Please find below feedback from The International Community of Women Living with HIV (ICW) on the second Draft of the WHO Global Plan of Action to strengthen the role of the health system in addressing interpersonal violence.

For many women and girls, but particularly women and girls living with HIV and other vulnerable populations, healthcare settings lie at the centre of discrimination, stigma, and mistreatment experienced within their lives. We are very pleased to see the inclusion of references to the types of violence experienced by women in health care settings [Intro. Section 8, pg 4] as well as specific actions for health care systems, governments, international partners to address the violence, stigma and discrimination experienced by women in a variety of health care settings including when accessing reproductive health services. We also appreciate the recognition of the deleterious impact of negative attitudes, stigma and discrimination from health care workers on the health and safety of women. [Section 20 pg 6]

We support the recognition in this document that a strong focus on women and girls as those who bear the disproportionate burden of intimate partner violence is needed. Although we recognize that the primary focus of this Global Plan of Action is women and girls broadly, we also recognize that the concerns of key populations of women including, as WHO defines it, vulnerable populations of women must also be specifically and clearly addressed and responses to unique needs identified and actioned in this plan. More specific attention needs to be paid with in the document and actions to encouraging and advising health systems to develop specific knowledge and responses that address the doubled burdens and specific kinds of violence experienced by key and vulnerable populations of women including women living with HIV, women who do sex work, women with disabilities, women who use drugs, migrant women, LBTQI women, indigenous women and other key populations who experience different risks for and vulnerabilities to violence. Additionally, we value the addition of references to the different types of violence experienced by vulnerable populations including women living with HIV [Section 9 page 4]. HIV should be understood as a cause and consequence of violence. Additions are suggested for understanding risks of violence for vulnerable populations of women should also be addressed in Annex 8.
We suggest that this plan include a section or recommendations that focus on the specific impacts, vulnerabilities to and consequences of intimate partner violence for women living with HIV. The plan should include a section that focuses on the specific impacts and vulnerabilities of women living with HIV to intimate partner violence. This will help shift the paradigm of where violence needs to be addressed within healthcare systems, including around diagnosis and disclosure of HIV status for women and their children.

It would be valuable to discuss in more detail the experiences of women who bear double burdens and negative impacts of stigma and discrimination in a variety of settings such as homelife, community and within the health care system, as key populations or vulnerable populations of women and girls, particularly women living with HIV to inform the development of supportive responses to these populations.

The proposed actions should specifically address HIV as both a cause and consequence of violence, particularly for women and girls, within homes, communities, and institutions, including healthcare systems and we appreciate the reference to the increased risk of HIV acquisition for women who experience violence. [Health consequences, Section 11 pg 4 & Annex 7]

It would be valuable to discuss the role of gender inequality, power dynamics and the ability to negotiate sex and contraception for women experiencing violence as a specific exploration of the health consequences of violence and how unsafe sex happens. [Section 12 pg 4] Additionally it would be valuable to discuss issues of criminalization of certain vulnerable populations of women as increasing vulnerabilities to violence at the community, and institutional levels.

We would encourage including a definition of civil society and definition of community based organizations as well as clarification on the need and role of organizations, networks and advocacy groups comprised of and led by women and particularly vulnerable populations of women.

We value the call to action issued in this document regarding health care worker trainings. Healthcare systems must ensure that their practices holistically reduce stigma, discrimination and violence experienced by women and particularly, vulnerable populations including women living with HIV, before they can reasonably hope to become a place of safety and support for women experiencing intimate partner violence.
Section 2: Vision, goal, objectives, strategic directions, and guiding principles:

- **Box 1:** It would be useful to point out here that the health care system has a role and obligation in ensuring that health care settings are not themselves places of violence and human rights violations.

- **Guiding principles:**
  
  o **We appreciate the scope of these guiding principles particularly the inclusion of human rights. We suggest a stronger focus on human rights throughout and we suggest in particular (in line with Agenda 2030) to describe (perhaps in an annex) key human rights including sexual and reproductive health and rights and resources on implementing a human rights-based approach to health care. We urge the provision of definitions and perhaps an annex on the specific requirements of ensuring sexual and reproductive health and rights, and definitions and resources on specific human rights values or principles such as respect for bodily integrity, informed consent and autonomy, and non-discrimination.**

  o **Gender Equality:** We suggest that power dynamics should not only be challenged externally in society by healthcare systems but within health care settings along with other kinds of unequal power dynamics between patients and doctors for example.

  o **Health Equity:** should call on the health system to do more than simply pay attention to the needs— they should take action to reduce discrimination within their health care settings.

  o **Community participation:** We applaud the inclusion of community participation as a guiding principle as community based responses can play and integral role in supporting survivors of violence and ending violence against women. However, given the somewhat vague potential application of that terminology we suggest that need to directly engage women’s groups more broadly and those working on behalf of communities of women and survivors of violence. A premium should be placed on the direct participation of women organizations led by women and organizations led by groups who are most impacted so as not to recreate unequal power dynamics and gender inequalities that often plague civil society engagement. It is absolutely critical that women are meaningfully engaged in processes as adviser’s designers, evaluators and monitors of anti-violence programming in the health care system. We reiterate our suggestion for a recommendation to include community systems strengthening including for networks of women.
Section 3: Actions for Member States, national and international partners and the WHO secretariat:

A. Violence against women and girls:

Section Description: In the section description it should be clear that it is not just a legal and health policy environment they need to create to address violence experienced by women, but a service delivery environment as well. Additionally, the section that states that countries should prioritize specific forms of violence that are the most relevant for their setting - is a bit of a slippery slope. It may be worth reiterating a suggestion that countries undertake some form of independent assessment of violence against women that includes input from civil society and in particular women’s groups be included as a tool to help countries decide where to allocate resources.

Strategic Direction 1:

We are very pleased about the inclusion of Section 6 to strengthen accountability within the health care system and we suggest adding a suggestion for accountability measures to be human rights based. Additionally any policy or practical requirements for involuntary partner notification, mandatory testing, mandatory disclosure, and partner participation requirements must be addressed as causes of violence. We also advocate that there be a specific role in this section for civil society, community based organizations and particularly networks or organizations led by women in monitoring and oversight as well as grievance mechanism design and implementation. This is described well in number 4 on page 15 under Strategic Direction 1 as we suggest reiteration of this in the guiding principles etc.

We also suggest adding to the last bullet point on codes of conduct for health care workers that stigma, discrimination be included therein as a specific subset of mistreatment and abuse of women and girls by health care workers.

We also suggest a reference to key or vulnerable populations of women doubly burdened by violence, including women living with HIV, sex workers, women with disabilities and other key populations. Specific resources and calls for training regarding the unique needs of vulnerable populations of women would be a valuable addition to this plan.
**Strategic Direction 2:** We applaud the inclusion of strengthening the health care system through the addition of accountability measures and protections for women around violence perpetrated in health care settings under Section 10.

**Cross-cutting Issues:**

Health Systems must increase internal governance around human rights violations and addressing stigma and discrimination within health care systems in tandem with developing responses to intimate partner violence for those accessing health care.

The actions for member states in this section should specifically include a provision on legislation and policy to end criminalization of HIV status, disclosure, and transmission as well as key populations based on their lifestyles and identities, including, but not limited to, lesbian, bisexual, and transgender people, women who use drugs, sex workers, and migrant women.

Criminalization of HIV non-disclosure, exposure and transmission, in particular, is counterproductive and undermines evidence based public health strategies for prevention as well as the scientific knowledge of actual risk. It discourages women living with HIV from accessing care, undermines the goals of counseling and the service provider relationship with patients, increases the risk of violence against women living with HIV, and can discourage people who know they have HIV from disclosing that fact to potential sexual partners and others.

**Section 4. Accountability and monitoring framework:**

We strongly suggest the inclusion of a mandate for the direct involvement at all levels of women-led organizations and groups in accountability and monitoring of this Global Plan of Action. Beginning with the development of national level indicators and all the way to program implementation. We also suggest a clear indication of adherence to principles of transparency, gender equality and involvement of most impacted persons at all levels including accountability and program monitoring.