Understanding and addressing violence against women as a public health problem: What do we know?

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Geneva

*Nigel Walker Lecture, Cambridge University*
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Presentation

• History and overview of prevalence and health burden
• Summary of evidence on prevention interventions
• Health sector and criminal justice/police responses
• Political considerations
VIOLENCE AFFECTS GIRLS AND WOMEN AT EVERY AGE AND STAGE OF LIFE

CHILD SEXUAL ABUSE
Approximately 20% of women and 5-10% of men report being sexually abused as children.6

FORCED/EARLY MARRIAGE
Latest international estimates indicate that more than 60 million women aged 20-24 years were married before the age of 18 years. About half of the girls in early marriage live in south Asia.4

KILLINGS IN THE NAME OF HONOUR
A total of 1,957 honour killing events occurred in Pakistan from 2001 to 2007.7

INTIMATE PARTNER VIOLENCE
Globally, 30% women who have ever been in a relationship have experienced physical and/or sexual violence by their intimate partner.9

FEMALE GENITAL MUTILATION / CUTTING
More than 128 million women and girls alive have been cut in 39 countries in Africa and the Middle East where FGM/C is concentrated.4

TRAFFICKING OF WOMEN AND GIRLS
11.4 million2

SEXUAL VIOLENCE
It is estimated that globally 73% of women have been sexually assaulted by someone other than a partner since age 15, although data is lacking in some regions.2

A FEW COMMON TYPES OF VIOLENCE
Public health systems can contribute to the prevention of violence against women.

- **Identify risk and protective factors**: What are the causes?
- **Develop and evaluate interventions**: What works? And for whom?
- **Implementation**: Scalling up effective policy and programmes
Magnitude of the problem

**2005:** 11 countries
**2018:** 37

**2013:** 81 countries
**2018:** 135
Lifetime prevalence of intimate partner violence

1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or 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>
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<td>25-29</td>
<td>32.3</td>
<td>30.0 to 34.6</td>
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<tr>
<td>30-34</td>
<td>31.1</td>
<td>28.9 to 33.4</td>
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<tr>
<td>35-39</td>
<td>36.6</td>
<td>30.0 to 43.2</td>
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<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)
Life-time prevalence of non-partner sexual violence:
7.2% globally

Table 4. Lifetime prevalence of non-partner sexual violence by WHO region

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Prevalence, %</th>
<th>95% CI, %</th>
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</thead>
<tbody>
<tr>
<td>Low- and middle-income regions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>11.9</td>
<td>8.5 to 15.3</td>
</tr>
<tr>
<td>Americas</td>
<td>10.7</td>
<td>7.0 to 14.4</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Europe</td>
<td>5.2</td>
<td>0.8 to 9.7</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>4.9</td>
<td>0.9 to 8.9</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>6.8</td>
<td>1.6 to 12.0</td>
</tr>
<tr>
<td>High income</td>
<td>12.6</td>
<td>8.9 to 16.2</td>
</tr>
</tbody>
</table>
7% of women globally have experienced sexual violence by a non-partner.
Life-time prevalence of intimate partner OR non-partner sexual violence: 35.6% globally

Table 5. Lifetime prevalence of intimate partner violence (physical and/or sexual) or non-partner sexual violence or both among all women (15 years and older) by WHO region

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Proportion of women reporting intimate partner violence and/or non-partner sexual violence, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income regions:</td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>45.6</td>
</tr>
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<td>Eastern Mediterranean</td>
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</tr>
<tr>
<td>South-East Asia</td>
<td>40.2</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>27.9&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>High income</td>
<td>32.7</td>
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</tbody>
</table>
Pregnancy is not always a protected
Pathways and health effects of intimate partner violence

Figure 1. Pathways and health effects on intimate partner violence

INTIMATE PARTNER VIOLENCE

PHYSICAL TRAUMA
- INJURY
  - musculoskeletal
  - soft tissue
  - genital trauma
  - other

PSYCHOLOGICAL TRAUMA/STRESS
- MENTAL HEALTH PROBLEMS
  - PTSD
  - anxiety
  - depression
  - eating disorders
  - suicidality

- SUBSTANCE USE
  - alcohol
  - other drugs
  - tobacco

- NONCOMMUNICABLE DISEASES
  - cardiovascular disease
  - hypertension

- SOMATOFORM
  - irritable bowel
  - chronic pain
  - chronic pelvic pain

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

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

- PERINATAL/MATERNAL HEALTH
  - low birth weight
  - prematurity
  - pregnancy loss

- SEXUAL AND REPRODUCTIVE HEALTH
  - unwanted pregnancy
  - abortion
  - HIV
  - other STIs
  - gynaecological problems

DISABILITY

DEATH
- homicide
- suicide
- other
Health consequences of intimate partner violence

**HEALTH IMPACT:** Women exposed to intimate partner violence are

**Mental Health**
- TWICE as likely to experience depression
- ALMOST TWICE as likely to have alcohol use disorders

**Sexual and Reproductive Health**
- 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

**Death and Injury**
- 42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result
- 38% of all murders of women globally were reported as being committed by their intimate partners
Mental health consequences of VAW/IPV
Complex, inter-related linkages; often bi-directional

STRONG EVIDENCE
(systematic review of cohort studies)

• Women experiencing recent IPV are more likely to experience depressive symptoms
• Women experiencing depressive symptoms are more likely to experience subsequent IPV
• Positive association between recent IPV and postpartum depression

Women’s drinking and IPV

Women’s Drinking

- Meta-analysis finds positive association between heavy/binge drinking and lifetime experience of IPV – but could be driven by abuse in childhood

% of women murdered by their intimate partner among all female homicides

% of men murdered by their intimate partner among all male homicides
Child marriage, sexual violence and domestic violence cited as main GBV concerns. (Voices from Syria, 2017)

“I know a woman who was used to being beaten by her husband. Now she can't move because her knee cartilage was broken. I told her that her personality is weak.”

87% of Afghan women experience at least one form of domestic violence.

(Global Rights, 2008 “National Report on Domestic Abuse in Afghanistan”)
68.2% of respondents had experienced IPV.

(Myers Tlapek S., *Journal of Interpersonal Violence* 30(14) · October 2014)

65% of women and girls experience physical and/or sexual violence in their lifetime. A third experienced sexual violence by a non-partner.

(CARE, George Washington University, IRC, 2017)
Sexual abuse of children and adolescents is highly prevalent

Violence Against Children Surveys from Five Countries

Percentage of individuals who experienced sexual violence prior to age 18

Global estimates:
- 18% girls
- 8% boys

> 1 in 4 girls in these 5 countries have experienced sexual abuse

120 million girls worldwide have experienced sexual abuse
Few survivors seek or receive services

Disclosure and service usage by individuals who experienced childhood sexual violence, as reported by 18 to 24 year olds*

- **% Females**
  - 7 Kenya
  - 22 Tanzania
  - 4 Zimbabwe
  - 3 Kenya
  - 13 Tanzania
  - 3 Zimbabwe
  - **46** Kenya
  - **52** Tanzania
  - **52** Zimbabwe

- **% Males**
  - <1 Kenya
  - 4 Tanzania
  - 2 Zimbabwe
  - **2** Kenya
  - **12** Tanzania
  - **2** Zimbabwe
  - **36** Kenya
  - **31** Tanzania
  - **45** Zimbabwe

- **Told someone about sexual violence**
  - 46 Kenya
  - 52 Tanzania
  - 52 Zimbabwe

- **Sought services for sexual violence**
  - 7 Kenya
  - 22 Tanzania
  - 4 Zimbabwe
  - 3 Kenya
  - 13 Tanzania
  - 3 Zimbabwe

- **Received services for sexual violence**
  - <1 Kenya
  - 4 Tanzania
  - 2 Zimbabwe
  - 2 Kenya
  - 12 Tanzania
  - 2 Zimbabwe
  - 36 Kenya
  - 31 Tanzania
  - 45 Zimbabwe
Social and economic consequences of VAW/IPV

Experiences of violence

- Loss of wages
- Social isolation
- Limited ability to care for self and children
- Inability to work
- Lack of participation in regular activities
Risk factors for violence against women

**Societal**
- 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)

**Community**
- 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

**Interpersonal**
- Men’s multiple sexual relationships
- Attitudes condoning or justifying violence as normal or acceptable
- Childhood experience of violence and/ or exposure to violence in the family
- Mental disorders
- Men’s use of drugs and harmful use of alcohol
- Attitudes condoning or justifying violence as normal or acceptable

Protective factors for violence against women

- **Societal**
  - Laws that:
    - promote gender equality
    - promote women’s access to formal employment
    - address violence against women

- **Community**
  - Norms that support non-violence and gender equitable relationships, and promote women’s empowerment

- **Interpersonal**
  - Intimate relationships characterized by gender equality, including in shared decision-making and household responsibilities

- **Individual**
  - 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

Factors Associated with Men’s Perpetration of Intimate Partner Violence

Factors Associated with Men’s Perpetration of Rape Against a Female Non-Partner


2+ LIFETIME SEXUAL PARTNERS

CURRENT FOOD INSECURITY

FIGHTS

PHYSICAL INTIMATE PARTNER VIOLENCE

GANG INVOLVEMENT

ALCOHOL ABUSE

DEPRESSION

CURRENT DRUG USE

EXPERIENCED HOMOPHILIC ABUSE

SEXUAL VICTIMIZATION

CHILDHOOD EMOTIONAL ABUSE OR NEGLECT

CHILDHOOD SEXUAL ABUSE

TRANSACTIONAL SEX

NON-PARTNER RAPE
What works to prevent and respond to violence against women?
Implement 7 strategies to prevent violence against women

- 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 evidence on interventions
Strengthen enabling environment for prevention

Build political commitment from leaders and policy makers to speak out, condemning violence against women.

Put in place and facilitate enforcement of policies and laws that address violence against women and that promote gender equality.

Allocate resources to programmes, research, and to strengthen institutions and capacities of the health, education, law enforcement, and social services sectors to address violence against women.

Invest in, build on the work of, resource, and support women's organizations.

World Health Organization
Prevention and response evidence: What works to empower women?

Promising interventions include:
• Empowerment training for women and girls including life skills, safe spaces, mentoring
• Inheritance and asset ownership policies and interventions

Example: Microfinance plus gender and empowerment (IMAGE – S Africa)

- Women empowered through microfinance, receive training on gender and power and community mobilization activities
- Reduction in domestic violence by 50% over 2 years at an overall cost of $244 per incident case of partner violence

Prevention and response evidence: What works to prevent child and adolescent abuse?

Promising interventions include:
- Home visitation and health worker outreach
- Parenting interventions
- Psychological support interventions for children who experience violence and who witness intimate partner violence

Example: Right to play - preventing violence among and against children in schools (Pakistan)

Children learn life skills like confidence, communication, empathy, coping with negative emotions, critical thinking, resilience, cooperation, conflict resolution

33% decrease in peer victimization in boys, 59% in girls
45% decrease in corporal punishment in boys, 66% in girls
65% decrease in witnessing of domestic violence by boys, 70% by girls
Prevention and response evidence: What works to reduce poverty?

Promising interventions include:
- Economic transfers, including conditional, unconditional cash transfers, plus vouchers and in-kind transfers (2 systematic reviews -2017)
- Labour force interventions including employment policies, livelihood and employment training

Example: Economic transfers (Ecuador, WFP)

Women in poor urban areas receive cash, vouchers, and food transfers equivalent to $40 month/6 months conditional on attending monthly nutrition trainings

Reductions in women’s experience of controlling behaviors, 19% to 30% decrease in physical/sexual violence by intimate partners

The health sector response:
What do we know?
The health sector does more than offer care to survivors

Provide comprehensive services to survivors and their children:
- Prevent reoccurrence
- Mitigate negative consequences
- Provide immediate and ongoing care

Strengthen the coordination between the health system and relevant sectors

Collect data on prevalence, risk factors, and consequences, to inform and evaluate policies and programs

Support prevention efforts by:
- Documenting VAW and its burden
- Fostering and informing prevention programs
- Piloting and evaluating

Advocate for the recognition of violence as a public health problem
Violent event occurs

Primary Prevention
- Advocacy / awareness raising
- Home visitation, parenting and other interventions to reduce child maltreatment*
- Reduce alcohol consumption
- Data collection

Secondary Prevention
- Identification through clinical inquiry
- Acute care for health problems
- Long-term care for health, including mental health
- Addressing alcohol and substance use disorders
- Referral to legal and other support services

Tertiary Prevention
- Rehabilitation
- Long-term mental health and other support
- Support with other needs, e.g. employment, loans, housing, and legal
- Advocacy for survivors within criminal justice system

Design, evaluate and implement research to identify what works
How are WHO evidence-based guidelines created?

- Scoping
- Systematic Review
- Expert Group
- GRADE
- Practitioners
- Guideline
### Evidence for interventions

<table>
<thead>
<tr>
<th>Women-centered care and first line support</th>
<th>Screening for IPV</th>
<th>Clinical inquiry and low threshold for asking</th>
<th>Mental health interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good practice recommendation with some evidence for psychological first aid</td>
<td></td>
<td></td>
<td>• Cognitive Behavior Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Eye Movement Desensitization Reprocessing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lay provider delivered</td>
</tr>
</tbody>
</table>

**Mental health interventions:**
- Cognitive Behavior Therapy
- Eye Movement Desensitization Reprocessing
- Lay provider delivered

**Brief counselling interventions and advocacy/support (psychosocial or advocacy interventions)**

Updated: VEGA Project, 2018
### Evidence about other interventions

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Description</th>
</tr>
</thead>
</table>
| ✓ | Children exposed to IPV at home  
  - Psychotherapeutic interventions  
  - Psychoeducation |
| ✓ | Women’s shelters may provide safety for women at immediate risk, and their children |
| ? | Couples interventions  
  - not recommended in HICs  
  - emerging data LMICs |
| ? | Insufficient evidence for or against:  
  - Peer support interventions for IPV  
  - Perpetrator interventions |

Source: WHO 2013 and VEGA Project, 2018
What are the key elements of a health sector response to violence against women according to current evidence?

Offer immediate first-line support when women disclose violence

Ask questions to identify violence when potential indicators are present

Offer comprehensive clinical care for survivors of VAW:
- first-line support
- emergency contraception / abortion
- STI and HIV prophylaxis
- mental health care

Integrate training for health care providers at pre- and in-service levels

Integrate care for survivors of violence into existing health services rather than as a stand-alone service

Health care providers should not report violence to police, unless the survivor requests it
WHO tools to support health systems:

Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines

Health care for women subjected to IPV or SV: A clinical handbook

Strengthening health systems to respond to women subjected to IPV or SV: A manual for health managers

Training Curricula on Violence Against Women Response (forthcoming)

WHO Clinical Guidelines for responding to children and adolescents who have been sexually abused

Strengthening the medico-legal response to sexual violence
Ignoring VAW within health settings can lead to harm

<table>
<thead>
<tr>
<th>Provider behavior</th>
<th>Possible consequences to women and children</th>
</tr>
</thead>
</table>
| Doesn’t recognize VAW is behind chronic or recurring conditions | • Inadequate diagnosis = inadequate care  
• Missed opportunity to mitigate harm  
• Women (and their children) experience negative outcomes |
| Doesn't address VAW within SRH services or HIV counseling    | • Unplanned pregnancy, STIs/HIV/AIDS, unsafe abortion, additional violence      |
| Ignores signs of fear or distress                           | • Missed opportunity to improve safety and reduce reoccurrence  
• Woman is injured, killed or commits suicide |
What can be accomplished when health care providers are aware of a woman’s experience of violence?

*Basic criteria must be met prior to addressing VAW: protocol, training, privacy, confidentiality, referral system

- Providers conduct better assessments and offer better care
- Survivors receive appropriate care and support to access other services (justice, social)
- Survivors understand impact of violence on own health and that of kids and are able to make informed choices
- Improved health outcomes
- Improved safety of women and children
- Mitigation of negative consequences and reduction of reoccurrence
- Violence is prevented
- Intergenerational impact of violence is interrupted

Improved health outcomes

Improved safety of women and children

Mitigation of negative consequences and reduction of reoccurrence

Violence is prevented

Intergenerational impact of violence is interrupted
The police and legal sector response: What do we know?

Police and justice sector responses

• Police and security personnel training
  – Low quality evidence. Insufficient evidence to recommend
  – Some evidence of positive changes in the attitude and behaviour of police
  – Often ‘one-off’ events, not institutionalised, no refresher training sessions or follow-up
  – Police training in evidence-based practices do not increase the length of time officers spend with victims at DFV incidents or improve conviction rates.

• Pro-active arrest policies (mandatory or preferred arrest)
  – At least one RCT - conflicting evidence and no recommendation for or against
  – Evidence that may have a modest effect on preventing violence perpetration amongst some men - especially are first-time domestic violence offenders with no other criminal history. Not associated with reductions in homicide or repeat victimization.
  – Most cases of DV reported to the police perpetrated by a very small group of men who are repeat offenders and so do not appear to have much, if any, impact on them
  – Can create further harm to victims, particularly from racial minorities
  – Promising results regarding victim understanding of violent behaviours, no-contact orders, and help-seeking behaviours
Police and justice sector responses

• Mandatory reporting

  – Fair evidence to recommend against: may increase arrests, however, outweighed by the unintended negative consequences, including increased risk to survivors.
  – Survivors often reluctant to testify
  – Evidence that some perpetrators may become more violent after arrest or prosecution (unmarried and unemployed)
  – Fear of negative consequences may discourage women from disclosing domestic violence to healthcare providers that have a mandatory reporting policy
Police and justice sector responses

• Protection orders
  – Fair evidence to recommend the intervention, although violence does not always stop after a protection order is issued. There are also risks to women’s autonomy and choice that should be considered.
  – No evidence from LMICS (1 Safrica study) Hard to implement in LMICs, where options for independent residence are limited due to economic and socio-cultural constraints.
  – Some evidence that reduce violence for some survivors some of the time (i.e. a lower number of incidents), but levels of violence remain high (US) useful in chronic cases (UK)
  – Contradictory evidence re women’s feelings of safety
Police and justice sector responses

• Second respondent’s programmes
  – existing evidence is conflicting and does not allow for a recommendation to be made for or against the intervention; some indication that can lead to an increase in violence in some circumstances

• Sex offender programmes and disruption plans
  – Insufficient evidence to recommend for or against
  – Radford et al. (2014) highlights the lack of evidence on child sexual abuse response interventions in low- and middle-income countries.

• Community policing
  – Insufficient evidence to recommend
Police and justice sector responses

- **Women police stations**
  - No evidence that reduce VAW or improve access to justice or punishment for perpetrators
  - Some evidence can increase reporting and access to services
  - May be entry point to justice sector

- **Specialized courts**
  - Limited evidence
  - May increase conviction rates (one South Africa study)
  - Enhanced effectiveness of support services and court and improved info sharing (UK)

- **Increased number of female police officers**
  - Increased reporting by women of DV by 13.6% and of all crimes by 5.1%; no impact on male reporting and decrease in DV escalation
Police and justice sector responses

• **Paralegal programmes** (5 studies one RCT)
  – Some evidence that can reduce short term re-abuse and increase access to justice (particularly being accompanied to court)
  – Legal advocacy is associated with greater social support, better quality of life, reduced likelihood of further abuse, and greater access to community resources. (HICs)
  – In LMICs this needs broad reform of the judicial system to address corruption, procedural delays, lack of transparency and lack of judicial presence in poor and rural settings

• **Alternative and restorative justice**
  – Insufficient evidence to support
  – Controversial
  – Some studies in HICs find less emergency visits to home and improvements in perpetrator empathy and self-esteem
What remains to be done or learned?

- Train and support providers
- Integrate VAW within university-level education
- Promote system-wide changes
- Monitor and evaluate efforts: Do no harm

- What works for whom, when?
- What do women perceive to be positive outcomes of health or legal interventions?
- How do we leverage existing programmes?
- How do we improve coordination across sectors and across VAW and VAC services?
- How do we enhance quality of delivery?
- Train and support providers
- Integrate VAW within university-level education
- Promote system-wide changes
- Monitor and evaluate efforts: Do no harm
Impact of social movements on violence against women
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.
Sustainable development goal 5: Achieve gender equality and empower all women and girls

**Target 5.2**: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

**Target 5.3**: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

**Target 16.1**: Significantly reduce all forms of violence and related death rates everywhere.

**Target 16.2**: End abuse, exploitation and all forms of trafficking against and torture of children.

For further information

http://www.who.int/reproductivehealth/topics/violence/en/

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