Human Rights Watch Comments on the World Health Organization’s Draft Global Plan of Action to Strengthen Health System Response to Interpersonal Violence

October 16, 2015

Human Rights Watch is pleased to comment on the second discussion paper containing Draft One of a proposed Global Plan of Action to Strengthen the Role of the Health System in Addressing Interpersonal Violence, in particular against Women and Girls, and against Children.

We note the guiding principles of human rights, gender equality, and survivor-centered care that respects dignity, and hope that these can be further developed and integrated throughout the plan and its implementation. The vision for strengthening the health system within a multisectoral response is appropriate and vital for effectiveness. We appreciate the retention of a clear focus on violence against women and girls, and against children, as well as domestic violence in the scope of the plan. We note and support several references to marginalized populations who are often at heightened risk of violence but who are underrepresented in research and often face formidable barriers to health care, including those with disabilities, sexual minorities, and older individuals. We also welcome the decision to coordinate the time frame and objectives of this plan of action with the major global effort around the Sustainable Development Goals.

We have particular concerns about the monitoring and accountability framework. It is difficult to assess the modesty or ambition of the 2030 targets without baseline data, and none of the current proposals address disparities in health system response within and between countries. We would also like to highlight areas throughout the draft plan of action where a human rights-based framework could be strengthened. We offer our recommendations below.

Section 1.2, Progress in countries and gaps
In paragraph 15, we recommend noting that not only is there weak enforcement of existing laws on violence, but that many countries’ laws have significant gaps or harmful provisions. For example, many governments do not recognize marital rape or domestic violence as crimes, have narrow definitions of sexual assault, or fail to prohibit child marriage or female genital mutilation. In other instances, governments criminalize activities such as consensual homosexual conduct and voluntary sex work by adults, which may place individuals who engage in these activities at heightened risk of violence, including from authorities, as well as preventing them from accessing health care.

In paragraph 23 on limited availability of data, we suggest additionally noting that even for countries with the most robust population-based survey data on intimate partner violence against women, this is often limited to women and girls between the ages of 15 and 49, and fails to capture the prevalence of abuse among younger girls and older women. Furthermore, we suggest adding violence against people with disabilities, in addition to the other groups already listed, as a particular gap in data.

Section 2.3, Objectives
Draft one reads:
3. The objectives are:
   • To mitigate the health and other negative consequences of interpersonal violence, in particular against women and girls and against children, by providing comprehensive health services and facilitating access to multi-sectoral services;
To prevent interpersonal violence, in particular against women and girls and against children.

It is critical that an overarching objective of the plan address the quality and accountability of these services. An earlier reference to “survivor-centered care and services” in the goals section of the previous draft has been removed although referenced in the “Guiding Principles,” and the reference to acceptability, accessibility, availability, and quality of care has been moved to “Strategic Direction 2.”

Retaining an overarching objective linked to the quality and accountability of services would greater align with the original intention of World Health Assembly Resolution 67.15 which is the basis for this plan of action and urges Member States to ensure that all people have “timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination.”

We suggest adding a third objective, “to provide timely, effective, and affordable access to survivor-centered health services that are free of abuse, disrespect and discrimination.” Alternatively, the first objective could be amended to read, “To mitigate the health and other negative consequences of interpersonal violence, in particular against women and girls and against children, by providing quality, comprehensive, and survivor-centered health services, and facilitating access to multi-sectoral services based on the informed consent of the survivor.”

Section 2.4 Strategic Directions
The strategic directions section of the document is very strong and should be retained in the final version.

Section 2.6 Time frame
We agree that it is strategic to align the time frame of this global plan of action with the implementation of the Sustainable Development Goals.

Section A: Violence against Women and Girls
Human Rights Watch strongly supports the actions outlined for Member States, national and international partners, and the WHO secretariat in this section.

Strategic Direction 1
We recommend including “forced sterilization and forced abortion” as a harmful practice under point 1.

We recommend that point 3 additionally includes a reference to sexual and reproductive health, “Advocate for and adopt reforms in laws, policies and regulations, their alignment with international human rights standards and their enforcement, that inter-alia: criminalize all forms of VAWG; end all harmful practices and discrimination against women and girls; ensure women and girls’ control over the number and spacing of their children including access to comprehensive health information, contraception, and safe and legal abortion; and promote gender equality and women’s empowerment including in relation to inheritance and family laws.”

We recommend that point 4 reads, “Establish a unit or designate a focal point at a sufficiently senior level to effectively address violence against women in the Ministry of Health and ensure response to VAWG and harmful practices is clearly articulated in health policies, regulations, plans, programmes and budgets...”
Strategic Direction 2
We recommend that point 7 be expanded to “Develop or update and implement guidelines, protocols and/or standard operating procedures for the identification, clinical care, support and referrals for VAW survivors, including for marginalized populations such as women and girls with disabilities, undocumented migrants, and those in institutions, building on the WHO guidelines and tools.

The WHO secretariat should also expand their technical cooperation and update evidence-based guidelines and tools to improve response to the often invisible and neglected needs of these populations.

Point 8 should stress that “All health services, including reproductive healthcare, should be based on informed consent of the survivor.” Human Rights Watch research in India and Indonesia has found that survivors, particularly women and girls with disabilities, often undergo HIV testing and are forced to receive reproductive care or mental health treatment without their knowledge or consent.

Point 10 should include a bullet point to “Eliminate discriminatory and degrading practices in health care settings that have no scientific validity, including so-called virginity tests.”

Point 11 should include “Sensitize health practitioners on interacting with, caring for, and supporting survivors with disabilities.”

Strategic Direction 3
We recommend adding a point to “Coordinate with relevant authorities and consult with women and girls in humanitarian settings to promote safety and dignity, including in the design of refugee and internally displaced persons (IDPs) camps, such as the strategic location and lighting of toilets and water sources.”

Strategic Direction 4
We recommend including disaggregation of data by “disability” in Point 18.

We recommend expanding point 20, “Facilitate efforts by NGOs, researchers and other sectors to: conduct research on key knowledge gaps on VAWG and harmful practices, including against marginalized populations; and to develop, pilot and evaluate interventions to address VAWG.” We also urge the WHO secretariat to exercise leadership in identifying gaps and deepening knowledge on health needs and gaps in services for marginalized groups, including those in institutions, people with disabilities, the elderly, indigenous women, migrants, sex workers, and lesbian and transgender women.

Section B: Violence against children
Many of the recommendations in Section A are more specific and detailed than those in Section B, even when on similar topics. We recommend aligning the language in Section B to be parallel to the more developed language in Section A.

Strategic Direction 1
Point 1 should also include a reference to “workplace settings.”

Point 2 on advocacy for law and policy reforms should include specific references to ending harmful practices such as child marriage and female genital mutilation.
Similarly, on point 3, Member States, national and international partners, and the WHO secretariat should engage in sensitization programs to ensure that policy makers, the public, and health care providers understand the lifelong health consequences of child marriage, early childbearing, and female genital mutilation.

In point 6, “Create a unit or focal point with sufficient seniority to effectively address violence against children within the Ministry of Health.”

Add a point to “Coordinate with other national and subnational initiatives that address violence against children, including to end child marriage, to end human trafficking, and to eliminate the worst forms of child labor.”

Add a point saying “All forms of care and services should take into account the child’s will and preferences in accordance with his or her evolving capacity.”

Strategic Direction 3
Add a point to “Coordinate with education ministries to include age-appropriate, comprehensive reproductive and sexual health education in schools.”

In point 7, add “Ensure that policies and programmes to prevent violence against children include targeted interventions for children from marginalized groups such as children with disabilities.”

Strategic Direction 4
The WHO secretariat should work to strengthen the capacity of civil society, research institutions, and program implementers to conduct research on violence against children in a safe, sensitive, and ethical way as well as in rigorous monitoring and evaluation.

Section C: All forms of interpersonal violence: cross-cutting actions

Strategic Direction 1
In point 3 for the WHO Secretariat, we recommend initiatives to fill gaps in global and regional estimates of violence against marginalized groups, including people with disabilities, racial and ethnic minorities, LGBTI, migrant and displaced populations.

Strategic Direction 2
In point 6 for Member States, we recommend adding an emphasis on survivor-centered care and the principle of informed consent, for example, “Strengthen health services, and in particular pre-hospital services and emergency medical care, and ensure that victims of violence have access to quality, survivor-centered, and affordable care based on informed consent.

In point 6 for the WHO Secretariat, we suggest noting that an example of a cross-cutting issue where greater guidance is needed includes sensitizing health practitioners on interacting with and caring for survivors with disabilities.

Strategic Direction 4
At the end of point 17, add “Strengthen capacity of researchers...on less researched types of violence such as elder abuse and violence against people with disabilities.”
**Section 4: Accountability and monitoring framework**

Human Rights Watch recommends that independent stakeholder reports and robust consultation and engagement with civil society augment the periodic reporting by Member States through the World Health Assembly.

**We recommend increasing the number of indicators.** Much of the richness in the vision and objectives of the plan is lost due to the narrowness and small number of the indicators, which is likely to drive the priorities of Member States’ and their national and international partners.

- Currently, there is only one proposed indicator for Section 3 on cross-cutting action across all forms of interpersonal violence.
- Of the currently proposed 10 indicators, only one (A3.1) explicitly addresses prevention of violence.

For example, additional indicators could address the number of Member States that:

- Adopted legal reforms to prevent violence (such as gun safety laws) or made national-level investments in programs or sensitization campaigns to prevent violence.
- Improved by XX percent the geographic distribution of adequate post-rape care services to underserved areas, including rural areas, urban slums, or humanitarian contexts.
- Established policies and oversight mechanisms to address mistreatment of abuse of women and girls by health workers.
- Created focal points/units to address violence against women and girls, and against children in the Ministry of Health.
- Expanded by XX percent the availability of trained mental health care providers and services to address the psychological and mental health consequences of violence.

**It is difficult to assess the modesty or ambition of each target without baseline data, and none address disparities in health system response within and between countries.** We suggest that these targets not be finalized until this data is available, or that there is an opportunity to revisit and update the targets once baseline data becomes available.

- The 2030 targets provide absolute targets and are not relative to the baseline data, therefore may not represent meaningful progress. For example, a target aiming for 50 percent of Member States’ achievement will not be a significant advance if we learn the baseline data is already 40 percent.
- The success of this plan of action should hinge on whether progress is made not only in countries with the most resources and developed health systems, but especially in countries where the gaps are the most pronounced and the unmet needs are the greatest. This would also provide greater alignment with the theme of inequalities in the 2030 Sustainable Development Goals agenda.
- The first four targets in Section A on violence against women and girls are disappointingly low, especially given the 15 year timeframe and when considered in conjunction with the political attention and resources that will be devoted to the complementary agendas of the Sustainable Development Goals and the Global Strategy for Women’s, Adolescents’ and Children’s Health. These should be significantly increased.
We recommend:

- The reporting of these indicators be disaggregated by level of economic development and by region, to better measure and incentivize progress in the countries where the health response to violence is the weakest.
- Including indicator/s on improving the health system response to violence among the least-developed countries, for example, “A 40 percent expansion of services addressing intimate partner violence and comprehensive post-rape care in the bottom third of countries according to XXX (eg the Human Development Index).”
- Including or amending some indicators to address progress within a country rather than the total number of Member States that have achieved the goal. For example, in the 2013-2020 Mental Health Action Plan, global target 2 is, “Service coverage for severe mental disorders will have increased 20% (by the year 2020)” and global target 3.2 is, “The rate of suicide in countries will be reduced by 10% (by the year 2020).” This method could accompany the examples of additional indicators that we recommend above.
- Indicator A1.1, and A2.1 should be increased significantly based on baseline data, for example to 80 percent achievement.
- Indicator A2.2, along with the other indicators, should be revisited depending on baseline data.
- Indicator A3.1 should be revised upward, for example to 75 percent, and should read, “Number of Member States that have implemented, including through obtaining adequate resources (through national budgets or partnerships) for a national multisectoral plan addressing violence against women and girls that promises at least one strategy to prevent violence against women and girls.”