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Gender-based violence interventions for young people in East and Southern Africa

Implementation Brief

2gether 4SRHR

SYP Safeguard Young People PROGRAMME

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This brief covers one of five themes examining sexual and reproductive health (SRH) and human immunodeficiency virus (HIV) programme evidence and implementation experiences for adolescents and youth in East and Southern Africa (ESA). This series serves as a resource for programmers aiming to implement strategies and understand potential barriers to scaling-up effective programmes for adolescents and youth.

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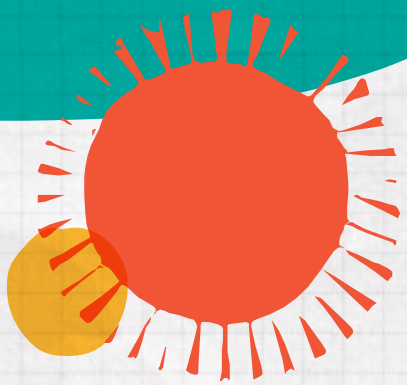

Acronyms

AGYW	Adolescent girls and young women
AIDS	Acquired immune deficiency syndrome
CBT	Cognitive behavioural therapy
CSE	Comprehensive sexuality education
ESA	East and Southern Africa
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

Background

Adolescence represents a period of transition, development and vulnerability due to substantial biological, social and psychological changes that occur during this time [1–3]. In sub-Saharan Africa, the adolescent and youth population (Box 1) is rapidly growing and expected to increase from 225 to 350 million between 2021 and 2040 [4]. Young people in ESA experience significant sexual and reproductive health challenges, including high rates of unintended pregnancy, HIV and sexually transmitted infections, unmet demand for contraception [5] and increased risk of gender-based violence (GBV). GBV exacerbates these challenges, and GBV survivors are at increased risk of poor health, SRH and mental health outcomes such as depression, anxiety and substance use [6–8].

Box 1: Adolescents and youth

Young people represent a diverse population with unique health needs. In ESA, young people experience complex individual, sociocultural, health system and legal barriers to accessing quality, comprehensive and integrated HIV and SRH services. Definitions of adolescent, youth and young people vary by country and region. In this brief, unless otherwise stated, adolescents are defined as individuals aged 10 to 19 years, youth as those 15 to 24 years and young people as individuals 10 to 24 years [2].

Gender-based violence is a global public health and human rights challenge – nearly one in three women worldwide will experience sexual or physical violence in their lifetime [9]. GBV involves any harmful act perpetrated against a person's will that is based on socially ascribed gender differences between females and males. It includes acts that cause physical, sexual or mental harm (and threats of these acts), coercion and deprivation of liberty in public or private life [10]. Gender-based violence

can take multiple forms, including violence against women and girls (VAWG)[1], intimate partner violence (IPV)[2] or non-partner sexual violence[3, 4]. Violence against children (VAC)[5] and GBV intersect at multiple points, share common risk factors, and both generate lifelong and intergenerational impacts on the health and well-being of children, youth, families and communities [11]. Social norms that support both violence against children and GBV and discourage care-seeking often coincide in households, and intersect during adolescence, entrenched by gender norms, creating a unique period of vulnerability.

Technology-facilitated gender-based violence[6] is a growing concern amid rapid digitalization and increased access to web-based services; more than 58 per cent of adolescent girls and young women (AGYW) across 31 countries globally have experienced online harassment [12].

Prevention, risk mitigation and response to GBV are essential to achieving multiple global development objectives, including the Convention on the Elimination of All Forms of Discrimination against Women [13] and the Sustainable Development Goals [14]. Regional frameworks, such as the African Youth Charter, also outline States' obligations and legal standards related to addressing GBV among adolescents and youth, as well as the 2025 adopted African Union Convention of ending violence against women and girls. Multiple continental commitments to eliminating gender-based violence for AGYW include the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (known as the "Maputo Protocol"), Solemn Declaration on Gender Equality in Africa, African Union Strategy for Gender Equality and Women's Empowerment,

1 Violence against women is defined as any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, in public or private life (World Health Organization, 2016). It also encompasses (but is not limited to) physical, sexual and psychological violence within families (e.g. sexual abuse of female children, marital rape, female genital mutilation and other harmful traditional practices to girls and women), non-spousal violence, violence related to exploitation, physical/sexual/psychological violence in the community (including rape, sexual abuse, sexual harassment and intimidation at work, in education settings and elsewhere) and trafficking girls and women in forced prostitution [10].

2 Intimate partner violence is self-reported experiences of one or more acts of physical and/or sexual violence by a current or former partner since age 15 years [9].

3 Non-intimate partner violence describes the forced performance of any unwanted sexual act by an individual other than partner/spouse [9].

4 Female genital mutilation is also a from of gender-based violence. However female genital mutilation is excluded from this brief, due to the unique challenges, specific drivers and distinct response strategies required to address female genital mutilation effectively.

5 Violence against children includes all forms of violence against people under 18 years of age, whether perpetrated by parents/caregivers, peers, romantic partners or strangers [10].

6 Working definition of technology-facilitated GBV: an act of violence perpetrated by one or more individuals that is committed, assisted, aggravated and amplified in part or fully by the use of information and communication technologies or digital media, against a person on the basis of their gender [12].

African Charter on the Rights and Welfare of the Child and African Union Agenda 2063 [15,16].

Experiences of GBV and harmful practices often begin early in life; nearly one in four girls (15 to 19 years) have already experienced physical and/or sexual violence from an intimate partner at least once in their lifetime [17,18].

Globally, an estimated 28 per cent of adolescent girls (15 to 19 years) and 29 per cent of young women (20 to 24 years) reported experiencing lifetime physical or sexual IPV. ESA has among the highest prevalence of lifetime physical or sexual IPV, at 31 per cent and 35 per cent, respectively [15]. Among sexually active AGYW in the region, rates of forced sexual debut are high (21.2 per cent and 14.6 per cent, respectively) [17].

GBV is indicative of systemic gender inequality and power imbalance, deeply rooted in patriarchy which perpetuates a lack of empowerment and decision-making ability among AGYW, including inadequate reproductive and bodily autonomy [19]. AGYW in ESA are at particularly high risk of GBV due to the intersection of determinants at various levels: i) **individual** (e.g. gender, age, sexual orientation, religious interpretations, gender identity, lack of education, orphanhood, alcohol and drug use, social isolation, history of childhood abuse, exposure to violence during childhood and mental or physical disabilities); ii) **relational** (e.g. stigma, shame, silence, marital conflict, male control over women/finances and harmful use of alcohol among partners); iii) **community** (e.g. social norms of GBV tolerance and discrimination against victims seeking care, high rates of violence/crime in communities, poverty, unemployment and availability of drugs, alcohol or weapons); and iv) **societal** (e.g. gender inequality, discriminatory laws related to land ownership, marriage or custody of children). Multiple risk factors are linked to the perpetration of violence (e.g. hypermasculinity, prior victimization/perpetration, violence/unsupportive family environments, low socioeconomic status and patriarchal social norms, values and laws) [10,20].

AGYW living in humanitarian contexts experience a disproportionate burden of gender-based violence due to their age and gender, increased risk factors (e.g. mental health challenges, loss of loved ones, changes in family structures/functioning, mistrust of institutions, insecure living conditions, displacement, armed conflict) and weakened protective systems (e.g. reduced social supports, eroded health/education/legal structures). Although emergencies tend to heighten related gender-based violence risks among AGYW,

most cases of gender-based violence occur within families or communities due to violence and inequities that pre-date emergencies [6]. Adolescents and youth (particularly AGYW) with disabilities, migrants and those who belong to the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other gender and sexual identities community are also at higher risk of experiencing GBV, yet they remain poorly represented in GBV policies and programming. Limited data is available to measure the intersecting and overlapping discrimination experienced within these heterogeneous groups [21–23].

Gender-based violence among young people

Prevention, risk mitigation and response

GBV significantly impacts the sexual, physical and psychological health and well-being of adolescents and youth and interventions that target boys and girls, men and women for prevention, risk mitigation and response and support services are essential.

1. GBV prevention can occur at three levels:

a. **Primary prevention** involves actions or interventions across communities or society to prevent GBV from occurring in the first place. These strategies address underlying drivers of violence (e.g. government policy promoting gender equality, educational programmes in schools, empowerment programmes or mass media awareness campaigns).

b. **Secondary prevention** aims to prevent violence from continuing or escalating by targeting individuals or groups at risk of being exposed or individuals perpetrating violence (e.g. behaviour change or screening programmes, interventions that address risk factors, such as alcohol use).

c. **Tertiary prevention** aims to minimize the impact of violence, restore health and safety, hold perpetrators accountable and prevent the reoccurrence of violence (e.g. criminal justice and child protection responses, or mental health treatment and support) [24,25].

2. GBV risk mitigation – interventions that reduce the risk of exposure to GBV.
For example, risk mitigation may be employed to ensure that humanitarian response and services do not cause harm or increase the risk of violence.

3. GBV response and support services – interventions to address the consequences of GBV and provide support for survivors [26,27].

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Key barriers to accessing gender-based violence services and support

Substantial individual, sociocultural and structural factors prevent AGYW and GBV survivors from seeking help, reporting incidents of violence, and/or accessing appropriate services. Lack of knowledge and awareness related to their health, human rights and available services (including SRH), perceived stigma, blame or discrimination, fear of retaliation and financial constraints prevent young people, especially AGYW from seeking care [27,28]. In addition, AGYW with disabilities [29] and refugees [30] encounter unique obstacles, highlighting the need to tailor GBV interventions to specific contexts and priority groups.

Although East Africa has among the world's highest prevalence of lifetime physical or sexual intimate partner violence, services for GBV survivors in the region remain poorly resourced or inaccessible [31]. System-level barriers to accessing GBV services and support include the following: distance to facilities and inadequate GBV support in rural regions, complex referral processes placing individuals at risk of re-victimization and/or re-traumatization [32], lack of confidential community-level reporting mechanisms, lack of trained service providers and psychosocial support, impunity for perpetrators due to weak or corrupt judicial systems and inadequate GBV policies [31]. Gaps in institutional capacity (e.g. limited financial and human resources) to facilitate the provision of quality services also contribute to deficiencies in GBV service provision. Additionally, attitudes of service providers and community members may further deter help-seeking and access to GBV care [31,33].

GBV prevention and response is severely underfunded —particularly in humanitarian settings —less than 0.1 per cent of humanitarian response funding from 2016 to 2018 was allocated to GBV prevention and response efforts, and more than two-thirds of requests for

support by community-based organizations were unfunded, highlighting significant challenges to implementation and sustainability of GBV interventions [34]. GBV services remain limited for persons with disabilities due to barriers related to mobility service aids, lack of universal design and reasonable accommodation and entrenched stigma [22,23,29]. At the same time, the criminalization of migrants without legal status, sex workers [35] and lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other gender and sexual identities make it difficult to provide quality services to those particularly vulnerable to experiencing GBV [27].

Despite national, regional and international policy and legal frameworks, progress to address GBV among young people (and adults) in many countries in the ESA region is slow. Policy-level barriers include the disconnect between traditional or customary laws/practices and statutory legislation, and inadequate recognition of diverse forms of GBV (beyond domestic violence) in existing policies. This leaves many types of violence ignored and unaddressed. A lack of national GBV policies and piecemeal implementation of those that do exist illustrates a gap between international commitments and national-level capacity to implement GBV strategies [36].

Interventions addressing gender-based violence for young people in East and Southern Africa[7]

Interventions that address GBV among adolescents and young people are essential to supporting their educational attainment, employment, financial and economic independence, and the realization of their health, well-being and human rights [17,41]. Evidence-based strategies to prevent, mitigate and respond to GBV among adolescents and young people in ESA, include: a) educational approaches, including comprehensive sexuality education[8] (CSE), skill-building and empowerment; b) partner, parent and family-focused strategies; c) response and support services; d) safer schools and environments; e) addressing norms and

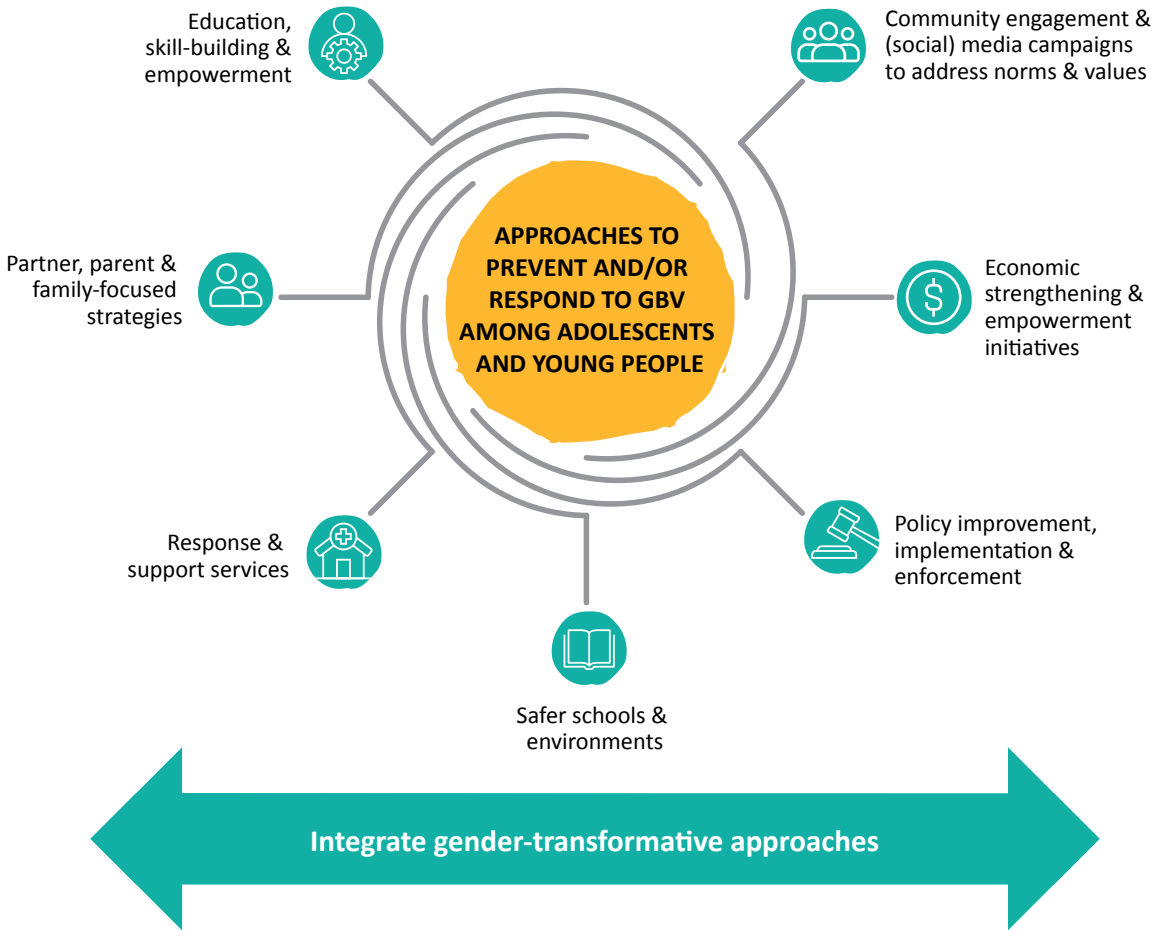
7 A summary of GBV strategies was developed based on a critical review of peer reviewed and grey literature between 2012 and 2022.

8 Comprehensive sexuality education (CSE) involves "developmentally and culturally relevant, science-based, medically accurate information on a wide range of topics, including human development, gender identity, sexual behaviours, communication skills, empathy and mutual respect" [79]. CSE is critical to healthy relationship development and improving gender equitable relations between boys and girls. Global standards and technical guidance on the implementation of CSE were published in 2018 [80].

values through community engagement and (social) media campaigns; f) economic strengthening and empowerment initiatives; and g) policy improvement, implementation and enforcement (Figure 1). Gender-transformative principles and strategies are cross-cutting and inform diverse prevention, risk mitigation and response approaches [8,20,28,42,43] (as illustrated in Box 2).

Figure 1

Available GBV prevention, risk mitigation and response approaches for adolescents and young people in ESA (adapted based on [8,20,28,42,43])



Box 2: Gender-transformative approaches: Promoting positive masculinities and changing norms

The extent to which gender norms, roles and relations are recognized and addressed in programmes can be assessed along a continuum —ranging from gender exploitative, gender-blind, gender-sensitive, gender-responsive or gender-transformative [44]. Gender-transformative approaches aim to support gender equality by overcoming root causes of gender inequality, including discriminatory legislation, policies, institutions, harmful masculinities[9] and inadequate support for women's agency and human rights. This involves more equal distribution of power, resources and opportunities between men and women. The importance of adopting a gender-transformative approach in all interventions is increasingly recognized, especially for programmes focused on SRH and GBV. Gender-transformative principles advocate for implementers to centre girls and young women in interventions, engage both women and men, engage men as allies through a positive approach, acknowledge diversity and intersectionality and integrate across the lifespan [44].

Interventions that embed gender-transformative practices challenge gender and social norms to reduce physical GBV and/or sexual violence perpetration and victimization [42,43]. Engaging men and boys helps to prevent violence, build healthy relationships, transform parenting practices and promote positive masculinity and gender equality in families, communities and beyond [45,46]. For example, the *SASA!* initiative – a community mobilization intervention in Uganda – challenged community attitudes, norms and behaviours using activism, media and advocacy to address gender inequality, violence and risk of HIV among women [44]. Multisectoral collaboration and engagement of diverse stakeholders (including youth) are essential elements of gender-transformative approaches [47].

9 Masculinities are attributes or attitudes considered to be characteristic of men. Toxic/negative gender norms are often held by both women and men, thus fostering positive masculinities (among both men and boys, and women and girls) that promote more inclusive, empathetic, caring and equitable forms of manhood [43].

GBV interventions may be implemented across multiple levels (individual, interpersonal, community or structural) by a diverse range of implementers (e.g. trained researchers, health-care providers, lay counsellors or facilitators) [42]. A recent review of interventions to reduce GBV among girls and women in sub-Saharan Africa found that programmes that used participatory group learning, engaged male partners and other community members, and those that were integrated into existing school programmes or health service platforms were most effective [28]. Increasing knowledge, skills and awareness using psychotherapy and integrating gender-transformative activities to engage men and communities are essential elements of successful interventions to address GBV [42]. Some evidence also suggests that embedding GBV prevention and response within existing health services may improve accessibility for adolescents and youth (Box 3). Table 1 summarizes GBV intervention delivery strategies, methods, outcomes and implementation considerations to reach adolescents and youth in ESA. Box 4 showcases how during the COVID-19 pandemic the cases of GBV increased while the service provision was negatively affected, highlighting the lessons learned for future shocks and pandemics.

Box 3: Integration and linkages of gender-based violence services to care

A "coordinated, comprehensive and well-integrated response" is crucial to adequately address the complex needs of individuals, including adolescents and youth, experiencing GBV [59]. Integrating GBV services in health facilities may improve their accessibility and utilization, and support time-sensitive referrals and linkages for access to emergency contraception and post-exposure prophylaxis (PEP) [60]. Despite these advantages, routine screening for GBV in health-care settings is limited and may not be recommended due to a lack of evidence on outcomes, as well as concerns of possible harms caused by gaps in provider training or capacity [61]. A systematic review (based on primarily high-income country settings) found limited impact of integrating screening on key outcomes (e.g. referral, re-exposure to violence, health measures or harm from screening) [62]. However, the availability of clear guidelines, policies and protocols, management support, intersectoral coordination (with accessible on- and off-site referrals), training and expertise of health providers, and a supportive environment were acknowledged as key facilitators for integrating GBV services in health facilities in low- and middle-income countries [59].

GBV prevention and response services have been integrated mainly in primary health and antenatal care settings [59], however, recent evidence highlights opportunities for integration in HIV and SRH service delivery. For instance, integration of GBV services and referrals to HIV counselling and testing for AGYW in the United Republic of Tanzania and South Africa was considered acceptable and feasible, as long as confidentiality, staff empathy and absence of judgment were upheld. However, uptake of referral to GBV support services by GBV survivors was limited (10 per cent) [61]. GBV prevention and response efforts have also been integrated into the Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe (DREAMS) HIV prevention programme implemented by PEPFAR targeting adolescent girls (10 to 14 years) in 15 countries in sub-Saharan Africa [63]. Components of the DREAMS package, such as "IMAGE"—an intervention that combines microfinance opportunities with training on HIV prevention, gender norms and gender-based violence, led to decreased IPV among participants [64]. Providing a comprehensive package of GBV services is essential to delivering differentiated[10] care and reaching the most vulnerable young people.

10 Differentiated service delivery models adopt a person-centred approach that simplifies and adapts services to better meet individuals' needs and optimize health system resources [82].

Table 1:

Summary of GBV intervention delivery strategies, methods, outcomes and implementation considerations to reach adolescents and youth (adapted based on [8,20,28,42,43])

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
 **Education, skill-building and empowerment, including CSE**	Educational and skill development interventions to increase knowledge and awareness of GBV and change gender norms [42].	• **Individual interventions**: positive outcomes (decreased GBV victimization) for educational/awareness-raising interventions, including building knowledge and awareness about gender equality, GBV, health effects of GBV, normative gender beliefs and impact of gender norms; increased knowledge of health issues (including HIV and SRH, alcohol and substance use). Some evidence of decreased perpetration of GBV through group education, monthly newsletters/leaflets, and community workshops; increased awareness of harmful norms, gender roles and high-risk sexual behaviours [42]. • **Self-defence and assertiveness training**: decreased incidence of sexual assault [48] and had promising effects on related GBV attitudes [8]. • **Technology/digital delivery platforms:** increased resilience, and decreased IPV reported by users of an information, communication, and technology (ICT) safety decision aid mobile app. However, outcome data is weak [24].	• CSE is an important avenue to improving gender equitable relations and addressing gender and social norms. • Many individual-level interventions provide AGYW with education and skill development to reduce exposure to GBV. Interventions should employ group-based participatory strategies and offer equal opportunities to engage both girls/young women and boys/young men [8]. • Most technology-based interventions focus on risk mitigation, rather than primary prevention of GBV. Further research on interventions that aim to challenge or change gender norms among young people using digital platforms is needed [23]. • Although self-defence and empowerment initiatives may decrease the incidence of sexual violence, individual approaches inadequately address broader social and structural risk factors of GBV.

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
Partner, parent and family-focused strategies	Partner, parent and family-focused interventions that aim to prevent or reduce violence by fostering positive coping strategies [49], healthy relationships and promoting gender-equitable attitudes/norms [48].	• **Parenting programmes:** reduced physical/emotional abuse, improved caregiver mental health (reduced depression and substance use) and improved household financial status [49]. Some evidence suggesting parenting programmes may prevent IPV/sexual violence and perpetration among young people later in life [50]. • **Partner and boys and young men-focused programmes:** interventions focused on changing the behaviour of both boys and young men using transformative approaches encouraging new ideas and behaviours about the balance of power between men and women and by challenging traditional views regarding gender. Some evidence on reduced perpetration of IPV/adolescent dating violence [48,51].	• Targeting parents' well-being, building coping skills and alleviating financial stress may be effective pathways to reduce GBV and support the health and development of young people [49]. • Evidence of effectiveness of interventions involving boys and young men in violence prevention is still limited and further research is needed [51].
Response and support services	Interventions that provide GBV survivors with services that address acute and ongoing needs (e.g. youth-friendly and gender-sensitive services, trauma-focused counselling and cognitive behavioural therapy (CBT)), as well as access to criminal justice systems [20].	• **Youth/child-friendly and gender-sensitive GBV services** (e.g. One-Stop Centres providing medical, legal and social welfare services for children and adults): some evidence suggests client satisfaction with services, but outcome data is limited [52]. • **Trauma-focused counselling and therapy**: reduced trauma symptoms and increased functioning among young people experiencing sexual violence [20,53]. • **Counselling or support groups (using CBT)**: improved mental health, including symptoms of post-traumatic stress disorder (PTSD) among GBV survivors [25].	• Trauma-focused CBT is a promising intervention to support diverse GBV survivors (i.e. of varying age/gender) and should complement other support and response services [20]. CBT may be effectively delivered by trained lay providers [53]. • Crisis centres increased access to services (e.g. medical, legal and police) among adult GBV survivors [25]. Further research on whether crisis centres support young people in secondary and tertiary GBV prevention is needed.

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
 **Safer schools and environments**	Interventions that modify social and physical environments, particularly schools to strengthen protective factors, address norms and attitudes towards GBV, support healthy relationships, nonviolent conflict resolution and help-seeking [50,54].	• **"Whole school approach"[11]:** reduced sexual and physical violence and improved related GBV knowledge/ attitudes [54]. Decreased tolerance of dating violence among young people and increased knowledge of conflict resolution [55]. • **School-based interventions**: improved gender-equitable attitudes and increased self-reported likelihood of intervening in bullying/IPV [50].	• School-based GBV programmes should target both girls and boys to tackle gender inequality, gender norms and reduce GBV [54]. However, further evidence on the impact of school-based efforts in low-resource settings [50], including those in ESA, is needed.
 **Community engagement and (social) media campaigns to address norms and values**	Community-based interventions (e.g. group education, community mobilization, social norms marketing, media campaigns, mentorship and identification of safe spaces) which aim to increase awareness, inspire action, develop skills, promote gender-equitable attitudes and norms and decrease tolerance of violence [28,50].	• **Community mobilization through social marketing, media, local activism, community engagement or dialogue:** reduced GBV, including sexual violence, sexual/emotional IPV, and physical/sexual IPV [28]; improved GBV knowledge, attitudes and beliefs, increased equitable gender norms, decreased self-reported perpetration of violence/harassment, increased likelihood of intervening in a violent situation [50], and lowered social acceptance of IPV and decreased experiences of physical and sexual IPV [56]. • **Mass media campaigns:** decreased GBV, improved willingness to report GBV incidents to authorities, yet no changes in acceptance of GBV [57].	• Community mobilization initiatives that emphasize "power inequalities", rather than "gender" as it relates to GBV may facilitate broader engagement of boys and men [56]. • Social and economic empowerment interventions were more effective when implemented alongside community mobilization efforts, highlighting the importance of addressing GBV at multiple levels [28].

11 A whole school approach promotes gender awareness by integrating social and emotional learning and GBV prevention into daily interactions between teachers and students, staff and families [54].

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
Integration of economic strengthening and empowerment initiatives	Interventions that improve economic independence and decision-making power [50].	• **Cash transfers**: reduced GBV exposure among young people living with HIV [8]; cash transfers conditional on school attendance reduced physical, but not sexual IPV [28]. • **Microfinance interventions** (combined with education): show promising results to address IPV or sexual violence among young people [50]. • **Combined economic and social strengthening**: reduced controlling behaviours and GBV [42].	• Economic strengthening initiatives should be carefully implemented with attention to local social dynamics to ensure that interventions do not increase the risk of GBV. For example, microfinance or cash loans for AGYW may lead to inequitable distribution of power and resources in relationships and increase violence [58].
Implementation and enforcement of laws	Legislation and policies that prevent, support and enable justice for GBV survivors [20].	• **Laws**[12]: Critical to address GBV [20], but outcome data is limited.	• Accountability to ensure related GBV policies are prioritized for financial and human resources [31] and establishing and implementing policies that adequately reflect the diverse realities of young people and the forms of GBV experienced in ESA is critical.

Many of these strategies and adaptations may help to overcome key individual, family/community, health system and policy environment barriers to GBV prevention, risk mitigation and response services for young people as illustrated in Figure 2.

12 A 2019 systematic review by the Oak Foundation highlighted evidence on laws aiming to prevent sexual violence against children: ratifying international treaties/frameworks/legislation, implementing/enforcing laws that criminalize sexual violence against children/adults, victim-sensitive standards/services for policing/justice, eliminating statute of limitations for sexual violence crime [20].

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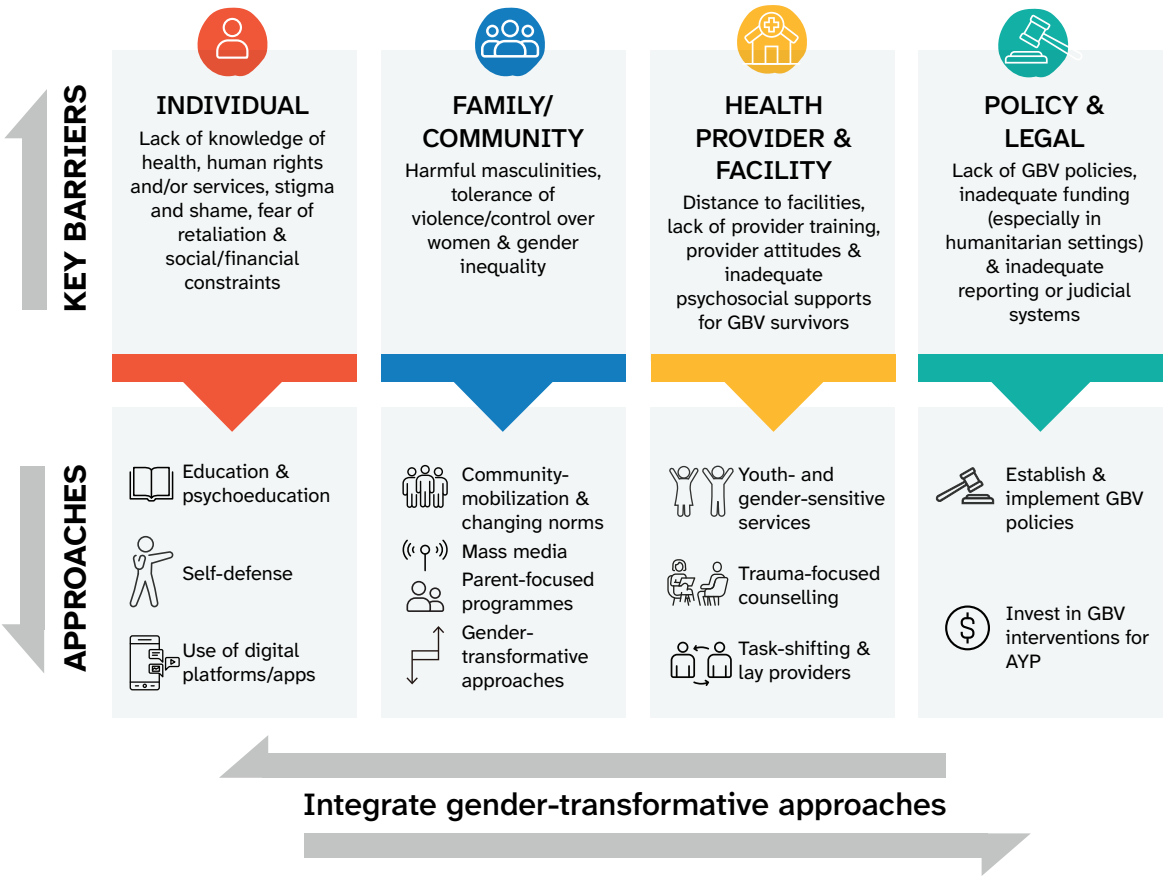
Figure 2:

Key barriers to accessing GBV supports and services, and promising implementation approaches



Box 4: Lessons learned from COVID-19 for future shocks and pandemics

Girls and young women are at increased risk of experiencing GBV during public health emergencies. During peak periods of the COVID-19 pandemic, increases in violence against girls and young women were considered a "shadow pandemic" [37]. Globally, reported cases of GBV have increased by 30 per cent since the beginning of the pandemic, and an additional 31 million cases of GBV were estimated for lockdowns continuing beyond six months [38]. Public health measures to reduce the spread of COVID-19 (e.g. travel restrictions, quarantine, curfews and social distancing), and isolation with perpetrators amid a period of increased interpersonal and economic stress, may have exacerbated pre-pandemic gender inequalities and undermined individuals' ability to leave abusive situations or households. Further, the lack of prioritization of GBV prevention and response services severely limited the accessibility and availability of vital support and significant disruptions to GBV prevention and response services were observed in many African countries after initial government-mandated public health restrictions and lockdown policies were introduced [39]. Research in Kenya, Nigeria, Uganda and South Africa found that restrictive public health policies and the failure of governments to recognize GBV prevention and response as essential services during initial lockdowns led to significant confusion among providers and severe disruption in vital service delivery, such as the clinical management of rape, legal services, psychosocial support and availability of shelters and community prevention efforts [39,40]. In ESA, exponential increases in calls to GBV hotlines were documented in the first two months post-lockdowns (775 per cent increase in Kenya and 500 per cent increase in South Africa). Although formal reporting of GBV cases was limited due to mobility and accessibility challenges, some evidence suggests that GBV cases reported to the police also increased during COVID-19 (e.g. cases of GBV nearly doubled between 2019 and April 2020) [40].

The main lessons learned from COVID-19 pandemic are:

- Importance of continuity of services: In some ESA countries, service provision continued while adhering to social distancing protocols. Other programmes pivoted to virtual service delivery, despite challenges with access to technology and limited digital literacy in some communities [39]. In Zimbabwe, authorities included GBV services on the list of essential services during lockdown in March-April 2020 and shifted GBV service

delivery to virtual/online delivery during this period. Establishing toll-free hotlines and using social media platforms for case reporting and service delivery also helped to overcome travel restrictions [66].

- Community outreach through community-based protection mechanisms (e.g. establishing GBV brigades to provide information about GBV referral pathways), strengthening and scaling-up GBV hotlines, shelters and transit centres, as well as establishing GBV mobile response (via One-Stop Centres) proved to be effective strategies [38].
- Increasing awareness through targeted (social) media campaigns was crucial during the COVID-19 pandemic [65]. In Eswatini, peer educators used social distancing and social media to provide comprehensive information related to HIV and sexual GBV. Social media and the U-Report social messaging tool and data collection system were also utilized to reach adolescents and youth with information on HIV, SRH, GBV and COVID-19 [67]. In Zimbabwe, media awareness campaigns were launched to address gender and social norms to prevent GBV in communities [66].
- Programmes need to improve their capacity to collect and use data to understand the burden of GBV during public health and other emergencies [65].

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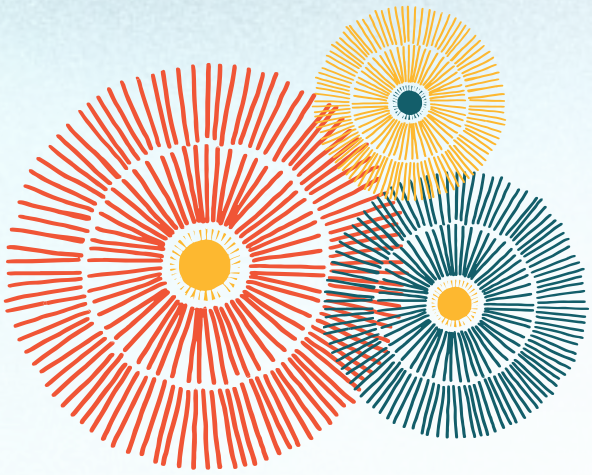
Programme case studies



Evidence on programme implementation experiences, impact and contributors to success is critical to understand how various GBV programme strategies can effectively reach adolescents and youth, and especially AGYW in ESA. Programme case studies[13] were purposively selected based on expert consultation to examine strategies employed to reach adolescents and youth across diverse geographic locations.

Case study 1
SASA!, a community mobilization intervention in Uganda

Programme description:

SASA! (meaning "now" in Kiswahili) is an evidence- and theory-based community mobilization intervention developed in Uganda and now implemented in many countries. It aims to transform community attitudes, norms and behaviours to improve gender equality and reduce intimate partner violence through community-led activism [68,69]. Four phases of the intervention include: i) *Start* – mapping formal/informal social, economic and physical community resources and structures, and engaging local activists ; ii) *Awareness* – empowering activists and encouraging critical thinking around gender and power inequities among community members; iii) *Support* – fostering skills and connections between community members to catalyse community change; and iv) *Action* – encouraging individuals to take action, try new behaviours and celebrate community change [69]. *SASA!* was one of the first programmes in sub-Saharan Africa to demonstrate that community

13 Best practices were identified by UNICEF and UNFPA country offices in ESA and purposely sampled by technical experts to reflect a diversity of approaches to provide GBV prevention, mitigation and response interventions. Case studies were produced using a descriptive qualitative approach to data generation and analysis [84]. Multiple research methods were employed, including document analysis of peer reviewed and grey literature, and key informant interviews with programme implementers.

mobilization can reduce gender-based violence and transform gender and social norms at the community-level [56]. The updated *SASA! Together* model maintains the same essential elements described above but also reflects changing priorities and advancements in evidence and practice. *SASA! Together* focuses more intentionally on engaging community leadership (e.g. faith leaders, traditional leaders) and institutions to improve support for GBV survivors (e.g. through partnership with health services, police services or local government) [68]. *SASA! Together* also includes new activities and improved guidance for partner organizations.

Timeline and programme sites:

The *SASA!* intervention was designed by Raising Voices in 2008, and the *SASA!* evaluation[14] was implemented from 2008 to 2012 in Kampala, Uganda by Raising Voices, the London School of Hygiene and Tropical Medicine, the Center for Domestic Violence Prevention and Makerere University. In 2018, Raising Voices initiated a comprehensive revision of the methodology and released *SASA! Together* in 2020, a strengthened and improved version of the original *SASA! Activist Kit,* informed by many years of practice-based learning. Globally, *SASA!* has been adopted and implemented by over 65 organizations in 25 countries [68], including adaptations targeting adolescents and youth to address power and violence [70].[15]

Programme impact:

An evaluation of the *SASA!* intervention reported reduced risk of physical IPV among women (by 52 per cent), reduced sexual concurrency[16] among men (27 per cent of men in *SASA!* communities versus 45 per cent in control communities) and reduced social acceptance of violence in intervention communities (76 per cent of individuals in *SASA!* communities rejected violence against women, versus 26 per cent in control communities) [56,68].[17] Other key outcomes include:

- Increased HIV-protective behaviours such as increased condom use and HIV testing [71].
- Improved intimate relationships via increased communication, trust and cooperation [68].

14 The *SASA!* evaluation involved a randomized controlled trial, economic evaluation, programme monitoring and evaluation and qualitative research [68].

15 *SASA!* materials are open source and freely available to partner organizations to support the implementation and scale-up of effective GBV prevention efforts globally. Visit the Raising Voices website to learn more about the approach, or contact the Raising Voices team – info@raisingvoices.org – for further information on training and technical support.

16 Defined as overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner [85].

17 Changes in social acceptance of gender inequality and IPV over time were not available, due to the use of different outcome measures at baseline and follow-up [56].

- Children's exposure to, and witnessing of, IPV in homes decreased by 64 per cent; qualitative evidence suggests *SASA!* improved parent-child relationships and increased rejection of using violence to discipline children [69].

Contributors to success:

- Adopting a **holistic approach** to engage and elicit change across individual, interpersonal, community and institutional levels is acknowledged as an essential driver of change.

"One of the strengths of SASA! is that it is a broad community mobilization approach —it really is looking to reach people of all genders and ages…trying to engage wide sections of the population to shift norms and attitudes [around] how all of us use our power in intimate relationships and day-to-day interactions."
[Raising Voices Representative]

- Community-based **activism** is central to *SASA!*, while training and ongoing mentorship help support local activists to facilitate dialogue, discussion and community changes.

"SASA! is driven by this idea of activism and [it] relies on identifying people from within communities, people who live in those communities…who have the drive, the skills, the intrinsic passion to create change on this issue and then supporting, nurturing, and equipping them to engage their peers, their friends, their families, their neighbours, their community members in conversation […] change is led from within and by people they know, by people they respect."
[Raising Voices Representative]

- Employing **benefits-based framing** to focus on the benefits of change, rather than the negative consequences of violence helps to encourage individuals, families and communities to envision the potential impacts of healthier, non-violent relationships.

- Using language and strategies centred on **power** dynamics, rather than language around gender helps to increase the relevance, applicability and accessibility of SASA! and address the root causes of GBV [56].

- Adopting a **phased approach** informed by behaviour change theories helps to gradually introduce new concepts and support communities through a process of change. This sustained and systematic approach is critical to shift underlying social and cultural gender norms and attitudes.

- Integrating a robust, multifaceted evaluation framework composed of quantitative, economic and qualitative data is critical to documenting important lessons learned, programme reach, pathways to change and essential intervention components [68,71].

- Leveraging social media platforms (e.g. WhatsApp groups) as well as traditional media (e.g. radio dramas), can effectively encourage community dialogue and maintain programme messaging during health emergencies.

Case study 2

Fathers Matter: Using edutainment and community outreach to promote positive and active roles of fathers in South Africa

Programme description:

Fathers Matter is a community-based outreach and entertainment education (also known as edutainment) initiative implemented in South Africa to promote the active and positive presence of men and fathers. It involves multiple components, including community-based outreach, mass social change programming (e.g. a series of six short films on fatherhood and relationships and radio talk shows) and social media [45,72]. The programme aims to increase awareness and shift attitudes on the importance of engaging fathers in the health and well-being of children, families and communities using television, radio and social media. Fathers Matter aims to promote positive fatherhood through fostering a supportive environment, encouraging dialogue and engagement, providing resources and training and embedding outreach within local community structures (e.g. churches and community-based organizations) [45,72]. In addition, the establishment of Fathers Matter Connect Groups in communities helps train community leaders and encourages peer mentorship and accountability in workplaces, social clubs, churches and other settings [73].

Timeline and programme sites:

Fathers Matter is implemented by the social change organization Heartlines, the Centre for Values Promotion, with funding from the Oak Foundation. Formative research on the importance of engaging fathers was conducted by Heartlines in 2020 to inform the development of the programme's theory of change [45]. The six-part edutainment film series was broadcast on South African television in September and October 2022 and re-broadcasted in June 2023 [73].

Programme impact:

During the initial broadcast and mass media campaigns in September to October 2022, Fathers Matter reached over 1.42 million individuals via social media (e.g. 1.1

million people on Facebook, 53,668 users on Instagram and over 118,000 views on YouTube) and 3.2 million by radio [74].

Other key outcomes include:

- In 2022–2023, over 3,770 individuals attended trainings, workshops and promotions via church and faith-based organizations, non-governmental organizations and men's groups on the importance of fathers and promoting positive fatherhood [75].
- In June 2023 the re-airing of the programme reached almost 627,000 individuals [74].

Contributors to success:

- Using extensive formative research to develop the Fathers Matter values, theory of change and edutainment intervention was critical to ensure that interventions are culturally and contextually relevant and adequately address the lived realities of adolescents and youth experiencing GBV.
- Training community leaders and embedding the Fathers Matter programme in local community structures, particularly faith-based organizations, was critical to reaching diverse groups of men and fathers.
- Leveraging diverse media (e.g. radio stations) and current events (e.g. Father's Day and National Youth Day) helped to increase awareness and foster dialogue around the importance of engaging men and fathers in efforts to improve the health and well-being of children and youth.
- Sharing relatable narratives in high quality multimedia films is a powerful strategy to engage communities on sensitive social and health issues, including GBV.

"The 'power of using story', I think is contributing to its success. People see the films and they're always moved and want to have conversations about them and engage with it. I think community-based work of running workshops and embedding that within churches, specifically, because churches have such a wide reach in this country is contributing enormously."
[Heartlines Representative]

- Using media mapping and local data to target media and advocacy campaigns helps to tailor messaging and reach intended audiences.
- Using virtual platforms during COVID-19; developing a series of evidence-based webinars on fathers' role in their children's emotional and social well-being, attitudes, beliefs and practices related to fatherhood, and barriers to fathers' participation (e.g. toxic masculinity); as well as positive interventions to promote engagement [76].

Case study 3

Rapariga Biz *"Action for Girls"*: Integrating sexual and reproductive health and gender-based violence services for adolescent girls and young women in Mozambique

Programme description:

The Rapariga Biz (or "*Action for Girls"*) initiative aims to improve the sexual and reproductive health and rights (SRHR) of AGYW aged 10 to 24 years in Mozambique by supporting girl-focused empowerment and decision-making, quality integrated youth-friendly SRH and GBV services and comprehensive CSE curriculum to change gender norms and build SRH knowledge among adolescents and youth in schools [77]. Key components include: i) mentorship and peer counselling sessions for AGYW in safe community spaces via young female mentors; ii) integrated adolescents and youth-friendly and gender-sensitive SRH and GBV services in health facilities (including "One-Stop Centres"), schools (e.g. school health corners) and communities (e.g. mobile clinics); iii) reintegrate out-of-school AGYW to attend schools; iv) comprehensive SRH education for adolescents and youth; v) economic empowerment of AGYW; and vi) community mobilization and behaviour change communication related to SRH and GBV. The programme also addresses SRH and GBV through a sexual health hotline, radio programmes, social media, community dialogues, training and engagement of adolescents and youth in media clubs, collaboration with community partners (e.g. Ministry of Justice and police services) and engaging boys and young men to prevent GBV [77]. Rapariga Biz adopts a multisectoral approach to prevent and respond to GBV, involving coordination across health, gender, social and behavioural change, education, youth and justice areas.

Timeline and programme sites:

Rapariga Biz, the first joint United Nations programme for AGYW in Mozambique, was launched in 2016 and implemented in 20 districts across the Nampula and Zambezia provinces. Key partners include the Secretariat of State for Youth and Employment, the Ministry of Health, the Ministry of Gender, Children and Social Action, the Ministry of Education and Human Development, and the Ministry of Justice, Constitutional and Religious Affairs, civil society organizations as well as United Nations agencies (e.g. UNFPA (lead agency), UNICEF, UNESCO and UN Women). In 2020, additional funding and technical assistance was committed by the Embassy of Sweden and High Commission of Canada to extend

efforts within Zambezia and Nampula [78]. In 2021, peer mentorship efforts were expanded to engage boys and young men across six districts [77].

Programme impact:

Since its inception, Rapariga Biz mentors have reached 970,310 girls aged 10 to 24 years across 20 districts in Nampula and Zambezia with mentorship to increase knowledge, capacity and agency related to SRHR, including GBV. In Nampula, 3,975 cases of violence were supported with referrals and services for GBV survivors. In 2022, the child helpline ("Linha Fala Criança") received 170,655 phone calls (122,422 required interventions, with 4,843 cases registered – 42 per cent reported child marriage and 28 per cent sexual violence) [77]. Other key outcomes include:

- In 2021, over 1.7 million people were reached monthly with Rapariga Biz dramas, shows and programmes [77].
- In 2022, 170,737 AGYW accessed integrated youth-friendly services for SRH, GBV, STI and HIV; 44 per cent adopted at least one modern method of contraception in addition to condoms, and 60 per cent accessed HIV testing. Mobile clinics reached 26,224 young people with integrated SRHR and GBV services.
- Rapariga Biz has increased access to SRH services, with focal regions observing decreased early and unintended pregnancy (0.9 per cent versus 46 per cent nationally).
- The child marriage rate among AGYW enrolled in the programme is 0.7 per cent (approximately half of the national estimate).
- In 2022, 3,280 peer mentors were engaged to lead peer community sessions on SRH and GBV.
- In 2022, 2,089 AGYW were supported to return to school through scholarships.
- In 2022, 132,809 young people subscribed to SMS Biz (also known as U-Report) (an increase of 72 per cent since 2021) and received peer-to-peer counselling.
- In 2022, 2,730 young people were trained and engaged in media clubs through national radio and television (including 1,230 media producers and 1,500 adolescent parliamentarians) in the Nampula and Zambezia provinces. From these trainings, 2,060 studio/live programmes were produced and aired by adolescents and youth reaching an estimated five million young people and communities with content related to SRHR, GBV, child marriage, mental health, education, COVID-19 and climate change.
- In 2021, over 1.7 million people were reached monthly with Rapariga Biz dramas, shows and programmes [77].

Contributors to success:

- Adopting a holistic and multisector approach has created an enabling environment to address GBV through

community-based peer mentorship (for both AGYW and boys/young men), comprehensive CSE, facility-based support, community mobilization and behaviour change and economic empowerment [77].

- Integrating SRHR and GBV services in schools, health facilities and communities helps provide differentiated and timely delivery of youth-friendly and gender-sensitive information and services for adolescents and youth.

"We have a one-stop model where… adolescent girls and boys, and young women and young men are attended, it includes the [whole] package…sexual and reproductive health, but also gender-based violence. [Youth] can have all the services needed, at the same point… without any kind of discrimination."
[UNFPA Staff]

- Peer-to-peer mentorship of AGYW offers an extensive community-based network for counselling, information and support. Peer education is vital to improving young people's knowledge of SRHR, HIV and acquired immune deficiency syndrome (AIDS), GBV, life skills, decision-making, self-esteem, as well as referrals to health, education and justice services.
- Engaging boys and young men in peer-to-peer mentorship helps create an enabling environment by promoting gender equality, positive masculinities, and supporting prevention and response to GBV [77].
- Public-private partnerships with telecommunication companies increased the accessibility of the mobile platform (SMS Biz) by enabling adolescents and youth to send and receive bulk SMS messages at no cost [77].
- During the COVID-19 pandemic, Rapariga Biz was adapted to provide thematic community-based radio sessions co-led by young female peer mentors, and individual mentorship was offered by peer mentors via phone or SMS Biz [78]. Mass media (e.g. radio and television) remain effective platforms to reach diverse young people with SRHR and GBV information.
- Engaging community and traditional leaders, including faith-based leaders, is an important strategy to foster buy-in and support for the programme, as well as young people's SRHR and prevention of GBV.
- Government leadership and involvement in training peer mentors helps ensure ownership and sustainability of the programme.
- Integrating economic empowerment (e.g. financial literacy, vocational/ business management training and income generating activities) with SRHR service delivery helps to overcome risk and enhance protective factors associated with GBV among AGYW.

Overall summary of lessons learned

- **Increased efforts to embed gender transformative principles and approaches in policies and programmes are essential to address the root causes of gender inequality, as well as prevent and respond to GBV among young people in the ESA region**. Challenging discriminatory policies, practices and social and gender norms, encouraging positive masculinity, building support systems, as well as engaging men and boys are important avenues to ensuring the more equitable distribution of power, resources and opportunities.
- **Integrating GBV services within primary health care (along with comprehensive SRH information and services) offers young people timely access to vital health and GBV services and support**. Integration of GBV services is considered acceptable and feasible when informed by principles of confidentiality and

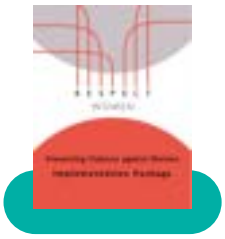
empathy. However, increased efforts to support linkages to care is needed. Providing a comprehensive package of services to address GBV is essential to the differentiated delivery of care for adolescents and youth.

- **Engaging, training and supporting community activists is a critical strategy to challenge deeply rooted social and gender norms that underlie power and gender inequities and GBV**. Local activism through image-based activities (e.g. posters), radio and community-based dramas and performances are evidence-based strategies to encourage dialogue, discussions and critical reflection among individuals, families and communities.
- **Mass media and digital edutainment initiatives represent promising approaches to increase knowledge and awareness of GBV.** Engaging men/fathers and outlining their important roles in supporting the health and development of children, adolescents and youth are increasingly recognized as essential to disrupting intergenerational cycles of violence.
- **Documenting and sharing key lessons learned on effective GBV prevention, response and support initiatives for young people** is critical to reach more young people and improve the quality of outcome data. This can be achieved through robust programme monitoring and evaluation, developing and validating reliable measures to be used consistently across interventions, and capitalizing on opportunities for national, regional and international knowledge exchange.
- **Multisector delivery methods that embed GBV prevention and response within schools, communities, health systems and broader policy structures** are essential to fostering an enabling environment and supporting young people. Programmes should target adolescents and youth with mentorship, economic empowerment and capacity-building on SRHR, GBV and human rights. These efforts should occur in tandem with improved services and support for SRHR and survivors of GBV.
- **Establishing, implementing, and enforcing comprehensive policies and legislation that target various forms of GBV experienced by young people** is essential to meet national, regional, and global commitments to addressing GBV.

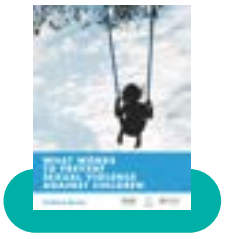
Key resources

Essential Services Package for Women and Girls Subject to Violence (2015). Available here.

Global, Regional and National Prevalence Estimates for Intimate Partner Violence Against Women, and Global/Regional Estimates for Non-partner Sexual Violence Against Women (2021) report by the World Health Organization. Available here.



RESPECT Women: Preventing Violence Against Women – Implementation Package (2020) offers practical resources and tools to implement the RESPECT Women: Preventing violence against women framework developed by WHO, with UN Women and endorsed by other United Nations agencies and bilateral partners. Available here.



Together for Girls, the Equality Institute and Oak Foundation (2019) is a systematic review of proven solutions and best practices to prevent and respond to sexual violence against children and young people. Evidence review available here.

Inter-agency Minimum Standards and Essential Services Package (2022) to address gender-based violence across a range of contexts, including emergencies. Available here.

The **2016 Global Plan of Action** is a technical document synthesizing evidence, best practices and WHO technical guidance for Member States to strengthen health systems and intersectoral collaboration to prevent and respond to interpersonal violence, particularly against women and girls and children. Available here.

Gender-transformative Approaches to Achieve Gender Equality and Sexual and Reproductive Health and Rights (2023) providing practical clarity and guidance on applying this approach to programmes and interventions. Available here.

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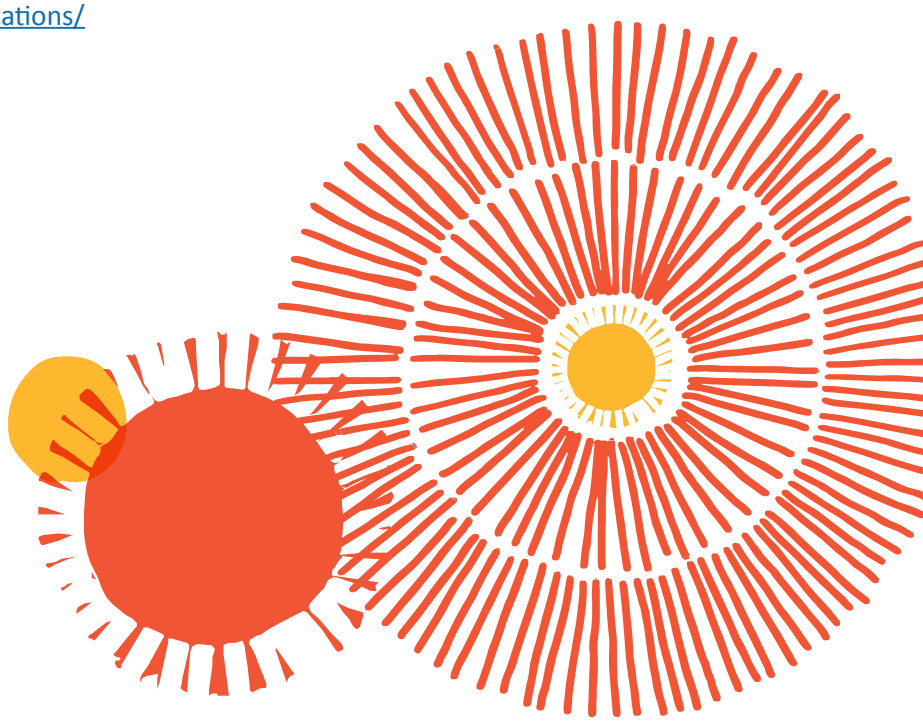

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