Tithetse Nkhanza!

Malawi Violence Against Women and Girls Prevention and Response Programme

Referral mechanisms research report

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Violence against women and girls (VAWG) Referral Protocols in the formal and informal justice sectors in Southern and Eastern Africa

Assignment:

- Present available VAWG referral pathways for formal and informal justice and non-justice actors in Eastern and Southern Africa.
- Present legal and non-legal pathways in Eastern and Southern Africa, Africa and globally.
- Present the relationships between the referral pathways and applicable laws for VAWG survivor service provision i.e. whether the pathways are taken from legal provisions, policies or mere practices.
- Present 2-3 designs of complete referral best pathways ('complete' must combine formal and informal justice and non-justice actors – whether distinct from each other or coordinated).

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Contents

1. Definitions and Overview

1.1. Overview

The purpose of this report is to provide information and learning from existing gender-based violence (GBV) referral pathway best practices to support Tithetse Nkhanza Programme staff in developing a referral pathway for Violence Against Women and Girls (VAWG) survivors in Malawi. Priority has been given to referral pathways which include a visual diagram to demonstrate how the different elements of the referral pathway work together effectively.

A 2015 systemic literature review of gender-based violence in Malawi **identifies an urgent need for implementation of a basic and universal referral system for addressing sexual and domestic violence** (Mellish et al, 2015). It also notes that although healthcare workers understand the links between violence and physical and psychological health, they do not feel sufficiently equipped to deal with these issues, which leads to gaps in care (Ibid.). A 2013 PhD thesis analysing health sector responses to intimate partner violence in Malawi reports that whilst there is evidence that inter-sectoral linkages are being developed between the health sector and other agencies, **significant confusion still remains amongst service providers about how a multi-sector approach should work in practice,** who should work with whom, and where responsibility and accountability for the process lie (Chepuka, 2013).

Overall, the evidence is limited on what constitutes best practice for VAWG referral pathways in low income settings. Studies in general are of low quality with little evidence of the effectiveness of referral systems in supporting survivors of VAWG. Existing referral pathways are often fragmented, which results in disconnected service provision to survivors. **Clear reporting and referral procedures which are agreed by all institutions in the referral pathway are important for improving national responses to GBV.** Further research is required to understand (1) how national GBV plans can ensure that referrals work for survivors, and (2) how they can provide choice within the referral system so that survivors can find the support they want (Fraser and Ahlenback, 2019b).

However, examples of promising practice in referral pathways do exist. Following a definition of terminology and a brief description of the methodology used (in section 2), this report then provides **examples of good practices in GBV referral pathways in various countries in Eastern and Southern Africa** (Uganda, Zimbabwe, Botswana and Kenya). This report has aimed to include referral pathway diagrams that involve informal duty bearers as well as formal actors. Examples of such referral pathways are extremely rare, but one used in Uganda has been included in this report.

Beyond Africa, **a promising practice has been identified in Guyana**. The national policy on domestic violence (2009) introduced a common service protocol for the health, police, education and social services sectors, with referral pathways for medical assistance, counselling, shelter and other services. **Specific provisions are made for persons with disabilities and for interventions with elderly persons** (Fraser and Ahlenback, 2019b; UN Women 2012).

1.2. Definitions

The Malawi VAWG Prevention and Response Programme notes that VAWG is a broad category, so it narrows its focus to:

1. intimate partner violence (IPV) between spouses and unmarried couples (both cohabiting and not) which comprises physical, sexual, emotional and economic violence;
2. domestic violence including IPV and violence perpetrated by other family members;
3. harmful traditional practices affecting women and girls.

This review understands the term referral and referral pathway as follows:

Referral: The process of directing a survivor of any kind of gender-based violence (GBV) to another service provider when s/he requires help that is beyond the expertise or scope of work of the current service provider.

Referral pathway: A flexible mechanism that safely links survivors to supportive and competent services. These may include any or all of the following:

- Healthcare services, including support for physical rehabilitation
- Psychosocial support, such as trauma counselling
- Security and protection services, such as shelters/refuges
- Material or financial assistance for reintegration
- Social welfare services
- Formal and informal legal and justice services, such as mediation[1], alternative dispute resolution (ADR) in the formal sector (e.g. ADR facilitated by legal aid services, a Victim Support Unit (VSU) or a court as a preliminary stage before a civil court case begins); or in the informal sector (e.g. ADR facilitated by a community chief or an NGO)
- Informal community services, such as traditional authorities/chiefs, religious leaders, community-based organisations and women's rights organisations.

2. Methodology

The methodology is described below.

Search strategy: Studies were identified through the following search strategies:

- **Google search, Google Scholar, HINARI and JSTOR** using a selection of key search terms.[1]
- **Focus**: Relevant data and evidence on gender-based violence referral pathways (adults and/or children) being used within country systems, involving formal and informal actors.
- **Time period:** 2008 – 2019
- **Language**: English
- **Publication status:** publicly available and published online.
- **Geographic focus:** Specific countries in Southern and Eastern Africa and globally.

Limitations: Research for this assignment has revealed that many referral pathways appear to be focused on specific types of violence – such as sexual violence; or on specific types of support – such as HIV prevention/response or psychosocial services; or in specific settings – such as schools; or on specific types of victim/survivor – such as children. In addition, humanitarian settings tend to have separate referral pathways due to their specific conditions. This has made it challenging to identify comprehensive GBV referral pathways. The report highlights the kind(s) of violence which the referral pathways cover and where possible suggests where best practice examples for specific types of violence are likely to be applicable to other forms of violence.

3. Examples of referral pathways in Southern and Eastern Africa

3.1. Uganda

In 2013 the Government of Uganda developed a national referral pathway guideline on GBV which is in line with international GBV guidelines, including the Inter Agency Standing Committee guidelines on GBV (Fraser and Ahlenback, 2019b). According to the UN Global Database on Violence against Women,[2] this national guideline provides primary duty bearers with information about how to respond to GBV cases appropriately and how to provide guidance to survivors about the services available to them at different referral points, as well as information about where to seek this assistance. It also sets minimum standards for the creation and management of GBV shelters for both public and private actors. This guideline is not currently available online for review and inclusion in this report.

[1] Key search terms included: referral pathway, referral mechanism, gender based violence, GBV, diagram, legal aid bureau, victim support unit, VSU, religious leaders, traditional leaders/authorities/chiefs, informal, Southern Africa, Eastern Africa, various country names.
[2] Source: http://evaw-global-database.unwomen.org/en/countries/africa/uganda/na/national-referral-pathway-guideline-for-prevention-and-response-to-gbv

A companion document to the national referral pathway guideline is the **National Guidelines for the Provision of Psychosocial Support for Gender Based Violence Victims/Survivors**, which *is* publicly available.[3] These guidelines provide minimum standards and procedures for duty bearers and service providers with regards to the provision of **psychosocial support for GBV survivors** in Uganda. In doing so, they address a major gap in Uganda's National GBV Framework. The guidelines state that "GBV occurs in the form of physical, emotional, sexual, and economic violence" (p.1), which is in line with this programme's understanding of IPV (as described above). They list several GBV-related laws which the government of Uganda has passed (see p.2 of the guidelines). According to these guidelines, they are in sync with these laws and the policy framework which aim at eliminating all forms of GBV and ensuring justice and dignity for survivors.

The guidelines are based on principles of Do No Harm, a survivor/victim-centred approach and a human rights-based approach. There is also a focus on providing psychosocial support that is culturally relevant/sensitive whilst ensuring that cultural practices do not inadvertently cause further harm to victims.

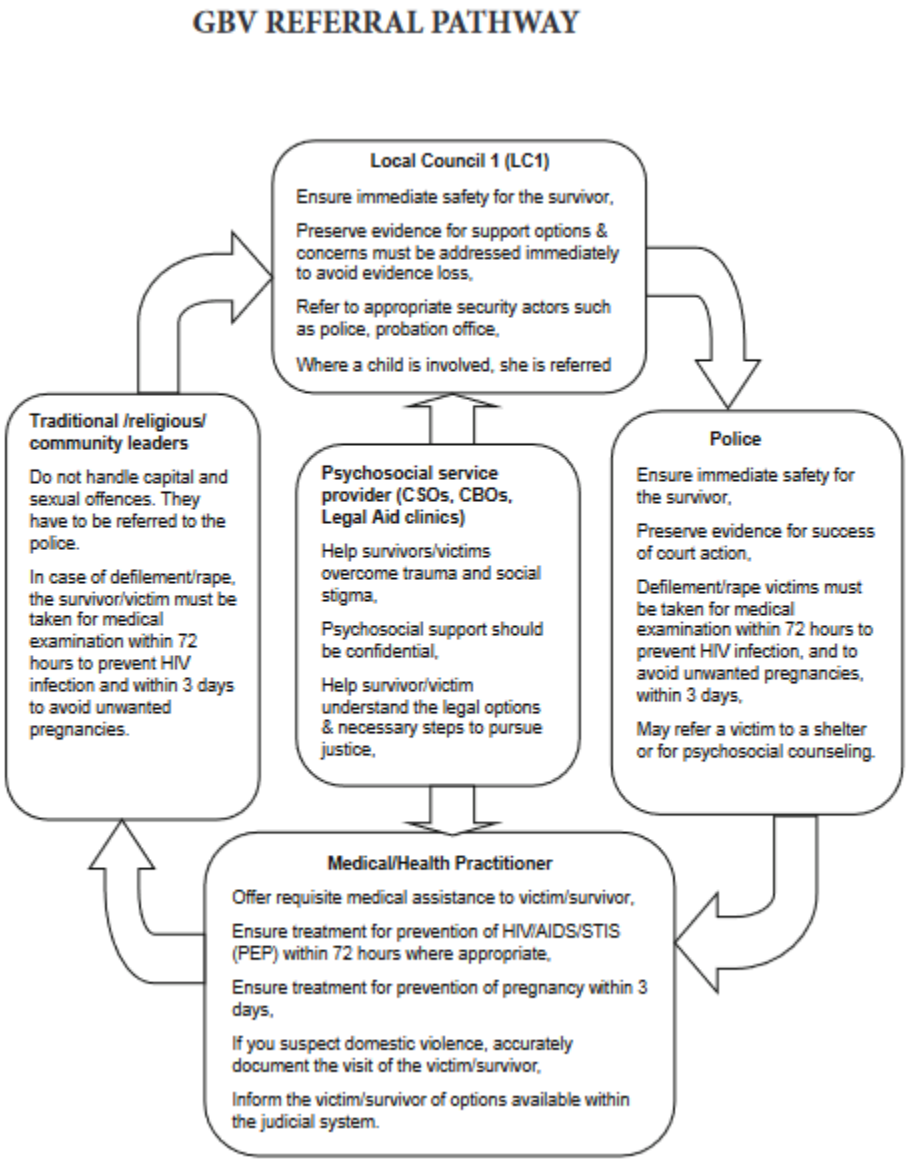
The guidelines are targeted at a wide range of users, including state and non-state actors involved in the delivery of psychosocial support interventions with regards to GBV prevention and response. **These include clan and cultural leaders, who are identified as often being the first people to hear about GBV violations, especially when they are of a domestic nature**. Traditional healers, faith-based leaders, Civil Society Organisations (CSOs) and Community Based Organisations (CBOs) are also identified as important non-state duty bearers in the psychosocial response to GBV. As such they are recognised within the referral pathway provided by these guidelines (see Figure 1 below). **However, it is important to note that the referral pathway states clearly that traditional/ religious/ community leaders must report capital or sexual offenses to the police**, i.e. they must not handle these cases themselves.

The guidelines further recognise that religious and cultural leaders play an important role in handling GBV incidents and brokering family reconciliation in Uganda, including in cases that are considered harmful, such as widow inheritance and child marriage. However, the guidelines are clear that certain cultural norms that can lead to GBV are violations of the basic principles of human rights. For this reason, **mediation by religious and cultural leaders as part of the referral pathway should only be sought in minor cases. Major cases that violate human rights must be referred to the relevant state actors** (see pp.16-20 of the guidelines for specific guidance for primary and secondary duty bearers).

A review of Uganda's GBV and family planning policy framework examines these along with 21 other policy, strategic and planning documents to ascertain the extent to which GBV policies and operational guidelines are being implemented by the Ugandan health system, and whether policies are implemented to the scope and depth needed to generate positive GBV outcomes. It also includes key informant interviews with healthcare workers, NGOs and other duty bearers. The review concludes that Uganda has clear policies and guidelines on GBV, high quality GBV training curricula for healthcare workers and **burgeoning multisectoral coordination mechanisms.** However, weaknesses include **inadequate policy and guideline dissemination to districts and healthcare workers**, and exceptionally low levels of public funding for GBV policy implementation (Rottach et al, 2018).

[3] Link to the Guidelines: https://uganda.unfpa.org/sites/default/files/pub-pdf/15_03_%2018_PSYCHOSOCIAL%20SUPORT%20BOOK_0.pdf

Figure 1: Referral pathway for psychosocial support to GBV survivors in Uganda[4]



A separate example from Uganda comes from the Men Engage project. This referral pathway is designed to be displayed in public places such as churches, mosques, markets and community spaces to ensure that people affected by GBV can access medical, legal and counselling services. It is a **community-based referral network designed by male champions which includes informal actors such as religious leaders and community elders** in the referral pathway.

[4] Source: Ministry of Gender, Labour and Social Development, *National Guidelines for the Provision of Psychosocial Support for Gender Based Violence Victims/Survivors.* https://uganda.unfpa.org/sites/default/files/pub-pdf/15_03_%2018_PSYCHOSOCIAL%20SUPORT%20BOOK_0.pdf

Figure 2: Example of a community-based referral network[5]

3.2. Zimbabwe

In 2012, the Government of Zimbabwe issued a Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe.[6] This was led by the Judicial Commission Service. This Protocol is based on the Victim Friendly System (VFS) which is a set of measures designed to ensure the protection and active participation of survivors in the criminal justice system.

The Protocol focuses on sexual violence and abuse. However, where relevant and applicable, its response system and guiding principles are used by the Government of Zimbabwe to support survivors of other forms of violence, such as physical and emotional violence. For the purposes of this report, it should mainly be read as relevant to cases of sexual violence. However, **it is useful to know that it is intended to be used in cases of other forms of violence**. It has not been possible to find evidence of where it has been used in such cases.

The Protocol is a guidance tool for duty bearers for the provision of holistic, effective and efficient services to SGBV survivors, with a focus on coordinated and comprehensive care and support. It establishes minimum standards and key procedures for all duty bearers to provide **individualised, participatory and survivor-centred** services. **It also**

[5] Source: https://eassieassi.wordpress.com/tag/womens-rights/
[6] Link to the Protocol: https://www.togetherforgirls.org/wp-content/uploads/2017/10/Multi_Sectoral_Protocol_2012-Zimbabwe.pdf

promotes an approach that is sensitive to the age, disability and gender status of survivors, including special measures to be taken in this regard.

The purpose of the Protocol is to:

1. Safeguard the rights of survivors of sexual violence and abuse, guaranteeing that they receive a holistic package of age and gender sensitive, survivor-centred services for their psychosocial well-being and protection by the welfare and justice systems;
2. Provide a standard set of age- and gender-sensitive procedures that must be followed to ensure a holistic response to child and women survivors of sexual abuse;
3. Strengthen and clarify the roles and responsibilities between service providers and agencies that have statutory responsibilities for the delivery of age- and gender-sensitive, survivor-centred services.

Figure 3 below outlines a basic referral pathway featured in the Protocol, with associated timeframes for action. Figure 4 provides more guidance at various stages of the referral pathway. **Both figures are relevant to the handling of cases of sexual violence. As stated above, it is intended for the Protocol to be used more broadly, but the diagrams below specifically relate to referral pathways for sexual violence.**

Figure 3: Minimum package of survivor centres services of sexual abuse and timeframe for service provision

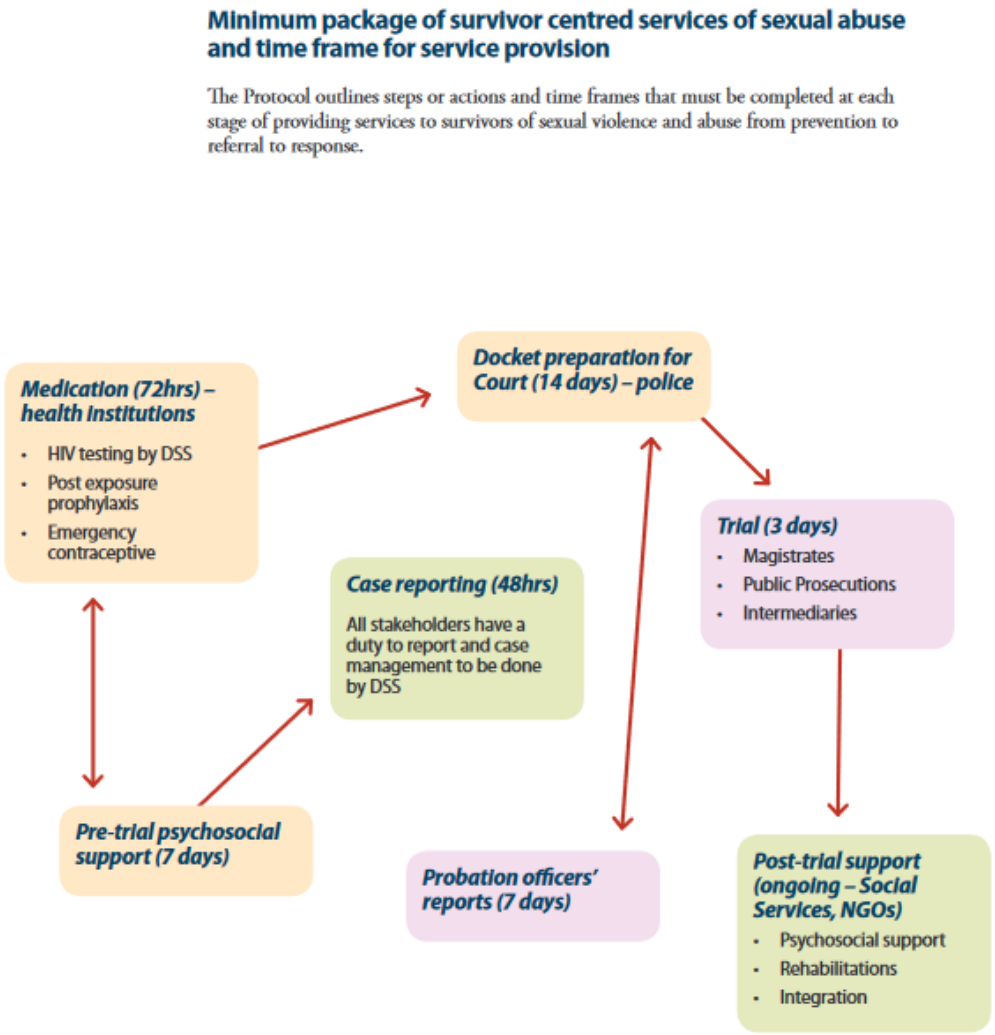
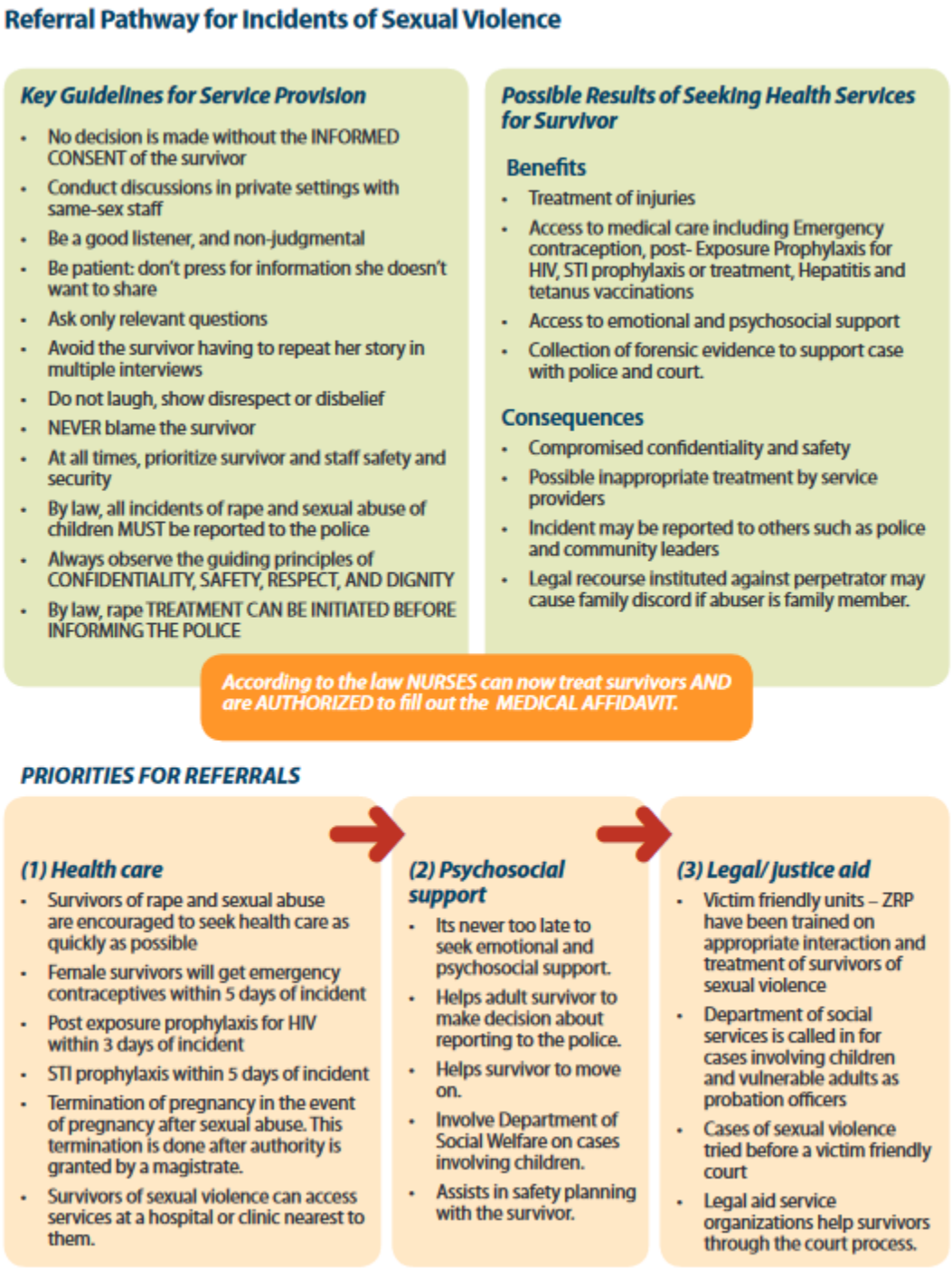


Figure 4: Referral pathway for incidents of sexual violence



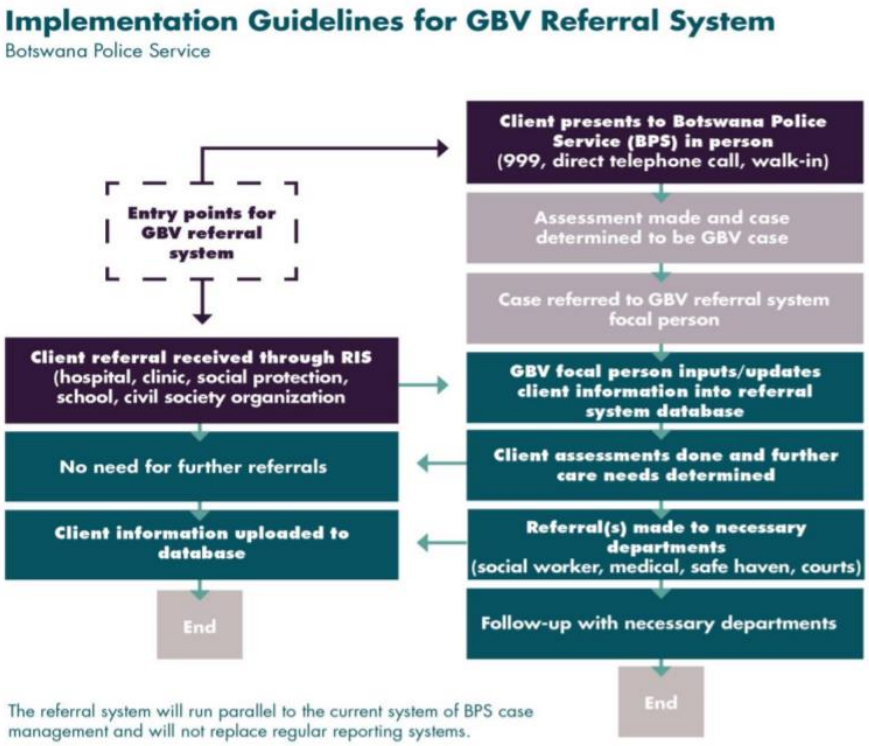
3.3. Botswana

In 2016 the Government of Botswana's Gender Affairs Department (part of the Ministry of Labour and Home Affairs) piloted a new referral system – **the Botswana GBV Referral System Project (GBVRSP) – which uses mobile technology to refer survivors to relevant GBV services** (Cannon et al, 2018; Martineau-Searle and Fraser, 2019). The pilot was carried out in four communities (both rural and urban in both the North and the South of the country) over the course of a year. It uses simple mobile technology that is available across 95% of Botswana (Cannon et al, 2018).

This mobile-based referral information system (RIS) enables service providers to make and receive referrals at different stages of the referral pathway. When a GBV survivor presents to a service provider, the RIS allows services providers to document, via mobile technology, the services that are needed and that are provided at the initiating agency, and then to refer the survivor to another agency to provide services that are unavailable at the initiating agency. Service providers at the receiving agency then use the same mobile record to document the services provided to the survivor, and so on to other agencies. Only one referral is allowed at a time, so the referring provider must choose the most important service at that point in time (Ibid.).

Both state and non-state actor service providers use the RIS, **including the police, social workers, health services, educators, NGOs and tribal authorities**. Training on GBV issues and on how to use the RIS was provided to these service providers, and GBV awareness activities were organised at community and national level to sensitise the population to GBV issues. Draft standard operating procedures (SOPs) for the provision of care to GBV survivors and flowcharts showing how to incorporate the RIS into GBV services were also developed for service providers (Ibid.). Figure 5 below is an example of how to incorporate the RIS into existing case management practices. These flowcharts were developed for all sectors involved in GBV response.

Figure 5: Example flow chart documenting RIS role in case management practices[7]



The RIS also incorporates an electronic record system which allows data relevant to the GBV incident to be shared among service providers. **This has the advantage of decreasing the need for survivors to have to repeat the details of their case to multiple service providers (which could be re-traumatising)** whilst also reducing the need to keep track of paper referrals (Ibid.).

This system allows for much more efficient data management than a paper system since it captures all GBV cases reported to any service provider in any sector; tracks all referrals that are made, received and completed; identifies any services that are not completed; facilitates client tracking and follow-up; and allows real-time data access (Ibid.).

Importantly, the GBVRSP has been evaluated (Cannon et al, 2018). Key findings include:

[7] Source: Cannon, A., Traves-Kagan, S., Cutherel, M., Fehringer, J., Apps, H., Ramaphane, P. and Bloom, S. (2018) *Botswana's Gender-Based Violence Referral System Project: Operations Research End line Report* https://www.measureevaluation.org/resources/publications/tr-18-253

- Service providers in the intervention sites were both positive and enthusiastic about the GBVRSP and suggested **it had resulted in increased collaboration, trust, and knowledge of GBV services among providers.**
- Uptake of the RIS varied by site and provider: 30% of referrals were marked as completed.
- Implementation of the GBVRSP **required substantial staff time to coordinate trainings and monthly meetings, provider technical support for the RIS, and to encourage uptake of the system**. Implementing partners suggested that an increase in coordination, support, and accountability from the central government and ministry leads would help increase the success of the GBVRSP.

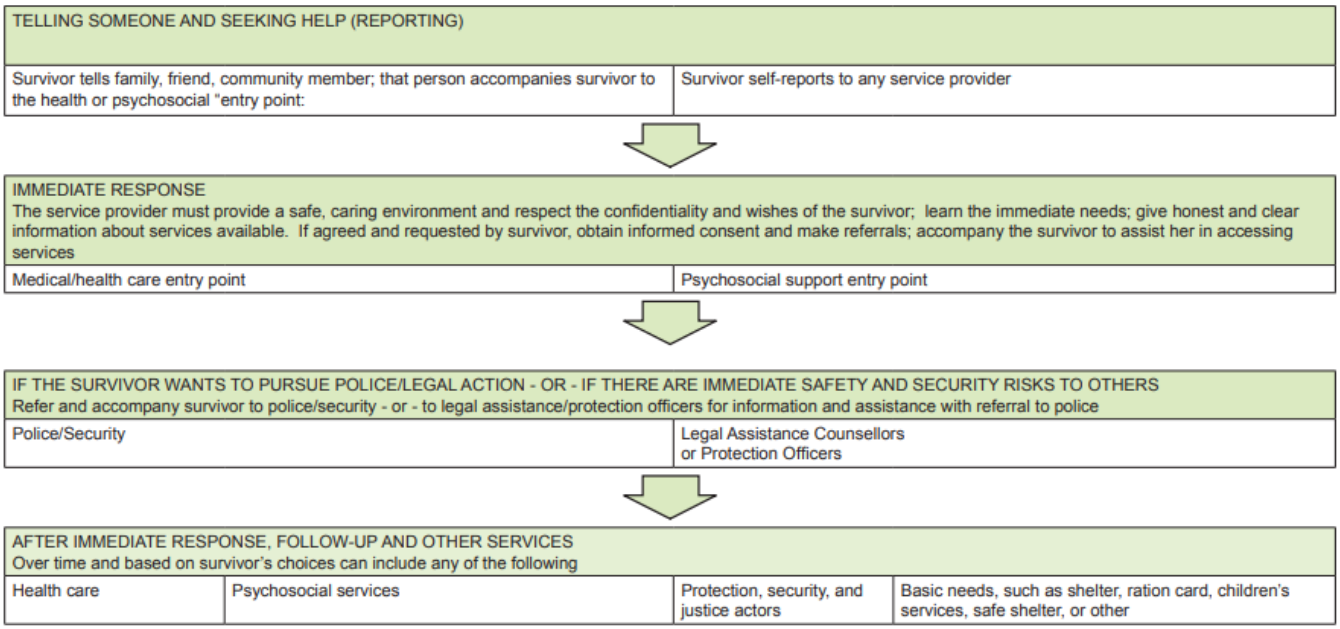
A slide share giving a brief overview of the GBVRSP is available here.

3.4. Kenya

In Kenya, various referral pathways and standards have been developed, but these tend to be **focused either at referral pathways at the national sectoral level (e.g. health), regional level, or focusing on violence against a particular group (e.g. children**[8]). It is not clear from publicly available information how these referral pathways connect, and whether they apply to all types of GBV. For example, the health sector standard operating procedures (SOPs) for sexual violence provide a referral pathway on the linkages between other sectors (figure 6 below), as do the SOPs for sexual violence against children (figure 7 below).

Figure 6: Help-seeking and Referral Pathway in Health Sector

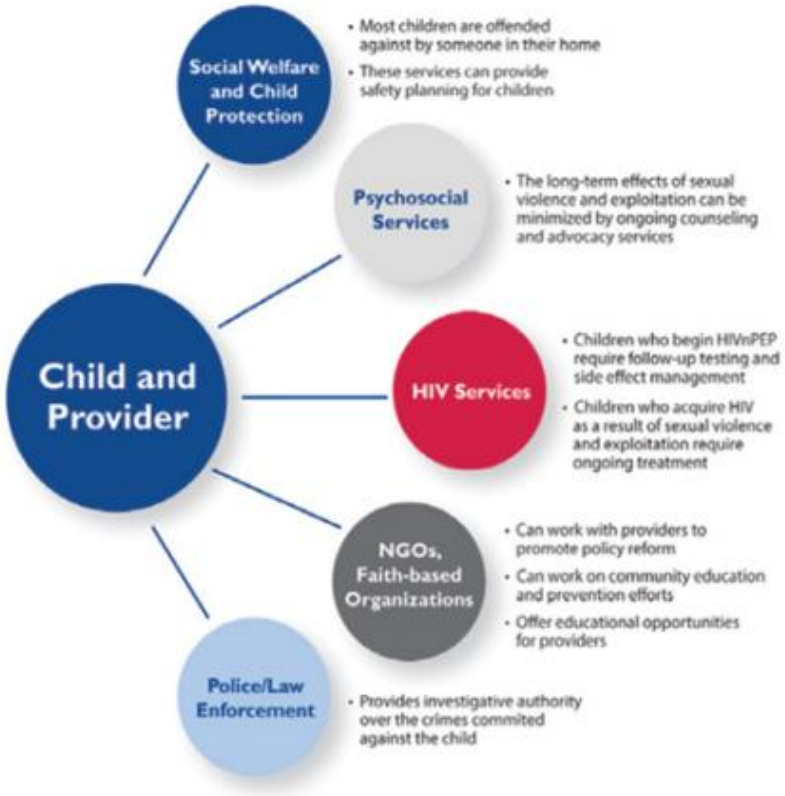
(Source: National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya, 2014, p.35)



[8] See National Standard Operating Procedures for the Management of Sexual Violence Against Children https://www.popcouncil.org/uploads/pdfs/2018RH_KenyaMOH-SOPsMgmtSVAC.pdf

Figure 7: Referral and Linkages for Sexual Violence against Children in Kenya

(Source: National Standard Operating Procedures for the Management of Sexual Violence Against Children in Kenya, 2014, p.61)



In 2018, the World Bank commissioned research to look at service provision, gaps and referrals in four counties in Kenya (Müller and Schauerhammer, 2019).[9] The research observed that **referral pathways varied considerably between and within counties, and between sectors**, with most informants observing that services were '**uncoordinated', informal and with a weak referral network structure that relied on individuals rather than institutions.** Problems with referrals were observed in all counties, although referrals within each sector were clear. The report notes the following **differences in local referral pathways between counties with different roles for duty bearers (both formal and informal), which also differed by type of violenc**e (e.g. sexual violence vs. economic violence):

- Kwale: community health visitors are often the first point of contact for GBV, although cases are often also reported to the chief, local police, or area advisory councils. GBV cases are then escalated to different stakeholders, such as village elders, the children officer, police, or the peace committee – who then individually or together decide which hospital a client should be taken to, and who will undertake the follow-up.
- Kisumu: the report notes that despite an existing referral network between police, hospitals, community-based organisations, and NGOs, there was not a clear pathway between the police and the courts.
- Bomet: Stakeholders described an informal system of referrals between individuals in different institutions, but cases were often taken back to the community via local 'kangaroo' courts.
- Kitui: Stakeholders described using informal channels such as WhatsApp to keep on top of emerging cases and referrals.

Similarly, a desk review of the evidence around **economic violence and land grabbing** in Kitui county, Kenya found that the county's formal referral network is generally haphazard and can be difficult to access (Social Development Direct, 2019).

[9] Bomet, Kwale, Kitui and Kisumu

However, in Kitui county as well as more broadly, there is reportedly **much more effective cooperation between non-state actors** via the formation of alliances and networks to strengthen service provision (Ibid.).

For example, the Centre for Health Solutions (a Kenyan national healthcare not-for-profit) is reportedly leading the process of forming a committee to share the GBV-related activities of different organisations and how cases are processed. Meanwhile, a technical working group comprised of police, judges, social workers, lawyers and NGOs holds meetings at sub-county level to 'institutionalise collaboration' (Ibid., p.23) and has plans to establish gender desks in every ward to escalate GBV cases from village to county level. **These are examples of promising practice of creating solutions to gaps in GBV referral pathways, with a focus on land grabbing and other forms of economic GBV**. This kind of initiative led by civil society could also be applied to improve referral pathway coordination in relation to other forms of GBV.

3.5. Malawi

In Malawi the 2017 UNICEF Malawi annual report,[10] indicated that there was need to enhance the child protection system by strengthening the capacity of health surveillance officers to ably identify, respond and refer cases of child abuse to appropriate service providers. It largely emphasised strengthening of SGBV referral system and follow up mechanism that includes a multisectoral response which coordinates the services by all relevant service providers.

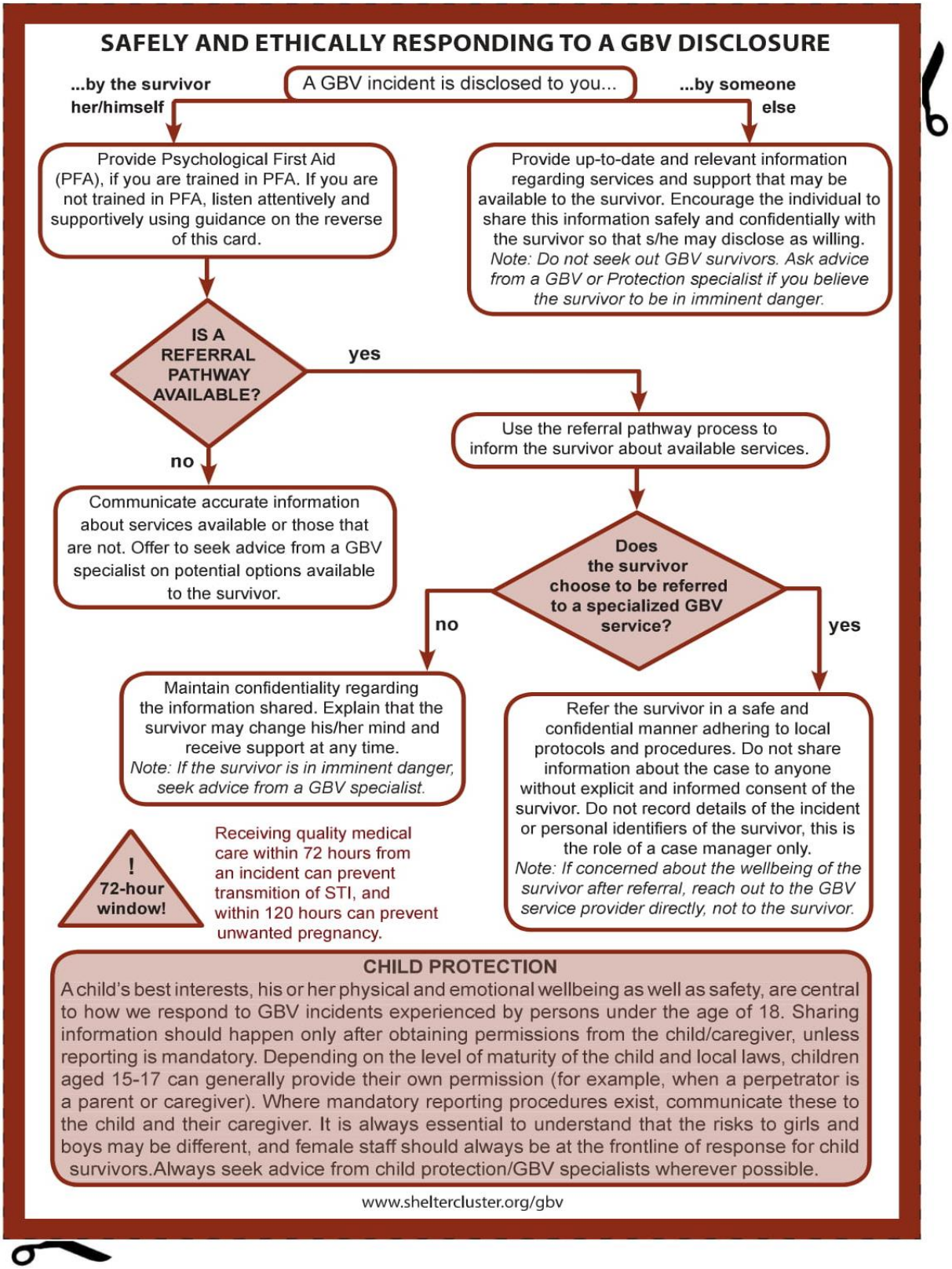
Tithetse Nkhanza's initial Programme Document report (2018)[11] also emphasizes the need to strengthen the referral system for various VAWG cases and improve the accountability mechanisms among duty bearers. There were not sample images of the referral pathways designs in these reports. Likewise, Spotlight Initiative Programme document for Malawi (2018) recognises disconnected referral pathways for GBV as one of the areas that require strengthening.

Most Recently, Care Malawi (2019)[12] designed humanitarian GBV referral system for Nsanje District that would be adaptable in general situations. The Women staying in relief camps are at increased risk of sexual violence and/or coercion in return for aid. See image below of the design on how to ethically handle GBV matter upon disclosure by the survivor.

[10] UNICEF Annual Report (2017) Malawi.
[11] Tithetse Nkhanza Programme document (2018)
[12] Care Rapid Gender Analysis Malawi (2019)

Figure 8: Ethical response to GBV

(Source: Care Rapid Gender Analysis Malawi: Nsanje District Cyclone Idai Flooding 8 April 2019, April, 2019, p.16)



With regard to informal sector referral pathways, a survey report by Gender Justice Unit[13] which was conducted in Lilongwe Peri Urban revealed that women mostly used informal sector referral systems to address their family grievances against their spouses. The main reason for mistrusting the formal referral system was that the perpetrators corrupt and bribe their way in the formal systems such as police courts and others. The referral system gets disconnected and abandoned without any accountability mechanisms even after being referred to the court by VSU or Legal Aid or by survivors approaching court on their own. There does not seem to be much accountability for duty bearers that refer cases to follow through the case to the end, rather the responsibility ends as soon as a referral is made. Likewise, the duty bearers do not take responsibility to be accountable to report to those that refer cases to them, for instance, the court would throw out a case without formally informing the VSU that referred a survivor there.

The GIU survey findings are confirmed in the Tithetse Nkhanza Formative Research conducted in Lilongwe, Karonga and Mangochi in 2019. Most survivors of non-criminal matters prefer using informal sector systems to address VAWG cases faced rather than the formal system. The Spotlight Initiative report indicates ill-treatment, gender stereotyping behaviours by duty bearers, hostile environment for survivors and generally lack of proper accountability mechanisms in the formal justice sector being some of the reasons that hinder women from accessing these services. These factors indirectly influence the habit non-reporting of criminal VAWG matters as the communities do not trust that the formal justice sector will best handle and emit justice for VAWG survivors. As long as the referral pathways for criminal and non-criminal VAWG matters remain disconnected and unclear, the non-responsiveness of the systems in both formal and informal sector will continue to escalate.

4. Conclusion

From the preceding analysis, countries in the Eastern and Southern Africa have made attempts to create and design referral pathways in the formal sector for most of sexual offences and some criminal GBV matters. There is little or no such designs for informal sector. On the ground, however, non-coded pathways still exist as learnt from the formative research by Tithetse Nkhanza and GIU that survivors prefer using informal sector systems. This means that the practices and structures are there but are not yet properly documented. The case with Malawi shows that there have not yet been a government led referral pathway system established despite that there is a critical gap identified and beginning to be worked on by various stakeholders. However, most stakeholders still focus more on SGBV rather than the comprehensive GBV criminal and non-criminal matters that survivors face.

Recommendations

- There is need to ascertain through field research on the existing non-coded VAWG referral pathways in the informal sector
- The common types of violence that survivors are more comfortable using the informal sector, must be ascertained, in order to feed in into the designing process
- The design for VAWG referral pathways must be clear for both criminal and non-criminal VAWG cases
- There must be clear linkages from formal to informal sector
- There must be clear referral pathways within institutions apart from one organisation to another
- The process of reviewing and establishing/ designing pathways must involve stakeholders with interest in the area and he government through the Ministry of Gender, Children, Disability and Social Welfare.
- Best referral pathways **use simple language for easy understanding by survivors and duty bearers.**
- In the referral pathways designing, programme must be mindful of possible Strategic interventions that can facilitate a best working referral system for VAWG to be supported by the Strategic Opportunities Fund

[13] Gender Justice Unit, (2019), The Civil Justice Needs of women in Rural and Peri-Urban Lilongwe.

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