Preventing and responding to violence against women

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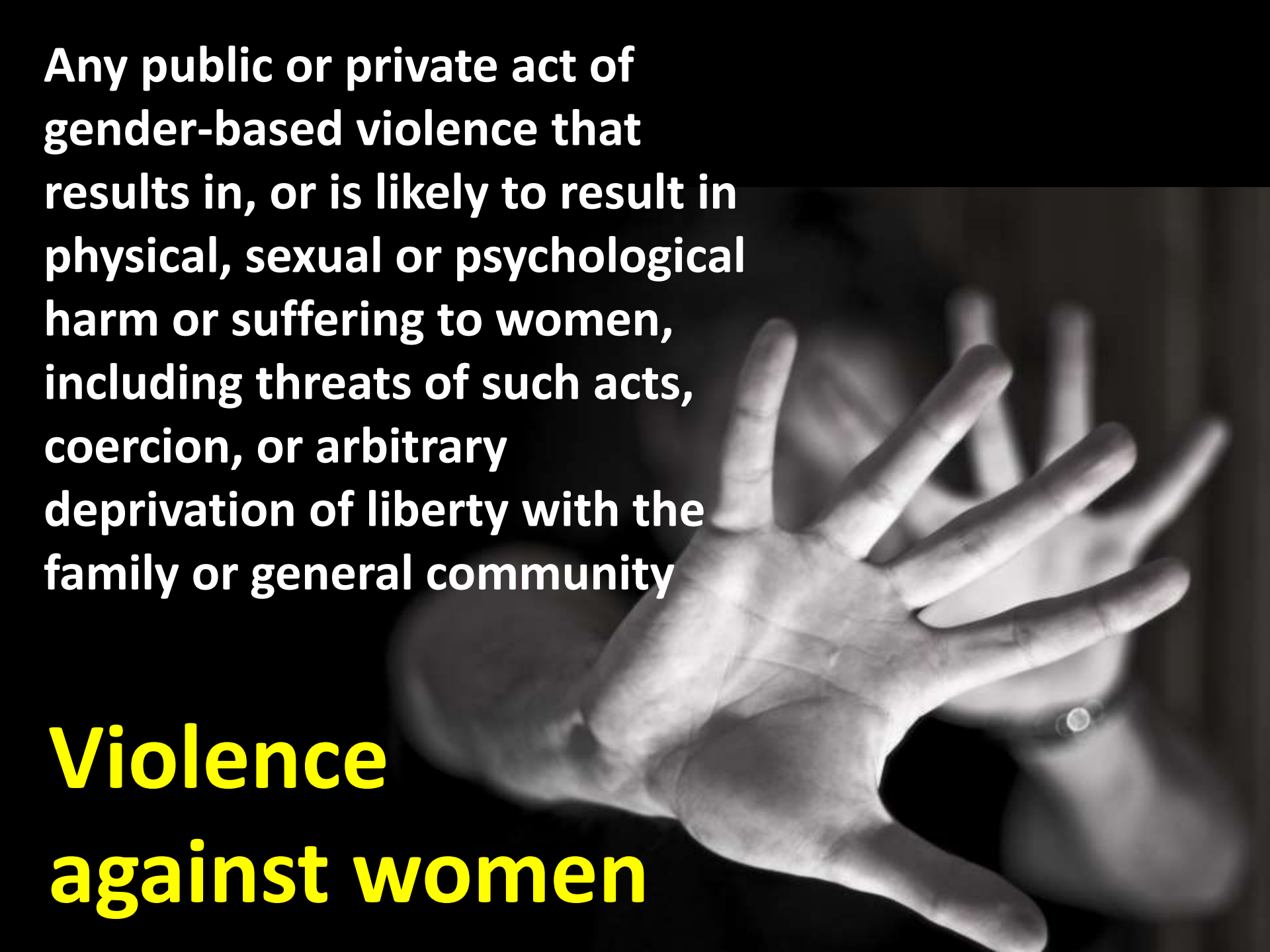
Training course in adolescent sexual and reproductive health 2018

World Health Organization

Overview

- Definitions and forms of violence against women
- Prevalence of violence against women globally
- Health and other social consequences of violence against women
- Risk factors
- Prevention interventions
- WHO recommendations for health response
- Tools and resources

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

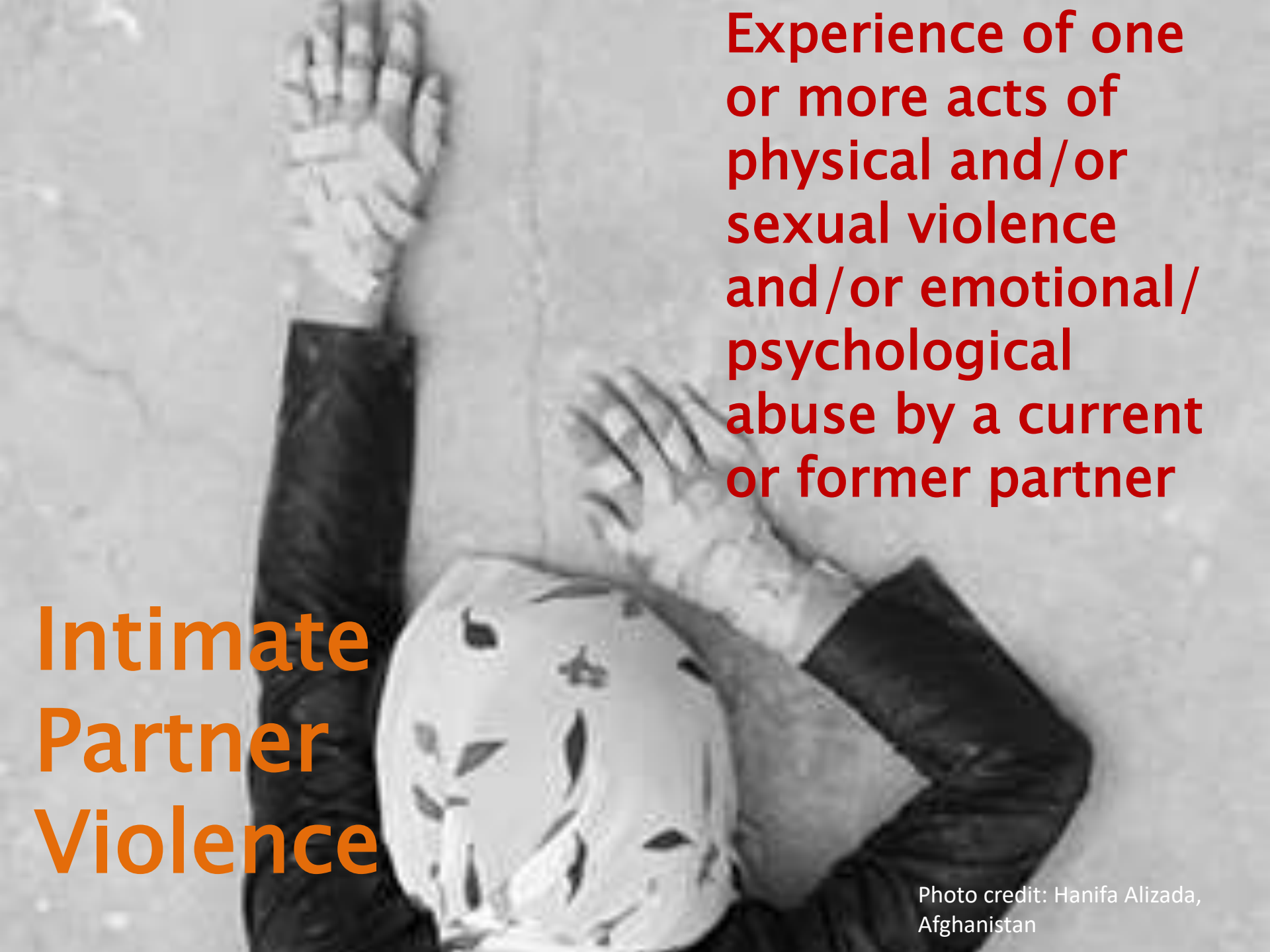


Violence against women

Violence against women…

…takes many forms

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

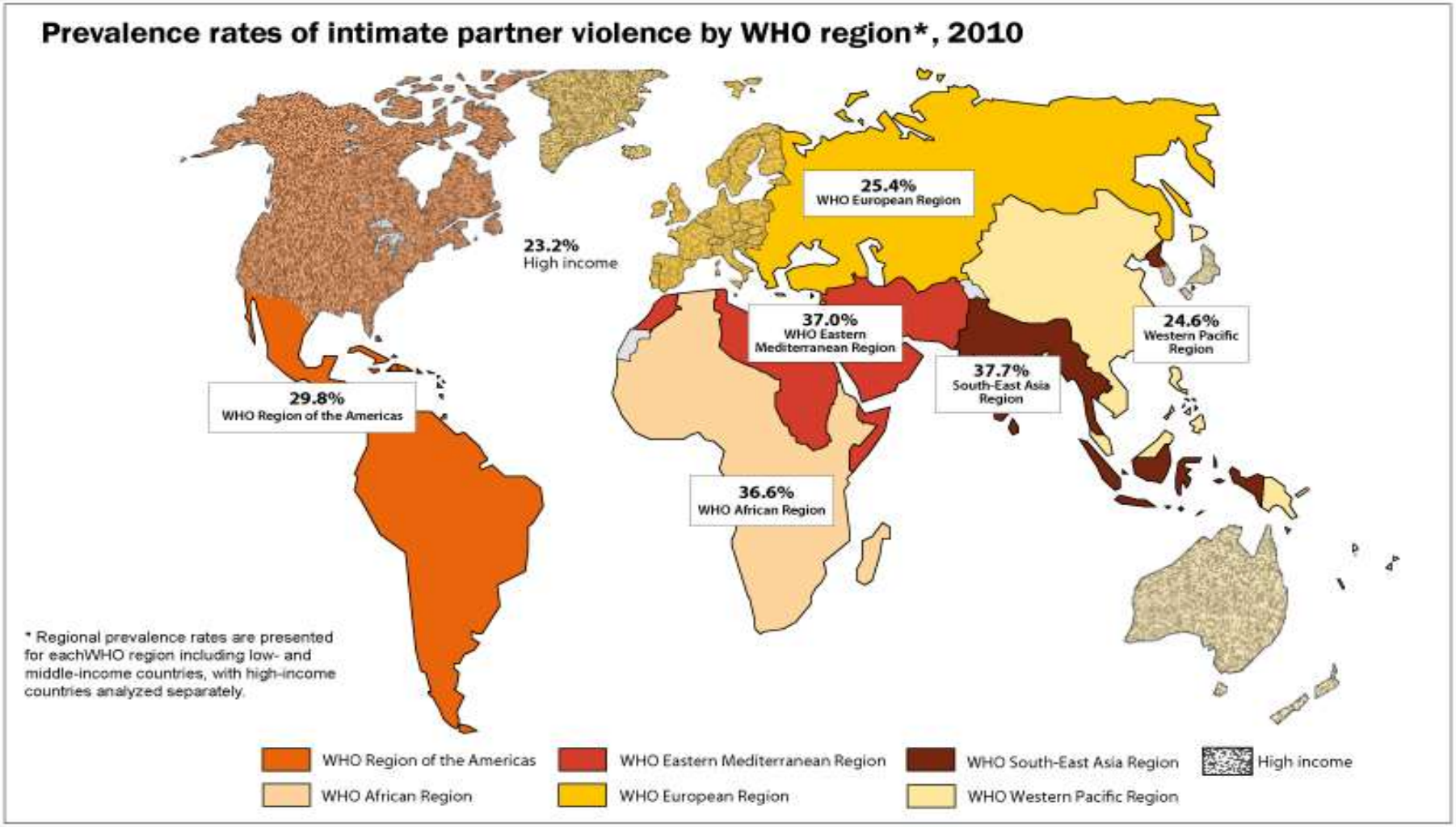


Intimate Partner Violence

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

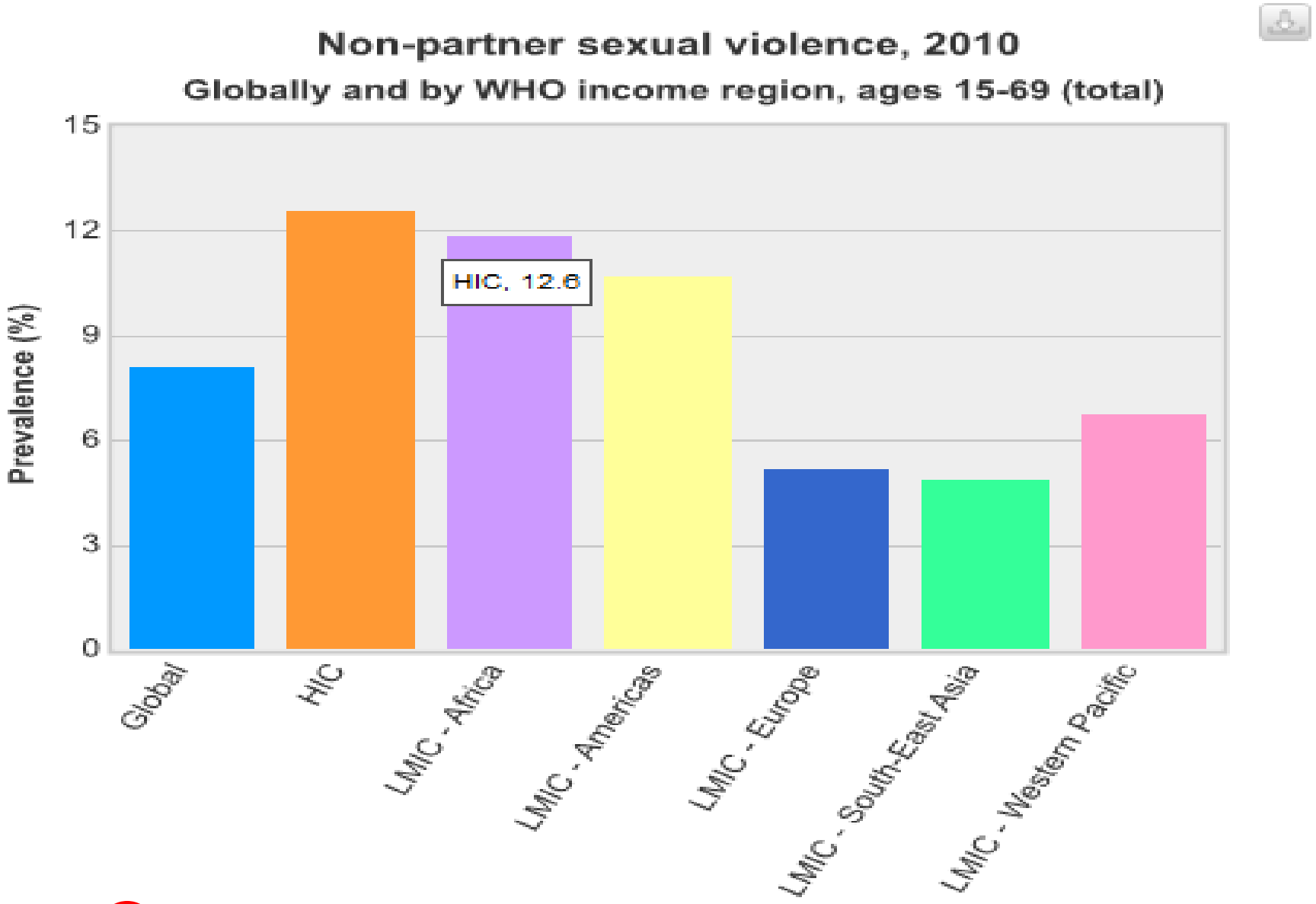
Photo credit: Hanifa Alizada, Afghanistan

30% ♀ globally: have experienced physical &/or sexual violence by an intimate partner



Data Source: *Global and regional estimates of violence against women*. WHO, 2013.

World Health Organization



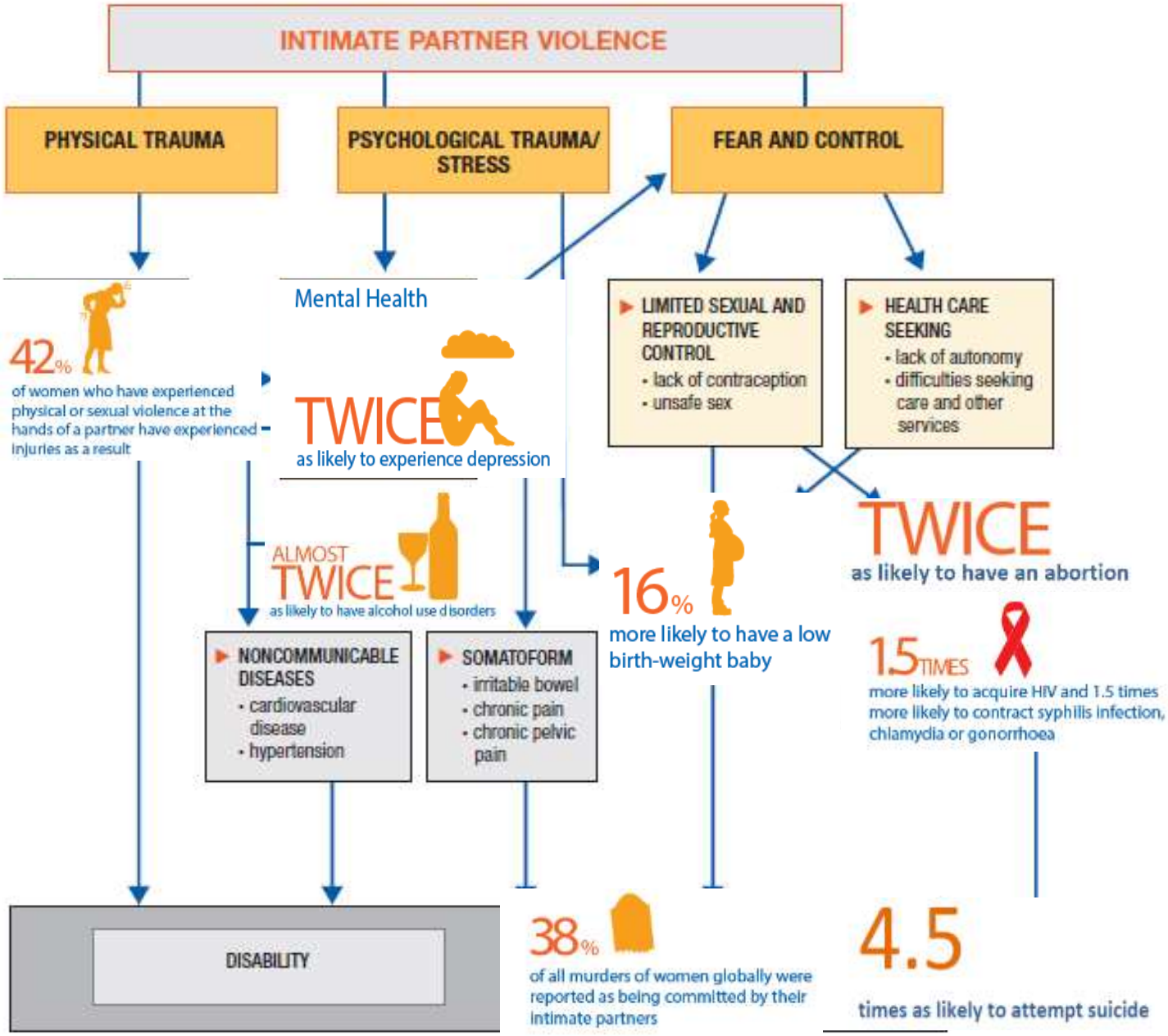
7% **globally** **have experienced sexual violence by a non-partner**

Violence starts early in lives of women

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

Lifetime prevalence of intimate partner violence by age group among ever-partnered women (WHO, 2013)

Pathways & health effects of IPV



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

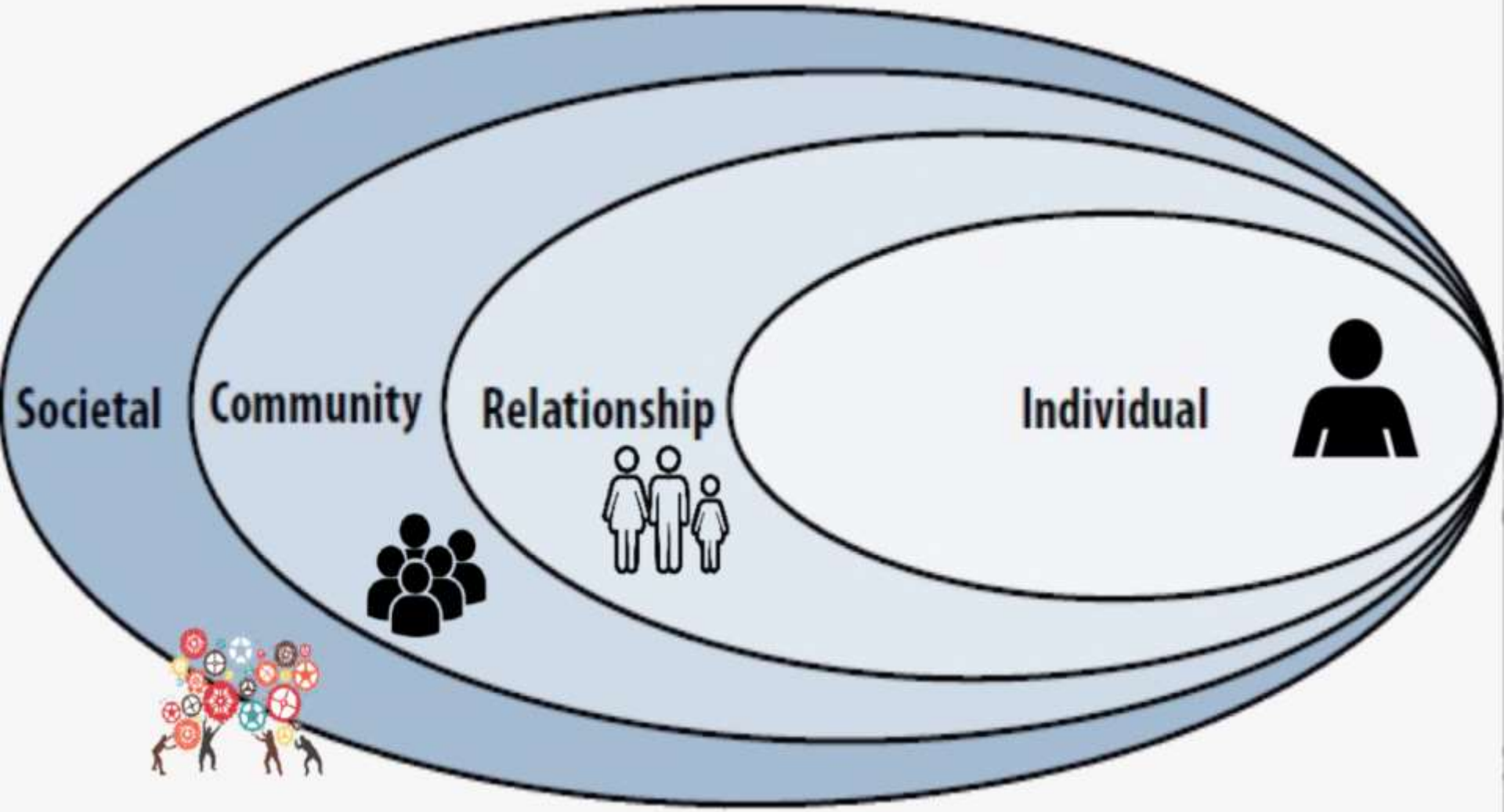
UGANDA

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

Risk factors can occur at multiple levels



Risk factors

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)

Violence is preventable

Key Message

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

Criteria for assessing effectiveness of prevention programmes

Promising

Effectiveness unclear or harmful

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 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

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)

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

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

Video on role of health sector

https://youtu.be/Qc_GHITvTmI

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

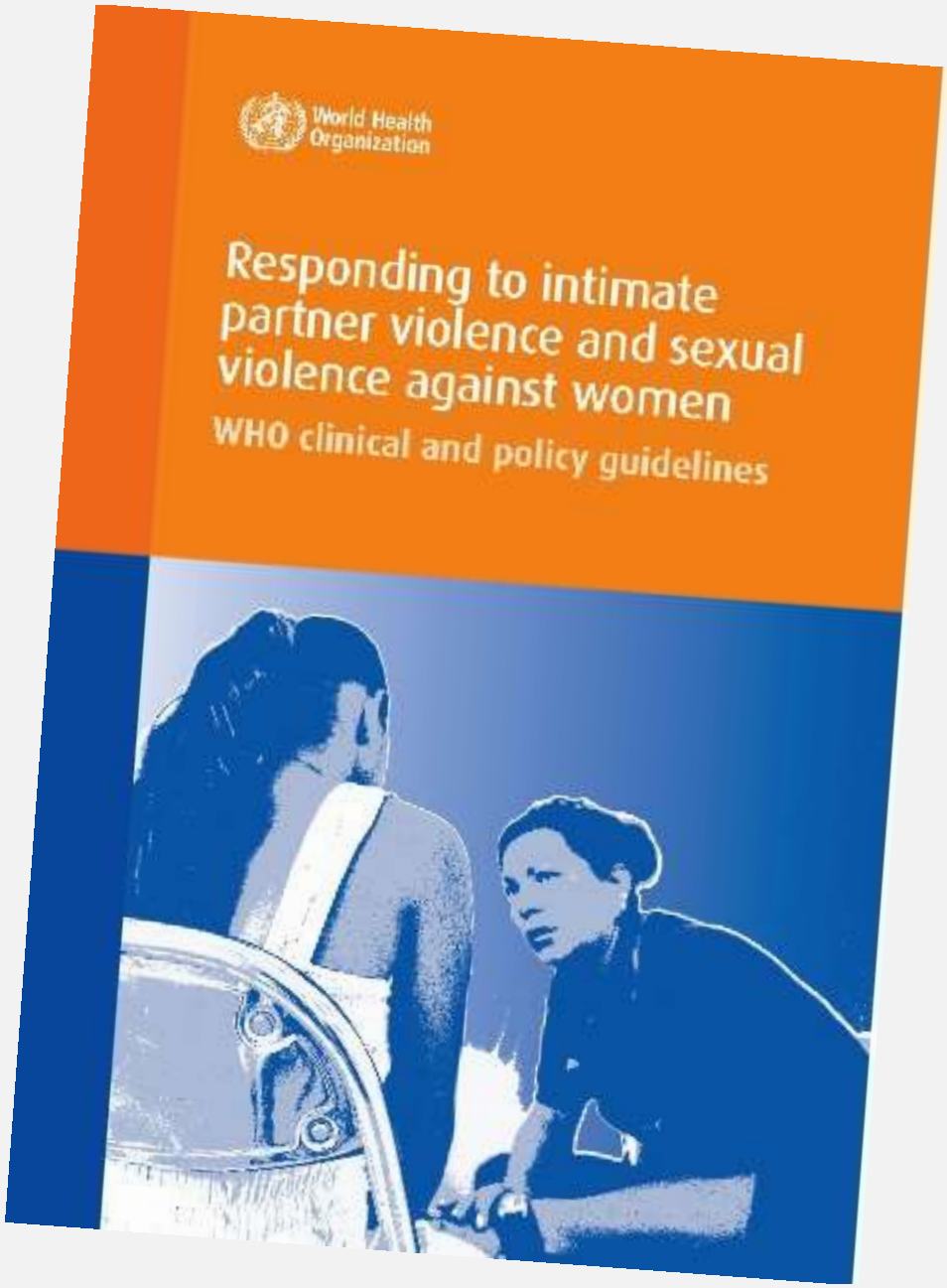
5. Human rights obligations to the highest standard of health care

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:

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).

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.

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.

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.

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.

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.

Scaling up efforts to ending violence against women and girls

Contribution of the health sector to SDG targets on VAWG and VAC and to women's, children's and adolescent's health

Political mandate for health response to VAW

69th World Health Assembly, May 2016

The Ministries of Health of the 193 Member States of WHO, endorse the global plan of action on strengthening the health system's response to violence against women and girls and against children

What actions can health sector take?

1.

YOU CAN

Strengthen health system leadership and governance

2.

YOU CAN

Strengthen health service delivery and health providers' capacity to respond to violence against women and girls

3.

YOU CAN

Strengthen programming to prevent violence against women and girls

4.

YOU CAN

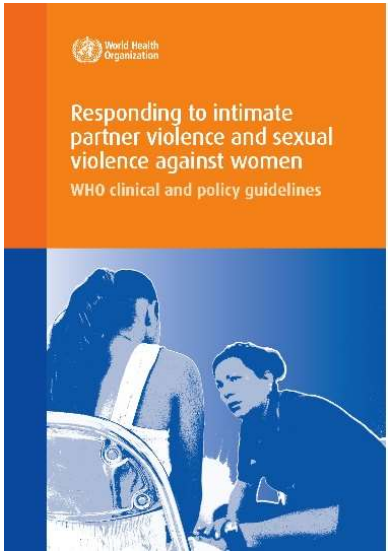
Strengthen information collection and evidence

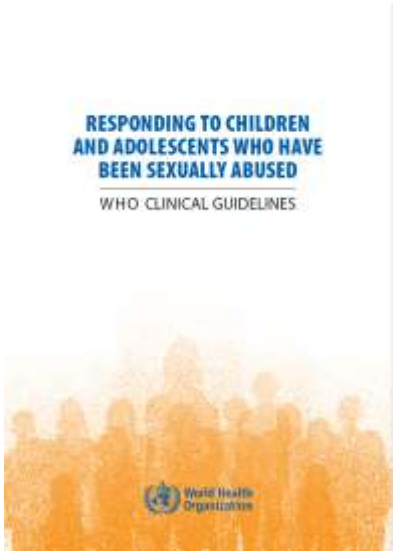
Small changes make a BIG difference

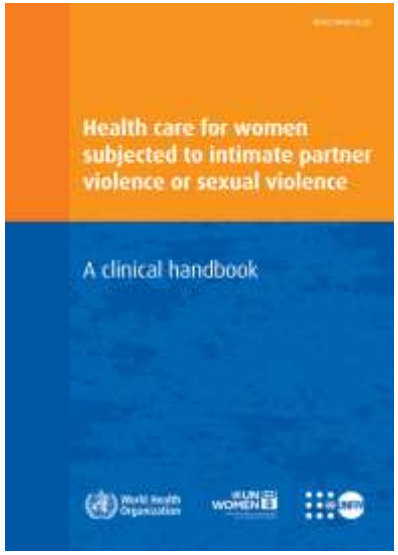
" The doctor helped me feel better by saying that I don't deserve this treatment, and he helped me to make a plan to leave the house the next time my husband came home drunk"

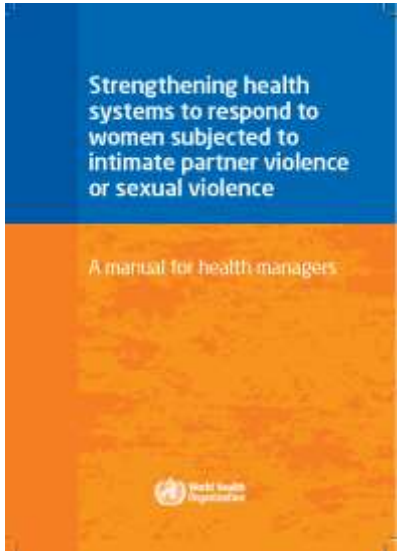
Salvadoran woman

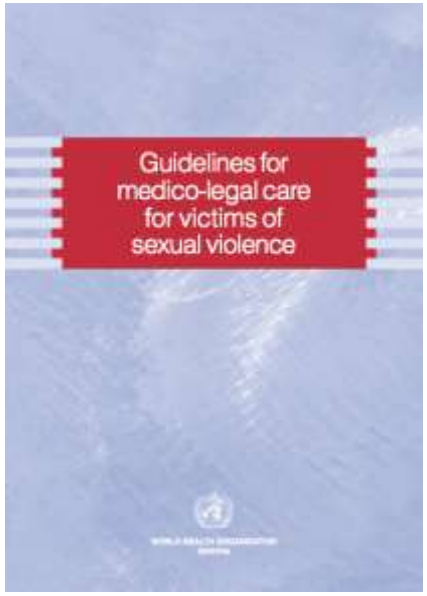
Tools and Resources

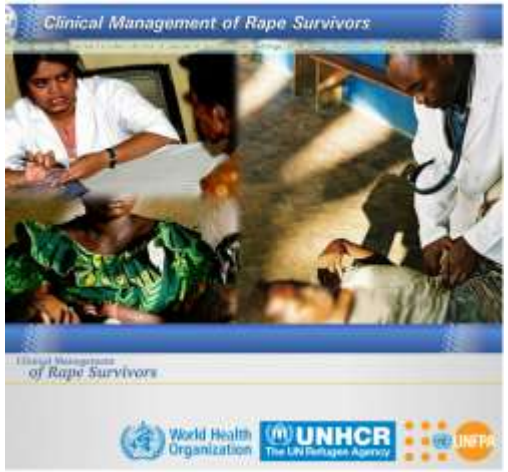


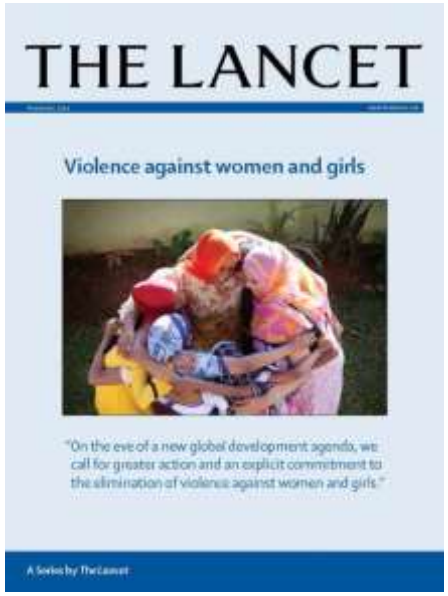












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