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

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World Health Organization

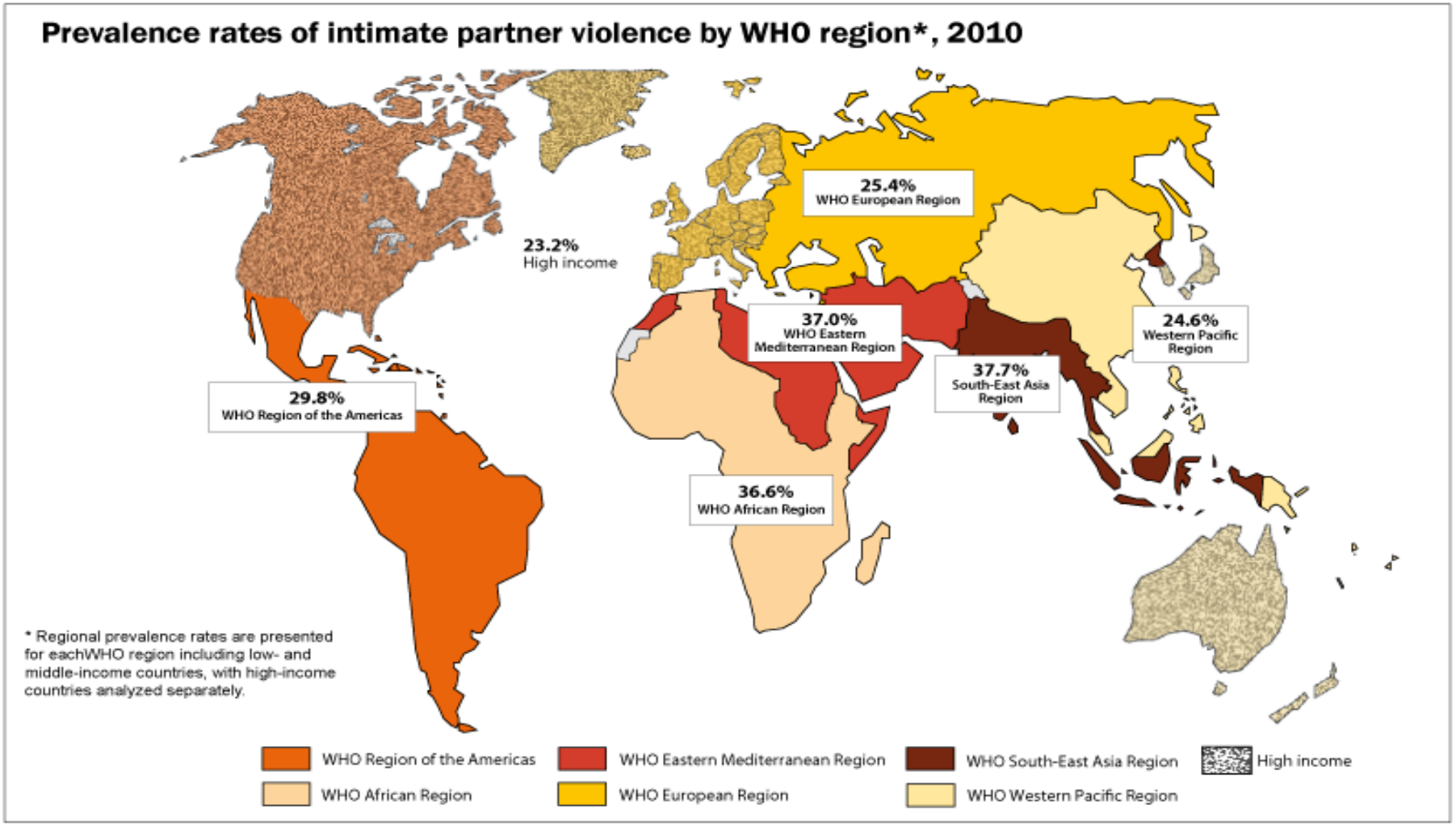
human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · THE WORLD BANK

Violence against women…

forms

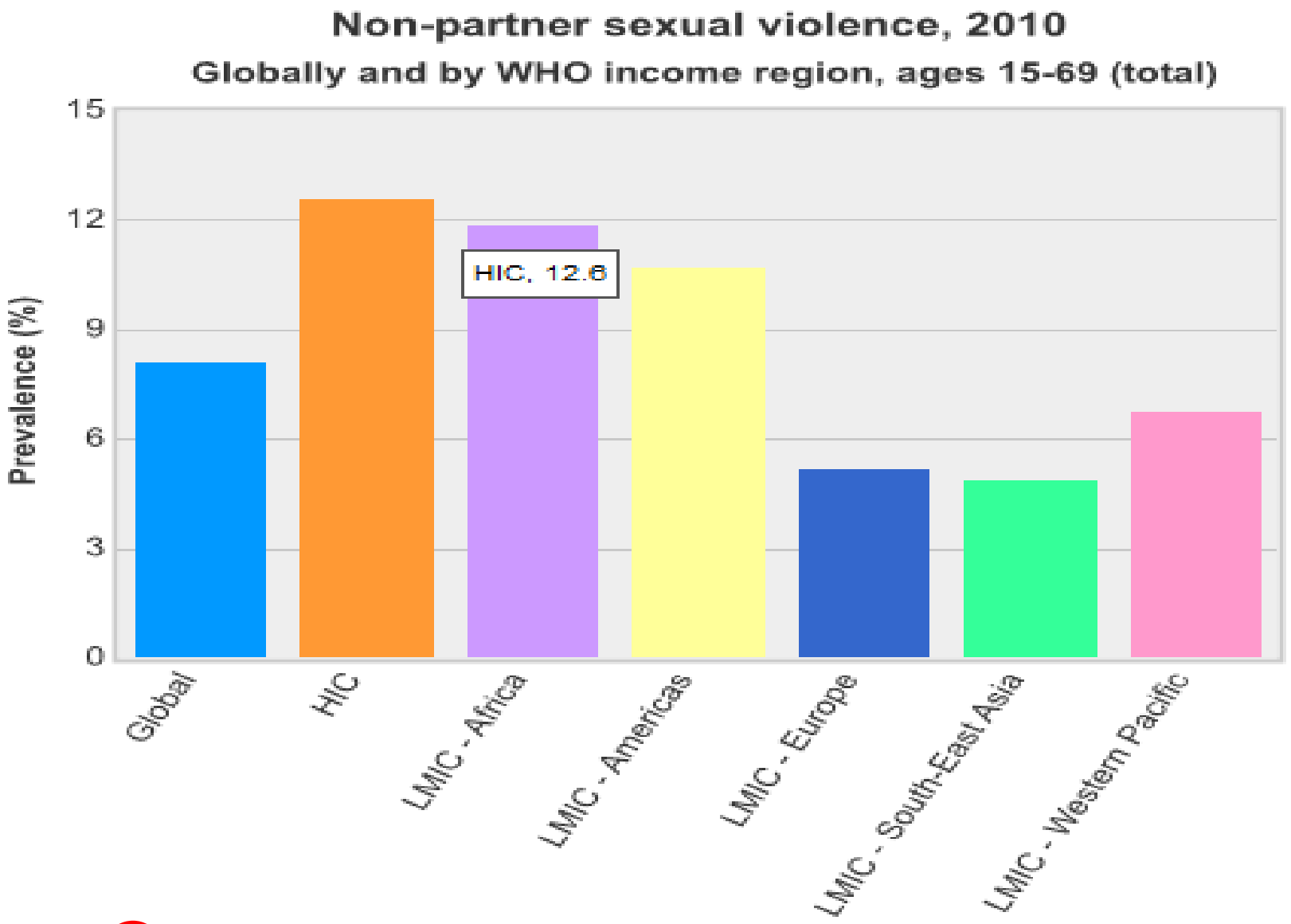
Intimate partner violence: the most common form of violence experienced by women

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**

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

RESPECT WOMEN

Preventing violence against women

World Health Organization
UNITED NATIONS HUMAN RIGHTS
UNDP
UNFPA
UNODC
UN WOMEN
Ministry of Foreign Affairs of the Netherlands
Australian Government
UKaid
USAID
Sida
WORLD BANK GROUP

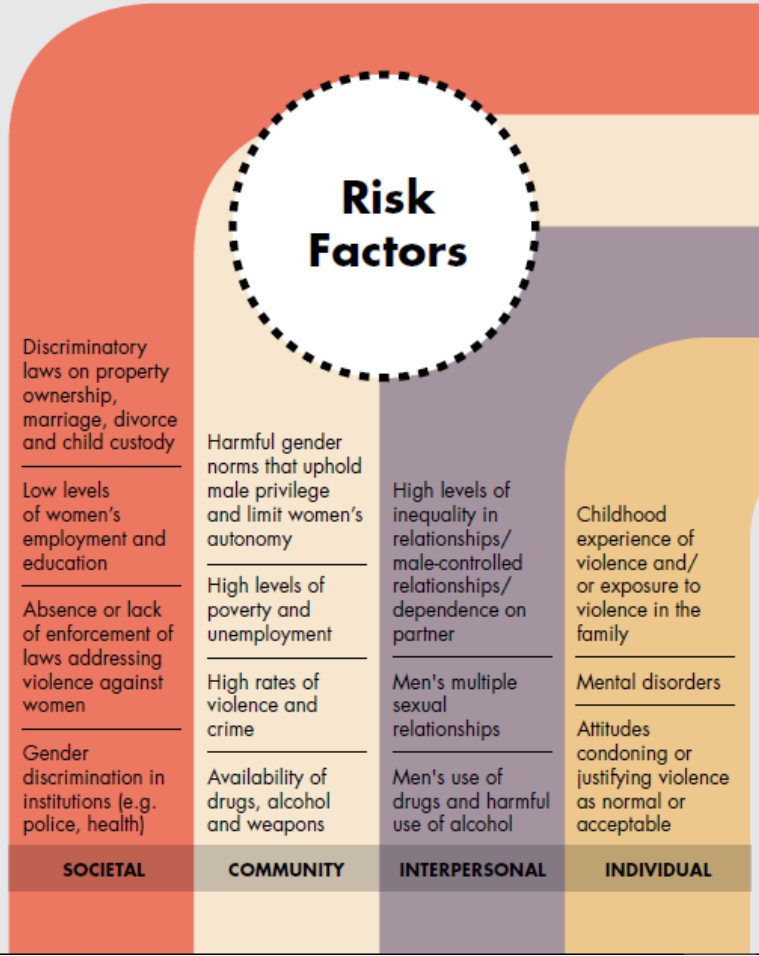
RESPECT

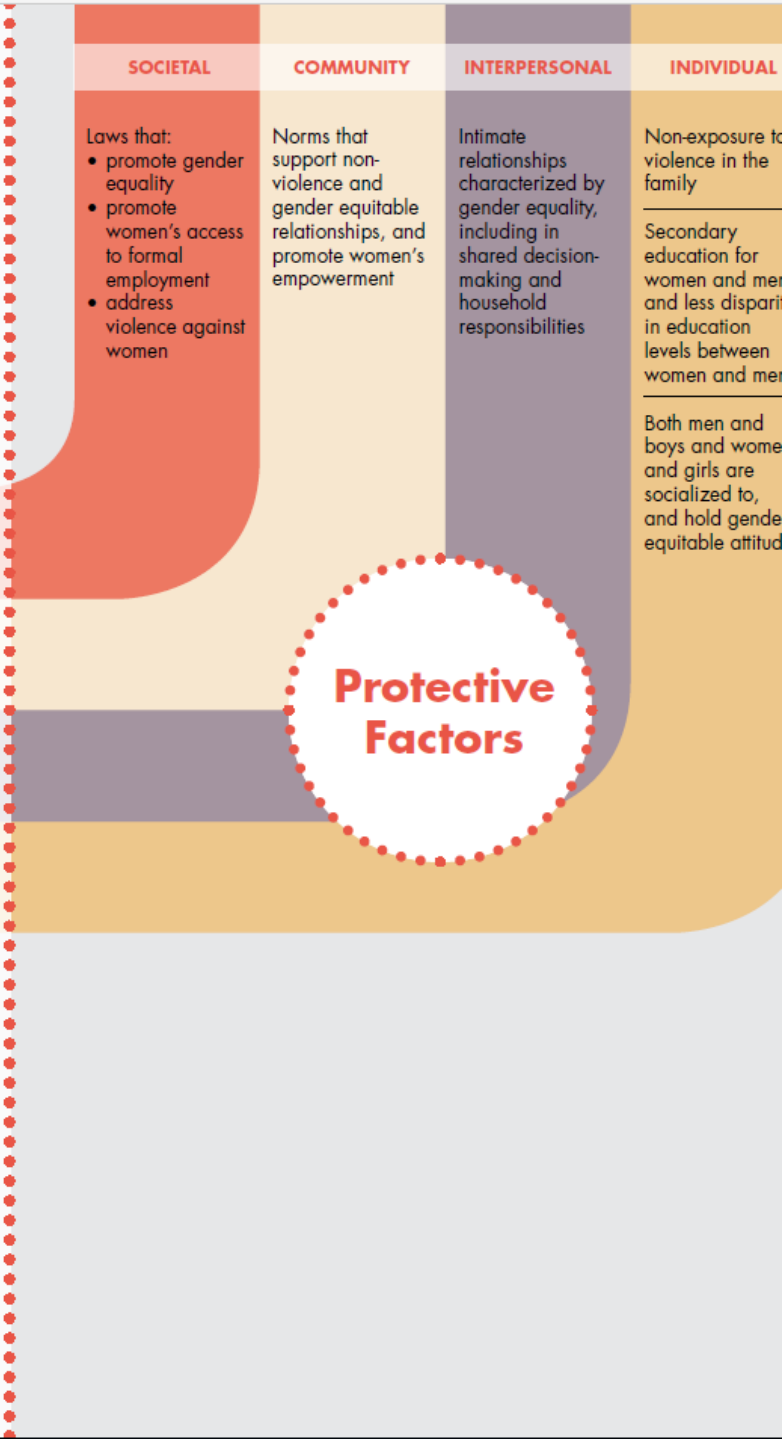
RESPECT women.
Prevent violence against women.

World Health Organization

Implement 7 strategies to prevent violence against women

Assess **the risk & protective factors**[1]





Relationships skills strengthened

Group-based workshops with women and men to promote egalitarian attitudes and relationships

H L

Couples counselling and therapy

H L

EXAMPLE

Group-based Workshops

In the two-year period following the implementation of *Stepping Stones* in South Africa with female and male participants aged 15–26 years, men were less likely to perpetrate intimate partner violence, rape and transactional sex in the intervention group compared to the baseline.[x]

Empowerment of women

Empowerment training for women and girls including life skills, safe spaces, mentoring

H L

Inheritance and asset ownership policies and interventions

H L

Micro-finance or savings and loans plus gender and empowerment training components

H L

EXAMPLE

Microfinance plus gender and empowerment

The *iMAGE project* (intervention with Microfinance for Aids and Gender Equity) in South Africa empowers women through microfinance together with training on gender and power and community mobilization activities. Studies show it reduced domestic violence by 50% in the intervention group over a period of two years. At US$244 per incident case of partner violence averted during a 2-year scale up phase, the intervention is highly cost-effective.[w]

Services ensured

Empowerment counselling interventions or psychological support to support access to services (i.e. advocacy)

H L

Alcohol misuse prevention interventions

H L

Shelters

H L

Hotlines

H L

One-stop crisis centres

H L

Perpetrator interventions

H L

Women's police stations/units

H L

Screening in health services

H L

Sensitization and training of institutional personnel without changing the institutional environment

H L

EXAMPLE

Advocacy for survivors

The *Community Advocacy Project* in Michigan and Illinois, United States, is an evidence-based program designed to help women survivors of intimate partner abuse re-gain control of their lives. Trained advocates provide advocacy and individually tailored assistance to survivors so that they can access community resources and social support. The intervention was found to lower recurrance of violence and depression and improve quality of life and social support. Two years after the intervention ended, the positive change continued.[y]

Poverty reduced

Economic transfers, including conditional/ unconditional cash transfers plus vouchers, and in-kind transfers

H L

Labour force interventions including employment policies, livelihood and employment training

H L

Microfinance or savings interventions without any additional components

H L

EXAMPLE

Economic transfers

In Northern Ecuador, a cash, vouchers and food transfer programme implemented by the World Food Programme (WFP) was targeted to women in poor urban areas, intending to reduce poverty. Participating households received monthly transfers equivalent to $40 per month for a period of 6 months. The transfer was conditional on attendance of monthly nutrition trainings. The evaluation showed reductions in women's experience of controlling behaviours, physical and/or sexual violence by intimate partners by 19 to 30%. A plausible mechanism for this was reduced conflict within couples related to poverty-related stresses.[p]

Environments made safe

Infrastructure and transport

H L

Bystander interventions

H L

Whole School interventions

H L

EXAMPLE

Right to play - preventing violence among and against children in schools

In Hyderabad (Sindh Province), Pakistan, a right to play intervention reached children in 40 public schools. Boys and girls were engaged in play-based learning providing them opportunity to develop life skills such as confidence, communication, empathy, coping with negative emotions, resilience, cooperation, leadership, critical thinking and conflict resolution that help combat conflict, intolerance, gender discrimination and peer violence. An evaluation showed decreases in peer victimization by 33% among boys and 59% among girls at 24 months post intervention; in corporal punishment by 45% in boys and 66% in girls; and in witnessing of domestic violence by 65% among boys and by 70% in girls.[o]

Child and adolescent abuse prevented

Home visitation and health worker outreach

H L

Parenting interventions

H L

Psychological support interventions for children who experience violence and who witness intimate partner violence

H L

Life skills / school-based curriculum, rape and dating violence prevention training

H L

Transformed attitud beliefs, and norms

Community mobilization

H L

Group-based workshops wi women and men to promote changes in attitudes and no

H L

Social marketing or edutain and group education

H L

Group education with men boys to change attitudes an norms

H L

Stand-alone awareness campaigns/single compone communications campaigns

H L

EXAMPLE

Community Mobilizations *S* is a community intervention in Uga that prevents violence against wom by shifting the power balance beN men and women in relationships. S show that in SASAI communities 7 of women and men believe physic violence against a partner is not acceptable while only 26% of wor and men in control communities be the same. At the cost of US$ 460 incident case of partner violence a in trial phase, intervention is cost-el and further economies of scale ca achieved during scale-up.[v]

LEGEND[4]

- **promising**, >1 evaluations show significant red violence outcomes
- **more evidence needed**, > 1 evaluations sho improvements in intermediate outcomes related to
- **conflicting**, evaluations show conflicting results violence[z]
- **no evidence**, intervention not yet rigorously eva
- **ineffective**, >1 evaluations show no reductions outcomes
- **H** World Bank High Income Countries (HIC)
- **L** World Bank Low and Middle Income Countries (L

Assess the **evidence** on **interventions**[3]

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

- **R**elationship skills strengthened
- **E**mpowerment of women
- **S**ervices ensured
- **P**overty reduced
- **E**nvironments made safe
- **C**hild and adolescent abuse prevented
- **T**ransformed attitudes, beliefs, and norms

Building on resiliency and knowledge, and resourcing and supporting communities to find solutions

Women facing violence

Families affected by violence

Communities with high levels of violence

BARRIERS

- **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**

OUTPUTS

- Programmes 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

OUTCOMES

- 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

V Adapt and **scale-up** what works

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.

a **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.[7]

b **Identify and maintain fidelity to core principles** of gen equality, rights and safety as well as to minimum "dosage", while a adapting to context, including language and culture.

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

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

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

f **Design with "scale" in mind**, investing for the long-term, keeping costs and sustainability in mind.

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

h **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

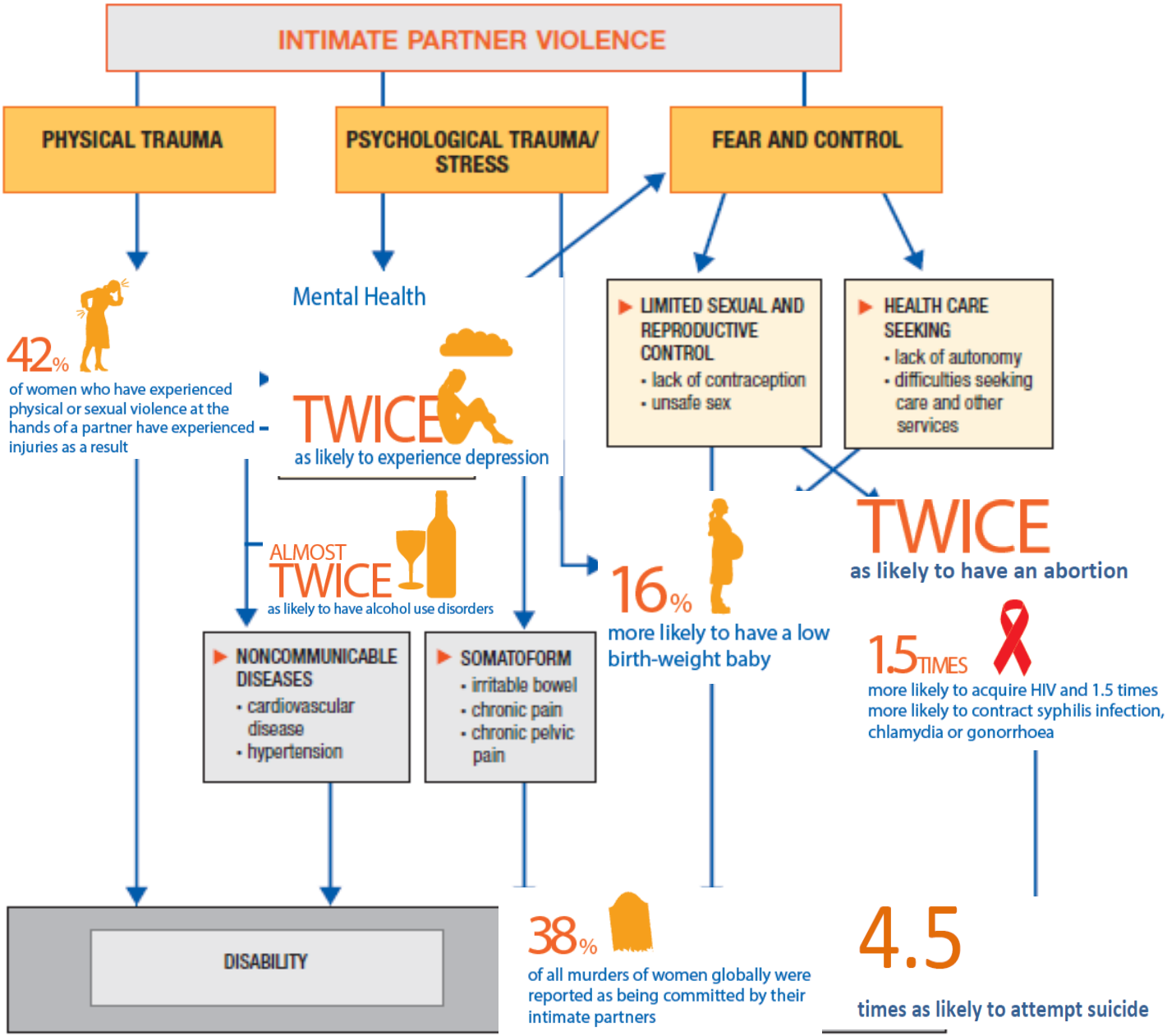
2. Violence is an underlying cause of injury and ill health

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

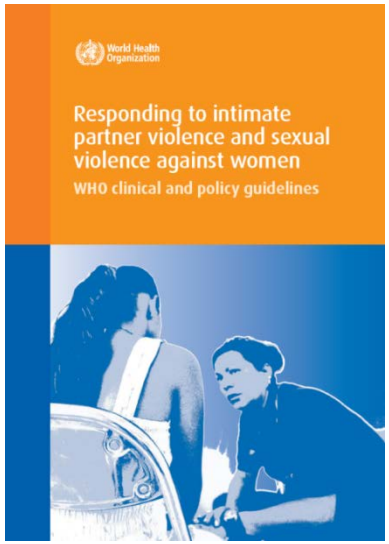
4. If health workers know about a history of violence they can give better services for women
   - Identify women in danger before violence escalates
   - Provide appropriate clinical care
   - Reduce negative health outcomes of VAW
   - Assist survivors to access help / services/ protections
   - Improve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

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

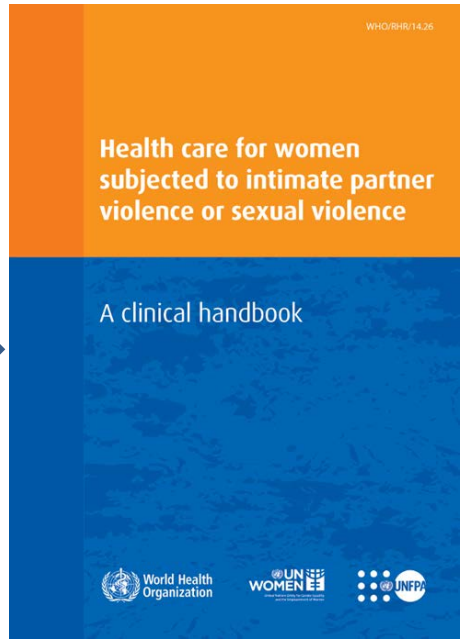
Pathways & health effects of IPV

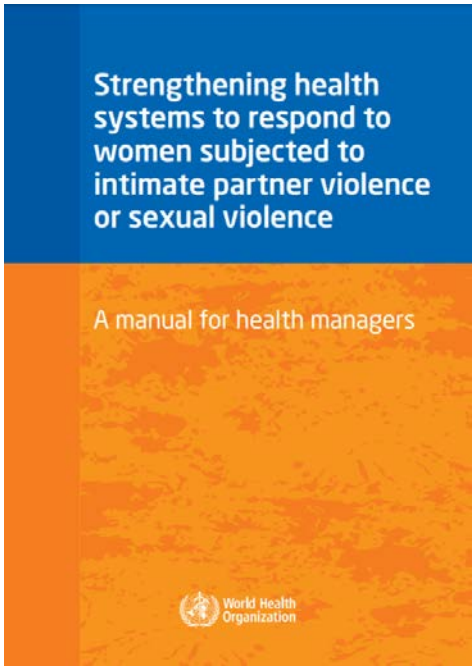


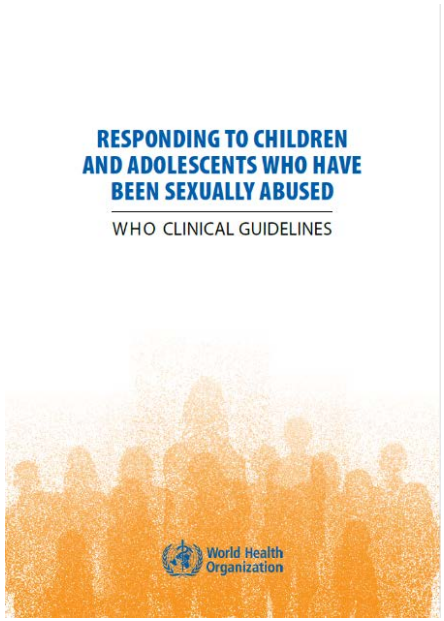
WHO guidelines & implementation manuals: A toolkit



"What"







"How"

Ongoing

1. **Curricula – e-learning + print**

2. **Toolkit with all products with instructions on how to roll out / implement, monitor and evaluate**

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

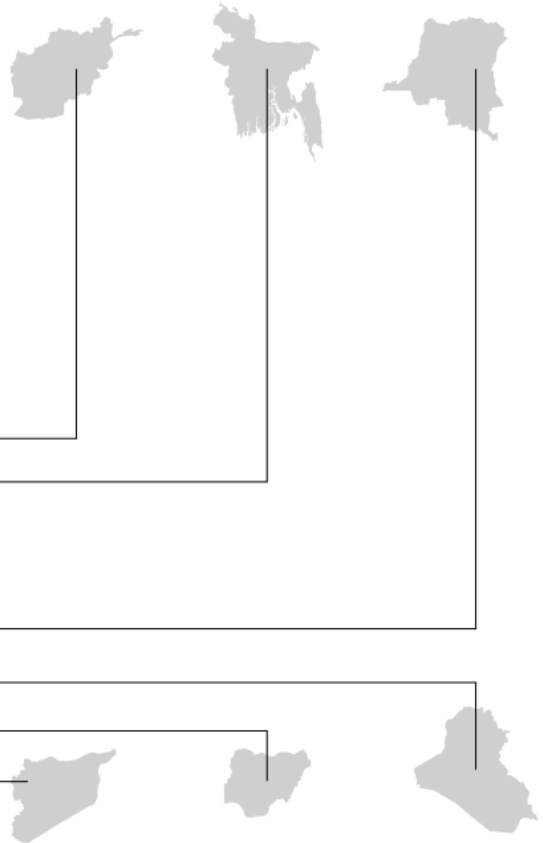
Countries being supported

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

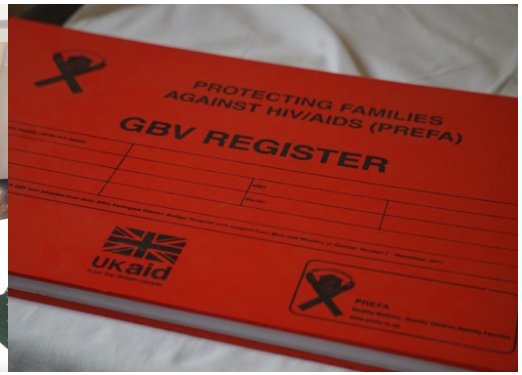
Afghanistan is scaling up the health sector response to violence against women: it has developed a health protocol in line with WHO guidelines, translated the clinical handbook into local languages and is training 6000+ health workers across all 34 provinces.

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

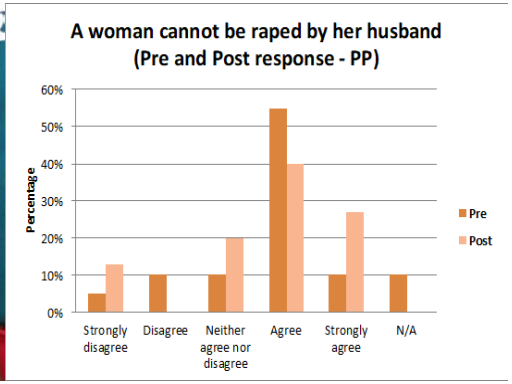
WHO is building the capacity of health care providers in humanitarian settings, through the health cluster, in **Afghanistan, Bangladesh, Democratic Republic of Congo, Iraq, Nigeria,** and the **Syrian Arab Republic**.



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

Stories from the field

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