Accelerating Health Sector Response to Sexual and Gender-Based Violence

At a glance

- Sexual and Gender Based Violence (SGBV) which refers to any act of violence and coercion that is committed against a person's will because of gender norms and power inequalities can be physical, sexual emotional and psychological in nature, and is made up of intimate and non-partner violence.
- On the average, almost 40% to over 50% of women in the Pacific have experienced intimate partner violence across their life course; compared to less than 30% globally.
- As the likely 1st point of contact for most women and girl survivors of SGBV, the health sector is in a unique position to identify, prevent and respond to cases of violence, and facilitate referral for other support services including legal and social protection services.
- However, Health Facility Readiness and Service Availability Assessments (HFRSAA) across 8 PICs reveal that less than 4% of facilities in any country meet the quality requirements of health workforce capacity and numbers, job Aids and tools, medicines and supplies and conducive facility environment to provide SGBV services.
- According to SDG target 5.2 and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which most PICs have ratified, zero tolerance to SGBV is a goal, and the most opportune place to start in achieving it, is by accelerating the health sector response to it.

Current situation

The Pacific has some of the world's highest rates of physical and sexual violence against women. The DHS/MICs surveys and National Violence against Women (VAW) Studies 2005-2020 for PICs, reveal an average of 39- 51% of women have experienced sexual or physical violence at the hands of their intimate partners in their lifetime, with Fiji, Kiribati and Solomon Islands ranking highest at 64%, 67% and 64% respectively, compared to an average of 27% globally (Figures 1 and 2).

While most PICs have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and have legislation and policies that criminalize GBV and seek to improve the Sexual and Reproductive Health and Rights (SRHR) of women and girls, most of it is not implemented nor resourced. Traditional and customary practices have also continued to supersede implementation of laws and policies, as power is held by churches, chiefs, and men in society over women, young people, and marginalised populations.

Figure 1: Most recent prevalence rates of physical and/or sexual violence by intimate partners (lifetime and past 12 months)

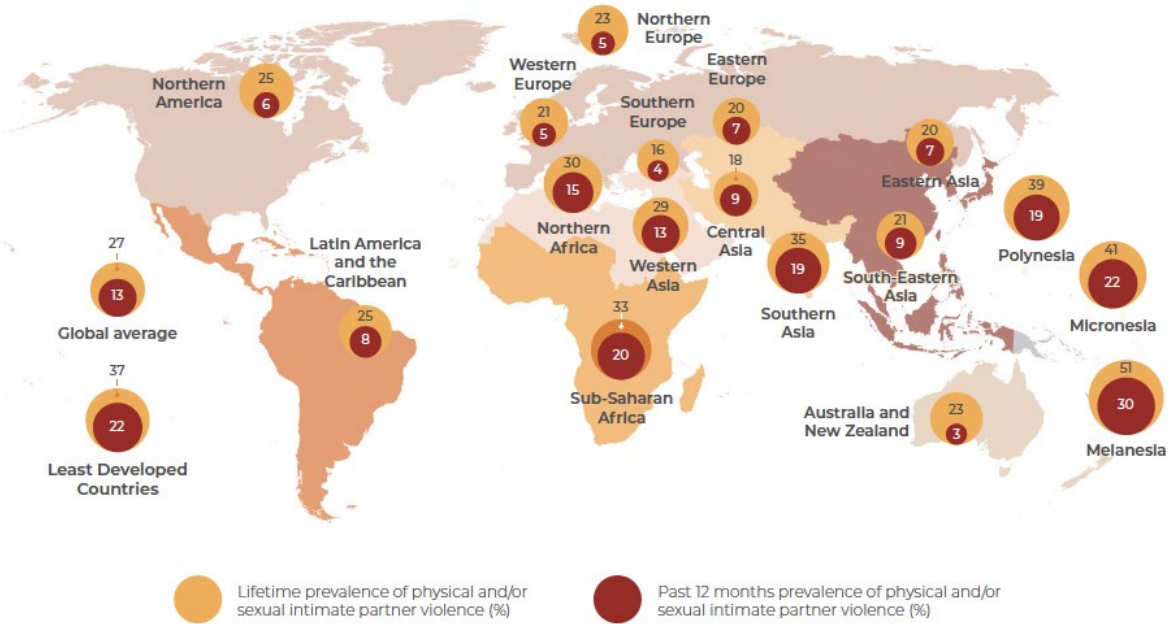
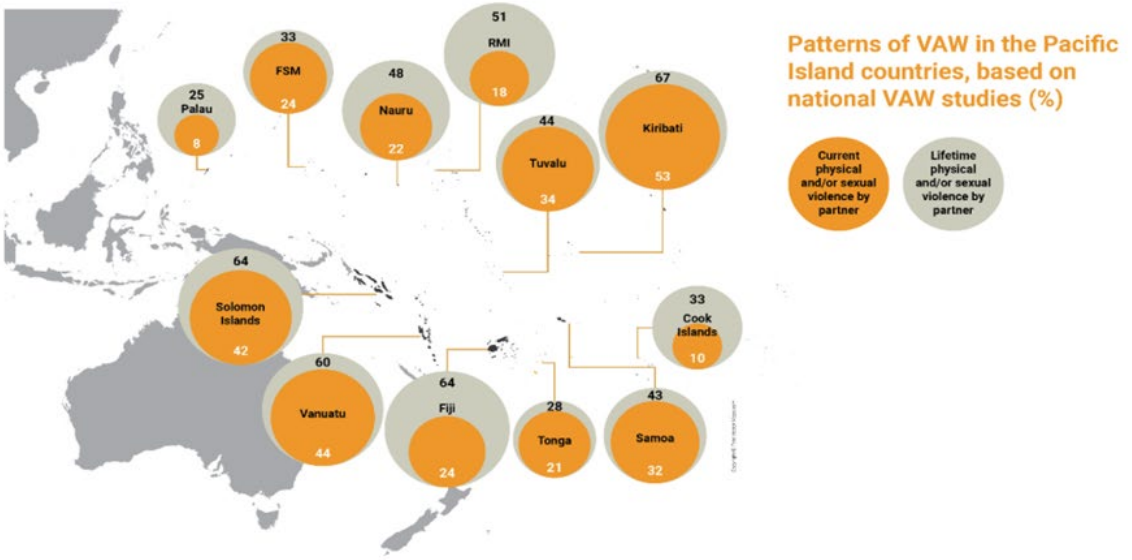


Figure 2: Patterns of VAW in the Pacific Island Countries, based on National VAW studies (%)



While SGBV prevalence rates are very high in the PICs, less than 4% of facilities in any country meet the criteria for SGBV service readiness. Through ministries of health led Health Facility Readiness Assessments, of the 8 PICTs surveyed, only Fiji had 4% of health facilities classified as service ready to provide sexual and gender-based violence services, followed by RMI at 3%. Micronesia, Samoa, and Tonga, have zero facilities that are service ready to provide SGBV service (Table 1). This means that not only do most PICs have a low density of Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH) health workforce to provide GBV and SRH services, but among the workforce available, there is inadequate qualified staff to provide quality counselling, psychosocial support and first aid, and support identification and management of survivors of SGBV. In addition, there are stock outs of relevant medicines, supplies and commodities, including Emergency Contraceptive Pills and HIV Post exposure Prophylaxis (PEP) for management of sexual violence.

Table 1: Health Facility Readiness and Service Availability Assessment (HFRSAA) 2018-2021, to provide GBV services in the PICs

HFRSAA (2018-2021)	Fiji	Kiribati	Marshall Islands	Micronesia	Samoa	Solomon Islands	Tonga	Vanuatu	Total
Total No. facilities included in analysis	212	113	34	30	14	196	31	159	790

% facilities offering at least one SGBV service	74%	72%	26%	30%	57%	58%	58%	54%	61%
% facilities SGBV Service Ready	4%	2%	3%	0%	0%	1%	0%	1%	2%
% facilities that have staff trained to provide SGBV services	20%	27%	21%	10%	21%	26%	32%	23%	23%
% facilities providing post-exposure prophylaxis for SGBV	25%	32%	9%	17%	21%	9%	26%	12%	18%
% facilities that have verified SGBV job aids or checklists	8%	9%	3%	3%	7%	9%	3%	4%	7%
% facilities that have private space for SGBV services	61%	36%	18%	17%	14%	13%	39%	13%	31%
% Facilities with SGBV room that has both auditory and visual privacy	58%	29%	15%	17%	0%	11%	29%	9%	27%
Does the facility provide forensics for SGBV?	20%	25%	N/A	N/A	N/A	15%	22%	23%	31%

SGBV prevention and response is also not integrated into primary health care, and in the provision of SRH services, which limits capacities of PICs to universally provide SGBV life-saving interventions, especially in remote, isolated provinces and outer lands.

The situation is worse during emergencies. The health sector is further at test during natural disasters, as provision of health services become stretched thus deprioritizing SRH and GBV

services. The Tanna Women's Counselling Centre (WCCC) reported a 300% increase in new domestic violence cases after two tropical cyclones hit Tafe Province in Vanuatu, and a 50% increase in GBV was reported during the Tonga Tsunami in 2021 by WCCC.

Future vision

Four of the eight SRHR SDG targets are aimed at addressing SGBV and specifically SDG target 5.2 **i.e., Eliminate all forms of violence against all women and girls** in the public and private spheres, including trafficking and sexual and other types of exploitation. Closely linked to the achievement of this target is SDG target 3.7: **By 2030, ensure universal access to sexual and reproductive health services (inclusive of GBV services)**. This directly correlates with the Pacific 2050 Blue Strategy on achieving gender equality and elimination of Violence against women and girls as a pathway to sustainable development.

All countries now have either legislation or pending family law bills that can provide protection for women from gender-based violence. Under most laws, violence against women is criminalised. In some cases, laws also cover child protection and sexual violence. Marital rape is now recognised as a crime in all countries, but implementation of legislation remains limited and access to justice far from reach to many women and girls, especially those who are disabled, vulnerable and/or poor.

Fully implementing the health sector response to SGBV in countries will accelerate it's elimination and contribute to the full realisation of the rights of all persons especially women and girls in the PICs to a life free of all forms of violence, coercion and discrimination.

Examples of recent progress

In recent times, some progress has been made in the health sector response to GBV through the:

- Integration of GBV into RMNCAH Policies in 5 PICs (Tonga, Vanuatu, Kiribati, and draft policies in Fiji and RMI)

- Development of GBV Standard Operating Procedures in 8 countries to guide health care workers in a uniform way on the appropriate responses to intimate partner violence and sexual violence against women, including clinical interventions and emotional support. They also seek to raise awareness, among health-care providers and policymakers, of violence against women, to better understand the need for an appropriate health sector response to violence against women.

- In countries where training and roll-out of GBV SOPs has happened (Vanuatu and Samoa), there is evident increase in seeking of health services especially among sexual violence survivors.

Why urgent action is needed now

GBV is a human rights violation and negatively impacts a woman and her family's lives, health and wellbeing, and the consequences are often inter-generational. In the Pacific where two out of three women have experienced intimate partner sexual or physical violence in their lifetime, compared to one out of three globally, it is a major concern to communities and governments, requiring a multi-sectoral action to prevent and respond to it, on the path to its complete elimination. Research has demonstrated increasingly adverse physical and mental health outcomes, in both the short and long term to GBV[1], (figure 1) which is worsened in times of humanitarian crises to which PICs are often subjected, particularly in recent times with increasing climatic changes and natural disasters.

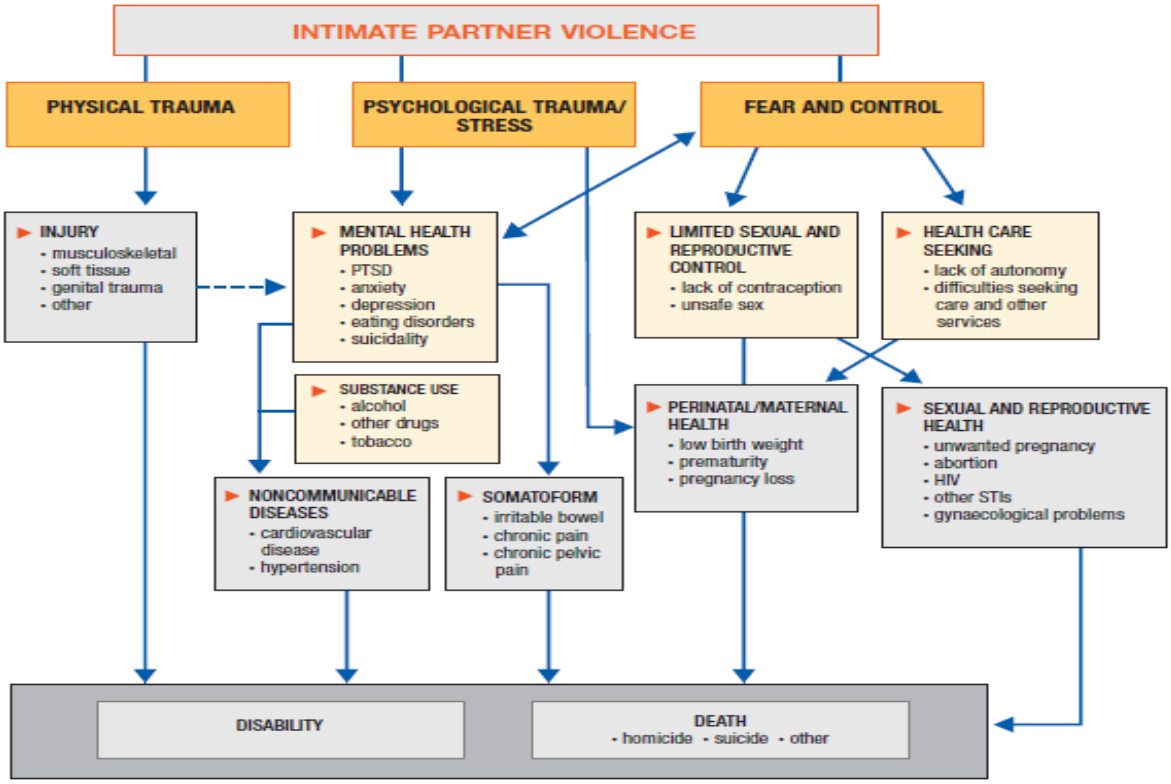
Hence, an urgent need for the health sector, which may be the first or only point of contact outside the home for GBV survivors, to respond. Health care providers and the health system have a critical role in preventing violence, minimizing the impact of violence, and supporting survivors of GBV, as they offer the most neutral point of service provision for survivors to seek help and services. Women who have been subjected to violence often seek health care, including for their injuries, even if they do not disclose the associated abuse or violence. A health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. They also identify health-care providers as the professionals they would most trust with disclosure of abuse[2]

Yet the health sector across the pacific is not service ready to provide and manage GBV services, as:

- There are less than 4% of health facilities in any country that meet the criteria for GBV service readiness: in terms of numbers of health workers with capacities to manage GBV and refer for further assistance, adequate tools, guidelines and job aides, medicines, and supplies; and conducive space for clinical response.
- Across PICs, heath systems do not provide integrated GBV and SRH services. This is a missed opportunity in increasing access and availability of GBV services in the health sector. In addition, both SRH and GBV services are not available especially to remote and isolated populations.
- Besides the limited number of healthcare workers with capacities to manage GBV, attitudes and perceptions of health workers inhibit reporting and seeking help, especially by victims of Intimate Partner Violence and sexual Violence.

[1] Campbell, 2004; García-Moreno et al., 2005; Ellsberg et al., 2008; Bott et al., 2012
[2] WHO (2013). Responding to Intimate Partner Violence and Sexual Violence against Women, WHO Clinical and Policy Guidelines. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf

Having well trained health workers, the health sector offers the opportunity to increase confidence and trust among GBV survivors which can improve reporting, access to further support services e.g., justice and social protection and increase awareness of GBV among the population.



Recommendations to be considered by the Heads of Health

Recommendations for governments

1. Acknowledge SGBV as a significant public health issue that requires a comprehensive rights-based health response inclusive of comprehensive sexual and reproductive health services, capacitated health personnel, health protocols, treatment and commodities, and health information management systems.

2. Ensure that health services are available for women and girls experiencing SGBV including mental health care before, during and after emergencies.

3. Strengthen workforce capacity development in SGBV clinical health sector response to survivors of SGBV, including the ability to identify and refer for further assistance.

4. Ensure health sector budget allocations for SGBV management and capacity development including in the operationalization of RMNCAH implementation plans.

Recommendations for development partners

1. Invest into integrated provision of SRH, SGBV and MHPSS services, including in the capacity building of health workers and during outreaches, as vertical /silo approaches are no longer viable in increasing scale and improving quality of services. Most development partners are interested in investing in specific issues, which do not allow comprehensive provision of services.

2. Support Governments with provision of supplies and commodities for SGBV and improving logistics management for GBV supplies and commodities.

3. Develop and implement male engagement strategies and activities to challenge and transform harmful masculinities related to SRH and SGBV in the Pacific