

**VIOLENCE
AGAINST
WOMEN
AND GIRLS
HELPDESK**

**DFID GUIDANCE NOTE: PART A
RATIONALE AND APPROACH**

**Addressing Violence against Women and Girls in
Health Programming**

July 2015

Emma Bell and Kate Butcher

About this Guidance Note

This guidance note was produced by the DFID-funded Violence Against Women and Girls (VAWG) Helpdesk on behalf of the DFID VAWG team in the Inclusive Societies Department. The lead authors were Emma Bell and Kate Butcher, both of Social Development Direct, with research support from Rachel Mohun and Victoria Schauerhammer, also of social Development Direct. The note was informed by technical advice from a group of experts: Dr Lyndsay McLean Hilker (Technical Team Leader of VAWG Helpdesk, Social Development Direct), Sanni Bundgaard (International Rescue Committee), Lynne Elliot (International Health and Development consultant), Gladys Mwangi, (consultant in Clinical and Social Research) and Helen Parry (independent consultant).

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About the Violence against Women and Girls Helpdesk

The Violence against Women and Girls (VAWG) Helpdesk is a research and advice service for DFID (open across HMG) providing:

- Rapid Desk Research on all aspects of VAWG for advisers and programme managers across all sectors (requests for this service are called “queries”). This service is referred to as the “VAWG Query Service”.
- Short term VAWG expert Country Consultancy support in DFID programme countries including research and advice on programme design, formation of programme documentation, implementation, review and evaluation; referred to as “Short-term Country Assignments”;
- Technical Guidance Material primarily targeted to DFID staff, but also useful across HMG and development partners;
- Strategic Engagement and support to the DFID VAWG Team.

The Violence against Women and Girls (VAWG) Helpdesk Service is provided by an Alliance comprising of Social Development Direct, ActionAid, the Institute of Development Studies (IDS), International Rescue Committee (IRC), Womankind and a wider roster of experts. For further information, please contact: enquiries@VAWGHelpdesk.org.uk

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PART A: Strategic rationale, vision and principles

Overview

Violence against women and girls (VAWG) is the most widespread form of abuse worldwide, affecting one third of all women in their lifetime. VAWG undermines the mental and physical health of women and girls, violates their human rights and can have a negative impact on long-term peace and stability. In line with its international and national commitments, preventing VAWG is a top priority for the UK Government and DFID.

This two-part guidance note is part of a series of DFID guidance notes on VAWG (see Annex 1 for links to other guidance notes). It focuses specifically on **how to address VAWG in health programming**, where DFID aims to make progress towards one key impact:

- Women's and girls' health outcomes improve as a result of the health sector response to VAWG.

This guidance note aims to provide practical advice, tips and examples to support DFID advisors and programme managers and other UK government departments to **strengthen the impact of health programmes on preventing and responding to VAWG**. It is based on international good practice from bilateral and multilateral donors, UN agencies, international and national NGOs, and DFID's own programme experience, as well as the latest academic research on health and VAWG.

Part A (this document) sets out the strategic rationale and broad approach to addressing VAWG in health programming and covers the following:

- ❖ Introduction to VAWG
- ❖ Rationale for health programmes to address VAWG
- ❖ Addressing VAWG through health programmes: the challenges
- ❖ Addressing VAWG through health programmes: entry points
- ❖ DFID's vision and key outcome areas to address VAWG through health programming
- ❖ Principles to guide health programming related to VAWG

Part B provides specific guidance on designing programmes for each key outcome area.

1.0 Introduction

Violence against women and girls (VAWG) is the most widespread form of abuse worldwide:

- One in three ever-partnered women (30%) have experienced physical and/or sexual violence by an intimate partner.¹
- More than 130 million women and girls have undergone FGC/M.²
- 7% of women globally have experienced sexual violence from a non-intimate partner.³
- The scale of violence against marginalised and vulnerable populations of women is even greater than against the wider community (see box 6).⁴
- During conflict and displacement approximately 1 in 5 women experience sexual violence.⁵
- New research shows that intimate partner violence (IPV) in humanitarian settings is common, normalised and accepted.⁶

VAWG includes physical, sexual, social and psychological harm, both actual and threatened, and can take a range of forms in different contexts and situations. VAWG reduces progress towards poverty reduction, health and other development goals and threatens women's and girls' rights to access affordable health care, to live free from violence and to live up to their full potential. VAWG is a major global public health issue.

DFID's health position paper 'Delivering Health Results' (2013) highlights the insufficient investment in approaches which address the social, economic and environmental determinants of health.⁷ Evidence suggests that the physical and psychological impact of VAWG in all its forms presents a significant health burden for the individual, her family, her community and the State. Health services provide a critical entry point for survivors to access support, recover from their experiences, avoid future violence and realise improved health outcomes more generally.

DFID recognises that VAWG is rooted in unequal power relations between men and women, but the specific risk factors, forms and types of VAWG – and the groups of women and girls targeted – can vary by context. During conflict and humanitarian emergencies, the incidence of physical and sexual violence can dramatically increase, and levels of VAWG can also be high in the aftermath of crisis. Equally, there are often high levels of violence, abuse and exploitation of women and girls in contexts characterised by high levels of deprivation, inequality and structural violence.⁸

Tackling VAWG is a key UK Government commitment and a high-level priority for DFID as articulated in [DFID's Business Plan 2011-2015](#), [the updated Strategic Vision for Women and Girls \(2014\)](#), [the Theory of Change on VAWG \(2012a\)](#), and the [International Development \(Gender Equality\) Act \(2014\)](#). The UK has committed to end VAWG in situations of armed conflict and is signatory of several international agreements on preventing and responding to VAWG (see Annex 1). DFID currently has over 29 country programmes that directly address violence against women and girls. These cover a wide range of interventions from stand-alone programmes (reaching more than one million women and girls), to broader programmes focusing on the delivery of security, access to justice, health and health services, which include components on violence against women and girls.

This guidance note aims to support HMG advisors and programme managers to consider VAWG in all health programming and policy dialogue. It focuses on the following types of violence: domestic violence including intimate partner violence (IPV) and violence against children, sexual violence, institutional violence in

¹ WHO, 2013

² UNICEF website: <http://data.unicef.org/child-protection/fgmc>

³ WHO, MRC and LSHTM, 2013

⁴ Middleton Lee, 2013

⁵ Vu et al, 2014 – based on reported figures

⁶ IRC, 2015

⁷ DFID, 2013a

⁸ Fancy and McAslan Fraser, 2014

health services (e.g. forced sterilisation, abortion) and female genital cutting/mutilation (FGC/M).⁹

Box 1. Definition of Violence against Women and Girls (VAWG) - The UK Government's [Call to End Violence Against Women and Girls](#) defines VAWG according to the [UN Declaration on the Elimination of Violence against Women](#) (1993): 'Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'. Despite internationally agreed definitions, the definition of VAWG varies across countries and within communities.

WHO definition of health - Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (Source: <http://www.who.int/about/definition/en/print.html>)

Box 2. Health consequences of IPV:

- In the 2005 WHO multi-country study, the prevalence of **injury** among women who had ever been physically abused by their partner ranged from 19% in Ethiopia to 55% in Peru. (WHO, 2005).
- Abused women were twice as likely as non-abused women to report poor health and physical and mental health problems including '**functional disorders**' or '**stress-related conditions**', even if the violence occurred years before (WHO, 2005).
- Women who have experienced physical or sexual abuse from their partners are almost **twice as likely to experience depression** (WHO, MSC and LSHTM, 2013).
- IPV is linked with unintended pregnancies, with women who have experienced IPV being **more than twice as likely to have an abortion** (WHO, MSC and LSHTM, 2013).
- IPV is also linked to sexually transmitted infections, including HIV - directly through forced sexual intercourse or indirectly as women are less able to negotiate condom use with their partner. In some regions, **women who experience IPV are 1.5 times more likely to acquire HIV** (WHO, MSC & LSHTM, 2013).
- Women who experience IPV are **16% more likely to have a low birth-weight baby** (WHO, MSC & LSHTM, 2013). Violence during pregnancy has also been associated with: miscarriage; late entry into prenatal care; stillbirth; premature labour and birth; and foetal injury (WHO, 2012).
- The **impacts on children** of IPV against women, including anxiety, depression, future male perpetration and female experience of IPV in later life, as well as children's negative health outcomes, such as lower immunisation, higher rates of diarrhoeal disease, and greater infant mortality rates (WHO, 2012).

Adapted from Fraser, Cansfield and Trimiño Mora, 2015

⁹ It is beyond the scope of the note to include early and forced marriage and trafficking.

2.0 The importance of addressing VAWG in health programmes and policies

There are four main reasons for addressing VAWG in health programmes:

- The negative impact of VAWG on women's and girls' health outcomes .
- Health programmes / providers have a critical role to play in addressing VAWG.
- Failure to address VAWG through and in the health sector can lead to increased risk and harm for service users and poorer overall health outcomes.
- Tackling VAWG in the Health Sector is part of the UK's commitment to human rights.

1. The negative impact of VAWG on women's and girls' health outcomes

Violence against women and girls across their lifespan (e.g. FGC/M, intimate partner violence, acid attacks, rape, denial of resources) contributes disproportionately to poor health outcomes. Those experiencing violence encounter more health problems (See box 2) and incur significantly higher health care costs than those who have not experienced violence.¹⁰ Survivors visit health facilities more frequently (when they have access) without necessarily revealing the root cause of their health problem, yet the violence they experience is significant in shaping their mental and physical health and social well-being.¹¹

Health programmes have a critical role to play in addressing VAWG

In many contexts, health services are the first port of call for women who have experienced VAWG. Health services present a unique opportunity to identify and start to address the violence that women and girls suffer at home.¹² Health care settings and confidential patient/provider relationships can provide women and girls with safe environments where they can confidentially disclose their experiences and receive a supportive response.¹³

Evidence suggests that the most significant contribution that the health system can make is through improved secondary and tertiary prevention (see box 3). This is through the integration of a response to VAWG into health services in order to facilitate easier access to essential treatment, care and support.¹⁴ Systems for monitoring service user experiences can also enable the collection of data and evidence to highlight the health impacts and costs of VAWG. The integration of a response to VAWG is particularly important for sexual and reproductive health (SRH) and HIV services as well as Maternal Newborn and Child Health (MNCH) services, as violence can lead to adverse sexual and reproductive health outcomes.

Box 3. Definitions

Primary prevention - Any programmes, interventions or strategies aimed at stopping violence before it occurs.

Secondary prevention - Any strategy aimed at minimising the harm that occurs once a violent event is taking place and immediate post-violence intervention aimed at preventing re-victimisation. Examples include interventions to reduce the duration of interpersonal violence events or damage inflicted, or the early identification by health professionals of child abuse and subsequent interventions to prevent further abuse.

Tertiary prevention - All efforts aimed at treating and rehabilitating victims and perpetrators and facilitating their re-adaptation to society. Contrary to secondary prevention activities, which are usually in the short-term after the event, tertiary prevention activities are usually long-term.

Health promotion - is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

(Sources: UN Women <http://www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html> and WHO - http://www.who.int/topics/health_promotion/en/)

Although there is little evidence that health interventions can improve primary prevention, health facilities can model good practice by ensuring zero tolerance of violence, by establishing an environment that is safe for women and girls to use, or to be employed in, and by promoting awareness about VAWG (rights, impact

¹⁰ Klugman et al, 2014

¹¹ Garcia-Moreno et al, 2014

¹² WHO with UNDP and UNODC (2014); Bonomi et al, 2009

¹³ Garcia-Moreno et al, 2014

¹⁴ Jewkes, 2014; Fulu et al, 2014

etc.) through health promotion work. HIV and Sexual Reproductive Health (SRH) services provide a unique opportunity to reach men in health facilities, for example through voluntary male circumcision camps and STI services as well as through general day to day service delivery, where male partners and/or decision makers can receive information on SRH issues and the negative effects of VAWG can be addressed.¹⁵

Health care workers, particularly frontline workers, many of whom are women, face high levels of workplace violence. In an analysis of data for more than 150,000 nurses, drawn from 160 global samples, researchers found that overall, about a third of nurses have been physically assaulted, bullied or injured at work, while around two-thirds have experienced non-physical assault.¹⁶ Taking a zero tolerance approach to VAWG in the health sector will send out a clear signal that this violence is unacceptable.

3. Failure to address VAWG through and in the health sector can lead to increased risk and harm for service users and poorer health outcomes

A lack of consideration of VAWG in the design and implementation of health services can increase women's and girls' risks of violence. When health care providers are not trained in the guiding principles of working with women survivors or those at risk (e.g. when providers do not protect patient informed choice and confidentiality), women and girls may be at risk of additional violence from partners or family members.¹⁷ For example, non-voluntary HIV testing services situated in antenatal clinics can oblige women to be tested in the presence of their partners and risk them being blamed by family members for bringing HIV into the relationship.¹⁸ It is thus important for health programmes to integrate an approach to VAWG to ensure that they "do no harm" as well as, where possible, contributing to preventing VAWG (see Part B).

VAWG can also be perpetuated in a number of ways within the health sector (see box 4) with severe consequences for women and girls' health. This is particularly the case for women from marginalised and vulnerable populations, including women living with HIV, women engaged in the sex trade, women who use drugs, adolescents, transgender women and women with disabilities. Stigma and discrimination by health care professionals towards these women is often high, meaning that frequently they either do not access services or fail to receive quality, non-judgemental care if they do.¹⁹ Furthermore, when health care workers respond to reports of VAWG with victim-blaming attitudes they may cause further emotional harm and even discourage women from seeking health or VAWG services.²⁰

Box 4: Types of violence perpetrated within health services

Physical violence, coercion, discrimination, medicalisation of FGC/M, sex selection, virginity testing, denial and/or promotion of services based on HIV status, disability, socio-economic status and involvement in transactional sex and drug/alcohol use, breaches of confidentiality and negative attitudes around (post) abortion care.

Women and girls who visit health clinics where providers are not trained to recognise and address VAWG may be misdiagnosed or otherwise receive inadequate or inappropriate treatment and care (such as failure to provide emergency contraception, STI treatment and/or post-exposure prophylaxis for HIV after experiencing sexual violence).²¹ This violates medical ethics and the principle of 'do no harm'. Understanding whether a woman or girl is a survivor of violence can be important for ensuring that the health services offered or sought are tailored to improve women and girls' health (whether related to the violence experienced or other non-VAWG related health outcomes).²²

¹⁵ Middleton Lee, 2013

¹⁶ Spector et al, 2012

¹⁷ Ward, 2011; World Bank, 2014

¹⁸ Nudelman, 2013

¹⁹ Middleton Lee, 2013

²⁰ Ward, 2011

²¹ Ward, 2011

²² Remme et al 2014; WHO 2013; World Bank, 2014

4. Tackling VAWG in the Health Sector is part of the UK's human rights commitments

VAWG is a human rights abuse as recognised by the Universal Declaration of Human Rights, the *Convention on the Elimination of Discrimination against Women* (CEDAW) and the Convention on the Rights of the Child - all of which the majority of countries have signed and many have ratified. There are also various international agreements on VAWG (See Annex 1). The UK is obliged to address VAWG in the health sector due to its being a signatory of relevant international agreements and its own policy commitments: DFID's Business Plan 2011-2015; the updated Strategic Vision for Women and Girls (2014); the Theory of Change on VAWG (2012a); the Development Gender Equality Act (2014); the DFID commitment to end VAWG in wartime; the UK's Framework for Results for Improving Reproductive, Maternal and Newborn Health in the Developing World (2012c), and; DFID Health Position paper (2013a) (see Annex 1).

Furthermore, the recent WHO Resolution on Violence Against Women requests UN member states to take actions to address VAWG and mandates WHO to develop an implementation plan on the health sector's response to VAW (see box 5).

Box 5: WHO Resolution on Violence against Women

WHO Member States adopted a resolution to strengthen the role of the health system in addressing violence, in particular against women and girls, and against children at the 67th World Health Assembly (2014). The resolution requests Member States to: ensure access to timely, effective and affordable health services, particularly sexual and reproductive health; improve the collection and dissemination of comparable data; enhance capacities to respond to and prevent such violence; and establish and support standard operating procedures aimed at identifying victims of violence and providing effective and appropriate services. It also requests the Director-General to develop a "global plan of action to strengthen the role of health systems to address interpersonal violence, in particular against women and girls, and against children".

(Source: World Health Assembly, 2014)

3.0 Addressing VAWG through health programmes: the challenges

There are a number of important challenges to addressing VAWG through health policy and programmes. These include:

The high levels and significant impacts of violence discussed above make it imperative for health services to address VAWG, but also places a significant burden on sector capacity and resources. For example, estimated overall productivity loss due to domestic violence against women in Viet Nam comes to 1.78 per cent of GDP. Women experiencing violence earn approximately 35 per cent less than those not abused, representing another significant drain on the national economy.²³

Various forms of gender inequality mean that women and girls are devalued and discriminated against in the home, the community and the health system. These inequalities including women's lack of resources, lack of decision making power (especially around SRH issues) and lack of knowledge about existing services - create barriers to disclosing violence as well as accessing, receiving and benefitting from appropriate, quality health services.²⁴ Furthermore, discriminatory attitudes can be replicated within health services due to insufficient training, a high turnover of trained staff and a lack of inclusion of training in VAWG response in national medical curricula. Staff sensitisation, specialised training, and on-going supervision and staff support are key to ensuring supportive responses to survivors.²⁵

Difficulties in addressing the needs of marginalised and vulnerable populations (including unmarried adolescent girls and older women beyond reproductive age and women and girls with disabilities): Those who are vulnerable or marginalised often suffer higher levels of violence (See box 6)²⁶ and are often in most need of health services, while having the poorest access to those services. They face specific legal,

²³ Duvvury, Carney and Huu Minh, 2013

²⁴ Sen, Östlin and George, 2007

²⁵ Ward, 2011

²⁶ Middleton Lee, 2013

social and economic barriers accessing services as well as significant discrimination within services. For example, health services may subject sex workers to disapproval, refuse to treat their health problems, subject them to mandatory HIV testing, demand they disclose their HIV status and threaten to report them to the authorities. Also, women with disabilities who have experienced intimate partner or sexual violence report not being taken seriously within services because of a general denial of their sexuality and sexual and reproductive health needs.²⁷ Improving the health sector response to violence faced by marginalised and vulnerable populations involves not just the provision of better, more inclusive health services but also simultaneously tackling barriers such as stigma and discrimination. It also entails building the capacity of these women to understand and advocate for appropriate and tailored services that meet their needs.²⁸

Box 6. Violence against key and vulnerable populations:

- Lifetime prevalence of violence against sex workers (work-based or any) ranges from 45% to 75%, and incidence over the past year from 32% to 55%. (Deering et al., 2014)
- In Latin America, 826 transgender people were murdered in a four-year period. (International HIV/AIDS Alliance, 2012)
- The prevalence of sexual violence among refugees and internally displaced people is (conservatively) estimated at 21.4% (Vu et al., 2014)
- In Ukraine, 55% of women who inject drugs report psychological violence by their partners, while 49% report physical violence and 41% economic violence. (International HIV/AIDS Alliance, 2009)
- Women with disabilities are found at least twice as likely as their non-disabled counter-parts to be victims of rape, sexual abuse and IPV. (Van Der Heijden, 2014)
- In Tanzania, odds of reporting partner violence was 10 times higher among younger (< 30 years) HIV-positive women than among younger HIV-negative women (Maman et al, 2002)

The physical capacity of health services to integrate VAWG is limited in many contexts, particularly in fragile and conflict-affected communities where access is poor, needs are high and resources limited. In these contexts, women and girls often face increased risk of multiple types of violence during displacement and a lack of access to quality services that can effectively address the short and long-term consequences of VAWG. To save lives and maximise protection, a minimum set of activities must be rapidly and routinely undertaken and coordinated to prevent and respond to VAWG from the earliest stages of an emergency.²⁹

Weak evidence about what works: While evidence is fairly robust on the relationship between VAWG and negative health outcomes, little is known about what works when implemented and integrated into primary health care in low-resource settings. The problem is exacerbated by under-reporting – by marginalised groups in particular – and by the fact that service user cases are often recorded according to exit diagnosis (e.g. injuries, antepartum bleeding, post-abortion care, STIs) yet a user’s experience of, and the negative impact of, violence are not captured. At a health systems level, health services need to collect data on core VAWG indicators in order for VAWG to be understood as a serious health concern.

Weak management of health systems: Weak health systems, competing priorities and limited budgets all combine to weaken appropriate responses to VAWG. For example, VAWG health services as part of the Sexual Reproductive Health/Maternal Child Health services often competes with other areas such as family planning, safe facility delivery and child immunisations, which have a proven high return/impact that is easily measured on money invested. Traditionally in low-resource settings, training staff on protocols and procurement of drugs has been seen as sufficient for health facilities in order for them to offer clinical care for sexual assault survivors. The health sector has taken less responsibility for recognising and addressing other types of violence experienced by women from different backgrounds (beyond rape) including addressing the impact on survivors’ mental health.³⁰ These weaknesses are exacerbated where there is poor leadership or political commitment to addressing VAWG. For example, there may be a lack of clear institutional policies on violence, a lack of coordination among various actors and departments involved in

²⁷ Pers comms Chitra Nagaranjan, 2015

²⁸ Health Policy Project, 2014

²⁹ IASC, 2005

³⁰ Ward, 2011

planning integrated services or developing a multi-sectoral response, and a lack of commitment by health administrators.

Lack of application of minimum standards: Minimum standards exist for the health sector to respond to partner and sexual violence against women (see Part B).³¹ However, due to the sensitive nature of VAWG, cultural constraints and negative attitudes and the fact that health professionals (providers, managers and policy makers) are not routinely trained on the health sector response to GBV, there is limited understanding and expertise among VAWG actors to offer clear and concise guidance for health workers, particularly in emergency contexts. This could be further confounded in situations where several forms of abuse co-exist – such as sexual violence and FGC/M – and where children are concerned.³²

Bureaucracy and corruption: Evidence suggests that ‘petty’ or ‘retail’ corruption (when basic public services are sold instead of provided by right) disproportionately affects poor women. Women’s disempowerment and their dependence on public service delivery mechanisms for access to essential services such as health increases their vulnerability to the consequences of corruption-related service delivery deficits - for example when they are charged for services and supplies that should be free. In addition, women’s limited access to public officials and low-income levels diminishes their ability to pay bribes, further restricting their access to basic services.³³

The weak legal and policy environment: National laws and policies regulating domestic violence, sexual violence, harmful traditional practices such as FGC/M and child marriage, access to safe abortion, inheritance rights, marriage and divorce vary widely throughout the world and can even be inconsistent or conflicting within various domestic frameworks. Furthermore, laws criminalising HIV transmission, sex work and drug use, or laws that do not recognise the rights of migrants severely limit access to services. Even in settings where comprehensive laws and policies addressing VAWG exist and are aligned, there are challenges in their implementation, due to lack of technical and financial resources, poor coordination, culturally ingrained attitudes and weak prioritisation of violence issues. Developing legislation on VAWG, including in the context of HIV, is the basis for prevention and response programming.³⁴

4.0 Entry points for addressing VAWG through the health sector

Health programmes have a crucial role to play in responding to VAWG. As figure 1 shows, not only must health services provide appropriate care to survivors of violence, the health system must also support its health care providers to be able to do so effectively. For a successful response, the health system must work in tandem with a wide array of other sectors. The key entry points at different levels within the health system are outlined below (at all levels change needs to be monitored – this is elaborated on in section B).

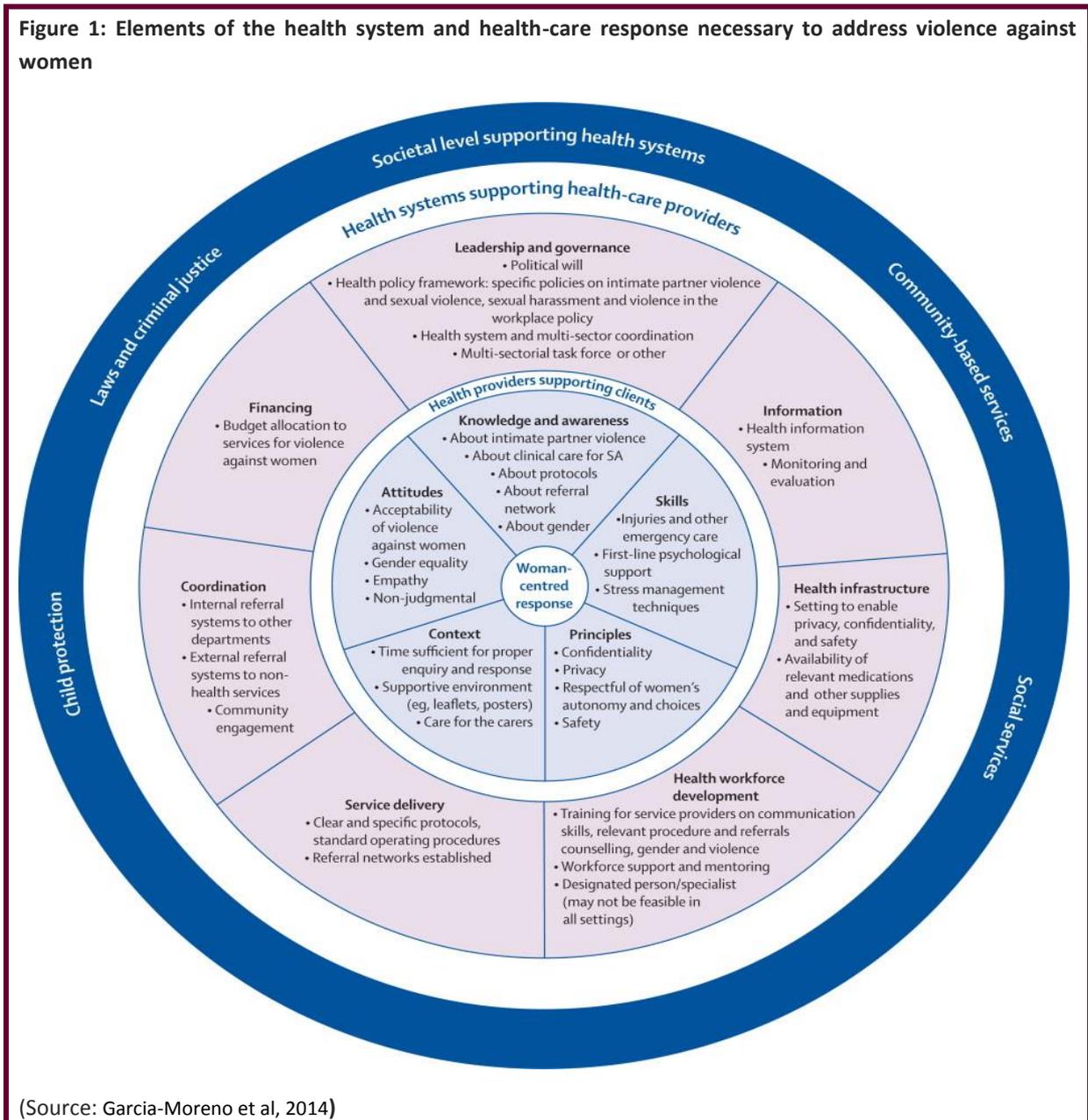
³¹ WHO - http://www.who.int/reproductivehealth/publications/violence/VAW_WHO_Guidelines.jpeg

³² Mwangi and Jaldesa, 2009

³³ Hossain and Nyamu Musembi, 2010

³⁴ Ward, 2011

Figure 1: Elements of the health system and health-care response necessary to address violence against women



(Source: Garcia-Moreno et al, 2014)

Enabling environment: Leadership within health care settings to put in place interventions to motivate and sensitise colleagues is key to ensuring that work to address VAWG gains traction.³⁵ It is important that health sector policy makers and managers establish policies and mechanisms both to address the importance of dignified and respectful treatment of users by health workers and for preventing and dealing with violence against health care workers themselves.³⁶

A system-wide approach within health facilities is essential to ensure delivery of quality medical and psycho-social support to VAWG survivors and women at risk. This should pay attention to the following as well as other areas that are relevant to specific contexts, populations, type of violence and programmes.³⁷

- Policies, protocols and standard operating procedures.
- Infrastructure
- Medical supplies

³⁵ Bacchus et al, 2012

³⁶ Expert contribution from Gladys Mwangi

³⁷ Ward, 2011

- Staff capacity, training and other professional development opportunities
- Adequate financing
- Case documentation and data information management systems
- Functional referral networks (and links with other relevant sectors),
- Safety and risk assessments
- M&E systems.

Linking with other stakeholders and sectors to ensure a holistic response is a cornerstone of an effective response, including:

- Identifying and engaging with key partners for multisectoral collaboration at different levels with other key sectors, such as social services, law enforcement, the judiciary, the security forces or military, and child protection authorities³⁸ (see figure 1).
- Strengthening referral links between health facilities and institutions of justice
- Strengthening coordination of VAWG data collected by health workers (including institutions of justice) through systematic MIS channels.
- Enhancing the role of health care workers in provision of testimonials in court

Service Delivery

Community level: As noted by García-Moreno and colleagues, ‘*Health professionals also have a role in championing primary prevention and being agents of change not only in clinical settings but also in the wider community, for example by promoting the health benefit of delayed marriage for girls.*’ (2014). Entry points at the community and facility level include supporting community health workers and volunteers, traditional birth attendants (TBAs), traditional healers, and NGOs/CBOs who seek in their work to address negative social/gender norms, to improve women and girls’ health and to provide legal and social support to women and girl survivors of violence. Working with community health workers and CBOs can provide numerous benefits to the health sector response to VAWG, including:

- Reaching “hard to reach” women and girls, including those who face high levels of stigma and discrimination (e.g. sex workers or transgender women) and those with limited mobility due to disabilities or social restrictions
- Providing follow-up care to survivors of violence
- Linking women and girls to a range of support services
- Addressing the social norms that underpin violence, including by working directly with men and boys.

Strengthening collaboration with, and support to, local NGOs and CBOs is essential in developing and humanitarian settings including settings where there is a risk of, or those recovering from, crisis. These CBO partners often do not have the capacity to apply for funding and manage grants appropriately, yet they are the first responders during emergencies, know the local context and communities and are also the ones that remain when international NGOs pull out.

Health facility level: Entry points include one-stop centres within the primary health care setting, integrated services within a facility or referrals to other health facilities and non-health services (e.g. police, social and legal support). What is appropriate will depend on specific contexts (e.g. humanitarian), populations (e.g. sex workers, migrants, women and girls living with HIV), types of violence (e.g. IPV, sexual abuse, trafficking, FGC/M) and types

Box 7. WHO Health Systems Building Blocks:

- health service delivery
- health workforce
- Information systems and research
- medical products and technologies
- health systems financing
- leadership and governance

Source: WHO, <http://www.wpro.who.int>

³⁸ Fulu et al, 2014

of programme (e.g. primary health care, ANC, maternal health, family planning).

Key services include (see part B for more detail):

- Identification, treatment and care for survivors of IPV (and other types of violence)
- First line support when women disclose
- Clinical care for survivors of sexual violence
- Psychological support
- Documentation
- The collection of forensic evidence when appropriate
- Information and referral so they can obtain a range of support within and outside of health facilities.³⁹

Capacity building: In order to institutionalise VAWG response into professional practice, it needs to be incorporated into pre- and in-service training curricula. These curricula should include VAWG prevention and response; health and human rights obligations; gender equality and social inclusion; VAWG counselling skills (facility and community level), facilitating networks between community health facilities, facility based health services and other sectors (and with actors interested in, or working on, addressing VAWG), workforce support and mentoring and where possible ensuring a designated person/specialist on site.⁴⁰

5.0 DFID's vision and key outcome areas to address VAWG through health programmes

In line with the Theory of Change on violence against women and girls (VAWG), **DFID aims to make progress towards one key impact through its health programming:**

- Women's and girls' health outcomes improve as a result of the health sector response to VAWG.

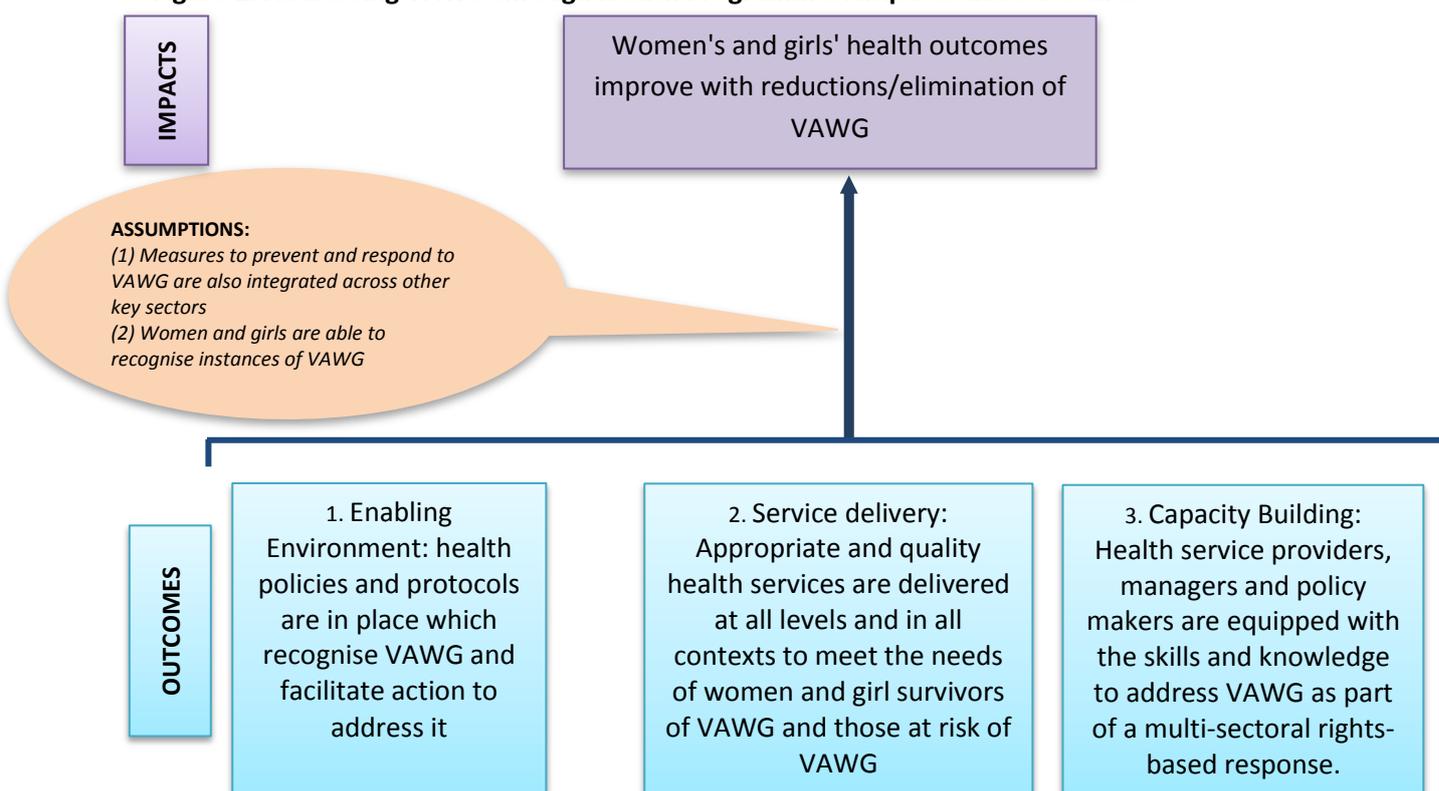
DFID has therefore defined **three outcome areas** in which health programmes can strengthen their approaches to achieve these impacts:

- Outcome 1 - Enabling Environment: health policies, standardised M&E system and protocols are in place which recognise and facilitate action to address VAWG
- Outcome 2 - Service delivery: Appropriate and quality health services are delivered at all levels and in all contexts to meet the needs of all women and girls at risk and VAWG survivors.
- Outcome 3 - Capacity Building: Health service providers, managers and policy makers are equipped with the skills and knowledge to address VAWG as part of a multi-sectoral rights-based response.

³⁹ http://www.who.int/reproductivehealth/publications/violence/VAW_WHO_Guidelines.jpeg

⁴⁰ Garcia-Moreno et al, 2014

Figure 2. Addressing VAWG through Health Programmes: Impacts and Outcomes



Part B of this guidance note provides detailed guidance and suggestions for programming in each of the three outcome areas including key challenges to be addressed, possible entry points and intervention strategies, key lessons, case studies and examples of indicators. The rest of Part A summarises the broad principles and approaches that need to guide programming to address VAWG through the health sector.

6.0 Principles to guide health programming related to VAWG

The general principles outlined in DFID's *Guidance Note 1: A Theory of Change for Tackling Violence Against Women and Girls*,⁴¹ DFID's Framework for Results (DFID, 2010) and DFID's Health Position Paper (DFID, 2013) should inform the design of all DFID programming on VAWG. In the case of health programming specific emphasis should be given to the following principles: context-specific, woman and girl-centred, developmentally-appropriate, inclusive, gender-aware (and where possible transformative), holistic and multi-sectoral, and evidence-based or innovative approaches to enhance accountability. Some principles may be more relevant than others, depending on the particular aims of the programme.

6.1 Context specific

Interventions aimed at preventing and responding to violence in health settings should be based on rigorous analysis of the specific context and tailored to the forms of violence that girls and women experience (including type of violence, populations experiencing violence, risks that exist, and the environment), possible entry points and the resources available to support health facilities, staff and service users to tackle VAWG. It is therefore vital that a **preliminary situation analysis is undertaken early in the programme identification phase** to determine priorities and inform programme design. Cultural diversity *within* countries needs to be accounted for. Key questions on the types and extent of VAWG, and to map actors and initiatives, are proposed in Part B.

⁴¹ DFID, 2012a

In many cases, data and analysis may already be available from different sources to respond to many of these questions and this information should be used before any additional assessment is undertaken to avoid ‘over-researching’ of vulnerable populations. In other cases, particularly in humanitarian and conflict/fragile contexts, not all of this information is likely to be available before starting up programming.

Conflict is often a driver of VAWG, hence **healthcare that integrates an approach to addressing VAWG is even more critical in emergencies**. The Inter-Agency Working Group on Reproductive Health in Crises field manual on Reproductive Health in Humanitarian Settings (2010) includes information on the Minimum Initial Services Package (MISP) and comprehensive reproductive health. One chapter is devoted to gender-based violence, and addresses sexual violence, intimate partner violence, female genital mutilation and child and/or forced marriage. DFID also has guidance on addressing VAWG in emergencies (2013c). Part B considers options for interventions in such contexts.

6.2 Woman and girl-centred and ‘do no harm’ approach (gender aware)

The needs of women and girls are at the heart of DFID health programming. Programmes supporting women and girls at risk and VAWG survivors must be designed to promote their health and, at the very least, provide: firstline support when women disclose, identification and care for survivors of IPV, clinical care and psychological support for survivors of sexual violence, training for health care providers on IPV and sexual violence and integrate VAWG provision into policies and programmes.⁴² They should also minimise risks to survivors. Basic ethics regarding confidentiality, informed consent, appropriate treatment of children/legal minors, safety and security, and upholding the rights, dignity and choice of survivors must be a minimum standard in all interventions. It is also critical that risk factors to survivors seeking services are identified and mitigated (such as perpetrators coming to services with survivors, police known to be abusive of women, community punishment for women seeking services).⁴³

Box 8: Basic precautions to protect women’s lives, health, and well- being include:

- Protection of women’s privacy and confidentiality.
- Healthcare providers with adequate knowledge, attitudes, and skills to offer the following:
 - A compassionate, non-judgmental response that clearly conveys the message that violence is never deserved and women have the right to live free of violence.
 - Appropriate medical care for injuries and health consequences, including STI and HIV prophylaxis and emergency contraception post-rape.
 - Information about legal rights, and any legal or social service resources in the community.
 - Assessment of when women might be in danger and provision of safety planning for women in danger.
 - Safe and reliable referrals to services not available in the facility.

Source: Ward, 2011

6.3 Promoting empowerment and accountability

Evidence shows that interventions to address VAWG are most effective when they prioritise women’s needs and rights, are accountable to them, and include their empowerment and rights as both means and ends in themselves (see Principle 1.7 on p. 11 of the DFID *Guidance Note 1: A Theory of Change for Tackling Violence Against Women and Girls*). Women and girls involved in the prevention and response to VAWG (individually or via community structures) can be well-placed (both in terms of relationships as well as experience and understanding of this work) to inform programme design, collect data and monitor the uptake (and experience) of health services, patterns of VAWG at the community level, and many other intended outcomes of VAWG programming. By involving beneficiaries and other key stakeholders, and

⁴² http://www.who.int/reproductivehealth/publications/violence/VAW_WHO_Guidelines.jpeg

⁴³ IRC, 2012

providing skills for the design and M&E process, it can be made more sustainable and targeted. It may also be possible to collect data that would otherwise be inaccessible or overlooked.⁴⁴

6.4 Inclusive

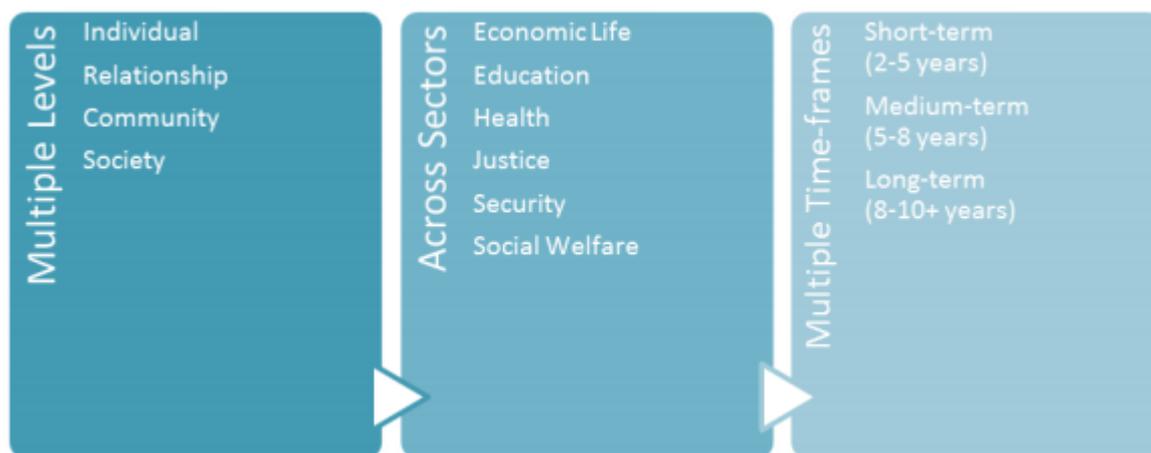
Intervention programmes need to reach and address the needs of the most vulnerable women and girls: the poorest, marginalised and stigmatised including in rural and conflict affected areas, including adolescents, women and girls with disabilities, women and girls who are engaged in the sex trade and/or use drugs, indigenous populations or ethnic minorities, transgender women and women and girls living with HIV, among others. It may be appropriate, for example, to screen for VAWG in specific services and among specific at risk populations. Critical to an effective approach will be the addressing of stigma and discrimination that certain populations experience in health services.

6.5 Holistic and multi-sectoral⁴⁵

While the health sector has a key role to play in addressing VAWG, it cannot do everything. For efficiency and effectiveness, responses must play to the sector’s strengths and establish referral mechanisms to other sectors where appropriate (legal services; police; economic support). Interventions are more likely to be effective when they work in partnership with stakeholders at all levels of the health sector and use a coordinated, multi-sectoral approach with other key sectors, such as social services, law enforcement, the judiciary, the security forces or military, and child protection authorities⁴⁶ (see figure 2). This is in order to ensure that the immediate and ongoing needs of survivors (e.g. for medical treatment, psychosocial support, shelter, economic and legal support) are met, and to bring about sustainable changes in the underlying factors that contribute to VAWG.

Interventions should also engage over multiple time-frames and at multiple levels (see Figure 3), including at the national level (e.g. Ministries of health, women’s organisations and civil society groups), the regional level (e.g. regional and district health officers), facility and community-based level (e.g. health workers, local women’s organisations and civil society groups). The sequencing and timing of interventions is also important in order to work within (and address) the realities of a particular political and institutional context; to ensure that the needs and priorities of VAWG survivors are respected; to determine the appropriate level of ambition in terms of expected results; and to define realistic programme timeframes.⁴⁷

Figure 3: DFID’s Theory of Change: holistic and multi-sectoral approaches are more likely to have impact⁴⁸



⁴⁴ DFID, 2012b; WHO, 2014; Shepard (nd)

⁴⁵ Adapted from Fancy and McAslan Fraser, 2014

⁴⁶ Fulu et al, 2014

⁴⁷ DFID, 2012a

⁴⁸ DFID, 2012a: p.8

6.6 Evidence-based or innovative

Given the limited evidence base there is space for innovation and for ensuring that interventions supported are accompanied by robust M&E processes. DFID is also committed to strengthening the evidence base through improved health information systems. Health programmes usually collect data on processes rather than on results or outcomes and may not focus on whether their activities were beneficial or effective, so it is important to collect both (see Bloom 2008 for examples of results indicators).⁴⁹ It is also vital to include indicators to assess the acceptability of services to users. This list can be adapted to include indicators that capture shifts in norms and progress on promoting empowerment and accountability of and by service users (see part B).

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⁴⁹ Ward, 2011

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Annex 1: UK Government's commitments to VAWG and Health

Ending VAWG⁵⁰ is a top priority for the UK Government, which has made a number of international commitments:

- The UK is a signatory of Committee on the Elimination of Discrimination against Women (CEDAW), UN Convention on the Rights of the Child (CRC), International Covenant on Economic, Social and Cultural Rights (UNESCR). While CEDAW has n specific provision for violence against women, the Committee's General Recommendation no 19 (GR19) fills this gap by clarifying that GBV against women is a form of discrimination and therefore covered by the scope of CEDAW (Article 2: comprehensive state obligation to eliminate discrimination against women; Article 5 :elimination of prejudices and practices, based on the stereotyped roles of women and men; Article 16: elimination of discrimination against women in marriage and family relations: equality of women and men, same rights and responsibilities. GR19 defines VAWG as "*violence that is directed against a woman because she is a woman or that affects women disproportionately*", and includes "*acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.*" GR 19 also specifies that GBV may constitute a violation or women's human rights, such as the right to life, the right to equal protection under the law; the right to equality in the family; or the right to the highest standard attainable of physical and mental health. (Source: CEDAW General Recommendation No. 19 on VAWand discrimination against women includes gender-based violence. The UNESCR commits States to 'ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant' under Article 3.
- The UK is a signatory to international commitments on VAWG including the [UN Declaration on the Elimination of Violence against Women](#) (1993) [UN Security Council Resolution 1325 on Women, Peace and Security](#) (2000) and subsequent, related resolutions - [SCR 1820](#) (2008), [SCR 1888](#) (2009), [SCR 1889](#) (2009), [SCR 1960](#) (2010), [SCR 2106](#) (2013) and [SCR 2122](#) (2013). These binding agreements set out a framework of commitments to improve the protection of women and girls and promote their rights in conflict and post-conflict situations.
- In 2013, the UK played a leading role in delivering a successful outcome at the [UN Commission on the Status of Women](#) (CSW 57), which commits UN member states to comprehensive measures to eliminate and prevent all forms of VAWG across all contexts.
- In November 2013, the DFID-organised Call to Action event '[Keep Her Safe](#)' committed countries and humanitarian agencies to protecting girls and women in emergencies.
- Agreed conclusions (relevant to VAWG) at the [58th Commission on the Status of Women](#) including: Reaffirms commitment to the full and effective implementation of and follow-up to the Declaration on the Elimination of VAW; Recognises that VAW impedes social and economic development, as well as the achievement of the MDGs; Commits member states to eliminating all forms of VAWG in public and private spaces, through multi-sectoral and coordinated approaches to prevent and respond to VAWG.
- The UK is also working to ensure that the [post-2015 development framework](#) includes strong commitments on VAWG.
- As part of its G8 Presidency, the UK worked hard to secure the [G8 Declaration on Preventing Sexual Violence in Conflict](#), adopted in April 2013. This sets out commitments to assist conflict-affected countries in ensuring that their future national security sector and justice reform programmes are gender and child-sensitive and are designed to deter and address gender-based violence, including sexual violence, and promote the full participation of women. Support should be provided to both state and non-state service providers where appropriate.

The UK's international commitments are also matched by a **robust framework of UK national commitments**:

- In November 2010, the UK Government published its [Call to End Violence Against Women and Girls: Strategic Vision](#) and updated it in [2014](#), followed by annual action plans in [2011](#), [2012](#) and [2013](#) and

⁵⁰ DFID acknowledges the importance of preventing and responding to the sexual and gender-based violence suffered by women, men, boys and girls. However, the focus of this How to Note is on women and girls, given that this is the focus of UK Government policy.

2014. These set out specific actions for government departments, including DFID, the FCO and MOD, to work together to make progress towards ending VAWG in the UK and overseas.

- [The UK's Framework for Results for Improving Reproductive, Maternal and Newborn Health in the Developing World](#) outlines the government commitment to support locally-led social change of norms that constrain women's choice, control over resources and body (eg early marriage, FGM/C, violence, cultural preferences for sons), respond to survivors of sexual and other violence, particularly but not only in conflict affected areas and tackle the drivers of HIV including GBV.

Preventing VAWG is also a **priority for DFID's Ministerial team:**

- [DFID's Business Plan \(2011-15\)](#) commits DFID to pilot new and innovative approaches to prevent VAWG and to help 10 million women to access security and justice services by 2015.
- Preventing VAWG is also one of four pillars in [DFID's Strategic Vision for Girls and Women](#) (2011), which includes support to *"reform and strengthen security services, police, and policy and decision making bodies to improve women's access to security and justice services"*. It also stresses the need to Support the "enabling environment" by challenging discriminatory attitudes & behaviours, increasing the value given to girls and women; building effective legal frameworks to protect rights of women and girls; increasing the power of women to make informed choices and control decisions that affect them.
- The UK government has expressed its continued commitment to the key role of health as part of the [Millennium Development Goals \(MDGs\)](#) and the [post-2015 development framework](#), as well as the broader [Health for All Goals](#).
- DFID Health Position paper '[Delivering Health Results](#)' (2013) acknowledges the importance of social determinants of health including 'insufficient investment in the social, economic and environmental determinants of health.... Including child marriage, female genital cutting and violence against women and girls, alongside supporting women's economic empowerment and women's political participation and leadership'.

Related guidance and resources

For more detailed information on DFID's Theory of Change on VAWG and overall approach to addressing VAWG, consult the guidance note: ['A Theory of Change for Tackling Violence Against Women and Girls'](#).

For more detail on programming approaches that can be taken at the community level across a range of sectors, please consult the guidance note: ['A Practical Guide to Community Programming on Violence against Women and Girls'](#).

For more detailed guidance monitoring and evaluation (M&E) on VAWG, please consult the guidance note: ['Guidance on Monitoring and Evaluation for Programming on Violence against Women and Girls'](#).

For more detailed guidance on addressing VAWG in:

- [humanitarian emergencies](#)
- [security and justice programmes](#)
- [the health sector](#)
- [through economic development](#).

Other guidance on addressing VAWG through programming in different sectors will be made available on the [Gov.uk website](#).