

Draft global plan of action on violence

Report by the Director-General

1. In January 2016, the Executive Board, at its 138th session, considered and noted this report¹ and adopted resolution EB138.R3.
2. As requested by resolution WHA67.15 (2014), the Director-General has the honour to transmit the report of the Formal Meeting of Member States to conclude the work on the development of a global plan of action to strengthen the role of the health system to address interpersonal violence, in particular against women and girls, and against children, which met in Geneva from 2–4 November 2015 (Annex 1).

PROCESS

3. The Secretariat published a first discussion paper on 20 March 2015,² containing a zero draft of the global plan of action, which served as input into:
 - a web-based consultation open to Member States, organizations of the United Nations system, nongovernmental organizations, WHO collaborating centres, academics and other relevant non-State actors;
 - an informal consultation with non-State actors on 3 June 2015;
 - an informal consultation with Member States and organizations of the United Nations system on 4 June 2015;
 - regional informal consultations with Member States, including:

WHO region	Dates
African	1–2 July 2015
Americas	26–27 February 2015
Eastern Mediterranean	27–28 April 2015
European	11–12 May 2015
South-East Asia	23–24 April 2015
Western Pacific	23–24 April 2015

¹ See documents EB138/9 and EB138/9 Add.1 and the summary records of the Executive Board at its 138th session, twelfth meeting, section 6 (document EB138/2016/REC/2).

² Available at <http://www.who.int/topics/violence/interpersonal-violence-first-phase/en/> (accessed 9 December 2015).

4. The Secretariat published a second discussion paper on 31 August 2015,¹ containing a first draft of the global plan of action, which served as input into:

- a web-based consultation open to Member States, organizations of the United Nations system, nongovernmental organizations, WHO collaborating centres, academics and other relevant non-State actors;
- a formal meeting of Member States from 2–4 November 2015.

5. As requested by the Formal Meeting, the Secretariat has worked further on the draft global plan of action, taking into consideration all the specific elements that were raised during the discussions. The attached draft global plan of action (Annex 2) is the result of this further work.

ACTION BY THE HEALTH ASSEMBLY

6. The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB138.R3.

¹ Available at <http://www.who.int/topics/violence/interpersonal-violence-against-women-children/en/> (accessed 9 December 2015).

ANNEX 1

(Agreed)

**REPORT OF THE “FORMAL MEETING OF MEMBER STATES TO CONCLUDE
THE WORK ON THE DEVELOPMENT OF A GLOBAL PLAN OF ACTION TO
STRENGTHEN THE ROLE OF THE HEALTH SYSTEM TO ADDRESS
INTERPERSONAL VIOLENCE, IN PARTICULAR AGAINST
WOMEN AND GIRLS, AND AGAINST CHILDREN”**

1. The Formal Meeting convened by the Director-General to conclude the consultation process on the development of 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, met in Geneva from 2–4 November 2015 and was chaired by Mr Keshav Desiraju (India). The session was attended by delegates from 65 Member States, the European Union and the African Union;
2. The Formal Meeting considered the second WHO Discussion Paper dated 31 August 2015 (A/VIO/INF./1), which was the result of five regional consultations involving the six WHO regions, a global consultation and two web-based consultations, and which contains the draft WHO global plan of action to strengthen the role of the health system in addressing interpersonal violence, in particular against women and girls, and against children;
3. Based on inputs from Member States, the Secretariat developed a revised draft WHO 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;
4. The Formal Meeting requested the Secretariat to further work on the document, taking into consideration all specific elements which were brought up during the discussions;
5. The Secretariat reaffirmed that, in accordance with paragraph 2(4) of WHA67.15, the Director-General will submit this report and a revised draft of the WHO 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, for consideration to the 138th session of the Executive Board in January 2016;
6. During discussions, several delegations expressed concerns on pornography and child pornography, which deem the particular attention of the Director-General.

ANNEX 2

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

Third Discussion Paper dated 22 November 2015 containing the Second Draft

SECTION 1. INTRODUCTION

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 scope of the global plan of action is guided by resolution WHA67.15. The plan focuses on violence against women and girls and against children, while also addressing common actions relevant to all types of interpersonal violence. It also addresses interpersonal violence against women and girls, and against children, in situations of humanitarian emergencies and post-conflict settings, recognizing that such violence is exacerbated in these settings.
3. All forms of interpersonal violence lead to negative health outcomes and should be addressed by the health system. However, there are compelling reasons for a particular focus on violence against women and girls, and against children. Women and girls bear an enormous burden of specific types of violence that are rooted in socially accepted gender inequality and discrimination and are thus sanctioned, despite constituting a violation of their human rights. Because of this, women and girls experience shame and stigma, and the violence often remains hidden. All too often, health and other institutions are slow to recognize and address this violence, and services are not available or have limited capacity. Until recently, violence against women and girls was largely invisible within national and international statistics and surveillance systems. 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 it within the health system (1).¹
4. Violence against children (aged 0 to 18 years), including adolescents, is widespread and constitutes a violation of their human rights. It has lifelong negative consequences, including ill-health, health risk behaviours, and experiencing and perpetrating subsequent violence. In many countries, violence is often considered an acceptable way of disciplining children. Violence against

¹ This is reflected in the 20-year review of the Programme of Action of the International Conference on Population and Development (2014), where 90% of the 176 Member States who participated in the review highlighted violence against women as a priority issue for them.

children is often invisible, and few children who experience abuse have access to the programmes and services they need. Increasing attention is now being paid to violence against children, making it an opportune time to raise awareness and strengthen the response of the health system.

5. Responsibility for addressing interpersonal violence rests clearly with national and subnational governments. Addressing such violence requires a multisectoral response, where the health and other sectors need to work together. As the lead agency for health within the United Nations system, WHO has developed this global action plan for Member States in particular, and for national and international partners, using a public health approach and focusing specifically on the role of the health system.

6. Health services and programmes are an appropriate entry point for addressing interpersonal violence, in particular against women and girls, and against children. Women who experience violence are more likely to use health services than those who do not, although they rarely explicitly disclose violence as the underlying reason (2). Health care providers are often the first point of professional contact for survivors/victims of violence, and yet the underlying violence is often invisible to them. Children who are suffering violence also frequently come to health services without the violence being identified by health workers. The plan of action purposefully focuses on what the health system can do, in collaboration with other sectors and without detriment to the importance of a multisectoral response.

7. The global plan of action is a technical document informed by evidence, best practices and existing WHO technical guidance. It offers a set of practical actions that Member States can take to strengthen their health systems to address interpersonal violence, in particular against women and girls, and against children.

8. The past two decades have seen an increase in the evidence concerning the prevalence of some types of violence against women and girls. More recently, there has also been accumulating evidence concerning the prevalence of violence against children. However, there is still a lack of evidence on many aspects of different forms of violence, and the science and programming to address them are still in their initial stages. In addition, policies and programming to address both violence against women and girls, and violence against children, have developed as separate fields. At the level of the health system, injury management, trauma care and mental health services are relevant for all forms of violence, but the sexual and reproductive health consequences of violence against women and girls require particular interventions. The hidden nature of violence against women and girls and against children requires specific training of providers in how to identify these problems. Therefore, the nature of guidance that the global plan of action provides is different across these forms of violence.

9. The global plan of action is linked to several other World Health Assembly resolutions, global action plans and strategies, as well as to other work of WHO (see Appendices 2–5). It builds on and links with the numerous other efforts across the United Nations system to address violence, in particular against women and girls, and against children (see Appendix 5). This includes the Programme of Action of the International Conference on Population and Development, the Beijing Declaration and Platform for Action and the outcome documents of their review conferences, and all relevant treaties and conventions, resolutions and declarations by the United Nations General Assembly and the Human Rights Council, as well as the relevant Commission on the Status of Women Agreed Conclusions, among others (see Appendix 2). The global plan of action is also aligned with several of the goals and targets proposed for the Sustainable Development Goals and the 2030 Agenda for Sustainable Development (see Appendix 6).

10. The global plan of action is not intended to be a comprehensive multisectoral or United Nations-wide plan. Rather, this plan addresses the specific mandate of WHO and focuses on the health system component of a multisectoral response. In doing so, the plan takes cognizance of the roles and mandates of the different United Nations organizations in coordinating and leading wider multisectoral efforts to address violence, in particular against women and girls and against children.

Adaptation of the global plan of action to regional and national contexts

11. The global plan of action needs to be adapted at the regional and national levels, in line with the international commitments that Member States have already made, including to the Sustainable Development Goals, while taking into account region-specific situations and in accordance with national legislation, capacities, priorities and specific national circumstances. There is no single formulation of a global plan of action that fits all Member States, as they are at different points in their progress in strengthening the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, and at different levels of socioeconomic development. However, all Member States can benefit from the comprehensive approach 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 presented in this global plan of action.

12. There are evidence-based approaches which, if implemented to scale, would enable all Member States to make significant progress in addressing interpersonal violence, in particular against women and girls and against children. The exact manner in which the actions in this plan can be undertaken varies by country, and is affected by: the availability of data and knowledge; the magnitude and health burden of different forms of interpersonal violence, in particular against women and girls and against children; existing initiatives for addressing the different types of such violence; and the readiness or capacity of the health system to address such violence.

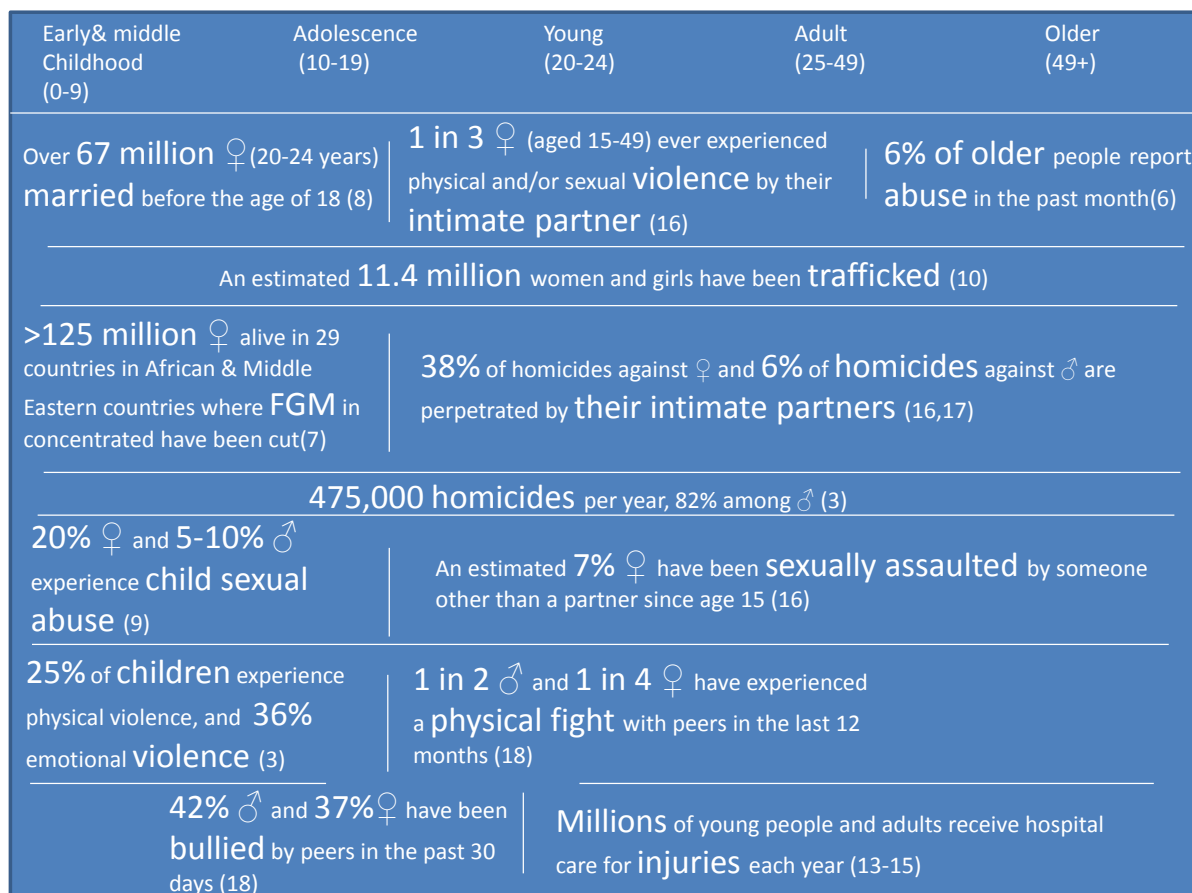
13. Member States will need to consider implementing the actions in the plan in an incremental manner over time and adequately resourcing these efforts.

Overview of the global situation (see also Appendices 7 and 8)

Magnitude

14. *Violence* affects the lives of millions of people and when not fatal can have long-lasting consequences. Deaths are only a fraction of the health and social burden arising from interpersonal violence. Women, children and elderly people bear a higher burden of non-fatal physical, sexual and psychological consequences of abuse (3). Figure 1 summarizes data on the magnitude of some of the common types of interpersonal violence, across the life course.

Figure 1. Magnitude of interpersonal violence, in particular violence against women and girls and against children, across the life course (3, 6–10, 13–18)



15. *Violence against women.* Women are affected by different forms of gender-based violence (i.e. violence that is rooted in gender inequality) at different stages of their lives. This includes, but is not limited to:¹

- violence by intimate partners and by family members (4);
- sexual violence (including rape) by non-partners (e.g. acquaintances, friends, teachers and strangers);
- trafficking, including for sexual and economic exploitation;
- femicide, including intimate partner femicide (i.e. murder of a woman by a current or former partner), murders in the name of honour or because of dowry, murders specifically targeting women but by someone other than their partner, or murders involving sexual violence (5);
- acid throwing;

¹ See, in particular, Articles 1 and 2 of the Declaration on the Elimination of Violence against Women (United Nations General Assembly resolution 48/104 (1994)).

- sexual harassment in schools, workplaces and public places, and increasingly also online through internet or social media.

16. Intimate partner violence and sexual violence are prevalent in all settings and are also the most common forms of violence experienced by women globally. Older women also experience intimate partner violence and sexual violence, as well as specific forms of elder abuse. However, data on prevalence of elder abuse, particularly from low- and middle-income countries, are very limited (6).

17. *Violence against girls.* Girls, including adolescent girls, face all the forms of child maltreatment covered in the points below on violence against children, as well as specific forms of gender-based violence and harmful practices that are rooted in gender inequality and discrimination. These include:

- female genital mutilation, which is concentrated in about 29 countries in Africa and the Middle East but also occurs elsewhere, including in countries with diaspora communities (7);
- child, early and forced marriage, which has a higher prevalence and rates of increase in some regions (e.g. South and Central Asia, parts of sub-Saharan Africa) (8);
- girls being more likely to experience sexual abuse or be trafficked for sex than boys (9, 10);
- adolescent girls, especially those who are married or are in dating relationships, also being more likely to experience intimate partner violence (4).

18. *Violence against children.* This affects boys and girls, including adolescents, aged 0–18 years and includes:

- child maltreatment perpetrated by adults in positions of trust and authority, which can involve physical abuse (including corporal punishment), sexual abuse (including incest), and psychological/emotional abuse and neglect;
- early forms of youth violence¹ that occur largely among peers in adolescence, such as bullying, physical fighting, sexual abuse, and relationship/dating violence.

19. Families with safe and nurturing relationships between parents, caregivers and children are a protective environment for children. However, there is maltreatment of children in some families, which implies the need for the support and strengthening of such families.

20. *Intersections and linkages across different forms of interpersonal violence.* Child maltreatment and intimate partner violence against women can occur in the same household. Child maltreatment increases the risk of subsequently experiencing or perpetrating intimate partner violence and sexual violence against women, as well as bullying and fighting among children and adolescents. Efforts to address violence against women and against children need to take into account the intersections of the different forms of violence. Child maltreatment and peer violence among children and adolescents are precursors to some forms of youth violence and other forms of violence later in life.

¹ WHO defines youth violence as violence occurring outside the home among children, adolescents and young men, covering 10 to 29 years. For the purposes of this global plan, youth violence is addressed under violence against children, including youth up to the age of 18 years.

21. *Disproportionate vulnerability in certain settings.* Interpersonal violence against women and girls and against children is exacerbated during situations of humanitarian emergencies and post-conflict settings, and in situations of displacement.

22. *Disproportionate vulnerability in certain institutions.* Violence is also exacerbated in institutions such as prisons, juvenile detention centres and institutions for persons with mental illness and other disabilities, and for the elderly. The perpetration of violence against women can also occur within the health system, particularly in settings providing sexual and reproductive health services (e.g. mistreatment and abuse of women during childbirth, forced sterilization) (11, 12). Health workers themselves may be subjected to violence in their homes, communities and in the workplace.

23. *Disproportionate vulnerability of certain populations.* Certain groups are more likely to be exposed to, or experience, different types of violence because of social exclusion, marginalization, stigma and multiple forms of discrimination.

Health consequences

24. Millions of women, girls, children and young people who are exposed to, or experience violence suffer a range of short- and long-term consequences (13–15). These include, but are not limited to, physical injuries – for which millions of people around the world receive hospital emergency care – mental health problems such as depression, anxiety and post-traumatic stress disorder, suicide, disabilities and a higher risk of noncommunicable diseases, including hypertensive disorders and cardiovascular disease.

25. In addition, women and girls exposed to violence experience sexual and reproductive health problems, including unwanted pregnancies, adverse maternal and newborn health outcomes, sexually transmitted infections and HIV infection, and gynaecological problems. Intimate partner violence against women often persists or starts during pregnancy, leading to miscarriage, stillbirths, premature birth and low birth-weight babies (16).

26. Exposure to violence, as a victim or a witness, particularly in early childhood, has significant detrimental effects on the development of a child's brain that can lead to social, emotional, and behavioural problems. Individuals, especially children, who experience violence are also more likely to engage in health-harming behaviours such as smoking, alcohol and drug abuse and unsafe sex, with lifelong consequences for health, and are more likely to perpetrate or be victims of interpersonal as well as self-directed violence in later life. Violence impacts productivity and entails substantial human and economic costs for the survivors/victims, their families and society as a whole. (See Appendix 7 for more information.)

Risk and protective factors and determinants

27. No single factor explains the increased risk of victimization or perpetration of the different forms of violence, or why violence is more prevalent in some countries and communities than others. Rather, there are multiple risk factors associated with both perpetration and victimization at the individual, relationship, community and societal levels. Violence against women and girls, and against children, both have unique risk factors that require specific attention. These are further summarized in Appendix 8. In addition, there are several risk factors/determinants that cut across all forms of interpersonal violence. These common underlying risk factors/determinants include: gender inequality, unemployment, harmful norms on masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate

enforcement of laws. Addressing these common risk factors/determinants can strengthen stand-alone programmes for each type of violence, and synergies and efficiencies can be made by combining programming where appropriate.

Progress in countries and gaps

28. Countries are at different stages of implementing health system actions to address violence in terms of their readiness and capacity.

29. Laws are in place to address some forms of violence, but their enforcement is weak. Most of the 133 countries which reported for the Global status report on violence prevention (3) have laws in place that penalize at least some forms of violence, including some forms of violence against women and girls (such as domestic violence, rape), and against children. However, in many countries legislation continues to be inadequate to cover a number of specific forms of violence. Few countries are fully enforcing their laws against these and other forms of violence (3).

30. *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 (child maltreatment) (3). Funding to address violence against women is absent from most national budgets (20).

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

32. *Few women and children access services in case of violence.* Evidence highlights the fact that a majority (55–95%) of women survivors of violence do not disclose or seek any type of health, legal or police services (4). 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 (21, 22).

33. *Coverage and quality of services needed by survivors/victims are limited and uneven.* Only half of all countries report having services in place to protect and support survivors/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 (3). Available services are often fragmented, dispersed and poorly resourced. They are not integrated into the health system. Women and girls often have to navigate different agencies for services and hence bear huge costs and experience long waits (20). 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, beatings and burns) are poorly developed in most low- and middle-income countries. Few countries (less than half) report having mental health services for survivors/victims of violence (3).

34. *There is limited availability of trained and sensitized personnel in the health workforce.* In most countries, there is a lack of skilled health workers to address violence (such as sexual assault nurses or forensic specialists), or health care providers lack the skills or training to respond appropriately to violence against women and girls and against children (20, 23). Surveys worldwide have documented that attitudes condoning the acceptability of violence against women and girls are widespread and that health workers often share the prevailing social norms, values and attitudes towards violence (4, 19).

Studies have documented disrespect and abuse of women seeking reproductive health services (11, 12). Health workers do not always respect the autonomy, safety and confidentiality of survivors/victims. Neither violence against women nor violence against children are included systematically in the educational curricula of nursing, medical and other health care professionals (20).

35. Coverage of large-scale prevention programmes is limited. Few countries are systematically implementing large-scale programmes to prevent different types of violence (3).

36. *Civil society plays a critical role.* The global political momentum for addressing violence against women and girls is a result of strong civil society advocacy, particularly from women's organizations (24). They have often partnered with ministries of health, local health authorities and social services to provide services and implement prevention programmes.

37. *There is limited availability of data and information.* While there are nearly 100 countries with population-based survey data on intimate partner violence against women, fewer countries have data on sexual and other forms of violence against women and girls, or on men's perpetration of such violence. In particular, there is a lack of data from humanitarian settings or on violence faced by older women (16) and vulnerable groups (24). Similarly, fewer countries report having population-based data on child maltreatment or other forms of violence against children, although their numbers are growing. Promising interventions also need to be more rigorously tested through monitoring and evaluation (3).

Process and roadmap of the plan

38. This draft of the global plan of action has incorporated the inputs from consultations with Member States in all six WHO regions, civil society organizations, entities of the United Nations system and other international partners, as well as two global consultations with Member States in June and November 2015 (see Appendix 9 for details of the process). The finalized global plan of action will be presented at the Sixty-ninth World Health Assembly in 2016.

39. This document is organized as follows:

- Section 1 introduces and describes the scope of the plan.
- Section 2 sets out the vision, goals, objectives, strategic directions and guiding principles of the plan.
- Section 3 outlines the actions to be taken by Member States, national and international partners, and WHO: This section is further subdivided into three sections:
 - Section 3.A focuses on violence against women and girls. Specific forms of violence that are particular to or disproportionately affect girls are covered in this section, whereas forms of violence that are common to both boys and girls are covered in section 3.B.
 - Section 3.B focuses on violence against children. It includes child maltreatment and peer violence among adolescents, both boys and girls, which are precursors to some forms of violence later in life.

- Section 3.C focuses on all forms of interpersonal violence: cross-cutting actions. These include actions that are common across the forms of violence covered in sections 3.A and 3.B, as well as other forms of interpersonal violence across the life course, such as youth violence and elder abuse. This section complements and reinforces sections 3.A and 3.B.
- Section 4 describes the monitoring and accountability framework, including mechanisms for reporting and suggestions for global-level indicators and targets.
- Appendices include a glossary of terms, links to relevant resolutions and consensus documents, and details of the Secretariat’s work.

SECTION 2. VISION, GOAL, OBJECTIVES, STRATEGIC DIRECTIONS AND GUIDING PRINCIPLES

This section articulates the vision, goal, objectives, strategic directions and guiding principles of the global plan of action in the context of the role that the health system plays in a national multisectoral response. It also highlights the roles of the different stakeholders in relation to the implementation of the plan.

Box 1: The role of the health system within a multisectoral response

The health system can play a role in both preventing and responding to all forms of interpersonal violence, in particular against women and girls, and against children, given the hidden nature of such violence. The role of the health system is to:

- advocate for a public health perspective;
- identify those who are experiencing violence and provide them with comprehensive health services at all levels of health service delivery (i.e. primary health care and referral levels);
- develop, implement and evaluate violence prevention programmes as part of its population-level prevention and health promotion activities;
- document the magnitude of the problem, its causes and its health and other consequences, as well as effective interventions.

However, the health system alone cannot adequately prevent and respond to interpersonal violence, in particular against women and girls and against children. Many of the risk factors and determinants of violence lie outside the health system, requiring a holistic, integrated and coordinated response across different sectors, professional disciplines, and governmental, private and nongovernmental institutions. Therefore, in line with the “health in all policies” approach (25), governments should enable the health system to interact and coordinate its own response with a number of other sectors, including police and justice, social services, education, housing/shelter, child protection, labour and employment, and gender equality or women’s empowerment. As part of a comprehensive multisectoral prevention effort, the health system can:

- advocate with other sectors to address the risk factors and determinants of violence;
- facilitate the access of survivors/victims of violence to multisectoral services, including through strong referral mechanisms;
- inform multisectoral violence prevention policies and programmes;
- support the testing and evaluation of interventions in other sectors.

Vision

1. A world in which all people are free from all forms of violence and discrimination, their health and well-being are protected and promoted, their human rights and fundamental freedoms are fully achieved, and gender equality and the empowerment of women and girls are the norm.

Goal

2. To strengthen the role of the health system in all settings and within a national multisectoral response to develop and implement policies and programmes and provide services that promote and protect the health and well-being of everyone, and in particular of women, girls and children who are subjected to, affected by or at risk of interpersonal violence.

Objectives

3. The objectives are:
- to address the health and other negative consequences of interpersonal violence, in particular against women and girls and against children, by providing quality comprehensive health services and programming, and by facilitating access to multisectoral services;
 - to prevent interpersonal violence, in particular against women and girls and against children.

Strategic directions

4. In order to achieve the objectives, four strategic directions are proposed that address both the health system mandate of the plan and the public health approach to addressing interpersonal violence, in particular against women and girls and against children. These are:

Strengthen health system leadership and governance

- This strategic direction covers actions related to: advocacy within the health system and across sectors; setting and implementing policies; financing, including budget allocations; regulation; oversight and accountability for policy and programme implementation; and strengthening coordination of efforts with other sectors.

Strengthen health service delivery and health workers'/providers' capacity to respond

- This strategic direction covers actions related to: improving service infrastructure, referrals, accessibility, affordability, acceptability, availability and quality of care; integrating services; ensuring access to quality, safe, efficacious and affordable medical products and vaccines; and training and supervision of the health workforce.

Strengthen programming to prevent interpersonal violence

- This strategic direction covers actions to prevent violence that the health system can directly implement, including identifying people at risk and carrying out health promotion activities, as well as those to which it can contribute through multisectoral actions (see Box 1).

Improve information and evidence

- This strategic direction includes actions related to: epidemiological, social science and intervention research; improved surveillance, including through health information systems; and programme monitoring and evaluation.

Guiding principles

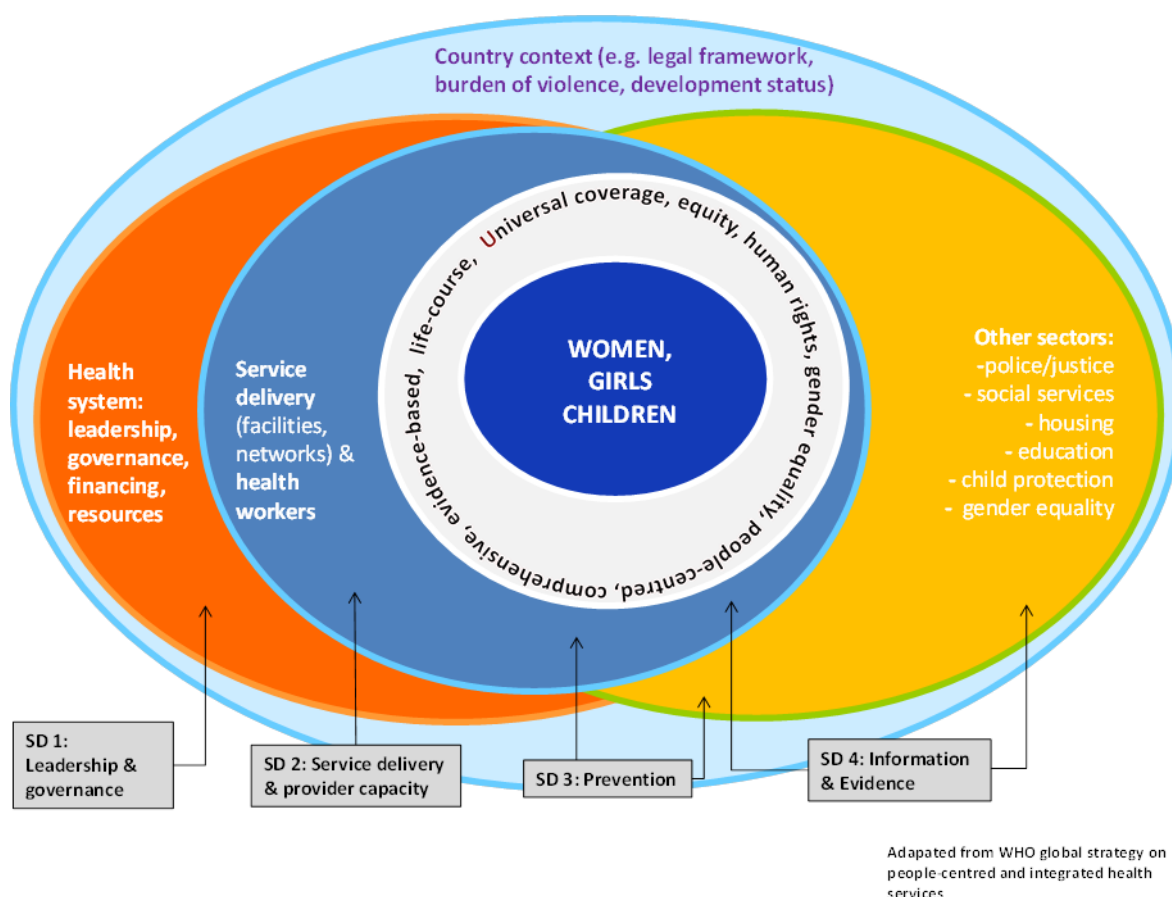
5. The plan is guided by 10 guiding principles, set out in Table 1.

Table 1: Summary of guiding principles to inform the implementation of this plan

Guiding principles		
1.	Life-course perspective	Address the risk factors and determinants of violence and the health and social needs of survivors/victims at the early stage of the life course, focusing on children, as well as at all other stages of the life course (adolescence, adulthood and older ages)
2.	Evidence-based approach	Be informed by the best available scientific evidence while tailoring interventions to each context
3.	Human rights	Respect, protect and fulfil human rights, including those of women, girls and children, in line with international human rights norms and standards, including the right to the highest attainable standard of health
4.	Gender equality	Advocate for addressing gender inequality and gender-based discrimination as key underlying determinants of violence, in particular against women and girls, by: (a) challenging unequal power relations between women and men and sociocultural norms that emphasize male dominance and female subordination; and (b) strengthening the engagement of men and boys in prevention, alongside efforts to empower women and girls
5.	Ecological approach	Address the risk factors and determinants that occur at multiple levels of the ecological framework (individual, relationship, community and societal)
6.	Universal health coverage	Ensuring that all people and all communities receive the quality services they need and are protected from health threats, while not suffering from financial hardship
7.	Health equity	In addition to universal health coverage, pay particular attention to the needs of groups that are marginalized, face multiple forms of discrimination and are more vulnerable to violence and barriers in access to services
8.	People-centred care	Provide victim/survivor-centred care and services that: respect their autonomy to make full, free and informed decisions regarding the care they receive; respect their dignity by reinforcing their value as persons, not blaming, discriminating or stigmatizing them for their experience of violence; empower them by providing information and counselling that enable them to make informed decisions; and promote their safety by ensuring privacy and confidentiality in provision of care
9.	Community participation	Listen to the needs of communities, and in particular: encourage the voices of women and adolescents to be heard; support and ensure their full and equal participation; use participatory approaches to build community ownership; form partnerships with civil society, especially women's and youth organizations; and strengthen capacities for identifying sustainable solutions
10.	Comprehensive multisectoral response	Build and strengthen partnerships and coordination between the health and other sectors, and between the public and private sectors, including for profit and non-profit service providers, civil society, professional associations and other relevant stakeholders, as appropriate to each country's situation

6. Fig. 2 summarizes how the health system role fits within the larger multisectoral response to interpersonal violence, in particular against women, girls and children (26). It depicts the guiding principles, as well as how the four strategic directions correspond to the health system and multisectoral response. Actions related to health system leadership and governance (strategic direction 1) and provision of health services and health worker capacity (strategic direction 2) are core health system actions that require an interface with other sectors (such as police, justice, social services, child protection, education, gender equality). Prevention (strategic direction 3) requires multisectoral actions with a strong contribution from the health system. The generation of information and evidence through research, monitoring and evaluation (strategic direction 4) also requires multisectoral actions with a strong contribution, and often the lead, from the health system.

Figure 2. The health system's role within a multisectoral response in relation to the strategic directions of the global plan of action (26)



Time frame

7. The time frame for this global plan of action is 15 years or until 2030, which is in line with the period of implementation of the Sustainable Development Goals. In many countries, the public health approach to violence, in particular violence against women and girls and against children, is beginning to be understood and applied. Ministries of health are beginning to play a greater role in providing services to survivors/victims and promoting prevention. However, strengthening the role, engagement and capacity of the health system to address violence within a national multisectoral response is a

long-term process, as preventing and responding to violence requires transformational change in societies.

The role of Member States, national and international partners

8. The actions elaborated in the next section (Section 3) are the primary responsibility of Member States, and in particular of national and subnational¹ governments. Ministries of health working in close collaboration with other relevant ministries will need to assume leadership in operationalizing the plan. The implementation of the plan will require political commitment at the highest levels of the government.

9. National and international partners are expected to play a key role in supporting the implementation of this plan by Member States, as stakeholders who work in partnership with or alongside public sector health programmes and services. These include: private sector (for profit and non-profit) services; civil society (women's organizations, youth organizations, community and faith-based organizations, international nongovernmental organizations, etc.); parliamentarians; professional health and medical associations; bodies of the United Nations system and multilateral organizations; bilateral agencies; and academic and research institutions. They also include international and national institutions, agencies and organizations involved in humanitarian response work.

10. The roles of Member States and of national and international partners often overlap and can include multiple actions across the areas of: leadership and governance; health services delivery and capacity-strengthening of health workers; prevention; and generation of information and evidence. For example, in many countries, the health system includes a large private sector that is implementing preventive programmes and providing health services. Similarly, professional health and medical associations can be instrumental in capacity-strengthening, advocacy and policy development. Civil society organizations are crucial partners in conducting advocacy, raising awareness, mobilizing communities, and supporting the government in policy development, capacity-strengthening and service delivery. A number of organizations of the United Nations system are involved in setting norms and standards and in supporting the implementation of programmes and initiatives that are relevant for this global plan of action (see Appendix 6). The roles, responsibilities and division of labour of the different partners will need to be assessed and clarified as part of the implementation of the plan at national level.

The role of the WHO Secretariat

11. The WHO Secretariat has been active for the past 20 years in addressing the prevention of interpersonal violence and the prevention of, and response to, violence against women and against children, in particular. Building on the progress made in addressing the different forms of violence and in accordance with WHO's mandate, the Secretariat will continue to generate evidence, develop guidelines and other normative tools, and advocate in support of implementation of the global plan of action. The Secretariat will also continue to work with Member States to raise awareness about prevention of and responses to interpersonal violence, in particular against women and girls and against children, and to assist them in the implementation of WHO tools and guidelines in order to strengthen their policies and programmes (see Appendices 4 and 5 for a description of WHO's efforts

¹ In many countries with a federal or decentralized system of government, regions or states may have responsibility for the design and implementation of health- and health system-related laws, policies, programmes and services to address interpersonal violence.

and tools and guidelines in addressing violence). The Secretariat participates in a number of United Nations and other interagency partnerships and initiatives on violence that are relevant for the plan (see Appendix 6).

SECTION 3. ACTIONS FOR MEMBER STATES, NATIONAL AND INTERNATIONAL PARTNERS, AND THE WHO SECRETARIAT

This section describes broad evidence-based actions that can be taken by Member States, national and international partners and the WHO Secretariat focusing on violence against women and girls (section 3.A) and violence against children (section 3.B), as well as cross-cutting actions that contribute to addressing all forms of interpersonal violence (section 3.C).

3.A. Violence against women and girls

This section covers health system actions to respond to and prevent gender-based violence against women and girls (VAWG). These include:

- *creating an enabling legal and health policy environment that promotes gender equality and human rights and empowers women and girls;*
- *provision of comprehensive and quality health care services, particularly for sexual and reproductive health;*
- *evidence-informed prevention programmes promoting egalitarian and non-violent gender norms and relationships;*
- *improving evidence through collection of data on the many forms of VAWG and harmful practices that are often invisible in regular surveillance, health and crime statistics.*

All forms of violence against women and girls need to be addressed. Member States should prioritize specific forms that are the most relevant for their setting, based on evidence of prevalence and burden. This plan prioritizes actions to address intimate partner violence and sexual violence as the forms of violence that are prevalent in all settings and most commonly experienced by women globally. Specific forms of violence or harmful practices that disproportionately affect girls owing to gender inequality (such as sexual violence) or that are particular to girls, and that are high on the global health and development agenda (child, early and forced marriage and female genital mutilation), are also prioritized and covered in this section. Forms of violence during childhood that are common to boys and girls are covered in section 3.B.

Strategic direction 1: Strengthen health system leadership and governance

Member States	National and international partners	WHO Secretariat
<p>1. Strengthen political will by publicly committing to address and challenge the acceptability of all forms of VAWG throughout the life course, advocate to eliminate all forms of VAWG and end all harmful practices against women and girls (including female genital mutilation and its medicalization and child, early and forced marriage), and promote gender equality.</p> <p>2. Allocate appropriate budget /resources for the prevention of and response to violence against women and girls and include VAWG services in universal health coverage.</p> <p>3. Advocate for the adoption and reform of laws, policies and regulations, their alignment with</p>	<p>1. Strengthen political will by publicly committing to address and challenge the acceptability of all forms of VAWG throughout the life course, advocate to eliminate all forms of VAWG and end all harmful practices against women and girls (including female genital mutilation and its medicalization and child, early and forced marriage), and promote gender equality.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, that, inter alia: criminalize VAWG; end all harmful practices and discrimination against women and girls; promote and protect their sexual and</p>	<p>1. Strengthen WHO leadership, political will, resource allocation and integration of responses to VAWG in relevant global health programmes (such as maternal and child health, sexual and reproductive health, adolescent health, noncommunicable diseases, ageing, mental health, humanitarian emergencies) and in universal health coverage.</p> <p>2. Raise awareness and understanding of VAWG through evidence-based advocacy among senior policy-makers about its nature, health and other consequences, risk and causal factors, and the need for it to be integrated within health policies, plans and programmes and within health responses to humanitarian emergencies, including health clusters.</p>

<p>international human rights standards and their enforcement, that, inter alia: criminalize VAWG; end all harmful practices and discrimination against women and girls; promote and protect their sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences; and promote gender equality and women's empowerment, including in relation to inheritance and family laws.</p> <p>4. Establish a unit or designate a focal point in ministries of health at all administrative levels to address violence against women and girls, in order to strengthen the health system's contribution to a multisectoral response.</p> <p>5. Ensure that the response to VAWG and harmful practices is clearly articulated in health policies, regulations, plans, programmes and budgets¹ (27, 28), in particular those related to sexual and reproductive health, HIV, maternal and child health, adolescent health, mental health, healthy ageing and health responses in humanitarian emergencies. Women's organizations and survivors must be involved in planning, policy development, implementation, and monitoring and accountability; their leadership must be encouraged and supported; and particular attention must be paid to the life-course needs of women and girls, including those who face multiple forms of discrimination and marginalization.</p> <p>6. Strengthen coordination within the health system with other sectors for a strong multisectoral response to VAWG, including: police and justice; housing and social services; women's affairs and child protection.</p>	<p>reproductive health and reproductive rights; and promote gender equality and women's empowerment, including in relation to inheritance and family laws.</p>	<p>3. Advocate with ministries of health and other relevant health system stakeholders for strengthening the allocation of human and financial resources for programming and services to address VAWG and for their inclusion in universal health coverage.</p> <p>4. Provide technical support and build capacity for the integration of interventions addressing VAWG within all relevant health programmes, plans and policies, such as those for maternal and child health, sexual and reproductive health, HIV, mental health and emergency response.</p> <p>5. Develop and support the dissemination of tools for policy-makers and managers for designing and managing programmes and services to respond to VAWG.</p> <p>6. Support and facilitate efforts to coordinate the health system's response to VAWG within the United Nations system at global and national levels, including by participating in relevant joint United Nations initiatives on VAWG (see Appendix 6).</p>
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<p>7. Strengthen the accountability of the health system in preventing and responding to VAWG by:</p> <ul style="list-style-type: none"> • providing quality services and programmes and establishing oversight mechanisms; • addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services, by establishing codes of conduct for health workers, and confidential feedback mechanisms and grievance procedures to address mistreatment and abuse of women and girls by health workers; • preventing and responding to violence experienced by health workers in the workplace, including by establishing policies. 		
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Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond

Member States	National and international partners	WHO Secretariat
<p>8. Develop or update and implement guidelines, protocols and/or standard operating procedures for the identification, clinical care, support and referrals for VAW survivors, building on WHO guidelines and tools (29-33).</p> <p>9. Provide comprehensive health care services to all women and girls who have experienced violence, including in humanitarian settings. These should include: first-line support, care for injuries, sexual and reproductive health and mental health, services for post-rape care including emergency contraception, provision of safe abortion in accordance with national laws, STI and HIV prophylaxis and Hepatitis B vaccination (29-31); services to manage the health complications among women and girls who have undergone female genital mutilation; and community awareness about availability of and need for timely access to health care services, particularly for post-rape care.</p>	<p>3. Provide comprehensive health care services to all women and girls who have experienced violence, including in humanitarian settings. These should include: first-line support, care for injuries, sexual and reproductive health and mental health, services for post-rape care including emergency contraception, provision of safe abortion in accordance with national laws, sexually transmitted infections and HIV prophylaxis and hepatitis B vaccination (29-31); services to manage the health complications among women and girls who have undergone female genital mutilation; and community awareness about availability of and need for timely access to health care services, particularly for post-rape care.</p>	<p>7. Provide technical cooperation to ministries of health and other partners in developing or updating guidelines/protocols/standard operating procedures to address VAWG, building on or adapting WHO guidelines and tools (29-33).</p> <p>8. Develop or update and disseminate evidence-based guidelines and tools including those related to addressing sexual violence, including in conflict settings, and management of health complications of female genital mutilation.</p> <p>9. Include health services to address VAWG as part of universal health coverage for sexual and reproductive health, maternal, child and adolescent health, and mental health, including in humanitarian settings.</p>

<p>10. Improve access to quality health care services by integrating identification of and care for women experiencing intimate partner violence including during pregnancy and sexual violence into existing programmes and services addressing: sexual and reproductive health; HIV, maternal and child health, adolescent health; mental health; routine checks and health services for the elderly; and health responses to humanitarian emergencies. Facilitate access to multisectoral services (police, justice, housing, social, child protection, and livelihood and employment, etc.) including through provision of medicolegal care, building on WHO guidelines and tools (29, 33). Ensure health care services are sensitive, accessible and affordable to all, and especially to those facing multiple forms of discrimination.</p> <p>11. Improve accountability of services and quality of care by: eliminating discrimination and violence in the health workplace; promoting women-centered care; providing gender-sensitive services that respect and promote women's human rights; and addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services.</p> <p>12. Integrate content about the identification of, and response to VAWG and harmful practices into pre-service and in-service training curricula for health workers/providers (medical, nursing and midwifery), including those working in humanitarian emergencies, building on WHO guidelines and tools (29-33).</p>	<p>4. Improve access to quality health care services by integrating identification of and care for women experiencing intimate partner violence including during pregnancy and sexual violence into existing programmes and services addressing: sexual and reproductive health; HIV, maternal and child health, adolescent health; mental health; routine checks and health services for the elderly; and health responses to humanitarian emergencies. Facilitate access to multisectoral services (police, justice, housing, social, child protection, livelihood and employment, etc.) including through provision of medicolegal care, building on WHO guidelines and tools (29, 33). Ensure health care services are sensitive, accessible and affordable to all, and especially to those facing multiple forms of discrimination.</p> <p>5. Improve accountability of services and quality of care by: eliminating discrimination and violence in the health workplace; promoting women-centered care; providing gender-sensitive services that respect and promote women's human rights; and addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services.</p>	<p>10. Develop and support the implementation of tools to monitor and evaluate the quality of health care services addressing VAWG.</p> <p>11. Develop and disseminate a model curriculum for both pre- and in-service training of health workers/providers in responding to VAWG.</p> <p>12. Identify a pool of experts who can support Member States to develop and implement training of health workers/providers in responding to VAWG.</p>
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Strategic direction 3: Strengthen programming to prevent interpersonal violence

Member States	National and international partners	WHO Secretariat
<p>13. Develop, test and implement/scale-up programmes to prevent and reduce VAWG that can be delivered through the health system.</p> <ul style="list-style-type: none"> Support programmes addressing intimate partner violence to meet the needs of children exposed to such violence, strengthening linkages with child and adolescent health programmes. 	<p>6. Develop, test and implement/scale-up programmes to prevent and reduce VAWG that can be delivered through the health system including</p> <ul style="list-style-type: none"> Support programmes addressing intimate partner violence to meet the needs of 	<p>13. Develop or identify, evaluate and disseminate evidence-based interventions to prevent VAWG, including those that promote egalitarian gender norms and challenge harmful practices and those that can be implemented by the health system through maternal, sexual and reproductive health,</p>

<ul style="list-style-type: none"> • Address risk factors associated with intimate partner violence such as harmful alcohol and substance use and maternal depression. • Integrate education/messages on egalitarian and non-violent gender norms, and consensual and respectful sexual relations, in behavior change communication campaigns and health promotion activities by community health workers. <p>14. Support or collaborate in the development, testing and implementation of VAWG prevention programmes that challenge harmful gender norms (i.e. those that perpetuate male dominance and female subordination, stigmatize survivors, condone or normalize VAWG; or perpetuate discrimination and harmful practices against women and girls), including by engaging men and boys to address gender inequality and abusive sexual relations, alongside women and girls as agents of change.</p> <p>15. Inform policies and programmes in other sectors and those implemented by civil society about evidence-based prevention interventions, including through advocacy with the education sector to implement comprehensive sexuality education programmes, and promotion of economic and livelihood interventions for women.</p>	<p>children exposed to such violence, strengthening linkages with child and adolescent health programmes;</p> <ul style="list-style-type: none"> • Address risk factors associated with intimate partner violence such as harmful alcohol and substance use and maternal depression; and • Integrate education/messages on egalitarian and non-violent gender norms, and consensual and respectful sexual relations, in behavior change communication campaigns and health promotion activities by community health workers. <p>7. Support or collaborate in the development, testing and implementation of VAWG prevention programmes that challenge harmful gender norms (i.e. those that perpetuate male dominance and female sub-ordination, stigmatize survivors, condone or normalize VAWG; or perpetuate discrimination and harmful practices against women and girls), including by engaging men and boys to address gender inequality and abusive sexual relations, alongside women and girls as agents of change.</p> <p>8. Inform policies and programmes in other sectors and those implemented by civil society about evidence-based prevention interventions, including through advocacy with the education sector to implement comprehensive sexuality education programmes, and promotion of economic and livelihood interventions for women.</p>	<p>mental health, HIV and adolescent health programmes and services.</p> <p>14. Develop recommendations on how to provide support to children of women identified as experiencing intimate partner violence.</p> <p>15. Support efforts of Member States and in collaboration with organizations of the United Nations system and other partners to develop or strengthen existing prevention interventions that address the risk factors and determinants of VAWG, particularly those that promote gender equality and address gender norms.</p>
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Strategic direction 4: Improve information and evidence		
Member States	National and international partners	WHO Secretariat
<p>16. Strengthen routine reporting of VAWG statistics across all ages and monitoring of progress in implementing the health system's response by including indicators and collection of data on VAWG in health information and surveillance systems, prioritizing those programmes and services reaching women and girls.</p> <p>17. In line with proposed VAWG indicators for the Sustainable Development Goals,¹ support the establishment of baselines for the prevalence of VAW throughout the life course including against adolescent girls and older women, and of harmful practices through recent (i.e. in the past five years) population-based surveys.</p> <p>18. Integrate modules to regularly collect data on VAWG across all ages in demographic and health or other population-based health surveys implemented at regular intervals.</p> <p>19. Conduct or support analysis and use of data on VAWG and harmful practices and disaggregate them by age, ethnicity, socioeconomic status and education, among other factors.</p> <p>20. Conduct or support research to develop, pilot, evaluate and implement/scale up VAWG prevention and response interventions that can be implemented by the health system.</p> <p>21. Facilitate efforts by nongovernmental organizations, researchers and others to conduct research on key knowledge gaps on VAWG and harmful practices, and to develop, pilot and evaluate interventions to address VAWG.</p>	<p>9. Integrate modules to regularly collect data on VAWG across all ages in demographic and health or other population-based health surveys implemented at regular intervals.</p> <p>10. Conduct or support analysis and use of data on VAWG and harmful practices and disaggregate them by age, ethnicity, socioeconomic status and education, among other factors.</p> <p>11. Conduct or support research to develop, pilot, evaluate and implement/scale up VAWG prevention and response interventions that can be implemented by the health system.</p> <p>12. Facilitate efforts by nongovernmental organizations, researchers and other sectors to: conduct research into key knowledge gaps on VAWG and harmful practices; and to develop, pilot and evaluate interventions to address VAWG.</p>	<p>16. Develop and disseminate harmonized indicators and measurement tools to support Member States in collecting standardized information on VAWG and monitoring progress in implementing a health systems response to VAWG in a confidential and safe manner through routine health information and surveillance systems.</p> <p>17. Encourage Member States to implement population-based surveys on VAW and provide technical cooperation to Member States wanting to implement these surveys, in particular those using the WHO methodology (4).</p> <p>18. Engage in technical cooperation with Member States and support partners to build capacity in analysis of data, including data that are disaggregated (by age, ethnicity, socioeconomic status, education, etc.) on VAWG and harmful practices, and their use to inform policies, programmes and plans.</p> <p>19. Regularly update estimates of prevalence of VAW.</p> <p>20. Support Member States in piloting and evaluating health system interventions to address VAWG.</p> <p>21. Conduct and support research efforts to improve understanding of mistreatment and abuse of women within the health system.</p>

¹ Includes proposed indicators for targets 5.2 and 5.3.

		<p>22. Conduct evidence synthesis and disseminate information on what works, including best practices to prevent and respond to VAWG.</p> <p>23. Strengthen the capacity of civil society, including women's organizations, research institutions and programme implementers, to conduct research on VAWG, including on ethical and safety aspects and the application of more rigorous evaluation.</p>
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3.B. Violence against children

This section addresses violence against and among children and adolescents up to the age of 18 years. For infants and younger children, such violence mainly involves child maltreatment (i.e. physical, sexual and psychological/emotional abuse and neglect) at the hands of parents and other authority figures; as they grow older, peer violence, in addition to child maltreatment, becomes highly prevalent. Violence perpetrated against children in institutions is also addressed in this section.

Being a victim of child maltreatment increases the likelihood of being involved in adolescent peer violence, which in turn predicts subsequent perpetration and victimization in adulthood. Although limited to childhood and adolescence, many of the actions included here are relevant for the prevention of subsequent violence in adulthood.

Strategic direction 1: Strengthen health system leadership and governance

Member States	National and international partners	WHO Secretariat
<ol style="list-style-type: none"> 1. Integrate strategies to address child maltreatment into early childhood development and maternal and child health programmes, and strategies to address peer violence into child and adolescent health and school health programmes, educational settings, youth development schemes, workplaces, and juvenile justice systems. 2. Advocate for the adoption or reform of laws and policies, ensure their alignment with international human rights standards (34), and enforce existing laws and policies to prevent violence against children and adolescents, including corporal punishment, in all settings and in particular in the home, schools, communities, and residential care and detention facilities. 3. Strengthen policy-maker and public knowledge about and capacity to address the lifelong health consequences of child maltreatment, its roles as a risk factor for involvement in other forms of violence, such as youth violence and intimate partner violence, and the high prevalence of homicide and non-fatal violence-related injuries due to peer violence among adolescents. 4. Develop and adapt sex- and age-specific performance and accountability measures to monitor how well the health system is addressing violence against children and adolescents. 	<ol style="list-style-type: none"> 1. Advocate for the adoption or reform of laws and policies, ensure their alignment with international human rights standards (34), and enforce existing laws and policies to prevent violence against children and adolescents, including corporal punishment, in all settings and in particular in the home, schools, communities, and residential care and detention facilities. 2. Strengthen policy-maker and public knowledge about and capacity to address the lifelong health consequences of child maltreatment, its roles as a risk factor for involvement in other forms of violence, such as youth violence and intimate partner violence, and the high prevalence of homicide and non-fatal violence-related injuries due to peer violence among adolescents. 	<ol style="list-style-type: none"> 1. Raise awareness among senior policy-makers and decision-makers about the health, social and financial consequences of child maltreatment and peer violence, the need for these to receive greater attention within the health sector and other sectors, and the importance of prevention and response. 2. Provide technical assistance to develop and implement national plans of action for addressing violence against children and adolescents. 3. Provide technical support and build capacity within health ministries to respond to child maltreatment and peer violence. 4. Support global efforts to coordinate health systems involvement in prevention of and response to violence against children, within the United Nations system and at national level by participating in relevant joint United Nations and multistakeholder initiatives.

<p>5. Ensure appropriate allocation of budget/resources for the prevention of and response to violence against children and adolescents in relevant health plans and policies.</p> <p>6. Create a unit or focal point within ministries of health to address violence against children and to liaise with other ministries, departments and agencies to prevent and respond to violence against children.</p>		
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Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond

Member States	National and international partners	WHO secretariat
<p>7. Integrate identification and gender-sensitive case management procedures for survivors/victims of child maltreatment and peer violence into the provision of routine health services for mothers and infants, children and adolescents. Services should be gender-sensitive and keyed to the child's developmental stage, and take into account the child's evolving capacities and preferences.</p> <p>8. Train health care providers in recognizing child and adolescent conditions that may lead to the perpetration of future violence, such as behavioural problems, conduct disorders, and early alcohol and substance abuse, and treating these conditions and their underlying causes. Equally, behaviour problems in children and adolescents, which may have developed as a way to cope with past victimization, may be wrongly diagnosed as attention deficit hyperactivity, oppositional defiant, and conduct disorders, and health care providers must be alerted to these possibilities.</p> <p>9. Strengthen individual and institutional capacities to respond to child and adolescent survivors/victims of violence in relevant health system institutions and allied sectors (such as police, education, social services), and ensure that health workers and other professionals are adults who children and young people can trust and confide in.</p> <p>10. Integrate content on identifying and caring for child maltreatment and peer violence survivors/victims into national curricula for the basic training and continuing education of all</p>	<p>3. Train health care providers in recognizing child and adolescent conditions that may lead to the perpetration of future violence, such as behavioural problems, conduct disorders, and early alcohol and substance abuse, and treating these conditions and their underlying causes. Equally, behaviour problems in children and adolescents, which may have developed as a way to cope with past victimization, may be wrongly diagnosed as attention deficit hyperactivity, oppositional defiant, and conduct disorders, and health care providers must be alerted to these possibilities.</p>	<p>5. Develop and disseminate evidence-based clinical and policy guidelines and standard operating procedures for survivors/victims of child maltreatment and peer violence that are child friendly and gender-sensitive.</p> <p>6. Engage in technical cooperation with ministries of health and/or other relevant ministries in adapting WHO normative guidance on services for survivors/victims of child maltreatment and peer violence to specific country contexts.</p> <p>7. Develop and disseminate model curricula for both pre- and in-service training of health care providers on responding to violence against children.</p>

<p>health professionals, and develop quality standards and regulations for practitioners.</p> <p>11. Ensure that national guidelines and protocols are aligned with WHO and other evidence-based guidelines on services for survivors/victims of child maltreatment and peer violence.</p>		
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Strategic direction 3: Strengthen programming to prevent interpersonal violence

Member States	National and international partners	WHO Secretariat
<p>12. Strengthen individual and institutional capacities to prevent child maltreatment and peer violence in relevant health system institutions and allied sectors (such as police, education, social services).</p> <p>13. Implement evidence-based interventions to prevent child maltreatment, in particular programmes that can be delivered through the health system, such as home visiting and parenting support programmes, that aim to strengthen safe and nurturing relationships within families and between parents, caregivers and children, and ensure that such programmes meet the prevention needs of marginalized groups.</p> <p>14. Advocate for and support the development and implementation by other sectors of programmes to help children and adolescents develop life and social skills, and maintain positive relationships in order to prevent peer violence.</p> <p>15. Integrate interventions to prevent child maltreatment into early child development programmes, and peer violence interventions into youth development programmes, mental health programmes and school health services, and monitor their effectiveness.</p> <p>16. Promote the participation of children and adolescents in the development of policies and programmes to prevent violence against children.</p>	<p>4. Implement evidence-based interventions to prevent child maltreatment, in particular programmes that can be delivered through the health system, such as home visiting and parenting support programmes, that aim to strengthen safe and nurturing relationships within families and between parents, caregivers and children, and ensure that such programmes meet the prevention needs of marginalized groups.</p> <p>5. Advocate for and support the development and implementation by other sectors of programmes to help children and adolescents develop life and social skills, and maintain positive relationships in order to prevent peer violence.</p>	<p>8. Synthesize and disseminate information on what works to prevent child maltreatment and peer violence.</p> <p>9. Engage in technical cooperation with Member States in strengthening their capacities to design, implement and evaluate policies and programmes to prevent child maltreatment and peer violence, including by assessing the readiness of a country to implement and scale up prevention efforts.</p> <p>10. Develop, test and disseminate affordable programmes to prevent child maltreatment and peer violence.</p>

Strategic direction 4: Improve information and evidence		
Member States	National and international partners	WHO Secretariat
<p>17. Conduct population-based surveys of violence against children, and strengthen routine reporting of statistics on violence against children by including relevant indicators in health information and surveillance systems, and by prioritizing programmes and services that reach children and adolescents.</p> <p>18. Conduct studies on the effectiveness of programmes to prevent child maltreatment and peer violence, and on victim services.</p> <p>19. Strengthen national capacities for research on all aspects of violence against children and adolescents, including on the magnitude, consequences and economic costs of such violence, and the economic savings from prevention, and on effective prevention and response interventions.</p> <p>20. Conduct and support research, including for health system interventions and services, in order to scale up effective interventions to address child maltreatment and peer violence.</p>	<p>6. Conduct studies on the effectiveness of programmes to prevent child maltreatment and peer violence, and on victim services.</p> <p>7. Strengthen national capacities for research on all aspects of violence against children and adolescents, including on the magnitude, consequences and economic costs of such violence, and the economic savings from prevention, and on effective prevention and response interventions.</p> <p>8. Conduct and support research, including for health system interventions and services, in order to scale up effective interventions to address child maltreatment and peer violence.</p>	<p>11. Develop standardized definitions of peer violence and harmonized methods for establishing the prevalence rates of child maltreatment and peer violence, and advocate for their use.</p> <p>12. Engage in technical cooperation with Member States to evaluate health and multisectoral interventions to prevent and respond to violence against children and adolescents.</p> <p>13. Engage in technical cooperation with Member States to strengthen their capacities to conduct research on all aspects of violence against children and adolescents, and to integrate indicators of violence against children and adolescents into routine surveillance systems.</p> <p>14. Develop guidance on safe and ethical collection of data on violence against children and adolescents.</p> <p>15. Develop a research agenda to address violence against children and adolescents.</p>

3.C. All forms of interpersonal violence: cross-cutting actions

This section addresses actions that are common to or cross-cutting across all forms of interpersonal violence. As such, they are complementary to the ones in sections 3.A and 3.B on violence against women and girls and violence against children; they address the linkages between the two, and they serve to foster synergies and strengthen responses to the different types of interpersonal violence across the life course, including youth violence and elder abuse. These actions include strengthening:

- *services common to all forms of interpersonal violence;*
- *programmes to prevent all forms of interpersonal violence by addressing shared risk factors; and*
- *data collection mechanisms.*

Strategic direction 1: Strengthen health system leadership and governance

Member States	National and international partners	WHO Secretariat
<p>1. Strengthen policy-maker and public knowledge about the need for: (a) a public health approach to preventing and responding to violence; (b) addressing violence at the different stages of the life course; (c) addressing risk factors and determinants that are common to the different forms of interpersonal violence; and (d) strengthening the capacity of health care services to provide effective care for survivors/victims.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, so as to address common risk or causal factors and determinants for several types of violence, such as those that: promote gender equality; prevent harmful alcohol and substance use; reduce firearm availability; ensure access to education and keep adolescent boys and girls in secondary schooling; reduce concentrated poverty.</p> <p>3. Integrate violence prevention and response in health policies, programmes, plans and budgets, and strengthen the health system's role within national multisectoral plans of action for all forms of interpersonal violence.</p>	<p>1. Strengthen policy-maker and public knowledge about the need for: (a) a public health approach to preventing and responding to violence; (b) addressing violence at the different stages of the life course; (c) addressing risk factors and determinants that are common to the different forms of interpersonal violence; and (d) strengthening the capacity of health care services to provide effective care for survivors/victims.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, so as to address common risk or causal factors and determinants for several types of violence, such as those that: promote gender equality; prevent harmful alcohol and substance use; reduce firearm availability; ensure access to education and keep adolescent boys and girls in secondary schooling; reduce concentrated poverty.</p>	<p>1. Continue to develop guidance on comprehensive policies addressing violence and injuries across the life course.</p> <p>2. Support advocacy efforts of Member States and other relevant partners by disseminating evidence on the shared risk factors for the different types of violence.</p> <p>3. Continue to monitor efforts to address violence across Member States, including through regular updates of global and regional estimates of violence against women, and global status reports on violence.</p> <p>4. Engage in technical cooperation with ministries of health and other relevant ministries (such as those responsible for gender equality/women's empowerment, child protection, education, criminal justice, and social welfare), to strengthen the links between the health system and other sectors responsible for formulating and implementing multisectoral violence prevention action plans and policies.</p>

<p>4. Ensure active participation of the focal points of national and subnational ministries of health in multisectoral coordination mechanisms for addressing violence and strengthen coordination between health and other sectors, especially sectors working on gender equality/women's empowerment, child protection, education, social welfare and criminal justice.</p> <p>5. Develop and implement performance and accountability measures to monitor how well the health system is addressing violence.</p>		<p>5. Strengthen the linkages between those working on violence and cross-cutting issues, in particular mental health.</p>
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Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond

Member States	National and international partners	WHO Secretariat
<p>6. Strengthen health services, and in particular pre-hospital services and emergency medical care, and ensure that all survivors/victims of violence have access to quality, affordable care.</p> <p>7. Strengthen mental health care in social services and in general health care services, including by increasing the workforce and their capacities to deliver these services in order to address the wide range of psychological and mental health consequences of violence, building on WHO mhGAP guidelines and tools (35).</p> <p>8. Address the intersections between different forms of violence. For example, assess the situation of children of women who are identified as experiencing intimate partner violence, and the situation of the mothers and siblings of children who are identified as experiencing child maltreatment, and provide psychological and other necessary support and referrals.</p> <p>9. Sensitize health workers about the interactions between violence and other health risk behaviours and problems such as alcohol and substance use, smoking and unsafe sex.</p>	<p>3. Strengthen health services, and in particular pre-hospital services and emergency medical care, and ensure that all survivors/victims of violence have access to quality, affordable care.</p> <p>4. Strengthen mental health care in social services and in general health care services, including by increasing the work force and their capacities to deliver these services in order to address the wide range of psychological and mental health consequences of violence, building on WHO mhGAP guidelines and tools (35).</p> <p>5. Address the intersections between different forms of violence. For example, assess the situation of children of women who are identified as experiencing intimate partner violence, and the situation of the mothers and siblings of children who are identified as experiencing child maltreatment, and provide psychological and other necessary support and referrals.</p> <p>6. Sensitize health workers about the interactions between violence and other health risk behaviours</p>	<p>6. Engage in technical cooperation with Member States to strengthen their health system response to violence, including through the dissemination of existing WHO guidelines and tools, and the development of further guidance addressing the common risk factors and other cross-cutting issues, as required.</p> <p>7. Support implementation of curricula for health workers and policy-makers (health care providers and managers) on understanding and addressing the intersections and cross-cutting issues related to different types of violence.</p>

<p>10. Strengthen the engagement of and partnerships with civil society organizations and community leaders in raising awareness of communities about the health consequences of violence, available services and the importance of seeking health services promptly.</p> <p>11. Identify and address the barriers in access to services for survivors of violence, including as part of universal health coverage, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.</p>	<p>and problems such as alcohol and substance use, smoking and unsafe sex.</p> <p>7. Strengthen the engagement of and partnerships with civil society organizations and community leaders in raising awareness of communities about the health consequences of violence, available services and the importance of seeking health services promptly.</p> <p>8. Identify and address the barriers in access to services for survivors of violence, including as part of universal health coverage, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.</p>	
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Strategic direction 3: Strengthen programming to prevent interpersonal violence		
Member States	National and international partners	WHO Secretariat
<p>12. Increase knowledge among health workers/providers, policy-makers, 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.</p> <p>13. Intensify advocacy to strengthen investments in evidence-based violence prevention programmes within the health system and with other sectors in order to address common risk factors such as gender inequality, unemployment, norms concerning masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate enforcement of laws.</p> <p>14. Increase human and institutional capacity to design, implement and evaluate evidence-based violence prevention programmes that focus on addressing risk factors common to different forms of violence.</p> <p>15. Implement and monitor prevention interventions within the health system that address common risk</p>	<p>9. Increase knowledge among health workers/providers, policy-makers, 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.</p> <p>10. Intensify advocacy to strengthen investments in evidence-based violence prevention programmes within the health system and with other sectors in order to address common risk factors such as gender inequality, unemployment, norms concerning masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate enforcement of laws.</p> <p>11. Increase human and institutional capacity to design, implement and evaluate evidence-based violence prevention programmes that focus on addressing risk factors common to different forms of violence.</p>	<p>8. Collect and disseminate data on effective violence prevention policies and programmes, including by maintaining a global database of information about effective programmes to prevent different types of violence.</p> <p>9. Engage in technical cooperation with Member States to help strengthen human and institutional capacity to design, implement and evaluate policies and programmes that address common risk factors to prevent violence.</p> <p>10. Collaborate with organizations of the United Nations system and other partners in the development, dissemination and implementation of policies and programmes that can prevent different forms of interpersonal violence.</p>

factors, such as those that reduce harmful use of alcohol and substance use and promote mental health.	12. Implement and monitor prevention interventions within the health system that address common risk factors, such as those that reduce harmful use of alcohol and substance use and promote mental health.	
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Strategic direction 4: Improve information and evidence

Member States	National and international partners	WHO Secretariat
<p>16. Improve the ability of vital registration, health information, and routine injury and surveillance systems to document and compile standardized statistics on homicide and violence-related conditions presented to health workers using the relevant International Classification of Disease (ICD) codes and ensure that these data are disaggregated by sex and age and include information on the relationship between the perpetrator and victim.</p> <p>17. Strengthen the capacity of researchers, particularly in low- and middle-income Member States, to conduct research on all forms of interpersonal violence and their intersections, on their costs to society, and on less researched types of violence that are largely neglected, such as elder abuse.</p> <p>18. Support research on and expand the evidence base on risk factors associated with the perpetration of different forms of violence.</p>	<p>13. Strengthen the capacity of researchers, particularly in low- and middle-income Member States, to conduct research on all forms of interpersonal violence and their intersections, on their costs to society, and on less researched types of violence that are largely neglected, such as elder abuse.</p> <p>14. Support research on and expand the evidence base on risk factors associated with the perpetration of different forms of violence.</p>	<p>11. Support research on and expand the evidence base on all aspects of violence, including prevention and response, inter alia by producing regular updates on research findings.</p> <p>12. Develop and disseminate standardized tools and indicators to facilitate the collection and compilation of statistics on the different forms of violence.</p>

SECTION 4. ACCOUNTABILITY AND MONITORING FRAMEWORK

This section outlines a monitoring and accountability framework for implementing the global plan of action. It presents indicators for monitoring progress in implementing the plan of action at global level over a 15-year period (to 2030).

12. The framework is in line with the targets and outcome indicators proposed for the Sustainable Development Goals (see Appendix 6). Given the health system mandate of this plan, the proposed indicators specify the contributions of the health system, while recognizing that achievement of the targets and outcome indicators requires multisectoral efforts.

13. The monitoring and accountability framework is in line with the due diligence obligations of the State to prevent, investigate and, in accordance with national legislation, punish acts of violence against individuals. These include obligations in terms of provision of health care services, legal assistance, shelters, and counselling support (36-38).

14. The proposed indicators are designed to facilitate global-level reporting on the implementation of this plan of action. They are a small subset of the monitoring and information needs that Member States will have to meet in order to monitor, at national level, their health system's response to violence, in particular violence against women and girls and against children. As such, they reflect the contribution of the health system to attainment of the targets in the Sustainable Development Goals, as well as the actions set out in this plan. Member States may need to develop or update their national indicators, building on their existing plans, policies and programmes and in line with how they adapt the actions proposed under this plan.

15. The proposed indicators and targets are voluntary and global. Given that Member States are at different levels of readiness in their health system response to violence, in particular against women and girls and against children, the indicators will be monitored at the aggregate level. Member States will need to adapt their plans and set incremental benchmarks for implementation and monitoring, tailored to their national and local legislation and capacities and starting points, while maintaining the highest levels of ambition to achieve the goals and targets.

16. In order to assess progress towards the global targets, it is proposed that reporting be through the World Health Assembly every five years. Reporting on progress will also serve to identify gaps and challenges, and to exchange best practices and countries' experiences in implementing the plan. The aim is to build on existing reporting systems (such as the outcome and output indicators in WHO's programme budgets), not to create new or parallel systems.

17. The role of the Secretariat will be to: (a) support Member States in identifying and developing indicators for national-level monitoring; (b) develop baseline measures for global targets and propose interim milestones in collaboration with Member States; (c) develop standardized tools for collecting and analysing the data for monitoring progress at global level; (d) prepare regular global progress reports, based on national data and in collaboration with Member States, in order to benchmark the progress made, identify gaps and challenges, and share best practices and country experiences; and (e) offer guidance, technical support and training to Member States, upon request, in strengthening their national information systems for capturing the data related to the proposed indicators.

Table 2: Summary of indicators and global targets

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
A. Violence against women and girls				
<i>SD 1: Strengthen health system leadership and governance. Outcome: An enabling policy environment to address violence against women and girls.</i> Relevant targets in the Sustainable Development Goals (SDGs) (see Appendix 6): 3.7 – By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 5.6 – Ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.				
A 1.1	Number of Member States that have included health care services to address intimate partner violence and comprehensive post-rape care in line with WHO guidelines (29) in their national health or sexual and reproductive health plans or policies.	To be defined (TBD)	(TBD)	Member States have included health care services to address intimate partner violence and comprehensive post-rape care in line with WHO guidelines (29) in their health or sexual and reproductive health plans or policies (yes/no). Violence against women and girls is included in the package of services for the Global Strategy for Women’s, Children’ and Adolescents’ Health (2016–2030). Means of verification: baseline and means of verification will need to be established.
<i>SD 2: Strengthen health service delivery and health workers/providers capacity to respond. Outcome: Comprehensive and quality health services delivered and health workers with skills to be responsive to the needs of women and girls subjected to violence.</i> Relevant SDG targets: 3.3 – End the epidemic of AIDS; 3.4 – Reduce premature mortality from noncommunicable diseases and promote mental health; 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 3.7 – By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 5.2 – Eliminate all forms of violence against women and girls; 5.6 – Ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action and the outcome documents of their review conferences.				
A 2.1	Number of Member States that have developed or updated their national guidelines or protocols or standard operating procedures (SOPs) for the health system response to women experiencing intimate partner violence and/or sexual violence, consistent with international human rights standards and WHO guidelines (29).	(TBD)	(TBD)	Member States have a national guideline or protocol or SOP that specifies the health system response to intimate partner violence and/or sexual violence aligned with WHO guidelines (29) and international human rights standards (yes/no). Means of verification: content review of national guidelines, protocols or SOPs. At a minimum, the protocols/guidelines for the health system response should address: identification of intimate partner violence; first-line support; provision of comprehensive post-rape care; provision (either direct or through referrals) of mental health care; and referrals to other services needed by women.

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
A 2.2.	Number of Member States that provide comprehensive post-rape care in a medical facility (department) in every territorial and/or administrative unit, consistent with WHO guidelines (29).	(TBD)	(TBD)	Member States are providing comprehensive post-rape care in at least half of all their emergency health care facilities (yes/no). Means of verification: provision of comprehensive post-rape care is included in WHO's HIV health sector response progress reporting. In line with WHO guidelines (29), post-rape care will include: first-line support, emergency contraception, provision of safe abortion in accordance with national laws, post-exposure prophylaxis of sexually transmitted infections and/or HIV as per applicable protocols, and hepatitis B vaccination.
<p><i>SD 3: Strengthen programming to prevent interpersonal violence. Outcome: evidence-informed programming to prevent violence against women and girls being implemented.</i></p> <p>Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 16.1 – Significantly reduce all forms of violence and related deaths everywhere; and 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
A 3.1	Number of Member States that have a national multisectoral plan addressing violence against women and girls (that includes the health system) which proposes at least one strategy to prevent violence against women and girls.	(TBD)	(TBD)	Member States that have a national multisectoral plan addressing violence against women and girls that includes the health system and which proposes at least one prevention strategy/intervention (yes/no). Means of verification: review of national multisectoral plans of action on violence against women and girls. Prevention strategies can include one or more interventions that propose to: promote early identification of women experiencing partner violence or children exposed to violence and provide psychological support and appropriate referrals to reduce future violence; address gender/patriarchal social norms that perpetuate violence against women and girls and which condone or normalize such violence; promote social and emotional learning skills among children and adolescents related to respectful and non-violent relationships; approaches to empower and build self-efficacy among women and girls; legal and policy approaches (e.g. promoting gender equality, reducing harmful use of alcohol).

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
<p><i>SD 4: Improve information and evidence. Outcome: Evidence base to inform policies, programmes and plans to address violence against women and girls strengthened.</i> Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 16.1 – Significantly reduce all forms of violence and related deaths everywhere; and 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
A 4.1.	Number of Member States that have carried out a population-based, nationally representative study/survey on violence against women or that have included a module on violence against women in other population-based demographic or health surveys within the past five years, disaggregated by age, ethnicity, socioeconomic status etc.	100	(TBD)	<p>Member States have a nationally representative survey on violence against women or have included a module on violence against women in a population-based demographic, health or other type of survey within the past five years (yes/no)</p> <p>Means of verification: as part of its efforts to produce estimates of the prevalence of violence against women, WHO has a database on prevalence of intimate partner violence and non-partner sexual violence from population-based surveys conducted in countries, which it regularly updates. While WHO's 2013 global and regional estimates of violence against women were based on surveys from 80+ countries, since then an additional 20+ population-based surveys have been conducted. It remains to be assessed how many Member States have conducted surveys in the last five years.</p>
<p>B. Violence against children</p>				
<p><i>SD 1: Strengthen health system leadership and governance. Outcome: An enabling policy to address violence against children.</i> Relevant SDG targets: 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 4.2 – By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education; 4a – Build and upgrade education facilities that are non-violent and inclusive learning environments; 5.3–Eliminate all harmful practices; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
B 1.1.	Number of Member States that have included actions to address violence against children in their national health plans and/or policies	(TBD)	(TBD)	<p>Violence against children is not only mentioned in the goals or objectives, but there are specific actions in the country's operational plans (yes/no)</p> <p>Means of verification: This will be verified by a review of the most recent/current national health policies and plans available in the WHO database on health plans and policies.</p> <p>For Member States with a federal system, this will need to include the plans of the majority of states/provinces within the country. Plans or policies can include general health plans or specific plans for child and adolescent health and mental health.</p>

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
<p><i>SD2: Strengthen health service delivery and health workers'/providers' capacity to respond. Outcome: Comprehensive and quality health services delivered, and health workers with the skills to be responsive to the needs of children and adolescents subjected to violence.</i></p> <p>Relevant SDG targets: 3.4 – Reduce premature mortality from noncommunicable disease and promote mental health; 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
B 2.1.	Number of Member States that have developed or updated their national guidelines, protocols or SOPs for the health system's response to survivors/victims of child maltreatment, consistent with international human rights standards.	(TBD)	(TBD)	<p>Member States have a national guideline, protocol or SOP that specifies the health system's response to survivors/victims of child maltreatment aligned with international human rights standards (yes/no).</p> <p>Means of verification will be a content review of national guidelines, protocols or SOPs (in line with WHO guidelines on child maltreatment under development).</p>
<p><i>SD 3: Strengthen programming to prevent interpersonal violence. Outcome: Evidence-informed programming to prevent violence against children being implemented</i></p> <p>Relevant SDG targets: 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
B.3.1	Number of Member States that report large-scale implementation of at least four out of eight evidence-based interventions to prevent violence against children.	(TBD)	(TBD)	<p>Member States report large-scale implementation of at least four out of the eight evidenced-based interventions to prevent violence against children: (i) home visiting; (ii) parenting education; (iii) child sexual abuse prevention; (iv) pre-school enrichment; (v) life skills/social development programmes; (vi) bullying prevention; (vii) mentoring, and (viii) after-school programmes.</p> <p>Means of verification: Methodology as used to compile the WHO Global status report on violence prevention 2014 (3).</p>
<p><i>SD 4: Improve information and evidence. Outcome: Evidence-base to inform and monitor policies, programmes, and plans to address violence against children strengthened.</i></p> <p>Relevant SDG targets: 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
B.4.1.	Number of Member States that have conducted a nationally representative survey or included questions on child maltreatment in other household surveys (such as multiple indicator cluster surveys) within the past eight years	(TBD)	(TBD)	<p>Member States reporting having conducted a population-based survey on child maltreatment (violence against children) or included questions on child maltreatment in other household surveys (such as multiple indicator cluster surveys) within the past eight years (yes/no).</p> <p>Means of verification: WHO Global status report on violence prevention 2014 (3). In 2014, of the 133 countries who responded, 41% reported having conducted a survey; however, the proportion of countries in which surveys have been conducted in the past eight years was not assessed.</p>

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
<i>C. All forms of interpersonal violence: cross-cutting actions</i>				
<i>SD 4: Improve information and evidence.</i> Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.				
<i>C 4.1</i>	Number of Member States that have usable data on homicide from vital registration sources.	(TBD)	(TBD)	Using information from the WHO mortality database, the WHO Global status report on violence prevention 2014 ascertained that fully 60% of countries do not have usable data on homicide from vital registration sources (3). To count as usable, vital registration data had to be at least 70% complete, no more than 30% of injuries could be classified as “intent undetermined”, and homicides had to be defined according to ICD 10 codes X85-Y09; Y87.1 or ICD9 codes E960-E969. Data should be disaggregated by age and sex and document the relationship between victim and perpetrator. Means of verification: WHO mortality database, count of Member States with usable homicide data.

APPENDICES

Appendix 1

Glossary of key terms

This glossary provides definitions of the key terms used in the global plan of action and by the Secretariat in its work. The definitions have been derived from technical documents of WHO and other relevant bodies of the United Nations system.

(in alphabetical order)

Adolescence is defined by the United Nations as individuals aged 10–19 years. A difference can be made between early adolescence (10–14 years) and late adolescence (15–19 years).¹

Child, early and forced marriage is “marriage in which at least one of the parties is a child” – a person below the age of 18. It also “refers to marriages involving a person aged below 18 in countries where the age of majority is attained earlier or upon marriage. Early marriage can also refer to marriages where both spouses are 18 or older but other factors make them unready to consent to marriage, such as their level of physical, emotional, sexual and psychosocial development, or a lack of information regarding the person’s life options”. Furthermore it is “any marriage which occurs without the full and free consent of one or both of the parties and/or where one or both of the parties is/are unable to end or leave the marriage, including as a result of duress or intense social or family pressure”.²

Child maltreatment is defined as “the abuse and neglect of 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”.³

Child sexual abuse “is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim.”⁴

¹ UN Children’s Fund (UNICEF). Adolescence, an Age of Opportunity: The State of the World’s Children 2011, February 2011, ISBN: 978-92-806-4555-2 (http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf accessed 6 August 2015).

² UN General Assembly. Preventing and eliminating child, early and forced marriage. Report of the Office of the United Nations High Commissioner for Human Rights. 2014. A/HRC/26/22 (http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session26/Documents/A-HRC-26-22_en.doc accessed 13 August 2015).

³ World Health Organization (WHO), Global Status Report on Violence Prevention 2014, 2014 (http://apps.who.int/iris/bitstream/10665/145086/1/9789241564793_eng.pdf?ua=1&ua=1).

⁴ WHO & International society for prevention of child abuse and neglect. Preventing Child Maltreatment: a guide to taking action and generating evidence. World Health Organization: Geneva; 2006. (http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf).

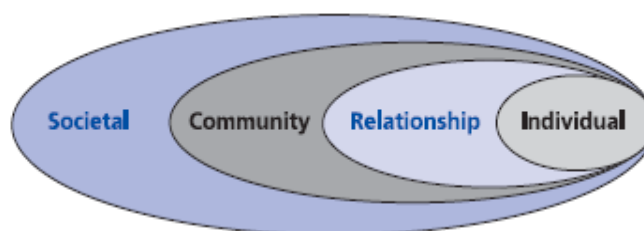
Comprehensive health services are “health services that are managed so as to ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.”¹

Comprehensive sexuality education is “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. It provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.”²

Corporal punishment is “any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting (“smacking”, “slapping”, “spanking”) children, with the hand or with an implement – a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children’s mouths out with soap or forcing them to swallow hot spices).”³

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).⁴

Ecological model for understanding violence



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”.⁵

¹ Health systems strengthening glossary. World Health Organization. (http://www.who.int/entity/healthsystems/Glossary_January2011.pdf).

² International technical guidance on sexuality education: an evidence-informed approach for schools, teachers and health educators. Paris: UNESCO. 2009. (<http://unesdoc.unesco.org/images/0018/001832/183281e.pdf> accessed 9 November 2015).

³ Convention on the rights of the child. General comment no. 8. 2006. CRC/C/GC/8 (https://srsg.violenceagainstchildren.org/sites/default/files/documents/docs/GRC-C-GC-8_EN.pdf accessed 13 August 2015).

⁴ World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ Elder Abuse. Factsheet N 357. 2014 (<http://www.who.int/mediacentre/factsheets/fs357/en/>).

Femicide “is generally understood to involve intentional murder of women because they are women.” It “is usually perpetrated by men, but sometimes female family members may be involved. Femicide differs from male homicide in specific ways. For example, most cases of femicide are committed by partners or ex-partners, and involve ongoing abuse in the home, threats or intimidation, sexual violence or situations where women have less power or fewer resources than their partner”.¹

Gender-based violence against women is “violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty”.²

Gender inequality and discrimination is “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field”.³

Gender equality “refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women’s and men’s rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration – recognizing the diversity of different groups of women and men. Gender equality is not a “women’s issue” but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centred development”.⁴ Gender inequality therefore refers to the absence of such rights, responsibilities and opportunities.

Harmful practices “are persistent practices and forms of behaviour that are grounded in discrimination on the basis of, among other things, sex, gender and age, in addition to multiple and/or intersecting forms of discrimination that often involve violence and cause physical and/or psychological harm or suffering. The harm that such practices cause to the victims surpasses the immediate physical and mental consequences and often has the purpose or effect of impairing the recognition, enjoyment and exercise of the human rights and fundamental freedoms of women and children. There is also a negative impact on their dignity, physical, psychosocial and moral integrity and development, participation, health, education and economic and social status”.⁵

¹ Understanding and addressing violence against women: Femicide. World Health Organization: Geneva, 2012 (http://apps.who.int/iris/bitstream/10665/77421/1/WHO_RHR_12.38_eng.pdf).

² Convention on the Elimination of All Forms of Discrimination against Women. General recommendation no. 19 (1992) (<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>).

³ Convention on the Elimination of All Forms of Discrimination against Women. Article 1. 1979. (<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article1>).

⁴ OSAGI. Gender Mainstreaming: Strategy For Promoting Gender Equality. 2001. (<http://www.un.org/womenwatch/osagi/pdf/factsheet1.pdf>).

⁵ CEDAW & CRC. Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices. 2014. CEDAW/C/GC/31-CRC/C/GC/18 (http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fGC%2f31%2fCRC%2fC%2fGC%2f18&Lang=en accessed 10 November 2015).

Health sector “consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related nongovernment organizations and community groups, and professional associations”.¹

Health system refers to “(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health”.²

Health workers “all people engaged in actions whose primary intent is to enhance health”.³

Interpersonal violence as distinguished from self-inflicted violence and collective violence, is divided into family and partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes.⁴

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”.⁵

Intimate partner refers to a husband, cohabiting partner, boyfriend or lover, ex-husband, ex-partner, ex-boyfriend or ex-lover. The definition of intimate partner varies between settings and studies and includes formal partnerships, such as marriage, as well as informal partnerships, including cohabiting, dating relationships and unmarried sexual relationships. In some settings, intimate partners tend to be married, while in others more informal partnerships are more common.⁶

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

¹ Health Promotion Glossary. World Health Organization: Geneva; 1998. WHO/HPR/HEP/98.1 (<http://www.who.int/entity/healthpromotion/about/HPR%20Glossary%201998.pdf?ua=1>).

² WHO. Health systems strengthening glossary. 2011. (http://www.who.int/entity/healthsystems/Glossary_January2011.pdf accessed 19 August 2015).

³ The World Health Report 2006 – working together for health. World Health Organization: Geneva. (<http://www.who.int/entity/whr/2006/chapter1/en/index.html>).

⁴ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ WHO. Violence against women. Intimate partner and sexual violence against women. World Health Organization: Geneva; 2014. (http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.11_eng.pdf?ua=1).

⁶ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf, accessed 19 February 2015).

perspective helps to identify early risk factors for violence and the best times to implement a primary prevention approach”.¹

Multisectoral response “entails the coordination of resources and initiatives across sectors, involving both government institutions and civil society.” “A coordinated framework provides for the delivery of a diverse range of health care, protection and justice services that survivors need which cannot be provided by a single sector or intervention. Integrated approaches strengthen advocacy efforts; establish long-term collaboration across sectors; improve the efficiency and reach of services and prevention efforts; and maximize the available technical expertise, resources and investments on the issue”.²

Primary health care “is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constituted the first element of a continuing health care process”.³

Public health approach to violence prevention refers to four steps: defining and monitoring the problem; identifying risk and protective factors; developing and testing prevention and response strategies; and supporting widespread adoption.⁴

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”.⁵

Survivor/victim refers to people who have experienced/are affected by violence. The term survivor is usually preferred by those working on violence against women to emphasize that women affected by violence have agency and are not merely passive ‘victims’ in the face of violence. The term victim is however used in criminal justice. For the purposes of this document they are used interchangeably.

¹ Preventing intimate partner and sexual violence against women. Taking action and generating evidence. World Health Organization: Geneva, 2010. (http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf).

² Ensuring holistic multisectoral policies and national plans of actions. UN Women virtual knowledge centre to end violence against women and girls (<http://www.endvawnow.org/en/articles/316-ensuring-holistic-multisectoral-policies-and-national-plans-of-actions-.html>).

³ Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. World Health Organization: Geneva, 1978. (www.who.int/publications/almaata_declaration_en.pdf).

⁴ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ WHO. Violence against women. Intimate partner and sexual violence against women. World Health Organization: Geneva; 2014. (http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.11_eng.pdf?ua=1).

Vulnerable groups are groups who are disproportionately likely to be exposed to or experience different types of violence because of social exclusion, marginalization, stigma and multiple forms of discrimination.

Violence against children is defined as: any violence against a boy or girl 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”.¹

Violence against women and girls (VAWG) refers to violence against women as defined above, and includes also forms of violence against girls, because they are girls and that are rooted in gender inequality (e.g. harmful practices, early, child and forced marriage). It emphasizes the heightened risk of women and girls to violence throughout the life course because of gender inequality and discrimination against them.

Youth violence is “violence occurring between people aged 10–29 years of age.”² 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.

¹ United Nations General Assembly. Declaration on the Elimination of Violence Against Women. A/RES/48/104. 1993 (<http://www.un.org/documents/ga/res/48/a48r104.htm> accessed 6 August 2015).

² Global status report on violence prevention 2014. Geneva: World Health Organization; 2014 (http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/).

Appendix 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;¹
- WHA50.19 (1997), about the development of a plan of action for a public health approach to violence prevention based on scientific data;²
- EB95.R17 (1995) on emergency and humanitarian action which requests WHO to include management of health effects in situations of collective violence;³
- WHA56.24 (2003) on implementing the recommendations of WHO's 2002 *World report on violence and health*;⁴
- 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;⁵
- WHA60.25 (2007), about the global strategy on integrating gender analysis and actions into the work of WHO;⁶
- 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;⁷
- WHA63.13 (2010), about the global strategy to reduce harmful use of alcohol;⁸
- WHA66.8 (2013), about the comprehensive mental health action plan 2013–2020;⁹
- WHA66.9 (2013), resolution including call to develop WHO global action plan 2014–2021: Better health for all people with disability.^{10,11}

¹ Available: http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_eng.pdf.

² Available: http://www.who.int/substance_abuse/en/WHA50.19.pdf.

³ Available: <http://whqlibdoc.who.int/hq/1995/C.L.3.1995.pdf>.

⁴ Available: http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf.

⁵ Available: http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf.

⁶ Available: http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R25-en.pdf.

⁷ Available: http://www.who.int/reproductivehealth/topics/fgm/fgm_resolution_61.16.pdf.

⁸ Available: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R13-en.pdf.

⁹ Available: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf.

¹⁰ Available: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R9-en.pdf.

¹¹ Available: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf.

Consensus resolutions and documents

- United Nations General Assembly work on violence against women;¹
 - Resolution 67/144 (2012) Intensification of efforts to eliminate all forms of violence against women;²
 - Resolution 69/147 (2014) Intensification of efforts to eliminate all forms of violence against women and girls;³
- Commission on the status of women (CSW)
 - CSW 57 agreed conclusions 2013;⁴
 - CSW 51 agreed conclusions 2011;⁵
 - CSW 42 agreed conclusions 1998;⁶
- International Conference on Population and Development (ICPD Programme of Action, 1994) and all the outcomes of its review as follows;⁷
 - Key actions for further implementation of the programme of action of the international conference on population and development (2014);⁸
 - Resolution 2000/1 Population, gender and development (2000);⁹
 - Resolution 2005/2 Contribution of the implementation of the Programme of Action of the International Conference on Population and Development, in all its aspects, to the achievement of the internationally agreed development goals, including those contained in the United Nations Millennium Declaration (2005);¹⁰
 - Resolution 2006/2 International migration and development (2006);¹¹

¹ Available: <http://www.un.org/womenwatch/daw/vaw/v-work-ga.htm>.

² Available: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/67/144&Lang=E.

³ Available: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/147.

⁴ Available: <http://www.unwomen.org/~media/headquarters/attachments/sections/csw/57/csw57-agreedconclusions-a4-en.pdf>.

⁵ Available: http://www.unwomen.org/~media/headquarters/attachments/sections/csw/51/csw51_e_final.pdf.

⁶ Available: http://www.unwomen.org/~media/headquarters/attachments/sections/csw/42/csw42_i_e_final.pdf.

⁷ Available: <http://www.unfpa.org/publications/international-conference-population-and-development-programme-action>.

⁸ Available: <http://www.unfpa.org/publications/international-conference-population-and-development-programme-action>.

⁹ Available: http://www.un.org/en/development/desa/population/commission/pdf/33/CPD33_Res2000-1.pdf.

¹⁰ Available: http://www.un.org/en/development/desa/population/commission/pdf/38/CPD38_Res2005-2.pdf.

¹¹ Available: http://www.un.org/en/development/desa/population/commission/pdf/39/CPD39_Res2006-2.pdf.

- Resolution 2009/1 The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals (2009);¹
- Resolution 2010/1 Health, morbidity, mortality and development (2010);²
- Resolution 2011/1 Fertility, reproductive health and development (2011);³
- Resolution 2012/1 Adolescents and Youth (2012);⁴
- Resolution 2014/1 Assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development (2014);⁵
- United Nations General Assembly Resolution 65/277 (2011) Political declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS;⁶
- Beijing Declaration and Platform for Action (1995);⁷
- Human Rights Council Resolution 7/24 Elimination of violence against women (2008);⁸
- Human Rights Council Resolution 23/25 Accelerating efforts to eliminate all forms of violence against women: preventing and responding to rape and other forms of sexual violence (2013)⁹

UN conventions, documents and instruments:

- Universal Declaration of Human Rights (1948);¹⁰
- International Covenant on Civil and Political Rights (1966);¹¹
- International Covenant on Economic, Social and Cultural Rights (1966);¹²

¹ Available: http://www.un.org/en/development/desa/population/commission/pdf/42/CPD42_Res2009-1.pdf.

² Available: http://www.un.org/en/development/desa/population/commission/pdf/43/CPD43_Res2010-1.pdf.

³ Available: http://www.un.org/en/development/desa/population/pdf/commission/2011/documents/CPD44_Res2011-1b.pdf.

⁴ Available: http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf.

⁵ Available: http://www.un.org/en/development/desa/population/pdf/commission/2014/documents/CPD47_Resolution_2014_1.pdf.

⁶ Available: http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-RES-65-277_en.pdf.

⁷ Available at: <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>.

⁸ Available: http://ap.ohchr.org/Documents/E/HRC/resolutions/A_HRC_RES_7_24.pdf.

⁹ Available: http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/23/L.28.

¹⁰ Available: <http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx>.

¹¹ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>.

¹² Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

- Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1962);¹
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979);²
- Optional Protocol to the Convention on the Elimination of Discrimination against Violence (1999);³
- Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974);⁴
- Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (2000);⁵
- Recommended Principles and Guidelines on Human Rights and Human Trafficking (2002);⁶
- Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949);⁷
- Declaration on the Elimination of Violence Against Women (A/RES/48/104, 1993);⁸
- Geneva Convention relative to the Protection of Civilian Persons in Time of War (1949);⁹
- Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II) (1977);¹⁰
- Convention on the Rights of the Child (CRC, 1989):¹¹
 - 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.

¹ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MinimumAgeForMarriage.aspx>.

² Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

³ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCEDAW.aspx>.

⁴ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtectionOfWomenAndChildren.aspx>.

⁵ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx>.

⁶ Available: <http://daccess-ods.un.org/access.nsf/Get?Open&DS=E/2002/68/Add.1&Lang=E>.

⁷ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TrafficInPersons.aspx>.

⁸ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ViolenceAgainstWomen.aspx>.

⁹ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtectionOfCivilianPersons.aspx>.

¹⁰ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolII.aspx>.

¹¹ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.

UN general comments and recommendations:

- Convention on the Elimination of All Forms of Discrimination against Women (1979);¹
 - General recommendation no. 24 (1999);²
 - General recommendation no. 12 (1989);³
 - General recommendation no. 19 (1992);⁴
- Convention on the Rights of the Child;
 - General comment no. 13 (2011);⁵
- Committee on economic, social and cultural rights;
 - Article 12, General comment no. 14 (2000)⁶

Regional Instruments:

- Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) (2011);⁷
- Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) (2007);⁸
- Protocol to the African Charter on Human and Peoples' rights on the rights of women in Africa (2003);⁹
- Inter-American Convention on the prevention, punishment and eradication of violence against women "Convention of Belém do Pará" (1994);¹⁰
- Declaration on the elimination of violence against women in the ASEAN region (2004);¹¹
- Arab Strategy for Combating Violence Against Women 2011–2020 (2011).¹²

¹ Available: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

² Available: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>.

³ Available: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom12>.

⁴ Available: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>.

⁵ Available: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f13&Lang=en.

⁶ Available: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En).

⁷ Available: <http://www.coe.int/t/dghl/standardsetting/convention-violence/convention/Convention%20210%20English.pdf>.

⁸ Available: <http://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=0900001680084822>

⁹ Available: http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf.

¹⁰ Available: <http://www.oas.org/juridico/english/treaties/a-61.html>.

¹¹ Available: <http://www.asean.org/communities/asean-political-security-community/item/declaration-on-the-elimination-of-violence-against-women-in-the-asean-region-2>.

¹² Available: <http://www.arabwomenorg.org/Content/Publications/VAWENG.pdf>.

Appendix 3

Details of relevant work by 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 Appendix 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 Member States 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 (4). 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,¹ and will be regularly updated. The Secretariat has published several guidelines and tools to identify effective prevention interventions and guide Member States 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 Appendix 4). The Secretariat is supporting ministries of health with capacity strengthening for a public health approach to prevention and response to violence against women, and is assisting Member States 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. WHO published *Preventing Child Maltreatment: a Guide to Taking Action and Generating Evidence* in 2006,² and this has become a key reference for policy makers and practitioners. WHO has also 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 Member States 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).³ The Secretariat has worked with selected low- and middle-income Member States 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.

¹ Available at: <http://apps.who.int/gho/data/node.main.SEXVIOLENCE>.

² Available at: http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf.

³ Available at: <http://www.who.int/chp/gshs/en/>.

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 survivors/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 Appendix 5).

Appendix 4

List of relevant WHO Secretariat publications**Violence against women and girls**

- Health care for women subjected to intimate partner violence or sexual violence (2014)¹
- Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013)²
- WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence against women (2013)³
- Violence against women in Latin America and the Caribbean: a comparative analysis of population-based data from 12 countries (PAHO, 2013)⁴
- Three 2012 publications on provision of mental health and psychosocial support to survivors of sexual violence (2012)⁵
- 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)⁶
- WHO Multi-country Study on Women's Health and Domestic Violence against Women: Results report (2005)⁷
- Clinical management of rape survivors (2004)⁸
- Guidelines for medico-legal care for victims of sexual violence (2003)⁹
- E-learning programme: Clinical management of rape survivors in humanitarian settings (WHO, UNFPA and UNHCR, 2009)¹⁰
- Violence and injury prevention short course: Preventing intimate partner and sexual violence against women¹¹

¹ Available at: http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf.

² Available at: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.

³ Available at: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.

⁴ Available at:
http://www.paho.org/hq/index.php?option=com_content&view=article&id=8175&Itemid=1519&lang=en.

⁵ Available at: http://apps.who.int/iris/bitstream/10665/75175/1/WHO_RHR_HRP_12.16_eng.pdf;
http://apps.who.int/iris/bitstream/10665/75177/1/WHO_RHR_HRP_12.17_eng.pdf;
http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf.

⁶ Available at: http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf.

⁷ Available at: http://www.who.int/gender/violence/who_multicountry_study/en/.

⁸ Available at: http://www.who.int/hac/network/interagency/news/manual_rape_survivors/en/.

⁹ Available at: <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>.

¹⁰ Available at: <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>.

¹¹ Available at: http://www.who.int/violence_injury_prevention/capacitybuilding/courses/intimate_partner_violence/en/.

Child maltreatment

- European report on preventing child maltreatment (WHO Europe, 2013)¹
- Preventing child maltreatment: a guide to taking action and generating evidence (WHO and International Society for Prevention of Child Abuse and Neglect, 2006)²
- Violence and injury prevention short course: Child maltreatment prevention³

Interpersonal violence

- Global status report on violence prevention (2014)⁴
- Violence prevention: the evidence (2010)⁵
- Preventing injuries and violence: a guide for ministries of health (2007)⁶
- Developing policies to prevent injuries and violence (2006)⁷
- Guidelines for conducting community surveys on injuries and violence (2004)⁸
- Guidelines for essential trauma care (2004)⁹
- Preventing violence: a guide to implementing the recommendations of the World report on violence and health (2004)¹⁰
- World report on violence and health (2002)¹¹

Youth violence

- Preventing youth violence: an overview of the evidence¹²
- European report on preventing youth violence and knife crime among young people (WHO Europe, 2010)¹³

¹ Available at: http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf.

² Available at: http://www.who.int/violence_injury_prevention/publications/violence/child_maltreatment/en/.

³ Available at: http://www.who.int/violence_injury_prevention/capacitybuilding/courses/child_maltreatment/en/.

⁴ Available at: http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/.

⁵ Available at: http://apps.who.int/iris/bitstream/10665/77936/1/9789241500845_eng.pdf.

⁶ Available at: http://whqlibdoc.who.int/publications/2007/9789241595254_eng.pdf.

⁷ Available at: http://www.who.int/violence_injury_prevention/publications/39919_oms_br_2.pdf.

⁸ Available at: <http://whqlibdoc.who.int/publications/2004/9241546484.pdf>.

⁹ Available at: <http://whqlibdoc.who.int/publications/2004/9241546409.pdf>.

¹⁰ Available at: <http://whqlibdoc.who.int/publications/2004/9241592079.pdf>.

¹¹ Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/.

¹² As of 22 September 2015, available at: http://apps.who.int/iris/bitstream/10665/181008/1/9789241509251_eng.pdf?ua=1.

¹³ Available at: http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf.

Elder abuse

- European report on preventing elder maltreatment¹
- A global response to elder abuse and neglect. Building primary health care capacity (2008)²
- Missing voices: views of older persons on elder abuse. A study from eight countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden.³

¹ Available at: http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf.

² Available at: http://www.who.int/ageing/publications/ELDER_DocAugust08.pdf.

³ Available at: http://www.who.int/ageing/publications/missing_voices/en/.

Appendix 5

WHO Secretariat involvement in violence-related partnerships and initiatives

Essential Services for Violence Against Women and Girls is a joint UN initiative managed by UN Women and UNFPA with WHO, UNDP and UNODC as partners in different aspects of the initiative. WHO is a partner in the health component of the initiative. It has contributed its guidelines and tools on the health response to violence against women that will be implemented through this initiative.

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 policies.

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.

Appendix 6

Linking the global plan to the sustainable development goals and targets

Sustainable development goals	Description	Links to the plan of action
Goal 3: Ensure healthy lives and promote well-being for all at all ages		
Target 3.4	By 2030 reduce by one-third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being.	Promotion of mental health and well-being and provision of mental health care is recognized as essential for both prevention and response to the different forms of interpersonal violence, in particular against women and girls and against children.
Target 3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	Harmful use of alcohol is a risk factor for involvement in most forms of interpersonal violence, and its prevention will therefore contribute to preventing violence. Exposure to intimate partner violence and sexual violence against women, child maltreatment and youth violence increases the likelihood of drug abuse and harmful use of alcohol, so preventing such violence can reduce drug abuse and harmful use of alcohol.
Target 3.7	By 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	Recognizing the sexual and reproductive health consequences of violence against women and girls, the plan proposes SRH services as key entry points for integrating violence against women services and the inclusion of violence against women as part of national RH strategies and programmes.
Target 3.8	Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.	The principle of UHC is a key guiding principle for provision of health services to survivors/victims of interpersonal violence, in particular against women and girls, highlighting the need for financial protection, and provision of quality essential services for managing the health consequences of such violence.

Sustainable development goals	Description	Links to the plan of action
Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all		
Target 4.2	By 2030, ensure that all boys and girls have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.	Quality early childhood development, care and pre-primary education are protective against subsequent involvement in violence when boys and girls become older.
Target 4.7	By 2030 ensure that all learners acquire knowledge and skills needed to promote sustainable development including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.	The plan recognizes the need for the health system to advocate with the education sector and to support it in implementing comprehensive sexuality education, life and social skills with an emphasis on non-abusive, respectful and egalitarian relations that maintain positive relationships and prevent all forms of violence later in life.
Target 4a	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent inclusive learning environments for all.	Boys and girls are subject to peer violence such as fighting and bullying in education facilities, and in some instances teaching staff use violent means of discipline and control.
Goal 5: Achieve gender equality and empower all women and girls		
Target 5.2	Eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation.	The plan recognizes the need for the health system to work in tandem with other sectors in applying a public health approach to addressing violence against women and girls. It includes evidence-based actions that contribute to prevention and response within the health system and across sectors.
Target 5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations.	The plan includes child, early and forced marriage and female genital mutilation as priority harmful practices against women and girls that need to be addressed by the health system in terms of response and prevention.

Sustainable development goals	Description	Links to the plan of action
Target 5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.	The plan recognizes the promotion of all human rights including those related to sexual and reproductive health as key to preventing and responding to violence against women and girls and builds on the actions specified in the ICPD PoA and the Beijing Platform for action, chapter on violence against women.
Goal 11: Make cities and human settlements inclusive, safe, resilient and sustainable		
Target 11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, particularly for women and children, older persons and persons with disabilities.	The plan recognizes the risk of exposure to violence including sexual harassment in public spaces, particularly for women and girls
Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels		
Target 16.1	Significantly reduce all forms of violence and related death rates everywhere.	The plan aims to strengthen the critical role of the health system in reducing interpersonal violence and to mitigate the health and other negative consequences of such violence, focusing on women and girls and children as population groups that are disproportionately affected by such violence.
Target 16.2	End abuse, exploitation, trafficking and all forms of violence and torture against children.	The plan prioritizes violence against children as another major form of violence in addition to violence against women. The plan recognizes that girls face particular vulnerabilities to certain forms of violence including trafficking for sexual exploitation.
Target 16.3	Promote the rule of law at the national and international levels, and ensure equal access to justice for all.	The plan includes actions to strengthen interface between the health and police/justice sectors, particularly through medico-legal evidence as a key element of supporting access to justice for survivors of violence, particularly women and girls.

Appendix 7

Summary of health consequences of violence

Population group exposed to violence and type of violence	Health and socioeconomic consequences
1. All groups subjected to violence	<ul style="list-style-type: none"> • Physical injuries • Mental health problems (e.g. depression, anxiety, post-traumatic stress disorders) • ↑ Suicide • ↑ risk of noncommunicable diseases. • Health-harming behaviours (e.g. alcohol and drug use, smoking, self-harm and risky sexual behaviour). • ↓ Productivity • Human and economic costs for survivors, families & society
2. Women and girls¹ a. Intimate partner violence	<p><i>In addition to 1 above, sexual and reproductive health problems (3) including unwanted pregnancies, STI and HIV, pregnancy loss including miscarriages and induced abortions, low-birth weight babies, pre-term births, traumatic gynaecological fistula, chronic pain syndrome</i></p> <ul style="list-style-type: none"> • 2X↑ induced abortion • 1.5X↑ STI and HIV • 41% ↑ pre-term birth • 16%↑ low-birth weight babies • ↑ infant mortality • Children with developmental and behavioural problems
b. FGM	<ul style="list-style-type: none"> • ↑ obstructed labour and perinatal mortality • Infections • Cysts and abscesses • Fistula • Psychological and mental health problems • Sexual dysfunction
c. Early marriage	<ul style="list-style-type: none"> • Early pregnancy and ↑ risk of perinatal and maternal mortality and morbidity • ↓ Girls' access to education, livelihood skills • Social isolation
3. Children including adolescents	<ul style="list-style-type: none"> • ↑ health harming behaviours • ↑ mental and other health problems • ↓ Educational attainment and future employment prospects • Intergenerational perpetuation of cycle of violence – i.e. <ul style="list-style-type: none"> • ↑ Likelihood of girls later being subjected to intimate partner violence or sexual exploitation and trafficking • ↑ Likelihood of boys becoming perpetrators or being subjected to violence later in life. • Youth violence ↑ involvement over time in other forms of violence as victims and perpetrators.

¹ World Health Organization (WHO), London School of Hygiene and Tropical Medicine, South African Medical Research Council 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.

Appendix 8

**Summary of risk factors¹ and determinants of victimization and
perpetration of different types of interpersonal violence²**

Population group and type of violence	Risk factors for victimization	Risk factors for perpetration
1. Common community and societal level factors across different types of interpersonal violence (These factors may be exacerbated in settings of humanitarian crises, including conflicts)	<ul style="list-style-type: none"> • Gender inequality (e.g. harmful masculine norms) • High rates of violence and crime in community • Poverty • Unemployment • Availability of drugs, alcohol (e.g. high density of alcohol outlets) and weapons (e.g. firearms, knives) • Low levels of enforcement of laws against violence 	
2. Women and girls	Gender inequality and discrimination causal factor across all types of violence against women and girls	
Intimate partner violence	<ul style="list-style-type: none"> • History of childhood abuse³ • Exposure (witnessing) to intimate partner violence in childhood • Less than secondary education • Mental disorders and other disabilities • Partner's harmful use of alcohol • Male control/authority over women • Acceptability of violence to discipline women who violate prevailing gender norms • Women's lack of employment • Discriminatory laws (e.g. ownership of land and property, marriage, divorce, children's custody) 	<ul style="list-style-type: none"> • History of childhood abuse or neglect • Exposure (witnessing) to intimate partner violence in childhood • Low levels of school education • Depression • Alcohol abuse • Controlling behaviours • Low gender equitable attitudes • Frequent quarrelling with partner • Sexual entitlement (e.g. history of transactional sex and multiple sexual partners) • Involvement in violence outside the home
3. Children including adolescents		
Child maltreatment	<ul style="list-style-type: none"> • Young age of children • Higher work load for care givers associated with children with special needs 	<ul style="list-style-type: none"> • Young age of parent • Parents have large #s of children • Lack of understanding of child development • Lack of parenting skills

¹ Protective factors are not highlighted separately, but would be the converse of or opposite to the risk factors highlighted in this table.

² Heise LL and Kotsadam. Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys. *Lancet Global Health*. 2015;3(6): e332-e340.

³ The factors highlighted in bold are ones that are either statistically significant or make the biggest contribution to explaining different rates of partner violence across different geographical settings.

		<ul style="list-style-type: none"> • Attitudes supporting harsh disciplinary measures • Parents history of childhood abuse • Presence of non-biological caregiver in the home • Alcohol or drug misuse • Mental illness of caregivers • Poor parent-child relationships (e.g. poor family bonding, chaotic family life) • Intimate partner violence in same household
Peer violence among adolescents (i.e. bullying, fighting)		<ul style="list-style-type: none"> • Some similar risk factors for perpetration of child maltreatment. • Behavioural problems • Antisocial peers • Alcohol and drug misuse • History of involvement in violence

Appendix 9

Timeline and process for developing the global plan of action

The process for developing the global plan of action was 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 was the basis of *draft zero* of the global plan of action was issued in March 2015 and included input from members of the core working group, representatives of other concerned WHO departments, as well as regional advisers from all six WHO regions.
3. Draft zero was presented for consultation and received inputs from Member States (MS) – Ministries of Health as well as other relevant line ministries (e.g. gender, justice, child development), civil society groups, professional associations as well as UN partners and other bilateral and multilateral institutions. The consultation process involved the following:
 - a. *Regional Consultations with Member States*: PAHO (February 2015); WPRO and SEARO (April, 2015); EMRO (April, 2015); EURO (May 2015); AFRO (July 2015). Participants were: Majority MS (i.e. Ministries of Health, other relevant line Ministries); NGOs, a few experts and UN agencies;
 - b. *Web Consultation*: April to June 4, 2015 – 48 inputs received including from 9 MS;
 - c. *Informal Consultation* with NGOs, Academic Experts and UN Partners and other multi-lateral institutions (3 June 2015) included 40 participants;
 - d. *Informal Briefing of Member States*: Geneva-based Permanent Mission Representatives (4 June 2015).
4. Based on feedback received from these consultations, draft zero was revised and the second discussion paper containing *draft 1* of the global plan of action was issued on 31 August 2015.
5. Additionally, an annotated outline of draft 1 was circulated in support of discussions that may take place at the Regional Committees that will take place between September and October 2015.
6. Draft 1 was posted for web consultation (1 September–23 October 2015), and 40 inputs were received including from 10 MS. It was presented for a final agreement from Member States at a Formal Member State meeting from 2–4 November 2015.
7. Based on feedback received from the Formal Member State meeting in November 2015, a revised draft (i.e. *draft 2*) of the global plan of action (i.e. this document) has been 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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