



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

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Claudia García-Moreno, M.D.  
*Medical Officer & Technical Lead, VAW*

World Health Organization  
Geneva

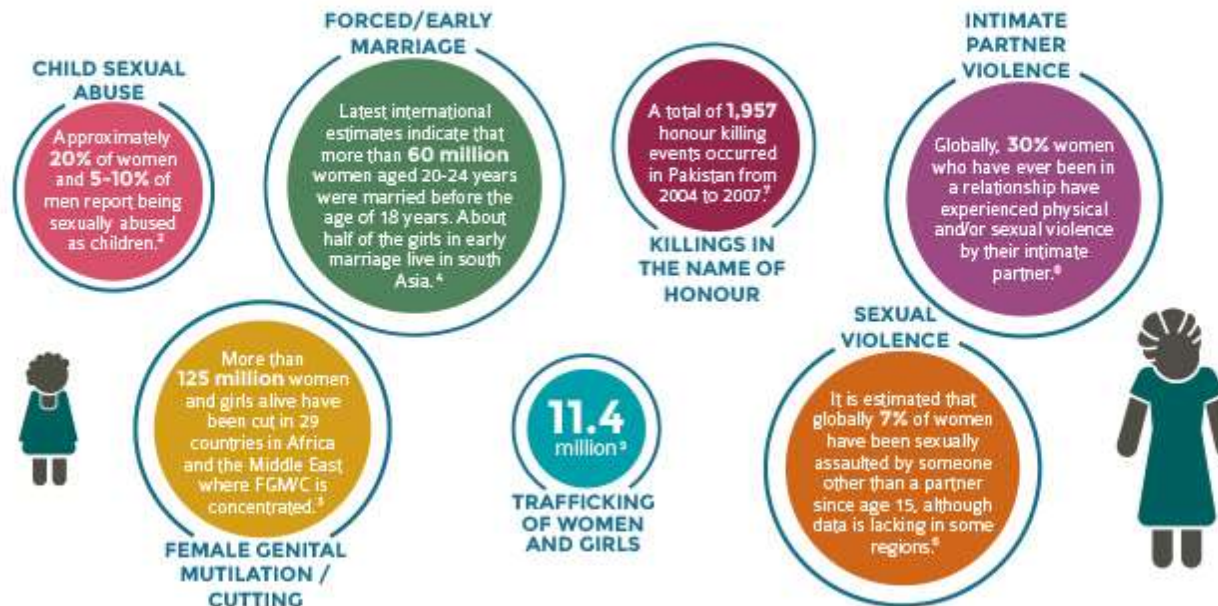
**Nigel Walker Lecture,**  
Cambridge University  
23 May, 2019



# Presentation

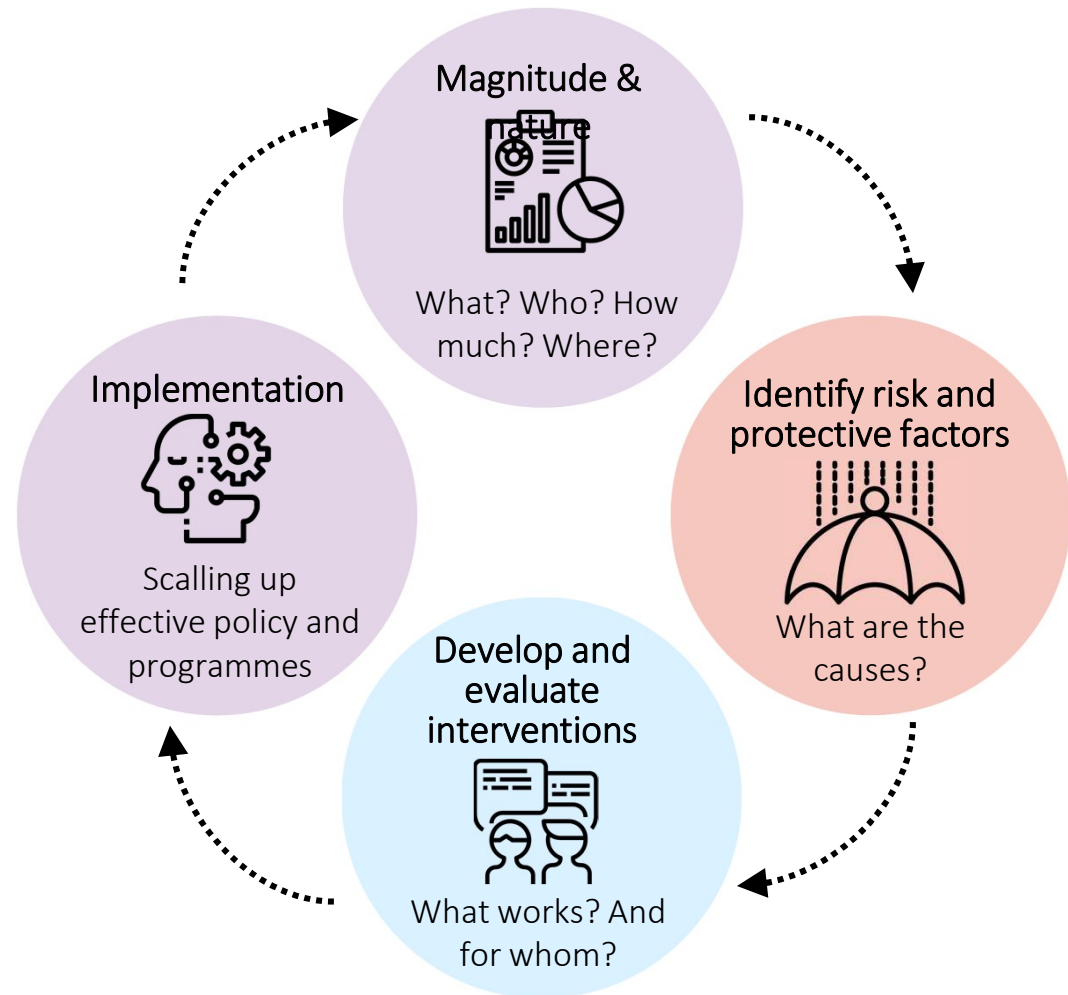
- History and overview of prevalence and health burden
- Summary of evidence on prevention interventions
- Health sector and criminal justice/police responses
- Political considerations

## VIOLENCE AFFECTS GIRLS AND WOMEN AT EVERY AGE AND STAGE OF LIFE

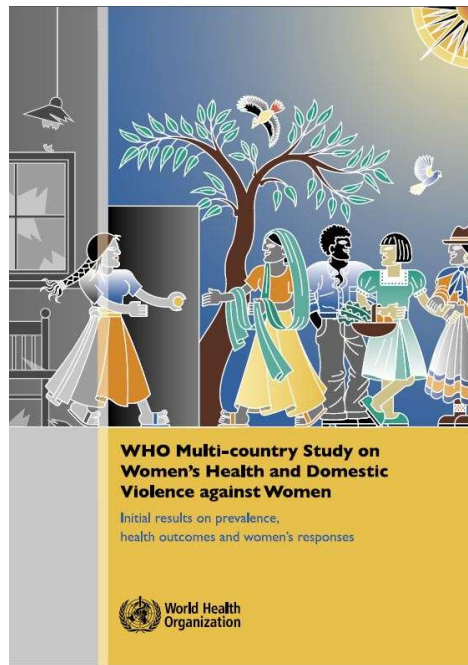


A FEW COMMON TYPES OF VIOLENCE

**Public health  
systems can  
contribute to the  
prevention of  
violence against  
women**

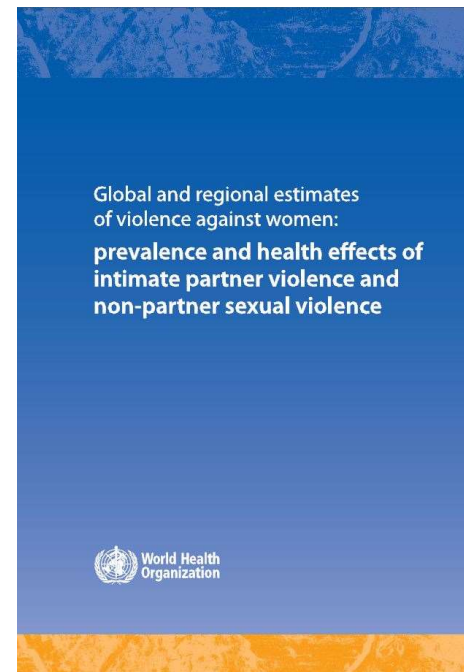


# Magnitude of the problem



**2005:** 11 countries

**2018:** 37



**2013:** 81 countries

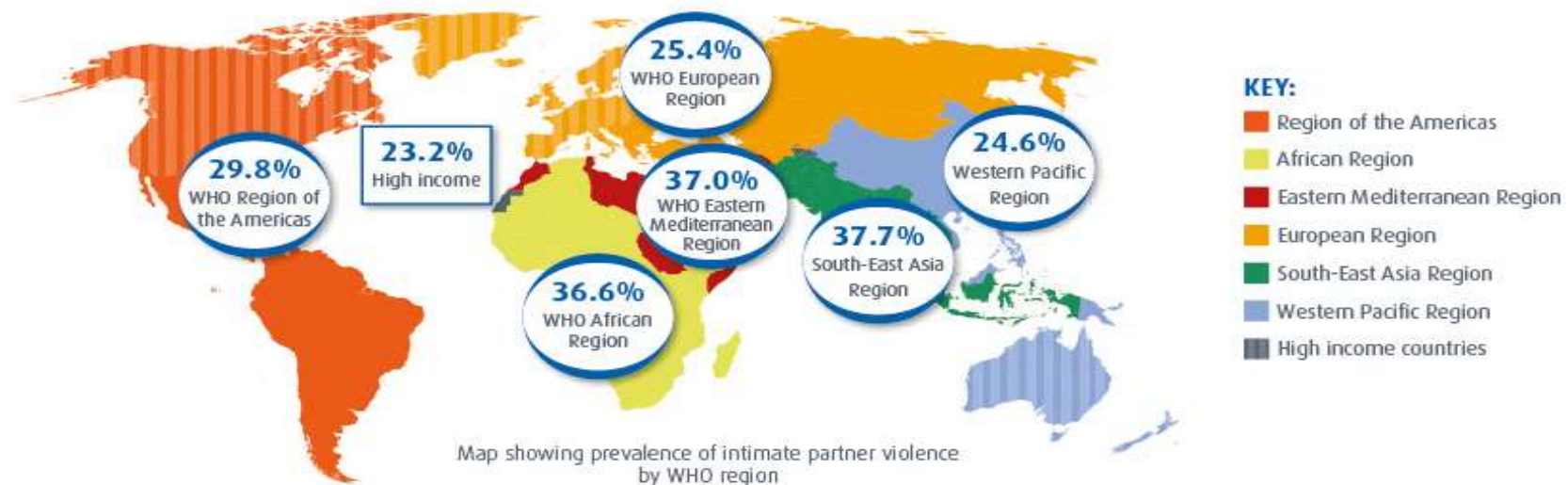
**2018:** 135



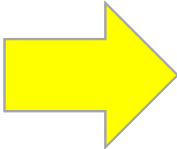
# Lifetime prevalence of intimate partner violence

**1 in 3 women**

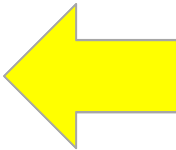
throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner



## Violence starts early in lives of women



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)**



## Life-time prevalence of non-partner sexual violence : 7.2% globally

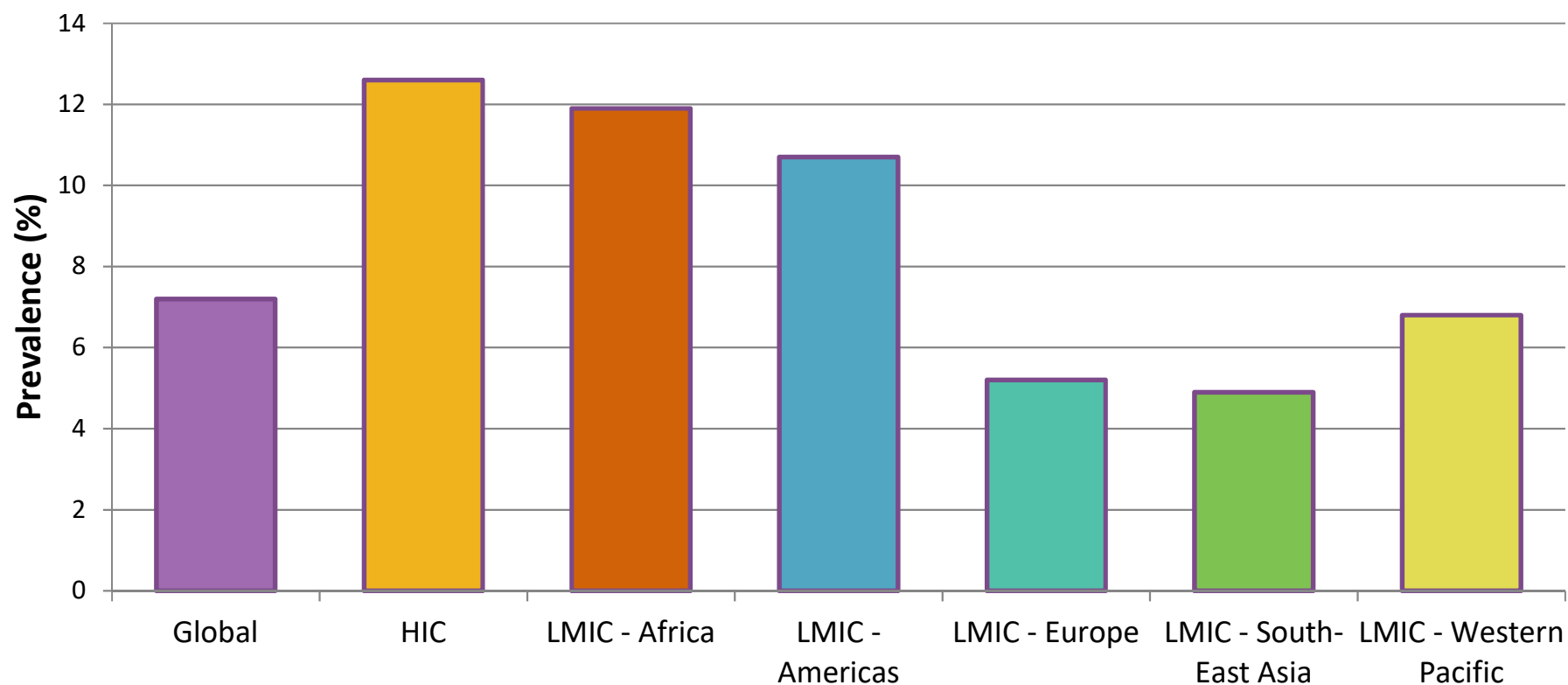
**Table 4.** Lifetime prevalence of non-partner sexual violence by WHO region

WHO region	Prevalence, % <sup>a</sup>	95% CI, %
Low- and middle-income regions:		
Africa	11.9	8.5 to 15.3
Americas	10.7	7.0 to 14.4
Eastern Mediterranean <sup>b</sup>	–	–
Europe	5.2	0.8 to 9.7
South-East Asia	4.9	0.9 to 8.9
Western Pacific	6.8	1.6 to 12.0
High income	12.6	8.9 to 16.2



## Non-partner sexual violence, 2010

Globally and by WHO Region, ages 15-69 (total)



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

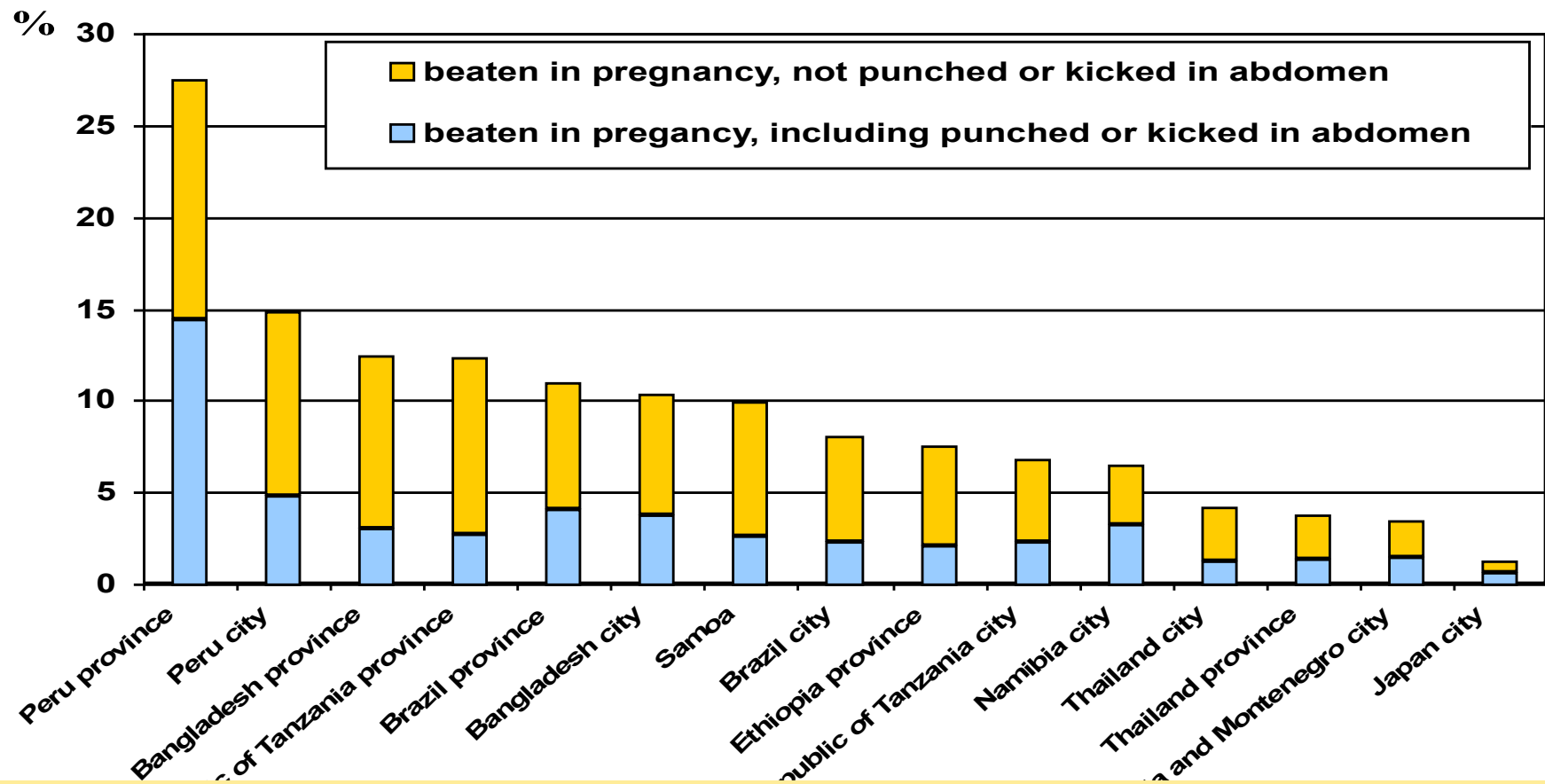
## Life-time prevalence of intimate partner OR non-partner sexual violence: 35.6% globally

**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

WHO region	Proportion of women reporting intimate partner violence and/or non-partner sexual violence, %
Low- and middle-income regions:	
Africa	45.6
Americas	36.1
Eastern Mediterranean	36.4
Europe	27.2
South-East Asia	40.2
Western Pacific	27.9 <sup>a</sup>
High income	32.7

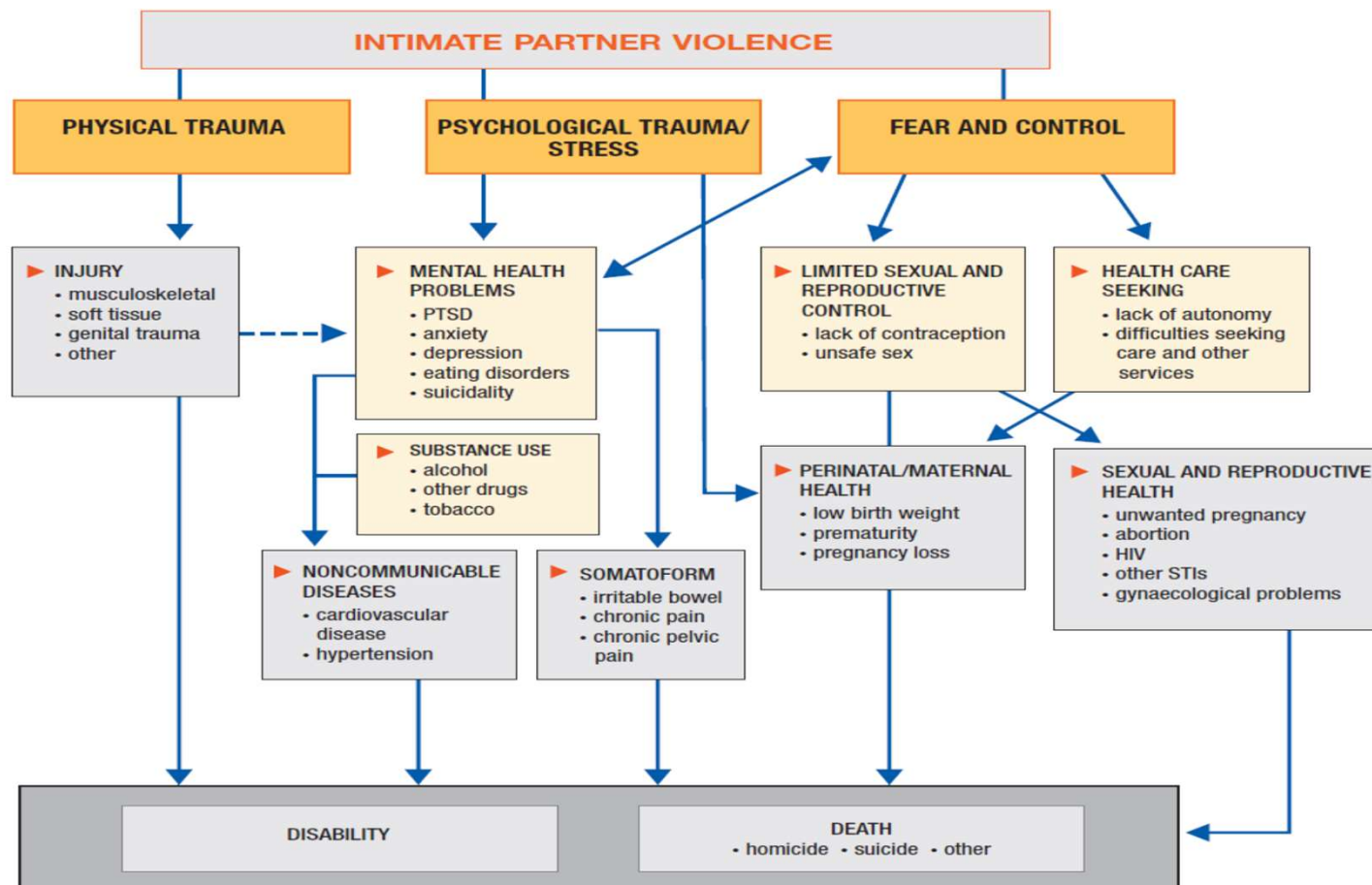


# Pregnancy is not always a protected



# Pathways and health effects of intimate partner violence

Figure 1. Pathways and health effects on intimate partner violence



# 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



Bacchus LJ, et al. Recent intimate partner violence against women and health: A systematic review and meta-analysis of cohort studies. *BMJ Open* 2018; **8**: 1–20.

Trevillion K, et al. Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS One* 2012; **7**: e51740.

Spencer C, et al. Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychol Violence* 2019; **9**: 1–17. Only focuses on Physical IPV.

# Women's drinking and IPV

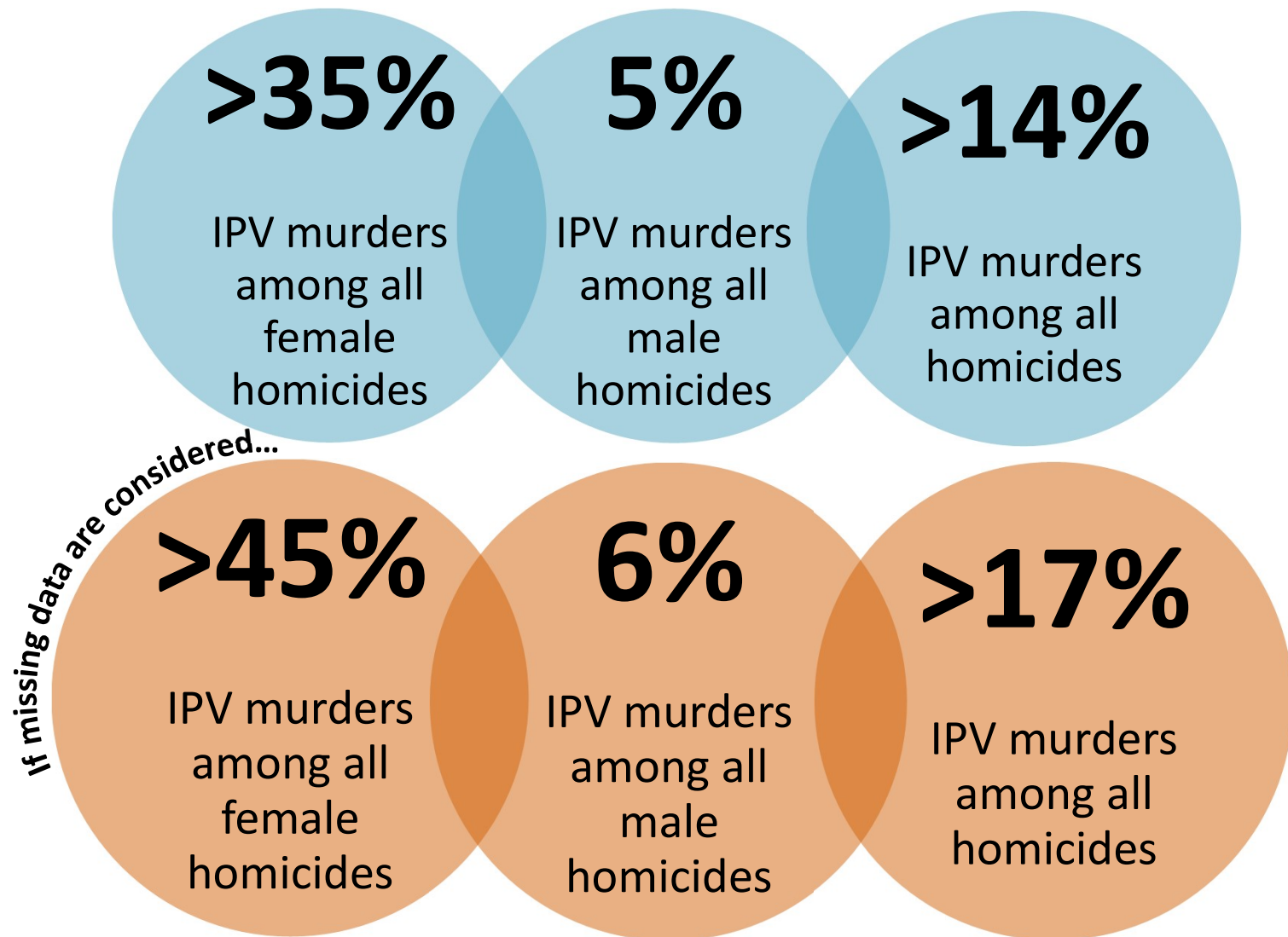
## Women's Drinking

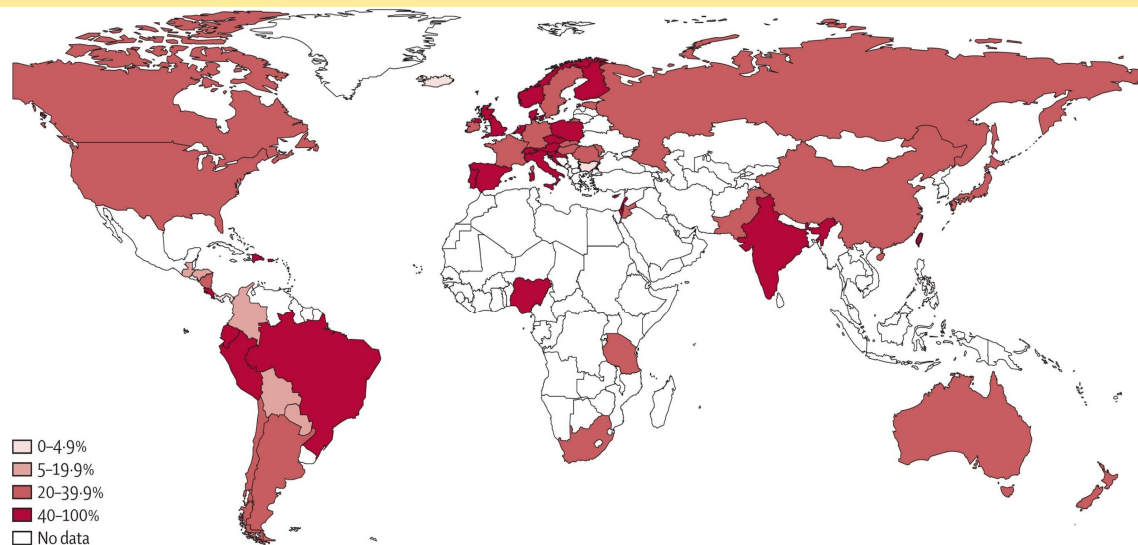
- Meta-analysis finds positive association between heavy/binge drinking and lifetime experience of IPV – but could be driven by abuse in childhood





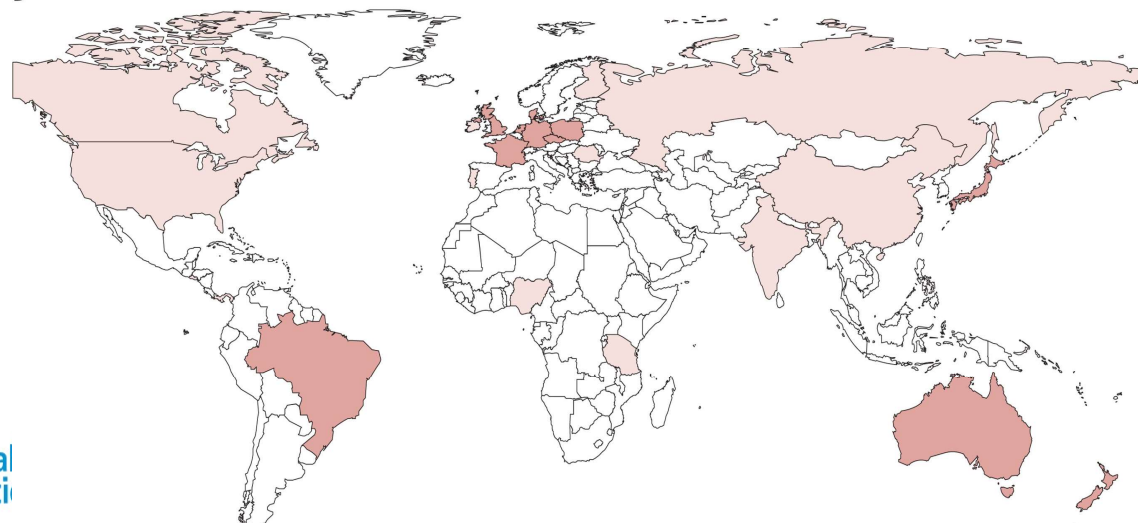
# HOMICIDE





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

**B**



**% of men  
murdered by  
their intimate  
partner among  
all male  
homicides**

## The risk of violence increases for women during emergencies

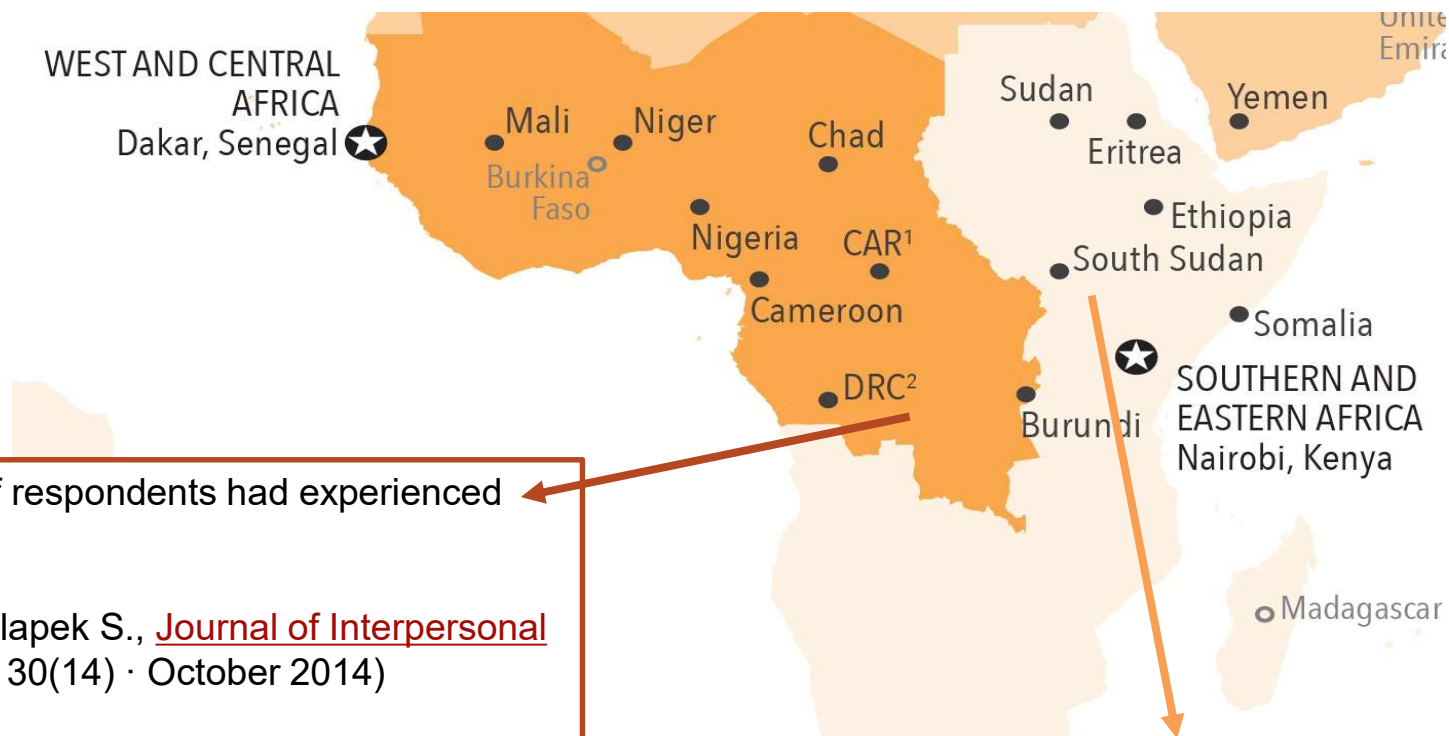


Child marriage, sexual violence and domestic violence cited as main GBV concerns.(Voices from Syria, 2017)

*"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



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\*

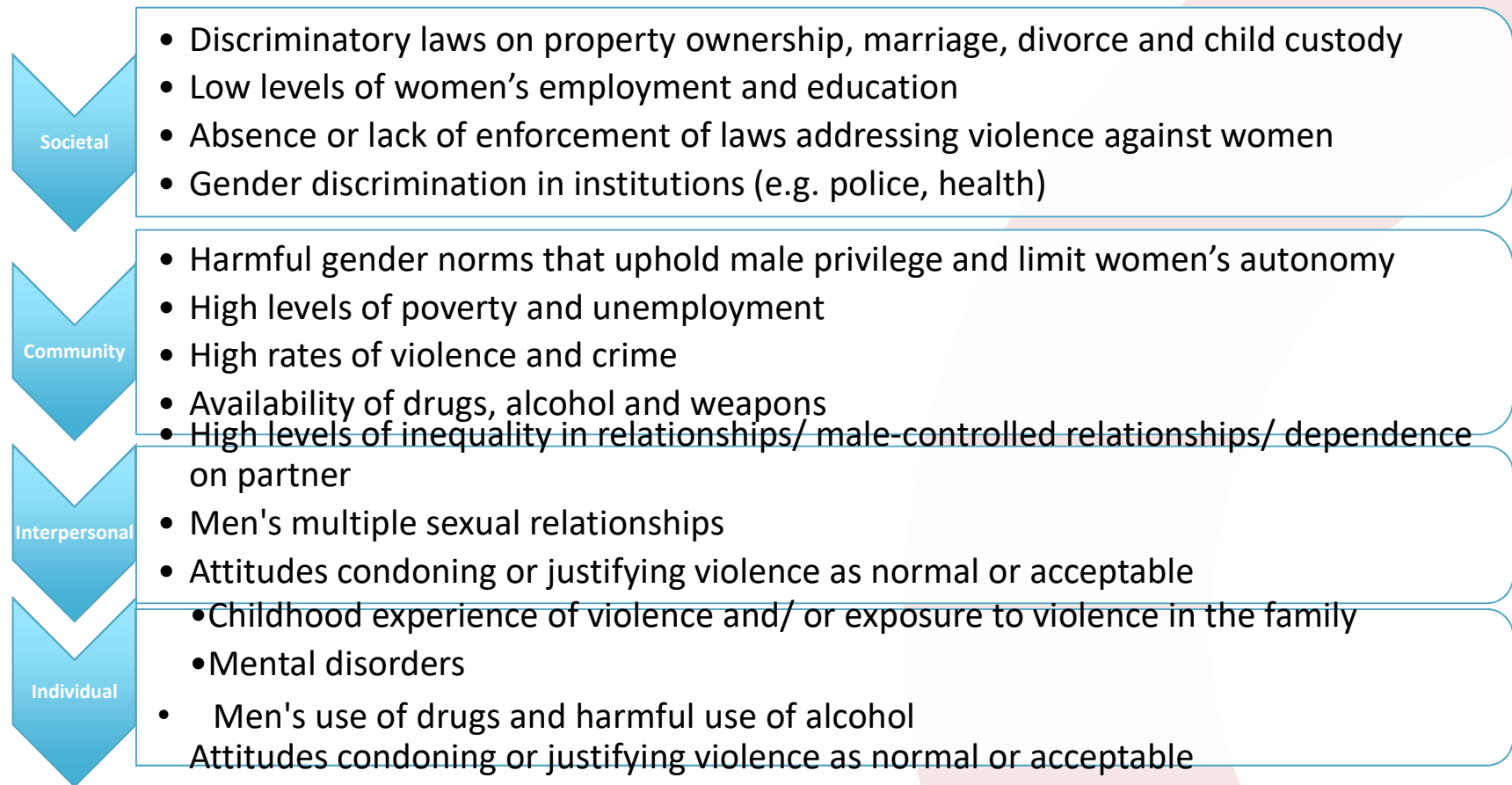


# Social and economic consequences of VAW/IPV

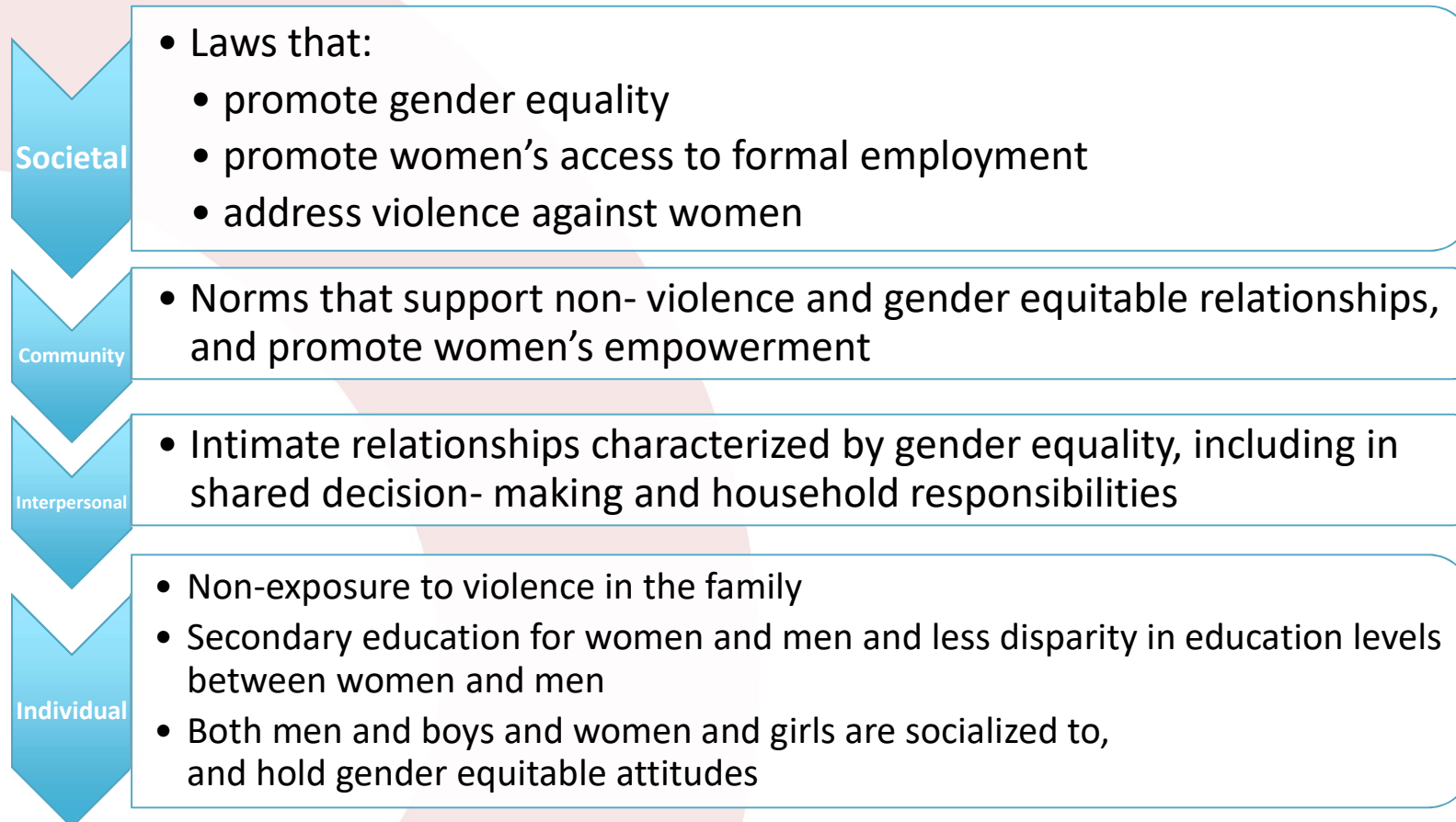




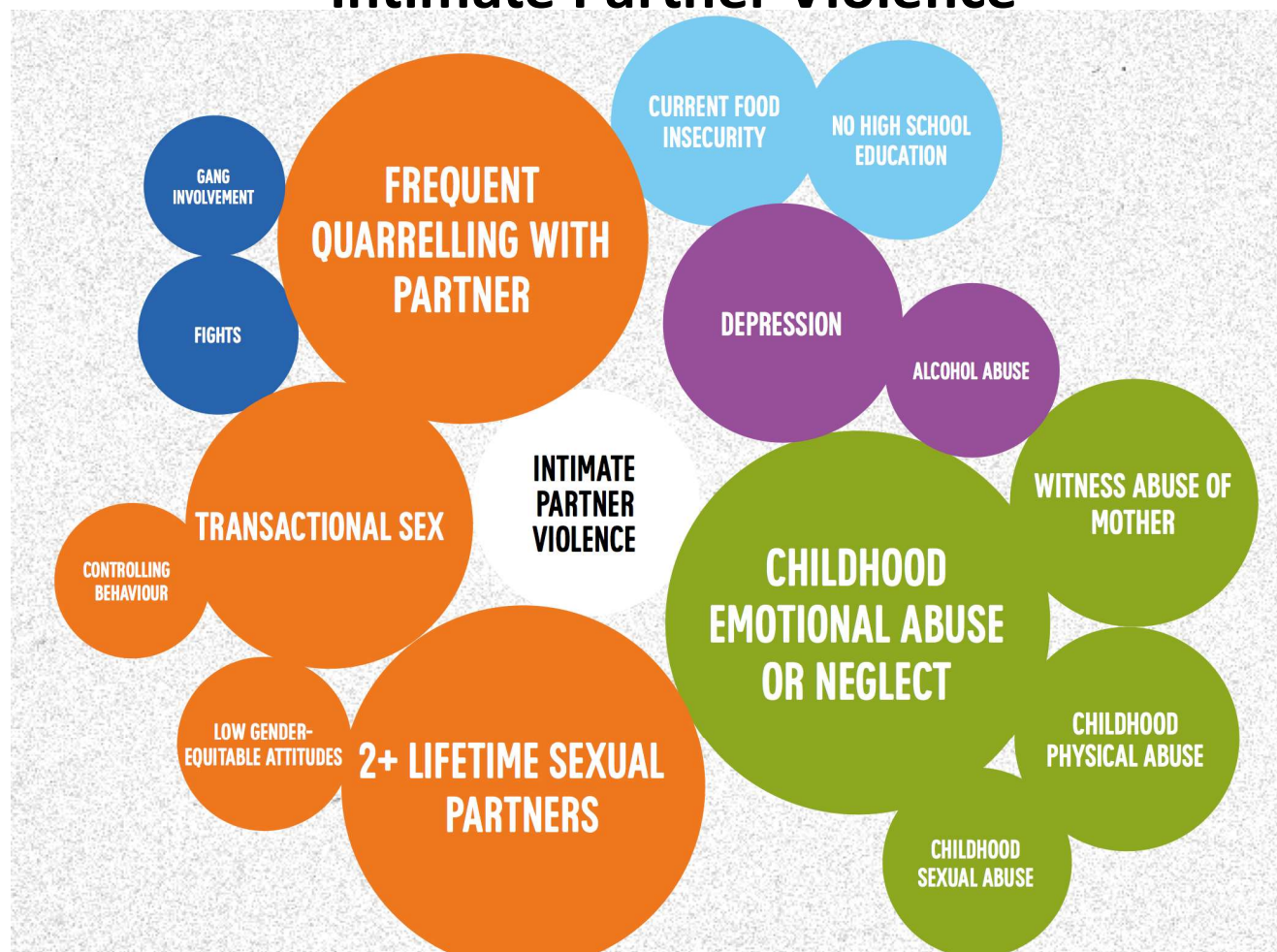
# Risk factors for violence against women



# Protective factors for violence against women

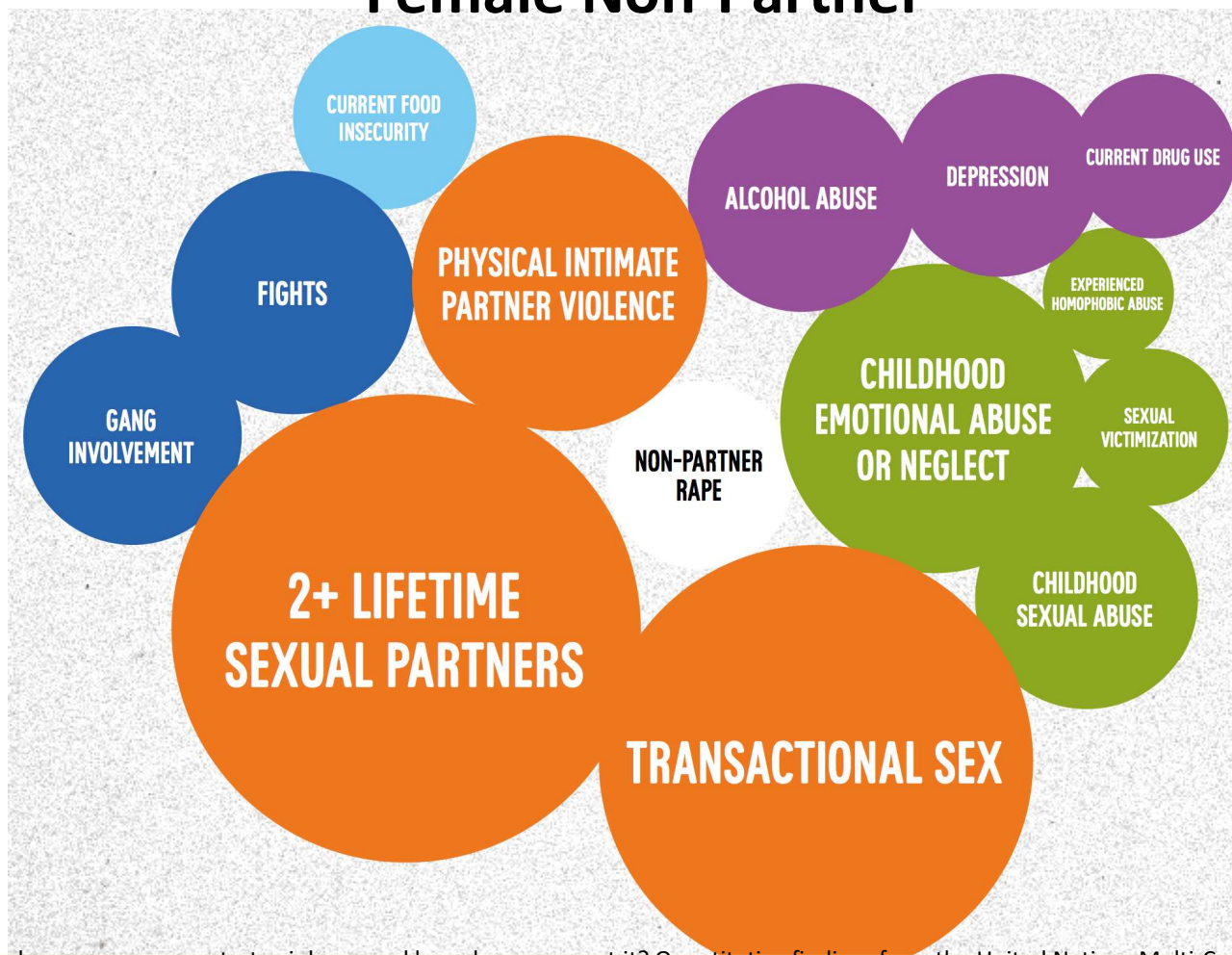


## Factors Associated with Men's Perpetration of Intimate Partner Violence



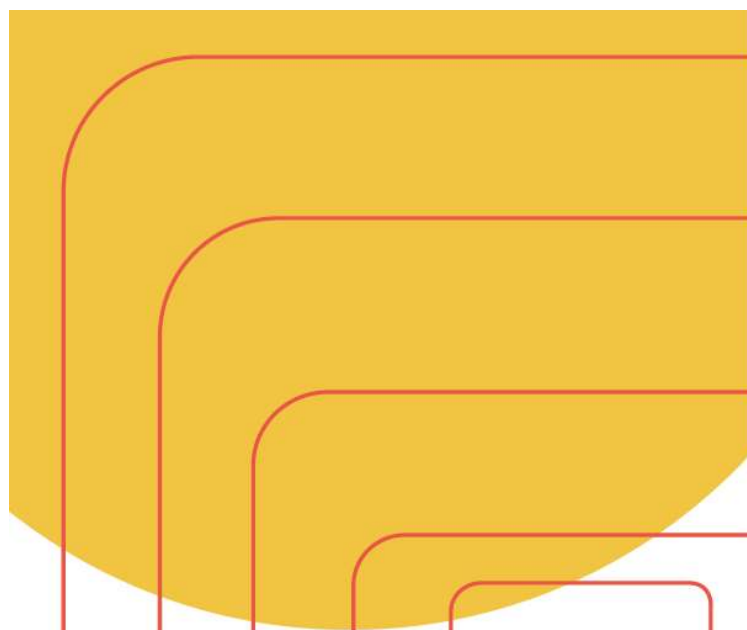
United Nations. 2013. Why do some men perpetrate violence and how do we prevent it? Quantitative findings from the United Nations Multi-Country Study on men and violence in Asia and the Pacific.

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



United Nations. 2013. Why do some men perpetrate violence and how do we prevent it? Quantitative findings from the United Nations Multi-Country Study on men and violence in Asia and the Pacific.

**What works to prevent and respond to violence against women?**



**R E S P E C T**

→ **Relationship skills strengthened** \_\_\_\_\_

→ **Empowerment of women** \_\_\_\_\_

→ **Services ensured** \_\_\_\_\_

→ **Poverty reduced** \_\_\_\_\_

→ **Environments made safe** \_\_\_\_\_

→ **Child and adolescent abuse prevented** \_\_\_\_\_

→ **Transformed attitudes, beliefs, and norms** \_\_\_\_\_



**Implement  
7 strategies to  
prevent violence  
against women**



## Relationships skills strengthened

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



Couples counselling and therapy



## Empowerment of women

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



Inheritance and asset ownership policies and interventions



Microfinance or savings and loans plus gender and empowerment training components



## Services ensured

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



Alcohol misuse prevention interventions



Shelters



Hotlines



One-stop crisis centres



Perpetrator interventions



Women's police stations/units



Screening in health services



Sensitization and training of institutional personnel without changing the institutional environment



## Poverty reduced

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



Labour force interventions including employment policies, livelihood and employment training



Microfinance or savings interventions without any additional components



## Environments made safe

Infrastructure and transport



Bystander interventions



Whole School interventions



## Child and adolescent abuse prevented

Home visitation and health worker outreach



Parenting interventions



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



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



## Transformed attitudes, beliefs, and norms

Community mobilization



Group-based workshops with women and men to promote changes in attitudes and norms



Social marketing or edutainment and group education



Group education with men and boys to change attitudes and norms



Stand-alone awareness campaigns/single component communications campaigns



Assess the  
**evidence** on  
**interventions**



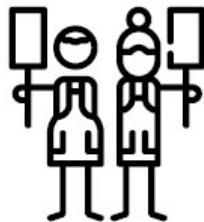
# Strengthen **enabling environment** for prevention



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.



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



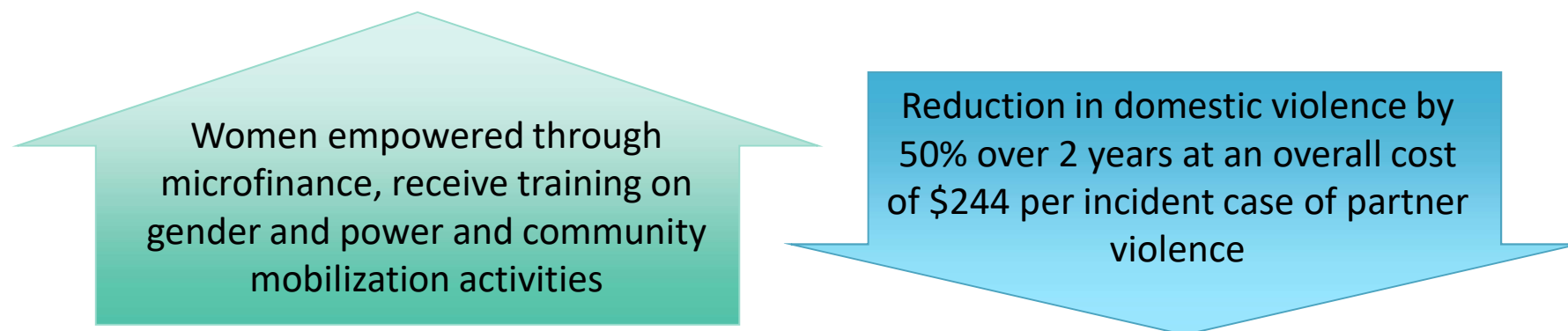
**Allocate resources** to programmes, research, and to strengthen institutions and capacities of the health, education, law enforcement, and social services sectors to address violence against women.

# 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)

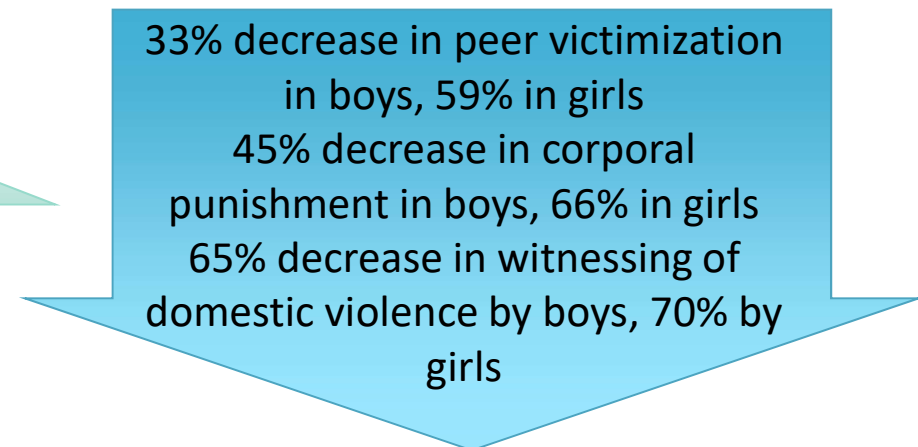
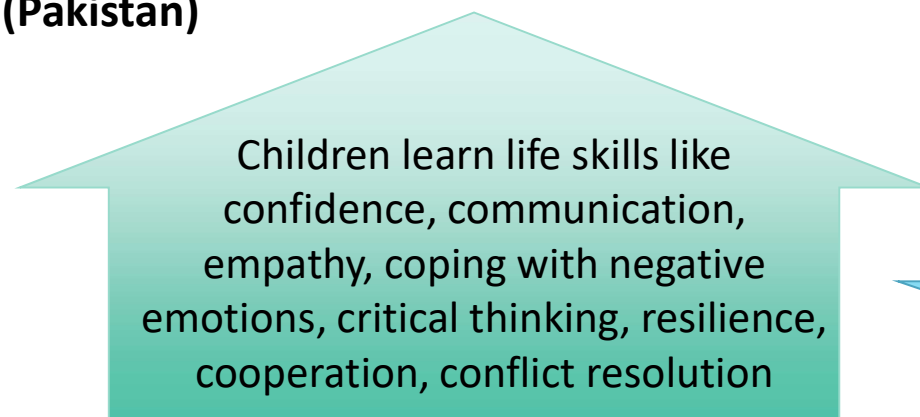


# Prevention and response evidence: What works to prevent child and adolescent abuse?

## 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)

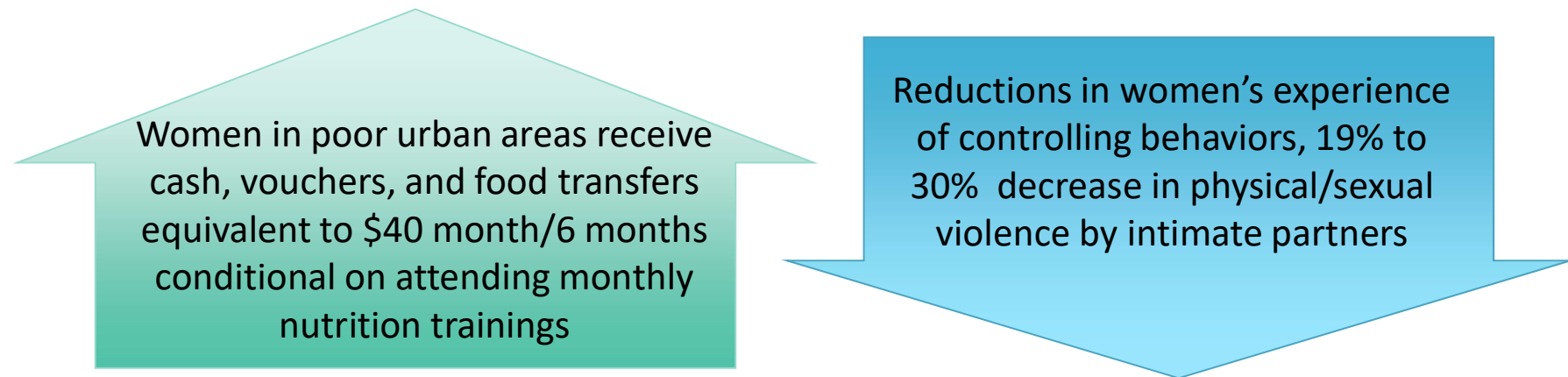


# Prevention and response evidence: What works to reduce poverty?

## Promising interventions include:

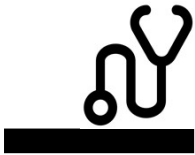
- Economic transfers, including conditional, unconditional cash transfers, plus vouchers and in-kind transfers (2 systematic reviews -2017)
- Labour force interventions including employment policies, livelihood and employment training

## Example: Economic transfers (Ecuador, WFP)



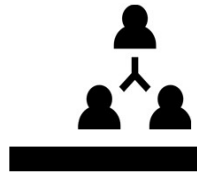
# **The health sector response: What do we know?**

# 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

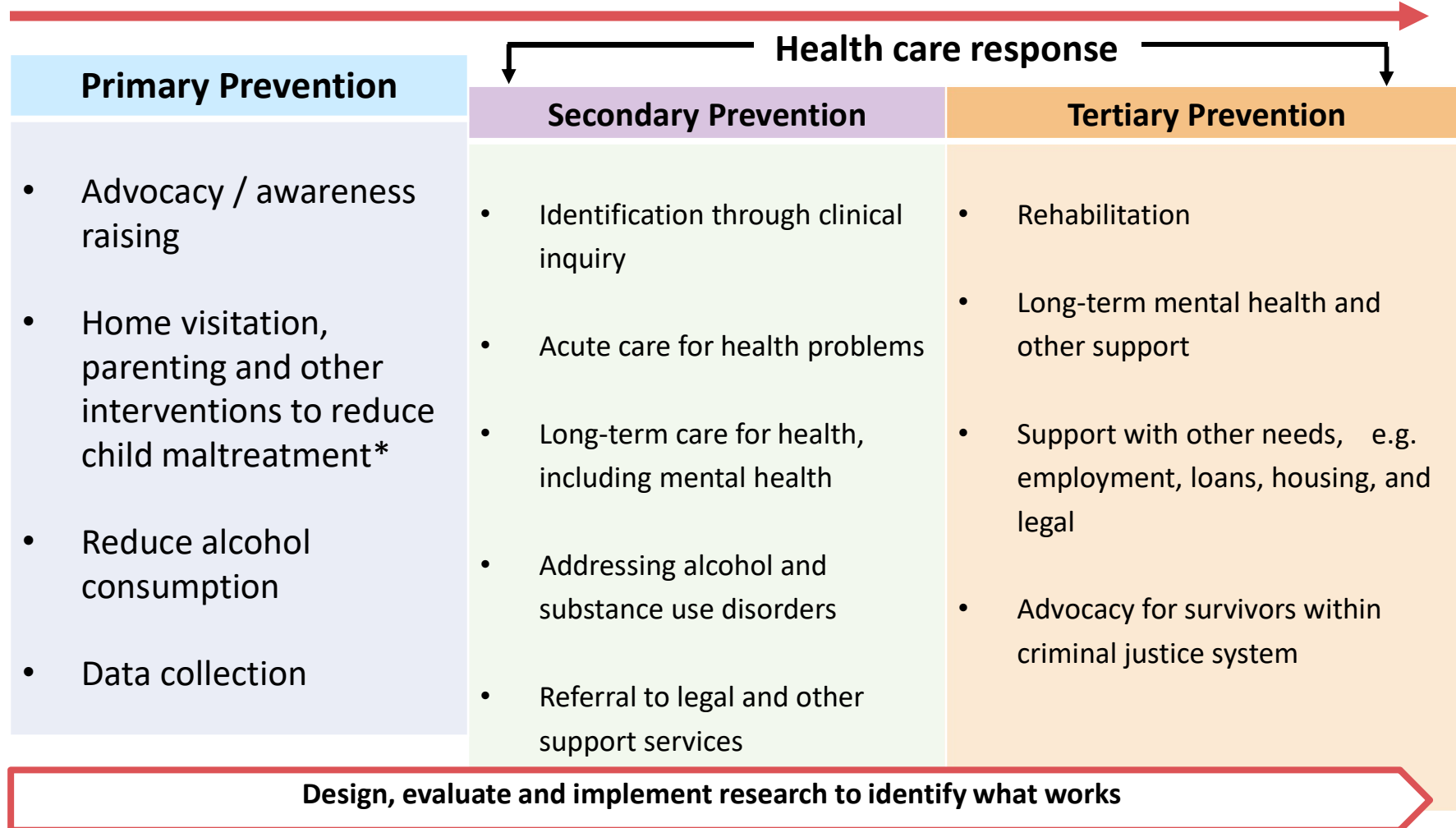


**Advocate** for the recognition of violence as a public health problem

**PAST**

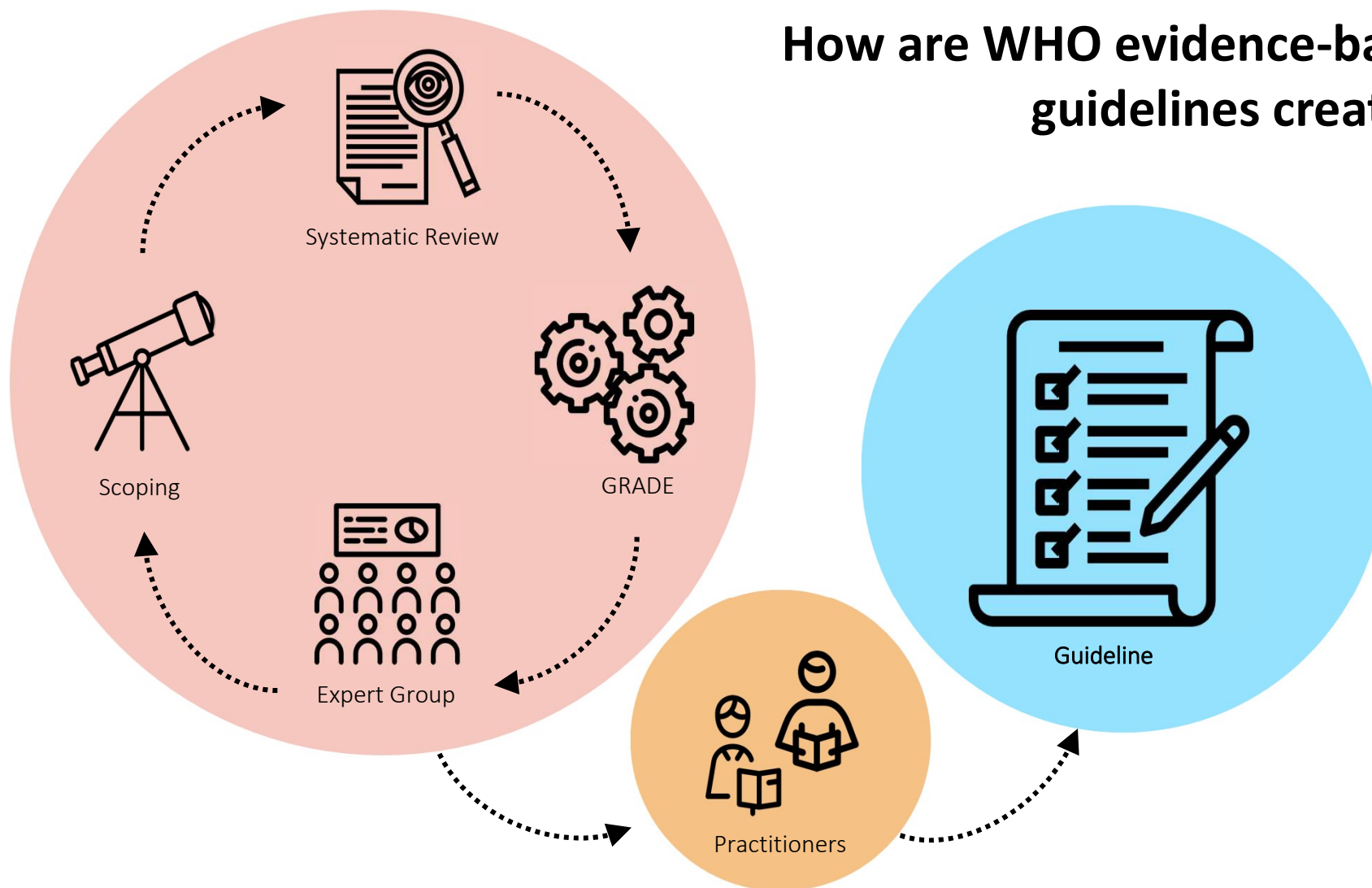
## Violent event occurs

**FUTURE**





## How are WHO evidence-based guidelines created?



# Evidence for interventions



## **Women-centered care and first line support**

Good practice recommendation with some evidence for psychological first aid



## **Screening for IPV**

## **Clinical inquiry and low threshold for asking**



## **Mental health interventions:**

- Cognitive Behavior Therapy
- Eye Movement Desensitization Reprocessing
- Lay provider delivered



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

Source: Responding to intimate partner and sexual violence. WHO Clinical and Policy Guidelines. WHO, 2013  
Updated: VEGA Project, 2018

## Evidence about other interventions



### **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



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



Ask questions to identify violence when potential indicators are present



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



Offer comprehensive clinical care for survivors of VAW:

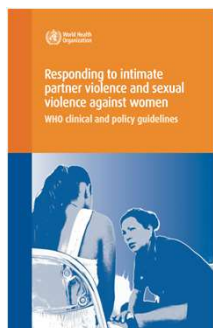
- first-line support
- emergency contraception / abortion
- STI and HIV prophylaxis
- mental health care



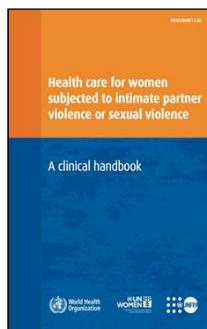
Health care providers should not report violence to police, unless the survivor requests it

# WHO tools to support health systems:

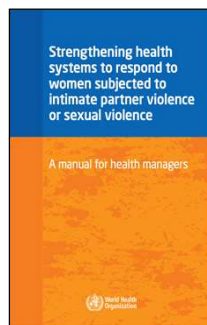
Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines



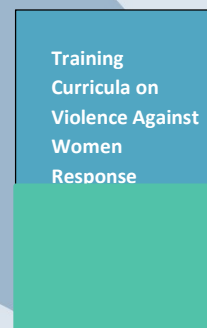
Health care for women subjected to IPV or SV: A clinical handbook



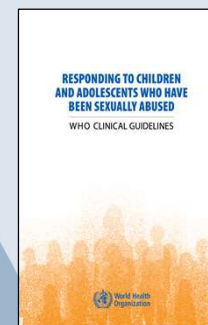
Strengthening health systems to respond to women subjected to IPV or SV: A manual for health managers



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

Provider behavior	Possible consequences to women and children
Doesn't recognize VAW is behind chronic or recurring conditions	<ul style="list-style-type: none"><li>• Inadequate diagnosis = inadequate care</li><li>• Missed opportunity to mitigate harm</li><li>• Women (and their children) experience negative outcomes</li></ul>
Doesn't address VAW within SRH services or HIV counseling	<ul style="list-style-type: none"><li>• Unplanned pregnancy, STIs/HIV/AIDS, unsafe abortion, additional violence</li></ul>
Ignores signs of fear or distress	<ul style="list-style-type: none"><li>• Missed opportunity to improve safety and reduce reoccurrence</li><li>• Woman is injured, killed or commits suicide</li></ul>

# 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





## The police and legal sector response: What do we know?

Sources: Mazerolle L et al. *What works to prevent violence against women and girls - Evidence Reviews Paper 3: Response mechanisms to prevent violence against women and girls.* September 2015; Jewkes R et al. *Criminal and Justice Responses to Domestic and Family Violence. A review of the evaluation literature*, U of Queensland, Australia, September 2018

# 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 s 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 Safrica 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?

# Impact of social movements on violence against women



# Political mandate for health response to VAW

**69<sup>th</sup> 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**



# Sustainable Development Goals



## 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/>

garciamorenoc@who.int

