La violenza domestica in gravidanza
Bologna, 25 November 2016

# Addressing the health impacts of intimate partner violence during pregnancy

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# Presentation

- Global context (SDGs and WHO Global Plan of Action on Strengthening the Health System Response to violence against women)
- Global prevalence of partner violence
- Health consequences on women's and infant's health
- Health system responses and WHO Guidelines

# Global context

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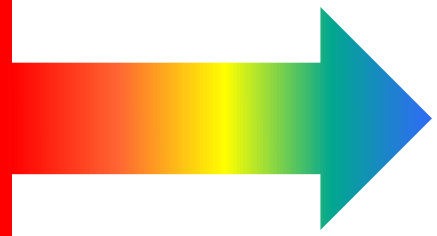
# Violence is on the development map…

**Millennium Development Goals**

**No Millennium Development Goals targets or indicators related to violence against women**



**Sustainable Development Goals**

**SDG Target 5.2**
Eliminate all forms of violence against women and girls

**SDG Target 5.3**
Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation

**SDG Target 16.1**
Significantly reduce all forms of violence and related death rates everywhere

**SDG Target 16.2**
End abuse, exploitation, trafficking and all forms of violence against children

Pan American Health Organization

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REGIONAL OFFICE FOR THE Americas

# World Health Assembly, May 2016

The Ministries of Health of the 193 Member States of the World Health Assembly of the World Health Organization, adopt a historic **global plan of action on health systems response to violence against women and girls and against children**

## Global plan of action: 4 strategic directions

1. Strengthen health system leadership and governance in addressing violence
2. Strengthen health service delivery and health workers' capacity to respond to violence against women
3. Strengthen programming to prevent violence
4. Improve information and evidence on violence

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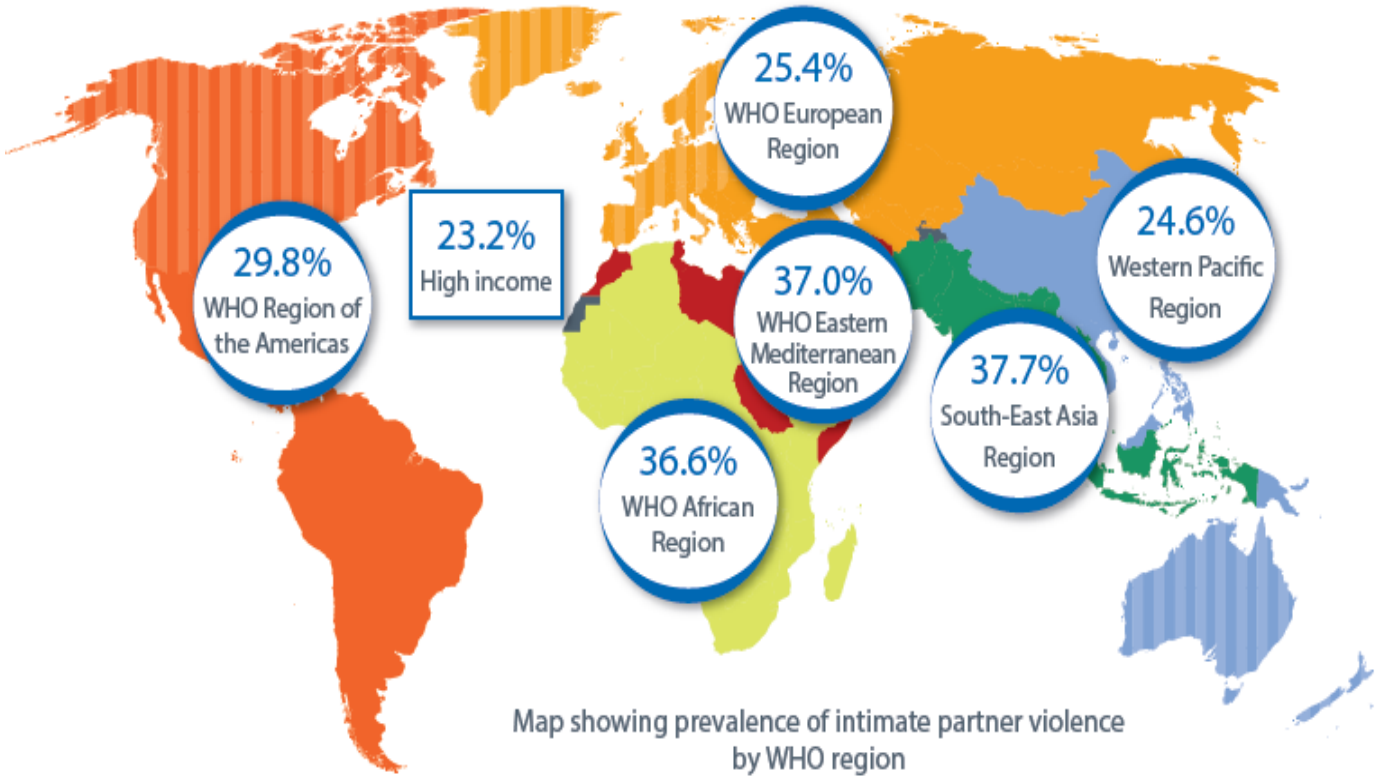
# Prevalence

# The prevalence of lifetime intimate partner violence by WHO region (2010)

PREVALENCE →

**1 in 3 women** throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner




Map showing prevalence of intimate partner violence by WHO region

# Partner violence starts early in the lives of women

Table 3. Lifetime prevalence of intimate partner violence by age group among ever-partnered 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 |

CI = confidence interval.

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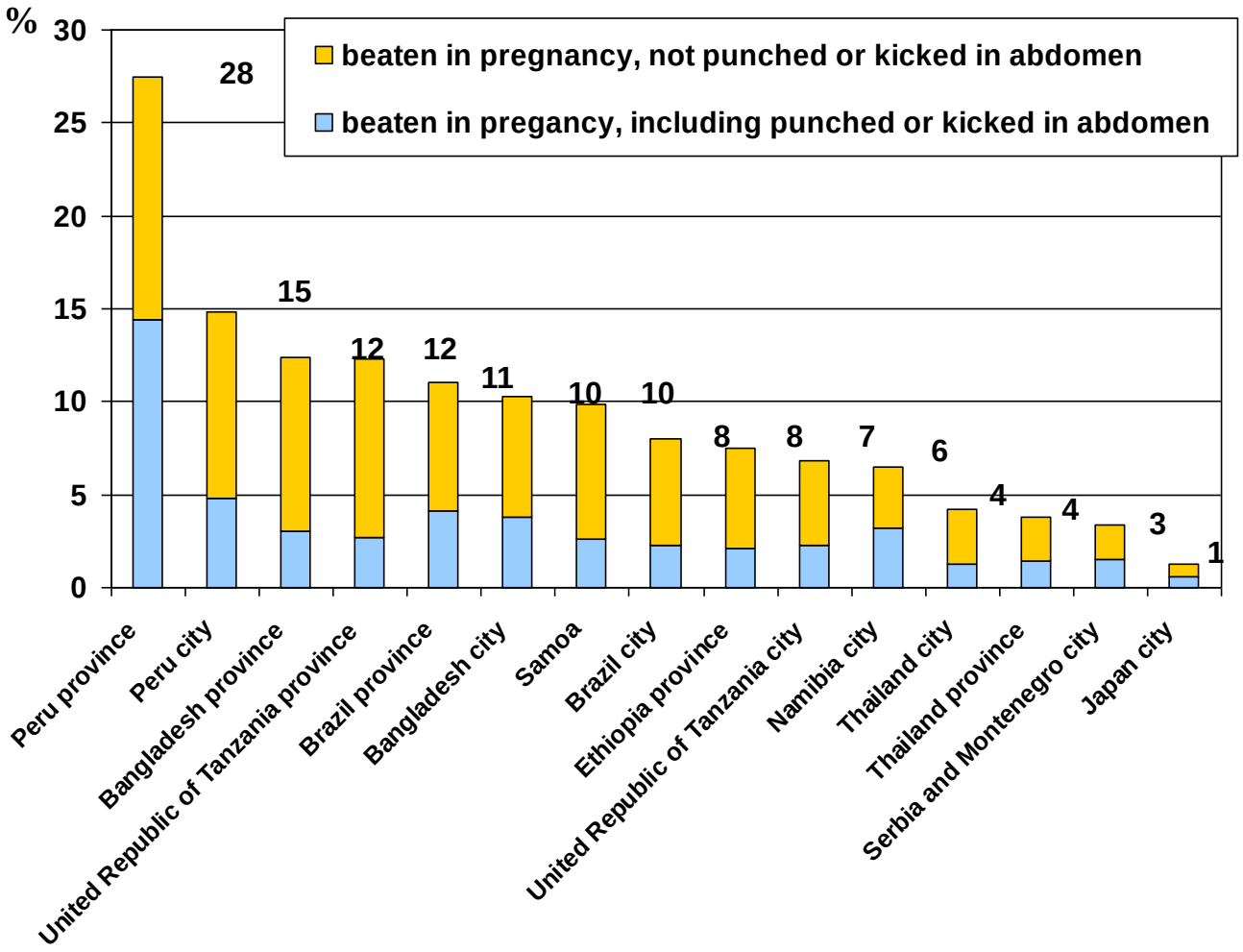
# HIGH levels of VIOLENCE during pregnancy

> He hit me in the belly and made me miscarry two babies - identical or fraternal twins, I don't know. I went to the hospital with heavy bleeding and they cleaned me up.

Woman interviewed in Peru




**WHO Multi-country Study on Women's Health and Domestic Violence, 2005**





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# Prevalence of Violence against women in pregnancy: Europe

| Country | Prevalence | Year | Author |
|---|---|---|---|
| North England | 17.0% | 2003 | Johnson, Haider, Ellis, Hay, &Lindow. |
| Belgium | 10.6% | 2014 | Van, Deschepper, Michielsen, Temmerman & Verstraelen |
| Spain | 7.7% | 2014 | Velasco, Luna, Martin, Caño, & Martin-de-las-Heras. |
| Italy | 4.5% | 2005 | Lucchetta, Romito, Molzan, Scrimin. |
| Philippines | 3.0% | 2010 | Devries KM, *et al*. |
| Denmark | 2.8% | 2011 | Finnbogadottir, Dejin-Karlsson , Dykes AK |
| Sweden | 1.0% | 2014 | Finnbogadóttir, H., Dykes & Wann-Hansson |

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# Prevalence of Violence against women in pregnancy

| Country | Prevalence | Year | Author |
|---|---|---|---|
| Chile | 44.4% | 2012 | Quelopana. |
| Japan | 30.1% | 2010 | Inami, Kataoka, Eto, & Horiuchi |
| Thailand | 27.0% | 2013 | Saito, Creedy, Cooke, Chaboyer. |
| Nigeria | 17.1% | 2011 | Adesina, Oyugbo, & Olubukola. |
| India | 15.0% | 2013 | Das, Bapat, More, Alcock, Joshi, Pantvaidya, & Osrin. |
| Iran | 14.1% | 2015 | Abdollahi, Abhari, Delavar, & Charati. |
| Uganda | 13.5% | 2012 | Devries *et al*. |
| China | 11.9% | 2011 | Ko Ling, Brownridge, Tiwari, Fong, Wing Cheong, & Pak Chung. |
| Canada | 10.5% | 2016 | Taillieu, Brownridge, Tyler, Chan, Tiwari, & Santos. |
| Vietnam | 5.0% | 2010 | Henrica, *et al*. |

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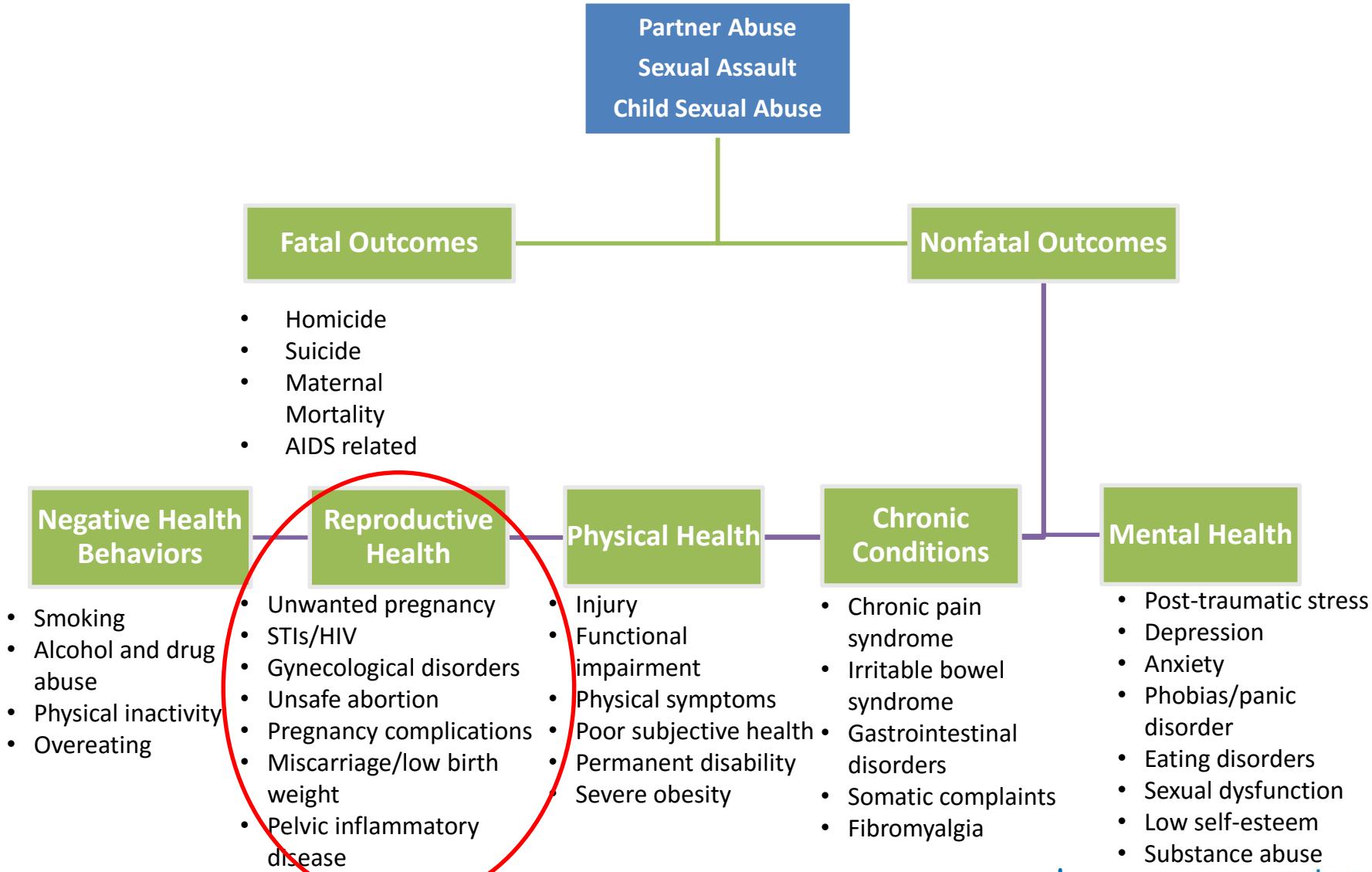
# Health consequences

# Health related consequences of violence against women

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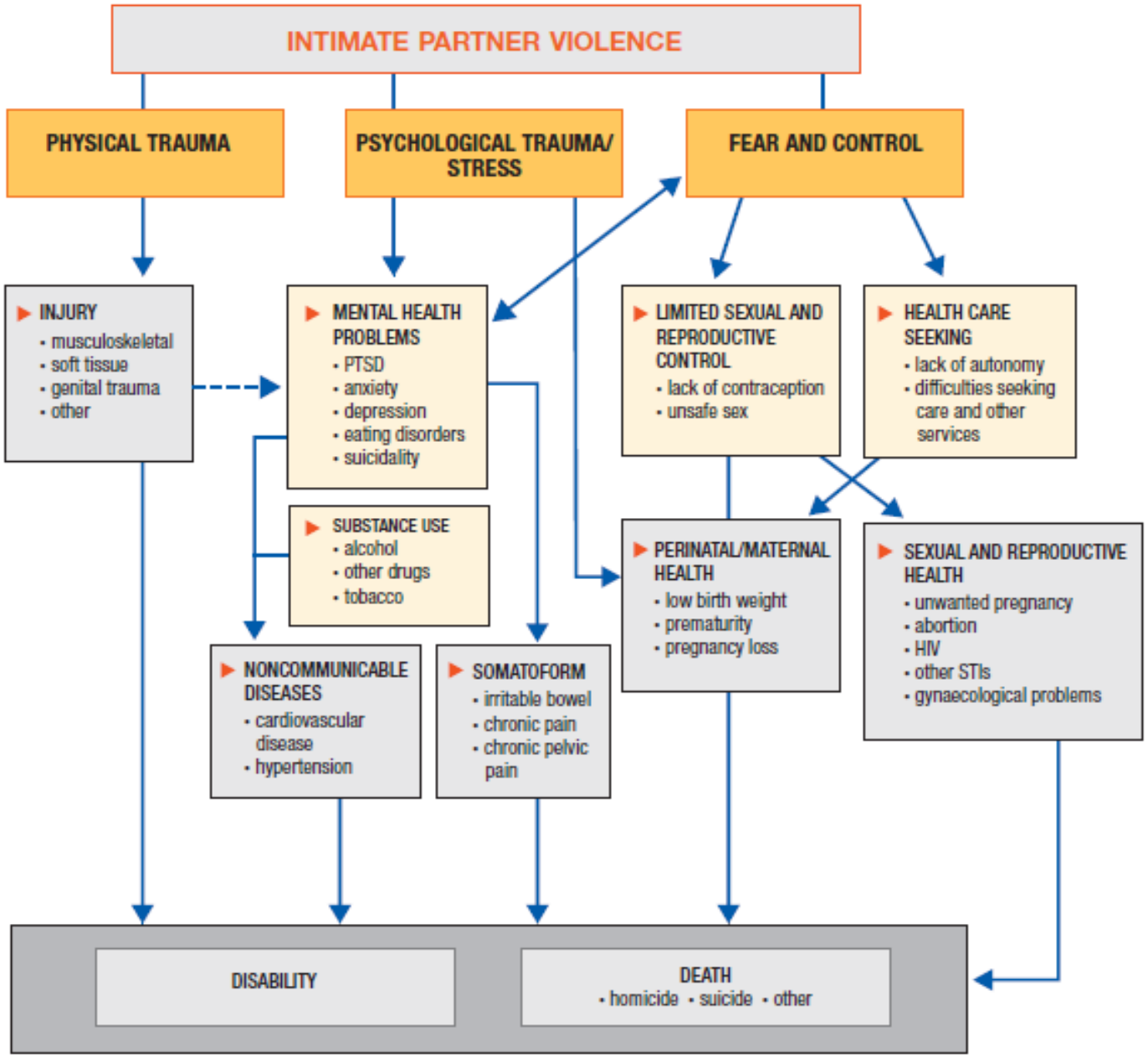
# Pathways & health effects of partner violence



# Effects of intimate partner violence on pregnancy outcomes

| | | |
|---|---|---|
| Physical injuries to fetuses and infants | Fetal death | Maternal deaths |
| Low birthweight | Intrauterine growth restriction | Poor maternal nutrition |
| Placental abruption | Pregnancy complications due to trauma | Use of tobacco, alcohol and illicit drugs |
| Preterm labour and delivery | Miscarriage | Delayed entry into prenatal care/no prenatal care |
| Fetomaternal haemorrhage | Maternal infections | Poor maternal weight gain |

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# Effects of intimate partner violence on pregnancy: in numbers

- Higher levels of unwanted or unintended pregnancy, greater parity, and first childbirth before age 17
- Increases the odds of pregnancy loss:
  - Abortion: > 2 times
  - Stillbirth or miscarriage: 1.4 times
- Increases the odds of a low birth weight baby (<2500g): 1.16 times
- Increases the odds of premature birth (gestational age <37 weeks): 1.41 times

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# Inter-generational and socio-economic consequences

| | |
|---|---|
| **Effects on children of women who experience abuse** | • Higher rates of infant mortality<br>• Behavior problems<br>• Anxiety, depression, attempted suicide<br>• Poor school performance<br>• Experiencing or perpetrating violence as adults<br>• Physical injury or health complaints<br>• Lost productivity in adulthood |
| **Effects on families** | • Inability to work<br>• Lost wages and productivity<br>• Housing instability |
| **Social and economic effects** | • Costs of services incurred by victims and families (health, social, justice)<br>• Lost workplace productivity and costs to employers<br>• Perpetuation of violence |

# Health system responses

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# WHY should the health sector address VAW?

- Abused women more likely to seek health services
- Violence is an underlying cause of injury and ill health (accounts for high burden among women of reproductive age
- Most women attend health services at some point, especially sexual and reproductive health
- If health workers know about a history of violence they can give better services for women
  - Identify women in danger before violence escalates
  - Provide appropriate clinical care
  - Reduce negative health outcomes of VAW
  - Assist survivors to access help / services/ protections
  - Improve sexual, reproductive health and HIV outcomes
- Human rights obligations to the highest standard of health care

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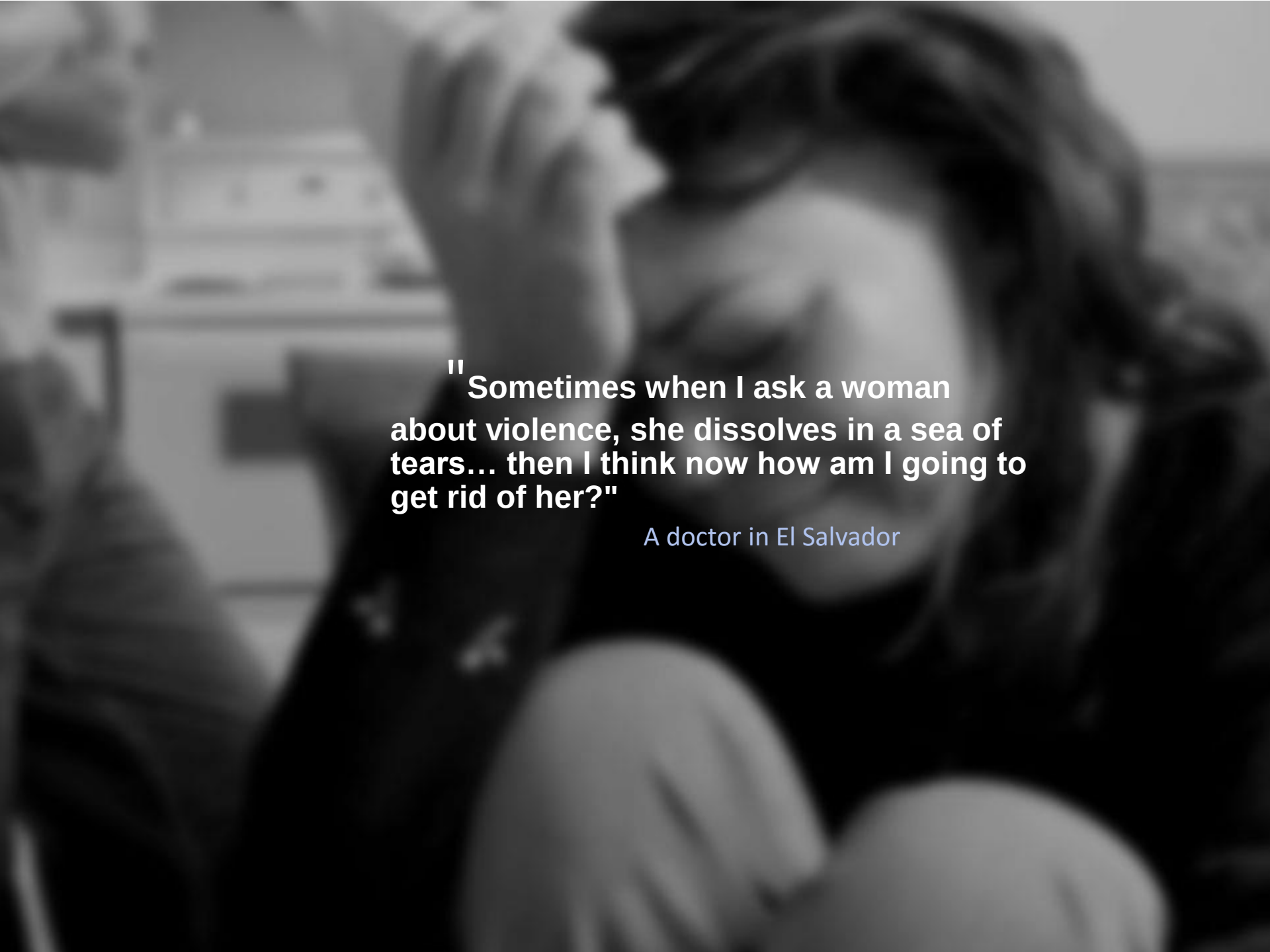

"Sometimes when I ask a woman about violence, she dissolves in a sea of tears… then I think now how am I going to get rid of her?"
A doctor in El Salvador

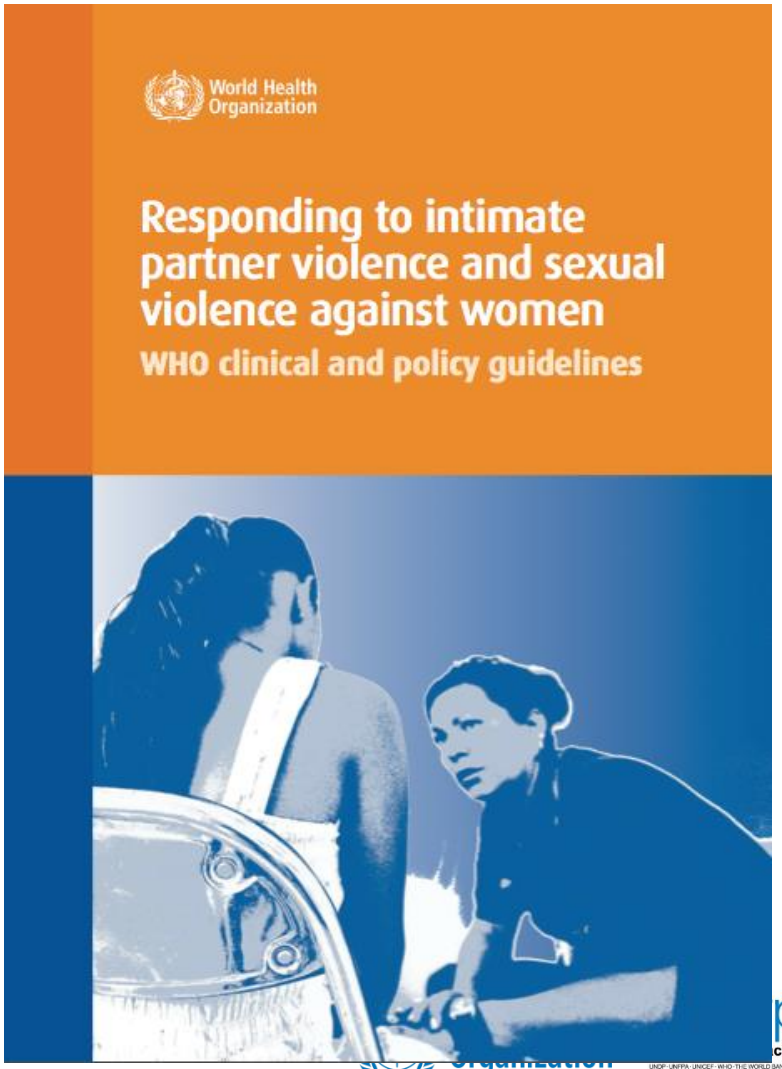
# WHO Clinical and Policy Guidelines for Responding to IPV and SV (2013)

The Guidelines

- Provide evidence-based guidance for clinicians on how to respond to intimate partner violence (IPV) and sexual violence (SV)

- Guidance to policy makers on what models of health care provision may be useful and how to deliver training

- Inform educators designing medical, nursing and public health curricula regarding training



# Guidelines for health sector response

### 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).

### 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.

### 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.

### 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.

### 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.

### 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.

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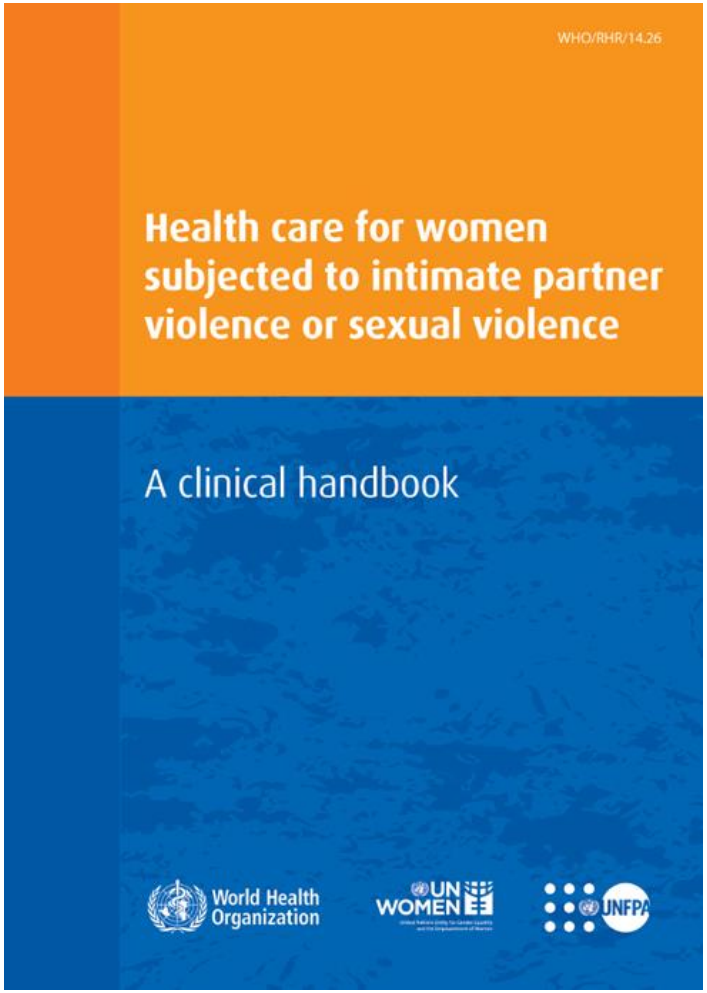
# The Clinical Handbook (2014)

## Objective

To strengthen the capacity of health-care providers, including at the primary level, for assisting women subjected to ***intimate partner violence*** *(IPV)* and ***sexual violence*** *(SV)*.

## What does it do?

- Provides ***operational guidance*** *(the 'how to')* based on WHO guidelines (the '*what*')
- It is an ***easy-to-use, helpful guide*** including practical tips and job aids
- Addresses ***physical, sexual and emotional violence***, by an intimate partner or any perpetrator
- It does not directly address young women (under 18) and men, although many of the suggestions can be applicable them.

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# Women-centred care: Survivors' wishes

- **To be safe.**
- **To be believed, taken seriously and respected.**
- A single person or agency to get help from so that they don't have to keep repeating intimate details of their abuse.
- Options based on their circumstances explained to them clearly.
- To be kept informed of developments.
- **Support to cope with the effects of abuse on their children.**
- To have their views incorporated into services that are offered to them.
- Contact with others in similar circumstance

# What about the identification of women suffering intimate partner violence?

- Universal screening not recommended, but…
  - Certain sites may want to consider it provided certain requirements are met, including mental health, HIV testing and counselling, **antenatal care**
- Clinical enquiry is recommended – especially where can improve diagnosis and treatment
- Written information on IPV should be available in health care settings in the form of posters and pamphlets or leaflets made available in private areas such as women's washrooms (with appropriate warnings about taking them home)

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# What are the minimum requirements that must be in place before asking women about violence?

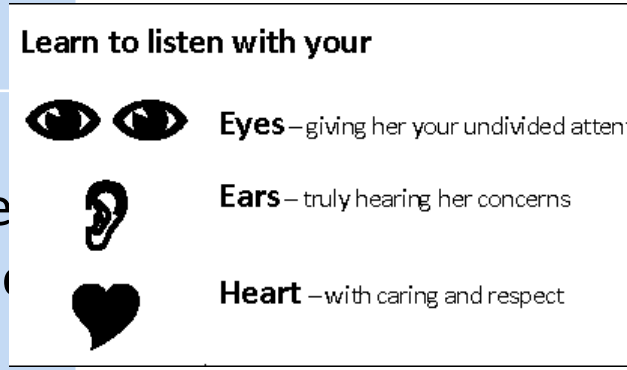
- A protocol or standard operating procedures
- Training on how to ask and a first-line response or beyond
- Private setting
- Confidentiality ensured
- System for referral in place

# Provide women-centered first-line support for sexual assault and intimate partner violence

- Providing practical care and **responding to a woman's emotional, physical, safety and support needs**, without intruding on her privacy.
- It is about…
  - identifying her **needs and concerns**
  - **listening and validating** her concerns and experiences
  - helping her to **feel connected** to others, calm and hopeful
  - **empowering** her to feel able to help herself and to ask for help
  - exploring what her **options** are
  - **respecting** her wishes
  - helping her to find **social, physical and emotional support**
  - enhancing **safety**.
- It is often the **most important care** that you can provide.

# First-line support: Job aid

| | |
|---|---|
| **L**isten | Listen to the woman closely, with empathy, and without judging |
| **I**nquire about needs and concerns | Assess and respond to her various needs and concerns |
| **V**alidate | Show her that you understand and believe her. Assure her that she is not to blame |
| **E**nhance safety | Discuss a plan to protect herself and her children from further harm |
| **S**upport | Help her connect to information, services and social support. |

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# SYSTEM-WIDE changes necessary


- Emphasis in many countries is on training or routine identification of VAW cases

  BUT, training or identification of VAW alone not lead to sustained changes, unless accompanied by system-wide changes

- Health system changes include: improving infrastructure & procedures around patient flow, documentation, privacy and confidentiality, supervision & feedback to health workers, strengthening referral linkages with other services,

- Safety of those who disclose is CRITICAL.

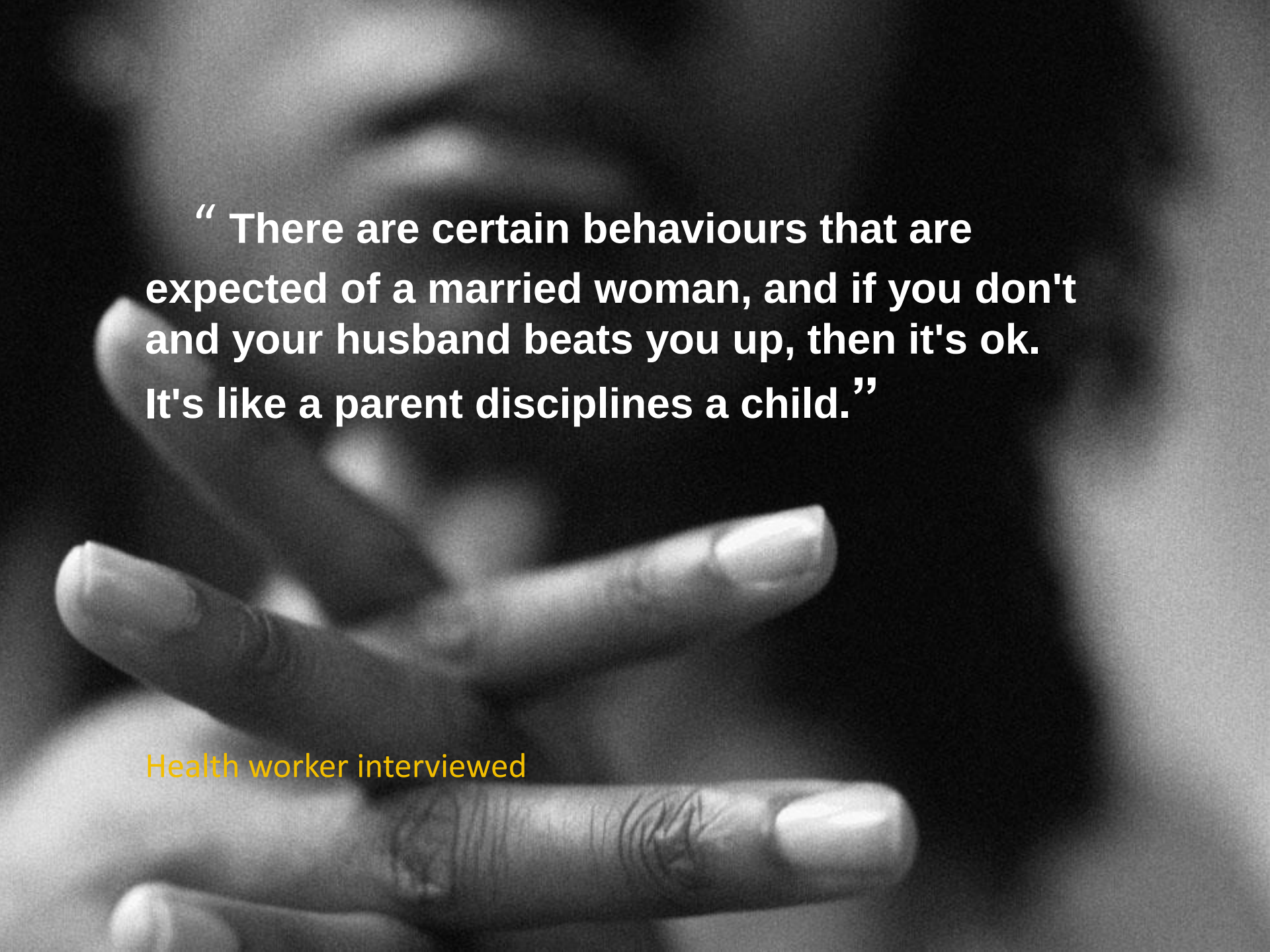
- Important role in changing attitudes towards VAW in communities.

# What are the key elements for training health providers?

- All health care providers should be trained in first-line response and acute post-rape care.
- Health-care providers offering care to women should receive in-service skills-based training, including:
  - when and how to enquire
  - the best way to respond to women
  - when and how is forensic evidence collection appropriate.
- Training should be integrated into undergraduate curricula for health care providers
- Training must address attitudes of health care workers
- Trainings should be accompanied by reinforcement and provision of continual support

# A supportive health care provider needs:

- Knowledge and awareness (about: issue, clinical care, protocols, referral network, other)
- Skills: emergency care, first-line psychological support, stress management, TVIC
- Attitudes: gender equality, empathy, non judgemental
- Principles: confidentiality, privacy, respectful of women's choices and autonomy, safety


“ There are certain behaviours that are expected of a married woman, and if you don't and your husband beats you up, then it's ok. It's like a parent disciplines a child.”
Health worker interviewed

# Conclusions

- Violence against women needs to have a higher priority in health policies, budget allocations and in training/capacity building of health care providers
- Need to integrate into undergraduate curricula and also in service, with ongoing support and supervision
- Sexual and reproductive health services offer a unique entry point to address violence against women
- Use existing opportunities to integrate programming to address violence, e.g. sexual and reproductive health, adolescent SRH, maternal and child health, HIV
- Strengthen mental health programmes/capacities
- Health policy makers need to show leadership and raise awareness of the health burden and cost

**EVERY woman and girl has the right to live without violence.**

# For more information about WHO's work on VAW

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http://www.who.int/reproductivehealth/publications/violence/en/

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