AN ASSESSMENT OF GENDER-BASED VIOLENCE IN EMERGENCIES IN SOUTHERN BENIN

Emergency Program, CARE Benin

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CPS	Centre de Promotion Sociale, or Center for Social Promotion
DFID	United Kingdom Department for International Development
ECHO	European Commission Humanitarian Aid and Civil Protection
EMPOWER	Enabling Mobilization and Policy Implementation for Women's Rights
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
KI	Key Informant
NFI	Non-Food Items
NGO	Non-Governmental Organization
PEP	Post-Exposure Prophylaxis
RHRC	Reproductive Health Response in Conflict
SEA	Sexual Exploitation and Abuse
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
VSL	Village Savings and Loans
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
UNHCR	United Nations High Commissioner for Refugees

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EXECUTIVE SUMMARY

The present assessment on violence against women and girls was undertaken to better understand the gender-based risks and vulnerabilities faced by women and girls since the excessive flooding in 2010, and to assess the support services available to survivors of violence. The main purpose of this study was to make plans for addressing gender-based violence in the next rehabilitation phase of CARE Benin's emergency response, including pre-planning to address the vulnerabilities of women and girls in future emergencies.

Data was collected from February 28th to March 3rd, 2011, in four sites (one displacement camp and three villages) in the communes of Adjohoun and Zangnanado. Selection criteria included extensive flood damage, CARE presence, and the inclusion of at least one displacement site. CARE's emergency response team worked with community mobilizers to identify community members from population sub-groups of men, women, adolescent boys and girls for focus group discussions.

Ethical concerns for researching violence against women and girls were managed in the course of collecting and analyzing data. Data was kept confidential to prevent disclosure of sensitive information. To protect the participants' privacy, focus group discussions and interviews were held in areas where discussions could not be overheard, and no identifying information was recorded for respondents. Verbal informed consent was obtained for all respondents. Research team members received specialized training in ethical considerations for researching violence against women and girls, and ongoing support throughout data collection. Data collectors were trained in referral systems for medical, psychosocial, legal and security services.

Consistent with the EMPOWER baseline study in 2008, the most common forms of gender-based violence mentioned by respondents in the present study were intimate partner violence (i.e., wife beating, economic and psychological violence), forced and early marriage, rape, and sexual harassment. Other types of violence reported include widow inheritance (*levirat*), trafficking of girls (*placement*), prostitution of minors, and kidnapping. Women and girls are the main targets of these forms of violence. Perpetrators include men, boys, husbands, teachers, traditional healers, nomadic herders (Fulani ethnic group), external workers[1], and school guards.

The main sources of vulnerability to gender-based violence include loss of resources and livelihoods (especially women's loss of income-generating activities), risky sexual practices and beliefs among adolescents, social stigma of survivors of sexual violence, forced marriage, family and community pressure not to report violence, community-based resolution mechanisms that protect perpetrators and punish survivors, alcohol consumption, polygamy, and cohabitation, lack of supervision of girls, and crowding in the displacement camp. In addition, women in the displacement camp are also being beaten by their husbands or partners for refusing to have sex with them frequently on the hard floor (e.g., without a mattress) when their backs hurt from a long day of grueling work.

[1] Workers from outside of the community who are recruited to fix or build flood survivors' infrastructure. Participants from one men's focus group said that "some NGO agents" were also perpetrators.

Overall, by destroying resources, livelihoods and infrastructure, the flooding seems to have exacerbated existing types of violence that are fueled by financial hardship—namely, intimate partner violence, and possibly trafficking and forced marriage as economic coping strategies.

There is a general lack of knowledge about where survivors can go if they are abused, especially in more remote communities. Fear, shame, social stigma, and distance to services also prevent survivors from seeking help and reporting cases of violence. The severity of social sanctions against speaking about violence varied in the sample sites, but in general, intimate partner violence is considered to be a private matter that should be handled by the family. If survivors seek recourse against perpetrators, women and girls prefer to go through community mechanisms over official channels (i.e., the police), despite the fact that survivors are often punished by these community solutions (e.g., forced marriage in cases of early or denied pregnancies, etc.).

Health centers, the government-run Centers for Social Promotion (CPS), the police, and an NGO (Action Plus) are some of the institutions that provide services for survivors in the four communities sampled. CPS and NGOs are under-resourced, and health centers and police lack specific training and resources to handle cases of sexual violence.

Recommendations include: 1) Increase human and financial resources for Centers for Social Promotion (CPS); 2) Strengthen capacity of medical staff and police to handle cases of sexual violence; 3) All emergency responders implement the Inter-Agency Standing Committee (IASC) *Gender Handbook in Humanitarian Action* and *Guidelines for Gender-Based Violence Interventions in Humanitarian Situations* in emergency pre-planning, onset, and recovery phases; 4) Support viable, diversifiable income-generating activities for men and especially women in the rehabilitation phase; 5) Organize and support community-based networks to mobilize against violence and support survivors; 4) Prioritize family planning and sexual and reproductive health programming; and 6) Continue to raise awareness about women's rights, services for survivors, GBV and related laws, and address stigmatization of survivors.

BACKGROUND

During the 2010 rainy season, exceptionally heavy rainfall and the overflow of major rivers and their tributaries led to unprecedented floods in 30 years throughout Benin. The Ouémé, one of the rivers that runs through Benin, overflowed and caused extraordinary flooding, affecting over 700,000 people, displacing over 250,000, and damaging or destroying infrastructure, assets, and homes. In response, the Beninese government declared a national emergency and called for international assistance to respond to the crisis, which affected 45% of the communes.

The most affected departments are Atlantic (So-Ava), Ouémé (Aguégués, Dangbo, Adjohoun, Bonou), Zou (Ouinhi, Zangnanado, Zogbodomey), Collines (Dassa), Alibori (Karimama, Malanvile in the North) and Borgou (Tchaourou). These communes are spread throughout the country, although the worst of the flooding is in the South and North.

CARE International Benin/Togo is a non-governmental humanitarian organization that has been implementing programming throughout Benin since 1999. With the financial support of partners such as ECHO, DFID, and the Gates Foundation, CARE has focused its flood response efforts on six of the worst hit communes in the departments of Ouémé and Zou where there are few actors and where CARE has a strong presence.

The overall objective of CARE's emergency response strategy in Benin is to help reduce the vulnerability of women, children and men affected by 2010 flooding. As part of this objective, the present assessment on violence against women and girls was undertaken to better understand and better address the risks and vulnerabilities faced by women and girls during and after the floods.

After a disaster, women and girls, and less frequently men and boys, are at increased risk of sexual and gender-based violence for reasons such as disruption of communities and services, poor living conditions, and loss of livelihoods. The lack of food, shelter and water compounds these impacts to make women and girls more vulnerable to sexual exploitation and abuse. Although comparative data on gender-based violence before and during emergencies is scarce, some studies have been able to show that levels of domestic and sexual violence increase following natural disasters across contexts.[2]

Violence against women and girls is a widespread and deeply-rooted problem in Benin. Physical violence, trafficking of women and girls, sexual violence, negative traditional practices, such as widow inheritance and forced marriage, and psychological and economic violence are common. In the 2008 baseline study for the EMPOWER project, in most communes, 96% of interviewed women survivors reported psychological violence as the predominant form of violence against them, followed by physical violence (mentioned by 57%), trafficking (33%), negative traditional

[2] Enarson, E. "Surviving Domestic Violence and Disasters." Freda Centre for Research on Violence against Women and Children, January 1998. Retrieved 11/2/10 from http://www.harbour.sfu.ca/freda/reports/dviol.htm; Women Thrive Worldwide, "Women, Natural Disasters, and Reconstruction." International Museum of Women (n.d.). Retrieved 11/2/10 from http://www.imow.org/wpp/stories/viewStory?storyId=1383.

practices (32%), and sexual violence (16%).[3,4] During the first three-years of EMPOWER's implementation, the most reported types of violence against women and girls were physical violence, rape and attempted rape, and abandonment of wives and children. Other reports included kidnapping, maltreatment of children, and some rare accusations of witchcraft.[5]

Benin's criminal law punishes physical violence, but no specific laws exist to address violence against women and girls. Benin has passed laws against sexual harassment, female genital mutilation, and trafficking in 2003 and 2006. Persons and Family Code regulates inheritance and the legal age for marriage at 18, but early and forced marriage remains widespread.[6] No laws exist to recognize or punish marital rape, or to protect women and girls who are accused of, and consequently molested for, "witchcraft." Benin has ratified key international legal instruments on women's and girls' rights (e.g., CEDAW, the Protocol to the African Charter for Human and Peoples' Rights on the Rights of Women in Africa, Convention on the Rights of the Child). However, these commitments have been poorly disseminated at various levels and implementation is weak.

Services for survivors are very limited and underfunded, and there is a lack of coordination among the different actors. The government's Centers for Social Promotion (CPS) are the designated support structures for the protection of vulnerable populations, but these centers are poorly resourced and lack visibility.[7]

Since November 2007, CARE has been implementing the EMPOWER project, the first ever country wide GBV project in Benin. EMPOWER's goal is to reduce violence against women and girls in all 77 communes of Benin. The project is part of the USAID-funded American Presidential Women's Justice and Empowerment Initiative (WJEI), a three-year initiative implemented in four African countries. EMPOWER includes a range of activities to raise awareness and change attitudes about GBV and to build capacity of government support structures to respond to survivors' needs, including moral and psychological support, legal procedure facilitation, medical assistance, and economic/professional empowerment and food provision. EMPOWER's support to 77 of the government Centers for Social Promotion has been crucial in making them visible and active serving vulnerable women and girls.

CARE Benin has also recently initiated another three-year anti-GBV project, Etode, which is co-funded by the European Economic Commission. Etode began in February 2011, and covers 20 communes.

[3] EMPOWER, baseline study, CARE Benin, December 2008. The baseline covered all 12 departments of Benin. Data collection took place in 30 villages/neighborhoods located in the 13 communes.
[4] The prevalence of sexual violence was likely under-represented, given the risks associated with speaking about sexual violence, and the prevailing perception that sexual violence does not include abuse between intimate partners, which is a widespread in Benin.
[5] EMPOWER, Fiscal Year 3 Narrative Report – final version, November 30, 2010.
[6] EMPOWER, Compiled texts and modes regulating some social attitudes and reproving forms of violence against women – Draft, February 2011.
[7] Rachel, L. & Olodo, S. EMPOWER Evaluation Report – Final report. August, 2010.

OVERVIEW OF THE STUDY

CARE International Benin has set up a mechanism to monitor and evaluate the implementation of its 2010 Flooding Emergency Response Strategy. This mechanism has several activities, one of which is an assessment on violence against women and girls in times of flooding.

The main purpose of this study was to make plans for addressing gender-based violence in the next rehabilitation phase of CARE Benin's emergency response, including pre-planning to address the vulnerabilities of women and girls in future emergencies.

The objectives of this study were:

- To understand the phenomenon of violence against women and girls in emergencies, especially in areas that had experienced flooding during 2010
- To assess the existing support services for survivors of gender-based violence in food-affected areas and identify any gaps

The assessment was conducted from February 28th to March 3rd, 2011, in four villages in the communes of Adjohoun (Gangban and Dannou) and Zangnanado (Kpoto and Ahlan).

The study was initiated by the Head of Impact Measurement, Learning and Accountability and led through all stages by the Chief of Part of the EMPOWER project, focal point for gender and GBV issues for CARE Benin, with the technical support from the CARE USA Gender Unit Director and GBV Program Officer. The development of the data collection tools was run by the Head of Monitoring and Evaluation (M&E) for Benin's Emergency Program (sampling, methodology and data analysis) and the GBV Program Officer from CARE USA (data analysis and drafting of report). Data collection was supervised by a Zonal Supervisor of EMPOWER and M&E Supervisors of the emergency program. The research team was comprised of staff from the EMPOWER project, CARE USA Gender Unit, and the emergency program, including M&E specialists. Three data analysis and reporting workshops were co-led by the EMPOWER Chief of Party and the CARE USA Program GBV Officer, with the logistical support of the EMPOWER Project Assistant.

METHODOLOGY

Data was collected in four villages (one with population displacement) in the communes of Adjohoun and Zagnanando. Communes were selected based on the following criteria: representativeness of flood damage, experience of population displacement, and no experience of population displacement. CARE's emergency response team worked with community mobilizers to identify community members for focus group discussions (purposive sampling). The findings of this assessment are not intended to be generalizable to the entire population affected by the flooding, but do suggest challenges and vulnerabilities for the broader flood-affected population in emergencies.

Focus group discussions were held with population sub-groups of men and women (over age 18), boys, and girls (ages 15-18) to learn from their different perspectives. Focus groups members and facilitators for each group were same-sex. A total of 15 focus group discussions were conducted, one with each sub-group in each village except for Kpoto, where girls were not available for interview because it was a weekday and they were out of the village attending school. Focus groups ranged from 11-17 participants.

Key informant interviews were held with institutions providing services to GBV survivors in the sample communities. These included commune-level health centers, Centers for Social Promotion (CPS), police, and any NGOs involved in addressing GBV in the data collection sites (i.e., Action Plus). At each institution, interviews were held with officials and mangers familiar with cases of violence against women and girls and their organization's response. A total of six interviews were held with these actors.

In total, the sample consisted of 216 total participants: 55 women, 50 men, 34 girls and 61 boys, and 16 key informants.

Given the potentially threatening and traumatizing nature of the subject matter, the study paid close attention to addressing the specific ethical considerations for researching violence against women and girls, including safety, confidentiality and privacy, and respect. Data was collected by experienced CARE staff from the emergency team and EMPOWER project. All data collectors were trained in ethical considerations for researching violence against women and girls, and ongoing support was provided through discussion of ethical issues and challenges in daily debrief sessions. Each research team was trained and experienced in local referral systems for medical, psychosocial, legal and security services for GBV survivors. To protect the participants' privacy, focus group discussions and interviews were held in areas where discussions could not be overheard, and no identifying information was recorded for respondents. Verbal consent was obtained for all respondents. Data was recorded by hand and kept confidential (raw data stored in locked office) to prevent disclosure of sensitive information.

Data collection tools for key informant interviews and focus groups with men and women were designed by the research team. Questions for adolescent boys and girls were derived from the RHRC Consortium *Gender-Based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation in Conflict-Affected Settings*.[8] A slightly modified version of a WHO/UNHCR needs checklist for clinical management of rape survivors was also used in interviews with health facilities.[9] Tools were pre-tested prior to data collection.

Notes were taken by hand during interviews and discussions and then transcribed onto computer. Data analysis debrief sessions with the research team were carried out in French and English (through a translator) after each day of data collection to share, discuss, group, and synthesize data. Following debrief sessions, all interview transcripts and notes from the debrief session

[8] Reproductive Health in Response in Conflict (RHRC) Consortium, *Gender-Based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation in Conflict-Affected Settings. RHRC Consortium: New York*, 2004.
[9] WHO/UNHCR, *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (revised edition), 2004, Geneva.

analysis were translated into English using Google Translator and further analyzed by a co-facilitator of the debrief sessions.

RESULTS

1. PERCEPTIONS OF VIOLENCE AGAINST WOMEN AND GIRLS & FACTORS CONTRIBUTING TO VULNERABILITY

There was a great deal of consistency across respondent groups and data collection sites about violence against and vulnerabilities of women and girls.

The most common types of gender-based violence reported by respondents were intimate partner violence (wife beating, economic and psychological violence), forced marriage, rape, and sexual harassment. Respondents also reported wife inheritance (*levirat*), trafficking (*placement*), prostitution of minors[10], and kidnapping. These findings are consistent with the findings of the 2008 baseline study for the EMPOWER project.

- **Intimate partner violence: Physical, economic and psychological violence**

Nearly all respondents mentioned high levels of intimate partner violence against women by husbands, including beatings, economic violence (e.g., deprivation of food and support) and psychological violence (e.g., threats, insults). Beatings commonly occur over disputes about providing for the family, women's refusal to have sex (especially after childbirth), misunderstandings between spouses, and suspicion of infidelity (e.g., men suspect their wives of infidelity if they refuse sex). Deprivation of food to the wife and children was noted as a possible punishment for refusing sex. Although no one referred to marital rape, several women explained that if they refused sex, sometimes their husbands would simply force them. Polygamy was also cited as a factor contributing to women's vulnerability to beatings and economic violence, as men provide support unevenly to their wives and take sides in resultant disputes among co-wives.

Stigma, fear, and pressure from family and community to stay silent contribute to women's vulnerability to spousal abuse. Intimate partner violence is considered a family affair, and women face consequences if they report marital violence outside the family: *"The community will say you are a bad woman and wife and are bad for the community"* (female, FGD). Women who report violence are threatened with abandonment and risk having their children taken away: *"I prefer to keep quiet and suffer violence in order to stay under the roof with my children"* (mother, FGD). In the most isolated village sampled, survivors did not seek help for fear of endangering anyone they asked for help: *"You don't seek help, even for violence. If you do, when someone helps you, even if it's your mother-in-law, they will be cursed"* (married woman, Ahlan).

[10] Specifically organized prostitution in a group or network led by a pimp/madam

The recent flooding appears to have exacerbated intimate partner violence by aggravating economic stress and household tensions. Loss of resources and the disruption of livelihoods have exacerbated household tensions over providing for family needs, multiplying disputes. *"With the flood, these arguments have increased almost every day and end with beatings or starvation"* (woman respondent, Adjohoun). *"Men are aggressive, nervous and very tense because of problems related to the flooding"* (woman respondent, Ahlan). Men expressed their frustration and anger at their wives for demanding money when they know they do not have anything.

The loss of income-earning activities for women has increased their vulnerability to abandonment by their husbands, some of whom leave them to marry women with more money or who continue to earn income. Women respondents explained that the increased stress of this physical and economic violence are sometimes leading to "psychological disorders" among women.

Women in the displacement camp faced additional vulnerabilities to intimate partner violence. In the camp, women reported increased incidence and even new causes of violence related to the circumstances of displacement: *"Our husbands want us to have sex on a rough floor. Back home, before the flooding, we had bed and traditional mattresses, at least. In the camp, no such things exist. They don't want to understand that our backs hurt badly, and they beat us when we refuse to submit our body to this torment"* (women's FGD, Kpoto). These women explained that husband beat their wives most often in the evenings after the Red Cross workers have left the camp for the day. Overcrowding, idleness and increased alcohol consumption in the camp were also reported to be making women more vulnerable to violence. The CPS has seen an increase in cases of physical and emotional abuse due to overcrowding among displaced communities. Disputes between co-wives have increased due to the cohabitation of co-wives and their children in camps, who usually live separately.

- **Forced marriage**

One of the most common forms of violence brought up across respondent groups was forced marriage, particularly of girls who become pregnant before marriage. If the father of the child denies paternity, girls are "sold off" by their parents to men in other villages for marriage. In addition, girls who become pregnant are usually withdrawn from school, stigmatized, and "cursed" by their families. As another form of forced marriage, a men's group discussion in Adjohoun also mentioned instances of men selling their wives to men in other villages for marriage in order to earn revenue.

Adolescent girls are extremely vulnerable to forced marriage due to risky sexual practices and beliefs that make them likely to become pregnant. Adolescents reported engaging in frequent unprotected sex and resorting to ineffective and dangerous birth control methods (e.g., chloroquine tablets, lemon mixed with potassium for abortions). In Adjohoun, adolescent girl respondents neither knew how to use condoms, nor did they want their boyfriends to use them: *"If a boy uses a condom, it means that he does not like the girls and does not want to marry her"* (adolescent girl, Gangban). Boys did not like condoms either and some thought that the lubricant in condoms caused infections in women. Adolescents' responses suggested a high prevalence of

sexually transmitted infections (STIs) and a lack of knowledge about treatment and prevention. Boys reported going to the health centers or using leaves to treat themselves.

Adolescent respondents felt that girls who did not attend school were more likely to become pregnant, because they had more free time and few diversions. Some reasons why girls do not attend school include lack of support from their parents, distance to school, poverty, and in some cases parents' fear of sexual harassment by teachers.

Increased economic hardship due to the flooding is forcing some girls to drop out of school because their parents can no longer afford to pay for their school fees and other expenses. Alongside women, girls have taken up grueling, time consuming tasks for meager wages to help pay for their schooling and personal supplies (e.g., toiletries), and to contribute to the household expenses.[11]

The immediate effect of flooding on incidence of forced marriage is unclear. In Adjohoun, female respondents observed no increase in the incidence of forced marriage since the flooding, while men said there were many cases of forced marriage (of girls) and trafficking (of boys and girls) at the onset of flooding as a strategy to generate funds.

- **Rape**

Rape is a common problem in the sample communities, but many survivors suffer in silence. As with intimate partner violence, stigma prevents survivors of rape from speaking out or seeking help, and fuels impunity. Adolescent boys in Zangnanado said that rape was not something special: *"A woman never accepts sex (when you propose to have sex with her) even when she wants it anyway; women don't say 'yes' to sex; and if you try to have sex with her and do not achieve your goal, she will complain to her parents and publish your name, and you will get punished by the family; but if you succeed, then she will keep quiet."* At the same time, when first asked about rape, the boys said that it had been a while since they had heard about any cases of rape in their community.

Women and girls are the most vulnerable groups for rape. Perpetrators mentioned include men and boys broadly, and more specifically teachers, traditional healers, nomadic herders (Fulani ethnic group), school guards, and foreign workers who have come to repair flood damage. In the camp, respondents reported that women and girls were most at risk of attacks by Fulani men in the evening when they are working in the fields, or traveling back to the camp. Men and boys are also at risk of being killed by Fulani men. Adolescent boys in Adjohoun identified traditional healers as perpetrators of rape. When sick women and girls seek treatment from the healers, they exploit the opportunity to grope, molest, and rape them as part of the treatment.[12]

[11] Since the flooding, girls and women described earning income by carrying loads of sand from sand mines to lorries. They begin these activities as early as 4AM and work until 1PM, earning from 1000 to 2600 CFA (about $2-$5) per day.

[12] The EMPOWER project saw many cases of this abuse. Traditional healers tell the women or girls to lie down with their eyes closed to "wait for the spirit," then they molest them and rape them. EMPOWER staff also noted that sometimes parents promise their daughter to the traditional healer for marriage if he can heal her. (EMPOWER, Reports of Cultural Diagnoses for Behavioral Change, EMPOWER 2008-2009).

Boys living in the displacement site felt that any kind of sexual violence had increased since living in the camp, because of overcrowding and less supervision of young girls: *"In the village, people were spread out – now that they're all together, it's easier to find girls"* (adolescent boy, Kpoto).

- **Sexual harassment**

All respondents mentioned sexual harassment of women and girls as a common problem. Married women, adolescent and young girls are most vulnerable to sexual harassment. Perpetrators are males of all ages, from boys to old men. Women reported high rates of sexual harassment as both a type of violence and a cause of further violence against them, as sexual harassment of married women raises suspicions about their fidelity and puts them at risk of severe punishment by their husbands,[13] including beating and being cursed. Girls are also vulnerable to sexual harassment in school by teachers and school guards.

- **Widow inheritance**

Widow inheritance, or *levirat*, is customary and requires a widow to marry a family member of her deceased husband. *Levirat* constitutes another form of forced marriage, and women who refuse are threatened with death. Widows who have their own wealth are more likely to be able to refuse these unions, so any events that negatively impact women's wealth or ability to earn income may make them more vulnerable to *levirat*.

- **Trafficking**

Respondents noted trafficking, or *placement*, as a practice that makes girls vulnerable to violence. *Placement* refers to the practice of parents selling their children, usually girls, into domestic servitude in households in other villages or cities. Initially, placement was regarded as a mark of mutual aid and solidarity between close families, based on a vision of coeducation and better opportunities for the children. However, over time, the practice became purely exploitative, used as a strategy to alleviate the family's burden of care and to raise money to support the rest of the family.[14] According to the national survey on child labor, one out of three Beninese children aged five to 17 years is in the labor force. More than six out of ten trafficked children (63%) are girls. [15]

Both men and boys in both villages in Adjohoun felt that trafficking has increased since the floods, because it gives parents a way to get money for the family in the absence of other income-generating opportunities. This trend was not reported in Zangnanado, which is further inland from the Nigeria border. The research team noted that people in the lake areas (including

[13] Punishment for suspected infidelity can be severe. A cultural assessment carried out by CARE's EMPOWER project found a deadly practice for "testing" women's fidelity by going through a ceremony, and if the accused dies five days afterwards, she is proved innocent, but if she lives, she is guilty. The study found that in some communities, women chose to end their lives rather than face the suspicion for infidelity. (CARE Benin, EMPOWER, Reports of Cultural Diagnoses for Behavioral Change, 2008-2009).
[14] SIN-DO, « Le Phenomene Vidomegon: Une gangrène pour l'éducation des Filles », 2003.
[15] INSAE (Institut National de la Statistique et de l'Analyse Economique), Enquête nationale sur le travail des enfants, 2008.

Adjohoun) engage in more travel to and cross-border trading with Nigeria, which may contribute to higher levels of human trafficking.

- **Soliciting girls for prostitution**

In the displacement camp, respondents reported that girls are being solicited for prostitution, especially at nightfall after the Red Cross volunteers left the site for the day. Less supervision and control over girls in camps is making them more vulnerable to being solicited for prostitution.

- **Kidnapping**

The police in Adjohoun mentioned that kidnapping was a problem, particularly of girls (ages 5-15) by men. Focus group participants also reported cases of kidnapping of girls in Zangnanado.

2. RESPONSES TO VIOLENCE AGAINST WOMEN AND GIRLS

Community-based dispute resolution mechanisms

Respondents reported that there were no community-based women's support groups to help survivors of violence in any of the study sites.[16] Community-based dispute resolution mechanisms are male-dominated and tend to rely on traditional solutions that burden survivors (e.g., forced marriage in cases of rape).

Male and female respondents' perceptions differed when it came to violence against women and girls and community-based systems for response. Men and boys described community and family measures to respond to rape and wife battering. Intimate partner violence is usually handled within the family by male family members, who confront and embarrass the abuser. In one village, male respondents described the community's system to deal with cases of battering in which the village chief has a committee that takes down the information as soon as a woman is beaten. The chief then looks into the case and imposes penalties (i.e., money or beverages given to the chief, who keeps them for the community). Rape was described as rare by male respondents. Men in Adjohoun explained that perpetrators of rape are expelled from the village.[17]

Female respondents focused on the barriers to seeking help, such as lack of information about support services, pressure from family and community not to report violence, and lack of support from community leaders. Respondents spoke about the negative role of traditional leaders in

[16] EMPOWER Chief of Party also said that EMPOWER staff have not come into contact with any community-based women's groups that are specifically address GBV, but that there are community-organized women's groups around other issues, like cultural activities such as dances and social events, or economic activities. Also, there are NGO women's organizations that address GBV through awareness raising and various behavior change activities at the village level, but these activities do no reach all villages, and are not based in villages.

[17] EMPOWER staff also added that in some southern regions, perpetrators of rape are sometimes bewitched, or covered in ash and forced to circulate naked in the community's public places, such as markets and major roads.

upholding traditions that punish survivors of violence. Women asked for the creation of a community support network and training for members.

External services to support survivors

This study interviewed the entities that provide support services for survivors in the four communities sampled. These include communal health centers, Centers for Social Promotion (CPS), the police, and an NGO (Action Plus).[18]

Health centers provide medical certificates, which are used for legal suits and to enable the reimbursement of cost incurred by survivors. The two communal health centers interviewed reported having no specific equipment or supplies for treatment of rape.[19] The certificate usually costs at least 5.000 CFA (about $12), making it out of reach for the large majority of the survivors. The fee is supposed to be waived with a letter from the CPS if the survivor qualifies for the significantly under-funded Vulnerable Persons Fund. However, most health centers refuse to waive these fees because they are considered the private resources of medical doctors. The certificate fees are part of the assistance which is provided to GBV survivors through the EMPOWER project's referral system.

The **Centers for Social Promotion (CPS)** are managed and funded by the Ministry of Family and Children and operate in all 77 communes. The purpose of the CPS are to assist local populations in solving social problems, with a priority on assisting women and children. CPS are usually the first point of contact for survivors. CPS speak with the survivors, identify and advise them of their options (negotiation, legal, financial, etc.), and guide them to the other services. The CPS are providing support and outreach to communities, but are greatly under-resourced and centralized, making it difficult for people in more remote areas to access services. Community and family control also interferes with survivor support at the CPS. Women who seek support for intimate partner violence often waive prosecution, because their husbands and witnesses refuse to respond when they are summoned to the CPS.

The **police** listen to reports from survivors, refer survivors to appropriate services, and conduct investigations as requested by the local court. Survivors from the more remote village of Ahlan (in Zangnanado) did not like to go to the police because of the far distance and multiple visits required. The role of the police is very crucial in the prosecution of the GBV cases, as they are the ones to conduct investigations. If police officers lack sensitivity to women's rights, abusers easily escape trial and arrange deals with survivors and their families either at the police stations or at home.

Action Plus is an NGO active in Adjohoun and provides services to survivors of violence, including welcome and support, shelter for abused children, and referrals (reference sheets) to health centers, CPS, police, and, as a last report, the court in Porto Novo. Although none of the respondents mentioned the organization, it was known by the research team.

[18] This assessment did not interview court officials because courts were far away from the study sites, and cases of gender-based violence rarely make it to the courts.

[19] Zonal or regional hospitals (*Hopital de Zone* or *Hopital departemental*) are better equipped to handle cases of sexual abuse, including surgery and gynecological materials, but are usually far away.

The referral system among agencies serving survivors is ad hoc. Survivors are referred to other services verbally, by phone call or letters. Case records are kept by the CPS and police, but not by the health centers.

Health centers and police lack of specific training and resources to handle cases of sexual violence. When asked, a health center respondent replied that there was no specific training on clinical management of rape "because the victims' injuries are not specific and are similar to other injuries."

Both the health center and police in Zangnanado reported seeing only about one case per month. If survivors seek recourse against perpetrators, they prefer to go through community mechanisms over official channels (i.e., the police), despite the fact that survivors are punished by these systems (e.g., forced marriage in cases of rape, etc.).

3. COMMUNITY RECOMMENDATIONS

Participants in the study were invited to provide suggestions to improve prevention of GBV and services for survivors, especially during and after an emergency. Many recommended awareness raising and education, especially of men, about women's rights, GBV-related laws and punishment. Women and girls also requested awareness raising activities about support services for survivors and what to do if violence occurs, and recommended the creation of support groups. CPS recommended hiring and deploying more social workers to communities to raise awareness and help direct survivors seeking services.

In terms of practical measures to prevent violence in displacement, respondents recommended separating women and men in tents in order to prevent violence that occurs from cohabitation with non-family members.

All respondents emphasized the need to support income-generation activities and provide micro-credit, especially for women, as a way to mitigate violence against women and girls. As one female respondent explained, "When women have incomes or money, the man respects you to the ears, even if you refuse sex" (woman respondent, Gangban).

Underscoring the key link between girls' education and vulnerability to violence, adolescent girls and others recommended support for girls' education and implementation of programs for professional training.

Many respondents called for punishment of perpetrators. Adolescent boys emphasized that punishments for perpetrators must come from within the community in order to be accepted: "If the decision comes from the community, it will mean more than if it comes from somewhere else" (teenage boy, Adjohoun).

Community members also suggested measures to reduce risk for future flooding, including raising the elevation of homes and granaries, digging trenches around farming plots to channel

water, and building fences between roads and farm plots to prevent cattle herds from destroying crops.

RECOMMENDATIONS

Based on the study findings, the research team came up with recommendations to address the factors contributing to the vulnerability of women and girls to violence, in emergencies as well as stable periods.

To Government:

- Increase human and financial resources for Centers for Social Promotion (CPS). Among other support, CPS need more trained outreach workers and more funding for the Vulnerable People Fund *(Fonds d'indigents)* to assist survivors.
- Waive fees for first (urgent) health aid and medical certificates for all GBV survivors to ease treatment, proof documentation and legal suits.
- Establish more health centers at the lower administrative levels and equip them with adequate GBV technical capacities, materials and medications, and ensure their accountable management (e.g., sensitive, empathetic survivor reception, care and support).
- Provide police stations with sufficient and adequate equipment, supplies and financial and human resources to assist survivors in a timely and appropriate manner
- Increase police capacity to sensitively, safely, confidentially, and respectfully receive and support survivors of GBV in accordance with guiding principles of safety, confidentially, respect and nondiscrimination. Although the EMPOWER project is working with the police to strengthen their capacity to support survivors, much more needs to be done.
- Strengthen and establish a formal referral system between support services for GBV survivors.

For emergency response:

Emergency response could be strengthened by implementing the Inter-Agency Standing Committee (IASC) *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings* and the *Gender Handbook in Humanitarian Action* in the pre-planning, early response, and stabilization phases of an emergency. These guides include minimum steps for prevention and response of GBV that should be taken during emergencies, and checklists for each sector (WASH, shelter, etc.) to mainstream gender and address the vulnerabilities of women and girls throughout response.

Based on consultations with CARE's emergency team, the writers highlight several specific recommendations to address vulnerability of women and girls in emergencies in Benin:

Pre-planning:

- Map all services available to GBV survivors in flood-prone areas and identify gaps in comprehensive care (e.g., medical, psychosocial, legal, security, shelter); update routinely and disseminate this list among all emergency actors
- Train all emergency team in GBV, gender, and guiding principles: confidentiality, safety, non-discrimination, and respect
- Continue providing awareness-raising sessions on sexual exploitation and abuse for staff and other personnel in the organisation on a regular basis, including newcomers

Food Security & Nutrition:

- Ensure that women are recipients of food aid for themselves and their children**.** Separate food ration cards should be issued for each wife and her dependents to mitigate the risk that men distribute food unevenly among their wives and children.
- Monitor security and instances of abuse in the food distribution site and departure roads.

Protection:

- Inform community about sexual violence and available services. Key messages should include services and how to access them, sexual exploitation and abuse and confidential reporting procedures. Put up posters in strategic places with quick and easy messages on how survivors of sexual violence can be referred to health and psychosocial services.
- Ensure that all staff are trained on code of conduct for prevention of sexual exploitation and abuse
- Ensure that mechanisms are put in place to ensure people can report any harassment or violence

Shelter & Site Planning:

- Conduct routine spot checks and discussions with communities to ensure people are not exposed to sexual violence due to poor shelter conditions or inadequate space and privacy
- If communal shelters are necessary, make sure to provide material for partitions between families, and ensure that there are separate communal booths for single or unaccompanied women and children and single men
- Provide lighting for communal areas (e.g., latrines, water pumps) and for individuals (e.g., torches for families)

Water, Sanitation & Hygiene:

- Monitor sanitation facilities and water collection points to ensure they are safe and accessible (locks, lighting)
- Include sanitary supplies for women and girls in hygiene kits

Rehabilitation phase (including strategies for pre-planning):

- Support viable, diversified income-generation activities for men and especially women. This may involve conducting a market analysis in flood-affected and flood-prone areas to identify viable income-generation opportunities for men and women. Monitor programs for any possible negative effects.
- Organize and support community-based structures to mobilize against violence and support survivors – e.g., work with EMPOWER to expand model of GBV community outreach workers to flood-prone/affected areas to mobilize community action groups to analyze security threats and plan response
- There is a need to analyze the psychological problems in flood-affected communities and develop a strategy for strengthening or creating structures for community-based psychosocial support (e.g., women's support groups, gender-balanced community mediation groups, etc.)

General programming priorities to address women's and girls' vulnerability to violence

The research team recommended the following program priorities and strategies to address the underlying causes of violence against women and girls in Benin:

- Sexual and reproductive health and family planning programming, especially targeting adolescent girls and boys. Ideas discussed include awareness raising and behavior change communication (BCC) around safe sex and family planning; family planning committees in villages and camps to manage condom supplies, conduct outreach to educate and raise awareness about birth control and safe sex; youth clubs; and education for men around women's healing process after childbirth
- Promotion of girls' education and vocational training
- Address stigmatization of survivors of GBV, especially in more remote villages
- Awareness raising about women's rights, GBV and related laws and punishments, and services for survivors
- Increased community outreach for GBV prevention and response
- Increase and expand EMPOWER's work with traditional and religious leaders to raise awareness and change attitudes and beliefs about women's rights and GBV (e.g., EMPOWER's "champions of change" training workshops with traditional and religious workers)
- Explore working with existing community-organized women's groups for opportunities to integrate survivor support

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