Training course in adolescent sexual and reproductive health 2019

Violence against women and girls: prevention, support and care

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Question 1:

Name 3 forms of gender-based violence that you are aware of, occurs in your community/country.

Gender-based violence is defined as "violence directed against a woman because she is a woman or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty." Women can be affected by different forms of gender-based violence at different stages of their lives. Intimate partner violence and sexual violence are prevalent in all settings and are also, the most common forms of violence experienced by women globally. The WHO conducted a study in which globally, they found 30% prevalent rates of intimate partner violence. The Eastern Mediterranean region has a higher intimate partner violence prevalence rate of 37%.

Three forms of gender-based violence that are noticeably prevalent in Egypt are:

1. *Female Genital Mutilation (FGM):*

    With an FGM prevalence of 87.2% among all women aged 15-49 in a population of nearly 95 million, Egypt has the greatest number of women and girls who have experienced FGM of any country in the world.

2. *Early/forced marriage:*

    17% of girls in Egypt are married before their 18th birthday and 2% are married before the age of 15. According to UNICEF, Egypt has the 13th highest absolute number of child brides in the world - 683,000.

3. *Sexual harassment:*

    According to a 2013 study by the United Nations, more than 99% of all Egyptian women have been the victims of harassment with Cairo being named the most dangerous city in the world for women.

Question 2:

Gender-based violence has negative consequences to women and girls, their families, and their communities and societies. Name three such consequences.

Violence affects the lives of millions of people and, when not fatal, can have long-lasting consequences. Deaths are only a fraction of the health and social burden arising from interpersonal violence. Women, children and the elderly bear a higher burden of non-fatal physical, sexual and psychological consequences of abuse.

Three consequences of gender-based violence are:

1. Women and girls exposed to violence experience sexual and reproductive health problems, including unwanted pregnancies (twice as likely to have an abortion), adverse maternal and newborn health outcomes, sexually transmitted infections (STIs) and HIV infection (1.5 times more likely), and gynaecological problems. Intimate partner violence against women often persists or starts during pregnancy, leading to miscarriage, stillbirths, premature birth (4.1% more likely) and low birth-weight babies (16% more likely).

2. Exposure to violence, as a victim or a witness, particularly in early childhood, has significant detrimental effects on the development of a child's brain, which can lead to social, emotional and behavioural problems. Individuals, especially children, who experience violence are also more likely to engage in health-harming behaviours such as smoking, alcohol (twice as likely) and drug abuse, and unsafe sex (due to fear/control), with lifelong consequences for health.

3. There is an intergeneration perpetuation of cycle of violence for those that have been exposed to violence. They are also more likely to perpetrate or be victims of interpersonal as well as self-directed violence in later life. There is an increased likelihood of girls later being subjected to intimate partner violence or sexual exploitation and trafficking. There is a likelihood of boys becoming perpetrators or being subjected to violence later in life. Violence impacts productivity and entails substantial human and economic costs for the survivors/victims, their families and society as a whole.

Question 3:

In many places health care providers do not respond effectively and with sensitivity to women and girls who experience gender-based violence. Firstly, in your opinion, why is this so? Secondly, name three things that could be done to change the situation.

First.

Health services and programmes are an appropriate entry point for addressing interpersonal violence, in particulate against women and girls, and against children. Those who experience violence face major barriers when disclosing it, including those related to stigma, blame and shame that result in/from a lack of support from

families and communities. Health care providers frequently and often unknowingly come into contact with women affected by violence. They have a unique and critical role in supporting women, minimizing the impact and preventing violence from happening. The majority of women survivors of violence do not explicitly disclose violence or seek any types of services. Only 10-40% of survivors seek any type of help in which health care providers are likely to be the first professional contact for survivors.

Health care providers are often slow to recognize violence for many reasons. Although it is a violation of human rights, many health services are reluctant to talk about it. They do not consider violence as a health problem but rather violence as a criminal justice issue and view partner violence in particular as a domestic matter. They are also ill equipped to deal with the issue and to effectively respond with sensitivity to women and girls who have experience gender-based violence, or otherwise do not know how to help. Health care providers lack the training and skills to recognize signs of abuse and provide the support and care a survivor needs as often, violence is hidden. Often, health service workers do not make sensitive enquiries, or do not want to know because of the consequences and the burden of duty for action that results. Many carry biased and prejudiced cultural views about the position of women in society and do not consider gender-based violence as violence. This attitude is detected often by women and children, and puts them off revealing the violence inflicted on them.

Second.

Health service delivery and health provider's capacity to respond to violence against women and girls should be strengthened. This is with purpose to identify women in danger before violence escalates, provide appropriate clinical care, reduce negative health outcomes of violence against women, assist survivors to access help, services, protection and to improve sexual, reproductive health and HIV outcomes. The global plan of action is a technical document informed by evidence, best practices and existing WHO technical guidance. It offers a set of practical actions that Member States can take to strengthen their health systems to address interpersonal violence, in particular against women and girls, and against children. The plan of action purposefully focuses on what the health system can do, in collaboration with other sectors and without detriment to the importance of a multi-sectoral response. There are three things that can be done to improve access to high quality support and care:

1. *Improve access to services by integrating care for women experiencing violence into existing programmes and services:*

- Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.
- A country needs multiple models of care for survivors of intimate partner violence and sexual assault, for different levels of the health system. However, priority should be given to providing training and service delivery at the primary level of care.

- A health-care provider (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (on location or on-call) at a district/area level.

2. *Provide quality care to survivors which is woman- centered and gender-sensitive:*

- Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support.
- Health-care providers should, as a minimum, offer first line support when women disclose violence.
- First-line support includes: being non-judgemental and supportive and validating what the woman is saying; providing practical care and support that responds to her concerns, but does not intrude; asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved); helping her access information about resources, including legal and other services that she might think helpful; assisting her to increase safety for herself and her children, where needed; providing or mobilizing social support.
- Providers should ensure that the consultation is conducted in private, confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting).
- If health-care providers are unable to provide first line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.
- There must be adequate supervision and regular appraisal of health care workers to ensure that they discharge their duties with sensitivity and without prejudice or pre-conceived ideas that compromise of the protection and support given to women and children.

3. *Train health care providers and integrate training on violence against women and girls in pre- and in-service curriculum for all health professionals:*

- Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault, should be given to health-care providers (in particular doctors, nurses and midwives).
- Health-care providers offering care to women should receive in-service training to:
  - enables them to provide first-line support;
  - teaches them appropriate skills, including when and how to enquire; the best way to respond to women (identification and care for survivors of intimate partner and clinical care for survivors of sexual assault); how to conduct forensic evidence collection where appropriate;

- addresses basic knowledge about violence, including:
  - laws that are relevant to victims of intimate partner violence and sexual violence;
  - knowledge of existing services that may offer support to survivors of intimate partner violence and sexual violence (this could be in the form of a directory of community services);
  - inappropriate attitudes among health-care providers (e.g. blaming women for the violence, expecting them to leave, etc.), as well as their own experiences of partner and sexual violence.

Question 4:

Firstly, what are the seven strategies that comprise RESPECT? Secondly, what do R and T stand for, and what is the evidence of the effectiveness of both? Thirdly, what will it take to implement R and T in your context?

First.

To truly end violence against women and girls, we need to dismantle the foundations of gender inequality and discrimination. No single factor explains the increased risk of victimization or perpetration of the different forms of violence, or why violence is more prevalent in some countries and communities than others. Rather, there are multiple risk factors associated with both perpetration and victimization at the individual, relationship, community and societal levels. Violence against women, girls and children has unique risk factors that require specific attention. In addition, there are several risk factors/determinants that cut across all forms of interpersonal violence. These common underlying risk factors/determinants include: gender inequality, unemployment, harmful norms on masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing and inadequate enforcement of laws. Addressing these common risk factors/determinants can strengthen standalone programmes for each type of violence, and combining programming where appropriate can result in synergies and efficiencies.

Violence against women and girls is preventable, where an ecological approach can be taken, whereby risk factors at societal, community, interpersonal and individual levels can be mitigated and protective facts can be amplified. A programme called RESPECT aims to do just this. R.E.S.P.E.C.T is comprised of seven letters, in which each stand for an intervention, building on resilience, knowledge, resources and supporting communities to find solutions.

R. *Relationship skills strengthened:* This refers to strategies aimed at individuals or groups of women, men or couples to improve skills in interpersonal communication, conflict management and shared decision-making.

E. *Empowerment of women:* This refers to both economic and social empowerment including inheritance and asset ownership, microfinance plus gender and empowerment training interventions, collective action, creating safe spaces and mentoring to build skills in self-efficacy, assertiveness, negotiation, and self-confidence.

S. *Service ensured:* This refers to a range of services including police, legal, health, and social services provided to survivors.

P. *Poverty reduced:* This refers to strategies targeted to women or the household whose primary aim is to alleviate poverty ranging from cash transfers, savings, microfinance loans, labour force interventions.

E. *Environments made safe:* This refers to efforts to create safe schools, public spaces and work environments, among others.

C. *Child and adolescent abuse prevented:* This refers to establishing nurturing family relationships, prohibiting corporal punishment, and implementing parenting programmes as mentioned in INSPIRE - 7 strategies for preventing violence against children.

T. *Transformed attitudes, beliefs, and norms:* This refers to strategies that challenge harmful gender attitudes, beliefs, norms and stereotypes that uphold male privilege and female subordination, that justify violence against women and that stigmatize survivors. These may range from public campaigns, group education to community mobilization efforts

Second.

The first strategy of RESPECT **(R.)** is relationship skills strengthening aimed at individuals or groups of women, men or couples to improve skills in interpersonal communication, conflict management and shared-decision making. An example of an intervention is group-based workshops with men and women to promote egalitarian attitudes and relationships. A study, over a two-year period following the implementation of Stepping Stones in South Africa with female and male participants age 15-26 years found that, men were less likely to perpetrate intimate partner violence, rape and transactional sex in the intervention group compared to the baseline. Its effectiveness in low-income countries has been shown to be promising with significant reductions in violence; however, for high-income counties more evidence is needed to show improvements in intermediate outcomes related to violence. A second example of an intervention is couples counselling and therapy: its effectiveness in high-income counties has been promising with significant reductions in violence outcomes; however, in low-income countries, more evidence is needed to show improvements in intermediate outcomes related to violence.

The last strategy of RESPECT **(T.)** is transforming attitudes, beliefs and norms. This aims at challenging harmful gender attitudes, beliefs, norms and stereotypes that

uphold male privilege and female subordination and justify violence against women and stigmatize survivors. There are currently five interventions:

1. The first is community mobilization. A study in Uganda called SASA! found that 76% of women and men believe physical violence against a partner is not acceptable, while only 26% of women and men in control communities believe the same. The effectiveness of SASA! has been shown to be promising in low-income countries, with significant reduction in violence outcomes; however, in high-income countries, similar programmes no evidence has yet been found due to lack of rigorous evaluation.
2. The second intervention is group-based workshops with men and women to promote changes in attitudes and norms. Similar to community mobilization, in low-income countries this intervention showed to be promising with significant reductions in violence outcomes; however, more evidence is needed in high-income countries to show intermediate outcomes related to violence.
3. The third intervention of social marketing and edutainment and group education has shown to need more evidence in both high and low-income countries to be considered effective in intermediate outcomes related to violence.
4. The fourth intervention of group education with men and boys to change attitudes and norms.
5. The fifth intervention of stand-alone awareness campaigns/single component communication campaigns.

Both fourth and fifth interventions have been shown to be ineffective in low-income countries where evaluations show no reductions in violence outcomes. In high-income countries, group education with men and boys needs more evidence to show improvements in intermediate outcomes of violence. In contrast, in high-income countries, communication campaigns have been shown to be ineffective where evaluations showed no reduction in violence outcomes.

Third.

One of the most important sectors in the efforts to prevent violence against women and girls is that of education. The intersection of education and violence against women and girls is particularly relevant as schools are environments where children and adolescents learn and develop social and behavioral norms. By working with the education sector at multiple levels, there is a unique entry point to help shape future generations' (both boys and girls) ideas of healthy relationships and balanced power dynamics. The implementation of relationship skills strengthening (R) and transformed attitudes, beliefs and norms (T) in the context of educational institutes, can be achieved through the following:

1. *Developing leadership, school policies and coordination methods:*
-   Develop a school policy that condemns violence and is enforced fairly for everyone. Make violence prevention an essential part of the day-to-day work of

the school, and work towards building a school culture that does not tolerate violence.

2. *Preventing violence through curriculum-based activities:*
- Develop children's life skills;
- Teach children about safe behaviour and protecting themselves from abuse;
- Challenge and transform social, cultural and gender norms that justify violence and promote equal relationships;
- Address key risk factors for violence (alcohol, drugs, low academic achievement).

3. *Working with teachers on values and beliefs and train them in positive discipline and classroom management:*
- Train teachers in positive discipline and classroom management;
- Address and transform teachers' harmful beliefs and social, cultural and gender norms.

4. *Respond to violence when it happens:*
- Train teachers and school staff in recognizing violence and asking children in a responsible way about violence;
- Train teachers in managing situations where children tell them they have experienced violence;
- Deal with violent incidents immediately, using methods learned in teachers' training, for example positive discipline and classroom management;
- If referral mechanisms do not exist at school level, make sure to be informed of service providers available;
- Train parents in recognizing and asking appropriately about violence and supporting children exposed to violence.

5. *Involve parents in violence prevention activities:*
- Keep parents involved and informed about violence prevention activities and school policies on violent behaviour;
- Distribute messages on how parents can support their child's learning;
- Invite parents to sit on prevention coordinating committees;
- Create awareness among parents on how to recognize and ask appropriately about violence.

Prevention of violence through curriculum-based activities: A central part of school-based violence prevention involves working directly with children to look at some of the root causes of violent behaviour. It is practical, and beneficial in the long term, to include skills to recognize violence, to stay safe, to resolve conflicts in non-violent ways, to manage emotions, to access help and support and to support someone else who may be experiencing violence in the curriculum. These are more effective than one-off measures. The following three key strategies can be applied in schools and form part of the INSPIRE package that outlines seven strategies for ending violence against children and which is rolled out globally.

1. *Develop life skills:* there are cognitive, social and emotional skills used to cope with everyday life. They include problem-solving, critical thinking, communication, decision-making, creative thinking, relationship skills, self-

awareness building, empathy, and coping with stress and emotions. These skills allow children to manage emotions, deal with conflict and communicate effectively in non-aggressive ways, reducing the risk of violent behaviour. They can also improve a school's performance, which protects against youth violence through students playing a greater part in school life and having better employment prospects. Life skills can also reduce risk factors for violence, such as alcohol and drug use.

2. *Teach children about safe behaviour:* This includes the ability to recognize situations in which abuse or violence can happen and understand how to avoid potentially risky situations and where to find help. This knowledge can make children less vulnerable to abuse and reduce the risk of violence happening again (through telling a trusted adult, for example). Also address risk factors for violence, such as alcohol and drug use, through making children aware of these substances, including the consequences of using them and recognizing high-risk situations.

3. *Challenge social and cultural norms and promote equal relationships:* Social and cultural behaviour and stereotypes around, for example gender, sexual orientation, religion, ethnicity and disability, increase the risk of bullying and violence. Challenging harmful norms and strengthening those that promote nonviolent, positive and equal relationships can reduce any justification for violent behaviour. Promoting political, religious and ethnic tolerance is also likely to be important in preventing hate crimes as well as violent extremism and radicalization. Challenging perceived social norms around young people's use of substances is also an important part of preventing substance abuse that helps address risk factors for violence.

Question 5:

Gathering and using data on violence against women and girls is important. Identify three actions that you believe all countries could carry out immediately.

While services are an essential element of any well-rounded portfolio designed to address partner violence, the long term vision of advocates – of a world substantially free of violence against women, or at least greatly reduced in frequency and severity – demands an emphasis on reducing partner violence before it starts. Therefore, understanding the causes of violence is essential through information collection and evidence to allow monitoring, evaluation, and measurement of progress with a result to develop, evaluate and scale up interventions to prevent or reduce violence against women and girls.

Three actions that should be carried out immediately to measure progress in preventing violence against women in the short and the long term:

1. *Strengthen routine reporting of violence against women and girls statistics by including indicators and collection of data in health information and surveillance systems.*
- At the global level, countries are required to report progress in preventing violence against women as part of SDG targets. Two indicators are proposed:
  - Prevalence of intimate partner violence in the last 12 months among women aged 15 years and older (SDG target 5.2 - eliminate all forms of violence against women and girls);
  - Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18 (SDG target 16.2 - end abuse, exploitation, trafficking and all forms of violence against and torture of children).
2. *Conduct research to develop, evaluate and scale up health systems interventions to prevent or reduce violence against women and girls.*
- It is important to evaluate before scaling-up and to monitor the scaling-up on an on-going basis to ensure that resources are invested in programmes that work, unintended or harmful outcomes are mitigated, and the scaling-up process takes into account the local context.
3. *Facilitate efforts by others to research violence against women and girls knowledge gaps and evaluate interventions.*
- Strengthen national capacities for research on all aspects of violence against children and adolescents, including on the magnitude, consequences and economic costs of such violence, the economic savings from prevention, and on effective prevention and response interventions.