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. DRAFT ONE. 31 AUGUST 2015.

ISPCAN Councilor Responses collated at 161015:

“I have read the report and I think it is a good start. I won’t address the division of women and girls versus children as others have. I think the WHO has missed one important area of having impact. Accreditation of medical schools, nursing schools, and other health professions, and accreditation of residencies and internships are governed by either the Ministries of Health or by NGO’s with regulatory power in virtually all countries of the world. Accreditation standards for medical and nursing schools should include training in violence and abuse. WHO itself maintains a master list of schools that is used by licensing authorities when a person trained in one country moves to another country. WHO should set a standard of minimal training in violence and abuse for each school and not list any school that does not meet a country or its own standard for training after some date such as the first of January of 2019.

I also think local data drive local action. Every country should be expected to present national or local data on the prevalence and incidence of VAC and VAWG to the WHO by the same date. Clearly, many countries are doing this as we have 25 countries that have already published data using at least one of the ICAST instruments. A clad standard for data collection and analysis is needed.

I think the table presenting numbers overstates the level of physical violence against children at 25%. The MICS-3 data and WorldSafe data (Runyan et al) suggest that the number is high but not that high. The Multiple Cluster Indicator Survey (MICS-3) and our survey of 19 communities in 6 countries found the median level of physical violence against children, defined as: hitting with an object not on the buttock, choking, kicking, beating up with a closed fist, or shaking, to be 15%. This number is still far too high but not nearly as high as the 25% listed in the document. The numbers of sexual trafficking are completely made up as there are absolutely no studies that I have seen actually tried to assess this in some other way than a guess. This is true in the US and internationally.”

“Good point on the accreditation – and perhaps this should extend to allied professions. Also continuing professional education is critical given the advances in evidence based prevention research and practice.”

“I would like to make a few comments. Although the language of under Strategic Direction 2 focuses on health service delivery there is little that emphasizes the importance of strategic development of health care professionals who understand the unique aspects of child maltreatment and have the knowledge and skills necessary to identify maltreatment, substantiate concerns for child maltreatment when the concern arises and do so in a manner that is therapeutic for children. Without substantiation there cannot be effective intervention, protection and ultimately treatment. We need to develop medical diagnostic and treatment resources. I am concerned when there is too much focus on the forensics and less
on the well-being of the child. There has been too much emphasis on legal outcomes when the best interests of children are generally served in the child protection, medical and mental health outcomes.

I am concerned when all maltreatment is framed as an issue of “Violence” as there are many things that children experience that have a seriously adverse impact on them which are not violent which implies physical aggression, force and restraint. For example, most sexual victimization is not violent yet it is potentially seriously disruptive to the health and welfare of the child. When child sexual abuse is framed as a violent act then people expect to see signs of violence which are rare in this form of victimization. Because there are rarely physical signs of violence some might not believe the history of victimization.”

“In addition, policies and programming to address both violence against women and girls, and violence against children, have developed as separate fields. “ I think this statement is too general and dramatic, and would be difficult to gain consensus. Why not a more positive emphasis on all parties working together?

Psychological maltreatment is mentioned, but not as much as physical/sexual violence. Probably should be the other way around.

Good vision statement.

Prevention is listed multiple times, but it seems identification and treatment comes up even more often. I think prevention should be much more prominent.

Role of religious interpretation sustaining violence/sexual mistreatment seems absent.

I wish there would be a stronger emphasis on positive parenting.”

“Essentially the right models are being referred to both in terms of understanding the complexity of the problem and arguing for evidence based interventions that are continuously monitored. At time where even in high income countries services are being cut, it is good to emphasise the need for high quality MDT interventions. However, in terms of public health levels of intervention, there is, as has been noted, very little on prevention. This probably explains why there is little on positive parenting and work with men and boys.

The later omission is serious as work man and boys have to be included in any systemically effective prevention and intervention programs. Many (not all) perpetrators are victims of unequal social divisive societies, living in poor conditions and marginalised (Barker’s work in Brazil and the extensive gender informed work on masculinities). Often interpersonal violence is a manifestation of structural violence mentioned briefly in Strategic Direction 1 point 2. Possibly not for this document, but we need to continue to champion this perspective otherwise the vision, as stated in the paper is unlikely to be achieved.”

“This document seems doable. I particularly like the accountabiity part. In addition, reporting of cases/data under each section
is particularly useful. It would be good if ISPCAN can be involved in this data / measurement tool work too.”

“I think this is a terrific document, so I enthusiastically support it.

If a fraction of this pans out, we’ll have a better world!”

“1. I agree with [above comment] – this plan, if committed to and implemented globally gives us great hope.

2. The continued ‘tacking on” of the phrase – and children – is clumsy – and I think this should continue to be emphasised although the political reasons for this are acknowledged.

3. The point 1.1.3 – introduction and scope:
   However, there are compelling reasons for a particular focus on violence against women and girls, and against children. Women and girls bear an enormous burden of specific types of violence that are rooted in socially-accepted gender inequality and discrimination, and are thus sanctioned, despite constituting a violation of their human rights. Because of this, women and girls experience shame and stigma, and the violence often remains hidden. All too often, health and other institutions are slow to recognize and address this violence and services are not available or have limited capacity. Until recently, violence against women and girls was largely invisible within national and international statistics and surveillance systems.

   applies equally to boys – perhaps even more so. Violence against boys – both sexual and physical – is in many countries measured as equal to that against girls – and violence against boys is definitely largely unaddressed. Facilities across sectors are not sensitive to the difficulties boys have in acknowledging victimisation, especially in cultures that are patriarchal and in which men and boys have to be tough and strong. They are not sensitive to the challenges of responding to boys victims appropriately. Acknowledging sexual violence is particularly challenging for boys, as the majority of sexual crimes appear to be committed by boys and men and the fear of being labelled as homosexual, even in countries with strong equality laws and policies that purport to accept a range of sexual preferences, remains a challenge to disclosure. I therefore find this statement discriminatory.

4. Although I agree with the public health approach to the prevention of violence in principle and in health systems, it cannot be assumed that health services are the initial entry point for victims or perpetrators. The multi-sectoral sector approach to VAW and VAC is applauded but the entry point to services may differ from one country to another. This is not emphasised enough in the plan – except for the interface with justice and policing – which are usually tertiary level interventions.

5. There is little focus on verbal and emotional violence which may be as harmful as physical and sexual violence, especially for the developing child.

6. There is a need to acknowledge male genital mutilation in cultures where male circumcision is culturally sanctioned but places the lives (usually of adolescent boys) at risk or leaves them with mutilated/incomplete genitalia as a result of botched circumcisions or unmanaged infections. It is of note that on average 100 boys lose
their lives to this each year in South Africa, and hundreds more boys may have damaged penises that preclude them from normal adolescent/adult relationship and sexual enjoyment.

7. I agree with [x] comment that there is little focus on protective factors – both with regard to perpetration and victimisation – strengthening protective factors should be a strong focus of this global plan, and integrated more fully into the principles in particular and into the actual plan itself.”

“I agree that it’s a very good initiative, discrimination of genders is not necessary (and I also agree with [x] that circumcision of boys should be revisited as well as it also may give physical and psychological harm to boys).

My main point in this document is the need for more emphasis on prevention and role of health service providers in prevention. Health services are universal in many parts of the world and health personnel, both nurses and doctors see the children starting from very early ages. I think well child care visits especially in the first years of life gives us a great opportunity both to detect the risks and to train and help parents to supply what their infants need.”

“This is a very timely plan of action with a framework in line with proposed targets and outcome indicators of global STGs and these health system perspectives will surely expand on the those of STG 3 (healthy lives) as VAC has been situated under STG 16 (peaceful societies) and VAW women and girls under STG 5 (gender equality).

The WHO definition of health is a state of complete physical, mental and social wellbeing which emphasizes the prevention perspective and health and well being (and indeed development in VAC discussions) should be highlighted. This is the ultimate goal…

Training of health professionals very important as they are not only the ones to manage (and train multi sectors) victims of violence but also the ones to champion/advocate for changes in the system.

Great that the VAW and VAC are coming together in this doc despite the awkwardness but as has been said many times males need to be on this agenda as part of the solution. Agree with [x] this is discriminatory…”

“WHO can play a leadership role in its implementation in low income and developing countries with large child population. Child rights and protection issues should be regarded as major society and public health problem. They should become integral part of medical curriculum’s. Medical and allied front line professionals need to be adequately trained to identify, assess, treat and manage victims of child maltreatment. Through this document, I sincerely hope WHO can influence the respective Governments to align their national plans, policy and laws.

We urgently need prevention and more appropriate response to child abuse and neglect world wide.”