WHO-EM/HLP/089/E

Summary report on the

Regional consultation to review the draft global plan of action to strengthen the role of health system in addressing interpersonal violence, in particular against women and girls, and against children

Cairo, Egypt
27–28 April 2015

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1. Introduction

In 2014, World Health Assembly resolution 67.15 on "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children" requested the WHO Director General to develop, with the full participation of Member States, and in consultation with UN organizations and other relevant stakeholders, a draft global plan of action to strengthen this role of health systems within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children, building on existing relevant work of WHO. The overall goal of the global plan of action is to upgrade the capacities of health systems to engage within a multisectoral national response in promoting and protecting the physical and mental health and well-being of those subjected to, affected by or at risk of violence, in particular against women and girls, and against children.

The WHO Regional Office for the Eastern Mediterranean thus organized a regional consultation to review the draft global plan of action in Cairo on 27 and 28 April 2015. The objectives of the consultation were to endorse the main components of the global action plan and to provide the regional and country perspectives to its provisions.

Twenty-two representatives from 19 countries from the Region participated in the consultation, in addition to representatives from the League of Arab States and concerned United Nations organizations as well as independent regional and international experts.

The consultation was opened by Dr Haifa Madi, Director of Health Protection and Promotion, who delivered the opening remarks of Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Alwan stressed the importance of the consultative process

in ensuring that regional, country and partner perspectives and considerations were adequately reflected in the final global action plan. He referred to the pre-consultation interagency coordination meeting organized by the Regional Office the day before, which had brought together WHO, the League of Arab States and concerned United Nations organizations to exchange information on the work done by different agencies to develop a common position towards the global action plan and to explore the establishment of a sustainable regional interagency mechanism on prevention and response to interpersonal violence.

The regional consultation (and pre-consultation meeting) was held against a backdrop where the most recent estimates show that 475 000 homicide deaths occurred across the world in 2012, of which 8% were in the low-and middle-income countries of the Eastern Mediterranean Region. In terms of homicide rates, the Region's low- and middle-income countries are ranked third compared with other regions, at 7 deaths per 100 000 population. Estimated homicide rates for the countries of the Region range between 0.8 and 18.6 deaths per 100 000 population.

WHO also estimates that, generally, as many as 38% of homicides of women are committed by intimate partners, compared with 6% of homicides of men. For every death due to violence, there are many more non-fatal and hidden cases, a disproportionate number of whom are women, children and older people. Globally, 1 in 3 women (15 years and older) experience physical and/or sexual violence by a partner, or sexual violence by perpetrators other than a partner. The Region has the second highest prevalence (37%) of intimate partner violence among the WHO regions. Many of these forms of violence are exacerbated during times of war and other humanitarian crises, which prevail in many countries in the Region.

Women and girls bear an enormous burden of specific types of violence rooted in gender inequality, often hidden and stigmatized and even socially sanctioned. Girls face all the forms of child maltreatment as well as these specific forms of violence discrimination in addition to harmful traditional practices such as female genital mutilation (FGM) and child, early and forced marriage. Five countries in the Region are among the 29 countries where female genital mutilation is concentrated.

Violence against children, including maltreatment of boys and girls as well as some forms of youth violence, is widespread. Among children, homicide rates increase dramatically in late adolescence. Child maltreatment has lifelong negative consequences, including ill-health, health risk behaviours, and experiencing and perpetrating violence in later life stages.

During the consultation, presentations were given on violence prevention and response efforts. These included presentations by WHO on the global situation and WHA resolution 67.15, with an overview of the draft global plan, along with other presentations on the regional situation and efforts aimed at violence prevention and response. International experts also gave two presentations on the role of health systems in preventing and responding to violence.

Discussion took place in plenary sessions and in groups in which country perspectives were given on the different components of the draft global plan. Suggestions were made for modifications and recommendations on feasible actions to be undertaken pending the finalization of the plan. The next steps in the consultations around the global plan until its endorsement by the sixty-ninth session of the World Health Assembly in 2016 were also presented.

2. Summary of discussions

While acknowledging the importance of global and regional initiatives, they only become meaningful when they are translated into action at the country level. The global action plan is thus seen as only a first step towards guided practical action in different countries.

The current overall structure of the global plan was endorsed; this includes a section on crosscutting issues, one on violence against women and girls and one on violence against children, covering youth and peer violence up to the age of 18 years.

Regarding the terminology used throughout the plan, "sexual and reproductive health" was considered an acceptable term by the majority of Member States. "Intimate partner violence" was flagged as a challenging term. A clarification would be added that the term could be adapted/defined according to different contexts. Some Member States indicated that "early marriage" was not sufficiently well defined. However, most country representatives stated that there was enough evidence that this was a problem in their countries and needs to be addressed.

It was emphasized that there was a need for a conceptual framework focusing on the health system's role within the multisectoral approach in prevention of and response to interpersonal violence, in particular against women and girls, and against children. While a strategic outlook is needed, a more operational action-oriented plan with an implementation framework would aid translation into actual efforts to enhance health system responsiveness on the ground. The implementation framework would include core and additional actions, examples of successful interventions or best practices, partners, tools and resources, etc.

Multisectoral aspects also need to stress the importance of community involvement and engagement as well as the role of concerned UN organizations, nongovernmental organizations, media and various governmental sectors. Such multisectoral collaboration increases access to resources, and strengthens shared responsibility and ownership of any efforts and activities undertaken. To meet its intended objectives, collaboration needs to be organized at international, regional and national level.

Coordination within the health systems is equally important, including strengthening the mental health services at all levels, especially at the primary health care level, and including psychosocial support services and consultations for victims of interpersonal violence, in particular againstwomen and girls, and against children. It is important to integrate prevention and response to violence against women and girls and against children (and other forms of violence) in other health programmes/platforms where relevant.

Health information systems are key to strengthening data on fatal and non-fatal violence in coordination with other sectors. Policies, strategies and plans need to be evidence-based, relying on structured and systematic collection, analysis and use of quality data, including data on the economic cost of violence, with support from WHO. This is closely linked to the monitoring and accountability frameworks of the global plan yet to be developed. The need for a core of indicators for integration into health management information systems was emphasized, aided by standardized data collection forms (both quantitative and qualitative).

Strong political commitment, support and national ownership at the highest possible level is crucial in ensuring that violence prevention and response is included among the high priority programmes.

It is important that different contexts, including the special situation of humanitarian settings and consequently fragile systems, are well reflected in the global plan. The plan could recommend a core/basic set of actions that could be adopted across all settings, as well as a list of additional actions for settings with more-evolved health systems. This would offer a sufficient level of flexibility to allow countries to instigate the plan at different starting points based on their own circumstances.

Actions across different forms of violence should not overlook community engagement, sensitization, partnerships, social mobilization and multisectoral coordination. Advocacy targeting policy-makers based on the health consequences of violence and public health approaches is important.

More specific changes were included in the draft text of the plan under the components on violence against women and girls and against children during the respective group work.

3. Recommendations

To Member States

1. Actively engage in subsequent steps of the consultation process around the global action plan in different forums and platforms.
2. Ensure that country representatives who attended the consultation liaise with national entities/persons who will be involved in the next stages of the consultation process around the global action plan until its finalization.
3. Take necessary preparatory steps, with the support of WHO, for the development and implementation of national action plans based on the global action plan and their specific contexts, until the finalization and endorsement of the plan, as appropriate. This could include

stakeholder analysis and mapping of the current situation in addition to ongoing efforts towards violence prevention and response.

To WHO

4. Ensure that inputs from different regions and countries are reflected in the final version of the global action plan.
5. Take into consideration the different contexts in countries, including level of development. Conflict and emergency situations should be taken into consideration in the final version of the global action plan and the subsequent development and implementation of national plans where relevant.
6. Provide technical support to countries' capacity-building and advocacy efforts, and also to guide countries while developing their own policies and guidelines.
7. Closely coordinate with the League of Arab States and concerned United Nations agencies at the global, regional and national level for implementation of the plan after finalization.
8. Invest in WHO collaborating centres on interpersonal violence, in particular against women and girls and against children, and get them involved in the application of the global action plan in different contexts.

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