World Health Organization

Resource package for strengthening countries' health systems response to violence against women

WHO/SRH/21.5

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Why focus on violence against women?

Nearly one in three women 15 years and older (30%) have experienced physical or sexual violence by an intimate partner or sexual violence by any perpetrator.[1] Violence against women is a public health problem. The issue is rooted in gender inequality and is a violation of women's human rights. Such violence negatively affects women's mental and physical health, including sexual and reproductive health, and well-being.

What is the role of health systems and sectors?

Within a multisectoral response, the health system is an important entry point to identify and support women experiencing violence, even though most women who experience violence do not explicitly disclose this. Women who are abused are more likely to seek health services compared with those who are not abused.[2]

Since most women seek health-care services at some point in their lives, particularly in relation to sexual and reproductive health, the health system provides an important opportunity to identify women being subjected to violence, provide first-line support (psychological first-aid), treat-injuries and other presenting health conditions, mitigate health consequences, and refer to other support services, including psychological support, shelters and legal aid.

The health system also provides an opportunity to promote prevention through messages to communities about the non-acceptability of violence, its harmful health consequences, the importance of mutually respectful and equal relationships, and services to address risk factors such as alcohol and substance use.

What are the political mandates and commitments made by Member States?

Eliminating all forms of violence against women and girls in public and private spheres is a target (5.2) of Sustainable Development Goal 5 on gender equality and women's empowerment. The health system response to violence against women and girls has been prioritized by WHO Member States through the World Health Assembly (WHA Resolution 67.15) and the Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular against Women and Girls, and against Children (WHA Resolution 69.5). It has also been prioritized in the WHO General Programme of Work 13 (2019–2023) and is a core area of focus for WHO's work on sexual and reproductive health and rights.

What is in this resource package?

To support and guide countries and partners to strengthen a health systems response to address violence against women, WHO has produced several tools, including:

- clinical and policy guidelines;
- implementation handbooks and manuals;
- training curriculum;
- evidence-based policy, prevention and intervention strategy packages.

The resource package consolidates these documents to support countries to develop or update their national or subnational guidelines, protocols, standard operating procedures, health provider training materials, and multisectoral action plans to prevent and respond to violence against women.

The resource package is also intended to be used for training and sensitization of policy-makers, advocates, health care providers and managers of services and programmes to address violence against women.

Figure 1 shows the different documents with weblinks, and their intended audiences and uses.

Partnerships in implementing the toolkit

Implementation of the tools in this resource package in countries has been achieved through a wide range of partnerships and collaborations. The primary partnership has been with Ministries of Health (MoH) and United Nations partners, including through the Joint United Nations initiative on the Essential Services Package for Women and Girls Subjected to Violence, which involves UN Women, UNFPA, UNDP, UNODC, and WHO. International (e.g. International Planned Parenthood Federation, Care, JHPIEGO) and national nongovernmental organizations have also been key partners and collaborators.

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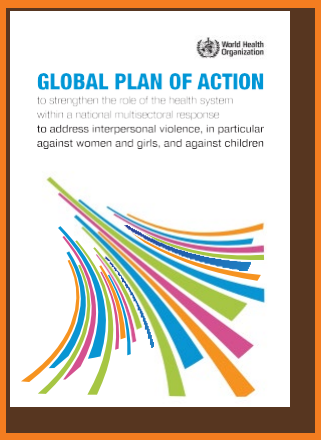
[1] Violence against women prevalence estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data (UNICEF, UNFPA, UNODC, UNSD, UNWomen); 2021.

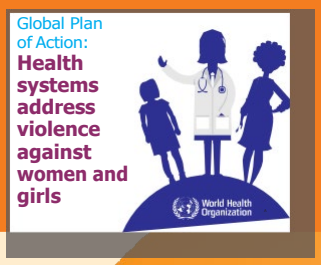
[2] Garcia-Moreno C, et al. The health-systems response to violence against women. Lancet. 2015;385(9977):1567–79.

Figure 1. Overview of resource package

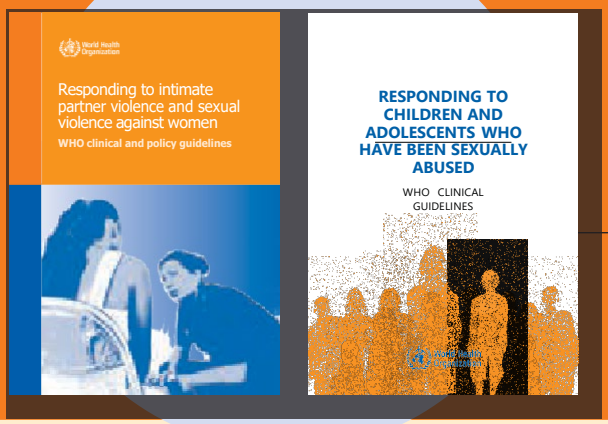
POLICY-MAKERS

Mandate

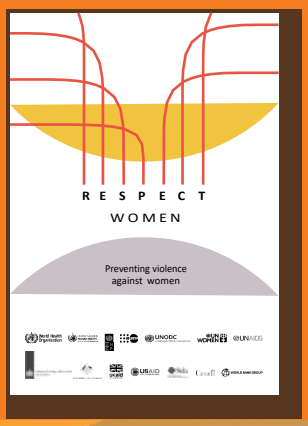




Guidelines: health-sector response to violence against women

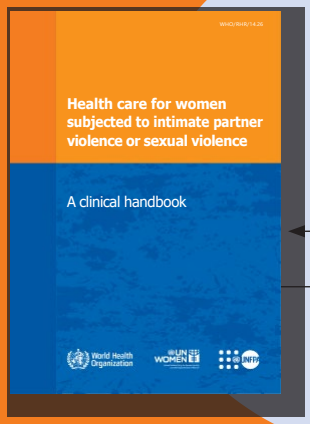


Framework for prevention of violence against women

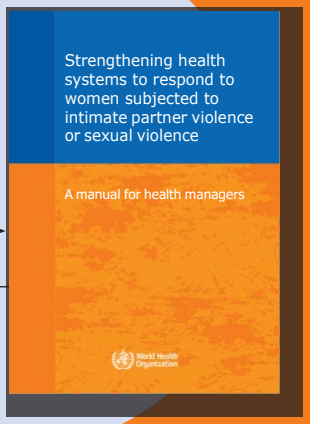


PROVIDERS AND MANAGERS

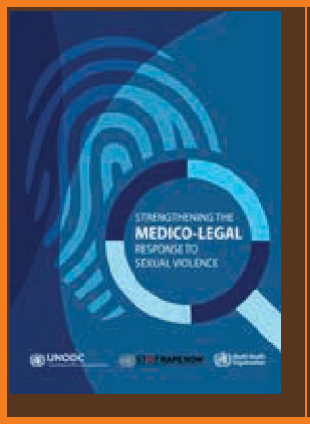
Implementation tool: providers



Implementation tool: managers



Implementation tool - Forensics



Implementation tool - Emergencies

Implementation tools: providers and managers

Training curriculum

e-Learning

Implementation tool

e-Learning

ALL AUDIENCES

Advocacy: videos

Advocacy: infographics

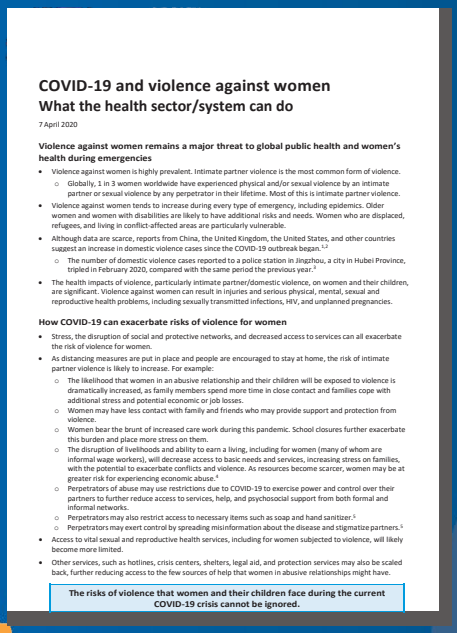
MONITORING AND EVALUATION

Quality assurance

Assessing KAP providers

Assessing facility readiness

COVID-19 and violence against women: All Audiences



COVID-19 and violence against women
What the health sector/system can do

7 April 2020

Violence against women remains a major threat to global public health and women's health during emergencies

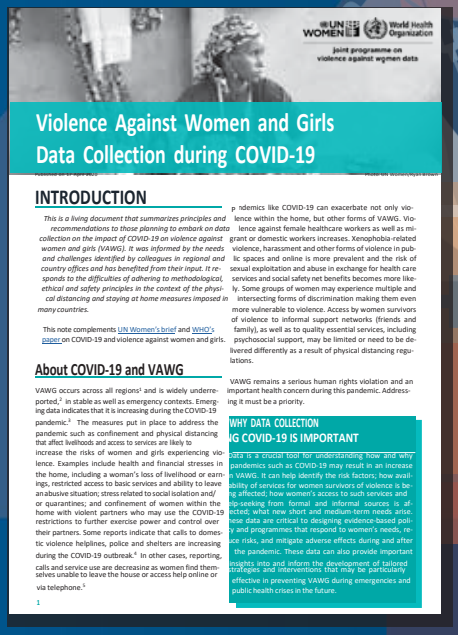
- Violence against women is highly prevalent. Intimate partner violence is the most common form of violence.
  - Globally, 1 in 3 women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by any perpetrator in their lifetime. Most of this is intimate partner violence.
- Violence against women tends to increase during every type of emergency, including epidemics. Older women and women with disabilities are likely to have additional risks and needs. Women who are displaced, refugees, and living in conflict-affected areas are particularly vulnerable.
- Although data are scarce, reports from China, the United Kingdom, the United States, and other countries suggest an increase in domestic violence cases since the COVID-19 outbreak began.[1,2]
  - The number of domestic violence cases reported to a police station in Jingzhou, a city in Hubei Province, tripled in February 2020, compared with the same period the previous year.[3]
- The health impacts of violence, particularly intimate partner/domestic violence, on women and their children, are significant. Violence against women can result in injuries and serious physical, mental, sexual and reproductive health problems, including sexually transmitted infections, HIV, and unplanned pregnancies.

How COVID-19 can exacerbate risks of violence for women

- Stress, the disruption of social and protective networks, and decreased access to services can all exacerbate the risk of violence for women.
- As distancing measures are put in place and people are encouraged to stay at home, the risk of intimate partner violence is likely to increase. For example:
  - The likelihood that women in an abusive relationship and their children will be exposed to violence is dramatically increased, as family members spend more time in close contact and families cope with additional stress and potential economic or job losses.
  - Women may have less contact with family and friends who may provide support and protection from violence.
  - Women bear the brunt of increased care work during this pandemic. School closures further exacerbate this burden and place more stress on them.
  - The disruption of livelihoods and ability to earn a living, including for women (many of whom are informal wage workers), will decrease access to basic needs and services, increasing stress on families, with the potential to exacerbate conflicts and violence. As resources become scarcer, women may be at greater risk for experiencing economic abuse.[4]
  - Perpetrators of abuse may use restrictions due to COVID-19 to exercise power and control over their partners to further reduce access to services, help, and psychosocial support from both formal and informal networks.
  - Perpetrators may also restrict access to necessary items such as soap and hand sanitizer.[5]
  - Perpetrators may exert control by spreading misinformation about the disease and stigmatize partners.[6]
- Access to vital sexual and reproductive health services, including for women subjected to violence, will likely become more limited.
- Other services, such as hotlines, crisis centers, shelters, legal aid, and protection services may also be scaled back, further reducing access to the few sources of help that women in abusive relationships might have.

The risks of violence that women and their children face during the current COVID-19 crisis cannot be ignored.

COVID-19 and violence against women: What the health sector/system can do?



UN WOMEN | World Health Organization
joint programme on violence against women data

Violence Against Women and Girls Data Collection during COVID-19

INTRODUCTION

This is a living document that summarizes principles and recommendations to those planning to embark on data collection on the impact of COVID-19 on violence against women and girls (VAWG). It was informed by the needs and challenges identified by colleagues in regional and country offices and has benefited from their input. It responds to the difficulties of adhering to methodological, ethical and safety principles in the context of the physical distancing and staying at home measures imposed in many countries.

This note complements UN Women's brief and WHO's paper on COVID-19 and violence against women and girls.

About COVID-19 and VAWG

VAWG occurs across all regions[1] and is widely underreported,[2] in stable as well as emergency contexts. Emerging data indicates that it is increasing during the COVID-19 pandemic.[3] The measures put in place to address the pandemic such as confinement and physical distancing that affect livelihoods and access to services are likely to increase the risks of women and girls experiencing violence. Examples include health and financial stresses in the home, including a woman's loss of livelihood or earnings, restricted access to basic services and ability to leave an abusive situation; stress related to social isolation and/or quarantines; and confinement of women within the home with violent partners who may use the COVID-19 restrictions to further exercise power and control over their partners. Some reports indicate that calls to domestic violence helplines, police and shelters are increasing during the COVID-19 outbreak.[4] In other cases, reporting, calls and service use are decreasing as women find themselves unable to leave the house or access help online or via telephone.[5]

p ndemics like COVID-19 can exacerbate not only violence within the home, but other forms of VAWG. Violence against female healthcare workers as well as migrant or domestic workers increases. Xenophobia-related violence, harassment and other forms of violence in public spaces and online is more prevalent and the risk of sexual exploitation and abuse in exchange for health care services and social safety net benefits becomes more likely. Some groups of women may experience multiple and intersecting forms of discrimination making them even more vulnerable to violence. Access by women survivors of violence to informal support networks (friends and family), as well as to quality essential services, including psychosocial support, may be limited or need to be delivered differently as a result of physical distancing regulations.

VAWG remains a serious human rights violation and an important health concern during this pandemic. Addressing it must be a priority.

WHY DATA COLLECTION IG COVID-19 IS IMPORTANT

Data is a crucial tool for understanding how and why pandemics such as COVID-19 may result in an increase in VAWG. It can help identify the risk factors; how availability of services for women survivors of violence is being affected; how women's access to such services and help-seeking from formal and informal sources is affected; what new short and medium-term needs arise. These data are critical to designing evidence-based policy and programmes that respond to women's needs, reduce risks, and mitigate adverse effects during and after the pandemic. These data can also provide important insights into and inform the development of tailored strategies and interventions that may be particularly effective in preventing VAWG during emergencies and public health crises in the future.

1

Violence Against Women and Girls - Data Collection during COVID-19

COVID-19 and violence against women: Infographics

How to use the resource package

The documents in the resource package can be used in multiple ways. Depending on the audience they can be used for:

Awareness-raising and sensitizing

Documents intended for policy-makers are meant to sensitize policy makers about WHO recommendations for the health system response to intimate partner violence and sexual violence against women and against children and adolescents who have been subjected to sexual abuse. The Global Plan of Action and RESPECT framework for prevention are intended to raise awareness about global commitments. Policy dialogues and sensitization workshops should include policy-makers across health and other sector ministries, United Nations partners, donors and nongovernmental organizations. There is also the option of using the materials as is and translating them into relevant languages. Expected outputs can be roadmaps or action plans by countries to address violence against women. Materials for organizing such a workshop or policy dialogue can be requested **here**.

Developing or updating national guidelines or protocols for health responses to violence against women in line with WHO recommendations

Documents intended for managers and providers can be used to convene managers and policy-makers from the health, police and social services sectors (e.g. women's and children's protection units) to develop or update national guidelines or protocols for a health systems response to violence against women. Figure 2 describes an example of: the process for adapting or updating national guidelines or protocols in line with WHO recommendations and for rolling these out on a pilot basis before they are scaled up. A technical working group can guide the adaptation process. Stakeholder workshops and policy dialogues can help build consensus and ownership for adoption of the national protocol or guideline. There is also the option of using the materials as is and translating them into relevant languages. Possible outputs can be: updated or new national protocols or guidelines in line with WHO guidelines and/or implementation manuals or handbooks. Materials for the adaptation process and stakeholder workshop or policy dialogue can be requested **here**.

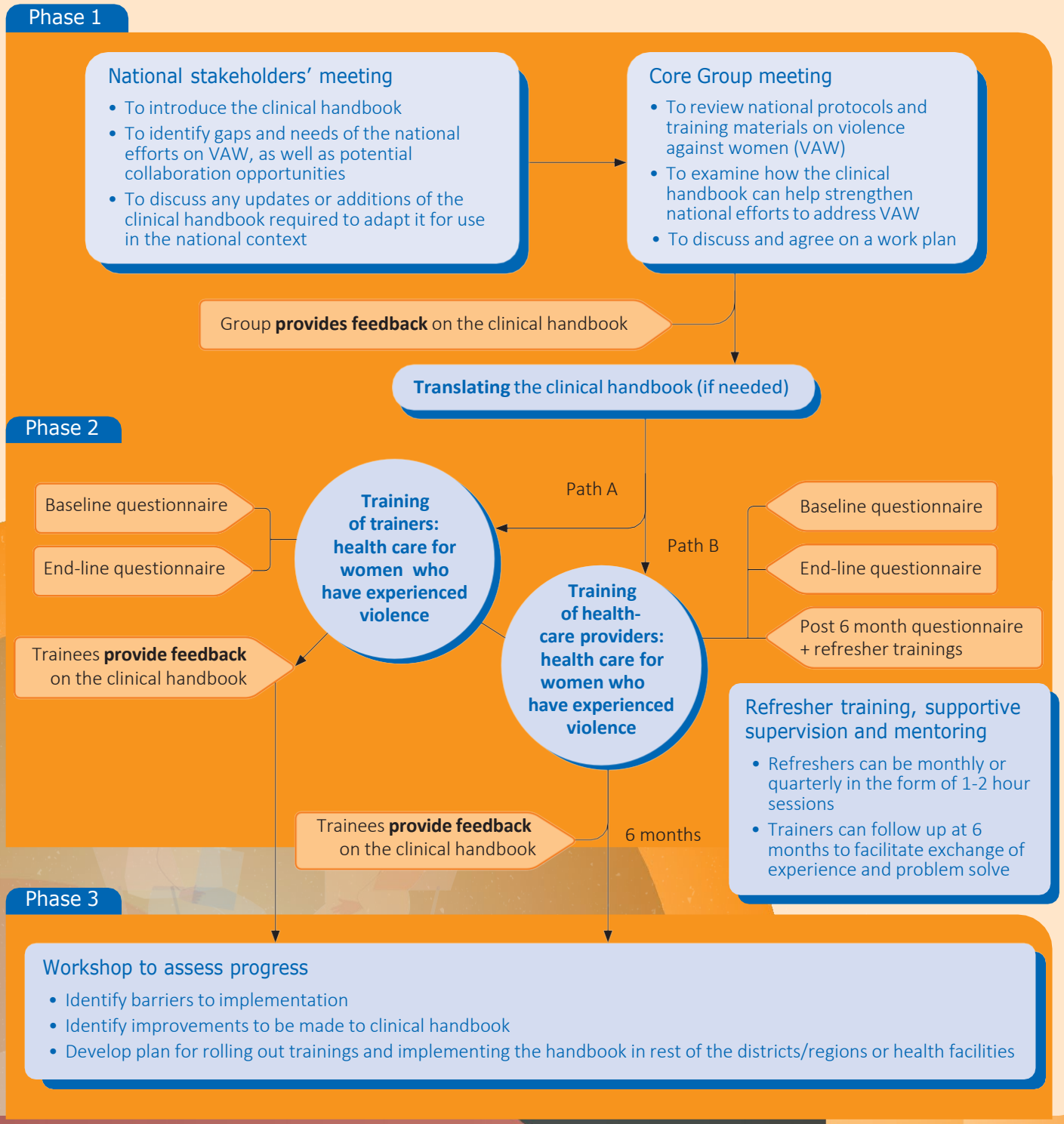
Training of trainers, health care providers and health managers

Documents intended for providers can be used to strengthen capacity and improve knowledge, attitudes and skills of front-line health care providers to provide good-quality care for survivors of violence. Documents intended for managers can be used to strengthen capacity of health managers to improve service quality and facility readiness. Training workshops can be tailored to the specific needs and availability of providers and managers. The e-learning training can be offered for self-study before or after and in addition to face-to-face sessions. Training of trainers may require additional time to strengthen also facilitation skills using participatory approaches. Expected outputs of training include improved knowledge skills and readiness to provide care to survivors of violence.

Monitoring and evaluating training and service readiness to deliver good-quality care to survivors of violence

Documents in the section on monitoring and evaluation can be used to assess improvements in knowledge, attitudes and skills of health care providers from baseline to post-training, and at three to six months after training. The quality assurance tool and the service readiness assessment checklist can be used to track improvements in service readiness. These tools can be used to improve quality of care and services on an incremental and ongoing basis.

Figure 2. Process for adapting the WHO clinical handbook to the national context and rolling it out on a pilot basis



Acknowledgements

This document was developed by staff in the Department of Sexual and Reproductive Health and Research (Avni Amin, and Claudia Garcia-Moreno). It draws on the lessons from piloting and implementing the WHO guidelines and tools on preventing and responding to violence against women in several countries. The information contained in the document was requested by regional offices and other implementing partners in order to replicate and expand the process of implementing WHO guidelines and tools in other countries.

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www.who.int/health-topics/violence-against-women

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