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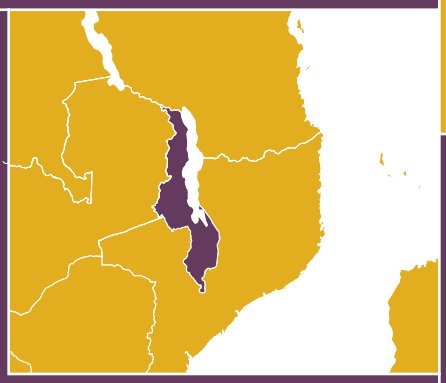
GENDER-BASED VIOLENCE IN MALAWI



A Literature Review to Inform the National Response

This publication was prepared by Madison Mellish, Susan Settergren, and Henry Sapuwa of the Health Policy Project.

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Gender-based Violence in Malawi: A Literature Review to Inform the National Response

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EXECUTIVE SUMMARY

The government of Malawi has taken important actions to address gender-based violence (GBV), recognizing its detrimental impact on the people of Malawi and the progress of the country. The Department of Gender Affairs of the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) coordinates the national GBV response and is working to strengthen GBV data systems and improve the use of data for GBV policy development and program implementation. In support of this effort, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a literature review to identify and synthesize existing studies and key government documents on GBV in Malawi. The literature review focused on the following questions:

- What are the various forms of GBV that exist in Malawi, and how prevalent are they? What are the trends?
- What is known about GBV among specific populations or in specific settings?
- What factors are associated with GBV?
- What is the impact of GBV?
- What interventions have been undertaken to address GBV and how effective have they been?
- What key government documents on GBV exist and what do they say?

This literature review provides answers to these questions by compiling information from available published and unpublished sources and presenting it in a succinct format so that researchers and policymakers can familiarize themselves with existing research and key documents, use it to inform policy and program decision making, and build a research agenda and portfolio that targets knowledge strengths and gaps.

The review includes 74 documents related to GBV in Malawi. Most focus on various forms of violence experienced by women, including domestic or intimate partner violence (IPV). Several large nationally representative surveys have been conducted, notably the Malawi Demographic and Health Surveys 2004 and 2010, as well as a national GBV study that focused on IPV (Pelser et al., 2005). These provide prevalence estimates for GBV and a wealth of other information on factors associated with GBV experienced by women. Also, a large portion of the reviewed studies and policy documents examined GBV among children. One nationally representative study looked at the prevalence of several forms of violence experienced by school-aged children, both inside and outside the school environment (Burton, 2005). Another looked at experiences of GBV among girls and young women, and focused on educational impact (Bisika et al., 2009). A third nationally representative survey examined prevalence of coerced first sex in Malawi and three other African countries (Moore et al., 2007).

About one-third of the reviewed research studies addressed GBV among specific populations, including people living in specific geographic locations, school children, employees, female domestic workers, female university students, prisoners, street children, people living with HIV, women with disabilities, and refugees. A slightly larger number of studies examined knowledge and attitudes related to GBV and other associated factors, including demographics, harmful traditional practices, the school environment, controlling behaviors, and substance use. Several of the reviewed studies examined the impact of GBV in Malawi, focusing on individuals' health and education, as well as Malawi's economy. Only a few studies were found that evaluated GBV interventions, despite the fact that many GBV interventions are occurring in Malawi. Summaries of findings from all reviewed studies are included in this report.

The literature review also included a review of 30 government policy documents that address GBV, including international agreements, national policies, laws, plans, strategies, and guidelines. The international agreements signed by Malawi's government reaffirm its commitment to addressing and eliminating GBV. The national policies, plans, strategies, and guidelines span various sectors (e.g., health, police, labor, education) and put into place actions and measures to prevent and respond to GBV. The GBV laws that are in place exist to protect citizens against GBV and to help survivors. This report includes summaries of the GBV-related information contained in each of these documents.

While variations were found across studies in terms of the types of GBV studied, definitions used, study populations, and methodologies, findings were consistent in demonstrating the magnitude of the problem and many of its consequences. The studies offer a wealth of information that can be used for policy making and programming. The review of government documents suggests that some information has been used to shape policies and plans, but it also reveals that a more comprehensive look at the data could contribute to improved priority setting and more strategic approaches to ending GBV and supporting survivors.

The literature review also revealed some information gaps. These include research on boys' and men's experience of GBV, the prevalence of and factors associated with perpetration of GBV, and an understanding of how risk and protective factors play out in different settings and among different populations. The most critical gap, however, is in studies to evaluate GBV policy and program interventions. Although the literature review did not set out to assess the quality of information presented in the identified documents beyond the criteria established for the search process, variations were observed in the scientific rigor of the studies, accuracy or completeness in presentation of the methods and results, and interpretation of the findings.

In order to improve GBV research in Malawi, and the use of research and other information to strengthen the national response to GBV, the authors recommend wide dissemination of this report with translation of research findings for different audiences; prioritization of research to evaluate impact and costs of GBV programs and services; and capacity strengthening of organizations and individuals within Malawi to conduct high-quality GBV research and evaluations, and to report on and translate the findings for policy making and programming.

ABBREVIATIONS

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DFID	Department for International Development
DHS	Demographic and Health Survey
GBV	gender-based violence
HPP	Health Policy Project
IPV	intimate partner violence
JSSP	Joint Sector Strategic Plan
MDHS	Malawi Demographic and Health Survey
MKW	Malawian Kwacha
MoGCDSW	Ministry of Gender, Children, Disabilities and Social Welfare
NSO	National Statistical Office
PLA	participatory learning and action
SGBV	sexual and gender-based violence
SRGBV	school-related gender-based violence
TWG	technical working group
UN	United Nations
USAID	United States Agency for International Development
VAC	violence against children
VAW	violence against women
VSU	Victim Support Unit

INTRODUCTION

Malawi's National Response to Gender-based Violence

The government of Malawi recognizes the problem of gender-based violence (GBV) and acknowledges its impact on vulnerable groups, gender equality, and poverty reduction efforts (Ministry of Gender, Children, Disability and Social Welfare, 2014a). The government is committed to preventing and responding to GBV through a variety of actions, including laws, policies, international commitments, programs, and services.

The Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) is the government institution tasked with coordinating Malawi's national GBV response. The national GBV Technical Working Group (TWG), comprising government and civil society representatives from various sectors (i.e., health, social welfare, education, justice, and faith), "consolidate[s] and coordinate[s] the activities of all relevant stakeholders to improve and support the prevention of and response to GBV amongst Malawian population in line with the National Response to Gender based Violence" (GBV TWG, 2008, p. 1). Along with coordination, other priorities for this group include information sharing (i.e., of programs, tools, training resources, awareness-raising materials, and research), advocacy, and capacity building to prevent and respond to GBV. The director of the Department of Gender Affairs of the MoGCDSW chairs the GBV TWG.

The *National Plan of Action to Combat Gender-Based Violence in Malawi 2014–2020*, currently in final draft form, outlines four priority areas for the national GBV response in coming years. Among these is "Research, monitoring and evaluation" (Priority Area 4), which aims to strengthen GBV data systems and improve the use of GBV data for policy development and program implementation. Planned activities include establishing a research task force within the GBV TWG, developing and harmonizing data collection methods and tools, developing a national research strategy, building research capacity, and implementing research priorities based upon the research strategy.

Purpose of the Literature Review

A first step in strengthening the information base and promoting the use of GBV data for decision making is being aware of what information exists, understanding it, and identifying gaps. To this end, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a literature review to identify and synthesize existing studies and key government documents on GBV in Malawi. The literature review was conducted with the following analysis questions in mind:

In Malawi:

- What are the various forms of GBV that exist, and how prevalent are they? What are the trends?
- What is known about GBV among specific populations or in specific settings?
- What factors are associated with GBV?
- What is the impact of GBV?
- What interventions have been undertaken to address GBV and how effective have they been?
- What key government documents on GBV exist and what do they say?

This literature review aims to provide answers to these questions by compiling information from available published and unpublished sources and presenting it in a succinct format, so that researchers and policymakers can familiarize themselves with existing research and key documents, use it to inform

policy and program decision making, and build a research agenda and portfolio that targets knowledge strengths and gaps. Because the topic of GBV and its various forms can be approached from a range of perspectives, the literature review takes a comprehensive look at existing information without attempting to present any singular point of view. Further synthesis of the information is left for the reader to undertake in accordance with her or his interests and needs.

METHODOLOGY

Search Strategy

An online search was conducted from June to July 2014 for published and grey literature on GBV in Malawi. The search was limited to documents from 1995 to the present, as major research on GBV began in Malawi in 1995 and few relevant studies exist before this year.

The following databases were searched for documents:

- Google
- Google Scholar
- PubMed
- POPLine
- Development Experience Clearinghouse

Search terms used included both "Malawi" AND one of the following:

- gender-based violence
- physical violence
- emotional violence
- sexual violence
- assault
- rape
- intimate partner violence

Documents that met the search criteria were retrieved and then reviewed for relevancy. Relevancy was determined by whether or not the document would provide information to answer one of the literature review's key analysis questions. Documents that only summarized research from other original source documents (and, as such, did not contribute any new data or interpretation) and documents that were otherwise non-empirical in nature were excluded. Exceptions were made, however, for a few documents that presented information from other sources, if the original source documents could not be obtained. Documents that contained internally inconsistent or incomplete information were excluded.

Government documents were identified using the above methods as a first step. Additional government documents were identified through references within the first-retrieved documents. The referenced items were then obtained using a targeted Google online search, or from government staff and local GBV experts when the documents were not available online.

As a final step, members of the GBV TWG were asked to review the list of documents for completeness and to recommend any missing documents for inclusion in the literature review. These documents were also reviewed for relevancy before inclusion.

Search Results

Seventy-four documents were identified through the search strategy and are included in the literature review. The complete list of documents is provided in the References section.

The studies and government documents within the reviewed literature examined various forms of GBV. Table 1 presents the number of reviewed documents by form of GBV, broadly defined. Notably, some documents addressed multiple forms of GBV; these are counted under all categories addressed.

Women's experience of violence—that is, experiences by adult and young women, both within and outside an intimate partnership—were the most commonly studied forms of GBV. The literature also contained a significant number of studies and policies that focused on GBV among children, both girls and boys, but especially girls. Fewer documents looked at men's experience of GBV, and only one document focused specifically on male GBV experience.

Table 1. Forms of GBV Addressed by the Literature Review Documents

Type of GBV	Number of Reviewed Documents that Addressed this Type of GBV
GBV (male and female, adults and children)	12
Gender-based violence among women	31
Domestic violence or intimate partner violence (experienced by women)	23
Gender-based violence among children (female and male)	35
Sexual harassment (female and male)	4

Most of the reviewed literature included definitions of GBV or the GBV-related terms used. Typically, these definitions were not standardized across studies/documents, but many contained common elements. Comparisons of definitions used in the various documents are presented in the sections on Findings Reported in Research Studies (beginning page 6) and Government Documents on GBV (beginning page 38), along with the findings from those documents.

For analysis purposes, the documents were categorized according to the types of information they contained. Table 2 shows the categories created and the number of documents that fell within each category. Again, some documents contained multiple types of information and, thus, fall within more than one category.

Table 2. Types of Information Found in the Literature Review

Type of Information	Number of Reviewed Documents that Contained this Type of Information
Research studies	
Prevalence estimates (national-level)	6
GBV among specific populations	17
Knowledge, attitudes, and norms related to GBV	8
Other factors associated with GBV	16
Impact of GBV	7
Evaluation of GBV interventions	6

Type of Information	Number of Reviewed Documents that Contained this Type of Information
Government documents on GBV	
International agreements	7
National policies	7
Laws	7
National plans and strategies	5
Guidelines	4

FINDINGS REPORTED IN RESEARCH STUDIES

Prevalence Estimates

Prevalence estimates from large nationally-representative studies

Six large, nationally representative studies have been conducted in Malawi that provide prevalence rates for various forms of GBV among women and children.[1] The most widely cited and largest of these studies are the two Malawi Demographic and Health Surveys (MDHS) funded by USAID and conducted by the National Statistical Office (NSO) of Malawi, in 2004 with ORC Macro and in 2010 with ICF Macro (NSO and ORC Macro, 2005; NSO and ICF Macro, 2011). In addition to the MDHS, the Department for International Development (DFID) funded two large, nationally representative studies in 2005, through the National Statistical Office Crime & Justice Statistical Division: one on intimate partner violence (IPV) (Pelser et al., 2005) and the other on gender-based violence in schools (Burton, 2005). Bisika, Ntata, and Konyani (2009) also conducted a nationally representative study in 2004 that examined experiences of gender-based violence among girls and young women in Malawi, focused on educational impact (described further in the section on Studies on GBV Among Specific Populations, page 17). Moore et al. (2007) conducted a nationally representative survey in 2004 to determine prevalence of coerced first sex in Malawi and three other African countries.

The six reviewed studies provide a wealth of nationally representative data on GBV over a six-year time period. In the sections below, information across studies is summarized by the different measures of GBV studied.

Prevalence of violence experienced by women

Physical violence, any perpetrator: Both the MDHS 2004 and 2010 surveys measured prevalence of the experience of physical violence, by any perpetrator, using two reference periods: "since age 15" and "in the past twelve months." Questions on physical violence were asked of all women in the survey, who were ages 15–49.

As shown in Table 3, the overall prevalence of reported physical violence (ever experienced since age 15, and experienced in the last 12 months) remained fairly constant from 2004 to 2010 (around 28% for ever experienced since age 15 and around 14% for experienced in the past 12 months). Table 3 also presents these estimates by region and shows variation across regions within each survey and over time.

Table 3: MDHS Results for Prevalence of Physical Violence, All Perpetrators

MDHS Interview Question: "…has anyone hit, slapped, kicked or done anything else to hurt you physically?"				
	Percentage of women ages 15–49 who have			
Region	Ever experienced physical violence since age 15		Experienced physical violence in the past 12 months	
	MDHS 2010	MDHS 2004	MDHS 2010	MDHS 2004
Northern	29.8	28.1	17.9	14.5
Central	26.1	29.6	13.0	15.2
Southern	29.8	27.6	14.5	14.0
TOTAL	**28.2**	**28.1**	**14.2**	**14.5**

[1] Additionally, in 2013, the government of Malawi, CDC, and UNICEF conducted a nationally representative survey on violence against children (VAC). Results were not available at the time of the literature search and, thus, are not included in this review.

Sexual violence, any perpetrator: The MDHS 2010 also reported lifetime prevalence of sexual violence by any perpetrator. As shown in Table 4, 25.3 percent of women reported having ever experienced sexual violence by any perpetrator, with respondents from the Northern region reporting the highest prevalence rate, at 32.2 percent.

Table 4: MDHS Results for Prevalence of Sexual Violence, All Perpetrators

MDHS 2010 Interview Question: "At any time in your life, as a child or as an adult, has anyone ever forced you in any way to have sexual intercourse or perform any other sexual acts?"	
Region	**Percentage of women ages 15–49 who have ever experienced sexual violence**
Northern	32.2%
Central	25.2%
Southern	23.7%
TOTAL	**25.3%**

Force at sexual initiation: The MDHS 2010 asked women ages 15–49 who had reported ever having sex, "The first time you had sexual intercourse, would you say that you had it because you wanted to, or because you were forced to have it against your will?" The study found that 14.7 percent of women reported their first sexual experience was forced against their will. An earlier nationally representative household survey of 4,012 females and males ages 12–19 found that 38.1 percent of girls who had a sexual experience reported that they were "not willing at all" during their first sexual experience (Moore et al., 2007).

Physical violence during pregnancy: The MDHS 2004 and 2010 surveys also asked women who had ever been pregnant if they had experienced physical violence, by any perpetrator, during pregnancy. Physical violence rates during pregnancy increased over the six-year period, from 5.3 percent in 2004 to 6.2 percent in 2010. The age-disaggregated rates, given in Table 5, show that the greatest increase occurred among 15–19 year olds, from 3.6 percent in 2004 to 9.4 percent in 2010. Other changes in rates between 2004 and 2010 mentioned in the MDHS 2010 report include an increase in the percentage of ever-pregnant urban women reporting physical violence during pregnancy (from 3.8% in 2004 to 8.3% in 2010) and an increase in the percentage of ever-pregnant, never-married women reporting physical violence during pregnancy (from 4.0% in 2004 to 6.7% in 2010).

Table 5: MDHS Results for Prevalence of Physical Violence During Pregnancy

Interview Question: "Has any one ever hit, slapped, kicked, or done anything else to hurt you physically while you were pregnant?"		
Percentage of ever-pregnant women reporting physical violence during pregnancy		
Age	**MDHS 2010**	**MDHS 2004**
15–19	9.4%	3.6%
20–24	4.5%	5.7% (*for ages 20-29)
25–29	8.0%	
30–39	6.2%	5.4%
40–49	4.5%	4.6%
TOTAL	**6.2%**	**5.3%**

Domestic violence/intimate partner violence: Domestic violence, or IPV, is the most studied form of GBV in Malawi. Three nationally representative surveys measuring IPV prevalence were reviewed: the two MDHS surveys already mentioned and one conducted in 2005 (referred to in the tables below as "IPV 2005"), which sampled women over the age of 18 (Pelser et al., 2005). All three surveys measured the prevalence of women's experience of three types of IPV (physical, sexual, and emotional). The IPV 2005 survey also measured a fourth type: economic IPV.

The questions used in the three studies to measure various forms of IPV are presented below together with the prevalence rates. Caution should be exercised when comparing results between the two MDHS studies and the IPV 2005 study because the interview questions differed. The surveys also differed in other ways, including:

- *Survey samples:* MDHS 2004 and 2010 samples included women ages 15–49, while the IPV 2005 report included women over 18 years of age with no upper age limit specified.
- *Intimate partner definitions:* While the MDHS defined an intimate partner as someone the respondent lived with or was married to, the IPV 2005 study report did not define the term.
- *Reference periods and scope:* The MDHS asked about experience of intimate partner violence committed by either current or last husband or partner (ever and in past 12 months); the IPV study reports that "women were asked about their experiences of abuse over their lifetime" (p. 9) and specifically "whether their intimate partners had ever perpetrated such acts against them" (pg. vi).

For this literature review, research findings are organized by type of IPV, as follows:

1. *Physical IPV*: The MDHS 2004 and 2010 and the IPV 2005 studies all reported prevalence for experience of physical IPV. The MDHS 2010 also asked specifically about experience of physical IPV in the past 12 months. The interview questions used in the three surveys are given in Table 6. While the structure of questions differed slightly among the three surveys, the component acts of violence that were asked about were nearly identical. One exception is that the IPV 2005 study included questions about suffocation and physical harm to children or family members, while the two MDHS studies did not.

Table 6: Interview Questions on Experience of Physical IPV

MDHS 2010	MDHS 2004	IPV 2005
(Does/did) your (last) husband/partner do any of the following things to you (ever and in past 12 months) • Push you, shake you, or throw something at you? • Slap you? • Twist your arm or pull your hair? • Punch you with his fist or with something that could hurt you? • Kick you, drag you, or beat you up? • Try to choke you or burn you on purpose? • Threaten or attack you with a knife, gun, or any other weapon?	(Does/did) your (last) husband/partner ever • Push you, shake you, or throw something at you? • Slap you or twist your arm? • Punch you with his fist or with something that could hurt you? • Kick you or drag you? • Try to strangle or burn you? • Threaten you with a knife, gun, or other type of weapon?	Respondents were asked if a partner had ever • Thrown something at them that could harm them • Pushed or shoved them • Twisted their arm • Pulled their hair • Slapped or hit them • Kicked or punched them • Choked, strangled, or suffocated them • Hit them with some object • Burned or scalded them • Used a knife or gun on them • Physically harmed any children or other members of the family
In each survey, experience of IPV was coded "yes" if a respondent answered "yes" to one or more of the components of violence.		

Physical IPV prevalence rates found in the surveys are shown in Table 7. There was a small increase in prevalence from 2004 to 2010, according to the MDHS, which used identical questions at the two points in time. The IPV 2005 prevalence is considerably higher than either MDHS estimate, likely due to the study differences noted above. The MDHS 2010 reported recent experience of violence (i.e., in the past 12 months) at 14.7 percent.

Table 7: Prevalence of Physical IPV

Study	Physical IPV Prevalence	Measurement
MDHS 2010	21.7%	Ever experienced physical IPV, defined as answering "yes" to one or more of the 7 questions; among ever-married women ages 15–49
MDHS 2004	20.0%	Ever experienced physical IPV, defined as answering "yes" to one or more of the 6 questions; among ever-married women ages 15–49
IPV 2005	30.1%	Ever experienced physical IPV, defined by the given question; women ages 18+
MDHS 2010	14.7%	Experienced physical IPV in the past 12 months, defined as answering "yes" to one of or more of the seven questions, and then answering that it had happened either "often" or "sometimes" in the past 12 months; among ever-married women ages 15-49

2. *Sexual IPV:* The MDHS 2004 and 2010 and the IPV 2005 surveys each asked questions to measure experience of sexual IPV. The MDHS 2010 also asked specifically about experience of sexual IPV in the past 12 months. Table 8 presents the questions that were asked in the three surveys.

Table 8: Interview Questions on Prevalence of Sexual IPV

MDHS 2010	MDHS 2004	IPV 2005
(Does/did) your (last) husband/partner (ever and in past 12 months) • Physically force you to have sexual intercourse with him even when you did not want to? • Force you to perform other sexual acts you did not want to?	(Does/did) your (last) husband/partner ever • Physically force you to have sexual intercourse with him even when you did not want to? • Force you to perform other sexual acts you did not want to?	Respondents were asked if a partner had ever • Kissed, touched, or felt their body against their will • Tried or succeeded in having sex, or in inserting penis in places they were not happy with, without vaginal penetration taking place • Had any other form of sex (including penetrative, anal, oral, or thigh) against them • Touched their private parts with their mouth against their will • Forced them to touch their private parts with your mouth • Forced them to watch any of the above on film, or in real life, against their will
In each survey, experience of IPV was coded "yes" if a respondent answered "yes" to one or more of the components of violence.		

Prevalence rates of sexual IPV are given in Table 9. Since the MDHS 2004 and 2010 asked the same questions, the data can be compared. They show that the rate of women reporting experience of sexual IPV committed by current or last husband/partner has increased from 13.4 percent in 2004 to 18.9 percent in 2010. The IPV 2005 survey asks the question in a different way by providing multiple examples of sexual IPV so comparisons of this estimate to the MDHS estimates should be made with caution.

The MDHS 2010, the only survey that asked about experience of sexual IPV in the past 12 months committed by current or last husband/partner, found that 13.4 percent of ever-married women reported this experience.

Table 9: Prevalence of Sexual IPV

Study	Result	Measurement
MDHS 2010	18.9%	Ever experienced sexual IPV, defined as answering "yes" to one or both of the 2 questions; among ever-married women ages 15–49
MDHS 2004	13.4%	Ever experienced sexual IPV, defined as answering "yes" to one or more of the 2 questions; among ever-married women ages 15–49
IPV 2005	17.7%	Ever experienced sexual IPV, defined by the given question; women ages 18+
MDHS 2010	13.4%	Experienced sexual IPV in the past 12 months, defined as answering "yes" to one or more of the 2 questions, and then answering that it had happened either "often" or "sometimes" in the past 12 months; among ever-married women ages 15-49

3. *Emotional IPV:* All three surveys (MDHS, 2004; MDHS, 2010; and IPV, 2005) asked questions regarding experience of emotional IPV. The MDHS 2010 also asked about experience of emotional IPV in the last 12 months. The interview questions used to measure emotional IPV are given in Table 10.

Table 10: Interview Questions on Emotional IPV

MDHS 2010	MDHS 2004	IPV 2005
(Does/did) your (last) husband/partner (ever and in past 12 months) • Say or do something to humiliate you in front of others? • Threaten to hurt or harm you or someone close to you? • Insult you or make you feel bad about yourself?	(Does/did) your (last) husband/partner ever • Say or do something to humiliate you in front of others? • Threaten you or someone close to you with harm?	Respondents were asked if a partner had ever • Prevented them from communicating with other people • Limited their movements outside the house (after the age of 18 years) • Humiliated them in front of people • Called them crazy, possessed, or threatened to take them to a mental hospital/facility • Threatened to hurt them or harm their children or other family members • Threatened to damage any of their possessions • Threatened to take their life, or that of their children • Threatened to commit suicide if they did not do what they wanted
In each survey, experience of IPV was coded "yes" if a respondent answered "yes" to one or more of the components of violence.		

Table 11 presents the prevalence rates for experience of emotional violence from the three surveys. A significant increase in rates of women who reported having experienced emotional violence committed by current or last husband/partner was found from MDHS 2004 to MDHS 2010, but may be explained, at least partially, by the addition of the interview question "insult you or make you feel bad about yourself" in the latter. While rates from the MDHS 2010 and the IPV 2005 are similar, these results should be interpreted cautiously because of interview question and survey differences. The MDHS 2010, the only survey that measured experience of emotional violence in the past 12 months, found that 21.2 percent of women had this experience.

Table 11: Prevalence of Emotional IPV

Study	Result	Measurement
MDHS 2010	25.2%	Ever experienced emotional IPV, defined as answering "yes" to one or more of the 3 questions; among ever-married women ages 15–49
MDHS 2004	12.7%	Ever experienced emotional IPV, defined as answering "yes" to one or more of the 2 questions; among ever-married women ages 15–49
IPV 2005	24.8%	Ever experienced emotional IPV, defined by the given question; women ages 18+
MDHS 2010	21.2%	Experienced emotional IPV in the past 12 months, defined as answering "yes" to one or more of the three questions, and then answering that it had happened either "often" or "sometimes" in the past 12 months; among ever-married women ages 15–49

4. *Economic IPV:* Only the IPV 2005 study measured women's experience of economic IPV. The interview questions are given in Table 12. Results showed a prevalence of 27.7 percent for lifetime experience of economic IPV among ever-partnered women ages 18 and older.

Table 12: Interview Questions on Economic IPV

IPV 2005
Respondents were asked if a partner had ever • Taken money from their purse without consent • Refused to pay child support/maintenance • Prevented from knowing about/accessing family income • Forced to hand partner money • Prevented from earning an income • Not paid for work undertaken as promised • Forced them to work without pay • Prevented them from accessing income-earning resources • Withdrawn money from account with consent • Forced them to ask for money • Forced them to be the sole breadwinner
Experience of IPV was coded "yes" if a respondent answered "yes" to one or more of the components of violence.

Prevalence of violence experienced by children

One nationally representative study conducted in 2005 looked at the prevalence of several forms of violence experienced by school-aged children, both inside and outside the school environment (Burton, 2005). The study interviewed 4,412 children ages 9–18.

Table 13 shows the aggregate percentages of girls and boys reporting experiences of various types of GBV, together with the definitions used and the study population on which these data were collected. Nearly all children reported experiences of physical bullying and nearly one-quarter reported experiencing forced sex.

Table 13: Prevalence of Violence Among Children Reported in the Burton 2005 Study

Type of Violence	Percentage Having Reported Experiencing the Type of Violence	Definition	Study Population
Bullying	99.9%	slapped, beaten, punched or kicked, or threatened with harm in some way	all children ages 9–18
Forced touching	14.9% (sexually or non-sexually) 14.0% (breasts/genitals)	kissed, touched or had body felt against his/her will; or forced to touch the perpetrator in places/he did not want to	all children ages 9–18
Forced oral sex	3.9%	forced to touch the perpetrator's private parts with his/her mouth, the perpetrator touched the respondent's private parts with his/her mouth, or forced to have any other kind of oral sex s/he did not want	all children ages 14–18
Forced penetrative and non-penetrative sex	23.8%	forced to have sex (including thigh sex); or the perpetrator attempted to insert his penis or other foreign objects into places/he was not happy with	all children ages 9–18

Prevalence estimates from a large survey of selected districts

Physical, sexual, and psychosocial violence

In 2012, the NSO and the Ministry of Gender, Children and Community Services conducted a large joint survey on GBV with several donors within 17 European Union/United Nations (UN) intervention districts (NSO et al., 2012). These districts are Chitipa, Karonga, Mzimba, Nkhatabay, Salima, Dowa, Mchinji, Dedza, Mangochi, Machinga, Chiradzulu, Chikhwawa, Nsanje, Phalombe, Mulanje, Mwanza, and Neno. The survey was designed to provide information on GBV prevalence for the Gender Equality and Women Empowerment Programme, as well as a few selected UN Women districts. The respondents included girls, boys, women, and men ages six and older, from 3,238 households, for a total of 10,841 respondents (5,102 male and 5,739 female respondents). The survey measured the prevalence of lifetime experience of various types of violence by any perpetrator.

Table 14 shows results for physical, sexual, and psychosocial violence disaggregated by sex. Definitions of these forms of violence are also given in the table. Results show that for each type of violence, prevalence is higher among females than males, although the difference is small for psychosocial violence. Of note, prevalence of physical violence among females is similar to that found in the MDHS 2010 (29.5% versus 28.2%), but prevalence of sexual violence is considerably higher (40.3% versus 25.3%). However, because of differences in study locations, samples, and interview questions, the estimates between these surveys are not comparable.

Table 14: Prevalence of GBV from the NSO et al., 2012 Study

	Percentage who reported ever experiencing one or more types of violence included in the definition		
Type of Violence	**Male**	**Female**	**Definition**
Physical	18.8%	29.5%	beating, hitting, or battering; female genital mutilation; human trafficking; abduction; property grabbing; and threat using a weapon
Sexual	29.8%	40.3%	rape; attempted rape; defilement; marital rape; incest; sex deprivation; exchanging coupons for sex; forced early marriage; forced sexual intercourse; unwanted sexual touch; and other violence respondents regarded as sexual
Psychosocial	42.0%	43.6%	sexual harassment; criticism in front of children, friends, relatives, or others; humiliation; unpleasant remarks about one's appearance, dressing code, hair style, or behaviour; dictating one's dressing code, hair style, behaviour, or conduct in public; hurt you by staying away from you or isolating you from friends, relatives, or other people; threatened to kill you; preventing you from seeing or talking to a friend, relative, or other people; being denied freedom of movement; refusing to give you food or refusing to eat from you; refusing to talk to you or choosing to stay silent; refusing to have sex with you when you ask for it; shouting at you in presence of people; belittling your action, decisions, or achievements; and other violence respondents regarded as psychosocial

For each type of violence, experience was coded "yes" if a respondent answered "yes" to one or more of the components of violence in the definition.

Specific forms of physical violence

The NSO et al., 2012 survey also examined specific forms of physical violence, for which prevalence rates are shown in Table 15. The most common form of physical violence experienced among both females and males was beating, hitting, or battering. However, experience of this form of violence was twice as high among females as compared to males (24.5% versus 12.4%).

Table 15: Prevalence of Forms of Physical Violence from the NSO et al., 2012 Study

National Statistical Office, Ministry of Gender, Children and Community Services, European Union, UN Women, and UNFPA Study Findings		
	Percentage of respondents reporting having experienced a particular form of physical violence	
Form of physical violence, categories reported in survey	**Male**	**Female**
Beating, hitting, or battering	12.4%	24.5%
Property grabbing	5.0%	5.8%
Threat using weapon(s)	3.3%	3.3%
Trafficking	2.3%	1.0%
Abduction	0.4%	0.4%

Specific forms of sexual violence

The study also reported the prevalence of different forms of sexual violence. The percentages of males and females who ever experienced these various forms are given in Table 16. Prevalence rates were higher among females, when compared to males, for all forms of sexual violence except sexual deprivation and incest. The most prevalent form of sexual violence experienced by males was sexual deprivation, while the most prevalent form experienced by females was marital rape.

Table 16: Prevalence of Types of Sexual Violence from the NSO et al., 2012 Study

	Percentage of respondents reporting having experienced a particular form of sexual violence	
Form of sexual violence, categories reported in survey	**Male**	**Female**
Unwanted touch	11.7%	20.6%
Marital rape	6.8%	24.2%
Sex deprivation	19.1%	10.3%
Forced sex	6.7%	16.9%
Forced early marriage	4.4%	12.3%
Attempted rape	1.7%	5.8%
Incest	2.9%	2.3%
Other	1.2%	1.2%
Rape	0.8%	1.3%
Defilement	0.5%	1.3%
Exchange sex for coupons	0.7%	0.8%

Specific forms of psychosocial violence

Table 17 shows prevalence rates for different forms of psychosocial violence for males and females. Consistent with the findings on sexual violence, the most prevalent form of psychosocial violence among males was "refused to have sex with you." The most prevalent form among females was "criticism in front of the children." Prevalence rates were higher among females compared to males for all forms of sexual violence measured, except "refused to have sex with you," "sexual harassment," and "refused to give you food or eat food from you."

Table 17: Prevalence of Types of Psychosocial Violence from the NSO et al., 2012 Study

	Percentage of respondents reporting having experienced a particular form of psychosocial violence	
Form of psychosocial violence, categories reported in survey	**Male**	**Female**
Criticism in front of children, etc.	13.5%	15.9%
Refused to have sex with you	22.7%	6.3%
Sexual harassment	10.8%	9.9%
Denied freedom and movement	6.6%	11.6%
Humiliation	8.0%	9.3%
Shouted at you in the presence of people	6.4%	9.7%
Refused to talk to you or choose to stay in silence	7.0%	7.4%
Refused to give you food or to eat food from you	6.8%	6.4%
Unpleasant remarks	4.9%	6.5%
Belittled your act, etc.	4.1%	6.1%
Hurt you by staying away or isolating you	3.1%	3.9%
Prevented you seeing/talking to a friend, etc.	2.7%	3.9%
Dictated one's dressing code, etc.	2.8%	3.5%
Threatened to kill you	2.0%	2.5%
Others	1.0%	1.8%

Studies on GBV Among Specific Populations

The literature review identified 17 studies that focused on GBV among specific populations of people, defined by setting or living conditions, age, occupation, health status, and other factors. None of these studies was national in scope, and they varied in size, methodology, and measurement of GBV. The studies are summarized below by focus population.

School children

The literature review identified four studies on GBV among school children. The most recent was a baseline study conducted in 2013 as part of a project titled *Ending School Related Gender-Based Violence in Malawi*, implemented by Concern International. The study took place at ten of the seventeen project participant schools in the Nsanje District (Rancourt, 2013). Study respondents were 293 students and 63 teachers from these ten schools. Students were asked if they had experienced specific acts of violence in the past year. Definitions of violence used in the study are presented in Table 18.

Table 18: Sexual and Physical GBV Definitions Used in Rancourt, 2013

Type of GBV	Definition Used
Physical	• **Mild:** Minor acts of aggression (e.g., pinching, pushing, grabbing and shoving), sudden angry or violent outbursts or brief reactions • **Moderate:** More lasting and hurtful violence—beating, hitting, slapping, spanking, tripping, and kicking, excluding the use of weapons • **Severe:** Intended to inflict pain and fear—use of weapons (e.g., whips, canes, or other objects), other forms of torturous abuse (e.g., kneeling on a sharp surface, or holding heavy objects for a long period)
Sexual	• **Mild:** Uncomfortable or embarrassing sex-related situations (e.g. obscene remarks or gestures, unwelcome jokes), being made to watch pornography or sexual acts • **Moderate:** Inappropriate bodily contact with sexual overtones (e.g. brushing, pinching, inappropriate kissing, fondling or touching), sex-related situations with a physical manifestation that make a person feel uncomfortable, violated or afraid (e.g. being forced to undress, or being forced to touch, kiss or caress someone in a sexual way) • **Severe:** Unwanted sexual intercourse (vaginal, anal or oral), physically forced or socially pressured, may involve a body part or a foreign object, may be committed by one or more people

The study found that

- 56 percent of students reported some form of physical violence on school grounds or on the way to and from school in the past year (53% of females and 59% of males)
- 45 percent of students reported having experienced an incident of sexual violence in the past year (42% of females and 48% of males)

An earlier study, conducted in 2001 in three schools in Malawi (one urban, one rural, and one peri-urban), found that, among the 106 girls and 65 boys who took part in the study, the majority knew of incidents of GBV occurring in their schools (Leach et al., 2003). The researchers defined GBV as including "sexual harassment and abuse; bullying, intimidation and threats; verbal abuse, taunts and insults; physical violence and assault, including corporal punishment and other physical punishments; emotional abuse (e.g. tempting someone into a sexual relationship under false pretenses such as promises of marriage); and

psychological abuse (e.g. threatening to beat a pupil or to fail them in an exam)" (p.1). Additional results reported included the following:

- 50.0 percent of girls knew at least one girl who had been approached by a teacher for sex, with 25.5 percent reporting that they knew a girl who had accepted the proposition.
- 38.7 percent of girls and 64.6 percent of boys knew of a teacher having sex with a girl student.
- Over 80 percent of the girls reported they had been beaten by at least one teacher.
- 64 percent of the girls said they had had problems with boys in the school, including that the boys had done things like touching their breasts or butts.

Many girls also reported experiencing verbal or sexual abuse on the way to or from school. Most students indicated that they did not report violence incidents to authorities, noting reasons such as that the schools would not do anything or that they were fearful of potential retaliation from the perpetrator following the report. Sixteen teachers, also interviewed as part of the study, reported that many of the girls were transported via minibus and the drivers would exchange free rides for sex. All teachers interviewed reported that abuse of girls, generally physical and verbal abuse, was common in the schools. Most teachers reported that this abuse was primarily perpetrated by male pupils against female pupils. Only three teachers noted that male teachers were in some cases the perpetrators, which differed from the student responses.

In 2004, a large study was conducted in nine districts (three districts from the Northern, Southern, and Central regions) to understand if, and how, GBV affects girls' education (Bisika et al., 2009). The study collected quantitative data through a questionnaire with girls and young women (age range not specified), both in and outside of school, from 1,496 households: 85.2 percent of respondents were currently enrolled in school, while 14.8 percent were not. One girl or young woman was selected from each of the sampled households. Additionally, 112 focus group discussions were conducted with girls, parents, boys, and community leaders to better understand the types of violence girls experienced in schools. The discussions revealed that the predominant types included corporal punishments; beatings, verbal abuse, sexual assault, and rape by boys and teachers; inappropriate touching; and discriminatory classroom practices. The study showed that this violence had a deleterious effect on girls' education: 60.9 percent of the girls reported that their experience of GBV had resulted in performance problems at school. Other findings included the following:

- Nearly half of the girls (43.9%) reported having been touched on the breasts, butt, or genitals without permission. Of those who had been inappropriately touched, 38.8 percent said this experience had negatively affected their education, and 3.3 percent stopped going to school as a result of the incident.
- Among the girls who reported cases of inappropriate touching, 48.7 percent reported that it had occurred on school premises; 34.8 percent reported it had occurred at home; 10.5 percent reported it had occurred on the way to or from school; 4.9 percent reported it had occurred while in public, traveling to town or church, or collecting firewood; and 1.1 percent reported it had occurred at a religious function.
- When respondents identified the perpetrator of the inappropriate touching, 52.2 percent reported that it was a classmate, 16.2 percent reported it was a friend, 16.2 percent reported it was a stranger, 3.8 percent reported it was a teacher, 3.5 percent reported it was a local villager, 3.2 percent reported it was a male relative, 2.5 percent reported it was a boyfriend, and 2.4 percent reported it was a street vendor.

- About half (47.8%) of the respondents who reported having experienced an incident of violence reported the incident to someone. Among those who had reported, 37.5 percent told teachers, 35.0 percent told parents, and only 0.6 percent reported the incident to the police.
- Among those who didn't report the incident (52.2%), the majority of respondents said that they did not realize that it was an offense, while 15.4 percent said they were intimidated into not reporting, and 11.4 percent indicated fear as the reason for not reporting.

A participatory learning and action (PLA) research activity[2] on school-related gender-based violence (SRGBV) was conducted in Machinga District in 2005, as part of the USAID-funded Safe Schools Program (The Centre for Educational Research and Training and DevTech Systems, Inc., 2008). This activity included participation from 952 students in PLA workshops; focus group discussions with 961 students, 824 parents, and 239 teachers; and key informant interviews with 370 community members, including traditional leaders, initiation counselors, members of school management committees and parent teacher associations, head teachers, government Primary Education Advisers, religious leaders, members of school disciplinary committees, and club patrons. These data revealed that

- GBV, broadly defined, was not clearly understood among students, parents, and members of the school committees.
- Head teachers had the best understanding of GBV, but understood it primarily as sexual or physical violence, and failed to recognize some forms of psychological violence.
- Boys and girls are both victims and perpetrators of SRGBV.
- SRGBV occurs both at school and while traveling to and from school. The most common form of SRGBV reported by students was corporal punishment.
- Students and teachers agreed that it is common for students who experience SRGBV to have poor attendance following the violence or drop out of school.
- Respondents from all the schools and communities agreed that most cases of SRGBV are not reported. When cases are reported at school, they are usually reported to a school monitor (classmate) or to a teacher. When cases are reported outside of school, they are reported to the School Management Committee/Parent Teacher Association or the traditional leader/village headman. Students reported that schools' responses to SRGBV were ineffective and actions taken were not sufficient, while teachers almost universally agreed that they were effective and the actions taken were appropriate.
- Although mechanisms for action against perpetrators of SRGBV may exist in schools, they may not be effective. The authors cite the example of a teacher having sex with a student. In such cases, the teacher may be transferred to another school as punishment, but then his behavior at the new school persists.

[2] The PLA research activity was used to facilitate community action planning. It aimed to identify and understand the various forms of SRGBV occurring in schools, to then create a community action plan that would map out reporting and response systems. PLA activities consisted of the workshops, focus group discussions, and key informant interviews. The workshops consisted of a mapping activity to report places where students felt safe and unsafe, an activity where students ranked forms of abuse occurring at home and at school, creating a cause and consequence tree for the abuse, drawing a seasonal calendar of when the abuse occurs, and a facilitated walk from the school to students' homes to learn about what students encountered during their travel.

Female university students

GBV among university students was cited as a concern in several of the sources reviewed. However, only one report that involved primary data collection could be located. This study was conducted in 2007 at Chancellor College, and examined sexual harassment, defined as "… unwanted conduct of a sexual nature. The unwanted nature of the conduct distinguishes it from consensual behavior" (Kayuni, 2009, p.84). Quantitative results from the study were not reported due to very low response rates, but results from the study's qualitative component suggested that sexual harassment, along with other forms of GBV, was occurring at the university. Respondents reported knowing of incidents of rape, students selling sex for grades, and verbal assaults. Almost all respondents reported that sexual harassment between peers occurred at the university, and that sexual harassment committed by male professors against female students also exists, albeit on a smaller scale.

Results from a study of university students conducted in the mid-1990s[3] were reported in both the Kayuni, 2009 document and in another document included in the literature review (Bisika et al., 2009, p. 288). This study reportedly found that "12.6% of female students [at Chancellor College] that responded to the questionnaire had been raped on campus. Out of all the students that had been raped, only 61% reported the incident. However none of these reported to the college administration or the police. The study also revealed that 67% of female students had been sexually harassed while on campus" (Kayuni, 2009, p. 89).

Employees in the workplace

Sexual harassment was also the focus of a study conducted among employees in the work place (Salephera Consulting Ltd and Prime Health Consulting and Services, 2013a). This was a case study of six institutions (Sunbird Tourism Limited entities, Chancellor College, Minibus Owners Association of Malawi, Farmers Union of Malawi, Malawi Police Service, and National Organisation For Nurses and Midwives) representing both the public and private sectors. The study interviewed 121 employees (male and female) from these institutions. Researchers used the following definition of sexual harassment to guide their study: "Sexual harassment is generally defined as any conduct, comment, gesture, or contact of a sexual nature that is likely to cause offence or humiliation to any employee; or that might, on reasonable grounds, be perceived by that employee as placing a condition of a sexual nature on employment or on any opportunity for training or promotion" (Salephera Consulting Ltd and Prime Health Consulting and Services, 2013a, p. 9). The study then asked respondents to define sexual harassment and answer questions about experiences of sexual harassment. Key findings included the following:

- Forty-one percent of respondents reported that either they themselves or a colleague had experienced sexual harassment in the workplace. Among those, 29 percent indicated that they themselves had experienced sexual harassment.
- Among those who reported having experienced sexual harassment, 45 percent indicated that they did nothing about it, while 33 percent indicated that they reported the incident to management and 22 percent reported it to a friend.

Female domestic workers

The literature review identified three peer-reviewed journal articles on GBV among female domestic workers, all based on research conducted in 2005 by Dr. Lucy Mkandawire-Valhmu (Mkandawire-Valhmu et al., 2009; Mkandawire-Valhmu and Stevens, 2007; Mkandawire-Valhmu, 2010). The

[3] The reference for this study is Phiri, I., L. Semu, F. Nankhuni, and N. Madise. 1994. *Violence Against Women in Educational Institutions: The Case of Sexual Harassment and Rape on Chancellor Campus*. Research report, Chancellor College. The document for this study could not be located, so it was not reviewed directly.

researchers noted that domestic workers in Malawi can be at higher risk for GBV due to the fact that their work is informal and unregulated. Additionally, because women employed as domestic workers often have few other employment options, it may difficult for them to leave their employment even when they experience violence (Mkandawire-Valhmu et al., 2009).

The 2005 study conducted focus groups and in-depth interviews with former female domestic workers to understand their experiences of GBV. Former domestic workers, rather than those currently employed, were interviewed to protect the subjects from potential abuse arising from their participation in the study. The study found that, among the 48 women interviewed, 96 percent reported having experienced some form of GBV: 48 percent experienced verbal abuse, 27 percent experienced sexual abuse, and 23 percent experienced physical abuse from their employers or other members of the household where they worked (Mkandawire-Valhmu et al., 2009). Although these forms of GBV were not defined, examples were cited. For example, reported physical abuse included "beating or slapping, overwork, food deprivation, insufficient pay or lack of payment, and isolation from the outside community" (Mkandawire-Valhmu et al., 2009, p. 794). The women who experienced GBV reported seeking social support from friends or family, and in some cases from the employment agency that placed them in their jobs.

Prisoners

The literature review identified two documents that examined GBV in Malawi prisons (Kangaude, 2014; Jolofani and DeGabriele, 1999). Both studies noted the challenges in studying GBV in this setting, in part because of the prison system's unwillingness to acknowledge the existence of GBV in its institutions. One study suggested that this reluctance stems from the illegal and socially unacceptable sexual conduct between persons of the same sex that occurs in prisons. Prison officials were reluctant to discuss sex and violence because admittance of these acts could be viewed as a failure to do their job to stop this abuse (Jolofani and DeGabriele, 1999). Additionally, while not mentioned in either article, conducting studies with prisoners is challenging due to the ethical concerns around prisoner participation, since prisoners are a population with restricted freedom and autonomy (O'Gostin et al., 2007).

A study conducted in 1999 interviewed incarcerated persons and wardens in the Zomba, Blantyre, and Lilongwe prisons (Jolofani and DeGabriele, 1999). Respondents reported that several forms of GBV occurred in these prisons. Examples cited included men being raped, either for "initiation" or for no reported reason; prisoners selling sex to other prisoners for money; and prisoners selling sex to prison officials for food.

Other information on GBV among prisoners in Malawi comes from an unpublished dissertation, as reported in another published article (Kangaude, 2014). Kangaude reported that the dissertation author, Kainja[4], who was a prison official at the time of the research, found that 21 percent of the persons he interviewed had experienced some form of sexual violence. Kanguade also reported that Kainja found that his respondents believed that 34 percent of sexual violence in prison was coerced sex, 26 percent was unwanted touching, and 4 percent was rape. No information was provided on the number of people interviewed or the data collection methods.

Street children

A recent study that interviewed 23 children living in the streets in Lilongwe and Blantyre found that street children are at high risk for GBV (Mandalazi et al., 2013). Interviewees reported trading sex for food, lodging, and other basic needs as a means to survive. They also described how girls and boys new to the street community were often raped by the older boys on the street. Very low levels of knowledge about

[4] The citation for the dissertation is Kainja, C. 2011. "Analysis of "Inmate on Inmate" Sexual Victimisation in Prisons: A Case Study of a Few Selected Prisons in Malawi." Unpublished BA dissertation, Mzuzu University. Reviewers were unable to locate this original source for the literature review.

sexually transmitted infections and HIV were found among the street children and noted as a concern, given the interview reports of high-risk sexual behavior and sexual violence.

People living with HIV

A study on IPV and HIV in Ntchisi, Salima, Thyolo, Nsanje, Rumphi, and Karonga districts was conducted via 254 individual interviews and focus group discussions with 107 people, including persons living with HIV, religious and community leaders, and HIV service providers (Mwanza, 2012). The study found that about 20 percent of the persons living with HIV interviewed reported experience of physical violence, about 50 percent reported experience of psychological violence, and 41 percent reported experience of sexual violence in the 12 months prior to the study. The study documented experiences of IPV in the context of HIV testing and counseling and disclosure of results. Cultural practices and rituals that constitute GBV and condone sex without condoms were also identified as GBV and HIV risk factors.

Women with disabilities

A study involving 23 in-depth interviews with women with disabilities was conducted to determine the extent to which they experienced GBV. Researchers hypothesized that these women may be at high risk for GBV given their other vulnerabilities (Kvam and Braathen, 2008). Results showed that the women did not report any childhood sexual abuse and were unaware of any girls with disabilities who had experienced sexual abuse. Only two of the women reported having experienced sexual violence as an adult. Almost all interviewees viewed abandonment as a form of sexual abuse and felt that women with disabilities had a greater risk of experiencing this type of abuse. The researchers noted that these findings were contrary to their expectations, given that some communities in Malawi believe that sex with a person with disabilities can cure HIV and AIDS.

Refugees in Dzaleka camp

Two studies have been conducted on GBV and its risk factors among refugees from Rwanda, Burundi, the Democratic Republic of the Congo, and Somalia living at Dzaleka refugee camp in Malawi. The first involved semi-structured interviews with more than fifty refugee men and women, along with interviews of camp administrators, security personnel, healthcare practitioners, social services counselors, and primary and secondary school teachers (Carlson, 2005). This study found that prevailing risk factors for GBV perpetration, as described by respondents, were alcohol; boredom and feelings of uselessness that contributed to stress; hunger and poverty; and being a refugee. Respondents noted that there were few options for women to generate income; some women made alcohol for extra cash, which the men would get drunk on and then become violent at home.

The second study was a participatory assessment involving 25 children in the Dzaleka refugee camp (UNHCR, 2005). The types of GBV reported by the children were harassment of girls, sexual exploitation of girls, rape, forced marriage, and trafficking of girls. The vulnerable economic position of the refugee children was seen as a contributing factor to this violence.

Studies on Knowledge, Attitudes, and Norms Related to GBV

The literature review identified eight studies that examined knowledge of GBV and attitudes toward GBV perpetration. These studies are consistent in their findings that knowledge is generally poor and acceptance of GBV is pervasive.

Understanding of GBV

A qualitative study by the Centre for Human Rights and Rehabilitation that conducted in-person interviews and focus group discussions with community members and leaders in the Chitipa, Karonga, Mchinji, Lilongwe, Dedza, Salima, Mongochi, and Zomba districts found that community members had varied understandings of GBV. The women interviewed were generally hesitant to label acts they considered "normal" as GBV (Centre for Human Rights and Rehabilitation, 2005). For example, wife battering and verbal abuse were described by respondents as being part of normal life, so the need to report such instances was not recognized. On the other hand, adults and children, both male and female, tended to classify other acts of violence, such as theft, as GBV. The report concluded that there is a lack of information and awareness on what constitutes GBV (Centre for Human Rights and Rehabilitation, 2005).

The IPV 2005 study (Pelser et al., 2005) asked female respondents to address their understanding of what constitutes GBV. The most common responses were acts of physical violence like beating or strangling (55%). Other responses included failure to take care of wives (cited by 11% of respondents) and men's failure to show love to wives (cited by 5%).

The Safe Schools Program qualitative PLA research study asked respondents what they understood by the term "gender-based violence" (The Centre for Educational Research and Training and DevTech Systems, Inc., 2008). As reported previously, the study found that teachers had a better understanding of GBV than students, but that the term was not clearly understood by either group.

Attitudes and norms

The MDHS 2004 and 2010 studies asked women ages 15–49 and men ages 15–54 whether a husband is justified in beating his wife in five situations: if she burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sexual intercourse with him. The results, presented in Table 19, show that acceptance of wife beating, as measured by the respondent's agreement with at least one of these five reasons, declined substantially from 2004 to 2010—from 28.2 percent to 12.6 percent among women, and from 16.1 percent to 12.6 percent among men. Variations across regions were found in both 2004 and 2010, with women and men in Northern region reporting the highest acceptance of wife beating.

Table 19: Attitudes Toward Wife Beating

	Percentage of women ages 15–49 who agree with at least one of the 5 specified reasons for wife beating	
	MDHS 2010	**MDHS 2004**
Northern	26.1%	45.1%
Central	14.0%	31.8%
Southern	7.7%	20.2%
Total	12.6%	28.2%

	Percentage of men ages 15–54 who agree with at least one of the 5 specified reasons for wife beating	
	MDHS 2010	MDHS 2004
Northern	18.0%	22.7%
Central	13.2%	21.1%
Southern	11.2%	9.5%
Total	12.6%	16.1%

An analysis of the MDHS 2004 study examined demographic variables and justification of wife beating (Uthman et al., 2009). The following factors were found to be associated with acceptance of wife beating (by multiple logistic regression analysis):

- Being female (compared to being male)
- Being younger (15–24 years of age, compared to 35 or older)
- Having never married (compared to being currently or formerly married)
- Lower educational attainment (no education or primary education, compared to secondary or more)
- Lower income levels (poorest, poor, middle, or richer, compared to richest)
- Employment (compared to unemployment)
- Rural residence (compared to urban residence)
- Independent decision making (those who make decisions by self or those whose husband/partner makes decisions alone, compared to those who have joint husband-wife decision making)
- Reading the newspaper (compared to those who do not)

A nationally representative, cross-sectional household survey conducted in 2002 as part of a baseline study for the HIV intervention, *Soul City*, measured attitudes and norms about GBV among 2,863 women and men ages 16–60 (Andersson et al., 2007). Key findings are summarized in Table 20. The study found similarities in attitudes and norms among males and females. Notable among the findings was the low reporting of cultural acceptance of wife beating (13% of males and 15% of females agreed with the statement "in my culture is it acceptable for a man to beat his wife"), while 30 percent of males and 39 percent of females agreed with the statement "women sometimes deserve to be beaten." This suggests that personal attitudes may not always align with perceived cultural norms.

Table 20: Attitudes and Norms About GBV (Andersson et al., 2007)

Percent Who Agree with the Statement	Male	Female
Attitudes		
• Women sometimes deserve to be beaten	30%	39%
• If a woman gets raped it's her own fault	44%	37%
• Forcing sex with someone you know is not rape	26%	26%
• Forcing your partner to have sex is not rape	39%	45%
• Violence between a man and a woman is a private matter in which others shouldn't interfere	75%	80%

Percent Who Agree with the Statement	Male	Female
Norms		
• In my culture it is acceptable for a man to beat his wife	13%	15%
• Most people in our community feel women have a right to refuse sex with their partners	50%	44%
• Most people in our community feel forcing your partner to have sex is rape	54%	48%

Studies and Analyses on Other Factors Related to GBV

Review of the literature identified 16 documents that analyzed factors associated with GBV. Some studies measured the association of these factors with GBV, while others looked only at the factors themselves. Key findings reported in the literature are presented below by type of factor.

Demographic factors

A number of demographic factors have been found to be associated with GBV experience. Findings from the five large studies that examined these associations are presented in Table 21 (MDHS, 2010; Pelser et al., 2005; Moore et al., 2007; Burton, 2005; Bisika et al., 2009).

Table 21: Demographic Factors Associated with GBV

Demographic Variable	Findings, as Reported in the Studies[5]
Age	MDHS, 2010 • Women ages 20–29 are more likely than women of other age groups to have experienced physical violence (by any perpetrator) during the 12 months prior to the survey; those ages 15–19 are the least likely to have experienced this form of violence. • Lifetime experience of sexual violence (by any perpetrator) increases from ages 15–19 to 25–29, and then decreases among women ages 40–49. • Women are more likely to experience sexual violence (by any perpetrator) for the first time between ages 15–19, compared to other age groups (20–24, 25–29, 30–39, or 40–49). • Women who are younger than their husbands by 10 or more years are more likely to have experienced emotional IPV, compared to women who are the same age as their husbands, older than their husbands, or younger than their husbands by less than 10 years. • Women who are older than their husbands are less likely to have experienced physical IPV, compared to those who are the same age as their husband or partner. • Women who are the same age as their husbands are the least likely to have experienced sexual IPV, followed by women who are older than their husbands; women who are younger than their husbands (by one to nine years) are the most likely to report experiencing this form of violence. • Among those who had ever experienced emotional intimate partner violence, the likelihood of having experienced it in the past 12 months decreases by age group. Pelser et al., 2005 • Across the various types of IPV (economic, emotional, physical, and sexual), women ages 21–30 were the most likely to have experienced IPV, while women over 50 were the least likely. • Women and girls ages 10–20 were more likely to have experienced sexual IPV than any other type of IPV (economic, emotional, or physical). Moore et al., 2007 • Being close in age to one's partner was found to increase the probability of one's first sexual intercourse being reported as "not willing at all." Burton, 2005 • Prevalence rates of all forms of violence were higher among children over 13 years old, compared to those of younger children (9–13 years).

[5] For more information on survey questions, samples, and measurements, refer back to the Findings section (beginning page 6).

Demographic Variable	Findings, as Reported in the Studies[5]
Education	MDHS, 2010 • Women with primary and secondary education were more likely to report having ever experienced sexual violence than women with no education and women with more than secondary education. • Women with secondary education were more likely to have experienced physical violence during pregnancy than women with other levels of education. • Women with no education and women with more than a secondary education were less likely to have ever experienced each of the three types of IPV (sexual, physical, and emotional) than women with primary or secondary education. • Women with more than a secondary education were less likely than women with primary education or no education to have experienced physical violence by any perpetrator since age 15; little variation was found in experience of physical violence by any perpetrator among women with secondary education, primary education, or no education.
Employment	MDHS, 2010 • Women employed for cash were most likely to have experienced sexual violence by any perpetrator, compared to women who were either unemployed or employed not for cash.[6] • Women not employed were less likely than those employed to have ever experienced emotional, physical, or sexual IPV. • Women who were employed and earned cash were more likely to report having experienced physical and sexual IPV than women who were employed not for cash. • Women employed for cash were more likely than women employed not for cash and unemployed women to both have ever experienced physical violence since age 15 and in the 12 months prior to the survey (any perpetrator). • Unemployed women were less likely to have experienced physical violence (any perpetrator), both since age 15 and in the 12 months prior to the survey, when compared to employed women. Pelser et al., 2005 • The majority of women reporting economic and emotional IPV were self-employed. • The majority of women reporting sexual IPV were women dependent on remittances from family, friends, or their partner.

[6] The MDHS study asked respondents who responded that they were employed, "Are you paid in cash or kind for this work or are you not paid at all?" The four response options were cash only, cash and kind, in kind only, or not paid. "Employed not for cash" refers to the "in kind" and "not paid" response categories.

Demographic Variable	Findings, as Reported in the Studies[5]
Marital status	MDHS, 2010 • Divorced, separated, or widowed women were more likely to have experienced physical violence by any perpetrator, compared to women who were currently married, living with a partner, or never married. They were also more likely to have experienced sexual violence by any perpetrator, compared to women who were currently married, living with a partner, or never married. • Divorced, separated, or widowed women were more likely to have experienced all three forms of spousal violence (physical, emotional, and sexual), as well as each individual form of spousal violence, compared to women who were currently married, living with a partner, or never married. • The likelihood of having experienced emotional or physical violence committed by one's current or last husband or partner was found to increase with marital duration, but this relationship was not found for sexual violence. Pelser et al., 2005 • Married women made up the majority of women reporting abuse: 76% of the respondents reporting physical violence were married women, as were 86% of respondents reporting economic abuse. Moore et al., 2007 • Girls whose first sexual intercourse was with their husband were significantly less likely to report having been coerced at sexual debut.
Region	MDHS, 2010 • Women in the Northern and Southern regions were slightly more likely to have experienced physical violence since age 15 than women from the Central region. • Women in the Northern region were more likely to have experienced sexual violence (any perpetrator), compared with women in the Central and Southern regions. • Women in the Central region were most likely to have ever experienced emotional IPV and least likely to have experienced physical IPV, compared to women in the Northern and Southern regions. • Little regional variation was found in experience of physical violence during pregnancy. Bisika et al., 2009 • Regional differences were found in the prevalence of unwanted touching on the breasts, buttocks, or genitals; respondents from the Northern Region reported the lowest rate and those from the Central Region reported the highest. • A greater number of identified perpetrators of unwanted touching on the breasts, buttocks, or genitals were unknown to victims in Central Region, compared to the other regions.

Demographic Variable	Findings, as Reported in the Studies[5]
Residence	MDHS, 2010 • Women in urban areas were more likely than women in rural areas to have experienced physical violence (by any perpetrator) since age 15 and in the 12 months prior to the survey. • Rural women were more likely than urban women to have ever experienced sexual violence (by any perpetrator). • Women in urban areas were slightly more likely to have experienced physical violence during pregnancy than women in rural areas. • Compared to rural women, urban women were more likely to have ever experienced physical IPV and not to have experienced emotional IPV in the past 12 months. Small differences were seen between those living in urban and rural areas for ever having experienced emotional or sexual IPV. Burton, 2005 • Children of all ages (9–18 years) living in rural areas were more likely to experience GBV than those living in urban areas. The largest differences were seen for bullying and unwanted touching of the genitals and breasts.
Number of children	MDHS, 2010 • Women with one to four children were more likely to have experienced physical violence (any perpetrator), ever or in the past 12 months, compared to women with no children or women with five or more children. • Women who had given birth but had no living children were twice as likely as women with at least one living child to have experienced physical violence during pregnancy. • Women with five or more children (compared with women with fewer or no children) were least likely to report having experienced each type of IPV (emotional, physical, and sexual). • Women with no living children were most likely to have experienced emotional violence by a partner in the past 12 months.
Wealth	MDHS, 2010 • Little difference was found in ever in experience of physical violence since age (by any perpetrator) by wealth quintile. • No clear relationship was found between wealth and lifetime experience of sexual violence (by any perpetrator). • Women in the lowest two wealth quintiles were more likely than those in the highest three quintiles to have experienced physical violence during pregnancy. • There is no clear relationship between wealth and ever having experienced the different forms of IPV (emotional, sexual, and physical). • Women in the lowest wealth quintile were more likely to have experienced emotional IPV often in the past 12 months, compared to women in the other wealth quintiles.

Harmful traditional practices

While many of the reviewed studies on GBV in Malawi mentioned traditional practices that promote gender-based violence, five focused specifically on traditional cultural practices that either constitute GBV or put women and girls at risk for GBV (Centre for Human Rights and Rehabilitation, 2005; Salephera Consulting Limited and Prime Health Consulting and Service, 2013b; Malawi Human Rights Commission, 2005; Bisika, 2008; National Statistical Office, Ministry of Gender, Children and Community Services, European Union, UN Women, and UNFPA, 2012). Factors identified as being associated with GBV are summarized in Table 22.

Table 22: Findings from Studies that Examined Traditional Practices Associated with GBV

Study	Methodology	Traditional Practices Associated with GBV
Centre for Human Rights and Rehabilitation, 2005	In-person interviews and focus group discussions with community members and leaders in Chitipa, Karonga, Mchinji, Lilongwe, Dedza, Salima, Mongochi, and Zomba districts (number of study participants unknown)	• **Property grabbing:** When a man dies, the property is taken away from the widow and children by the relatives of the deceased. This practice was reported by respondents as a common form of GBV in all districts studied, but especially in Karonga and Mangochi. • **Wife inheritance:** When the husband dies, the widow is forced to marry one of husband's relatives. This was the most commonly mentioned practice among respondents in Chitipa. • **Wife detention:** The wife is forced to live in her father's house because the husband has not paid the dowry in full. This practice was mentioned as a form of GBV in Chitipa. • **Polygamy:** The practice of having multiple wives. Respondents in the study did not view this practice as GBV. It was reported as commonly practiced in Chitpia and Karonga. • **Dowry:** Paying to marry someone's daughter. This was found to be common in Karonga. • **Fisi:** Elders arrange for older men in communities to sleep with girls to remove their virginity, or a man who cannot have children arranges for his wife to have sex with another man to get pregnant. These two types of fisi were reported in Dedza and Salima.

Study	Methodology	Traditional Practices Associated with GBV
Salephera Consulting Limited and Prime Health Consulting and Services, 2013b	Interviews with implementing partners in Chitipa, Mzimba, Nkhata-Bay, Karonga, Dowa, Mchinji, Salima, Dedza, Mangochi, Nsanje, Chikhwawa, Chiradzulu, and Machinga (number of respondents and organizations represented unknown)	• **HIV cleansing myths:** Myths that having sex with a person with disabilities can cleanse a person of HIV • **Polygamy** • **Female genital mutilation** • **Property inheritance** • **Initiation ceremony rituals**
Malawi Human Rights Commission, 2005	99 focus group discussions and 262 in-person interviews with women, men, and children (ages 10 and over) from all economic groups, selected through random sampling methods, in Chitipa, Mzimba and Nkhata Bay, Dowa, Lilongwe, Mchinji, Ntcheu, Mangochi, Mulanje, and Nsanje	• **Messages given at counseling sessions before marriage** that encourage women to be submissive at all times to their husbands and to never refuse sexual intercourse when the husband asks for it, subjecting the women to marital rape • **Lobola, or bride price/dowry**, treats women and children as objects that have been purchased; women in abusive relationships may not be able to leave the husband until the lobola is repaid • **Various systems of property rights** • **Various forms of forced marriage**, including wife inheritance and cultures in which young girls are pressured into marriage by relatives promising misfortune if they do not comply • **Polygamy** (the cultural practice of having multiple wives) was found across all ethnic groups studied; in some situations, wives and children of these marriages essentially become slaves; in many cases, the practice led to economic abuse as the man stopped caring for the earlier wives and children • **Ceremonial dances** can lead to GBV due to the fact that they force girls to dance naked in a sexual manner • **Mourning traditions** prohibit women from bathing, using utensils others used, or speaking to others for matters other than mourning during the mourning period (can be up to a month in length)

Study	Methodology	Traditional Practices Associated with GBV
Bisika, 2008	Quantitative and qualitative study involving 613 men, women, boys, and girls from the Ntchisi, Zomba, and Mangochi districts	• **Chiongo-dowry** • **Polygamy** • **The idea that the man is the "household head"** • **Initiation ceremonies** in which women are told to persevere and satisfy the man • **Acceptance of extramarital sex** • **Chikamwini or chitengwa**, in which a woman is asked to live with the man's relatives or village • **Male mobility** • **Forced marriage** • **Cultural tradition** of not having sex with a woman when she is menstruating and during post-partum abstinence, which leads men to pursue extramarital sex

School environment

Three studies that looked at violence among children (mentioned in previous sections) also looked at factors associated with the violence and presented findings about the risk posed by the school environment. Key findings from these studies on school environment risk factors are as follows:

- Travel to and from school, especially in rural areas, puts children at risk for experiencing GBV—i.e., experiencing verbal, physical, and sexual assault while walking to school (Burton 2005; Leach et al., 2003).
- Being currently enrolled in school in Malawi was found to increase the probability of experiencing an unwanted sexual debut; thus, school enrollment was not found to be a protective factor for unwanted sexual debut (Moore et al., 2007).
- For children of all ages, bullying and sexual harassment through forced touching were more likely to occur at school than in other settings (Burton, 2005).

Substance use

Eight studies looked at the consumption of alcohol and drugs as risk factors for GBV. One analysis of the MDHS 2004 data found that the risk of experiencing physical or sexual IPV was higher among women who reported that their husbands consume alcohol sometimes or frequently, compared to those who reported that their partners drink but do not get drunk or do not drink at all (Hindin et al., 2008). Another analysis of these same data found that partners' alcohol consumption (analyzed as a dichotomous variable—i.e., drinks alcohol or does not drink alcohol) was positively associated with women's experience of physical IPV (Mandal and Hindin, 2013). The MDHS 2010 survey showed similar associations between partners' alcohol consumption and women's experience of IPV. The survey report states, "There is a very strong relationship between experience of spousal emotional, physical, or sexual violence and husband's alcohol use. Women whose husbands or partners get drunk often are more than twice as likely to experience each of the three types of spousal violence compared with women whose

husbands do not drink or who drink but never get drunk. Those whose husbands get drunk sometimes fall in between" (MDHS, 2010, p. 253).

In the IPV 2005 study, 18 percent of male respondents reported that "alcohol and chamba [drugs]" were a cause of IPV. This was the second-most frequently cited cause, after "misunderstandings and disagreements" (reported by 27% of male respondents). Among the main findings from female respondents in the same study, the authors noted that "alcohol [use by perpetrator] was commonly associated with acts of violence, while there was almost no drug association" (Pelser et al., 2005, p. vii). Among female respondents reporting violence, the perpetrator was believed to be under the influence of alcohol in 18.2 percent of incidents of economic abuse, 24.9 percent of incidents of emotional abuse, 36.0 percent of incidents of physical abuse, and 33.2 percent of incidents of sexual abuse.

A 2007 study involving qualitative interviews with women ages 18 and over in two urban and two rural villages found a strong linkage between men's substance use (both alcohol and drug use) and women's experiences of GBV (Braathen, 2008). Respondents suggested that substance use leads to GBV for many reasons, including that men can become irritable and aggressive due to alcohol and drug use; and, in some cases, men use all the family's money on these substances and then beat the women when there is no food at home.

A study on the socioeconomic costs of violence conducted through interviews and focus group discussions with GBV survivors and community members from Mzimba, Lilongwe, Dowa, Mangochi, and Blantyre found that respondents mentioned alcohol use as one of the main "driving forces" behind IPV (Economic Commission for Africa and UN Women, 2013, p. 18).

A baseline study conducted on intimate partner violence among people living with HIV mentioned alcohol abuse as one of the major causes of HIV-related IPV (Mwanza, 2012). In this study, 6.2 percent of respondents reported that they had experienced sexual violence because their partner was drunk.

A study of men convicted of a sexual offense with a child under age 18 identified alcohol and drugs as a contributing factor to the crimes (Mtibo et al., 2011). The study interviewed 58 inmates at the two largest prisons for men in Malawi: Zomba Prison and Chichiri Prison. When asked the question, "What influenced you to commit the offence?" 10.3 percent responded that they were influenced by alcohol and drugs. Other factors cited were sexual desires (46.6%), influence by the victim (5.1%), and peer pressure (1.7%). Approximately 36 percent (36.2%) of the inmates denied they had committed a crime.

Controlling behaviors

Association has been found between a woman's experience of IPV and display of controlling behaviors by her partner. Both the MDHS 2004 and MDHS 2010 studies asked women whether or not their partner displayed six specific behaviors: he is jealous or angry if she talks to other men; frequently accuses her of being unfaithful; does not permit her to meet her female friends; tries to limit her contact with her family; insists on knowing where she is at all times; and does not trust her with any money. The results are given in Table 23. In 2010, 21.8 percent of ever-married women ages 15–49 reported that their partner had ever displayed three or more of these behaviors; respondents in the Northern Region reported a somewhat higher percentage than those in the Central and Southern regions. In 2004, regional estimates were not provided, but the overall estimate was 30.0 percent, suggesting that the prevalence of controlling behaviors may have decreased over the six-year period.

Table 23: Prevalence of Controlling Behaviors Measured in the MDHS

	Percentage Who Reported Partner Displayed Three or More of the Six Specific Behaviors	
	MDHS 2010	**MDHS 2004**
Northern	26.5%	No regional results reported
Central	22.2%	
Southern	20.4%	
Total	21.8%	30.0%

An analysis of the MDHS 2004 results found that the association between having a controlling partner (defined in the analysis as a partner who displays at least one of the controlling behaviors) and reported physical IPV in the past 12 months was statistically significant (Mandal and Hindin, 2013). This finding mirrors information found in the MDHS 2010 report, which stated that, "Controlling behaviours are strongly associated with spousal violence. Spousal violence increases in a linear fashion with the number of controlling behaviours displayed by the husband or partner. Women with husbands who exhibit none of the controlling behaviours are less likely to experience emotional, physical, and sexual violence (less than 1 percent), compared with women whose husbands exhibit five to six of the controlling behaviours (40 percent), followed by women with husbands who exhibit three to four of the marital control behaviours (18 percent), and those whose husbands exhibit one to two of the controlling behaviours (4 percent)" (MDHS, 2010, p. 253).

Studies on the Impact of GBV

Gender-based violence has numerous impacts on individuals, families, communities, and society at large. Impacts studied in Malawi include those related to health, education, and the economy.

Health impact

HIV

Three studies examined the link between GBV and HIV. In two studies that independently analyzed data from the MDHS 2004 and MDHS 2010, no association was found between IPV and HIV, as measured in the surveys by women's self-reported IPV experiences and their laboratory-confirmed HIV serostatus (Harling et al., 2010; MacQuarrie et al., 2013). Results of a study that involved semi-structured interviews and focus group discussions with men, women, and youth from the Nkhota-kota district suggest that cultural acceptance of GBV in Malawi makes women more vulnerable to HIV infection and infringes on their rights (Kathewera-Banda et al., 2005).

Physical injury from IPV

The MDHS surveys collected information on reported physical injury resulting from IPV. The MDHS 2010 found that, among those who had ever experienced sexual or physical IPV, 32.0 percent had cuts, bruises, or aches; 10.0 percent had eye injuries, sprains, dislocations, or burns; 9.8 percent had deep wounds, broken bones, broken teeth, or another serious injury; while 35.0 percent experienced one or more of these injuries. The MDHS 2004 found that, among those who had ever experienced sexual or physical IPV, 22.9 percent had bruises and aches; 5.0 percent had injuries or broken bones; and 6.4 percent went to a doctor or health center.

An analysis of data from the MDHS 2004 found that women who had ever experienced sexual violence by a partner, experienced sexual violence by a non-partner in the last 12 months, or reported first forced sex were approximately 70 percent more likely to report incontinence than women who had not experienced this violence (Peterman and Johnson, 2009).

Education impact

In the 2004 household survey of in- and out-of-school girls from nine districts in Malawi, GBV was found to have negative outcomes for girls' education (Bisika et al., 2009). Among girls who reported having experienced violence, 60.9 percent said that it resulted in performance problems at school. Among those who said that they had been inappropriately touched, 38.8 percent said it had negatively affected their education and 3.3 percent reported that they had stopped going to school permanently because of it.

Economic impact

In 2013, the Economic Commission of Africa and UN Women conducted a study on the socioeconomic cost of violence against women in Malawi (Economic Commission of Africa and UN Women, 2013). Data collection included focus group discussions, in-depth interviews, and review of administrative records, censuses, and surveys conducted by various organizations and donors working in Malawi. The study examined direct costs—defined as "those that come from the use of goods and services for which monetary exchange is made and include treating or preventing violence through medical; police; criminal justice; housing; and social services" (p. 30)—and indirect costs, defined as "those costs which do not involve actual money exchange but rather have an imputed value and these include pain and suffering resulting from increased morbidity; mortality through homicide and suicide; abuse of alcohol and drugs; severe injuries; and depression disorders and inability to perform household and other domestic tasks by IPV survivors" (p. 30–31). The study estimated costs of handling one case of physical domestic violence as follows:[7]

- MKW 250,000 through the formal courts
- MKW 25,000 through faith-based organizations
- MKW 3,500 though a One-Stop Centre[8]
- MKW 3,500 through a human rights institution
- MKW 2,500 through a government hospital
- MKW 1,667 through a police station
- MKW 1,500 through a community-based organization
- MKW 1,100 through a local leader

The total direct economic cost of physical domestic violence in Malawi in 2013 was estimated at MKW 877 million, at an average cost per case of MKW 1,800, based on the assumptions that a victim used each service only once and that, while some victims go to the formal courts, others may go to lower-cost local leaders or community-based organizations instead. The study estimated that the indirect costs of physical domestic violence are even greater—about MKW 28 billion per year. This puts the total annual cost to Malawi's economy at close to MKW 29 billion. Based on responses from domestic violence victims, most of whom indicated that their experiences of violence generally prevented them from working, the study concluded that this loss of productive workers has a large impact on the country's gross domestic product.

[7] In this study, the exchange rate given was US $1= MKW 325 (325 Malawian Kwacha).

[8] One-Stop Centres are a model developed to house an array of GBV services in one location to help ensure that victims receive comprehensive care. Services offered include health, judiciary, police, and social welfare.

Evaluation of GBV Interventions

Many of the studies reviewed were conducted to assess the GBV situation prior to the implementation of an intervention to address GBV or related issues. This information was then used to design the intervention, or to establish a baseline against which its effects could be measured. The literature search, however, found only four documents that included final results of nongovernmental program evaluations. It also found two reports that assessed the governmental GBV response and interventions.

Two of the documented studies involved clinical interventions to improve care for children who had experienced sexual abuse. Both took place at Queen Elizabeth Hospital in Blantyre. The first study, conducted in 2004, aimed to strengthen delivery of HIV post-exposure prophylaxis to children who presented as sexually abused (Ellis et al., 2005). This intervention was found to be successful among those children who returned for follow-up, as none seroconverted. The sample size was small (17 cases total) and follow-up was limited—i.e., 11 cases at one-month follow-up, seven at three-month follow-up, and two at six-month follow-up. The second study involved a two-day, two-hour educational intervention (one hour of lecture per day) with 21 doctors at the hospital (Miller and Barlup Toombs, 2014) that aimed to improve doctors' capacity to correctly identify sexual abuse among children presenting at the hospital. The sample size was small—i.e., only 11 doctors completed the post-test—but the number who could correctly label and interpret a photograph of a hymen increased following the training, compared to before the training.

A wide-scale intervention to strengthen police and health sector capacity to respond to GBV at the national and district levels was implemented from 2006–2009 (Keesbury and Askew, 2010). Hospital, police, and judiciary personnel reported that they were better prepared to handle GBV cases after participation in the program. Additionally, significant improvements were observed in the quality of care delivered to GBV survivors, including increases in the proportion of survivors who received post-exposure prophylaxis, emergency contraception, and prophylaxis for sexually transmitted infections. An increase in the use of services was also reported. As a result of the intervention, the Lilongwe Police Station started operating 24 hours a day. Better coordination of GBV cases presented in court was reported as well.

The Safe Schools Program was a five-year program (2003–2008) intended to reduce school-related violence. This intervention was conducted in 40 schools in the Machinga district. The program focused on advocacy for improved policy, legislation, and funding of prevention and response efforts for school-related gender-based violence; creation of a teacher's code of conduct in the schools; community mobilization, action planning, and implementation for behavior change; and student, teacher, and community counselor programs. A decrease in the number of GBV cases reported by teachers was observed. Positive outcomes were also observed among student and teacher attitudes toward violence. Following the program, teachers were more likely to view whipping boys as an unacceptable form of student discipline (96%, compared to 76% at baseline). Girls were more likely to disagree with the statement that it is okay for a teacher to get a girl pregnant as long as he marries her (almost 90%, compared to 70% at baseline). However, little change was observed among teachers and students for ideas and attitudes related to harmful cultural norms (DevTech Systems, Inc., 2008).

In 2011, the Malawi Ministry of Health commissioned a study to assess the health sector response to violence against women and children in Malawi (Chepuka et al., 2012). The assessment covered the following areas:

- Policies, guidelines, and protocols related to violence against women and children
- Human resources capacity
- Scope and coverage of preventive and responsive services
- Information management systems

The study methodology included a desk review of literature (not only of research studies, but also legislation, policies, and strategies), as well as both qualitative and quantitative data collection.

The report highlighted that—while violence against women and children is widely recognized as a major issue by healthcare workers, nongovernmental organizations, and policymakers—there is still a great deal of underreporting of violence by victims for a variety of reasons. It also revealed that healthcare workers understand the links between violence and physical and psychological health, but that they do not feel adequately equipped to deal with these issues, resulting in gaps in care. Healthcare workers were also found to be confused about the roles and responsibilities of the Ministry of Health and other sectors in dealing with these issues. The study report recognized the huge commitment within the sector to addressing sexual and domestic violence, but identified various conflicts and gaps in laws that must be addressed, as well as an urgent need for implementation of a basic and universal referral system. Finally, the report made a number of recommendations, including specific legal priority areas to focus on; mainstreaming policy and planning for better coordination and clarity on roles and responsibilities; a paradigm shift toward the perception that violence is a health issue, rather than just a gender or a social issue; and improving gaps in referral and reporting mechanisms.

In 2014, the MoGCDSW commissioned a review of the National Response to Combat GBV 2008–2013 (Centre for Development Management, 2014). The review's objective was to evaluate the progress and results achieved during the strategy's implementation and make recommendations for the new strategy. The review looked at results achieved during implementation, the extent of coordination and partnership, the effectiveness and sustainability of the plan, the effectiveness of approaches used in the national response, and the extent of the plan's linkage with other sectoral policies. It found that the strategy was successful in changing the government's approach to GBV and violence against women; it mainstreamed a gender-based approach to domestic violence with a targeted focus on female victims of violence. However, poor dissemination and the lack of a budget to support the response affected its implementation at all levels. Furthermore, a lack of national-level impact indicators or a functional monitoring and evaluation system affected the ability to measure impact of interventions. Among its major findings, the report underlined the need for the following:

- Improved coordination and partnerships
- Capacity building for the MoGCDSW Department of Gender Affairs and other stakeholders
- Increased awareness of GBV through dissemination of research
- Implementation of existing laws and policies
- Engagement of the private sector

GOVERNMENT DOCUMENTS ON GBV

Malawi's national government has put into place numerous frameworks and systems to prevent and respond to GBV. Among them are international agreements, policies, laws, plans, strategies, and guidelines that cover several sectors. An overview of the content of these documents is presented in the following sections.

International Agreements

Malawi is a signatory to a number of international agreements that address GBV. Table 24 summarizes the seven agreements identified during the literature review.

Table 24: International Agreements that Address GBV

Title	Year	Summary of How the Agreement Addresses GBV
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	1979	While CEDAW was adopted in 1979, the CEDAW Committee adopted General Recommendation No. 19 in 1992 on violence against women (VAW), recognizing GBV as a form of discrimination and recommending that states take measures to prevent and respond to VAW.
African Charter on Human and Peoples' Rights	1986	Article 18 states, "The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions" (p. 6).
Convention on the Rights of the Child	1990	Nations that have signed on to the convention should take measures to protect children from all forms of physical and mental violence, including sexual abuse.
Vienna Declaration on Human Rights	1993	This declaration states that GBV must be eliminated and calls on governments to take various measures to address it, including legal measures, national action, and international cooperation efforts.
Beijing Platform for Action/Malawi National Platform for Action	1995	The Beijing Platform outlines a number of actions to respond to and prevent GBV. The Malawi National Platform for Action (1997) is a commitment from the Malawi government following the 1995 Beijing Fourth World Conference on Women. It has four priority areas for advancement of women, one of which is VAW.
SADC Declaration on Gender and Development	1997	The declaration reaffirms commitments and resolves to "[take] urgent measures to prevent and deal with the increasing levels of violence against women and girl child" (p. 4).
Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa	2005	The protocol ensures a number of rights protecting women, including property rights, rights to a consensual marriage, protection against child marriage, the right to medical abortion in cases of rape, widows' rights, inheritance rights, and protection against violence. It also stipulates that states shall take measures to prevent and respond to all forms of violence against women.

National Policies

Seven national policies currently in place in Malawi reference GBV or abuse. Several include explicit strategies or objectives to address it. Table 25 lists these policies and summarizes their content related to GBV.

Table 25: National Policies that Address GBV

Title	Year Signed	Summary of How the Policy Addresses GBV
National Gender Policy	2014 (Draft)	The policy speaks of an increasing number of cases of GBV under the main problem statement. One of the four policy outcomes is "reduced gender-based violence at all levels" (p. 10). One of the seven policy objectives is to reduce gender-based violence. The policy also states "The policy shall ensure that: i. Laws and policies shall be formulated and enforced to eliminate gender based violence and human trafficking ii. Response and access to socio economic services are improved to address gender based violence and human trafficking iii. Knowledge, attitudes and practices on Gender Based Violence are improved" (p. 15)
Sexual and Reproductive Health Rights Policy	2009	One of the ten policy themes of this policy is harmful practices/domestic violence, which includes "initiation, wife inheritance, fisi (hiring of the man for sex and conception), dry sex, death rituals, use of traditional herbs to induce labour, battery, rape, sexual harassment, psychological abuse, and genital mutilation" (p. 15). The goal for this theme is "To reduce the incidence of harmful practices and domestic violence among women, men, and young people" (p. 15). The policy statements are as follows: • "Elimination of harmful SRHR [sexual and reproductive health] practices shall be fully integrated in the delivery of sexual and reproductive health and rights services • Service providers shall not perform prenatal sex selection or female genital mutilation" (p. 15) The strategy for this goal is to "Strengthen awareness of practices that have a negative impact on maternal health among both men and women in the community" (p. 15).
National HIV/AIDS Policy	2003	The policy contains various strategies to address GBV, including • Ensuring that women and girls are protected against violence and harmful traditional practices • Protecting women's rights to have control over issues of sexuality free from violence

Title	Year Signed	Summary of How the Policy Addresses GBV
		• Protecting prisoners from sexual violence • Providing victims of sexual violence with PEP and other support services
National HIV and AIDS Workplace Policy	2010	This policy states that employers must have procedures in place for women to safely and freely submit sexual abuse or harassment claims, and that employers must not condone sexual violence or harassment in the workplace.
National Policy on Early Childhood Development	2003	Two main objectives of the policy are "to protect children against any form of abuse or discrimination" and "to protect and safeguard children who are in difficult circumstances, i.e. orphans, street children, children with disabilities, abused and exploited children" (p. 13). The background section of the policy also references that children in Malawi suffer from sexual, physical, and emotional abuse.
National Youth Policy	2013	The policy states that protection against "exploitation, discrimination and abuse" is one of the rights of all youth (p. 5). It also references the vulnerability of youth to sexual harassment and the need to inform them of laws that protect them.
National Policy on Equalisation of Opportunities for Persons with Disabilities	2007	GBV is not specifically referenced. However, a strategy is included to "Enforce systems … to protect the rights of persons with disabilities against any form of discrimination and abuse in society" (p. 17).

Laws

Currently, seven laws in Malawi either mention GBV directly or address some of the cultural risk factors for GBV. Table 26 lists the laws and summarizes their GBV-related content.

Table 26: Laws that Address GBV

Title	Year	Summary of How the Law Addresses GBV
Prevention of Domestic Violence Act	2006	A broad definition of domestic violence is used to encompass not only violence between man and wife, but also violence between persons living in the same household (e.g., including family members) and violence toward persons who are socially or financially dependent. It recognizes physical, sexual, emotional, psychological, and financial abuse as forms of violence. The law's stated purpose is "to ensure the commitment of the State to eliminate gender-based violence occurring within a domestic relationship, and to provide for effective legal remedies and other social services to persons affected by domestic violence" (p. 5). It establishes structures for protection of victims by defining who can apply for a protection order, occupancy order, or tenancy order under the Act, and outlining what the different orders mandate and entail, as well as detailing the enforcement of the orders. It speaks to roles and responsibilities of enforcement officers as well as service providers. It establishes the duty to report GBV by anyone who witnesses it or has a reason to believe it is occurring.
Gender Equality Act	2013	GBV is addressed in the context of prohibiting harmful practices, along with sexual harassment. Harmful practices are social, cultural, or religious practices that, "on account of sex, gender or marital status" [are likely to, or do] "undermine the dignity, health or liberty of any person," or "result in physical, sexual, emotional or psychological harm" (p. 3). The act also mandates that the government ensure that employers create and implement policies to comply with the law regarding sexual harassment.
Child Care, Protection and Justice Act	2010	Legal procedures to keep children safe are outlined. This includes procedures on what to do in cases of suspected or known violence, including sexual abuse, child trafficking, abduction, harmful cultural practices, and forced marriage.
Penal Code	1974	The Penal Code establishes punishments and legal definitions for various forms of gender-based violence. These include rape, punishment for rape, attempted rape, abduction, abduction of girls under sixteen, indecent assaults on females, insulting the modesty of a woman, defilement of a girl under thirteen, attempt of defilement of a girl under thirteen, defilement of the mentally handicapped, prostitution (obtaining or forcing a girl into), detention with intent or in brothel, conspiracy to defile, attempt to procure abortion, assault of boys under fifteen, incest, and assault.

Title	Year	Summary of How the Law Addresses GBV
Constitution	1994	Specific references to GBV in the Constitution include mandates that no person should be forced to marry against her/his will, that early marriage should be discouraged, and laws should be passed to end violence against women.
Deceased Estate (Wills, Inheritance and Protection) Act	2011	This law protects spousal property rights.
Marriage Act	1903	GBV-related elements include establishing consent procedures for marriage of minors, making marriages to deceased wife's sister or niece invalid, and making bigamy illegal and punishable by imprisonment of five years.

National Plans and Strategies

GBV is explicitly addressed in five current national plans and strategies in Malawi. Table 27 lists these plans and strategies and describes how they address GBV.

Table 27: National Plans and Strategies that Address GBV

Title	Author	Summary of How the Plan or Strategy Addressees GBV
Malawi Growth and Development Strategy II (MGDS II, 2011 to 2016)	Ministry of Finance and Development Planning	*Theme Six: Cross-Cutting Issues, Sub-theme 1: Gender* includes several strategies and activities related to GBV, including enhancing awareness of GBV, strengthening GBV service delivery systems, and strengthening GBV research and dissemination of data.
National Plan of Action to Combat Gender-Based Violence in Malawi 2014–2020 (draft, 2014)	Ministry of Gender, Children, Disabilities and Social Welfare	The purpose of this National Plan is to reduce GBV at all levels. The four priority areas are "1. Prevention of GBV and its relationship with HIV, SRH and maternal and newborn health. 2. Support for survivors and rehabilitation of perpetrators of GBV 3. Coordination, implementation and sustainable financing of GBV programmes 4. Research, monitoring and evaluation" (p. 19) The plan outlines priority actions and includes an implementation plan, a risk management plan, and a monitoring and evaluation plan.
Joint Sector Strategic Plan (JSSP), 2013–2017	The Gender, Children, Youth and Sports Sector Working Group	The JSSP outlines how the gender, children, youth, and sports sectors will work together to "protect children and empower youth and women economically, socially and politically while striving to achieve gender equality and equity" (p. 7). Outcome Four of the JSSP is to reduce violence against children, youth, and women. It contains several planned strategies and activities, including • Lobbying for modification of harmful cultural practices that perpetuate GBV • Strengthening GBV service delivery systems • Raising awareness on rights and GBV (including sensitization campaigns)

Title	Author	Summary of How the Plan or Strategy Addressees GBV
		• Empowerment for GBV survivors • Male involvement activities • Documenting and disseminating lessons learned and best practices in GBV prevention and response efforts
Education for All National Action Plan (2004)	Ministry of Education and Human Resources Development	Sexual harassment is addressed under the rationale for the policy framework. The action plan itself addresses violence against children and includes a strategic objective for ages 3–6 "to strengthen the protection of children against any forms of abuse and exploitation" (p. 16). Specific activities are as follows: • "Conduct awareness campaign on child protection • Develop Child Protection Act and other pieces of legislations on child protection • Orient community child protection groups • Set up and strengthen child rehabilitation and counseling centers for children in difficult circumstances, including children with disabilities • Train 745 professional staff to provide adequate and efficient professional services • Provide counseling services, information, and education to 745 families and children at risk • Undertake studies to assess the situation of child abuse in the country • Develop mechanisms to prevent child abuse, discrimination, and exploitation" (pgs. 23–24)
Health Sector Strategic Plan 2011–2016	Ministry of Health	GBV is referenced as a major health issue contributing to negative health outcomes in Malawi; the role of the MoGCDSW in spreading knowledge of GBV to contribute to reduction of GBV is noted.

Guidelines

The literature review identified four current GBV-specific guidelines developed in and for Malawi. All address the management of GBV cases within the health sector and some also include guidance for other sectors, such as the police and social welfare. Table 28 outlines these documents.

Table 28: Guidelines that Address GBV

Title	Developer	Intended Users	Summary Description
Guidelines for the Provision of Comprehensive Services for Survivors of Physical and Sexual Violence (One-Stop Centres) in Malawi (2012)	Ministry of Health	Personnel working with GBV survivors (to be made available at health facilities with One-Stop Centres, District Social Welfare Offices, police and NGOs that provide services to survivors of abuse)	Provides guidance for helping GBV survivors access medical, social, and legal services. Provides information on procedures and referral and reporting mechanisms for cases. The focus is on care for women and children, although the definition of a victim/survivor acknowledges that men can also be victims or survivors.
Guidelines for the Support and Care of Victims of Gender Based Violence, HIV and AIDS Related Abuses, and other Human Rights Violations (year unknown)	Malawi Police Service and Malawi Human Rights Resource Centre	Victims Support Unit (VSU)[9] officers	Outlines roles, responsibilities, and procedures to be followed by service providers working in VSUs.
Management of Sexually Transmitted Infections using Syndromic Management Approach (2007)	Ministry of Health	Health service providers	Includes a section on GBV, discussed in terms of human rights. It notes everyone's right to live a life free of sexual violence and states that access to information and services is also the right of all persons.
Guidelines for Paediatric HIV Testing and Counselling (2007)	Ministry of Health	Policymakers and healthcare providers who need guidance on pediatric HIV testing and counseling	Includes a section on HIV testing and counselling procedures for children who have been (or are suspected to have been) victims of sexual abuse or assault.

[9] A VSU is a room set aside in a police station for victims of violent crimes to report their cases to the police in private. These units were created beginning in 2001 to protect victims' rights.

OBSERVATIONS AND RECOMMENDATIONS

The literature review identified a considerable number of studies and policy documents on GBV in Malawi. While variations were found across studies in terms of the types of GBV studied, definitions used, study populations, and methodologies, findings were consistent in demonstrating the magnitude of the problem and many of its consequences. The studies offer a wealth of information that can be used for policy making and programming. While the review of government documents suggests that some information has been used to help shape policies and plans, it also reveals that a more comprehensive look at the data could contribute to improved priority setting and more strategic approaches to ending GBV and supporting survivors.

The literature review also revealed some information gaps. These gaps include research on boys' and men's experience of GBV, prevalence and factors associated with perpetration of GBV, and an understanding of how risk and protective factors play out in different settings and among different populations. The most critical gap, however, is in studies that evaluate GBV policy and program interventions. Evidence is scant for what does and doesn't work regarding changes to harmful attitudes about GBV, stopping the different forms of violence, and getting survivors the help they want and need. Such information is critical in helping to ensure that national efforts to address GBV are effective. Better information on the costs of interventions, combined with evidence of effectiveness, will help to ensure that scarce resources are allocated strategically and rationally and achieve the greatest impact.

Finally, although the literature review did not set out to assess the quality of the information presented in the identified documents beyond the criteria established for the search process, variations were observed in the scientific rigor of the studies, accuracy or completeness in presentation of methods and results, and interpretation of the findings. In reviewing each document, the reviewers sought only to summarize what was presented in the original source. They did, however, in some cases omit results that were inconsistent with (or could not be substantiated from) other information within the document. In particular, caution should be exercised in interpreting findings that are inconsistent across studies, as this may be due to quality of the research and the document, in addition to differences in study methodologies.

Based on these observations, the reviewers recommend the following actions to improve the use of research and other information to strengthen the national response to GBV in Malawi:

1. **Disseminate the findings of this literature review widely.** Given that many of the reviewed documents are not easily accessible to those outside the research community, the literature review findings can be used to help audiences become aware of existing information sources. Dissemination should also include translation and interpretation of the findings for different audiences. As many of the findings are oriented to technical audiences, this should include translation for non-technical audiences such as policymakers, program designers and implementers, and the communities that are their target audiences.
2. **Prioritize funding and implementation of more research and evaluations that focus on impact and costs of GBV programs and services.** Such information is needed to identify best practices and to know what to scale-up. A national GBV program evaluation agenda should be developed to reach consensus on priority topics, monitor research, and promote the use of results.
3. **Strengthen the capacities of organizations and individuals within Malawi to conduct high-quality GBV research and evaluations, and to report on and interpret findings for policy making and programming.** Strengthening the quality and increasing the quantity of research and evaluation will ensure that findings are accurate, reliable, and valid, and can be used with confidence.

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