Implementing a public health approach to VAW: what is the evidence

Dr Avni Amin
Violence against women... 

forms

Intimate partner violence: the most common form of violence experienced by women
30% of women globally: have experienced physical &/or sexual violence by an intimate partner.
7% of females globally have experienced sexual violence by a non-partner.
WHO’s efforts to strengthen VAW: Priority Areas

1. **Research and evidence-building** to highlight the magnitude of violence against women, its risk factors and consequences, and to identify effective interventions for prevention and response.

2. Developing **guidelines and tools, setting norms and standards** for an effective health response to violence against women.

3. **Strengthening country capacity** of health systems to respond to violence against women.

4. Encouraging leadership in health systems and **building the political will** to address violence against women through advocacy and partnerships.
Political commitment to the health system’s response to violence

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.

Global Plan of Action: Health systems address violence against women and girls
RESPECT women.
Prevent violence against women.
Implement 7 strategies to prevent violence against women

RESPECT

- Relationship skills strengthened
- Empowerment of women
- Services ensured
- Poverty reduced
- Environments made safe
- Child and adolescent abuse prevented
- Transformed attitudes, beliefs, and norms
Assess the risk & protective factors

Risk Factors
- Discriminatory laws on property ownership, marriage, divorce and child custody
- Low levels of women’s employment and education
- Absence or lack of enforcement of laws addressing violence against women
- Gender discrimination in institutions (e.g., police, health)
- Harmful gender norms that uphold male privilege and limit women’s autonomy
- High levels of poverty and unemployment
- High rates of violence and crime
- Availability of drugs, alcohol and weapons
- High levels of inequality in relationships/male-controlled relationships/dependence on partner
- Men’s multiple sexual relationships
- Men’s use of drugs and harmful use of alcohol

Protective Factors
- Laws that promote gender equality
- Promote women’s access to formal employment
- Address violence against women
- Non-exposure to violence in the family
- Secondary education for women and men and less disparity in education levels between women and men
- Both men and boys and women and girls are socialized to, and hold gender equitable attitudes
Apply the guiding principles for effective programming

**CORE VALUES**
- Put women’s safety first and do no harm
- Promote gender equality and women’s human rights
- Leave no one behind

**GENERATE AND DISSEminate KNOWLEDGE**
- Develop a theory of change
- Promote evidence informed programming

**PROGRAMME DESIGN**
- Use participatory approaches
- Promote coordination
- Implement combined interventions
- Address the prevention continuum
- Take a life-course approach
Develop a theory of change

**INTERVENTIONS**

- Relationship skills strengthened
- Empowerment of women
- Services ensured
- Poverty reduced
- Environments made safe
- Child and adolescent abuse prevented
- Transformed attitudes, beliefs, and norms

**OUTCOMES**

- Programme to address VAW widely implemented
- Increased resources and political will to address VAW
- Increased awareness about VAW as a public health problem and that it is preventable
- Sectoral outcomes related to health, economic, and social development improved (e.g., improved mental health, reduced household poverty, improved women’s and child health, improved women’s education and earnings, and reduced absenteeism)
- Families, communities and institutions believe in and uphold gender equality as a norm and no longer accept VAW
- Men accept and treat women as equals
- Women can make autonomous decisions
- Women have knowledge of their rights and access to programmes

**IMPACT**

- Improved health and development outcomes in households, community and society
- Women are exercising their human rights and contributing to development
- Violence against women is reduced or eliminated
- Equality and respect are practiced in intimate, family and community relationships
- Interpersonal conflicts are resolved peacefully

**BUILDING ON RESILIENCE AND KNOWLEDGE, AND RESOURCING AND SUPPORTING COMMUNITIES TO FIND SOLUTIONS**

- Limitations on women’s autonomy
- Children exposed to violence
- Social norms that perpetuate male power
- Inadequate services
- Inadequate legal and social protections for women
- Lack of political will and resources

**POPULAR**

- Families affected by violence
- Communities with high levels of violence
- Women facing violence
Violence prevention interventions that have been shown to work on a pilot basis can be scaled-up in different ways. They can be expanded by adding more beneficiaries; they can be adapted and replicated in another geographic location; and there can be expansion in coverage of the same intervention over a wider geographic area. Interventions that are being scaled-up in a new setting need to be adapted to context. This requires an understanding of the local culture, values and resources.

Interventions identified as promising (pages 10-11) can be adapted and scaled-up with attention to the guiding principles for prevention and to the adaptation and scaling-up considerations on the next page; those classified as “more evidence needed” (pages 10-11) may need to be replicated or further refined before they are scaled-up; and those identified as “conflicting” or “no evidence” need to be further evaluated.

Align with national commitments (e.g. a national plan, policy, strategy) to end violence against women, or to promote gender equality or women’s health.

Identify and maintain fidelity to core principles of gender equality, rights and safety as well as to minimum “dosage”, while adapting to context, including language and culture.

Programme for synergy, combining multiple strategies and interventions at the individual, interpersonal, community and societal levels for sustained impact.

Invest in capacity among implementers, and giving enough time to scale-up and to allow for change to occur and sustain.

Build on on-going initiatives, integrating prevention activities into existing health, development and other existing sectoral programmes.

Design with “scale” in mind, investing for the long-term, keeping costs and sustainability in mind.

Start small, document and evaluate the adaptation and scale-up in order to innovate and strengthen evidence-informed programming.

Support a community of practice among programme developers and implementers to facilitate learning and knowledge sharing.
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
Pathways & health effects of IPV

INTIMATE PARTNER VIOLENCE

PHYSICAL TRAUMA

PSYCHOLOGICAL TRAUMA/STRESS

FEAR AND CONTROL

Mental Health

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

TWICE as likely to experience depression

ALMOST TWICE as likely to have alcohol use disorders

NONCOMMUNICABLE DISEASES
- cardiovascular disease
- hypertension

SOMATOFORM
- irritable bowel
- chronic pain
- chronic pelvic pain

LIMITED SEXUAL AND REPRODUCTIVE CONTROL
- lack of contraception
- unsafe sex

HEALTH CARE SEEKING
- lack of autonomy
- difficulties seeking care and other services

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

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

4.5 times as likely to attempt suicide

DISABILITY
WHO guidelines & implementation manuals: A toolkit

"What"

Ongoing
1. Curricula – e-learning + print
2. Toolkit with all products with instructions on how to roll out / implement, monitor and evaluate

"How"
How to use the guidelines & tools to strengthen country capacities

1. Raise awareness among policy-makers, health managers & health care workers
2. Adapt or update guidelines or protocols and standard operating procedures for health response to VAW
3. Training of trainers and/or of health providers and managers
4. Monitoring and evaluating trainings and service readiness to deliver care to survivors
Countries being supported

Botswana, Cambodia, Namibia, Pakistan, Uganda, Uruguay, and Zambia have adapted and implemented the clinical handbook.

**Afghanistan** is scaling up the health sector response to violence against women: it has developed a health protocol in line with WHO guidelines, translated the clinical handbook into local languages and is training 6000+ health workers across all 34 provinces.

**Cambodia** has implemented a national population-based prevalence survey using the WHO multi-country study methodology.

WHO is building the capacity of health care providers in humanitarian settings, through the health cluster, in Afghanistan, Bangladesh, Democratic Republic of Congo, Iraq, Nigeria, and the Syrian Arab Republic.
Key achievements

Uganda: MoH is sensitized to the issue, piloted in 3 districts, and has a plan for scaling up services

Cambodia: Trainings being scaled-up in 11 districts + pre-service

Afghanistan: training 6500 providers + service improvements in facilities in all 34 provinces
A man in his forties raped a teenage girl in his village and brought five cows to her parents as a bride price. The girl was devastated and ran to the health care facility where she had been treated following her rape by a trained health worker who had been kind to her.

The health workers did not disclose her whereabouts. They talked to the community and the girl’s family and helped them understand what they were doing was wrong, that this young girl had the right to choose a partner, that she had been raped which was a crime, and that her right to safety should be respected. The community accepted her back and her family allowed her to marry the man she loved.

CEDOVIP, Uganda 2018

A 27-year-old woman came to a clinic in Afghanistan with injuries on her face and in a state of emotional distress. The doctor asked her about violence and she disclosed that while her husband was working overseas, her husband’s brother beat her almost everyday. She suffers from insomnia and severe headaches.

Reassuring her about confidentiality, the doctor examined her, attended to injuries, prescribed medication, and referred her for counseling. The counselor provided regular counseling. After 3 weeks, the woman’s mental health symptoms improved.

Mid-wife, community health center, Afghanistan
Lessons learned: sustained changes require

- Improving infrastructure
  - patient flow
  - mechanisms for privacy
- Procedures for confidentiality
- Documentation
- IEC, job aids
- Supervision, mentoring & refreshers
- Strengthening referral linkages with other services
- Supportive managers willing to champion
- Community outreach to raise awareness
- Institutional change takes time