UNITED NATIONS UNIVERSITY

UNU-IIGH
International Institute for Global Health

WHAT WORKS

IN GENDER AND HEALTH IN THE UNITED NATIONS

CASE STUDY 5:

Violence against women acknowledged as a global public health priority through sustained strategic leveraging of opportunities by WHO gender experts

Gender & Health Hub

Knowledge. Policy. Action.

Project summary

The United Nations University International Institute for Global Health (UNU-IIGH) co-produced a practice-based study with five UN agencies working in global health (UNAIDS, UNDP, UNFPA, UNICEF and WHO). The project focused on analysing and understanding what worked, where, for whom, why and how, institutionally and programmatically, to successfully mainstream gender (click here for the consolidated project report).

The research involved in-depth analyses of 14 case studies that were considered examples of successful gender mainstreaming identified by respective UN agencies. Interview and published material relevant to each case study were analysed to ascertain the factors contributing to successful gender mainstreaming within the UN system. Key findings of the project included:

- Leaders can catalyse, accelerate and sustain success, by investing in gender architecture across the organisation with dedicated core funds.
- Organisational strategies that include gender equality with measurable outcome and output indicators, links between gender teams and budget planning teams, and strong performance and financial accountability mechanisms were gamechangers.
- Feminist civil society expertise and pressure can ensure alignment with local priorities, grounding in ethical frameworks, external accountability and sustainability.
- Joint interagency collaboration can have real impacts on the ground when comparative advantages of the agencies involved are leveraged.
- Evidence, data and programmatic learning that shows what works (and what the problem is) can drive action and change.

Overview of Case Study Series

This Case Study Series consists of briefs for each of the 14 successful cases of programmatic and institutional gender mainstreaming analysed as part of the 'What Works' project. Each brief presents further details about the particular case study, including the outcomes achieved, the pre-existing contextual factors that enabled the change, the factors that triggered change, and the mechanisms that sustained the change over time. Broadly, the case studies are categorised into three groups based on the types of successful outcomes achieved namely those that:

1. empowered women and girls to resist harmful gender norms and practices and advocate for their own health needs;
2. put gender and health issues on the global agenda; or
3. embedded gender equality issues in institutional processes and structures that supported gender equality in health programming.

These three types of outcomes reflect the different levels that UN agencies work on and illustrate the capabilities and strengths of the UN system.

Case study 5: Background

This case study, which relates to the second outcome group, focuses on the contributions of the WHO to advocate for and implement programmes that position Violence against Women (VAW) as a global public health priority.

While VAW has long received attention, mainly from women's movements, getting VAW to be framed as a health issue and eliciting a health sector response has been a long struggle. Dedicated and competent gender experts within WHO collaborated with external feminist groups and academics working on VAW to use every window of opportunity to advance work on VAW in accordance with WHO's mandate of evidence generation, standard-setting and capacity-building among Member States. A handful of gender experts and medical professionals (who established credibility within the predominantly biomedical organisation) framed VAW as an opportunity for WHO's leadership to build evidence, set standards, and build capacity among Member States.

Epidemiological data relating to prevalence was gathered and intervention effectiveness studies (clinical trials) showed how to reduce the incidence of VAW[1]. The Women's Health Unit in WHO, presented evidence and produced guidance material, including clinical guidelines for medical professionals to respond to VAW within hospital settings[2,3]. Global events and declarations, such as the Beijing Platform for Action were used strategically to secure additional buy-in[4]. The VAW programme moved to the Department of Sexual and Reproductive Health and Research (SRH) in 2011.

Following two decades of persistent and sustained work across networks of feminists internal and external to World Health Organization (WHO), gender-based violence (GBV) is now recognised as a global health priority. In 2016 the World Health Assembly (WHA) passed Resolution WHA67.15 on "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children"[5].

More recently, an outcome indicator has been included in WHO's 13th General Work Plan (GPW13), making it mandatory for WHO and Member States to report progress in reducing levels of violence against women and girls[6].

Figure 1 provides an overview of the mechanisms and contextual factors that triggered, enabled and sustained changes that led to the successful positioning of VAW as a priority within global public health.

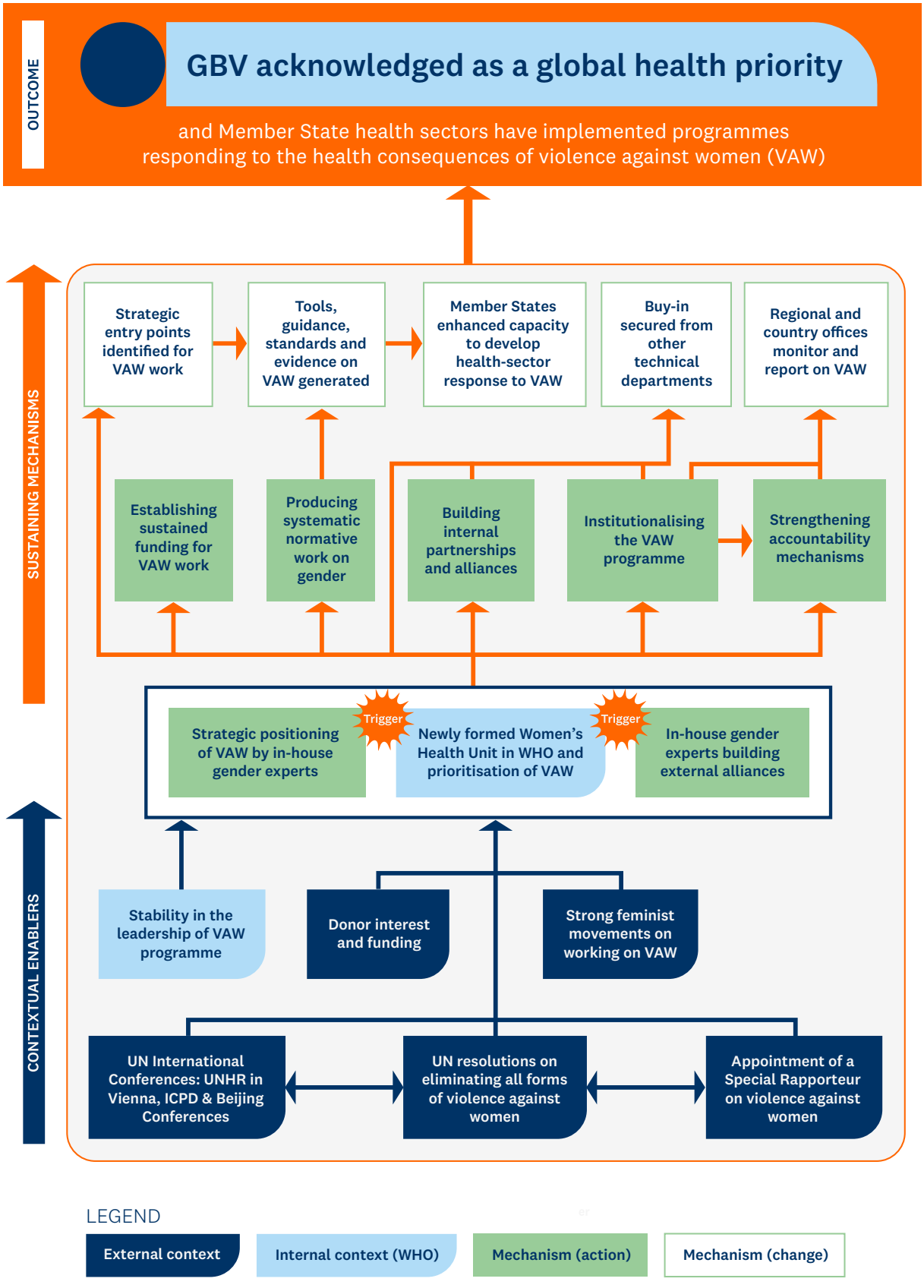
What were the triggers that catalysed change that led to VAW prioritisation as a global health issue?

By triggers, we refer to catalytic moments, whereby a change in the internal or external context opened windows of opportunity, which were identified and seized by specific actors. In the context of this case, the triggers were:

The establishment of a Women's Health Unit

In 1994, the WHO established the Women's Health Unit, which offered opportunities to create a new agenda on women's health issues.

FIGURE 1. Overview of the triggers, contextual enablers and sustaining mechanisms that contributed to violence against women being recognised as a global public health priority



The Unit adopted a two-pronged approach—mainstreaming gender across all technical areas and addressing key health issues related to gender-based inequalities. VAW and female genital mutilation (FGM) were identified as priorities in the second prong as WHO was not focused on either area at the time[7].

Building partnerships and alliances with leaders in the global feminist and women movements working on VAW. The agenda on VAW was jointly developed with women's rights and health advocates and experts, with decades of policy, advocacy and research experience, all of whom collectively contributed to building a consensus on VAW[7]. For example, the landmark multi-country study on women's health and domestic VAW brought together research institutions, women organisations in the pilot countries and policymakers, resulting in robust evidence and strengthening of national policy on violence[1].

Strategic positioning of Violence against Women. The in-house gender experts at the Women's Health Unit decided to focus on evidence-building as the centrepiece of WHO's work on VAW. The Beijing Platform of Action (PoA) identified the lack of data on the health consequences of VAW, which help to provide the basis for focusing on evidence building. This framing of VAW was particularly useful, given that the agency is primarily a technical organisation with a biomedical focus[8].

In the participating Member States, VAW is framed in strategic language, taking into account the cultural and political sensitivities, to facilitate buy-in from governments. In some settings, VAW has been framed within the language of social justice and human dignity, which may be more acceptable than human rights[8].

What enabling contextual factors facilitated change?

The initial triggers occurred in a broader enabling context at the global level, across the UN-wide system, and within WHO.

Within the global context and UN-wide system, the enabling contextual factors included:

- The second-wave feminist movement during the 1970s and 1980s in many countries, which had begun to address VAW and provide services to women survivors of violence[9].
- Several UN system-wide normative guidance, policies, and procedures on women and girls which provided a conceptual and operational framework. For example, The *UN General Assembly Resolution on the Elimination of all Forms of Violence Against Women* in December 1993, and the appointment in 1994 by the Human Rights Commission of a *Special Rapporteur on violence against women*, consolidated the global political mandate to address VAW[10,11].
- Similarly, the 1993 UN Human Rights Conference, the ICPD and the Beijing Conference all raised VAW as an issue of concern[4]. The Beijing PoA included a paragraph pointing to the severe dearth of data on the prevalence, nature and consequences of VAW[12].

Within WHO, the crucial enabling contextual factors were:

- Within the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), the leadership decisions and commitment to engage civil society groups. This resulted in a series of global consultations between scientists leading contraceptive research and

women's health advocates and created the space for discussing gender equality in health within WHO[13].

- The Head of the newly constituted Women's Health Unit was a medical professional and a feminist with considerable gender expertise. She was networked with the global feminist movement and committed to advancing the gender equality agenda in health[7].

What actions sustained changes to facilitate VAW being prioritised as a global health issue?

Producing systematic normative work on gender. Gender experts who led the VAW programme combined a high level of technical competence with commitment and contributed substantially to prioritising the health consequences of VAW. The normative work included:

- evidence building on prevalence and health consequences, and effective interventions[1];
- standard-setting through clinical guidelines and handbooks for the care of survivors[2,3];
- guidelines for ethical research and strengthening health systems response to VAW[14,15] ;
- technical support and capacity building in the Member States to develop policies and programmes on health sector-response to VAW[7].

The tools and guidance documents have been developed into training materials in simple, operational and jargon-free language that makes them user-friendly for Ministry of Health partners to implement VAW programmes[16].

Building internal partnerships and alliances. Soon after establishing the VAW programme, buy-in was sought from technical programmes, such as maternal health and HIV, and alliances were forged with the HIV department[7]. Alliances were also formed with in-house gender advocates building on prior networks. For example, in the late 1990s, an informal network within WHO of gender experts and others committed to advancing gender equality in health that met regularly and brainstormed on gender, including VAW, was a source of internal support to the VAW team. Subsequently, a gender and health network was established, which consisted of the Gender, Women and Health Department at the headquarters and gender advisors or teams from the regional offices[8].

Establishing sustained funding for VAW work. For many years, advocacy, strategic collaborations, and positioning of the issue—for example, VAW as a driver of HIV—were needed to secure funding for the programme. However, more funding has become available unlike any other point in past, probably in response to the renewed momentum following the inclusion of VAW on the Sustainable Development Goal (SDG) agenda[8,17].

Institutionalising the VAW programme. Two mechanisms have been vital for the institutionalisation of the VAW programme:

- The 2016 Global Plan of Action *to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and children*, was endorsed by WHA Resolution 69.5[5].

The resolution mandates the WHO Secretariat to report periodically to the WHA on implementing the Global Plan[5].

- More recently, the GPW13 for 2020-21 has as a target "Decrease the proportion of ever-partnered women and girls aged 15-49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%"[6].

Strengthening accountability mechanisms.
The VAW Programme moved to the SRH department in 2011. Since then, the Gender, Rights, Advisory Panel of HRP and SRH Department serves as an accountability mechanism, monitoring and supporting the programme[7]. This accountability mechanism is in addition to two other accountability mechanisms: the accountability enforced through the 2016 WHA resolution on the Global Plan of Action and reporting to the WHA against WHO's GPW13[5,6].

Conclusion

This case study showcases how specific gender and health issues were put on the global agenda when agencies successfully partnered with feminist civil society actors and capitalised on their roles in global agenda-setting work, including convening, thought leadership, evidence generation, advocacy and technical support. This brief, alongside analyses of the other case studies within the What Works in Gender and Health Case Study Series, fills a major gap at a critical juncture in time by providing an evidence-base of what has worked, where, for whom, why and how, to promote gender equality in health in a multilateral system. For further details of consolidated findings across all 14 case studies and overall recommendations please click here for the full project report.

References

1 World Health Organization (2005). WHO Multi-country study on women's health and domestic violence against women. Summary report. http://apps.who.int/iris/bitstream/handle/10665/43310/9241593512_eng.pdf?sequence=1.

2 World Health Organization (2014). Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. https://www. who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/.

3 World Health Organization (2013). Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. Geneva: World Health Organization; 2013. https://www.ncbi.nlm.nih.gov/books/NBK174250/pdf/Bookshelf_NBK174250.pdf.

4 UN Women (2015). Timeline: The UN at 70 – Gender Equality Milestones & Memorable Moments. https://www.unwomen.org/en/digital-library/multimedia/2015/9/timeline-un-at-70-gender-equality

5 World Health Assembly (2016). Sixty-ninth World Health Assembly, Geneva, 23-28 May 2016: resolutions and decisions, annexes. World Health Organization. https://apps.who.int/iris/handle/10665/259134

6 World Health Organization (2019). The Thirteenth General Programme of Work, 2019–2023. https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf.

7 Data from key informant interviews.

8 Data from case study workshop.

9 Nair S (2001). Violence Against Women: Initiatives in the 1990s. Development, 44: 82–84. https://doi.org/10.1057/palgrave.development.1110268

10 United Nations. Office of the High Commissioner for Human Rights (1993). Declaration on the Elimination of Violence against Women Proclaimed by General Assembly Resolution 48/104 of 20 December 1993.https://www.ohchr.org/Documents/ProfessionalInterest/eliminationvaw.pdf

11 United Nations. Office of the High Commissioner for Human Rights (2010). Fifteen years of the United Nations Special Rapporteur on violence against women, Its Causes and Consequences (1994-2009). A critical review. https://www.ohchr.org/Documents/Issues/Women/15YearReviewofVAWMandate.pdf

12 United Nations (1996). Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women, 27 October 1995. https://www.refworld.org/docid/3dde04324.html.

13 Cottingham J (2015). Historical note: How bringing women's health advocacy groups to WHO helped change the research agenda, Reproductive Health Matters, 23(45):12-20. https://www.tandfonline.com/doi/full/10.1016/j.rhm.2015.06.007

14 World Health Organization (2016). Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication, Putting women first: ethical and safety recommendations for research on domestic violence against women. http://apps.who.int/iris/bitstream/handle/10665/251759/9789241510189-eng.pdf?sequence=1

15 World Health Organization (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/

16 World Health Organization (2019). Caring for women subjected to violence: A WHO curriculum for training health-care providers. https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/

17 United Nations (2021). Sustainable Development Goals Report 2021. https://unstats.un.org/sdgs/report/2021/The-Sustainable-Development-Goals-Report-2021.pdf

Authors: Ravindran, TK Sundari, Atiim, A. George, Remme, Michelle & Riha, Johanna

Suggested citation: Ravindran, TK Sundari, Atiim, A. George, Remme, Michelle & Riha, Johanna (2022). Case Study 5: Violence against women acknowledged as a global public health priority through sustained strategic leveraging of opportunities by WHO gender experts. What Works in Gender and Health in the United Nations: Case study series. United Nations International Institute for Global Health. Kuala Lumpur, Malaysia.

Layout and design: The Creativity Club

DOI: 10.37941/SNWG2018