

The WHO's priority to address intimate partner and sexual violence

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Outline

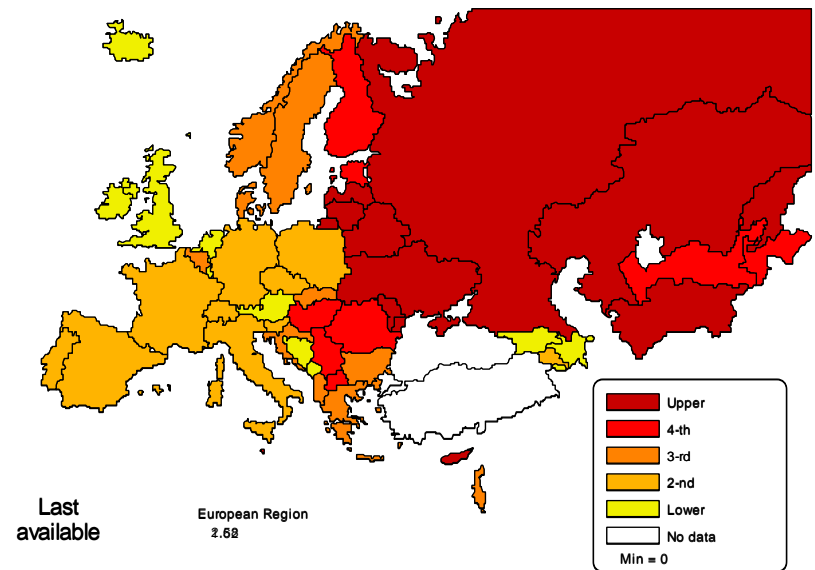
1. The burden of intimate partner and sexual violence on women
2. Risk and protective factors
3. Evidence-based interventions
4. Conclusion and priorities



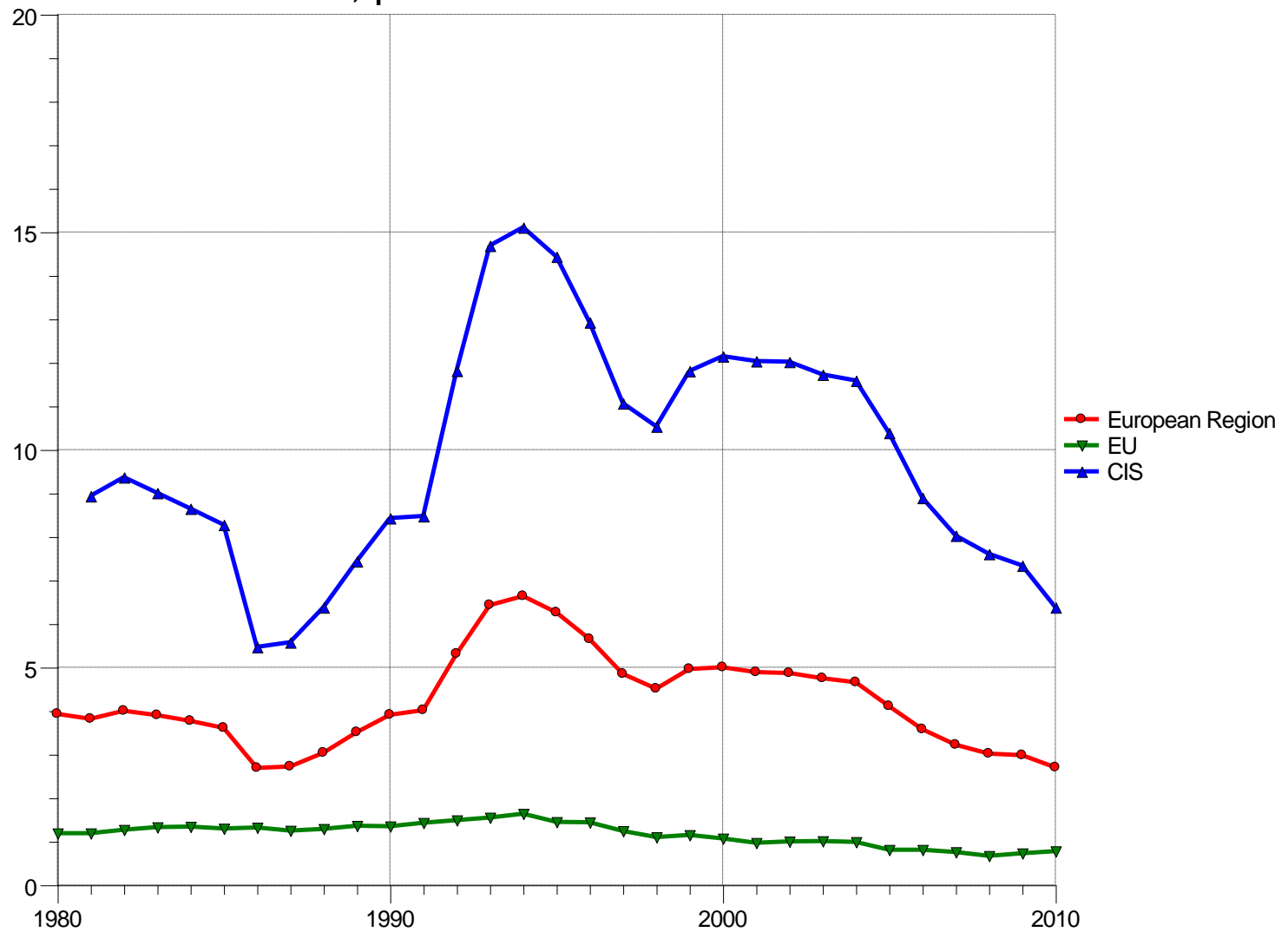
Mortality

- 4432 homicides in women aged 15-49 in the WHO European Region (GBD 2011)
 - of which 726 in EU (DMDB 2013)
- Half of women murdered are killed by their partners or ex-partners
- 3716 (84%) in low-and middle-income countries (LMIC), 16% in high-income countries (HIC)
- Rate ratio LMIC/HIC= 6.072

Women 30-44 yrs

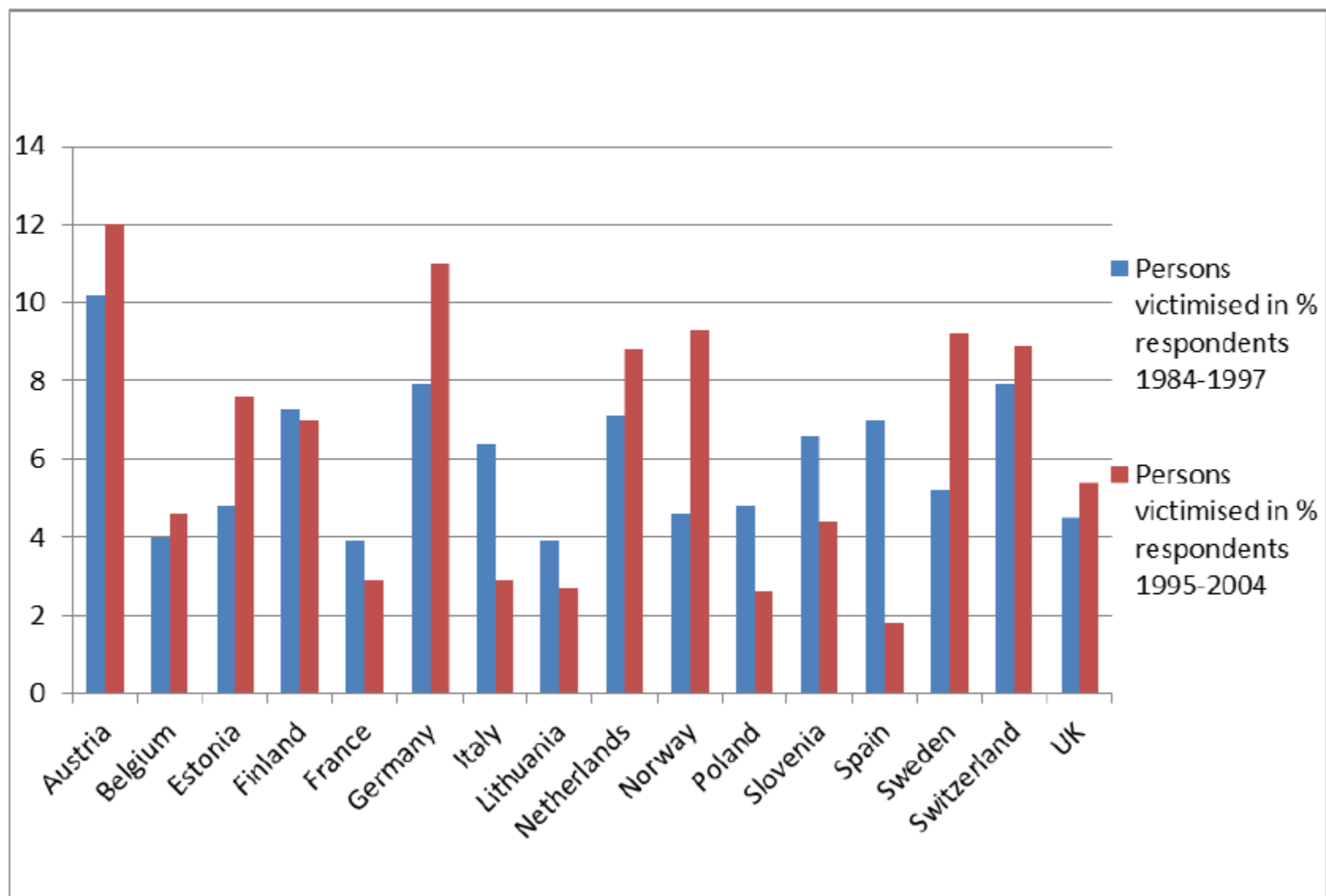


SDR(30-44),females, Homicide and assault, per 100000



Source: WHO HFA MDB, July 2013

Table 2: International Crime Victims Survey: Persons victimised in the last five years (in % of respondents) of sexual assault offences 1984-2004



Source: European Sourcebook of Crime and Criminal Justice Statistics (Aebi et al. 2010).

- The IPV part is on physical violence and sexual violence
- Non-partner sexual violence
- Systematic review
- Women over 15
- Data from 15 EURO countries, both HIC and LMIC
- Meta-analysis

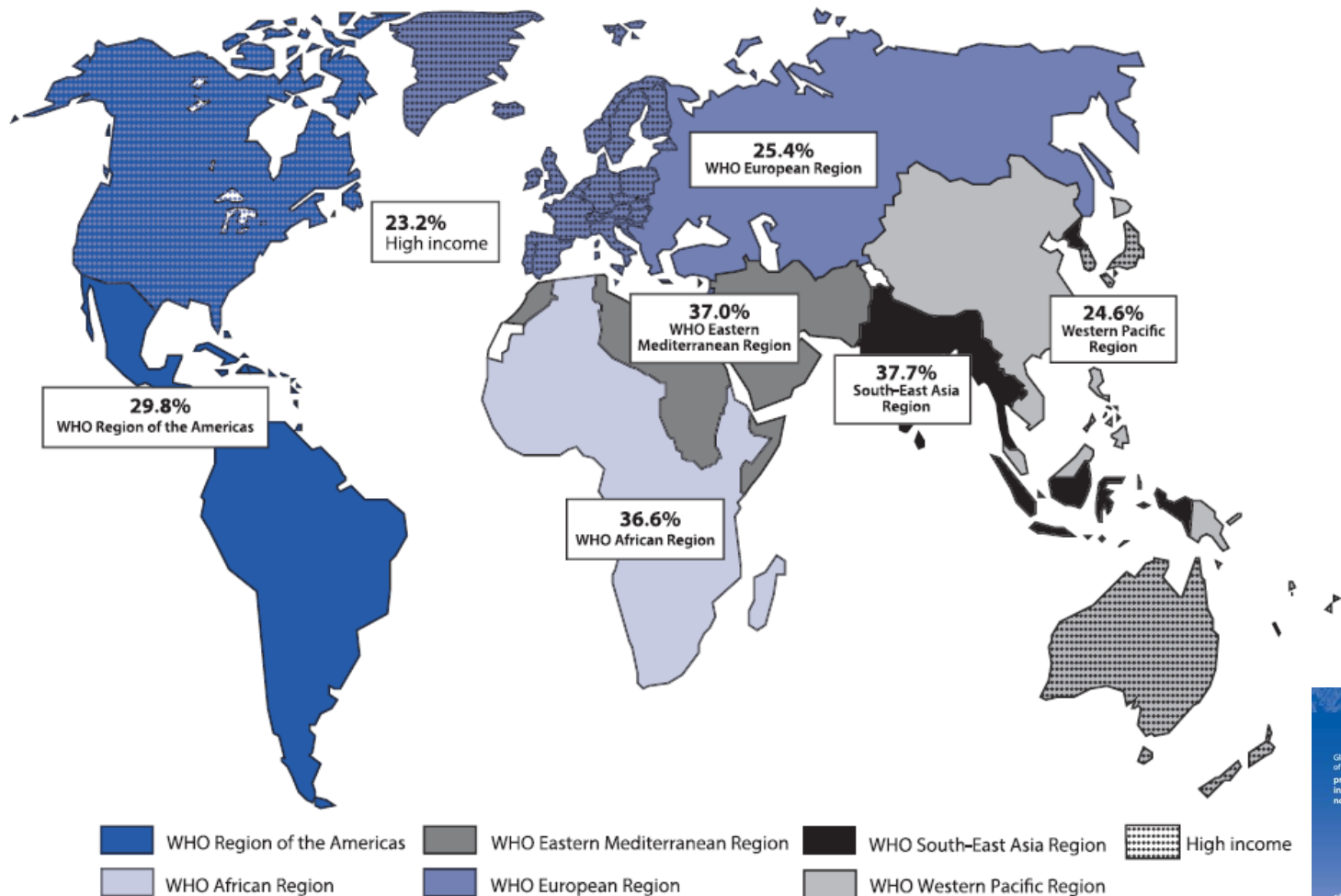
Global and regional estimates
of violence against women:
**prevalence and health effects of
intimate partner violence and
non-partner sexual violence**



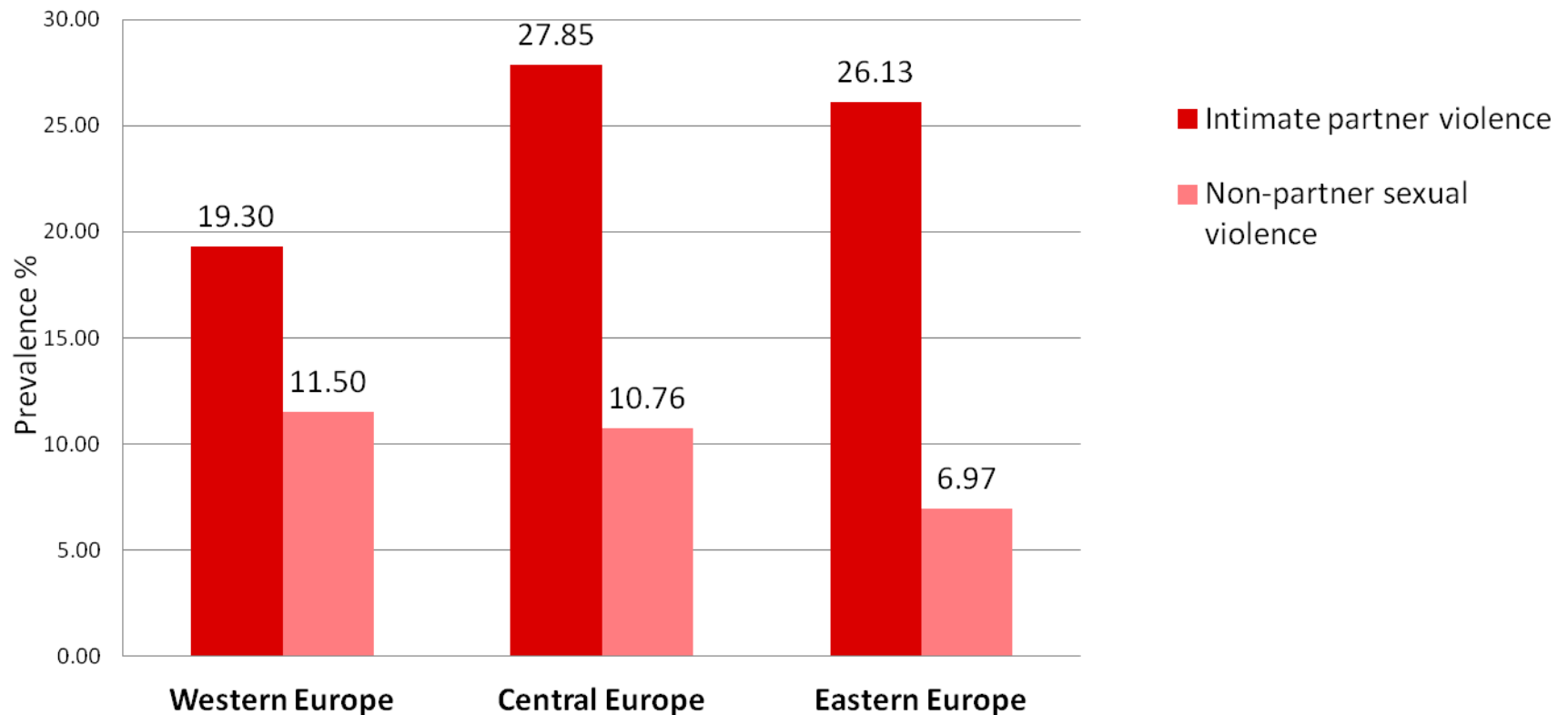
WHO 2013

Physical and/or sexual violence: results

- **Global** lifetime prevalence of IPV among ever-partnered women: 30.0% - data available by age group and region



Prevalence of intimate partner violence and non-partner sexual violence in the European Region



Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization, 2013.

Global lifetime prevalence of non-partner sexual violence: 7.2%

Violence against women and children are hidden forms of violence that are too common

Types of abuse	Prevalence	Numbers abused
Violence against women*	25.4%	49 million
Child sexual abuse**	9.6%	18 million
Child physical abuse	22.9%	44 million
Child emotional abuse	29.1%	55 million

Child abuse may co-occur in 40% of families with intimate partner violence

*Derived by applying prevalence of 19% in HIC and 25% in LMIC to female population age 15-49 (WHO 2013)

** European report on preventing child maltreatment

Prevalence of child sexual abuse in girls (Adverse Childhood Experiences study)

- Lithuania: 6%
- Latvia: 13.7%
- Albania: 4.7%
- The former Yugoslav Republic of Macedonia: 7.3%
- ...results for Montenegro, Romania, Serbia, Turkey, Russian Federation will be published soon
- Meta-analysis will be published soon on the Bulletin of the World Health Organization

VIOLENCE AGAINST WOMEN: 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

1.5 TIMES 
more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhoea

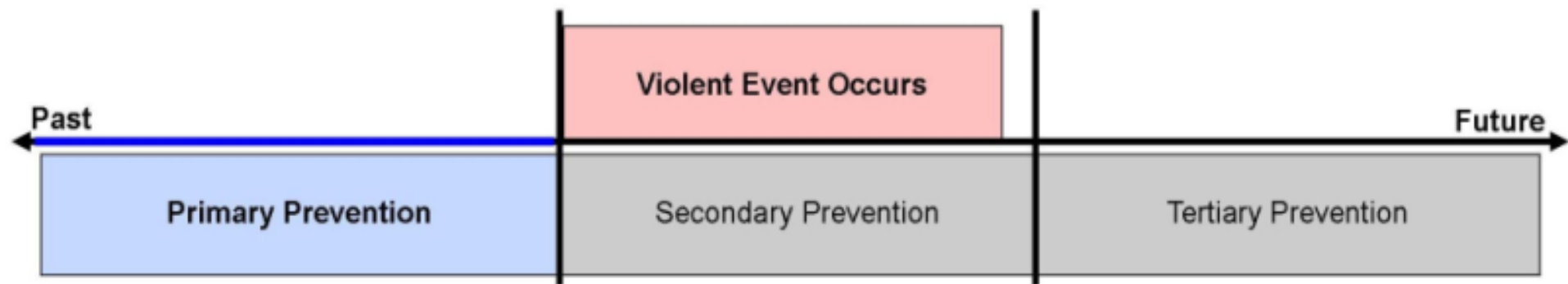
Death and Injury

42% 
of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result

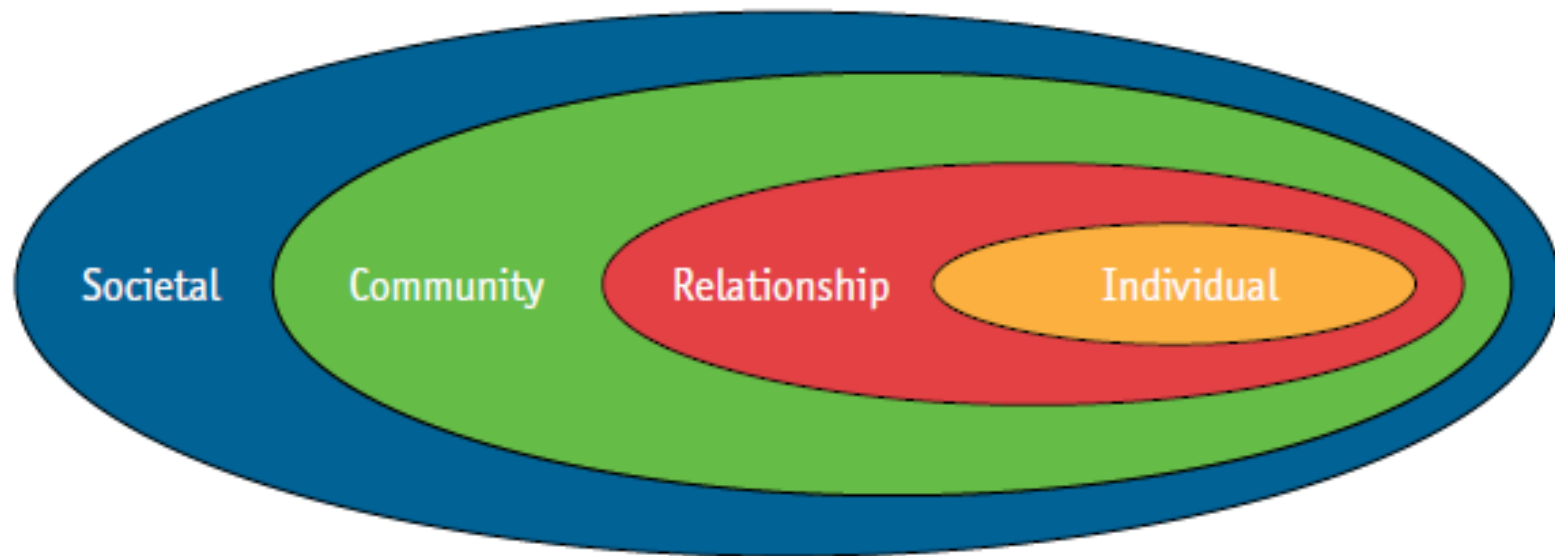
38% 
of all murders of women globally were reported as being committed by their intimate partners

All statistics can be found in the report entitled Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence by the World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council, found here:

<http://www.who.int/reproductivehealth/publications/violence/en/index.html>



Time Perspective



Risk factors

Perpetration by men

Victimization of women

INDIVIDUAL LEVEL

DEMOGRAPHICS

- Low socio-economic status/income

DEMOGRAPHICS

- Young age
- Lower education
- Separated/divorced and single women

- Gang membership

- Early exposure to sexual activity

EXPOSURE TO CHILD MALTREATMENT

- Sexual abuse
- Physical abuse
- Intraparental violence

EXPOSURE TO CHILD MALTREATMENT

- Intra-parental violence
- Sexual abuse

MENTAL DISORDER

- Antisocial personality

MENTAL DISORDER

- Depression

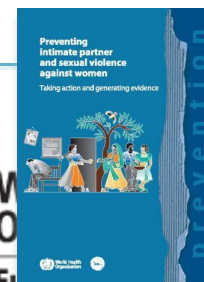
SUBSTANCE USE

- Harmful use of alcohol
- Illicit drug use

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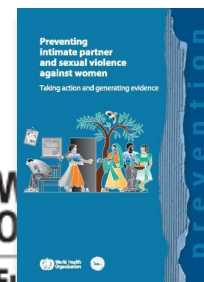
- **Prior victimization**



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Risk factors

Perpetration by men	RELATIONSHIP LEVEL	Victimization of women
<ul style="list-style-type: none"> ▪ Multiple partners/infidelity 		<ul style="list-style-type: none"> ▪ Multiple partners
<ul style="list-style-type: none"> ▪ Low resistance to peer pressure 		
<ul style="list-style-type: none"> ▪ Family honour and sexual purity 		
Perpetration by men	COMMUNITY LEVEL	Victimization of women
<ul style="list-style-type: none"> ▪ Weak community sanctions 		<ul style="list-style-type: none"> ▪ Weak community sanctions
<ul style="list-style-type: none"> ▪ Poverty 		<ul style="list-style-type: none"> ▪ Poverty
Perpetration by men	SOCIETAL LEVEL	Victimization of women
<p>Traditional gender norms and social norms supportive of violence</p>		<ul style="list-style-type: none"> ▪ Traditional gender norms and social norms supportive of violence
<ul style="list-style-type: none"> ▪ Ideologies of male sexual entitlement 		<ul style="list-style-type: none"> ▪ Ideologies of male sexual entitlement
<ul style="list-style-type: none"> ▪ Weak legal sanctions 		<ul style="list-style-type: none"> ▪ Weak legal sanctions



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Protective factors

Some protective factors that have been identified; these include:

- Having a higher level of education
- Having benefited from healthy parenting as a child
- Having a supportive family
- Living within an extended family/family structure
- Belonging to an association
- Women having the ability to recognize risk
- Having a marital duration of more than 15 years

However, much more scientific research into these protective factors is required.



Prevention strategies with some evidence

STRATEGY	INTIMATE PARTNER VIOLENCE	SEXUAL VIOLENCE
DURING INFANCY, CHILDHOOD AND EARLY ADOLESCENCE		
Interventions for children and adolescents subjected to child maltreatment and/or exposed to intimate partner violence	□	?
School-based training to help children recognize and avoid potentially sexually abusive situations	?	□
DURING ADOLESCENCE AND EARLY ADULTHOOD		
School-based programmes to prevent dating violence	■	NA
Sexual violence prevention programmes for school and college populations	NA	?
Rape-awareness and knowledge programmes for school and college populations	NA	X
Education (as opposed to skills training) on self-defence strategies for school and college populations	NA	X
Confrontational rape prevention programmes	NA	XX
DURING ADULTHOOD		
Empowerment and participatory approaches for addressing gender inequality: Microfinance and gender-equality training	□	?
Empowerment and participatory approaches for addressing gender inequality: Communication and relationship skills training (e.g. Stepping Stones)	□	?
Home-visitation programmes with an intimate partner violence component	?	?
ALL LIFE STAGES		
Reduce access to and harmful use of alcohol	□	?
Change social and cultural gender norms through the use of social norms theory	?	□
Change social and cultural gender norms through media awareness campaigns	□	?
Change social and cultural gender norms through working with men and boys	□	?

- Effective
- Emerging evidence of effectiveness
- ? Effectiveness unclear
- X Emerging evidence of ineffectiveness
- X Ineffective
- XX Probably harmful
- NA Not applicable.

VIOLENCE AGAINST WOMEN: HEALTH-CARE WORKER INTERVENTION

Violence against women is a global public health problem of epidemic proportion, requiring urgent action. Health-care providers are in a unique position to address the health and psychosocial needs of women who have experienced violence, provided certain minimum requirements are met:



- ✓ Health-care providers are trained
- ✓ Standard operating procedures are in place
- ✓ Consultation takes place in a private setting
- ✓ Confidentiality is guaranteed
- ✓ A referral system is in place to ensure that women can access related services
- ✓ Health-care settings are equipped to provide a comprehensive response, addressing both physical and mental consequences
- ✓ Health-care providers gather forensic evidence when needed

VIOLENCE AGAINST WOMEN: GUIDELINES FOR HEALTH SECTOR RESPONSE

WHO's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:



Women-centred care:

Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).



Training of health-care providers on intimate partner violence and sexual violence:

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.



Identification and care for survivors of intimate partner violence:

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.



Health-care policy and provision:

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.



Clinical care for survivors of sexual violence:

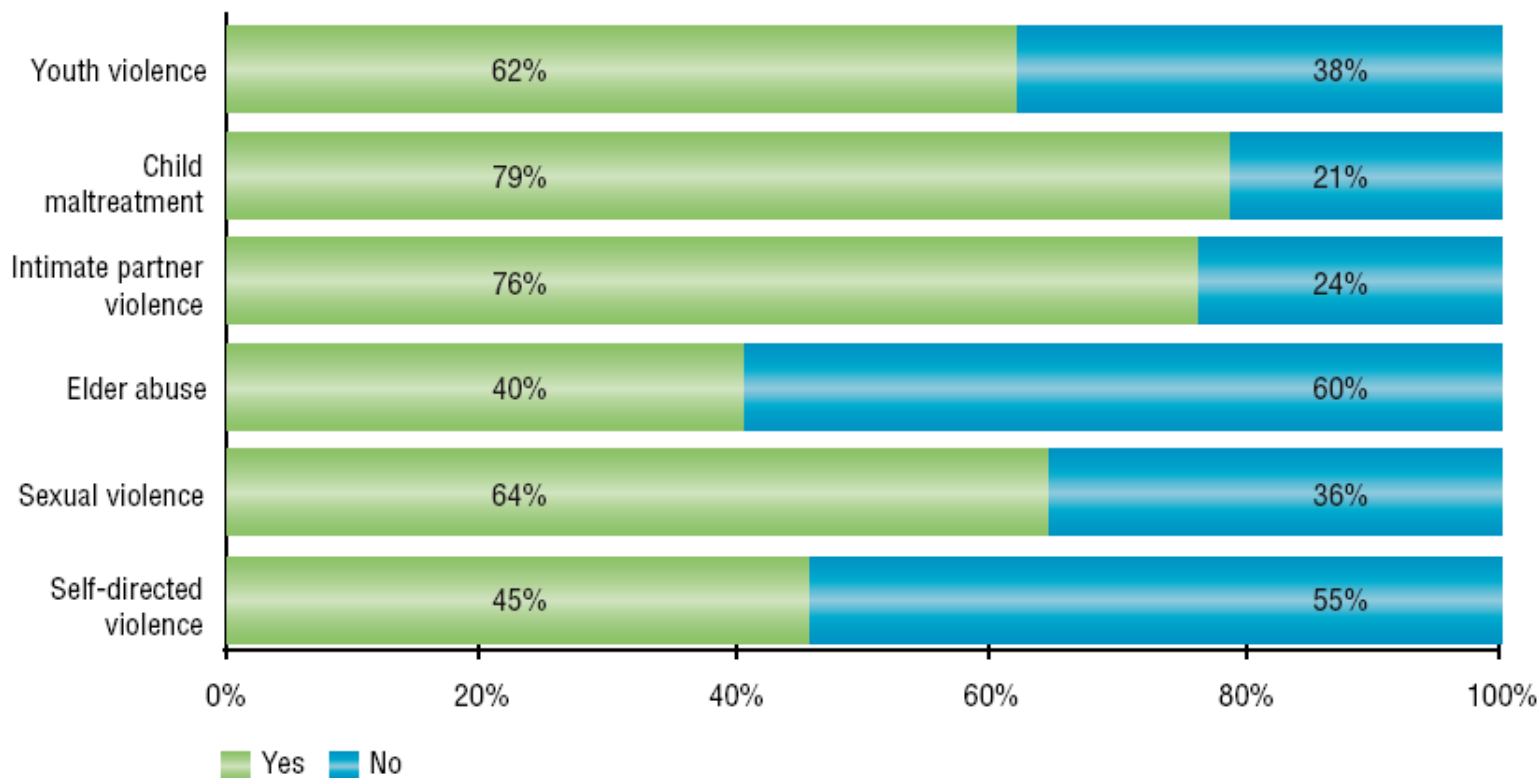
Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.



Mandatory reporting of intimate partner violence:

Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.

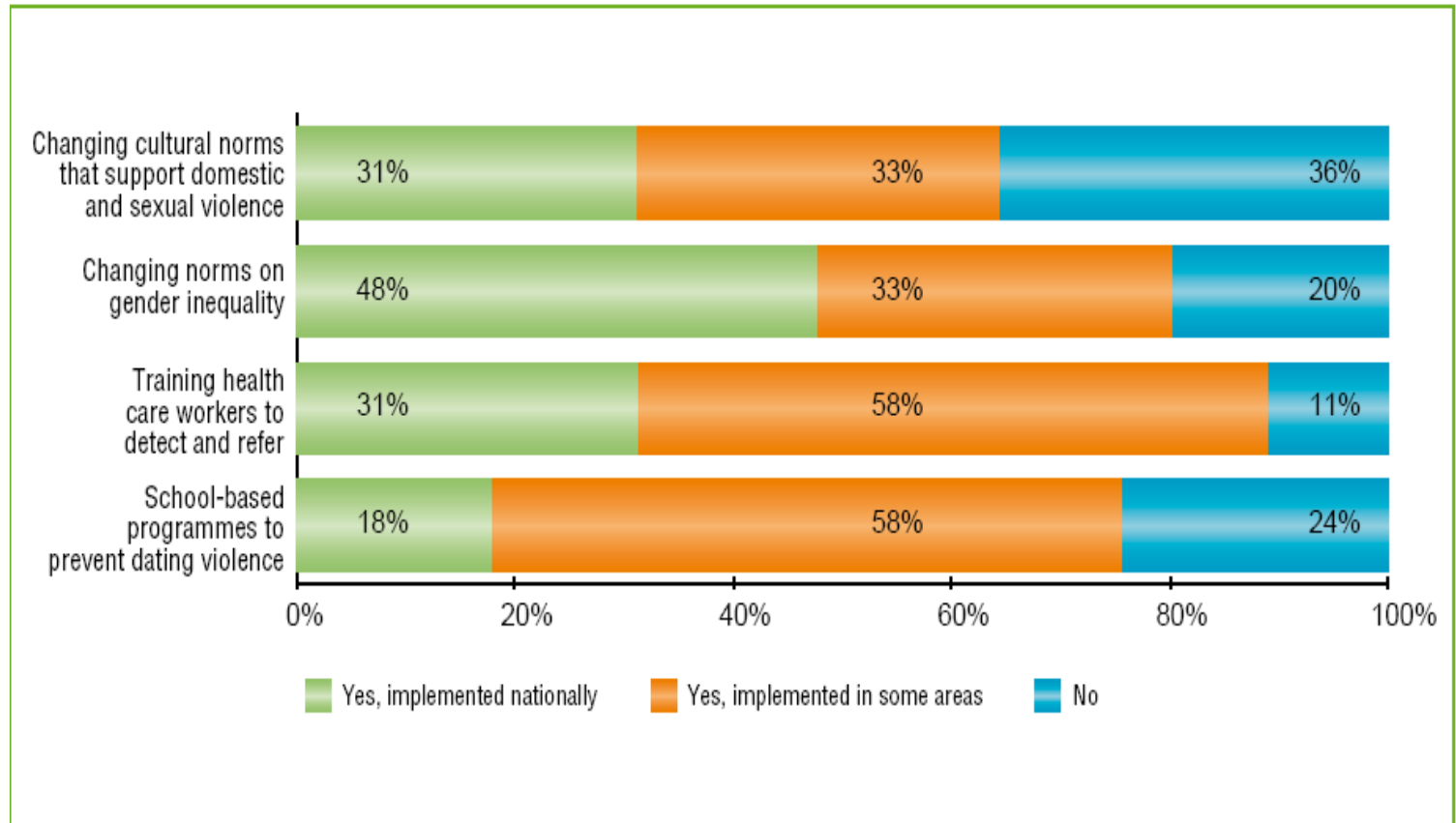
A WHO survey: national policies for violence prevention (2010)



76% of countries reported policies for intimate partner violence and 40% for elder abuse (out of 47 countries)

More updated data will be available at the end of 2014 with GSRVP

Do you have in place any of the following programmes for preventing intimate partner?



The majority of 47 European country respondents do not have prevention programmes on a national level

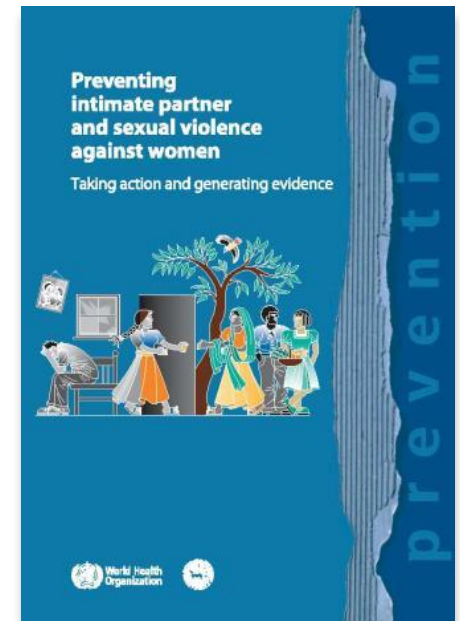
More updated data will be available at the end of 2014 with GSRVP

WHO in Latvia

- Country activities started in 2006
- TEACH VIP course translated and integrated into students curricula
- Guidance for IPV for doctors developed
- Nordic–Baltic workshop on family violence – journalists (2009)
- TOT workshop (2010)
- Subregional workshop on alcohol and violence (2012)
- ACE survey

Greater need for prevention

- Prioritize programmes and evaluations that focus on younger age groups and LMIC
- Evidence mainly comes from HIC
- Gather more evidence on community and societal risk factors
- Conduct more research on cost-benefits
- Evaluate different policies



Policy framework

- WHA Resolution on Violence against women and gender violence discussed **today** in Geneva
- Council of Europe Convention on preventing and combating violence against women and domestic violence (2011)
- Health 2020: no health equity without addressing gender inequities
- Multisectoral approach: health, social services, police, media, education, local government (Vienna conference)
- Child Maltreatment Action Plan: life-course approach and links to VAW