



## Policy Position and glossary – Gender-Based Violence (GBV)

This document sets out Health Poverty Action’s position on gender-based violence (GBV). Annex 1 provides a glossary of key terms relating to GBV, annex 2 outlines some of the key international frameworks and annex 3 provides a list of further reading. This paper was written in March 2014 and updated in November 2022.

### Defining GBV

Gender-based violence (GBV) is violence directed against a person because of their gender or violence that disproportionately affects persons of a particular gender.

GBV poses a greater threat to women’s health than traffic accidents and malaria combined<sup>i</sup> and kills and disables as many women aged 15 to 44 as cancer. GBV is one of the most widespread forms of human rights abuse worldwide:<sup>ii</sup> 1 in 3 women experience violence in their lifetimes; 45% of girls report that their first sexual experience was forced;<sup>iii</sup> and women and girls constitute 80% of people trafficked across national borders.<sup>iv</sup>

Data on transgender and non-binary people is limited, however they often experience high rates of domestic and sexual violence, transphobic hate crimes and state violence. In 2021, the Human Rights Campaign recorded 50 fatalities as a result of GBV against transgender and non-binary people in the US alone.<sup>v</sup>

GBV encompasses a wide range of violations. It includes: domestic abuse; rape; sexual assault; psychological violence; female genital mutilation; femicide (including murder by an intimate partner, ‘honour’ and dowry-related killings and ‘non-intimate’ femicide, for example the torture and murder of hundreds of women in Guatemala in 2008<sup>vi</sup>); forced prostitution; enforced sterilization; acid burning; forced abortion; coercive/forced use of contraceptives; violence in schools, (including teachers trading sex for better grades); workplace mobbing or harassment; and female infanticide. In conflict, sexual violence may be used as a weapon of war. GBV also includes economic violence such as controlling access to money, credit, health care, education, inheritance, property and land rights<sup>vii</sup> and structural discrimination and violence (institutional and social structures that result in inequitable treatment and place avoidable barriers to the fulfilment of needs.)<sup>viii</sup>

GBV results from disparities in power. It is usually perpetrated against women and non-binary people by men, and is both a consequence and a cause of gender inequality.<sup>ix</sup> It is premised upon unequal power relations, resulting from socially constructed gender norms and ideas of gender. It also helps to further imbed these norms. Men are not born violent or sexual predators, yet notions of masculinity – one prevalent example is the concept of *machismo* in parts of Latin America - perpetuate and reinforce the notion that these characteristics are an inherent part of being a man.<sup>x</sup> Attitudes resulting from these norms can also result in survivors of GBV being blamed for their experiences and becoming further disempowered as a result. The effects can be enduring;

witnessing or experiencing abuse as a child increases girls' risk of experiencing GBV and boys' risk of becoming perpetrators,<sup>xi</sup> further evidence of its cyclical nature.

The risks of GBV are increased by a number of factors including: social marginalisation; limited economic opportunities; lack of control over property and land rights; lack of safe spaces for women and girls; poor mental health; limited legislative and policy frameworks; impunity for perpetrators; and low levels of awareness among state actors.<sup>xii</sup>

The terms Gender Based Violence (GBV), Sexual and Gender Based Violence (SGBV) and Violence Against Women (VAW) are often used interchangeably, yet their meanings are distinct. Violence Against Women is defined by The *UN Declaration on the Elimination of Violence Against Women* as:

*“any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”*

It is therefore a narrower definition that does not recognise gender-based violence against men. GBV or SGBV, are broader terms that both encompass VAW, but the key distinction is that the separation of 'sexual' in SGBV can imply that sexual violence is not gendered.

*“my teacher turned me to woman”.*  
10 year old boy supported by Health Poverty Action after he was raped by his teacher.

Whilst GBV disproportionately affects women and non-binary people, men too can be victims. This usually happens when they act in ways which are seen to challenge dominant ideas of masculinity, for example many people, including men, who identify as LGBTIQ+ may be subjected to violence because of their sexual orientation. These acts are often used to reinforce conventional norms; the expression of violence serving to assert the masculinity of the perpetrator, whilst 'emasculating' the victim. Whilst work to tackle GBV is usually focussed on women as victims, given the intrinsic links between the social construction of gender and GBV, it has been argued that acts of GBV perpetrated against both men and women and their relation to gender norms should be analysed holistically.<sup>xiii</sup>

Whilst recognising GBV as predominantly a violation of women's human rights, Health Poverty Action therefore uses the term GBV in the majority of our work. We do so in acknowledgement of male victims, that sexual violence is a form of gendered violence, and that an analysis of the ways in which ideas of gender are constructed under patriarchy - as well as a dismantling of these structures- is essential to tackling GBV. However, we acknowledge that in certain national or local contexts, other terms may be more appropriate - for example if the term GBV is not widely utilised or understood, or when an alternative term is preferred within the community.

### **GBV and human rights**

GBV impedes social, economic, political, and legal rights. It is a barrier to development and poverty reduction. GBV and gender discrimination restricts girls' access to education, women's employment opportunities and impacts on both individual and national income. In Nicaragua, women's lost earnings as a result of domestic violence in 1997 cost US\$29.5 million or 1.6 percent of the national GDP.<sup>xiv</sup> The police, health and legal services required to respond to GBV are expensive both for individuals and governments. In Guatemala some survivors are forced to withdraw from seeking justice, because they are unable to cover the costs of transport to court, whilst others' decisions to

report GBV are influenced both by a fear of violent repercussion as well as potential economic insecurity posed if they should lose their husband's financial support. In Guatemala, the costs of violence amounted to the equivalent of 7.3% of GDP<sup>xv</sup> and in Sweden, the annual cost of intimate partner violence, US\$19.81 billion.<sup>xvi</sup> Measures to address GBV must therefore be closely linked to increasing women's empowerment in all areas of life.

### **GBV and the right to health**

*"Violence against women is a global health problem of epidemic proportions,"*  
Dr Margaret Chan, Director-General, WHO, press release 20 June 2013.

GBV is a public health issue. Direct health impacts include: death; injury; suicide; unwanted pregnancies; sexually transmitted infections; depression; alcohol use and chronic diseases. The specific health impacts of FGM include incontinence, problems with childbirth and sexual dysfunction. GBV is both a cause and consequence of HIV. Physical trauma that can result from rape increases the risk of contracting the virus.<sup>xvii</sup> Due to their subordination, women may find it difficult to negotiate safe sex, have limited access to information about sexual and reproductive health, and be less able to access contraceptives and testing services. In some regions, women who experience intimate partner violence are 1.5 times more likely to be infected with HIV and 1.6 times more likely to contract syphilis.<sup>xviii</sup> Notions of masculinity also affect HIV, with men more likely to engage in risk taking behaviour or be reluctant to access health services.<sup>xix</sup>

Intimate partner violence poses a greater threat to women during pregnancy than some of the maternal health conditions routinely screened for in antenatal care.<sup>xx</sup> Between 23 and 53% of women who experience intimate partner violence during pregnancy are kicked or punched in the abdomen. They are more likely to miscarry<sup>xxi</sup>, experience premature delivery, and are more than twice as likely to have an induced abortion. They also have 16% greater odds of having a low-birth weight baby<sup>xxii</sup>; and are less likely to breastfeed.<sup>xxiii</sup> A report on intimate partner violence in Kenya, Honduras and Malawi suggests that it plays a role in child malnutrition and mortality.<sup>xxiv</sup>

GBV and gender norms also restrict access to health services. Stigma or fear of violence can prevent health seeking behaviour, and in some cases women are not able to access health services without permission from a man. When accessed, health services may be a survivor's first point of contact for help, and provide a unique opportunity to identify and address cases of GBV. <sup>xxv</sup>Yet, despite the duty of public sector health workers to address violence against women, providers often do not recognise it as a public health issue and therefore part of their responsibilities.

### **Health Poverty Action's approach to GBV**

Health Poverty Action recognises that tackling GBV is fundamental to realising the right to health. Our work is based on the following principles:

#### **A holistic and multi-sectoral approach**

Given the many determinants of health, addressing one issue in isolation from the broader context results in only partial solutions that are less likely to be effective and sustainable.<sup>xxvi</sup> It can also result in unintended consequences. For example, increasing girls' entry into education without implementing safeguards against abuse from boys and teachers can increase their likelihood of experiencing GBV.<sup>xxvii</sup>

We ensure our programmes take a holistic and comprehensive approach to address the numerous drivers and impacts of GBV, empower women, and reduce their vulnerability to risk (see reducing risk). For example in Rwanda, women who have experienced or are at risk of violence are provided with health care, physiological support, supported to access justice and integrated into voluntary savings and loan groups (VSL) and income generating activities.

*'Women should not keep quiet about violence'*

Berille is 50 years old and lives in Rwanda with her 4 children. She was subjected to economic violence after her husband remarried and blocked her access to their land, meaning she lost her only means of income. After Berille was referred to our project by the police, Health Poverty Action paid for her to access a lawyer, and enrolled her in a Voluntary Savings and Loans Group which provided both financial and emotional support. When her case went to court the judge ruled that her husband must return her access to land. Now she is able to provide for herself and her children and is President of her local Voluntary Savings and Loans Group, supporting other women who have survived violence.

In addition to addressing the determinants of GBV we work with all relevant actors including health, police, judiciary, education and local community leaders and organisations. Multi-sectoral approaches such as these are recognised as the most effective method to address GBV. <sup>xxviii</sup>

### **Reducing risk**

Tackling GBV poses risks. Threats to social norms can result in a 'backlash' from those who wish to uphold them. <sup>xxix</sup>This poses dangers for individual women. There is well-documented evidence of the increased threat to women participating in activities that increase women's economic or political participation. <sup>xxx</sup> Drawing attention to individual women or encouraging them to speak up in front of men (for example in mixed discussion groups) can put them at risk. <sup>xxxi</sup>Those working with survivors also face dangers. In Nicaragua a major barrier to health staff identifying and reporting violence against women are the subsequent threats that they receive from the aggressor or community members. Working with perpetrators is also recognised as having particular risks. For example, whilst assessments of the effectiveness of programmes for perpetrators show mixed results, the programmes can encourage women to feel safer staying with a violent partner, under the assumption that the programme will be effective. <sup>xxxii</sup> Therefore particular safeguards and monitoring are needed when working with perpetrators. <sup>1</sup>

Programmes must be designed to minimise risk<sup>2</sup>, should be based on a gender risk analysis and uphold basic standards of ethics regarding confidentiality, informed consent, safety and security<sup>xxxiii</sup> Research and awareness raising about violence with women and girls should follow ethical guidelines.<sup>3</sup> Health Poverty Action follows a Programme Participant Protection Code of Conduct and

<sup>1</sup> See UN Women for guidance on working with perpetrators. <http://www.endvawnow.org/en/articles/229-perpetrators-of-violencebatterers.html>

<sup>2</sup> See DFID's 'How to' Note on VAWG written by the Gender and Development Network [http://www.gadnetwork.org.uk/storage/VAWG\\_guidance2\\_community%20programming1.pdf](http://www.gadnetwork.org.uk/storage/VAWG_guidance2_community%20programming1.pdf)

<sup>3</sup> See [ethical guidelines](#) see WHO's Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women (WHO, 2001) (also available in Spanish and French) [http://www.endvawnow.org/uploads/browser/files/WomenFirst\\_Eng.pdf](http://www.endvawnow.org/uploads/browser/files/WomenFirst_Eng.pdf) (Whilst focussed on

our work to challenge GBV runs in conjunction with ensuring adequate services are in place for those who do experience violence. We monitor progress to check for any adverse outcomes.

### **A solid evidence base**

Power relations operate differently in each in society and amongst different strata (individual, family, community and society). It is vital to understand these interactions and drivers in each community, in order to design appropriate programmes and to mitigate against dangers. We work to understand existing knowledge, attitudes, practices and beliefs, the factors that contribute to survivor's decisions (in reporting, seeking support etc.), and actions of perpetrators to help us develop specific, focused strategies.

Weak coordination and monitoring mechanisms and lack of data and research are recognised as some of the key challenges to addressing GBV.<sup>xxxiv</sup> We collate data through our programmes to enable us to monitor our interventions and enhance our knowledge, in addition to encouraging governments to strengthen their own evidence base. For example, in Rwanda and Nicaragua we have developed data collection systems. Community GBV Network members are supported to collect information in their local area which feeds into the project's M&E system and is used for discussion of trends and gaps at GBV Network meetings as well as forming a basis for advocacy at the local and national levels.

### **Respecting culture**

Our understanding of the context and power dynamics of the communities in which we work is enabled through our work with local organisations - including women's rights and feminist organisations – and existing community structures and leaders. The communities we work with are often marginalised from mainstream society and women may therefore face intersecting forms of discrimination. In order for services to be sustainable they must be in keeping with local traditions of health and well-being, provided in the local languages and in a culturally appropriate setting. We work with local community structures to ensure we tackle the specific drivers of GBV in each community, demonstrate the relevance of our approach to that community and provide programmes that are appropriate to the local culture.

### **Challenging attitudes and changing norms**

We are committed to developing both the capacities of rights holders (individuals) as well as 'duty-bearers' (representatives of the State).

### **Public education and empowerment**

Challenging public attitudes that contribute to women's marginalisation is vital. Even where laws are in place, social norms and practices can make it difficult for survivors to seek justice.<sup>xxxv</sup> In Guatemala, domestic violence and rape within marriage are considered private problems. In Sierra Leone the incidence of gender-based violence is extremely high, due in part due to its level of social

acceptability. As a result 40% of rape victims do not inform anyone of the incident and only 2.1% of boys and 0.8% of girls reported GBV incidents to the authorities.

We work to shift social norms and challenge dominant conceptions of gender. This includes informing survivors about the existing support services, legal frameworks and legal duties of state actors, and encouraging women to understand that they should not expect or accept violence. In Rwanda, in collaboration with local leaders we have identified GBV advocates who work with project staff to increase knowledge of available services and act as a link between the GBV survivors and service providers to increase referral to appropriate services. We also run GBV clubs for women and young people who then disseminate GBV messages within their communities. We also work to redress power imbalances in society and increase women's power in public life. In Sierra Leone we have established GBV Advocates and community health volunteers who promote women's participation and membership in Village Development Committees (VDCs).

Whilst it is important to increase women's empowerment and ensure individuals are aware of their rights, ending GBV must not be seen as the responsibility of potential victims. Emphasis must be on addressing the behaviour of the perpetrators, and ending impunity. We therefore work with various members of the community including opinion leaders such as traditional and religious authorities, to embed the notion that that GBV is a matter for whole communities, and challenge dominant myths around GBV. In a number of countries we do this through Community Conversation (CC), a transformational participatory methodology involving a process of engaging communities in interactive discussions. This helps community members to openly discuss issues together and bring out taboo issues for public discussion.

*Rape is no shame for the woman who experienced it, only for the man who committed it.*  
Campaign message from our Guatemala programme.

We also use a range of communication approaches, such as radio programmes, pamphlets, billboards, community theatre, quizzes, community events, and local media coverage to "break the silence" surrounding GBV. Where possible these are integrated with our services, for example equipping health centres with television sets and DVD players to enhance health education.

We also target men and potential perpetrators. In Sierra Leone we produce monthly radio shows targeted at men. We also provide training on the Gender Acts and their implications to Okada drivers, who are often perpetrators of GBV.

It is particularly important to reach out to boys when their notions of masculinity are developing and before they may become perpetrators. In Guatemala, Somaliland and Sierra Leone, we work with young people in schools to facilitate discussion about gender and GBV in order that young people can identify school-related GBV and prevent, respond and report it.

### **Institutional change**

The Declaration on the Elimination of Violence Against Women (1993) bestows the state with a duty to prevent, investigate, and punish acts of violence against women.

Whilst in many of the countries in which we work, regulatory environments to implement this duty do exist, a low level of knowledge and attitudes of state representatives - those working in the police, health services, education and judiciary – and traditional leaders mean they are not implemented in some cases resulting in institutional violence.

Whilst health centres are often the first point of contact for the survivor, especially in cases of physical violence, in many cases staff perceive the problem as a purely medical one. Police protocols may not exist and discriminatory attitudes amongst police and the judiciary - not only in terms of gender but also in relations to class and ethnicity - all help to enable a culture of impunity for perpetrators. Our work includes training key actors including police, judges, court officials and traditional authorities, on existing legal frameworks, as well as challenging attitudes to GBV in order that they can better uphold GBV legislation. For example, in Nicaragua, we trained traditional judges in GBV law using a technique called “walking in my shoes” in which real case studies are used to reflect and identify what should be done in different cases of gender based violence.

In Rwanda training for health staff includes a focus on evidence collection based on our GBV protocol tool which enables health staff to accurately document and report GBV cases.

Schools can sometimes be place where sexual violence is perpetrated for example, with teachers trading better grades for sex. In Sierra Leone, where girls experience high levels of sexual violence in schools, we train teachers on detection of signs of violence (changes in appearance, attention, educational performance, etc); the "listening technique" with girls; the creation of a safe environment free of violence in the classroom; how to deal with sexual games in the classroom, and behavioural codes of conduct.

### **Improving services**

Challenging norms and informing survivors of their rights increases demand for services. It is therefore imperative that this runs alongside efficient and accessible health, psychological and legal services.

HPA works to support states in providing accessible, safe, confidential, non-discriminatory and integrated services for survivors. Our involvement is intended to be transitional/temporary until the capacity of the state is sufficiently enhanced to assume full responsibility.

UN Women’s guidance for service provision for survivors at the facility level, states that services should be based on the following:

- An ecological approach: understanding risks and protective factors at the individual, relationship, community and society levels.
- A multi -sectoral approach: linking health programming with other key sectors involved in prevention and response.
- A systems approach: ensuring that building capacity of health facilities to address violence against women and girls is system-wide, not just limited to specific training of key providers.

- An integrated approach: A fundamental role for health providers is to assess the safety of a survivor and help her stay out of danger. After assessing each woman's level of danger providers can work with survivors to establish safety plans. <sup>xxxvi4</sup>

HPA's approach to GBV services is made up of manifold components. We provide essential, potentially life-saving, medical services including access to and administration of prophylaxis. We provide psychosocial support, such as shelters or safe spaces for survivors, alongside a range of support services. In Sierra Leone the safe houses are provided by trained Community Hosts who offer a room in their own home as refuge for GBV victims. We also support peer mentoring groups to provide emotional support for survivors. In Nicaragua, we support an existing shelter for women. Here survivors can access information on a range of relevant themes including violence, personal hygiene, health and self-confidence and can take part in a self-care program comprising individual and group therapy sessions, whilst their children are supported into formal education.

We help to facilitate access to justice: Key to this is strengthening coordination of GBV interventions, evidence collation and referral protocols. In Rwanda, prior to the trainings, each service involved in addressing GBV (e.g. health services, the police and the courts) were working independently of each other. Following the development of a robust referral protocol, services are now working in collaboration and in a complementary manner, and also feeding into the national referral protocol. In keeping with our commitment to cultural relevance, this also includes the establishment of community referral networks. For example, in Guatemala we have supported the creation of a network of community counsellors, trusted local women who are trained in crisis intervention and basic psychosocial support who provide a first point of contact and accompany survivors through the reporting path. In Sierra Leone we help victims to obtain medical reports, have constructed private interview areas in police stations and established a mobile court in Kamakwie to prevent survivors taking a long and expensive journey to file cases. We also provide financial support covering legal services, transport and accommodation in addition to advice on navigating the various legal, judicial and medical services available.

In many of the areas in which we work, community leaders are involved in the response to GBV, and therefore coordination between them and state service is imperative. In Nicaragua we have facilitated communication between community leaders and senior police representatives to improve coordination and enable each side to provide feedback on the implementation of the law from both perspectives.

### **Advocacy for public policy change**

Effective national legislation and policies are important steps in ensuring States are addressing their duty to tackle GBV as well as streamlining policies and protocols at the national, regional and institutional level. Our work includes advocating for effective legislation. In Guatemala we are working through existing women's networks to lobby for a change in protocols which limit the introduction of medical evidence, and in Rwanda and Nicaragua we are advocating for increased

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<sup>4</sup> See UN Women standards for health service delivery. <http://www.endvawnow.org/en/articles/427-standards-for-health-service-delivery.html?next=655>



resources and support for GBV structures. In Sierra Leone we document and share best practice to advocate for replication of our referral system and the concept of a 'minimum package of services' and advocate for a stronger voice for GBV survivors and GBV Committees to feed into the development of more effective prevention and response services. In Somaliland we work to support clinic health committees (attached to each health facility) to provide a link between the community and the regional health office and Ministry of Health and Labour to provide feedback on services; mobilise communities; affect community level referrals for obstetric emergencies, FGM complications, and GBV; and resolve conflict and misunderstandings between service providers and the community.

In Somaliland, which currently has no clear policy on FGM, we are working alongside the Ministry for Health and Labour to facilitate a process for developing a national policy on FGM. Alongside our local partner we have also established a women's champion group against FGM.

In Nicaragua two new commitments related to GBV have been made as a result of the project's advocacy: the inclusion of the civil society network on the '*National Inter-institutional Commission in the fight against violence towards women*' and commitment to a strategic plan for the National Network of Shelters, to provide a platform for the shelters to articulate actions in favour of survivors and for combined funding applications to increase resources.

### **Monitoring and evaluation**

Monitoring and evaluation is vital in understanding the factors underlying GBV and assessing the effectiveness of the response. Given the particular risks to participants in GBV programmes and the fact that globally evidence on effective strategies for tackling GBV are weak, a comprehensive monitoring and evaluation strategy is vital.

At all stages our projects follow a robust monitoring and evaluation plan and we remain flexible to tackle issues as they arise, to ensure the most of effective response to GBV. For example, following the identification of various barriers to obtaining a reliable medical report in Sierra Leone, future projects may consider addressing problems in accessing free medical reports, and training medical providers to improve the quality of such reports.

### **Working with others**

We know that Health Poverty Action alone cannot tackle the problem of GBV. We work with others at all levels – communities, local civil society organisations, national alliances, and global networks, to achieve lasting change.

Our experience suggests that the above approaches: holistic and multi-sectoral working; reducing risk; a solid evidence base; respecting culture; challenging attitudes and changing norms; improving services; advocacy for public policy change and; effective monitoring and evaluation provide a comprehensive and sustainable approach to tackling GBV, yet we remain flexible and committed to learning and sharing experiences amongst ourselves and with others and adapting and building on our work to implement an effective and robust approach to addressing GBV.

## Annex 1 - Glossary of key terms

This is a glossary of commonly used terms relating to gender-based violence (GBV). Definitions of GBV can vary across organisations and in different contexts; this document is intended to outline how Health Poverty Action understands and utilises these terms. Where there is more than one commonly used definition, Health Poverty Action's preferred term is indicated. However, context is key, and we should use discretion in utilising the most appropriate term for the local or national setting.

NB. In an attempt to streamline data and improve analysis of GBV, the UN Population Fund (UNFPA), International Rescue Committee (IRC), and the UN High Commissioner for Refugees (UNHCR) developed a GBV classification tool intended to standardize GBV data collection across GBV service providers. This glossary includes some of their definitions (marked with a \* and in italics), in some cases with additional comments.

**Cisgender**, a person whose gender identity aligns with the sex they were assigned at birth

### **Consent**

*When a person makes an informed choice to agree freely and voluntarily to do something. There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation. The use of a threat to withhold a benefit to which the person is already entitled, or a promise is made to the person to provide a benefit.\** We should also consider whether it is possible to exercise consent when alternatives are severely limited. For example, when someone 'chooses' to engage in prostitution due to an absence of alternative means of income.

***Denial of Resources, Opportunities or Services:*** *denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.\** Health Poverty Action prefers to use the term **Economic Violence** to emphasize that the above acts constitute violations of human rights.

**Female genital mutilation/cutting/circumcision (FGM/C)** – see Health Poverty Action's summary position on FGM for more information.

The WHO defines FGM/C as: *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.* It classifies FGM/C into four types.

*Type I: involves the excision of the prepuce with or without excision of part or all of the clitoris.*  
*Type II: excision of the prepuce and clitoris together with partial or total excision of the labia minora.*  
*Type III: excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening, also known as infibulation. This is the most extreme form and constitutes 15 per cent of all cases. It involves the use of thorns, silk or catgut to stitch the two sides of the vulva. A bridge of scar tissue then forms over the vagina, which leaves only a small opening (from the size of a matchstick head) for the passage of urine and menstrual blood.*  
*Type IV: includes pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and or the labia; cauterisation or burning of the clitoris and surrounding tissues, scraping of the*

*vaginal orifice or cutting (Gishiri cuts) of the vagina and introduction of corrosive substances or herbs into the vagina.*

The following meanings are associated with the three terms.

**Female Genital Mutilation (FGM)** is widely used. However, some consider the term “mutilation” disempowering and stigmatising for survivors. It also can be seen as condemnatory of traditional practices and alienating to communities. Others argue this term is important in emphasising that the practise is a violation of women’s human rights. **This term is preferred by Health Poverty Action in most circumstances.**

**Female Genital Cutting:** A more neutral term which may be less alienating and stigmatising when approaching the issue in practising communities. However some feel the objective nature of the terms diminishes the harmful impact of the practice and removes the emphasis on this as a human rights violation.

**Female Circumcision:** Sometimes used to refer to type 1 FGM/C. Like cutting, circumcision is a more neutral term, however in equating FGM/C with male circumcision it has received particular criticism - for being both inaccurate and in normalising the practise.

#### **Femicide**

The murder of women or girls as a result of misogynist attitudes. This includes ‘honour’ related murders.

#### **Feminism**

Belief in and advocacy towards equality between men and women

**Forced Marriage:** *The marriage of an individual against her or his will.\** We should also consider the definition of consent here. For example if the individual gives agreement as a result of a lack or perceived lack of alternatives.

#### **Gender**

The socially constructed roles and characteristics attributed to people. Usually categorized as male, female or nonbinary.

#### **Gender-based Violence (GBV)**

Commonly defined as: *“violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society”<sup>xxxvii</sup>* This definition encompasses violence against women but recognises that men too can experience violence linked to dominant gender norms.

#### **Gender norms**

Societies’ expectations of people based on their gendered identities.

#### **Gender roles**

Societies’ expectations of people based on their biological sex.

#### **Harmful (traditional) practices**

Harmful practices carried out on the basis of culture, tradition, religion or superstition. They are carried out with the purpose of upholding gender norms. Some argue that the word traditional

should be removed from the definition due to its particular association with indigenous or minority groups (ignoring the fact that all societies have practices that are harmful to women). Others emphasize that its inclusion is necessary in order to emphasize that no custom, tradition or religion can be used as justification for states' failure in their duties to address Violence Against Women. **Harmful practices** is the preferred term used by Health Poverty Action.

### **Institutional violence**

See 'structural violence' but used when this the violence is perpetrated by institutional structures.

### **Intersectionality**

The recognition that various forms of oppression (e.g. class, race, gender, age) intersect.

### **Intimate partner violence**

Violence perpetrated by an intimate partner or former-partner that causes physical, sexual or psychological harm.

### **LGBTIQA +**

Lesbian, Gay Bisexual, Transgender, Intersex, Queer, Asexual and other sexual orientations

**Nonbinary** people who do not describe themselves or their genders as fitting into the categories of man or woman

### **Patriarchy**

A social system in which men are dominant.

**Physical Assault:** *an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.\**

**Psychological / Emotional Abuse:** *infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.\**

**Rape:** *non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.\**

### **Sex**

The biological, physical and genetic differences between men, women and intersex persons.

**Sexual Assault:** *any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.\**

### **Sexual and Gender-based Violence (SGBV)**

See entries for GBV and Sexual Violence. However this definition separates sexual violence from other forms of gender based violence and has been criticised for implying sexual violence is not linked to gender norms.

**Sexual harassment** unwanted conduct of a sexual nature.

**Sexual violence.** This defined by the WHO as: *any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.*<sup>xxxviii</sup>

### **Structural violence**

A term first used by Johan Galtung, used to refer to violence not committed by an individual actor but when unequal power relations bound up in social or institutional structures place avoidable barriers in the way of meeting basic needs. One example he gives is of a security in which life expectancy is twice as high amongst the highest social group as the lowest.<sup>xxxix</sup>

### **Survivor**

Someone who has survived violence. Sometimes used interchangeably with the term 'victim'. However survivor emphasizes the person's agency and is considered less disempowering. Victim should only be used when someone has died as a result of the violence inflicted.

**Transgender** someone whose gender identity differs from the sex assigned at birth

### **Victim**

Someone who has died as a result of violence. Sometimes use interchangeably with 'survivor'. However the term victim is considered disempowering and should not be used to describe the living.

### **Violence Against Women (VAW)**

A component of Gender Based Violence, when the act is perpetrated only against women. VAW has been recognised in numerous international frameworks and was defined in the Declaration on the Elimination of Violence against Women as:

*"any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."* Particular legal duties rest on states to address VAW.

## **Annex 2 - Key International Frameworks relating to GBV<sup>5</sup>**

Violence Against Women<sup>6</sup> is addressed specifically in a number of international frameworks. Key ones include:

The 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) defined discrimination against women. The convention is legally binding. Whilst the Convention itself does not mention violence explicitly, General Recommendations 12 and 19 clarify that the Convention includes violence against women and makes recommendations to States.

The 1993 World Conference on Human Rights recognized violence against women as a human rights violation.

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<sup>5</sup> For a comprehensive list see. <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/global-norms-and-standards>

<sup>6</sup> These frameworks are specific to VAW, rather than GBV perpetrated against men.

The 1993 Declaration on the Elimination of Violence against Women is the first international instrument that explicitly addresses violence against women. It provides a framework for action by states and at the international level. It asserts that states have an obligation to prevent, protect and punish acts of violence against women, whether committed by the State or in the private domain.

The 1995 Beijing Platform for Action identifies specific actions for Governments to take to prevent and respond to violence against women and girls. Ending violence is one of 12 areas for priority action. It also acknowledges a particular vulnerability to violence amongst women belonging to minority groups, indigenous women, refugee women, women migrants and women in detention.

The 2011 Council of Europe Convention on preventing and combating violence against women and domestic violence is the second legally binding regional instrument on violence against women and girls. Although it is regional, it can be signed and ratified by any State.

### Annex 3 - Further reading

DFID 'How to' note (written by the Gender and Development Network) Guidance Note 2, May 2012, *A Practical Guide on Community Programming on Violence Against Women and Girls*  
[http://www.gadnetwork.org.uk/storage/VAWG\\_guidance2\\_community%20programming1.pdf](http://www.gadnetwork.org.uk/storage/VAWG_guidance2_community%20programming1.pdf)

WOMANKIND Worldwide, Women's Rights Advocacy Toolkit  
<http://www.endvawnow.org/en/>

UN Women, Virtual Knowledge Centre to End Violence Against Women and Girls has a range of programming guidelines and links to resources. <http://www.endvawnow.org/en/>

Researching Violence against Women: A Practical Guide for Researchers and Activists; [Chapter 2: Ethical Considerations for Researching Violence Against Women](#) (Path 2005), Available in [English](#)

Working with perpetrators: UN Women, Virtual Knowledge Centre to End Violence Against Women and Girls, Perpetrators of violence/batterers  
<http://www.endvawnow.org/en/articles/229-perpetrators-of-violencebatterers.html>

Evaluating Batterer Counseling Programs: A Difficult Task Showing Some Effects and Implications (Gondolf, 2004). Available in [English](#).

AWID, *Strengthening Monitoring And Evaluation For Women's Rights: Thirteen Insights For Women's Organizations* [http://www.awid.org/eng/Media/Files/MnE\\_Thirteen\\_Insights\\_Women\\_Orgs\\_ENG](http://www.awid.org/eng/Media/Files/MnE_Thirteen_Insights_Women_Orgs_ENG)

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<sup>ii</sup> GAD Network VAWG Working Group, Factsheet, *Violence Against Women and Girls*  
<http://www.gadnetwork.org.uk/storage/csw/Violence%20Against%20Women%20and%20Girls.pdf>

<sup>iii</sup> **UNAIDS, *Breaking the silence around gender-based violence*, 11 December 2013**  
<http://www.unaids.org/en/resources/presscentre/featurestories/2013/december/20131211xgbvart/> (accessed 20 Jan)

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- iv UN Women, Virtual Knowledge Centre to End Violence Against Women and Girls, *Fast Facts* <http://www.endvawnow.org/en/articles/299-fast-facts-statistics-on-violence-against-women-and-girls-.html?next=300> (accessed 04 February 2014)
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- vii **Economic Violence To Women and Girls Is It Receiving the Necessary Attention? Olufunmilayo I. Fawole, *Trauma Violence Abuse* July 2008 vol. 9 no. 3 167-177**
- viii Violence, Peace, and Peace Research Author(s): Johan Galtung Source: *Journal of Peace Research*, Vol. 6, No. 3 (1969), pp. 167-191
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- x *Ending Violence Against Women: An Oxfam guide*, 30 November 2012, <http://policy-practice.oxfam.org.uk/publications/ending-violence-against-women-an-oxfam-guide-254118>
- xi UN Women, Virtual Knowledge Centre to End Violence Against Women and Girls, Causes, protective and risk factors <http://www.endvawnow.org/en/articles/300-causes-protective-and-risk-factors-.html?next=301> Accessed 04 February 2014)
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- xvii UN Women, Facts and Figures: HIV and AIDS <http://www.unwomen.org/en/what-we-do/hiv-and-aids/facts-and-figures#sthash.LIBvViCB.dpuf> (accessed 24 January 2014)
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