AHO STRATEGY AND PLAN OF ACTION FOR VIOLENCE AGAINST WOMEN

AFRICA HEALTH ORGANISATION

JOSHUA OSBORN

BS CRIMINOLOGY, UNIVERSITY OF BRISTOL


ACDC
AFRICAN CENTRE FOR DISEASE PREVENTION AND CONTROL


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Introduction

Violence against women can inflict physical and mental long-term harm to the victims, their families and children as well as the local community. The Africa Health Organisation (AHO) recognises that to achieve their vision of "delivering high quality sustainable health service" and "ensuring that all the peoples of Africa enjoy optimal health", the gender implication of health must be acknowledged. This report examines the prevalence of physical and/or sexual intimate partner violence and the prevalence of sexual violence by a non-partner in Africa and makes comparisons between other continents. As well as discussing findings and existing policy, new recommendations are made which takes into consideration the relationship between global pandemics and violence against women.

Forms of violence against women

Violence against women in Africa is extremely prevalent, with one in three women being affected (AHO, 2019). However, violence against women is frequently considered a 'silent epidemic' due to the existing barriers (fear, stigma, financial or cultural attitudes) preventing women from reporting their victimisation (Muluneh et al, 2020). Forms of violence against women can be compartmentalised into five sub-definitions including intimate partner violence, severe intimate partner violence, current intimate partner violence, prior intimate partner violence and non-partner sexual violence (see figure 1).

Term	Definition for this review
Intimate partner violence[a]	Self-reported experience of one or more acts of physical and/or sexual violence by a current or former partner since the age of 15 years.[b] • Physical violence is defined as: being slapped or having something thrown at you that could hurt you, being pushed or shoved, being hit with a fist or something else that could hurt, being kicked, dragged or beaten up, being choked or burnt on purpose, and/or being threatened with, or actually, having a gun, knife or other weapon used on you. • Sexual violence is defined as: being physically forced to have sexual intercourse when you did not want to, having sexual intercourse because you were afraid of what your partner might do, and/or being forced to do something sexual that you found humiliating or degrading.[c]
Severe intimate partner violence	Is defined on the basis of the severity of the acts of physical violence: being beaten up, choked or burnt on purpose, and/or being threatened or having a weapon used against you is considered severe. Any sexual violence is also considered severe.
Current intimate partner violence	Self-reported experience of partner violence in the past year.
Prior intimate partner violence	Self-reported experience of partner violence before the past year.
Non-partner sexual violence	When aged 15 years or over,[b] experience of being forced to perform any sexual act that you did not want to by someone other than your husband/partner.

Figure 1 - Working definitions of forms of exposure to violence (WHO, 2013).

Findings

Using indicators outlined by the WHO (2014), it is possible to gauge the magnitude of violence against women in Africa compared to other Global Burden of Disease (GBD) continents. A consensus was reached to monitor global levels of violence against women using two indicators:

1) Prevalence of physical and/or sexual intimate partner violence in the last 12 months as measured by: the proportion of ever-partnered women (15-49) who experienced physical and/or sexual violence by a current or former husband/male intimate partner in the last 12 months; and

2) Prevalence of sexual violence by a non-partner as measured by: the proportion of women (aged 20-29) who have ever experienced sexual violence by a non-partner from the age of 15 on.

Intimate partner violence is considered a human rights breach which conclusively damages women's physical and mental health (Devries, K et al, 2013). Prevalence of intimate partner violence is not standardised and can vary depending on the region (Cools and Kotsadam, 2017). Figure 2 denotes Sub-Saharan Africa (Central) has the highest prevalence of intimate partner violence of 65.64% compared to 23.68% identified in Sub-Saharan Africa (Southern), the lowest prevalence within Africa.

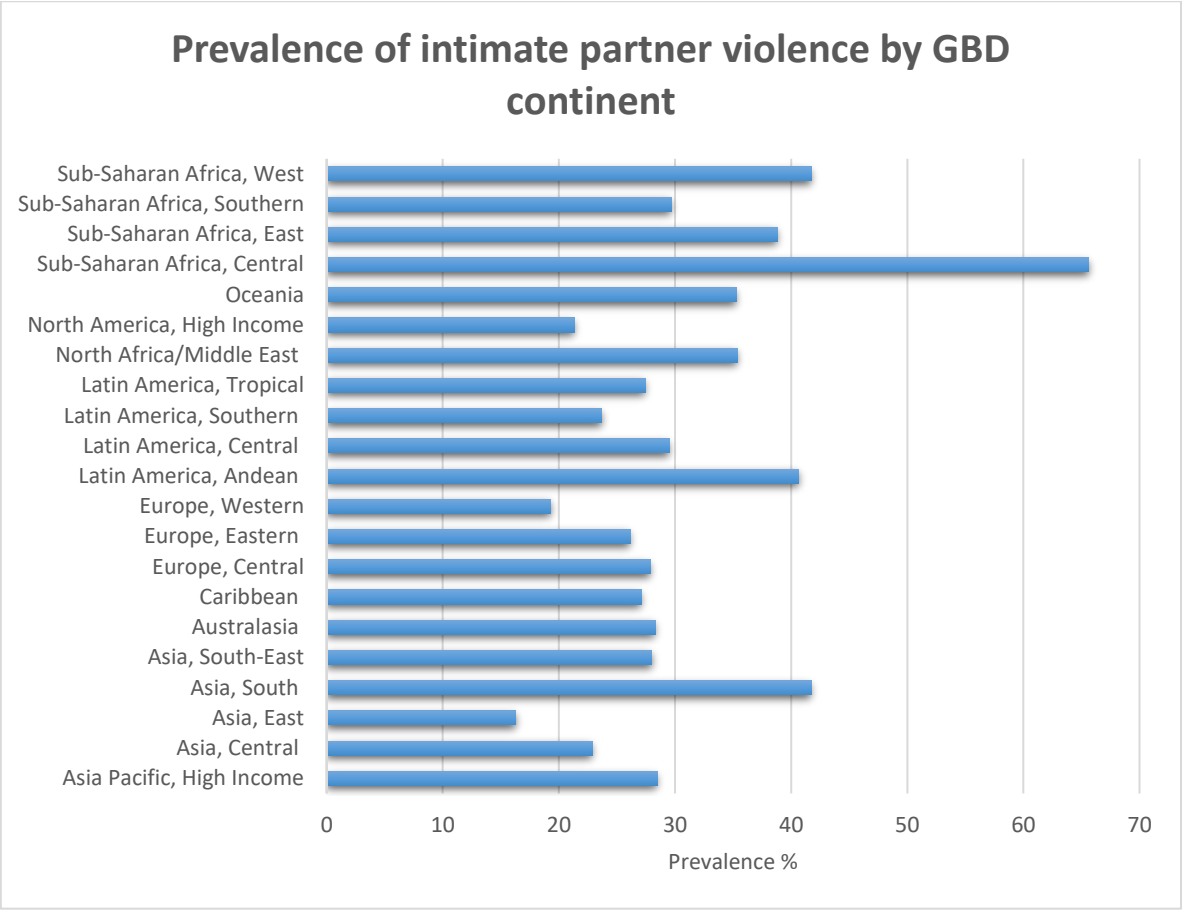

Figure 2 - Comparing the prevalence of intimate partner violence between GBD continents (WHO, 2013).

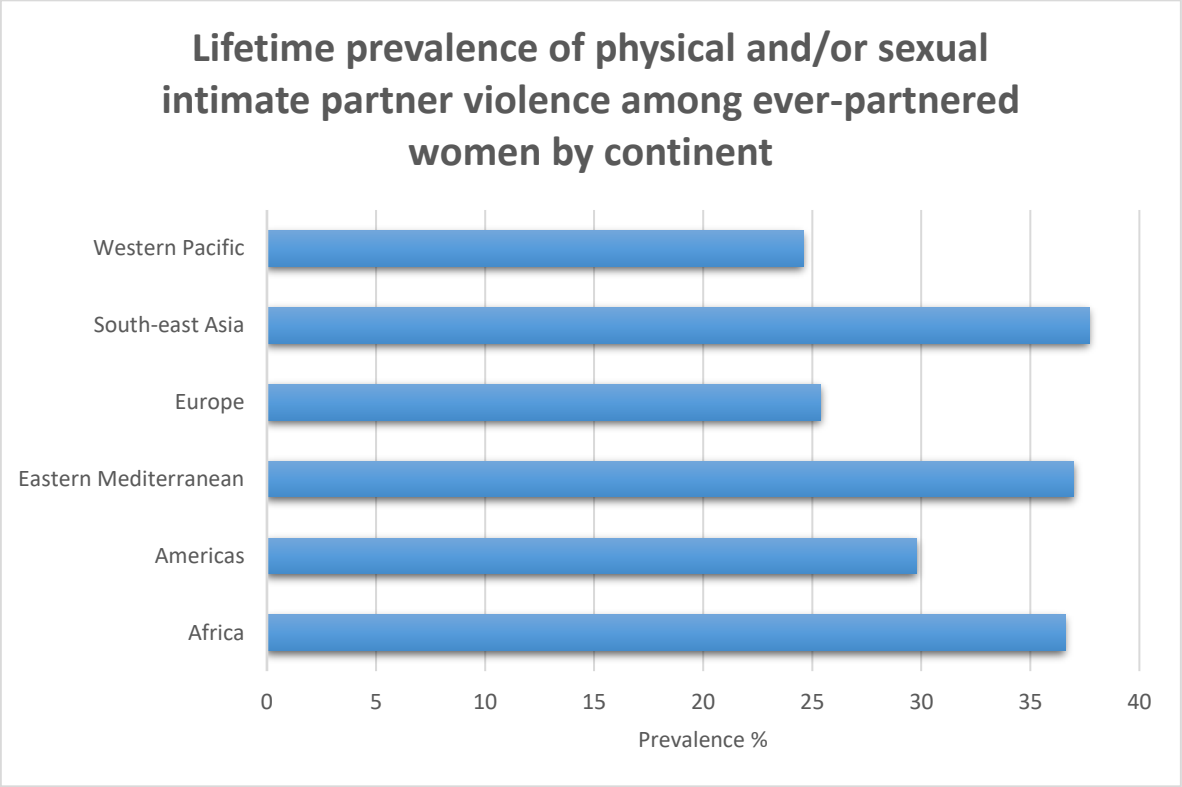

Figure 3 - Comparing the lifetime prevalence of physical and or/sexual intimate partner violence among ever-partnered women by continent (WHO, 2013).

Non-partner sexual violence shares related health outcomes associated with intimate partner violence such as pregnancy loss and sexually transmitted infections (STIs) (Durevall and Lindskog 2015). However, sexual violence from non-partners can be correlated with an increased possibility of STI symptoms and levels of depression and anxiety (Mathur et al, 2018). Figure 4 determines that the prevalence of non-partner sexual violence by GBD continents is highest in Sub-Saharan Africa (Central) at 21.05% compared to 9.15% identified in Sub-Saharan Africa (West), the lowest prevalence within Africa.

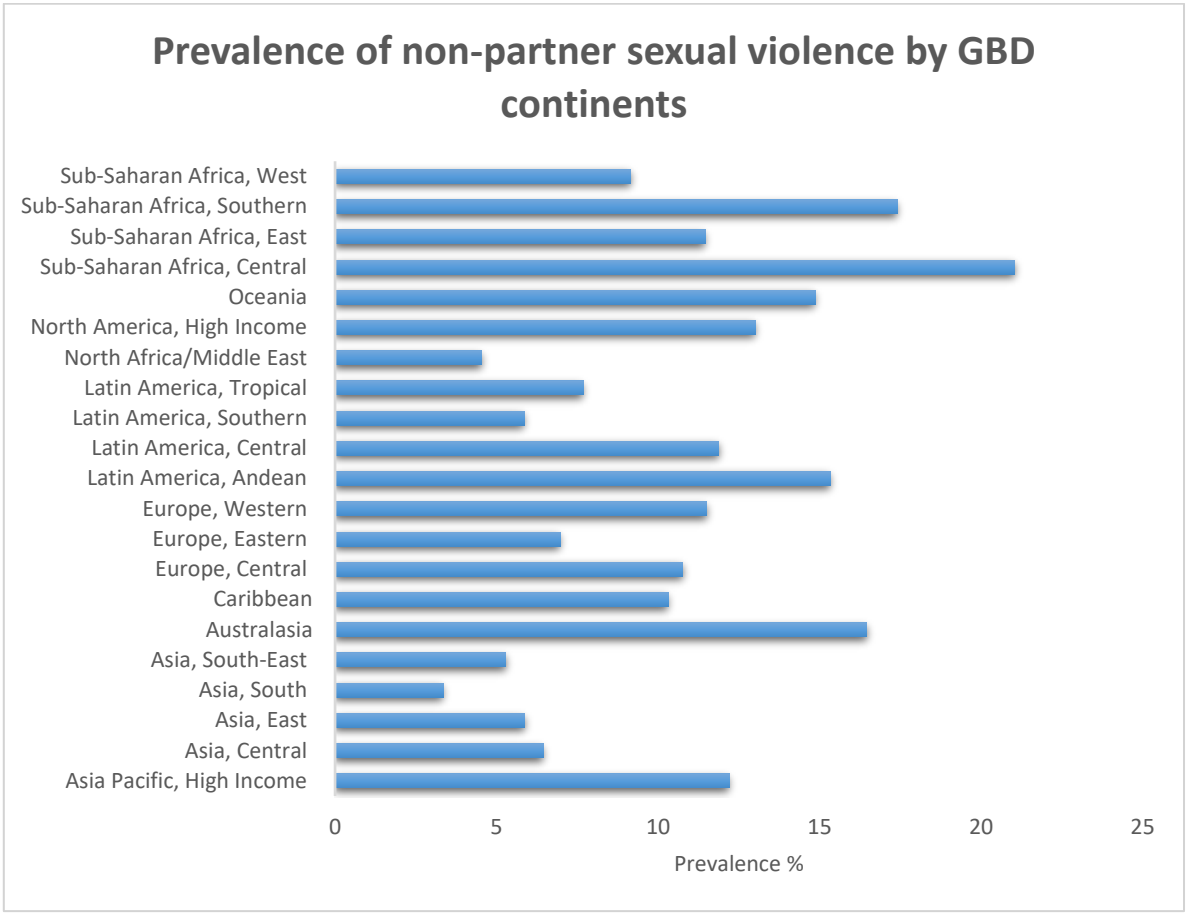

Figure 4 - Comparing the prevalence of non-partner sexual violence between GBD continents (WHO, 2013).

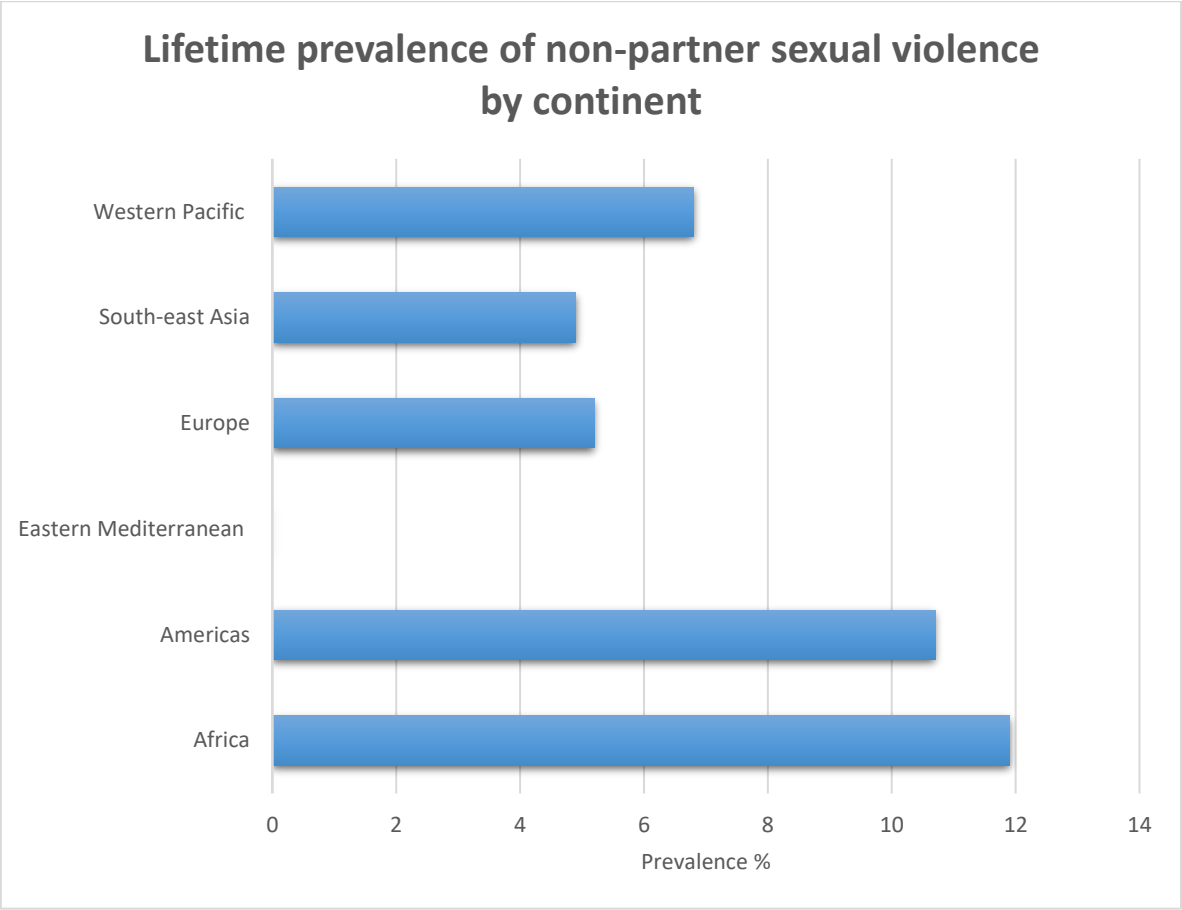

Figure 5 - Comparing the lifetime prevalence of non-partner sexual violence between continents (WHO, 2013).

When comparing lifetime prevalence of intimate partner violence (physical and/or sexual) or non-partner sexual violence or both among all women (15 years and older) between continents, Africa has the highest prevalence percentage at 45.6%.

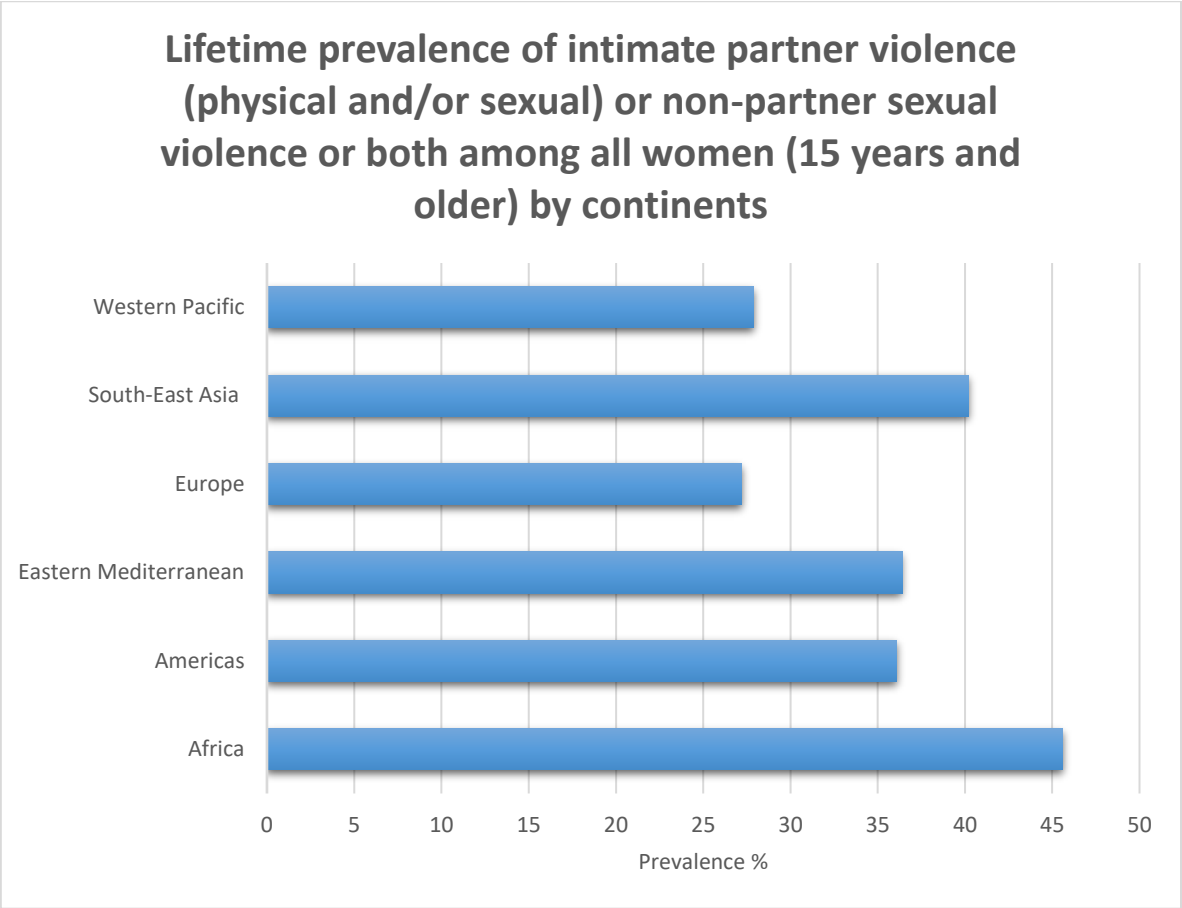

Figure 6 – Comparing the lifetime prevalence of intimate partner violence or non-partner sexual violence or both among all women between continents (WHO, 2013).

Consequences of violence against women

There are two immediate effects of intimate partner violence, fatality and injury (Plichta, 2004). Moreover, other physical outcomes of intimate partner violence can include but are not limited to disability, chronic pain, substance abuse, reproductive issues and unsuccessful pregnancy outcomes (ibid). However, intimate partner violence can prompt a myriad of consequences that go beyond the initial physical abuse (Durevall and Lindskog, 2015) (see figure 7). Physical outcomes of intimate partner violence can create pathways to psychological and emotional harm to the victim. As well as this, intimate partner violence can cause external harm and psychological stress to the witnesses of violence (Jewkes, 2002). Traumatic stress generated from intimate partner violence combined with a fear of seeking healthcare advice and assistance forces victims into isolation (WHO, 2013). Subsequent feelings of depression and suicidal behaviour are increased (Hyde, 2008). Despite these identified pathways and outcomes, the existing data is limited with most research being conducted in a cross-sectional fashion (WHO,2013). As a result of this, temporality or causality between immediate and secondary outcomes cannot be determined (ibid). Nevertheless, the physical and psychological consequences of violence against women are real and further research should be conducted to conclusively highlight the pathways and health effects on intimate partner violence.

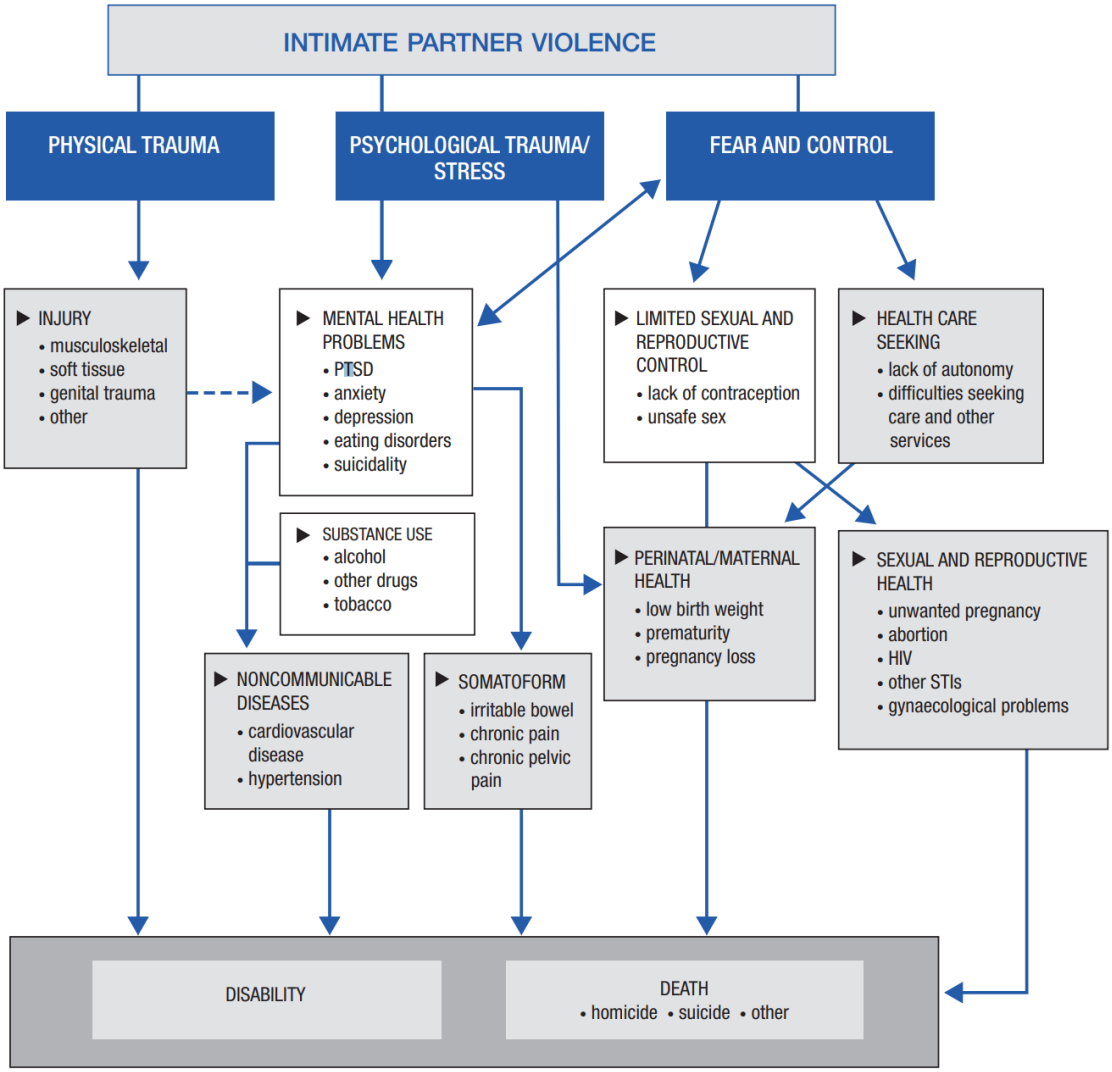

Figure 7 – Displays the pathways and health effects on intimate partner violence.

Existing Policy

An international effort led by The European Union (EU) and the United Nations (UN) has established the Spotlight Initiative intending to eliminate all violence against women (UN, undated). The Spotlight Initiative prioritises the principle of 'leaving no one behind' whilst following the 2030 Agenda for Sustainable Development (ibid). Similarly, the AHO (2019) share the overall goal of the reduction/eradication of violence against women. To achieve this goal, the AHO has outlined four goals as a part of their Strategy and Plan of Action of Strengthening the Health System to Address Violence Against Women in Africa.

Goal 1 - Strengthen the availability and use of evidence about violence against women

As much as it is important to collect data regarding violence against women, this data must be representative of age, ethnicity and socio-economic status and, ideally, can determine temporality between violence and pathways of trauma (WHO,2013; Walby, 2005). Not only does this enable initiatives and policy to be more effective, but it also highlights how social detriments affect violence against women. Furthermore, it would be beneficial if longitudinal studies took

place to measure levels of violence over time (AHO,2019). As well as this, repeated data collection would indicate whether interventions are causing further harm (ibid).

Goal 2 - Strengthen political and financial commitment to addressing violence against women within health systems

The AHO (2019) recognises that health care systems play a vital role in addressing violence against women. Although some public services do collect information relating to domestic violence, it is rarely applicable to policy (Walby, 2005). Despite this, commitment and implementation of plans to end violence against women require a cross-departmental approach involving, policymakers, academics, legislators, national human rights commissions, law enforcement agencies, civil society and women's organizations and community members (AHO, 2019). National implementation plans require a multi-sector coordinated commitment to encourage accountability to succeed (Michau et al, 2015).

Goal 3 - Strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or non-partner sexual violence

The health care systems in Africa must be prepared to provide survivors of violence physical and emotional care, safety and support their individual needs (AHO, 2019). Given the disproportionate number of racially and ethnically marginalized women, healthcare should consider intersectional requirements to best deliver care. To maximise the effectiveness of care, health systems should engage with health, criminal justice, security, faith, education, and civil society sectors to provide additional support across the social ecology to achieve structural change (Michau et al, 2015). Furthermore, the cost of implementing policy varies due to geographical location, reach and policy components. Therefore, it is important to conduct a cost-effective analysis to determine the value for money of interventions (Torres-Reuda, S et al, 2020).

Goal 4 - Strengthen the role of the health system in preventing violence against women.

To eradicate violence against women, prevention should take the forefront of policy initiatives which involves raising awareness as a public health concern (AHO,2019). A priority should be to challenge existing attitudes and social norms regarding violence. Currently, 15-19-year olds living in Africa disproportionately justify violence in a relationship (see figure 8). Programmes which condone gender inequality and violence, promote non-violent relationships and support learning can directly strengthen the role of the health system in preventing violence against women. Furthermore, these programmes of change should amalgamate to reinforce each other's learning objective rather than stand as independent from one another (Michau et al, 2015).

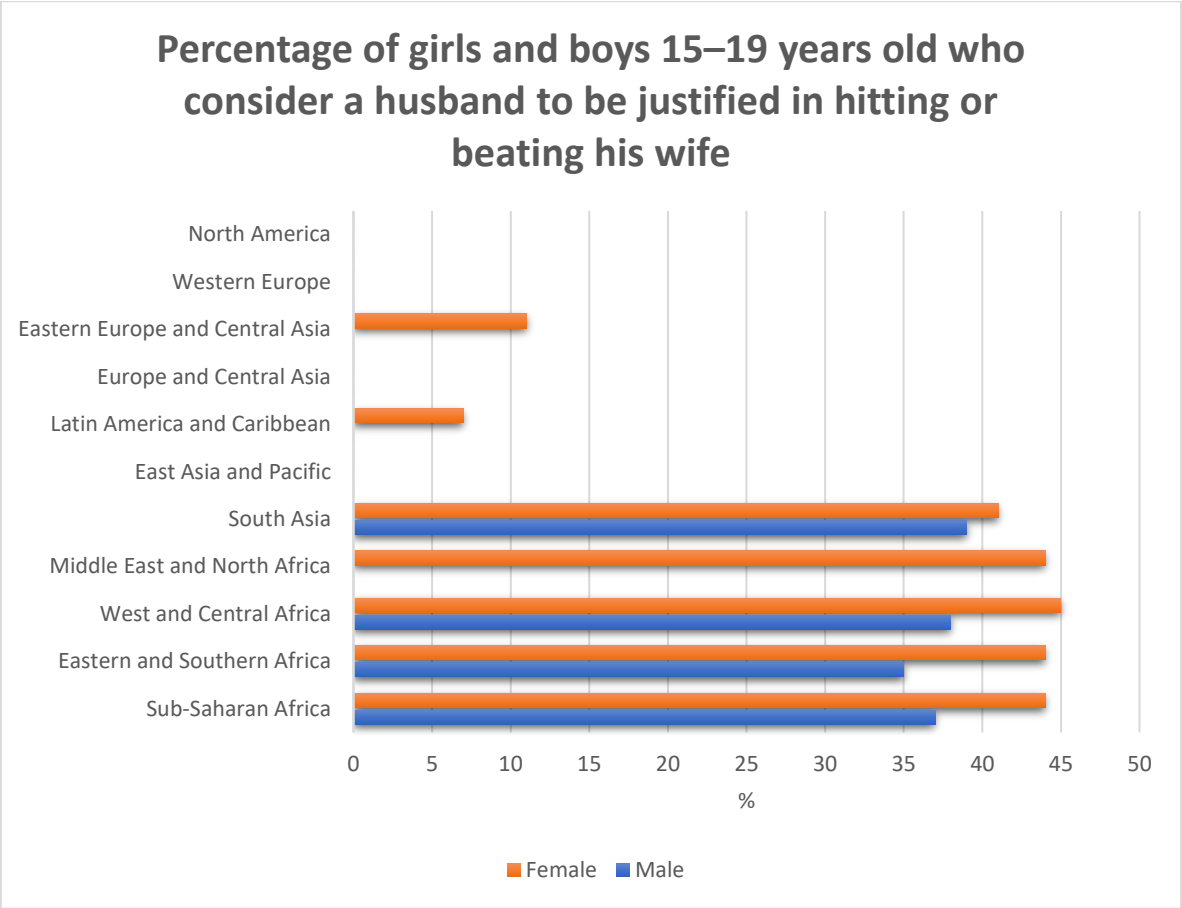

Figure 8 – Comparing the percentage of girls and boys 15–19 years old who consider a husband to be justified in hitting or beating his wife for at least one of the specified reasons, i.e., if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations between continents (Unicef, 2020).

Violence against women and COVID-19

Global pandemics can instigate economic uncertainty and civil unrest, which is associated with risk factors that can increase violence against women and children (Peterman et al, 2020). The COVID-19 pandemic is no exception with women's organizations, human rights activists, governments, non-governmental organizations and the United Nations denouncing a sharp increase in violence against women (Ndedi, 2020). More specifically, Kenya, South Africa and Uganda have all experienced an increase in the prevalence of domestic and sexual violence against women (ibid). As a result of the ongoing pandemic, several pathways of violence have been highlighted including (Peterman et al, 2020):

1) Economic insecurity and poverty-related stress.

2) Quarantines and social isolation.

3) Disaster and conflict-related unrest and instability.

4) Exposure to exploitative relationships due to changing demographics.

5) Reduced health service availability and access to first responders.

6) Inability of women to temporarily escape abusive partners.

7) Virus-specific sources of violence.

8) Exposure to violence and coercion in response efforts.

9) Violence perpetrated against health care workers.

To combat these pathways of violence, a gender-informed policy approach must be taken to evade additional violence against women during the COVID-19 pandemic but also future epidemics (Willmer, 2020). Appropriate training should be conducted that prepares care providers for a surge in violence against women cases at the start of any pandemic (Peterman et al, 2020).

Furthermore, security, health, and money related concerns are exacerbated when living in confined conditions (Ndedi, 2020). An increase in social assistance, such as monetary, will enable victims of violence to continue to access other services. Additionally, expanding temporary shelter for victims provides an instant method of refuge for victims of violence (Peterman et al, 2020).

The social and economic cost of responding to violence against women is substantial (Johnson and Dawson, 2011). Education and advocacy are essential to prepare for surges in violence against women during a pandemic. Awareness should be raised about the increased prevalence of violence against women during COVID-19, this includes media outlets (Ndedi, 2020). Moreover, stakeholder engagement should be prioritised ensuring the private sector are informed on how to prevent and respond to violence against women, especially those who work from home because of COVID-19 (ibid).

Summary

The prevalence of violence against women in Africa is undeniably disproportionate in comparison to other continents. Campaigns such as the Spotlight Initiative have generated the necessary attention to raise awareness of the global issue, whilst the AHO has also established their goals required to eradicate violence against women in Africa. In consideration of the COVID-19 pandemic, a reformed approach to tackling violence against women must be taken in response to the unique pandemic environment. Not only is this relevant for the ongoing COVID-19 virus, but also future pandemics.

References

AHO (2019) 'AHO Strategy and Plan of Action of Strengthening the Health System to Address Violence Against Women in Africa' *(available at) https://aho.org/wp-content/uploads/2019/03/AHO-Strategy-and-Plan-of-Action-on-Strengthening-the-Health-System-to-Address-Violence-Against-Women.pdf (accessed 20/11/2020).*

Cools, S., Kotsadam, A (2017) 'Resources and Intimate Partner Violence in Sub-Saharan Africa'. *World Development, 95(no issue). Pp, 211-230.*

Devries. K.M., Mak, J.Y., Garća-Moreno, C., Petzold, M., Child, J.C., Falder, G., Rosenfeld, L (2013) 'The global prevalence of intimate partner violence against women'. *Science, 34(6140). Pp, 1527-1528.*

Durevall, D., Lindskog, A (2015) 'Intimate partner violence and HIV in ten sub-Saharan African countries: what do the Demographic and Health Surveys tell us'. *The Lancet Global Health, 3(1). Pp, 34-43.*

Hyde, J.S., Mezulis, A.H., Abramson, L.Y (2008) 'The ABCs of depression: integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression'. *Psychological Review, 115(2). Pp, 291–313.*

Jewkes, R (2002) 'Intimate partner violence: Causes and prevention'. *The Lancet, 359(no issue). Pp, 1423-1429.*

Johnson, H., Dawson, M (2011) 'Violence Against Women in Canada: Research and Policy Perspectives'. *Don Mills, Ontario. Oxford University Press Canada.*

Mathur, S., Okal, J., Musheke, M., Pilgrim, N., Patel, S.K., Bhattacharya, R., Jani, N., Matheka, J., Banda, L., Mulenga, D., Pulerwitz, J (2018) 'High rates of sexual violence by both intimate and non-intimate partners experienced by adolescent girls and young women in Kenya and Zambia: Findings around violence and other negative health outcomes'. *PLoS ONE 13(9) (no Pp) (available at) https://doi.org/10.1371/journal.pone.0203929 (accessed 15/12/2020).*

Michau, L., Horn, J., Bank, A., Dutt, M., Zimmerman, C (2015) 'Prevention of violence against women and girls: lessons from practice'. *The Lancet, 385(9978). Pp, 1672-1684.*

Muluneh, M.D.,Stulz, V., Francis, L., Agho, K (2020) 'Gender Based Violence against Women in Sub-Saharan Africa: A Systematic Review and Meta-Analysis of Cross-Sectional Studies'. *Environmental Research and Public Health, 17(3). Pp, 1-23.*

Ndedi, A (2020) 'Framework in Ending Violence Against women and Girls with the Advent of the COVID 19 from an African Perspective'. *(available at) http://dx.doi.org/10.2139/ssrn.3575288 (accessed 11/12/2020).*

Peterman, A., Potts, A., O'Donnell, M., Thompson, K.,Shah, N., Oertelt-Prigione, S., van Gelder, N (2020) 'Pandemics and Violence Against Women and Children'. *CGD Working Paper 528. Washington, DC: Center for Global Development. (available at) https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children (accessed 11/12/2020).*

Plichta, S. B (2004) 'Intimate Partner Violence and Physical Health Consequences: Policy and Practice Implications'. *Journal of Interpersonal Violence, 19(11). Pp, 1296–1323.*

Torres-Rueda, S., Ferrari, G., Orangi, S., Hitimana, R., Daviaud, E., Tawiah, T., Kyerewaa, R., Prah, D., Karmaliani, R., Kapapa, E., Barasa, E., Jewkes, R., Vassall, A (2020) 'What will it cost to prevent violence against women and girls in low- and middle-income countries? Evidence from Ghana, Kenya, Pakistan, Rwanda, South Africa and Zambia'. *Health Policy and Planning, 35(7). Pp, 855-866.*

UN (undated) 'Ending Violence Against Women and Girls'. *(available at) https://www.un.org/sustainabledevelopment/ending-violence-against-women-and-girls/ (accessed 30/11/2020).*

Unicef (2020) 'Attitudes and social norms on violence' *(available at) https://data.unicef.org/topic/child-protection/violence/attitudes-and-social-norms-on-violence/ (accessed 20/11/2020).*

Walby, S (2005) 'Improving the Statistics on Violence Against Women'. *Statistical Journal of the United Nation, 22(no issue). Pp, 193-216.*

WHO (2013) 'Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence'. *(available at) https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf;jsessionid=1FF448CE8508FB0DF29274B23A25ABF9?sequence=1 (accessed 18/11/2020).*

WHO (2014) 'Consensus on priority indicators on violence against women'. *(available at) https://www.who.int/reproductivehealth/topics/violence/vaw-indicators/en/ (accessed 18/11/2020).*

Willmer, G (2020) ''Gender blind' coronavirus policies could hinder disease fight'. *(available at) https://www.scidev.net/global/news/gender-blind-coronavirus-policies-could-hinder-disease-fight/ (accessed 15/12/2020).*