WAR@HOME

Gender-Based Violence Indicators Study

MAURITIUS COUNTRY REPORT

Gender Links (GL) is a Southern African NGO that is committed to a region in which women and men are able to participate equally in all aspects of public and private life in accordance with the provisions of the Southern African Development Community (SADC) Protocol on Gender and Development. GL achieves its vision by coordinating the work of the Southern African Gender Protocol Alliance formed around the sub-regional instrument that brings together all key African and global commitments for achieving gender equality. Working with partners at local, national, regional and international level, GL aims to:

- Promote gender equality and the media, and in all areas of governance.
- Develop policies and conduct effective campaigns for ending gender violence, HIV and AIDS.
- Build the capacity of women and men to engage critically in democratic processes that advance equality and justice.

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Acknowledgements

The Gender Based Violence (GBV) Indicators Project is a regional research study aimed at testing tools to measure and monitor the extent, effect, cost of and efforts to end violence against women in light of the Southern African Development Community Protocol on Gender and Development's target to halve levels of GBV by 2015. The study has so far been conducted in Botswana, Mauritius and South Africa. The project is being rolled out in Zimbabwe and Zambia in 2012/ 2013. This report presents findings from the research conducted in Mauritius from 2010 to 2011.

Gender Links (GL) expresses appreciation to the 1357 women and men that consented to participate in this study through the household survey. We are especially indebted to the additional 25 women and 10 men who shared their personal testimonies or *"I" Stories* and agreed to have them published in this research. Most of the survivors preferred not to be referred to by their real names. The asterisk in the text denotes a pseudonym. To protect their identity and to avoid any further suffering, the editors have referred to those who gave first-hand accounts using pseudonyms that they chose. Special thanks to Sheila Baguant, Director of Shelter for Women and Children in Distress and Ambal Jeanne, Director of SOS Femmes for their assistance in collecting the *"I" Stories*. The voices of those most affected give this study power and urgency.

The Mauritius Research Council (MRC) formed part of the working group and managed the survey. The MRC - in particular research staff Harris Neeliah, Aveeraj Peedoly, Havina Mungun-Jhurry - organised and coordinated the fieldwork and collected the survey data. We would also like to commend the contribution of administrative staff of the MRC and the team of interviewers and supervisors.

GL Chief Executive Officer (CEO) Colleen Lowe Morna provided the overall strategic management and oversight of the study. GL Director for Mauritius and Francophone, Loga Virahsawmy and GL GBV Indicators Research Manager Mercilene Machisa managed the research project in Mauritius. Kubi Rama, GL Chief of Operations, Aveeraj Peedoly and Harris Neeliah, Senior Researchers at MRC conducted the researcher ethics training. Dev Virahsawmy, linguist and Creole expert translated the questionnaire into Mauritian Creole. Carl Fourie from Jembi Health Systems provided invaluable technical support including training the researchers on the use of personal digital assistants and programming of all equipment. Field workers under the supervision of the MRC visited households and administered survey questionnaires to the sampled respondents.

Machisa conducted the analysis of the prevalence and attitudes study and interrogated the administrative data. Davinah Sholay, former GL Mauritius Programme Officer, collected data from ministries, the police and the courts. Virahsawmy, Sholay, Mauritius Local Government Facilitator Mary Coopan (now retired) and media practitioner, Jimmy Jean Louis wrote the personal testimonies of women and men. Virahsawmy wrote all the case studies. Machisa and Virahsawmy wrote the report. Dev Virahsawmy edited all the personal testimonies. Lowe Morna edited the final report.

We would like to thank all stakeholders in this research for their guidance and assistance with accessing and contributing valuable information and statistics as well as inputs into the final draft of the report. These include the Ministry of Gender Equality, Child Development and Family Welfare, Ministry of Health and Quality of Life, the Supreme Court, the Mauritian Police Force, the Police Family Protection Unit and the Library of the Legislative Assembly.

We wish to thank the participants at a one day validation workshop of the final report on 18th October 2012 convened in partnership with the Ministry of Gender Equality, Child Development and Family Welfare. The participants included: Appanah Emraj, Survivor; Aveeraj Peedoly, Harish Neeliah and Y. Buxsoo, Mauritius Research Council; D. Potheegadoo, Statistics Mauritius; Dr. U Kowlessur, Ministry of Health and Quality of Life; S. G. Sookooram, Jayshree Bunjhun and Lucilda Jupin, Ministry of Gender Equality, Child Development and Family Welfare; S. Kangloo, Ministry of Social Security; Anouchka Saddul, National Aids Secretariat (Prime Minister's Office); Nalini Senevrayar-Cunden, Judiciary; Asha Pillay Nababsing, Attorney General's Office; Jagdish Sanhye, Victim Support; Gunneeta Aubeeluck, Mauritius Prisons; Michelle Thomas, Head Police Family Protection Unit (Mauritius Police); Reshma Sewchurn, Ministry of Local Government; Moorghen Vanessa, Dr. Idrice Goomany Centre, Preetila Khadun, Moka Flacq District Council; Ashwini Rughoodass, Black River District Council; Roselyne Young Shee, Councillor Black River District Council; Natacha Chowreemootoo, City Council of Port Louis; Bernarde Bazerque and Neesha Chetty, Municipal Council of Curepipe; S. Kaudeer, Municipal Council of Beau Bassin Rose Hill; R. Dobee and R. Ramoo, Municipal Council of Vacoas Phoenix; Satyam Chummun, Village Councillor and Pandita, Neeraj Ramburn, Grand Port Savanne District Council; Vimala Lallmohamed, Shelter for Women and Children in Distress; R. Kaidoonankoo, NaTresa; Dr. Ameenah Sorefan, Media Watch Organisation; Bruneau Woomed, WIN Ltd; Tanusha Prayag and Sangeetah Seetulparsad, MACOSS; Jean Yves Valls, Men Against Violence; S. Georgijevic and M. Paroomal, University of Mauritius; Deepika Faugoo, University of Technology; Sadna Teeluckdhary, Shirley Chamroo and Avinash Bissoondoyal, Mauritius Broadcasting Corporation; Usule Lareine, Le Defi Quotidien; Marie Annick Savripene, L'Express; Dev Seesa, The Independent Daily.

GL worked with the South African Medical Research Council in developing the research tools first tested in the Gauteng province of South Africa. Professor Rachel Jewkes, Director of the South African Medical Research Council Gender & Health Research Unit and Nicola Christofides, Senior Lecturer and Head of the Master of Public Health Programme at the University of the Witwatersrand School of Public Health, advised on and developed the survey research methodology and instruments. Nwabisa Jama Shai, former GL GBV Indicators Research Manager contributed to the development of research tools during her tenure. Jayshree Bunjhun, Head of Family Unit of the Ministry of Gender, Child Development and Family Welfare gave inputs in the development of the questionnaire.

We are deeply indebted to the United Nations Trust Fund for supporting the conceptual phase of this project; the Norwegian Council for Africa and UKAID through the Department for International Development (DFID) for funding the research and report and La Sentinelle for printing the report at a substantially reduced cost.

The Management and Editorial Team

Colleen Lowe Morna is the GL CEO. She began her career as a journalist specialising in gender and development, coordinating the Africa office of Inter Press Service in Harare and serving as correspondent for South Magazine, as well as Africa Editor of the New Delhi-based Women's Feature Service. She served as a senior researcher on the Commonwealth Secretariat Africa desk and later as Chief Programme Officer of the Commonwealth Observer Mission to South Africa. As an advisor on gender and institutional development for the Commonwealth Fund for Technical Assistance special programme for South Africa, Lowe Morna advised on gender structures for the new South Africa and served as founding CEO of the South African Commission on Gender Equality. She holds a Master of Science in Communications from Columbia University; Bachelor of Arts in International Affairs from the Woodrow Wilson School of International Relations, Princeton University; and a certificate in executive management from the London Business School.

Loga Virahsawmy is GL Director, Mauritius and Francophone Office, and Chairperson of Media Watch organisation - GEMSA Mauritius. She has participated and contributed in a variety of research for GL. Some of her research work include Gender and Media Baseline followed by the Progress Study; HIV and AIDS and Media Baseline Study; Gender in Local Government; Gender in Media Education. She helped media houses to develop HIV and AIDS and Gender Policies as well as Gender Policies. She wrote the Mauritius SADC Protocol on Gender and Development Barometers report. As the Francophone Director she conducts workshops on media literacy and leadership skills and conducts training in media enterprises and localities as part of GL Centres of Excellence in Mauritius, Madagascar and DRC. As a gender activist Loga talks regularly on gender issues. She was awarded the high distinction of Grand Officer of the Star and Key of the Indian Ocean (GOSK) by the President of the Republic on the advice of the Prime Minister on 23 July 2009.

Kubi Rama is the GL COO. She is the former CEO of the Gender and Media Southern Africa (GEMSA) Network where she was responsible for the programme, financial and institutional development of GEMSA. In her earlier time as Deputy Director and Network Manager of Gender Links she was responsible for managing a new audience research project, coordinating the regional network, setting up a virtual resource centre for media trainers, co-ordination and sustaining the 16 days of activism,

organising a regional media summit and mainstreaming gender as part of training curricula. Prior to joining Gender Links, Rama served at the Department of Journalism (Durban Institute of Technology) as a senior lecturer.

Mercilene Tanyaradzwa Machisa is the GBV Indicators Research Manager. Machisa joined GL in 2010 and has managed and analysed the data from the household prevalence and attitudes surveys in Gauteng, Botswana and Mauritius. She also co-ordinated the implementation of the other research components, subsequent data analysis and drafted the research reports including this Mauritius report. Prior to joining GL, Machisa worked for the National Institute of Health Research in Zimbabwe as a Medical Research Officer. Machisa also provided part time statistical consultations and support to postgraduate students in the Faculty of Health Sciences at the University of Witwatersrand. She holds a Master of Science in Medicine degree specialising in Epidemiology and Biostatistics from the University of Witwatersrand and a first class Bachelor of Science Honours degree in Biological Sciences from the Midlands State University in Zimbabwe.

Davinah Sholay's first encounter with the concept of gender was in 2007 at the time she joined Media Watch. She was involved in various projects including Gender and Advertising, Gender and Local Government and Gender and the Media. She participated in the 2008 GL Summit in Johannesburg where she made a presentation on Gender and Advertising in Mauritius. Sholay studied Mass Communications and obtained a Bachelor's degree in 2008 from the Curtin University of Technologies. Prior to joining Gender Links in 2010, Sholay worked as a researcher at Ceridian Ltd. She served the Mauritius Satellite Office as Programme Officer at the time of the research.

Mary Coopan worked as a Kindergarten teacher at the Municipality of Beau Bassin - Rose Hill for twelve years after which the Council sponsored her for studies leading to a Diploma in Social Work. She got promoted and moved to Municipality of Port-Louis and then to the Municipality of Curepipe where she worked as Chief Welfare Officer. During her stay at Curepipe she represented the Council at a workshop organised by GL on Gender in Local Government and got training in Johannesburg. She took early retirement from her work in July 2009 to serve as Local Government Facilitator, at the Mauritius GL Satellite Office at the time of the research (Coopan has since retired). Coopan worked with Councils to adopt local GBV Action Plans. She also worked with all the nine localities of Mauritius to become Centres of Excellence in Gender and Local Government, and share best practices at the annual GL Gender and Local Government Summits.

Acronyms

ADVC	-	Area Domestic Violence Committee
AIDS	-	Acquired Immune Deficiency Syndrome
ARV	-	Anti-retroviral drugs
CAC	-	Coordinating Advisory Committee
CASR	-	Centre for Applied Social Research
CEDAW	-	Convention for the Elimination of Discrimination Against Women
CEDEM	-	Centre d'Education de Développement pour les Enfants Mauriciens
CEO	-	Chief Executive Officer
COO	-	Chief of Operations
CS	-	Court Services
CBO	-	Community Based Organisation
CNEGBV	-	Costed National Action Plan to End Gender-Based Violence
CWO	-	Child Welfare Officer
GDP	-	Gross Domestic Product
CDU	-	Child Development Unit
DV	-	Domestic violence
FSBx	-	Family Support Bureaux
FWPO	-	Family Welfare Protection Officer
FWPU	-	Family Welfare Protection Unit
PDVA	-	Protection from Domestic violence Act
GBH	-	Grievous Body Harm
GBV	-	Gender- based violence
GL	-	Gender Links
GMBS	-	Gender and Media Baseline Study
GMPS	-	Gender and Media Progress Study
GIS	-	Government Information Service
HIV	-	Human Immuno Deficiency Virus
Hons	-	Honours

IPV	-	Intimate Partner Violence
MBC	-	Mauritius Broadcasting Corporation
MRC	-	Mauritius Research Council
MGECDFW	-	Ministry of Gender Equality, Child Development and Family Welfare
NGO	-	Non Governmental Organisation
PEP	-	Post Exposure Prophylaxis
PDA	-	Personal Digital Assistant
PDVA	-	Protection from Domestic Violence Act
PSU	-	Primary Sampling Unit
PFPU	-	Police Family Protection Unit
PLHIV	-	People Living with HIV and AIDS
NATRESA	-	National Agency for the Treatment and Rehabilitation of substance abusers
NPEGBV	-	National Platform to end GBV
PMO	-	Police Medical Officer
NAP	-	National Action Plan to end violence against women and children
RES	-	Rapid Emergency Service
SADC	-	Southern African Development Community
SRH	-	Sexual and Reproductive Health
STI	-	Sexually transmitted infections
UN	-	United Nations
UNECA	-	United Nations Economic Commission for Africa
UTM	-	University of Technology
UNIFEM	-	United Nations Development Fund for Women
VAM	-	Violence against men
VEARP	-	Victim Empowerment and Abuser Rehabilitation Policy
VAW	-	Violence against women
VSM	-	Victim Support Mauritius
VCT	-	Voluntary Counselling and testing
WHO	-	World Health Organization

Foreword

Prime Minister
Republic of Mauritius

I welcome the publication of the Gender-Based Violence Indicators Study commissioned by Gender Links.

Gender-based violence is human rights violations and reflects inequality between women and men. Such violence has profound implications on the health, dignity, security and autonomy of those affected not only the victims but also the entire family. Unfortunately this is often ignored.

The indicators compiled in collaboration with the Mauritius Research Council, review attitude and behavioural problems that prevail in our society. They are an important source of information and may serve as guidelines for our policy development.

Mauritius has ratified several important human rights instruments and has signed, amongst others, the SADC Declaration on Gender and development.

My Government is fully committed to continue working towards an inclusive, harmonious and peaceful society. Creating the appropriate legislative and institutional framework for gender equality and family welfare, will remain high on our agenda. I wish to thank Mrs Loga Virahsawmy, GOSK, and Director, Gender Links and President of Media Watch Organisation and all those who collaborated in the preparation of this very revealing report.

Dr the Hon Navinchandra Ramgoolam, GCSK, FRCP
Prime Minister
10 August 2012

Preface of Honourable Mrs Mireille Martin
Minister of Gender Equality, Child Development and Family Welfare
Gender-Based Violence Indicators Report
July 2012

This Gender-Based Violence (GBV) Indicators Report commissioned by Gender Links Mauritius, provides useful insights on the reality of GBV in the Mauritian society.

This subject is an issue of national importance encompassing a wide range of human rights violations. GBV reflects and reinforces inequities between men and women compromising the health, dignity, security and autonomy of victims.

Mauritius has been relentless in its fight against first, domestic violence and subsequently GBV. Worldwide, after decades of struggle, GBV is positioned high on intergovernmental policy agendas for peace and security, poverty reduction and development, human rights and gender equality. Gender-based violence highlights a deep dysfunction in society carrying with it profound suffering and substantial economic and social costs.

Mauritius is party to a number of international and regional instruments including inter alia, the Beijing Platform of Action, the Millennium Development Goals, the SADC Protocol on Gender and Development and has also aligned its policies with the IOC Gender strategy.

All these international commitments have identified GBV as a critical priority area.

We believe that the key to ending GBV is a well-defined roadmap that allows for a more coordinated, multi-sectoral and holistic approach.

The Ministry of Gender Equality, Child Development and Family Welfare launched the National Platform to End Gender-Based Violence in October 2011.

The Costed National Action Plan to End Gender-Based Violence 2012-2015, adopting a multi-pronged approach was subsequently validated in November 2011, enabling Mauritius to take leadership of the African region as regards the launching of the AfricaUnite Campaign to end violence against women and girls. The Protection from Domestic Violence (Amendment) Act 2007 has been proclaimed and is fully effective.

As an NGO, Gender Links comes forward with these indicators. The project aims at testing tools to measure the prevalence of gender-based violence in Mauritius through different sets of indicators. This endeavour is viewed as a useful contribution in the concerted effort of one and all to address GBV.

This project deserves to be commended. It is fully in line with the objectives of my Ministry to rope in all stakeholders to combat GBV.

Our aim is to promote a nation free from violence. I trust that the content of this report will be a useful contribution to better understand and act against GBV in our Republic.

Hon. Maria Francesca Mireille Martin
Minister of Gender Equality, Child Development and Family Welfare
July 2012

Executive Summary

Sixteen Days Campaign 2011 March at Municipal Council of Beau-Bassin Rose-Hill. *Photo: Mary Jane Piang-Nee*

About a quarter (24%) of women in Mauritius have experienced some form of gender-based violence in their lifetime including partner and non-partner violence. An almost similar proportion of men (23%) admit to perpetrating violence against women in their lifetime. One in twenty-five women (4%) experienced gender-based violence and a similar proportion of men (4%) perpetrated gender violence in the 12 months before the survey.

Most of the violence occurs within intimate relationships. Almost a quarter of ever-partnered women (23%) have experienced while 22% of men perpetrated Intimate Partner Violence (IPV) in their lifetime. One in twenty women (5%) experienced IPV while 4% of men perpetrated IPV in the twelve months before the survey. In contrast, only 0.3% of Mauritian women reported domestic violence cases to the police in a similar period. *Thus, the prevalence of intimate partner violence reported in the survey is 15 times higher than that reported to the Family Support Bureaux (FSBx) of the Ministry of Gender Equality, Child Development and Family Welfare.* These findings are evidence that the actual levels of GBV in Mauritius are higher than those reported in official statistics.

Emotional violence was the most commonly reported form of IPV. One in every six women (16%) experienced emotional IPV in their lifetime while 4% of women experienced emotional IPV in the 12 months before the survey.

A greater proportion of men reported perpetration of non-intimate partner rape compared to the women that reported experience. One in twenty-five (4%) men raped a non-partner in their lifetime while less than one percent (0.7%) of women were raped by non-partners. Women in the survey sample (0.1%) also reported experiencing non-partner rape in the 12 months before the survey. *The prevalence of non-partner rape in the survey is eleven times the prevalence of non-partner rape reported to the police in a similar period. More interestingly, the prevalence of intimate partner sexual violence reported in the survey is sixty one times the prevalence of sexual assault by spouse cases reported to the police.*

While the findings from the survey show that the majority of GBV cases perpetrated either by partners or non-partners goes unreported, politicians still do not address it in public discourse. Only 9% of the analysed 266 speeches delivered by politicians from 2010 to 2011 referred to GBV. Of the speeches with reference to GBV, only 22% had GBV as the main topic. GBV receives little media coverage as it accounts for 2% of total coverage, which is less than the regional average of 4%.

GBV in Mauritius is intergenerational and conservative gender attitudes are at the core of drivers of violence against women. Other factors found to exacerbate GBV in Mauritius are alcohol and in-law interferences.

These are among the glaring findings of the GBV Indicators Research project in Mauritius undertaken by GL and the MRC from 2010 to 2011. The findings show the merits of conducting periodic GBV household surveys as opposed to relying on available administrative data including police data. These findings that show a lower prevalence of GBV in Mauritius compared to studies using similar methods in South Africa and Botswana. But they show that GBV is highly underreported and needs to be placed high on the political agenda.

Inspired by the Southern African Development Community (SADC) Protocol on Gender and Development target of halving GBV by 2015, the research project provides a comprehensive assessment of the extent, effects and response to GBV in Mauritius. The Mauritius study is part of a regional initiative. GL conducted similar studies in four provinces of South Africa (Gauteng, Western Cape, Kwazulu Natal and Limpopo) and in Botswana. In each of the study sites, the project employed five research methods with a prevalence and attitudes household survey being the flagship. Two separate questionnaires were used in the survey: one to determine lifetime and past 12 month experiences of GBV by women aged 18 and above and the other to determine perpetration of GBV by men of similar age.

A representative sample of 679 women and 678 men across Mauritius completed questionnaires in their preferred local language on behaviour and experiences related to GBV. The focus on violence against women is justified by overwhelming evidence that the majority of gender violence cases consists of violence against women and these cases result in extensive and well-documented adverse health consequences (Krug *et al* 2002). Comparing what women say they experience to what men say they do adds credibility to the findings. The study explored both intimate partner and non-partner violence. Forms of IPV include physical, emotional, economic, and sexual.

In addition to the prevalence survey, tools used include the interrogation of administrative data from Family Support Bureaux (FSBx), police, courts and shelters; collection of first-hand accounts of women's and men's experiences of GBV, media monitoring and political discourse analysis. Forms of non-partner violence include sexual harassment and rape.

Some of the main findings from the study are:

Extent of GBV

Table one: Extent of GBV					
Criteria	Prevalence of GBV survey				Extent of reporting to police
	Women's experience in a lifetime %	Men's perpetration in a lifetime %	Women's experience in the past year %	Men's perpetration in the past year %	Reporting in a lifetime %
Prevalence of GBV	23.8	22.9	4.3	4.0	-
Prevalence of intimate partner violence	22.9	22.4	4.7	4.0	-
Prevalence of emotional intimate partner violence	16.2	16.3	3.8	2.2	-
Prevalence of physical intimate partner violence	10.1	8.9	1.8	1.8	3.1
Prevalence of economic intimate partner violence	8.4	6.2	2.1	1.0	-
Prevalence of sexual intimate partner violence	8.7	3.0	1.1	0.7	-
Prevalence of non- intimate partner rape	0.7	3.5	0.1	0.6	0.1
Prevalence of attempted rape	1.0	4.8			-
Prevalence of sexual harassment		-	-	-	-
Prevalence of sexual harassment in schools	0.3	-	-	-	-
Prevalence of sexual harassment at work	6.3	-	-	-	-

Table one shows that:

- Similar proportions of women and men - that is 16% - experienced or perpetrated emotional IPV respectively.
- There is a disjuncture between the extent of physical, sexual and economic IPV reported by women and men. Women report higher extent of experience compared to the extent of perpetration reported by men.
- In contrast, men report higher extent of lifetime non-partner and attempted rape perpetration than the extent reported by women.
- Six percent of women who have ever worked have experienced some form of sexual harassment at the workplace.
- The proportion of women reporting experience of all forms of IPV in the past 12 months is higher than the proportion of men reporting perpetration.
- A higher proportion of men (0.6%) reported perpetrating non-partner rape while 0.1% of women experienced non-partner rape in the 12 months before the survey.

Patterns and drivers of GBV

The study also investigated different individual and community factors associated with GBV experience by women and perpetration by men.

Individual factors

Table two: Individual factors associated with perpetration of IPV				
Factors	**Ever IPV % men perpetrating**	**Chi(p)**	**Current IPV % men perpetrating**	**Chi(p)**
Age				
18-29	12.1	0.2	0	0.05
30-44	20.8		6.2	
45+	24.8		2.6	
Level of education				
High school incomplete and lower	24.9	0.01	4.2	0.6
High school complete and over	12.4		3.3	
Worked in past 12 months				
No	0	0.3	0	0.04
Yes	1.2		4.7	
Child neglect				
No	18.9	0.04	3.4	0.3
Yes	28.7		5.2	
Child physical abuse				
No	13.4	0.001	2.6	0.1
Yes	29.7		5.2	
Child sexual abuse				
No	21.2	0.001	3.2	0
Yes	44.8		20.7	

Table two shows that:

Socio-demographic factors

- Age is not a statistically significant driver for IPV experience or perpetration.
- Educational attainment is significantly associated with IPV experience by women. Women who did not complete high school (25%) experienced IPV compared to 12% of women who had completed high school.
- Men who were employed in the 12 months before the survey were less likely to perpetrate IPV compared to men who were not employed in a similar period.

Child abuse

- Men who were sexually abused as boys are more likely to perpetrate violence against their intimate partners. Twenty one percent of men sexually abused as children perpetrated IPV.
- These findings correspond to the ecological model of IPV, which posits that individual childhood and interpersonal experiences affect attitudes and behaviour in adulthood.

Alcohol and drug abuse

- Drinking alcohol in the 12months before the survey was associated with perpetrating IPV. Six percent of men who drank alcohol compared to one percent of men who did not drink alcohol perpetrated IPV in a similar period.
- There is no significant difference in the proportion of perpetrators using drugs and non-drug users.

Relationship factors

- Analysis of qualitative first-hand accounts of GBV experience shows that in-laws play a role in exacerbating conflict and violence between married couples.

Community factors

The survey measured personal and perceived community attitudes around gender relations.

Table three: Personal gender attitudes		
Criteria	Strongly agree/agree	
	Women (%)	Men (%)
I think people should be treated the same whether they are male or female	88.4	83.3
I think a woman should obey her husband	77.3	83.8
I think a man should have the final say in all family matters	16.3	44.3
I think a woman needs her husband's permission to do paid work	78.9	82.4
I think that if a woman works she should give her money to her husband	12.7	18.2
Sexual entitlement		
I think there is nothing a woman can do if her husband wants to have girlfriends	21.8	20.9
I think that if a man has paid dowry for his wife, he owns her	6.4	15.9
I think that if a wife does something wrong her husband has the right to punish her	37.8	54.5
I think that a woman cannot refuse to have sex with her husband	29.8	38.4
I think that if a man has paid dowry for his wife, she must have sex when he wants it	10	12.3
Attitudes towards rape		
I think it is possible for a woman to be raped by her husband	37.1	33.5
I think that in any rape case one would have to question whether the victim is promiscuous	1.6	59
I think in some rape cases women actually want it to happen	22.9	27.7
I think if a woman doesn't physically fight back, it's not rape	31.2	46
I think that when a woman is raped, she is usually to blame for putting herself in that situation	13.8	22.3

Table three shows that:

- Women are generally more progressive than men in terms of gender relations in the home.
- Although women appear more progressive than men they also affirm a high extent of conservative gender attitudes.
- There is a lower expectation among women and men for sexual entitlement to follow marriage.
- Men revealed more conservative attitudes around sexual entitlement than women.
- A greater proportion of men than women showed negative attitudes towards rape. Fifty-nine percent agreed that in any rape case the victim has to be questioned for promiscuity while only a marginal 1.6% of women agreed to this.
- Twenty-eight percent of men agreed that in some rape cases women wanted it to happen while 22.9% of women agreed to this.
- Almost one in two men (46%) agreed that if a woman did not fight back then it could not be rape. About one in three (31.2%) women agreed to this.
- Twenty-two percent of men agreed that if a woman is raped, she is to be blamed for putting herself in that situation. Only 14% of women concurred.

Societal factors

Table four: Political leadership	
Criteria	**%**
Percentage of speeches by politicians which mention GBV	8.6
Percentage of GBV speeches by politicians which refer to GBV as main topic	22
Percentage of GBV speeches by politicians which refer to emotional abuse	8.5
Percentage of GBV speeches by politicians which refer to physical abuse	12.8
Percentage of GBV speeches by politicians which refer to sexual abuse	23.4
Percentage of GBV speeches by politicians which refer to economic abuse	2.1
Percentage of GBV speeches by politicians which refer to domestic violence	29.8
Percentage of GBV speeches by politicians which refer to femicide	2.1

Table four shows that:

Political environment

- Of the 266 speeches analysed, less than a tenth (9%) referred to GBV but only 22% of these had GBV as the main topic.
- The most commonly referred form of GBV is domestic. About three in every ten GBV speeches refer to domestic violence.
- About a quarter of GBV speeches (23%) refer to sexual violence.
- Femicide and economic violence are the least referred to forms of GBV.

Media

The results of the Gender and Media Progress Study (GMPS) to examine amongst others the proportion of GBV coverage, GBV topics, who speaks, and who reports on GBV in Mauritius show that:

- Only 2% of all news articles monitored in Mauritius covered GBV.
- Women constitute 26% of sources on GBV in Mauritius.
- The most commonly covered GBV topic is rape. Nineteen percent of GBV articles were about or referred to rape.
- More men (56%) than women (44%) report on GBV in the media.

Effects of GBV

The survey explored individual effects associated with experience of GBV by women.

Table five: Effects of physical abuse	
Criteria	**% Women**
Physical injury	
Percentage of physically abused women who sustained injuries	38.7
Average number of times injured	6
Percentage of physically injured women who spend days in bed because of injuries	41.7
Average number of days in bed	9
Percentage of physically injured women who missed work as a result of injuries	50
Average number of days off work	7
Sexual and reproductive health	
Percentage of women who were abused by intimate partners and diagnosed with STI	66.7
Poor mental health	
Percentage of women who were abused by intimate partners and attempted suicide	16.1
Percentage of women who were abused by intimate partners and have high levels of depressive symptoms	26.1

Table five shows that:

- Thirty-nine percent of all women that reported experiencing physical IPV suffered injuries.
- Forty-two percent of the injured women spend days in bed as a result. The average length time spent by all women was nine days.
- Fifty percent of the injured women took days off work. The average length of time spent away from work was seven days.
- Two thirds of women (67%) of women who experienced IPV in their lifetime were also diagnosed with STIs.
- Sixteen percent of women who were abused by intimate partners, attempted suicide.
- Over a quarter (26%) of women who were abused by intimate partners have high levels of depressive symptoms.

Response

Table six: Knowledge of legislative measures and helplines

Criteria	% Women	% Men
Awareness of legislation		
Proportion of participants aware of the protection from Domestic Violence Act	75.4	86.0
Proportion of participants aware of protection orders	67.9	72.8
Proportion of participants who know about the Hot Line 119	45.9	51.2
Proportion of participants who used the Hot Line 119	25.3	24.6
FSBx		
Number of spousal domestic violence cases with female victims reported in 2010	1722	
Number of spousal domestic violence cases with female victims reported in 2011	1235	
Population prevalence of IPV based on FSBx statistics	0.3%	
Mauritian Police Services		
Number of sexual offences cases recorded by Mauritian Police Services in 2010	254	
Number of sexual offences cases recorded by Mauritian Police Services in 2011	282	
Number of rape cases recorded by Mauritian Police Services in 2010	49	
Population prevalence of rape in 2010 based on police statistics	0.009%	
Judiciary		
Number of new PDVA cases at court in 2010	1905	
Number of PDVA cases disposed by courts in 2010	1819	
Number of new sexual offences cases at court in 2010	393	
Number of sexual offences cases disposed by courts in 2010	91	
Health sector		
Number of domestic violence cases reported at the public hospitals in 2009	856	
SOS Femmes shelter		
Number of women in shelter January-June 2011	244	
Number of children in shelter January- June 2011	204	
Number of women seeking advice January-June 2011	1073	
Number of calls received from abused women January - June 2011	1102	

Table six shows that:

Awareness of laws

- A greater proportion of men (86%) than women (75%) have heard about the Protection from Domestic Violence Act.
- The main source of knowledge for both men and women is the radio followed by television.
- Forty-five percent of women and 37% of men heard about the Protection from Domestic Violence Act from radio.

- Forty percent of women and 35% of men heard about the Protection from Domestic Violence Act from television.
- One in six men (16%) of men compared to one in sixteen (6%) women heard about the Protection from Domestic Violence Act through the print media.
- More men (73%) had heard about the protection orders than women (68%).
- More men (51%) had heard about the helpline than women (46%).
- An almost similar proportion (25%) of women and men had heard of the helpline also used it.

FSBx

- According to official statistics of the Ministry of Gender Equality, Child Development and Family Welfare, the number of domestic violence reported at the Family Support Bureaux (FSBx) is 2215 for year 2010 and 1752 for 2011.
- The prevalence of intimate violence reported in the survey is 15 times more than that reported to the FSBx.

Police Family Protection Units

- The number of sexual offences cases reported to the police increased from 254 in 2010 to 282 in 2011.
- According to official statistics from the Police Family Protection Unit the number of domestic violence reported is 3525 for 2010 and 3478 for 2011.

District Courts

- The district courts received 1905 new and disposed 1819 PDVA cases in 2010.
- The district courts received 393 new sand disposed 911sexual offences cases in 2010.

Hospitals

- The hospitals in Mauritius dealt with 856 cases of domestic violence in 2009.

Shelters and counselling services

- There are only three registered shelters in Mauritius namely SOS Femmes, Shelter for Women in Distress and Shelter La Colombe.
- SOS Femmes received 1102 calls from abused women and provided shelter to 244 women from January to June 2011.

Prevention

Table seven: Knowledge and participation in GBV campaigns

Criteria	% Women	% Men
Awareness of campaigns		
Proportion of participants who know of events or campaigns to end GBV	36.9	38.5
Proportion of participants who heard of the Sixteen Days campaign in the 12 months prior to the survey	9.6	21.2
Proportion of participants who heard of the 365 Days campaign in the 12 months prior to the survey	4.6	21.4
Proportion of participants who have participated in a march or event to protest against GBV	4.9	15.0
Source of GBV information		
Proportion of participants who access information on GBV from radio	48.0	35.2
Proportion of participants who access information on GBV from newspapers	8.6	21.7
Proportion of participants who access information on GBV from television	35.3	29.3
Proportion of participants who access information on GBV from from a neighbour/friend	0.8	2.8
Proportion of participants who access information on GBV from community meetings	2.5	5.5
Proportion of participants who access information on GBV from other sources	4.9	5.5
Secondary Prevention		
Number of police officers trained on domestic violence by the Ministry of Gender from 2008-2011	105	

Table seven shows that:

Awareness campaigns

- Almost similar proportions of women and men are aware of GBV prevention campaigns. Thirty-seven percent of women and 39% of men are aware of GBV prevention campaigns.
- The main source of GBV knowledge is the radio followed by the television.
- Forty-eight percent of women and 35% of men heard about the GBV campaigns from radio.
- Thirty-five percent of women and 29% of men heard about the GBV campaigns from television.
- More men than women heard about the GBV campaigns from the print media.
- Twenty-eight percent of men and 9% of women heard about the GBV campaigns from the newspaper.
- More men (21%) than women (10%) had heard about the 16 days of Activism, the 365 days campaign and had participated in marches or events to protest against GBV.
- Almost one in every two women (48%) found campaigns to end GBV empowering.
- All the women participating in the survey agreed that campaigns have made women more aware of where to go for help.
- Every four in five (82%) men agreed that campaigns to end violence against women have helped to change attitudes of men.

Secondary prevention

- The MGECDFW organised workshops to train Family Welfare and Protection Officers, Police Officers, Health Personnel, Local Government and faith-based organisations on GBV.
- The MGECDFW trained 105 police officers from 2008 to 2011.

Integrated approaches

- MGECDFW successfully implemented the National Action Plan to Combat Domestic Violence (2007-2011) with the collaboration of other stakeholders.
- Mauritius implemented 92% of recommended actions by December 2011.
- A National Platform to End Gender- Based Violence was set up in October 2011 which was followed by a two-day Consultative Workshop for the elaboration of a Costed National Action Plan to End GBV (2012-2015) which was subsequently launched in November 2011.

Conclusions and recommendations

The table summarises the main conclusions and recommendations of the study:

Table eight: Conclusions and recommendations

Conclusions	Recommendations	Who responsible
Extent		
Intimate partner violence is a significant social problem prevailing in Mauritius. However, women are more ready to disclose experience than men are to disclose perpetration.	GBV campaigns and messages in Mauritius should give emphasis to IPV. The campaigns should also be deliberate in engaging men and boys. The development of more perpetrator rehabilitation programmes like VEARP is critical.	All GBV stakeholders including the MGECDFW, the police, media, community groups, faith groups, civil society
Emotional IPV, a form of GBV not usually addressed or reported in administrative data, is reported in this study as the most common form of GBV.	Provision of psychosocial support should be made a priority in responding to GBV. More resources should be allocated towards a health sector response that places mental health services at the centre.	Ministry of Health and Quality of life
The majority of women who experienced physical IPV or rape by a non-partner did not report this to the police or health care facilities. This indicates a high level of underreporting of GBV in Mauritius	Further research is necessary to understand the underreporting of GBV in Mauritius.	
	The police and health sector needs to improve on provision of victim friendly services and support.	Mauritius Police; Ministry of Health and Quality of life
	GBV campaigns need to empower women's and encourage them to speak out and seek help.	All GBV stakeholders including the MGECDFW, the police, media, community groups, faith groups, civil society

Conclusions	Recommendations	Who responsible
Patterns and drivers		
A complex set of factors drive the perpetration of GBV in Mauritius. Socio-economic factors such as age, education, employment status are associated with GBV perpetration.	GBV prevention campaigns need to take into consideration the identified risk groups and target these. In particular, work-place based initiatives will go a long way in targeting the employed men who are more likely to be perpetrators.	All GBV stakeholders including the Ministry of Gender, the police, media, community groups
Experience of child abuse, conservative community beliefs and values, and patriarchal gender attitudes are other major drivers of GBV in Mauritius.	Programmes should prioritise child rehabilitation programs as a form of GBV prevention strategy. There is need for the introduction of school based GBV prevention initiatives.	All GBV stakeholders including the MGECDFW, the police, media, community groups, faith groups, civil society
Politicians do not give GBV adequate attention in their speeches. When GBV is addressed, it is mainly a passing reference. Politicians can improve in placing GBV on the political agenda.	Civil society and activist organisations need to continue to hold political leaders accountable for addressing GBV and placing it on the political agenda.	All GBV stakeholders including the MGECDFW, the police, media, community groups, faith groups, civil society
Effects		
Women survivors suffer a range of health effects including physical injury, hospitalisation, pregnancy complications, unplanned pregnancy, STIs, HIV, suicidal tendencies and depressive symptoms.	Health systems strengthening to respond to GBV is essential. Health practitioners need to be trained to provide victim friendly services to survivors. Inclusion of the health sector in the GBV referral system should be mandatory.	Ministry of Health
Social stigmatisation for women survivors and fear of family fragmentation hampers them from leaving abusive relationships.	Campaigns should aim to change conservative attitudes towards gender relations and should encourage communities to be more supportive to GBV survivors.	All GBV stakeholders including the MGECDFW the police, media, community groups, faith groups, civil society
Response and support		
Mauritius has protective laws in the form of the PDVA, the Sex Discrimination Act, and the Equal Opportunities Act. However, the Sexual Offences Bill is still to be enacted.	Activists should continue to lobby for the enactment of the Sexual offences Bill.	All GBV stakeholders including the MGECDFW, judiciary, civil society
Both women and men are relatively aware of the PDVA and Sex Discrimination Act.	Public awareness campaigns should aim to sensitise communities about the PDVA and GBV related laws.	Judiciary, Ministry of Gender Equality
Administrative data falls short in depicting the true extent of GBV within the Mauritian community.	Government should adopt the GBV Indicators and commit to allocating resources for periodic GBV studies and dedicated surveys.	MGECDFW, Ministry of Finance and all stakeholders concerned
There is lack of implementation of a clear referral system for GBV survivors.	Stakeholders in the GBV sector need to develop and implement a referral system that has an efficient surveillance system.	All GBV stakeholders including the Ministry of Gender, the police, Ministry of health, judiciary, and civil society
Shelter services in Mauritius are not proportionate to the need by GBV survivors.	Government should allocate more resources to existing shelters and for the establishment of new shelters.	MGECDFW, Ministry of Finance
Currently shelters are prioritising accommodating children over abused women.	New shelters should be established which provide services to abused women and their children only. Other separate shelters for children should also be established.	MGECDFW, Ministry of Finance, civil society
The hotline 139 is relatively unknown and minimally utilised by survivors.	GBV campaigns should sensitise communities and raise awareness about the hotline 139.	MGECDFW
There is a low disposal rate of rape cases within the district courts.	The judiciary should consider means of addressing the low disposal rate . This could be through the establishment of dedicated courts.	Judiciary
Politicians refer more to GBV response and support than to prevention in their discourse.	Politicians need to place GBV prevention at the centre of their discourse.	Political leaders: Prime Minister and Ministers
Prevention		
The majority of interventions lack efficient monitoring systems to measure impact.	GBV programmers need to develop programme specific indicators to ensure the collection of baseline and routine data. There is also a need for capacity building of programmers in monitoring and evaluation.	All GBV stakeholders including MGECDFW, civil society
The majority of women and men are unaware of GBV campaigns. The current main source of campaign information is the radio followed by television.	Media has to improve on the coverage of GBV campaigns. Stakeholders should ensure the decentralisation of campaigns to village level.	Media, all stakeholders including MGECDFW, civil society
Men have more access to GBV related information compared to women. While the majority of women find GBV campaigns empowering feel indifferent.	Strategic communications should be put in place which ensure access to GBV information by women.	Media, all stakeholders including MGECDFW, civil society

CHAPTER 1
Introduction

Participants during the Sixteen Days march in Curepipe. *Photo by Mary Jane Piang-Nee*

Key facts

- ✓ GL developed a set of indicators to measure baselines and progress towards the SADC Protocol on Gender and Development target of halving GBV by 2015 through expert consultation.
- ✓ Mauritius as a country is progressing well in meeting the 28 targets of the SADC Protocol on Gender and Development.
- ✓ The SGDI of 2011, ranked Mauritius fifth compared with other SADC countries in progress towards achieving the protocol targets.
- ✓ The period of the research (2010-2011) was marked by key GBV related events such as the reporting on the Convention on the Elimination of Discrimination Against Women and the amendment of the Protection from Domestic Violence Act of 1997 (PDVA).
- ✓ GL in partnership with the MRC conducted the GBV Indicators research to complement previous research on domestic violence in conjugal relationships and fill critical information gaps such as the extent of violence in non-marital intimate relationships or violence outside intimate relationships.

"Sometimes what we least expect, happens in life. Sometimes the new day that we expect to dawn turns out be the very same day with the very same sufferings. The colourful picture actually turns out to be colourless one. This is a true reflection of the past 27 years of my life.

My married life lasted for 25 years and during all this time I was beaten. I have five daughters and they suffered as much as I did, physically as well as psychologically. Before marriage, my whole conception about married life was just like in the movies but still, I was conscious that my husband and I would undergo difficulties. I never imagined that the difficulties would have been so life threatening. Instead of loving me for what I was, he treated me as a mere object and even insulted me with names. One of them was that I was a "poule noir", which in the Mauritian language is derogatory for being a black or coloured. He would always find flaws in me and subsequently, belittle me.

My tragic life story began from the very beginning itself when I was pregnant with my first two children who were twins. My husband did not want to have daughters and when I gave birth he did not come to visit me at the hospital. When I was in labour, I had to look for a means of transport by myself in order to go to the hospital. When my husband came to the hospital he decided that the one who resembled him would be his favourite and that he would ignore the other one. While my husband showered one twin with love, he rejected the other twin and denied the other his affection. This was a torture for me. At that time, I was already being slapped and kicked.

His abusive nature became worse when I became pregnant for the second time. It was even worse when he learned that the third child was a girl. This was the same for my fourth and last children, who were girls too. My failure to give him a son frustrated him.

One such incident happened when I was seven months pregnant of my fifth child. He kicked me and beat me up severely.

On a separate occasion, he went to the disco and left all of us at home. When he came back, I asked him where he went and why he did not let us accompany him. His reply was "if you want to go away take your five pieces of shit and go dance!" On another day, while tidying up the house, my elder daughter had put his sweater in the drawer. When my husband came home he could not find his sweater in its usual place. Suspecting that I was the one who had misplaced the sweater, he took me by the neck and tried to strangle me in front of my daughters. Fortunately, he stopped as my daughters were trying to pull him away from me.

He also had another flaw; that of having extra marital affairs. Whenever I discovered an affair, either through text messages or overheard conversations, I demanded explanations. The answers he gave would make me understand once and for all. His answer to all questions was physical violence. Instead of answering my persistent questions, he would pull me and throw me hard on the ground. He beat me up till I would bleed. Accompanying the thrashing, were the unbearable insults, which my daughters had to listen to.

I reported him to the police a number of times. But they did nothing that could free my daughters and me from this real nightmare. One day, when I went to file a complaint against my husband, the police officer wrote a false version of what had happened. This was depressing for me. I did not know where to look for help.

If the authorities did not want to help me, who would? I had no option but to turn to God. God is the one who gave me the courage to deal with this traumatic life and He is still doing it. He is and will always be at the centre of my life.

We have been living separately for two years now, however under the same roof. The only difference is that we do not have an intimate relationship. This did not prevent him from breaking the door one night and demanding sex from me. When I refused, he tore my clothes, and raped me.

Following that incident, I obtained a protection order against him and I now feel more secure. Now I must say that I do not regret having taken the decision of leaving my husband.

Instead of suffocating in an abusive relationship, I can now depend on myself. I may have suffered a lot in my life but I will never, I insist on the word never, regret having given birth to five girls. They are my pride and courage. I have striven so that these girls do not end up with a fate same as mine. I do not want them to give in as I did, to a man's beastly manners. I want them to be independent, financially as well as emotionally."

Annabelle* like other women has experienced multiple forms of violence mainly at the hands of her husband. She experienced abuse during pregnancy, and acts of physical abuse such as slapping and kicking. Annabelle was also emotionally abused by being insulted and belittled by her partner. After separation her partner still sexually forced himself on to her.

This chapter outlines the background and rationale to the GBV Indicators research, unique features, country context and previous related research.

Background and rationale

GBV is one of the most common yet unacknowledged and serious human rights violations in the Southern African Development Community (SADC) region.[1] In response to the high levels of violence, and the 2006 call by the UN Secretary General to all member states to develop plans for ending GBV, many Southern African countries have shifted from campaign mode to a more integrated programmatic approach to address GBV.

GL has been working in the gender justice arena for the last ten years, using the Sixteen Days of Activism on Violence Against Women as a platform for training activists in the SADC region in strategic communications. These campaigns led to inevitable questions about how such campaigns would be sustained beyond the Sixteen Days. In 2006 GL began working with nine countries in the SADC region to extend the Sixteen Days to a 365 Day National Action Plan strategy to end gender violence.

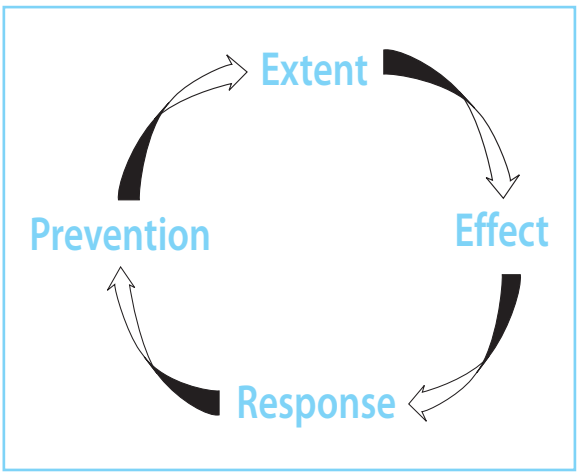
[1] SADC Gender Protocol Alliance Barometer, 2010.

Developing action plans inevitably led to the need for reliable baseline data, targets and indicators for measuring progress in an arena where most violence is under-reported or not reported at all, leaving administrative data as an unreliable source of information.

In August 2008, SADC Heads of State adopted the Protocol on Gender and Development that, among others, aims to halve gender violence by 2015. This reinforced the need for reliable baseline data against which to benchmark progress. From the outset, GL viewed this as a regional project, piloting it in Gauteng (the most populous province of South Africa) but also in the two countries where the organisation had satellite offices: Mauritius and Botswana.

Drawing on the 2007 UN Expert Group Report on developing indicators for measuring GBV, some preliminary work began in earnest in Southern Africa through an initiative supported by UN Trust Fund and spearheaded by GL. The key players included representatives of government (i.e. gender, justice, health, police, and prosecuting authority), research institutes and NGOs working on gender justice issues.

The UN Economic Commission Africa Gender Centre (UNECA/AGC) commissioned desktop research for the rest of Africa following similar methods used by GL and partners for the pilot project. The Centre for the Study of Violence and Reconciliation found through administrative data collection and situational analysis that there are gaps in the data collected by many different countries on GBV. Some countries do not even have the recording systems on any aspect of GBV. Laws in the different countries do not regard certain acts of GBV as punitive violations, thus making it difficult for countries to speak the same messages on GBV. This is taking place despite the fact that most countries are in unanimous agreement that GBV is a gross violation of human dignity based on gender, and have made demonstrable strides in combating its existence, mainly through ratifications such as the SADC Protocol on Gender and Development.



In July 2008, GL convened a reference group meeting comprising 16 representatives from government, research organisations and regional NGOs focusing on gender violence. This meeting sought to get conceptual clarity on what is required as well as get buy in from key stakeholders on developing a composite set of indicators to measure gender violence that is methodologically solid; pre-tested and can eventually be applied across the region. The meeting resulted in key conceptual decisions that have since informed the design of this research.

Key conceptual decisions

A stand-alone dedicated survey not linked to existing surveys: While there are cost and logistic arguments for a GBV prevalence survey attached to another broad population survey (such as Demographic Health Survey; HIV and AIDS) this dilutes the focus and poses potential ethical dilemmas. GBV is a complex, specialised area requiring dedicated attention. By conducting a stand-alone GBV prevalence survey (the first of its kind), GL and the MRC hoped to establish the principle that such studies and analysis must be routinely conducted.

GBV versus violence against women: Unlike previous studies that recruited either men or women, this study made use of two separate questionnaires: for women (focusing on their experiences of GBV) and men (focusing on perpetration) of violence against women. The focus on women is justified by overwhelming evidence (the routinely collected police data) that shows that the majority of gender violence cases consist of violence against women. Comparing women's reports of experience and men's reports of perpetration makes this study different from any other GBV study conducted in Mauritius.

Combining a prevalence and gender attitudes study: As such studies require similar sampling techniques, this is more cost effective, and allows for correlations to be drawn between experiences, attitudes and behaviour when the data is drawn from the same sources.

Using prevalence studies to determine the extent of under-reporting and rarely reported types of violence such as emotional and economic abuse: This gap is critical in understanding the effectiveness of response mechanisms, and informing policies and actions needed to improve them.

Interrogation of existing administrative data: While administrative data - that is information collected from the courts and police - is not adequate, it is important. There are several ways in which this data collection can be improved to provide information that is more meaningful. For example, many police services in the region do not have specific categories for gathering gender violence data and this is not analysed in annual crime reports. The study has sought from the outset to work with the police and justice systems with the aim of improving collection, analysis and presentation of administrative data.

Overall, the team emphasised the need to test a draft set of indicators in a pilot project at local level before these are cascaded nationally and regionally. This study would gradually build support and buy- in for a comprehensive set of indicators that provides meaningful and nuanced measures of progress or regression.

GL first held a stakeholder inception meeting in Mauritius on 3rd August 2009 with the participation of the former Attorney General, former Minister of the then Women's Rights, Child Development and Family Welfare, several Ministries, Representatives from the Prime Minister's Office, the National Aid Secretariat, the Police, Central Statistical Office and the Mauritius Research Council.

SADC Barometer Reference Group Meeting, Mauritius. *Photo: Gender Links*

Unique features of the project

Unlike previous prevalence surveys that have focussed on a few aspects of GBV, the set of indicators seeks to measure:

- The extent of the problem (what uniform administrative and survey data could be obtained across all SADC countries).
- The social and economic effects of GBV.
- Response and support interventions as measured by the multi stakeholder National Action Plans to End Gender Violence based on the SADC Protocol on Gender and Development.
- Prevention interventions that underscore the importance of a paradigm shift towards prevention rather than focus primarily on response.

GL has conducted the regional study in Gauteng, Kwazulu Natal and Western Cape provinces of South Africa and in Botswana. Research is on-going in the Limpopo province of South Africa and in Zimbabwe.

This report outlines the background, methods and findings of the GBV indicators project in Mauritius conducted by GL in partnership with the Mauritius Research Council from 2010 to 2011.

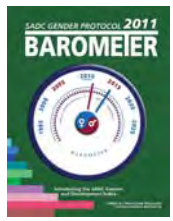
Country context

Mauritius presenting during the cultural show. *Photo: Trevor Davies*

The Republic of Mauritius is a volcanic island surrounded by lagoons and palm-fringed beaches in the Indian Ocean. The country's population was estimated at 1,283,415 as at 31 December 2010. Females constitute the majority of the population. There were 97.3 males for every 100 females (Republic of Mauritius, 2011).

Status of women

Forty-four years after independence in 1968 societal patriarchal structures still relegate power to males. There are clear-cut divisions between the public-political and the private-domestic spheres - women are largely relegated to domestic activities of childcare, home maintenance and low paid jobs. Men continue to dominate the arena of economic and political decision-making. Women occupy only 33% of the key economic decision positions. Mauritius occupies global rank number 60 in terms of governance with a 19% women's representation in parliament and a 12% women's representation in cabinet (GL, 2011). Women's labour force participation is 45% compared to 80% for men. This difference in labour force participation among men and women is the highest among the Southern African countries (GL, 2011).



The 2011 Mauritius Gender Protocol Barometer shows that the country is progressing well in meeting the 28 targets of the SADC Protocol on Gender and Development set for 2015. This is despite the fact that the country has not yet signed the Gender Protocol.

The SADC Gender Protocol Barometer 2011 rates Mauritius at 71 % and ranks the country fifth after Seychelles, South Africa, Lesotho, and Namibia using the SADC Gender and Development Index (SGDI). The Mauritian rating surpasses the regional average of 64%. The SGDI on the status of women consists of 23 performance indicators. The indicators are grouped into six categories, namely sexual and reproductive health (SRH) (3 indicators), HIV and AIDS (3 indicators), Economy (5 indicators), Education (3 indicators), Governance (3 indicators) and media (6 indicators). The SADC Gender and Development Index (SGDI) rates the country's performance as shown in Table 1.

Table 1.1: SADC Gender and Development Index Country ranking							
Country	Overall rank - SGDI	Governance rank	Education rank	Economy rank	Sexual and reproductive health rank	HIV and AIDS rank	Media rank
Seychelles	1	7	2	8	3	2	1
South Africa	2	1	5	2	2	7	3
Lesotho	3	2	9	5	11	8	2
Namibia	4	6	4	6	5	4	4
Mauritius	5	12	3	13	1	1	6
Botswana	6	11	1	1	4	3	5
Swaziland	7	9	6	4	7	5	7
Tanzania	8	5	14	7	10	6	8
Zimbabwe	9	10	8	9	6	10	12
Zambia	10	13	10	10	12	9	9
Madagascar	11	14	7	3	9	13	10
Mozambique	12	4	13	15	14	11	13
Angola	13	3	12	11	15	15	Not rated
Malawi	14	8	11	12	13	12	11
DRC	15	15	15	14	8	14	14

Source: SADC Gender Protocol Alliance Barometer, 2011.

The SGDI ranks Mauritius first in sexual and reproductive health; and HIV/AIDS; third in education; sixth in media; twelfth in governance and thirteenth in economy.

Sexual and reproductive health

Mauritius adopted a comprehensive National Sexual & Reproductive Health Policy (NSRHP) in 2007. The NSHRP addresses emerging reproductive health issues with a greater emphasis on promoting SRH needs of individual women and men as key to improving their quality of life. The NSHRP also lays a framework for stakeholders to provide a comprehensive range of contraceptive methods and to promote dual protection for individuals and couples to protect them from STIs, HIV and avoid unplanned pregnancy. The policy promotes the use of and calls on improved accessibility to female condoms.

With a total fertility rate of 1.48 in 2009, the family planning programme has shifted its focus from achieving demographic targets to improving the quality of delivery of reproductive health services of the population, which is in line with the recommendations of the International Conference on Population and Development (ICPD) Plan of Action. The policy is guided by the principles of human rights, gender equality and equity, social justice, quality service provision and universal access to comprehensive SRH services.

Mauritius is one of five SADC countries (including Namibia, South Africa, Swaziland and Zimbabwe) that now have contraceptive use rates of more than 50%. Mauritian women tend to favour use of traditional methods over modern methods. Withdrawal is the most commonly used method (27.1% percent) among currently married Mauritian women age 15-49 years, followed by the pill (15.8%); whereas, injectable (25.1%) and the pill (23.4%) are the most popular methods among their Rodriguan, counterparts. Use of withdrawal method is higher among rural women (28.9%) than among urban women (24.6%) and use of any family planning method is higher among Mauritian women who have received formal education beyond the primary level (13.7%) than among those who have not completed primary education (5.8 %) (GL, 2011).

Table 1.2: Key sexual, reproductive and health indicators	
Indicator	**Statistic**
Current maternal mortality rate (Lifetime Chance of Death from Maternal Causes (1 in how many)	28 per 1,000 live births
Percentage births attended by Skilled Personnel	99.6%
Percentage modern contraceptive use among sexually active women	76%
Number of deaths annually as a result of illegal abortions	1,635

Source: Mauritius Family Planning Association 2011.

While most of these indicators reveal a high gender responsiveness of health policies, there is need to bring about policy and legal reforms to decriminalise abortion and to remove barriers for adolescents and young people to access Family Planning and Sexual Reproductive Health services without parental consent.

HIV/AIDS

The Republic of Mauritius is signatory to the 2011 Political Declaration on HIV/AIDS and is striving to meet the Millennium Development Goals. The HIV and AIDS Act provides for the protection of people living with HIV and AIDS (PLHIV). Antiretroviral Treatment (ARV) and Post Exposure Prophylaxis (PEP) are free. Children born from HIV positive mothers receive HIV treatment at birth get milk for free up to the age of two (GL Mauritius, 2011).

According to the 2012 Global AIDS Response Progress Report, the country has made significant progress in a number of areas, namely Prevention of Mother to Child Transmission (PMTCT) coverage and harm reduction among Key Affected Population (KAP), as well as data collection, analysis, and its use to monitor and evaluate programmes. However the government has to make greater efforts to achieve universal access targets in certain programme areas such as HIV testing and counselling, life-skills education and condom use.[2]

The National AIDS Secretariat convened a multi-sectoral meeting in March 2012 to estimate the prevalence among the adult population aged 15-49 yrs. Prevalence figures for HIV in Mauritius have been calculated to 0.97% (Confidence Intervals 0.6%-1.96%) amounting to an average of 8,000 PLHIV4. Such a prevalence of HIV and AIDS is lower than in other SADC states. Also unlike the rest of SADC, the majority of those living with HIV and AIDS in these islands are men. HIV and AIDS in the country unlike in the other SADC states, is driven by intravenous drug exchanges (GL, Mauritius).

The Global AIDS Response has been worked out with all stakeholders, including the Ministry of Health and Quality of Life. As the National AIDS Secretariat is leading the response to HIV and AIDS matters, the report reflects the policy of the Government and is in line with the objectives of the programme of the Ministry of Health and Quality of Life.

The issue of gender has been addressed in the forthcoming National Multisectoral Strategic Framework 2012-2016.

[2] Republic of Mauritius. 2012.

Table 1.3: Key HIV Indicators for 2011	
Indicator	**Statistic**
Percentage of women among detected cases of HIV	19%
Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	6.9%
Percentage of HIV positive pregnant women who receive antiretroviral treatment to reduce the risk of mother to child transmission	95.7%
Percentage of eligible adults and children currently receiving ART	64.3%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	87.4%
Percentage of eligible adults and children currently receiving ART	75%
Percentage of women with comprehensive knowledge on HIV and AIDS3	80.1%
Percentage of men with comprehensive knowledge on HIV and AIDS3	75.6%

Source: National AIDS Secretariat: 2012.

The 2012 Global AIDS Response Progress Report also identified gender norms and relations as a key factor in determining who acquires HIV in Mauritius, and in determining treatment, care and support outcomes. In light of this the Mauritian national program prioritises addressing gender norms and relations. The program also addresses the prevention and care needs of women and girls combined with attention to male behaviour and cultural norms that increase the likelihood of women contracting HIV.

Another area identified as requiring improvement is HIV care work. There are no policies and programmes to ensure the recognition of voluntary caregivers. But as an incentive the Ministry of Health pays peer leaders working in collaboration with the Ministry of Health who work with women drug users. The motivation for social worker payment is that the main mode of HIV transmission in Mauritius is intravenous drug use. Activists have advocated need for the recognition of voluntary work and review of HIV and AIDS care workers' remuneration. They have also called for more psychosocial support to made in hospitals for HIV and AIDS patients and personnel (GL Mauritius, 2011).

Media

GL and the Media Institute of Southern Africa conducted the *Gender and Media Progress Study* (GMPS) in 2010 as a follow-up to the *Gender and Media Baseline study* (GMBS) conducted in 2003. The GMPS sought to compare and benchmark the performance of media in SADC countries against their performance in the GMBS.

The key findings of the research are:

- Women constitute just 19% per cent of the news sources in the Mauritian media monitored in this study, an increase of only 2% in seven years since the GMBS.
- There are differences in women sources between the individual media houses with the MBC Television at 28%, Week End and Le Mauricien at 14% and Radio Plus at 15%. Women's voices on MBC radio (22%) is less than on the MBC television.
- Although women are more vocal on gender equality at 86%, children at 67% and gender violence at

46%, on certain subjects, e.g. economics, sports or housing they speak at less than 15% and yet all these subjects concern women as well. Women's voices are heard at only 9% on politics.

- Women predominate in the home makers and sex workers categories at 100% and beauty/fashion at 92%. And yet there are more and more men in the model and fashion business.
- There are more men reporters than women reporters in the Mauritian Media with an average percentage of 29% (this is comparable with the regional average of 28%). There is a vast difference between media houses with Radio Plus having more women (66%) than men (34%). The MBC Television has nearly the same percentage of female and male presenters with 51% female and 49% male.

Governance

Performance on women representation is mixed across parliament, cabinet and local government: Mauritius has 19% of women's representation in parliament and 6% of women's representation at local government level. Although Mauritius is ranked low in terms of women's representation at local government there has been a slight increase in women's representation in parliament from 17.1% in 2005 to 18.8% in 2010 (GL Mauritius, 2011).

Mauritius is ranked number 15 out of the 15 SADC countries with the proportion of women in cabinet having gone up by a mere 2% from 10 % in 2009. The average representation of women in cabinet has remained stagnant between 2009 and 2011 at 12% (GL Mauritius, 2011).

March asking for more women in politics. *Photo: Loga Virahsawmy*

Following extensive lobbying by the Office of the Attorney General, Ministry of Gender Equality and other Ministries, the promulgation of the Local Government Bill in 2011 made provisions for a 30% quota system in local elections. According to the bill all political parties will have to field at least 30% women or 30% men for any local elections that take place. This has led to the amendment to the Constitution to allow positive discrimination to achieve gender equality (GL Mauritius, 2011).

Economy

Mauritius has one of the most successful and competitive economies in Africa. The 2010 GDP at market prices was estimated at $9.5 billion and per capita income at $7,420, one of the highest in Africa. The economy is based on tourism, textiles, sugar, and financial services. In recent years, information and communication technology, seafood, hospitality and property development, healthcare, renewable energy, and education and training have emerged as important sectors, attracting substantial investment from both local and foreign investors.[3]

Mauritius has a long tradition of private entrepreneurship, which has led to a strong and dynamic private sector. Firms entering the market will find a robust legal and commercial infrastructure. Mauritius has a well-developed digital infrastructure and offers state-of-the-art telecommunications facilities including international leased lines and high-speed Internet access. Government policy is to act as a facilitator to business, leaving production to the private sector. The government however, still controls key utility services, including electricity, water, waste water, postal services, and television broadcasting, directly or through parastatals.[4]

Section five of the Sex Discrimination Act (2002) preserves the right to the same employment opportu-

[3] Republic of Mauritius, 2012.
[4] Source Government website: http://www.state.gov/r/pa/ei/bgn/2833.htm

nities between men and women and specifies, "No employer shall, in relation to recruitment, selection or employment of any other person for purposes of training, apprenticeship or employment, discriminate against that other person on the grounds of sex, marital status, pregnancy or family responsibility". Despite these provisions of the Sex discrimination Act there is still a gender disparity in the employment status of women and men at a national level as shown in Table 1.4.

Table 1.4: Women and men in employment

	Number of women	Number of men	Total	% women	% men
Employed	168,700	272,500	4,41,200	38	62
Unemployed	28,500	16,700	45,200	63	37
Self employed	21,700	73,200	94,900	23	77

Source: Central Statistics Office Year 2011.

Women making pickles in Mauritius. *Photo: Gender Links*

The National Women Entrepreneur Council and the Small and Medium Development Enterprise are currently training women and creating opportunities for them to get loans as a means of addressing this gender disparity. Women are trained on how to market their products and are given stands in fairs.

Equal numbers of men and women participate in policy formulation and implementation of economic policies. A significant number of women hold high positions, be it at the administrative levels or technical levels. There are at least 10 women who are Permanent Secretaries heading Ministries. In the Education, Health and the judiciary services, there are more women employed than men, but overall among 50,000 civil servants two thirds are men and one-third women (GL Mauritius, 2011).

However, this is not the case in the private sector, where policy formulation is done more by men as they hold the highest positions in the organization. Women occupy mostly mid-management level positions (GL Mauritius, 2011).

Public procurement processes are currently gender neutral. Activists have called on government to introduce affirmative action measures to ensure that women benefit equally from economic opportunities especially through public procurement processes (GL Mauritius, 2011).

Other economic indicators are:

- Thirteen percent of women and four percent of men are unemployed.
- Forty-five percent of women and 80% of men participate in the labour force. These statistics show the biggest gap in terms of labour force participation when compared to other SADC countries.

Participants at the launch of the Gender in Media Education Research report, University of Mauritius.
Photo: Davinah Sholay

Education

Section 14 of The Sex Discrimination Act 2002 provides that "no institution shall discriminate against a person on the ground of the person's sex by refusing or failing to admit him/ her as a student or to limit the students' access to any benefit provided by the educational institution". Education is therefore free at all levels and is compulsory up to the age of 16 years. The result is that there are no gender gaps in enrolment at pre-primary, primary and secondary levels as shown in Table 1.5

Table 1.5: Access and enrolment in education sector in 2010

	Boys/men	Girls/women	Total	% girls/women	% boys/men
Enrolment					
Primary School	59672	57760	117432	49.2	50.8
Secondary school - Academic	54855	60148	115003	52.3	47.7
Secondary - Pre-Vocational	4764	2678	7442	36.0	64.0
Tertiary level *	10248	15971	26219	60.9	39.1
Vocational **	7037	2227	9264	24.0	76.0

Source: Central Statistics Office.
** Public Funded Tertiary Institutions.*
*** Vocational figures include Mauritius Institute of Training and Development (MITD) Centres.*

There is however, a need to improve the quality of pre-vocational education and increase access to vocational education to allow women and girls to enter currently male dominated disciplines and fields. (GL Mauritius 2011).

> "...a need to improve the quality of pre-vocational education and increase access to vocational education..."

Political and social context of GBV

GL and the MRC conducted the research from 2010 to 2011. GBV featured prominently in national discourse during this period. Key events included:

- The presentation of the sixth and seventh periodic country report to the Committee on the Elimination of the Discrimination Against Women (CEDAW).
- The amendment of the Protection from Domestic Violence Act (PDVA) of 1997.
- The setting up of the National Platform to End GBV.

Reporting on implementation of the CEDAW
A high-level delegation led by the Minister of Gender Equality, Child Development and Family Welfare, Mrs Mireille Martin, presented the combined sixth and seventh periodic country reports to the Committee on the Elimination of the Discrimination against Women on 7 October 2011.

Below is a report of the proceedings available from the government of Mauritius website.

CEDAW - UN Committee discusses Mauritius status

Mireille Martin (left), Minister of Gender Equality, Child Development and Family Welfare, Mauritius.
Photo: Loga Virahsawmy

GIS-October 10, 2011: The status of Mauritius with regards to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was discussed at the 50th Session of the Committee to the Elimination of all Forms of Discrimination Against Women on 7 October 2011 in Geneva. This exercise builds on previous reporting on the Convention, outlines the progress achieved and the challenges that remain in implementing.

The Minister of Gender Equality, Child Development and Family Welfare, Mireille Martin, led the Mauritian delegation to Geneva to that effect.

In fact, countries party to CEDAW are given the opportunity to discuss the implementation of their obligations under the Convention and to provide an update of the situation on the ground since the submission of last reports. The consideration of periodic state reports is a means by which state parties are able to contribute to the dialogue on the human rights situation in their respective countries thereby enhancing the protection of these rights.

The Mauritian government acceded to the Convention on the Elimination of all Forms of Discrimination against Women in 1984 and submitted at the initial and second periodic reports 14th session of the Committee in 1995.

In her address at the 50th Session of the Committee in Geneva, Martin, said, "successive governments have taken bold measures to reduce discrimination against women. Mauritius has since its accession to CEDAW upheld numerous challenges to uproot the entrenched causes of gender inequality and to change mind-sets and attitudes for a gender inclusive society. Since Mauritius' last review in 2006, government has continued its steadfast efforts to achieve social justice and gender equality through a range of measures aimed at consolidating and sustaining the advancement of women in socio-economic, political and cultural spheres. Our actions to address the issue of GBV are now geared towards gender sensitive policies. We shall, in the context of International Day against Violence against Women in November 2011, set up a National Platform on GBV involving all stake-holders. In addition, my Ministry will shortly launch the Africa UNite Campaign to end violence against women".

Source: http://www.gov.mu/portal/site

Key achievements noted include:

- Amendments to the PDVA in 2007 and 2011.
- The formulation of National Action Plan to Combat Domestic Violence in 2007 by the MGECDFW.
- Ratification to the Optional Protocol to the CEDAW in October 2008.
- Establishment of National and Area Domestic Violence Committees (ADVCs) by the MGECDFW.

Concerns raised by the committee include:

- The low numbers of shelters and the fact that only one shelter is operated under the aegis of the ministry.
- The low numbers of domestic violence reported to the police.

Protection from Domestic Violence Act

The national government has shown commitment to protecting women's rights, improving their standard of living and quality of public or private life. In May 1997, the PDVA was enacted which reaffirms the rights of women in their private lives. "Domestic Violence" includes any of the following acts committed by a person against his spouse or a child of such spouse:

- wilfully causing or attempting to cause physical injury;
- wilfully or knowingly placing or attempting to place the spouse in fear of physical injury to himself or to one of his children;
- intimidation, harassment, ill-treatment, brutality or cruelty;
- compelling the spouse by force or threat to engage in any conduct or act, sexual or otherwise, from which the wife has the right to abstain;
- confining or detaining the spouse against his will;
- any harm or threat to cause harm to a child of the spouse;
- causing or attempting to cause damage to the spouse's property;
- a threat to commit any act mentioned above.

(Excerpt from the PDVA, 1997)

The PDVA is aimed to protect spouses and children from violence at home. It also provides for the issues of protection, occupancy and tenancy orders.

Although marital rape is not included as a criminal offence, according to the PDVA, Section 249 of the Criminal Code criminalises the offence of rape.

Decriminalisation of sex work

Other issues featuring in public discourse during the period are decriminalisation of sex work and the Sexual Offences bill. Clients regularly abuse sex workers yet criminalisation prevents sex workers from reporting abuse to the police or from seeking legal recourse after robbery, rape or sexual assault. Police harassment of sex workers in the form of assault, repeated arrest, rape, extortion, and demands for sex is not well documented as it is very often said that rape forms part of their work.

Political discourse on the need for research

In the 2009 budget debate held on the opening of the annual 16 days' campaign commemorations, Hon. Maya Hanoomajee said "we still see women being battered to death, women being burnt alive and what is more serious is that these things happen when they are under protection order." She then recommended that "there should in an in-depth study to the root causes of the problem." This research responds to this need by exploring GBV from the perspective of both women and men so as to guide strategies to address GBV in Mauritius.

Previous Study on "The Extent, Nature and Costs of Domestic Violence to the Mauritian Economy"

The UNDP has commissioned a "Study of the Extent, Nature and Costs of Domestic Violence to the Mauritian Economy" which was conducted by the Centre for Applied Social Research (CASR) of the Mauritius Research Council (MRC) with the support of MGECDFW. The MGECDFW in collaboration with UNDP launched the report in December 2010.

Rationale

The CASR conducted the study to fill in the gap in terms of the magnitude of this social problem at national level. This was against the background that "it is widely held that official figures provide at best a partial picture of the reality and that this social problem is generally perceived to affect a significant

number of people, predominantly women. In the same vein, for policy evaluation and making purposes, it was important to collect such information as well as attempt to put an economic cost on this phenomenon at the level of the country" (CASR, 2010).

MRC Staff during focus group discussion. *Photo: Mary Cooopan*

Study design

A nationwide survey method was employed which involved the administration of survey questionnaires to 600 women and 600 men living in a conjugal relationship. The survey employed a multi-stage random sampling method. The equal proportions of women and men in the survey was meant to roughly match the current sex distribution of the population. The study was complemented with more qualitative methods such as focus group discussions with relevant actors in domestic violence (victims themselves, perpetrators, service providers) and case studies using semi-structured interviews with victims (CASR, 2010)

Findings

Extent of domestic violence

Some of the findings from the research of domestic violence within conjugal relationships were as follows:

- The past year prevalence of physical abuse construed as arguments between intimate partners turning into physical fights (at least once over the last year prior to the administering of the interview) was 3.9%.
- The past year prevalence of sexual abuse was 1%. This was calculated as the proportion of the sample that reported being victims of episodes of sexual abuse over the last 12 months from the time of the study.
- Emotional abuse was more widespread than physical and sexual abuse. About a tenth (10.5%) of the sample reported such cases of abuse.
- A higher proportion of women (5.9%) compared to men (1.9%) are victims of physical abuse. Male victims of sexual forms of domestic abuse make up only 0.2% of the sample as compared to 1.4% for female victims.
- For emotional forms of abuse, there seemed to be just a marginal difference between males and female victims.
- Other characteristics of victims of the various forms of abuse were that they tended to be over-representative of the lower educational achievement; lower income as well as lower occupational status backgrounds.

Cost of domestic violence

The study reports also placed a monetary value on the burden that such type of violence has on the economy, using established approaches in the relevant literature. Based on a series of assumptions and the most conservative approach of estimation, the report found:

- The direct cost to victims amounted to approximately Rs221 million;
- The indirect costs to the economy and society, in terms of low productivity at work, loss of household chores and absence from work, amounted to Rs988 million; and
- The direct cost incurred by service providers amounted to Rs196 million.

Based on the above estimated costs, the study put the total cost of domestic violence to the Mauritian economy for the period 2008-2009 at Rs1.4 billion (CASR, 2010).

Causes of domestic violence

The qualitative data from the focus group discussions with the victims and perpetrators and the interviews with the victims shows that some common factors associated with domestic violence include alcohol, drugs, extra-marital affairs, and money matters. The victims admitted that the consumption of alcohol or drugs exacerbated the violence. In-laws were also implicated for their role in promoting intimate partner violence. The interviews and the focus group discussions show that although in-laws had a role in the violence this was not often a direct cause of violence but rather was a contributing factor in exacerbating the violence (CASR, 2010).

Why this research

This research complements previous research and provides further evidence on GBV as a societal problem in Mauritius. Previous research has focused mostly on domestic violence. Data on violence perpetrated outside intimate relationships for example rape and sexual harassment is limited. Previous research did not cover prevention, response and support. GL and MRC undertook the GBV Indicators Research Project to provide one overall comprehensive report on the extent, causes, response, support and prevention measures in relation to GBV.

CHAPTER 2
Methodology

Hon. Prime Minister, Navin Ramgoolam, launching the *"I" Stories* 2008 on Hiv and Aids at the Chrysalide Women Rehabilitation Centre. *Photo by Loga Virahsawmy*

Key facts

- ✓ The GBV Indicators research project in Mauritius measured the extent, effects and the response to GBV as provided by the National Action Plan to end Domestic Violence in Mauritius 2008-2011.
- ✓ The study flagship method was a prevalence and attitudes household survey based on a two-stage cluster random sampling strategy. The survey comprised 679 women and 678 men from across the country.
- ✓ Other methods include analysis of administrative data from the police, shelters, health services and social services; the *"I" Stories* or first-hand accounts methodology; political content analysis; and monitoring media coverage of GBV.
- ✓ The findings from the other methods are triangulated to strengthen the survey findings.

"Ours was a love marriage, he was like a prince straight from my dreams and I even went against my parents for him. Little did I know that after four years of marriage pandemonium would wreck my life.

My name is Rita*. I can still remember the very first time when my husband raised his hands on me. I was with my daughter waiting for him to return from work. As soon as he got home, I opened his bag while he went to freshen himself. To my surprise, there was a box of cigarettes in his bag. Despite the fact that I prohibited him from smoking, he had a box of cigarettes with him. Upon questioning, he told me that it belonged to his friend. When I persisted with the questions, he strangled me and kicked me in my lower belly in his fury. If it were not for our four year old daughter, I would not have been spared. His daughter is the apple of his eye.

I then decided to get a protection order. He promised to never do this again. However, after only one week the nightmare started all over again. This time it happened after I questioned him about coming home late.

Rubbing salt into my wound, my mother-in-law, brother-in-law and his wife did nothing to stop my husband. My mother-in-law commanded my husband to discipline me and make me obey to his orders. She did this because she said I had refused to give birth to another child. I decided not to have another child because we could barely make ends meet from the little money my husband earned coupled with his gambling habits.

Again, I got a protection order: a lifeline to me. Since then, my husband has not raised his hand on me. We are living happily in our new house and I keep my fingers crossed that our lives goes on smoothly."

Rita's story highlights the complex nature of human relations linked to GBV. Rita's husband punished her for being inquisitive and although her in-laws witnessed this, they did not speak against it. Instead they even contributed to her dilemma. Her husband has now reformed after she obtained a second protection order against him and they are still together.

This chapter outlines the project aim, key research questions and methods employed in this study. The five tools provide several different prisms from which to view GBV. The use of several tools - quantitative and qualitative - reflects the complexity of the subject and the need for more than one tool to triangulate, interrogate and interpret the data in ways that strengthen policy-making and action planning.

Definition

The 1993 UN Declaration on the Elimination of GBV defined GBV as "any act which results in, or is likely to result in, physical, sexual or psychological harm or

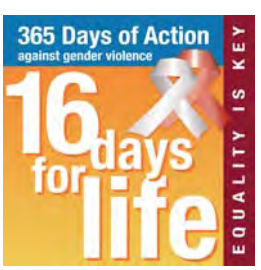
suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life".[1] It indicated that this definition encompassed, but was not limited to:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prosti-tution; and
- Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.[2]

For the purposes of this study GBV includes:

- Physical, sexual, psychological and economic intimate partner violence;
- Rape and sexual assault by a partner, stranger, acquaintance or family member, experienced by adults and in childhood; and
- Sexual harassment.

Project aim



Inspired by the SADC Protocol on Gender and Development (SADC Protocol) which sets a target to reduce the current levels of GBV by 50% by the year 2015, this study seeks to test the GBV Indicators developed through expert consultation and provide baseline data of GBV in Mauritius. The findings from this study will be useful for a comprehensive assessment of the extent, effects and the response to GBV as provided by the National Action Plan to end Domestic Violence in Mauritius.

The outcomes of this research study are expected to lead to policy changes especially resource allocation and priorities for response to GBV as well as strengthen the National Action Plan.

Objectives

The specific objectives of the project were to:

- Quantify the prevalence of GBV in all its different forms; determine the extent of under-reporting; track and report changes;
- Quantify the economic, social and psychological costs of violence;
- Assess the effectiveness of the response by the police; courts; health; social and all related services;
- Assess the way GBV is covered by the media, how this is perceived by audiences and the extent to which the media is playing its role in helping to end or perpetuate GBV;
- Assess the level of political commitment to address GBV;
- Map the underlying attitudes towards gender equality that fuel GBV;
- Assess the effectiveness of prevention campaigns from the point of view of some of the respondents to the prevalence study;
- Provide pointers for government and civil society in Mauritius to strengthen strategies for preventing and responding to GBV.

Key research questions

The research seeks to answer the following questions:

- What is the scope and extent of GBV perpetration and survivor experiences in Mauritius?
- What is the physical, social, and economic impact of GBV on society?
- What is the response of public services to GBV in Mauritius?
- What is the level of political commitment to address GBV shown by the national and government?
- To what extent is the media helping to end or to perpetuate GBV in Mauritius?
- What is the impact of prevention interventions and mainstream media on GBV in Mauritius?

[1] Cited in (2008), Population Council, "Sexual and Gender-based Violence in Africa - A literature review", available at: http://www.popcouncil.org/pdfs/AfricaSGBV_LitReview.pdf
[2] Ibid.

Key elements of the project

This study used a combination of research methodologies to test a comprehensive set of indicators and establish a baseline of GBV in Mauritius. The project components are:

- Prevalence and attitudes household survey;
- Analysis of administrative data gathered from the criminal justice system (police, courts), health services, and government-run shelter;
- Qualitative research and collection of as first-hand accounts women's experiences and men's perpetration of GBV;
- Media monitoring; and
- Political content and discourse analysis.

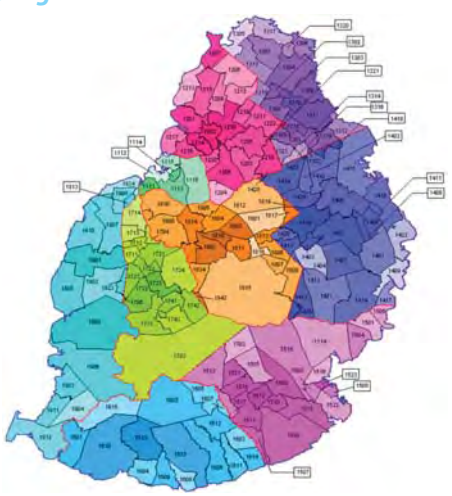
Prevalence, attitudes and costing survey

The purpose of the prevalence, attitudes and costing survey was to investigate the extent and individual effects of GBV, the underlying factors that influence GBV and to find ways to use this data to improve prevention messages and interventions.

Study design

The survey is cross-sectional and employed a multi-stage random sampling method to recruit men and women aged 18 years and above living in selected households.

Sampling



Map showing the Island of Mauritius divided into 1073 clusters.
Courtesy MRC

The Central Statistics Office divided the Island of Mauritius into 1,073 clusters of households, stratified by the district to which they belong and also by their respective Relative Development Index available from the Housing and Population Census carried out in 2000. The size of the clusters varies from cluster to cluster with an average of around 300 households. The list of PSUs covering the Republic of Mauritius will constitute the sampling frame for the first stage. Once the PSUs had been selected at the first stage, a listing of all households in the selected PSUs was compiled to constitute the frame for the second stage sample.

When the interviewers met the head of households, they listed individuals 18 years and over in the household by sex and if the person to be interviewed was male then the group of persons in the "male category is listed by age". From this shortlist, researchers selected the respondent according to the relevant Kish table. The Kish table ensures representativeness by age distribution and allows the selection procedure to be verified by the supervisor. This reduces considerable biases when sampling. Members of each household selected at the second stage were listed and constitute the final sampling unit for the survey.

Sample size

Researchers pre-selected a total of 1440 households i.e. 720 males and 720 females. The sample size was overestimated to cater for non-responses. The final sample comprised 679 women and 678 men.

Strengths of the sampling method

The sampling method employed has several merits including:

- The sampling method ensured that each member of the population had an equal chance of being selected.
- The sampling method ensured random selection of the sample, a characteristic which gives the possibility of carrying out further inferences such as standard errors, confidence intervals and hypothesis testing.
- The fixed number of sample members within each PSU allowed better administration of field work and supervision.

- The stratification at all three stages ensured representativeness of the sample over the whole country and thus improved precision compared to a simple random sample.
- The selection of one person per selected household reduced the risk of interference of the responses and protection of survivors, which is considered high for such type of surveys involving sensitive questions.

Limitations of the sampling method

The survey sampling methods also presented limitations such as:

- Some questions were applicable to only a part of the respondents for example survivors only or perpetrators. The result is that only a small proportion of the sample (3%-10%) based on previous research responded to these.
- The sampling method did not allow substitution of non-respondents and so researchers made three follow-up visits in an attempt to contact a potential participant.

Description of the questionnaire

Researchers administered two questionnaires one for women as survivors and the other for men as perpetrators. The women's questionnaire aimed to describe the prevalence and patterns of women's experience of GBV, HIV risk behaviour, pregnancy history, mental health, help-seeking behaviour after experiences of GBV, gender attitudes and exposure to media and prevention campaigns. The men's questionnaire aimed to describe men's perpetration of GBV, gender attitudes, HIV risk behaviour, fathering, and exposure to prevention campaigns.

The questionnaire provides information about the following areas:

- A description of gender attitudes, attitudes towards rape and relationship control among women and men;
- A description of the prevalence and patterns of childhood trauma among women and men;
- A description of the experiences of witnessing and intervening with domestic violence among women and men in all countries;
- A description of the risk/protective factors for experiencing GBV among women including socio-demographic characteristics, attitudes, partner characteristics, substance use;
- A description of the prevalence and patterns of women's experience of GBV, and associated health risks, including HIV risk factors including condom use, concurrent partners, number of sexual partners and transactional sex;
- A description of the health consequences associated with experience of GBV including: self-reported Sexually Transmitted Infections (STI)s, HIV testing, unwanted/unplanned pregnancy, substance use, depression and post-traumatic stress disorder among women;
- A description of the prevalence and patterns of men's perpetration of gender-based violence in all countries, and associated risk factors and health risks;
- Association between gender attitudes, relationship control and perpetration of gender-based violence among men;
- Association between men's perpetration of gender-based violence and HIV risk factors including condom use, concurrent partners, number of sexual partners, substance use and transactional sex;
- A description of the health consequences associated with perpetrating GBV in all countries including STIs, HIV testing, fathering a unplanned pregnancy;
- A description of the awareness of campaigns against GBV and relevant legislation including the Protection from Domestic Violence Act;
- An exploration of men's experience of IPV; and
- An exploration of economic abuse and its relationship to violence against women.

Fieldworker training

GL and the MRC trained fieldworkers prior to the survey. The field worker training covered the purpose of the study, the sampling approach, the content of the questionnaires, and a comprehensive training on the use of personal digital assistants (PDAs). The trainers carefully explained the ethics and consent processes to the researchers. Trainers observed fieldworkers during the pre-test pilot and gave detailed feedback on their approach and skills.

Due to the sensitive nature of the questions that inquire about experiences of violence, GL and MRC trained the researchers in essential principles of trauma counselling.

Ethical Considerations

The MRC gave ethical clearance for the study. Researchers invited participants to participate voluntarily. They told them that non-participation would not affect them in any way and that they could skip any question they chose or withdraw from the interview at any time. Participants received an information sheet about the study, read to them when necessary. After the full briefing, respondents signed a consent form for the interview.

To ensure anonymity, researchers identified all questionnaires using non-consecutive study ID numbers. The study thus cannot link identified individuals to their questionnaires.

Inclusion criteria

Eligible men and women needed to be aged 18 years or older, normally resident in the sampled household and apparently mentally competent to complete the questionnaire.

Data collection

Either participants self-administered the questionnaire or researchers assisted them to do so if requested. Participants chose their language of preference (English or Creole). A skip button allowed participants to skip over any question they did not wish to answer.

"Researchers invited participants to participate voluntarily. They told them that non-participation would not affect them in any way and that they could skip any question they chose or withdraw from the interview..."

Researchers conducted the interviews in private with no other person present. The researchers also assured the respondents of confidentiality and handed out information sheet about the study and a list of referral support organisations.

The researchers used forms to record the visits made to each PSU, the participants recruited into the study, as well as the challenges they experienced.

Data management and analysis

The researchers downloaded data daily from the PDAs and merged it into a complete dataset. GL conducted data analysis using Stata version 11 taking into account the survey's two stage sample design. To meet objectives, descriptive statistics are presented in this report for the relevant variables and constructs. Data analysts compared the proportions or means for the different variables using tests of statistical significance. This report presents the results of bi-variate analyses for the chi-squared tests of association between exposures and outcomes.

Characteristics of women and men in the prevalence and attitude study

The survey included 679 women and 678 men aged 18 years and above, permanently resident in randomly preselected households.

Table 2.1 shows that a predominantly Mauritian sample. The majority of participants were 30 years old or more; had been intimately involved or were currently involved in relationships. Ninety-one percent of women and 90% of men were 30 years old or more. Ninety two percent of women had been intimately involved while 88% of men had ever been in an intimate relationship. A greater proportion of men (86%) were in current relationships compared to women (76%). Almost similar proportions of women (89%) and men (92%) had sexual intercourse. However, a greater proportion of women (20%) than men (16%) had their sexual debut before the age of 18.

A greater proportion of men (86%) than women (41%) were employed in the 12months before the survey. The majority of women (97%) and men (98%) reported households seldom or never without food.

Table 2.1: Survey demographic, socio-economic status and relationship characteristics of participants				
Criteria	Women		Men	
	No.	%	No.	%
Age				
18-29	64	9.4	67	9.9
30-44	314	46.2	295	43.5
45+	301	44.3	316	46.6
Nationality				
Mauritian	668	98.5	675	99.7
Foreigner	10	1.5	2	0.3
Level of education				
High school incomplete and lower	569	83.8	539	79.5
High school complete and over	110	16.2	139	20.5
Worked in past 12 months	275	40.6	564	84.1
Did not work in past 12 months	403	59.4	107	16.0
Kind of work				
Police, security or armed forces	2	0.7	28	5.0
Professional	65	23.6	58	10.3
Domestic work/cleaner	69	25.1	19	3.4
Driver/transportation industry	4	1.5	59	10.5
Other	135	49.1	399	70.9
Food availability				
Often or sometimes without food	24	3.5	15	2.2
Seldom or never without food	655	96.5	652	97.8
Ever in intimate relationship	609	92.2	595	87.8
Never been in an intimate relationship	70	7.8	83	12.2
Currently in intimate relationship	507	76.2	568	85.5
Not in a current relationship	158	23.8	96	14.5
Ever had sex	586	89.2	608	91.6
Never had sex	71	10.8	56	3.4
Age at first sex				
Below 18	114	19.6	98	16.1
18 +	469	80.5	510	83.9

Administrative data

Police force ensuring the smooth running of the march during the Sixteen Days campaign 2011. *Photo by Mary Jane Piang-Nee*

GL gathered administrative data to document the extent of GBV as recorded in public services, namely the Ministry of Gender Equality, police, health services and shelters.

The main purpose of collecting and analysing administrative data was to complement the results of the prevalence and attitudes survey data. It is widely accepted that administrative data does not accurately provide information on the extent of GBV, more especially of intimate partner violence, mainly due to the high levels of underreporting.

In the words of Sylvia Walby: *"... it would be most unwise to treat such data as a guide to the actual level of violence in that if it were used as an indicator it might create a perverse incentive to minimise the amount of violence over time in order to suggest improvements".*[4]

However, this data provides a basis for assessing the costs of GBV and - most importantly - it can provide information on the use of services by survivors and the areas in need of improvement.[5]

Focus group discussions on shelter services
GL with assistance from SOS Femmes and the Shelter for Women in Distress contacted and interviewed women who had previously stayed in the shelters. The researchers asked the participants to give their own assessment of the shelter services.

Speaking out can set you free: the *"I" Stories* experience

In 2004 GL started the *"I" Stories* project as a part of the Sixteen Days of Activism on Gender Violence campaign. GL worked with women who had experienced violence, and men who used to perpetrate violence, to write their stories. These personal accounts were published in a booklet called the *"I" Stories*.

This study used the GL *"I" Stories* methodology to gather the experiences of violence against men and

4 Walby, S, op cit.
5 Ibid.

women. GL gathers women's and men's experiences of physical, sexual, psychological and economic abuse. Support organisations assist in the identification of survivors and perpetrators. During the writing workshops, facilitators share examples of published *"I" Stories* with participants so that they are aware of what the final product will look like.

The facilitators ask participants to write their personal experiences of violence. Participants submit the first draft of writing to the GL editor, who edits the story and reverts to the writer for clarification. Once the story is in final draft form, the editor sends the articles to the writers to ensure that the editing has not resulted in a change of meaning or intention.

Loga Virahsawmy explaining how to write *"I" Stories* during a media workshop.
Photo by Mary Jane Piang-Nee

Violence against women

The stories from women survivors were aimed to assist in identifying the following key research questions for violence against women:

1. Are women able to identify the various forms of abuse? (physical, sexual, psychological or economic)
2. How many women interviewed are experiencing the various forms of abuse?
3. What are the causes of violence against women?
4. What are the effects of violence against women? (physical, psychological, economic or social)
5. How does abuse impact on ability of women to leave abusive relationships?
6. What support has been available for women experiencing abuse?

Perpetration of violence against women

In order to understand perpetration of violence against women and inform rehabilitation programmes, known reformed perpetrators of violence against women were identified through support organisations. Key research questions for perpetrating violence against women included:

1. What forms of violence (physical, sexual, psychological or economic) do men perpetrate?
2. What are the causes of violence against women?
3. What brought about the reformation?
4. What support has been available for perpetrators of violence?

Ethical considerations

During the process of collecting stories, facilitators:

- Inform participants how their stories would be used and distributed.
- Seek permission from the participants to use their photographs and reveal their identities.
- Give participants the option of using a pseudonym and not revealing their identities.
- Require participants to sign off the final versions of their stories and approve any changes or revisions.

In this study, GL worked with the SOS Femmes and the Shelter for Women in Distress. The partners mobilised women and men who told their stories. Some of the participants who told their stories asked not to be named. The writers chose pseudonyms. At the request, of these participants, we have not used their photographs.

We present the stories in this report in the language of the participant's preference that is either in English or French.

Media monitoring

Participants monitoring the media during a media workshop. *Photo by Loga Virahsawmy*

The GL Gender and Media Progress Study launched in 2010 covered the nature and extent of GBV coverage in Mauritius. This project analysed GBV content in the media over a period of one month. The media monitoring on GBV assessed the extent of GBV coverage, sex of sources, topics covered, depiction of survivors, and sex of the reporters.

The study sought to answer the research questions outlined below.

- What topics are given the most and least coverage in the media?
- What proportion of coverage is specifically on GBV?
- What proportion of coverage mentioned GBV?
- How do media houses in each country compare with each other in their coverage of GBV?
- Of the coverage on GBV, what proportion is on prevention, the effects on victims and others, support and response?
- How do the GBV topics further break down into sub-topics?
- What is the overall breakdown of genres (news and briefs, cartoons, images and graphics?
- Editorial opinion, features, analysis, feedback, interviews, profiles and human interest.
- How does GBV coverage break down with regard to these genres?
- Where do the stories come from (international, regional, national, provincial, local)?
- How does GBV coverage breakdown with regard to origin of stories?
- On average, how many sources per story are there on GBV stories?
- On average, how many stories indicate the connection between GBV and HIV and AIDS?
- Overall, what is the proportion of women and men sources?
- How do individual media houses in each country compare with regard to male and female sources?
- What is the breakdown of women and men sources in the stories about, and stories that mention, GBV?
- What is the breakdown of women and men sources in the further breakdown of GBV topic category into prevalence, effects, support and response?
- In the case of GBV sources, what proportion are persons living with HIV and AIDS, persons affected by HIV and AIDS, traditional or religious figures, experts, civil society, official and UN agencies or other?

Research tools

The media monitoring combined both quantitative and qualitative research methods. Monitors gathered quantitative data on the media's coverage of gender, HIV and AIDS and GBV. Team leaders in each country selected articles for further analysis to give more in-depth analysis to the quantitative findings.

Quantitative research

The quantitative monitoring consisted of capturing data on the media's coverage of gender, GBV and HIV

and AIDS using a coding instrument. Data was captured into a database pre-designed for this research. Monitors had to capture a specified set of data from each item.

This included information about the item itself, who generated or presented the story (presenter, anchor, reporter, and writer) and who featured in the item. The process included:

- Filling in standard forms each day for each item monitored with the assistance of a user guide prepared by GL;
- Submitting forms for checking to the team leader who generally monitored at least one;
- Medium to better understand any difficulties that the monitors encountered;
- Entering of data into a database;
- Quality control by GL;
- Delivery of the database by e-mail to GL to be synthesised into one central database that has made possible this regional overview report, as well as country comparisons with regional averages; and
- Data analysis and generation of graphs.

Qualitative research

After the quantitative monitoring, monitors selected articles for further analysis. The qualitative analysis enhances and strengthens the quantitative findings. These case studies highlight best practices in the coverage of gender, HIV and AIDS, GBV as well as areas that need to be improved. The case studies serve to further elaborate and support many of the observations made in the quantitative analysis and answer the following questions:

- How are women and men labelled as sources in the media?
- Is there a good balance of men and women sources?
- Do women and men speak on the same topics, or do media reserve specific topics for men only and specific topics for women?
- Does the language promote stereotypes of men and women?
- Are physical attributes used to describe women more than men?
- How are women portrayed in the story? How are men portrayed in the story?
- Are all men and women in a society represented and given a voice in the media?
- What are the missing voices, perspectives in the story?
- What are the missing stories?

Political content and discourse analysis

The views and attitudes articulated by political leaders impact on what information citizens access and what issues are discussed in the public sphere. To measure the prevailing GBV discourse articulated by political leaders, GL analysed 266 speeches to assess the extent, understanding and commitment to GBV.

GL accessed speeches were from the Library of the Legislative Assembly for Parliamentary Debates (Hansard); Government Information Service (GIS) http://gis.gov.mu, the Government Portal www.gov.mu and websites of different Ministries from January to December 2009. Political party websites consulted did not give much result. GL only analysed official written speeches or records of Parliamentary debates.

Minister of Social Security, Sheila Bappoo (left), and Labour Party Communications Manager, Nita Deerpalsing, at the Women Politics Workshop by Gender Links.

Photo by Loga Virahsawmy

Table 2.2: Project components and tools used to gather data					
RESEARCH TOOL/ INDICATORS	**Prevalence and attitudes survey**	**Adminis-trative data**	***"I" Stories***	**Media monitoring**	**Political content analysis**
Extent	✗	✗	✗		✗
Effect	✗		✗		
Response	✗	✗	✗	✗	✗
Support	✗	✗	✗	✗	✗
Prevention	✗		✗	✗	✗

Table 2.2 shows how these tools inter-relate and how the research uses them to triangulate findings throughout the research to answer the key questions relating to extent, effect, response, support, and prevention. The flagship tool is the prevalence/ attitude study, justified on the basis that statistics obtained from administrative data do not cover many forms of gender violence, and even those that are covered are under-reported. However, the *"I" Stories*, or lived experiences, give a human face to all aspects of the research. The administrative data, media monitoring and political content analysis provide key insights in relevant areas. Triangulation helps to verify and strengthen the findings, as well as provide key insights for policy-making and action planning.

CHAPTER 3
Extent of GBV

A gender-based violence drama being played out for the Sixteen Days of Activism in Black River, Mauritius. *Photo by Mary Coopan*

Key facts

Lifetime prevalence

- ✓ About a quarter (24%) of women experienced some form of GBV at least once in their lifetime compared to 23% of men perpetrated GBV at least once in their lifetime.
- ✓ About a quarter (23%) women experienced while 22% of men perpetrated intimate partner violence.
- ✓ Sixteen percent of women experienced while 16% men perpetrated emotional IPV in their lifetime.
- ✓ A tenth (10%) of women experienced while 9% of men perpetrated physical IPV in their lifetime.
- ✓ One in three women who were physically abused reported to the police while one in six physically abused women sought medical attention for injuries.
- ✓ Less than a tenth (9%) of the women experienced and 3% of men perpetrated sexual IPV in their lifetime.
- ✓ One in thirteen (8%) of women experienced and 6% of men perpetrated economic IPV in their lifetime.
- ✓ Less than one percent (0.7%) of women were raped by a non-partner in their lifetime.
- ✓ Only one in seven women rape survivors reported it to the police.
- ✓ Six percent of women that ever worked had been sexually harassed in the workplace.

Past 12 months prevalence

- ✓ Five percent of women experienced while 4% of men perpetrated intimate partner violence in the 12months before the survey.
- ✓ Four percent of women experienced and 2% of men perpetrated emotional IPV in the 12 months before the survey.
- ✓ Two percent of women experienced and 1% of men perpetrated economic IPV in the 12 months before the survey.
- ✓ Equal proportions of women experienced (2%) and men perpetrated (2%) physical IPV in the 12 months before the survey.
- ✓ One percent of women experienced and 0.7% of men perpetrated sexual IPV in the 12 months before the survey.
- ✓ Less than one percent (0.1%) of women experienced and 1% of men perpetrated non-partner rape in the 12 months before the survey.

"What's wrong with me? Why should I keep on living in an abusive relationship? The glimpse of light that I find at the end of this long dark tunnel is my children.

My name is Anita*, I am still not sure what will become of me. And yet I am trying to cope because of my children. I hope that one day they will take care of me and I will no longer have to live in this abusive relationship. After so many years of domestic violence, I still cannot leave my husband. I have tried. I have even reported him to the police a few times. I have stayed in a shelter but could not resist when he asked me to return home with him.

I am telling my story in the hope that the hundreds of women who are suffering like me do not make my mistake. I get the impression that the fault lies in me. The shelter I went to did everything for me and I will always be grateful. I got all the support that a victim could get and yet I am now back to square one.

I was only 23 when I fell under the spell of this charming man for the first time. We got attracted to each and fell madly in love. We started to meet regularly. My mother was not happy with this relationship and even objected. Maybe deep inside her she knew I was in for trouble, a mother's instinct!

We were so much in love that Robin insisted that I leave my mother's house and live with him in his parents' house until he could find a house. Later, he rented a small house so that we could live together. When my mother heard that she came for me on the very same day and I had to go with her.

How could my mother do this to me? I was 23 years old after all and an adult who could make my own

decisions. I, therefore, ran away from home and went to live with Robin. We got married soon after and we stayed with his mother.

We lived happily for two years until he got a contract to work overseas. While he was still working abroad, he telephoned his mother to tell her that he had received a letter from a friend informing him that my behaviour was unacceptable. I was apparently having an affair with someone else. My mother-in-law ordered me to leave the house on the spot and to return to my mother's place. I was pregnant at that time.

I was very happy when I heard that Robin had returned to Mauritius after his two years' contract as deep inside me I knew he would come and get me and our daughter and we would live a happy family life.

My dream came true when soon after my mother's death; Robin did come for me and our daughter. But I could not believe my eyes as soon as I stepped foot in the house and saw another woman there. I was shocked. I had nowhere to go and because of our daughter, I decided to stay with him. It was only later that I learnt that he had been living with that other woman for quite some time.

I was depressed but for the sake of my child, I accepted the double life of my husband. We lived in this relationship for eight years. During this time, I gave birth to three children.

Soon after my second child was born, he started beating me. He brought all sorts of women in the house. I even had to change the room of the children so that he could be free to have his sexual debaucheries. It was hard for me to stay under the same roof of a husband having affairs with all kinds of women under the eyes of our children.

"This was the worse decision that I had ever taken in my life. I am still being abused physically and psychologically. In addition I have to cope with another woman staying in the same house..."

The beatings became regular and sometimes I had to run away. I went to the police a few times but each time they told me that they could not get involved in domestic affairs and I must sort out my problems. They made me feel as if I should be blamed. Sometimes I even believed them.

I cannot count the number of times I sought refuge at my neighbour's place. They were good indeed and let me sleep overnight until my children would come for me when things had calmed down at home.

Four years ago, I decided to go to a shelter and stayed there for two and a half months. The people there were very nice to me. They helped me a lot and gave me moral, financial and psychological support. They even found a job for me so that I could be economically independent and did not have to go back to this abusive relationship.

One day Robin came to see me. That became the end of my short happy life in the shelter. He told me that my kids wanted me back and that my younger daughter was going through a depression. As soon as I heard about my daughter's illness, I was heartbroken and left everything behind and followed him.

This was the worse decision that I had ever taken in my life. I am still being abused physically and psychologically. In addition I have to cope with another woman staying in the same house knowing that my husband is making love to her.

Is it worth making this kind of sacrifice? Will I find some light one day? Will my children really be able to help me?"

Anita faces a dilemma common to many women in abusive marriages. After years of suffering at the hands of her spouse, she is still unable to leave the marriage. According to her, she has had to stay for "the sake of the children". She however lives a life of blaming herself for failing to leave.

This chapter presents the extent of the different forms of GBV experienced by the women and perpetrated by the men within and outside intimate relationships.

GBV in lifetime

The survey used two separate questionnaires to determine lifetime experiences of GBV by women aged 18 and above and perpetration of GBV by men of similar age was collected.

Figure 3.1: Any experience of GBV by women or perpetration of GBV by men

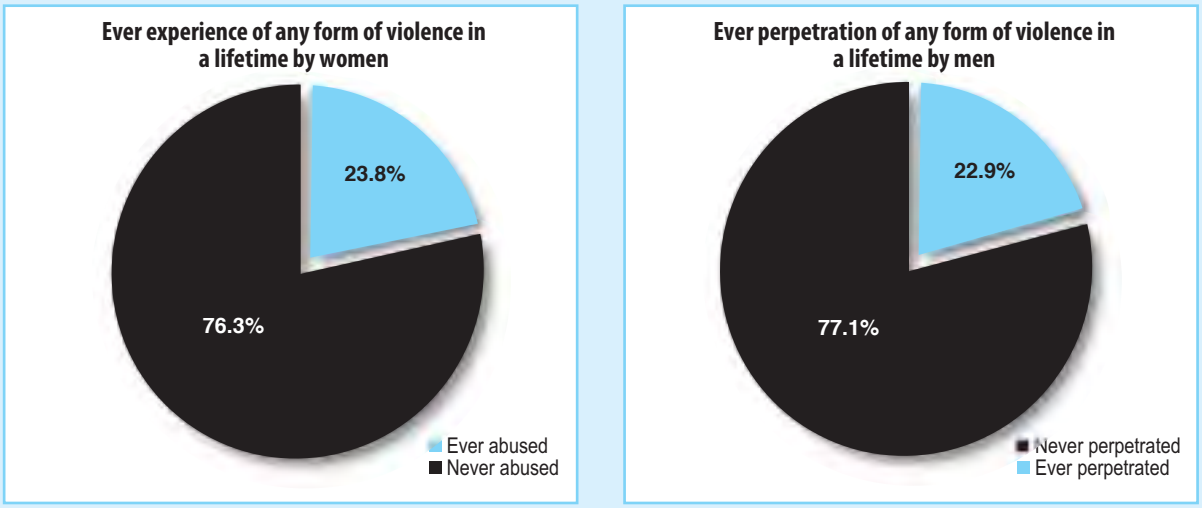


Figure 3.1 shows that 24 % of women interviewed in the study reported experience of some form of GBV at least once in their lifetime while 23% of men reported ever perpetrating GBV in their lifetime.

These statistics are lower than in the other project sites using the same tools. Studies found that 67% of women in Botswana; 51% of women in Gauteng; 45% of women in Western Cape; and 36% of women in Kwazulu Natal have experienced GBV. A higher proportion of men in Gauteng (76%) and Kwazulu Natal (41%) admitted to perpetrating violence against women in their lifetime. A lower proportion of men, compared to the proportion of women reporting GBV said they perpetrated GBV in Botswana (44%); Western Cape (35%); and Mauritius (23%) (GL, 2012).

The forms of violence measured in this study include intimate partner violence, non-partner rape and sexual harassment.

Figure 3.2: Forms of violence experienced or perpetrated in a lifetime

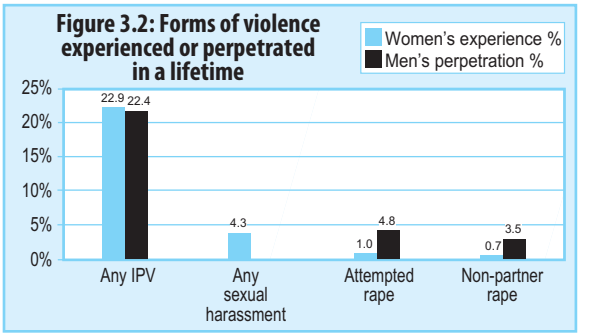


Figure 3.2 shows that the most commonly reported form of GBV by women and men is intimate partner violence and the least reported is non-partner rape. Twenty three per cent of women that were ever in heterosexual relationships experienced violence at the hands of their partners.

Again, these prevalence statistics though marked are lower than found elsewhere. 60% of women in Botswana, 51% of women in Gauteng, 44% of women in Western Cape and 29% of women in Kwazulu Natal reported experiencing Intimate Partner Violence (IPV) in their lifetime (GL, 2012).

Intimate Partner Violence

The term "intimate partner violence" (IPV) in this study describes physical, sexual, economic or emotional harm by a current or former partner or spouse.

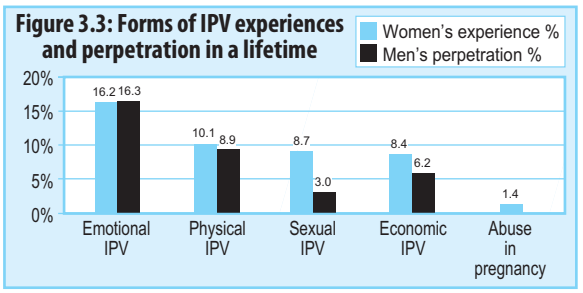


Figure 3.3 shows that the proportion of women reporting experience was greater than the proportion of men admitting perpetration. The most commonly experienced and perpetrated form of IPV is emotional IPV whilst the least commonly reported form is economic IPV. 16% of ever-partnered women experienced or men perpetrated emotional IPV in their lifetime respectively.

Emotional IPV

Emotional IPV was assessed by six questions that asked about a series of different acts that were controlling, frightening, intimidating or undermined women's self-esteem. Women participants were asked if a male partner had ever insulted them or made them feel bad; belittled or humiliated them in front of other people; threatened to hurt them; stopped them from seeing friends; done things to scare or intimidate them; or boasted about or brought home girlfriends. Men were asked if they had done any of these things to a female partner.

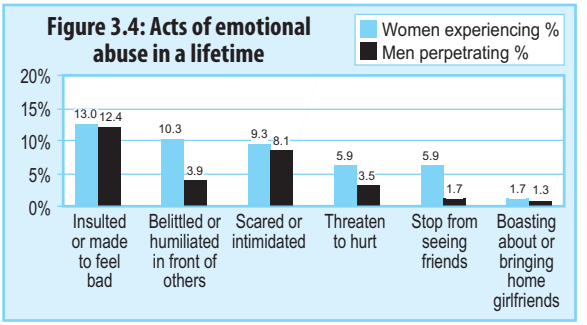


Figure 3.4 shows that the most common act of emotional violence reported by women is being insulted or made to feel bad. Thirteen percent of women had been insulted or made to feel bad by their partners while 12% of men perpetrated this act of emotional violence. The least common act of emotional violence reported by women and men was boasting about or bringing home girlfriend. Low prevalence of this act of violence may also be indicative of low prevalence of promiscuity within the relationships of surveyed participants. The most common acts of emotional violence committed by men are insulting, scaring or intimidation. One in every eight men that were ever partnered (12%) had insulted whilst one in twelve (8%) of men admitted to scaring or intimidating their partners.

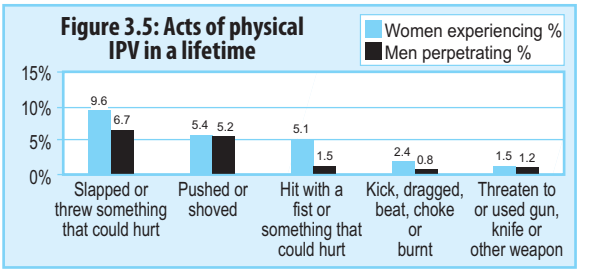
GBV Validation workshop - participants sharing their ideas during the group work.
Photo by Girish Abdhoossee

Physical IPV

Physical IPV was assessed by asking five questions about whether women had been slapped, had something thrown at them, were pushed or shoved, kicked, hit, dragged, choked, beaten, burnt or threatened with a weapon. Similarly men were asked if they had done any of these acts to their intimate partners.

Overall 10% of women disclosed that this had ever happened and 8.9% men disclosed lifetime perpetration.

The most commonly experienced act of physical IPV by women is slapping or having a dangerous object thrown. Ten percent of women experienced and 7% perpetrated such acts of violence. The least common act of physical IPV is threats or use of weapons. Two



percent of women were threatened with a gun, knife or other weapon while 1% of men reported this.

Extent of reporting physical IPV in lifetime

The questionnaire asked women who reported experience of physical IPV in their lifetime whether they reported the incidents to the police or health facility.

Table 3.1: Extent of reporting physical IPV in a lifetime

Criteria	%
Proportion of ever partnered women who were physically abused, injured and who sought medical attention in a lifetime	1.8
Proportion of ever partnered who were physically abused and who reported abuse or threats to police in a lifetime	3.1

Anoucka Saddul from the National Aids Secretariat (N.A.S) giving her opinion during the GBV Validation workshop. *Photo by Girish*

Table 3.1 shows that two percent of women were physical abused by intimate partners and sought medical attention because of the injuries sustained. Three percent of physically abused women reported their experiences to the police.

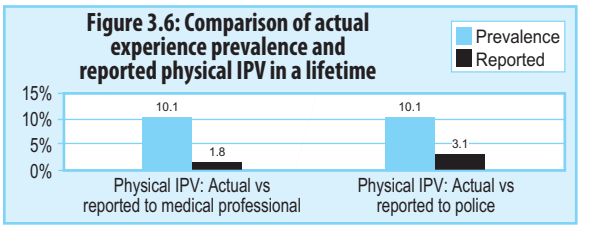


Figure 3.6 shows that there is huge under-reporting of physical IPV and non-partner rape both to police and to health care facilities. Only one in six women

(1.8%) who were physical abused by intimate partners in their lifetime sought medical attention after injuries. A higher proportion of women reported the incidents to the police. One in every three (3.1%) of physically abused women in the survey have reported to police.

Sexual IPV

The study assessed sexual IPV experienced by women using three questions. These covered: if their current or previous husband or boyfriend had ever physically forced them to have sex when they did not want to; whether they had had sex with him because they were afraid of what he might do and whether they had been forced to do something sexual that they found degrading or humiliating.

Table 3.2 shows that the majority of women that experienced either sexual or physical IPV in fact experienced this on more than one occasion. Similarly, the majority of men perpetrating sexual or physical IPV have done so more than once.

Table 3.2: Frequency of sexual or physical IPV in lifetime

Criteria	Women experiences %		Men perpetration %	
	Once	More than once	Once	More than once
Sexual or physical IPV frequency	4.7	9.8	6.2	3.2
Sexual IPV frequency	2.0	6.4	1.7	1.3
Physical IPV frequency	4.6	5.4	5.9	3.0

Economic IPV

Economic IPV was the third most prevalent form of IPV perpetrated by men and the least experienced form of IPV reported by women. Eight percent of ever-partnered women experienced while 6 % of men perpetrated some act of economic IPV in their lifetime.

Acts of economic IPV in this study include withholding money for household use, prohibiting a partner from earning an income, taking a partner's earnings or forcing a partner and children to leave the house in which they were staying.

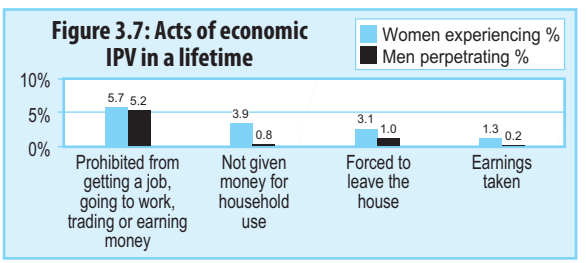


Figure 3.7 shows that the most common act of economic IPV experienced by women and perpetrated by men is prohibition to employment or participating in income generating activities. Almost similar proportions of women and men reported this. The least common act of economic IPV is taking earnings.

Abuse in pregnancy

This study explored the prevalence of intimate partner violence among pregnant women prompted or intensified by pregnancy. Abuse in pregnancy maybe due to longstanding abusive relationship that continues after a woman becomes pregnant. It may also commence because of various reasons such as unintended pregnancy or suspicion of birth control sabotage. The questionnaire asked if women had experienced acts of abuse during any of their pregnancies.

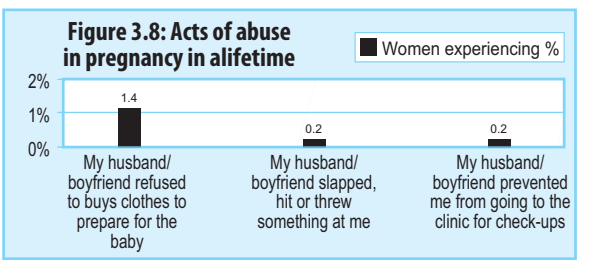
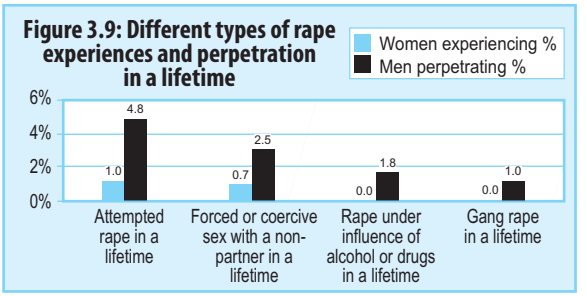


Figure 3.8 shows that the most common act of abuse in pregnancy is economic and involves partners refusing to assist in the preparation for the baby. One percent of women who were ever pregnant reported that their partner had refused to buy clothes to prepare for the baby.

Non-partner rape

The study assessed rape of women by men by asking three questions. These covered: whether a man not a husband or boyfriend forced or persuaded the women to have sex against their will; whether they had been forced to have sex with a men when too drunk or drugged to stop him, and whether men forced the women to have sex with more than one man at the same time. The latter is an indicator of gang rape. The men's questionnaire asked men if they had ever forced women to have sex.

Figure 3.9 shows that none of the women interviewed had experienced drugged or drunk rape or gang rape.



However, 2% of men admitted to raping non- partners under the influence of drugs while 1% had gang raped.

Under-reporting of rape

The questionnaire asked women raped by non-partners whether they had reported the incidents to the police or if they had sought medical help.

Table 3.3: Extent of reporting rape in a lifetime

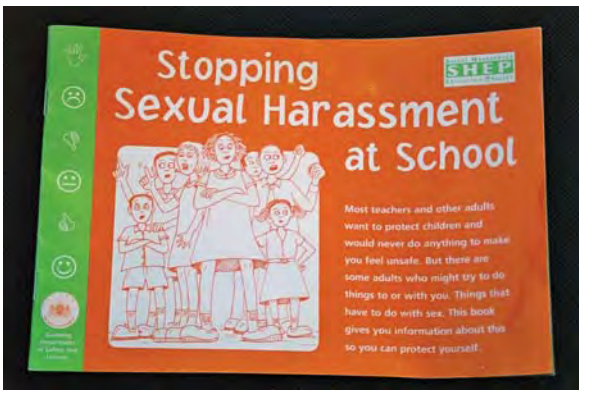
Criteria	%
Proportion of all women who were raped in a lifetime	0.7
Proportion of all women who were raped and reported incident to police in a lifetime	0.1
Proportion of all women, who were raped and who sought medical attention in a lifetime	0.1

Table 3.3 shows that there is huge underreporting non-partner rape both to police and to health care facilities. Only one in every seven (0.1%) women raped by non-partners had reported to police or sought medical attention after injuries. These findings show a huge extent underreporting of non-partner rape, compared to physical IPV.

Sexual harassment

Sexual harassment means any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another. Such sexual advance or request arises out of unequal power relations (SADC Protocol on Gender and Development).

Women participating in this study were asked whether they had experienced sexual harassment in the workplace, schools, whilst using public transport or when seeking help from traditional healers.



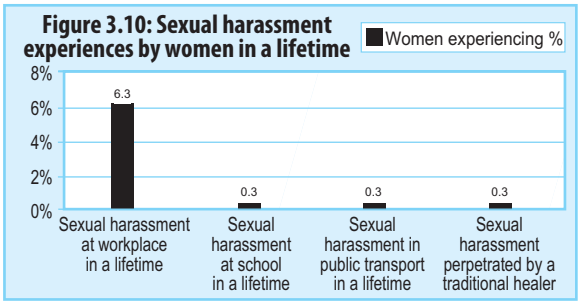


Figure 3.10 shows that most incident of sexual harassment occurred in the workplace. Six percent of women that were ever employed had been sexually harassed. Similar proportions of women were sexually harassed at school, in public transport and by traditional healers.

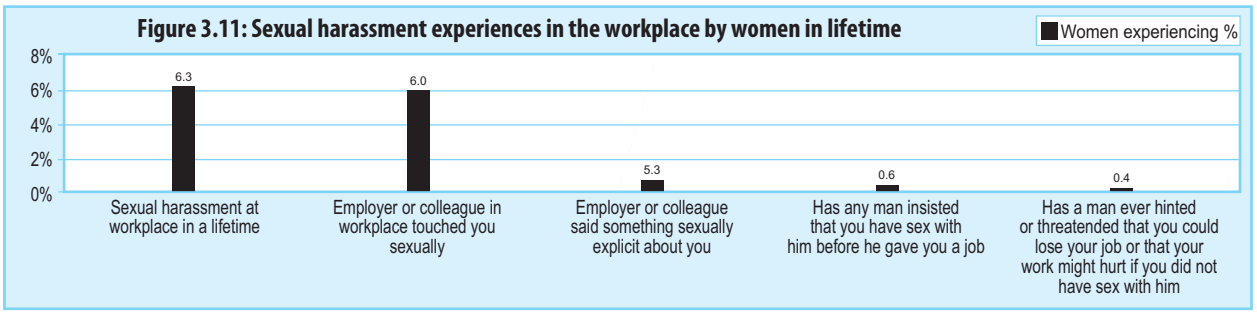


Figure 3.11 shows the different acts of sexual harassment experienced by women in the workplace. Six percent of women said a colleague sexually touched them and five percent of women said colleagues or employers said sexually explicit things about them. Less than one percent of women reported that they were asked for sex as a prior condition to getting a job or asked for sex to avoid losing a job.

GBV in past 12 months

Women and men were asked whether their experiences or perpetration of GBV had occurred in the 12 months before the survey.

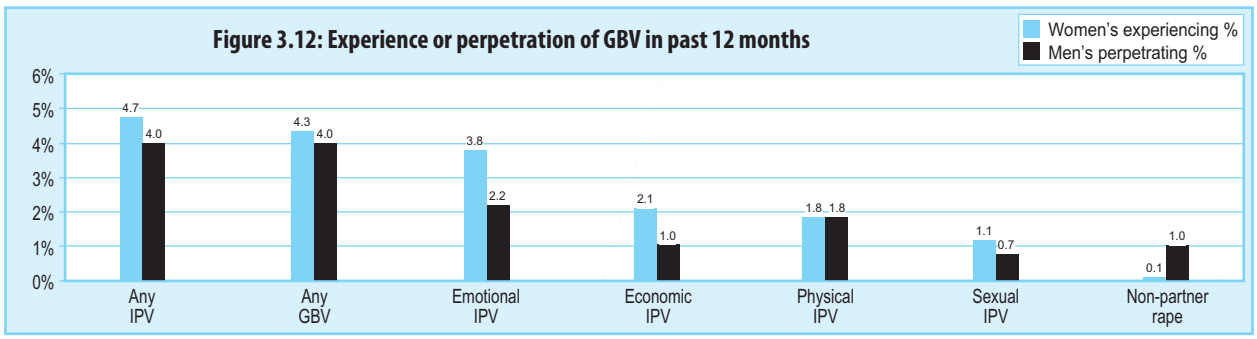


Figure 3.12 shows that almost one in twenty five women experienced and men perpetrated GBV in the 12months before the survey. IPV is still the most commonly experienced and perpetrated form of GBV and the most common form was emotional followed by economic IPV. Sexual IPV is the least common form

of IPV. For all the IPV forms a higher proportion of women reported experience than men reported perpetration.

Non-partner rape is the least common form of GBV experienced or perpetrated in a similar period. A higher proportion of men reported rape perpetration compared to the proportion of women reporting experience. One percent of the men had raped in the 12 months to the survey.

"...women may be more willing to disclose experience of violence in intimate relationships than men would disclose perpetration. "

Table 3.4: Comparison of study findings with previous research

Form of IPV	CASR study (2008 - 2009)	GBV Indicators survey research (2010)
Any IPV	-	4.7
Emotional IPV	11.5	3.8
Physical IPV	5.9	1.8
Sexual IPV	0.2	1.1

Table 3.4 shows that the prevalence findings from this study are lower than those reported in the CASR study. The difference can be attributed to differences in definitions of violence. Secondly, the research was conducted in different times. Given the almost similar sampling techniques used in both surveys it may be intuitive that the levels of domestic or intimate partner violence for 2010 were less than that of 2008-2009.

Conclusion

The findings in this chapter show GBV to be prevalent in Mauritian intimate relationships and communities. The high levels of underreporting from this study give further evidence of the inadequacy of administrative data as a measure of the extent of GBV in Mauritius.

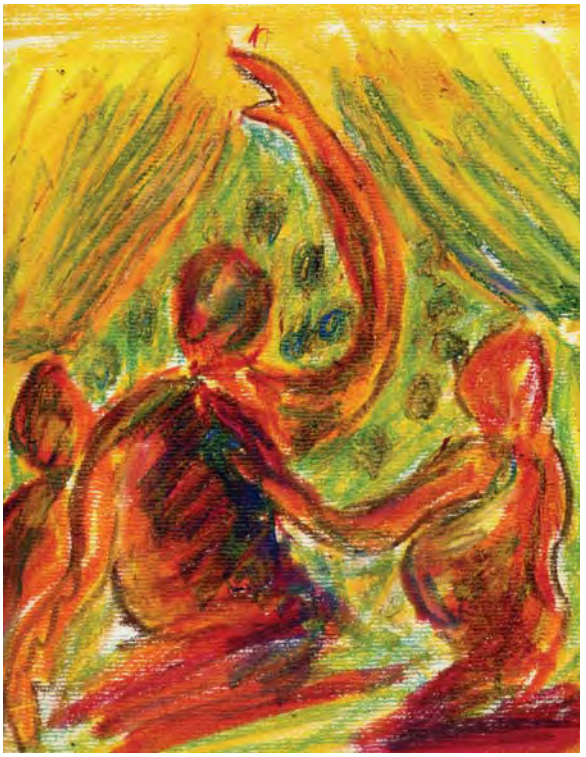
For all the forms of IPV, a greater proportion of women disclosed experience than men disclosed perpetration. This finding points to the fact that women may be more willing to disclose experience of violence in intimate relationships than men would disclose perpetration. Although not verified in this study there could be potential information bias from men responding or providing information that they perceive to be more socially desirable.

CHAPTER 4
Patterns and drivers of GBV

Girls participating in a march during Sixteen days campaign 2011. *Photo by Mary Jane Piang-Nee*

Key facts

- ✓ Age is a statistically significant driver for IPV perpetration in the 12 months before the survey.
- ✓ Educational attainment is significantly associated with IPV experience by women.
- ✓ A significantly higher proportion of men who were unemployed in the 12 months before the survey were less likely to perpetrate IPV compared to those who were employed in a similar period.
- ✓ Child abuse experience by men is associated abusive behaviour in intimate relationships.
- ✓ A significantly higher proportion of men who were sexually abused, neglected or physically abused as boys were more likely to perpetrate violence against their intimate partners.
- ✓ Alcohol consumption in 12 months to survey was associated with IPV perpetration in a similar period.
- ✓ Substance abuse was not significantly associated with IPV perpetration.
- ✓ There is a disparity in the attitudes of women and men towards gender relations.
- ✓ Women interviewed in the study were more progressive than the men and perceived their communities as being more progressive than did the men.



« Je suis un homme violent. Je ne l'ai jamais caché et même si j'avais essayé, ce serait impossible, parce que je suis violent de nature. Depuis l'époque où j'étais à l'école, ma vie fut marquée par la violence. Mon adolescence a été marquée par des disputes, bagarres sanglantes m'envoyant même dans un centre correctionnel à Beau-Bassin. Ma famille était aussi plongée dans la violence. Mes parents se battaient souvent et quand il y avait une fête de famille ou une réunion, cela se terminait très souvent par des bagarres sanglantes. J'ai malheureusement hérité de cela. Quand je me suis marié et même avant je frappais ma compagne. Je trouvais cela normal, de la battre. Bon, elle répliquait aussi et cela m'encourageais à la battre à nouveau. Donc, des disputes qui finissaient par des actes violentes étaient chose commune dans notre couple.

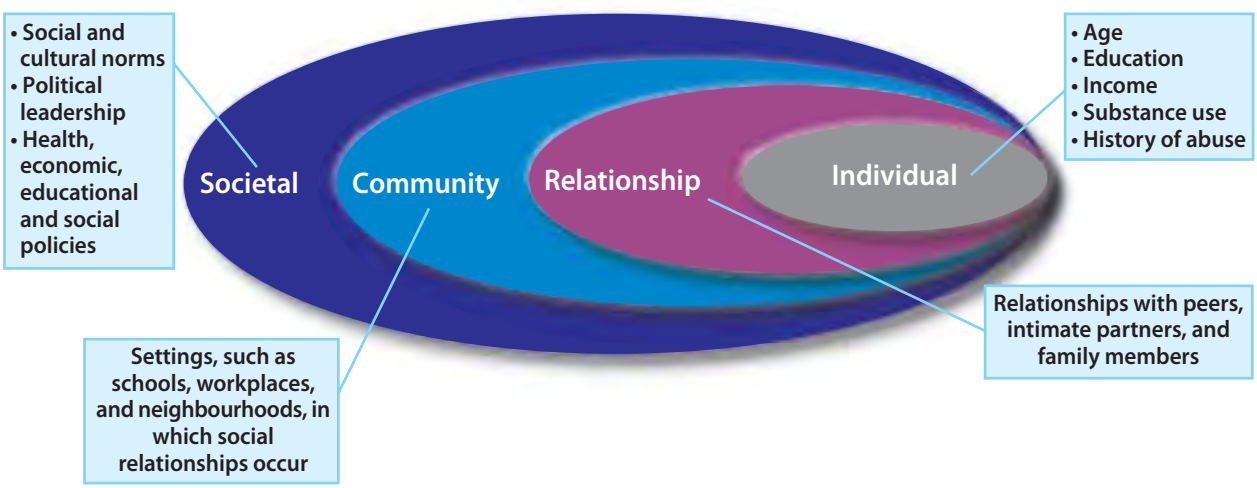
Ma femme n'a jamais porté plainte. Je ne sais pas pourquoi mais je pense qu'elle trouvait cela normal également. Donc nos violentes disputes restaient entre nous. Cependant, il y a trois ans, j'ai failli la tuer et j'attends actuellement le verdict de la cour de district de Port-Louis. J'ai faillit tuer ma femme avec un marteau et heureusement elle n'est pas morte de cette violente agression.

Mon avocat m'a aussi dit que j'ai eu de la chance, car normalement on aurait pu m'incriminer de tentative d'homicide ou d'agression grave causant incapacité mais je me suis trouvé avec une simple accusation d'agression. Ce soir-là j'avais frappé ma femme avec toute la force avec un marteau. Elle saignait abondamment et mes voisins ont alerté la police. Heureusement qu'elle a eu tous les premiers soins très rapidement. J'étais complètement ivre et c'est peut-être pour cela qu'on s'est bagarré, enfin je ne me rappelle pas trop. Tout ce que je me souviens c'est que ma femme faisait des travaux dans notre chambre et clouait quelque chose. Quand je suis rentré, ivre, elle m'a dit que je ne valais rien, qu'on ne pouvait jamais compter sur moi. J'ai l'ai donc rossé, avec une pelle puis avec un marteau. Elle hurlait et les voisins qui d'habitude ne font rien car c'est tellement commun nos affrontements ont vu la violence que j'exerçais et ont préféré appeler la police. Au lieu de m'enfuir j'ai continué à infliger des actes de violences sur ma femme, qui était déjà inconsciente face aux coups que je lui avais infligé.

Quand la police est venue, j'ai essayé de prendre la poudre d'escampette mais les policiers ont réussi à me maitriser et m'arrêter. J'ai passé quelques jours en cellule avant d'être libéré sous caution. Lors de la première audience, la première confrontation avec ma femme a failli dégénérer en violence mais la police est intervenue. J'en veux à ma femme parce que je ne suis jamais allé en prison. Certes, j'ai failli la tuer ce soir la mais elle m'a vraiment provoqué, m'a mis carrément hors de moi. Elle avait déclaré que je ne suis pas un homme, un vrai et que je ne méritais pas de porter un pantalon. Je ne voulais pas le faire tant de mal mais elle a atteint mon orgueil et ma fierté en tant que mari et père. C'est ce que j'ai dis à la cour et j'espère qu'elle sera clémente avec moi. Je crois en la justice et je pense qu'on m'infligera une amende. C'est la première fois que je me suis fait inculpé, et j'ai vraiment peur de la prison, très peur car j'y ai jamais été. «

Rakesh's* story shows that when a child grows up in a violent environment, violence may become a way of life. As a child, Rakesh saw his parents quarrelling all the time. Family and social gatherings ended up in bloody fighting. When he was growing up, he fought with friends and was sent to a Youth Correctional Centre. Even before getting married, he used to beat his future wife. The violence became worse after his wedding. His wife did not go to the police. When he was on the point of killing her with a hammer, the neighbours called the police. Had the police not arrived on time he would have killed his wife. He was charged with assault. At the time of writing this book, Rakesh was waiting for his sentence. This chapter explores individual, family/relationship, community and societal factors that impact on adult behaviours as shown by the ecological model framework. The chapter draws on the prevalence and attitude survey, as well as the political content analysis, to draw out the causes or drivers of gender violence in Mauritius - both immediate and longer term.

Figure 4.1: The ecological model of factors associated with VAW



The ecological model in Figure 4.1 explains why some of the violence occurs, why some men are more violent than others are, and why some women are consistently the survivors of abuse. Understanding the reasons for and the factors associated with experience or perpetration of gender violence is a precursor in the design of GBV prevention programmes. The study investigated the association between the experience or perpetration of violence with individual, family, community and societal characteristics of participants. The study also explored social norms around gender relations.

Individual level factors

Individual level influences are personal factors that increase the likelihood of becoming a victim or perpetrator. Examples include socio-demographic factors, attitudes and beliefs that support IPV, isolation, and a family history of violence.

Socio demographic factors

Socio-demographic characteristics explored include age, education level and employment status.

> "...the neighbours called the police. Had the police not arrived on time he would have killed his wife. "

Table 4.1: Socio-demographic factors associated with experience and perpetration of IPV								
Factors	**Ever IPV**				**Past 12 months IPV**			
	% women survivors	Chi(p)	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	26.9	0.5	12.1	0.2	7.7	0.6	0	0.05
30-44	24.6		20.8		5.3		6.2	
45+	20.7		24.8		3.8		2.6	
Level of education								
A level incomplete and lower	24.6	0.01	24.9	0.01	4.8	0.9	4.2	0.6
A level complete and over	12.5		12.4		4.5		3.3	
Worked in past 12 months								
No	23.2		0	0.3	3	0.01	0	0.04
Yes	22.4	0.8	1.2		7.3		4.7	

Age

Table 4.1 shows that there is no statistically significant difference in the proportion of lifetime IPV survivors (p=0.5) and perpetrators (p=0.2) by age. However, there is a significant difference in proportion of perpetrators by age in the past 12 months. Men in the 30-44 years age group were almost three times more likely to perpetrate IPV in the 12 months before the survey compared to men in the 45 years and above age group. Men in the 18-29 years age group were least likely to perpetrate IPV in the past 12 months.

In contrast, age was not a significant factor for IPV experience by women either in the preceding 12 months or in lifetime. There was no statistically significant difference in the proportion of women experiencing IPV by age group.

Education level

Table 4.1 shows that there is no significant difference in the proportion of survivors or perpetrators of IPV in the past 12 months by the level of education. However, there is a significant difference in the proportion of survivors and perpetrators of IPV in a lifetime by level of education. A greater proportion of men who did not complete high school ever-perpetrated IPV compared to the men that had completed high school. Similarly, a greater proportion of women who had not completed high school experienced GBV in their lifetime compared to the women who had completed high school.

These findings are consistent with the CASR study that found that those with lesser educational achievement levels were significantly represented among victims of physical and sexual abuse (CASR 2010).

Employment status

Table 4.1 shows that men who had been employed in the 12 months the survey were more likely to perpetrate IPV in a similar period. Women that had worked in the 12 months before the survey were significantly more likely to experience IPV in a similar period. These findings conform to the resource theory of causes of GBV. According to the theory, when couples share equal power there is lower incidence of conflict and when conflict arises they are less likely to resort to violence. On the contrary when a partner desires more control and power they may resort to abuse. This may be the case for employed women who are likely to be more empowered and less dependent on their spouses to the point they believe in equal power relations (Goode, 1971).

Child abuse

Childhood experiences explored include childhood

neglect, sexual and physical abuse. Participants in the study were asked about experiences of childhood neglect and abuse. Child abuse was ascertained through a series of questions about forced sex, unwanted sexual touching, being severely beaten leaving marks and neglect by family, teachers or other community members.

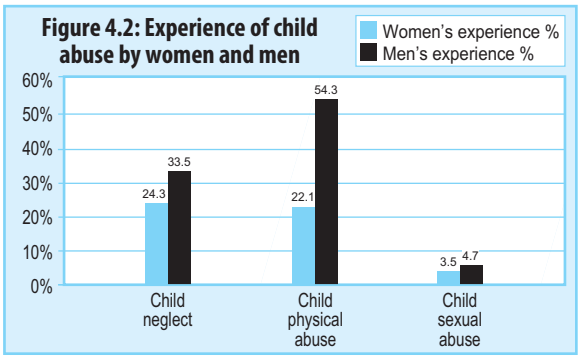


Figure 4.2 shows that for both women and men suffered child abuse. However, a higher proportion of men than women experienced all forms of child abuse studied. The most common form of child abuse experienced by men was physical abuse followed by neglect and lastly sexual abuse. The most common form of child abuse experienced by women was neglect. The least common form of child abuse experienced by both women and men was child sexual abuse.

The finding that child neglect was most commonly experienced by women, in fact a quarter of the women, shows that women suffer from a continuum of emotional abuse that may stretch from childhood into adulthood. This is also true for physical abuse.

Child physical abuse

Child physical abuse is defined as ever experiencing an incident such as being beaten with a whip and left with a bruise or mark. This could have occurred at home, school or in the community. Almost one in every five (22%) women interviewed and one in every two (54%) men experienced child physical abuse.

Child neglect

Child neglect in this study includes not being given enough food, parents being too drunk to care for their children, or children spending time outside the home without any adults aware where they were. Almost one in every four (24%) women and one in every three (34%) men experienced child neglect. The excerpt - the child neglected by her mother and her boyfriend - is an example.

Child sexual abuse

To ascertain experiences of child sexual abuse participants were asked whether they had ever been touched sexually or forced to touch someone, whether they had sex with someone of the opposite sex who was more than five years older, or whether they had been forced to have sex before they turned 18 years old. Four percent of women and five percent of men experienced child sexual abuse.

The women who told their *"I" Stories* also alluded to experiencing child sexual abuse. An example is the story of Rani*, sold by her grandmother to a man who later sexually abused her.

"I come from a broken home and after the separation, my mother married another man. I was a burden for both of them and was sent to my "nani." My nani was very poor and we lived in a small house made of old sheets of corrugated iron. We hardly had any food to eat.

When I turned nine years old, my nani sold me to an old man. The first night it really hurt but I did not even know what that old man was doing to me. This torture went on for three long years on every single night. When the old man came to my nani's house, my nani left the house and I was on my own with the old man. The next morning I would go to school as if all was normal, but I was suffering a lot inside." - Rani

Child abuse as a risk factor for IPV perpetration

Experiences of abuse throughout life can influence an individual's inclination to engage in family violence either as a victim or as a perpetrator. We explored the link between child abuse experience by men and perpetration of IPV in lifetime using chi square tests of association.

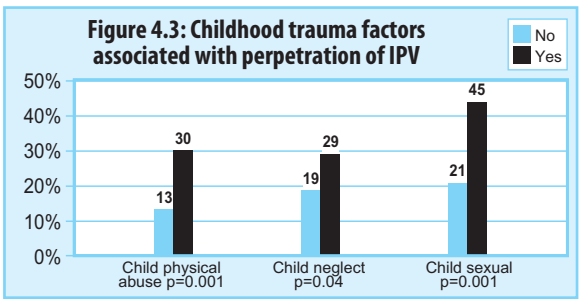


Figure 4.3 shows that a higher proportion of men who were victims of child abuse were themselves abusive compared to those that were not abused as children. Three in every ten men (30%) who were physically abused as boys perpetrated IPV at least once in their lifetime while 13% of men who were never physical abused perpetrated IPV at least once in their lifetime. Forty five per cent of men who were sexually abused as boys perpetrated IPV in their lifetime compared to 21% of men were never sexually abused.

These findings indicate the existence of an inter-generational cycle of violence in Mauritius. According to Kalsmuss and Seltzer 1984, people who are abused as children may incorporate abuse into their behaviour within the relationships they establish as adults. It is therefore imperative to prioritise response programmes targeted at rehabilitating children that have been exposed to domestic violence.

Alcohol and substance abuse

This study looked at the links between alcohol and substance abuse and GBV. Questions relating to alcohol and drugs included whether the respondent had taken alcohol in the 12 months to the survey and if the response was yes, then how often. Participants were asked whether their current or most recent partner consumed alcohol and how often they did this. Questions on substance use included whether the respondent or their partner used drugs and how often they did this.

Table 4.2: Alcohol and drug consumption patterns by women and men

	% Women	% Men
Have you drunk alcohol in past 12 months		
No	70.9	38.0
Yes	29.1	62.0
How often do you take a drink containing alcohol		
Monthly or less	64.5	36.1
2-4 times a month	33.3	31.7
2-4times a week	2.2	23.8
4+ times a week	0	8.1

	% Women	% Men
More than 5 drinks on one occasion		
Never	82.0	40.0
Less than monthly	14.8	22.6
Monthly	2.7	13.2
Weekly	0.5	20.6
Daily or almost daily	0	3.7
Current partner alcohol frequency		
Every day/nearly every day	6.8	0.3
Only at weekends	29.6	5.6
A few times in a month	14.2	1.7
Less than once a month	14.8	14.7
Never drank	32.8	77.3
Stopped drinking	1.9	0.3
Current or most recent partner drug use		
No	98.4	99.2
Yes	1.6	0.8

Table 4.2 shows that about three in every ten women (30%) interviewed drank alcohol in the 12 months to the survey. However, the majority of women (65%) were occasional drinkers. Less than one per cent of women who drank alcohol were binge drinkers who took more than five drinks per occasion on a weekly basis. Sixty five per cent of the women were in intimate relationships with men who drank alcohol while two per cent of women had partners that used drugs.

Almost two-thirds (62%) of men drank alcohol in the 12 months to the survey. The men who drank alcohol were regular drinkers. Thirty-two per cent of drinkers drank alcohol at least two times a week. One in twenty-five (3.7%) who that drank alcohol were binge drinkers consuming more than five drinks at once.

Table 4.3: Association between partner alcohol or substance use and experience of IPV in past 12 months

	% women survivors in past 12 months	Chi (p)
Partner drank alcohol	6.1	0.2
Partner did not drink alcohol	3.8	
Partner used drugs	0	0.5
Partner did not use drugs	5.5	

Table 4.3 shows that in this study there was no significant difference in the proportion of women who experienced GBV in the 12 months to the survey among women whose partners drank alcohol and those whose partners did not drink alcohol (p=0.2).

However, more women whose partners drank alcohol experienced GBV in a similar period. There was also no significant difference in experience of GBV between women whose partners used drugs and those whose partners did not use drugs (p=0.5).

Table 4.4: Association between partner alcohol or substance use and perpetration of IPV in past 12 months		
	% men perpetrators in past 12 months	Chi (p)
Drank alcohol	5.6	0.007
Did not drink alcohol	1.0	
Used drugs	3.4	0.9
Did not use drugs	3.9	

Table 4.4 shows that drinking of alcohol was associated with perpetrating IPV in the 12 months to the survey (p=0.007) .Six per cent of men who drank alcohol also perpetrated IPV while only one per cent of non-alcohol drinking men perpetrated IPV in a similar period. There was no significant difference in the proportion of perpetrators who used drugs and those who did not use drugs.

Nita* spoke of how her husband Paul* abused alcohol. When drunk he would insult her and become physically violent. The sober Paul was loving and kind. As a coping strategy, Nita also started to abuse alcohol. Her husband eventually died because of his destructive habit.

"I nearly lost myself in trying to find the answer to this question. He looked good. Almost as handsome as when we first met. I was barely twenty and now I am not yet thirty. Lying there on the bier, his head completely dressed in bandage from the post-mortem, he looked like the bridegroom who wed me ten years ago. The memories stung my eyes and tears poured out.

He had a smirk on his face. It was almost as though he was enjoying some private joke. Looking at him lying there on the bier, I felt anger and resentment well up inside me. He was gone at such a young age because of such a stupid reason. What a waste. If only Paul had listened.

But Paul had never listened. Not when my family warned him off drinks repeatedly. Nor when, sick of being beaten and abused, I slit my wrist open. He could not even heed the doctors' instruction to stop taking the deadly nectar. Now that he is gone, I feel a weird sense of relief wash over me even as grief tightens its grip around my heart.

Torn between tears and laughter, I sat there stunned, with eyes riveted on my husband's corpse and ears deaf to all the moaning and weeping going around. Unbidden, the heart-breaking memories from last year flood in as though it happened yesterday. I touched my jaw reflexively.

I remember waking up at the hospital with a swollen face. My teeth held together with some kind of wiring. My head wanted to burst from the thudding pain. I had a broken jaw, the doctor told me. My teeth were all loose from the blow I had received. He wanted to know how it all happened. Once, I would have lied and assured him that I had had a bad fall. This time, I threw caution to the winds and told him the truth.

I had been beaten up by my younger brother- in-law, a burly man who lives next door to me. He was unhappy about a guest we were entertaining that night and had started an argument about it, demanding that we show her the door. My husband was too drunk to tell his brother to mind his own business. Besides, he was no match for the younger man. So I spoke up. And when he tried to drag our guest out of our house, I tried to push him away. But then, he shoved me down and kicked me all over, including my face.

After two days in hospital, I was free to go home. Paul never came to pick me up. I had neither proper clothing nor a single cent on me. How would I go home? He was not picking up my calls. I later learned that this was because he had passed out from drinking too much.

Tears stung at the back of my eyes as I watched my old mother walk in the ward at visitor's time. She had been the only one visiting me at the hospital. She took me to her place and nursed me like a baby. She would feed me soup with a straw since I was unable to eat.

Encouraged by my family, I decided never to go back. This was one time too many. Paul was such a loving husband when he was sober. But I couldn't remember the last time when he was off drinks! When drunk, he would insult me. He would get physical and the next day, he would go out of his way to show contrition.

I tried everything possible to keep peace in my home. I became his drinking buddy. I gave in to all his whims and demands. I even distanced myself from my parents whom he resented and disliked. He didn't like my going anywhere on my own. I ended up becoming a recluse. But nothing was ever quite enough for Paul.

And now, he was too much of a sick alcoholic to be able to work. We would go weeks without proper meals; the utilities disconnected us due to unpaid bills. As he got sicker and weaker, my in-laws became more and more interfering. And this time, when his brother would have beaten me to death had he had his own way, my husband was not even fit to protect me… Why indeed should I stay married to him?

Eventually, Paul started insisting that I come back home. My mother set her foot down but he would keep nagging on the phone. When I eventually gave in, I learned that he had acted under pressure from his parents. They wanted to persuade me to drop charges against my brother in-law. I eventually did that. Though part of me despised my husband for choosing to side with them, I still loved him.

And now he is gone, leaving me totally unprepared to fend for myself. It is funny how a slave can grow to love his torturer. Freedom suddenly seems very scary."

Relationship influences

Relationship level influences are factors that increase risk due to relationships with peers, intimate partners, and family members. A person's closest social circle, peers, partners and family members can shape an individual's behaviour and range of experiences.

Christine* told how her in-laws interfered with their relationship:

"He went out every night to drink and gamble. After a while, I moved to my in-laws' place where they lived upstairs in the same house and family interference did not help us as couple. I did not like the fact that my in-laws constantly watched my every move and also that my husband consulted his family before taking any decision. Things get worse when he began humiliating and morally harassing me. He would even go to the extent of saying, "If you did not fall pregnant, I would already have left you. You know I can easily get a pretty doll to marry." His stepmother, who was 60 years old, cut the hot water supply and stopped buying food for me, telling me to go into prostitution."

Christine's and Nita's* stories are consistent with findings from the CASR study that also found that in-laws play a role in exacerbating conflict and violence between married couples. In both cases, their husbands were abusive alcoholics who took advice from their families regarding their relationships. The husbands were also unable to fend for their wives because of alcoholism. In Nita's case, the in-laws forced her to drop charges of physical abuse. In Christine's case, her husband's family accused her of promiscuity and this exacerbated conflict within their relationship.

Gino*, who was violent to his wife for ten years because the latter belonged to a different religious sect, told his story.

« J'ai connu ma femme Selma quand je n'avais que 19 ans. Elle était encore mineure et je suis le premier homme de sa vie. Dés le début, notre relation était marquée par la violence parce que j'étais un homme très jaloux. Ma femme était belle et je ne supportais pas qu'elle dit bonjour a qui que ce soit. Par courtoisie, elle souriait à mes amis masculins des fois et cela me rendait dingue. Je la tabassais toujours. Mais elle était soumise et me respectait malgré tout.

Quand on s'est marié, les choses se sont empirées. Je finissais tout l'argent dans les jeux : Je jouais aux cartes, essayant de gagner gros mais finalement je me suis ruiné. Selma travaillait dans une usine textile et quand elle touchait son salaire, je la rouis de coups si elle ne me filait pas de l'argent pour que j'aille jouer. Plusieurs fois elle a été admise à l'hôpital après que je l'ai battu. Elle n'a jamais porté plainte contre moi. Puis avec la venue d'un enfant, je lui avais promis que j'allais changer de vie mais j'étais devenu accroc aux jeux. Je ne pouvais travailler car je voulais toujours jouer et la vie de Selma est devenue un calvaire.

Je l'ai même violé à deux reprises. J'étais furieuse qu'elle ne fût plus disposée à avoir des relations sexuelles avec moi. Je la forçais à me faire des pratiques sexuelles et elle a supporté cela par amour pour moi alors que je me comportais comme un vrai cochon. Puis j'ai arrêté pendant un moment : Je savais ce que je faisais n'était pas bien et disons que j'ai fais une pause. Mais le pire allait venir : Quelques années plus tard, Selma a commencé à fréquenter une église que beaucoup de gens

qualifiaient à l'époque de secte. Elle donnait beaucoup d'argent en finançant cette secte et je devenais fou quand elle me prêchait les enseignements de ces gens. Je suis redevenu violent. J'étais devenu un mari frustré. Selma passait tout son temps dans les activités de cette église. Elle me négligeait moi, mon fils, notre foyer, Elle ne me touchait plus. Dès fois, elle restait en jeune pendant des jours et ne cuisinait que des légumes et ma vie était devenu un calvaire. J'ai commencé à la frapper de nouveau. Elle avait à plusieurs reprises tenté de me faire entrer dans cette secte. Une fois je lui ai cassé la figure devant son pasteur.

J'étais devenu malgré moi le bourreau dans sa vie. Mais finalement, l'amour de Selma a guéri la violence en moi. Malgré le fait que j'étais son bourreau, elle m'a pardonné et aujourd'hui on est ensemble et on va dans la même église. Je regrette mes comportements du passé. Ma femme a toujours des cicatrices qui me rappelle les violences physiques, y compris sexuelles qu'elle a enduré pendant des décennies. J'aurai certainement été en prison de longues années si ma femme m'avait dénoncé. Elle a choisi le silence et le pardon. Son comportement, sa foi en notre foyer a changé mon caractère et aujourd'hui on vit ensemble sans la moindre violence conjugale.

Je pense que j'étais un homme et mari frustré qui se défoulait sur ma femme parce qu'elle était faible physiquement. Je me sentais forte quand je lui cassé la figure. Je sentais une satisfaction entre moi mais j'étais qu'un pauvre imbécile. Un vrai homme ne frappe pas sa femme et j'ai décidé d'être un vrai et de rester un vrai. Mes bras ne servent qu'a réconforter ma femme et non la frapper. »

Gino met his wife Selma at age 19. Selma was still a minor. Being a jealous man, the relationship started with violence. Selma was beautiful and Gino got mad when a man would greet her. Gino became violent but she was submissive. After their wedding, things got worse. Gino lost all his money in gambling and beat his wife to get her money. Selma was admitted to hospital several times but never made an official complaint. After the birth of their first child Gino promised to change but the gambling got over and the life of Selma became painful. She was raped twice by Gino when she refused to have sex and over and above she was forced into sexual debauch. For a certain time Gino stopped being violent but when Selma started to go to a Church (called a sect) where she gave lots of money, tried to teach Gino and started doing religious observance by cooking only vegetables, Gina became furious and started with the violence. Selma forgave Gino who finally joined the Church. Gino would have been in prison long time ago but now they live happily together.

Community Factors

Community level influences are factors that increase risk based on individual experiences and relationships with community and social environments such as schools, workplaces, and neighbourhoods.

Attitudes towards gender relations

Previous research has shown that social norms that legitimise male dominance are key drivers of GBV. This study explored the personal attitudes of women and men and their perceptions of their communities' attitudes towards gender relations.

"...their husbands were abusive alcoholics who took advice from their families regarding their relationships. The husbands were also unable to fend for their wives... "

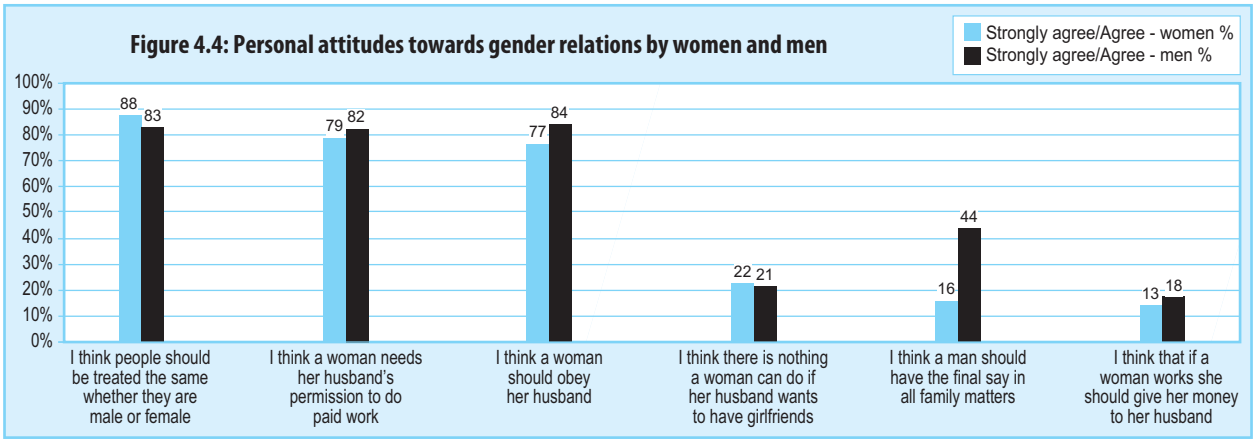


Figure 4.4 shows that women are generally more progressive than men in terms of gender relations in the home. A high proportion of women (88%) agreed that women and men should be treated equally. Eighty-three percent of men agreed to this. A lower proportion of women (16%) agreed that men should have the final say in family matters while 44% of men agreed to this. Thirteen percent of women agreed that women should hand over their wages to their spouses while 18% of men agreed to this.

Although women appear more progressive than men, they also displayed conservative gender attitudes. Almost four in five (77%) of women agreed that women should obey their husbands while 79% agreed that women should get permission from spouses to pursue paid work.

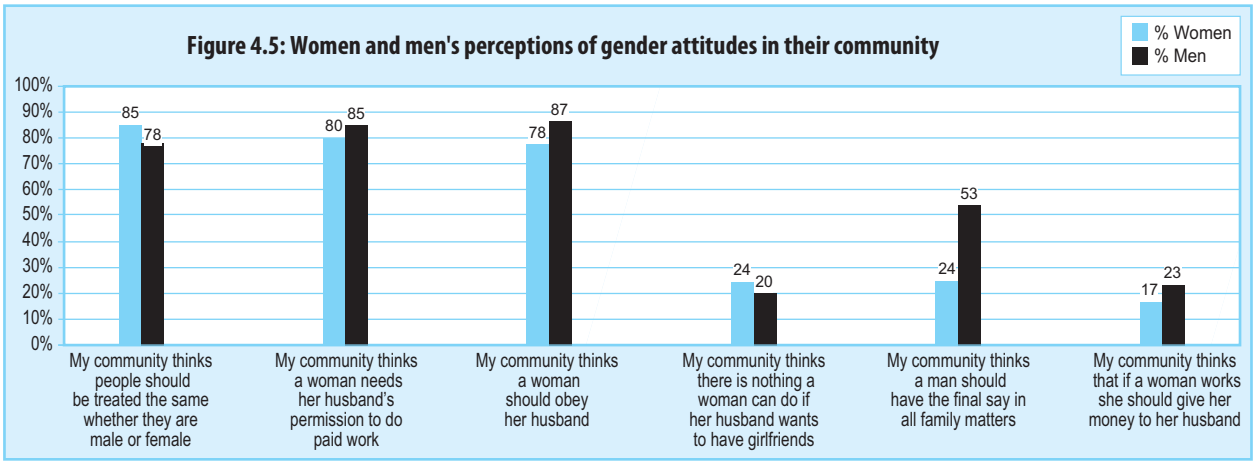


Figure 4.5 shows that generally both men and women feel that their communities have conservative attitudes towards gender relations. Interestingly, women perceived their communities as being more progressive than the men. Eighty-five percent of women agreed that their community believed that people should be treated equally irrespective of sex while only 78% of men agreed to this.

In contrast a lower proportion of women than men thought that in their community a woman was expected to obey her husband or get his permission to assume paid work or if she was allowed to work to hand over her earnings. There is also a marked difference in the women and men's perceptions about community expectations for a man to have the final say. While only 24% of women agreed that they perceived such a norm in their community, 53% of men believed this to be the community attitude.

Sexual entitlement in marriage and legitimacy of violence

Sexual violence committed by men is rooted in societal norms that promote male sexual entitlement and limit women's options to refuse sexual advances. This is especially true when traditional norms regarding marriage demand women to be sexually available to their husbands. In this study, we explored personal and perceived attitudes around sexual entitlement.

Figure 4.6: Personal attitudes about sexual entitlement in marriage and legitimacy of violence by women and men

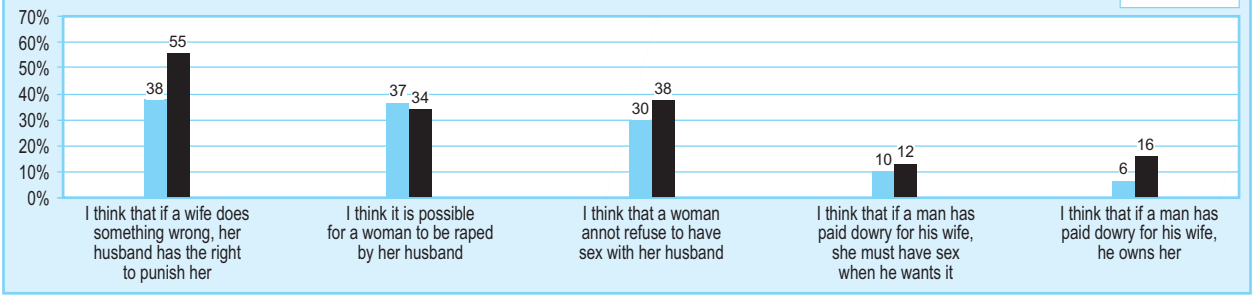


Figure 4.6 shows that overall there is a lower expectation among women and men for sexual entitlement to follow marriage. However, men revealed more conservative attitudes around sexual entitlement than women. Thirty-eight percent of men agreed that a woman cannot refuse her husband sex while thirty percent of women agreed to this. Twelve percent of men agreed that if a man pays dowry his wife should have sex whenever he wanted it while 10% of women agreed to this. Thirty-seven percent of women agreed that it was possible for a woman to be raped by her husband while 34% of men agreed to this.

Figure 4.7: Women and men's perceptions of community attitudes on sexual entitlement and legitimacy of violence

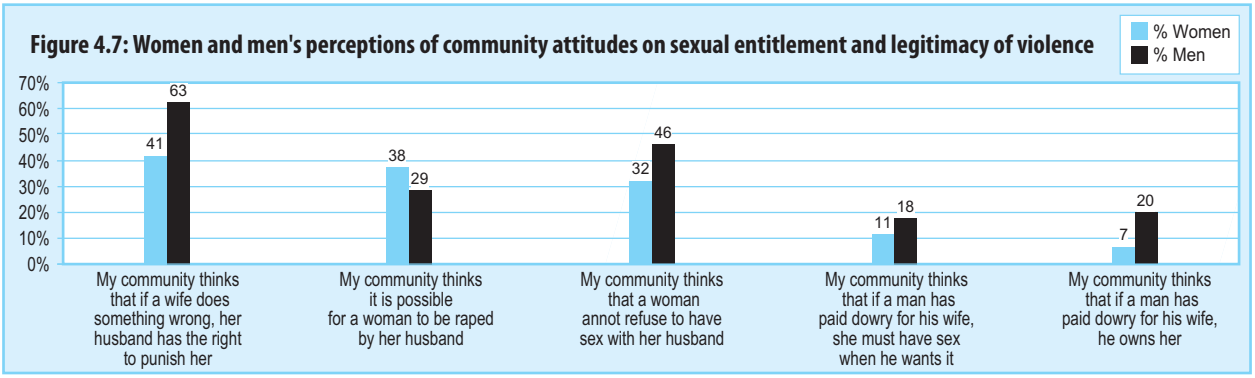


Figure 4.7 shows that a significantly greater proportion of women perceived their community to be more progressive than men. While a marginal 7% of women affirmed that the community agreed to the notion of wife ownership to accompany marriage, 20% men thought their community expected a woman to become her husband's belonging.

Similarly, 32% of women felt that communities believed a woman could not refuse her husband sex compared to 46% of men. These findings show that while the participants did not perceive their communities to view a wife as a husband's belonging, they perceived communities to expect sexual entitlement in marriage.

Both women and men perceived that their communities legitimised violence in relationships as a means of ensuring male control. Forty one percent of women and 63% of men believed that the community expected a wife to be punished by her husband for wrongdoing.

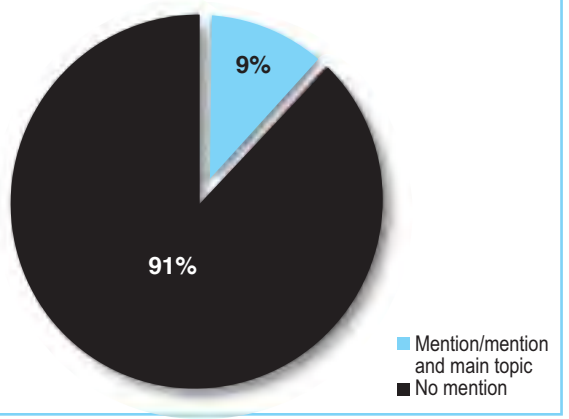
Societal factors

The political environment

The ecological model recognises the importance of societal factors in reinforcing or challenging gender stereotypes that create a supportive environment for GBV survivors. An analysis of 266 available speeches obtained through Hansards, Library of the Legislative Assembly, websites of political parties and the media show that only rarely do politicians do not refer to GBV in their speeches.

Figure 4.8 shows that only 23 (9%) of all speeches analysed referred to GBV. Of these speeches however most of them made a mere passing reference to GBV without addressing the issue in depth or holistically. Seventy eight per cent of speeches merely mentioned GBV while 22% of speeches had GBV as a main topic.

Figure 4.8: Reference to GBV by political leaders



An example of a speech with GBV as the main topic is Gender Minister's Martin's speech to the CEDAW Committee.

Mauritius Prime Minister, Navi Ramgoolam. *Photo by Colleen Lowe Morna*

"The Government of Mauritius is also fully committed to strengthen its legislative framework. Amendments have thus been brought to the Protection from Domestic Violence Act that is the PDVA in 2007 and 2011 respectively. Amendments provide for a substantial increase in the penalty for an offender on a first, second or subsequent conviction.

Concurrently, the 2007 Amendment in the PDVA also makes provision whereby District Court can make orders for payment of alimony to an aggrieved spouse or to a child of the parties at the same time

as an Order for Protection is made on such terms and conditions as the Court thinks fit.

The 2007 Amendment allows for referral of cases to my Ministry for psychological counselling in exceptional cases. The PDVA has recently been proclaimed as rules to enable Magistrates at District Court level to handle cases of domestic violence in a standard manner have been finalized by the Rules Committee of the Supreme Court.

Madam Chairperson, I am pleased to inform the Committee that our actions to address the issue of violence are now geared towards gender sensitive policies. We shall, in the context of International Day Against Violence Against Women in November 2011, set up a National Platform on GBV involving all stakeholders. In addition, my Ministry will shortly launch the Africa UNite Campaign to end violence against women."

This study further explored the forms of GBV referred to in speeches.

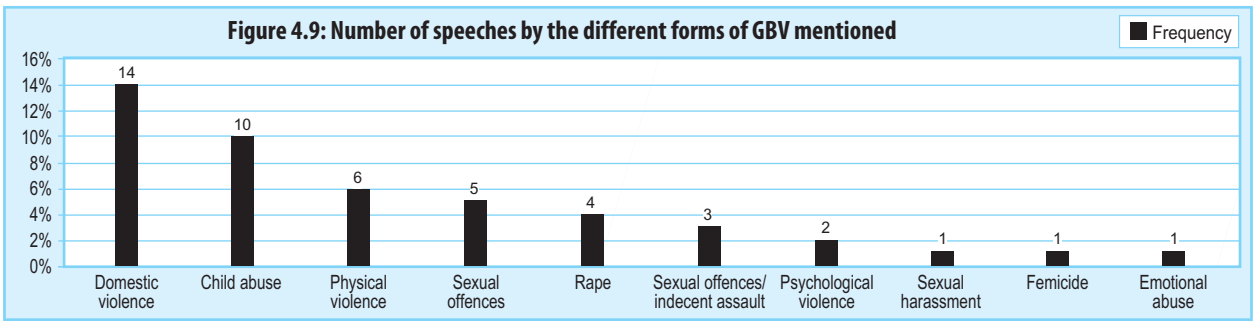


Figure 4.9 shows that the form of GBV that politicians referred to most is domestic violence; followed by child abuse. Despite being the highest form of violence in the study, emotional violence is the least commonly referred to form of GBV by politicians. These findings indicate a degree of awareness by politicians of the different forms of GBV and their manifestations. More reference to partner violence as compared to non-partner violence could be corroborated with the higher prevalence of IPV recorded through the survey compared to the prevalence of non-partner violence. However, the least reference to emotional violence shows that this form of violence, which is most prevalent, is given the least attention even by politicians.

Framing GBV

The context in which violence is framed is closely related to particular ideas of how that violence should be addressed. All speeches were analysed to explore how GBV was framed.

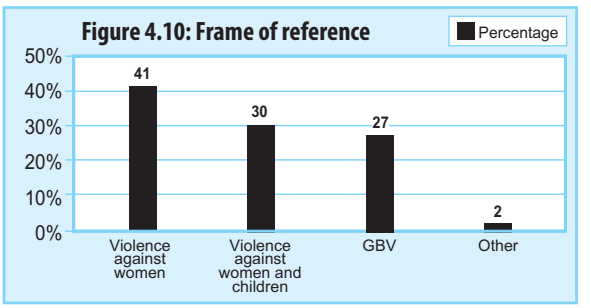


Figure 4.10 shows that most of the speeches (41%) referred to violence against women. Thirty per cent of speeches referred to violence against women and children while 27% of speeches referred to GBV. This shows that although there is primary focus to violence

against women there is a tendency for politicians to subsume VAW and child abuse into one. This is reflected in the structuring of government where one ministry, the Ministry of Gender Equality, Child Protection and Family Welfare is mandated to drive both the women's and children's issues.

Reference to extent of GBV in speeches

Figure 4.11: Reference to extent of GBV

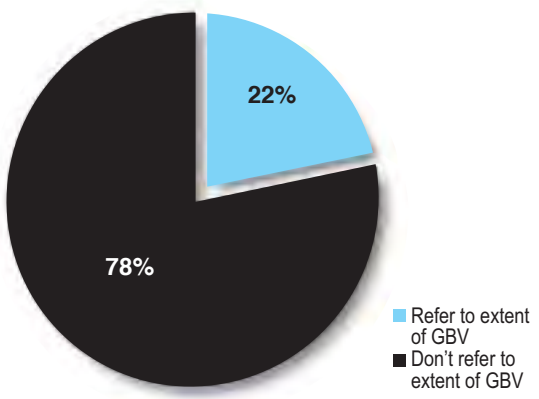


Figure 4.11 shows that although speeches referred to the various forms of GBV, few of the speeches referred to the extent of GBV neither was this extent substantiated by evidence. It is not enough for politicians to refer to forms of GBV without referring to the extent of the problem. Reference to the extent of the problem is critical in identifying issues requiring programme prioritisation.

Reference to causes of GBV by politicians

Speeches were analysed to determine the proportion that referred to causes of GBV.

Figure 4.12: Reference to causes of GBV in speeches

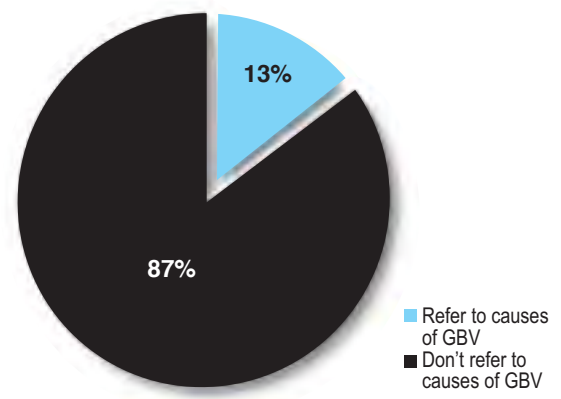


Figure 4.12 shows that the majority of GBV speeches (87%) do not refer to any causes of GBV. This is indicative that politicians either do not have conceptual clarity to the causes of GBV in their society or that they are failing to delve more deeply into the issues.

Former Ombudsperson for Children, Shirin Aumeeruddy-Cziffra, talking on violence during 16 Days campaign. *Photo by Gender Links*

Cedric Lecordier, Melissa Seebaluck and Corinne Maunick at a GBV workshop for the Media held at Le Mauricien ltd. *Photo by Mary Jane Piang-Nee*

The Gender and Media Progress Study in 2012 followed the Gender and Media Baseline (GMBS). It sought to compare and benchmark the performance of media in SADC countries. The key findings of the GMPS research on the coverage of GBV in Mauritius include:

- GBV and stories that mentioned GBV accounted for 2% of coverage. GBV is a major problem in Mauritius and Mauritians count on the media for accurate news with statistics. The percentage is low as there were not many cases of GBV during this period except for a major one on horrific violence, rape and femicide.
- Even though GBV primarily affects women, men constitute 63% of sources, compared to women (37%).
- Survivors of violence constituted 26% of sources, compared to a regional average of 19%.
- Eight per cent of stories covered by the Mauritian media were about femicide. This is higher than the regional average of 4%.
- Rape constitutes 19% of coverage in Mauritius compared to 11% in the SADC region.
- More men (56%) than women (44%) report on GBV.
- Few articles offer information on where to go for help.
- As elsewhere GBV in the region, GBV in Mauritius is often reported in sensationalist ways that trivialise the experiences of women. This leads to women fearing to speak out and suffering secondary victimisation at the hands of the media. The result is that the media is often more a part of the problem than of the solution when it comes to GBV.

COUR

Viol d'une mineure : une peine de 22 ans de prison maintenue

ILS jugeaient leur peine excessive. Jean Wins Legoffe et Jean Kersley Marie ont violé une mineure en présence de son petit ami en 2006. Condamnés à 22 ans de prison, les accusés avaient fait appel. Mais le *Full Bench* de la Cour suprême, composé du chef juge Bernard Sik Yuen et des juges Bushan Domah et Nirmala Devat, ont donné raison au juge de première instance en maintenant la sentence.

Au moment du délit, les deux violeurs étaient âgés de 19 ans. Accompagnés de deux autres complices, ils ont violé la fille en présence de son petit ami en les menaçant avec un couteau sous leur gorge. Cela s'est passé aux petites heures du matin sur la plage de Flic-en-Flac.

A tour de rôle

Les violeurs ont également fait main basse sur les bijoux, l'argent et les portables que possédait le couple. Les deux amoureux sortaient de discothèque et se prélassaient sur la plage lorsqu'ils ont été surpris par les quatre voyous.

C'est grâce à une caméra de réussi à mettre la main sur les accusés. Les deux accusés qui habitaient à Baie-du-Tombeau de nuit dans cette région.

L'enquête de la police a établi que les deux accusés et leurs que les quatre malfrats ont violé la jeune fille à tour de rôle.

L'accusé Marie était le premier cette dernière.

Cette sentence, disent le juges, servira de leçon aux autres

■ Jean Wins Legoffe et Jean Kersley Marie (à g.) ont violé une adolescente sous les yeux de son petit ami en 2006.

Article about the rape of a minor, and the perpetrators who were sentenced to 22 years in prison.
Clipping from L'express

Conclusion

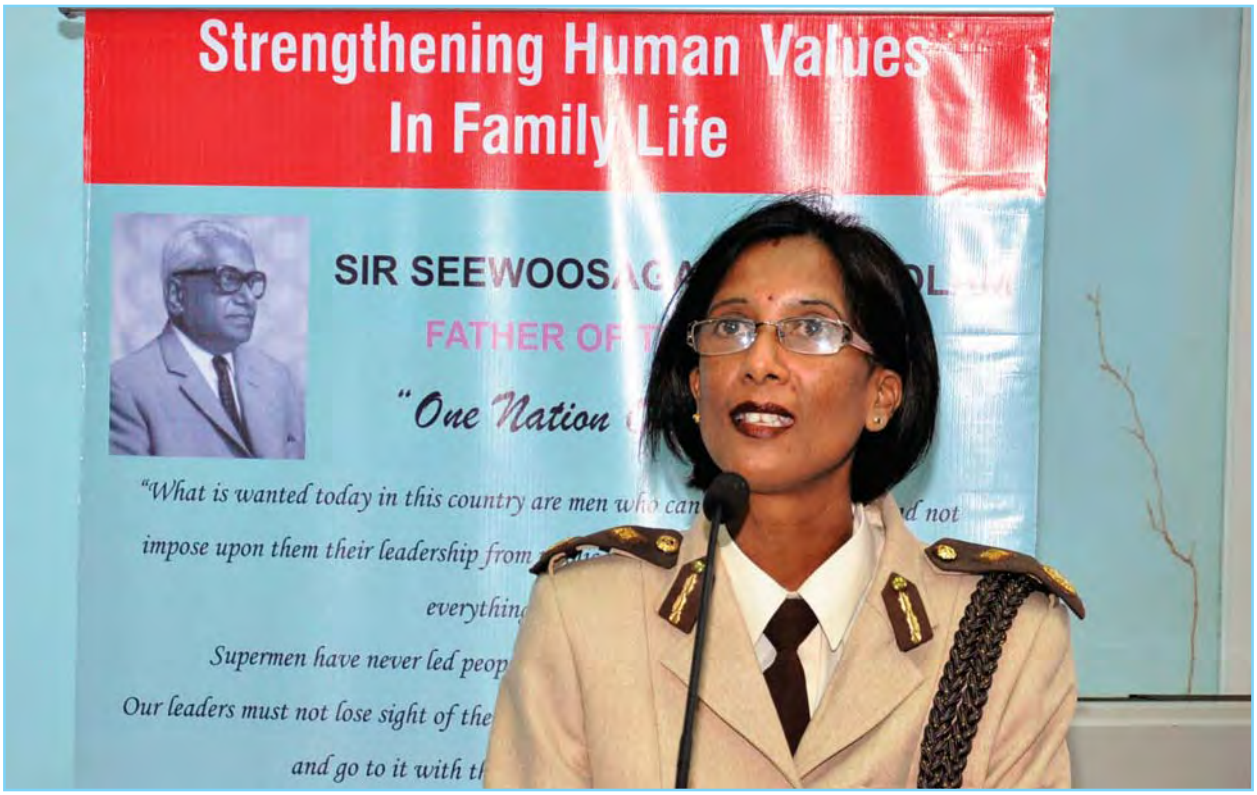
This chapter shows that there are individual and societal factors driving GBV in Mauritius. Age, education and employment status are socio-demographic associated with IPV experience and perpetration. Child abuse experience and alcohol consumption by men increases risk of adult IPV perpetration.

GBV is driven by conservative attitudes by women and men towards gender relations. However, women are exhibiting more progressive attitudes than their male counterparts. This disparity in which women appear to be more progressive than men may be the source of relationship conflict and cause for violence. In the CASR study perpetrators referred to "the emancipation of women who could not hold their traditional role but claimed their rights". A common statement associated with this was "Madam pe vine misier".

Despite the prevalence of GBV in Mauritian communities, politicians don't refer much to it as a key priority warranting attention in speeches. They also do not refer to the extent of GBV neither do they refer to statistics in a bid to problematize the issue. Politicians need to speak more and in depth about the extent of GBV in Mauritius.

The media needs to improve on gender sensitive coverage of GBV. More journalists should be trained on how to cover GBV, increase women's voices and how to extend the repertoire of topics that are currently being offered. Based on the findings in this chapter the media should become more active in the fight against GBV by developing productions that challenge societal norms and aim to at change gender attitudes.

CHAPTER 5
Effects of violence



Talk on Human Values : Maya Aubeeluck, Assistant Commissioner of Mauritius Prisons. *Photo courtesy Mauritius Prisons*

Key facts

- ✓ Survivors of GBV in Mauritius suffer a range of effects including physical injury, hospitalisation, death, miscarriages, pregnancy complications, loss of days from work, STI symptoms and out-of pocket expenses.
- ✓ About two in every five(39%) of physically abused women suffered injury.
- ✓ Over two fifths (41%) of the injured women had serious injuries and were bedridden as a result.
- ✓ Half (50%) of the injured women had to take days off work because of the injuries.
- ✓ Two thirds (66.7%) of women that experienced IPV in a lifetime were diagnosed with an STI.
- ✓ Experience of IPV was associated with ever having an ulcer or abnormal vaginal discharge.
- ✓ The majority of women (93%) of women in the study have never tested for HIV.
- ✓ One in every six (16%) of women who experienced IPV in lifetime attempted suicide.
- ✓ About a tenth (9%) of women who experienced IPV in the 12 months to the survey had suicidal thoughts in the four weeks before the survey.
- ✓ Over a quarter (27%) of women who experienced IPV in the 12 months before the survey had depressive symptoms.

"I was only nine years old when my father started having sexual relationship with me. I really cannot explain how it all started but there was no violence and he did not force me.

This lasted for nearly four years. I cannot explain why I accepted and why he did it. May be I thought it was normal because he was my father. He was not violent and has never taken out my clothes by force.

Nobody knew about this until one day while I was cleaning the house I could feel my cousin staring at me. She could not take her eyes off me. I started to question her and she said that she saw that there was something inside my belly. I was taken aback and said there was nothing under my dress. She insisted that she saw something and came closer to me to touch my stomach. We were both horrified to learn that indeed there was something. She immediately told my mother and my uncle who then accompanied us to the doctor. The doctor confirmed that I was six months pregnant.

I attended antenatal visits at the hospital and the baby was born by caesarean. I stayed in hospital for a few days while the Child Protection Unit investigated my case. After my stay in hospital instead of returning home, I was sent to the shelter with my baby. I was told that my father went to prison because he should not have had sex with me."

Mary* is still living in the shelter where she is happy and her baby is well looked after. She takes part in all activities of the shelter and there is a good environment. The problem will arise when she has to live on her own with her baby after leaving the shelter. The effect of bearing a child of her father, and facing society, will certainly have a psychological effect on her. The shelter will need to give her all their support even after she leaves the shelter.

GBV can have a continuum of effects that affect the health and well-being of survivors and their families as illustrated by Mary's story. She had an unplanned pregnancy at a tender age as a result of incest and had to leave home to stay in a shelter after her baby's birth.

According to those responsible in the shelter, Mary is so well surrounded and participates in all the activities of the shelter. She does not show any sign of distress. She looks happy and her baby is well looked after.

This chapter covers the effects of GBV on women participating in this study. The women's questionnaire covered a range of indicators about their health, including contraceptive use, condom use, HIV testing and results, sexually transmitted infections, and aspects of their mental health.

Physical Injuries

The effects of physical abuse include death; permanent disability such as blindness, deafness, seizures, loss of mobility; hospitalisation for broken bones, concussion, head and spinal injuries; gynaecological problems including losing an unborn baby, or birth defects; infertility; treatment for broken teeth, cuts, headaches; and bruises, pain, trauma. Women who participated in the survey were asked about the injuries they sustained because of physical abuse.

Table 5.1: Prevalence, frequency and severity of injuries by physically abused women	
Criteria	
Percentage of physically abused women who suffered injuries	38.7%
Average number of times injured	6
Percentage of physically abused women who spend days in bed because of injuries	41.7%
Average number of days in bed	9
Percentage of physically abused women who took days off work because of injury	50%
Average number of days off work	7

Table 5.1 shows that 39% of women who were physically abused sustained injuries on about an average of six counts. Forty-two percent of the injured women had to stay in bed for an average number of nine days. Half of the women (50%) had to lose about seven days on average from work because of sustained injuries. Christelle's story of how her father battered her mother to death, told from a shelter for abused children at the time of the research, is a stark reminder of the extreme injuries that often come with GBV.

A teenager's advice - do not suffer in silence

"I am Christelle and I am 17 years old. My sister is 12 years and my brother is 9 years old. We have lived in a centre for abused and vulnerable children in Mauritius, for three years now.

Since I was six or seven years old, I saw my father beating my mother almost every day until the day he killed her.

As I grew up, it was hard for me to witness the suffering endured by my mother and I stood up for her against my father. My father became very violent towards me. I was often hurt and had bruises all over my body. Once he fractured my arm. My mother accompanied me to the hospital, but did not disclose anything. She told the nurse that I hurt myself whilst playing. On another occasion when my father hurt me she said that I fell down from a tree.

When the doctor started questioning my mother, she denied the fact that I was a battered child. After that, my mother stopped taking me to the hospital and I suffered in silence without medical assistance.

I could not go to school regularly. I felt sad and anxious to leave my mother alone at home with my father. I could not study. I could not do my homework. My teacher was not aware of my family problems and scolded me.

When my brother was 2 months old, my father cut my mother's hand and she stayed in hospital for some time. I took charge of the household, my sister and brother.

The situation worsened when my mother returned. Every day they both drank and quarrelled. It always ended in violence. My father threw things and once tried to strangle my mother with an electric wire.

When my mother ran away at night, I always took my sister and little brother with me. Sometimes I left them with my neighbour, and in the dark, I went to look for my mother.

It was a Wednesday evening; both my mother and father were drunk. In the middle of the night, I got up hearing my mother screaming and my sister crying. I saw my mother lying on the floor and my dad kicking her in the stomach. I tried to remove my mother, and was angry with my father. He gave me a slap. When he heard my sister and brother crying, he went outside.

I saw blood coming from my mother's mouth. I tried to clean it. What I can still remember is that my mother wanted to speak to me but the words she uttered were not clear. When my father came inside, he asked me to help him to place my mother on the bed, which I did. He then asked us to go to bed.

At about six o'clock in the morning, my father came to my room and told me that my mother did not want to wake up. I talked to her but she did not respond. I thought she was pretending not to hear us. When my father left to look for his mother, I told my mother not to be afraid as my father was out, but she still did not answer.

My grandmother came and, as she touched my mother, she told us that she had passed away. We all started crying and the neighbours came. My mother's relatives came with police officers who took my father to the police station. The post-mortem examination confirmed that my father battered my mother to death."

Sexual and reproductive health

The effects of GBV may include pregnancy, miscarriage, inability to negotiate condom use during sex, sexually transmitted infections including HIV, and pregnancy-related problems. In the introduction to this chapter, Mary* spoke of her teenage pregnancy that was a result of rape by her father.

Sexually transmitted infections

Women were asked about their experiences of sexually transmitted infections in a lifetime. They were questioned whether they had had an ulcer on the vagina, whether they had had a discoloured, smelly, itchy or uncomfortable discharge from the vagina and whether they had ever been told by a health worker that they had an STI.

Table 5.2 shows that symptoms associated with IPV in lifetime include ulceration on the vagina and abnormal discharge. All the women that suffered from ulceration twice and from vaginal discharge on three or more occasions were also survivors of IPV.

HIV /AIDS

Previous research in different settings has shown positive association between GBV and HIV. This study did not test participants for HIV but they were asked whether they had tested for HIV and what result they obtained.

Table 5.2: Symptoms of sexually transmitted infections by women		
Symptoms	**% women survivors experiencing IPV**	**Chi (p)**
Ulcer on Vagina		
Never	25.6	0.03
Once	66.7	
Twice	100	
Vaginal discharge		
Never	21.9	0.00
Once	53.9	
Twice	90	
Three or more times	100	
STI diagnosed by health worker		
Never	25.4	0.1
Yes	66.7	

Table 5.3: HIV testing and results		
When did you last have an HIV test	**Number of women**	**% Women**
Never tested	479	93.4
Last 12months	7	1.4
2-5years ago	12	2.3
More than 5 years ago	14	2.7
Total	**513**	**100**

Table 5.3 shows that the majority (93%) of women had never tested for HIV. All of the women that tested and collected their results were HIV negative. This study is therefore limited in investigating the link between GBV and HIV/ AIDS. The findings are consistent with the National Secretariat's Global AIDS Response report for 2012 in that they still highlight challenge to addressing HIV, which is that the majority of participants have never tested.

Candle lighting ceremony on World AIDS Day in Mauritius. *Photo by Gender Links*

Government is putting new strategies in place to reach a maximum number of people and encourage them to come for testing.

However, some survivors of sexual violence like Helene not only contract HIV but have to bear discriminatory treatment from hospitals.

« Après avoir connu l'enfer de la drogue, j'ai dû subir les foudres d'un mari violent qui me frappait sans raison. Seule et impuissante face à mon bourreau, je ne pouvais rien faire d'autre que de me soumettre, ne serais-ce que pour ne pas me retrouver à la rue.

J'étais enceinte et en me rendant à l'hôpital, je ne me doutais pas une seule seconde ce jour-là qu'une nouvelle aussi terrible me tomberait dessus. Je croyais m'y rendre pour un simple suivi médical. Malgré tout le tact dont a fait preuve le personnel soignant pour m'annoncer la chose, je n'arrivais pas à croire que j'étais séropositive. « Ayo, pa mwa. Non pa mwa. Pa mo premie zanfan. » Il y avait forcément erreur sur la personne. Au pire, c'était un faux résultat et il fallait refaire le test, une, deux ou trois fois. Mais je ne pouvais nier l'évidence : j'étais séropositive.

J'ai pris beaucoup de temps à me faire à cette idée. Cependant, tout espoir n'était pas perdu. On était en 1998, année où les antirétroviraux ont été gratuitement offerts aux personnes vivant avec le virus. J'ai d'ailleurs fait partie des tous premiers malades à bénéficier du traitement. Au cours de la même année, un autre médicament est venu m'apporter le sourire. Celui-ci avait la propriété de diminuer considérablement les risques de transmission du virus de la mère à l'enfant qui allait naître. La chance a fini par tourner en ma faveur.

Mais j'avais un autre ennemi à affronter: L'ignorance. Celle des infirmières qui croyaient, malgré leur formation, que le VIH/SIDA est une maladie contagieuse. Pour suivre ma grossesse de près, j'ai été placée dans une chambre d'isolation. Avec une interdiction formelle de quitter le lit et de ne pas parler aux autres occupantes des lieux. Bref, des consignes démoralisantes. Mon seul soutien est venu d'une travailleuse sociale exemplaire, qui m'a convaincue de rester dans ma 'prison'. C'était l'unique précaution pour ne pas attraper des maladies opportunistes pouvant mettre ma vie et celle de mon bébé en danger. C'est également cette bonne samaritaine qui a multiplié les démarches pour m'obtenir du lait, parfois même clandestinement, en prévision de la venue de mon petit garçon, qui s'est révélé, Dieu merci, séronégatif.

Après un bref moment d'accalmie dans mon couple, je suis encore tombée enceinte l'année suivante. Malgré ma séropositivité, j'ai donné naissance à une petite fille en bonne santé. Néanmoins, peu de temps après sa naissance, j'ai de nouveau subi les crises de violence de mon incorrigible mari. Celui-ci a été jusqu'à oser frapper nos enfants.

Ne pouvant plus prendre mon mal en patience, j'ai décidé de quitter le toit conjugal avec mes deux enfants. Quitte à aller louer une maison à n'importe quel prix, du moment que j'avais la tranquillité d'esprit et que mes enfants y étaient en sécurité. Les années ont passé. L'envie de me sentir aimée par un homme a refait surface. Un jour en rencontrant Jacqueline, une amie, je lui ai fait part en plaisantant, de mon intention de refaire ma vie avec un type bien. J'étais loin de

me douter que cette dernière avait pris mon souhait au sérieux.

Après quelques semaines, Jacqueline a insisté pour que je vienne passer le week-end chez elle. Devant pareille insistance, j'ai accepté l'offre. En arrivant chez elle, elle m'a présenté à Robert, le meilleur ami de son mari, qui est apprenti maçon. Pour briser la glace, nous avons bu de l'alcool. C'est connu que l'alcool aide à délier les langues et à faire tomber les inhibitions. Nous n'avons pas mis longtemps à devenir intimes. Sous l'effet de l'alcool, je n'ai hélas pas eu le temps d'avouer ma séropositivité à Robert. Ni ce jour-là, ni les autres jours où nous nous sommes rencontrés pour faire l'amour.

Je vivais un dilemme. Fallait-il dire à Robert que j'étais séropositive, quitte à perdre son amour parce que je ne lui avais rien dit la première fois ou se taire ? Que faire ? Il ne se passait pas un jour, sans que cette interrogation ne me vienne en tête. Il fallait faire un choix entre la vérité et le mensonge. J'ai opté pour la vérité et ses conséquences. J'ai cru qu'il n'allait jamais me le pardonner. J'ai pris mon courage à deux mains et j'ai avoué à Robert que j'étais séropositive et qu'il y avait de grands risques que je lui ai transmis le virus lors de nos ébats. Je l'ai supplié de me quitter. Mais j'avais sous-estimé l'ampleur de l'amour qu'il me portait. Il n'a fait que me dire: « Je t'aime. Et ce n'est pas le VIH/SIDA qui m'empêchera de continuer à t'aimer. Tu es la femme de ma vie. Ma vie, je souhaite d'ailleurs la partager avec toi. »

C'était incompréhensible. Cela paraissait trop beau pour être vrai. Et pourtant, c'est ce qu'a fait Robert. Il a quitté sa famille pour venir vivre avec moi et mes enfants.

Aujourd'hui, cela fait trois ans que nous sommes ensemble. Trois ans depuis que Robert se lève chaque matin pour aller trouver de quoi nous nourrir. Il considère mes enfants comme les siens. D'ailleurs, ces derniers le lui rendent bien. Ils l'appellent papa et aiment profondément cet homme qui les a arrachés à un père biologique violent et égoïste. Avec Robert, la vie a repris toutes ses couleurs. Séropositif comme moi, Robert ne compte pas en parler à quiconque. Comme moi d'ailleurs. Aucun membre de nos familles n'est au courant. Nous voulons protéger notre couple et surtout les enfants des ragots qui pourraient affecter leurs études, leur vie.

Comme dans tout couple, nous connaissons des hauts et des bas. Mais l'amour est toujours là. Nous voulons que les enfants grandissent et fassent leur avenir. Plus tard, quand ils seront en âge de comprendre, nous leur avouerons notre maladie. Je suis heureuse, enfin, grâce à Robert, l'homme qui a accepté de partager ma vie malgré ma maladie.

Helene* talked about her traumatic experience with her husband as a result of the underworld of drugs. While pregnant and in hospital, she found out that she was HIV positive. She was among the first persons to get access to free ARV. She also got treatment so that her baby was not contaminated. But she faced the stigmatisation of being put in separate room as even the nurses pronounced HIV and AIDS to be contagious. A social worker gave her support.

She became pregnant again and gave birth to a girl in good health and not contaminated. The violence started and the husband even struck the children. Helene decided to leave her violent husband with her children. One day she met her friend Jacqueline who invited her to spend the week end at her place.

She was introduced to Jacqueline's husband best friend, Robert. They both had a couple of drinks and became intimate. She faced a dilemma over whether or not to tell and was afraid of losing Robert by telling him of her status. She finally decided to tell him the truth. It was then that Helene realised the depth of this relationship when Robert told her “I love you and it is not your HIV status that will prevent me from loving you. You are the woman of my life”.

Pregnancy complications

Minita* spoke of how she lost her baby after physical abuse by her partner.

> "The series of lies by my husband were soon followed by all sorts of ordeals. I became pregnant but was beaten so badly that I lost my baby girl in hospital. After seven years of ill-treatment, I nevertheless gave birth to a boy."

Veronique* also spoke of how her husband's physical abuse could be the reason of her children's poor development.e of how she lost her baby after physical abuse by her partner.

> "I made several trips to the hospital, hoping that my husband would change and that things would become as they were, before sinking into alcoholism. However, when I was pregnant with our third child he started to beat me again. I was six months pregnant and my husband showed no sign of paternal responsibility. I regret the sad fate of my children whose development is retarded."

Christine* added:

> "When we split, he laughed. He came back after 15 days and started to beat me again. He hit me so hard once that I could not go to work for three days. Even my boss was aware of my plight. My son grew up with psychomotor problems, probably caused by the difficult family situation, and had stuttering problems. He now goes to a special educational needs school called SENS and I have done everything on my own for my son to get admission there."

Poor mental health

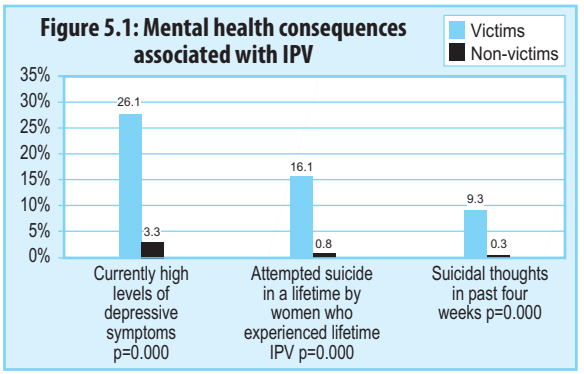


Figure 5.1 shows that experience of IPV is associated with mental health problems. Women who experienced IPV in the 12 months to the survey were significantly more likely to have depressive symptoms and suicidal thoughts in the four weeks before the survey. Twenty seven percent of women who experienced IPV in the 12 months before the survey had depressive symptoms. Almost a tenth (9%) of these women had suicidal thoughts in the four weeks to the survey.

Experience of IPV in lifetime was significantly associated with attempted suicide. Sixteen percent of women who experienced IPV in lifetime also attempted suicide.

Stigma and secondary victimisation

Communities often blame rape survivors for contributing to their unfortunate victimisation by giving reasons such as that survivors are promiscuous or seduce their perpetrators. Women and men participating in the survey responded to questions about their personal views of rape survivors as well as their communities' views.

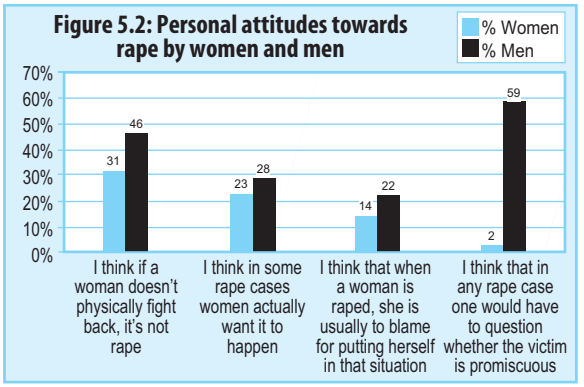


Figure 5.2 shows that a higher proportion of men than women showed negative attitudes towards rape survivors. Over half (59%) of men agreed that in any rape case the victim has to be questioned for promiscuity while only a marginal 1.6% of women agreed to this. Over a quarter (28%) of men agreed that in some rape cases women wanted it to happen while 23% of women agreed to this. Almost half the men (46%) said that if a woman did not fight back then it is not rape, compared to one third of women (31%). Over a fifth (22%) of men said that if a woman is raped, she is to be blamed for putting herself in that situation compared to 14% women.

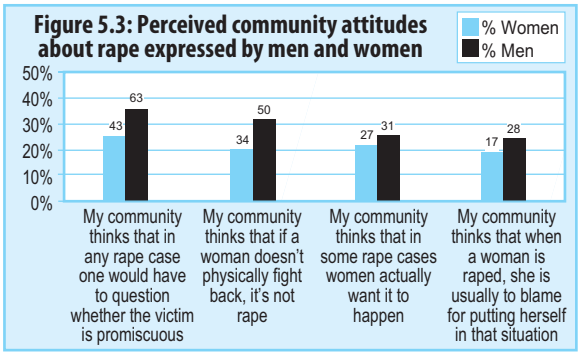


Figure 5.3 shows that women generally perceived their communities to have more progressive attitudes towards rape survivors than men. Forty three percent of women compared to 63% of men said that their community associated rape with promiscuity. About a third of women compared to half of men perceived that in their community when a woman did not physically fight back, then it was not rape. Seventeen percent of women and 28% of men perceived that their communities blamed the rape survivors.

Overall, the personal and perceived community views of the participants in this study reflect a high degree of stigma against rape survivors. Fear of stigmatisation is a common reason for non-disclosure of rape. These findings point to the importance of GBV programmes aimed at reducing secondary victimisation and changing negative attitudes so that communities are more supportive towards survivors.

Out of pocket expenses

Women who suffer from the effects of abuse such as injury, hospitalisation, STIs, depression or any other health problem also encounter costs associated with reporting the incident or seeking out care. While no women in the survey said they encountered out of pocket expenses women who told their stories alluded to this.

For example, Sunita* had to pay for her husband's rehabilitation:

> "God knows how I tried everything I could possibly think of to help him out. First I sent him to the psychiatric hospital and where he attended the inpatient rehabilitation program. Then he started an outpatient treatment with the hospital. However, as soon as he is out the first thing he comes looking for is drugs."

Costs of leaving

At times women suffer financial or material loss when they decide to leave an abusive relationship. This fear of loss may also result in women staying in abusive relationships.

For example, in her story Sunita* related:

"Whenever the situation runs out of control, my husband becomes violent. In these cases, I have no other choice than to leave the house and run away with my children. Recently, my son came to my rescue while I was getting beaten. My husband seized the harpoon and tried to harm him. Fortunately, although the harpon pierced my son's T-Shirt, he was not hurt. He could have been badly injured. He could have died.

How can I leave this man when I have no other place to go? I managed to build us a small shelter made of iron sheet, on my own, and I cannot leave this place.

Fortunately, I was able to get a job at a woman's place where I take care of the household chores. But who do you think would leave her house in the hands of an HIV positive drug addict. All I want is this big weight lifted off my shoulders but I have no other choice than to be patient as I hope for a better day to dawn soon."

Other non-financial costs of leaving are family disintegration. Anita*, who at one time left an abusive relationship to live in a shelter related:

"What's wrong with me? Why should I keep on living in an abusive relationship? The glimpse of light that I see at the end of this long dark tunnel is my children.

I am still not sure what will become of me. And yet I am trying to cope because of my children. I hope that one day they will take care of me and I will no longer have to live in this abusive relationship. After so many years of domestic violence, I still cannot leave my husband. I have tried. I have even reported him to the police a few times. I have stayed in a shelter but was not strong enough to resist when he asked me to return home with him.

I am telling my story in the hope that the hundreds of women who are suffering like me do not make my mistake. I get the impression that the fault lies in me. The shelter I went to did everything for me and I will always be grateful. I got all the support that a victim could get and yet I am now back at square one."

Anita left her husband several times but he would always go back to her begging to return and insisting that he will change. In November 2010, she decided to separate for good because she went through too much humiliation, even having to beg him in order to go out. But she was not working and could not put her children's education at stake. In her house, Anita lived a life of imprisonment and terror.

Costs to the economy

Responding to GBV has financial implications on the economy because it requires a substantial amount of financial resources to be allocated to programmes targeted at survivors. A study by the CASR entitled "The extent, nature and cost of domestic violence in Mauritius", revealed that domestic violence for the period 2008-2009 amounted to Rs1.4 billion. If the GBV programme thrust shifted from response to prevention, the resources allocated towards these social costs could be allocated to other economic endeavours with positive outcomes.

"...domestic violence for the period 2008-2009 amounted to Rs1.4 billion."

Costing domestic violence by the CASR MRC study of 2008-2009

The operational framework used by the MRC to cost domestic violence from 2008-2009 was based the economic costs of domestic violence into the direct and indirect costs. The main direct economic costs are costs incurred by victims and by organisations which provide services to victims of domestic violence such as police, health, Government Ministries, and non-Government institutions. The indirect economic costs are economic output loss based on lower performance and absenteeism, and loss of household chores. Only costs which fall within duration of 12 months were taken into account. Thus, absenteeism and lower performance at work, loss of household chores were taken into account while the long term effect of loss in employment, child development and other effects which span over more than 12 months were not included within the scope of the study.

The findings of the CASR study showed that direct cost to male and female victims of domestic violence from 2008-2009 amounted to approximately Rs221million; indirect costs to the economy and society, in terms of low productivity at work, loss of household chores and absence from work, amounting to Rs988million; and direct cost incurred by service providers, nearing Rs196million. The total cost of domestic violence was estimated at Rs1.4billion. The majority of costs were those incurred by the women victims.

Table 5.4: Summary breakdown of costs

Parameter	Cost in Rs	% of total costs
Total direct costs to women victims	213, 924, 000	15.2%
Total direct costs to men victims	7, 935, 000	0.6%
Total indirect costs by women victims	812 , 850, 441	57.8%
Total indirect costs to men victims	175, 687, 559	12.5%
Total direct costs incurred by service providers	196, 104, 000	13.9%
Total costs of domestic violence	**1,406,501,000**	**100%**

Source: CASR study report 2010.

Table 5.4 shows that women victims incurred 73% of costs while men victims incurred 13% of costs. Macro-economic service provider response contributed 14% of total costs.

Direct costs

Table 5.5: Summary breakdown of direct costs incurred by women victims

Parameter	Rs	% of total costs incurred by women victims
Seeking assistance from social network (parents, friends, colleagues, etc)	20, 164, 000	9.4%
Seeking assistance from the Police Family Protection Unit	975, 000	0.5%
Seeking assistance from the Ministry of Women	1, 457, 000	0.7%
Seeking assistance from SOS Femmes	150, 000	1.9%
Seeking medical care	191, 178, 000	89.4%
Total direct costs to women victims	**213, 924, 000**	**100.0%**

Source: CASR study report 2010.

Table 5.5 shows that the majority of costs incurred by women victims relate to seeking medical care. Medical costs account for 89% of total direct costs incurred by women victims.

Table 5.6: Summary breakdown of medical costs incurred by women victims		
Parameter	**Cost in Rs**	**% of medical costs incurred by victims**
Medication and pharmaceutical products	111, 174, 000	58.2%
Visiting private doctors	35, 829, 000	18.7%
Visiting clinics	27, 000, 000	14.1%
Medical (social workers and hospitals)	17, 175, 000	9.0%
Total direct costs to women victims	**191, 178, 000**	**100.0%**

Source: CASR study report 2010.

Table 5.6 shows that 58% of medical costs included the purchasing of medication and pharmaceutical products. The CASR study also deduced the costs associated with experience of different forms of domestic violence.

Table 5.7: Breakdown of medical costs by form of domestic violence experienced		
Medical costs by women victims per type of violence	**Cost in Rs**	**% of medical costs incurred by women victims**
Emotional	106, 267, 000	55.6%
Physical	46, 239, 000	24.2%
Sexual	38, 672, 000	20.2%
	191, 178, 000	**100%**

Source: CASR study report 2010.

Table 5.7 shows that 56% of medical costs were incurred by women victims of emotional domestic violence. These findings are indicative of the high burden of mental health problems associated with experience of emotional IPV shown earlier in this chapter. They also provide a basis for advocating for a more effective and coordinated public health sector response which places emphasis on the provision of mental health services.

Indirect costs

Indirect costs measured included lost resources and opportunities resulting from domestic violence particularly loss of productivity from paid and unpaid work and household chores as elaborated by Morrison and Orlando (2004).

The loss of productivity from household chores was calculated as follows: the total number of hours in activities related to household chores lost due to domestic violence (which is identified by responses from survey questions) multiplied by an imputed wage to yield a monetary estimate of lost earnings. This was further disaggregated by the different forms of violence experienced. The total hours lost were estimated at 12,016,856 hours and computed to an estimate of monetary loss of Rs817.5million for women and men victims. Women victims lost productivity worth Rs705, 7million which is 86% of total costs due to loss of productivity.

> "...total hours lost were estimated at 12,016,856 hours and computed to an estimate of monetary loss of Rs817.5million for women and men victims."

As shown earlier through the qualitative stories, victims of domestic violence lose time from their regular working activities due to injury and health problems. This implies that victims are unlikely to give maximum concentration at work and produce effectively.

Table 5.8: Summary disaggregation of indirect costs incurred by women victims	
Indirect cost of domestic violence to women victims per form of domestic violence	**Loss of economic outputs in Rs**
(a) Loss of productivity in household chores	
Emotional	578, 062, 000
Physical	48, 189, 000
Sexual	79, 473, 000
Subtotal	
(b) Loss of productivity at work	
Emotional	62, 890, 000
Physical	12, 080, 000
Sexual	16, 146, 000
Subtotal	
(c) Loss of economic output due to absenteeism	16, 010, 441
Total indirect costs by women victims	**812, 850, 441**

Source: CASR study report 2010.

Table 5.8 shows a summary of indirect costs incurred by women. Analysis of the costs incurred by form of violence still shows that the highest proportions of costs are associated with experience of emotional violence. Also, the highest indirect costs relate to loss of productivity at work.

Macro-economic direct costs

Direct costs include law enforcement, judicial, health, and social services which are provided to victims of domestic violence. Specific costs include police, legal and criminal justice, civil justice, and health costs, including medicines, social welfare assistance and others. The costing by the MRC included five institutions which provide direct support services to victims are identified in Mauritius: Ministry of Women, hospitals, Police Station, judiciary and Non-Governmental Organisations.

Table 5.9: Summary breakdown of macro-economic direct costs		
Parameter	**Cost in Rs**	**% of total indirect costs**
Support service from the Ministry of Women	9, 121, 000	4.7%
Support service from hospitals	163, 359, 000	83.3%
Support from the Police	17, 405, 000	8.9%
Support from the Judiciary	784, 000	0.4%
Support from SOS Femmes	5, 435, 000	2.8%
Total direct costs incurred by service providers	**196, 104, 000**	

Source: CASR study report 2010.

Table 5.9 shows concurrence between the direct micro-economic costs incurred by survivors and the macro costs incurred by service providers. The highest costs are those relating to provision of services by hospitals whilst the least are from the judiciary.

Politicians oblivious to the effects of GBV

Despite the manifold effects of GBV on women, only three of the 266 speeches (less than one percent) made by politicians and analysed in this study referred to the effects of GBV. One speech alluded to mental health effects while another alluded to loss of days from work. The third speech referred to macro-economic effects of GBV.

Launching the Costed National Action Plan to End Gender-Based Violence (CNEGBV), Minister of Gender Equality, Child Development and Family Welfare, Hon Mireille Martin said, "The UNDP has to date supported my Ministry in several projects including the elaboration of the National Policy Paper on the Family in 2006, the National Action Plan to Combat Domestic Violence in 2007 and a study on the Extent, Nature and Cost of domestic violence in our country, launched in December 2010.

This study revealed that the costs of domestic violence to the Mauritian Economy for the period 2008-2009 amounted to an astounding figure of Rs1.4 billion.

Had domestic violence not implied such a massive social cost, this substantial chunk of our national budget could have been allocated to productive endeavours with positive outcomes for our women-folk."

Conclusion

The findings from this chapter show that women survivors of GBV in Mauritius suffer a range of effects including physical injury, hospitalisation, death, miscarriages , pregnancy complications, loss of days from work, STI symptoms and out-of pocket expenses. GBV also has huge societal economic costs. While this is the case politicians still barely refer to effects of GBV in their speeches. The result is that GBV - the worst form of human rights violation in Mauritius at this time - is not getting the political profile and attention that is necessary for a concerted prevention campaign.

CHAPTER 6
Response

Group participants for the Reference Group Meeting.

Photo by Mary Jane Piang-Nee

Key facts

- ✓ Mauritius is party to international and regional instruments on human rights including the Optional protocol to the CEDAW and the African Charter on Human and People's rights.
- ✓ The Protection from Domestic Violence Act (PDVA) of 1997 is the main legislation covering issues of domestic violence in Mauritius. The PDVA was amended in 2004, 2007 and 2011.
- ✓ Other GBV related laws include the Equal opportunity Act, the Sex Discrimination Act and the Sexual Offences Bill.
- ✓ Three quarters (75%) of women and 86% of men participating in the survey were aware of the PDVA.
- ✓ About half (46%) of women and men (51%) participating in the survey had heard about Hotline 119.
- ✓ The FSBx, police, hospitals and judiciary enforce mechanisms provided for in the PDVA.
- ✓ The FSBx recorded 2215 cases of domestic violence in 2010.
- ✓ The police recorded 3525 cases of domestic violence cases with female victims in 2010
- ✓ The police recorded 254 sexual offences cases with adult victims in 2010.
- ✓ The Judiciary recorded 1905 new cases of domestic violence and disposed 1819 domestic violence cases in 2010.
- ✓ The judiciary recorded 393 new sexual offences cases and disposed 91 sexual offences cases in 2010.
- ✓ The public hospitals recorded 856 domestic violence cases in 2009.

"My name is Appamah Emraj. At the age of 16, my world turned upside down with the death of my mother. I was still at secondary school doing my fourth form. Remaining in school for another year would have meant sitting for my school certificate which would have helped me in getting a job.

Overnight my dreams became a nightmare. On the very same day of the funeral, all my years of studies became something of the past. Soon after the funeral I had to pack all my educational materials and look for a job. At that point I looked for any job so long as it brought money for household use. Fortunately for me, I got a job in a textile factory.

Being the youngest one and the only girl in my family I had no say in family matters. I was however, told that I should find a job so that I could buy food, pay electricity and water bills. My father, whose best friend was a bottle of rum, did not provide anything. He would come back in the evening drunk and demand that we put food in front of him even though he had not contributed towards buying it.

At the age of 18 I met what I thought would be the love of my life. At the age of 21 we got married and moved in together. What a shock lay ahead of me. The "palace" that I had assumed to be our new home was worse than a shack covered with corrugated iron sheets. The shack had no water, no electricity, no furniture and not even a bed to sleep on. We slept on the floor for a few days waiting for the furniture to arrive. My husband told me that furniture was bought on hire purchase and would be delivered.

The furniture never arrived and I decided to buy some furniture and the basics needed for the house on hire purchase. All sorts of ordeals soon followed the series of lies by my husband.

I became pregnant but I lost my baby girl in hospital because of beatings. After seven years of ill-treatment, I gave birth to a boy. During the same time a bad cyclone badly damaged our house. I took a loan and my colleagues assisted me to make repairs on the house. However I had to work harder to repay the loan.

By then my husband was drinking so heavily that he lost his job. The beating became worse. I reported him to the police several times and obtained a protection order against him.

After I got a protection order against him, my husband went to the police to report that he was a battered man. I don't understand but they also gave him a protection order. In addition I had to pay Rs.2,480 for legal charges. I always keep this receipt in my purse as a reminder of blatant discrimination because I am a woman.

My husband getting a protection order against me was the last straw. I left the house and went to SOS Femmes where I got all the legal, medical and psychological help. I stayed there for three years. I am now working in a hotel."

Appamah participated in a focus group discussion for previous shelter residents as part of the GBV Indicators Research. After the discussion, she said "Gender Links helped me because I have never told my story to people and even less to the media." Appamah gave her personal testimony during a GBV Workshop at the Mauritius Broadcasting Corporation (MBC). Appamah's story illustrates how she reported her abuse to the police and got a protection order. However the system did not work for her because her husband also got a protection order against her.

Effective response and support give survivors a viable and safe alternative. This chapter explores the response to survivors of GBV from the political commitment by the government to the enforcement mechanisms in place to respond to GBV. The chapter also assesses the use of available services by GBV survivors based on available statistics.

Political commitment to addressing GBV

One of the indicators to measure political commitment to end GBV is the ratification and adoption of legal instruments and the existence of institutional mechanisms which facilitate the elimination of GBV.

Ratification to international instruments

Yatin Varma, Attorney General, and Loga Virahsawmy, launching the SADC Gender Protocol Barometer. *Photo by Davinah Sholay*

The Government of Mauritius ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in October 2008, the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict in February 2009. Mauritius withdrew its reservation to Article 22 of the CRC in June 2008. Mauritius ratified the Convention on the Rights of Persons with Disabilities in January 2010. Mauritius signed the Statement on Human Rights, Sexual Orientation and Gender Identity made at the UN General Assembly in December 2008 along with 65 other signatories.

Ratification of regional instruments

At regional level, Mauritius is party to the African Charter on Human and People's Rights of 1981, the Protocol to the African Charter on Human and People's Rights on the Establishment of the African Court on Human and People's Rights of 1998 and the African Charter on the Rights and Welfare of the Child which entered into force in 1999. Mauritius has not signed the SADC Protocol on Gender and Development because of the provision on affirmative action. In 2011, Mauritius amended its Constitution to allow for a quota for women in local government in the 2012 elections. This has led to hopes that Mauritius will soon sign the SADC Protocol.

Legislative framework

Protection from Domestic Violence Act of 1997

The Protection from Domestic Violence Act (PDVA), enacted in 1997, aims to reduce and prevent domestic violence and ensure that where such violence occurs, there is effective legal protection. According to the PDVA, domestic violence includes:

- Physical injury.
- Placing the spouse in fear of physical injury to him/herself or to one of his/her children.
- Intimidation, harassment, maltreatment, brutality or cruelty.
- Compelling the spouse by force or threat to engage in any conduct or act, sexual or otherwise from which the spouse has a right to abstain.
- Confining or detaining the spouse against her will.
- Any harm or threat to a child of the spouse.
- Causing or attempting to cause damage to the spouse's property.
- A threat to commit any of the acts mentioned above.

The PDVA provides for the issue of:

Protection Orders

These restrain the abusers from engaging in any conduct which may constitute an act of domestic violence, and order the abuser to be of good behaviour towards the victim.

Occupancy Orders

These grant exclusive rights to the victim to live in the residence, which may belong to the victim or the abuser or both. This order may last for a maximum period of 24 months.

Tenancy Orders

These give the victims the exclusive right to occupy a rented house and if the abuser rents the house, he would continue to pay the rent unless the Court orders otherwise.

Amendments to PDVA

Amendment to PDVA (2004)

In 2004, amendments were made to the PDVA to:

- extend the definition of domestic violence to cover all cases of domestic violence committed by any person living under the same roof;
- increase the time limit before a notice is served from 7 days to 14 days;

- increase the penalty applicable in case of offences; and
- include provision for counselling.

Amendment to PDVA (2007)

In line with Government Programme 2005-2010, further amendments have been brought to the PDVA in 2007 and 2011 respectively. The 2007 Amendment in the PDVA:

- provides for a substantial increase in the penalty for an offender on a first, second or subsequent conviction;
- makes provision whereby District Court can make orders for payment of alimony to an aggrieved spouse or to a child of the parties at the same time as an Order for Protection is made on such terms and conditions as the Court thinks fit;
- includes provisions of counselling. In exceptional cases, the Court may order a perpetrator to attend counselling sessions organised by the MGECDFW instead of sentencing him. However, before referring the perpetrator for counselling sessions, the Court will consider:

  - The circumstances including the nature of the offense and the character, antecedents, mental or psychological conditions, age, health and home surroundings of the perpetrator.
  - The willingness of the perpetrator to comply with the Order.
  - Whether the victim has no objection thereto.

- If the perpetrator fails to comply with the order to attend counselling sessions, the Court will sentence the perpetrator for his original offence.
- Proclaims the rules finalised by the Rules Committee of the Supreme Court which enable Magistrates at District Court level to handle cases of domestic violence in a standard manner.

Amendment to PDVA (2011)

In 2011 the Protection from Domestic Violence Act was further amended to:

- give to the Chief Justice the power to make rules for the purposes of the Protection from Domestic Violence Act;
- include rules for the hearing of applications for occupation and tenancy orders; and
- provide for the coming into operation of different sections of the Act.

Awareness of the PDVA and protection orders

Laws are only as effective as legal literacy and access to justice. The survey asked if respondents know of laws in Mauritius that protect women and children against abuse and the PDVA.

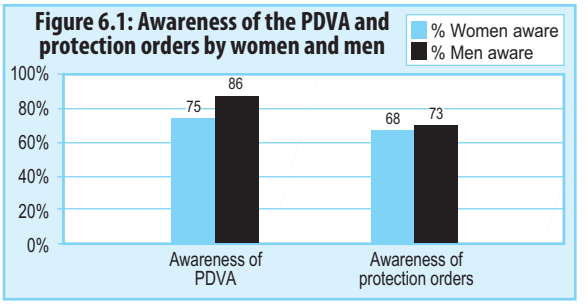


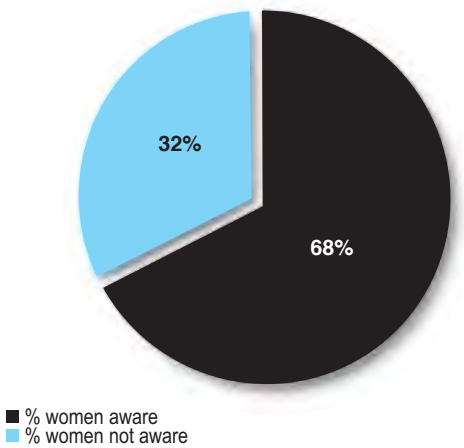
Figure 6.1 shows that 75% of the participating women and 86% of the participating men had heard about the Act. A lower proportion of women (68%) and men (73%) knew about protection orders. Based on these findings there is still need to raise awareness about the PDVA and its provisions. Raising awareness around the Act and its provisions is critical in improving the access to justice by women survivors.

Sex Discrimination Act

The Sex Discrimination Act contains provisions which define and prohibit any form of sexual harassment. Government has devised an anti-harassment policy. The Sex Discrimination Unit of the National Human Rights Commission compiled guidelines to ensure the prevention of Sexual Harassment of men/women in the workplace/institutions.

"Laws are only as effective as legal literacy and access to justice."

Figure 6.2: Awareness of the Sex Discrimination Act by women and men



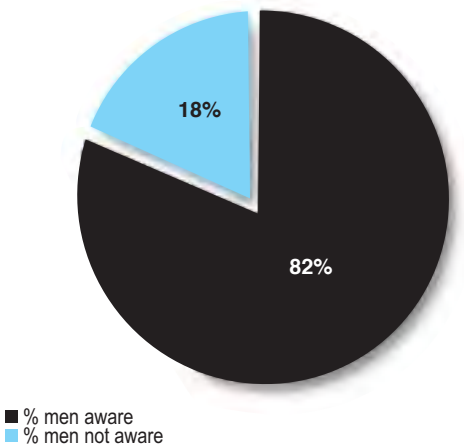


Figure 6.2 shows that more men (82%) than women (68%) know about of the Sex Discrimination Act. These findings and the statistics showing awareness of the PDVA are indicative of differential access to information between men and women. In both cases, a greater proportion of men were aware of legislation and legislative provisions compared to women.

Sexual Offences Bill

The draft Sexual Offences bill of 2007 has not yet been passed into an Act. The bill aims to:

- Provide for further and better provisions for sexual offences.
- Redefine rape.
- Create new categories of offences of sexual assaults in order to cover various acts of sexual perversions committed by offenders.
- Pay particular attention to persons under sixteen, as well as specified persons, in other words persons having close blood relationship or living under the same roof, or those who are mentally handicapped.
- Provide for harsher penalties for a term of up to 45 years and 60 years of penal servitude are provided in respect of offences involving those persons.

Equal Opportunity Act

The Equal Opportunity Act of 2008 incorporates all the different grounds of discrimination covered under sections 3 and 16 of the Constitution. These include age, pregnancy, mental and physical disability and sexual orientation in areas dealing with employment, education, the provision of accommodation, goods, services and other facilities, sports, the disposal of immovable property, admission to private clubs and premises open to members of the public. The Act also provides for the establishment of an Equal Opportunities Commission and an Equal Opportunities Tribunal.

PDVA Enforcement mechanisms

Jayshree Bhunjun, Head of Family Unit from the Ministry of Gender Equality, Child Development and Family Welfare making a presentation on GBV at Le Defi Media Group. *Photo by Loga Virahsawmy*

The Family Welfare and Protection Unit of the Ministry of Gender Equality, Child Development and Family Welfare, the Police Family Protection Unit, and the Judiciary are government departments responsible for the implementation of the enforcement mechanisms of the PDVA.

Family Support Bureaux

The Unit operates from the Ministry's Head Quarters and has a network of six Regional Officers known as Family Support Bureaux (FSBx). A hotline 119 is operational on a 24 hour basis to cater for family related problems and another hotline 139 which is dedicated to domestic violence is also operational.

The following services are offered at the Family Support Bureaux in a holistic way with a view to minimise further trauma to victims of violence:

- Family Counselling Service
- Psychological Counselling
- Legal Counselling
- Assistance to adult victims of domestic violence

Psychologists and Legal Resource Persons are also present in each FSB to provide psychological and legal counselling respectively.

Access of FSBx by domestic violence survivors and perpetrators

Statistics obtained from the Family Welfare Unit show that 2215 and 1752 cases of domestic violence were reported to the FSBx in 2010 and 2011 respectively. The perpetrators in the reported cases of domestic violence included the spouse or others living under the same roof. This study focused on cases in which the perpetrator was a spouse.

Table 6.1: Spousal domestic violence cases reported to FSBx

	2010			2011		
	Number of cases with female victims	Percentage of total cases with female victims	Total	Number of cases with female victims	Percentage of total cases with female victims	Total
Physical assault by spouse/partner	653	93.3	700	609	91.3	667
Verbal assault by spouse (ill-treatment, harassment, abuse, humiliation)	685	89.7	764	292	86.3	338
Threatening assault by spouse	*	*	*	222	92.5	240
Sexual assault by spouse(rape, sodomy, sexual harassment)	*	*	*	6	100	6
Ill-treatment by spouse	*	*	*	44	88.0	50
Emotional abuse (by spouse)	*	*	*	23	95.8	24
Damage to property	40	76.9	52	21	77.8	27
Psychological abuse	125	72.3	173	23	74.2	31
Other	219	98.6	222	3	42.9	7
Total spousal domestic violence cases	1722	90.1	1911	1243	89.3	1390
Grand Total on all nature of problem including others in the same domestic set up	1952	88.1	2215	1558	88.9	1752

Source: MGCEDFW.

Table 6.1 shows that 1722 women reported domestic violence by a spouse to an FSBx in 2010 while 1243 women reported spousal domestic violence cases in 2011. This shows a decrease in the total number of reported cases from 2010 to 2011. Care should be taken in interpreting this difference, as it is either indicative of a true decrease in the incidence of domestic violence or it could indicate a regression in terms of survivors speaking out and reporting cases.

Table 6.1 shows that although both women and men can be victims of domestic violence, women constitute a significantly higher proportion of victims in reported cases compared to men. In both 2010 and 2011, women constituted 88% and 89% of victims in the total reported cases respectively. Table 6.1 shows that between 2010 and 2011 a greater proportion of men reported cases of psychological abuse. About one in four (27% in 2010 and 26% in 2011) reported spousal psychological abuse cases had a male victim.

Table 6.1 shows that after the introduction of new categories for recording data specifically on sexual assault, threatening to abuse, ill-treatment and emotional abuse, women still constitute the majority of victims in these cases. According to the FSBx data, the most common form of spousal domestic violence reported by women in 2010 was verbal assault, followed by physical assault. The least common was the damage to property. The majority of reported cases by women in 2011 were physical assault by spouse followed by verbal assault.

Table 6.2: Comparison of FSBx reported prevalence to survey prevalence statistics

	Number of reported cases	2010 population statistics women 15 years and above	Population prevalence based on reported cases	Survey prevalence in past 12 months	Prevalence factor
Spousal domestic violence cases reported by females to FSBx in 2010	1722	561378	0.3	4.7	15.3
Physical intimate partner violence (assault) cases reported by females to FSBx in 2010	653	561378	0.1	1.8	15.5

Table 6.2 shows that the prevalence of domestic violence as reported to the FSBx is substantially lower than reported in the survey. The prevalence of intimate partner violence in the survey is 15 times more than that reported to the FSBx in a similar period. The prevalence of physical IPV in the survey is 16 times more than that reported to FSBx.

Protocol of Assistance to Victims of Sexual Assault 2006

The Protocol defines the role and responsibilities of all the stakeholders concerned with addressing GBV, namely Family Support Bureaux; the Ministry of Health and Quality of Life and the Police Department. The purpose of the Protocol is to ensure coordinated, prompt and timely assistance to victims of sexual assault by all authorities dealing with such cases.

In line with the provisions of the Protocol, the Ministry of Gender Equality, Child Development and Family Welfare is informed of cases of sexual assault by the Police on hotline 139 (operational on a 24 hour basis) and arrangements made for psychological assistance and legal counseling to the victim. Follow up action is ensured through the Family Support Bureaux of the Ministry (Bell Village, Goodlands, Flacq, Bambous, Phoenix and Mare D'Albert, now situated at Rose Belle).

Participants in the survey were asked whether they had ever heard about or used the hotline.

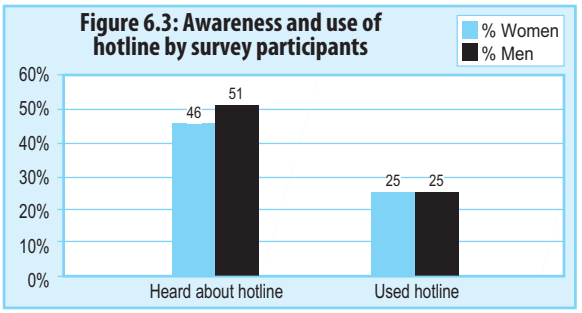


Figure 6.3 shows that 46% of women and 51% men knew about the hotline. Of the participants that had heard about the hotline only about a quarter had used it. Interestingly, an equal proportion of women *and* men reported having used the hotline. This calls for greater awareness raising efforts around the hotline.

Victims of Domestic Violence who use the hotline are attended to by a Family Welfare and Protection Officer. The victims are provided with first-hand counselling and support. They are also assisted to apply for Court Orders. A temporary shelter is also provided to the victim if need be. Follow-up actions are ensured by officers of Family Welfare and Protection Unit in terms of drafting of affidavits and accompanying victims to Courts for the application of any other Orders falling under the PDVA.

At the hospital, a fast track approach is employed to assist victims with emergency treatment in the Sexual Assault Unit, which is isolated from other patients attending hospital. Police Medical Officers examine the victims. The Protocol also provides for the victim to be seen by specialists such as a gynecologist, pediatrician, psychologist or medical social worker.

Police Family Protection Unit (PFPU)

In addition to the role of the Ministry of Gender Equality, Child Development and Family Welfare, the police also help to address domestic violence. The Police Family Protection Unit (PFPU), set up in September 1994, provides specific services to victims of domestic abuse. The PFPU has adopted a special policing approach that is effective and sensitive to respond to the needs of victims. The PFPU staff deals with cases of domestic violence, conflict among
neighbours as well as child and elderly abuse.
The services offered to survivors include the following:

- Victim Support (carry out compassionate investigation)
- Court preparation
- Collating evidence
- Agency referrals
- Assisting victims in application for protection, occupancy or tenancy orders in accordance with Protection from Domestic Violence Act

In addition to above, the (PFPU) provides attention on a priority basis, to victims of Domestic Violence, Child Abuse and Elderly Abuse and caters for their needs and expectations. It also offers a victim friendly service where victims are reassured, valued, assisted and encouraged to talk in an environment that is conducive to trust and confidentiality.

PFPU adopts a victim friendly and caring approach, and respect confidentiality while responding to cases of violence against vulnerable people. Visit to victims of abuse is also effected at their homes and hospital as a follow-up measure.

Pope Hennessy Police Station in Mauritius. *Photo by Mary Jane Piang-Nee*

In addition to services to victims of Domestic Violence, PFPU conducts training courses on laws relating to Domestic Violence, Child Abuse and Elderly Abuse for Police Officers. The Unit also carries out information and awareness campaigns on Domestic Violence, Child Abuse including Commercial Sexual Exploitation of Children and Elderly Abuse with a view to sensitising the public at large to these issues. Teen dating violence is also being addressed by the PFPU. In this context, students of Primary and Secondary Schools are targeted.

The PFPU is decentralised to regional stations namely: Port Louis; Abercrombie; Piton; Flacq; Rose Hill; Moka; Curepipe; Rose Belle and Port Mathurin.

Map of police stations in Mauritius.

Domestic violence reporting to PFPU

Table 6.3: Domestic violence cases reported to the PFPUs

Criteria	2010	2011
Number of reported domestic violence cases with female victims	3525	3478
Number of reported domestic violence cases with male victims	807	827
Total number of reported domestic violence cases	4332	4305
Percentage women victims in reported domestic violence cases	81.4%	80.8%
Prevalence of domestic violence experienced by women based on police reporting	0.6%	0.6%

Table 6.3 shows that 3525 women reported cases of domestic violence to the PFPUs in 2010. There was a decrease in reporting in 2011 to 3478. Based on the number of reported cases in 2010 and 2011, 0.6% of the women in Mauritius reported a case of domestic violence to the PFPUs.

Damini* praised the police for assisting her to obtain a protection order: "I could either choose to remain silent and keep on being tortured or I could opt to file a complaint against him and get the help and assistance that I so much need. With this thought culminating in my mind, I was on my way to the police station. I made the right choice. I didn't do it for me and despite everything that I had endured; the first thing that came to my mind was him. I wanted my decision to open his eyes. I wanted my decision to help him. My numerous desperate attempts were all crowned with failure after failure and I thought to myself that this was the last resort and our last chance. I did it in the name of justice. I was very well aware that by so doing I was going to lose everything. The police did a wonderful job.

They were extraordinary in showing me that they care and treat GBV as a very serious matter. I felt reassured and protected. I felt welcomed and most importantly, I felt that I was gaining back what I had lost: My sense of identity and dignity. I am not the one to blame and I should not feel guilty. I trust the police and I trust that they are the law. I received my protection order and they advised that I should rather leave the place where we lived for my own security and I did."

Sexual Offences reporting to PFPU

Table 6.4: Sexual offences handled by police 2010-2011

Offence	Number of cases handled in 2010	Number of cases handled in 2011
Attempt upon chastity	70	79
Rape	49	53
Indecent act in public	60	45
Solicits/importunes another person for immoral purpose	17	34
Sodomy	28	29
Dealing in obscene matters	12	9
Sexual harassment	1	8
Brothel keeping		7
Sexual intercourse with a specified person	6	6
Attempt upon chastity upon specified person	9	6
Other offences under Sex Discrimination Act	1	3
Sexual intercourse with a mentally handicapped person	1	1
Sodomy (Handicapped)		1
Procuring, enticing and exploiting prostitutes		1
TOTAL	**254**	**282**

Source: Mauritius Police Service.

Table 6.4 shows 282 cases of sexual offences reported in 2011, up from 254 the previous year. This increase should be interpreted with caution as it may reflect a true increase or an increase in reporting by survivors. Sexual assault cases included "attempt upon chastity" followed by indecent acts in public and thirdly rape. Fifty-three rape cases were reported in 2011 compared to 49 cases in 2010. This translates to a report rate per population of 0.009%. *Therefore, the prevalence of rape reported in the survey is 11 times higher than that reported to the police in a similar period.*

Inter-agency coordination

With the application of the Protocol, victims may now call either at the Police Station of the region where the incident took place or directly to any of the five regional hospitals namely Dr. A.G. Jeetoo, SSRN, Victoria, Flacq and J. Nehru. Victims who report cases at the Police Station are conveyed by the Police to the nearest regional hospital.

A reform programme under the National Policing Strategic Framework (NPSF), was launched on 24th February, 2010, aimed at a paradigm shift from a Police "Force" to a Police "Service". NPSF rest on six pillars as follows:-

(i) Community Policing;
(ii) Achieving a Human Right Compliant Organisation;
(iii) Human Resource Management Capability;
(iv) Permanent Strategic Planning Capability;
(v) Intelligence-Led Policing; and
(vi) Enhancing our Reactive Capability.

Since the implementation of NPSF, new structures, systems, processes and procedures have been established ushering in a new policing philosophy and work culture resulting in greater accountability, transparency, fairness and operational efficiency and effectiveness thereby improving our service delivery.

Community Policing, which is at the heart of the reform, has been introduced in all Police Station areas throughout the island. Community Policing Forum meetings are organised with members of the public in the region, and with civil societies, and other stake-holders.

Under the community policing pillar, several new initiatives have been implemented such as:-
(a) Victim Support and Advice;
(b) Mediation Process; and
(c) Policing Pledge.

The community policing officers and neighbourhood officers at different police stations work in close collaboration PFPUs.

Judiciary

The judiciary consists the Supreme Court and the subordinate courts. The subordinate courts include the Court of Rodrigues and the district courts. There are twelve district courts in the Island of Mauritius and one in Rodrigues. The district courts have jurisdiction to try and determine both civil and criminal cases as provided for by the law. Each district court is presided by a senior district magistrate and a number of district magistrates as decided by the Chief Justice.

Supreme court of Mauritius. *Photo by Mary Jane Piang-Nee*

The jurisdiction to implement justice under the Protection from Domestic Violence Act (PDVA) falls under the district courts. In terms of the PDVA, the district clerks are entrusted with the duty of receiving and processing applications for a protection order from aggrieved spouse victims of domestic violence. The district magistrates hear and determine such cases. The district magistrates issue protection orders when the court is satisfied that there is a serious risk of harm for the applicants. The district magistrates also receive and determine applications for the issue of occupation or tenancy orders. Occupation and tenancy orders give the victim of domestic violence the exclusive right to the use and occupation of the conjugal house (Annual Report of Judiciary, 2010).

Access to court services by domestic violence survivors

Table 6.5: Protection from Domestic Violence Act cases at the District courts in 2010

District court	Cases lodged 2010	Cases disposed 2010
Lower Plaines Wilhems	543	520
Pamplemousses	233	216
Port Louis Div 1	208	201
Upper Planes Wilhems	204	196
Riviere du Rempart	168	158
Flacq	167	151
Grand Port	115	112
Black River	106	104
Moka	94	86
Rodrigues	38	40
Savanne	29	37
Total (Republic of Mauritius)	**1905**	**1819**

Source: Mauritius Police Service.

Table 6.5 shows that in 2010, the District Courts received 1905 cases of domestic violence and disposed of 1819 such cases. Lower Plaines Wilhelms, which has the highest population, received the highest number of cases, while Savanne received the lowest number of cases. Although Savanne has a larger population than Rodrigues and Black River, it has a lower incidence of domestic violence cases reported to the courts.

Access to court services by survivors of sexual offences

Table 6.6: Sexual offences cases before courts by district			
District	**All sexual offences**	**Rape**	**Sodomy**
Plaine Wilhelms	95	12	10
Port Louis	76	10	7
Flacq	43	5	3
Pample-mousses	38	6	3
Black River	38	6	4
Riviere du Rempart	35	1	3
Savanne	26	5	4
Grand Port	25	3	2
Moka	17	1	3
Total	**393**	**49**	**39**

Source: Annual Judiciary Report 2010.

Table 6.6 shows that in 2010 393 cases of sexual offences cases came before the courts. This translates to a population prevalence of 0.07%. Plaine Wilhelms district followed by Port Louis recorded the largest number of sexual offences. Moka had the least number of sexual offences reported.

Sexual Offences cases disposal

Of the 393 sexual offences cases before the courts in 2010, only 91 cases were disposed. The convictions for the cases can be grouped into four categories namely imprisonment, fines, probation and diversion institutions for juveniles.

Table 6.7: Convicted offences for 2010					
Offences	**Imprisonment**	**RYC, CYC and other institutions**	**Fine**	**Probation, conditional discharge, community service and absolute charge**	**Total**
Rape	7	-	-	-	7
Sodomy	9			1	10
Attempt upon chastity	12	1	-	13	26
Sexual intercourse with minor under 16	13	-	1	25	39
Incest (sexual intercourse with a specified person)	4	-	-	-	4
Dealing in obscene matter	-		5	-	5
Total (sexual offences)	**45**	**1**	**6**	**39**	**91**

Source: Annual Judiciary Report 2010.

Table 6.7 shows that only seven cases of rape were disposed in 2010, compared to the 49 cases lodged (14%). These findings are also indicative of prolonged disposal periods for rape cases in Mauritius. However in all these cases resulted in a prison sentence - this is to be commended.

Cases of sexual intercourse with minors constituted the greatest number (about one third) of sexual offences cases disposed of. But in 25 cases (60%) perpetrators only received light sentences including community service.

Ministry of Health and Quality of Life

With the Protocol of Assistance for Victims of Sexual Assault , victims may now call either at the Police Station (to give gist of case) of the region where the incident took place or go directly to any of the 5

regional hospitals namely Dr. Jeetoo, SSRN, Victoria, Flacq & J. Nehru. It is the responsibility of the police to convey victims to the nearest regional hospital.

Jeetoo Hospital, Port-Louis, Mauritius. *Photo by Mary Jane Piang-Nee*

In line with the Protocol of Assistance for Victims of Sexual Assault, standards were put in place in 2008 within the Ministry of Health and Quality of Life to ensure psychological and legal assistance to victims of sexual assault and fast tracked medical assistance.

Standard for Nursing practice No 3/2008

The Standard for Nursing practice No 3/2008 responds to the World Health Organisation (WHO) recommendation "to strengthen the quality of existing services that support and provide care to women and girls who have experienced sexual violence" (WHO, 2004). Sexual assault is defined as "any act of nonconsensual sexual conduct or sexual penetration". The term "sexual assault survivor" means a person who presents for hospital emergency services in relation to injuries or trauma resulting from a sexual assault.

Objective

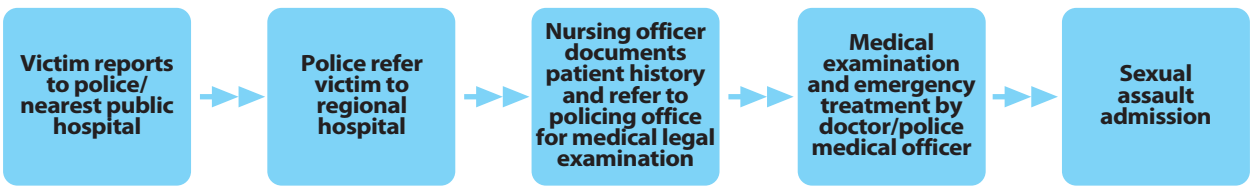
The Standard for Nursing practice No 3/2008 aims to:

- Increase knowledge and skills of nurses in the management of care provided to victim/survivors of sexual assault.
- Provide a victim centered approach which is defined as the systematic focus on the needs and concerns of sexual assault victim/survivor.
- Ensure a compassionate and sensitive delivery of care to victim/survivors in a non-judgmental manner.

Management cycle

The management cycle for sexual assault care begins at the local police station where the victim/survivor of sexual assault reports and ends with admission. The following flow chart illustrates the stages in the management cycle.

Figure 6.4: Flow chart of sexual assault management



The victim should report to the police station found in the area where the offence has been committed or to the nearest public hospital. In the case that the victim reports to the nearest police station, police officers have to convey the victim to the casualty department of the nearest regional hospital for emergency treatment and follow up. The charge nurse or the nursing officer, after getting the initial history of sexual assault informs the police officer on duty at the casualty department for the purposes of medico-legal follow up. The doctor attends to the victim for any emergency treatment when necessary. Thereafter the police medical officer (PMO) examines the victim. For all reported cases of sexual assault admission is mandatory.[1]

Nursing responsibility

It is the responsibility of the nurse attending to victim/survivor of sexual assault to:

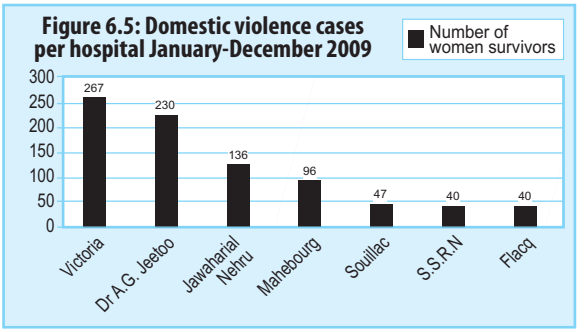
- Ensure safety and well-being of the victim/survivor of sexual assault take priority in all matters and procedures.

[1] http://www.gov.mu/portal/site/women-site/menuitem.f06150a6b5e9f7243cd63cb9a0208a0c/

- Inform the patient to preserve evidence for collection.
- Properly record the handing over of belongings of the victim/survivor to the police officer. For example the date, time and detail of belongings.
- Obtain consent from the victim/survivor for the examination by the PMO.
- In case of a child victim, ensure that examination is carried out in the presence of the Child Welfare Officer (CWO). The CWO is responsible for arranging for psychological support for the child as and when required.
- Ensure all specimens/swabs are collected by the PMO for forensic examinations.
- Ensure that privacy, confidentiality and universal precautions are maintained at all time.
- Ensure that the admission of victim/survivor of sexual assault is done to the specific ward either for female adults and in case of child victim in the paediatric ward.
- Inform other medical officers including the gynecologist or paediatrician, psychologist, and medical social worker about the case so that they can arrange to attend to the victim/survivor at the hospital.
- Ensure arrangements are in place for children victims to be treated in the presence of their mother /close female relative.
- Provide oral and written information concerning the possibility of infection, sexually transmitted diseases and pregnancy resulting from sexual assault.
- Provide emergency contraception and appropriate treatment for HIV/AIDS.
- Keep appropriate record and ensure safety of documents at ward level for all admission of victim/survivors of sexual assault.[2]

Access of health services by domestic violence survivors

For the period January to December 2009, public hospitals received 3525 domestic violence cases. Figure 6.5 shows that Victoria hospital received the greatest number of domestic violence survivors in the defined period while Flacq saw the least number of survivors.



Source: Ministry of Health and Quality of Life.

Table 6.8 shows that of the 6112 reported cases reported in 2010, 58% went to the Police Family Protection Unit, 28% to the FSBx and 14% to the Police. This shows that specialised facilities do make a difference, as the majority of survivors reported to these facilities. During the same period, only one third of the total number of cases reported went to court. This shows that there are still gaps in the criminal justice system.

Table 6.8: Comparative data on cases received and disposed of

Cases of domestic violence reported in 2010		Cases of domestic violence in court in 2010
Cases reported to the Police Family Protection Unit	3525	1905
Domestic violence cases reported to FSBx in 2010	1722	
Domestic violence cases reported to police in 2010	865	
TOTAL	**6112**	

Source: Gender Links.

Conclusion

There is need for a clear referral system that can be used to track survivors from one mechanism to the other so that data on survivors can be centralised and readily accessible to all service providers. The system could also allow comparisons to be made about the access to the different services by survivors. The current disintegrated system makes it almost impossible to make such comparisons.

[2] http://www.gov.mu/portal/site/women-site/menuitem.f06150a6b5e9f7243cd63cb9a0208a0c/

CHAPTER 7
Support

Shenaz Sooba (right) presenting on gender and the economy at the Mauritius National Summit 2012, Gold Crest Hotel, Quatre Bornes in Mauritius.
Photo by Mary Jane Piang-Nee

Key facts

- ✓ There are three registered shelters for abused women in Mauritius namely SOS Femmes, Shelter for Women in Distress and Shelter La Colombe.
- ✓ Only one of the shelters , La Colombe is state run and managed by the Ministry of Gender Equality.
- ✓ Shelters in Mauritius provide counselling and a range of empowerment programmes, for women survivors.
- ✓ Current shelter services are disproportionate to the need and give priority to housing children.
- ✓ Six percent of women (5.9%) and 51% men have heard about Hotline 139.

"The best thing that has happened to me is living in the shelter. I never thought a shelter could give me so much happiness. I am well surrounded by friends. I am learning a lot and being looked after by caring people.

I loved my father to bits but unfortunately, when I turned two my father knew he would have to leave this world. He did not want any harm to happen to me and gave me to a woman he trusted. The woman was so kind and caring that I considered her like the one who gave birth to me. She sent me to school and fended for me for nine years. I never went to school on an empty stomach or without any goodies in my lunch box. I got everything that I needed. But I was doomed the day I met my biological mother.

One day a woman knocked at our door and she told my mother that she has come for me by right being my biological mother. She wanted me to live with her. We were both taken aback and got a shock but unfortunately I had no alternative but to follow her. No need to say how heartbroken I was to leave the house and the person with whom I spent the best years of my life.

It did not take long for me to have a taste of hell in my new environment with a step father and his son. Yes, my mother soon got married when she divorced my father and this is why he wanted me to live with him.

My step father had drinking bouts and with each bout my mother became the target for a good beating. I tried my best to stop this cruelty but in vain.

One day my stepfather decided that his son should have sex with me. I resisted with all my energy and my stepfather said that if I keep on resisting my mother would get a good beating. I refused and struggled but my stepbrother had the upper hand and he raped me. I became dirty and hated my own body. I was only 13 years old.

The only person whom I trusted was my mother and I told her what I went through. She refused to believe me and said I was lying.

This happened a few times. Unfortunately, by then the woman whom I still considered like my mother had passed away. Not knowing where to turn to, I went to see a neighbour. She took pity on me and gave me some money so that I could take a bus to go and see my aunt.

I told my aunt everything including how I was being raped regularly and my mother being beaten. She telephoned the Child Development Unit and the officers did a full enquiry. I was then placed in the shelter.

I am supposed to stay here until I turn 18 but would like to stay forever as I am so happy here. Soon I will be sent to follow a course in hairdressing and I am really looking forward to that. I would like to open my own business.

I have heard that my mother is in prison. I do not even know if I want to see her. To tell you the truth I am starting to have doubts whether she is my biological

mother. How can a mother not believe her daughter? How can a mother let her own daughter be raped regularly under her own roof?

Grace's* story reflects how shelters for abused women and children in Mauritius are a haven for survivors. Beyond providing shelter and basic necessities, shelter residents get the care enabling to move from being victims to being survivors. Survivors are even equipped with life skills to enable them to follow a career after leaving the shelter. This chapter presents institutional case studies of the three shelters for women and abused children in Mauritius. It also covers an assessment of shelter services by previous shelter residents.

Shelter for Women and Children in Distress Trust Fund

In 1991, the Ministry of Women's Rights (now Ministry of Gender Equality, Child Development and Family Welfare) under the aegis of the Minister Sheila Bappoo opened a family counselling service and a National Children Council in response to the many reported incidents of women and child battering. The two units offered help, advice and support to abused women and children but did not offer temporary housing.

The Women's Ministry established a Trust with representatives of the Ministry, Social Security and Finance as well as professionals and individuals involved in social work under the name of Shelter for Women and Children in Distress.

Sheila Baguant, Chairperson of the Shelter for Women and Children in Distress, Mauritius. *Photo by Loga Virahsawmy*

Nature of the Shelter

The shelter accommodates only victims referred by the Ministry of Gender Equality. Initially, the facility served as an emergency shelter and women with children came for a short period. With time, the shelter has had to take children, adolescents and pregnant girls for longer periods. The period of stay is on a case-by-case basis and can be as long as 10 years. The aim is to ensure that when "residents leave the shelter they are back in a good environment and can stand on their feet with good jobs".

Objectives

The shelter aims to:

- Offer a 24/7 hours of services of safe lodging, clothing, food.
- Support, rehabilitate and integrate.
- Provide individual and group counselling.
- Provide legal advice.

Beneficiaries

The shelter can accommodate 45 residents at one time. The shelter had 40 residents at the time of the research. The majority of the residents are from a low-income background. The beneficiaries include:

- Emotionally, verbally or physically abused.
- Abandoned or neglected children.
- Victims of child labour.
- Sexually abused.
- Victims of incest.

Services at the Shelter

The shelter gives a 24-hour service seven days of the week. Services are available for abandoned children and sexually abused, battered or neglected women coming from violent relationships or alcoholic partners/husbands.

Skills Development Programme

The shelter has a classroom with all facilities and a full time teacher is employed to teach those children who cannot join the mainstream. Very often, these children are traumatised or are over a certain age and cannot attend mainstream schooling. They follow the primary or secondary school syllabus and sit for examinations.

The residents also get training by professionals in music, dance and drama, arts and crafts, food and nutrition, hairdressing and beauty care and home economics. Regular talks by experts are organised on moral and spiritual values. For the past two years a Project Trust based in London has been sending volunteers to work at the Shelter. According to Bagaunt, "The children have gained a lot not only in terms of academic work but socially and in extra mural activities like music, painting and dancing."

Administrative staff of the Shelter for Women and Children in Distress. *Photo by Loga Virahsawmy*

The shelter has also benefited from the expertise of students from different Universities such as: Delhi, Kenya, Norway, Pakistan, Poland, China, Japan, Germany, Scotland, Tunisia and University of Mauritius and UTM (University of Technology Mauritius).

Residents grow their own herbs, a variety of vegetables and maize in their own garden at the back of the building. The shelter has received several prizes in poem writing. There are regular exchange programmes with colleges in Mauritius. The shelter children spend one day in a college of Mauritius and vice versa. Regular educational and recreational tours are organised so that the residents know Mauritian history and places of interest. According to the Chairperson, "this is a great learning experience for both parties. On the one hand our children know they are getting the best and not being left out and on the other hand children in the mainstream know the lives of residents in shelters."

Staff

The shelter has a dedicated team of administrative staff; care wardens; one psychologist; one doctor; resource persons providing professional help through counselling, group work, educational assistance and special learning support as well as volunteers. The members of staff make a great effort in learning how to run an institution.

Funding

The shelter gets regular funding from the Government of Mauritius but according to the Chairperson "with this kind of work finance is always a problem. We therefore knock on doors very often and get support in kind. We have friends who bring food for all the residents on a regular basis while others give money for food. A group of ladies celebrate all birthday parties of the residents. They are offered birthday gifts followed by a reception."

Challenges

The shelter faces challenges such as the girls running away. The Rapid Emergency Service (RES) of the police has been helpful in tracing the run-away girls. Managing some of the children taken from the streets has been another challenge.

Perpetrators who come to the shelter are another challenge. According to the Chairperson, Sheila Bagaunt: "Mauritius is a small place. Sometimes the police do not realise that addresses must be kept confidential. The perpetrators are capable of all sorts of wickedness to frighten us. We must be prepared for all sorts of risks."

Outcomes

All former residents now stand on their feet and the shelter is on regular contact with them. Some of the former residents are now volunteering at the shelter. Other residents opened their own businesses while others have joined the Small and Medium Development Enterprises.

Sustainability

This initiative can be sustained but this will require the appointment of a full time manager. For the past 20 years, the current chairperson has voluntarily driven the work at the shelter. The shelter needs other dedicated volunteers to take up this responsibility.

Client satisfaction assessment

GL interviewed survivors regarding their experiences and perceptions around using the shelter after they had experienced GBV. The researchers asked the survivors about their experiences as inmates and what they thought of the services provided.

All interviewees who were also in their twenties said they did not go to the shelter on their own. They all had traumatic experiences as children that brought them to the Child development Unit (CDU) of the Ministry of Gender Equality. The CDU referred them to the shelter. They all said that it was not difficult for the CDU to get accommodation for them in the shelter.

The respondents said it took them some time to adapt to the shelter. After some time of adaptation, they felt secured and were happy to be part of the family life at the shelter. They rated the service of the shelter very highly mainly due to the free services, breakfast, lunch and dinner. "But dinner was quite basic at the beginning as very often we had to count on food donations. The situation has changed a lot and the residents now get food like in a five star hotel. We hope the residents realise how much they are being spoilt."

Elodie, Angelique and Francesca - Young women living in a shelter for Women and Children in Distress. *Photo by Loga Virahsawmy*

Staying at the shelter is free but residents have to participate in the daily chores of the shelter. They helped with the cleaning, the laundry and assisted the small ones. They found the experience positive. They had a place of safety and on top of that, they could pursue studies. The shelter provided schooling facilities and raised funds for mainstream schooling. One of the respondents sat for her school certificate whilst staying in the shelter. She obtained good results and proceeded to the level of Higher School Certificate while the other girls followed computer classes.

From their personal experiences of staying in a shelter all the respondents said that they would recommend the shelter to all survivors. They said that they have a family life at the shelter. They have all the facilities and can follow training in whatever field they are interested in. "We accompanied our wardens to the market. We had lots of activities on Sundays. The shelter helps survivors to come to terms with their traumatic experiences. We really felt empowered after some time in the shelter. We are happy we stayed in the shelter. We do not have any regrets. We were well surrounded and loved by everybody."

One of the respondents added that when she was living at home she was stressed and sometimes she could not go to school. "I did not want my friend to ask me questions about all the wounds and blows received by my mother. But at the shelter I did not receive one single blow."

The respondents talked about their experiences of Christmas at the Shelter. "There are memorable experiences that we will always cherish. For us, Christmas started as early as October as people would start bringing us gifts. We had too many gifts and huge variety of perfumes that when we left the shelter we needed a suitcase to carry all our gifts."

The respondents could not think of any negative experience at the shelter. However, one respondent said, "we all have different personalities and charac-

ters. We are sometimes jealous when we see one of our friends getting a banana and we are not given one. But we soon get over it. We are also sad after the departure of those who come to visit us because we know we do not have anywhere to stay and our relatives cannot come to visit as much as we would wish".

All residents have free medical and dental service on a regular basis. The psychologist and the doctor come once a week. One of them added, "I was getting everything for free at the shelter including dance and swimming lessons and now that I have my own children I realise how much it costs for all these extra mural activities."

The women affirmed that shelters are important as a refuge for abused women. One respondent said, "It is like a second home." The respondents felt the training courses that they participated in and the experiences they received at the shelter enabled them to get their current employment.

The women interviewed are always in touch and feel much at home when they visit the shelter. They are gradually achieving towards their goals. From victims, to survivors, they are very assertive and confident in their roles in society. They all said that their positive experience at the shelter have made them realise that they must help others. "When we see victims of GBV, we know we can call the CDU."

Educational sponsorship - Success stories decorating Christmas Tree. *Photo by Loga Virahsawmy*

SOS Femmes

Background

SOS Femmes is a shelter registered in 1990 to give advice, support and shelter to women and children victims of domestic violence, incest and rape as well as campaigning on domestic violence.

Nature of the Shelter

SOS Femmes is open to all women regardless of their religious beliefs, social class, political opinion, level of education and ethnic group. The focus is to help women, to stand up on their own feet and become completely independent.

Stay at the Shelter

SOS Femmes is open seven days a week. The length of the stay depends on the state and the gravity of the resident's problem. Stay at the shelter can range from a few days to over one year depending on whether the survivor is ready to go back in society. The shelter has also had cases where the same woman is readmitted several times. "They are readmitted if they are abused again because it is understood how difficult it is to leave an emotional relationship."

On the contrary, the shelter empowers survivors to be able to regain control over their lives. When they decide to leave the shelter they receive support to build a new life free of violence. The shelter assists the former residents to find jobs and accommodation.

The residents live in spacious rooms with all amenities. There are enough bathrooms and toilets for all the women. The residents do their own cleaning and cooking. The residents take their meals in a big dining room. After dinner, the women move freely to their hobbies or watch television in a spacious and well-decorated living room.

The children have their own corner. The shelter has a playground in the yard close to the fully furnished and equipped kindergarten. There is a wide variety of children's toys.

Referrals

The shelter takes survivors who report to the shelter. Cases of serious assaults are sent to the hospital. They also refer survivors to the police. When the women suffer from nervous depression due to domestic violence the help of a psychiatric hospital is sought.

Skills Development Programmes/Capacity Building Programmes

The main target for SOS Femmes is to help victims of domestic violence to take control over their lives by getting back their self-esteem and assisting them come to terms with all their traumatic experiences. SOS Femmes gives the survivors literacy courses during their stay and ensures that when they leave the shelter they can sign their names, know which bus to take, count their money, know how to open a bank account and can manage their finances.

"I" Stories

At SOS Femmes, women are encouraged to write their stories. For those who cannot write, a worker does the writing but reads the stories to the survivors to make sure that they agree with the contents. According to the director, there are also those are so traumatised that they cannot even tell their stories. The shelter refers these cases to the psychologists but the survivors are well prepared before going there. When survivors are unable to share their stories with the psychologists, they are given time until they are healed and prepared to talk.

Staff

There is a dedicated and skilled permanent staff and a few volunteers who help two to three times a week. SOS Femmes also has a legal councillor and a psychologist.

Ambal Jeanne, Director of SOS Women Shelter. *Photo by Loga Virahsawmy*

Funding

For its first seven years, a German Foundation funded SOS Femmes. Funds were used to rent a place in Moka and to meet the running costs and payment of staff. In 2010, the shelter moved to the house in Coromandel that is also a donation. European Union (EU) funds were used to add a storey to accommodate more bedrooms, a library cum computer room and a room for the social assistants staying at night. The shelter also receives some donations from private companies.

The shelter has submitted proposals for additional funding from the government. Under a special joint programme, the government awarded Rs2million to SOS to enlarge the shelter.

Targets

The beneficiaries to the shelter are abused women from all over Mauritius. However, the shelter can only accommodate 40 women and children at a time. The shelter has also accommodated pregnant women and there have been cases where they had their

babies while they were with SOS Femmes. Women can be admitted together with their children with the exception of boys are over 15 years of age.

Challenges and risks

One challenge is that of security problems due to the perpetrators coming to the shelter. According to the words of the director, "When we were in Moka we were attacked by Molotov cocktail and once a man barged into the shelter looking for his wife with a knife. Fortunately we have built up a good relationship with the police. As soon as we telephone them they come in the minutes that follow".

Another challenge noted is with the court system. Although magistrates have always given protection orders, only in few instances have they issued occupation or tenancy orders. Application for occupation orders, that is, to have the sole right to live in the conjugal home with the children is never granted and when the couple is not the owner of the conjugal home the tenancy order has been rarely issued.

Outputs

In 2009, SOS Femmes accommodated 782 women and 862 children over and above the 3112 who went to the shelter for advice and the 4089 telephone calls received to get on line support. This figure declined in 2010 as SOS Femmes was moving from Moka to Coromandel and did not take new clients but from January to June 2011 the shelter accommodated 244 women and 204 children. The shelter gave advice to 1073 women and gave on line advice to 1102 callers.

Table 7.1: SOS Femme indicators January-June 2011

Criteria	
Number of women in shelter January-June 2011	244
Number of children in shelter January- June 2011	204
Number of women seeking advice January-June 2011	1073
Number of calls received from abused women January - June 2011	1102

Table 7.1 shows that although the shelter provides secondary housing for women, a greater proportion of women seek advice or make calls.

Outcomes

According to the director, the success of the shelter is with those who decide to leave violent relationships. Over 80% of women that leave the violent relationships return to society with a decent house and a good job. The majority of these women are working and have found a place of safety for themselves. An example is five women that have been able to buy low cost houses with the National Housing Development Corporation, a parastatal body building houses for low-income group.

SOS Femmes has kept a good relationship with most of their former residents who live on their own. The shelter frequently invites them to events.

Sustainability

To ensure sustainability, SOS Femmes must get proper funding. According to the director, "a shelter for battered women and children cannot, by the very nature of its work ever become self-financing." The next step for SOS Femmes is a half way home. This is of utmost importance as women need intermediate accommodation where they can feel secure and are assisted till they are strong enough to move to a completely independent home of their choice.

Replication

SOS Femmes is a replicable model for not only in Mauritius but also for the region. The success rate is quite high and survivors of SOS Femmes are role models for other women who are living in violent relationships.

Client satisfaction assessment

Three survivors were interviewed regarding their experiences and perceptions around using the SOS Femmes shelter after they had experienced GBV. The researchers asked the survivors about their experiences as clients and what they thought of the services provided.

A child's bedroom at the Shelter. *Photo by Loga Virahsawmy*

The three survivors are aged 36, 41 and 52. They all lived with their partners before they moved to the shelter. They found it very easy to get access to the shelter as there were no formalities. The only information needed was proof that they there were victims of domestic violence. "SOS Femmes is a unique place of safety as we can go there on our own, on the advice of friends or on the advice of the police. We do not need to have reference letters or go into all sorts of formalities before going there." All three survivors had accessed protection orders; in fact, one survivor had accessed six protection orders.

Two survivors learnt about the shelter from the police and the other one learnt about the shelter from a friend. The three survivors suffered continuous violence from their partners and needed a place of safety. Their lives were at stake and therefore they decided to seek help. All the three survivors got lots of encouragement from friends and the police to leave their homes and to go to SOS Femmes. They said that it would have been difficult for them to take this decision without proper moral support of friends and the help from the police.

The three respondents commended the shelter because they felt secure and the shelter accommodated their children. One survivor said, "We not only felt secure but we got everything for free, that is, breakfast, lunch and dinner. On top of that, the shelter took care of our children and sent them to schools. When our children came back from school there was always somebody at the shelter to help them with their homework and any other educational problems."

One of the survivors shared her story of how the shelter readmitted her several times. The first time she stayed at the shelter for six months and decided to go back to her husband thinking that she would be able to lead a normal life but after a few days, the beating resumed and she had to return to the shelter. The second time she stayed for one whole year before going back to the abusive relationship. The shelter did not reject her and took her for the second time. The third time she stayed for over one year and wanted to give her married life another chance but the situation got worse when she went back to her husband. It was at the fourth time that she took a final decision. She stayed at the shelter for less than a year and by the time she was ready to leave, she knew her life would take another course. The shelter liaised with the Corporate Social Responsibility at The Link Hotel and secured a job for her. The other two survivors are also working at the same hotel.

All the survivors found the experience positive as they knew they were living in a place free of violence and had to go according to the rules of the shelter. They were happy that the shelter accommodated their children.

One of the survivors said that her own family rejected her and nobody wanted to help her. She believed she would have been a complete wreck without the shelter "At least we knew where we could turn to and there was always somebody to listen to us."

From their personal experiences of staying in a shelter, all three respondents said that there should be more shelters in Mauritius and women in general should get more information on shelters. One of them said,

"Very often I meet women in the streets who have been beaten by their husbands and not knowing where to go." The survivors suggested that there should be proper structures in place where they can go as a follow up of what they have experienced.

Shelter La Colombe

This is a shelter located at Pointe aux Sables and run by the National Children's Council under the aegis of the Ministry of Gender Equality, Child Development and Family Welfare. The CDU refers the children to the shelter. The shelter accommodates children who have experienced physical and or sexual abused children, abandoned children, and children living or working in the streets.

Although the shelter is equipped to accommodate 60 children, the shelter often accommodates more children because they cannot be referred elsewhere.

Asessment of adequacy of shelter services in Mauritius

Table 7.2: Summary capacity of shelters

Name of Shelters	Maximum capacity of shelters	Women/children
La Colombe (Govt. run)	60-75	Children including a few adults
SOS Femmes (NGO)	60 (but is only taking 40 due to financials problems)	Mothers and children
Shelter for Women and Children in Distress (Trust)	40	Women and Children
Total	**175**	

Table 7.2 shows that the maximum capacity of all the shelters at any given point is 175 persons. The shelters provide services to both children and women and thus the number of women accommodated at the shelters at any given time is less than 165. In December 2011 Minister of Gender Equality, Child Protection and Family Welfare Mireille Martin announced that in 2012, Government will provide six additional shelters for distressed and needy children the at a cost of Rs 33 million. This may relieve some of the pressure of places of safety for women. But considering that 6112 people reported cases of domestic violence in 2010, there is still a considerable gap between the need and the availability of shelters. Greater state support for shelters is required. Beyond temporary shelters, the government needs to explore and invest in secondary housing for survivors when they leave.

Victim Support Mauritius (VSM)

VSM is a non-profit making, charity organization created by Volunteers in collaboration with the Ministry of Social Security. The organisation offers free emotional, psychological & practical support services. VSM trains volunteers to provide direct help to victims, witnesses and their families.

Victim Support
MAURITIUS
We help people affected by crime

Objectives

VSM aims to:

- Provide support and assistance to victims, witnesses, their families and friends.
- Raise public awareness and recognition of the effects of the consequences following a crime and provide victims' rights guidelines.
- Provide a comprehensive and flexible service to reduce the effects of Crime.
- Show victims that they should not feel guilty.

Beneficiaries

VSM cares for victims of crimes such as burglary, rape, incest, murder, racism and domestic violence, through making referrals to police, ministries and NGOs. VSM ensures that no victim is discriminated either directly or indirectly in the provision of victims' services on the basis of age, gender, sexuality, disability, culture, race, religious belief, occupation or political opinion.

Support line

VSM operates a Support line (6704815) from 10.00 to 18.00 on weekdays and 12.00 to 15.00 on Saturdays.

Reference to support by politicians

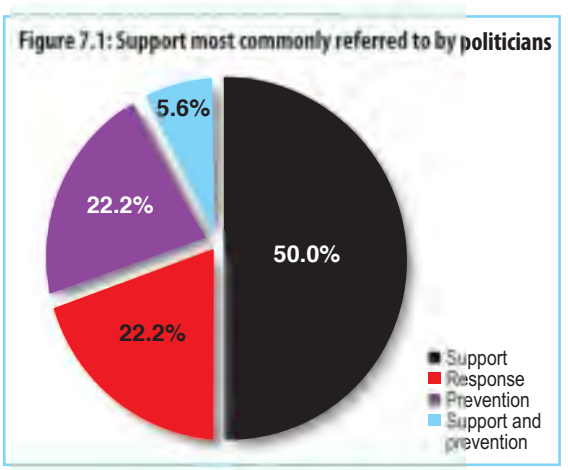


Figure 7.1 shows that the half of the speeches (50%) analysed placed emphasis on support for GBV survivors. An example of a speech with reference to support is a speech by Prime Minister, Dr. Navin Ramgoolam in November 2009 in parliament. He said, "The Women and Children Solidarity Programme was introduced in the 2007-2008 Budget and its main objective is to support NGOs which are deeply committed especially in helping women and children who are victims of abuse and violence and who are in distress."

In a separate speech during the budget debate of 2009, Hon. Francoise Labelle raised the question "Are there counsellors or psychologists who give counselling to the victims of domestic violence and has a survey has been carried out to know the impact of these campaigns?"

> "...its main objective is to support NGOs which are deeply committed especially in helping women and children who are victims of abuse and violence and who are in distress. "

Responding to Hon Labelle, the Prime Minister said "For domestic violence, this being done by the Ministry of Women's Rights, Child Development and Family Welfare. There is a study being carried out by the Mauritius Research Council at the moment."

The Prime Minister also talked about "the need to strengthen the enforcement mechanism of Protection from Domestic Violence Act (Amendment) of 2007."

The findings also show that politicians in their discourse prioritise response and support as opposed to prevention. Such a stance explains the allocation of more resources to response and support. Placing prevention at the centre is critical if ever the fight against GBV is to be won.

Plans to increase shelter services

The Minister of Gender Equality, Child Protection and family Welfare in a speech in December 2011, highlighted the need and plans put in place to increase shelter services. In December 2011, Minister Martin announced that in 2012, Government will

provide six additional shelters for distressed and needy children against the backdrop that the present shelters are operating beyond capacity and in a bid to extend comprehensive social protection to children across the island. To the tune of some Rs 33 million, the Minister said the new shelters will be located in Flacq and Grand Port (for boys), as well as Black River, Savanne, Pamplemousses and Moka.

(www.gov.mu)

Conclusion

The findings of this chapter show that support services for GBV survivors are in place in Mauritius through shelters. However, the current number of available shelters and their capacity is too small to accommodate GBV survivors. The available shelters provide services to both women and children but seem to prioritise housing children. The CDU refers children to the shelters. Although shelter services for children are critical, government also needs to provide more shelter services for women because currently the limited services are having to be shared with children. This would include increasing the capacity of existing shelters to accommodate more women and establishment of new shelters in other locations. Another recommendation is the development of a system to provide secondary housing to women when they leave the shelters.

CHAPTER 8
Prevention

Sixteen Days march in Curepipe. *Photo by Mary Jane Piang-Nee*

Key facts

- ✓ GBV prevention strategies can be primary, secondary or tertiary. Arena for action of prevention strategies includes the individual, relationships, community or broader society.
- ✓ Over half of politicians (52%) who referred to GBV in their speeches said they were committed to ending the scourge.
- ✓ Women and men are relatively unaware of events or prevention campaigns to end GBV.
- ✓ Only about two fifths of women (37%) and men (38%) were aware of events or prevention campaigns to end GBV
- ✓ Only 10% of women and 21% of men had heard about the Sixteen days campaign in the 12months before the survey.
- ✓ A lesser proportion of women (5%) and 21% of men had heard about the 365days campaign in the 12months before the survey.
- ✓ Almost half of the women (48%) of women and less than a tenth (8%) of men who were aware of GBV campaigns found them empowering.
- ✓ Gender Links conducts annual commemorations of the Sixteen Days Campaign and works with local councils to develop and implement local action plans to end GBV
- ✓ The Mauritius Broadcasting Corporation runs several programmes aimed at GBV prevention.
- ✓ MGECDFW holds capacity-building workshops with stakeholders aimed at secondary prevention. Since 2008 till 2011 the Ministry of gender Equality trained 126 officers.

"I come from a broken home and after the separation my mother got married to another man. I was a burden for both of them and was sent to my "nani" (grandmother). My poor nani lived in a small house made of old sheets of corrugated iron.

We hardly had any food to eat. When I turned nine years old my nani sold me to an old man. The first night it really hurt but I did not even know what that old man was doing to me. This torture went on for three long years on every single night. When the old man came to my nani's house, my nani left the house and I was on my own with the old man. The next morning I would go to school as if all was normal but I was suffering a lot inside.

One day I said to myself that this could not be normal and I had to tell somebody about what was happening to me. I walked to my neighbour's house and told her that I could no longer live with my nani and asked her for shelter. She started questioning me and very slowly I told her the full story on how I was sold to a man and what this man was doing to me every night. Without hesitating she took me to the police who opened a full enquiry. My nani did not deny that she sold me. She said that she was so poor she had no other means to survive and needed the money so that she could feed me. She was released on bail and I really do not know what has happened to her nor to the old man since.

The Police contacted the Child Development Unit and they placed me in a shelter.

I am now 18 years old and I can say my life has changed completely since I have joined the shelter. After my primary and secondary education the shelter sent me for extra curricula activities. I have even followed courses in drama and dancing. I participate in all activities of the Shelter be it at the shelter itself or outside on special events, for example, International Women's Day or International Family Day.

Although I know I was sold by my own nani, I have come to terms with myself and this due to the psychological and emotional support that I receive from the shelter. I am well surrounded in a convivial environment. I have found my happiness in the shelter. But like any young woman I have my own aspirations and would like to get a proper job and fly by own wings."

Rani's* story shows how her family's socio-economic status exposed her to abuse. It would be easy to condemn Rani's grandmother, but it is necessary to understand the underlying factors. Prevention, as the old adage goes, is always better than cure.

This chapter explores prevention initiatives implemented in the Mauritian context and their effectiveness.The interventions fall into three categories[1], namely:

- ***Primary prevention:*** Interventions aimed at addressing GBV before it occurs, in order to prevent initial perpetration or victimisation. These include targeted actions aimed at changing behaviour and

[1] Centres for Disease Control and Prevention. Sexual Violence Prevention: Beginning the Dialogue. Atlanta, GA (2004) p. 3.

attitudes. Interventions are also aimed at changing risk producing environments.

- ***Secondary prevention:*** Interventions that happen immediately after the violence has occurred to deal with the short term consequences for example treatment, counselling.
- ***Tertiary prevention:*** Long term interventions after the violence has occurred, in order to address lasting consequences. Examples of this are perpetrator-counselling interventions.

In this study, we place emphasis on documenting primary and secondary prevention initiatives in Mauritius in the different arenas for action.

Areas for action

The ecological model referenced earlier in this study locates key arenas for action including:

- ***Individual:*** The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpe-trator of violence. Some of these factors are age, education, income, substance use, or history of abuse.
- ***Relationship:*** The second level includes factors that increase risk because of relationships with peers, intimate partners, and family members. A person's closest social circle-peers, partners and family members-influences their behavior and contributes to their range of experience.
- ***Community:*** The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpe-trators of violence.
- ***Societal:*** The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Primary prevention

Primary interventions for GBV aim to address the root causes at an individual, relationship, community and societal level. Strategies include:

- Political will and commitment to address GBV;
- Public awareness programmes;
- Using media to raise awareness on GBV.

Political will and commitment to address GBV

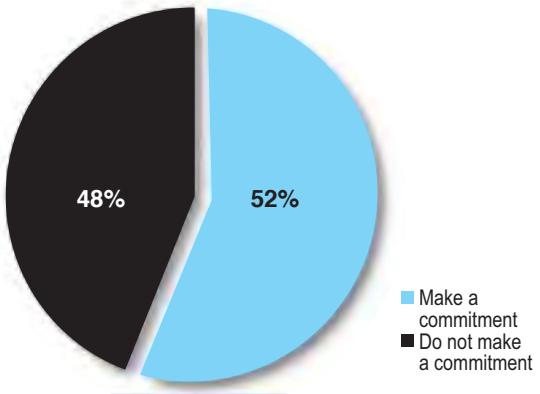
Loga Virahsawmy, Marlene Ladine, Minister of Tertiary Education, Hon. R. Jeeta and Prime Minister, Dr. Navin Ramgoolam at the launch of *"I" Stories* 2008 in Mauritius.
Photo by Danny Phillip

For a violence prevention strategy to be successful it has to be unified, coordinated, scientifically-informed, well-resourced and directed across all clusters of society, government departments and civil society.[2] Political leadership at its helm should be committed to ending GBV and consistently publicly denounce GBV. Leaders should also facilitate and support necessary changes in community norms that influence GBV-related behaviours of boys and young men.[3]

Figure 8.1 shows that in 52% of the speeches analysed in this study, politicians commited to ending GBV. This shows that more women politicians in Mauritius are engaging in GBV discourse and refer to commitments than men. This finding is useful in lobbying for women's representation in politics with the hope that they will put women's issues on the political agenda.

[2] Jewkes, Abrahams, Mathews, Seedat, et al, 2009.
[3] UN General Assembly. 2006b. Rights of the Child: Report of the Independent Expert for the United Nations Study on Violence against Children. New York: UN.

Figure 8.1: Proportion of speeches referring to political commitments to end GBV



Sixteen days of Activism campaigns

Each year the Sixteen Days of Activism campaign has provided a rallying point for the governments, NGOs, CBOs and other stakeholders in the region to mount events aimed at raising awareness, influencing behaviour change and securing high level political commitment to end GBV. The campaign takes place annually in the period between 25 November and 10 December.

Key dates include:

- 25 November: International Day of No Violence Against Women
- 1 December: World Aids Day
- 3 December: International Day for the Disabled
- 10 December: Human Rights Day

Reclaiming unsafe spaces - Take Back the Night

"Take back the night marches" bring together local councils in partnership with NGOs around Southern Africa to various locations to march, as a way to raise awareness around GBV and reclaim spaces deemed unsafe for women and children. GL and the local partners in Mauritius organised a march on the 25th November 2011 as an opening to the Sixteen Days Campaign. Over 100 participants marched in Rose-Hill. Participants included political figures, Rose-Hill Municipality members and various other supporters for the cause.

Cyber dialogues

The GL annual cyber dialogues are an integral part of the Sixteen Days' campaign. These dialogues are moderated online discussions related to specific gendered themes hosted on GL's website. In 2010, dialogues were only possible through collaboration with local councils and GEMSA partners. Under the theme of connecting local languages and citizens across artificial boundaries, 11 countries through the SADC region were encouraged to participate in the cyber dialogues. Mauritian participants had the option to dialogue in any of the two language rooms, namely; French and English.

Municipal council of Beau-Bassin, Rose-Hill, marching at the Sixteen Days campaign. *Photo by Marie Jane Piang-Nee*

Table 8.1: Cyber dialogue schedule and themes 2010		
Date	**Theme**	**Language**
18th November	Media debate - Is media part of the problem or the solution?	English and French
25th November	Taking stock of National Action Plans to end GBV.	English and French
29th November	Click of the mouse. GBV and the internet.	English and French
30th November	Gender and economic violence.	English and French
1st December	World AIDS day - Making care work count.	English and French
2nd December	Sexual orientation and GBV.	English
3rd December	Disability and GBV.	English
6th December	Culture, tradition, religion and the role of men.	English
7th December	Sex work and GBV.	English
8th December	Human trafficking and migrant women.	English
9th December	Local action to end GBV (local government).	English and French
10th December	GBV: What is the political agenda?	English and French

Key issues raised in the dialogues, regarding prevention included that:

- Women must speak out in order to break the silence and put GBV in the centre of daily interactions so people understand it better and are empowered to speak out even more.
- Media has a role to expose societal ills for public discussion and engagement.
- Without the media we could not be talking about making progress. Today we boast about moving forward as the country or lagging being because the media has and will always give platforms for GBV violence.
- Blaming the media, or NGOs or the church will not help, we need to look at ourselves and ask what role we play in ending GBV. Partnerships and collaboration among different stakeholders is necessary in addressing GBV. NGOs and activists should work hand in hand with the media so issues of GBV are adequately addressed.
- GBV should be taught in schools along with gender and development issues. GBV is not an issue for the media to address alone. The drivers of change are culture and society.
- Until GBV becomes a priority on the political agenda, little change would come. Participants noted that political figures and celebrities had a lot of influence over people, and could potentially address negative social practices, views and norms.
- While GBV appears to be on the political agenda on paper through policy frameworks and enabling legislation, implementation of these is not effective.
- Awareness programmes must be driven from a multi-sectoral approach were government, private sector and civil society formulate joint communication strategies to provide holistic information.

The UNiTE to End Violence Against Women campaign

In 2008, the United Nations Secretary-General Ban Ki-moon launched the UNiTE to End Violence against Women campaign that reiterates the need for a multi-sector approach to ending GBV. The campaign is a multi-year effort aimed at preventing and eliminating violence against women and girls in all parts of the world.

The African Component of the UNiTE campaign was launched in Addis Ababa in November 2008. In her address to CEDAW in October 2011, Hon Minister Mirielle Martin said the UNiTE Campaign would be launched in Mauritius.

Awareness of GBV campaigns

The prevalence/attitude survey for this study asked women and men about their knowledge and participation in GBV campaigns.

Figure 8.2: Knowledge of events or campaigns to end GBV by women and men

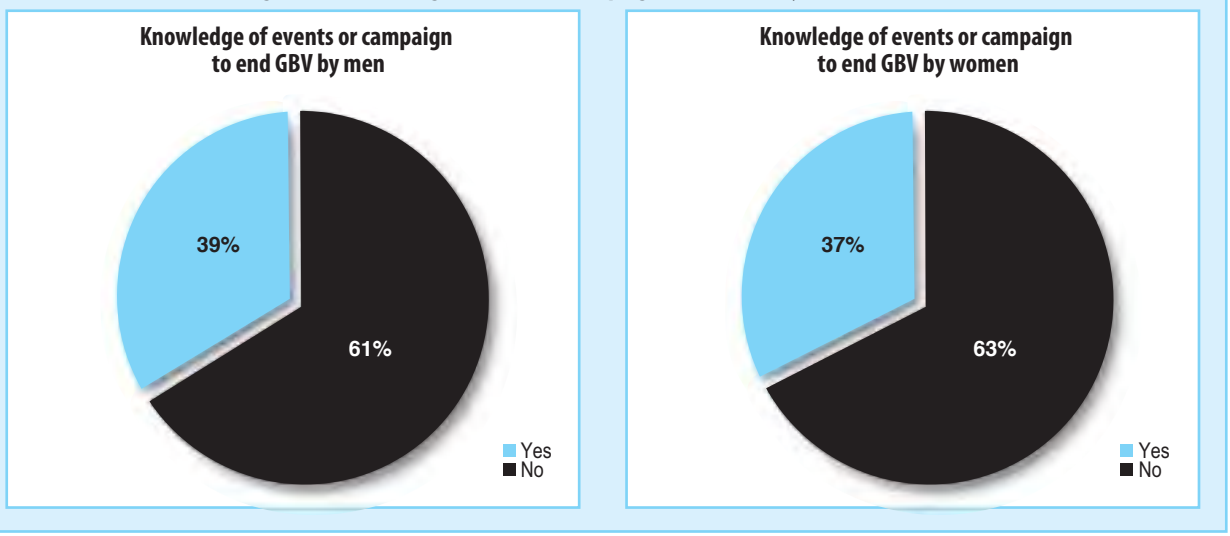


Figure 8.2 shows that only 37% of women and 39% of men said they had heard about GBV campaigns or events. These findings that actors in the GBV sector need to put more efforts in sensitising communities about GBV and broaden community outreach during campaigns.

Figure 8.3 shows that more men (21%) than women (10%) had heard about the Sixteen Days of Activism campaign. Twenty-one percent of men and five percent of women had heard about the 365-Day campaign. A small proportion of the participants had participated in GBV campaign events. Fifteen percent of men and five percent of women had participated in a march or event to protest against GBV. For a small island with good communication these figures are exceptionally low. There is need to step up the reach and impact of campaigns.

Figure 8.3: Knowledge and participation in campaigns to end GBV by women and men

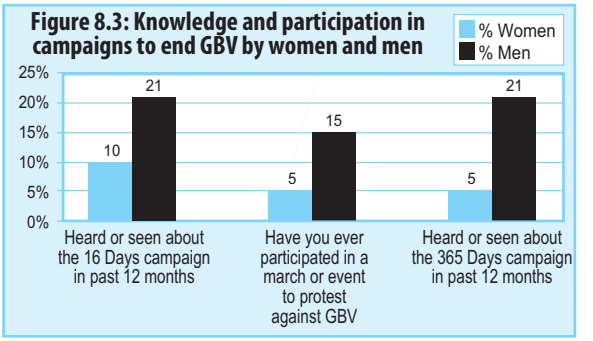


Figure 8.4: Sources of GBV campaign information

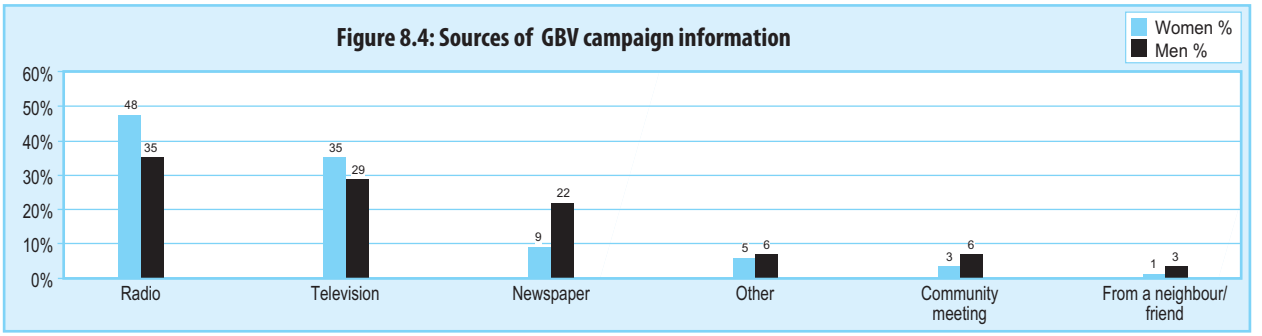
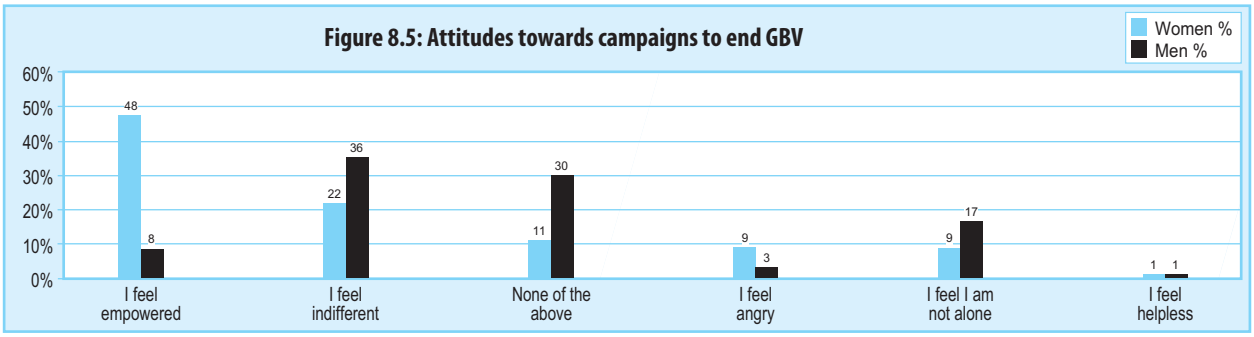


Figure 8.4 shows that the majority of women and men access knowledge about GBV campaigns through radio. Almost half (48%) of women and 35% of men interviewed said they had heard about GBV campaigns through the radio. A greater proportion of men than women heard about the campaigns through the newspaper. Twenty percent of men and nine percent of women had heard about the campaigns from the newspapers. Smaller proportions of women and men had heard about the campaigns in community meetings or from neighbours or friends.



Female Security Guard at the Abercrombie Women Centre.
Photo by Mary Jane Piang-Nee

Figure 8.5 shows that almost half of the women (48%) found the campaigns empowering compared to only 8% of men. The majority of men (36%) said they felt indifferent about the campaigns while 30% said they felt nothing about the campaigns. 22% of women also felt indifferent towards the campaigns.

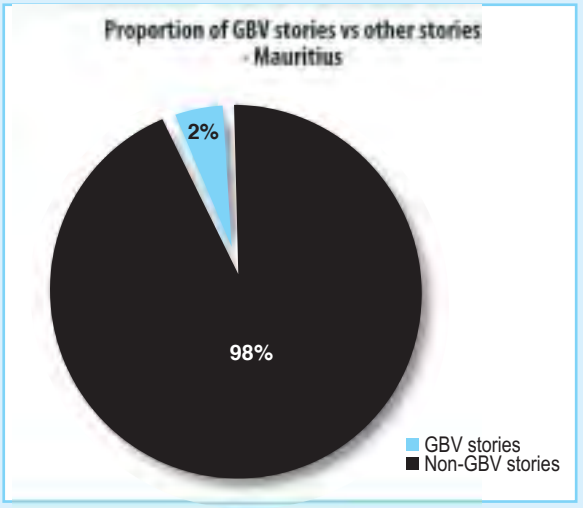
Zero Tolerance Clubs (ZTCs)

The Ministry of Gender Equality has facilitated the setting up six ZTCs with various community-based organisations. The ZTCs are initiatives that involve the communities to combat GBV. Members of the ZTCs act as watchdogs to ensure that their respective localities are violence free. ZTCs are available in Abercrombie, Goodlands, Mare D'Albert Pointe aux Sables, Montagne Blanche and Grand Gaube.

Media

Mauritius has a strong and fiercely independent media. The liberalisation of the airwaves began in 2002, but the public broadcaster, the Mauritius Broadcasting Corporation (MBC), is still the dominant broadcaster. The MBC operates under the MBC Act, which stipulates that the broadcaster should strike a balance between ethnic and religious interest. The Act is silent on gender.

Figure 8.6: Comparison of country vs regional GBV coverage



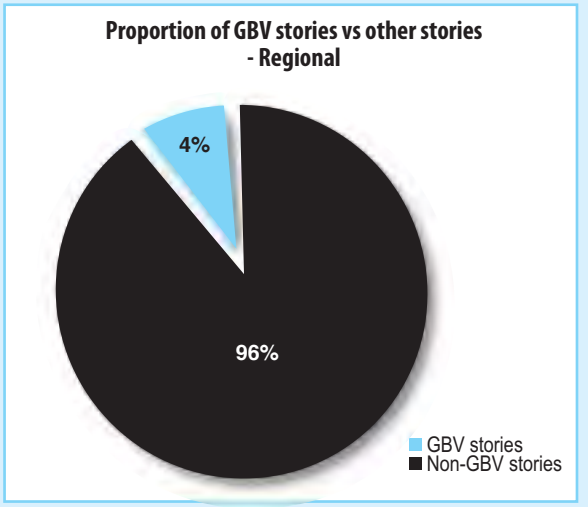


Figure 8.6 shows that according to the Gender and Media Progress Study (GMPS) conducted by GL in 2010, GBV accounts for 2% of total coverage in Mauritius, less than the regional average of 4%.

Figure 8.7: GBV coverage by country and media - Mauritius

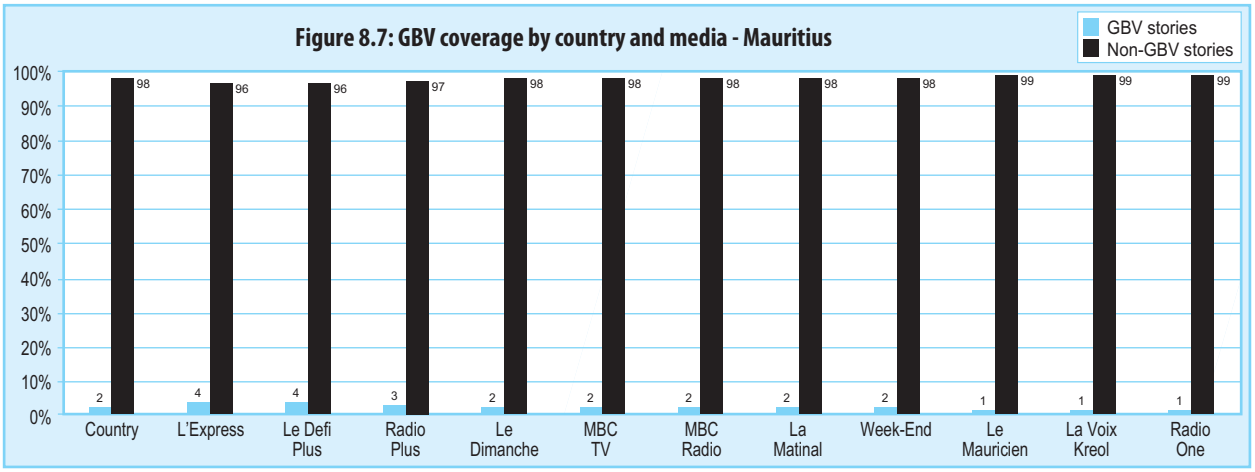


Figure 8.7 shows that all media houses in Mauritius give very little coverage to GBV stories ranging from L'Express and Le Defi Plus at 4% each to Le Mauricien, La Voix and Radio One at 1% each. The findings reflect that GBV stories are not newsworthy for the media in Mauritius.

The report recommended that:

- Journalists need to be equipped with more information on the different aspects of GBV which happens behind closed doors, for example, verbal and psychological abuses and other subtle forms of GBV.

- The media should stop portraying women as victims, but more as survivors and there must be more in-depth analysis articles on GBV.
- Voices of experts and NGOs from both sexes must be sought.
- Radio, which is a powerful medium in the prevention mechanism and curbing GBV, should work as an agent for change and give more voices to women and help those in abusive situations to speak.

Case study on the MBC

The MBC is one of the first media houses in the region that GL worked with in developing a gender policy accompanied by an action plan in 2006. The findings of the GMPS in 2010 showed that although women sources at MBC leapt from 14% in the Gender and Media Baseline Study in 2003 to 28% in the GMPS, the public broadcaster still lagged behind in terms of GBV coverage.

Several developments have occurred since the launch of the GMPS study launch. The MBC reviewed its gender policy in 2010. In October 2011, the MBC signed a Memorandum of Understanding with GL to become a Media Centre of Excellence (COE). The MBC is now the only media institution in a SADC country to run a series of call-in radio programmes on the SADC Protocol on Gender and Development.

Training journalists to cover GBV

In October 2011, GL facilitated a workshop for media practitioners of the MBC on "Reporting on GBV and the 16 days activism campaign". Fifteen female and five male media practitioners and producers from the different departments participated actively in the workshop.

Content

The training manuals on "Reporting on GBV and 16 days" as well as SADC Protocol leaflets, GMPS CD, the Media COE leaflets, *"I" Stories*, leaflet on statistics on violence in Mauritius and M & E Forms were given to all participants at the start of the workshop.

After doing the different exercises and questioning the different issues, participants had a good grasp of the different definitions of violence, the different types of violence and the effects of violence on women, children, the family and the society. The participants understood the relationship of GBV and HIV and AIDS and protocols in place to deal with GBV and HIV.

Dan Callikan, Director General of the MBC with GL Francophone director Loga Virahsawmy. *Photo by Colleen Lowe Morna*

Avinash Appadoo from the Ministry of Gender Equality explained the framework for understanding GBV and talked about laws in place as well as the implementation of laws. The participants understood the effects, the responses, the support, prevention campaigns and integrated approaches to addressing GBV. He explained the roles of the FSBx in the country and the integrated service being given including psychological and legal support. He also explained the Protection from Domestic Violence Act; the support of police posts in all hospitals of Mauritius to deal with cases of GBV and other structures in place to deal with GBV.

A survivor who is now working and raising her young son gave a moving testimony on all the problems she is facing although she is no longer living with her violent husband. Participants came out with a series of story ideas not only to create

awareness on GBV but to find solutions and make sure that policy makers walk the talk.

GBV programming

The MBC has television and radio programmes that are aimed at raising awareness about GBV. The MBC Director Generral reiterated "We are showing the other face of Mauritius where people live in poverty, where GBV is rife and where children cannot go to school because men just leave and refuse to bear the family responsibility. In some cases, GBV is due to alcohol. We want to show these realities. We know how to get people to talk. We give lots of women voices in our programmes and they are not afraid to break the silence and we are breaking new grounds. Our programmes have fantastic impact and we go beyond. We make sure with the authorities and Ministries concerned that these people are given all the support, help and infrastructure needed. Our broadcast is eye opening. Our aim with these programmes is to change peoples' lives. We can assure you that change is happening. The viewers can see how the MBC has helped to improve people's lives with the support not only of authorities but by NGOs, stakeholders, students, individuals and Mauritians who care."

Anou Bouze

This is a 26 minutes fortnightly television programme at peak time on Wednesday with a repeat on Sunday. The title of the programme "Anou Bouze" (Getting involved) speaks volumes as it ensures that the whole Mauritian population is aware and sensitised on social problems.

Kendy Mangra on Anou Bouze, MBC. *Photo by Gender Links*

According to Director-General Dan Callikan: "We want to show the hidden face of Mauritius. We tell people that they all have a responsibility when children are not going to school because of GBV or poverty. We want to create this movement of solidarity. We want Ministers and Ministries to be proactive and take prompt action. We want the authorities and NGOs to come forward and change the situation. Although some of our programmes are not focused on GBV as such we have noticed that in one way or the other GBV is at the heart of nearly all social problems, be it drugs, alcohol, HIV and AIDs or street children."

Kahan Jaat Ba Hamni ke Samaj

"Kahan Jaat Ba Hamni ke Samaj" (where is our society going) is the Hindustani version of "Anou Bouze" by Karuna Lalloo but with more focus on women. The programme runs at peak time on Friday with a repeat on Wednesday. "Before we do the actual shooting and interviews we do some research and meet with all those concerned not only to know the extent of the problem but also to find out if the cases are genuine and worth coverage," the Editor in Chief of the MBC, Datta Ramyead said. "Women are breaking the silence on poverty and GBV and they are getting incredible help"

Karuna Lalloo

During 26 minutes of the programme, women talk about all their problems including GBV. "It is not true to say that women do not talk. They have confidence in us and they know we are not using them for our coverage but because we want to help them," says a commentator on the programme.

Cool FM a l'ecoute

Djemillah Mourade presents on a daily talk show for two hours on MBC Radio called "Cool FM a l'ecoute" (meaning Cool FM is listening to you). The majority of callers to the show are mostly women

who share their traumatic experiences on GBV, their children who are refusing to go to school or their children who are beyond control and other social problems. Representatives of the PFPU, FSBx, the CDU, a lawyer and a psychologist co-present on the show. The panel on the show provides women with advice. Mourade said" Sometimes we even get cases where women want to commit suicide. We direct them to the proper authorities and NGOs where they can get help. There are some cases when women choose not to talk on radio but send us telephone messages. We do not leave any stone unturned and help them all."

Djemillah Mourade, former Gender Links intern, now an MBC journalist. *Photo by Loga Virahsawmy*

When asked if two hours on a daily basis is not too much, Mourade replied: "the programme could have gone for a whole day. There are so many people especially women out there who appreciate the chance to talk about their problems. We are giving them back the voices they have lost. We have so many calls and assist many people. Maybe people feel more secured with us than official hotlines. We encourage people to call us even when they are not personally involved. They do call us when they hear cases of GBV and we get the police to take action. We have helped so many women with problems of GBV, alcohol and drugs as well as street children. Very often women do not know their rights. They do not know where to go for legal aid. Our Legal Adviser, Harry Bansroopun, who is on our programme gives the survivors free advice on radio as well as in his office. Often we assist women who seek for help by just calling without talking on the radio."

Mourade showed the GL interviewer her diary with all the complaints, the telephone number and the organisations where people are referred to. "We even have cases where women are verbally abused by their boss and we tell them where to go for help and guidance."

"Constat"

David Bodhna, the Production Manager, does a monthly television programme "Constat" (Fact) on different social problems including GBV by interviewing a series of experts as well as survivors on the problems and trying to find solutions. "We have interviewed those responsible for shelters, survivors as well as officials."

The MBC television and radio programmes show the efforts to raise awareness about GBV as well as helping the women and men to find solutions to different social problems including GBV.

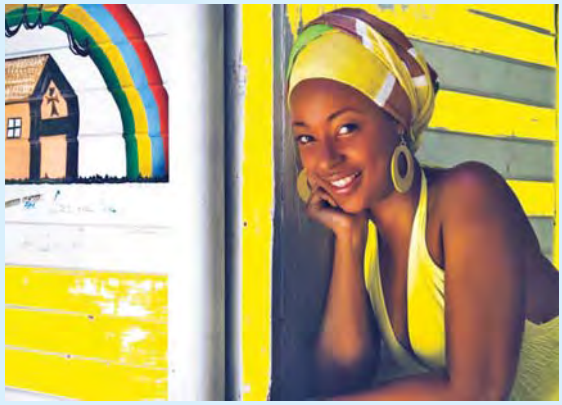
The Arts join the fight against GBV

One area of action for GBV prevention is the arts sector which includes performing art and music. Here we present an example of a music project conducted in Mauritius in 2010 to raise awareness around GBV.

Project Valer Fam

In front of a rise of different forms of violence, a movement of musicians called Kolektif Revey Twa (Wake up together) was set up to denounce and make sensitisation on this plague, in the commemorations of the 2010 International Woman's Day. Linzy Bacbotte, the most popular woman singer in Mauritius under the banner of Kolektif Revey Twa presented the "Valer Fam" (the value of women) album. The project "Valer Fam" includes a CD of six audio titles with the song *"Bondie li enn fam"* (If God was a woman), a composition of the French artist Corneille. The other songs talk on prevention and sensitisation on violence against woman as well as the importance of woman's respect. The album was a way to raise awareness in the Mauritian society about various problems affecting women, particularly the feminisation of HIV & AIDS, violence and murders. The album was launched in January, 2010 in Lacaz A.

The album was dedicated to Marie-Ange Milazar (a sex worker) killed by a gang in December 2009. A memorial was observed, organised by Collectif Citoyen (Coalition of Civil Society) with the collaboration of Kolektif Revey Twa. Two other NGO's namely the Women in Networking (WIN), and the Prevention Unit of Centre de Solidarité (CDS) participated in this initiative. A national campaign, named "Men against Violence", was run from March 2010.A music concert, was held on the 6 March 2010 at the Swami Vivekananda Convention Centre in Pailles.



Linzy Bacbotte. *Photo google.com dossier-valer-fam*

The objectives of the project Valer Fam included to:

- Increase women's worth and trust in themselves.
- Denounce all the forms of violence against women by organising sensitisation and awareness campaigns
- Collect funds for associations and centers helping women

Engaging faith based organisations

One priority area of action identified in the National Action Plan to Combat Domestic Violence is the need to sensitise religious and community leaders with a view to breaking down taboos regarding domestic violence and conducting sensitisation campaign against domestic violence. In this endeavour, the Ministry has successfully engaged into partnership with religious bodies in the following ways:

- A workshop was organised with religious bodies and the Council of Religions to sensitise them on the issue of domestic violence on 8 March 2008. A booklet on "Domestic Violence and Communities of Faith - Engaging Religious Organisations the fight Against Domestic Violence" was launched and disseminated.
- The Ministry collaborated with the Youth Wings of the Council of Religions in 2009 to sensitise them on the issue of domestic violence so that they can promote a culture of non-violence in the society.
- Currently the Council of Religions is among the NPEGBV members.

Secondary prevention

Secondary GBV prevention interventions empower those charged with the responsibility of addressing GBV with the skills to promote prevention and the ability to deal sensitively with the topic. Strategies include training key stakeholders: police; health personnel; traditional leaders; prosecutors and faith-based organisations.

Police officer training

Minister Mireille Martin at the Launch of GIME. *Photo by Davinah Sholay*

The National Action Plan to Combat Domestic Violence provides for holistic combination of response programmes comprising a range of issues, inter alia, social, employment, housing, childcare, education, health, safe community and justice. The lives of survivors depend on coordinated efforts across sectors and different stakeholders. Following the launching of the National Action Plan to Combat Domestic Violence, the Family Unit of the MGECDFW trained officers from the PFPU on GBV related issues. The aim of the programme was to make sure that the police is equipped to effectively deal with cases of GBV and especially domestic violence.

The programme consists a three-day training workshop every six months. Officers from the different regions also meet every two months for a half day to compare notes on cases referred to courts, action taken, reports from medical social workers dealing with the victims and other matters. Referral reforms have been developed for both the staff of the Ministry and the police.

Impact

The police became more aware of how to protect survivors, the effective enforcement of legislation in place and the referral system.

Funding

All programmes on GBV come from the national budget earmarked for the MGECDFW. UNDP and other international agencies such as UNODC and UN Women have also assisted the Ministry for consultancy services regarding the elaboration of action plans, Capacity Building Programmes and launching of Africa Unite Campaign amongst others.

Outreach

The programme was organised in such a way that all Districts of Mauritius are covered. The Ministry has nine full time staff in the six family support bureaux as well as three full time staff at its Head Office. The officers got on the job training that they can put into practice.

Table 8.2: Number of police officers trained 2008-2011

Year	Course name	Number of officers trained
2008	Workshop on the Protection from Domestic Violence Act and drafting of affidavits.	46
2008	Sensitisation workshop on handling of domestic violence cases by police officers posted at Police stations.	60
2009	Awareness session on the Protocol of Assistance to Victims of Sexual Assault delivered to Police officers posted in Police Stations.	Not provided
2011	Training of Trainers Programme for the Development of Effective Police Response to Violence against Women.	20

Training of Family Welfare and Protection Officers (FWPOs)

Family Welfare and Protection Officers (FWPOs) are present in the six FSBx to assist victims of domestic violence. Most of the FWPOs are degree holders either in social studies or social work. However, to better assist victims of domestic violence the ministry holds on the job training and capacity building programmes. The FWPOs are trained on the provisions of the Protection from Domestic Violence Act, the impact of GBV on women and their sexual reproductive health, drafting of affidavits; counselling techniques and strengthening values for family life, amongst others.

Training for local government authorities and other stakeholders

The MGECDFW has intensified its efforts to combat GBV and believes that stakeholders such as Mauritius Police Services, Ministry of Health and Quality of Life, the Judiciary, including local government which are close to the community are in a better position to respond to GBV. In April 2009, the Ministry ran a capacity-building programme with senior officials from the Local Government Authorities, the Ministry of Social Security, National Solidarity, Senior Citizens Welfare and Reform Institutions through their Social Welfare Centres, the Ministry of Environment and National Development Unit through the Citizens Advice Bureau and the Sugar Industry Labour Welfare Fund. The aim of the programme was to assist the Ministry in implementing a multi-sectoral approach to combating domestic violence. Issues discussed included:

- How to combat domestic violence in your locality/ area;
- Domestic violence and its psychological Impacts;
- Domestic violence and services offered by the FSBx; and
- Domestic Violence and the provisions of the Protection from Domestic Violence Act.

The Ministry plans to replicate the same exercise with the Local Government Authorities and other stakeholders including NGOs so that maximum people at grass roots levels are sensitised and can respond to domestic violence.

Conclusion

There is evidence of primary and secondary prevention strategies at work in Mauritius. However, there is need for systems to be put in place to monitor the effectiveness of these interventions. The Sixteen Days of Activism, 365 days campaign are relatively unknown. Efforts should be made to increase awareness and participation in GBV campaigns.

CHAPTER 9
Integrated approaches

16 Days march, Curepipe, Mauritius.

Photo by Mary Jane Piang-Nee

"Commitment is primordial in the fight against GBV. Political will is spelt out through legislation, strategies, and National Action Planning, like the one we are here to elaborate today. GBV goes beyond the responsibility of the Police and the legal system, and necessitates the provision of support services, rehabilitation, awareness raising and education amongst others.

I make a special appeal to all of you as participants to build on our current strengths and target our weaknesses, so that a national, integrated, realistic and holistic action plan emerges out of this two-day consultative workshop.

Today, we have a chance to make a difference in the lives of not only victims of GBV, but of potential aggressors as well.

The launching of this National Platform is a hallmark, because it heralds the beginning of a new dawn. That of a renewed national commitment to help our fellow citizens, irrespective of their geographical location within our Republic, to combat and eradicate GBV.

It is time for us to be conscious that we must address all forms of violence that pervade in our society. For peace to prevail on our streets, it should beforehand prevail behind closed doors.

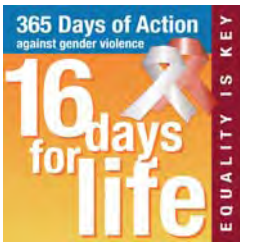
We urgently need to prepare the present and future generations for non-violence to be integrated in our way of living.

Let us work together to make our schools, our work places, our homes, our communities, violence free zones. And if we want change, like Mahatma Gandhi rightly said, - we should start by being THE agent of change ourselves."

Excerpt from the speech delivered by Hon. Mireille Martin, Minister of Gender Equality, Child Development and Family Welfare at the launching of the National Platform to end GBV
Source:www.mu.gov

The excerpt reflects the commitment by Mauritius to a multi-sector approach for ending GBV similar to the call made by the UN for all countries to develop, adopt and implement multi- sector National Action Plans to End GBV. This chapter outlines the objectives of the Mauritian National Action Plan to Combat Domestic Violence and an evaluation of progress in its implementation. It also assesses Terms of Reference of the newly formed National Platform to End GBV.

National Action Plan to Combat Domestic Violence 2007-2011



This multi-sector framework had five strategic objectives:

- Improving legislation on domestic violence and strengthening the justice system and other agencies;
- Providing appropriate, accessible, timely, coordinated multi-agency responses and support to all victims and children;
- Sensitising and changing attitudes to prevent domestic violence from happening in the first place;
- Promoting responsible advocacy, sensitisation and provision of forum by media specialists to encourage the community to discuss domestic violence; and
- Undertaking research and studies on domestic violence.

Evaluation of implementation

GL with support from UN Trust Fund convened a meeting to assess the progress made in implementing the National Action Plans to End GBV in the SADC region from 16-17 February 2011. This provided an opportunity for countries to take stock of progress made, identify existing gaps exist and propose possible solutions. Each country identified their key achievements and challenges in the implementation of the NAPs. The exercised placed special emphasis on devising strong monitoring and evaluation processes learning from the GBV indicators pilot project as a possible model.

Table 9.1: Evaluation of implementation of NAP by Mauritius	
Targets	**Progress against targets**
LEGISLATION	
Laws on Domestic violence	The PDVA in place. Amended in 2004,2007 and 2011.
Laws on Sexual assault	There is no specific legislation on sexual assault. The Sexual Offences bill is still pending.
Comprehensive treatment, including PEP	Post exposure prophylaxis is available to all accidental prick injury, health care professionals and all cases of rape.
Specific legislative provisions to prevent human trafficking	The Combating of Trafficking in Persons Act of 2009 is in place.
Sexual harassment	The Labour act and Sex Discrimination Act include clauses on sexual harassment in schools and in the workplace.
SERVICES	
Accessible, affordable and specialised legal services, including legal aid, to survivors of GBV	Six FSBx are in operation at the Ministry of Gender Equality, Child Protection and Family Welfare. Psychological counselling and legal advice are provided to survivors of GBV.
Specialised facilities including places of shelter and safety	Three shelters in place namely the Shelter for Women in Distress, Shelter La Colombe and SOS Femmes. The National Children's Council operating under the aegis of the Ministry of Gender Equality runs Shelter La Colombe. The other two shelters are run by an NGO and a Trust Aid. The Ministry plans to set up six more shelters in 2012.
COORDINATION , MONITORING AND EVALUATION	
Integrated approaches: National Action Plans	The National Action Plan to combat Domestic Violence 2008-20011 was adopted by cabinet in 2007. A new National Action plan to end GBV 2012-2015 is in place.
By 2015 construct a composite index for measuring GBV	Plans are underway to develop this.
By 2015 provide baseline data on GBV	The GBV Indicators Study in Mauritius is one vehicle to achieve this target.

Table 9.1 shows that Mauritius made substantial progress in the implementation of the 2007-2011 National Action Plan to Combat Domestic Violence (GL, 2011). The MGECDFW reported that 92% of the recommended actions had been implemented by December 2011. The remaining 8% comprised implementation of the Victim Empowerment and Abuser Rehabilitation Policy, and impact assessment of the Action Plan.

Since 2010, with the change from the Ministry from Women's Rights to Gender Equality, the areas of interventions of the Family Welfare and Protection Unit (FWPU) have broadened. In line with the international trend, the FWPU has shifted from domestic violence to gender-based violence. MGEDFW now has a Costed National Action plan on GBV (CNAPEGBV) - 2012-2015 that takes into consideration GBV and other than domestic violence.

Costed National Action Plan to End Gender-Based Violence 2012-2015 (CNAPEGBV)

The gender ministry convened a two-day consultative workshop with stakeholders to elaborate of a Costed NAPEGBV. The consultative workshop focused on the development of multi-agency responses by stakeholders with a view to:

- Enabling them to integrate and mainstream actions against Gender-Based Violence (GBV) in their respective existing programmes for sustainability.
- Ensuring that a co-ordinated multi-sectoral approach is adopted and implemented by them. Networking and partnership building in the fight against GBV will promote synergy, avoid duplication and contribute towards a shared vision of strategies adopted.
- Increasing accountability of stakeholders involved in the implementation of the Action Plan. Stakeholders should report on actions taken at their end as per the agreed-upon TOR. The challenges faced, opportunities seized, progress achieved, when shared, will contribute to re-engineer actions to be taken by members of the National Platform.

Objectives of the CNAPEGBV

The CNAPEGBV strives to integrate and mainstream actions to prevent and respond to gender-based violence into existing programmes and sectors. The guiding principle is that actions should not be established as special programmes or projects, as this undermines their sustainability over the long term.

The CNAPEGBV is also a framework to ensure co-ordinated multi-sectoral action by all actors. It entails the involvement of key sectors (community services, CBOs and NGOs, police and prison services, healthcare workers, lawyers, family protection officers, social security officers, media specialist, educationalists, trade unions and private sector employers) who should be willing to co-ordinate, co-operate and collaborate. This integrated approach consequently:

- promotes efficiency and adequacy of services;
- ensure that women victims of GBV have access to services at all levels through various organisational networks;
- maximises the expertise and experience of different organisations;
- builds the advocacy momentum and the capacity of service providers by increasing the resource base; and
- stimulates a process whereby gender-based violence is addressed within a holistic framework.

The specific objectives of the CNAPEGBV are to:

- Implement a multi-level approach to redress GBV by reviewing, adopting and enforcing protective laws and policies; improving health, legal/justice, security, education and social welfare systems to monitor and respond to GBV survivors and perpetrators, and ensuring prompt and compassionate services to survivors.
- Implement a coordinated multi-sectoral approach in tackling GBV issues in the country.
- Mobilise communities and specific target groups (men and boys) to change social norms likely to perpetuate GBV.
- Be in line with SADC protocol, that is, strategic area of focus address the following: legislation; social practices; support services; training of service providers and integrated approaches.

Source: CNAPEGBV, 2011

Key strategic pillars

Addressing GBV requires that strategic areas be identified and a multi-sectoral approach be adopted. Responses to GBV within the CNAPEGBV framework will focus on five key strategic areas or pillars namely:

1. Legislation and Prosecution.
2. Capacity building of service providers in the rehabilitation of survivors and perpetrators.
3. Prevention-awareness raising : Design and implement social marketing information and education campaigns to raise community on GBV.
4. Media Education and Advocacy.
5. Coordination, Research, Monitoring and Evaluation.

National Platform to End GBV (NPEGBV)

The Minister of Gender Equality, Child Development and Family Welfare launched the NPEGBV on 19th

October 2011. The NPEGBV is a multi-sectorial structure comprising government and civil society actors. The multi-sectoral NPEGBV will allow for an increased accountability at all levels and ensure an efficient, effective and coordinated effort leading to the elimination of GBV in Mauritius. The following table shows the government and civil society actors on the NPEGGBV:

Table 9.2 Members of the NPEGBV

Government ministries and departments	Institutions	NGOs/Private Sector/ Trade Union
1. Prime Minister's Office: (Police & Prison Departments) 2. Ministry of Foreign Affairs: Regional Integration and International Trade 3. Ministry of Housing and Lands 4. Ministry of Social Security 5. Ministry of Education and Human Resources 6. Ministry of Tertiary Education, Science and Technology 7. Ministry of Information and Communication Technology 8. Ministry of Youth and Sports 9. Ministry of Local Government and Outer Islands 10. Ministry of Arts and Culture 11. Ministry of Labour, Industrial Relations and Employment 12. Attorneys General's Office 13. Ministry of Health and Quality of Life 14. Ministry of Social Integration and Economic Empowerment 15. Ministry of Civil Service and Administrative Reforms 16. Government Information Services (GIS)	1. National Solidarity and Reforms Institutions 2. Mauritius Family Planning and Welfare Association (MFPWA) 3. Mauritius Council of Social Services (MACOSS) 4. Sex Discrimination Division (part of the National Human Rights Commission) 5. National Children's Council (NCC) 6. Mauritius Research Council (MRC) 7. University of Mauritius (UOM) 8. University of Technology Mauritius (UTM)	1. Media Watch Organisation and Gender Links 2. Mauritius Girls Guide Association, 3. Women in Networking (WIN) 4. SOS Femmes 5. Shelter for Women and Children in Distress 6. Trust Indian Ocean Centre for Education in Human Values (IOCEHV), Prévention Information et Lutte contre le SIDA (PILS) 7. Council of Religions 8. Mauritius Employers' Federation and Trade Unions

Objectives

The NPEGBV's objectives include:

- bringing together and consolidate the efforts of all stakeholders involved in reducing GBV in a holistic, systematic, complementary manner through multi-sectoral, and multi-dimensional approach.
- providing appropriate care and services to empower survivors and rehabilitate perpetrators.

A tailor-made single reporting system will be agreed upon by stakeholders to incorporate the type of intervention each stakeholder undertakes. Stakeholders will be trained on the reporting system. In her launch speech, the Minister explained: "A reporting mechanism on the actions of stakeholders will be established so as to enable the promotion and sharing of best practices, as well as the reengineering, whenever necessary, of actions taken by members of this Platform. The Costed National Action Plan to End Gender-Based Violence of Action shall in fact be the roadmap of the National Platform."

Co-ordinating Advisory Committee (CAC)

The CAC is a core team that will finalise the country strategies to fight GBV. This team is led by the Head of the Family Welfare and Protection Unit and comprises representatives of the following institutions:

- State Law Office;
- Ministry of Education and Human Resources;
- Ministry of Health and Quality of Life;

Table 9.3: Summary breakdown of the CNAPEGBV					
Pillar	**Objective**		**GBV programme description**	**Allocated costs - Rs**	**% of total budget**
Strategic area of focus: Pillar 1: Legislation and prosecution	Specific Objective 1-1	To review, strengthen and implement relevant Laws and Policies for the prevention of GBV.	Response	350,000	1.5%
	Specific Objective 1-2	To set up an efficient system of "chain of evidence" that allows forensic evidence collected from the health facility to proceed to a forensic laboratory for analysis and hence to the police for action.	Response	1,200,000	5.1%
	Specific Objective 1-3	To come up with a set of ethical principles of confidentiality and respect relevant to GBV issues.	Response	400,000	1.7%
Subtotal Pillar 1				*1,950,000*	*8.3%*
Strategic area of focus: Pillar 2: Capacity building of service providers in the rehabilitation of survivors and perpetrators	Specific Objective 2-1	To develop a manual of standardised procedures integrating changes in legislation on GBV for service providers (law enforcement officers, health officers, family protection officers, NGOs involved in GBV.	Response	905,000	3.9%
	Specific Objective 2-2	To sensitise law enforcement officers and service providers on amendments made on laws, the medical and psycho-social management of survivors, the chain of evidence and ethical issues regarding GBV offences.	Response	700,000	3.0%
	Specific Objective 2-3	To train relevant health personnel to adequately address GBV issues (domestic violence, rape, sexual assault, sexual abuse, abortion and sex trafficking) in the health sector.	Response	1,200,000	5.1%
	Specific Objective 2-4	To build capacity in organisations (shelter provision, health services, police departments, local governments, family support bureau, women health issues, Council of Religions) involved in providing psychosocial support in the rehabilitation of survivors and perpetrators.	Support	900,000	3.8%
	Specific Objective 2-5	To strengthen the institutional capacity of identified stakeholders in the implementation of the Victim Empowerment and Abuser Rehabilitation Policy (VEARP).	Support	850,000	3.6%

Pillar	Objective		GBV programme description	Allocated costs - Rs	% of total budget
	Specific Objective: 2-6	To improve the capacity of local authorities to mainstream GBV issues in the provision of services to local residents.	Response	1,400,000	6.0%
	Specific Objective 2-7 Specific	To develop and implement a gender responsive rehabilitation programme for specific and targeted juvenile GBV perpetrators	Response	300,000	1.3%
Subtotal Pillar 2				*6,255,000*	*26.6%*
Strategic area of focus: Pillar 3: Prevention-awareness raising: Design and implement social marketing information and education campaigns to raise community awareness about GBV	Specific Objective 3-2	To sensitise the public on the root causes of GBV (MGECDFW).	Prevention	2,380,000	10.1%
	Specific Objective 3-3	To educate key groups and the broader population about GBV as a public health problem.	Prevention	1,350,000	5.7%
	Specific Objective 3-4	To use multiple strategies to change community norms, including local media and advocacy, local activism, training and communication materials. (Media sector/ ICT).	Prevention	2,350,000	10.0%
	Specific Objective 3-5	To use religious texts to create awareness amongst congregations about GBV and ensure rehabilitation and recovery of victims (Council of Religions).	Prevention	900,000	3.8%
	Specific Objective 3-6	To strengthen the curricula on GBV and peer education programs in relation to GBV in the education sector.	Prevention	1,750,000	7.5%
	Specific Objective 4-1	To sensitise the youth about the causes and consequences of GBV (Ministry of Youth and Sports).	Prevention Prevention	1,100,000	4.7%
Subtotal Pillar 3				*9,830,000*	*41.9%*
Strategic Area of focus: Pillar 4: Media Education and Advocacy	Specific Objective 4-2	To enhance the capacity of Media to provide appropriate reporting on GBV at all levels.	Prevention	600,000	2.6%
	Specific Objective 5-1	To foster systematic collaboration between the media and stakeholders engaged in eliminating GBV.	Integrated approaches	1,100,000	4.7%
Subtotal Pillar 4				*1,700,000*	*7.2%*
Strategic area of focus: Pillar 5: Coordination Re-search monitoring and evaluation	Specific Objective 5-2	To ensure close collaboration among stakeholders responding to survivors of GBV. To research the nature and extent of the offences covered by GBV.	Integrated approaches	1,950,000 1,800,000	8.3% 7.7%
Subtotal Pillar 5				*3,750,000*	*16.0%*
Total budget				**23,485,000**	**100.0%**

Table 9.3 shows that the implementation of the costed activities in the CNAPEGBV amounts to Rs23,485million.

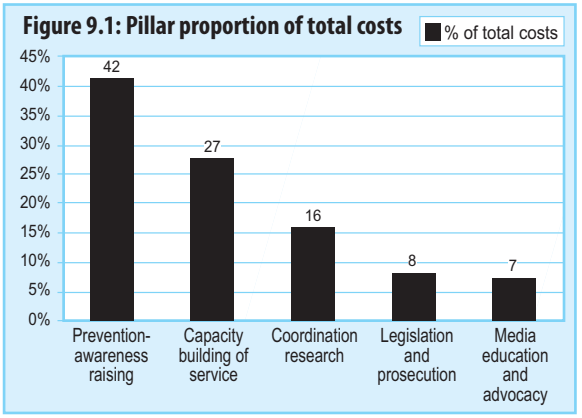
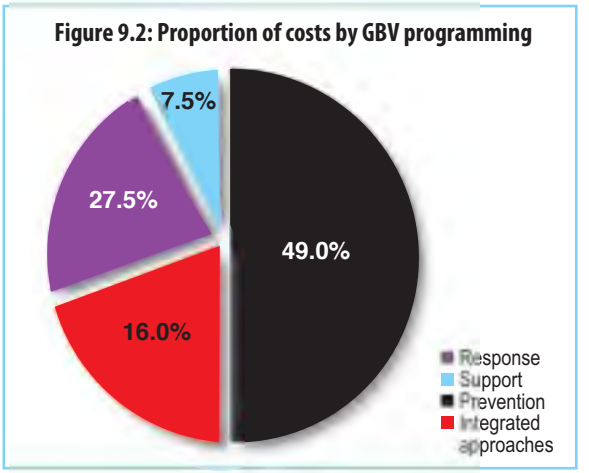


Figure 9.1 shows that 42% of costs for implementing the CNAPEGBV have been allocated to prevention and awareness raising. At 7% of the total, media education and advocacy receives the lowest percentage of the budget, but in reality this is a sub-set of prevention and awareness-raising. The high allocation and prioritisation of prevention is a good practice. There is abundant evidence from the fight against HIV and AIDS that prioritising prevention has long term benefits. However for such conclusions to be made, sound monitoring and evaluation systems have to be developed. Indicators used in this research provide a useful baseline. Periodic measurement of the same indicators will assist in measuring the effectiveness of prevention interventions and progress in the reduction of GBV in Mauritius.

GBV programming	Costs - Rs	% of total costs
Response	6,455,000	27.5%
Support	1,750,000	7.5%
Prevention	11,530,000	49 %
Integrated approaches	3,750,000	16.0%
Total	23,485,000	100.0%



Overall assessment

For purposes of this research, the budget is analysed according to four main functional areas identified in the study - response, support, prevention and integrated approaches. Figure 9.2 shows the greatest allocation (49%) is towards the prevention components of the CNAPEGBV while the lowest is towards support (7.5%). After prevention, response has the second highest allocations and budgetary priority. Responding to GBV accounts for Rs6,455 million which is 28% of total costs. The high proportion of state funding for prevention is rare and commendable. This reflects a long-term vision. However, as noted Chapter Seven on Support, greater resources are needed for places of safety, as well as other forms of socio-psycho support.

Costing gaps

A major gap in the costing of the CNAPEGBV is that there are no allocated resources for the Coordinating Advisory Committee (CAC) for the National Platform to End GBV and proposed technical committees intended to provide technical advice for the implementation of the Action Plan. Also lacking are funds to ensure the objective of establishing an effective referral system mapping the services that are available for survivors of GBV in each specific location.

Other important activities listed in the CNAPEGBV that have not been costed include:

- The adoption of ethical and safety standards for all sectors and for coordination.
- Setting up of referral systems for GBV survivors at the local level.
- Integrating community mobilization strategies against GBV into existing specific health projects, such as reproductive health and HIV projects.
- Conducting multi-religious seminars, specifically targeting men from different religions and including topics such as the effects and consequences of GBV.
- Provision of shelter and counselling services to victims of violence at existing religious structures.
- Integration of GBV topics into existing youth training programmes.
- Training journalism students on GBV and covering GBV.

Local government GBV action plans

The UN Secretary General's report on GBV calls on states to build and sustain strong multi-sectorial strategies, coordinated nationally and locally. Following the workshops on mainstreaming Gender in Local Government held in 2008 in the different local authorities across Mauritius, GL conducted action planning, workshops to ensure local action to reduce GBV. The intention of the GBV action plan workshops was to build on the preceding processes as well as to provide support and capacity building.

The GBV action plan workshops brought together a cadre of representatives from ministries of gender, local government, local councils and local government associations. The workshops covered a range of modules that include assisting councils in developing 365 Day Local Action Plans to end GBV or strengthen existing GBV action plans. The workshops were also aimed at developing strategic communication plans for the GBV action plans and sharing good practices for addressing GBV at the local level.

The result of the GBV action workshops in Mauritius was nine local GBV action plans. The local councils that have local GBV action plans include:

- Black River
- Curepipe
- Moka/Flacq
- Beau Bassin Rose-Hill
- Grand Port/ Savanne
- Port Louis
- Pamplemousses/Riviere du Rempart
- Quatre Bornes
- Vacoas/ Phoenix

Following the development and implementation of the GBV action councils, local councils submit award entries for the annual GL Gender Justice Local Government Summit and Awards. The summit is a regional event for show casing local level efforts to end gender violence and empower women. The Municipality of Curepipe presented their case study at the 2010 GL Gender Justice Local Government Summit and Awards and won an award for it.

Fighting GBV in Curepipe

The Municipal Council of Curepipe is among the nine local authorities under the aegis of the Ministry of

GBV Action Plan workshop at the Municipal Council of Curepipe in 2010. *Photo by Loga Virahsawmy*

Local Government. The councils has over 80,000 inhabitants. The role of the council is to make policies for the welfare of the citizens of the town and to make sure that these policies are implemented.

Objectives

The council's main objectives are to:

- Reduce, and eventually eradicate GBV
- Raise awareness of the public on key GBV targets and the debilitating effects on, and cost to society of GBV.
- Establish a research cell for diagnosing the specific causes of GBV and for making appropriate recommendations for remedial actions.

Strategies

GBV Public awareness campaigns

The municipality has been sensitising target audiences through:

- Rallies and marches conducted during the annual 16 days campaigns.
- Distribution of IEC materials.
- Stage plays.
- Publicising and implementing a Hotline Service.

Creation of safe spaces

The council made efforts to build up appropriate infrastructure and logistics for providing a safe and secure environment to the citizens of the town. Bare lands in town constitute fertile grounds for GBV such as assaults and rapes. Measures taken include:

- Cleaning bare lands.
- Implementation of a project of CCTV in town centre for the security of the citizens of the town.
- Ensuring there is street lighting in risky regions and on football grounds.

Engaging men and boys

The council encourages men to take part in healthy sports and leisure activities. So far, the council has constructed a sports complex and social halls.

Costs

The municipality allocated Rs 125.25 million for fighting GBV.

Challenges

The challenges experienced in addressing GBV in Curepipe are:

- inadequate budget;
- heavy administrative and bureaucratic procedures for implementing projects;
- inadequate buy in from stakeholders;
- A higher level of commitment and buy-in is required. Results are not obtained in the short term but sustained efforts should be made in the medium to long term to achieve set objectives.

Conclusion

Since the change from the Ministry of Women's Rights to Gender Equality, the areas of intervention of the Family Welfare and Protection Unit (FWPU) have broadened. In line with the international trend, the FWPU has shifted from domestic violence to gender-based violence. The MGECDFW has elaborated a CNAPEGBV (2012-2015) that takes into consideration GBV forms other than domestic violence. Mauritius is commended for costing the CNAPEGBV and allocating the major share of the budget to prevention. Another achievement to be noted is the setting up of institutional mechanisms to ensure the effective implementation of the CNAPEGBV in the form of the NPEGBV and the CAC. However, the lack of budget allocations to these structures and for the development of a referral system needs to be addressed.

CHAPTER 10
Conclusions and recommendations

The most glaring finding of this study is that the prevalence of GBV reported in the survey is 15 times higher than that reported to the FSBx. This shows that although GBV is rampant in Mauritius, administrative data does not give a true picture of its prevalence in the population. Conclusions drawn include:

Extent

- Intimate partner violence is a significant social problem prevailing in Mauritius. The corroboration between what women report they experience and the way men say they behave shows that these results must be taken seriously.
- Emotional IPV, a form of GBV not usually addressed or reported in administrative data, is reported in this study as the most common form of GBV.
- After emotional IPV, physical and sexual IPV are also common. The majority of women experience this on repeated occasions. This shows that violence against women, when it occurs, is cyclical.
- The majority of women who experienced physical IPV or rape by a non-partner did not report this to the police or health care facilities. This indicates a high level of underreporting of GBV in Mauritius.

Drivers and patterns

- A complex set of factors drive the perpetration of GBV in Mauritius. Socio-economic factors such as age, education, employment status are associated with GBV perpetration.
- Experience of child abuse, conservative community beliefs and values, and patriarchal gender attitudes are other major drivers of the in Mauritius.
- Although women appear more progressive than men, they affirm some conservative attitudes such as sexual entitlement to follow marriage, obeying husbands and legitimacy of use of violence by husbands as a means of controlling women.

Hon. Aurore Perraud, Hon. Sheila Bappoo, Loga Virahsawmy, Hon. Kalyanee Juggoo and Hon. Stephanie Anquetil. *Photo by Mary Jane Piang-Nee*

- Politicians do not give GBV adequate attention in their speeches. When GBV is addressed, it is mainly a passing reference. Politicians can improve in placing GBV on the political agenda.
- Although Mauritius media has made progress in gender sensitive reporting of GBV, compared to other SADC countries, there is room for improvement especially by increasing women's voices.

Effects

- Women survivors suffer a range of health effects including physical injury, hospitalisation, pregnancy complications, unplanned pregnancy, STIs, HIV, suicidal thoughts and depressive symptoms.
- Social stigmatisation for women survivors and fear of family fragmentation hampers them from leaving abusive relationships.

Response and support

- Mauritius has protective laws in the form of the PDVA and the Equal Opportunities Act. However, the Sexual Offences Bill is still being finalised.

- Both women and men are relatively aware of the PDVA and Sex Discrimination Act.
- The main enforcing mechanisms for the PDVA are the FSBx, the PFPUs, the hospitals and the judiciary.
- Comparing the results from the survey with reported official administrative data shows that administrative data falls short in depicting the true extent of GBV within the Mauritian community.
- The disparity in the number of reported cases by the different PDVA enforcement mechanisms shows the lack of implementation of a clear referral system for GBV survivors.
- There are three shelters in Mauritius but these are not proportionate to the need by GBV survivors. Shelters provide temporary housing and counselling for variable periods.
- Currently shelters are prioritising accommodating children over abused women.
- The Ministry of Gender Equality hosts a hotline to address family related problems. The hotline is only known to half of the interviewed participants and used by even less of the women and men.
- There is a low disposal rate (14%) of rape cases within the district courts.
- The Ministry of Health has put in place a standard for the management of victims of sexual assault.
- Politicians refer more to GBV response and support than to prevention.

Prevention

- Several primary and secondary prevention interventions are being implemented in Mauritius. The interventions span the individual, community and societal arena for action.
- The major challenge is that the majority of interventions lack efficient monitoring systems to measure impact.
- The majority of women and men are unaware of GBV campaigns. The current main source of campaign information is the radio followed by television.
- Men have more access to GBV related information compared to women, but women find the campaigns more empowering.

Integrated approaches

- Mauritius has made significant progress in the implementation of National Action Plans to end GBV. Currently Mauritius has developed a new NAPEGBV for 2012 to 2015. This is a commendable achievement because the plan is costed. Two multi-sector mechanisms, the NPEGBV and the CAC, have been set up to ensure successful implementation.
- The greatest allocation of funds (49%) is towards the prevention components of the costed NAPEGBV while the lowest is towards support (7.5%). After prevention, response has the second highest allocations and budgetary priority. Responding to GBV accounts for Rs6,455 million which is 28% of total costs. The high proportion of state funding for prevention is rare and commendable. This reflects a long-term vision. However, as noted Chapter Seven on support, greater resources are needed for places of safety, as well as other forms of socio-psycho support.

Recommendations

Extent

- GBV campaigns and messages in Mauritius should give emphasis to IPV. The campaigns should also be deliberate in engaging men and boys. The development of more perpetrator rehabilitation programmes like VEARP is critical.
- Provision of psychosocial support should be made a priority in responding to GBV. More resources should be allocated towards a health sector response that places mental health services at the centre.
- Further research is necessary to understand the underreporting of GBV in Mauritius.
- The police and health sector needs to improve on provision of victim friendly services and support.
- GBV campaigns need to increase women's agency and encourage them to speak out and seek help.

Patterns and drivers

- GBV prevention campaigns need to take into consideration the identified risk groups and target these. In particular, work-place based initiatives will go a long way in targeting the employed men who are more likely to be perpetrators.
- Programmers should prioritise child rehabilitation programs as a form of GBV prevention strategy. There is need for the introduction of school based GBV prevention initiatives.

- Civil society and activist organisations need to continue to hold political leaders accountable for addressing GBV and placing it on the political agenda.

Effects

- The health system response to GBV needs to be strengthened. Health practitioners need to be trained to provide victim friendly services to survivors. Inclusion of the health sector in the GBV referral system should be mandatory.
- Campaigns should aim to change conservative attitudes towards gender relations and should encourage communities to be more supportive to GBV survivors.

Response and support

- Activists should continue to lobby for the enactment of the Sexual offences Bill.
- Public awareness campaigns should aim to sensitise communities about the PDVA and GBV related laws.
- Government should adopt the GBV Indicators and commit to allocating resources for periodic GBV studies and dedicated surveys.
- Stakeholders in the GBV sector need to develop and implement a referral system that has an efficient surveillance system.
- Government should allocate more resources to existing shelters and for the establishment of new shelters.
- New shelters should be established which provide services to abused women and their children only. Other separate shelters for children should also be established.
- GBV campaigns should sensitise communities and raise awareness about the hotline 119.
- The judiciary should consider means of addressing the low disposal rate by a more elaborated victim support system. This should be through the establishment of dedicated courts.
- Victims of sexual offences to need be accompanied by an Officer from the Victim Support System (VSS) when the case comes for trial. VSS should support the survivor throughout her/his ordeal.
- Localities of Mauritius need to act as facilitators for information and referrals.
- Politicians need to place GBV prevention at the centre of their discourse.

Prevention

- GBV programmers need to develop programme specific indicators to ensure the collection of baseline and routine data. There is also a need for capacity building of programmers in monitoring and evaluation.
- Media has to improve on the coverage of GBV campaigns. Stakeholders should ensure the decentralisation of campaigns to village level.
- Strategic communications should be developed which ensure access to GBV information by women. Prevention and local level action

Integrated approaches

- The results of the GBV research should be taken up at the highest political level, and disseminated through every government ministry and local structure, as part of a concerted Zero Tolerance for GBV campaign.
- The Ministry of Gender Equality and National Platform to End GBV should adopt the GBV indi-cators as baselines in a strong Monitoring and Evaluation framework for the plan.
- A multi-sectorial monitoring committee should be set up as part of the machinery so that all stakeholders work in a concerted manner on the findings.
- Every government ministry, local authority and relevant stakeholders should be requested to state what actions they will take to support the reduction of GBV in Mauritius at the launch of this report and in subsequent stock-taking initiatives.
- The GBV indicators survey should be repeated at least every five years, with government support and funding, to benchmark progress.

Further research and sharing of this model

- In addition to repeating this study every three to five years, the indicators need to be expanded through a fully-fledged dedicated study on the economic impacts of GBV on the society.

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GBV AND THE SADC PROTOCOL ON GENDER AND DEVELOPMENT

Response and support

The SADC Protocol provides that by 2015 state parties shall:

- Enact and enforce legislation prohibiting all forms of gender-based violence;
- Ensure that laws on gender-based violence provide for the comprehensive testing, treatment and care of survivors of sexual assault;
- Review and reform their criminal laws and procedures applicable to cases of sexual offences and gender-based violence;
- Enact and adopt specific legislative provisions to prevent human trafficking and provide holistic services to the victims, with the aim of re-integrating them into society;
- Enact legislative provisions, and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres, and provide deterrent sanctions for perpetrators of sexual harassment.

Prevention

- The Protocol provides for measures, including legislation, to discourage traditional and cultural practices that exacerbate gender-based violence and to mount public campaigns against these.

Integrated approaches

- The SADC Protocol on Gender and Development calls on states to adopt integrated approaches, including institutional cross sector structures.

The ultimate goal….

- To reduce current levels of gender-based violence by 2015.

"I welcome the publication of the Gender-Based Violence Indicators Study commissioned by Gender Links. Gender-based violence is human rights violations and reflects inequality between women and men. Such violence has profound implications on the health, dignity, security and autonomy of those affected not only the victims but also the entire family. Unfortunately this is often ignored. My Government is fully committed to continue working towards an inclusive, harmonious and peaceful society. Creating the appropriate legislative and institutional framework for gender equality and family welfare, will remain high on our agenda."

Dr the Hon Navinchandra Ramgoolam, GCSK, FRCP
Prime Minister

"We believe that the key to ending GBV is a well-defined roadmap that allows for a more coordinated, multi-sectoral and holistic approach. The Costed National Action Plan to End Gender-Based Violence 2012-2015, adopting a multi-pronged approach, enables Mauritius to take leadership of the African region as regards the launching of the Africa Unite Campaign to end violence against women and girls. As an NGO, Gender Links comes forward with these indicators."

Hon. Maria Francesca Mireille Martin
Minister of Gender Equality, Child Development and Family Welfare

www.genderlinks.org.za