




LINKS BETWEEN VIOLENCE AGAINST WOMEN AND MATERNAL HEALTH

Seven country case studies in Sub-Saharan Africa and Haiti

Consolidated report



United Nations Entity for Gender Equality and the Empowerment of Women



“All the studies were made possible thanks to the funding from the French Government under the MUSKOKA Initiative for maternal, new born and child health.”

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Publication : UN Women

Title : UN Women/ Links between violence against women and maternal health : *Seven country case studies in Sub-Saharan Africa and Haiti*
Dakar, Senegal, June 2015, 80 pages


Cover Photo : UN Women


Photos credit : UN Women (unless otherwise stated)


Infographic : UN Women

Editorial Board : Cabinet CERA (Togo)

Publication available from **UN Women :**

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ACRONYMS AND ABBREVIATIONS

AIDS :		Acquired Immune Deficiency Syndrome
BMI :		Body Mass Index
CAR :		Central African Republic
CEDAW :		Convention on the Elimination of All Forms of Discrimination against Women
CFI :		Composite Fertility Index
CONAG-DCF :		National Coalition of Guinea for Women's Rights and Citizenship
DGGPF:		General Directorate for Gender and Women's Promotion
DHS :		Demographic and Health Survey
DRC :		Democratic Republic of Congo
EGDC :		ECOWAS Gender Development Centre
ECOWAS :		Economic Community of West African States
MMUS :		Mortality, Morbidity and Service Utilization Survey
FGM :		Female Genital Mutilation
GBV :		Gender Based Violence
GDP :		Gross Domestic Product
GPHC :		General Population and Housing Census

HIV :		Human Immune Deficiency
ITUC :		International Trade Union Confederation
MDG :		Millennium Development Goals
MICS :		Multiple Indicator Cluster Survey
NGO :		Non-Governmental Organization
STD :		Sexually Transmitted Disease
STI :		Sexually Transmitted Infection
TDHS :		Togolese Demographic and Health Survey
UN :		United Nations
UNDP :		United Nations Development Programme
UNFPA :		United Nations Population Fund
UNICEF :		United Nations Children’s Fund
UN Women :		United Nations Entity for Gender Equality and the Empowerment of Women
VAW :		Violence against Women
WAWA :		West African Women Association
WHO :		World Health Organization



PREFACE

Dr. Josephine ODERA

UN Women Regional Director
for West and Central Africa

African Woman's Decade has witnessed the birth of UN Women and the most significant studies ever conducted on the impact of violence on the health and lives of women and girls.

This year, we are celebrating the 20th Anniversary of the Beijing Platform which transformed women's lives and showed the world that it is possible to grant more rights to women, to protect them and ensure that they effectively contribute to building of societies and the development of humanity.

2015 is also the year in which UN Women chose to publish this consolidated report on the links between violence and maternal health in francophone Africa and Haiti, along with its partners, joint beneficiaries of the French Muskoka Fund, WHO, UNFPA and UNICEF. Indeed, far too many women and children are faced with the risk of maternal mortality due to early marriage and pregnancies, female genital mutilation, physical, sexual, moral, economic and legal violence, as well as poor governance. Far too many women and children in the Central African Republic, Chad, Guinea, Haiti, Mali, Niger, and Togo are dying or are threatened by the consequences of violence during pregnancy or childbirth.

This report is an assessment of the current situation and a plea, not only to governments and development partners, but also the main actors in the promotion of women's rights and health to redouble their efforts to build a political, legal and health environment able to promote women's health.

Respect for women's and girls' human rights must be at the heart of concerns in order to improve their health. Care provision should take into account their specific needs so that demand for care directly stems from the community and women can call upon qualified staff when available to them. The facts and figures show that community support is crucial in ending the violence which kills during pregnancy and childbirth. In fact, social-cultural constraints combined with women's lack of decision-making power, interpretations of religion and pernicious traditional practices, female poverty, absence of financial empowerment, and lack of access to education, training and information are all factors

forming the bedrock of violence against women and girls. The two decades of political, legal and social progress for women as well as the 15 years of action towards achieving the Millennium Development Goals, in particular

MDGs 4 and 5, give us high hopes that this report will be among those that ultimately strengthen the mobilization and adoption of effective laws and policies against violence and in favour of the health of women, girls and children. ■



Introduction

Despite the wide range of actions to curb inequalities between men and women, it is a sad fact that many women and girls around the world continue to be victims of gender-based violence. *According to UN Women's factsheet : Violence against women & Millennium Development Goals, "violence against women and girls is a global pandemic of alarming proportions, deeply rooted in gender inequality and discrimination".*

No woman or girl is entirely free of the risk of violence. Violence takes many forms and occurs in a number of places : domestic violence in the home; sexual abuse of girls in schools; sexual harassment at work and in public places; violence during pregnancy; and rape in cities and rural areas, in refugee camps and as a tactic of war.

The different forms of violence include detrimental practices such as female genital mutilation/cutting of young girls and forced marriage, so-called "honour crimes", acid attacks and dowry-related abuse as well as newer forms such as cyber bullying and harassment via the Internet and mobile phones.

Indeed, according to the WHO 2010 Multi-Country Study on Women's health and domestic violence against women (Garcia-Moreno et al., 2005), 15 to 71% of women have experienced physical violence and/or sexual abuse exerted by an intimate partner at some point in their lives.

According to the UN Women's fact sheet mentioned above, the murder of women because they are women (femicide) which is only the tip of the

iceberg, takes place in several parts of the world. In Guatemala, two women are murdered on average each day. In India, 8093 cases of dowry-related deaths were reported in 2007; an unknown number of killings of women and girls were falsely labelled as "suicides" or "accidents". In Australia, Canada, Israel, South Africa and in the United States, between 40 to 70% of female murder victims are killed by their intimate partners.

In the State of Chihuahua, Mexico, 66% of murders of women were committed by husbands, friends or other family members. In addition, young women are at high risk of violent assaults.

Worldwide, up to 50% of sexual assaults are committed against girls under the age of 16. An estimated 150 million girls under the age of 18 suffered some form of sexual violence in 2002 alone.

The first sexual experience of about 30% of women was forced. This percentage is even higher among those who were under 15 at the time of their sexual initiation, with up to 45% reporting that the experience was forced.

Moreover, millions of girls around the world are victims of harmful practices. WHO Fact Sheet No. 241, Female genital mutilation (2008), estimates that some 100 to 140 million girls and women worldwide have undergone female genital mutilation (FGM).

In Africa, each year, more than 3 million girls are at risk of undergoing female genital mutilation. The state of FGM between 2010 and 2012 in the seven countries covered by this report is shown Table 1.

Table 1: Prevalence of FGM among women aged between 15 to 49 years by country

Country	Source of information	Prevalence (%)		
		15-49	15-19	35-39
Guinea	2012 DHS	96,9	94	98,8
Haiti	-	-	-	-
Mali	2012 DHS	67	87,7	90,2
Niger	2012 DHS-MICS	2	1,4	3,0
CAR	2010 MICS	26	-	-
Chad	2010 MICS	44	-	-
Togo	2010 MICS	3,9	1,1	6,4

Source : Data from respective MICS and DHS of the seven countries



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According to the report *Early marriage : A harmful traditional practice (UNICEF, 2005)* over 60 million girls worldwide are children married before the age of 18, mainly in South Asia (31.3 million) and Sub-Saharan Africa (14.1 million). Violence and abuse epitomize married life for a good many of these girls. Women who get married at a young age are more likely to be beaten or threatened, and more likely to believe that wife-beating is sometimes justified.

Human trafficking keeps millions of women and girls in modern slavery. Each year, women and girls account for 80% of some 800 000 victims of cross-border trafficking, with the majority (79%) being trafficked for sexual exploitation or domestic servitude. A study conducted in Europe revealed that 60% of trafficked women had experienced physical violence and/or sexual abuse before being trafficked, identifying gender-based violence as a critical factor in trafficking of women, according to UN Women.

With regard to sexual harassment, between 40 to 50% of women in the European Union will experience unwanted sexual advances, physical contact or other forms of sexual harassment at work. In Asia, studies in Japan, Malaysia, the Philippines and South Korea show that 30 to 40% of women suffer from sexual harassment at work, while in Nairobi, 20% of women have been victims at work or at school. In the U.S., 83% of girls aged between 12 to 16 years have suffered from some form of sexual harassment in state schools. Nearly 60% of women surveyed in Montreal, Canada, stated they were afraid to walk alone in their neighbourhood at night compared to 17% of men.

In a study conducted in Lima, Peru, only 12% of women asserted that they could move about freely without fear of aggression.

Rape as a tactic of war is endemic and, according to conservative estimates, some 20,000 to 50,000 women were raped during the 1992-1995 war in Bosnia and Herzegovina, while about 250,000 were identified as victims of rape in the 1994 Rwandan genocide. Between 50,000 to 64,000 women in camps for people displaced within Sierra Leone were sexually assaulted by combatants between 1991 and 2001.



In the eastern Democratic Republic of Congo, at least 200,000 cases of sexual violence have been recorded since 1996 ; the true figures are considered to be much higher, according to the UN Women's factsheet. Based on the *Report of the UN Secretary General on conflict-related sexual violence (UN, 2014)*, the increase in the



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scope and scale of violence against women and girls in Africa is due to the many hot beds of armed conflict throughout the continent. In Mali, between 2012 and 2013, a total number of 5,724 cases of violence against women were reported, including 532 cases of sexual abuse, 521 physical assaults, 827 cases of psychosocial violence,

1,201 cases of resource denial and 1,233 cases of violence associated with traditional practices (forced marriages, FGM). Eighty-five percent of such violence was committed against women and 15% against girls according to UNFPA (2013). In the eastern DRC, about 200,000 cases of sexual violence, mostly against women

and girls, have been documented since 1996. Violence against women is a major public health issue as underscored by WHO's 2005 report on *Addressing violence against women and achieving the Millennium Development Goals and research* undertaken by Heise and Garcia-Moreno (2002) and Jewkes, Sen and Garcia-Moreno (2002), which indicated earlier that such violence led to a series of immediate and long-term physical mental and sexual health problems. *Global and regional estimates of violence against women : Prevalence and consequences of health effects of intimate partner violence and non-partner sexual violence (WHO, 2013)* highlights that the violence suffered by women and girls has consequences for both their physical and mental health.

These consequences include fractures, pregnancy complications, mental illnesses, and breakdown of the social fabric. This violence greatly increases women's vulnerability to a range of short and long-term health problems.

Violence has an adverse effect on reproduction as well as maternal and child health. Gender-based violence severely restricts women's ability to exercise their reproductive rights, with serious repercussions for their sexual and reproductive health. As many as one in four women experience either physical or sexual violence during pregnancy, which increases the likelihood of miscarriage, still birth and abortion, premature labour and low birth weight.

Between 23 and 53% of women physically abused by their intimate partners during pregnancy are either kicked or punched in the stomach. Furthermore, violence limits women's access to family planning, which can potentially decrease maternal mortality by an estimated 20 to 35% by reducing their exposure to pregnancy-related risks. Women who are victims of violence tend to have more children than they want. This not only shows how little control they have over decisions affecting their sexual and reproductive lives, but also pinpoints their limited knowledge about the potential demographic benefits of reproductive health that can reduce poverty by 14%.

Harmful practices also affect mother and child health. Child marriage resulting in early and unwanted pregnancies results in potentially

fatal risks for adolescent girls, with pregnancy complications being the leading cause of death among girls aged from 15 to 19 years old worldwide.

Female genital mutilation/cutting increases the risks of obstruction during labour, childbirth complications, neonatal mortality, postpartum bleeding, infections and maternal mortality.

In addition, violence feeds the HIV/AIDS pandemic because it limits women's ability to protect themselves against HIV, and women living with HIV or AIDS are often abused and stigmatized. Young women are predominantly at risk of gender-based violence and HIV: they account for approximately 60% of all the 5.5 million young people worldwide living with HIV and AIDS. Women are already two four times more likely than men to be infected with HIV during sexual intercourse. Forced sex or rape limits condom use and prompts physical injuries which heighten HIV infection risks.

In the United States, during the year preceding the study, 11.8% of new HIV infections among women over 20 years old were due to domestic violence. Studies in Tanzania, Rwanda and South Africa reveal that women who have suffered violence from their partners are more likely to contract HIV than those who have not. Up to 14.6% of women in Sub-Saharan Africa and Southeast Asia reported that when they disclosed their HIV status, their intimate partners subjected them to violence, and fear of violence is a barrier which prevents women from talking about their HIV status and accessing proper care.

Some reports indicate that violence leads to maternal deaths. In the World Report on violence and health in 2002, WHO emphasized that violence causes more than 1.6 million deaths each year. Generally, maternal deaths vary from one region of the world to another, with the highest rate concentrated in developing countries.

In 2013, 289,000 women around the world died as a result of complications during pregnancy, during delivery or during the postpartum period. Today, almost all maternal deaths (99%) occur in developing countries with 62% in Sub-Saharan Africa according to *Trends in Maternal Mortality:*

1990 to 2013 (WHO, 2014). The same document notes that the average maternal mortality rate is 16 per 100,000 in developed countries, but 230 per 100,000 in developing countries. Sub-Saharan Africa is the region of the world where maternal mortality is highest: 510 deaths per 100,000 births.

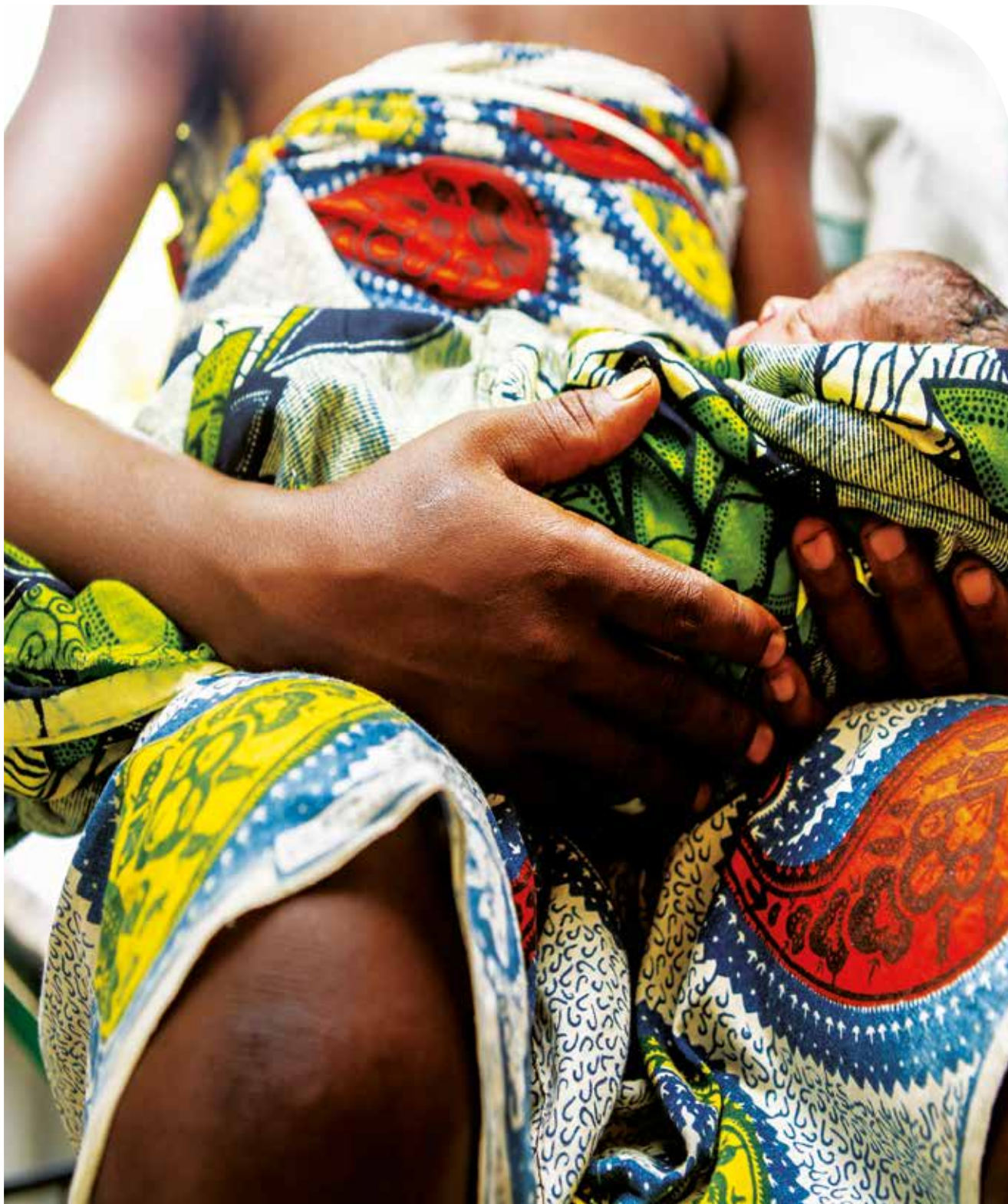
Chad has the highest rate among the countries studied in this report and where UN Women is currently implementing actions, followed by the Central African Republic.

The following table shows maternal mortality in the seven countries covered by this study.

Table 2 : Maternal mortality rates in the seven countries

Country	Source of information	Level per 100,000 live births
Tchad	2012 UN Estimates	1100
CAR	2010 MICS	850
Guinea	E2012 DHS-MICS	724
Haïti	2012 EMMUS IV	630
Niger	2012 DHS	535
Togo	2013 TDHS III	400
Mali	2012-2013 NDHS V	368

Sources : Data from DHS, MICS and UN



Faced with the situation of global violence and its succession of consequence for maternal deaths, several international measures have been adopted, among them CEDAW and its Additional Protocol, the United Nations Declaration on the Elimination of Violence against Women, the 1995 Beijing Platform of Action on violence against women and protection of girls, the provisions of the Millennium Declaration on the forms of

violence against women, the UN Resolution on the Intensification of efforts to eliminate all forms of violence against women, the Campaign to end violence against women by 2015 and the Solemn Declaration on Gender Equality in Africa.

UN Resolution 1325 back in October 2000 called on all Member States to take specific measures to protect women and girls during conflicts

and to implement a gender mainstreaming process in peacekeeping operations and post-conflict reconstruction; the Resolution 1820 of 2008 identifies sexual violence as a tactic of war and urges the immediate cessation of all forms of sexual violence against civilians in armed conflict; Resolution 1888 of September 2009 calls for the immediate establishment of a special representative whose mission would be to coordinate the efforts of international organizations and national authorities to end the violence.

At African and subregional level, during the Maputo Summit in July 2003, Heads of States reaffirmed their determination to promote gender equality by introducing gender parity into the Council of the Union and by amending the Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa. This commitment of the African Union was confirmed at the 2004 Conference of Heads of States, which adopted a solemn Declaration on equality between men and women in decision-making and in elective positions. ECOWAS Member States adopted a common position in promoting women's rights and gender mainstreaming as an effective way of addressing gender inequality in intervention programmes implemented within the subregion.

To realize its goal of advancing gender issues in the subregion, ECOWAS, at its 26th Meeting of Heads of State and Government, took institutional steps to create a Gender Committee and transform the West African Women Association (WAWA, headquartered in Dakar) into the ECOWAS Gender Development Centre (EGDC). At national level, the countries of Sub-Saharan Africa have almost all ratified international mechanisms against gender-based violence and developed national legislative and institutional frameworks policies and programmes to step up the fight to end it.

Despite all these national and international responses, gender-based violence persists and continues to represent not only an assault on the rights of women and girls, but also a public health problem at a time when the scourge of maternal mortality is the core concern.

According to Heise et al. (1994), violence constitutes greater risk than cancer, malaria

and road accidents combined for women aged between 15 to 49 years. Against a background of ongoing violence against women and in the wake of a raft of initiatives, UN Women was created in 2010 to foster gender equality and women's empowerment. The creation of UN Women falls within the perspective of raising awareness and harnessing the commitment of the international community to combat all forms of violence against women and girls and to reduce maternal mortality.

The French Muskoka Fund established at the G8 meeting in Muskoka (Canada) seeks to accelerate the achievement of MDGs 4 and 5 by upholding a UN mechanism involving WHO, UN Women, UNFPA and UNICEF that draws from this Fund to support 12 francophone African countries and the Caribbean.

Within this mechanism, UN Women leads active interventions in the Central African Republic, Chad, Côte d'Ivoire, Guinea, Haiti, Mali, Niger, and Togo. By engaging in this initiative, UN Women aims to support countries in their fight against discriminatory social practices, as well as the acts of sexual and gender-based violence which are causing a sharp upsurge in maternal and infant mortality.

UN Women commissioned studies in each of the countries in order to get a holistic situational analysis of the state of violence against women in the countries covered by the «Muskoka Initiative». The purpose of these studies was to map out the effects of gender-based violence against women and harmful cultural practices on health and maternal mortality in all the seven countries mentioned above. Following these studies, which had adopted various approaches in order to shed light on the current state of violence in the different countries and to spell out its links with health and maternal mortality, a summary was prepared in the form of a consolidated report.

This report describes country environments (extent of violence against women, response strategies, constraints/challenges) as well as the impact of VAW on health and maternal mortality. The report also makes specific and sometimes general recommendations that could contribute to effective action to curtail violence against women in Africa and Haiti.

CHAPTER I

Methodology

Review of the literature was the approach adopted in preparing this consolidated report. It begins by analysing the studies of the seven countries supported by UN Women, before examining complementary data in national reference documents such as DHS, MICS and gender policy documents in the seven countries covered by the report, as well as reports of other studies and international institutions and scientific articles.

A harmonized dashboard of indicators validated during a regional workshop was used to identify indicators relating to : (i) socio-demographic, educational, macro-economic and health factors; (ii) the risk of maternal mortality (iii) violence against women.

Values for all available indicators were extracted from the study reports of the seven countries and national reference documents.

Information from different sources was triangulated, with the latest national data taken into account in the analyses to describe the situation of violence against women and maternal health in the seven countries and the link between them.

It should be recalled that the study reports for the seven countries used different methodologies and approaches to determine the relationship between violence against women and health, as well as maternal mortality. General trends were identified, evaluated and consolidated in this report.

Methodologies of the (07) seven national studies

Guinea adopted an approach based on the use of secondary data. An essentially quantitative analysis was used to show the relationships between violence against women and maternal health, drawing on data from the *2005 Demographic and health survey and the 2009 Gender-based violence report*.

A sub-sample of 4,054 married women aged between 15 to 49 years old, who had given birth at least once during the five years preceding the survey, was selected. As part of this analysis, 33 variables were chosen; of these, 12 were related to maternal health and 21 to violence related to discriminatory practices against women.

A defined conceptual framework was used to analyse the links between violence against women, morbidity and maternal mortality, based on groups of variables and testing of hypotheses. The coefficients of Correlation between indicators and generated factors are used to calculate weighted maternal health and violence scores.

In Haiti, a qualitative analysis was undertaken based on a review of the literature to present the situation of violence, maternal and child health. The documents used are the *2005 Mortality, morbidity and services utilization survey, the 2003 Survey on living conditions in Haiti, the 2000 Household expenditure and consumption survey and the 2008 Report of the national consultation on violence against women and girls on evaluating care for victims*.

Socio-anthropological studies and project reports were also examined to identify health indicators that could possibly shed light on socio-cultural practices including violence

against women which have adverse health consequences, or even cause their death or kill their baby.

The study conducted **in Mali** was coordinated by CARE Mali in collaboration with UN Women and the National Institute for Statistics. IMAGES (International Men and Gender Equality Survey) was used and drew on investigative techniques as well as qualitative and quantitative analysis, including administration of questionnaires to a sample of 1,000 men and 500 women aged 18-35 and 36-59 years old, focus groups and interviews with key informants in urban and/or rural areas in the three regions of Bamako, Mopti and Segou. Univariate and bivariate analyses were carried out.

The available data provide information on the use of violence by men against their partners, their participation in the provision of care, their behaviour and roles in the household, as well as their attitudes towards the gender equality programme, among other topics. The study did not address the link between violence and maternal mortality.

In Niger, both qualitative and quantitative analyses were carried out, drawing on a case study conducted in Maradi, one of the three regions in Niger where UNWomen intervenes, with 584 women aged 12-49 years old. The study also used baseline national surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), to obtain an indirect evaluation of maternal mortality as a consequence of violence against pregnant women.

In the Central African Republic, the study carried out in seven health districts out of twelve is a cross-cutting, descriptive and analytical study with data mainly collected through the review of records gathered from health facilities, a survey of 381 women aged 15-49 years old, focus groups with women

and men, as well as individual interviews with health facility managers, community and religious leaders, and women witnesses or victims of violence.

The study analysed variables associated with risks of maternal mortality in connection with violence against women, namely the age of entry into union, number of living children, the use of contraceptive methods and the existence of discussion within the couple about family planning.

The study indicates that the lack of records of violence and deaths in health facilities and non-implementation of maternal death audits in health centres and within the community did not help in establishing the link between violence and maternal mortality.

In Chad, the logistic regression method was applied based on data from the Multiple Indicator Cluster Survey (MICS) undertaken in 2010. A model was constructed from the selected variables, available in the database to investigate the link between violence against women and maternal health.

With regard to violence-related variables, the age at first marriage, female genital mutilation, sexual and physical violence were all taken into account. Assistance during childbirth, prenatal care and use of modern contraception were selected as variables for the efficient use of health services.

The fact of having experienced morbid episodes and being low weight was used as proxy variables for maternal mortality.

A reference group was constructed, comprising married women aged 18 years older. On this basis, the probability of suffering any form of violence was examined at all levels.

In **Togo**, a cross-sectional, descriptive and analytical study was conducted in 17 UNWomen intervention districts; 1,208 women aged 15-49 years were surveyed, 82 women took part in group discussions and 255 individuals (community leaders, trainers, women witnesses/victims of violence, etc.) were interviewed.

In addition, a list of health, maternal and neonatal mortality indicators and risk of mortality was prepared, drawing on data from national surveys (TDHS, MICS, Basic Welfare Indicator Questionnaire, 2010 GBV report, 2012 Emergency Obstetric and Newborn Care, etc....). The most recent and nationwide available data were favoured.

An analysis of associated variables was carried out to identify the link between the risk of maternal mortality and violence against women. The variables used for this analysis are the age of entry into union, the number of living children, the use of a contraceptive method, discussion between the woman and her partner about the number of children.

Overall, it should be noted that the studies were conducted by individual consultants or national research institutions (See Annex, Table 5) and some chiefly addressed the levels of violence indicators in localized areas and only partially the link between violence and health and maternal mortality.

Conversely, other studies focused exclusively on the relationship between

violence and maternal health, thus showing that there was a lack of a harmonized understanding of the objectives of these studies.

Limitations of the country studies

Although the country studies provided data for basic indicators in most countries as tools to measure UN Women's progress in the areas of intervention, they fail to identify the clear links between violence against women and maternal mortality for a number of reasons : (i) lack of definition and non-harmonization of a list of essential variables of violence, health and mortality to be used for baseline studies; (ii) non-harmonized method of calculating the connection between violence against women and maternal mortality; (iii) use of data limited to regions/health districts and (iv) absence of key variables of violence, health and mortality in national databases and the quasi non-existence of maternal death audits in almost all the countries.

In order to demonstrate the relationship between violence against women and maternal mortality, it is necessary to put in place a model- framework for analysis by defining the key variables of violence, health and mortality and the method of calculating the link.

Additionally, advocacy is indispensable in each country to take account of the variables used in national surveys.

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CHAPTER II

Current state of violence against women in Sub-Saharan Africa and Haiti

In Sub-Saharan Africa and in Haiti, various almost identical forms and types of violence may be observed (rape, forced marriages, female genital mutilation, deprivation of financial resources, widowhood rites, assault and battery, etc.) albeit with certain peculiarities in some countries.

It should be recalled that gender-based violence stems from unequal relations of power between men and women. Although men can also be victims of violence, gender-based violence disproportionately affects women. In general, physical,

sexual, psychological, economic and institutionalized violence are the most common forms of abuse against women

Such violence is one of the most brutal consequences of the economic, socio-political and cultural inequalities that exist between men and women. In patriarchal African societies, different roles are assigned to girls and boys right from infancy, among other things, through the sexual division of labour, thereby planting the seeds of a demeaning perception of the status of women.



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These socio-cultural practices particularly breed gender inequality in access to knowledge as well as economic and political opportunities, to the detriment of women. In the Sub-Saharan African countries and in Haiti, the different forms and types of violence observed are of great magnitude with little variation from one country to another, affecting girls and women regardless of their economic and socio-demographic characteristics. Psychological violence seems to be more widespread and affects more than 79% of women; it is followed by physical violence which

also affects a great many women, ranging from 19 to 80% of women depending on the country.

Many women, too, are victims of institutionalized violence, the most common being female genital mutilation. The level of this type of violence is higher in some countries than in others. In Guinea for example, female genital mutilation affects almost all women (97%). The same applies for Mali (67%), Chad (44%) and the Central African Republic (26%). The proportion is lower in Togo (4%), as shown in Table 1.



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It emerges from these statistics that the proportion of women who have been victims of sexual violence, of whatever kind, is quite substantial in Sub-Saharan Africa and Haiti.

This form of violence is more prevalent in countries in socio-political turmoil.

Indeed, the armed conflicts arising in the region maintain and intensify the resort to certain types of violence, notably including the rape of women and girls. In Mali, the socio-political crisis in 2012 lay behind thousands of rapes, forced and early marriages.

Economic violence is reflected in confiscation of women's resources, denial of resources, prohibition on access to a bank account, as well as obtaining and keeping a job. Women in Sub-Saharan Africa and Haiti are generally the victims of such violence.

In the Central African Republic, 50% of women (in 7 out of 12 health districts) are denied the right to work and in 20% of cases, the husband decides the job his wife may hold. The proportion of women in Togo who have experienced this form of violence is 34%, according to the country studies supported by UN Women.

One of the practices which can be regarded as a specific form of violence against women is violence in a hospital environment documented in some countries. In the Central African Republic, where quantitative data exist in 7 out of the 12 health districts in the country, poor reception (50%) and negligence by health care providers (30%) have been reported.

In Togo, data collected in 17 health districts show that 5.1% of women report having experienced poor reception, 3.1% talked about indifference/negligence on the part of health care providers and 6.4% said that they had been insulted. This situation was described by a woman in a health district in Togo in these terms : *«There are midwives who insult, even slap you at times. That is why some of us stay home because we do not have the money to pay for consultation fees and we are afraid of being scolded by care staff.»*

Furthermore, in some countries such as Niger and Mali, the phenomenon of force feeding girls

to make them grow faster for early marriage is reaching alarming proportions, according to the documentary review report on the state of gender-based violence in preparation of the National Action Plan of Niger (Moussa Dan Koma-Ibrahim, 2012).

In response to violence against women, prevention strategies are being developed in each of the seven countries covered by the Muskoka initiative. These steps generally include the setting up of a legal framework and the implementation of prevention, support and care mechanisms.

With regard to the legal framework, each country has a legislative arsenal to combat violence against women, epitomized by the ratification of international instruments and adoption of national regulations. The countries have also strengthened their institutional framework by creating a ministry in charge of gender issues and prevention of violence against women and the relevant technical services.

States' commitment took shape through the development of policies and programmes to end violence against women.

The synergy of actions is a guarantee of effective prevention of phenomena as complex as gender-based violence which remains deeply rooted in socio-cultural values. In most of the countries, a partnership has been built between government actors, civil society organizations, and technical and financial partners through the Muskoka Initiative, through which responsibilities are defined and interventions circumscribed.

These provisions have helped to develop awareness and advocacy campaigns, training and dissemination of legislation on violence against women and women's empowerment programmes. On another level, support and care for women victims of violence has always been a major concern of all national stakeholders. In this regard, the creation of counselling centres has been noted in several countries, along with the implementation of paralegal networks local to communities in both rural and urban areas.

The achievements of the strategies that have been developed are: gender mainstreaming in development programmes and policies in



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most countries (Niger, Togo, Chad, etc.), involvement of women and girls' in some countries in the peace process, conflict prevention, management and resolution, the arrest of perpetrators of violence against women thereby affording them greater protection, enhancement of women's participation in some countries in policy making processes and strengthening of partnerships and coordination of activities.

Studies conducted in the seven countries have all underlined the existence of violence against women and girls in various forms, indicating that the schemes developed so far within the countries have failed to eradicate violence. This situation can be explained by the limitations of the various strategies implemented.

Indeed, national policy frameworks are often inconsistent with ratified international instruments.

In addition, it has been observed that modern law and customary law co-exist in most countries. The legislative framework in these countries is faced with socio-cultural constraints and the failure to adopt decisive tools to combat violence. Moreover, difficulties in implementing legal texts have been noted in several countries.

Regarding policies and programmes developed to combat violence against women, the data highlight the limited resources allocated by States to these programmes and also the insufficient resources allocated for their implementation.

Despite the plurality and diversity of action for prevention undertaken in each country, it is not unusual to find that these activities are generally concentrated in urban areas, while the socio-cultural factors underlying this violence are more prevalent in rural areas.

Finally, research in the field of violence against women is poorly developed and remains affected by the scarcity of studies on the issue, and thus the absence of up-to-date national statistics.

CHAPTER III

Links between violence against women and morbidity/maternal mortality



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Studies on violence against women (VAW) emphasize that such violence causes both immediate and deferred sexual and reproductive health problems. According to the report, *Global and regional estimates on violence against women : Prevalence and consequences of health effects of intimate partner violence and non-partner sexual violence (WHO, 2013)*, in partnership with the London School of Hygiene and Tropical Medicine and the South African Medical Research Council (June, 2013), physical or sexual violence is a public health problem affecting more than one third of women worldwide.

This report shows that the consequences of violence committed by the intimate partner on women's health are deaths and injuries (38% of murdered women globally were murdered by their intimate partner and 42% of women who have experienced sexual or physical violence from a partner have suffered injuries).

The same source indicates that the likelihood of contracting syphilis, chlamydia or gonorrhoea is 1.5 times higher among women who experience physical and/or sexual violence from their partners.

In some regions (including Sub-Saharan Africa), women are 1.5 times more likely to contract HIV.

Other health problems mentioned by the report are unwanted pregnancies and abortions. Indeed, violence by intimate partner and sexual violence by non-intimate partners lead to unwanted pregnancies; the report also shows that the probability of having an abortion is two times higher among women victims of physical and/or sexual violence committed by a partner.

Furthermore, this report stresses that the probability of having a child of low birth weight is increased by 16% among women who experience violence from their partners. On a global scale, 7.2% of women with mental illnesses have reported sexual violence exerted by non-intimate offenders.

Because of these acts, they were 2.3 times more likely to suffer from alcohol-related disorders, and 2.6 times more likely to experience depression or

anxiety; slightly higher figures than for women victims of intimate partner violence.

Women victims of violence can die from it. In general, maternal and neonatal mortality are related to one or more direct or indirect causes.

According to WHO's 2005 *World Health Report: Make every mother and child count*, women die due to a wide range of causes directly or indirectly related to pregnancy, childbirth or during postpartum. The four major direct causes are : severe bleeding (mostly postpartum haemorrhage), infections (mainly sepsis), hypertensive disorders during pregnancy (usually eclampsia) and obstructed labour.

Complications following unsafe abortions are part of this. Among the indirect causes of maternal deaths must be included diseases that complicate pregnancy or are aggravated during this period of life, such as malaria, an aemia, HIV/AIDS and cardiovascular diseases.

Figure 1 : Main causes of maternal mortality

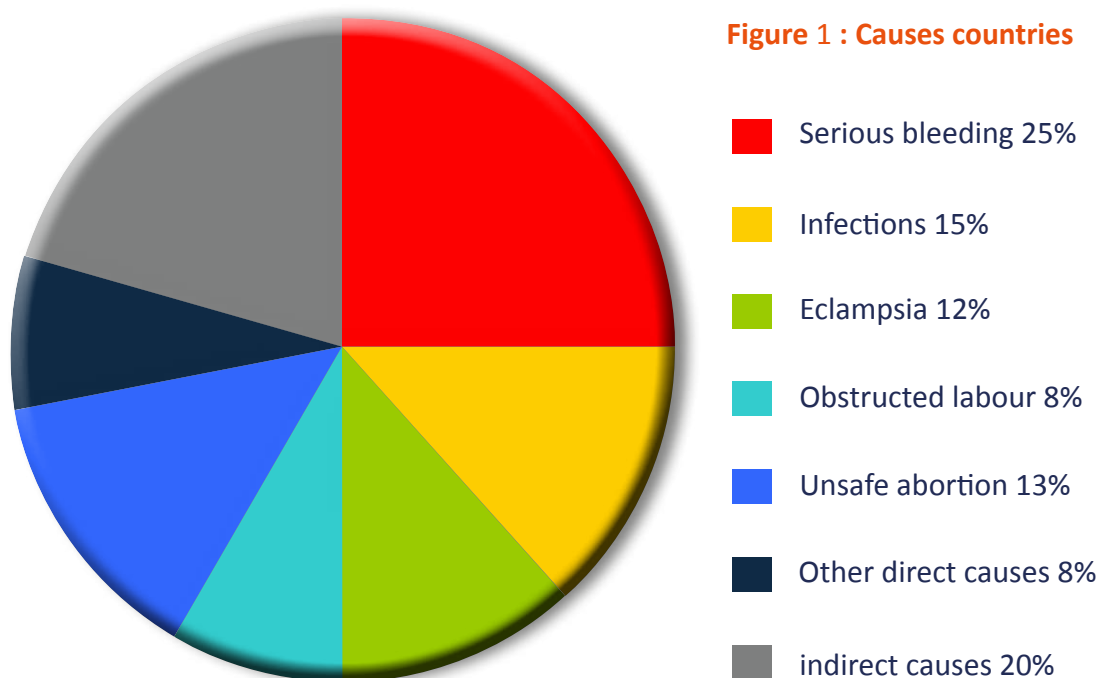


Figure 1 : Causes countries

In addition, it has been shown that the consequences of violence against women are deadly, since women who are victims can suffer from conditions such as gynaecological disorders (perineal injuries during sex involving violence, recurrent genital and urinary infections, sexually transmitted infections (STI), secondary infertility, unexplained chronic pelvic pain, dyspareunia, vaginismus, anorgasmia, dysovulation with menstrual irregularities and dysmenorrhea) or obstetric disorders.

Episodes of violence during the three months prior to pregnancy would be a key predictor. In a study conducted in France by Parsons et al. (1999) cited by Roger Henrion (2001)¹, 51.2% of pregnant women who died as a result of physical trauma were identified by their gynaecologist as victims of violence from their intimate partner or an acquaintance.

According to the study by Parker et al. (1994) and cited by Roger Henrion (2001),² other complaints related to the consequences of violence include unwanted pregnancies and complications from abortions. They further estimate that women are three times more likely to be victims of violence when pregnancy is not desired. The same report mentions that according to Fildes et al. (1992), physical violence can cause spontaneous abortions, premature rupture of membranes and premature labour, placenta abruption followed by pain and foetal death, haemorrhage or uterine rupture.

This type of violence can lead to maternal death following a homicide or resulting from complications during pregnancy : 25% of maternal deaths are due to physical violence committed by intimate partners. Through studies conducted in all seven countries, partial implementation of maternal death audits in health centres and within communities can be observed. In Togo, for example, although maternal death audits are compulsory in all health facilities, even for deaths in the community, this information is still not reported. Similarly, the lack of certain key variables on violence and on the risk of maternal mortality in national databases remained a major obstacle for the studies.

1 In Women victims of domestic violence: the Role of health professionals.

2 bid

It would have been interesting to consider maternal death audits and identify cases of women's deaths related to the causes of violence, regardless of the type and form, to highlight the link between violence and maternal mortality. Faced with the unavailability of these data, the studies took into account maternal death risk factors to determine the links.

Thus, some studies favoured research into the links between violence against women and health variables related to maternal mortality risk by crossing data from databases of various sources (mortality risk indicators from DHS and violence indicators from GBV studies), which poses a problem of consistency from a spatial and temporal perspective. Other studies sought to identify these links by focusing on the consequences of various forms of violence on women's reproductive health.

For example, quantitative analysis of data from the 2005 Demographic and Health Survey (DHS 2005)³ and the Gender-Based Violence Survey (GBV, 2009) carried out in Guinea, shows the existence of a statistically significant relationship between the risk of maternal mortality and the intensity of violence against women. Indeed, based on the calculation of violence and maternal health score using a linear combination of indicators, five groups of women were categorized by identifying a single health and violence score.

Tukey's test and regression were used to check that increased risk of maternal mortality is a function of the increase in the level of violence against women, and those women who face more violence, are at greater risk of morbidity and maternal mortality. Other studies have shown the adverse effects of various forms of violence, such as physical abuse, on women's health; violence that can lead to the death of abused women. Indeed, 15% of women surveyed in UN Women's intervention areas in Togo (N = 1,208) know of at least one case of maternal death due to violence that occurred during the

3 Twelve (12) maternal health variables and twenty-one (21) violence variables were selected in the 2005 DHS file. The data on these variables relate to a sub-sample of 4,050 women aged 15-49 years, married and having had at least one child over the period 2000- 2005. This sub-sample was selected from the national sample of about 8,000 women in the DHS.





12 months preceding the survey and in 66% of cases, it was the result of physical violence (kicking, beatings with a blunt object etc.), a reality conveyed by the speeches held by Nigerian women in the focus groups held in the Maradi region. According to women from the Mazadou Zika locality, Madarounfa Department in Niger, the most detrimental type of violence is beating, as it can rapidly lead to death. It can be the indirect result of another form of violence such as forced marriage, as reflected in this testimony collected in the Aguié Department in Niger: «A young woman who lived in the village of Ignadou, in Aguié district, was beaten to death on her wedding night by her husband with a flashlight in his mouth, after closing the door on them, because she refused to have sexual intercourse with him.» The Togo and CAR reports also draw a statistically significant correlation between the risk of maternal mortality and the variables of institutionalized sexual and economic violence against women: the age of entry into union, the number of living children, the use of contraception, discussion between the woman and her partner about the number of children, and women's economic status. These studies use a chisquare test⁴ based on data collected from the sampled women.

Among women surveyed, 75% were married before the age of 18 in the Central African Republic, against 14.7% in Togo. However, girls who enter early union are at not inconsiderable risk of morbidity and mortality due to complications during pregnancy, that include obstetric fistula, which may result from the physiological immaturity of their body; a relationship that tends to confirm the results of the statistical test.

Moreover, 75% of Central African women interviewed had five living children, whereas 21.5% of Togolese women had between four and six. Concerning the average age of respondents (26 years old for CAR and 27 years old for Togo), these figures revealed closely-spaced pregnancies that put women at greater risk of morbidity and maternal mortality, as confirmed by the chi-square test.

⁴ A chi-square test aims to test whether two variables are significantly associated. In reality, the independence of variables present in the crosstabs is actually being tested. The aim is to determine whether the combination of two variables is high enough to disregard the hypothesis of their independence.

These risks on maternal health would be even higher, given the low use of modern contraceptive methods in both cases (16.5% of Central African respondents and 15% of Togolese women), which can be explained by women's limited ability to discuss family planning with their spouse.

Similarly, Chadian women victims of one of the types of institutionalized violence, early marriage and female genital mutilation, are more likely to see their health deteriorate compared to women who do not suffer violence. Married before the age of 12, women are less likely to benefit from medical assistance at delivery ($r = 0.92$ at the 10% threshold) and are less likely to use modern contraception ($r = 0.51$ at the 10% threshold) than women married at or after the age of 18 years old. These women are at greater risk of experiencing a series of morbid episodes. Therefore, a woman who enters into marriage before her body is biologically mature is exposed to all the negative consequences on maternal health: poor medical assistance at delivery, limited use of birth control methods and more morbid episodes.

Female genital mutilation puts women at disadvantage vis-à-vis almost all the maternal variables studied. Indeed, compared with uncircumcised women, women who have undergone FGM are less likely to have medical assistance at delivery ($r = 0.83$ at the 5% threshold) and use modern contraception ($r =$ the threshold of 0.73 at the 10% threshold), according to the findings of the study conducted in Chad.

Economic violence weakening women's capacity to meet their health and nutritional needs, as well as those of their children, are a big risk for maternal, newborn and child health in Togo, as evidenced by the results of a chi-square test presented in the country report, based on data collected by the study.

Hence, 55% of women in the Oti district, one of the seventeen districts surveyed, who have been deprived of financial resources, suffered reproductive health-related problems, while 75% of women in the same district who had suffered such deprivation did not report any health issues. The following testimony collected from a pregnant

woman in the Savannah region of northern Togo, perfectly illustrates this problem :

«In the area where we live, there is a deficiency which is the men's fault. When the woman is pregnant, the husband pretends he does not know that his wife must go to the antenatal clinic (ANC). Caregivers ask us to start prenatal visits from the third month of pregnancy. Unfortunately, in this locality, it is a battle between the pregnant women and their husbands. A pregnant woman can wait up to 7 months before attending a prenatal consultation.

When she arrives at the clinic and the matron prescribes medication, it is yet another fight before these drugs are purchased. The time taken to buy these drugs is long, from fifteen days to several months, sometimes. So if the diagnosed condition becomes worse during this period, it would be too late. In case of a complicated delivery, husbands think that after giving money for prenatal visits, they did everything they had to do and they are no longer willing to buy additional prescriptions, on the pretext that they are broke. What can the woman do under these circumstances?»

Furthermore, healthcare managers interviewed in the Central African Republic within the area studied have identified economic violence, in particular, as the causes of complications during pregnancy that they frequently experience in their health centres. The death of a 13 year-old Muslim girl has thus been reported; a death that occurred due to childbirth complications as she was taken to the hospital late and the staff were not able to provide the necessary care in a timely fashion.

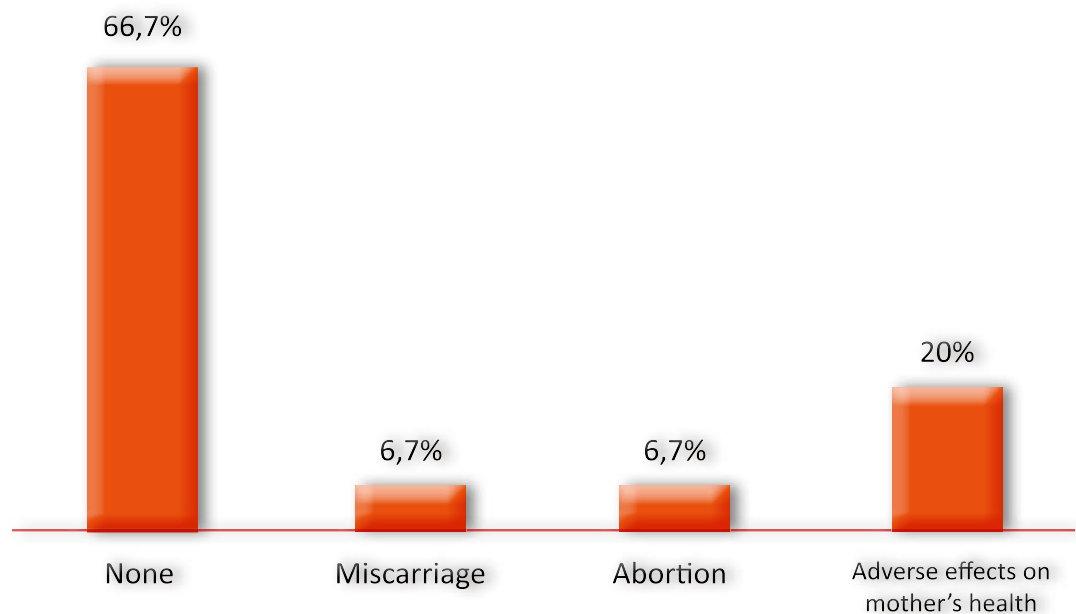
This case also represents an example of violence in hospitals as health institutions sometimes do not have emergency kits. Much of the data contained in the country reports support the argument of the existence of violence in hospital environments. It should be recalled that the three delays model (delay in recognition of danger signs and decision to seek care, delay in reaching an appropriate source of care and delay in obtaining adequate and appropriate treatment) can identify the major problems and bottlenecks that lead to maternal deaths.

The study carried out in the Central African Republic with 381 women has established that pregnant women who experience physical violence are twice as likely to give birth to a stillborn than other women (OR⁵ = 2, CI at 95%).

In the Maradi region of Niger, 7% of women identified miscarriage as a result of violence suffered during pregnancy and 7% also cited abortion (Figure 2)

5 OR = Odds Ratio

Figure 2 : Level of the consequences of violence against pregnant women in Niger



Sources : Data from the report *Violence against women and maternal mortality : Case study of the Maradi region in Niger, 2013*



Photo credits, UN Women

In addition, the high prevalence of anaemia among pregnant women in Haiti (60%) places them at risk of giving birth to a child of low weight, bleeding and contracting perinatal infections. Thus, according to a 2013 Haitian report, the basic nutritional status of the population of Haiti is characterized by the high prevalence of malnutrition with a poor and undiversified diet.

Nutritional deficiencies and insufficient protein and calorie intakes put women of reproductive age at an increased risk of obstructed labour, intrauterine growth restriction and low birth weight, and their children run the risk of physical and cognitive disabilities. An analysis of the data from the 2005 DHS in Guinea confirms that violence against women has a significant impact on maternal health. Thus, a basic linear⁶ regression model, introducing violence as the only explanatory variable, accounts for 8%

of the variation in the average score for maternal health.

A more sophisticated model which introduces six components of violence as explanatory variables accounts for 10% of the variation in the average score for maternal health. This is due to low decision-making power, limited freedom of action, low awareness of rights, barriers to healthcare, fear of the husband and weak control of resources. All coefficients of the components are positive and statistically significant, confirming that all aspects of violence against women exacerbate the risk of maternal mortality to varying degrees.

However, the model shows that the «socio-cultural barriers to healthcare⁷» component has a much greater influence on the risk of maternal mortality than other aspects of violence against women.

⁶ A multiple linear regression consists of determining to what extent a dependent continuous variable can be explained by other independent dichotomous or continuous variables.

⁷ As part of the Guinean study, socio-cultural barriers to healthcare refer to the difficulties women are confronted with when it comes to requesting permission to seek care and getting the money necessary to pay for such care.

Finally, a third regression model involving quintiles of violence as the only explanatory variables also accounts for 10% of the variation in maternal health scores.

It indicates that going from “the highest” quintile of violence to the “lowest” violence quintile would reduce by 14 points the risk of maternal mortality, falling from 43 to 29, on a scale ranging from 0 to 100. Poverty, religion and place of residence are also determinants of maternal mortality. Individual factors such as literacy and women’s poverty level, as well as contextual variables

(place of residence, ethnicity and religion) added to violence explained 32% of the variation in the average score of maternal mortality.

The risk of maternal mortality could be reduced by 18 points if a woman was moved from the lowest socio-economic class to “the richest” category, while maintaining all other factors as they are. Likewise, the risk of maternal mortality would decrease by about 8 points if a woman lived in the socio-cultural conditions of the cities rather than in rural settings.

Summary of the link between violence against women and maternal health

- Women who experience more violence are at greater risk of morbidity and maternal mortality. Women deprived of financial resources suffered from reproductive health related impairments, whereas women who were not deprived did not face any such problems;
- Pregnant women who have been victims of physical violence are twice as likely to give birth to a stillborn than other women;
- Food deprivation increases the prevalence of anaemia among pregnant women and puts them at risk of giving birth to a child of low weight, bleeding and perinatal infections;
- Maternal mortality risk could be reduced by 18 points if a woman was transferred from the “poorest” socioeconomic category to “the richest” with all other factors remaining unchanged;
- Maternal mortality risk would decrease by approximately 8 points if a woman lived under the socio-cultural conditions of the cities instead of those of rural settings.

CHAPTER VI



Photo credits, UN Women

Challenges for countries

Against a background of persistent violence against women in the various countries and its effects on health and maternal mortality and also the emergence of new forms of violence linked to permanent socio-political conflicts on the continent and within the different countries. In this peculiar setting, the following challenges need to be addressed :

- i) At institutional level, the main challenge is that all decision-makers and officials of relevant technical services in all the countries must be wholly aware of the necessity to strengthen the level of gender mainstreaming in policies, programmes and development projects;
 - ii) On the economic front, the major challenge remains the expansion of women's empowerment policies and programmes for the most vulnerable groups, mainly in rural areas, to allow women as a whole to acquire and build the capacity to enhance their economic power;
 - iii) In relation to education, the challenge remains of improving girls' school enrolment rates and women's literacy for the acquisition and development of the knowledge, intellectual skills and techniques vital to their promotion;
 - iv) In the sphere of health, the preservation of women's physical, mental and moral integrity constitutes a fundamental issue, as they need to perform their multiple roles of production and reproduction in a more protective environment;
 - v) From a legal perspective, the main challenge resides in the actual legal protection and women's full enjoyment of laws and regulations free of discrimination, through the alignment of national laws with all aspects of international texts and their active implementation;
 - vi) At regional level, pooling efforts is the key to sharing best practices in combating violence against women and driving subregional synergy of action;
- In terms of information, the promotion of research, monitoring and evaluation should foster an evidence-based decision-making and the implementation of strategies and policies to combat gender-based violence.

Country profiles in terms of violence against women

The state of violence against women varies from one country to another. In this regard, demographic data, changing trends, strategies developed as well as constraints and challenges in Sub-Saharan countries and the Caribbean emerge as follows :

GUINEA

Contextual analysis

In 2012, Guinea had 11,663,627 inhabitants and this population is growing at a rapid pace (3.1%) according to the Demographic and Health Survey and Multiple Indicator Cluster Survey (DHS-MICS, 2012). Women account for 52% of the total population, of whom, 75% live in rural areas. This population mostly consists of Muslims (90%) and Christians (5%) DHS-MICS(2012). The primary school enrolment rate is 48.9% (44.9% for women against 53% for men). The literacy rate among the population band aged between 15 to 24 years old is 55.4%, with 39.4% for women against 71% for men.

48 per cent of the Guinean female population lives in polygamous types of marriage (DHS-MICS, 2012). On average, husbands are about 14 years older than their wives. Guinean women enter into union at quite an early age. Indeed, 27% of women aged 25-49 years at the time of the survey were already in a union by the age of 15. Women's level of education is correlated with the age of entry into union; the more educated they are, the later they get married: the median age for women with no education is 16.5 years, against 17.7 years among those with a primary education and 22.9 for those with a secondary education or higher. Women's fertility has declined but still remains high, as by the end of their reproductive life, each woman has on average 5.1 children

(DHS-MICS, 2012). The social regime governing families in Guinea is patriarchal, and the man is paramount as the one responsible for the family and ensuring respect for social values. In the Guinean context, physical and cultural violence seem to be accepted. Domestic violence against women is far more tolerated than violence against men which remains much less likely.

Violence is more accepted by women than by men, even when women themselves are the victims. Female genital mutilation is a practice that affects almost all women (97%), although 81% of women aged 15-49 years old are fully aware that the Government has enacted a law banning female genital mutilation nationwide.

According to the DHS-MICS (2012), 70% of all women advocate maintaining the practice as traditionally performed (36%) or by a medical procedure, meaning that it must be done by health professionals (35%). Moreover, 23.7% of family planning needs in Guinea are unmet. Only 6% of women aged 15-49 years who are currently in a union use contraception, with the majority using modern methods (5%). In one per cent of cases, women use a traditional method (DHS-MICS, 2012).

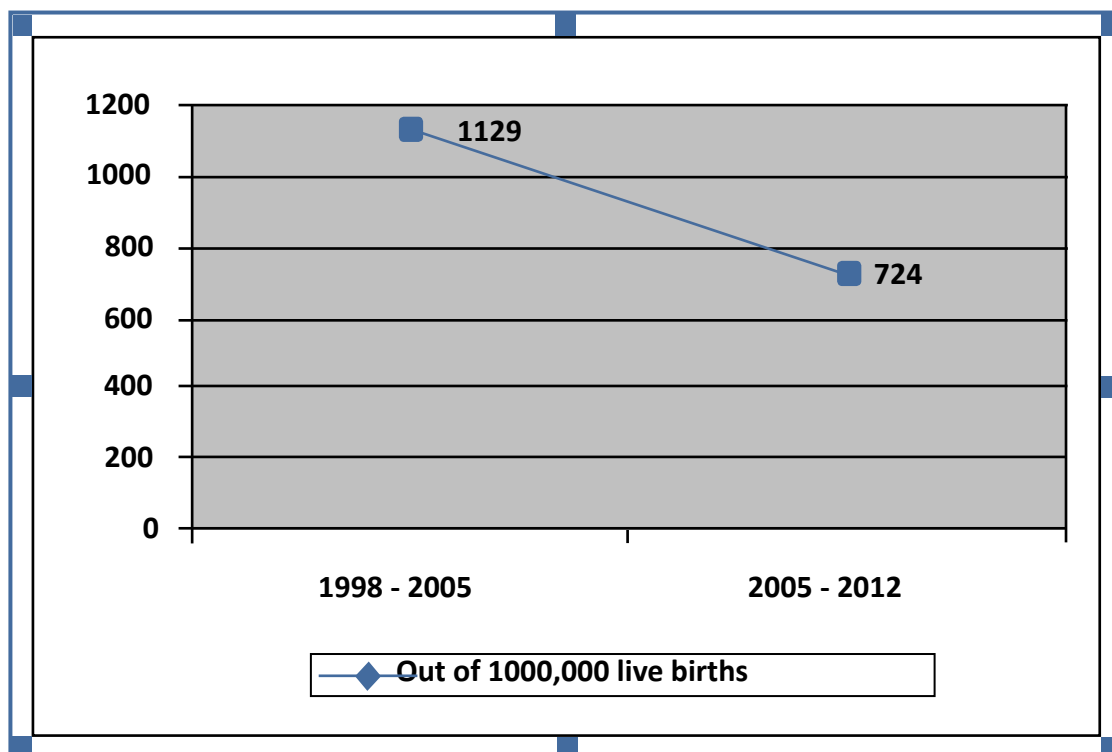
Access to primary healthcare is a concern, as it translates into high infant and maternal mortality rates. According to the DHS-MICS (2012), the maternal mortality rate in Guinea was 724 deaths per 100,000 live births between 2005 and 2012, although it has dropped compared to the period 1998-2005 (1129 deaths per 100,000 births).

In terms of equality in political and public life, the principle of parity between men and women that Guinea adopted through the African Union Commission and at national and local level

remains to be effectively implemented, as in 2007, only 10% of posts available in political and public institutions were held by women,

according to the NGO *Shadow report on implementing CEDAW in Guinea*, (CONAG-DCF, 2007).

Figure 3 : Trend in maternal mortality between 2005 and 2012 in Guinea



Sources : Data from 2012 DHS-MICS.

Scale : Prevalence of forms and types of violence against women

The prevalence of violence against women in Guinea is 92% among women aged from 15 to 49 years, according to the *National report on the elimination and prevention of violence against women and girls in Guinea* (Guinean Ministry of Social Affairs, Promotion of Women and Children, 2013).

It should be noted that violence against women is as widespread in urban areas as it is in rural settings. Most of this violence is perpetrated in 54% of cases by the spouse or former spouse and 13% by classmates or friends of the victim. Violence mainly occurs in the victim's house (84%) according to the report.

The same report also indicates that rape is the type of violence most commonly recorded (46%) by gender-based violence support centres from March 2011 to December 2012.

This is followed by physical assault (19%), denial of resources and opportunities (18%); other sexual assaults (9%), forced marriage (4%) and emotional abuse (4%).

Strategies to address violence against women

Preventive action and care provision strategies are usually developed to address violence against women. In Guinea, these actions involve the adoption of political, legal and institutional responses.



The political will of the Guinean authorities to protect women/girls against all forms of violence led them to sign and ratify several international legal instruments. Nationally, vulnerable people, including women, are protected, under the Basic Law and ordinary laws.

Regarding prevention and support strategies, Guinea has developed and implemented a National GBV Strategy during the period 2009-2012, encompassing inter alia the following components : empowerment, mobilization of the various stakeholders, development of the institutional care mechanism, promotion of victims' access to justice, development of research on GBV including the implementation of results, creation of a different socio-cultural perception of GBV, strengthening coordination of actions by setting up a Multisectoral Committee and a Working Group on GBV within the Protection Cluster bringing together representatives of the Government, the UN and NGOs.

Major achievements in the framework of implementation of this strategic plan are mainstreaming of gender issues in development policies and programmes, involvement of women/girls in the peace process, conflict prevention, management and resolution, and the protection of women/girls against sexual

violence and female genital mutilation as well as reinforcing women's participation in political decision-making.

Constraints and challenges

The following constraints and challenges need to be addressed: i) weak enforcement of laws and ratified international conventions; ii) inconsistency of national legislation with ratified international legal instruments on the protection of women (coexistence of modern and customary laws), iii) women's ignorance of their human rights; iv) limited resources allocated to the prevention of violence against women; v) prevention strategies which remain inadequate and incompatible with the social values of the communities; vi) illiteracy of the majority of women and low retention of girls in school; vii) insufficient involvement of defence and security forces and communities in actions against violence; viii) stigmatization and marginalization of victims of violence; ix) low medical, psychosocial and legal care for victims.

Recommendations

Most of the recommendations are geared towards implementing a consultation strategy with the guardians of traditional practices and habits, religious leaders and other stakeholders

to ensure compatibility of modern and customary laws.

Furthermore, advocacy programmes need to be developed in favour of the establishment of a specific budget line within the State budget to fund the National GBV Strategy; institutional mechanisms must be strengthened to revitalize the National Strategy for the prevention of GBV, the proper implementation of the 1325 and 1820 Action Plan as well as the 2012-2016 Strategic Plan for the Accelerated Abandonment of Female Genital Mutilation/Cutting, with the revival in particular of the National Observatory on GBV and the Regional GBV Prevention Committees. It is also necessary to implement a national programme for the socio-economic rehabilitation of victims of violence and launch pre-school and school programmes aimed at preventing violence against girls.

HAITI

Contextual analysis

In 2012, findings from the Mortality, morbidity and utilization of services survey (EMMUS-V) estimated the population of Haiti at 10,413,211 inhabitants with more than 43.6% urban dwellers. This population is spread over an area of 27,750 square kilometres. The vast majority of the population is Christian. The same source reveals that 74% of women and 79% of men aged between 15 and 49 years old are literate. Only 15% of women and 9% of men have never been to school. In contrast, 49% of women and 54% of men have either attended high school or university. The comparison of the 2012 EMMUS-V results with those of previous surveys indicates a steady downward trend in the fertility level. A Haitian woman has 3.5 children on average by the end of her fertile life, against 4.8 children in 1994-1995.

The average number of children per woman varies between 2.5 in urban areas to 4.4 in rural zones. Adolescent fertility is high in Haiti. In fact, one out of seven girls aged 15 to 19 years old (14%) is sexually active: 11% are already mothers and 3% are currently pregnant for the first time. Early fertility is three times higher among uneducated girls (27%) than among those with secondary or higher level education (9%).

The median age at first birth was 22.3 years for women aged 25-49. The median age at first birth for women living in urban areas is 23.5 years against 21.3 years for those living in rural areas. Nearly half of women aged 15-49 (55%) and 41% of men aged 15-49 were in a union at the time of the survey.

In Haiti, men enter into their first union at a later age than women: 18% of older women aged 20-24 were in a union before turning 18, against 3% of men from the same age group. Three out of ten women (29%) say their spouse had other wives (multiple unions). It is in the Metropolitan Area (36%) where the proportion is highest. According to that same survey, only 4% of women resorted to abortion at least once in their lifetime. Of these, only four abortions out of ten (40%) that occurred in the past five years were performed in a health institution.



Only 35% of currently married women use some type of contraception and 31% use a modern method. The most used ones are injectables (19%), male condoms (5%) and the pill (3%). More than a third of sexually active women not in a union (35%) use modern contraceptive methods. They mainly use male condoms (24%). The proportion of married women with unmet family planning needs is estimated at 35%. Among this particular group, there are more women who use contraception to limit (20%) rather than space (16%) births.

Thirteen percent (13%) of women aged 20-24 had at least one live birth before the age of 18. For 90% of births in the five years preceding the survey, mothers went to a prenatal visit with trained staff (doctor, nurse, nurse-midwife, or nurse auxiliary). Two thirds of mothers (67%) have attended at least the four recommended visits and six out of ten (60%) women went to their first prenatal visit before reaching their fourth month of pregnancy. Nearly one third of births (36%) took place in a health facility and 37% of deliveries were assisted by a skilled care provider. Six out of ten women (61%) did not receive postnatal care within 41 days after delivery.

Scale : Prevalence of forms and types of violence against women

There is a great disparity in employment by sex in Haiti: 66% of women aged 15 to 49 years in a union reported working during the 12 months preceding the survey, against 96% of men. Among women in a union who have been remunerated in cash for their work, 66% believe they earn less than their husband/partner (2012 EMMUS V).

In Haiti, nearly seven out of ten women in a union (73%) are involved in decision making for their own health care, 78% for large household purchases and 85% for visits to their relatives or parents. Seven percent (7%) of women do not have a say in any of the three decisions mentioned above (EMMUS V-2012).

Nearly three out of ten women (28%) report having been victims of physical violence at some point in their lives since the age of 15. One out of ten women (10%) suffered violence over the last 12 months preceding the survey.

This proportion is higher among young women under 25 years.

Overall, 13% of Haitian women have experienced sexual violence at some point in their lives. This proportion is higher among those in a union without cohabitation, and those in a union breakdown (18% each). For all women aged 15 to 49 years in a union or in a union breakdown, 29% have suffered domestic violence (emotional, physical or sexual abuse) from their husband/current or most recent partner. The rate of domestic violence is higher among women aged 15-19 years (43%) and among women from union breakdowns (35%).

Strategies to address violence against women

To guide its actions, the National Consultation adopted in November 2005 a plan covering the period 2005 to 2008. This national plan for the prevention of violence against women and girls has four spheres of intervention: data collection and analysis; care and support to victims; prevention, advocacy and communication; coordination, monitoring and evaluation. Operationally, three technical commissions are set up under the coordinating committee: data collection committee, support and care committee and advocacy and communication committee.

Constraints and challenges

After the demonstrations of political violence, including political rape during the Duvalier dictatorship 1991-1994, Haitian women continue to suffer from various forms of violence. In addition to the use of rape as a form of political oppression (sexual aggression for political purposes), rape has become a common phenomenon and a regular practice of criminal gangs (Zenglendos), according to the 2012 report Discriminatory cultural practices, gender based violence and maternal health in Haiti.

The culture of tolerance (machismo) with regard to violence against women led to many cases of violence not being reported (a society unresponsive to the concerns of women victims of violence).

Perpetrators of violence against women enjoy a high degree of impunity and a lack of medical care for victims of violence against women can be seen nation wide.

Haitian legislation dealing with violence against women is relatively weak and not in accordance with Haiti's obligations under international law. It is worth noting that Haiti had to wait 25 years before it could actually present in 2008 its first report under the Convention on the Elimination of All Forms of Discrimination against Women. The legislator has not paid particular attention to sexual abuse, sexual harassment and domestic violence.

Violence against women is punishable under the laws related to violence and assault. The high turnover of trained nursing staff was one of the major constraints identified in securing the continuity of proper care services for victims of violence against women.

These women victims are not fully protected by the Law. The ministries in charge of gender do not invest sufficient resources in developing and implementing prevention, rehabilitation and reintegration programmes for victims of violence efficiently.

Recommendations

The Ministry of Public Health and Population must work to raise the level of public trust in health institutions and, at community level, tackle the discriminatory social practices and gender-based violence that have damaging effects on women's health.

Direct action to improve women's health and reduce maternal mortality must go together with strategies to lessen women's vulnerability in the economic, educational and political

arenas. Empowerment strategies are required at all levels.

MALI

Contextual analysis

Mali has a total population of 14,528,662 inhabitants and 50.4% are women.

The population is mostly Muslim (94.8%) (4th GPHC, 2009). According to the Demographic and Health Survey of Mali (DHS-V 2012-2013), 18% of women and 21% of men are aged 15-19 years; about 20% of women and 14% of men belong to the 25-29 years age group. Regarding marital status, 85% of women and 63% of the male population were in a union at the time of the survey.

Because men tend to marry later than women, the proportion of singles is higher among men than women (37% against 14%). Conversely, the proportion of people out of union (divorce, separation or widowhood) is significantly higher among women (2%) than men (1%).

The 2012-2013 DHS-V indicates that overall, men are more educated than women. Indeed, 26% of men against 15% of women have reached secondary or higher level of education ; however, proportionally more women are uneducated than men (76% against 61%). The Malian economy mainly relies on the primary sector which employs over 80% of the population.

It remains one of the world's poorest countries, even although poverty declined between 2001 and 2010 (Figure 4). Mali therefore belongs to the category of least developed countries (LDCs) and ranks 173rd out of 177 countries with a Human Development Index.

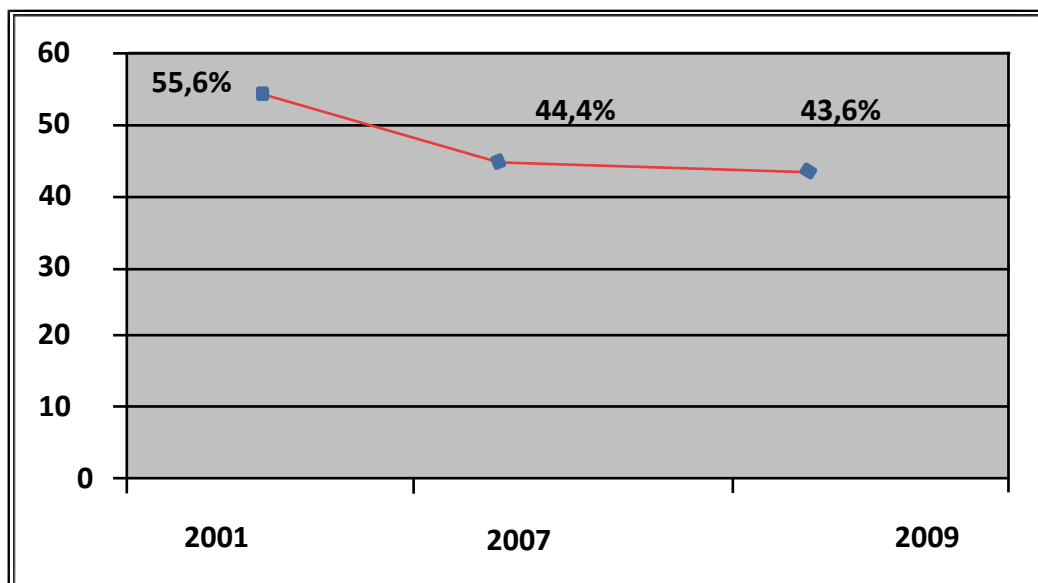






Photo credits, UN Women

Figure 4 : Trend in the Poverty Index between 2001 and 2009 in Mali



Sources : Data from the 4th GPHC– 2009

(HDI) of 0.371 according to the 2007 World Human Development Report.

In Mali, according to the 2012-2013 DHS-V, the Composite Fertility Index (CFI) is estimated at 6.14 children per woman and is higher in rural areas (notable for precocious fertility) than urban areas (on average, 6.5 children against 5.0).

The use of contraceptives by women aged 15-49 in a union is not very high. Contraceptive prevalence is 10%, although it has increased compared to the rate of 7% obtained in 2006 (2012-2013 DHS-V).

The proportion of women who visited a health professional during their recent pregnancy slightly increased in Mali between 2006 and 2013. It rose to 74% in 2013 against 70% in 2006 (DHS and DHS-IV-V).

The use of antenatal care varies by area of residence. Women living in urban areas (93%) consulted a health professional more frequently than those residing in rural areas (69%). Immunization coverage of pregnant women against tetanus is still low in Mali, as less than

half of women (47%) received tetanus injections required to prevent neonatal tetanus.

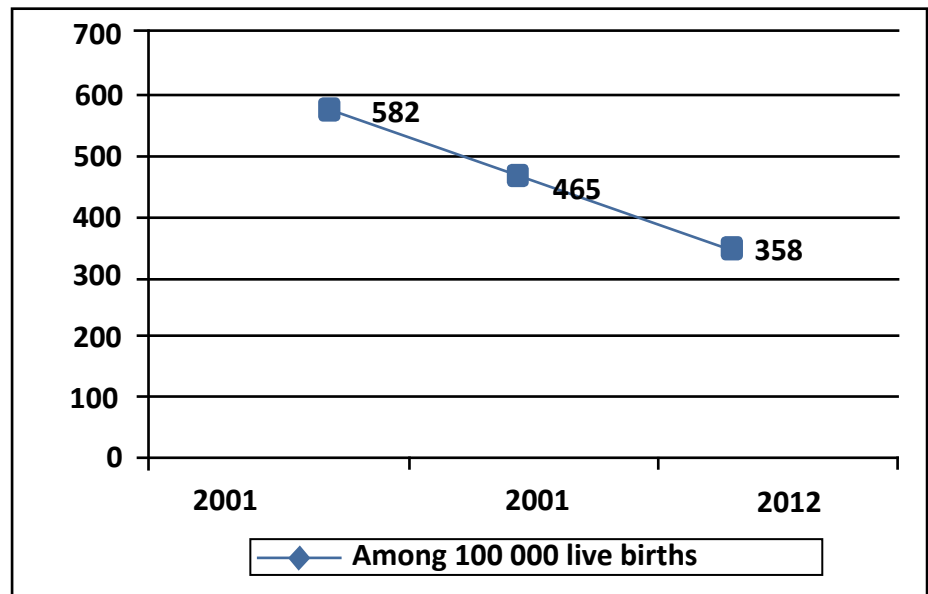
Just a little over one birth out of two (55%) took place in a health facility in Mali. Regarding attendance at birth, 59% of women benefited from the assistance of trained health workers during delivery (2012-2013 DHS-V).

According to DHS V, maternal deaths account for 32% of all deaths of women aged 15-49. The percentage of maternal deaths varies irregularly depending on age.

For every 1,000 live births in the past seven years (2007-2013), almost four women (3.7%) died during pregnancy, childbirth, or within two months after delivery.

The trend observed in the maternal mortality ratio has been declining since 2001 (Figure 5), falling from 582 deaths per 100,000 births in 2001 (MDHS III) to 465 deaths per 100,000 births in 2006 (DHS IV), and then down to 368 deaths per 100,000 births in the 2012-2013 MDHS V.

Figure 5 : Trend in maternal deaths in Mali



Sources : Data from Mali DHS - MICS

Scale: Prevalence of forms and types of violence against women

Violence against women is expressed in various forms, within the same cultural area and also differs from one cultural environment to another, according to the 2001 Demography and Health Survey III. The Study on violence against women (2002), reveals that all Malian women have experienced at least one of the forms of violence found in Mali.

Women of child bearing potential who have undergone female genital mutilation represent 77 to 98% of the female population. 41 to 92% of women have been either beaten by their biological parents or their husbands. Forty-one percent (41%) of women surveyed reported having experienced physical violence during their lives, and 34.9% of men declared that they used physical violence against a partner at some point in time. Forced marriage is widespread, reaching sometimes 80% of all unions in some parts of the country. Levirate and sororate marriage are still in force. In areas of high migration, women abandoned by their husbands wait for the latter for years, in solitude and psychological misery, according to the Study on violence against women (2002).

Another manifestation of violence against women in Mali raised by the Analytical Report the data collected on women and children (2007) is their exclusion from land management and inheritance in the community (head of family, district, village, etc.). In terms of inheritance, they do not have the same rights as men. Insults are common and are uttered all day long by women's "social elders" (spouse, elder brothers). Women also face discrimination in access to both appointed and elected senior positions. They are poorly represented within political parties' senior positions (between 17 and 35%), trade unions (30%), business/companies (14%) and in the media (12%). In 2002, women held 23% of all senior public service positions. In the police, they represent only 5% of all senior officers and 13% of judges. No region, no circle or any of the 19 urban districts is administered by a woman. At the same time, in 2002, women accounted for 14% of government members; 10% of members of the National Assembly and 0.72% of the rural mayors according to the Study on violence against women (2002).

Conflicts in Mali are opportunities seized by thugs (armed groups) to get away with committing sexual assaults on women and girls. Indeed, since January 2012, the country has witnessed



the emergence of a new rebellion, causing tensions within Malian society and leading to mass displacements of people to unoccupied areas.

Since the beginning of this conflict, many women and girls have been victims of rape, sexual, collective and individual violence. In the wake of the socio-political and security crisis that hit the country in 2012, the sub-sectoral working group on issues of violence, in coordination with UNFPA, recorded 2,383 cases of violence, including 211 cases of rape. In 2013, this working group identified “3330 cases of violence on women comprising 321 cases of sexual violence, 353 cases of physical violence, 1,410 cases of psychosocial abuse, 841 cases of denial of resources and 405 cases of violence related to some traditional practices (forced marriages, repudiation)”. In a statement, the coordinator of the GBV monitoring subgroup, Prof Lamine Boubacar Traoré reveals that «since January 172012, 5,724 cases of violence against women were identified”by his organization, among which 532 cases were incidents of sexual violence, 521 physical assaults, 827 cases of psychosocial abuse, 1,201 cases of resource denials and 1,233 cases of violence associated with

traditional practices (forced marriages, female circumcision); 85% of this violence was committed against women and 15% against girls.” An increase of 947 cases was noted in 2013 compared to 2012. He indicated, however, that “Responding to these violations, 1,172 of the cases received medical care, 1,153 cases were provided with psychosocial support, 600 households in Bamako and Mopti received a cash transfer (economic care) and 7 cases benefitted from legal support”. In Mali, there is generally strong public adherence to rigid gender norms and roles, with particular emphasis on the traditional role of men as heads of families and women as respectful of men’s roles and desires. Thus, 89.9% of men and 75% of women interviewed during the study strongly agree with the statement “a man should have the final word about decisions in his home.” Furthermore, 90% of men and 77% of women agreed with the statement: “a woman’s most important role is to take care of her house and family.”

Violence is generated by society and it is sometimes inherent to the culture of the perpetrators and victims. It also stems from society’s perception of the roles and status of

men and women and violence itself. Women's poverty, their economic vulnerability and economic dependence on men are aggravating factors of violence, which also hinder their access to health services.

Strategies to address violence against women

Since the late '80s and early '90s, the prevention of violence has become one of the major concerns in Mali for both the Government and other stakeholders, mainly NGOs. In this regard, a five-year action plan (1996-2000) was developed in 1996 by the Malian Government for the promotion of women's rights. It took into account violence against women and girls.

In 1998, as part of the African Regional Campaign to end violence against women, launched by UN Women, the Government of the Republic of Mali adopted a three-month National Action Plan. Under the auspices of the Ministry for the Promotion of Women, Children and the Family, it was drawn up by a committee composed of representatives of women's associations and NGOs and public services involved in the field. Despite its short duration and limited scope, this plan has had a real impact on communities.

Following this initiative, the Project MLI/04/03/01, "Support to the fight against harmful practices for women and children's health" was initiated by the Ministry for the Promotion of Women, Children and the Family, through the National Action Committee for the Abandonment of Harmful Practices for Women and Children' Health. Its implementation started in 2000, with the support of UNFPA, with the aim of conducting awareness campaigns for the abandonment of practices detrimental to the health of women and children, including female genital mutilation. Many civil society organizations, for their part, are carrying out training activities for young people on combating violence in order to raise awareness.

Government lobbying and public awareness raising campaigns are also carried out. Strategies based on paralegal staff responsible for informing people about these rights in rural areas have been developed, providing free legal defence in the courts of the rights of impoverished women victims of violence.

Constraints and challenges

Major obstacles to gender equality persist in Mali. These obstacles largely have to do with public perceptions of the population but also with the culture. Indeed, 86% of men and 62% of women believe that gender equality is an imported concept. The majority of men (63%) as well as 41.3% of women agree with the argument that "there are times when a woman deserves to be beaten", according to the study on Men, gender equality and gender relations in Mali: Findings of the IMAGE study (2012)".

The lack of understanding of the phenomenon, combined with the mistaken perception which consists of denying its existence, the indifference, not to say tolerance, of society of this scourge and the lack of official statistics limit the scope of actions to raise general awareness and the commitment of all against violence.

The rare cases known to the public come through the media, whence the need for a study to update the data and to cultivate a better understanding of the phenomenon throughout the country.

Recommendations

In general, violence against women persists in Mali despite government measures and actions undertaken by some NGOs and associations concerned with the phenomenon.

Given the limitations of the actions deployed and the persistence of the phenomenon, it is important that:

- i) more actors in all services and social groups get involved in the fight against violence, with an enlarged geographical coverage;
- ii) a new major comprehensive study is conducted in the country in order to identify all forms of violence and design appropriate strategies to make them accessible to all relevant actors;
- iii) training, advocacy and information programmes are scaled up so they gradually lead to a positive perception of women and a negative perception of violence.



NIGER

Contextual analysis

Niger has a population of 17,129,076 inhabitants, according to the 2012 census, and population growth is still very high (3.9%), with almost 85% of the population living in rural areas (GPHC, 2012).

The total composite fertility index (7.6) as well as maternal mortality (535 per 100,000 live

births) remain high. The dominant religion in this population is Islam (99%). There is deep poverty in the country, despite a real GDP growth rate of around 6.1% between 2008 and 2012 (2012 DHS-MICS).

Although there are more women than men in Niger (50.2%), they still suffer from large disparities compared to men in all areas of social life. The National Report on progress towards achieving the Millennium Development Goals drawn up in 2010 for this purpose regrets the slow pace of change in terms of gender equality

and recognizes that the persistent pattern of inequality makes meeting targets by 2015 out of the question (Desk Review Report on the state of gender-based violence for the development of the 2012 National Action Plan for Niger.)

According to the 2014-2016 National Diagnosis of Women's Leadership (Department for the Promotion of Female Leadership, 2014), this situation is due to several factors, with the main ones being: social and cultural constraints that keep women from Niger in their subservient position; low female literacy rate (9.3%); under-enrolment of girls in primary schools (28%), non-mainstreaming of women's roles, needs and responsibilities in the development of economic and social policies; women's under-representation in government entities, Parliament, executive bodies, as well as religious considerations that limit their freedom.

The Desk Review Report on the state of gender-based violence for the development of the 2012 National Action Plan describes the environment of Niger as being strongly linked to the weight of traditions, customs and religions that encourage conservation of violent practices against women (female genital mutilation, inheritance-related discrimination, forced and early marriage, etc.) and that such violence is sometimes exacerbated by the fear of perversion and depravity.

Thus, misinterpretation of religious precepts, along with scant knowledge of the texts, some what constrains women's freedom of action and reinforces gender disparity, which remains even more noticeable within communities and homes, where women are exclusively responsible for domestic housework, due to a long-standing socio-cultural heritage perpetuated from one generation to the next.

It imposes on women an excessive burden of work and subordination, which turns them into domestic labour available at all times and in all areas. Gender disparity is also perceptible in the legal and judicial environment. There are in fact some texts which contain provisions which are contrary to the principles of equality between men and women.

Nevertheless, according to the Desk Review Report on the state of gender-based violence for the development of the 2012 National

Action Plan, the Government and civil society organizations manifest a political will to enhance women's participation in decision-making at family, at community and national level.

Scale : Prevalence of forms and types of violence against women

The various forms of violence against women also exist in Niger with relatively high levels of prevalence (Figure 6).

Physical violence stemming from excessive anger or the deliberate intention of some people to attack others prevail almost at all levels in Niger (workplace, places of prostitution, within households, in prisons, on the streets).

According to the report Data collection mechanism for gender-based violence indicators in Niger (Niger NIS, 2011), physical abuse makes up 43.2% of the incidents of violence reported at the support and care centre for GBV victims in Niger.

Psychological violence, often difficult to detect, is the most frequent type of abuse in households, the workplace and in societal organizations. In Niger, it often takes the form of a series of tortures focused on the "psyche", often even harder to bear than physical assault. It accounts for 17.1% of the cases recorded in GBV management centres (Niger NIS, 2011). This form of violence is likely to trigger behavioural disorders or mental stress among women in Niger, which can lead to schizophrenia or even suicide. Economic violence is regarded as really driven by motives of exploitation.

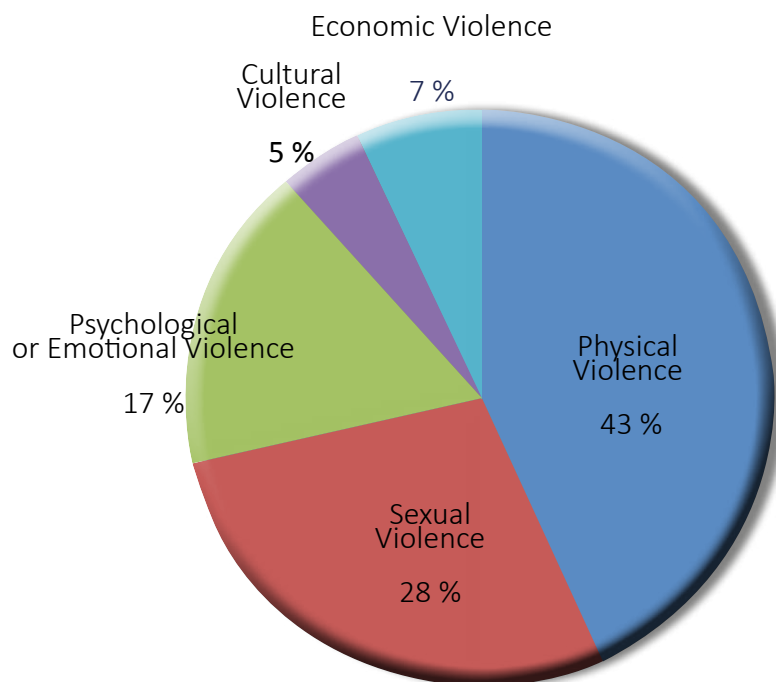
In Niger, it takes the form of exploitation of man by man and comprises a wide variety of subcategories: sexual exploitation, labour exploitation, women and children trafficking, forced prostitution and forced labour. Women and children's extreme economic vulnerability and discrimination related to inheritance are the main reinforcing factors of economic violence against women. Seven percent (7%) of women received in support centres are victims of economic violence (Niger NIS, 2011).

The Study on Violence and abuse perpetrated against women and children (Ministry for Social Development, Population, Advancement of Women and Protection of Children, 2005) reports that women in Niger are not properly represented and constantly suffer from representations and other socio-cultural practices which are perpetuated under the

heading of social conformism, cultural and/or religious beliefs.

These are : sexual mutilation, removal of the uvula, ritual scarification or scarring for initiation purposes, early and/or forced marriages, donation of women and children, slavery, confinement, widowhood rites, abduction, and forced feeding of girls.

Figure 6: Proportions of different forms of violence against victims received in care centres in Niger



Sources : Data collection mechanism on gender-based violence indicators in Niger (Niger NIS, 2011), Analytical Report, June 2011.



Photo credits: UN Women

According to the NIS (2011), like women in most African countries, women in Niger are subject to sexual violence (28%).

The report on Violence against women (CONGAFEN, 2013) reveals that abuse comes in the form of marital rape that affects married women aged under 25, with most cases occurring in early and forced marriages; sexual harassment and rape generally affect minors aged 10 to 14 and girls in high school and at university as well as unmarried girls. Incest is increasingly recurrent even if little documented.

The most common type of violence suffered by women during their pregnancies (Figure 6) is moral violence, mentioned by more than seven women out of ten (73.5%), followed by physical abuse cited by more than one in four women (28%) and sexual violence (13.20%), the third most frequent form of assault.

Violence against pregnant women

Women who had at least one pregnancy were asked whether or not they had been victims of some type of violence while they were pregnant. Just over one in ten (13.8%) reported having experienced some form of abuse (physical, moral, sexual, etc.) during their pregnancy. Pregnant women who were victims of some form of violence were asked about the type of violence experienced. It appears that of the different types of violence suffered by women during their pregnancies (Figure 6), moral violence is the most common reported by more than seven out of ten women (73.5%), followed by physical violence mentioned by more than one in four women (28%) and sexual violence (13.20%).

Figure N°6 : Proportion of pregnant women who have suffered a type of violence

Consequences of violence against pregnant women

Some of the consequences of violence against pregnant women include miscarriages, abortions, births of stillborn or children with deformities as well as harm caused to the health of the mother and child, etc.

During the survey, women were asked how violence affected them. Nearly seven out of ten women (66.7%) said that the violence that they suffered had no impact on the outcome of their pregnancies. The most frequently mentioned consequences are the damaging effects on mothers' health (20%). Miscarriages and abortions (7% each) are ranked second.

Figure N°7 : Type of consequences of violence against pregnant women

Sexual violence

Sexual violence is also a type of abuse encountered in the Maradi region. In fact, 7% of women reported having experienced forced sexual intercourse. Among women victims of forced sex, nearly nine out of ten women (89%) are married.

Failure to use family planning methods impacts on mother and child's health and repeated pregnancies at frequent intervals do nothing to promote mother and child health. This situation raises many questions as to what prevents women from using family planning. In the range of reasons mentioned, women's personal decision to simply refuse to use it predominates (48%), followed by their intimate partners' unwillingness to have them resort to birth control. Husbands' refusal to use family planning (15%) is a real obstacle to controlling population growth and curbing maternal, infant and child mortality.

Initiatives developed

The Republic of Niger has incorporated the prevention of violence against women in its policy agenda, through the mandates of the Ministry of Population, Promotion of Women and Children's Protection. Several women's associations, associations for the promotion of human rights and international NGOs as well as technical and financial partners support the country in these initiatives. At national level, four ministries are involved in combatting

violence against women and children through coordination of stakeholders' working to put an end to this violence. Noteworthy among the measures taken by the Government of Niger are the ratification of several international legal instruments, establishment of a national observatory for the promotion of women, the adoption of a National Gender Policy with the identification of gender focal points responsible for ensuring that gender is taken into account in sectoral ministries and the creation of the Department for the education of girls, responsible for promoting girls' schooling.

Civil society actors in Niger involved in the fight for gender equality and the rights of women and children have set up a specific framework for dialogue exclusively dedicated to eliminating violence against women. These associations carry out advocacy initiatives urging the Government to adopt laws against particular types of violence (female genital mutilation) or to raise greater awareness and seek alliances with a number of traditional and religious authorities.

Constraints and challenges

The environment surrounding the prevention of violence against women in Niger is marked by the following constraints and challenges :

- i) the burden of the culture, certain beliefs as well as customary and religious practices on the attitudes of the vast majority of the population;
- ii) the coexistence of modern and customary law, with sometimes conflicting provisions;
- iii) the patriarchal system that forges the idea that men have superior status and women are inferior;
- vi) the rise of some Islamic ideologies;
- v) the inadequacy of the resources of civil society organizations.

Recommendations

Considering these constraints, the State must reiterate its firm and abiding political will to combat violence against women by mainstreaming gender issues into development policies and ensuring their implementation, as well as improving legislation by aligning it with regional and international legal instruments.

The work of civil society organizations must be strengthened, as they must develop information, education and awareness activities on the ground; they must also support the fight against cultural violence, especially through a wide network of partnerships between social, political and religious actors.

It is vital that technical and financial partners continue advocacy actions to urge the State to take bold measures to tackle violence against women and provide appropriate technical and financial support.

Implementation of action plans should be continued, designed by multi-actor platforms on violence and maternal health composed of women, Ulemas, the media, civil society communicators/leaders, local authorities, traditional leaders, healthcare providers and paralegal staff who have a role to play in raising awareness and persuasion through preaching, roadshows, interactive programmes and radio advertisements.

Sensitizing policy makers, including national elected politicians, in particular, must be made to realise the importance of addressing violence and its impact on reproductive health.

Showing them how to adopt gender-sensitive budgets in order to improve maternal and child health is a top priority.

CAR

Contextual analysis

According to the 2003 DPHC forecast, the Central African Republic had a population of 4,685,070 inhabitants in 2012. Women account for 50.2% of the population and 48.6% of them are of childbearing age (15-49). As indicated by the report Central African Republic's Gender Profile (ADB, 2011), the average fertility is 5.1 children with both early and late reproduction. There are 139.7 live births per 1,000 women aged 15-19 years old in rural areas. In addition, women aged 40-49 years account for up to 11% of the overall fertility rate. This puts this section of the population at risk of maternal mortality and morbidity. Based on the 2010 MICS, 29% of girls aged 20-24 years were married before the age of 15 and 68% before they turned 18.

Results of the baseline study on the links between Gender based-violence and maternal mortality in the Central African Republic (2013), indicate that 75% of women had entered into a union before 18 and the median age of entry into union was 16 years. The same study showed that 73.5% of women surveyed do not use contraception and the fertility rate is high in the study area (75% of women surveyed have five living children with an average age equivalent to 26 years of age).

Table 3: Proportion of the different forms of violence in the CAR

Forms of violence against women %				
	Frustration in marriage	Emotional violence	Physical violence	Sexual violence
Proportions	74,8	81,2	17,5	11,5



This is a risk to maternal health and these risks become even higher in an environment marked by limited use of birth control methods. According to the report Central African Republic's Gender Profile (ADB, 2011), armed conflict in the CAR has affected women more than men.

Gender-based violence (GBV) has far more adverse impacts on their activities and on the living conditions of the households that they have to manage single-handedly. The same report highlights that Central African women are generally under-represented in decision-making bodies and consequently participate little in decision-making processes. This confines them a role of simply executing decisions taken, including

those which directly affect them. Furthermore, this does not allow them to speak their minds or express their opinions and choices. The Central African Republic ranks 10th worldwide among the countries most affected by the HIV/AIDS pandemic. The HIV/AIDS prevalence rate, 6.2% in 2006 for people aged 15 to 49, is the highest of the Economic and Monetary and Economic Community of Central Africa (CEMAC).

The prevalence of HIV/AIDS is almost two times higher among women (7.8%) than men (4.3%) within the same age group (ADB, 2011).

The same source notes that the higher vulnerability of Central African women

compared to man with respect to HIV/AIDS is linked to the fact that they have a low level of education and limited knowledge of the disease and ways of preventing it. In addition to that, women quite often do not have the possibility to negotiate (power to say “no” to the man) before engaging in risky sexual relation.

Scale : Prevalence of forms and types of violence against women

According to the 2006 MICS, 81.2% of women have experienced emotional violence, 74.8% suffered frustration in marriage, 17.5% were victims of physical violence, and 11.5% of sexual assault (Table 3). The findings of the national survey on gender-based violence conducted in February 2012 in the Central African Republics how that violence is present in every sphere of life, public, within families, at school, in the workplace and in marital relationships).

The prevalence of these types of violence in the public sphere indicates that verbal abuse is more widespread (55%) than physical assault (28.3%) and sexual violence (27%). In the family setting, the survey findings show that verbal abuse affects nearly 60% of respondents with 60.5% of women victims of this form of violence. In addition, three out of ten people surveyed (32%) experienced physical violence in the last twelve months preceding the survey. 6.1% of respondents reported having experienced sexual violence within the last 12 months. A study on the impact of sexual violence against women (2008) in the Central African Republic revealed that the victims had suffered rape in their homes in 56.3% of cases and committed by at least two men in 72.8% of cases. Rape was always perpetrated along with other types of violence including physical violence in 54.4% of cases. According to the same source, regarding marriage, 8.5% of respondents had gone through forced marriage, representing 10.2% of all women. The phenomenon usually occurs when the victim is still young.

Strategies to address violence against women

To address women's vulnerability to the violence to which they are subjected, the Central African Republic has developed a strategic

survival plan for both mother and child and has also adopted a roadmap for reducing maternal, newborn and child mortality. In addition, a number of commitments and legislative provisions have been adopted to secure women's legal protection against gender-based violence.

The Central African Republic, as a Member of the United Nations and regional organizations, has ratified almost all the regional and international instruments and has passed laws at national level. On the institutional front, the Ministry for Social Affairs, National Solidarity and Promotion of Gender is the institutional framework for designing policies and programmes to redress existing inequalities between men and women and eradicate gender-based violence. Strategic committees to combat violence against women have been set up and sectoral strategies against harmful practices and violence against women and girls have also been developed. Technical and financial partners and civil society organizations have been highly active on the ground in developing an array of projects for this purpose. Despite these numerous commitments and legislative provisions, gender-based violence remains a major problem in the CAR, especially bearing in mind the conflict situation prevailing in the country.

Constraints and challenges

These include :

- the political environment unfavourable to the protection of vulnerable groups(women and children);
- the shortage of qualified personnel (healthcare providers, social workers, police, justice...) to tackle gender-based violence;
- the lack of counselling and information centres for victims of gender-based violence;
- the scarcity of GBV care kits available in health care facilities;
- the non-enforcement of existing laws and regulations;
- social and cultural constraints.

Recommendations

Considering the scale and consequences of gender-based violence and its links with maternal mortality, the following recommendations are suggested: (i) develop a long-term strategic plan for the prevention of gender-based violence; (ii) revive maternal death audits in health centres; (iii) set up a committee against maternal deaths at national level; (iv) develop data collection tools (registers) of maternal deaths and gender-based violence and make them available in health facilities.

CHAD

Contextual analysis

Chad is a landlocked country of 1.284,000 square kilometres. In 2009, Chad had a total population of 11,039,873 of which 50.6% were women. This population is growing at a rate of 3.6% (GHPC, 2009). It is primarily rural (78.1%) and Muslim (58%). The country's maternal mortality rate is the highest in Africa, with 1,100 maternal deaths per 100,000 live births (according to the 2012 UN Report). Chad has a high illiteracy rate (78%) with wide gender disparities (69% for men against 86% for women) according to the 2009 GPHC findings. Adult illiteracy (15 years and older) in Chad increased from 67% in 2003 to 78% in 2009 (GPHC, 2009), a fall of 11 points. Indeed, the persistence of low primary completion rates coupled with strong growth of the school-age population (3.78%) resulted in a large number of children without a school education, estimated at 807,000 children for the 9 to 14 years old age group. Illiteracy is greater among women (86%) than men (69%) and rural women are even more affected with an illiteracy rate as high as 92%.

The 2010 MICS reveals a high level of early pregnancies (47%). Concerning family planning, there is a very low contraceptive prevalence (5%), with unmet needs amounting to 28%.

Regarding antenatal care coverage, the same source indicates that 53% of pregnant women have attended a consultation by qualified staff at least once, while 23% visited some kind of health care provider at least four times.

The rate of deliveries performed by trained personnel is 23%.

Scale : Prevalence of forms and types of violence against women

For the very first time in Chad, the Multiple Indicator Cluster Survey (MICS) conducted in 2010 allowed the collection of data on domestic violence. It shows that women suffer all kinds of violence from their spouse: psychological abuse, physical violence and sexual assault. Indeed, 18% of women aged 15-49 were beaten (physical abuse), 12% were victims of sexual violence, while all the women surveyed reported being psychologically affected by one of the forms of psychological abuse (100%).

The most common psychological threats stem from jealousy. Indeed, 55% of spouses are jealous when their wives talk to other men and 45% insist on knowing at all times where their spouse is. Physical violence is more prominent in the southern regions of Chad: Mandoul (30%), Moyen Chari (30%) and Mayo Kebbi (29%). Slapping or twisting a woman's arm is the most common physical violence.

According to the results of the same survey, 12% of women surveyed have been victims of sexual violence. A quarter of women were forced by their husbands/partners to have sex and 7% of women interviewed suffered sexual coercion. Sexual violence is as widespread in rural areas (12%) as in urban settings (11%). It is more prevalent in the regions of Moyen Chari and Mandoul (24%).

Various survey reports (2004 DHS; 2010 MICS, etc....) identified the causes of high maternal mortality, in particular, (i) inadequate monitoring during pregnancies (57% of pregnant women have not been monitored by a qualified person), (ii) poor content of care provided during prenatal consultations (only 18% of women had access to the three types of services offered as part of antenatal care), (iii) low contraceptive prevalence (less than 5% of married women or women living in cohabitation use birth control methods), (iv) women's poor health status (one in five women suffers chronic malnutrition with a body mass index below the critical threshold of 18.5), (v) inadequate care in case of complications



Photo credits, UN Women

(only 9.06% of deliveries take place in obstetric emergency care facilities which is lower than the minimum acceptable rate of 15%, and only 0.6% of deliveries are performed by caesarean, when the minimum acceptable is 5%), (vi) early marriage, precocious sexuality and fertility (34.9% of women are married by the age of 15 and 36% have already had their first sexual intercourse at 15-19, 30% are already mothers and 6% are pregnant for the first time) and (vii) prevalence of obstetric fistula with a rate which remains to be identified.

Strategies to address violence against women

There is a genuine national legislative and legalprotective framework against violence in general and gender-based violence in particular in Chad. Under the provisions of the 1996 Constitution of the Republic of Chad, amended

in 2005, the State “has a duty to ensure the elimination of all forms of discrimination against women and guarantee the protection of their rights in all areas of private and public life”. ActNo. 006 of 15 April 2002 on the promotion of reproductive health prohibits all forms of violence such as female genital mutilation (FGM), early marriage, domestic violence and sexual abuse of a human being.

The 1958 Civil Code punishes early marriage, forced or celebrated in violation of its provisions. The revision of the current Criminal Code prescribes penalties for female genital mutilation, blows to the breasts, sexual harassment, psychological abuse, rape, violence against pregnant women and children, early or forced marriage and eviction from the marital home.

The policies, strategies and programmes aimed at combating gender-based violence comprise

(i) a national gender policy (ii) a national strategy to end gender-based violence which are yet to be adopted. The institutional mechanisms set for combating gender-based violence consist of a national coordinating unit for the prevention of, protection against and response to gender-based violence and the Ministry of Social Action, National Solidarity and Family .

With respect to maternal and child health, the Government of Chad has developed and implemented several policies, strategies and programmes. These include: the National Strategy for Growth and Poverty Reduction (SNRP2), the National Health Policy, the National Strategy for Fighting against Obstetric Fistula, the National Road Map for Reducing Maternal, Newborn and Child Mortality, The Strategic Pathway to Securing Reproductive Health Commodities, the Campaign for the Reduction of Maternal Mortality in Africa (CARMMA), the “Hand in hand” Campaign - All United for Birth Spacing, the Chad-UNFPA Program for Cooperation and the Muskoka Programme supporting the funding of the national road map for reducing maternal, newborn and child mortality.

These policies, programmes and strategies are implemented through institutional mechanisms, the most important of which for maternal and child health is the Department of Reproductive Health and Immunization. Substantial services are offered through the Emergency Obstetric and Neonatal Care approach (EmONC), but in insufficient number to meet international standards.

Constraints and challenges

Few studies in Chad are carried out on violence against women and none of them examine the links between gender-based violence and maternal and child health. The data needed to understand the relationships between violence against women and their health are thus scarce.

From a legislative stand point, there are texts sanctioning perpetrators of violence against women. However, they are quite often ignored and unenforced.

The coexistence of modern law and the predominant customary law deeply rooted in

institutional practices creates an environment scarcely propitious to the implementation of laws and policies in favour of gender equality, particularly in the field of education, reproductive health and the enjoyment of human rights. In fact, Chad’s patriarchal society, assigns different roles to girls and boys at an early age (sexual division of labour, belittling perception of women...). These socio-cultural practices lead to inequality in access to knowledge as well as economic and political opportunities, to the disadvantage of women.

Recommendations

In order to work more effectively to end violence against women in Chad, special emphasis is needed in the first instance on research to have a better understanding of the phenomenon and to suggest suitable strategies. Next, the Chadian Government must be urged to adopt the National Gender Policy and the Strategy against Gender-Based Violence.

Lastly, there is good reason to promote information on legislation relating to gender-based violence to raise greater awareness of them.

TOGO

Contextual analysis

According to data from various censuses, Togo’s population growth remains relatively strong.

The Togolese population, 2,719,567 inhabitants in 1981, rose to 6,191,155 habitants with 51.4% of women in 2010.

The population of Togo has more than doubled over the past 30 years, with an annual growth rate of 2.84% according to the 2010 GHPC. This population is mainly concentrated in rural areas (62%).

In the field of primary school education, major advances have been made in Togo. According to the Multiple Indicator Cluster Survey (2010 MICS 4), the net primary school enrolment rate was 88.6% in 2010.

On the question of literacy, women are more disadvantaged than men.

The literacy rate among young women aged between 15 to 24 years old was 59.3% against 80% for men in the same age group according to the GPHC (2010).

In terms of family status, almost two thirds of women aged 15-49 (64.4%) are either married or in a union. Among women between the ages of 20 and 49 years old, nearly one out of three women (29.1%) was already married before the age of 18. Furthermore, 7% of women in the age

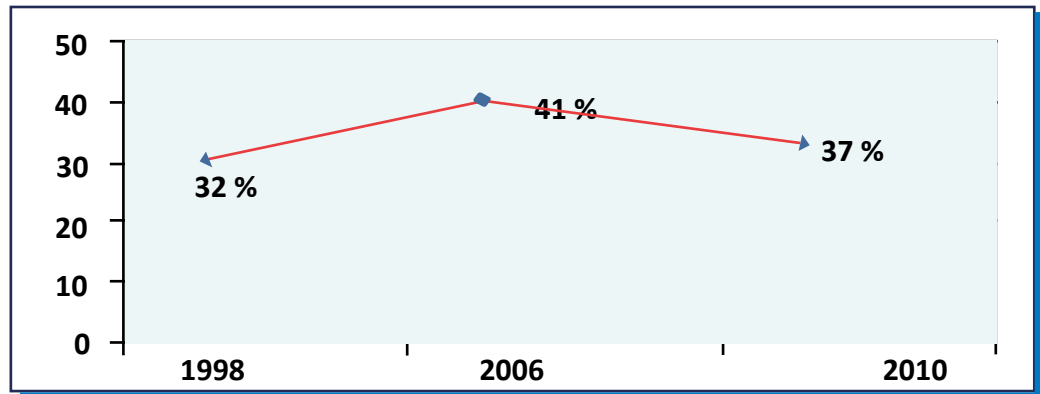
range 15 to 49 years entered into a union before they turned 15 (2010 GPHC 4,).

The baseline study on the links between gender-based violence and maternal mortality indicated that the vast majority of women surveyed were married. The findings suggest that 69% of women live in monogamous unions, whereas 22% are in polygamous unions according to the Baseline study of VAW and maternal mortality indicators in Togo (2013).

Photo credits, UN Women



Figure 8: Trend in unmet family planning needs between 1998 and 2010 in Togo



Sources : 2006 - 2010 MICS data



The same study reveals that 65.8% of women living with their partner entered into a union when they were between 18 and 29 years old. However, 14.7% of women were married before the age of 18, reflecting early entry into a union as highlighted by the Baseline study of VAW and maternal mortality indicators in Togo (2013). The results of MICS 4 (2010) show a fall in the rate for early marriage from 16% in 2006 to 11% in 2010. The total fertility rate (TFR), although declining to some extent, is still high in Togo. It declined by almost 20% between 1988 and 1998, and thereafter from 5.4 to 4.8, a decrease of 1.6% from 1998 to 2010 (2010 MICS).

The use of modern contraceptive methods in Togo is among the lowest in the world. Contraceptive prevalence (modern methods) among women of childbearing age increased from 3.1% in 1988 to 7% in 1998 and 11.1% in 2006 (MICS, 2006). It is more common among women with a secondary level of education (20.0%) than women with less education (17.3% in the group of women with a primary level of education, 11.3% in the group of women who have no education). Unmet family planning needs rose from 32% in 1998⁷ to 41% in 2006 and then fell back to 37% in 2010 (Figure 7).

Data from the study on the links between violence against women and maternal mortality (2013) showed that 75% of surveyed women living with their partners were not using contraception at the time of the survey. Though in relative decline, the level of maternal mortality remains high in Togo.

It dropped from 640 deaths per 100,000 births based on the Togolese Demographic and Health Survey (TDHS) conducted in 1988 to 478 deaths per 100,000 live births in 1998 (TDHS 1998), and then declined to 400 deaths per 100,000 live births in 2013 (DHS 2013). This level is still far from the MDG target threshold of 160 per 100,000 births by 2015.

Scale : Prevalence of forms and types of violence against women

According to the findings of the GBV study in Togo (2010), gender-based violence exists in all regions

of Togo and comes in various forms. The most common types of abuse are psychological violence (90.5%), physical assault (40.6%), economic violence (34.2%), sexual violence (32.8%) and institutionalized violence (19.5%). Gender-based violence occurs everywhere but most frequently takes place in matrimonial homes within couples or in households and much of the conflict within couples is related to economic difficulties and psychological factors.

However, the results of the study suggest that women victims of gender-based violence are reluctant to speak up and report those exerting violence on them. In addition, victims of violence receive little care and support.

The Baseline study of VAW and maternal mortality indicators in Togo (2013) carried out in the 17 health districts where UN Women operates showed that Togolese women are victims of a variety of forms of violence, chief among them being physical assault, psychological abuse and economic deprivation.

Concerning psychological violence, almost 14% of women reported having experienced “restriction of contact with friends,” and 13% were victims of their partner’s discontent while they were talking with another man. With regard to physical violence, the majority of the women surveyed had been slapped at least once (10%) or punched (10%).

Results from the same study showed that nearly 12% of respondents have suffered sexual violence at least once in the last 12 months. Furthermore, nearly 11% of the women surveyed stated that they had been victims of financial deprivation.

Women mention polygamy and food taboos as the most frequent cases of institutionalized violence. Between 4.8% and 5.6% of women admitted they had been victims of such violence. Verbal abuse remains the most widespread type of violence happening in hospital settings and health facilities.

Regarding perpetrators of violence against women, the study showed that while some types of violence fall within the community and social institutions or are committed by a third party, the bulk of the violence against women is committed by their own marital partners.

In the majority of cases (between 70% and 90%), intimate partners are the main perpetrators of physical violence against women.

Strategies to combat violence against women

Conscious of the scale of violence against women in the country, Togo has implemented several measures including the ratification of international texts. It has also launched several initiatives to improve the situation of women.

On the legal front, domestic laws have been adopted to combat different forms of violence. These include the Criminal Code, the Children's Code as well as the Act on female genital mutilation. Furthermore, efforts are in train to integrate specific provisions on emerging forms of violence in the Criminal Code and in the Criminal Procedures Code.

Several Togolese Civil Society Organizations are involved in the struggle to end violence against women through a variety of activities. These range from awareness raising, through capacity building, advocacy to the provision of support and care for victims of gender-based violence.

Grassroots communities have also initiated steps geared towards reducing violence against women. It is noteworthy that traditional authorities, religious and community leaders are important links in the chain in ending violence against women due to their roles within the different communities.

Constraints and challenges

Constraints include the persistence of certain socio-cultural factors unfavourable to maternal health, notably nutritional taboos and household and women's poverty; limited financial resources for long-term prevention mechanisms; insufficient enforcement of existing legislation and regulations due to a shortage of qualified personnel at all levels; the staff available do not receive regular capacity-building training. The result of these constraints is the lack of a risk reduction mechanism and failure to observe rules and procedures

Recommendations

The following recommendations are suggested to reduce the high level of violence against women in Togo: (i) strengthen awareness of violence against women in all regions especially in high-prevalence areas; (ii) enhance women's empowerment, especially in rural areas; (iii) further promote the use of family planning services; (iv) strengthen advocacy aimed at community leaders so that they take more into account issues related to violence against women.

Conclusion

Violence against women is regarded as a violation of human rights and, in certain contexts, as a crime against humanity. It is growing constantly worldwide and especially in the Sub-Saharan African countries and in Haiti. Given its adverse consequences for women's physical, mental and reproductive health, it constitutes a serious public health problem.

The various studies conducted conclude the existence of all forms of violence in the seven countries covered by the study and such violence affects a large proportion of girls and women, regardless of sociodemographic, economic and cultural factors. Armed conflict exacerbates the extent of violence perpetrated on women in some Sub Saharan African countries and in Haiti.

The factors underlying violence in the countries are inequalities between men and women, stemming from the different roles assigned to girls and boys right from their infancy, through gender division of labour, the demeaning status of women and pernicious sociocultural practices.

The studies conducted in the seven countries address in one way or another the relationship between gender-based violence and women's health and maternal mortality.

The intensity of the link between violence and maternal health depends on the forms of violence exerted on women specific to the context of each country.

General recommendations

Considering that the country profiles paint a sombre picture of the link between various forms of gender-based violence and the health of millions of women in Sub-Saharan Africa and in the Caribbean, high impact interventions are needed:

With the increasing number of conflict zones and the problematic cohabitation between modern law and customary law, UN Women must continue its efforts to persuade countries to include international provisions into their domestic laws, thus allowing national courts to bring to trial perpetrators of sexual violence in times of conflict and remove contradictions between them.

Bearing in mind the still limited scope of the multiple actions deployed against violence in the various countries, which remain limited and fragile, UN Women must intensify its advocacy and engage in discussions with technical and financial partners, in order to set up a substantial fund dedicated to the following

interventions: (i) strengthening the level of gender mainstreaming in development policies, programmes and projects; (ii) empowering the most vulnerable women especially in rural areas, so they can acquire skills and economic power; (iii) securing girls' enrolment in schools and female literacy in rural areas where unfavourable gender practices still prevail; (iv) raising awareness among community and religious leaders to take real ownership of the fight to end violence against women; (v) increasing access to care and support services for women victims of violence; (vi) protecting pregnant women.

Due to the low allocation of public funds by governments to combat violence against women, the persistent violence and maternal mortality rates and insufficient resources mobilized from partners, partnerships between governmental actors, civil society organizations, technical and financial partners must be strengthened in order to increase the level of public resources allocated to the prevention of violence against women.

This extra effort will reduce women's risks of exposure to violence and thus diminish the risk of maternal mortality during pregnancy and childbirth. The resurgence of conflicts on the continent and the use of rape

and violence against women and girls as a weapon of war require the putting in place of inter-country programmes involving women's leadership, to prevent violence against women and provide survivors with proper care and support. Data are scarce. Studies and research on sexual violence are not carried out at regular intervals and national surveys such as DHS and MICS fail to take into account key variables relating to the risk of maternal mortality and violence against women. This makes it difficult to make informed evidence-based decisions.

Consequently, UN Women must support countries in carrying out regular measurement of indicators related to violence against women through:

- Harmonization of a list of mortality risk variables related to violence against women;
- Establishment of a model framework (appropriate methodology) in order to facilitate studies on the issue;
- Advocacy, urging countries to take harmonized variables into account in national surveys.

The mechanism will be supplemented by the creation of a functioning inter-country framework for the monitoring and evaluation of the indicators.

Annex 1 Notes :

- **Data sources:**In the main, only indicators from the latest national survey reports (DHS, MICS and GBV) were used in the table below.
- **N/A (Not Available)** : represent indicators that were not included in surveys carried out at national level and UN Women’s advocacy must cover these indicators so that they are duly taken into account in national studies such as DHS and MICS.

Table 4 : of indicators and levels of risks for maternal mortality and violence against women for each of the selected countries

Indicators		GUINEA	HAITI	MALI	
Indicators of women’s socio-demographic and economic characteristics					
1	Proportion of women in the over all population	52%	50,5%	50,4%	
2	Proportion of women living in rural areas	75%	24,92%	39,18%	
3	Proportion of women heads of house hold	17%	41%	10,3%	
4	Proportion of women living in polygamous unions	48%	29%	42,9%	
5	Proportion of cohabiting women	NA	NA	NA	
6	Proportion of women living with one or several co-wives	NA	16%	NA	
7	Proportion of women having completed primary schooling	44,9%	83,1%	45,2%	
8	Proportion of literate women	39,4%	74%	22,4%	
9	Percentage of women who have not been to school	65%	15%	76%	
10	Proportion of women living below the national poverty threshold	49,3%	NA	25%	
11	Proportion of women with an employment	41,6%	81%	54,2%	
Maternal Mortality Risk Indicators					
12	Proportion of women having gone through pregnancy at an early age (20-24 years old)	40% (20 - 24 ans)	11%	NA	
13	Percentage of women who have had their first child before the age of 18	60%	16,5% (25 – 49 ans)	NA	
14	Percentage of women who have had a miscarriage. abortion or stillbirth	NA	NA	NA	
15	Percentage of women who have had an unwanted pregnancy in the last 5 years	2%	21%	2,7%	
16	National Composite Fertility Index	5,1	3,5	6,14	
17	Median age at first marriage	17 ans	21,8 ans	18,6 ans	
18	Median age at first childbirth	18,8 ans	22,3 ans (25 – 49 ans)	19,6 ans	
19	Contraceptive prevalence rate	5,6%	34,5%	10%	
20	Prenatal consultation rate (four or more visits)	56,6%	67,3%	34,9%	
21	Coverage of antiretroviral prophylaxis among HIV-positive pregnant women	NA	NA	NA	

- **N/Acc (Not Accessible)** : Relevant to the CAR where the 2010 MICS full report could not be accessed
- Some information was collected using the tools attached to the report but was not analysed in the reports, thus the unavailability of databases is the reason why the relevant indicators for that type of information could not be included.

COUNTRIES				
NIGER	CAR	CHAD	TOGO	
50,2%	50,2%	50,6%	51,4%	
NA	N/Acc	40%	31,97%	
NA	N/Acc N/A	20,7%	23,7%	
36%	N/Acc N/A	38,8%	33,8%	
NA	N/Acc N/A	0,3%	NA	
NA	N/Acc N/A	NA	NA	
NA	N/Acc N/A	33,9%	NA	
14%	52% (15 – 24 ans)	14%	55,8%	
NA	N/Acc N/A	78%	18%	
NA	N/Acc N/A	NA	NA	
79,8%	N/Acc N/A	NA	NA	
7,2%	N/Acc N/A	47,4%	17,3%	
48,8%	N/Acc N/A	47,4% (20 – 24 ans)	v	
NA	N/Acc N/A	NA	20%	
1%	N/Acc N/A	NA	NA	
7,6	6,2	6,9	4,8	
15,7 ans	N/Acc N/A	18,5 ans	NA	
18,5 ans (20 – 49 ans)	N/Acc N/A	NA	NA	
12%	9%	4,8%	17%	
33%	38%	23,1%	54,9%	
NA	N/Acc N/A	NA	60%	

22	Tetanus immunization coverage rate of pregnant women during their last pregnancy	76%	76%	47%
23	Prenatal consultation coverage rate (at least one visit)	69,6%	90%	34,7%
24	Percentage of women who have not received postpartum care	57%	61%	NA
25	Proportion of women having undergone C-section deliveries	2%	15,4%	3,8%
26	Proportion of women with unmet family planning needs	23,7%	35,3%	30,8%
27	Home delivery rates	50%	64%	43%
28	Percentage of women who gave birth without the assistance of a trained person over the last 5 years	55%	62,7%	41%
29	Percentage of women who have had sexually transmitted diseases over the last 12 months	31%	11,7%	26%
30	Maternal mortality ratio (per 100.000 live births)	724	630	368
31	Prevalence of obstetric fistula	0,6%	NA	0,6%
32	Prevalence of anaemia among pregnant women	65%	60%	60%
33	Malnutrition rates among pregnant women	NA	NA	ND
34	HIV/AIDS prevalence rate among women	2,2%	2,7%	1,3%
35	Neonatal mortality rate (children aged 0-1 month)	33‰	NA	34‰
36	Population living more than 5 km from a health facility	NA	NA	NA

VAW Indicators

37	Proportion of women who have experienced domestic physical violence in the last 12 months	75,6%	28%	21%
38	Proportion of women who have been slapped by an intimate partner in the last 12 months	45,9%	9%	15,6%
39	Proportion of women having been pushed, shaken or had something thrown at them by their partner in the past 12 months	ND	11,3%	6,1%
40	Proportion of women whose arm was twisted, or had their hair pulled, or were punched or hit with an object	ND	5,5%	5,1%
41	Proportion of women slapped	72,7%	NA	NA
42	Proportion of women kicked, dragged down on the floor, or beaten	ND	4,6%	3%
43	Proportion of women whose marital partners tried to strangle them or burn them in the last 12 months	NA	2,6%	0,7%
44	Proportion of women who have been threatened by their intimate partners or attacked with a knife, a gun or some other weapon over the past 12 months	8%	3,1%	0,6%
45	Proportion of women who have experienced sexual violence in the last 12 months	49,7%	11%	13,9%
46	Proportion of women who were victims of rape	23,4%	9,8%	10,1%

71%	65,5%	38%	77,1%
82,8%	68%	53,2%	72,7%
37%	N/Acc N/A	NA	NA
1%	5%	1,5%	8,8%
16%	N/Acc N/A	28,3%	37,2%
71%	45%	82,8%	33%
67%	46%	77,3%	40,7%
0,4%	N/Acc N/A	NA	NA
535	850	1100	400
0,2%	N/Acc N/A	1,4%	0,03%
58,6%	N/Acc N/A	NA	NA
NA	N/Acc N/A	NA	NA
0,4%	6,3%	NA	3,1%
NA	N/Acc N/A	39‰	27‰
NA	N/Acc N/A	NA	NA
NA	45%	18%	41%
NA	NA	15%	44%
NA	N/Acc N/A	9%	NA
NA	N/Acc N/A	6%	NA
NA	NA	NA	22%
NA	NA	6%	6%
NA	N/Acc N/A	2%	41%
NA	N/Acc N/A	1%	NA
NA	N/Acc N/A	12%	33%
NA	32%	10%	4% (9 – 18 ans)

47	Proportion of women who have been victims of harassment	16,1%	5,6%	3,8%
48	Percentage of women who are not able to ask their partners to wear a condom when they want them to do so	82%	91,3%	59,6%
49	Percentage of women who cannot refuse to have sexual intercourse with their husbands when they do not want to have sex	60%	NA	59%
50	Proportion of women who have suffered institutionalized violence in the last 12 months	NA	NA	NA
51	Proportion of women who have been victims of FGM	96,9%	NA	67%
52	Proportion of women who were victims of forced marriage	4%	NA	NA
53	Proportion of women who were victims of early marriage	60%	NA	60,8%
54	Proportion of women who have experienced food taboos	NA	NA	NA
55	Proportion of women who have suffered domestic psychological violence in the last 12 months	84,7%	22,1%	26,2%
56	Proportion of women who were victims of insults/domestic verbal abuse in the last 12 months	84,7%	18,9%	19,6%
57	Proportion of women who have suffered humiliation In front of others	NA	13,7%	14,2%
58	Proportion of women who were victims of restrictions on keeping in touch with friends	NA	25%	23,6%
59	Proportion of women who suffered economic violence in the last 12 months	NA	NA	NA
60	Proportion of women who were victims of the husband's refusal to let them work	NA	NA	NA
61	Proportion of women who experienced financial deprivation	18%	NA	NA
62	Percentage of women whose husbands mainly decide on how to use the money the women themselves earned through their own work	5%	NA	18%
63	Proportion of women who have experienced violence in a hospital environment in the last 12 months	NA	NA	NA
64	Proportion of women who were badly received in hospital facilities	NA	NA	NA
65	Proportion of women who have been rejected and denied care and support in hospitals	NA	NA	NA
66	Proportion of women who were victims of verbal abuse at the hospital	NA	NA	NA
67	Proportion of women who have been victims of neglect/indifference at the hospital	NA	NA	NA

ND	N/Acc N/A	7%	21%
29,7%	N/Acc N/A	NA	NA
ND	N/Acc N/A	NA	NA
ND	N/Acc N/A	NA	20%
2%	26%	44%	3,9%
ND	10%	NA	8%
30%	60%	69,1%	29,1% (20 – 49 ans)
ND	N/Acc N/A	NA	NA
ND	N/Acc N/A	100%	91%
ND	52%	NA	71%
ND	N/Acc N/A	7%	17%
ND	N/Acc N/A	27%	18%
ND	N/Acc N/A	NA	34%
NG	N/Acc N/A	28%	6%
NA	N/Acc N/A	NA	30%
7%	N/Acc N/A	NA	7%
NA	NA	NA	NA
NA	NA	NA	NA
NA	NA	NA	NA
NA	NA	NA	NA
NA	NA	NA	NA

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GLOSSARY

Early marriage : Marriage of an individual before the legal age of entry into union.

Maternal mortality : Death of a woman while pregnant or within 42 days after delivery, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Female genital mutilation : All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Family planning : Enables individuals and couples to anticipate on how many children they are willing to conceive and to space and plan births. This is possible thanks to the use of contraceptive methods and infertility treatment.

Maternal health : Encompasses all aspects of women's health from pregnancy, to childbirth, up until postpartum. Reproductive health embraces all reproduction mechanisms

and functioning of the reproductive system at all stages of life. It comes along with the possibility of having a responsible, satisfying and safe sexuality, and the freedom for people to decide if and when they want to have children.

Violence : Intentional use of physical force, threats against others or oneself, against a group or community that either results in or has a high likelihood of resulting in injury, psychological harm and growth disorders or death.

Gender-based violence : is a harmful act or series of harmful acts against an individual without his/her consent and based on socially ascribed differences that adversely affect physical and moral integrity.

Violence against women : All incidents of violence directed against women as such and causing or likely to cause women physical, sexual or psychological harm, including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or private spheres.

Report title	Author, Period and Year of Formulation	
<p>Baseline Study <i>Violence against women and maternal health in Guinea.</i> Evidence based on 2005 DHS data</p>	<p>Ministry of Public Health and Hygiene</p> <p>Consultant: Mohamed Lamine Keita, August 2012</p>	
<p><i>Discriminatory cultural practices, gender-based violence and maternal health in Haiti</i></p>	<p>UN Women Haiti, 2012</p>	
<p><i>Baseline study on the links between gender-based violence and maternal mortality in the CAR</i></p>	<p>Ministry of Public Health, Population and Fight against HIV/AIDS, 2013</p>	

Methodology Used	Limitations
<ul style="list-style-type: none"> - Use of 2005 DHS data - An essentially quantitative approach - Development of a conceptual framework from the literature review on the determinants of maternal mortality and on gender based violence concept - Selection of 33 variables including 12 on maternal health and 21 violence variables related to discriminatory practices against women - Identification of 4,050 married women aged 15-49 years old and having had at least one child during the 2000-2005 selected period, among the 8,000 women from the national DHS sample. 	
<ul style="list-style-type: none"> - Desk review (EMMUS- IV, 2005; ECVH, 2003; EBCM, IHSI, 2000; 2001). - An essentially qualitative approach to identify current maternal health indicators - Review of baseline studies conducted before implementation of projects in the field of maternal mortality - Data collection with different key actors on the field, to assess potential impacts of executed projects - Qualitative analysis and data triangulation 	<ul style="list-style-type: none"> - Links between violence and maternal mortality still hypothetical - No empirical analysis to demonstrate linkages between violence and maternal mortality
<ul style="list-style-type: none"> - Field Survey (qualitative and quantitative) and review of available data (national documents, registers and logs for admissions, consultations, childbirth mortality and deaths) - Descriptive and analytical cross-sectional study - Women aged between 15 to 49 years old (women pregnant in the past 12 months, women with children over one year old, women with no living children, women witnesses of gender based violence); 	<ul style="list-style-type: none"> - Study more focused on the description and classification of the different forms and types of violence and on the - Links between violence and maternal mortality are largely poorly established

Titre du rapport	Auteur, Période et Année d'élaboration	
<p><i>men, gender equality and gender relations in Mali: Results of the International Survey on men, and gender equality - Mali</i></p>	<p>CARE Mali, in collaboration with UN Women and INSTAT (National Institute of Statistics) Consultants: Henny Slegh, Gary Barker, Maimouna Toliver, Aliou Bah, 2012</p>	
<p><i>Violence against women and maternal mortality: Case Study of the Maradi region in Niger</i></p>	<p>INiger National Institute of Statistics, 2013</p>	
<p><i>Gender-based violence and maternal & child health in Chad</i></p>	<p>Chadian Association for Population Surveys, October 2012</p>	
<p><i>Baseline Study of VAW and maternal mortality indicators in Togo</i></p>	<p>Cabinet d'Expertise en Recherche-Action (CERA), November 2012</p>	

Méthodologie utilisée	Limites
<ul style="list-style-type: none"> - Primary Data Collection (qualitative and quantitative) carried out in Bamako urban areas and in Mopti and Segou rural areas - International Men and Gender Equality Survey (IMAGE) - Questionnaires were administered to a sample of 1,000 men and 500 women - Data source: in urban areas and/or rural areas in the three regions of Bamako, Mopti and Segou - Data analysis : - The survey was conducted during the conflict period in northern and eastern Mali - Using a stratified sampling of two age groups: (i) 18-35 years old, (ii) 36-59 years old 	
<ul style="list-style-type: none"> - Primary Data Collection (qualitative and quantitative) as a case study in Maradi - Literature review (DHS and MICS) - Quantitative and qualitative analyses - Approach to the link between violence and maternal mortality through the consequences of violence against pregnant women - Coverage area: Maradi Region along with its six departments (Aguié, Dakoro, Guidan Roudji, Mayahi, Tessaoua and Madarounfa) - Women aged 12-49 years old 	
<p>Use of existing data Logistic regression method on data from the 2010 MICS (descriptive and explanatory analysis)</p>	<p>The link between VAW and maternal mortality has not been established.</p> <p>The model drawn from variables used and available in the database has demonstrated to a certain extent the link between violence against women and maternal health, as the 2010 MICS database used for regression analyses does not provide all variables necessary for a logistic regression analysis of the theoretical framework.</p> <p>Conceptual Framework barely operationalized in the explanatory analysis</p>
<p>Literature review coupled with the collection of primary data (quantitative and qualitative) Coverage area: 17 health districts in Togo on a total of 35 nationwide (UN Women intervention areas) Women aged 15-49 years old (520 pregnant women, 625 women who gave birth in the last twelve months, 63 women with children over one year old or with no children were surveyed) 25 community leaders (traditional and religious leaders, the Village Development Committee), 53 healthcare facility managers were individually interviewed.</p>	<p>The study used primary data instead to demonstrate the link between VAW and maternal health without demonstrating the link between VAW and mortality. No explanatory analysis confirming an empirical link between violence against women and maternal mortality was performed.</p>

PRESENTATION

In July 2010, the United Nations General Assembly created **UN Women**, the United Nations entity dedicated to achieving gender equality and empowerment of women.

UN Women's core mission is to:

Support inter-governmental bodies such as the Commission on the Status of Women in designing policies, regulations and global standards;

Assist Member States in implementing these norms and stand ready to provide appropriate technical and financial support to countries requesting it and to build effective partnerships with civil society organizations; and

Hold the United Nations accountable for its own commitments to promote gender equality.

UN Women works for :

- Women's leadership and participation in political processes
- Women's economic empowerment
- Ending violence against women and girls
- Peace and security
- Sound governance
- Gender sensitive national planning and
- Enactment and enforcement of laws and regulations for greater gender equality.

ACKNOWLEDGMENTS

Instigated at UN Women's initiative, report, "Links between violence against women and maternal health: Seven country case studies in Sub-Saharan Africa and Haiti" was prepared within the framework of implementing the Muskoka Initiative.

UN Women would like to express its appreciation to all its partners thanks to whom this mission has been effectively executed, in particular the Ministry of Foreign Affairs and International Development, the Technical and Scientific Committees of the Multilateral Mechanism for Implementing the Muskoka French Fund for their precious guidance and all the other UN partner organizations involved, WHO, UNFPA and UNICEF.

Special thanks go to the Cabinet d'Expertise en Recherche-Action (CERA) from Togo for producing this consolidated report.

Extended thanks to all consultants who conducted the country studies and to the focal points including : LOUIS Eunide in Haiti; Mohamed Lamine KEITA and Dr Aly Camara in Guinea Conakry; INSEA in Niger; Henny SLEGH, Gary Barke, Maimouna Toliver, Aliou BAH; Dr Patrice FEILEMA MOHERESSE in CAR; Cabinet ATEP and Rachel MBAINDA of UNFPA in Chad; and Paul Koffi TEKOU in Togo.


Last but not least, UN Women is grateful to the ministries and government bodies responsible for gender and GBV related issues as well as the institutions responsible for statistics in the different countries covered by the study for their availability and support.


UN Women

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