

A Human Rights Approach to Preventing and Responding to Violence against Women and Girls

Submitted by the WFPHA Work Group on Women, Children and Adolescents

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Introduction

Recent global estimates have shown that 35% of women globally have experienced physical/sexual violence by a partner and/or sexual violence by a non-partner in their lifetime¹. These estimates are likely low due to underreporting of experiences of violence². There are several different terms utilized in talking about violence including but not limited to: gender-based violence (GBV), sexual and gender-based violence (SGBV), intimate partner violence (IPV), and violence against women (VAW), and violence against women and girls (VAWG) which differ based on the organization, the intent of the policy/work and the population served.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted in 1979 by the UN General Assembly and sought to define what constitutes discrimination against women and set up an agenda for global action to end such discrimination. It has been ratified by 189 countries, although over 50 have done so subject to certain declarations, reservations and objections. The United States and Palau have signed but not ratified the treaty³. CEDAW clearly defines violence against women only, and intentionally does not include men⁴, and since the passage of that treaty, there has been a development of terminology which extends the definition to include all forms of violence related to “(a) social expectations and social positions based on gender and (b) not conforming to a socially accepted gender-role”⁵. While in most cases, GBV still predominantly impacts females and women (both those born as women and whose sex at birth matches their gender and those who have transitioned as women; cis and non-cis), the above definition gives space for a wider spectrum of gender and sexuality within the lesbian, gay, bisexual and transgender (LGBT) community. For this policy, we have chosen to remain aligned with the World Health Organization’s *Global Plan of Action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children* and utilize **violence against women and girls**, (hereto forth termed simply VAWG) which is defined as:

*“...violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty”*⁶

However it should be noted that men across the globe experience violence related to their gender and sexuality identity and that addressing that issue requires a separate set of actions⁶.

Since 1981 when CEDAW was implemented, a number of policy actions have been written and enacted by global governing bodies. In May 2014, the sixty-seventh World Health Assembly (WHA) adopted resolution WHA67.15 on “Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children”⁷. It requests the Director-General “to develop, with the full participation of Member States, and in consultation with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, building on existing relevant WHO work”⁷. As a result, in 2016, the World Health Organization (WHO) released a guiding plan of action entitled “Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children”⁸, which serves to provide both WHO and member states with prioritized strategies and action steps with the ultimate goal:

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

Also in 2016 with the ushering in of the 2030 Agenda for Sustainable development, the issue of VAWG was addressed directly. This new agenda calls on countries to begin efforts to achieve 17 Sustainable Development Goals (SDGs) over the next 15 years. Specifically related to VAWG, Goal 5 seeks to achieve gender equality and empower all women and girls⁹. It includes 9 specific targets to reach this overarching goal all of which are directly or indirectly implicate a health system response.

Scope and purpose

Recognizing WHO’s “Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children” and the Sustainable Development Goal Five, and considering¹⁰:

- Global estimates published by WHO indicate that about 1 in 3 (35%) women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.
- Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime.

- Globally, as many as 38% of murders of women are committed by a male intimate partner.
- Situations of conflict, post conflict and displacement may exacerbate existing violence, such as by intimate partners, and present additional forms of violence against women.
- Between 2016 and 2030 as part of the Sustainable Development Agenda, there are the following targets⁹:
 - 5.1: End all forms of discrimination against all women and girls everywhere
 - 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
 - 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
 - 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

The WFPHA calls for the commitment and involvement of Governments and Civil Societies to reduce VAWG and provide appropriate quality and holistic treatment for women and girls who experience violence. VAWG is a human rights issue and gender equality is utilized as a key factor in the development of countries¹¹. Health services and programs can be an entry point for identifying women and girls who have experienced violence, especially interpersonal violence, as well as women and girls who have been trafficked^{12,13}. Health systems should have plans in place including medicolegal frameworks, clinical training and community partnership, which specifically address the needs of post-GBV care and larger wide-scale prevention efforts. This includes understanding the specific legal barriers such as one's sexual identity, immigration status, marital law, which may impact health-seeking post-GBV; economic, social and cultural barriers, in accessing healthcare and health interventions; the participation of stakeholders in policy and service development; and budgeting and accountability to ensure significant and sustained investment in addressing VAWG in a meaningful way.

The purpose of the WFPHA policy is to encourage national governments to increase their efforts to reduce VAWG, while increasing their provision of quality post-violence and post-rape services. The plan of action purposefully focuses on what the health system can do, in collaboration with other sectors and without detriment to the importance of a multisectoral response. With sustained efforts we hope that VAWG will be considerably reduced when governments meet in 2030 to assess whether the Sustainable Development Goals have been achieved.

Fields of applications

The policy aims to align itself with the WHO plan of action in order to:

- Assist public health associations with increasing efforts to assure the prevention of VAWG and treatment of VAWG survivors in their countries
- Advocate for ongoing research, improved surveillance, strengthened health information systems, program monitoring and evaluation, and data-driven policy implementation to assure the most effective interventions to prevent/reduce VAWG are in place in all locations in a nation
- Continue pressure on the global community to prevent/treat VAWG so the Sustainable Development Goals are met
- Ensure preventing and addressing VAWG remains a major focus of human rights and social justice in all nations

Main Content

Women and girls are affected by a number of different forms of VAWG including but not limited to: IPV, sexual violence including rape by non-partners, trafficking, femicide (ie. honor killings, murder involving sexual violence), sex-selective abortions, sexual harassment and corrective rape (specifically for lesbians to ‘turn straight’)⁸. Some of these practices are more prevalent in certain countries and cultures, and some such as IPV and rape are present on a more global scale. At the root of all VAWG is a patriarchal power and a need to control women- either from the interpersonal level, such as in IPV, or from the community/societal level such as in acid throwing or female genital cutting (FGC)¹⁴.

Overall there has been conflicting and inadequate research on associating factors with IPV. In a meta-analysis (228 studies) of the US, Canada, UK, New Zealand and Australia, factors identified with being a victim of VAWG included unemployment of partner, younger age, stress, low connectedness at school or in neighborhood, previous abuse, among others¹⁵. A meta-analysis (19 studies) conducted among African countries pointed to IPV in pregnancy being associated with previous experiences of abuse, alcohol abuse by partner, risky sexual behavior, low socioeconomic status and young age¹⁶. Jewkes et al., also found, in exploring factors related to IPV in South Africa in a cross-sectional study, it was most related to the “status of women in a society and to the normative use of violence in conflict situations as part of the exercise of power”¹⁷. Other factors include less than a secondary education, mental disorder or disabilities, male control/authority over women, acceptability of violence to discipline women who violate gender norms, unemployment, and discriminatory laws^{8, 18}.

There is also a disproportionate vulnerability of VAWG in humanitarian emergencies, post-conflict settings and among displaced persons; in prisons, juvenile detention centers and facilities for women with mental illness as well as for the elderly; in health systems in particular sexual and reproductive health (SRH) and gender-based violence (GBV) services, including sexual assault, rape and re-traumatization^{8,19-22}. Adolescent girls are of particular concern as well, as they are at particular risk for transactional sex, sexual coercion, and inter-generational sex including in school settings, along with child marriage, and cultural coming-of-age traditions, which may include harmful practices^{23,24}. Lastly, lesbian, bisexual and transwomen are particularly vulnerable to

sexual assault particularly through cases of corrective rape, which largely go unreported^{25- 27}. In the US, for example CDC's national intimate partner and sexual violence survey found for LGB people that 44% of lesbians and 61% of bisexual women experience rape, physical violence or stalking as compared to 35% of heterosexual women²⁷.

Most countries attending the WHA are at different stages of implementing health system actions to address violence, and even those with laws in place provide limited enforcement and budgeting⁸. The biggest challenge overall is intersectoral coordination of budgeting, programming and research. Additionally, specifically within the health sector, challenges include provision of adequate coverage and quality of services^{27,28}. Some countries may have excellent services at for example one-stop centers, but there exist only a few in country²⁹. Services may be fragmented and near impossible to navigate, and mental health services, which are arguably most critical are least funded. VAWG funding is often connected to other prevention funding sources, such as HIV, which may limit the scope of VAWG work. There is also lack of appropriately trained personnel in the workforce, which can lead to limited care and/or re-traumatization⁷. There is limited availability of surveillance and program data and information as well, and inadequate systems at the facility level to collect information in a confidential manner^{30,31}.

ACTION

While there has been some progress in national health sector response to VAWG, and there are evidenced strategies and case studies of effective multisectoral strategies, VAWG continues to be a focal area which is under-resourced and deprioritized. The WFPHA in alignment with the WHO recommends 4 specific strategic directions⁸:

- Strengthen health system leadership and governance to ensure sustained funding and prioritization of VAWG prevention and treatment efforts
- Strengthen health service delivery and health workers/providers' capacity to screen, treat, refer and document cases of VAWG
- Strengthen programming to prevent VAWG through non-traditional coalition building
- Improve information and evidence related to VAWG prevalence including epidemiological, social science and intervention research, improved surveillance through HMIS and M&E

The action steps are as follows (adapted from the WHO Global Plan of Action):

1. Strengthen political will by publicly committing to address and challenge the acceptability of all forms of VAWG throughout the life-course, advocate to eliminate all forms of VAWG, end all harmful practices against women and girls, and promote gender equality
2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement,

- which, inter alia, criminalize VAWG; promote and protect their sexual and reproductive health and reproductive rights
3. Provide comprehensive health-care services to all women and girls who have experienced violence, including in humanitarian settings. These should include: first-line support, care for injuries, sexual and reproductive health and mental health, services for post-rape care including emergency contraception, provision of safe abortion in accordance with national laws, STI and HIV prophylaxis and hepatitis B vaccination, and services to manage the health complications of women and girls who have undergone female genital cutting
 4. Improve access to quality health-care services by integrating identification of and care for women experiencing intimate partner violence and/or sexual violence, into existing programs and services addressing: sexual and reproductive health; HIV, maternal and child health, adolescent health; mental health; routine checks and health services for the elderly; and health responses to humanitarian emergencies.
 5. Facilitate access to multisectoral services (police, justice, housing, social, child protection, livelihood and employment, etc.) including through provision of medicolegal care
 6. Develop, test and implement/scale-up programs to prevent and reduce VAWG that can be delivered within and outside of the health system, including by engaging men and boys to address gender inequality and abusive sexual relations, alongside women and girls as agents of change.
 7. Integrate modules to regularly collect data on VAWG across all ages in demographic and health or other population-based health surveys implemented at regular intervals
 8. Collect data or support analysis and use of data on VAWG and harmful practices, and disaggregate them by age, ethnicity, socioeconomic status and education, among other factors

Note: the WHO “Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children” provided invaluable information for the development of this policy

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