it is against the law, they went and hid us in the bush, so we couldn't even get good care there."

After being cut, Christine's legs were tied while she was kept in seclusion. A month after being cut, a marriage proposal arrived for Christine from a man a few years older than her. .

"They bought them refreshments, mostly soda's, my parents accepted and drank their soda and negotiated my dowry. They bought the cows and that is how I got married."

She tried to run away but her parents locked her in the house. "I was young," she added. "I wanted to stay a little longer, to be older." A year later she gave birth to her baby boy, Amos.

Because of her young age and scarring from FGM, Christine struggled to give birth naturally. She was rushed to a hospital where medics told her she was experiencing obstructed labour and would have to undergo caesarean section.

"The doctors and nurses said that my child was big and I was small. The doctor asked me if I was married. I told him that my parents accepted me to be married at that age."

Now aged 14, she worries about future pregnancies. When asked about her experience of FGM and child marriage, Christine says she had no idea what she was agreeing to.

According to the UN, more than 125 million girls and women alive today have experienced FGM.⁵² Female genital mutilation, is a practice which involves partial or total removal of the external female genitalia. It is a manifestation of social norms that control women's and girls' sexuality and consider their bodies, their sexuality and their future to be the property of others.⁵³ A survivor's sexuality is physically controlled - she is denied sexual pleasure, she is prevented from having sex before marriage and her education and life choices are constrained.⁵⁴

Like many girls, Christine not only underwent FGM, she also experienced child marriage^{xv} – another phenomenon which overwhelmingly affects girls. There are currently 700 million women alive who married as children.⁵⁵ Child marriage perpetuates other forms of VAWG including: denial of education and reproductive health access,⁵⁶ and intimate partner violence prevalence and severity⁵⁷ with a diminished capacity to seek support. Girls in many contexts are often married off to the perpetrators of rape or sexual assault.⁵⁸ It is a violation of women's and girls' SRHR. Girls are usually physically and emotionally unprepared for sexual activity, pregnancy and childbirth. Child marriage is socially accepted sexual violence, exploitation and abuse against girls. It is important to note that if the perpetrator had had sex with the girl prior to the 'marriage' taking place, it would be regarded as rape.

^{xiv} Marriage before the age of 18

^{xv} Bangladesh, Burkina Faso, Cameroon, Chad, Congo Democratic Republic of Congo, Guinea, Guinea-Bissau, Liberia, Mali, Malawi, Niger, Nigeria, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe

Christine discussed being unprepared for sex on the night of her wedding. She didn't know what she had to do and she found it painful. But Christine was also physically unprepared for childbirth, and not just because of the FGM she had been through, but also because of the restrictions in movement she faced as a girl-child in her community, lack of access to SRHR information, as well as not being biologically mature enough to give birth. Globally, 16 million girls aged between 15 and 19, and 1 million girls under the age of 15, give birth each year.⁵⁹ And, almost half of women aged 20 – 24 in Southern Asia and two fifths in sub-Saharan Africa were married before age 18.⁶⁰ 70,000 girls die during pregnancy and childbirth. This makes complications during pregnancy and childbirth the second highest cause of death for girls aged 15-19 worldwide.⁶¹

Girls who marry as children are often also married to older men. This intensifies power imbalances in that relationship. IPV is more prevalent, and more severe amongst girls who marry as children, than amongst women who choose to marry.⁶² This therefore has an impact on the number of unintended pregnancies and abortions (safe and unsafe, induced and spontaneous) which take place (as demonstrated above). With such a high rate of FGM and child marriage in Christine's area, it is hardly surprising that according to a Kenyan government report there is only a 9% acceptance of contraception within West Pokot.⁶³

Reducing child marriage and the adolescent birth rate are necessary to not only improving the sexual reproductive health of women and girls, but also to reducing intimate partner violence and other forms of VAWG (including, but not limited to, boy child preference where dowry/bride price systems exist). Over the past 20 years there has been a decline in the adolescent birth rate universally. But progress has slowed in recent years and adolescent girls in many countries still experience high birth rates – especially in sub-Saharan Africa, Latin America and the Caribbean.⁶⁴ Interestingly, Christine's story demonstrates that laws and policies alone are not enough to make a change – despite FGM being against the law, the act was simply conducted in secret to avoid prosecution.

17 out of 44 FP2020 focus countries^{xv} had adolescent birth rates which were higher than 1 in 10.

Niger was the only country with a birth rate higher than 2:10. It is also the country with the highest rate of Child Marriage in the world, at 76%.⁶⁵

Adolescents are likely to struggle to access family planning. There are several reasons for this. First, adolescent girls have little autonomy, with many adolescent girls reporting that their first sexual experience was forced⁶⁶ and more than 700 million women alive today married before their 18th birthday – which reduces further their autonomy in relationships. There is also a correlation between the age of marriage and rate of incidence and severity of intimate partner violence. There is a similar correlation between the age a girl first has sex and her likelihood of experiencing VAWG. All of this points to an urgent need for a tailored and coordinated approach to the issues facing adolescent girls.

IN THE EYE OF THE STORM: VAWG AND SRHR IN HUMANITARIAN RESPONSE

It is shocking, if perhaps not surprising, that both preventing VAWG and guaranteeing SRHR are still not seen as life-saving aspects of humanitarian action. Issues which are related specifically to women's rights continue to be relegated to the margins of humanitarian programming. **Time and time again, the humanitarian women's rights community have proven that both VAWG and SRHR are life-saving interventions.** With roughly 32.7 million female refugees in the world (let alone those who are internally displaced, or just in need of humanitarian assistance),⁶⁷ women's rights and access to life-saving interventions are not issues which can be ignored any longer.

Women and girls are 14 times more likely to die in a natural disaster than men.

60 per cent of preventable maternal deaths and 53 per cent of under-five deaths take place in settings of conflict, displacement and natural disasters.

25% to 50% of maternal deaths in refugee settings are due to complications of unsafe abortion.⁶⁸

The incremental gains that have been made on women's and girls' rights in humanitarian action have been at the surface level, in policies rather than in practice. In 2014, inside Syria – one of the largest humanitarian crises the world has ever seen with volumes of articles produced on the impact of the crises on women and girls – there was 1 project which specifically addressed Gender-based Violence, out of 67 funded by the pooled funding mechanism. Only 3 projects were given a 2b gender mark (where the principle purpose of the project is to advance gender equality).⁶⁹

In Somaliland, for example, where ActionAid is responding to the food crisis in East Africa, men are leaving their families in search of food and water. Women and girls are being left behind alone to cope with hunger, girls are placed at increased risk of sexual violence and many drop out of school. As in any crisis, women and girls are also at increased risk of sexual exploitation and abuse perpetrated by aid workers themselves and girls are at increased risk of being married as a child – particularly those from displaced populations.

In 2012, the UN conducted a participatory assessment in camps set up to house those who had been displaced from Somalia as a result of conflict and the previous Horn of Africa drought and famine. Within that report, many women and girls stated that they had experienced sexual assaults, intimate partner violence, and forced adult and child marriage.^{xvi} Knowing that this had happened before, in very similar circumstances, it is dismaying to see a lack of large-scale interventions in these areas.

Child marriage endangers the life of girls, as described above. There is also a correlation between the number of child marriages taking place and maternal mortality in both development and humanitarian contexts. Ensuring an integrated SRHR and VAWG response on this issue – for example by raising awareness of how child marriage puts girls at risk of major health issues and even death – has been demonstrated to work.⁷⁰

Attempts are being made to address this, for example by including GBV as a priority in job descriptions of high-level UN actors in humanitarian crises - but the continued lack of appropriate funding to address both VAWG and SRHR in emergencies, is not only an outrage, it is proof that the system deprioritises women's rights in emergencies and

humanitarian contexts. It would appear then, that policies relating to women's rights are on paper only. We have also seen that women's rights have been deprioritised in some humanitarian agencies themselves recently – perhaps a reaction to a lack of resources, or, a patriarchal replication in and of itself.⁷¹

This patriarchal policy subversion can be further demonstrated in the continued lack of post-rape treatment kits being dispersed during some emergencies by UNFPA, as well as a lack of preparedness by Governments to provide timely, sensitive care to survivors of VAWG during disasters.

Many conflict-affected countries are making the slowest progress overall – with lower rates of contraceptive use, and higher maternal and infant mortality rates. Humanitarian interventions, particularly those relating to women's rights, provide an opportunity to affect change and to change and challenge harmful patriarchal norms – particularly gender roles and responsibilities. The opportunity, of course requires agencies and the humanitarian architecture to prioritise women's rights, and as we have demonstrated here, that is no easy task.

THE HEART OF THE MATTER: PATRIARCHY

"In a culture of domination everyone is socialized to see violence as an acceptable means of social control."

bell hooks, *Feminism is for Everybody*⁷²

ActionAid believes that patriarchy is the heart of the matter. It manifests itself in different ways: in the way in which people interact with each other, in the way in which VAWG is produced, in the way in which society facilitates, allows or prohibits gender inequality. That is why we believe that the only way sustainable, lasting change on both issues will come about, will be when the system of patriarchy and its multiplex manifestations are addressed – ensuring that women are free to access their rights – living a life where their voices are raised, their choices are respected and they have complete, informed control of every facet of their lives. We believe that harmful masculinities need to be addressed and to do this men and boys should be engaged in social norms change and encouraged to get behind work on women's rights - but women and adolescent girls have to lead the change in order to challenge,

rather than replicate, gender inequality in their communities.

"No man can take me for granted again. I have the right to say no to anything."

Clodine, Rwanda

Clodine Nizeyimana lives in Shingiro, Rwanda. At the age of 15 she was forced to marry her sister's widower. He was 57. When he died several years later from AIDS related complications, Clodine was left as the lone parent of four children. Clodine contracted AIDS from her husband. Clodine's story, told in her own words, highlights the way in which empowering women leads to a better life for everyone.

Clodine has joined an ActionAid-supported farmers' cooperative in order to provide food and money to support herself and her children.

"The cooperative has helped my children and me a lot. The money I've made from the cooperative has



Clodine, is mum to four children. She is a member of one of ActionAid's 120 women's cooperatives in Rwanda and strives for a different, more equal, future for her children.

^{xvi} Unpublished paper, author's own, available on request

helped us get things for our house, like utensils and a bowl to wash my kids in... Now I'm aware of both my rights and the rights of my children. I know that no one has the right to just come and grab me, or them. I have the right to disagree with someone. I have a voice. I wouldn't have married my husband if I knew what I know now about my rights.

When I think about the trauma I suffered marrying so young, it's like a form of torture. It was my parents who made that decision with my husband. I wasn't involved in making that decision at all. Initially I did say no. I ran away to my grandmothers. But my brother dragged me home by force. I was forced into that marriage.

I want my daughter to marry after she's 20 years old and not before. If she tries to marry before she's 20 I will consider it a disaster. I'd go to the local government to get her back if I have to. Even if my boys bring home a young girl for marriage before she's old enough to make up her own mind, I'll fight for her rights. I'd report them to the local authority.

Every evening I teach my children that child marriage is no joke. They have to be made aware that there are children who are still affected by this. I also teach them not to have underage sex. Many people have HIV here and it's important that they protect

themselves. We have free, open conversations about relationships and sex.

I lost my rights when I was a young girl, so now it's my obligation to protect young girls. I was forced to give up school when I was 15, like other girls, to start a home and have children. I was told that barely being able to read and write was enough education for a girl. My brothers got to go to school and get a good education, but I had to stop so I could cook for them. I wasn't given full rights like my brothers.

I treat my kids equally. I give them equal rights regardless of whether they are a boy or girl. ActionAid's training helped me see this. I teach my kids that they all have the same rights. Everyone, no matter who they are, have equal rights.

My advice to my daughter is to be careful in her interactions with men. If anyone tries to violate her or rape her, she should come to me first. I want her to stay away from men who mean her harm."



Beti Utsav, organised by ACTION INDIA (ActionAid's partner in Delhi), is an event that celebrates the birth of girls.

Collaborative Responses

"If you want to go fast, go alone. If you want to go far, go together."

African proverb

COLLABORATION 1: MULTILATERAL LEADERSHIP

In addition to enduring gender inequality in every community, country and region of the world, we are currently witnessing a backlash against women's rights. From the U.S. reinstatement and expansion of the Global Gag Rule (GGR) to the near-decriminalisation of domestic violence in Russia, examples of regressive steps which risk turning the clock back on hard-won rights are abundant. The recent UN Convention on the Status of Women (CSW61) was dominated by increased attacks on more progressive agendas (especially SRHR) by anti-choice and conservative groups pushing an anti-rights narrative during the negotiations. From Washington to Moscow, from Istanbul to Dhaka, from London to Rio - the multiple, targeted threats to women's rights are real.

Meanwhile, the SDGs, building on previous women's rights commitments, have acknowledged for the first time the centrality of gender equality to the global mission of ending poverty and injustice, and securing sustainable and inclusive development. With gender equality seen as a goal in and of itself and a core cross-cutting theme in all other goals, the SDGs require upscaled and collaborative effort on women's rights because without it, no goal will be met. Nowhere is this more relevant than in the interlinked issues of eliminating VAWG and realising SRHR, fundamental to women's struggles everywhere.

Collaboration in multilateral global leadership should:

1. Ensure that grassroots feminist and women's rights organisations and activists, with intersectional perspectives, are not just provided with a seat at the table, but are actively involved in the design of strategies and aid initiatives;
2. Embrace cross-government action on this issue at a regional level and engage in more

partnerships with multiple actors at national (and sub-national) level;

3. Ensure that the same organisations are provided with the appropriate funding and resources to enable them to make the changes in their community they want to see, and hold governments accountable for their commitments;

4. Ensure that 'engaging men and boys' programming is not prioritized at the expense of programmes which promote women's and girls' leadership;

5. Apply knowledge learned through 'What Works in preventing VAWG'⁷³ research, on a larger scale, and apply to VAWG and SRHR programming;

6. Develop and promote a clear understanding of the links between VAWG and SRHR to world leaders and challenge States which fail to implement conventions and laws which they have ratified;

7. Understand that in order to address the root causes of VAWG and SRHR, multiple theoretical and practical approaches need to be taken;

8. Apply the OECD gender marker to all strategies and programmes, and apply it throughout the programme cycle - at a minimum;

9. Apply an intersectional gender-impact analysis to all strategies and programmes;

10. Ensure that all programming includes advocacy components, are rights-based and have a component of social norms change;

11. Fund programming that seeks to address root causes as well as mitigate risk.

COLLABORATION 2: GOVERNMENTS

Governments have a responsibility to ensure that women and girls are able to access SRHR and in order to do this, there is a clear need to take responsibility for addressing institutional violence within the health care system and other institutional barriers. This can only be achieved through addressing social norms within all mechanisms of government and government run services as well as the individuals working within them. Social norms don't stop at the door of Government, they don't vanish when an individual goes to work.

Using access to clinical care for survivors of sexual violence as an example, we know that there are large numbers of countries where mandatory reporting is necessary, or where reporting to the police is necessary prior to provision of health care services. But despite repeated advocacy, despite it being a lifesaving issue, these laws or policies remain, and women remain without post-rape treatment because of them.

Geographical and financial constraints are two of the largest and most practical barriers to access. However, the prioritisation of SRHR and VAWG services is minimal. There is a need to look underneath the policies and laws countries sign up to, and to assess their implementation and funding to understand if there is real political will for initiatives or whether they are policies in name only.

Ensuring an enabling environment for women's rights organisations (WROs) and Civil Society organisations (CSO) to lobby, advocate and influence with regards to VAWG and SRHR is vital to the development and implementation of effective national and local strategies to address these key issues – both from a response perspective and a primary prevention angle. WRO/CSO involvement in the development of legislations, policy and service provision has the potential to challenge the discriminatory, patriarchal norms and their manifestation (explored above).

The recommendations for 'multilateral leadership' section above apply equally to governments.

Moreover, governments should also:

1. Ensure that policies focused on women's rights, and SRHR and VAWG in particular, are written with women's rights and needs at the centre, and that they are costed, and fully implemented;

2. Ensure that every woman or adolescent girl has access to free non-judgemental SRHR services in a nearby location, and that new locations for services are chosen in collaboration with women and adolescent girls from a diverse set of backgrounds – including women and girls who are not married;

3. Ensure health service staff are trained to be able to deliver care which is compassionate, confidential and does not replicate patriarchal norms. Individual social norms work and training on women's rights should be delivered to staff members on a regular basis;

4. Implement ambitious individual and institutional norms change work regularly and consistently;

5. Apply gender responsive budgeting methods throughout all government apparatus;

6. End policy-related barriers and ensure that institutions are trained in appropriate care for survivors of VAWG – including operating from a survivor-centred approach to work, ensuring that police and health care staff are aware of their responsibilities and aware of the appropriate referral pathway;

7. End policy-related barriers that prevent unmarried women and adolescent girls from receiving comprehensive SRHR services;

8. Ensure that all government SRHR providers are trained to understand the links between unintended pregnancy and IPV and to respond appropriately in order to offer support to potential survivors – again in a survivor-centred way;

9. Ensure that all VAWG service providers are aware of the links between IPV and SRHR and understand that a woman or adolescent girl in a violent relationship is at increased risk of restrictions to contraceptives and other SRH services and rights;

10. Adequately fund Ministries which have mandates relating to women's rights and embed respected national women's rights movement leaders into their civil service.

COLLABORATION 3: CROSS-MOVEMENT BUILDING

If the Sustainable Development Goals are to be achieved, a vibrant and active grassroots feminist movement, and effective and sustainable women's rights organisations are vital. In 2016, the OECD documented something that women's rights organisations have known for a long time, stating: *"Evidence shows that women's rights activism and movements are the key drivers of legal and policy change to address gender inequality."* Further, DFID's theory of change on VAWG states that: *"supporting women's rights organisations (WROs), especially those working to tackle violence against women and girls, to make changes and build strong and inclusive social movements, is the most effective mechanism for ensuring sustainable change in the lives of women and girls."*⁷⁴

Women's rights organisations, as demonstrated throughout this paper, are highly effective. It is welcome that they have started to receive the recognition that they deserve – if not yet the funding.⁷⁵ WROs create spaces for women to see themselves and their situations differently, through sharing stories, economic and psychosocial projects as well as learning about their rights. Women are then encouraged to collectively claim rights and to become advocates for others to claim theirs. They engage in community mobilisation activities to demand gender justice. Recent research has proven that grassroots women's rights organisations are the single most effective way to combat VAWG, more important than GDP, number of elected female representatives or level of education.⁷⁶

WROs and the movements they create are also fundamental to achieving sustained progress towards gender equality through transforming social norms – and therefore to the successful achievement of all the SDGs. Feminist and women's rights organisations and movements are able to reach women and girls from communities who experience multiple forms of inequality and oppression.

Not all women are the same, however, some have more power and privilege than others. As systems of oppression intersect with patriarchy, we understand that there is a need to end viewing women and girls as a homogenized group, and recognize that gender hierarchies play out within other complex and transitory notions of age, class, race, sexual orientation, disability, caste and these "change over time, and differ by location and cultural context."

Acknowledging the way in which systems of oppression intersect with one and another to play out in the experiences of women and girls, is necessary to ensuring that SRHR and VAWG services **leave no one behind**, a key message of the SDGs. An intersectional movement would seek to address root causes and change oppressive structures.⁷⁷

However, we also recognise the need for feminist and women's rights organisations working on VAWG and SRHR to adhere to local and international best practice standards. When working on prevention, there is a need to ensure that WROs understand the risks of addressing social norms, engaging men and boys (with a particular focus on mitigating male backlash in the community and in the home), and understanding the referral pathways available to survivors. If working on response programming – including referral – it is important that WROs understand the guiding principles of case management, survivor-centred approaches and confidentiality.

We therefore call for:

1. The provision of sustainable, long-term funding for intersectional feminist and women's rights movements, coalitions, campaigns and programming consortiums. Funding should be designed in consultation with intersectional feminist movements from across the world in order to avoid patriarchal organisational replication;

2. Flexible, direct funding to emerging feminist and women's rights movements - providing support to nascent groups, especially those using innovative technology, communications and those working on sexual positivity and bodily integrity;

3. Funding that supports tackling the spectrum of VAWG and SRHR- rather than focusing on single issues in isolation and without recognition that each form of VAWG is interlinked with others, that SRHR is linked to VAWG and that the root cause of both is gender inequality.

COLLABORATION 4: HUMANITARIAN ACTION

As with governments, the humanitarian system replicates patriarchy and gender-related policies tend to be subverted in practice. Because of the nature of the world we live in, the number of people seeking humanitarian assistance has almost doubled in the past decade. The number of humanitarian contexts has increased. We face climate change, more natural disasters than ever before and we will therefore face more conflict as we look ahead. The lines are blurred between the humanitarian and development sectors. The work we do in development programming has to prepare people for the worst and the work we do in humanitarian has to prepare people for development – women's rights work is key to this.

With 20 million people facing starvation and famine it's vital to ensure that gender equality and women's rights are at the centre of all humanitarian work. ActionAid is employing a two pronged and complementary approach that engages women and girls as change agents and leaders and also places their protection, particularly from VAWG, at the centre of our humanitarian work.

We therefore call for:

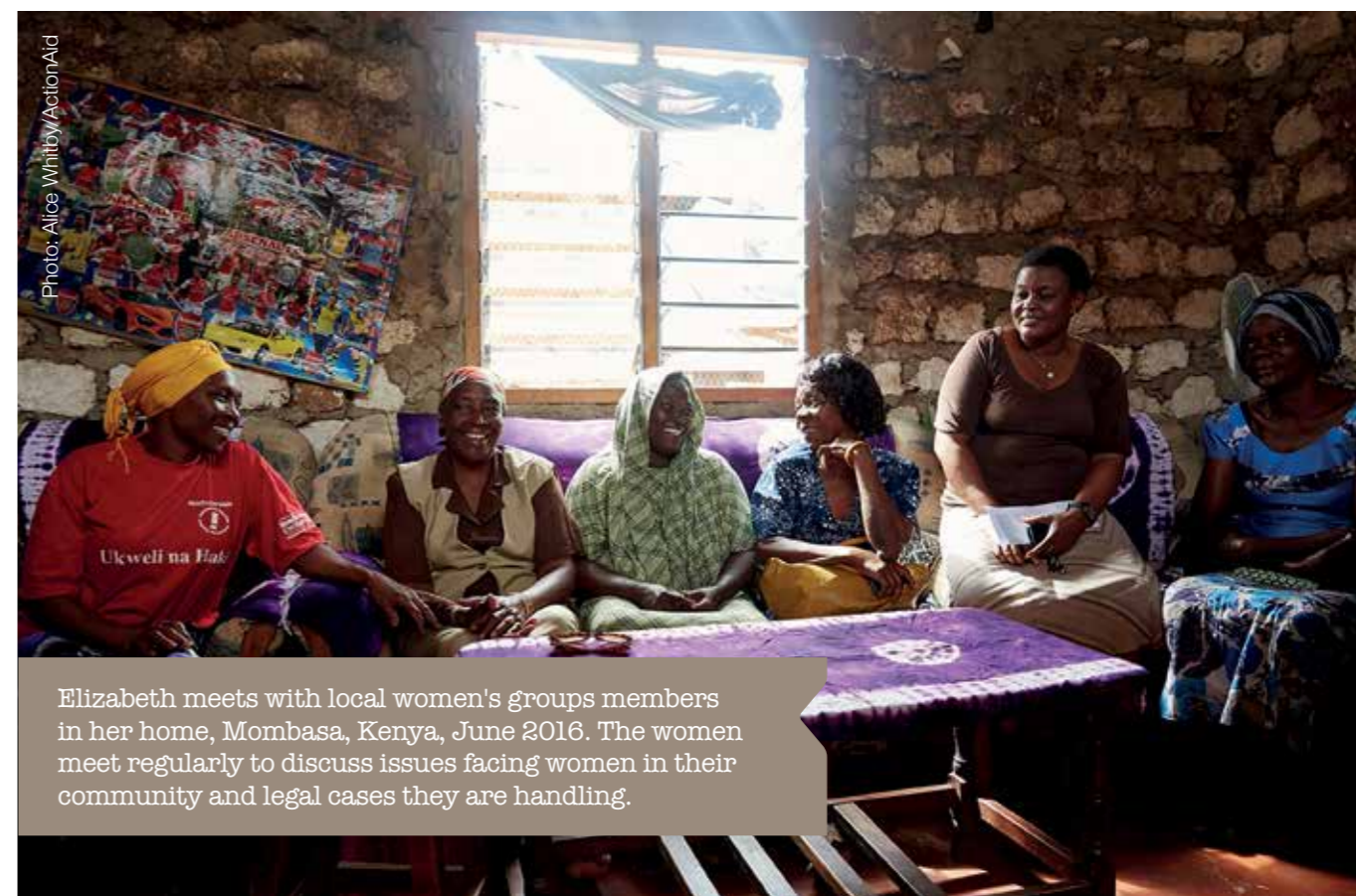
1. Humanitarian agencies to work alongside, and in solidarity with women's rights organisations in emergencies and to work with them in their preparedness efforts – in particular in the creation and monitoring of increases in VAWG and abuses of women's rights – as a means of conflict early warning mechanisms;
2. Governments to pre-position procurement and distribution mechanisms for post-rape treatment kits and to train health care workers in the clinical care of sexual assault survivors;
3. For the SRHR Minimum Initial Service Package to be delivered by humanitarian agencies, Governments and funded by donors, to facilitate its delivery within 48 hours of an acute emergency starting;
4. For the UK Department for International Development to adhere to the commitments made in September 2015 by the then Secretary of State, to make it a requirement

that all humanitarian proposals will include SRHR and to extend this to include VAWG;

5. For all humanitarian agencies to use the 2015 "Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action"⁷⁸ to guide all of their humanitarian programming;

6. For all humanitarian actors delivering case management, or components of case management for survivors of VAWG (health, psychosocial, legal, security) to adhere to the guidance outlined in the Interagency Gender-based Violence Case Management Resource Package;⁷⁹

7. Humanitarian actors should take IPV and child marriage seriously and consider them life-threatening areas of concern. All actors working on SRHR should be trained to understand the links between IPV/child marriage and be able to provide referral to VAWG case management service providers. Similarly, VAWG service providers should understand these links and be able to provide support in safely accessing contraception and other SRHR services to a survivor of VAWG.



Elizabeth meets with local women's groups members in her home, Mombasa, Kenya, June 2016. The women meet regularly to discuss issues facing women in their community and legal cases they are handling.

Conclusion: far from the finish line

Women's and girls' rights cannot be met simply by 'tinkering around the edges'. When working in siloes, agencies can mitigate the impact of gender inequality, but can never end it. Making services accessible and available, and ensuring they are properly resourced is the most obvious way to increase uptake of services, and one favoured by many actors. But without asking *why* women are unable to access services, and indeed *why* the most basic of service provision is still not being implemented by governments, the root cause of the problem will never be removed. This paper has sought to shed light on the answers to these very questions, exposing the common causes of VAWG and denial of SRHR, whilst highlighting their egregious effects.

By collaborating to address the joint root causes of the oppression, coercion and control women face – whether from their intimate partners, or from the state – it is possible to create change. We can build a joint movement grounded in the shared understanding that patriarchal oppression manifests in multiple ways and affects different women and girls in different sites, and different locations. Only together, with our different strengths and experiences of patriarchy, can such a movement work towards a world where we no longer have to plead for justice for 3.5 billion women and girls.

Until governments start to phrase their commitments to ending VAWG and SRHR issues in language that acknowledges that they are committing to giving half of their population access to things they already should have had; until women's and girls' rights are not addressed because it is economically or politically convenient at the time, but rather because women's and girls' rights *are* human rights and there is a genuine belief and commitment to ensuring that there is equality because it is the right thing to do – initiatives will never be fully effective. Attempting to address family planning without addressing intimate partner violence, reproductive coercion, obstetric violence and other issues which block women's and girls' bodily integrity and will deny millions the right to full control of their bodies and lives. By focusing on convincing men to allow women to use family planning services, governments and CSOs reinforce patriarchal norms and give further licence

to the control that men have over women's voice, choice and control.

Starting with July's Family Planning summit, the international community needs to recognise and address the links and common roots between VAWG and SRHR, situated firmly in a women's rights conceptual framework, which calls out patriarchy as the cause of injustice and rights violations.

Without making this leap, efforts to achieve gender justice, and end poverty and inequality, are destined to fail.

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Report designed by: Anna Patience

Front cover:

Hawa Jalloh, 45, shows off contraception available in her village through the medical centre. Mbundorbu community, Bo District, Southern Province, Sierra Leone.

Photo: Greg Funnell/ActionAid

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