



VIOLENCE AGAINST WOMEN

54TH DIRECTING COUNCIL
67TH SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS
STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE
HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN



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PREFACE

Violence against women affects one in three women in the Americas and can lead to profound and long-lasting health consequences for survivors, including physical injury, unwanted pregnancy, abortion, sexually transmitted infections (including HIV/AIDS) and a range of negative mental health outcomes. The international community has increasingly recognized that all efforts to improve women's health and well-being will be limited unless they also tackle the problem of violence against women.

Recognizing the urgent need to address violence against women globally, the 2030 Agenda for Sustainable Development adopted a target calling for the elimination of all forms of violence against women and girls under the gender equality goal.

Understanding the importance of the health system's role in addressing violence against women, ministers of health from 38 Member States of the Pan American Health Organization (PAHO) unanimously approved the 2015-2025 *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* during the 54th Directing Council, 67th Session of the Regional Committee for the Americas of the World Health Organization (WHO), in October 2015. The strategy takes a public health approach to the problem of violence against women and offers a roadmap for how health systems can join a multisectoral effort to prevent and respond to such violence in the Americas. In approving this document, the Region of the Americas became the first WHO region to have its highest authorities endorse a framework for action on violence against women.

More than 100 individuals representing governments, civil society organizations, academic institutions, multilateral organizations and United Nations agencies participated in the development of this strategy and plan of action and expressed their commitment to support its implementation.

By adopting the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women*, PAHO Member States have not only recognized that violence against women is a public health and human rights problem but have also pledged to ensure that their health systems fulfill their responsibilities to prevent and respond to such violence.

It is my sincere hope that this strategy and plan of action will not only provide guidance but also motivate everyone in the public health community to step up their efforts so that, together, we can eliminate the scourge of violence against women in our hemisphere.

Carissa F. Etienne
Director, PAHO/WHO

STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN

INTRODUCTION

1. Violence against women, an extreme form of gender inequality, is a public health and human rights problem that affects large numbers of women worldwide (1). In the Region of the Americas (“the Region”), one in three women has experienced intimate partner violence or sexual violence by a non-partner during her lifetime (1). Women belonging to some ethnically marginalized and indigenous groups are often at higher risk (2, 3).
2. The United Nations (UN) Declaration on the Elimination of Violence against Women (A/RES/48/104) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (4).
3. Violence against women takes many forms, but sexual, physical and emotional violence by a male partner are the most prevalent forms (5). Violence against women has long lasting and profound consequences for women’s physical and mental health; children’s health and psychosocial development; the well-being of families and communities; and national budgets and economic development (1).
4. Preventing and responding effectively to violence against women requires coordinated, multisectoral action. The Pan American Health Organization’s Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for 2015–2025 (“Strategy and Plan of Action”) offers a concrete roadmap to address the Region’s priorities for preventing and responding to violence against women. The Strategy and Plan of Action is designed to step up efforts by Member States, the Pan American Sanitary Bureau (“the Bureau”), and international organizations. This document takes a public health approach and focuses on what health systems can do as a complement to important actions undertaken by other sectors.
5. The Bureau recognizes that violence can occur at all stages of life—childhood, adolescence, adulthood, and old age. All violence against male and female children and adults can lead to negative health outcomes that should be addressed by health systems. There are compelling reasons for a specific focus on violence against women, however, including its invisibility within national and international statistics, its social acceptability, the economic and social barriers to help-seeking (including shame and stigma), weak legal sanctions, and health systems’ limited capacity to identify and care for survivors (6).
6. Violence against women has recently received significant international attention, creating momentum to catalyze change. Of particular note are the following:
 - a) the World Health Assembly (WHA) resolution Strengthening the role of the health system

- in addressing violence, in particular against women and girls, and against children, adopted by consensus in May 2014 (7);
- b) review of the International Conference on Population and Development Beyond 2014 by the United Nations Population Fund (UNFPA) in which countries identified violence against women as an area of priority for action (8);
 - c) efforts to report on violence against women in the 20 year anniversary of the Beijing Declaration and Platform for Action (Beijing+20) (9);
 - d) the inclusion of a specific target on eliminating all forms of violence against women and girls within the 2030 Agenda for Sustainable Development (10).

BACKGROUND

7. As a result of *a)* efforts of women's organizations, *b)* increased commitment by governments, *c)* innovative public policies, and *d)* growing evidence on magnitude and consequences, the international community has increasingly recognized violence against women as a violation or abuse of human rights with important public health ramifications (11).
8. The Convention on the Elimination of All Forms of Discrimination against Women (1981) aimed to eliminate all forms of discrimination against women and the related General Recommendations. The 1993 Declaration on the Elimination of Violence against Women recognized "the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings" (4). The 1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, known as the Convention of Belém do Pará, described violence against women as a violation of human rights and fundamental freedoms (3).
9. Many recent efforts across the UN system have sought to address violence against women, including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, General Assembly and Human Rights Council resolutions, and meetings of the Commission on the Status of Women (12-15). In 2006, the Secretary-General's study "Ending violence against women: From words to action," called on the UN to take stronger action to address violence against women (11). In addition, the 2030 Agenda for

Sustainable Development adopted a target on the elimination of all forms of violence against all women and girls under its stand-alone gender equality goal (10).

10. Various PAHO and World Health Organization (WHO) resolutions recognize violence as a worldwide public health problem and identify women as a group at increased risk of experiencing specific types of violence (16-19). The 2014 WHA resolution (*Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*) (WHA67.15) tasks WHO with the development of a Global Plan of Action to strengthen the role of the health system (7). As part of a synchronized effort, PAHO's Directing Council simultaneously tasked the Bureau with the development of this Strategy and Plan of Action on violence against women.

SITUATIONAL ANALYSIS

FORMS AND PREVALENCE OF VIOLENCE AGAINST WOMEN

11. Many forms of violence disproportionately affect women (1). At the global level, the most common forms of violence against women include but are not limited to:
 - a) intimate partner violence (physical, sexual, or psychological);
 - b) sexual violence (including rape) by non-partners;
 - c) child, early, and forced marriage;
 - d) human trafficking, including forced prostitution and economic exploitation;
 - e) female genital mutilation/cutting and other harmful traditional practices;

- f) femicide¹ and the killing of girls or women in the name of “honor”;
- g) sexual harassment in schools and workplaces (20).
12. Levels of violence against women may be particularly high in situations of armed conflict, displacement, natural disasters and other humanitarian crises; and in institutional settings, such as prisons and facilities for individuals with mental illnesses. The perpetration of violence against women can also occur within the health system itself: the abuse of women within the context of patient–provider interactions, particularly during the provision of sexual and reproductive health services, including childbirth, is receiving increased attention in the Region and is being addressed by PAHO and WHO (21).
13. Workplace violence against women, including physical, sexual and psychological assault within health services raises many of the concerns presented in this document and is being addressed by efforts to improve workers health and well-being and increase women’s participation in the workforce (22).
14. In some settings, women from minority ethnic groups may be at higher risk of violence than other women. An analysis of data from Bolivia found a twofold higher risk of partner violence against women who spoke a language other than Spanish at home (23). In Ecuador, women who self-identified as indigenous reported higher levels of partner violence than women who identified as mestizo or white (2). A study in Mexico among indigenous women seeking health services found that 25.55% of those interviewed reported experiencing some form of violence by a current partner, with wide variations across geographic regions.² In Canada, aboriginal women are nearly three times as likely to experience violence as non-aboriginal women (24). In many settings, however, there is a paucity of data on the prevalence of violence against women disaggregated by ethnicity/race, and more culturally relevant and methodologically rigorous research is needed.
15. Some evidence, including research from Canada, suggests that women who identify as lesbian or bisexual may be at higher risk of violence than women who identify as heterosexual (25), however there are limited data from the Region disaggregated by sex, gender identity, and sexual orientation. This is an area that requires more research.
16. Certain studies suggest that women with disabilities also face a higher risk of violence than other women. For example, a systematic review and meta-analysis found that individuals (both male and female) with disabilities are more likely to experience physical and sexual violence than their non-disabled counterparts (26).
17. Violence by an intimate partner is the most common form of violence experienced by women. WHO estimates that 30% of women in the Americas have experienced physical and/or sexual violence by a

1 Two terms are commonly used to refer to female homicide: femicide and feminicide; however, there is no consensus on the distinction between the two and on which is the most adequate. The term “feminicide” was coined to refer specifically to the killing of women because they are women; some definitions also refer to the participation of the State by act or omission. In this document, the broader term “femicide” is used to emphasize the scarcity of information in the Region to determine the context of female homicides and the intention behind them, but the existence of both terms is recognized.

2 The document can be found at: http://www.insp.mx/images/stories/Produccion/pdf/100722_cp7.pdf (in Spanish).

partner while 11% have experienced sexual violence by a non-partner (1).

18. Femicide is another important form of violence against women in the Region (27, 28). Femicide is generally understood to involve the intentional murder of women because they are women, but broader definitions include any killing of a woman or girl. Intimate partner femicide is the murder of a woman by her current or former partner, usually following a history of other forms of partner violence (29). Global data on femicide are limited due to a lack of systems to document motives for murder or the relationship between victims and perpetrators. However, WHO estimates that up to 38% of women murdered in the Region are killed by a partner or ex-partner (1).
19. The estimated prevalence of lifetime sexual violence against women by any perpetrator (including partners and non-partners) varies widely by study and site, but is substantial throughout the Region. An analysis of national survey data from eleven countries in the Region found that estimates of lifetime sexual violence against ever married women (including forced sexual intercourse, forced sex acts, and unwanted sex due to fear) ranged from about 1 in 10 women (10.3%) in Paraguay (2008) to more than 1 in 4 women (27.2%) in Haiti (2005 2006) (2).
20. Data suggest that a significant number of women in the Region experience forced or unwanted sexual debut. When asked whether their first sexual intercourse was wanted or forced, between 1.8% of women in Nicaragua (2006 2007) and 21.2% of women in Haiti (2005 2006) reported forced sexual debut (2). Similarly, a study of six countries of the Organization of Eastern Caribbean States (2005–2006) found that forced sexual

intercourse among females 15–24 years old ranged from 6% in Antigua and Barbuda to 12% in Saint Lucia (30). In Jamaica (2008–2009), only 4.7% of young women said their first sexual intercourse was “forced,” but nearly half (44.9%) said their first sexual intercourse was unwanted (2). Forced and unwanted sexual intercourse may contribute to adolescent pregnancy and HIV transmission, highlighting the need to address sexual violence as part of efforts to reduce unplanned pregnancy and HIV transmission in the Region.

RISK AND PROTECTIVE FACTORS

21. Research into risk and protective factors associated with violence against women has important limitations and gaps. First, most studies come from high-income countries and focus primarily on risk, rather than protective factors. Second, most use cross-sectional rather than longitudinal designs and thus provide limited evidence of causality. Finally, most studies examine individual rather than community or societal risk factors, which are key to prevention.
22. In spite of the shortcomings of existing research, it is clear that there is no single explanation for why certain individuals perpetrate violence against women or why such violence is more prevalent in certain communities. The existing evidence suggests that violence against women is rooted in gender inequalities and power imbalances between men and women but is also influenced by a complex interplay of factors at the individual, relationship, community, and societal levels, as articulated by the socio-ecological framework. The figure in Annex A illustrates the risk factors associated with the perpetration of intimate partner violence and sexual violence, according to a socio-ecological model.

23. Individual factors associated with a higher risk of male perpetration and female experiences of violence against women include low educational attainment, childhood exposure to violence (either as a victim of child abuse or as a witness to intra-parental violence), alcohol and illicit drug use, and mental health conditions. Community and societal level factors associated with higher levels of intimate partner violence and non-partner sexual violence include weak community sanctions against violence, poverty, gender inequality and social norms that support the acceptability of violence (37).
24. Although violence against women has been found in virtually all settings where it has been researched, prevalence rates vary considerably between and within countries, suggesting that high levels of violence against women are not inevitable. There are ongoing efforts worldwide to identify effective prevention strategies. Attention has focused on promising results from strengthening legal sanctions against violence, challenging gender norms, investing in women's economic empowerment, reducing harmful use of alcohol, and addressing child abuse against both boys and girls. Greater investment is needed to understand the individual-, relationship-, community-, and societal-level factors that are amenable to change so that comprehensive, effective prevention strategies can be implemented at a broad scale.

HEALTH CONSEQUENCES

25. Violence against women has many under-recognized health consequences, including death due to femicide, suicide, HIV/AIDS and maternal mortality, as well as non-fatal effects ranging from injuries, sexually transmitted infections (STIs), unwanted pregnancy, maternal morbidity, negative sexual and reproductive health outcomes, and

mental health conditions. The subsections below outline these consequences in detail.

INJURIES AND DISABILITIES

26. Evidence from the Region indicates that a substantial proportion of women living in situations of intimate partner violence experience physical injuries. In national surveys, the percentage of women in abusive relationships who reported being physically injured by a partner ranges from 41.2% (in Honduras, 2005 2006) to 81.6% (in Paraguay, 2008). In national surveys that assessed injury severity, the percentage of abused women who reported severe injuries (such as broken bones or deep wounds) ranged from 6.6% (in El Salvador, 2008) to 24.8% (in the Dominican Republic, 2007) (2).

MENTAL HEALTH AND SUBSTANCE USE

27. Violence has profound mental health effects such as post-traumatic stress disorder (PTSD), depression, anxiety, and alcohol and drug use disorders (1). Globally, women exposed to partner violence are twice as likely as other women to experience depression and almost twice as likely to have alcohol use disorders (1). Five national, population-based surveys from the Region found that large proportions of women who experienced partner violence in the past 12 months reported anxiety or depression so severe (as a result of their partner's aggression) that they could not complete their work or other obligations—ranging from nearly one-half of such women in Ecuador (2004) to more than two-thirds of women in Paraguay (2008) (2). In Guatemala (2008–2009) and Paraguay (2008), women who had experienced partner violence were significantly more likely than other women to contemplate or attempt suicide in the past month (2).

SEXUAL AND REPRODUCTIVE HEALTH

28. Research suggests that violence against women can have a host of negative sexual and reproductive health consequences. An analysis of national surveys from the Region found that intimate partner violence was significantly associated with unwanted or unintended pregnancy, greater parity, and first childbirth before age 17 (2). In some countries, unwanted pregnancy was two to three times more common among women who experienced partner violence compared with women who did not (2). The same study found that 3%–44% of women who had ever been pregnant had experienced partner violence during pregnancy (2). Violence during pregnancy has been associated with a higher risk of pregnancy complications, including miscarriage, preterm delivery and low birth weight (1, 23). Other consequences of intimate partner violence include gynecological disorders, and an increased risk of HIV (in some regions), syphilis, chlamydia, or gonorrhea (1).

PREGNANCY-ASSOCIATED MORTALITY

29. Studies from high-income countries suggest that partner violence can be an important contributor to maternal mortality. In one province in Canada, hemorrhaging was three times more frequent among pregnant women exposed to violence (32). A review of 2003–2007 data from the U.S. Centers for Disease Control and Prevention (CDC) National Violent Death Reporting System found that 54% of suicides and 45% of homicides of pregnant or postpartum women were associated with intimate partner violence, and these deaths were important contributors to pregnancy-associated mortality (33). These findings have important implications for efforts to reduce deaths during pregnancy and postpartum.

NONCOMMUNICABLE DISEASES AND RISK FACTORS

30. Growing evidence suggests a link between experiencing intimate partner violence and an elevated risk of noncommunicable diseases such as overweight, diabetes, ischemic heart disease, stroke, and cancer (34, 35). Causal pathways are not yet clearly understood, but evidence suggests that the damaging effects of chronic stress, combined with survivors' greater likelihood of engaging in harmful behaviors such as smoking, overeating and low use of preventive health care such as cholesterol checks and screenings for cervical or colon cancer may play a role (34, 35). Violence may also contribute to conditions such as chronic pain syndromes, irritable bowel syndrome, gastrointestinal disorders, somatic complaints and fibromyalgia (34, 35).

EFFECTS ON CHILDREN

31. Violence against women has important negative consequences for children. In addition to negative health outcomes mentioned above, evidence suggests that long-term health and social consequences of childhood exposure to intimate partner violence are similar to those of physical and emotional child abuse and neglect (23, 36, 37, 38). Childhood exposure to intimate partner violence has been linked to higher rates of under-five child mortality, (39) as well as to an increased risk of perpetrating or experiencing violence against women later in life (2, 40–42). Evidence from several countries in the Region suggests that children in households affected by violence against women are more likely than other children to be castigated with harsh forms of physical punishment (2). Pathways by which partner violence against women affects children is still under-researched, however, and merits greater attention.

ECONOMIC COSTS

32. Violence against women imposes direct costs on health, social service, criminal justice and family court systems. A U.S. study found that health care expenditures were approximately 42% higher for women who had experienced partner violence compared with women who had not (43). Violence against women also imposes indirect costs on survivors, families, employers, and the broader society due to lost productivity and negative psychosocial consequences among women and their children. A comprehensive analysis from Canada estimated that the annual economic impact of spousal violence—including direct and indirect costs—was C\$ 7.4 billion (44). A World Bank analysis concluded that intimate partner violence costs Peru 3.7% of their gross domestic product (GDP), largely due to lost labor days (45). A study in Colombia found significantly greater unemployment levels and reduced earnings among survivors of violence (46).

THE ROLE OF THE HEALTH SYSTEM

33. Health services can play an essential role in responding to violence against women. Health providers can identify women exposed to violence, provide immediate care, and mitigate harm through support and referrals to other sectors including legal and social services. Evidence suggests that women exposed to violence are more likely than non-abused women to seek health care but may not always disclose violence to their health providers (47). Initiatives to increase providers' early identification of women experiencing violence can improve their access to support, care, and referrals (48).

34. Health systems can also play a key role in multisectoral efforts to prevent violence. The public health approach to prevention involves four key steps: *a)* defining the problem by collecting data on the magnitude, characteristics and consequences of violence against women; *b)* investigating risk and protective factors to understand why the problem occurs; *c)* developing, implementing, and evaluating violence-prevention strategies for health and other sectors; *d)* disseminating information on program effectiveness and scaling up effective programs (49). In the process, health systems should coordinate with other stakeholders and sectors (in particular, education and justice), as well as collaborate with national multisectoral coordination mechanisms and civil society organizations.

STRATEGY AND PLAN OF ACTION

35. This Strategy and Plan of Action reflects the cumulative efforts of national governments and women's movements to draw attention to and catalyze action to address violence against women. It also builds on a growing body of evidence, practice, norms, principles, standards, and technical guidelines developed over the last several decades by PAHO/WHO and others, as well as many other efforts across the UN system.

GUIDING PRINCIPLES

36. The following 10 principles, outlined in greater detail in Annex B, guide the Strategy and Plan of Action:

- a) universal access to health and universal health coverage and equity;
- b) human rights;
- c) gender sensitivity and equality and cultural/ethnic diversities;
- d) a multisectoral response;
- e) evidence-informed practice;
- f) life-course approach;
- g) a comprehensive response;
- h) community involvement;
- i) autonomy and empowerment of survivors;
- j) engaging men and boys.

OVERALL GOAL

37. The overall goal of the Strategy and Plan of Action is to contribute to the reduction/eradication of violence against women. The strategic lines of action used in its implementation will promote the achievement of Outcome 2.3 of PAHO's Strategic Plan 2014–2019 and Outputs 2.3.2 and 2.3.3 of the PAHO Program and Budget 2014–2015.

STRATEGIC LINES OF ACTION³

38. The Strategy and Plan of Action will use the following strategic lines of action:

- a) strengthen the availability and use of evidence about violence against women;
- b) strengthen political and financial commitment to addressing violence against women within health systems;
- c) strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or non-partner sexual violence;
- d) strengthen the role of the health system in preventing violence against women.

STRATEGIC LINE OF ACTION 1: STRENGTHEN THE AVAILABILITY AND USE OF EVIDENCE ABOUT VIOLENCE AGAINST WOMEN

39. Understanding the nature, magnitude, risk and protective factors, and consequences of violence against women, including against indigenous and other racially and ethnically marginalized women, is the first step in preventing and addressing violence for several reasons. First, evidence-based, culturally relevant plans, policies, programs, and laws should be based on high quality quantitative and qualitative data, from both administrative data systems and population-based studies. Second, repeated data collection (ideally population-based) is needed to measure changes in levels of violence over time. Finally, in line with international human rights instruments applicable to health and the ethical principal of non-maleficence, data are essential for monitoring and evaluation to ensure that well-meaning interventions do not cause harm.

3 Monitoring of indicators for each strategic line of action should take into account the shared responsibilities of federated States.

Objective	Indicator	Baseline (2015)	Target (2025)
1.1 Increase the collection and availability of epidemiological and service-related data on violence against women*	1.1.1 Number of Member States that have carried out population-based, nationally representative studies 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	14	22
	1.1.2 Number of Member States that have carried out population-based, nationally representative studies on violence against women within the past five years (or that have included a module on violence against women in other population-based demographic or health surveys) that include an analysis of prevalence of violence against women across different ethnic/racial groups	2	10
	1.1.3 Number of Member States that are able to provide data on homicide, disaggregated by age, sex, and relationship of the victim to the perpetrator	9	15

*Unlike other public health issues, addressing violence against women within health systems is a relatively new area of work for many Member States, so uniform baseline indicators are not available from all countries. To address this gap, PAHO will develop a monitoring and evaluation plan and verify baseline data as part of implementing the Strategy and Plan of Action

40. When generating evidence, efforts should be made to collect and analyze data on equity stratifiers (such as age, ethnicity/race, socioeconomic status, place of residence, sexual orientation and gender identity, among others) in order to advance knowledge about how social determinants influence violence against women. Partnering with academic and research institutions could expand the availability and use of evidence.

STRATEGIC LINE OF ACTION 2: STRENGTHEN POLITICAL AND FINANCIAL COMMITMENT TO ADDRESSING VIOLENCE AGAINST WOMEN WITHIN HEALTH SYSTEMS

41. The health system has an important role to play in challenging the acceptability of violence against women. A strong, visible health system response conveys a message to society regarding the unacceptability of violence, and encourages more women to disclose abuse to health professionals (47). However, given the multidimensional

nature of violence against women, effective, comprehensive responses require the involvement of various sectors, including leadership, commitment and coordinated action among government leaders, policymakers, academics, legislators, national human rights commissions, law enforcement agencies, civil society and women's organizations and community members (50).

42. While many governments in the Region have developed national plans to address violence against women, there are often gaps between commitment and implementation. Effective implementation of national plans to prevent and respond to violence against women requires the availability of sound scientific evidence, the provision of robust support and know-how, and designated budgets within the health system (50).

Objective	Indicator	Baseline (2015)	Target (2025)
2.1 Strengthen national and subnational policies and plans to address violence against women within the health system	2.1.1 Number of Member States that have included violence against women in their national health plans and/or policies	18	35
	2.1.2 Number of Member States whose national health budget has one or more dedicated lines to support prevention and/or response to violence against women	4	10
	2.1.3 Number of Member States that have established a unit (or units) or focal point(s) in the Ministry of Health responsible for violence against women	4	10
2.2 Increase the health system's participation in multisectoral plans, policies and coalitions to address violence against women	2.2.1 Number of Member States that have a national or multisectoral plan addressing violence against women that includes the health system, according to the status of the plan: <ul style="list-style-type: none"> • in development • currently being implemented 	13	20

**STRATEGIC LINE OF ACTION 3:
STRENGTHEN THE CAPACITY OF HEALTH SYSTEMS
TO PROVIDE EFFECTIVE CARE AND SUPPORT
TO WOMEN WHO HAVE EXPERIENCED INTIMATE
PARTNER AND/OR SEXUAL VIOLENCE**

43. Given the high prevalence of violence against women and evidence that abused women seek health care services more frequently than other women (even if violence is not the presenting health condition), it is imperative that health systems be prepared to offer survivors first-line support that responds to women's physical, emotional, safety, and support needs. Health professionals need training and tools to identify survivors, to deliver appropriate clinical care, and to refer them to other services, as needed. Given

that many of the risk factors and determinants of violence lie outside the health system and in line with the "health in all policies" approach, health systems should pro-actively interact and coordinate with a number of other sectors, including: police and justice, social services, education, child protection, and gender equality or women's empowerment mechanisms.

44. Considering the disproportionate number of racially and ethnically marginalized women that experience violence in the Region, efforts should also include intercultural/culturally sensitive approaches to violence that reach beyond the formal health setting to include traditional health providers.

Objective	Indicator	Baseline (2015)	Target (2025)
3.1 Strengthen national standard operating procedures (protocols, guidelines) for providing safe and effective care and support for women experiencing intimate partner violence and/or sexual violence	3.1.1 Number of Member States that have national standard operating procedures/protocols/guidelines for the health system response to intimate partner violence, consistent with WHO guidelines ⁴	6	15
	3.1.2 Number of Member States that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines ⁵	2	15
3.2 Increase the capacity of health professionals to respond to violence against women	3.2.1 Number of Member States that have included the issue of violence against women in their continuing education processes for health professionals	2	10

45. Acknowledging that children's exposure to intimate partner violence against their mother is associated with a range of negative outcomes, including greater risk of violence in adulthood, greater efforts should be made to identify mechanisms to safely and ethically coordinate services for women and for children exposed to violence.

STRATEGIC LINE OF ACTION 4: STRENGTHEN THE ROLE OF THE HEALTH SYSTEM IN PREVENTING VIOLENCE AGAINST WOMEN

46. While addressing survivors' immediate needs is essential, long term reduction/elimination of violence depends on prevention. Similar to the ways in which it assumed responsibility for changing behaviors related to smoking and substance use, the public health community should raise awareness about violence against women as a public health problem.

47. The health system can contribute to preventing violence against women by gathering and disseminating evidence on the magnitude and consequences of violence; by developing and evaluating prevention programs and policies, and by scaling up promising or effective prevention strategies. These include programs that challenge attitudes and social norms that condone gender inequality and violence, that support socio-emotional learning and life skills that promote non-violent relationships, that reduce harmful use of alcohol, that aim to prevent child abuse (for example home visitation and parenting programs), and that assist children exposed to violence directly or as witnesses (50).

4 At a minimum, protocols/guidelines for health system response should address: a) empathic and non judgmental listening by health professionals; b) measures to help women enhance their safety; c) measures to help women enhance their children's safety and d) provision (directly or via referrals) of mental healthcare, social services, and legal support.

5 Comprehensive post-rape care services include: a) first-line support and psychological first aid; b) emergency contraception to women who seek care within five days; c) referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law; d) STI and/or HIV post exposure prophylaxis, per applicable protocols; and e) hepatitis B vaccination.

Objective	Indicator	Baseline (2015)	Target (2025)
4.1 Strengthen the participation and commitment of the health system in efforts to prevent violence against women	4.1.1 Number of Member States that have a multisectoral coalition/task force in place for coordinating efforts to prevent violence against women that includes the participation of Ministries of Health	3	10
	4.1.2 Number of Member States that have a national or multisectoral plan addressing violence against women (that includes the health system) that proposes at least one strategy to prevent violence against women, by type of strategy ⁶	0	10

MONITORING AND ASSESSMENT

48. The Strategy and Plan of Action will contribute to Outcome 2.3 of PAHO's Strategic Plan 2014-2019 ("Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth") and Outputs 2.3.2 and 2.3.3⁷ of the PAHO Program and Budget 2014-2015. Unlike other public health issues, addressing violence against women within health systems is a relatively new area of work for many Member States, so uniform baseline indicators are not available from all countries. To address this gap, PASB will develop a monitoring and evaluation plan and verify baseline data as part of implementing the Strategy and Plan of Action. Interim reports will be prepared for PAHO's Governing Bodies in 2018 and 2021 and a final report will be submitted in 2025.

FINANCIAL IMPLICATIONS

49. The total estimated cost of implementing the Plan of Action over its lifecycle from 2015 to 2025, including expenses for staffing and activities, is US\$ 4,900,000.

ACTION BY THE DIRECTING COUNCIL

50. The Directing Council is invited to review the proposed Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for 2015-2025, consider approving the proposed resolution in Annex C, and provide recommendations it deems pertinent.

6 Prevention strategies will be classified as follows: a) social and cultural norm change; b) *social-emotional learning approaches*; and c) *policy approaches (such as alcohol-related policies)*.

7 Output (OPT) 2.3.2: Countries and partners enabled to assess and improve national policies and programs on integrated violence prevention, including violence against women, children, and youth. OPT 2.3.3: Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines.

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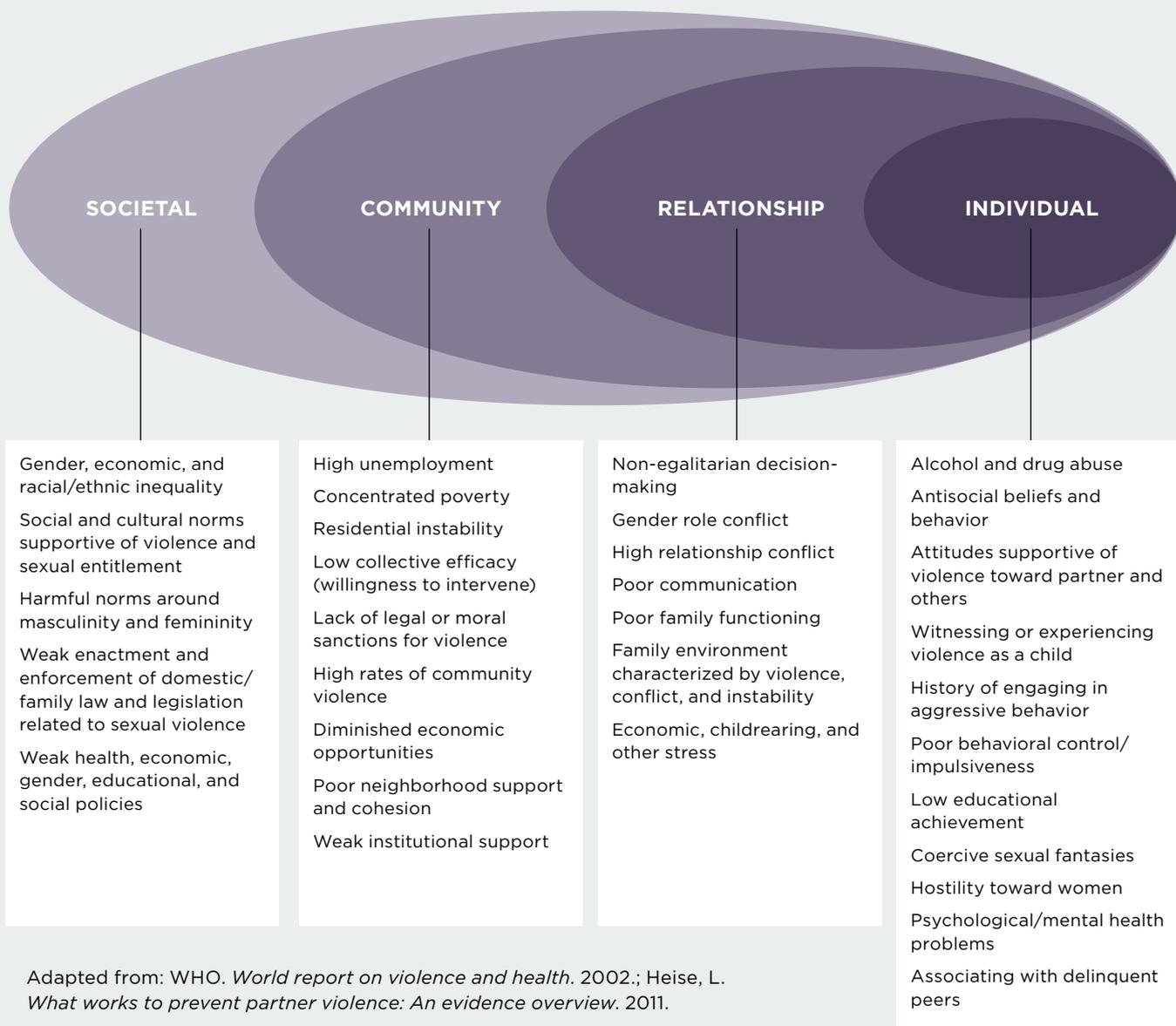
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ANNEX A

RISK FACTORS ASSOCIATED WITH THE PERPETRATION OF VIOLENCE AGAINST WOMEN



ANNEX B

PRINCIPLES GUIDING PAHO'S STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN

The following 10 principles guide this Strategy and Plan of Action:

- a) *Universal access to health and universal health coverage and equity*: Essential health services should be made available without risk of those needing services becoming impoverished or experiencing stigma or discrimination (on the basis of sex, age, socioeconomic status, ethnicity, or sexual orientation).
- b) *Human and civil rights*: Human and civil rights are set forth in applicable international and regional treaties as well as in national constitutions and laws. Program, laws, policies, and services to prevent and respond to violence against women should be aligned with these and should, in particular, promote the following principles, as outlined in WHO's *Clinical Handbook: Health care for women subjected to intimate partner violence or sexual violence (51)*:
 - i. life: a life free from fear and violence;
 - ii. self-determination: being entitled to make their own decisions regarding medical care and legal action;
 - iii. the highest attainable standard of health: health services of good quality available, accessible, and acceptable to women;
 - iv. non-discrimination: health care services offered without discrimination, and treatment not refused based on sex, race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation, or political beliefs;
 - v. privacy and confidentiality: provision of care, treatment, and counseling that is private and confidential;
 - vi. information: the right to know what information has been collected and to have access to this information.
- c) *Gender sensitivity and equality and cultural/ethnic diversities*: Prevention of and response to violence should also take into account gender norms, in particular, harmful constructions of masculinities that devalue the role of women, condone the use of violence, and blame women for the violence they experience. It is important to understand that violence against women is rooted in power imbalances and structural inequalities between women and men, that women may have less access than men to resources such as money or information, and that this may affect their ability to leave an abusive situation. It is also important to recognize and address multiple forms of discrimination that can contribute to increased vulnerability to violence on the basis of class, culture/ethnicity, age, disability, sexual orientation, gender identity, and others.
- d) *A multisectoral response*: A health systems response to violence against women should be situated within a comprehensive and coordinated multisectoral response. This requires partnerships among multiple sectors, including health, machineries for advancement of women or promotion of gender equality, child protection, education, law enforcement, judicial and social affairs. It also requires coordination and partnerships between public and private sector, as well as civil society, professional associations, academia and other relevant stakeholders, as appropriate to each country's situation.

- e) *Evidence-based practice*: Programs, policies and services to prevent and respond to violence against women should be based on the best scientific evidence available and/or best practice consensus, and should be tailored to the specific sociocultural context.
- f) *Life-course approach*: This approach recognizes that positive and negative factors can influence the trajectories and outcomes of an individual's health and development, and acknowledges the different manifestations of violence throughout the life course.
- g) *A comprehensive response*: A comprehensive response to addressing violence also requires phased programming that takes into account varying stages of health systems development across countries.
- h) *Community involvement*: Efforts should be made to listen to the needs of community members—including those who are living with or have experienced violence—and meaningfully involving them in policy and program development and in monitoring and evaluation.
- i) *Autonomy and empowerment*: Programming should respect the autonomy of individuals to make full, free, and informed decisions regarding the care they receive and the services they choose to pursue. Programs, policies, and services also need to empower those who experience or are affected by violence by respecting their dignity; reinforcing their value as persons; not blaming or judging them for their experience of violence; and providing information, counseling, and services that enable them to make their own decisions.
- j) *Engaging men and boys*: Engaging men and boys in prevention is a critical component in efforts to promote gender equality, empower women, and change social and cultural attitudes, practices, and stereotypes that contribute to male violence against women.

ANNEX C

PROPOSED RESOLUTION: STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN

54th DIRECTING COUNCIL

67th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 28 September-2 October 2015

CD54.R12
Original: English

RESOLUTION

CD54.R12

STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN

THE 54th DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* (Document CD54/9, Rev. 2);

Bearing in mind that the Constitution of the World Health Organization establishes that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;”

Observing that violence against women constitutes a public health problem of grave proportions and a violation or an abuse of women’s human rights and fundamental freedoms, and impairs or nullifies the observance, enjoyment, and exercise of such rights and freedoms;

Deeply concerned that violence against women affects one in every three women in the Americas;

Aware that violence against women can take many forms, but that sexual, physical, and emotional violence perpetrated by a male partner against a woman is the most prevalent form of violence against women;

Cognizant that violence against women is rooted in gender inequality and in power imbalances between men and women;

Aware that such violence has long-lasting and profound consequences for women's health, the health of their children, the well-being of their families and communities, and the economy and development of nations;

Recognizing that health systems have an important role to play in preventing and responding to violence against women as part of a comprehensive and multisectoral effort;

Recalling Resolution WHA67.15 (2014), Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children;

Recalling additional relevant PAHO Governing Bodies resolutions, including: Strategy for Universal Access to Health and Universal Health Coverage (CD53.R14 [2014]); Health and Human Rights (CD50.R8 [2010]); and Plan of Action for Implementing the Gender Equality Policy (CD49.R12 [2009]),

RESOLVES:

1. To approve and implement the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* within the context of the particular conditions of each country.
2. To urge the Member States, taking into account the shared responsibilities in federated States, to:
 - a) improve the collection and dissemination of comparable data on the magnitude, types, risk and protective factors, and health consequences of violence against women;
 - b) strengthen the role of their health systems to address violence against women to ensure that all women at risk or affected by violence—including women in situations of vulnerability due to their socio-economic status, age, ethnic or racial identity, sexual orientation, gender identity and/or disabilities—have timely, effective and affordable access to health services;
 - c) encourage addressing violence against women in relevant health initiatives, including maternal and child health, sexual and reproductive health, HIV/AIDS, and mental health;
 - d) promote the engagement of the health system with other government and civil society partners as part of a multisectoral effort to address violence against women;
 - e) consider the related budgetary implications and safeguard adequate resources to support the implementation of efforts to address violence against women.
3. To request the Director to:
 - a) support the implementation of the Strategy and Plan of Action in order to maintain and strengthen collaboration between the Pan American Sanitary Bureau and the countries and territories to address violence against women;

- b) continue to strengthen PAHO and WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence against women, and on effective strategies to prevent and respond to this type of violence;
- c) continue to support countries and territories, upon their request, by providing technical assistance to strengthen the capacity of health systems to address violence against women;
- d) facilitate PAHO cooperation with the human rights committees, bodies, and rapporteurships of the United Nations and Inter-American systems;
- e) continue to prioritize the prevention of violence against women and consider the possibility of allocating additional resources for implementing the Strategy and Plan of Action.

(Seventh meeting, 1 October 2015)

“Violence against women is a problem of great magnitude and wide-ranging health implications. It is a problem that the health sector must address.”

CARISSA F. ETIENNE, DIRECTOR, PAHO/WHO

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