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.

In Germany the most common form of gender-based violence is intimate-partner violence, however women also experience non-partner sexual violence such as sexual harassment or rape. Sexual harassment happens online as well and this development has seen an increase in the last years. However, figures are hard to find as many cases go unreported.

Question 2:

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

There are various different consequences of violence against women and girls. On a personal level reproductive health and mental health problems occur. On a family level negative consequences can be that income will be lost or even the home. If looking at a society level it will be visible that women's and girls' participation in public life will be less and by that their voices will not be heard.

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.

In my opinion the context plays a significant role. Health care providers in areas where rates of violence against women are high, might not consider this practice as the human rights abuse it actually is. Often women themselves don't report it because they think it is normal, part of the marriage and of being a woman. Furthermore it might also come with shame and taboo, and as health care staff is part of the same communities, they might be hesitant to address it appropriately.

To change this situation health care providers should receive comprehensive training to identify and respond to cases of gender based violence in an appropriate matter. Furthermore to do so, they need to be funded sufficiently. Accessibility is also an issue, as many facilities are in bigger cities or towns and not accessible for people living in remote areas. Mobile clinics could be a solution for this.

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?

RESPECT comprises of the following strategies:

R-Relationship skills strengthened: refers to strategies with the goal of improving communication skills, conflict management and shared decision-making. The target group are individuals, couples or groups of women and men.

E-Empowerment of women: This strategy looks at the economic and social empowerment of women which can come in the form of inheritance and asset ownership, microfinance, gender training interventions, collective action, creating safe spaces, mentoring.

S-Services ensured: This strategy focusses on services provided to survivors.

P-Poverty reduced: The main goal of this strategy is to alleviate poverty with different instruments, such as cash transfers, labour force interventions, etc.

E-Environments made safe: This strategy looks at safe public environments.

C-Child and Adolescent Abuse prevented: In this strategy the focus is on healthy family relationships, as mentioned in INSPIRE- 7 strategies for preventing violence against children.

T-Transformed attitudes, beliefs, and norms: In this aspect, traditional harmful practices and social norms are challenged.

As described above R is for Relationship skills strengthened and T is for Transformed attitudes, beliefs, and norms.

The evidence of intervention under R heavily depend on the context. It has been shown that group based workshops to promote egalitarian attitudes and relationships have been shown significant reductions in violence outcomes and are therefore a promising strategy for high income countries (HIC), whereas in low and middle income countries (LMIC) more evidence is needed as improvements have only been noted on an intermediate outcome level. For couples counselling and therapy the situation is the exact opposite. This intervention seems to be promising in low and middle income countries, as there are evaluations which show significant reductions in violence outcomes.

For T community mobilization has been proven promising in low and middle income countries whereas there is not enough evidence in high income countries. Group-based workshops with women and men to promote changes in attitudes and norms are an adequate instrument in LIMC as they seem to be promising, whereas we would need more evidence for HIC. Social marketing or edutainment and group education have shown improvements in intermediate outcomes related to violence in HIC and LMIC, but there is still more evidence needed. Group education with men and boys to change attitudes and norms would need more evidence in HIC, whereas in LMIC they have proven to be ineffective. Stand-alone awareness campaigns/single component communications campaigns have been shown ineffective in all settings.

In the German context couples counselling (under R-Relationship skills) could work really well but it would need some effort in reducing the barriers in accessing these services. Especially couples with violent behaviour patterns are probably quite hesitant in seeking such services, as they might fear it will be about blaming one another. Group-based workshops could be a way of solving this issue, however I also wonder if there is enough willingness to participate in such an activity as it comes with shame and stigma.

For T (Transformed Attitudes, etc.) I could only imagine the group-based workshops and it would be important to target the beneficiaries carefully. As the topic of domestic violence and

generally VAWG is a taboo and people don’t like to talk about it, it would need a sensitive approach.

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.

Generally I think it is hard to identify actions which could work in all contexts. However, I would suggest to focus on the SDG reporting, as this is an existing reporting mechanism and should be done by every country nevertheless. So the indicators “prevalence of intimate partner violence in the last 12 months among women aged 15 years and older” (SDG target 5.2) and “proportion of young women and men aged 18–29 years who experienced sexual violence by age 18” (SDG target 16.2) could be measured and monitored. Furthermore routine reporting should be strengthened and indicators on VAWG should be included in health information. Lastly thorough evaluation of ongoing programmes would be key before scaling up interventions, also to avoid unintended negative outcomes and to promote evidence based programmes.