Understanding violence against women/gender-based violence as a public health problem

Dr Avni Amin
Department of Reproductive Health and Research, World Health Organization
December 2015
Overview

- What is a public health approach to violence against women
- Definitions and forms of violence against women
- Prevalence of violence against women globally and in African Region
- Health and other social consequences of violence against women
- Risk factors
- Developing, implementing health response
Public health approach: Characteristics

- Population-level
- Interdisciplinary
- Multi-sectoral
Public Health Approach

Surveillance

Identify risk and protective factors
What are the causes?

Develop and evaluate interventions
What works? And for whom?

Implementation
Scaling up effective policy and programmes
Surveillance

Any public or private act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty with the family or general community.
Violence against women... takes many forms

Intimate partner violence: the most common form of violence experienced by women
Intimate Partner Violence

Experience of one or more acts of physical and/or sexual violence and/or emotional/psychological abuse by a current or former partner.

Photo credit: Hanifa Alizada, Afghanistan
Being slapped, having something thrown at you that could hurt you, being pushed or shoved, being hit with a fist or something else that could hurt, being kicked, dragged or beaten up, being chocked or burnt on purpose, and/or being threatened with or actually having a gun, knife or other weapon used on you.
Being physically forced to have sexual intercourse when you didn't want to, having sexual intercourse because you were afraid of what your partner might do and/or being forced to do something sexual that you found humiliating or degrading

Sexual Violence
Being insulted or being made to feel bad about oneself; being belittled or humiliated in front of other people. The perpetrator has done things to scare or intimidate her, by yelling or smashing things; and/or has threatened to hurt someone she cares about.
1 in 3 (35%) ♀ globally & 45% ♀ in Africa: have experienced physical &/or sexual violence by an intimate partner and/or non-partner
30% ♀ globally: have experienced physical &/or sexual violence by an intimate partner
7% ♀ globally & 11% ♀ in the African region: have experienced sexual violence by a non-partner
 Violence starts early in lives of women

<table>
<thead>
<tr>
<th>Age group, years</th>
<th>Prevalence, %</th>
<th>95% CI, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–19</td>
<td>29.4</td>
<td>26.8 to 32.1</td>
</tr>
<tr>
<td>20–24</td>
<td>31.6</td>
<td>29.2 to 33.9</td>
</tr>
<tr>
<td>25–29</td>
<td>32.3</td>
<td>30.0 to 34.6</td>
</tr>
<tr>
<td>30–34</td>
<td>31.1</td>
<td>28.9 to 33.4</td>
</tr>
<tr>
<td>35–39</td>
<td>36.6</td>
<td>30.0 to 43.2</td>
</tr>
<tr>
<td>40–44</td>
<td>37.8</td>
<td>30.7 to 44.9</td>
</tr>
<tr>
<td>45–49</td>
<td>29.2</td>
<td>26.9 to 31.5</td>
</tr>
<tr>
<td>50–54</td>
<td>25.5</td>
<td>18.6 to 32.4</td>
</tr>
<tr>
<td>55–59</td>
<td>15.1</td>
<td>6.1 to 24.1</td>
</tr>
<tr>
<td>60–64</td>
<td>19.6</td>
<td>9.6 to 29.5</td>
</tr>
<tr>
<td>65–69</td>
<td>22.2</td>
<td>12.8 to 31.6</td>
</tr>
</tbody>
</table>

Lifetime prevalence of intimate partner violence by age group among ever-partnered women (WHO, 2013)
HIGH levels of VIOLENCE during pregnancy

He hit me in the belly and made me miscarry two babies - identical or fraternal twins, I don’t know. I went to the hospital with heavy bleeding and they cleaned me up.

Woman interviewed in Peru
beaten in pregnancy, not punched or kicked in abdomen

Source: Garcia-Moreno C et al. 2005, WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses.
Consequences

Violence against women has not only health consequences, but also social and economic consequences for the individual, families, communities & societies.
Pathways & health effects of IPV

INTIMATE PARTNER VIOLENCE

PHYSICAL TRAUMA

PSYCHOLOGICAL TRAUMA/STRESS

FEAR AND CONTROL

Mental Health

TWICE as likely to experience depression

42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result.

ALMOST TWICE as likely to have alcohol use disorders

NONCOMMUNICABLE DISEASES
- cardiovascular disease
- hypertension

SOMATOFORM
- irritable bowel
- chronic pain
- chronic pelvic pain

16% more likely to have a low birth-weight baby

15 TIMES more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhoea

TWICE as likely to have an abortion

DISABILITY

38% of all murders of women globally were reported as being committed by their intimate partners

4.5 times as likely to attempt suicide
# Inter-generational & socio-economic consequences

| Effects on children of women who experience abuse | • Higher rates of infant mortality  
• Behavior problems  
• Anxiety, depression, attempted suicide  
• Poor school performance  
• Experiencing or perpetrating violence as adults  
• Physical injury or health complaints  
• Lost productivity in adulthood |
|---|---|
| Effects on families | • Inability to work  
• Lost wages and productivity  
• Housing instability |
| Social and economic effects | • Costs of services incurred by victims and families (health, social, justice)  
• Lost workplace productivity and costs to employers  
• Perpetuation of violence |
Healthcare Costs

CANADA
1.1bn (US$) per year for direct medical costs related to IPV in 2001

COLOMBIA
184bn pesos (US$73.7m) spent by the government in 2003 for prevention & services related to family violence, 0.06% of national budget

UGANDA
UGX 56bn (US$22m) costs of public provision of services (health, police & judiciary) to survivors of domestic violence in 2010-11, 0.75% of Uganda’s national budget

UK
£1.7bn for physical & mental health costs related to visits to general practitioners in 2008
Identify risk and protective factors

What are the causes?
Risk factors can occur at multiple levels
<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of violence in childhood</td>
<td>Addressing childhood abuse</td>
</tr>
<tr>
<td>Low education</td>
<td>Improving access to education &amp; social skills</td>
</tr>
<tr>
<td>Harmful use of alcohol</td>
<td>Reducing harmful drinking</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>Early identification &amp; treatment of conduct disorders</td>
</tr>
</tbody>
</table>
Relationship

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men’s control over women</td>
<td>Working men &amp; boys to promote gender equitable attitudes &amp; behaviours</td>
</tr>
<tr>
<td>Marital dissatisfaction</td>
<td>Promoting gender equitable attitudes &amp; behaviours / healthy relationship skills</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>among women, men &amp; couples</td>
</tr>
</tbody>
</table>
Community level

Risk factor
Unequal gender norms that condone violence against women & weak community sanctions

Intervention
Promoting equitable gender norms through mass media, community mobilization, schools & religious institutions
Societal level

Risk factor
Harmful use of alcohol

Intervention
Policies to reduce harmful use of alcohol

Women’s lack of access to education & employment

Intervention
Laws, policies & programmes that promote women’s access to employment & microcredit; girls’ access to education; & that prohibit violence against women

Gender & social norms accepting violence/ideologies of male entitlement

Intervention
Interventions addressing social & gender norms

Lack or poor enforcement of laws on VAW

Intervention
Strengthen & enforce legislation: prohibiting VAW; promoting equality in marriage & divorce, property & inheritance laws
Risk factors for women's experience of partner violence: history of abuse, gender norms, alcohol: data from 10 countries

### Prior to relationship

<table>
<thead>
<tr>
<th>History of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of mother beaten by partner (neither / his only / hers only / both)</td>
</tr>
<tr>
<td>Abused in childhood ** (neither / him only / her only / both)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed secondary education (neither / him only / her only / both)</td>
</tr>
</tbody>
</table>

*Control for woman's age

**Abused in childhood refers to physical beatings for men and sexual abuse for women

### Current situation

#### Demographics & relative status
- Household SES
- Woman's age (15-19/ 20-34/ 35-50)
- Age gap with partner (no gap / her older / him older)
- Relative educational status (same completed level / he has higher / she has higher)
- Relative employment (both working / him working / her working / neither working)

#### Other relationships
- Woman has children from more than one relationship
- Partner has had concurrent relationships

#### Non-partner violence
- Partner violent with others in past 12 months
- Woman experienced physical violence >15 yrs
- Woman experienced sexual violence >15 yrs

#### Characteristics of union
- Partnership type (married / cohabiting / not living together)
- Duration of relationship (<1yr / 1-5yrs / >5yrs)*
- Woman active in choosing husband**
- Bride price/dowry**
- Polygamy**

*among cohabiting women

**among married women

Figure 1 Predictors of current IPV - the 'relationship approach'.
Risk factors for men's perpetration of intimate partner violence – 6 countries, 10,000 men in Asia-Pacific
VAW & Gender equality & prevalence of recent IPV

ABOUT THE DATA: Prevalence data for all graphs is drawn from leading international surveys on violence against women: World Health Organization; International Violence Against Women Survey; MEASURE Demographic and Health Surveys (DHS) and the World Bank Domestic Violence Dataset and is based on physical and/or sexual violence by an intimate partner in the previous 12 months. Detailed Technical Notes on the methodology and sources are available on request at evaw.helpdesk@unifem.org.

NOTES ON GRAPH: Secondary school enrollment is measured as the percentage of eligible girls enrolled in secondary school, based on data from the UNESCO Institute for Statistics on Female Secondary Net Enrollment Rate (2000-2009), with countries categorized from low to high enrollment rates. Prevalence data shown is the average per cent for countries in each category.

Violence against women

Take home points

1. is widespread
2. has serious health consequences for women
3. has intergenerational consequences
4. has adverse socio-economic impact on families, communities & society
5. Two main set of modifiable risk factors: *Childhood abuse* & *gender inequality* (i.e. unequal gender norms, women's lack of empowerment, men's control & entitlement over women)
Develop and evaluate interventions

What works? And for whom?

Implementation

Scaling up effective policy and programmes
Prevention programmes should increase focus on:
1. Addressing childhood abuse
2. Empowerment of women and girls
3. Transforming harmful gender norms and attitudes
4. Promoting gender equality in laws and policies

Key Message
Violence is preventable
Criteria for assessing effectiveness of prevention programmes

- **Effective**: Effectiveness unclear or harmful
- **Promising**: Have potential but need testing/evaluation

- These criteria are ONLY in relation to outcomes related to reduction of IPV
Preventing child maltreatment & IPV & SV in adolescents: School-based strategies

- School-based programmes to prevent dating violence
- School-based training to help children recognize and avoid potentially sexually abusive situations
- Rape awareness & knowledge programmes for schools & colleges
- Sexual violence prevention programmes for schools & colleges
- Self-defence training for schools and colleges
- Confrontational rape prevention programmes
Community-based strategies to empower women & girls

- Integrated economic & gender empowerment strategies
- Cash Transfers – conditional and unconditional
- Increasing women's ownership of property, assets and securing their inheritance rights
Community & societal level strategies: to transform harmful gender norms

- Promoting gender equitable attitudes & behaviours by working with men and boys (in groups)
- Community mobilisation
- Social norms marketing/edutainment or behaviour change communication campaigns
Societal & policy level strategies

- Promoting & enforcing laws and policies that ban violence against and promote gender equality (e.g. girls and women's access to education, employment)

- Reducing harmful use of alcohol (policies to reduce availability)
Characteristics of effective prevention interventions

- Encourage autonomy and empowerment of women
- Combine multiple approaches as part of a single intervention.
- Duration of intervention is more than six months
- Address social norms regarding acceptability of violence
- Have elements of psychosocial interventions, victim advocacy
There is no magic bullet

No single intervention or single sector can prevent violence against women

- Multisectoral action needed
- Life course approach
- Underlying risk & protective factors need to be identified and addressed
Role of the health sector in a multi-sectoral response

**Provide**
Comprehensive health services for survivors

**Collect data**
about prevalence, risk factors and health consequences

**Inform**
policies to prevent violence against women

**Prevent violence**
by fostering and informing prevention programs

**Advocate**
for the recognition of violence against women as a public health issue
WHY should the health sector address VAW?

1. Abused women more likely to seek health services

2. Violence is an underlying cause of injury and ill health

3. Most women attend health services at some point, especially sexual and reproductive health

4. If health workers know about a history of violence they can give better services for women
   - Identify women in danger before violence escalates
   - Provide appropriate clinical care
   - Reduce negative health outcomes of VAW
   - Assist survivors to access help / services/ protections
   - Improve sexual, reproductive health and HIV outcomes

5. Human rights obligations to the highest standard of health care
“Sometimes when I ask a woman about violence, she dissolves in a sea of tears... then I think now how am I going to get rid of her?

Doctor in El Salvador
<table>
<thead>
<tr>
<th>Provider behaviour</th>
<th>Possible consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blames or disrespects women or girls</td>
<td>Inflicts additional emotional distress or trauma</td>
</tr>
<tr>
<td>Doesn’t recognize VAW behind chronic or re-occurring conditions</td>
<td>Woman receives inappropriate or inadequate medical care</td>
</tr>
<tr>
<td>Fails to provide adequate care to rape victims</td>
<td>Unwanted pregnancy, untreated STI, unsafe abortion</td>
</tr>
</tbody>
</table>
Ignoring violence can do harm

**Provider behaviour**
- Breaches privacy or confidentiality
- Doesn’t address VAW in family planning or STI/HIV counselling
- Ignores signs of fear or emotional distress

**Possible consequences**
- Partner or family member becomes violent after overhearing information
- Unwanted pregnancy; STIs/HIV/AIDS; unsafe abortion; additional violence
- Woman is later injured, killed or commits suicide
WHO Guidelines: Purpose

- Provide evidence-based guidance for clinicians on how to respond to intimate partner violence or domestic violence (IPV) and sexual violence (SV)

- Guidance to policy makers on how to deliver training and on what models of health care provision may be useful

- Inform educators designing medical, nursing and public health curricula regarding training
GUIDELINES FOR HEALTH SECTOR RESPONSE

WHO’s new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:

1. **Women-centred care:**
   Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).

2. **Identification and care for survivors of intimate partner violence:**
   Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.

3. **Clinical care for survivors of sexual violence:**
   Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.

4. **Training of health-care providers on intimate partner violence and sexual violence:**
   Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.

5. **Health-care policy and provision:**
   Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.

6. **Mandatory reporting of intimate partner violence:**
   Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.
Small changes make a BIG difference

"The doctor helped me feel better by saying that I don’t deserve this treatment, and he helped me to make a plan to leave the house the next time my husband came home drunk."

Salvadoran woman
CONTACT

WHO Department of Reproductive Health & Research

Claudia Garcia-Moreno
garciamorenoc@who.int

Avni Amin
amina@who.int