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 against children, building on existing relevant WHO work

First Discussion Paper containing Draft Zero

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Chapter 1. Introduction

1.1 Scope

1. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.15 on *Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children.* It requests the Director-General “to develop, with the full participation of Member States, and in consultation with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft **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 against children, building on existing relevant WHO work”.

2. The **global plan of action** will be guided by resolution WHA67.15 in terms of its scope. While the resolution was a politically negotiated process, the **global plan of action** will be informed by evidence, best practices and WHO technical guidance. It will offer a set of practical actions that countries can take to strengthen their health systems to address interpersonal violence,\(^2\) in particular against women and girls, and against children.

3. In many settings, health provides an appropriate entry point for addressing violence, particularly against women and against children. Health-care providers are often the first point of professional contact for survivors of violence. Therefore, while recognizing that preventing and responding to violence requires multisectoral efforts, this **global plan of action** will take a public health approach to addressing violence and purposefully focus on what the health sector can do, without detriment to the importance of actions by other sectors.

4. In line with resolution WHA67.15, the **global plan of action** will particularly address violence against women and girls and against children, while referring to other types of interpersonal violence.\(^3\) Interpersonal violence is preventable, and responsibility for addressing it rests clearly with national governments.

5. Women and girls bear an enormous burden of specific types of violence that are rooted in gender inequality. Such violence is often hidden and stigmatized and also often socially sanctioned. All too often, health and other institutions are slow to recognize and address this violence and services are not available. Until recently violence against women and girls has also been largely invisible within national and international statistics and surveillance systems.

Globally, there is a strong political momentum for addressing violence against women and girls in health and development agendas, which offers an opportunity to strengthen awareness of and response to the issues.\(^4\)

6. Violence against children, which includes maltreatment of boys and girls as well as some forms of youth violence, is widespread. Child maltreatment has lifelong negative consequences, including ill health, health risk behaviours, experiencing and perpetrating subsequent violence. In many countries, violence is often considered an acceptable way of disciplining children. Child maltreatment is often invisible and children who experience abuse do not generally have access to the programmes and services they need.

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2. Definitions of key terms used in this document can be found in the glossary, see Annex 1.

3. In this document, the term “types (or forms) of violence” is used to refer both to (i) violence that affects particular population groups (especially violence against women and girls, and violence against children), as well as (ii) different sub-categories of violence that can affect these groups (e.g. intimate partner violence, sexual violence, child maltreatment, etc.).

4. This is reflected in the 20-year review of the International Conference on Population and Development, Programme of Action (2014) where 9 out of 10 of the 176 Member States who participated in the review highlighted violence against women as a priority issue for them (1).
7. The science and programming for violence against women and violence against children are still in their initial stages. So far, the two fields have evolved separately, and the implementation of programmes and policies is fragmented. More progress has been made in terms of building the evidence for some types of violence than for others. The role of the health sector may also differ across the different forms of violence. While injury management and trauma care are relevant for all forms of violence, for women and girls sexual and reproductive health consequences require particular interventions. The hidden nature of some forms of violence also requires specific training of providers in how to identify these problems. Therefore, the level of guidance that the global plan of action can provide will be different across the different types of violence.

8. While the global plan of action will largely focus on interpersonal violence, in particular against women and girls and against children, where relevant it will also address the role of the health system in providing care and services for survivors of violence in conflicts and other humanitarian emergencies, in particular sexual and other forms of gender-based violence against women and girls.

9. Countries are at different stages of progress in terms of their health systems’ response to the different forms of violence. As the plan of action is global in nature, it will reflect the state of the field globally and will need to be adapted across regions and countries.

10. The global plan of action will be closely linked to several other World Health Assembly resolutions, global action plans and strategies, as well as to other work of WHO (see Annexes 2–5). It will build on the numerous other efforts across the UN system to address violence, in particular violence against women and girls, and against children. This includes relevant conventions, declarations and resolutions by the General Assembly and Security Council, among others (see Annex 2). It will take cognizance of the roles and mandates of the different UN organizations in coordinating and leading on wider multisectoral efforts to address violence.

1.2 Process and structure of this document

The global plan of action will be developed through consultations with Member States, civil society, UN agencies, and other international partners (see Annex 6 for details of the process). The finalized global plan of action will be presented at the 2016 World Health Assembly. This first discussion paper containing draft zero of the global plan of action presents a brief overview of the issues and a set of proposed objectives, actions and targets to elicit feedback and further develop the global plan of action. The document is organized into the following sections:

- Chapter 1 presents the scope of the global plan of action, an overview of the global situation, and the role of the WHO Secretariat in addressing violence.
- Chapter 2 presents the vision, goal, objectives, guiding principles and time frame for the global plan of action.
- Chapter 3 is organized into three main sections addressing:
  - A. Actions across different forms of violence
  - B. Violence against women and girls
  - C. Violence against children
- Each of the three sections of Chapter 3 include a core set of: (i) actions for Member States and national and international partners for each objective; (ii) actions for the WHO Secretariat; and (iii) global targets.
- Chapter 4 provides a template for developing a monitoring and accountability framework for the global plan of action.
• Chapter 5 is a placeholder for a future section on additional actions and options for adapting the global plan of action at the regional or country level.
• Annexes: glossary, lists of and links to relevant documents/materials, details of the Secretariat’s work, process for developing the global plan of action, explanation of the guiding principles for addressing violence.
• References.

1.3 Overview of the global situation

Magnitude
1. Violence affects the lives of millions of people. Interpersonal violence is a leading cause of death and when not fatal it can have long-lasting consequences. There were an estimated 475,000 deaths in 2012 as a result of homicide, 82% of which were among men and 18% among women (2). An estimated 38% of homicides of women were committed by intimate partners, compared to 6% of homicides of men (3, 4). Deaths are only a fraction of the health and social burden arising from interpersonal violence. Millions of young people receive hospital emergency care for injuries related to youth violence (5–7). Women, children and elderly people bear a higher burden of non-fatal physical, sexual and psychological consequences of abuse.
2. Violence against women: Women are affected by different forms of violence at different stages of their lives. This includes, but is not limited to: violence by intimate partners and other family members, sexual violence, trafficking for sexual exploitation, and femicide, including murders in the name of honour or because of dowry. Intimate partner violence is the most common form of violence experienced by women. Globally, 1 in 3 women (age 15 years and older) have experienced physical and/or sexual violence by a partner or sexual violence by a perpetrator other than a partner (3). Many of these forms of violence can be exacerbated during times of war and other humanitarian crises. Older women experience some of the same forms of violence as younger women as well as specific forms of elder abuse. While in some studies 6% of older adults report abuse in the past month, data on prevalence of elder abuse, particularly from low- and middle-income countries, are very limited (8).
3. Violence against girls: Girls face all the forms of child maltreatment covered in the next point below, as well as specific forms of violence that are rooted in gender discrimination and harmful traditional practices. These include female genital mutilation (FGM) and child, early and forced marriage. More than 67 million women who are currently aged 20–24 years are estimated to have been married before they reached the age of 18 (9). More than 125 million girls and women alive today have undergone FGM in the 29 countries of Africa and the Middle East where the practice is concentrated (10). Girls are also more likely to experience sexual abuse or be trafficked for sex than boys.
4. Violence against children(5) includes child maltreatment (i.e. physical, sexual and emotional abuse and neglect by adults) as well as early forms of youth violence such as bullying, physical fighting, dating violence that occurs largely among peers and is a precursor to other forms of youth violence later in life. A quarter of all adults report having been physically abused and 36% have experienced emotional abuse as children; 1 in 5 women and 1 in 10 men report having been sexually abused as a child (2). Data from selected countries show that self-reported involvement in physical fighting (over the past 12 months) was nearly 1 in 2 among boys and 1 in 4 among girls. With regard to bullying (i.e. having been bullied in the past 30 days), the average across countries was 42% for boys and 37% for girls.6

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5 This includes violence against boys and girls up to the age of 18 years.
6 Data from the Global school-based student health survey (GSHS), available at: http://www.who.int/chp/gshs/en/
5. **Intersections and linkages across different forms of violence**: Child maltreatment and intimate partner violence against women can occur in the same household. Child maltreatment increases the risk of subsequent involvement in violence against women and other forms of violence against children (e.g. bullying and fighting among youth), both as a victim and perpetrator. Therefore, efforts to address violence against women and against children need to take into account the intersections of the two, and their links to youth violence.

6. **Disproportionate vulnerability of certain groups**: Across all forms of violence, certain sub-groups are disproportionately more likely to be exposed to or experience violence because of social exclusion, marginalization and discrimination. This includes: persons with disabilities, indigenous groups, ethnic and racial minorities, sexual minorities, people living with HIV, and persons from the poorest families, among others.

**Health consequences**

1. People exposed to or experiencing violence suffer a range of short- and long-term consequences. These include but are not limited to physical injuries, mental health problems (including depression, anxiety and post-traumatic stress disorders), suicide and a higher risk of noncommunicable diseases. They are also more likely to engage in health-harming behaviours (e.g. alcohol and drug use, smoking, self-harm and risky sexual behaviour). Violence impacts productivity and entails enormous human and economic costs for the survivors, their families and for society as a whole.

2. In addition, women and girls exposed to violence often also experience sexual and reproductive health problems, including unintended pregnancies, a 2-fold increase in the likelihood of induced abortion (in many settings this is also unsafe), and a 1.5-fold increase in the likelihood of sexually transmitted infections including HIV (3). Intimate partner violence against women often persists or may start during pregnancy, leading to miscarriage, premature labour, a 41% increase in the likelihood of preterm birth and a 16% increase in the likelihood of low birth weight (3). It also has consequences for their children, including higher rates of infant mortality and developmental and behavioural problems. FGM is associated with obstructed labour and higher perinatal mortality, as well as other acute and long-term health consequences. Early marriage is associated with early pregnancy, which carries a high risk of perinatal and maternal mortality and morbidity. It also impedes girls’ access to education and livelihood skills and can lead to social isolation.

3. Violence against children can result in adoption of health-harming behaviours as described in point 1 above and lifelong consequences including mental and other health problems. It can also undermine educational attainment and future employment prospects. Moreover, girls who experience physical abuse or neglect and those who are exposed to intimate partner violence in the household early in life are at increased risk of later becoming victims of intimate partner violence or sexual exploitation and trafficking. Boys who are victimized are at increased risk of becoming perpetrators or victims later in life. Youth violence is also linked to increased involvement over time in other forms of violence, both as perpetrators and as victims.

**Risk and protective factors and determinants**

1. There is no single cause of the various forms of interpersonal violence affecting different groups of people. Rather, there are multiple risk factors associated with both perpetration and victimization across the socio-ecological model (see Annex 1).

2. **Common community- and societal-level risk factors**: While different types of violence affecting different groups of people have unique risk factors that require specific attention, they also share some common underlying risk factors. These include: high rates of violence and crime in the community; poverty and unemployment; availability of drugs and weapons (e.g. firearms, knives); low levels of enforcement of laws against violence; and a high density of alcohol outlets. These factors may be exacerbated in settings of humanitarian crises, including conflicts.
Addressing the common risk factors can help to strengthen stand-alone programmes for each type of violence, such that important synergies and efficiencies can be made by combining programming where appropriate.

3. **Violence against women and girls:** Gender inequality, including power imbalances between men and women and sociocultural norms that tolerate violence, is at the root of most forms of violence against women and girls. Specific risk factors associated with the experience of intimate partner violence include: (a) a history of childhood abuse, low education and/or mental disorders; (b) the partner’s harmful use of alcohol, male control over women; (c) acceptability of violence as a way to discipline women who violate prevailing gender norms; and (d) women’s lack of access to education and employment; discriminatory laws.

4. **Violence against children:** Factors associated with experience of child maltreatment include: young age of children and special needs of the child that might increase the burden to caregivers (e.g. disabilities). Risk factors for perpetration of child maltreatment are: (a) parental characteristics (including young age, large number of children, lack of understanding of child development, lack of parenting skills, attitudes supporting harsh disciplinary measures, a history of childhood abuse); presence of non-biological caregivers in the home; and alcohol or drug misuse or mental illness among caregivers; (b) poor parent–child relationships, poor family bonding, chaotic family life; intimate partner violence in the same household. Some of the risk factors for child maltreatment and child maltreatment itself are associated with other forms of violence among young people. Risk factors associated with perpetrators youth violence include: behavioural problems, anti-social peers, alcohol and drug use, and a history of involvement in violence.

**Progress in countries and gaps**

1. **Laws are in place to address some forms of violence, but their enforcement is weak:** Most countries’ report having laws in place that ban at least some forms of violence, including some forms of violence against women and girls (e.g. domestic violence, rape), and against children. Few countries, however, are fully enforcing their laws against different forms of violence (2).

2.** National plans and policies for addressing violence are not adequately resourced:** A majority of countries report having national multisectoral plans to address violence against women and some forms of violence against children (i.e. child maltreatment) (2). A small fraction of countries have included violence against women in their national health policies or plans (WHO unpublished data). Funding to address violence against women is absent from most national budgets (11).

3. **Intersectoral coordination is weak:** Intersectoral coordination for addressing the different forms of violence is weak, as is coordination within the health sector across different programmes and services. In many countries, ministries of health are minimally engaged in intersectoral coordination mechanisms for addressing different types of violence (2).

4. **Few women and children access services in case of violence:** Evidence highlights that a majority (55–95%) of women survivors of violence do not disclose or seek any type of health, legal or police services (12). Similarly, in high-income countries only a small fraction (0.3–10%) of victims of child maltreatment come to the attention of child protection services (13, 14).

5. **Coverage of different services needed by survivors of violence is limited and uneven:** In many countries services for different types of violence are inadequate in terms of quality and coverage. Only half of all countries report having services in place to protect and support victims of violence. While two thirds of the countries report having medico-legal services for sexual violence, these are usually concentrated in a few cities and there are gaps in terms of the quality of services and access for women and girls (2). Studies show that available services

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7 This represents findings from 133 countries that responded to the survey for the WHO *Global status report on violence prevention 2014* (2).
are often fragmented, dispersed and poorly resourced. Women and girls often have to navigate different agencies for services and, hence, bear enormous costs and experience long waits (11). While a majority of countries report having in place child protection services and systems for identification and referral of child maltreatment cases, few have specific protocols. Similarly, pre-hospital and emergency medical services to treat the severe injuries often associated with youth violence (e.g. due to gunshots, stabbings and beatings) are poorly developed in most low- and middle-income countries. Few countries (less than half) report having mental health services for victims of violence (2).

6. **There is limited availability of trained and sensitized personnel in the health workforce:** In most countries, health-care providers lack the skills or training to appropriately respond to violence against women and girls and against children. For example, in low- and middle-income countries, front-line emergency medical-care providers are unable to identify injuries caused by child maltreatment, intimate partner violence or sexual violence (15). Most health-care providers do not know how to respond to survivors beyond treatment for physical injuries; for example they are not trained to provide psychological support. Health-care providers often share predominant attitudes that condone the acceptability of violence against women and girls (11). Studies have documented disrespect and abuse of women clients in reproductive health settings (16, 17). Violence against women and violence against children are still not included systematically in the educational curricula of nursing, medical and other health-care professionals (11).

7. **Coverage of large-scale prevention programmes is limited:** Few countries are systematically implementing large-scale programmes to prevent different types of violence. For example, about half the countries report implementing awareness-raising campaigns on violence against women and girls to change attitudes. One third of countries report implementing programmes to improve skills in parenting in families at risk of violence.

8. **Civil society plays a critical role:** Globally, the political momentum for addressing violence against women and girls is a result of strong civil society advocacy, particularly from women’s organizations (18). In several countries, women’s and other civil society organizations have partnered with ministries of health or implemented prevention and response programmes.

9. **There is limited availability of data and information:** While there are more than 80 countries with population-based survey data on intimate partner violence against women, fewer countries have data for sexual and other forms of gender-based violence, including in conflict-affected settings (3). Similarly, fewer countries report having population-based data on child maltreatment or other forms of violence against children. Very few countries, and almost no low- and middle-income countries, have prevalence data on elder abuse. There is also a need for more evidence about factors associated with perpetrating and becoming a victim of violence. Promising interventions also need to be more rigorously tested through monitoring and evaluation (2).

### 1.4 The role of the WHO Secretariat

The WHO Secretariat has been active for the last 20 years in addressing violence as a public health problem. In accordance with WHO’s mandate, the Secretariat is generating evidence, developing guidelines and other normative tools and supporting advocacy in order to address the various types of violence. The Secretariat is also working with many Member States to raise awareness about prevention and responses to violence, in particular against women and girls, and to assist them in the implementation of WHO tools and guidelines in order to strengthen their policies and programmes (see Annexes 3–5).
Chapter 2. Vision, goal, objectives, guiding principles and time frame

2.1 Vision
A world in which women, men, girls and boys are free from all forms of violence and coercion; their health is protected and promoted; and their human rights – including the right to the highest attainable standard of health and reproductive rights – are fully achieved; and women and girls have equality with men and boys, and are free from discrimination.

2.2 Goal
The goal is to strengthen the role of health systems within a multisectoral national response in:

- promoting and protecting the physical and mental health and well-being of those subjected to, affected by or at risk of violence;
- providing survivor-centred care and services, including for sexual and reproductive health and mental health, to mitigate health and other negative consequences of violence;
- facilitating access to comprehensive care and multisectoral services; and
- preventing violence.

2.3 Objectives
Four objectives are proposed. They should be aligned to the Sustainable Development Goals (SDGs) and other commitments already made by countries.

1. Strengthen leadership, advocacy and governance of the health system in addressing violence, in particular against women and girls, and against children.
2. Strengthen the capacity of health services and health-care providers to respond to violence, in particular against women and girls, and against children.
3. Strengthen the capacity of the health system in programming to prevent violence, in particular against women and girls, and against children.
4. Improve research and evidence on violence, in particular against women and girls, and against children.

2.4 Guiding principles
1. Universal coverage and equity
2. Human rights
3. Gender equality
4. Autonomy and empowerment
5. Community involvement
6. Evidence-based practice
7. Life-course approach
8. Multisectoral response
9. Comprehensive response

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8 An explanation of the guiding principles for addressing violence is supplied in Annex 7.
2.5 Time frame
Preventing and responding to violence requires transformational change in societies. Strengthening the role, engagement and capacity of health systems to address violence is a long-term process. In many countries, the public health approach to preventing and responding to violence is beginning to be understood and applied, and ministries of health are beginning to play a greater role in providing services to survivors and promoting prevention. Hence, a proposed time frame for this global plan of action is 10 years.

Questions to elicit feedback from consultations:

- Are you in broad agreement with the vision, goals and guiding principles? Please provide suggestions for improving them.
- Are the proposed objectives adequate and feasible? Please provide suggestions for improving them.
- It may be unrealistic to expect objectives to be achieved in a short period of time. We welcome your feedback on the proposed time frame.
- Does the proposed structure for the draft zero of the global plan of action work?
Chapter 3. Proposed actions for Member States, national and international partners,\(^9\) and the WHO Secretariat

1. The role of the health system, within a multisectoral response, is to:
   a. provide comprehensive services to survivors of violence;
   b. document the burden of the problem, its causes, and health and other consequences;
   c. advocate for its recognition as a public health problem that all sectors need to address;
   d. coordinate the response of the health system with other stakeholders; and play an active role in national multisectoral coordination mechanisms;
   e. develop, evaluate, and implement violence-prevention programmes that can be carried out by the health sector; inform and support testing and evaluation of interventions to prevent and respond to violence in other sectors; and
   f. contribute to multisectoral prevention programmes by taking the actions specified in b to e above.

2. This chapter specifies core evidence-based actions that can be taken by Member States, national and international partners and the WHO Secretariat. To determine their priorities for implementing the actions in this plan, countries will need to consider the availability of data and knowledge, the burden, and existing initiatives for addressing the different types of violence. They will need to implement the actions in an incremental manner over time towards a strong health systems response.

A. Actions across different forms of violence

This section addresses actions relevant to all forms of interpersonal violence (i.e. child maltreatment, youth violence, violence against women, and elder abuse) including:

- Common service needs;
- Data collection mechanisms;
- Strategies for addressing shared risk factors;
- Prevention programmes that can help reduce all forms of violence.

As such these, these cross-cutting actions constitute the organizational foundations needed to support work addressing specific forms of violence, and can enable the health sector’s contribution to multi-sectoral prevention and response efforts.

Objective 1: Strengthen leadership, advocacy and governance of the health system in addressing violence

Actions for Member States and national and international partners

- Sensitize policy-makers about the need for: (a) a public health approach to preventing and responding to violence; (b) addressing violence, in particular against women and girls and against children, at different stages of the life course; and (c) addressing common risk factors and thus, building synergies across violence prevention and response programmes for different forms of violence.

\(^{9}\) Note: National and international partners include, among others: UN and other development agencies; civil society including women’s organizations, youth groups and community associations; professional bodies and associations; and academic and research institutions.
• Review legislation and policies, and advocate for law and policy reforms and enforcement of existing laws and policies that address shared risk factors for several types of violence, such as those that: prevent harmful alcohol and substance use; ensure access to education and keep young people in secondary schooling; reduce concentrated poverty.

• Strengthen coordination, data management and referral mechanisms across different programmes of the health sector and with other sectors, such as mechanisms to advance gender equality and women’s empowerment, child protection, education, law enforcement and judicial sectors.

• Develop and adapt performance and accountability measures to monitor how well the health system is addressing violence, in particular against women and girls, and against children.

**Actions for the WHO Secretariat**

• Continue to develop guidance on comprehensive policies addressing violence and injuries across the life-course.

• Continue to monitor efforts to address violence, in particular against women and girls and against children, across countries, including through regular updates of the global and regional estimates of violence against women, global status reports on violence and other relevant methods.

• Engage in technical cooperation with ministries of health and/or other relevant ministries (e.g. those responsible for advancement of women or gender equality, and child protection) in integrating measures to address violence, in particular against women and girls and against children into national health policies or plans and/or strengthening the health components of national multisectoral policies or plans to address violence, in particular against women and girls, and against children.

**Global targets**

• By XXXX, XX (number of) countries will have a national multisectoral action plan or policy that addresses the health aspects of at least one form of violence, in particular violence against women and girls and against children, or will have integrated violence into existing national health policies or plans.

• By XXXX, XX (number of) countries will have established one or more units or focal points in the ministry of health to cover at least one form of violence, in particular violence against women and girls, and against children.

**Objective 2: Strengthen the capacity of health services and health-care providers to respond to violence**

**Actions for Member States and national and international partners**

• Improve pre-hospital services and emergency room services, including by training emergency room staff to provide timely and quality pre-hospital and emergency trauma care to mitigate negative consequences of violence.

• Strengthen mental health care in social services and mental health care in general health services, and ensure they adequately address the wide range of psychological and mental health consequences of violence.

• Address the intersections between different forms of violence. For example, ensure that health services aimed at women experiencing violence are also arranging for the assessment of the situation of children in their homes and providing referrals and services for such children. And
likewise, ensure that health services aimed at children experiencing violence are also arranging for the assessment of the situation of women in their homes and providing referrals and services for such women.

- Raise awareness in communities about available services for violence, the health consequences and the importance of seeking health care promptly (e.g. for post-rape care).
- Identify and address barriers to access to services for survivors of violence, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.

**Actions for the WHO Secretariat**

- Engage in technical cooperation with Member States to strengthen their health sector response to violence, in particular against women and girls and against children, including through the implementation of existing WHO guidelines and tools.
- Develop and support implementation of curricula for health practitioners (policy-makers and health-care providers) on understanding and addressing the different types of violence.

**Global targets**

- By XXXX, XX (number of) countries will have a standardized coordination mechanism established between health and other relevant sectors, including social and legal services, to address violence, in particular violence against women and girls, and against children.

**Objective 3: Strengthen the role and capacity of the health sector in programming to prevent violence**

**Actions for Member States and national and international partners**

- Increase knowledge among health-care providers, policy-makers, community workers, personnel in other sectors and members of the public about the health burden of violence, its long-term consequences and costs to society, and the importance of preventing violence before it begins.
- Conduct and intensify advocacy to strengthen investments in evidence-based programming to prevent violence within the health and other sectors.
- Implement prevention interventions within the health sector that address common risk factors of several different types of violence, such as harmful alcohol and substance use.

**Actions for the WHO Secretariat**

- Continue to collect and disseminate data on effective interventions, including by maintaining a global database of information about effective programmes to prevent different types of violence, in particular against women and girls, and against children.
- Engage in technical cooperation with countries in strengthening human and institutional capacity to design, implement and evaluate policies and programmes to prevent violence, in particular against women and girls and against children, including by using existing courses and assessing the readiness of countries to scale up prevention efforts.

**Objective 4: Improve research and evidence on violence**

**Actions for Member States and national and international partners**
• Improve health information, vital registration and routine injury and surveillance systems to
document and compile standardized statistics on incidence of homicide and prevalence of other
forms of violence, and ensure that these data are disaggregated by sex and age and include the
relationship between the perpetrator and victim.

• Strengthen capacity of researchers, particularly in low- and middle-income countries, to
collect and research on violence, including types of violence such as elder abuse, that are largely
neglected.

**Actions for the WHO Secretariat**

• Support research on and expand the evidence base on risk factors associated with the
perpetration of violence, in particular violence against women and girls, and against children.

**Global targets**

• By XXXX, XX (number of) countries will be able to provide data on homicide, disaggregated by
age, sex and relationship of victim and perpetrator.

**B. Violence against women and girls**

This section covers actions of health system’s response to violence against women and girls and
appropriate prevention efforts including:

• Efforts to eliminate harmful practices directed against women because of their sex, and
social norms that support violence against women;

• Services to address the sexual and reproductive health consequences of violence against
women, and

• Prevention programmes that focus on reducing violence against women and girls.

**Objective 1: Strengthen leadership, advocacy and governance of the health system in addressing violence against women and girls**

**Actions for Member States and national and international partners**

• Publicly challenge the acceptability of all forms of violence against women and girls by:
  – advocating to end harmful practices against girls including female genital mutilation (FGM)
    and its medicalization, and child, early and forced marriages;
  – supporting actions to challenge harmful gender norms, discriminatory attitudes and
    behaviours towards women and girls that blame them and that perpetuate male control
    over female behaviours, as well as constructs of masculinity that encourage male violence.

• Advocate for law and policy reforms, and their alignment with international human rights
standards and for enforcement of laws that:
  – prohibit all forms of violence against women and girls;
  – end harmful practices (e.g. FGM and child, early and forced marriages);
  – end discrimination against women and girls and promote gender equality.

• Prioritize addressing violence against women and girls in national policies and plans.
  Specifically:
Actions for the WHO Secretariat

- Raise awareness among senior policy-makers and decision-makers about violence against women and girls, its health and other consequences, the need for it to be prioritized within the health sector, and about the important role the health system can play in prevention and response.
- Promote the integration of interventions addressing violence against women and girls within maternal and child health, early childhood development, adolescent health, sexual and reproductive health, HIV and mental health policies, plans, programmes and services.

Global targets

- By XXXX, XX% (suggest 50%) of countries will have health budgets with one or more dedicated line item addressing violence against women and girls

Objective 2: Strengthen the capacity of health services and health-care providers to respond to violence against women and girls

Actions for Member States and national and international partners

- Develop guidelines, protocols and/or standard operating procedures to provide care, support and services to women and girls who have experienced violence, building on WHO guidelines (19).
- Provide services to manage the complications and improve the health of girls and women who are living with FGM, including by training health workers.\(^\text{10}\)
- Address the health consequences of intimate partner violence or sexual violence by providing accessible health services that address injuries and sexual, reproductive and mental health consequences in a manner consistent with WHO guidelines (19).
- Integrate services to address violence against women into programmes for: sexual and reproductive health (e.g. family planning, maternal and child health, STI and HIV); adolescent health; mental health; and routine checks and health services for older people.
- Train health-care providers, using curricula consistent with WHO guidelines (19), such that they have the necessary skills to: identify women subjected to intimate partner violence or sexual violence; provide first-line support; and conduct forensic examination (as appropriate).
- Integrate management of health consequences of FGM, intimate partner violence and sexual violence into medical, midwifery and nursing undergraduate or pre-service curricula, and into continuing education or in-service training courses for health-care providers in line with WHO guidelines (19).

\(^{10}\) WHO is developing guidelines for clinicians on care for women with FGM, which will be ready by the time the global plan of action is finalized.
• Eliminate violence in the health workplace, including disrespect and abuse of women and girl clients, especially in reproductive health-care settings.

**Actions for the WHO Secretariat**

• Develop and disseminate clinical guidelines on the management of FGM.

• Develop and support the implementation of a model curriculum for both pre- and in-service training of health-care providers on provision of clinical care and psychosocial support to women survivors of intimate partner violence or sexual violence, building on WHO guidelines (19).

• Engage in technical cooperation with ministries of health and/or other relevant ministries (e.g. those responsible for advancement of women or gender equality, and child protection) in: developing or strengthening relevant national health sector guidelines/protocols/standard operating procedures to address violence against women in line with WHO guidelines (19); and making system-wide changes to support health-care providers in their efforts.

• Support efforts to monitor and evaluate the quality of services addressing violence against women and girls.

**Global targets**

• By XXXX, XX% (suggest 80%) of countries will have developed or updated their national guidelines/protocols/standard operating procedures for health systems response to women experiencing intimate partner violence and/or sexual violence, consistent with international human rights standards and WHO guidelines (19).

• By XXXX, XX% (suggest 40%) of countries will provide comprehensive post-rape care services in all their emergency health-care facilities, consistent with WHO guidelines (19, 20).

• By XXXX, XX% (suggest 50%) of countries will have included violence against women in their continuing education curricula for health workers (e.g. physicians, nurses, midwives, mental health professionals, social workers and other allied professionals), consistent with the WHO model curriculum.

**Objective 3: Strengthen the role and capacity of the health sector in programming to prevent violence against women and girls**

**Actions for Member States and national and international partners**

• Develop, test and implement programmes to prevent violence against women and girls that can be delivered through the health sector (e.g. early identification of survivors of violence; services including psychological care and referrals for women who have experienced violence and for children who have been exposed to parental violence or experienced violence themselves; addressing maternal depression).

• Support the development, testing and evaluation of prevention programmes that challenge harmful gender norms that: stigmatize and discriminate against women and girls; condone violence against women and girls; and promote male dominance over women and girls.

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11 Package of post-rape care to include: first line support, emergency contraception, referrals to safe abortion in accordance with applicable laws, STI and/or HIV post-exposure prophylaxis and Hepatitis B vaccination.

12 The WHO Secretariat is developing a model curriculum for health workers on health sector response to violence against women, which will be available by the time the global plan of action is finalized.
• Collaborate with other sectors to inform, test and evaluate programmes to promote gender equality and empowerment of women and girls in different sectors (e.g. microfinance, agriculture, water and sanitation), using existing development platforms and initiatives.

**Actions for the WHO Secretariat**

• Develop, test and disseminate interventions in the health sector that can be offered through maternal, sexual and reproductive health programmes to reduce violence against women and girls.

**Global targets**

• By XXXX, XX% (suggest 30%) of countries will be developing and testing evidence-based prevention activities as part of their national multisectoral plans of action on violence against women and girls.

**Objective 4: Improve research and evidence on violence against women and girls**

**Actions for Member States and national and international partners**

• Prioritize data collection, including national population-based surveys every five years to monitor progress, and improve data quality and reporting on violence against women to systematically document prevalence, risk and protective factors and consequences including health burden.

• Ensure that data collection covers all forms of violence against women and girls throughout the life-course including violence faced by older women, and use standardized and harmonized tools for collecting data.

• Support research to address key knowledge gaps relating to violence against women and girls. This includes longitudinal studies on health and other consequences of intimate partner violence and sexual violence, and studies on less researched forms of violence (e.g. trafficking, sexual violence during conflict, and abuse of older women, women with disabilities and indigenous women).

• Invest in and conduct research to test and evaluate interventions for prevention of and response to violence against women and girls.

• Build the capacity of researchers on the methodological, ethical and safety aspects of conducting research on violence against women.

• Support implementation research, including for health sector interventions and services, in order to scale up effective interventions to address violence against women and girls, and support rigorous evaluation of these interventions.

**Actions for the WHO Secretariat**

• Engage in technical cooperation with countries wanting to implement population-based surveys on violence against women and girls.

• Support countries in evaluating and testing health sector interventions and develop a health systems research agenda to address violence against women and girls.
• Conduct evidence synthesis and disseminate information on what works, including best practices to prevent and respond to violence against women and girls, so that effective interventions can be scaled up in other contexts.

• Strengthen capacity, including on the ethical and safety aspects of conducting research on violence against women and girls in low- and middle-income countries.

Global targets

• By XXXX XX% (suggest 80%) of countries will have conducted a nationally representative survey on violence against women or will have included a module on violence against women in other population-based demographic or health surveys within the past five years.

C. Violence against children

This section addresses actions to address violence against boys and girls up to the age of 18 years, and includes:

• Efforts to change social norms that are supportive of violence against children;
• Strengthening the ability of health providers to identify child victims of violence and ensure their age-appropriate treatment and management, and
• Strengthening prevention programmes to reduce violence against children in the family, schools and communities.

Although limited to childhood and adolescence, these actions include many that are relevant for the prevention of subsequent youth violence and violence in adulthood. Furthermore, these actions constitute one key element of a comprehensive approach to interpersonal violence. To ensure their effectiveness, it is therefore important that they are implemented in tandem with the actions relevant to all forms of violence, and those relevant to violence against women and girls.

Objective 1: Strengthen leadership, advocacy and governance of the health system in addressing violence against children

Actions for Member States and national and international partners

• Develop or integrate strategies into existing national policies and action plans on child and adolescent health, early childhood development and violence prevention in order to prevent and respond to violence against children that covers action:
  – to improve data collection and evaluation;
  – to address risk factors for violence against children;
  – to mitigate negative impacts, including health consequences of violence against children.
• Advocate for law and policy reforms, their alignment with international human rights standards and enforcement of existing laws and policies to prevent violence against children in all settings, including the home, schools and residential care facilities.
• Establish strong coordination and referral mechanisms among health services addressing violence against children, child protection social services, and the education sector.
• Ensure appropriate allocation of budget/resources for prevention of and response to violence against children in relevant national plans and policies.

• Develop guidelines/protocols/standard operating procedures on health sector actions to:
  – prevent violence against children;
  – provide care, support and services to children who have experienced violence, including mental health care where appropriate.

Actions for the WHO Secretariat

• Raise awareness among senior policy-makers and decision-makers about the health, social and financial consequences of violence against children, the need for it to be prioritized, both across sectors and within the health sector, and about the importance of prevention and response.

Objective 2: Strengthen the capacity of health services and health-care providers to respond to violence against children

Actions for Member States and national and international partners

• Integrate identification and case management procedures for children experiencing child maltreatment and peer violence into the provision of routine health services for children and adolescents, as appropriate.

• Strengthen individual and institutional capacities to address violence against children in relevant health sector institutions and allied sectors (e.g. education, child protection, social services, police). This includes integration of training on identification and provision of care to children experiencing child maltreatment and peer violence into national curricula of all professions of the health workforce as appropriate.

Actions for the WHO Secretariat

• Develop and disseminate evidence-based guidelines on clinical management and health services for children and adolescents exposed to violence.

• Engage in technical cooperation with ministries of health and/or other relevant ministries (e.g. child protection) in adapting WHO normative guidance on violence against children to specific country contexts.

• Provide technical assistance to countries in conducting capacity development measures on child maltreatment prevention and youth violence prevention using existing training courses.

Global targets

• By XXXX, XX% (suggest 50%) of countries will have included training sessions on the identification of risk factors for child maltreatment and on the provision of treatment and referrals in their continuing education curricula for health workers (e.g. physicians, nurses, mental health professionals, social workers, and allied professionals).

Objective 3: Strengthen the role and capacity of the health sector in programming to prevent violence against children

Actions for Member States and national and international partners

• Implement, evaluate, monitor and scale up evidence-informed interventions to:
• Prevent child maltreatment, in particular those programmes that can be delivered through the health sector (e.g. nurse home visiting and parenting support programmes);
• Help children and adolescents to develop life skills and social skills to solve problems, manage anger and emotions, and maintain positive relationships in order to prevent peer violence and bullying.

Integrate interventions to prevent violence against children into existing early child development programmes, schools-based life- and social-skills training and youth development programmes, and measure their results.

Actions for the WHO Secretariat

• Conduct evidence synthesis and disseminate information on what works, including best practices to prevent violence against children, so that effective interventions can be scaled up in other contexts.
• Engage in technical cooperation with Member States in strengthening their capacities to design, implement and evaluate policies and programmes to prevent violence against children including by assessing the readiness of a country to implement and scale-up prevention and response efforts.
• Develop, test and disseminate a low-cost parenting programme for prevention of child maltreatment and a low-cost life- and social-skills programme targeted at adolescents for the prevention of bullying and peer violence in low- and middle-income country settings.
• Collaborate with other UN partners in developing a joint strategy to address violence against children in schools.

Global targets

• By XXXX, the number of countries that report implementing evidence-based programmes to prevent violence against children will have increased by 10%.

Objective 4: Improve research and evidence on violence against children

Actions for Member States and national and international partners

• Regularly collect data on violence against children through national population-based surveys.
• Conduct outcome evaluations of programmes to prevent violence against children and services to mitigate negative consequences of violence against children.
• Strengthen national research capacities for research on the magnitude and consequences of violence against children and on effective prevention and response interventions.

Actions for the WHO Secretariat

• Develop a harmonized methodology to establish prevalence rates for types of violence in older children and adolescents (e.g. violence between peers, youth violence and bullying) and advocate for its use.
• Engage in technical cooperation with countries to evaluate and test health sector interventions to prevent and respond to violence against children.
• Develop a health systems research agenda to address violence against children.

Global targets
By XXXX, XX% of countries will have conducted a nationally representative survey on violence against children within the past five years.

**Questions to elicit feedback from consultations:**

We have proposed evidence-based actions to address the different types of violence.

1. Are you in broad agreement with these? Are there any revisions or additions to the proposed actions?
2. Which of these actions are appropriate for Member States and which are appropriate for other national and international partners?
3. Which of the proposed actions would you consider to be “core” or part of a “minimum package” to be implemented across all settings?
4. Which of these actions could be feasibly implemented with resources that are currently available and which ones would require additional resources?
5. What challenges would you face in implementing the proposed actions to strengthen your health system’s response?
6. What type of technical support, guidance and/or evidence would you find useful from WHO in order to implement the proposed actions?
7. What partnerships will you need to build in order to strengthen your health system’s response in addressing violence, in particular against women and girls, and against children?

We have proposed several global targets to monitor implementation of the global plan of action.

8. Are they feasible? Are there any others you would propose? Can you suggest how to improve these targets?
9. Which of the targets would you prioritize?
Chapter 4. Accountability and monitoring framework

This chapter presents the template for summary tables of proposed targets, actions, indicators and mechanisms for reporting on progress towards defined targets. A separate summary table will be prepared for each of the following:

A. Actions across different forms of violence

B. Violence against women and girls

C. Violence against children

Summary table

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Questions to elicit feedback from consultations:

1. What should be included in the accountability framework for this global plan of action?
2. Who should be responsible for reporting on progress made?
3. How frequently should progress in implementation be monitored?
4. What should the role of the WHO Secretariat be?
Chapter 5. Options for adaption and implementation

(Chapter to be written in mid-2015, after regional and web-based consultations)

Questions to elicit feedback from consultations:

1. Is it feasible to define options for adaptation and implementation of the plan at the global level?
2. What additional information could be provided to countries in order to guide them in adapting and implementing the plan?
3. What information might be useful for adapting the plan for fragile contexts (e.g. humanitarian crises, post-conflict settings)?
Annex 1: Glossary of key terms
(in alphabetical order)

Child maltreatment is defined as “the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power”.

Elder abuse is “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person. Elder abuse includes physical, sexual, psychological, emotional, financial and material abuse; abandonment; neglect; and serious loss of dignity and respect”.

Interpersonal violence is defined by WHO as “the intentional use of physical force or power, threatened or actual, against another person or group that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”. It includes forms of violence throughout the life course, such as child maltreatment, youth violence, violence against women (e.g. intimate partner violence, sexual violence) and elder abuse, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

Intimate partner violence “refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours”.

A life-course approach is based upon understanding how influences early in life can act as risk factors for health-related behaviours or health problems at later stages. Taking a life-course perspective helps to identify early risk factors for violence and the best times to implement a primary prevention approach.

Public health approach to violence prevention refers to four steps: defining and monitoring the problem; identifying risks and protective factors; developing and testing prevention and response strategies; and supporting widespread adoption.

Sexual violence “is any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.”

Socio-ecological model for understanding violence includes risk factors at the level of (a) the individual (e.g. individual characteristics and life histories); (b) interpersonal relationships (e.g. family dynamics and household characteristics); (c) the community (e.g. community norms, levels of poverty and crime); and (d) the society (e.g. societal norms, existence of laws, policies and their enforcement) (21).
**Violence against children** is defined as: any violence against a person under 18 years of age. It therefore includes child maltreatment and overlaps with **youth violence**. The most frequent forms it takes are child maltreatment and youth violence.

**Violence against women** (VAW) is defined as: “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”. It encompasses, but is not limited to: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

**Youth violence** is “violence occurring between people aged 10–29 years of age. It includes all types of physical and/or emotional ill treatment, and generally takes place outside of the home. It includes harmful behaviours that may start early and continue into adulthood. Some violent acts – such as assault – can lead to serious injury or death. Others, such as bullying, slapping or hitting, may result more in emotional than physical harm”.


Annex 2: Relevant resolutions, agreed conclusions, general comments and articles

World Health Assembly and Executive Board resolutions:

- WHA49.25 (1996), which declared violence a leading worldwide public health problem;\(^{13}\)
- WHA50.19 (1997), about the development of a plan of action for a public health approach to violence prevention based on scientific data;\(^{14}\)
- EB95.R17 (1995) on emergency and humanitarian action which requests WHO to include management of health effects in situations of collective violence;\(^ {15}\)
- WHA56.24 (2003) on implementing the recommendations of WHO's 2002 World report on violence and health;\(^ {16}\)
- WHA57.12 (2004), the global reproductive health strategy, which highlighted violence against women as one of the key forms of gender inequality that needs to be addressed to achieve sexual and reproductive health;\(^ {17}\)
- WHA61.16 (2008) on the elimination of female genital mutilation, which urges countries to improve health, including sexual and reproductive health, to assist women and girls who are subjected to this violence;\(^ {18}\)
- WHA63.13 (2010), about the global strategy to reduce harmful use of alcohol;\(^ {19}\) and
- WHA66.8 (2013) about the comprehensive mental health action plan 2013–2020.\(^ {20}\)

UN documents and instruments:\(^ {21}\)

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979);\(^ {22}\)
  - Article 19: The right of the child to freedom from all forms of violence (CRC/C/GC/13, 2011) refers to the right of boys and girls up to the age of 18 to be protected from all types of violence.
  - Article 24: The right of the child to the enjoyment of the highest attainable standard of health (CRC/C/GC/15, 2013) explicitly refers to freedom from violence.
- Declaration on the Elimination of Violence against Women (A/RES/48/104, 1993);\(^ {24}\)
- International Conference on Population and Development (ICPD Programme of Action, 1994);\(^ {25}\)
- Beijing Declaration and Platform for Action (1995).\(^ {26}\)

\(^ {13}\) Available at: http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_eng.pdf
\(^ {14}\) Available at: http://www.who.int/substance_abuse/en/WHA50_19.pdf
\(^ {16}\) Available at: http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf
\(^ {17}\) Available at: http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf
\(^ {18}\) Available at: http://www.who.int/reproductivehealth/topics/fgm/fgm_resolution_61.16.pdf
\(^ {19}\) Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R13-en.pdf
\(^ {20}\) Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf
\(^ {21}\) Additional references to human rights instruments and relevant WHO, UN General Assembly, Security Council and Human Rights Council resolutions, and agreed conclusions of the Commissions on the Status of Women, and general comments and other plans will be compiled and provided at a later stage.
\(^ {22}\) Available at: http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm
\(^ {23}\) Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx
\(^ {24}\) Available at: http://www.un.org/documents/ga/res/48/a48r104.htm
\(^ {25}\) Available at: http://www.un.org/popin/icpd/conference/offeng/poa.html
\(^ {26}\) Available at: http://www.un.org/womenwatch/daw/beijing/pdf/BDPFA%20E.pdf
Annex 3: Details of relevant work of the WHO Secretariat

1. The WHO Secretariat has developed several guidance documents and tools including training curricula and several documents summarizing the evidence for addressing interpersonal violence. See Annex 4 for a complete listing.

2. The WHO Secretariat is responding to the gaps identified in the health systems response to violence against women and girls in a number of ways. To support countries that want to undertake national surveys on violence against women, WHO has developed and made available the survey tools and methodology for the WHO Multi-country Study on Women’s Health and Domestic Violence against Women, considered to be the gold standard for measuring the magnitude of violence against women (12). The Secretariat has also compiled and published global and regional estimates of violence against women based on prevalence data for intimate partner violence and sexual violence from approximately 80 countries (3). These data are available on the WHO Global Health Observatory,27 and will be regularly updated. The Secretariat has published several guidelines and tools to identify effective prevention interventions and guide countries to strengthen their health systems’ responses to violence against women, including for addressing sexual violence and providing mental health care to survivors in humanitarian settings (see Annex 4). The Secretariat is supporting ministries of health with capacity strengthening for a public health approach to prevention and response to violence against women in countries, and is assisting countries to develop and/or update their national health sector protocols/guidelines for addressing violence against women and girls. For humanitarian settings, the Secretariat is supporting the implementation of tools through its role as Global Health Cluster Lead Agency in the humanitarian systems response.

3. The WHO Secretariat collects data on child maltreatment, has summarized information on effective interventions to prevent child maltreatment and disseminates this evidence widely. For example, it has developed and implemented an international questionnaire to measure adverse childhood experiences (ACEs), including child maltreatment, in a dozen countries. The Secretariat is testing a suite of low-cost parenting programmes aimed at preventing child maltreatment. It has developed a short course on child maltreatment prevention, which has been used to train policy-makers and practitioners in various countries. It also supports countries in developing policies and effective interventions to prevent child maltreatment, including by helping them assess their level of readiness to develop and scale up prevention programmes.

4. In partnership with UNESCO, the WHO Secretariat has published guidance on how to address violence within a health-promoting school. In partnership with the United States Centers for Disease Control and Prevention (CDC), it coordinates the Global school-based student health survey (GSHS)28. The Secretariat has worked with selected low- and middle-income countries to build a comprehensive policy response to interpersonal violence, focusing mainly on youth violence. It is currently developing an overview of the evidence on what works to prevent youth violence.

5. WHO’s work to address the problem of elder abuse promotes the use of evidence-based approaches to better understand the magnitude, causes and consequences, and what works to prevent such violence, and to mitigate the harm suffered by victims.

6. The WHO Secretariat has established or participates in various partnerships and initiatives, including the Sexual Violence Research Initiative, Together for Girls, UN Action for addressing sexual violence in conflict, and the Violence Prevention Alliance (see Annex 5).

27 Available at: http://apps.who.int/gho/data/node.main.SEXVIOLENCE
28 Available at: http://www.who.int/chp/gshs/en/
Annex 4: List of all WHO Secretariat publications on interpersonal violence

Interpersonal violence

- Global status report on violence prevention (2014)\(^{29}\)
- Violence prevention: the evidence (2010)\(^{30}\)
- Preventing injuries violence and violence: a guide for ministries of health (2007)\(^{31}\)
- Developing policies to prevent injuries and violence (2006)\(^{32}\)
- Guidelines for conducting community surveys on injuries and violence (2004)\(^{33}\)
- Guidelines for essential trauma care (2004)\(^{34}\)
- Preventing violence: a guide to implementing the recommendations of the World report on violence and health (2004)\(^{35}\)

Violence against women and girls

- Health care for women subjected to intimate partner violence or sexual violence (2014)\(^{36}\)
- Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013)\(^{37}\)
- WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence against women (2013)\(^{38}\)
- Violence against women in Latin America and the Caribbean: a comparative analysis of population-based data from 12 countries (PAHO, 2013)\(^{39}\)
- Three 2012 publications on provision of mental health and psychosocial support to survivors of sexual violence (2012)\(^{40}\)
- Preventing intimate partner violence and sexual violence against women: taking action and generating evidence (WHO and the London School of Hygiene and Tropical Medicine, 2010)\(^{41}\)
- WHO Multi-country Study on Women’s Health and Domestic Violence against Women (2005)\(^{42}\)
- Clinical management of rape survivors (2004)\(^{43}\)
- Guidelines for medico-legal care for victims of sexual violence (2003)\(^{44}\)
- E-learning programme: Clinical management of rape survivors in humanitarian settings (WHO, UNFPA and UNHCR, 2009)\(^{45}\)
- Violence and injury prevention short course: Preventing intimate partner and sexual violence against women\(^{46}\)

\(^{29}\) Available at: http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/

\(^{30}\) Available at: http://apps.who.int/iris/bitstream/10665/77936/1/9789241500845_eng.pdf

\(^{31}\) Available at: http://whqlibdoc.who.int/publications/2007/9789241595254_eng.pdf

\(^{32}\) Available at: http://www.who.int/violence_injury_prevention/publications/39919_oms_br_2.pdf

\(^{33}\) Available at: http://whqlibdoc.who.int/publications/2004/9241546409.pdf

\(^{34}\) Available at: http://whqlibdoc.who.int/publications/2004/9241546484.pdf

\(^{35}\) Available at: http://whqlibdoc.who.int/publications/2004/9241592079.pdf

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Child maltreatment

- European report on preventing child maltreatment (WHO Europe, 2013)\textsuperscript{47}
- Preventing child maltreatment: a guide to taking action and generating evidence (WHO and International Society for Prevention of Child Abuse and Neglect, 2006)\textsuperscript{48}
- Violence and injury prevention short course: Child maltreatment prevention\textsuperscript{49}

Youth violence

- European report on preventing youth violence and knife crime among young people (WHO Europe, 2010)\textsuperscript{50}

Elder abuse

- European report on preventing elder maltreatment (WHO Europe, 2011)\textsuperscript{51}

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Annex 5: WHO Secretariat involvement in violence-related partnerships and initiatives

The Sexual Violence Research Initiative (SVRI) is a network dedicated to bringing visibility to sexual violence as a public health problem and to developing, supporting and building capacity for research in this area. WHO was a founding member of this initiative and hosted the Secretariat for the first three years. The Secretariat was then transferred to the South African Medical Research Council following a bid for proposals. WHO has remained a member of the coordinating group and currently is co-chair.

Together for Girls (TfG) is a global public–private partnership dedicated to ending violence against children, with a focus on sexual violence against girls. The partnership includes five UN agencies (UNICEF, UNAIDS, UN Women, WHO and UNFPA), the U.S. government, the Canadian government and the private sector. The partnership supported population-based Violence Against Children Surveys (VACS) in several countries, which compiled comprehensive data on the magnitude and consequences of violence to inform future country polices.

UN Action for addressing sexual violence in conflict brings together 13 UN agencies to strengthen and provide a more coherent response to sexual violence in conflict. WHO leads the knowledge pillar of UN Action and contributes to this effort through generation of evidence and normative guidance.

The Violence Prevention Alliance (VPA) is a network of WHO Member States, international agencies and civil society organizations working to prevent interpersonal violence. VPA participants share an evidence-based public health approach that targets the risk factors leading to violence and promotes multisectoral cooperation.
Annex 6. Timeline and process for developing the global plan of action

The process for developing the global plan of action is as follows:

1. The WHO Secretariat constituted an internal core working group to lead, coordinate and develop various drafts of the global plan of action and to facilitate the consultative process.

2. A first discussion paper that will be the basis of draft zero of the global plan of action (i.e. this paper) is to be developed by March 2015, including input from members of the core working group, representatives of other concerned WHO departments, as well as regional advisors from all six WHO regions. This first discussion paper containing draft zero will be posted on the WHO website\(^{52}\), widely disseminated and used to facilitate consultations with relevant stakeholders. These consultations will include:

   a. Five regional consultations involving all six WHO regions, with the participation of representatives of Member States, UN agencies and other development agencies, civil society organizations, and academic institutions with expertise on violence against women and girls and on violence against children. These regional consultations will be held between February and June 2015.

   b. A global stakeholders consultation will be held in June 2015 (dates to be confirmed) that will include representatives of Member States, UN organizations and civil society, as well as researchers, parliamentarians and other relevant stakeholders.

   c. A web-based consultation will take place starting with the public posting of this first discussion paper containing draft zero of the global plan of action between March and October 2015 (dates to be confirmed). Information on the web-based consultation will be widely disseminated across WHO information channels and partner organizations to ensure that all interested parties can contribute to the development of the global plan of action.

3. Based on feedback received from these consultations, the draft global plan of action will be further developed. A discussion item on the draft global plan of action will be proposed to the WHO Regional Committees for their inputs. The Regional Committee meetings will take place between September and October 2015.

4. A revised draft of the global plan of action will be prepared for submission to the Executive Board in January 2016 and for further endorsement and approval by the World Health Assembly in May 2016.

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\(^{52}\) Available at: http://www.who.int/topics/violence/interpersonal-violence-against-women-children/en/
Annex 7: The guiding principles for addressing violence

1. **Universal coverage and equity:** Essential health services should be made available without risk of those needing services becoming impoverished, or experiencing stigma or discrimination (e.g. on the basis of sex, age, socioeconomic status, ethnicity, sexual orientation) from the health services. Following the principle of health equity, efforts must be made to improve access to services for those groups that are marginalized or likely to be excluded or face higher barriers in accessing services.

2. **Human rights:** Human rights are guaranteed in international and regional treaties as well as in national constitutions and laws. Programmes, laws, policies and services to prevent and respond to violence must be in line with the various international and regional human rights instruments.

3. **Gender equality:** Eliminating gender-based discrimination, changing socio-cultural norms that tolerate violence and lead to unequal gender relations, and empowerment of women and girls – are central to the prevention and response to violence, particularly violence against women and girls. Prevention of and response to other forms of violence must also address unequal gender roles and socio-cultural norms, in particular, constructions of masculinity (i.e. ideals of manhood that emphasize dominance and aggression) as a determinant of violence. It is also important to address multiple forms of discrimination that can contribute to increased vulnerability to violence including on the basis of class, caste, age, disability, sexual orientation, gender identity and others.

4. **Autonomy and empowerment:** Programming to prevent and respond to violence, including provision of health services, must respect the autonomy of individuals in making full, free and informed decisions regarding the care they receive and in the uptake of services. It must empower those who experience or are affected by violence by respecting their dignity, reinforcing their value as persons, not blaming or judging them for their experience of violence, and providing information, counselling and services that enable them to make their own decisions.

5. **Community involvement:** This refers to listening to the needs of community members – including those who are living with or have experienced violence – and meaningfully involving them in advocacy, policy development, planning and service provision, as well as in monitoring, research and evaluation.

6. **Evidence-based practice:** Programmes, policies and services to prevent and respond to violence must be based on scientific evidence and/or best practice consensus, and must take into account the specific sociocultural context.

7. **Life-course approach:** Violent behaviour in the present can be shaped by prior developmental stages and experiences. Therefore, programmes, policies and services for preventing and responding to violence must target children at an early stage and take into account the health and social needs at all stages of the life course including childhood, adolescence, adulthood and older age.

8. **A multisectoral response:** A health systems response to addressing violence needs to be situated within a comprehensive and coordinated multisectoral response to violence. This requires partnerships of multiple sectors, including health, machineries for advancement of women or promotion of gender equality, child protection, education, law enforcement, judicial and social affairs. It also requires coordination and partnerships between the public and private sector, as well as civil society, professional associations and other relevant stakeholders, as appropriate to the country situation.

9. **A comprehensive response** to addressing violence also requires programming that is implemented at multiple levels of the socio-ecological model with: individuals experiencing or affected by violence; families and other interpersonal relationships; communities; and societies more broadly.
Annex 8: Examples of promising interventions to address different types of violence

*(to be completed later)*

### References


