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

#### Introduction

1. Violence against women, one of the most extreme forms of gender inequality, is a public health issue and human rights violation that affects large numbers of women worldwide (1). In the Region of the Americas (“the Region”), one in every three women will experience intimate partner violence or sexual violence by a non-partner at some point in their lives (1). Certain groups of women, including ethnically marginalized and indigenous women, are often at higher risk of experiencing violence (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 can take many forms, but sexual, physical and emotional violence by a male partner is the most prevalent form of violence against women (5). Violence against women has long lasting and profound consequences for women’s physical and mental health; children’s health, safety, and psychosocial development; the well-being of families and communities; and national budgets and economic development (1). Such violence can occur at all stages of life – childhood, adolescence, adulthood, and old age.
  4. Violence against women is a complex and multifaceted issue that requires coordinated action in order to be effectively addressed. The Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for 2015-2025 (“Strategy and Plan of Action”) is the Pan American Health Organization’s response to this public health problem of far-reaching consequences. It offers a concrete roadmap to address the Region’s priorities for preventing and responding to violence against women. The Strategy and Plan of Action are designed to continue and step up efforts by Member States, the Pan American Sanitary Bureau (“the Bureau”), and international organizations.
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5. The Strategy and Plan of Action provides guidance for health systems to address violence perpetrated against adolescent and adult women. This includes physical, sexual, and emotional violence perpetrated by male intimate partners, as well as sexual violence perpetrated by acquaintances and strangers. The Bureau recognizes that younger girls are also exposed to gender-specific forms of violence (such as female genital mutilation/cutting and early and forced marriage) and further acknowledges the toll that additional manifestations of violence pose to the Region, including child abuse and neglect and youth violence. Indeed, all forms of violence lead to negative health outcomes and should be addressed by health systems. There are compelling reasons, however, for a specific focus on violence against women, including its invisibility within national and international statistics, its social acceptability, the burden of shame and stigma attached to this type of violence in many settings, weak enforcement of legal protections, and the health systems' limited capacity to identify and care for survivors (6).

6. Furthermore, violence against women has recently received significant international attention, creating momentum that can be used 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) efforts to increase attention to violence against women within the Post-2015 Development Agenda (10).

## **Background**

7. Largely as a result of *a)* the efforts of women's organizations, *b)* a growing commitment on behalf of governments, and *c)* innovative public policies and the availability of scientific evidence on its magnitude and consequences, violence against women is gradually shifting from being seen as a private matter to being recognized as a violation of human rights with important public health ramifications (11).

8. The Convention on the Elimination of All Forms of Discrimination against Women (1981) condemns and aims to eliminate all forms of discrimination against women. The Declaration on the Elimination of Violence against Women, adopted in 1993, recognizes "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,

considers that violence against women constitutes a violation of human rights and fundamental freedoms, and defines it as any act or conduct based on gender that causes death or physical, sexual, or physical harm or suffering to women, in the public or private sphere (3).

9. Multiple 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 agreed conclusions of relevant 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 a stronger role to address violence against women (11). In addition, the Post-2015 Development Agenda seems poised to call for the elimination of all forms of violence against all women under its 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 higher risk of experiencing specific types of violence (16-19). The WHA resolution approved in 2014 (*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 the Strategy and Plan of Action, which focuses on violence against women.

## **Situational Analysis**

### ***Forms and Prevalence of Violence against Women***

11. There are many forms of violence that affect women in particular (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 such as acquaintances and strangers;
- c) child, early, and forced marriage;
- d) human trafficking, including forced prostitution, and economic exploitation of girls and women;
- e) rape as a weapon of war;
- f) Female genital mutilation/cutting and other harmful traditional practices;

- g) femicide and the killing of girls or women in the name of “honor”;
- h) sexual harassment in schools and workplaces (20).

12. In addition, there are specific settings/situations in which violence against women can be exacerbated, including conflict, displacement, and other humanitarian crises; natural disasters; and prisons and other institutional settings, such as those for individuals with mental illnesses and other disabilities. 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. Although beyond the scope of the Strategy and Plan of Action, this important issue is being addressed by global and Regional efforts, primarily through improving the availability of evidence and setting standards for quality of care (21).

13. The issue of workplace violence, including the physical, sexual, and psychological assault of women, raises many of the concerns presented in this document. This issue is also being addressed by broader efforts and initiatives to improve workers’ health and well-being and women’s participation in the workforce (22).

14. In some settings, evidence suggests that 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 intimate partner violence than women who identified as mestizo or white (2). In Canada, aboriginal women are nearly three times as likely to experience violence as non-aboriginal women (24). There is, however, a paucity of data on the prevalence of violence against women by ethnic group, and more culturally relevant and methodologically rigorous research is needed to better understand the magnitude, risk factors, and consequences of violence faced by different groups of women.

15. Some evidence suggests that women who identify as lesbian or bisexual may be at higher risk of violence than women who identify as heterosexual. For example, research from Canada suggests that sexual orientation may be a risk factor for violence generally (25), though there is very limited data from the Region disaggregated by sex, gender identity, and sexual orientation. This is an area that requires more research. Certain studies suggest that women with disabilities also face a higher risk of violence. 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).

16. Violence perpetrated by an intimate partner is the most common form of violence experienced by women. WHO estimates that 36% of women in the Americas have experienced physical and/or sexual violence by a partner or sexual violence by a non-partner (1).

17. Femicide has been identified as an 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 or intimate partner homicide is the murder of a woman by her current or former partner, usually following a history of other forms of intimate partner violence (29). Global data on femicide is limited due to a lack of systems to document information such as motives for murder or the relationship between the victim and the perpetrator. However, WHO estimates that 38% of the murders of women in the Region are perpetrated by a partner or ex-partner (1).

18. 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. In a national survey conducted in Paraguay 2008, about 1 in 10 women (10.3%) reported experiencing forced sex in their lifetime, whereas more than 1 in 4 had experienced it in Haiti, according to a survey conducted in 2005-2006 (2).

19. Data also suggest that, for a significant number of women in the Region, sexual debut is forced or unwanted. When asked if their first sexual intercourse was wanted or forced, 1.8% of women in Nicaragua (2006-2007) and 21.2% of women in Haiti (2005-2006) reported that their first sexual experience was forced (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). However, when given a third option (“unwanted sexual intercourse”), a higher proportion of women answered affirmatively (although they may not have characterized it as “forced”). For example, in Jamaica (2008–2009), only 4.7% of young women said that their first sexual intercourse was “forced,” but nearly half (44.9%) said that their first sexual intercourse was unwanted (2). Unwanted sexual intercourse may contribute to adolescent pregnancy and HIV transmission, highlighting the need to address sexual violence during adolescence as part of efforts to reduce unplanned pregnancy and HIV transmission in the Region.

### ***Risk and Protective Factors***

20. 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, the vast majority of studies use cross-sectional rather than longitudinal designs and thus provide limited evidence of causality. Finally, most studies examine individual-level risk factors rather than community or societal risk factors, which are key to prevention.

21. 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 base 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 level articulated by the 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.

22. Various individual factors are associated both with male perpetration and female experiences of violence against women, including low educational attainment, exposure to violence in childhood (either as a victim of child abuse or as a witness to intra-parental violence), alcohol and illicit drug use, and mental health conditions. At community and societal levels, weak community sanctions against violence, poverty and norms that support gender inequality and/or the acceptability of violence are also associated with both perpetrating and experiencing intimate partner and sexual violence against women (31).

23. Although violence against women has been found in virtually all settings where it has been researched, prevalence levels vary considerably between and within countries, suggesting that high levels of violence against women are not inevitable. There is worldwide effort to identify effective prevention strategies. Attention has focused on strengthening legal sanctions against violence, challenging gender norms at the community level, investing in the economic empowerment of women, reducing the harmful use of alcohol, and intervening to reduce and respond to violence during childhood among both boys and girls. Ultimately, greater investment is needed to understand the individual-, 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*

24. Violence against women has many under-recognized health consequences, including death—due to femicide, suicide, HIV/AIDS, and maternal mortality—and non-fatal effects ranging from injuries, sexually transmitted infections (STIs), unwanted pregnancy, maternal morbidity, an array of negative sexual and reproductive health outcomes, and mental health conditions. The subsections below outline these health consequences in more detail.

### *Injuries and Disabilities*

25. 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 has ranged 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*

26. Violence has profound effects on the mental health of women, resulting in conditions such as post-traumatic stress disorder (PTSD), depression, anxiety, as well as alcohol and drug use disorders (1). At the global level, women exposed to intimate partner violence are twice as likely to experience depression and almost twice as likely to have alcohol use disorders than women not exposed to such violence (1). Evidence from the Region aligns with these findings. Five national, population-based surveys found that large proportions of women who experienced partner violence in the past 12 months—ranging from nearly one-half of women in Ecuador (2004) to more than two-thirds of women in Paraguay (2008)—reported anxiety or depression so severe (as a result of their partner’s aggression) that they could not complete their work or other obligations (2). In Guatemala (2008–2009) and Paraguay (2008), women who had experienced physical or sexual intimate partner violence were significantly more likely to have contemplated or attempted suicide in the past month compared with women who had never experienced such violence (2).

### *Sexual and Reproductive Health*

27. Research suggests that violence against women and girls is associated with a range of negative sexual and reproductive health consequences. An analysis of select countries 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 reported intimate 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). Evidence suggests that violence during pregnancy is associated with a higher risk of pregnancy complications, including miscarriages and low birth weight babies (1). Other consequences of intimate partner violence include gynecological disorders, and an increased risk of acquiring HIV (in some regions), syphilis, chlamydia, or gonorrhea (1).

### *Maternal Mortality*

28. Studies from high-income countries found that partner violence can be an important indirect 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 data for 2003–2007 in the U.S. Centers for Disease Control and Prevention (CDC) National Violent Death Reporting System found that homicide and suicide of women during pregnancy or within the first year postpartum are important contributors to maternal mortality, and these deaths are often associated with intimate partner violence, as are 54% of suicides and 45% of homicides of women during pregnancy or within the first year postpartum (33). These findings have important implications for efforts to reduce maternal mortality.

### *Noncommunicable Diseases and Risk Factors*

29. Many women who have experienced violence engage in behaviors such as smoking and overeating and are less likely to seek preventive health care such as cholesterol checks and screenings for cervical or colon cancer. While the causal pathways between experiencing intimate partner violence and noncommunicable diseases are not yet clearly understood, there is some evidence that the damaging effects of chronic stress over time, combined with survivors' greater likelihood of engaging in harmful behaviors, may put them at greater risk for conditions such as being overweight or having diabetes, ischemic heart disease, stroke, and cancer (34, 35). Evidence suggests that violence may contribute to other noncommunicable diseases such as chronic pain syndromes, irritable bowel syndrome, gastrointestinal disorders, somatic complaints, and fibromyalgia (34, 35).

### *Intergenerational Effects*

30. Strong evidence suggests that violence against women has important intergenerational consequences. For example, in households where women are subjected to violence, children are more likely to be castigated with harsh forms of physical punishment. In addition, children exposed to child abuse, neglect, or violence against their mother are at increased risk for both perpetration and victimization of violence against women as they grow older (2, 36-38).

### *Economic Costs*

31. Violence against women imposes direct costs on health, social service, criminal justice and family court systems. For example, a U.S. study found that health care expenditures are approximately 42% higher for women who have experienced intimate partner violence compared with women who have not (39). In addition to direct costs, violence against women imposes indirect costs on survivors, families, employers, and broader society due to lost productivity and negative psychosocial consequences among women and their children. A comprehensive analysis from Canada found that the annual economic impact of spousal violence alone—including direct and indirect costs—was estimated at C\$ 7.4 billion (40). A World Bank analysis concluded that intimate partner violence costs Peru 3.7% of the country's gross domestic product (GDP), largely as a result of lost labor days (41). A study in Colombia also found significantly greater unemployment levels and reduced earnings among survivors of violence (42).

### *The Role of the Health System*

32. Health services can play an essential role in preventing and responding to violence against women. Health providers can identify women exposed to violence, provide immediate care, and sometimes prevent future harm by responding with support and referrals to other sectors. Evidence suggests that women exposed to violence are more likely than non-abused women to seek health services but may not always disclose



the violence to their health care providers (43). Initiatives to integrate attention to violence within health services can increase early identification of women experiencing violence and improve their access to support, care, and referrals (44).

33. Identifying cases of violence against women and providing appropriate clinical care is the first step in a pathway of other services. Health system collaboration with other sectors is essential for increasing women's access to comprehensive care, including legal and social services.

34. In addition to responding to violence against women after it happens, health systems can play a key role in comprehensive, multisectoral efforts to prevent violence from occurring in the first place. The public health approach to prevention involves four key steps: *a)* describe the problem conceptually and through data collection; *b)* investigate risk and protective factors to understand why the problem occurs; *c)* explore which strategies help prevent the problem by designing, implementing, and evaluating interventions; *d)* disseminate information on the effectiveness of programs and scale up effective programs (45).

### **Strategy and Plan of Action**

35. The Strategy and Plan of Action reflects the cumulative efforts of national governments and women's movements to draw attention to and catalyze action around the issue of 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, as well as many other efforts across the UN system to prevent and address violence against women.

### ***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 as outlined in WHO's *Clinical Handbook: Health care for women subjected to intimate partner violence or sexual violence* (46);
- c) gender sensitivity and equality and cultural/ethnic diversity;
- 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 Action***<sup>1</sup>

38. The Strategy and Plan of Action will be implemented using 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 and/or 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 indigenous and other ethnically marginalized women, is the first step in preventing and addressing this critical issue for several reasons. First, the development of evidence-based and culturally relevant plans, policies, programs, and laws depends on the availability of data generated via systematic data collection and research. Second, the data are key to measuring changes in the levels of violence over time. Finally, in line with international human rights instruments applicable to health and the ethical principal of non-maleficence, the data are also essential for monitoring and evaluation to ensure that well-meaning interventions do not cause harm.

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<sup>1</sup> 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 groups	9	22
	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	2	8

***Strategic Line of Action 2: Strengthen political and financial commitment to addressing violence against women within health systems***

40. The health system has an important role to play in leading efforts to challenge the acceptability of violence against women. A strong, visible health system response will convey a message to society regarding the unacceptability of violence, and can also encourage more women to disclose abuse to health professionals (43). However, the multidimensional nature of violence against women means that effectively addressing the issue calls for interventions involving various sectors. It also requires leadership and commitment from a wide-ranging body of leaders and experts, including government leaders, policymakers, academics, legislators, national human rights commissions, law enforcement agencies, and community members (47).

41. 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 the availability of designated budgets within the health system (47).

Objective	Indicator	Baseline	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	25 in 2015	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	Not yet available	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.	Not yet available	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"> <li>▪ in development;</li> <li>▪ currently being implemented</li> </ul>	Not yet available	15

***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***

42. Given the high prevalence of violence against women and the evidence that abused women seek health care services more frequently than non-abused 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 provides practical care and responds to women's emotional, physical, safety, and support needs. This requires that health professionals be given appropriate training and tools to not only deliver adequate clinical care but also identify survivors early and refer them to other services as needed.

43. Given the disproportionate number of 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	Indicators	Baseline	Target (2025)
<b>3.1</b> 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	<b>3.1.1</b> 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 <sup>2</sup>	Not yet available	15
	<b>3.1.2</b> Number of Member States that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines <sup>3</sup>	Not yet available	15
<b>3.2</b> Increase the capacity of health professionals to respond to violence against women	<b>3.2.1</b> Number of Member States that have included the issue of violence against women in their continuing education processes for health professionals	Not yet available	15

***Strategic Line of Action 4: Strengthen the role of the health system in preventing violence against women***

44. While addressing survivors' immediate needs is essential, reducing or eliminating violence in the long term 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 must raise awareness about the unacceptability of violence against women and its extensive health burden. This includes challenging attitudes toward violence and harmful social norms that condone it, supporting socio-emotional learning and life skills that lead to non-violent relationships, promoting a decrease in alcohol use, and assisting children exposed to violence directly or as witnesses (47). The health system could play an important role in prevention through promising practices and initiatives such as home visitation and parenting programs.

45. The health system can play other roles essential for preventing violence, such as gathering and disseminating evidence, supporting the evaluation of prevention programs and policies, and contributing to culturally relevant public campaigns that aim to shift social and cultural norms that perpetuate violence against women.

<sup>2</sup> At a minimum, protocols/guidelines for health system response should address: *a)* empathic and non-judgmental listening by health professionals; *b)* measures to enhance a woman's safety; and *c)* provision (directly or via referrals) of mental health and legal support.

<sup>3</sup> Comprehensive post-rape care services include: *a)* first-line support or 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, in accordance with applicable laws; *d)* STI and/or HIV post-exposure prophylaxis, as per applicable protocols; and *e)* hepatitis B vaccination.

Objective	Indicators	Baseline	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	Not yet available	10
	4.1.2 Number of Member States implementing violence against women prevention strategies with collaboration from national, state, and/or municipal health authorities, by type of strategy <sup>4</sup>	Not yet available	15

### Monitoring and Assessment

46. The Strategy and Plan of Action will contribute to the achievement of 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 2.3.3<sup>5</sup> of the PAHO Program and Budget 2014-2015. Unlike other public health areas covered by PAHO, addressing violence against women within health systems is a relatively new area of work for many Member States, so baseline indicators are not available uniformly across countries. To address these gaps, PASB will develop a detailed monitoring and evaluation plan and verify baseline data as part of the implementation of the Strategy and Plan of Action. A midterm progress report will be prepared for PAHO's Governing Bodies in 2020 and a final report will be submitted in 2025. See Annex D for a summary of indicators.

### Financial Implications

47. 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 Executive Committee

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

<sup>4</sup> Prevention strategies will be classified as follows: *a*) behavior-change communication; *b*) school-based; *c*) community-based; *d*) facility-based.

<sup>5</sup> 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.

## Annexes

**References**

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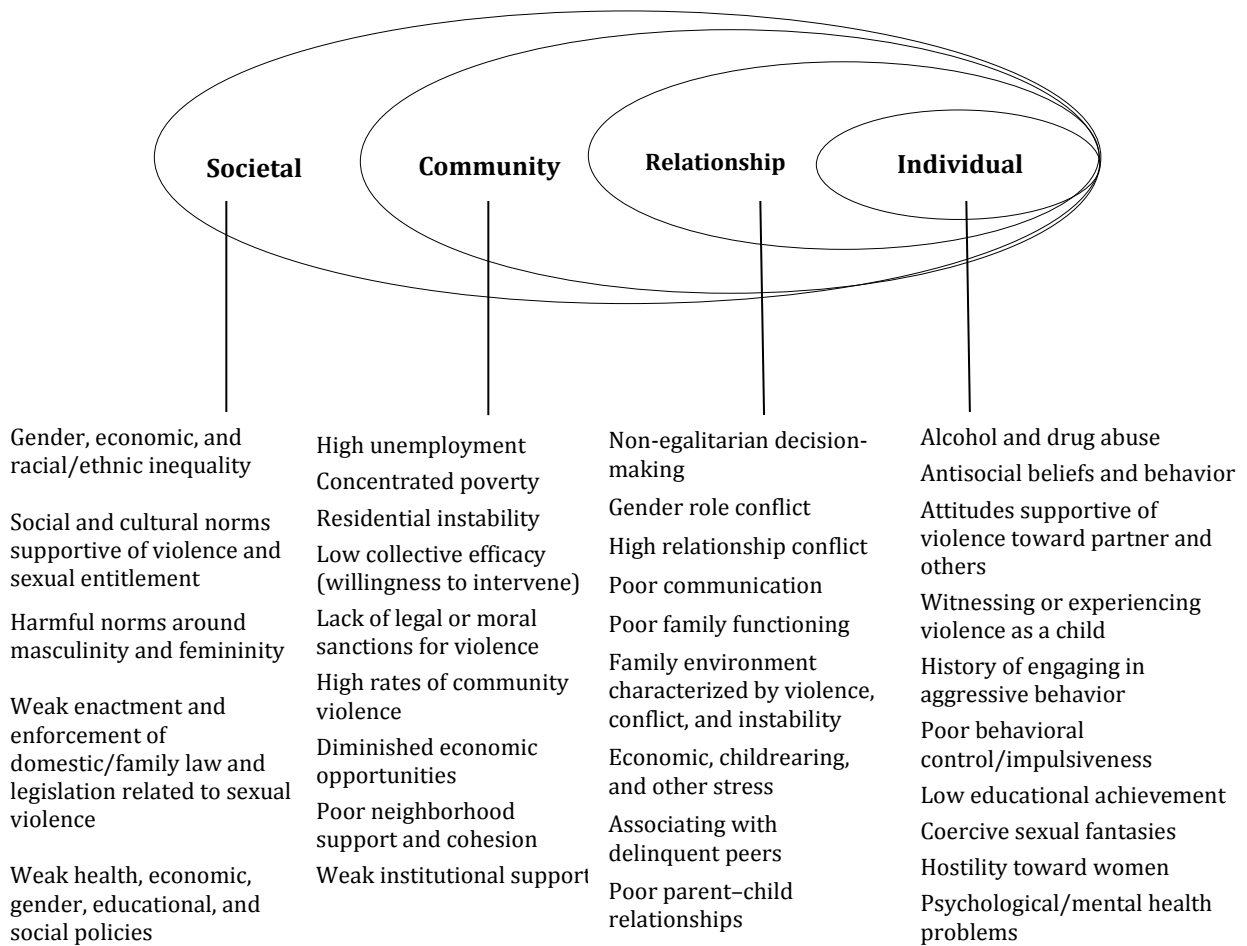
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**Annex A**

**Risk Factors associated with the Perpetration of Violence against Women**



Adapted from: WHO. *World report on violence and health*. 2002.; Heise, L. *What works to prevent partner violence: An evidence overview*. 2011.

## Annex B

### Guiding Principles

The following 10 principles guide the 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 rights*: Human rights are set forth in 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 must be aligned with these and must, in particular, promote the following rights, as outlined in WHO's *Clinical Handbook: Health care for women subjected to intimate partner violence or sexual violence (46)*:
    - 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 diversity*: Prevention of and response to violence must 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.
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- d) *A multisectoral response:* A health systems response to violence against women must be situated within a comprehensive and coordinated multisectoral response.
- e) *Evidence-based practice:* Programs, policies and services to prevent and respond to violence against women must be based on the best scientific evidence available and/or best practice consensus, and must 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 must 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 must 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.





## 156th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 22-26 June 2015

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CE156/14  
Annex C  
Original: English

### ***PROPOSED RESOLUTION***

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

##### ***THE 156th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* (Document CE156/14),

#### ***RESOLVES:***

To recommend that the Directing Council adopt a resolution along the following terms:

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

##### ***THE 54th DIRECTING COUNCIL,***

(PP1) Having reviewed the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* (Document CD54/\_\_);

(PP2) 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;”

(PP3) Observing that violence against women constitutes a public health problem of grave proportions and a violation of women’s human rights and fundamental freedoms, and impairs or nullifies the observance, enjoyment and exercise of such rights and freedoms;

(PP4) Deeply concerned that violence against women affects 1 in every 3 women in the Americas;

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(PP5) Aware that violence against women can take many forms, but that sexual, physical and emotional violence that is perpetrated by a male partner against a woman is the most prevalent form of violence against women;

(PP6) Cognizant that violence against women is rooted in gender inequality and in power imbalances between men and women;

(PP7) Aware that such violence has long-lasting and profound consequences to women's health, the health of their children, the well-being of their families and communities, as well as to the budgets and development of nations;

(PP8) 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;

(PP9) Recalling Resolution WHA67.15 (2014) (*Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*);

(PP10) 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 (CD49.12 [2009]),

**RESOLVES:**

(OP) 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.

(OP) 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 have timely, effective and affordable access to health services;
- c) encourage violence against women to be addressed 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.

(OP) 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/WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence against women;
- c) continue to support countries and territories, upon their request, by providing technical assistance for strengthening the capacity of health systems to address violence against women;
- d) facilitate PAHO cooperation with the human rights committees, organs 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.

## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

<p><b>1. Agenda item:</b> 4.5 – Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women</p>
<p><b>2. Linkage to Program and Budget 2014-2015:</b></p> <p>a) <b>Categories:</b> 2, Noncommunicable Diseases and Risk Factors, and 3, Determinants of Health and Promoting Health throughout the Life Course</p> <p>b) <b>Program Areas and Outcomes:</b></p> <p>Program Area 2.3 : Violence and Injuries Outcome (OCM) 2.3: Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women, and youth.</p> <p>Program Area 3.1: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health OCM 3.1: Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults.</p>
<p><b>3. Financial implications:</b></p> <p>a) <b>Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities):</b> US\$ 4,900,000</p> <p>b) <b>Estimated cost for the 2016-2017 biennium (including staff and activities):</b> \$980,000</p> <p>c) <b>Of the estimated cost noted in b), what can be subsumed under existing programmed activities?</b> The Bureau has one staff member in the area of violence against women, and limited funding for programmatic work in this topic area is included in the PAHO Strategic Plan 2014-2019; however, additional financial and human resources would be necessary for scaling up prevention and response to violence against women in the Region, particularly for the provision of technical support to Member States and territories.</p>
<p><b>4. Administrative implications:</b></p> <p>a) <b>Indicate the levels of the Organization at which the work will be undertaken:</b> This work will be carried out at all levels of the Organization: country, subregional and regional. Additionally, cross-regional collaborations will also be pursued.</p> <p>b) <b>Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):</b> In order to scale up efforts in the area of violence against women, another professional would be needed.</p> <p>c) <b>Time frames (indicate broad time frames for the implementation and evaluation):</b> The proposed resolution covers the period 2015-2025 and requires effort and commitment on the part of all the Member States and the Pan American Sanitary Bureau.</p>

## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

**1. Agenda item:** 4.5 – Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women

**2. Responsible unit:** Family, Gender and Life Course (FGL/HL)

**3. Preparing officer:** Alessandra Guedes

**4. Link between Agenda item and Health Agenda for the Americas 2008-2017:**

While preventing and responding to violence against women is linked to most of the areas of action outlined in the Health Agenda for the Americas, the action areas below are the most pertinent:

- Tackling Health Determinants
- Increasing Social Protection and Access to Quality Health Services

**5. Link between Agenda item and the amended PAHO Strategic Plan 2014-2019:**

Preventing and responding to violence against women is directly related to most of the categories of the PAHO Strategic Plan 2014-2019; however, the categories below are the most pertinent:

- Category 2: Noncommunicable Diseases and Risk Factors
- Category 3: Determinants of Health and Promoting Health throughout the Life Course
- Category 4: Health Systems

**6. List of collaborating centers and national institutions linked to this Agenda item:**

There are five collaborating centers working on violence and injuries prevention in the Americas, including:

- Canada: Collaborating Centre for Safety Promotion and Injury Prevention/National Public Health Institute of Quebec
- Brazil: Center for the Study of Violence (Núcleo de Estudos da Violência)/University of São Paulo
- Mexico: Instituto Nacional de Salud Pública
- USA: International Injury Research Unit / Johns Hopkins University
- USA: National Center for Injury Prevention and Control / Centers for Disease Control and Prevention

PAHO also has ongoing collaborative efforts with a number of additional organizations, including UN agencies (UNICEF, UN Women, UNFPA), academic centers (George Washington University, Johns Hopkins University School of Nursing) and others (Inter-American Development Bank, World Bank, Organization of American States).

**7. Best practices in this area and examples from countries within the Region of the Americas:**

- Develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence against women.
- Strengthen the capacity of health systems so that health professionals are able to identify and provide timely, safe and effective care and support for women experiencing intimate partner violence or sexual violence.
- Invest in evidence-based prevention strategies that target key risk factors, including but not limited to:
  - challenging gender norms that condone the use of violence against women;
  - preventing child maltreatment;
  - preventing the harmful use of alcohol.
- Ensure that violence against women is addressed within relevant health programs, including maternal and child health, sexual and reproductive health and mental health.

**8. Financial implications of this Agenda item:**

- The total estimated cost for implementation over the lifecycle of the resolution (2015-2025) is US\$ 4,900,000.
- The estimated cost for the 2016-2017 biennium is approximately \$980,000.

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