

Addressing the global challenge of violence, in particular against women and girls, and against children

Report by the Secretariat

1. The Executive Board at its 134th session noted an earlier version of this report,¹ and adopted decision EB134(6).² The version of the report that follows has been updated (in particular, paragraphs 2, 7, 10, 12, 14, 15, 16 and 18) in the light of new information available.

2. In 2011, 1.37 million people died as a result of violence. Of those deaths, 58% were due to self-directed violence, 35% to interpersonal violence and 6% to collective violence. A review of the literature found that between one fifth and one quarter of adults were physically abused as children, and 4–6% of elderly people report maltreatment. Women are particularly affected by intimate partner violence and non-partner sexual violence, with 35% of women worldwide having experienced those forms of violence. Women and girls also experience other forms of violence, including honour and dowry-related killings, early and forced marriages, sexual trafficking and female genital mutilation.

3. Different forms of violence share underlying causes and risk factors, and one kind of violence can contribute to another. The risk factors of most forms of interpersonal violence include being a victim of child maltreatment and harsh parental discipline; poor monitoring and supervision of children; witnessing violence; low educational attainment; alcohol and drug abuse; access to firearms; and norms that support violence as a way of resolving conflicts.

4. The risk factors for violence against women and girls, and for intimate partner violence in particular, include being exposed to parental violence; controlling behaviour by a male partner; unequal gender norms; and women's low educational attainment and lack of access to employment. Gender inequality and women's lack of rights are root causes underlying much of the violence against women and girls.

5. Beyond physical injuries and death, violent victimization is a risk factor for mental health problems and noncommunicable diseases and increases vulnerability to emotional, behavioural and physical health problems across the life course. In addition, the direct and indirect economic costs of violence are substantial. Violence against women and girls in particular can lead to death, serious injury, disability and a range of other mental, physical, and sexual and reproductive health problems. Compared to women who have not experienced violence, women who experience intimate partner and sexual violence are more than twice as likely to have an induced abortion, almost twice as likely to

¹ See document EB134/21 and the summary records of the Executive Board at its 134th session, thirteenth meeting, section 3 (document EB134/2014/REC/2).

² See document EB134/2014/REC/1 for the decision.

experience depression, and, in some regions, are 1.5 times more likely to acquire sexually transmitted infections, including HIV infection. They are also 16% more likely to have a low-birthweight baby. Women who were sexually abused as children are twice as likely to develop a panic disorder, have a one third higher likelihood of developing post-traumatic stress disorder and are more likely to attempt suicide than men who were similarly abused. These consequences have an immense negative impact on women's and girls' health and well-being, as well as on their families, communities and societies.

6. Globally, one in three women experience either physical and/or sexual intimate partner violence or non-partner sexual violence at least once in their lives, and 30% of women who have been in a relationship are affected by intimate partner violence. As many as 38% of all murders of women globally are by an intimate partner. Violence starts early in the lives of women and girls: nearly 30% of adolescent girls (aged 15–19 years) who have been in a relationship report having already experienced intimate partner violence in their lifetime. Violence against women and girls may be exacerbated in situations of humanitarian emergencies, including armed conflicts. Although data are scarce, a review of the literature found that between 4% and 22% of women are affected by sexual and other forms of violence in conflict.

ESTABLISHING THE EVIDENCE BASE

7. Targeting resources in the most effective way requires collecting sex- and age-disaggregated data about the magnitude, risk factors and consequences of violence, and conducting research on effective interventions to prevent and mitigate the consequences of violence, and of violence against women and girls in particular. Few countries currently collect detailed and high-quality data on the burden and scope of violence, and data on violence are largely absent from existing routine surveillance systems. Some countries have included violence against women in demographic health surveys and reproductive health surveys or implemented the WHO multi-country study on women's health and domestic violence. Countries need to invest in the collection of data on prevalence, risk factors and consequences and in the evaluation of programmes addressing violence against women and girls, in order to tackle the problem effectively and in a sustainable way. Countries should also monitor the extent of prevention and response programmes, services, laws and public health policies.

8. WHO has played a leading role in establishing the evidence base on the magnitude, risk factors and consequences of violence, and in particular of violence against women and girls, for example through the *World report on violence and health* (2002), the WHO multi-country study on women's health and domestic violence (2005) and, most recently, the publication of *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence* (2013).

POLICY BACKGROUND AND DEVELOPMENT

9. In 1996, The Health Assembly in resolution WHA49.25 declared violence a leading worldwide public health problem, urged Member States to assess the problem of violence in their own territories, and requested the Director-General to present a plan of action for progress towards a science-based public health approach to violence prevention. In 2003, the Health Assembly in resolution WHA56.24 urged Member States to promote the *World report on violence and health*, to make use of the report's recommendations to improve activities to prevent violence, and to provide medical, psychological, social and legal assistance and rehabilitation for persons suffering as a result of violence.

10. Several United Nations General Assembly resolutions and internationally agreed consensus documents focus on or make major reference to violence against women and girls. These include the

Declaration on the Elimination of Violence against Women (resolution 48/104, 1993), and United Nations General Assembly resolutions on the report of the International Conference on Population and Development (resolution 49/128, 1995); the follow-up to the Fourth World Conference on Women and full implementation of the Beijing Declaration and the Platform for Action (resolution 50/203); the elimination of all forms of violence, including crimes against women (resolution 55/68); the intensification of efforts to eliminate all forms of violence against women (resolution 67/144); and the elimination of domestic violence against women (resolution 58/147). A Declaration of commitment to end sexual violence in conflict was endorsed by 122 Member States attending the Sixty-eighth session of the United Nations General Assembly in New York in September 2013. At its fifty-seventh session in 2013, the Commission on the Status of Women adopted a set of conclusions on the elimination and prevention of all forms of violence against women and girls that include references to addressing the health dimensions. The heads of 11 United Nations agencies, including WHO's Director-General, also committed themselves to strengthening efforts to end violence against women and girls.

MULTISECTORAL ACTION

11. Responding to violence, particularly against women and girls, requires active engagement across multiple sectors within and outside of government. WHO, national health ministries and the public health community have a crucial role to play in advocating, inspiring and guiding multisectoral action to prevent violence and mitigate its consequences at global and national levels. As it is in direct contact with those affected by violence and its many consequences, the health sector has a leading role to play in providing services to survivors of violence, in collecting and disseminating data and evidence on the scale, risk factors and consequences of violence, and in identifying effective prevention and response strategies through research and evidence generation. In addition, WHO and health ministries can play a central role in advocating for increased attention to be paid to violence as a public health issue. Although evidence-based violence prevention programmes and services are reasonably well established in some high-income countries, many middle-income countries are only starting systematically to explore prevention and service options, and most low-income countries have very circumscribed prevention programmes and services.

ROLE OF THE HEALTH SECTOR

12. Although all forms of violence, and in particular violence against women and girls, have severe and long-lasting health consequences, the provision of services for survivors is often not recognized as a priority by ministries of health. The health sector has a leading role to play in giving care providers evidence-based guidance on appropriate responses to violence, and in particular to violence against women and girls, including clinical interventions and provision of mental health services and emotional support, as well as referral to other services such as legal or social services or those related to physical protection. Because a health care provider is likely to be the first professional contact for women and girls who experience violence, the health sector should increase awareness at different levels of its system and develop the capacity of the health workforce. Care for women and girls who experience intimate partner violence and sexual assault should be women-centred and integrated into existing health services. The special needs of children (both boys and girls) should be considered and appropriate services provided. Currently, only a limited number of countries offer comprehensive services to survivors of violence in general and of intimate partner and sexual violence in particular. Although most countries provide services for dealing with the immediate physical health consequences, mental health services for survivors of violence are widely absent. Often services are not accessible in those regions where they are most needed, and even where they exist women may not be able to use them because of the many obstacles they face, including stigmatization and lack of response from the health system.

13. As noted above, Member States, United Nations bodies and civil society, especially women's groups, have repeatedly called for the elimination of violence against women. Elimination requires the prevention of violence against women by addressing the root causes. To achieve lasting change, it is important to enact legislation and develop policies to counter discrimination against women and girls, promote gender equality and women's empowerment, and help to move societies towards non-violent cultural norms. Although most prevention efforts are led by other sectors, the health sector can play a leading or supporting role in calling for prevention of violence against women, ensuring that prevention efforts are science-based and implementing specific measures. Currently, there are few interventions whose effectiveness in preventing violence against women and girls has been proven through well-designed studies. School-based programmes to prevent violence within dating relationships; strategies that combine microfinance with gender equality training; strategies that promote communication and relationship skills within communities; strategies and policies that change cultural gender norms, and strategies that reduce access to and harmful use of alcohol all show promise, but need to be further evaluated. The health sector can also play a significant role in implementing parenting and home visitation programmes to address child maltreatment, which is a risk factor for other types of violence.

14. In line with decision EB134(6), Member States are undertaking a consultative process to finalize the text of the draft resolution submitted to the Board at its 134th session¹ in order to submit a revised text to the Sixty-seventh World Health Assembly for consideration.

ACTION BY WHO

15. The Secretariat has also developed, and provided support to Member States in the uptake of, norms, tools and guidelines for the health sector, such as *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (2013); *Preventing intimate partner and sexual violence against women: taking action and generating evidence* (2010); *Clinical management of rape survivors: developing protocols for refugees and internally displaced people* (2004); *Clinical management of rape survivors: e-learning programme* (2009); *Guidelines for medico-legal care for victims of sexual violence* (2003); *Preventing child maltreatment: a guide to taking action and generating evidence* (2006); *Preventing injuries and violence: a guide for ministries of health* (2004); and *Violence prevention: the evidence* (2010). WHO is strengthening efforts to integrate violence against women into sexual and reproductive health, maternal, child and adolescent health, HIV and mental health programmes.

16. All countries, in particular those that have endorsed various United Nations commitments to address conflict-related sexual violence (including the recent Declaration of commitment to end sexual violence in conflict) need to strengthen their response to violence against women and girls in humanitarian emergency situations, including conflicts. Through its standard-setting work and its leadership of the global and country health clusters, WHO fosters the integration of sexual and reproductive health and the prevention of and response to gender-based violence in the humanitarian health response.

¹ See the summary records of the Executive Board at its 134th session, thirteenth meeting, section 3 (document EB134/2014/REC/2).

17. WHO is actively involved in various alliances, partnerships and United Nations mechanisms, and it collaborates closely with UN Women (mandated to coordinate efforts within the United Nations system to address violence against women and girls), and with the United Nations Population Fund (UNFPA). WHO contributes to several United Nations processes, including leading the knowledge “pillar” of UN Action against Sexual Violence in Conflict, a concerted effort by the United Nations system to improve coordination and accountability, amplify programming and advocacy, and support national efforts to address conflict-related sexual violence. WHO is also part of Together for Girls, a global public–private partnership dedicated to eliminating sexual violence against children, with a particular focus on girls. WHO hosts the secretariat of the Violence Prevention Alliance and co-founded the Sexual Violence Research Initiative.

ACTION BY THE HEALTH ASSEMBLY

18. The Health Assembly is invited to note this report and consider the anticipated revised draft resolution that will be the outcome of the consultative process referred to in paragraph 14 above, and decision EB134(6).

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