

# Addressing violence against women in health and multisectoral policies:

a global status report





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# Foreword



Violence against women and girls has long been a pernicious problem. It affects the health of millions of women and girls and constitutes one of the most egregious human rights violations of our times. Almost one in three women are subjected to physical and/or sexual violence, mostly by their intimate partners, and one in four adolescent girls and young women who are partnered are also subjected to this violence. Clearly, we can no longer stand by while this issue is neglected in health and development policies, nor can we ignore the lack of resources allocated to implement proven interventions.

Over the years, many calls have been made to governments, political and business leaders, and heads of United Nations agencies and other institutions for urgent action to end violence against women. The Sustainable Development Goals have set a target of eliminating all forms of violence against women and girls everywhere by 2030. Although the COVID-19 pandemic has set us back, with increased reports of violence against women in many places, it is not impossible to resume progress towards reducing and eventually ending this public health and human rights crisis.

At the World Health Assembly in May 2016, WHO Member States made a commitment to strengthen health systems responses to violence against women and girls. WHO is proud to present in this report the first comprehensive assessment of how well Member States have fulfilled this commitment. The report shows the extent to which countries' health and multisectoral policies align with WHO recommendations, with the existing evidence base and with internationally agreed human rights standards.

The information presented in this report is derived from a global database developed from multiple data sources, including more than 600 policy documents in many languages. Collectively, the findings present a picture of a glass half full.

Although there is much to praise in the progress countries have made in putting in place multisectoral plans to address violence against women and girls, the health sector needs to do more. Governments must establish policies that enable the health system to implement the full package of WHO-recommended interventions that will result in universal access to survivor-centred essential services.

The report also highlights the need for policies to focus more on addressing violence against adolescent girls and young women, as they bear a significant burden of violence that can set them on a downward trajectory for a lifetime.

Ending violence against women and girls also requires adequate resourcing and vigorous implementation of evidence-informed prevention strategies across multiple sectors, including the health sector. Gender inequality is at the root of violence against women and girls and must be addressed. We can no longer justify or accept violence against women, and we cannot tolerate the perpetuation of women's subordinate status in societies worldwide. Across sectors, governments must put in place policies that include investments in strategies that are proven to have an impact in preventing and reducing violence against women and girls.

WHO offers several *evidence-based tools*<sup>1</sup> to support Member States in designing and implementing effective prevention and response policies and programmes. We must and can end violence against women! We have the means to do so. Strong evidence-informed policies are a step in the right direction. Much more needs to be done to strengthen the related policies, as this report shows. Furthermore, we must not stop at simply having policies; we must ensure that they are implemented. Women and girls are entitled to nothing less than the right to lives free of violence and coercion.

A handwritten signature in blue ink, appearing to read 'D. Jakab', is positioned above the printed name.

**Dr. Zsuzsanna Jakab**  
**Deputy Director-General**

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<sup>1</sup> See: Resource package for strengthening countries' health systems response to violence against women. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/WHO-SRH-21.5>).

# Acknowledgements

This report was produced under the overall technical oversight of Avni Amin, Violence Against Women Technical Officer, with the direction of Claudia García-Moreno Esteva, Unit Head, Addressing the needs of Vulnerable Populations, within the World Health Organization (WHO) Department of Sexual and Reproductive Health and Research (SRH Department), which also executes the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP).

This report is based on information in a database of policies on violence against women (VAW Policy Database), recently established by the SRH Department. The coordination and conceptualization of the database and this report, the data entry, extraction, analysis and report writing were all done by a team of consultants led by Katherine (Kat) Watson (Project Lead), Eva Burke, Gillian Eva and Judy Gold. Team members who contributed to data entry and extraction were Sophie Baumgartner, Mohamed Harby, Vanessa Maag, Sophie Morse, Noor El Nakib and Claire Veyriras, who between them spoke four out of the six United Nations languages, which was a consideration for the database. The VAW Policy Database was developed by Svetlozar Mihaylov and Zvezdalina Dimitrova. The report was edited by Green Ink, United Kingdom.

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# Abbreviations

<b>EC</b>	emergency contraception
<b>GBV</b>	gender-based violence
<b>HIC</b>	high-income country
<b>IPV</b>	intimate partner violence
<b>LIVES</b>	Listen with empathy, Inquire about her needs, Validate her experience, Enhance her safety and facilitate Support
<b>LMIC</b>	low- and middle-income country
<b>MoH</b>	ministry of health
<b>NCPI</b>	National Commitments and Policy Instrument
<b>NGO</b>	nongovernmental organization
<b>OSCC</b>	one-stop crisis centre
<b>PEP</b>	post-exposure prophylaxis
<b>RESPECT</b>	Relationship skills strengthened; Empowerment of women; Services ensured; Poverty reduced; Environments made safe; Child and adolescent abuse prevented; Transformed attitudes, beliefs and norms
<b>RMNCAH</b>	reproductive, maternal, newborn, child and adolescent health
<b>SDG</b>	Sustainable Development Goals
<b>SOP</b>	standard operating procedure
<b>SRH</b>	sexual and reproductive health
<b>SRMNCAH</b>	sexual, reproductive, maternal, newborn, child and adolescent health
<b>STI</b>	sexually transmitted infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV and AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>VAW</b>	violence against women
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

## Abbreviations for WHO regions:

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<b>AFR:</b>	African Region
<b>AMR:</b>	Region of the Americas (also known as PAHO: Pan-American Health Organization)
<b>EMR:</b>	Eastern Mediterranean Region
<b>EUR:</b>	European Region
<b>SEAR:</b>	South-East Asia Region
<b>WPR:</b>	Western Pacific Region

# Glossary of terms

The terms and definitions in this glossary have been adapted from the *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* (WHO, 2016),<sup>2</sup> unless other sources are cited in footnotes.

**Adolescent girls** refers to girls aged 10–19 years.

**Young women** refers to women aged 20–24 years.

**Emergency contraception** refers to “methods of contraception that can be used to prevent pregnancy after sexual intercourse. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse”.<sup>3</sup>

**First-line support** involves provision of immediate practical care that responds to a woman’s emotional and physical safety and support needs, without intruding on her privacy. It is an adaptation of “psychological first-aid”. A job-aid to implement first-line support identifies five steps using the mnemonic “LIVES” – Listen, Inquire about needs, Validate survivor’s experience, Enhance her safety, and facilitate Support.<sup>4</sup>

**Gender-based violence** against women is violence that is directed against a woman because she is a woman or that affects women disproportionately and is rooted in unequal gender power relations that disadvantage women. It includes acts that inflict physical, mental/psychological or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.<sup>5</sup>

**Gender equality** refers to the equal rights, responsibilities and opportunities of women, men, girls, and boys and gender-diverse individuals. Equality does not mean that women and men will become the same, but that people’s rights, responsibilities and opportunities will not depend on whether they are born male or female.<sup>6</sup>

**Health-care providers** are all people engaged in actions whose primary intent is to enhance health.<sup>7</sup>

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2 Available at: <https://www.who.int/publications/i/item/9789241511537>, see Appendix 1.

3 Emergency contraception. Geneva: World Health Organization; 2018 (<https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>).

4 Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 ([https://www.who.int/iris/bitstream/10665/85240/1/9789241548595\\_eng.pdf](https://www.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf)).

5 Adapted from: General Recommendation No. 19. Convention on the Elimination of All Forms of Discrimination against Women. Eleventh Session of the Committee on the Elimination of Discrimination against Women. New York (NY): United Nations; 1992 (<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>, accessed 22 November 2021).

6 Adapted from: Gender mainstreaming: strategy for promoting gender equality. Office of the Special Advisor on Gender Issues and Advancement of Women (OSAGI); 2001 (<http://www.un.org/womenwatch/osagi/pdf/factsheet1.pdf>).

7 World health report. Geneva: World Health Organization; 2006 ([https://www.who.int/whr/2006/whr06\\_en.pdf](https://www.who.int/whr/2006/whr06_en.pdf)).

**Health sector** refers collectively to all “organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related nongovernmental organizations and community groups, and professional associations”.<sup>8</sup>

**Health system** refers to “(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health”.<sup>9</sup>

**Intimate partner** refers to a husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover. The definition of intimate partner varies between settings and studies, and includes formal partnerships, such as marriage, as well as informal partnerships, including cohabiting, unmarried sexual relationships, and in some settings, dating relationships. In some settings, intimate partners tend to be married, while in others informal partnerships are more common.<sup>10</sup>

**Intimate partner violence** refers to “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours”.<sup>11</sup>

**Multisectoral response** “entails the coordination of resources and initiatives across sectors, involving both government institutions and civil society. A coordinated framework provides for the delivery of a diverse range of health care, protection and justice services that survivors need which cannot be provided by a single sector or intervention”.<sup>12</sup>

**Populations in vulnerable situations** are groups that are disproportionately likely to be exposed to or experience different types of violence because of social exclusion, marginalization, stigma and multiple intersecting forms of discrimination.<sup>13</sup>

**Relational databases** store information and provide access to data points that have pre-defined relationships between them.<sup>14</sup>

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8 Health promotion glossary. Geneva: World Health Organization; 1998 (WHO/HPR/HEP/98.1; <http://www.who.int/entity/healthpromotion/about/HPR%20Glossary%201998.pdf>).

9 Health systems strengthening glossary. Geneva: World Health Organization; 2011 ([http://www.who.int/entity/healthsystems/Glossary\\_January2011.pdf](http://www.who.int/entity/healthsystems/Glossary_January2011.pdf)).

10 Adapted from: Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 ([http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf)).

11 Violence against women. Intimate partner and sexual violence against women. Geneva: World Health Organization; 2014 ([http://apps.who.int/iris/bitstream/10665/112325/1/WHO\\_RHR\\_14.1\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.1_eng.pdf)).

12 UN Women virtual knowledge centre to end violence against women and girls. Ensuring holistic multisectoral policies and national plans of actions. In: UN Women [website]. (<http://www.endvawnow.org/en/articles/316-ensuring-holistic-multisectoral-policies-and-national-plans-of-actions-.html>).

13 Adapted from: Non-discrimination: groups in vulnerable situations. Office of the United Nations High Commissioner for Human Rights (OHCHR); 2021 (<https://www.ohchr.org/EN/Issues/Health/Pages/GroupsInVulnerableSituations.aspx>).

14 What is a Relational Database (RDBMS)? Oracle; 2021 (<https://www.oracle.com/au/database/what-is-a-relational-database/>).

**Sexual violence** refers to “being forced, coerced or threatened to perform any unwanted sexual act; this could include rape, attempted rape, unwanted sexual touching or non-contact forms of sexual violence”.<sup>15</sup>

**Survivor** refers to a person who has experienced/is affected by violence. The term “survivor” is usually preferred by those working on violence against women to emphasize that women affected by violence have agency and are not merely passive “victims” in the face of violence. The term “victim” is, however, used by the legal sector.

**Universal health coverage (UHC)** means that “all individuals and communities receive the full package of health services they need without suffering financial hardship. Quality services include those related to health promotion, prevention, treatment, rehabilitation and palliative care across the life-course”.<sup>16</sup>

**Violence against women (VAW)** is defined as: “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.” It encompasses, but is not limited to: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.<sup>17</sup>

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15 VAW against women prevalence estimates, 2018. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240022256>).

16 Fact sheet: universal health coverage. Geneva: World Health Organization; 2021 ([https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))).

17 Adapted from United Nations General Assembly resolution A/RES/48/104. Declaration on the elimination of violence against women. New York (NY): United Nations; 1993 ([https://www.un.org/en/genocideprevention/documents/atrocities-crimes/Doc.21\\_declaration%20elimination%20vaw.pdf](https://www.un.org/en/genocideprevention/documents/atrocities-crimes/Doc.21_declaration%20elimination%20vaw.pdf)).

# Executive summary

## Key messages



### Existence of policy on violence against women (VAW)

**81%** of countries have **multi-sectoral plans of action**

**48%** of countries have **clinical guidelines** addressing VAW



### Alignment with international human rights standards for woman-centred care

**45%** of countries mention the **right to a private consultation**

**26%** of countries mention **providers' obligations to inform survivors** about the limits to confidentiality



### Provision of health services

**75%** of countries include **first-line support**, in line with WHO recommendations

**35%** of countries include **mental health interventions** for survivors in their policies

**45%** of countries include all three **immediate post-rape care services** (emergency contraception, STI prophylaxis and HIV prophylaxis) in their policies



### Populations living in vulnerable situations

**14%** of countries recognize the high risk of violence faced by **adolescent girls and young women** and include specific services for them in their policies



### VAW prevention

**78%** of countries mention **gender norm-transformation interventions** for preventing VAW

**42%** of countries include **women's empowerment interventions** in their policies

## Introduction

Violence against women and girls is a major human rights violation and a global public health problem rooted in gender inequality. *World Health Organization (WHO) estimates* show that, globally, almost one in three women (30%) 15 years of age or older have experienced physical and/or sexual violence from a male intimate partner and/or sexual violence from someone other than an intimate partner at least once in their lifetime since the age of 15. Such violence starts early in the lives of women and girls, with almost one in four (24%) ever-partnered adolescent girls aged 15–19 years estimated to have been subjected to physical and/or sexual violence from a male intimate partner at least once in their lifetime since the age of 15. The COVID-19

pandemic response measures in the form of lockdowns and stay-at-home regulations have increased economic stress on households, put a greater care burden on women and increased their exposure to violence in the home, while at the same time there has been a decrease in the availability of social support and access to services.

Women and girls subjected to violence suffer a range of physical (including sexual and reproductive) health and mental health problems. Violence against women (VAW) also has socioeconomic consequences for the woman, her family, communities and societies. The health sector has a critical role to play in responding to and preventing VAW, since most women will come into contact with health systems at some point in their lives, and health-care providers are among those they are likely to trust with a disclosure. This provides an important entry point for ensuring that women who experience violence receive health services and referrals for other support services.

Recognition of VAW as a health and development crisis has grown in the last three decades. Governments have made numerous commitments in international and regional forums including a [2014 resolution at the United Nations General Assembly](#), the [1979 Convention of the Elimination of All Forms of Discrimination against Women \(CEDAW\)](#), and regional agreements such as the [2011 Council of Europe's Istanbul Convention](#) and the 1994 [Inter-American Convention of Belém do Pará](#). The Sustainable Development Goals (SDGs) have placed an emphasis on eliminating all forms of violence against women and girls (SDG target 5.2) as a pathway to achieving SDG 5: Achieve [gender equality and empower all women and girls](#).

Recognizing the public health burden of violence against women, at the Sixty-ninth World Health Assembly (WHA) in 2016, WHO Member States endorsed resolution WHA69.5 – the [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](#) (“the Global Plan”). To establish a baseline against which to monitor progress under the Global Plan, WHO commissioned the development of a VAW Policy Database, which has been used in generating the data contained in this report. The development of the database was also intended to facilitate country-level policy dialogue to support countries in strengthening their health and multisectoral responses to VAW in line with WHO recommendations, evidence-based strategies, and international human rights standards.

## Methodology

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Policy indicators for the VAW Policy Database were developed to align with the Global Plan and with [WHO guidelines for responding to intimate partner violence and sexual violence against women](#) and with the [RESPECT women](#) framework for preventing VAW. The indicators were refined in consultation with an external reference group of experts and relevant WHO staff, including in regional offices. A total of 54 indicators were organized into six areas: enabling environment; woman-centred care; health services in policy and their availability; inclusion of populations in vulnerable situations; prevention strategies; and availability of VAW prevalence data. The database was populated with data from 194 WHO Member States, 174 of which had policy documents available that were eligible for review.

## VAW Policy Database indicator overview

Area	Overview of indicators
1. Enabling environment for prevention and response	<ul style="list-style-type: none"> <li>• Existence of a policy</li> <li>• Budgetary commitments</li> <li>• Health-care providers' reporting requirements</li> <li>• Commitment to training health-care providers</li> </ul>
2. Woman-centred care	<ul style="list-style-type: none"> <li>• Privacy mentioned as a guiding principle</li> <li>• Privacy specified for consultation with survivors</li> <li>• Confidentiality as a principle</li> <li>• Requirement to explain the limits of confidentiality to survivors</li> </ul>
3. Health services: policy and availability	<ul style="list-style-type: none"> <li>• Intimate partner violence (IPV) identification</li> <li>• First-line support</li> <li>• Post-rape care: emergency contraception (EC), sexually transmitted infection (STI) prophylaxis, HIV post-exposure prophylaxis (PEP) and safe abortion</li> <li>• Mental health assessment, referral and treatment</li> <li>• Referrals beyond the health sector</li> <li>• Availability of comprehensive post-rape care services in line with WHO guidelines in at least one service delivery point</li> </ul>
4. Populations in vulnerable situations	<ul style="list-style-type: none"> <li>• Recognition of and specific provisions for               <ol style="list-style-type: none"> <li>(i) adolescent girls and/or young women,</li> <li>(ii) women with disabilities and</li> <li>(iii) pregnant women</li> </ol> </li> </ul>
5. VAW prevention	<ul style="list-style-type: none"> <li>• (E) Empowerment of women – social and economic</li> <li>• (S) Services</li> <li>• (T) Transformed gender attitudes, beliefs and norms</li> </ul>
6. VAW prevalence data	<ul style="list-style-type: none"> <li>• Availability of at least one national population-based survey with data on the prevalence of recent IPV (i.e. in the past 12 months before the survey) conducted between 2000 and 2018</li> </ul>

A list of search terms was developed, which was then used during the review of the available and eligible government-endorsed, national-level policy documents, to search for relevant information for each indicator. The following four types of national-level policy documents were eligible for inclusion and review: (i) national health policy, (ii) national multisectoral VAW policy; (iii) national health sector VAW policy (i.e. clinical guideline or protocol); and (iv) national VAW training curricula or manuals for the health sector.

Eligible policy documents were sourced from existing repositories at WHO headquarters, regional and country offices; the 2018–2019 WHO Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) policy survey repository; and through extensive online searches. A total of 604 policy documents were included, from 174 of WHO's 194 Member States, across all six WHO regions. The data were entered onto the VAW Policy Database using a set of answer options for each indicator and following a number of quality assurance measures. In addition, data were also brought into the VAW Policy Database from



the SRMNCAH policy survey, the UNAIDS-administered National Commitments and Policy Instrument (NCPI) survey, and from the WHO Global Database on the Prevalence of Violence Against Women. Reports were generated from the database, with data organized by WHO region for the purposes of analysis for this report.

## Findings

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### *Enabling environment*

An enabling environment for preventing and addressing VAW within the health system starts with the **existence (and implementation) of policy**. Multisectoral VAW policies were found for a majority (81%) of all 194 countries, while closer to half of countries had a national health policy that mentioned VAW (53%) and clinical guidelines/protocols addressing VAW (48%). **National budget commitments** are vital to ensuring the implementation of existing policies, yet funding allocation for VAW was only reported by 42% of countries that responded to the SRMNCAH policy survey.

WHO guidelines do not recommend **mandatory reporting** of VAW by health-care providers given that it can violate women's confidentiality, undermine their autonomy and deter them from disclosing their experiences and seeking help. In line with the WHO recommendation, more than two thirds of 174 countries did not include a mandatory reporting requirement. However, a quarter of countries had a policy requiring health-care providers to report VAW to the relevant authorities. Fostering an enabling environment also means ensuring that health-care providers are trained in how to respond to VAW. For over three quarters of countries (78%), a **commitment to training health-care providers** on VAW was clearly articulated in their policies.

### *Woman-centred care*

*WHO clinical and policy guidelines* stipulate that all health services should be consistent with human rights including the rights to autonomy, privacy, confidentiality, informed consent and choice. Fewer than half of the 174 countries recognized **privacy** as a principle of care for survivors (45%), though almost 60% recognized **confidentiality** as a principle. In a health-care setting, just under half of countries (45%) included requirements for privacy during consultation with survivors, and a quarter of countries (26%) included a requirement that health-care providers explain the limits of confidentiality to survivors, including whether a mandatory reporting requirement exists.

### *Health services*

WHO does not recommend universal screening as the approach to **identification of intimate partner violence (IPV)** but states that health-care providers should ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV – i.e. the clinical enquiry approach. Just under a quarter of 174 countries (24%) included clinical enquiry in their policy, while only 10% included universal screening and the rest did not mention identification of IPV. WHO recommends that **first-line support** should be provided as a minimum standard of care to all survivors who disclose IPV or sexual violence to health-care providers in all health-care settings. Three quarters of countries included first-line support in their policy documents.

Within 72 to 120 hours of a sexual assault/rape, survivors should be offered a package of **post-rape care services** that includes emergency contraception, HIV PEP and STI prophylaxis. Just over half of 174 countries included information about emergency contraception (56%), HIV PEP (54%) and STI prophylaxis (51%) in their policies; however, just under half of countries included all three services (45%). WHO guidelines also recommend provision of safe abortion services to the full extent of the law to those who become pregnant as a result of rape. However, just 17% of 174 countries included abortion in relation to VAW in their policy documents.

WHO guidelines recommend a range of **mental health care** interventions for survivors of violence, including basic psychosocial support, assessment of moderate to severe depression, referral to specialist care where applicable, and treatment for diagnosed mental health conditions such as depression and post-traumatic stress disorder. More than a third of the 174 countries (35%) included both mental health assessment and referrals to specialist services in their policies.

### **Populations living in vulnerable situations**

This report prioritized tracking of how policies address violence faced by three groups living in vulnerable situations. **Adolescent girls and young women** and **women with disabilities** were included because of the particular negative consequences of violence and because their specific needs are often neglected. **Pregnant women** were also included because the harms caused by violence during pregnancy are experienced not only by the woman, but also by the fetus/infant. WHO recommends actions to identify and respond to violence experienced during pregnancy, and antenatal and postnatal services offer important opportunities for identification and provision of care and support for IPV. Relatively few of the 174 countries (less than 15%) both recognized the vulnerabilities of and included specific services for any of these groups.

### **Prevention strategies**

*RESPECT women: prevention of violence against women* is an interagency framework developed by WHO and UN Women. It articulates seven evidence-based strategies for preventing VAW corresponding to each of the letters of RESPECT. Three of these strategies were prioritized for inclusion of relevant indicators in the VAW Policy Database: **E**mpowerment of women; **S**ervices ensured; and **T**ransformed gender attitudes, beliefs and norms. Forty percent of 174 countries included at least one prevention intervention from each of these three strategies in their policies.

- **Empowerment:** One third of countries included at least one economic empowerment intervention, but less than a quarter included a social empowerment intervention.
- **Services:** First-line support, shelters and police interventions are the most commonly mentioned VAW response services in policies, and over 90% of countries included at least one of these types of response services.
- **Transformed norms:** A majority of countries (78%) included at least one gender norm transformation intervention in their policy, but just 30% of countries included at least one of the two interventions with promising evidence of effectiveness (community mobilization and group education interventions).

### **Availability of VAW prevalence data**

Alongside the activism of feminist movements, the availability of evidence – particularly prevalence data – on VAW has been instrumental in placing VAW on the policy agendas of many governments and on the global health and development agendas. *WHO VAW prevalence estimates (2018)* and the *Global Database on the Prevalence of VAW* show that the availability of nationally representative population-based prevalence surveys on VAW has dramatically increased within the last 20 years. Globally, 81% of 194 countries have conducted at least one survey between 2000 and 2018 with data on prevalence of recent/current IPV (i.e. in the last 12 months).

## **Conclusions and implications**

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In a world where almost one in every three women experiences violence, mostly by an intimate partner, evidence-informed policies urgently need to be put in place. This report on policies reflects an assessment of governments' commitments and stated intentions in setting an agenda for VAW programme implementation and service delivery, and an assessment of the alignment of existing policies with WHO recommendations, evidence-based strategies and the principles of gender equality and human rights. Health and multisectoral policies that address VAW play a crucial role in setting this agenda for the health sector. This report calls for policy dialogues with policy-makers from across sectors, but particularly those in the health sector, to strengthen specific aspects of policy, emphasizing that policies should also be adequately resourced and implemented. The findings from this report have several implications that are summarized below.

### **Strengthening policies**

1. Interventions to address VAW need to be included as a strategic priority in national health policies, with accompanying budget allocations.
2. More countries need to develop clinical guidelines and protocols or standard operating procedures (SOPs) to guide health-care providers in caring for VAW survivors.
3. Clinical guidelines/protocols or SOPs need to be aligned with WHO evidence-based recommendations, with particular attention to mental health care and comprehensive post-rape care.
4. Effective responses to the specific violence-related risks facing adolescent girls and young women and women with disabilities need to be more clearly articulated in policies. IPV during pregnancy also needs specific attention given the opportunities that antenatal care provides for identification and a supportive response.
5. Prevention interventions, particularly those focused on the empowerment of women, need greater attention in VAW policies, as do group education and community mobilization interventions for gender norm transformation.

### ***Strengthening policy advocacy, research and programme implementation***

1. Civil society groups (e.g. women's rights groups, youth advocates and disability rights groups) can use this report to advocate that greater attention be given in policies to populations with increased risks or in vulnerable situations, particularly with respect to adolescent girls, young women, and women and girls with disabilities.
2. United Nations agencies can use these findings in their advocacy efforts for better-coordinated multisectoral prevention and response services, by bringing together sectoral ministries within countries and using this report to encourage the implementation of an essential VAW services package and use of the *RESPECT women* prevention framework to guide VAW policies and programmes.
3. Parliamentarians can introduce, endorse and vote in laws and policies that effectively address VAW, including ensuring that budgetary allocations are made for implementation of evidence-informed VAW policies and programmes.
4. Donors can use this report's findings to guide their sectoral and multisectoral investments to integrate evidence-informed strategies for VAW prevention and response, with particular attention to investments in sexual, reproductive, maternal, adolescent and mental health plans and emergency preparedness and response plans, among others.
5. Policy researchers can use these data to assess and compare implementation of policies against government intentions, and to highlight areas of strength and weakness in both policy-making and implementation. They can also identify methods to gather and track policy data with respect to VAW.

# 1. Introduction

## 1.1 Background

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Violence against women (VAW) and girls is a major human rights violation and a global public health problem rooted in gender inequality. World Health Organization (WHO) estimates show that, globally, almost one in three women (30%) 15 years of age or older have experienced physical and/or sexual violence from a male intimate partner and/or sexual violence from someone other than an intimate partner at least once in their lifetime since the age of 15. Such violence starts early in the lives of women and girls, with almost one in four (24%) ever-partnered adolescent girls aged 15–19 years estimated to have been subjected to physical and/or sexual violence from a male intimate partner at least once in their lifetime since the age of 15. The highest prevalence rates of lifetime and last-12-months intimate partner violence (IPV) are among those living in least developed countries (LDCs)<sup>18</sup> (1). Women and girls subjected to violence suffer a range of sexual, reproductive, mental and other health problems including injuries and disabilities (2). Violence against women (VAW) also has socioeconomic consequences for women, their families, communities and societies.

While most women and girls subjected to violence do not explicitly seek care for violence, they are more likely to use health services, even after the violence has ended (3). Moreover, most women are likely to come into contact with health systems at some point in their lives for sexual, reproductive, maternal or child health services, and health-care providers are among those they are likely to trust with a disclosure. Therefore, health systems and health workers have a critical role to play in responding to and preventing violence against women and girls.

Recognition of VAW as a health and development crisis has grown in the last three decades. Governments have made numerous commitments in international and regional forums including the United Nations General Assembly,<sup>19</sup> Commission on the Status of Women,<sup>20</sup> international conferences,<sup>21</sup> or committees such as for the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (8), the 2011 Council of Europe's Istanbul Convention (9) and the Inter-American Convention of Belém do Pará (10). The Sustainable Development Goals (SDGs) have placed an emphasis on eliminating all forms of violence against women and girls (SDG target 5.2) as a pathway to achieving SDG 5: Achieve gender equality and empower all women and girls.<sup>22</sup> More recently, efforts to mark the 25th anniversary of the International Conference on Population and Development (in 2019) and the 25th anniversary of the Beijing Platform for Action on Women (in 2020) have resulted in renewed commitments from numerous governments, civil

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18 See Table 4.2 in the cited document, which shows data by United Nations SDG regional groupings, including LDCs.

19 For example, Resolution 69/147 (2014) on Intensification of efforts to eliminate all forms of violence against women and girls (4).

20 The agreed conclusions of the 57th session of the Commission on the Status of Women in 2013 (5).

21 The 1994 International Conference on Population and Development (ICPD), Programme of Action (6), and the 1995 Beijing Platform for Action emerging from the Fourth World Conference on Women (7).

22 Further details on SDG 5 including target 5.2 are available at: <https://sdgs.un.org/goals/goal5>

society, United Nations agencies and donors on addressing gender-based violence against women and girls.<sup>23</sup>

In May 2014, at the Sixty-seventh World Health Assembly (WHA), Member States adopted resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children (13). It requested the Director-General of WHO to develop a global plan of action. In May 2016, WHO Member States endorsed resolution WHA69.5 – the 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, hereafter referred to as the Global Plan (14). To facilitate accountability, the Global Plan includes a framework to monitor whether Member States:

1. include health services to address IPV and comprehensive post-rape care, in line with WHO guidelines, in their national health plans or policies;
2. have developed or updated national protocols or guidelines for a health system response to women and girls experiencing violence, in line with WHO guidelines;
3. provide comprehensive post-rape care in a medical facility in every territorial or administrative unit, in line with WHO guidelines;
4. have a multisectoral plan of action which proposes at least one evidence-based strategy to prevent violence against women and girls; and
5. have carried out a population-based, nationally representative study or survey on VAW in the past five years (14).

To establish a baseline against which to monitor progress under the Global Plan, in 2019 WHO commissioned the development of a VAW Policy Database, which has been used in generating the data contained in this report.

### ***Violence against women (VAW) Policy Database***

The VAW Policy Database contains information related to the existence and contents of health and multisectoral policies aimed at preventing and responding to VAW from the 194 WHO Member States (henceforth referred to as countries). The contents of existing policies – available from 174 countries – are mapped in the database in relation to their alignment with (i) WHO's recommendations for a health sector response to VAW and (ii) evidence-based strategies for prevention.

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23 For example, the commitments of the Nairobi Summit on ICPD25 (11), and the commitments of the Paris Generation Equality Forum on Beijing25 (12).

## 1.2 WHO's work to strengthen countries' health systems' response to violence against women

To support countries in fulfilling their commitments to prevent and respond to VAW, WHO has published several guidelines and tools (see Figure 1). These guidelines and tools provide the normative framework to assess the extent to which the content of countries' policies aligns with WHO recommendations, evidence-based strategies and with human rights principles (15). The tools also ground the health system response to VAW in gender equality, with guiding principles that emphasize women's safety; respect for women's autonomy; addressing unequal power relations; and empowerment of women (15, 16).

WHO is also participating in several joint United Nations initiatives to assist countries in addressing VAW, including:

- *Essential services package for women and girls subject to violence*, a joint initiative of UN Women, UNFPA, WHO, UNDP and UNODC (17)
- Disseminating and implementing the *RESPECT women: preventing violence against women* framework for policy makers (16, 18)
- Joint Programme on strengthening VAW data collection, reporting and use.<sup>24</sup>

**Figure 1: Resource package for strengthening countries' health systems response to violence against women**



Source: WHO, 2021 (19).

24 UN Women–WHO Joint Programme on Violence Against Women Data (<https://www.endvawnow.org/en/initiatives/view/9-research-and-data.html>).

### 1.3 Report purpose, audience and structure

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The purpose of this global status report is to present an assessment of the extent to which countries' policies align with WHO's recommendations (20), evidence-based strategies, and with international norms and standards related to human rights and gender equality.

This report is being published at a time when the COVID-19 pandemic has contributed to an increase in exposure to IPV/domestic violence and an increase in reports of violence against women. COVID-19 response measures in the form of lockdowns and stay-at-home regulations have placed increased economic stress on households, have put a greater care burden on women and increased their exposure to violence in the home (27). At the same time, the pandemic has decreased the availability of social support and access to services. The enormous burden on the health sector due to COVID-19 has meant that its resources and response to VAW are likely to be stretched thinner than ever. Universal health coverage (UHC) cannot be achieved without the inclusion of services that are needed by millions of women affected by violence. While VAW services are included in WHO's current menu of UHC interventions<sup>25</sup> and are among the essential services to be maintained during the COVID-19 pandemic, many countries have not implemented this (22). It is crucial that this report be used in the post-COVID-19 context to support efforts to build back better for women affected by violence, and to monitor these efforts.

The report and the VAW Policy Database that underlies it will serve to facilitate policy dialogues with and support ministries of health (MoH) in their endeavours to strengthen policies on VAW and their implementation. At the same time, the report will enable the WHO Secretariat to report to the World Health Assembly (WHA) on progress made in the context of the Global Plan. Moreover, practitioners, implementers and service providers may find the report useful in guiding the implementation of VAW programming, particularly the health system's response, and advocates may find it useful for holding duty bearers accountable for policy commitments made relating to preventing and responding to VAW. Researchers may find the methodology for conducting policy analysis and validation of policy survey instruments useful and applicable to other health topics. And lastly, donors may find this report useful in assessing how impactful their investments in VAW have been at the policy level.

The report is organized as follows: methodology; findings; and conclusions and implications. The methodology section describes the development of indicators, identification of data sources and construction of the database, and presents the answer options and search strategies for content analysis of policy documents. The findings of the policy analysis are organized into six areas: (i) enabling environments for prevention and response; (ii) woman-centred care; (iii) health services in policy and availability; (iv) populations in vulnerable situations; (v) prevention; and (vi) availability of prevalence data. The concluding section highlights areas of progress and remaining gaps, and articulates implications for policy-makers, practitioners/programme implementers and policy researchers. The annexes of this report (available online) provide a detailed listing of indicators and their definitions (Web annex 1), search terms for policies and indicators (Web annex 2), complex answer options (Web annex 3), and tables with global and WHO regional disaggregation of all indicators across the six areas (Web annex 4: 4.1–4.6), and tables on source, language and translation of policy documents data tables (Web annex 4.7).

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25 The list of VAW health interventions for UHC can be accessed by filtering with the tag "response to violence against women" at the website for the UHC compendium: <https://www.who.int/universal-health-coverage/compendium>



# 2. Methodology

## 2.1 Indicators

The development of policy indicators for the VAW Policy Database and for the compilation of this global status report was an iterative process conducted from 2019 to 2021. The starting point was the development of indicators building on the five areas of monitoring contained within the Global Plan (see section 1.1) (14); detailed indicators and sub-indicators were developed for each of these five areas. An additional area of indicators was added to assess the extent to which policies addressed populations living in vulnerable situations. All of these indicators were then refined to align with recommendations from two WHO publications: the 2013 guidance *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (20) and the 2019 framework *RESPECT women: preventing violence against women* (16). Indicators were also revised in consultation with an external reference group and WHO staff in relevant departments and regional offices (see Acknowledgements for groups contributing to this report). In the final listing, a total of 54 indicators were organized into six areas as outlined in Table 1 (Web annex 1 provides the full list and definitions).

**Table 1: VAW Policy Database indicator overview by area**

Area	Overview of indicators	Related standards and commitments
<b>1. Enabling environment for prevention and response</b>	<ul style="list-style-type: none"> <li>• Existence of a policy</li> <li>• Budgetary commitments</li> <li>• Health-care providers' reporting requirements</li> <li>• Commitment to training health-care providers</li> </ul>	<p>The Global Plan asks Member States to integrate VAW into national health, sexual and reproductive health (SRH) or HIV policies and asks for national multisectoral plans to integrate the health response to VAW (14).</p> <p>WHO recommends training of health-care providers in how to respond to VAW (20).</p> <p>WHO recommends against mandatory reporting to the police, but recommends offering and facilitating reporting for women who wish to do so (20).</p>
<b>2. Woman-centred care</b>	<ul style="list-style-type: none"> <li>• Privacy mentioned as a guiding principle</li> <li>• Privacy specified for consultation with survivors</li> <li>• Confidentiality as a principle</li> <li>• Requirement to explain the limits of confidentiality to survivors</li> </ul>	<p>WHO recommends ensuring privacy including through private consultations (15, 20).</p> <p>WHO recommends ensuring confidentiality, including explaining to survivors limits to confidentiality where health-care providers are legally obligated to report (15, 20).</p>

Area	Overview of indicators	Related standards and commitments
<b>3. Health services: policy and availability</b>	<ul style="list-style-type: none"> <li>• Intimate partner violence (IPV) identification</li> <li>• First-line support</li> <li>• Post-rape care: emergency contraception (EC), sexually transmitted infection (STI) prophylaxis, HIV post-exposure prophylaxis (PEP) and safe abortion</li> <li>• Mental health assessment, referral and treatment</li> <li>• Referrals beyond the health sector</li> <li>• Availability of comprehensive post-rape care services in line with WHO guidelines in at least one service delivery point</li> </ul>	<p>WHO recommends identifying IPV through clinical enquiry and recommends against universal screening (15, 20).</p> <p>WHO recommends offering first-line support to all survivors who disclose violence, offering emergency contraception, HIV PEP, and STI treatment/prophylaxis and safe abortion to the full extent of the law as part of post-rape care services (15, 20).</p> <p>WHO recommends assessment for moderate to severe depression, referral or treatment for those with depression and/or post-traumatic stress disorder (PTSD), and facilitating referrals to support services in other sectors (15, 20).</p>
<b>4. Populations living in vulnerable situations</b>	<ul style="list-style-type: none"> <li>• Recognition of and specific provisions for               <ul style="list-style-type: none"> <li>(i) adolescent girls and/or young women,</li> <li>(ii) women with disabilities and</li> <li>(iii) pregnant women</li> </ul> </li> </ul>	<p>Groups or populations living in vulnerable situations and the disadvantages and risks they face with respect to violence may vary by country. For this report, we prioritized three populations or groups based on global data and recommendations.</p> <p>WHO estimates show adolescent girls and young women as bearing a high risk of violence, and emphasizes the need to recognize and respond to their specific risks and needs (7).</p> <p>WHO recommends identification of pregnant women who are being subjected to IPV and recommends that the response should include empowerment counselling (20).</p> <p>Data show that women with disabilities are disproportionately at risk of violence and, therefore, their specific service needs should be addressed (23).</p>
<b>5. VAW prevention</b>	<ul style="list-style-type: none"> <li>• (E) Empowerment of women – social and economic</li> <li>• (S) Services</li> <li>• (T) Transformed gender attitudes, beliefs and norms</li> </ul>	<p>The <i>RESPECT women</i> framework highlights seven strategies for prevention (and associated interventions for each). The seven strategies are:</p> <ul style="list-style-type: none"> <li><b>R</b>elationship skills strengthened;</li> <li><b>E</b>mpowerment of women;</li> <li><b>S</b>ervices ensured;</li> <li><b>P</b>overty reduced;</li> <li><b>E</b>nabling environments created;</li> <li><b>C</b>hild and adolescent abuse prevented;</li> <li><b>T</b>ransformed attitudes, beliefs and norms on gender and gender equality (16).</li> </ul> <p>Three of these strategies are prioritized in this report: E, S and T.</p>

Area	Overview of indicators	Related standards and commitments
6. VAW prevalence data	<ul style="list-style-type: none"> <li>Availability of at least one national population-based survey with data on the prevalence of recent IPV (i.e. in the past 12 months before the survey) conducted between 2000 and 2018.<sup>26</sup></li> </ul>	The Global Plan requests WHO Member States to regularly (e.g. at least every five years) collect national data on the prevalence of VAW through surveys, and disaggregate these data by age, ethnicity and socioeconomic status (14).

For each indicator, a list of key search terms was first developed in English. The terms were drawn from WHO guidelines (20) and regional variations in terminology were taken into account. The search terms were then translated into Arabic, French and Spanish – the languages spoken by team members.<sup>27</sup> The final sets of key search terms for each indicator in each language (see Web annex 2) were used to search the available and eligible policy documents for relevant information for each indicator (see section 2.2).

## 2.2 Data sources and selection criteria

Data were obtained and entered into the VAW Policy Database through a content analysis of 604 policy documents which were sourced and selected as described in this section. The term “policy documents” is used as a short-hand term in the VAW Policy Database to refer to a wide array of documents produced by countries in relation to VAW, including plans, strategies, protocols, standard operating procedures (SOPs), guidelines, training curricula and more. The inclusion and exclusion criteria are described in Table 2, and the various data sources and their connection with the VAW Policy Database are illustrated in Figure 2.

In addition to populating the database using information from eligible policies, data from three existing data sources were imported into the VAW Policy Database (see Figure 2). The first were data on the existence of national budget lines for VAW, which were imported into the VAW Policy Database from the 2018–2019 WHO Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) policy survey<sup>28</sup> completed by respondents representing 150 WHO Member States (25). These data contributed to the indicator on budget commitment in the “Enabling environment” section of the findings (Area 1 in Table 1 above). Second, the most up-to-date data available from each country on the availability of comprehensive post-rape care services were imported into the VAW Policy Database from the National Commitments and Policy Instrument (NCPI) survey,<sup>29</sup> which is administered by the Joint United Nations Programme on HIV and AIDS

26 The years 2000 to 2018 are selected because data are available in the WHO Global Database on the Prevalence of VAW (<https://srhr.org/vaw-data>).

27 For the remaining two United Nations language (Chinese and Russian), Google Translate was used to translate the documents into English (see section 2.6).

28 The questionnaire for the WHO SRMNCAH policy survey included Module 7 with questions on the availability and content of policies on violence against women/gender-based violence (24).

29 The NCPI Database can be found at: <https://onlinedb.unaids.org/ncpi/libraries.aspx/home.aspx>. The NCPI Database includes data from the NCPI survey conducted using the 2017 NCPI questionnaire, which is available in the 2016 UNAIDS guidance, or the 2019 data – whichever was the latest year in which countries had responded to the particular question (26). The relevant question (No. 115) reads: “Does your country have service delivery points that provide the following appropriate medical and psychological care and support for women and men who have been raped and/or experienced incest, in accordance with the recommendations of the 2013 WHO guidelines *Responding to intimate partner violence and sexual violence against women* (20): (a) First-line support or what is known as psychological first aid; (b) Emergency contraception for women who seek services within five days; (c) Safe abortion if a woman becomes pregnant as a result of rape, in accordance with national law; and (d) Post-exposure prophylaxis for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed.”

(UNAIDS) as a component of the Global AIDS Monitoring platform (27). These were used for the indicators related to the availability of post-rape care in service delivery points (Area 3 in Table 1). Third, data on the availability of national population-based prevalence surveys on VAW, available in the WHO Global Database on Prevalence of Violence against Women (28), were used to respond to the indicator in Area 6 (Table 1).

### ***Inclusion and exclusion criteria for policy documents***

Four types of national-level policy documents were eligible for review: (i) national health policy; (ii) national multisectoral VAW policy; (iii) national health sector VAW policy (i.e. clinical guideline or protocol); and (iv) national VAW training curricula or manuals for the health sector (see Table 2). These were sourced from the WHO SRMNCAH policy survey repository, from WHO headquarters, regional and country offices, and using targeted online searches (see Web annex 2 for the search terms used). Repositories at WHO headquarters and regional offices were checked for relevant policy documents. Additionally, targeted online searches were conducted to identify eligible policy documents.

**Table 2: Eligible national-level policy document types and inclusion criteria**

<b>Type</b>	<b>Inclusion criteria</b>
<b>National health policy</b>	<ul style="list-style-type: none"> <li>• National health sector-specific policy document; or</li> <li>• General, SRH, HIV or reproductive, maternal, newborn, child and adolescent health (RMNCAH) health policy; and</li> <li>• Addresses VAW</li> </ul>
<b>National multisectoral VAW policy</b>	<ul style="list-style-type: none"> <li>• National multisectoral policy document; or</li> <li>• Gender equality and/or other policies that address the advancement of women and contain a strong VAW component</li> </ul>
<b>National health sector VAW policy (i.e. clinical guideline or protocol)</b>	<ul style="list-style-type: none"> <li>• National health sector-specific document; and</li> <li>• Provides guidance for the health sector’s prevention and/or response to VAW; or</li> <li>• Provides clinical protocols/standard operating procedures (SOPs) or guidance for health-care providers, managers and/or administrators to respond to VAW</li> </ul>
<b>National VAW training curricula or manuals for the health sector</b>	<ul style="list-style-type: none"> <li>• National-level manual or curriculum specific to VAW; and</li> <li>• Targeted at health-care providers</li> </ul>

Only government-endorsed, national-level policy documents were included; third-party documents, such as literature from nongovernmental organizations or policy analysis reports were excluded, as were draft policy documents. The most up-to-date policy documents obtained were considered for inclusion. Policy documents that had seemingly “expired” (i.e. had an end date that had passed) were presumed to remain in force if another, more up-to-date document could not be sourced. Adolescent and maternal health policies, emergency preparedness and mental health policies were excluded. To determine the types of policy documents most likely to contain information about VAW, a pilot test phase of data entry (see section 2.4) was conducted and, based on this, the documents listed in Table 2 were prioritized. In the future, resources permitting, the VAW Policy Database will be updated to analyse policy documents that were excluded for this report.

Finally, based on the eligibility criteria, lists of all eligible policy documents for each WHO region were sent to the WHO regional and country offices for validation with a request for up-to-date national policy documents. This included multisectoral VAW policies that were older than five years; health sector VAW policies that were over 10 years old (published before 2011); and any policy documents that had no publication or start/end dates. This process generated new or updated policy documents for 33 countries.

Together with the documents that had already been sourced via the existing data sets, this created a pool of a total of 604 policy documents that were ultimately included in the VAW Policy Database and available for review. The various sources of these documents are summarized in Table 3.

**Table 3: Numbers and proportions of eligible policy documents, by source**

Source	<i>n</i>	%
SRMNCAH repository	151	25%
Targeted web searches	319	53%
WHO offices	134	22%
<b>Total</b>	<b>604</b>	<b>100%</b>

The most common types of policy documents reviewed were national multisectoral VAW policies (45%), followed by national health policies (29%), followed by health sector VAW policies (i.e. clinical guidelines/protocols; 23%), and lastly VAW training manuals (3%) (see Table 4).

**Table 4: Numbers and proportions of eligible policy documents, by type**

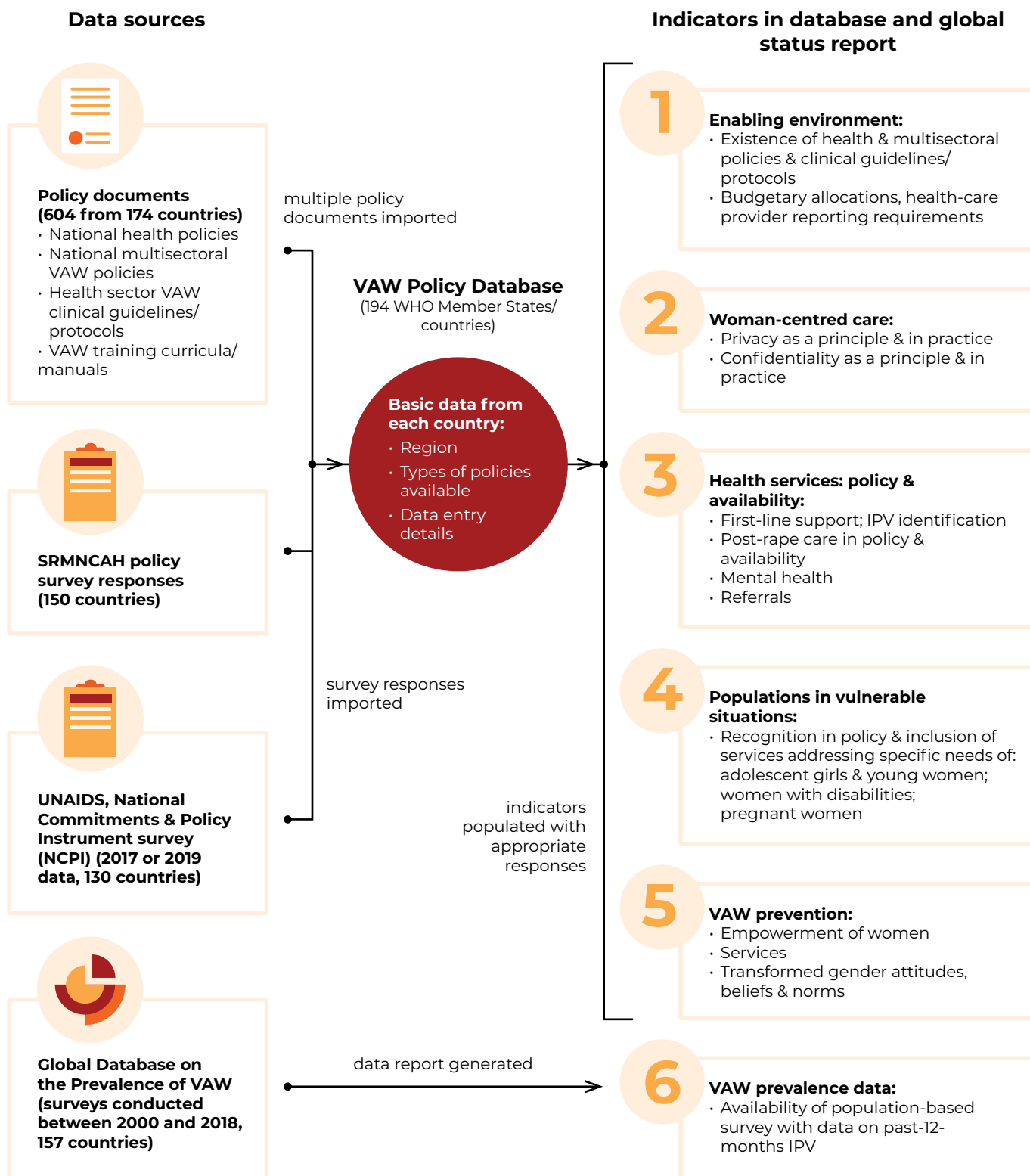
Type	<i>n</i>	%
National health policies	177	29
National multisectoral VAW policies	270	45
National health sector VAW policies (i.e. clinical guidelines and protocols)	138	23
National VAW training curricula or manuals	19	3
<b>Total</b>	<b>604</b>	<b>100%</b>

Of the total 604 policy documents across 174 countries, 82% (n=497) were in the four United Nations languages that team members could review without the assistance of online translation,<sup>30</sup> and 18% (n=107) required online translation, including for the two remaining United Nations languages (Chinese and Russian).<sup>31</sup>

<sup>30</sup> Arabic, English, French or Spanish

<sup>31</sup> 94 of the 107 documents were successfully translated, while the other 13 resulted in translations that were unusable, or translation could not be performed due to the file formatting (see Web annex 4.7, Table 4.7c)

**Figure 2: VAW Policy Database: sources for populating the indicators for each country**



## 2.3 Database development

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The VAW Policy Database is housed in a relational database used to store and manage data. The database is compliant with WHO's privacy and security policies,<sup>32</sup> and is currently for internal use only. A front end of the website may be developed in the future for visualization purposes. Reports can be generated with the data organized by region, according to SDG or WHO regional groupings, or World Bank Country Income Group. In this report, we have chosen to present disaggregation by WHO region. WHO has 194 Member States across six WHO regions.<sup>33</sup> The VAW Policy Database can be updated periodically to allow for tracking progress in policies over time, based on the indicators, by country, region or globally.

## 2.4 Data entry and quality assurance

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Data were entered onto the VAW Policy Database for all 194 WHO Member States (hereinafter referred to as "countries"). Eligible policy documents were obtained for 174 of these countries, while for 20 countries, policy documents were either not found or did not meet the inclusion criteria described above (see section 2.2).

For each indicator, a "priority" document type was identified. This was the type of document within which the information was most likely to be found. For example, information on post-rape care services was most likely to be found in the national health sector VAW policies (i.e. clinical guidelines and protocols). The priority document from the country was reviewed first for the indicator in question, and if the content needed to fulfil the indicator was not found therein, all other eligible policy documents for the country were reviewed.

Data entry was undertaken in two phases. During the pilot phase of data entry, data were double-entered for six countries and then analysed to assess the: consistency of entry across team members; suitability of search strategies; identification of "priority" documents; and refinement of indicators. Thereafter, in the next phase, the database was populated for all remaining countries with data for all 54 indicators.

### ***Answer options for entering indicator data***

For a majority of indicators addressing the content of policy, a standard set of answer options was used (see Table 5). These answer options did not apply to indicators using data from the SRMNCAH policy survey or the NCPI survey. Guidelines for the application of the answer options to each indicator in the database were developed for use by the research team to ensure standardization (available on request). In addition to the standard answer options, there were a variety of indicators for which bespoke answer options were developed. A full list of these complex answer options can be found in Web annex 3.

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32 Available at: <https://www.who.int/about/policies>

33 Details about the WHO regions are available here: <https://www.who.int/about/who-we-are/regional-offices>

**Table 5: Answer option description, applied at country level for each indicator**

<b>Answer option</b>	<b>Description</b>
<b>Yes, included</b>	When information to fulfil an indicator is found within a policy document
<b>Not specified</b>	When information to fulfil an indicator is not found within a policy document
<b>No, not included</b>	When information to fulfil an indicator is explicitly excluded from a policy document
<b>Unclear</b>	When information to fulfil an indicator is confusing or contradictory within a policy document
<b>Varies with jurisdiction</b>	When information to fulfil an indicator is only found in a subnational policy <sup>34</sup>
<b>No policy documents found</b>	When no policy documents were found
<b>Unknown – translation not available/usable</b>	When relevant policy documents were not able to be translated
<b>Other</b>	Any situation not covered by the other options

### **Quality assurance**

Quality assurance measures were applied to the VAW Policy Database, including built-in checks, peer consultation, buddy system for data entry team members, and quality assurance of selected indicators. Checks were built into the VAW Policy Database's functionality to minimize the risk of fields being skipped or incorrectly completed. In addition, for countries that responded to the WHO 2018–2019 SRMNCAH policy survey (25), their survey responses were mapped to the corresponding indicators in the VAW Policy Database and imported into the database for comparison purposes only. Before data entry could be completed for a country, the VAW Policy Database would automatically flag any case where the SRMNCAH policy survey response was different from the VAW Policy Database indicator response for the similar or comparable indicator. This served as a prompt for double-checking the VAW Policy Database responses.

After the pilot phase of data entry for six countries, a virtual consultation was held with an external reference group and WHO staff to present the proposed methodology, the results of the pilot phase, and to obtain feedback, based on which further revisions were made to the methodology before data were entered for the remaining countries.

During the second phase of data entry, for all countries and indicators, a buddy system was in operation whereby team members worked in pairs to provide each other with regular support for any challenging issues throughout the data entry process.

To minimize subjective interpretation, definitions and guidance for all indicators were developed and used across the whole data entry team (see Web annex 1 for definitions; additional guidance to aid the interpretation of indicators is available on request). During the pilot phase of data entry, some indicators were identified

<sup>34</sup> Subnational policies were not reviewed for the VAW Policy Database. However, where a national document made it clear that the relevant policy is made at a subnational level, this answer option was available.



as more challenging to assess than others due to the multitude of ways they were reflected in policies. These were scrutinized for all countries and, where needed, additional guidance was developed for use by the data entry team to ensure standardization of responses. The indicators that underwent this more rigorous method of quality assurance were: first-line support, mental health services, populations in vulnerable situations, and transformation of gender norms for preventing VAW.

## 2.5 Data analysis

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Reports of all fields associated with the indicators were generated from the VAW Policy Database at the conclusion of data entry. Descriptive analysis was run in Google Sheets to produce summary tables for each indicator. For all policy content indicators, only countries that had at least one eligible policy document were included in the analysis. This resulted in most of the indicator analysis using a denominator of 174 – i.e. the number of countries for which there was at least one eligible policy document available. Where this differs, the denominator is clearly indicated in the figure and/or text of the report (see Section 3). Tables for all indicators, including disaggregation by WHO region, where relevant, are available in Web annex 4 (including sub-annexes 4.1–4.6, providing data tables for all the findings, globally and by WHO region).

## 2.6 Limitations

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There are a variety of limitations that are inherent to analysis of policies against standardized indicators. The first is locating and identifying the most up-to-date policy documents from each country. Many countries do not update their policies before the given expiry date and/or do not promptly publish the newest version online for public access. Despite the multiple sources for obtaining the most up-to-date policy documents, for some countries it was not possible to access eligible policy documents. To address this limitation, there will be an effort made to obtain documents from countries for which no policy documents were found, and to validate the policy documents logged in the database to ensure that they are the most up-to-date documents.

A second limitation relates to the priority given to the types of policy documents that were included in the analysis. It was beyond the scope of this exercise to exhaustively analyse the content of every possible type of policy document across multiple sectors that could potentially contain information about prevention of and the health response to VAW. Therefore, priority was given to the types of policy documents that were assessed as being most likely to contain this information. This necessitated the exclusion of several types of policy and legal documents including, inter alia, VAW laws, adolescent, maternal and mental health policies, emergency preparedness policies, and justice, police and other sectoral policies. Therefore, it is possible that policy information on VAW may have been missed if it was contained in policy documents that were excluded from this database. To account for this limitation, the answer option for many indicators is “not specified” rather than “not included”.

A third limitation is related to the language of the policy documents. Data extraction and entry was possible for policy documents in four United Nations languages – Arabic, English, French and Spanish. Google Translate was used to translate documents into English from all others, including the two remaining United Nations languages. This has its own limitations including the inability to translate documents that are not in the right format or the production of translations that are incomprehensible. To address this limitation, countries were given the benefit of the doubt using the “Unknown or translation not available/usable” answer option.

# 3. Findings

The findings of the policy analysis are organized into six areas: (i) enabling environments for prevention and response; (ii) woman-centred care; (iii) health services: policy and availability; (iv) populations in vulnerable situations; (v) prevention; and (vi) availability of prevalence data. All regional findings are presented based on the six WHO regions.<sup>35</sup>



## 3.1 Enabling environment

### Key messages

**81%** of countries have **multi-sectoral plans of action**

**48%** of countries have **clinical guidelines** addressing violence against women (VAW)

**53%** of countries have **national health policies** that include references to addressing VAW

**25%** of countries have policies that include a **mandatory reporting requirement** for women who disclose violence

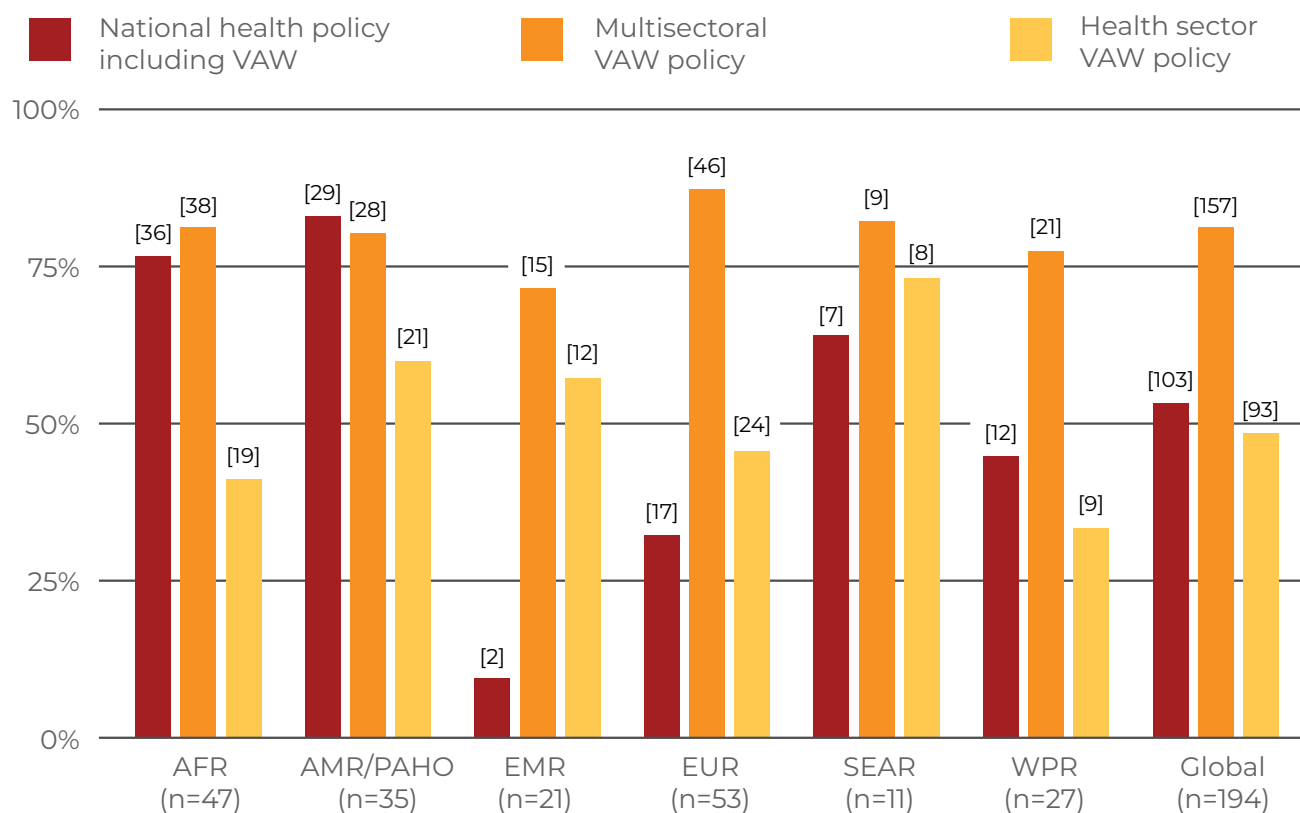
**78%** of countries have policies that clearly articulate a **commitment to training health-care providers** on addressing VAW

#### **Existence of policies on VAW**

An enabling environment for preventing and addressing VAW within the health system starts with the existence (and implementation) of policy. Indicators in this area relate to the existence of a policy document for preventing and addressing VAW (i.e. at least one of the four eligible types defined in Section 2, Table 2). Out of 194 WHO Member States, there were 20 for which no eligible documents were found (see section 2.3, and Web annex 4.1, Tables 4.1a–4.1c). The WHO region with the highest proportion of countries lacking any eligible policy documents was the WHO Western Pacific Region (22%), followed by the Eastern Mediterranean Region (19%). For the other four regions, eligible policy documents were found for 90% or more of countries (see Web annex 4.1, Table 4.1c).

35 The WHO regions along with the abbreviations used in this report are: AFR: African Region; AMR/PAHO: Region of the Americas – for which the regional office is also referred to as the Pan-American Health Organization or PAHO; EMR: Eastern Mediterranean Region; EUR: European Region; SEAR: South-East Asia Region; WPR: Western Pacific Region. These abbreviations are used in all the figures in this report where data are presented disaggregated by WHO regions.

**Figure 3: Proportion of all countries that have a national health policy that includes VAW, a multisectoral VAW policy and/or a health sector VAW policy (i.e. clinical guideline/protocol), by region and globally (n=194)**



A little more than half of all countries (53%, n=103/194) had a national health policy that mentioned VAW (Web annex 4.1, Tables 4.1a and 4.1b). The WHO Region of the Americas and the African Region had the highest proportion of countries with a national health policy that mentioned VAW, while this was lowest in the Eastern Mediterranean Region (Figure 3). One third of countries go beyond just mentioning VAW and specify it as one of the primary goals, objectives or strategic priorities in their national health policies (Web annex 4.1, Table 4.1d).

Approximately 81% of countries (n=157/194) had a multisectoral VAW policy for preventing and/or responding to VAW. The WHO Eastern Mediterranean Region had the lowest proportion of countries with this type of policy (see Figure 3 and Web annex 4.1, Tables 4.1a and 4.1b). Moreover, 86% of the 157 countries with a multisectoral VAW policy included the health sector; the most frequently mentioned other sectors involved in multisectoral VAW response were justice and education (Table 6).

**Table 6: Proportion of countries with a multisectoral VAW policy that included the health, justice, police, education and social services sectors in the VAW response (n=157)**

Health	Justice	Police	Education	Social services
86%	80%	61%	78%	72%

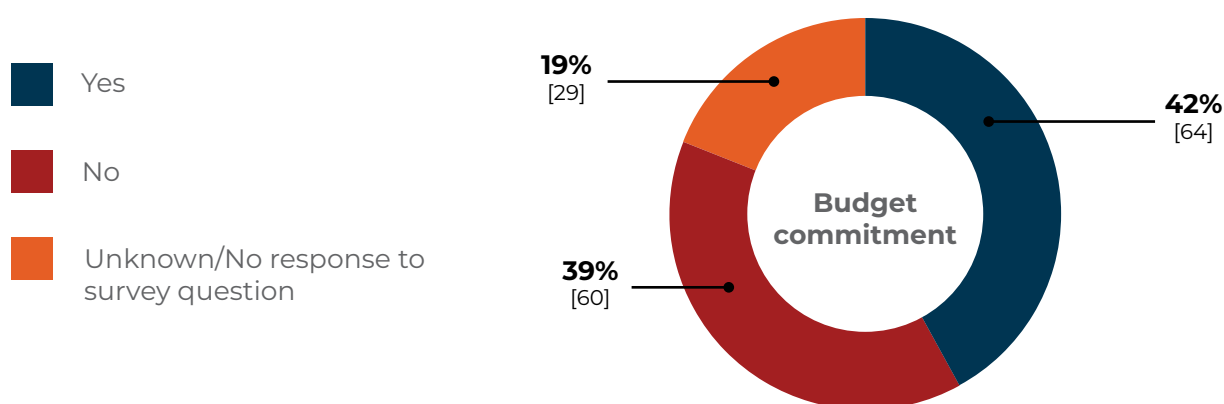
Almost half of all countries (48%, n=93/194) had at least one health sector VAW policy, such as clinical guidelines or protocols for health-care providers to use when responding to survivors (see Figure 3). At least 40% of countries in every region – apart from the WHO Western Pacific Region – had clinical guidelines or protocols for responding to VAW (see Figure 3, and Web annex 4.1, Table 4.1a).

In 41% of countries (n=79/194), the national health policy included VAW and the multisectoral VAW policy included the health sector, reflecting an ideal scenario where the health response to VAW is covered in both a stand-alone multisectoral VAW policy as well as integrated into national health policy (Web annex 4.1, Table 4.1e).

### Budget commitment

National budget commitments are vital to ensuring the implementation of existing policies. For all countries outside of the WHO Region of the Americas, data on the existence of a budget line item for health services for VAW was drawn from the 2018–2019 WHO Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) policy survey responses (24, 25). For countries in the WHO Region of the Americas, more recent data from a 2020 regional survey were used.<sup>36</sup> Data on budget commitment were available for 153 countries that responded to the policy survey questions (Figure 4).

**Figure 4: Proportion of countries that reported having a budget commitment for addressing VAW, among countries that responded to a WHO policy survey (n=153)**



Two fifths of countries (42%, n=64/153) reported having a budget line for VAW services. The WHO regions with the highest proportion of countries reporting a national budget line for VAW were the South-East Asia Region (64%) and the European Region (45%) (Web annex 4.1, Table 4.1f).

<sup>36</sup> The WHO Region of the Americas, represented by PAHO, utilized budget commitment data from its 2020 survey instrument entitled Questionnaire for Member States' Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women; progress report 2021. The question that elicited the data read as follows: "Is the Member State able to provide one or more dedicated lines to support prevention and/or response to violence against women in the national health budget?"

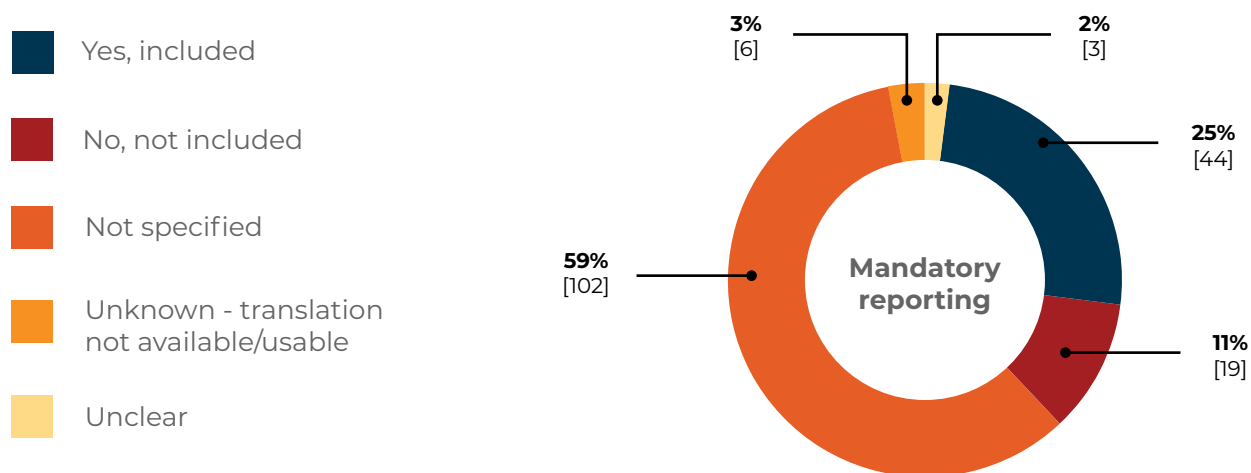
### Health-care providers' reporting requirements

Mandatory reporting refers to: "legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence" (20).

WHO does not recommend mandatory reporting for VAW on grounds that it can violate women's autonomy and confidentiality and act as a deterrent for survivors to disclose their experiences to health-care providers and thus can prevent them from accessing timely health services. Instead, WHO recommends that health-care providers provide information on the legal process so that women can make an informed decision about reporting, and then offer to report violence on their behalf or assist those women who wish to report for themselves (20). For child and adolescent sexual abuse, WHO recommends conducting a safety assessment of the implications of reporting for the child or adolescent survivor (29). In all cases, the obligation to report in countries with mandatory reporting requirements should be explained to the survivor before they disclose violence (15, 29).

Contrary to WHO recommendations, a quarter of countries (25%, n=44/174) include a mandatory reporting provision in policy that requires health-care providers to report VAW to the relevant authorities (usually the police) (Figure 5). In almost three out of five countries (59%, n=102/174), the policies did not contain any information about a mandatory reporting requirement, and only 11% of countries (n=19/174) specifically excluded such a requirement. In a handful of other countries (n=9), the information included in policy was unclear or the translation was not available/usable.

**Figure 5: Proportion of countries with eligible policy documents that include a mandatory reporting requirement (n=174)<sup>37</sup>**



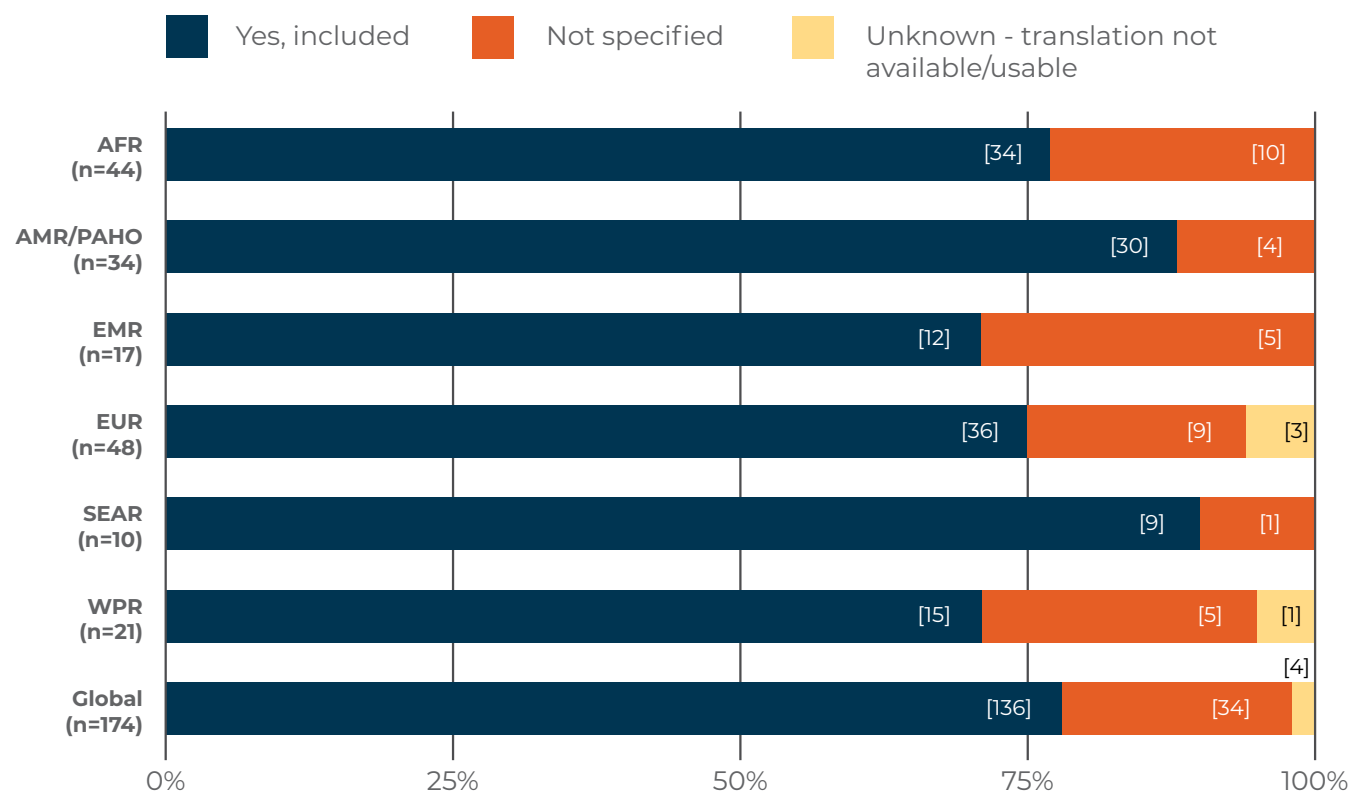
<sup>37</sup> Generally, a "Yes, included" answer option indicated that the policy document included information on the topic that was aligned with WHO recommendations or standards. However, the directionality of the "Yes, included" answer option was different for the mandatory reporting indicator. For this one, a "Yes, included" answer option was not desirable given that this contradicts WHO recommendations.

For the 102 countries where the available policy documents did not specify a mandatory reporting requirement, any available pertinent information on other reporting guidelines included in policy was recorded in the notes section for this indicator in the database. Analysis of these notes indicates that mandatory reporting was a requirement only in relation to minors in many countries, while for some other countries it is required when a survivor's health or life is in danger. Indeed, for several countries, the policies reviewed indicated that reporting requirements were found elsewhere, such as in domestic violence law.

### **Commitment to train health-care providers**

WHO recommends that all health-care providers should receive training in how to ask women about violence and provide first-line support and clinical care for sexual assault/rape and intimate partner violence (IPV), and that training should address inappropriate, unequal gender attitudes of health-care providers towards survivors (20). The assessment of whether countries have policies specifying that they have committed – at a minimum – to training health-care providers to respond to VAW showed that a little over three quarters of countries (78%, n=136/174) had such a commitment clearly articulated in their policies; across the six WHO regions, over 60% of countries in each region had this commitment in policy (Figure 6). For the remaining 38 countries with an eligible policy document, a commitment to training of health-care providers on VAW was either not specified in the documents reviewed (n=34 countries) or the relevant document was not translatable (Web annex 4.1, Tables 4.1g and 4.1h).

**Figure 6: Proportion of countries with eligible policy documents that commit in policy to training health-care providers on VAW, by WHO region and globally (n=174)**



### Good practice example: Sri Lanka

The health sector response to gender-based violence (GBV) is articulated in Sri Lanka's standard operating procedures (SOPs) for "first contact point" health-care providers (30). This explicitly includes not only a training commitment, but also how training should be done and what content should be included. Following is a translated excerpt.

"Capacity-building of the staff is important as the subject is new to some of them and needs a cautious approach especially at home visits.

- Include the topic of GBV in the routine training programmes for public health staff and highlight the linkages of GBV with other reproductive health issues.
- Use a participatory approach including problem-solving sessions in the training programmes so that staff can feel comfortable to share their experiences and challenges.
- Include at least one in-service training (full day) per year on gender and GBV. Try to highlight the importance of first-line support (LIVES) as given in the guideline, GBV/DV [domestic violence], and pregnancy and consequences for children."



## 3.2 Woman-centred care

### Key messages

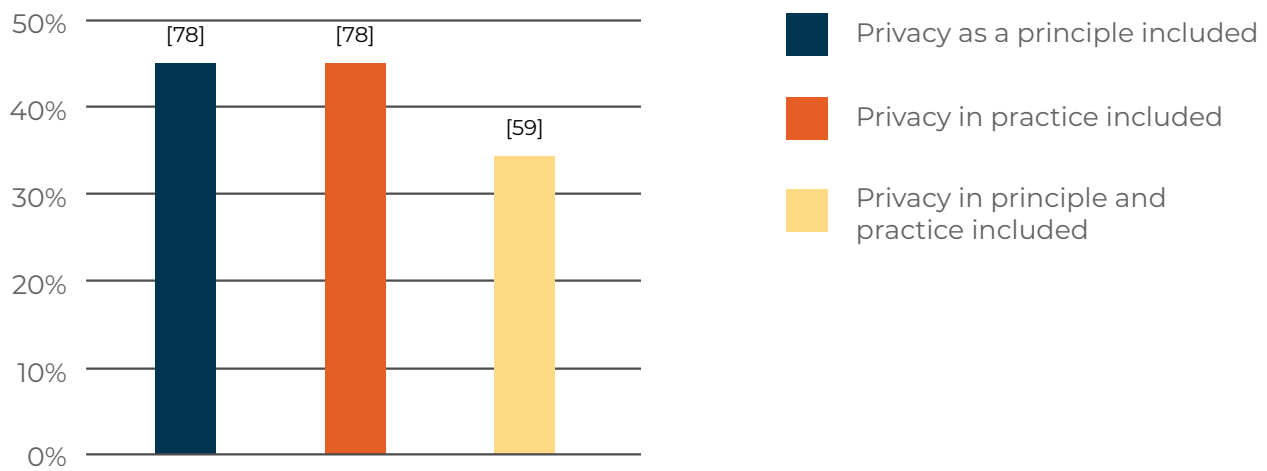
**34%** of countries recognize and apply the human rights principle of **privacy** in their policies with respect to health care for survivors of violence

**24%** of countries both recognize **confidentiality** as a principle and include a requirement to explain its limits to survivors

WHO clinical and policy guidelines stipulate that all health services should be "consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice" (20). In addition, the recommendations therein state that providers should ensure that consultations with survivors should be conducted in private and that women should be informed of the limits of confidentiality, including when there is a mandatory reporting requirement (15, 20).

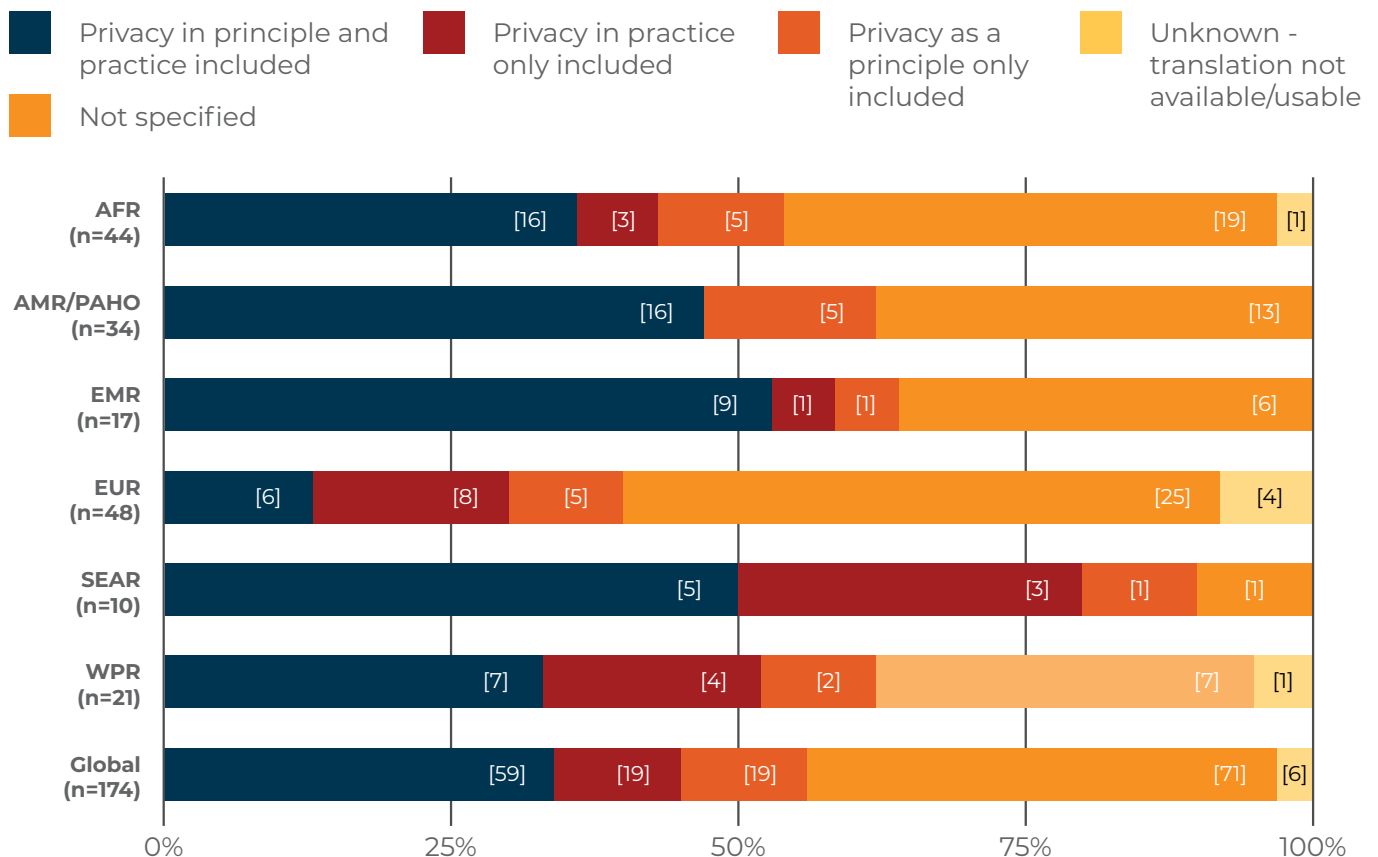


**Figure 7: Proportion of countries with eligible policy documents that recognize privacy in principle, in practice, and both in principle and practice, globally (n=174)**



In relation to privacy, fewer than half of the countries (45%, n=78/174) recognized privacy as a principle of care in the eligible policy documents (Figure 7). The same proportion of countries included a requirement to provide privacy in practice, during consultations with survivors, such as a requirement that auditory or spatial privacy is assured in a clinical setting. However, only a third of the countries (34%, n=59/174) specified it both as a principle of care and in practice (i.e. requirement for

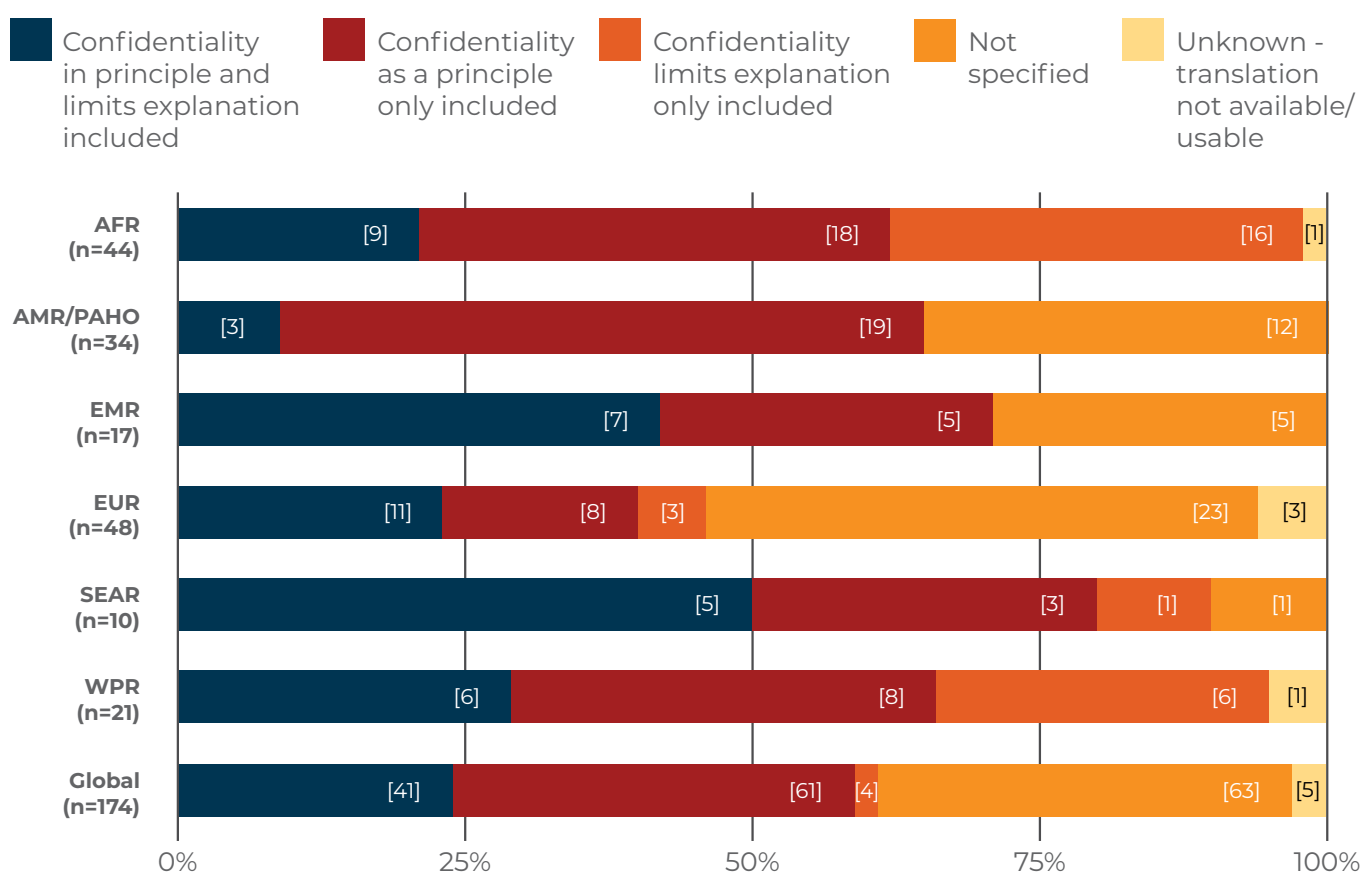
**Figure 8: Proportion of countries with eligible policy documents that include privacy in principle, in practice, and both in principle and practice, by WHO region and globally (n=174)**



a private consultation). The proportion that specified privacy both in principle and in practice varied by WHO region from 13% (in the European Region) to 53% (in the Eastern Mediterranean Region). In three WHO regions – the Region of the Americas and the Eastern Mediterranean and South-East Asia Regions – approximately half of countries included both (see Figure 8 and Web annex 4.2, Table 4.2a).

Turning to the question of confidentiality, while almost 60% of countries (n=102/174) recognized the human rights principle of confidentiality in policy, just over a quarter (26%, n=45/174) required health-care providers to explain the limits of confidentiality to VAW survivors. A little under a quarter (24%, n=41/174) specified confidentiality both as a principle and in practice (specifically the requirement for providers to explain its limits). This varies by region, with the WHO South-East Asia Region having the highest proportion of countries with policies that included both the principle of confidentiality and the requirement to explain its limits (see Figure 9, and Web annex 4.2, Table 4.2b).

**Figure 9: Proportion of countries with eligible policy documents that include confidentiality in principle, in practice, and both in principle and practice, by WHO region and globally (n=174)**



### Good practice example: Portugal

Portugal's guidelines on interpersonal violence (31) contain measures to ensure privacy and confidentiality for survivors. Following is a translated excerpt.

Firstly to ensure that consultation with survivors is conducted in privacy, ensuring that their confidentiality is protected, within the limitations imposed by the law (p. 111).

In health services:

- Ensure the victim's privacy during the provision of services.
- Do not allow the facility to be photographed or filmed while the victim is there (p. 118).
- The commitment to confidentiality on the part of health professionals is essential to gain and maintain the trust of users (p. 117).



## 3.3 Health services: policy and availability

### Key messages

**75%** of countries include **first-line support** in their policies, in line with WHO recommendations

**35%** include **mental health assessment and referral** for survivors

**45%** of countries include all three **immediate post-rape care services** (EC, STI prophylaxis and HIV PEP) in their policies

**85%** of countries that completed recent NCPI surveys reported having at least one **service delivery** point in the country that offers either three or all four of the following immediate **post-rape care services**: first-line support, HIV post-exposure prophylaxis (PEP) and/or STI prophylaxis, emergency contraception (EC) and safe abortion

**24%** of countries specify **clinical enquiry** as their approach to identifying IPV

**58%** of countries include **referrals to services in other sectors**, such as legal or social services or the police

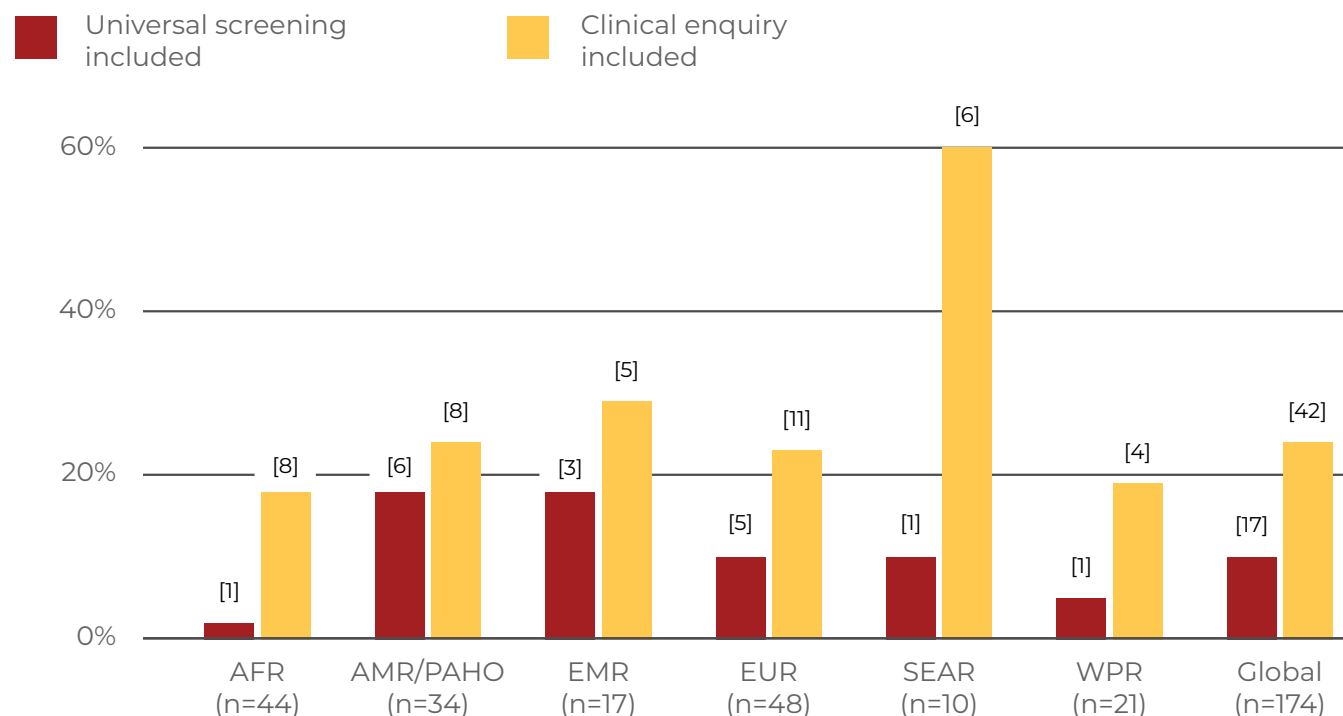
### Identification of intimate partner violence

WHO does not recommend universal screening for IPV but states that health-care providers should ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV, i.e. the clinical enquiry approach (20). Examples of conditions that may prompt clinical enquiry about IPV include symptoms of depression, adverse reproductive outcomes, alcohol or other substance use, and chronic gastrointestinal symptoms, among others (15, 20).

To assess the alignment of policies with WHO recommendations regarding identification of IPV, information on two different indicators was collected: one on universal screening or “routine enquiry” (which is not recommended) and the other on clinical enquiry or “selective screening” (which is recommended). A few countries included both approaches in their policy documents.

Just under a quarter of countries included clinical enquiry in policy (24%, n=42/174), while only 10% of countries included universal screening (n=17/174) (see Figure 10).<sup>38</sup> Of the 53 countries that mentioned IPV identification in their policies, nearly three quarters (74%, n=39/53) included clinical enquiry, suggesting that there are more countries aligning with the current WHO recommendation on how to identify IPV. The WHO South-East Asia Region has the highest proportion of countries with clinical enquiry specified in their policy documents (60%) (see Figure 10, and Web annex 4.3, Table 4.3b and 4.3c).

**Figure 10: Proportion of countries with eligible policy documents that include universal screening and/or clinical enquiry approaches to IPV identification, by region and globally (n=174)**



<sup>38</sup> Generally, a “Yes, included” answer option indicated that the policy document included information on the topic that was aligned with WHO recommendations or standards. However, the directionality of the “Yes, included” answer option was different for the universal screening indicator. For this one, a “Yes, included” answer option was not desirable given that this contradicts WHO recommendations.

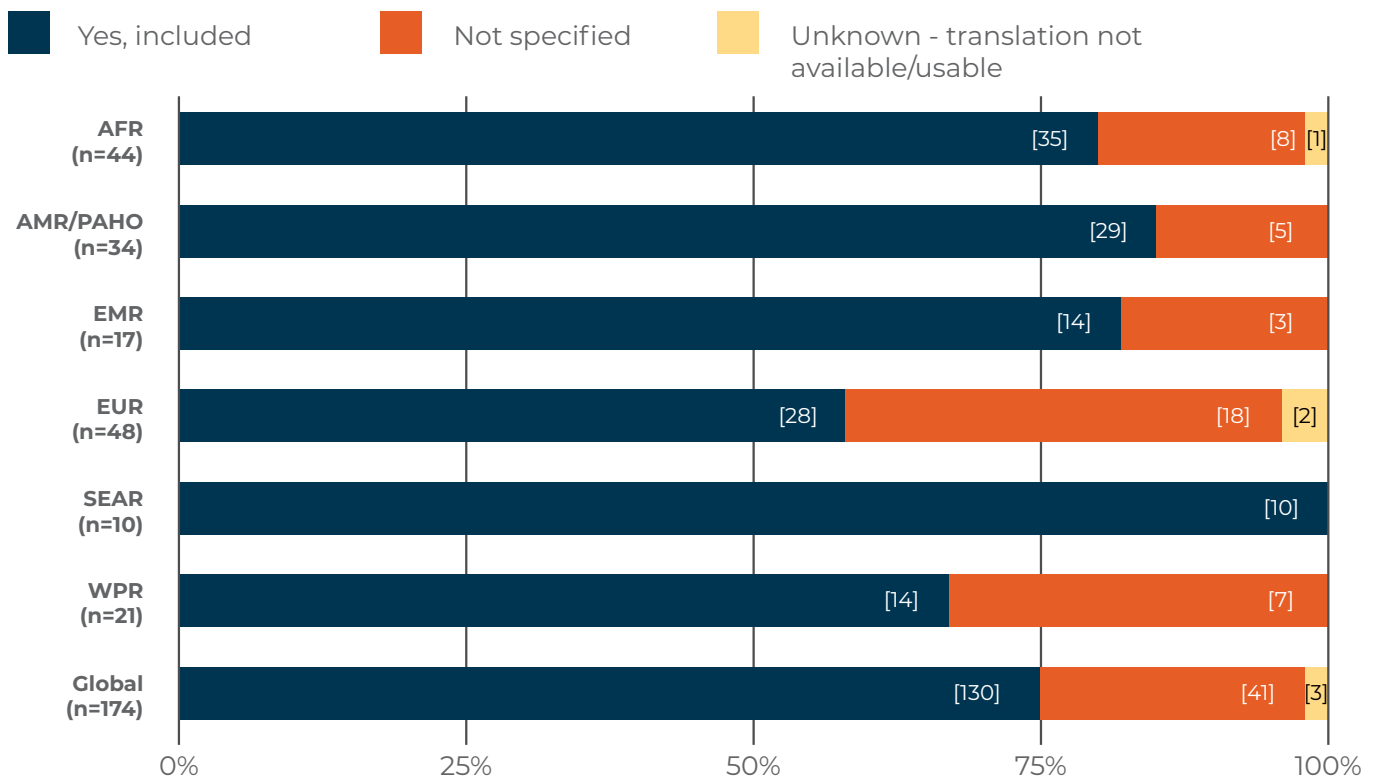
### First-line support

WHO recommendations specify that first-line support should be provided to all survivors who disclose IPV or sexual violence by anyone to health-care providers (20). Moreover, first-line support is the minimum standard of care that must be offered in all settings and at all levels of health service delivery. First-line support is an adaptation of psychological first aid and involves:

1. providing practical care and support, which responds to the survivor's concerns, but does not intrude on her autonomy;
2. listening without pressuring her to respond or disclose information;
3. offering comfort and help to alleviate or reduce her anxiety; and
4. offering information and helping her to connect to services and social support (20).

A job aid known as “LIVES” – with each letter corresponding to the steps to be performed – is the operationalization of first-line support that refers to: **L**isten with empathy, **I**nquire about her needs, **V**alidate her experience, **E**nhance her safety and facilitate **S**upport (15). Information found in policy on any one of the above four components of first-line support, broadly interpreted, or wording that specifically mentioned “LIVES” fulfilled this indicator. In line with WHO guidance, three quarters of countries (75%, n=130/174) included first-line support in their policy documents (Figure 11). All countries with eligible policies in the WHO South-East Asia Region (n=10) included first-line support, while in three other WHO regions (the Region of the Americas and the African and Eastern Mediterranean Regions) 80% or more countries' policies included it (see Figure 11, and Web annex 4.3, Table 4.3a).

**Figure 11: Proportion of countries with eligible policy documents that include first-line support for survivors, by WHO region and globally (n=174)**

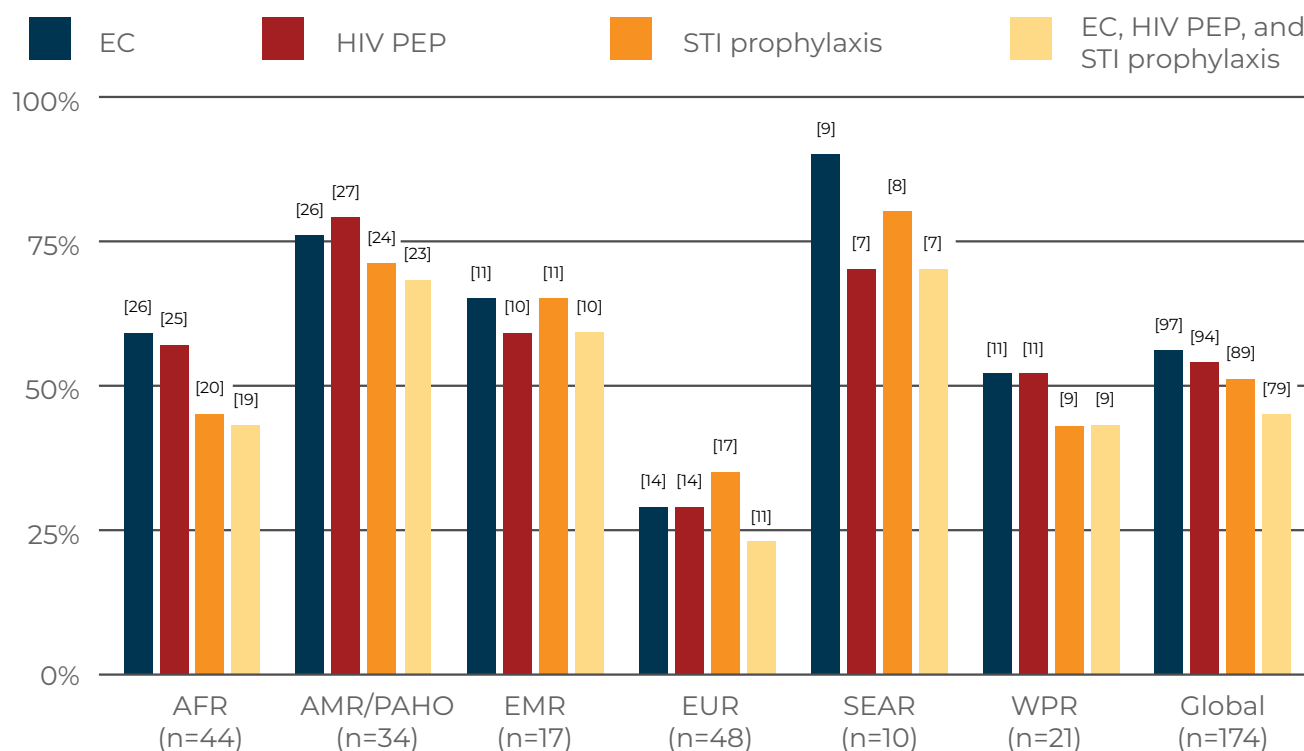


### Post-rape care policies and service availability

Within 72 to 120 hours of a sexual assault/rape, survivors should be offered a package of post-rape care services that includes emergency contraception (EC, within 120 hours), HIV post-exposure prophylaxis (PEP) (within 72 hours) and STI prophylaxis (15, 20). WHO guidelines specify that if a survivor accesses health services after the time limit for provision of EC has expired, or if EC was provided but failed, or if the woman is already pregnant as a result of rape, then safe abortion should be offered to the full extent of the law (15, 20).

Just over half of countries included information about EC (56%, n=97/174), HIV PEP (54%, n=94/174) and/or STI prophylaxis (51%, n=89/174) in their policies (see Figure 12, and Web annex 4.3, Table 4.3d). However, just under half of countries (45%, n=79/174) included all three in their policies (see Figure 12).

**Figure 12: Proportion of countries with eligible policy documents that include emergency contraception (EC), HIV PEP, STI prophylaxis, and all three services for survivors, by region and globally (n=174)**



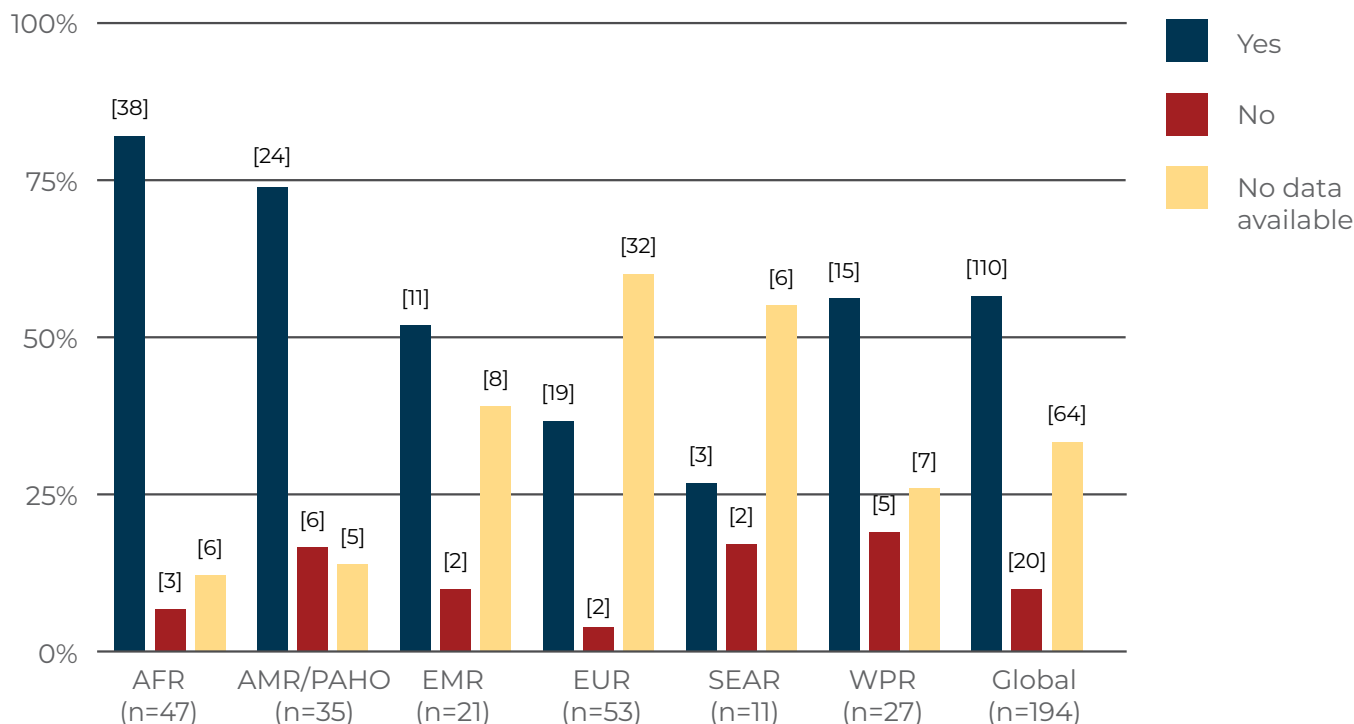
Seventeen percent of countries (n=30/174) included abortion related to VAW in their policy documents, while 70% (n=121/174) did not include any information on this and 6% (n=10/174) specifically excluded abortion as an available service for survivors of VAW (see Web annex 4.3, Table 4.3e). More information on countries' abortion laws and policies, including exemptions and conditions under which survivors of rape and IPV can access abortion by country, can be found in the Global Abortion Policies Database (32).

Data from National Commitments and Policy Instrument (NCPI) surveys provides self-reported information from governments on the availability of comprehensive post-rape care services (27). Of the 130 countries for which there were recent<sup>39</sup> NCPI data,

<sup>39</sup> Refers to data reported as part of the NCPI survey conducted in either 2017 or 2019 – whichever had the latest response to question 115 of the survey from the country (26).

85% (n=110) reported having at least one service delivery point with comprehensive post-rape care services available, in line with WHO guidelines (Figure 13). In other words, at least three of the following four services are available in at least one service delivery point in the country: (i) first-line support, (ii) EC, (iii) STI and HIV PEP, and (iv) safe abortion (to the full extent of the law).<sup>40,41</sup>

**Figure 13: Proportion of countries with NCPI data that reported the availability of comprehensive post-rape care services in line with WHO guidelines in at least one service delivery point, by WHO region and globally (n=130)**



The most commonly available elements of comprehensive post-rape care reported in the NCPI survey were first-line support and STI and HIV PEP within 72 hours of sexual assault/rape (each reported as being available by over 90% of countries with data), followed by EC (available in 88% of countries with data) (see Table 7). Safe abortion for a woman who is pregnant as a result of rape was the service least frequently reported to be available (available in only 60% of countries with data).

A comparison of how frequently each element of post-rape care services is mentioned in policy versus the frequency with which governments reported its availability in practice highlights discrepancies (see Table 7). Across all services, there are higher levels of reported provision of post-rape care services than there are commitments to providing them included in policy; but this comparison should be interpreted with caution as fewer countries (n=130) reported to the NCPI survey (i.e. data on service availability)

40 Note that the post-rape care indicator required that countries have three out of the four services available in at least one service delivery point. The data do not indicate the geographical coverage of these services.

41 HIV PEP and STI prophylaxis were included as separate indicators in the VAW Policy Database. In the NCPI survey, these were included in the same question which asked whether the country has service delivery points that provide STI and HIV PEP (within 72 hours of sexual assault) as needed (according to data provided by national authorities). In order to ensure the comparability of the policy and service data, a composite HIV-STI indicator was created from the two, separate VAW Policy Database indicators that represented the number and proportion of countries with both HIV PEP and STI prophylaxis. Related tables can be found in Web annex 4.4 (Tables 4.4a and 4.4b).

than the number of countries for whom policies were analysed (n=174). While there are shortcomings of this comparison, including the limitations of the data sources used and the self-reported nature of the data on the NCPI surveys, these comparisons indicate differences between what is written in national-level policy versus what services are reported as available on the ground in countries (i.e. implementation of policies).

**Table 7: Proportion of countries with post-rape care services included in policy and reported as available in at least one service delivery point in the country**

	<i>Included in policy</i>	<i>Reported as available in at least one service delivery point</i>
<i>Service</i>	<i>Countries with eligible policy documents (n = 174)</i>	<i>Countries with NCPI survey data (n = 127, 129, 124 and 124, respectively by service)</i>
<b>First-line support</b>	75%	93%
<b>HIV post-exposure prophylaxis (PEP)/STI prophylaxis (composite indicator)</b>	47%	92%
<b>Emergency contraception</b>	56%	88%
<b>Abortion (in accordance with national law)</b>	17%	60%

### **Good practice example: Argentina**

Argentina's recently revised *Protocol for comprehensive care for victims of sexual violence* (33) includes guidance for health-care providers on steps to follow when receiving survivors of violence at a health centre. Following is a translation of selected items.

- Encourage communication, active listening and trust.
- Believe their story, without blaming, revictimizing or influencing their decisions.
- Ensure confidentiality and privacy.
- Ask for consent for the medical practices and procedures chosen.
- Inform them in a clear and simple manner about the medical practices and procedures that can be performed; if there are therapeutic alternatives, detail the advantages and disadvantages of each in order to guarantee the patient's free choice.
- Generate an environment of empathy where the survivor can express their needs and fears. Use simple language, pose simple questions and repeat them if necessary; be caring and considerate.
- Offer emergency contraception as soon as possible, and medicines for the prevention of HIV, taking into account that they are more effective the earlier they are provided.
- Inform the person about her right to terminate the pregnancy, if she is pregnant as a result of the rape.
- If the victims are persons with disabilities, the following must be taken into account: the type of disability, the preferences and decisions of the victims, and how they wish to deal with those who accompany them if they need support.
- Take into account the presence of interpreters for persons who do not speak the language or have difficulties in doing so.



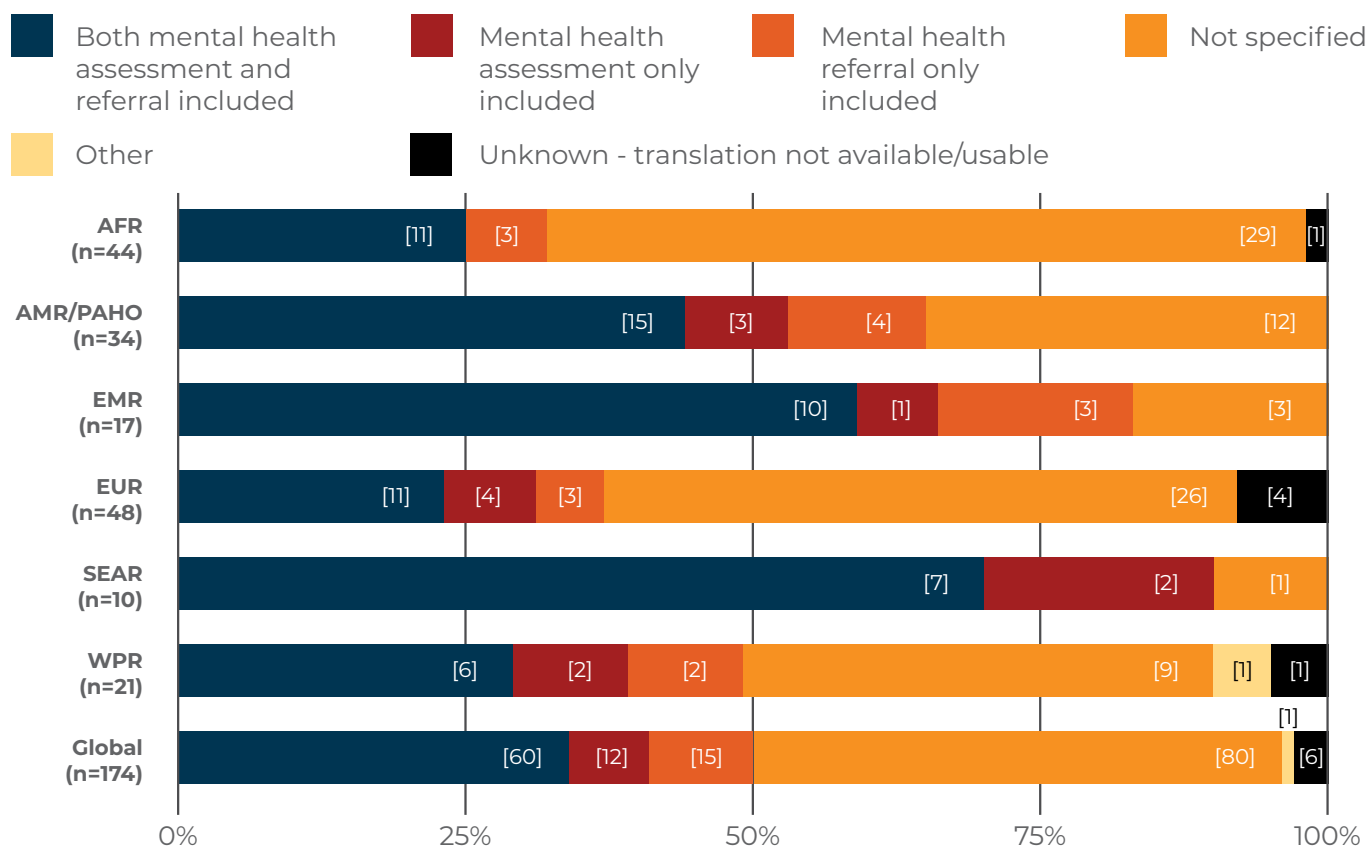
### Mental health care

WHO guidelines recommend a range of mental health care interventions for survivors of violence, including basic psychosocial support, assessment of moderate to severe depression, referral to specialist care where applicable, and treatment for diagnosed mental health conditions such as depression and post-traumatic stress disorder (PTSD) (15, 20).

Given that the details about the treatment component of mental health care are more likely to be found in specific mental health policies, which were not included in the VAW Policy Database, the two primary indicators for this section focused on mental health assessment and referral to specialist care. Mental health treatment was considered, but analysed separately. Further, in recognition of the exclusion of mental health policies from the database, the mental health indicator definitions were fulfilled through both specific mental health therapies (e.g. treatment for depression or PTSD, including cognitive behavioural therapy or eye movement desensitization and reprocessing) as well as general mention of mental health care, assessments, referrals or treatments of mental disorders in the policies that were reviewed.

Half of the 174 countries (50%, n=87/174) included mental health assessment or referral, or both, in their eligible policy documents. Just over a third of the countries (35%, n=60/174) included both assessments and referrals; this proportion was highest among countries in the WHO South-East Asia Region (70%) and the Eastern Mediterranean Region (58%), but less than half of the countries in the Region of the Americas (44%), and the Western Pacific (29%), African (25%), and European (23%) Regions (see Figure 14, and Web annex 4.3, Table 4.3f).

**Figure 14: Proportion of countries with eligible policy documents that include mental health assessment only, referral only, or both, by WHO region and globally (n=174)**



A little more than half of countries (52%, n=91/174) included mental health treatment in their eligible policies. Inclusion of mental health treatment in policy varied, with more countries including it the WHO Region of the Americas and the South-East Asia and Eastern Mediterranean Regions, and relatively few in the African, European and Western Pacific Regions (Web annex 4.3, Table 4.3g).

### **Good practice example: Iraq**

Iraq's clinical handbook (34)<sup>42</sup> for providing health care to women survivors of domestic and sexual violence outlines the need to conduct a psychological assessment and provides guidance on when to refer a survivor for more specialized mental health care. Following is a translated excerpt.

Perform a psychological assessment at the same time as the general health examination. Psychological assessment begins with careful observation and listening.

For depression, alcohol or substance abuse, or PTSD, refer her, if possible, for professional care by a specially trained health-care provider who has a good understanding of sexual violence.

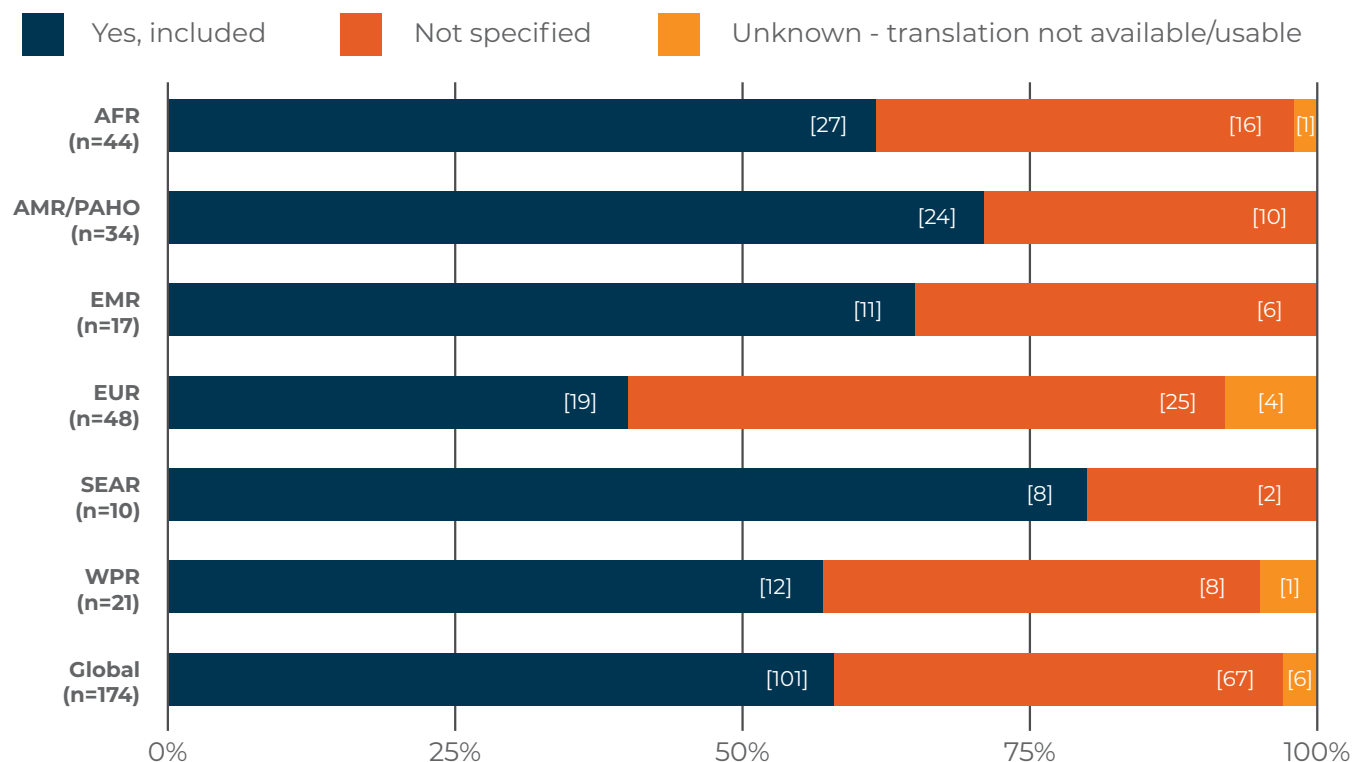
### **Referrals to other sector services**

The health sector can be an important gateway to a variety of other support services that survivors may need. Indeed, health-care providers are in a unique position to create a safe and confidential environment to facilitate disclosure of violence, while offering appropriate support and referrals to other resources and services (15, 20). Recognizing the need for a multisectoral response to VAW and for the health sector to establish appropriate linkages with other sectors, 58% of countries (n=101/174) included information in policy about referrals to sectors outside of health, including social services, legal aid and the police (Figure 15). The WHO Region of the Americas and the South-East Asia Region have the highest proportion of countries that included referrals for VAW survivors in their policies. Apart from the European Region, at least half of countries in all other regions included referrals in their policies (Figure 15).

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42 The clinical handbook of Iraq is an adaptation of the WHO clinical handbook (15).

**Figure 15: Proportion of countries with eligible policy documents that include referrals from the health sector to other sectors for VAW survivors, by WHO region and globally (n=174)**



### 3.4 Populations living in vulnerable situations

#### Key messages

**14%** of countries have policies that both recognize the vulnerable situations of **adolescent girls and young women** to violence and include specific services for them

**13%** of countries have policies that both recognize the vulnerable situations of **women with disabilities** to violence and include specific services for them

**6%** of countries have policies that both recognize the specific risks of violence against **pregnant women** and mention specific services for them

Certain population groups experience a higher risks and negative impacts of violence due to factors such as their age, (dis)ability or pregnancy status and/or ethnicity, which contribute to intersecting and multiple forms of discrimination against these groups. These factors also exacerbate their unequal power in relationships with perpetrators of violence and lead to them living in vulnerable situations (16).

While the higher risks of violence faced by populations living in vulnerable situations may vary by country, this report prioritized tracking of how policies address the specific needs of three populations or groups: adolescent girls and young women, women with disabilities, and pregnant women. Globally, regardless of context, violence has multiple negative impacts on their lives (see Table 1). Violence against adolescent girls has a lifetime of negative impacts. For women with disabilities, the high prevalence of violence and the additional challenges they may face in accessing help and services enhances their vulnerability. While pregnancy itself is not a risk for violence, the harms caused by violence during pregnancy are experienced not only by the woman, but also the fetus/infant. Therefore, identification of violence among pregnant women provides an opportunity to mitigate the associated harms and provide the necessary support and care. WHO guidelines on responding to VAW as well as on antenatal care both recommend actions to identify and respond to violence experienced during pregnancy (20, 35).

Differentiated services or services that respond to specific needs or situations of vulnerability are needed to effectively respond to the needs of groups that may be at higher risk of negative consequences when faced with violence (1, 16). Indicators in this section assessed whether policies included a recognition of the specific situations of vulnerability faced by adolescent girls and young women (10–24 years of age), women with disabilities, and pregnant women, as well as whether differentiated services were articulated for each group. The term “differentiated services” has been used for the indicator, defined as specific services that address the needs or situations of vulnerability of each group (see Web annex 1 for indicators definition).

### **Adolescent girls and/or young women**

A third of countries (33%, n=58/174) with eligible policies for review recognized adolescent girls and/or young women as a group facing specific risks or living in situations of vulnerability, and just under a third (31%, n=53/174) included services that addressed their specific needs in national policies. However, many fewer (14%, n=25/174) both recognized the need for and included differentiated health services. Twenty-nine percent of countries in the WHO Region of the Americas both recognized the need and included differentiated health services for adolescent girls and/or young women in their policies, 21% in the African Region, and 10% or below for all other regions (see Figure 16, and Web annex 4.5, Table 4.5a).

### **Women with disabilities**

A third of countries (34%, n=59/174) recognized that women with disabilities face specific risks or are living in situations of vulnerability, and a fifth (20%, n=34/174) articulated services that addressed their specific needs in national policies. However, once again, far fewer countries (13%, n=22/174) both recognized the need and provided differentiated health services. This proportion ranged from a high of 21% of countries in the WHO Region of the Americas and 20% in the South-East Asia Region down to 17% for the European Region, and 10% or under for all other regions (see Figure 16, and Web annex 4.5, Table 4.5b).

### **Pregnant women**

Less than a fifth of countries (16%, n=28/174) had policies that recognized that pregnant women face specific harms associated with violence, 11% of them (n=19/174) specified services to address their specific needs, and very few (6%, n=11/174) both recognized the need and mentioned services to address their specific needs. Ten percent of countries in the WHO South-East Asia Region both recognized the need for and specified violence-related services for pregnant women, 9% in the African Region, 8% in the European Region, 5% in the Western Pacific Region, 3% in the Region of the Americas, and none in the Eastern Mediterranean Region (see Figure 16, and Web annex 4.5, Table 4.5c).

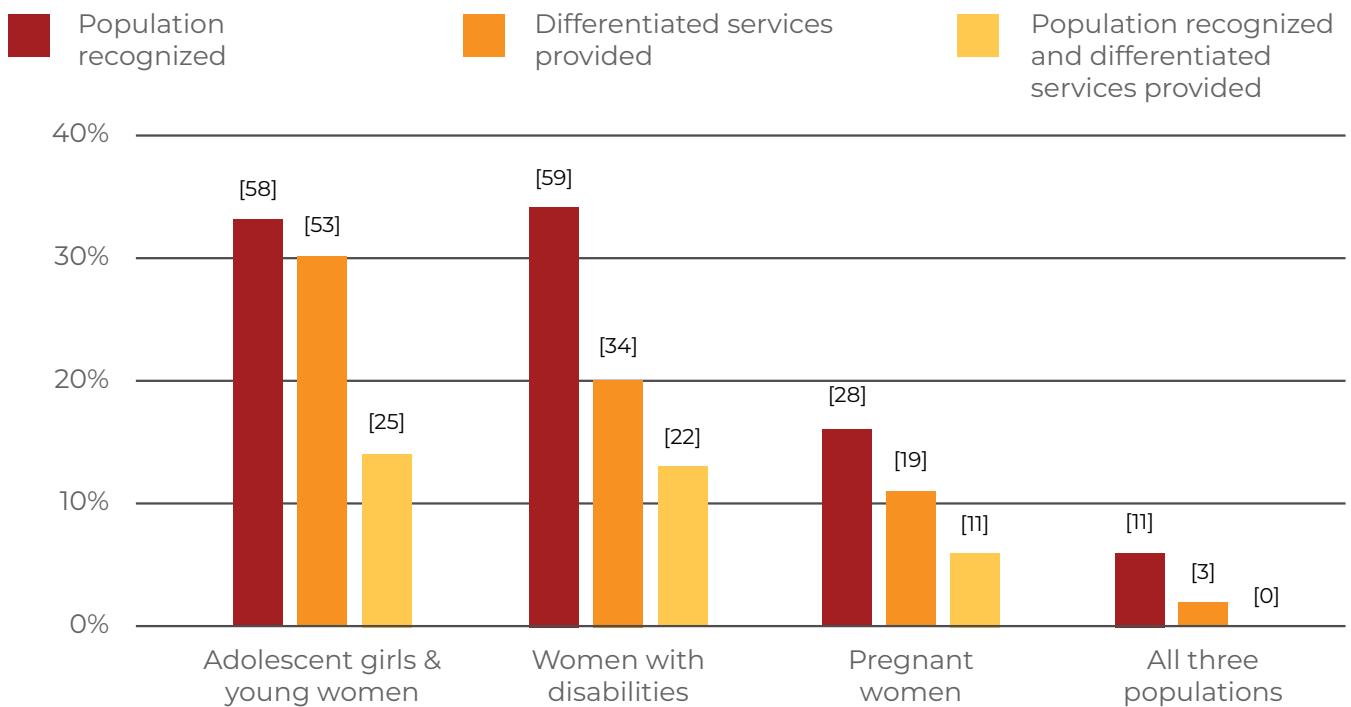
### **Good practice example: Ethiopia**

Ethiopia's handbook (36) for health-care providers to respond to VAW highlights the need to tailor approaches to providing support to survivors of violence from different groups with distinct needs, including for women with disabilities and adolescent girls (among others). Following is an excerpt.

It is essential that health-care providers understand and meet the needs of survivors with special needs:

- **Women with (mental and physical) disabilities:** This group of women has specific health and medical needs and special attention must also be given to the physical accessibility of these services. Those with hearing or visual impairments, for example, must be provided with appropriate means of communication.
- **Adolescents:** When providing health services for adolescent girls who are survivors of GBV/SV [sexual violence], health-care providers must adapt their provision of services in order to address their special needs. Services for adolescent survivors should be confidential; parental consent should not be required.

**Figure 16: Proportion of countries with eligible policy documents that recognize the vulnerable situation of and address specific needs of all three populations, globally (n=174)**



While more countries recognize a number of populations facing specific risks in their policies, fewer articulate services addressing their specific needs. Adolescent girls and/or young women, and women with disabilities are more frequently recognized in policy and specific services for them are more frequently mentioned in policy than for pregnant women.



### 3.5 Prevention of violence against women

#### Key messages

**40%** of countries include **at least one prevention intervention** from each of the following three strategies of the *RESPECT women: preventing violence against women* framework: **E**mpowerment of women, **S**ervices ensured, and **T**ransformed gender attitudes, beliefs and norms

**78%** of countries mention **gender norm-transformation interventions** for preventing VAW

**42%** of countries include **women's empowerment interventions** in their policies

First-line support, shelters and police interventions are the most commonly mentioned **response services** in national policies

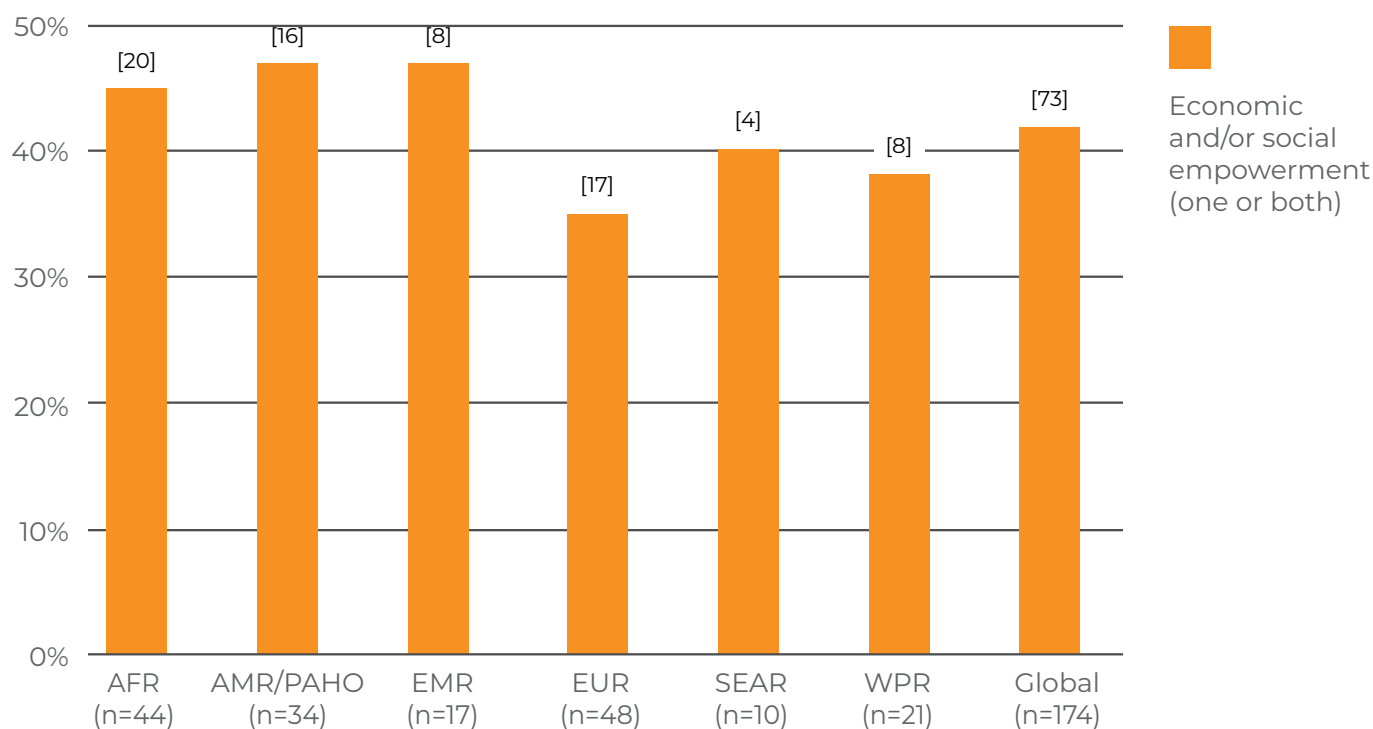
*RESPECT women* is an interagency framework for prevention of VAW aimed at policy-makers that has been developed by WHO together with UN Women and endorsed by 12 other United Nations, bilateral and multilateral agencies (16). It is aimed at helping policy-makers and practitioners design and implement evidence-informed, ethical and effective national and subnational policies, programmes and interventions for preventing VAW. The framework articulates seven strategies – one for each letter of the word RESPECT – relationship strengthening (R), empowerment of women (E), services ensured (S), poverty reduced (P), environments made safe (E), child and adolescent abuse prevented (C), and transformed gender attitudes, beliefs and norms (T). Three of these – E, S and T – were prioritized for inclusion in the VAW Policy Database because more interventions within these three strategies have been evaluated through research and have a longer history of maturity in VAW prevention programmes compared with the other four strategies of RESPECT. Two out of five countries (40%, n=69/174) have at least one prevention intervention from each of three strategies assessed.

### **Empowerment**

The first “E” of RESPECT relates to the empowerment of women (16). The overall indicator related to inclusion of empowerment strategies in policy is measured by two sub-indicators related to the inclusion of economic empowerment and social empowerment interventions in policy. The only type of policy document used to address prevention indicators in this section were multisectoral VAW policies, as prevention by its very nature requires multiple sectors and joint programming to address the many risk factors and drivers of VAW. When no multisectoral VAW policy was available for a country, the answer option “N/A no multisectoral VAW policy available” was used for the indicator (Web annex 3e).

Seventy-three countries (42%) included at least one economic and/or social empowerment intervention in policy, with the WHO Region of the Americas and the Eastern Mediterranean Region having the highest proportions of countries with one or both types of empowerment interventions (see Figure 17, and Web annex 4.6, Table 4.6a). One third of countries (33%, n=58/174) included at least one economic empowerment intervention, such as vocation and/or livelihood training for women. A little less than a quarter of the countries (24%, n=41/174) included a social empowerment intervention, such as mentoring or life skills-building for women. The WHO African Region (43%) and Eastern Mediterranean Region (47%) have the highest percentages of countries that included economic empowerment interventions in policy. The Region of the Americas (38%) and the Eastern Mediterranean Region (35%) have the highest percentages of countries with social empowerment interventions in policy.

**Figure 17: Proportion of countries with eligible policy documents that include one social or economic empowerment strategy, or both empowerment strategies, by WHO region and globally (n=174)**



### **Good practice example: Papua New Guinea**

Papua New Guinea's national strategy (37) to prevent and respond to gender-based violence (GBV) recognizes the importance of economic and social empowerment for survivors of violence. Following is an excerpt.

It is therefore important to cater for capacity-building programmes to help survivors to develop income-generating and social empowerment skills and become financially independent and emotionally strong. With increased independence, survivors may develop negotiation powers that can reduce their vulnerability to violence or help them leave violent situations. The interventions could be linked, for a limited period of time, with a social protection stipend, which would provide space to survivors to acquire necessary skills after leaving a violent environment.

- Output 3.4: Survivors of gender based violence and their dependents are supported in their reintegration through effective social and economic empowerment interventions.
- Targets 3.4: Income-generating programmes designed to support prevention and reintegration (2018–2025); Grant assistance to GBV survivors linked with income generating programmes (2018–2025).



### Response services

The “S” of RESPECT refers to the ensured availability of a range of services aimed at responding to VAW, including police, legal, health and social services for survivors (16). Services form an important component of prevention and should be seen as a continuum. Several response services – when delivered early – can contribute to reductions in reoccurrence, frequency or severity of VAW and thereby contribute to prevention. Identification, care and support for children who witness violence experienced by their mothers can further contribute to preventing them from becoming either perpetrators or victims of violence later in life. A number of sub-indicators contributed to the response services (S) indicators assessed in the VAW Policy Database. These are summarized with definitions in Table 8. All four types of policy documents included in the database (see Table 2) were reviewed in the assessment of all the services (S) indicators.

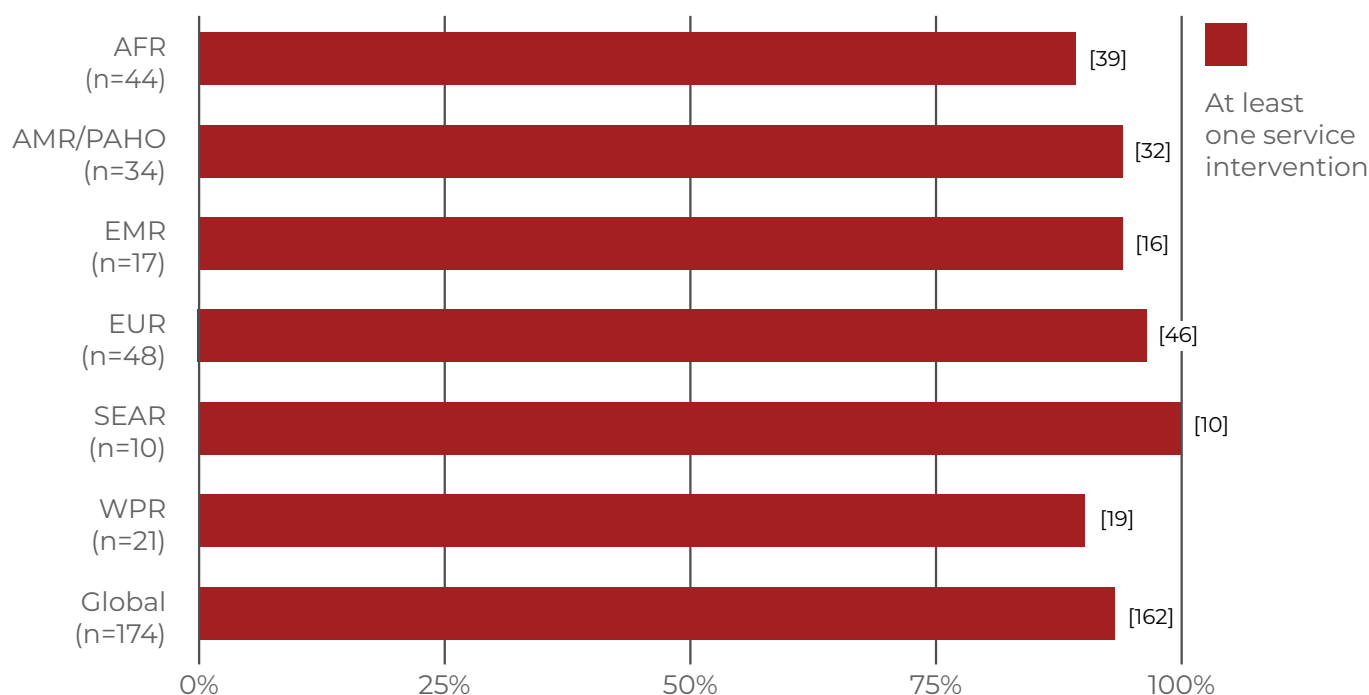
**Table 8: VAW response services sub-indicators and definitions**

Does the policy include...?	Definition
<b>Substance abuse prevention</b>	This indicator is met if the policy documents reviewed include interventions aimed at reducing alcohol use and/or substance use. Interventions include: Alcoholics Anonymous meetings; group or individual counselling to reduce alcohol use or substance use; training alcohol sellers to educate consumers about harmful drinking; increasing prices/taxation on alcohol; reduction in the open hours of shops that sell alcohol; restrictions on alcohol licensing in a geographical area; harm reduction interventions; drug rehabilitation therapies; and legal/policy restrictions banning certain drugs.
<b>Shelters</b>	This indicator is met if the policy documents reviewed include reference to safe houses, shelters, refuges, safe homes or temporary accommodations such as hotels.
<b>Hotlines</b>	This indicator is met if the policy documents reviewed include reference to crisis support including helplines, hotlines, crisis counselling and crisis interventions. Reference to a phone or web-based intervention that either refers survivors to the required services and support, or through which survivors can receive such services and support directly would also meet the criteria for this indicator.
<b>One-stop crisis centres (OSCCs)</b>	This indicator is met if the policy documents reviewed include reference to hospital-based or stand-alone centres that receive VAW survivors and provide health, psychosocial counselling/support, legal aid and/or police services, either under one roof or through linked/referral services.
<b>Perpetrator interventions</b>	This indicator is met if the policy documents reviewed include reference to interventions with perpetrators of violence, including: individual or group interventions with prisoners with a history of abuse; counselling interventions; mental health interventions; alcohol reduction interventions; and behaviour change interventions such as motivational interviewing to reduce recidivism. Publicly available lists of sexual offenders living in a given area would also be included within the scope of this indicator.

Does the policy include...?	Definition
Police interventions	This indicator is met if the policy documents reviewed include reference to police or law enforcement services provided to VAW survivors, or interventions aiming to enhance police officers' skills, including police training, and use of protection/restraining orders. Availability of women's police stations and female police officers are also included within the scope of this indicator, as are medico-legal and forensic interventions.
First-line support	First-line support and clinical enquiry were assessed under the "Health services: policy and availability" section of the VAW Policy Database; however, they were also sub-indicators that fed into the sub-indicators for the Services (S) pillar of RESPECT. See Web annex 1 for definitions of these two indicators.
Clinical enquiry	

Most countries (93%, n=162/174) had eligible policy documents that included at least one VAW response service, with all WHO regions having over 85% of countries with at least one response service in policy (see Figure 18, and Web annex 4.6, Table 4.6b).

**Figure 18: Proportion of countries with eligible policy documents that include at least one response service intervention, by WHO region and globally (n=174)**



First-line support was the most commonly mentioned service (74%), followed by shelters and police (see Table 9). On the other hand, substance abuse interventions to reduce or prevent violence was the service intervention least frequently included in policy. One-stop crisis centres (OSCCs) is a model of providing several integrated services to survivors under one roof, often including health, legal, police and social services. In recent years, despite a lack of evaluations demonstrating whether OSCCs are effective, a number of countries have invested in these centres (38). Fewer than two out five countries, however, have included a mention of OSCCs in policy documents. On the other hand, interventions with perpetrators of violence, despite the mixed evidence on their effectiveness (16), are mentioned in policies by half of all countries.

**Table 9: Number and percentage of countries with eligible policy documents that include each service, globally (n=174)**

	<i>Substance abuse</i>	<i>Shelters</i>	<i>Hotlines</i>	<i>One-stop crisis centres (OSCC)</i>	<i>Perpetrator</i>	<i>Police</i>	<i>First-line support</i>	<i>Clinical enquiry</i>
<b>n</b>	27	126	96	67	87	122	130	42
<b>%</b>	16%	72%	55%	39%	50%	70%	74%	24%

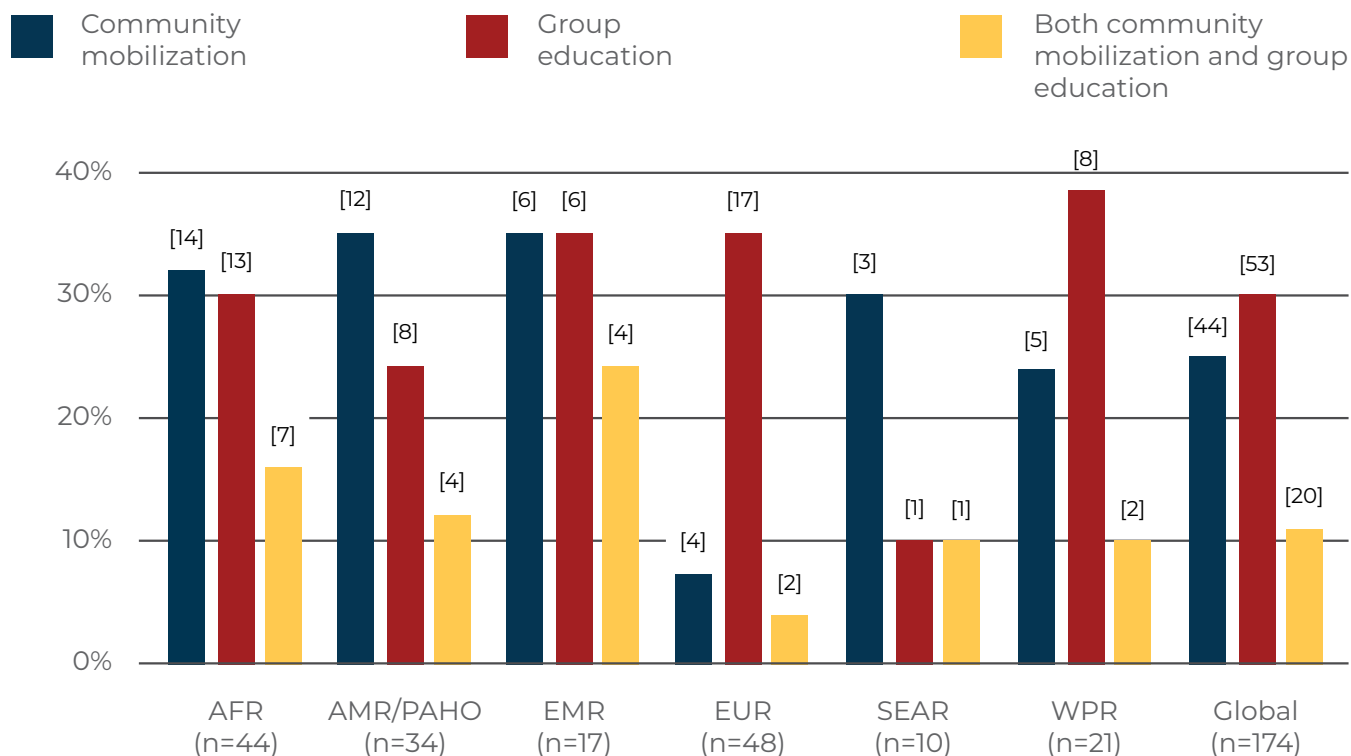
### ***Transformed gender attitudes, beliefs and norms***

The “T” of RESPECT refers to “strategies that challenge harmful gender attitudes, beliefs, norms and stereotypes that uphold male privilege and female subordination, that justify violence against women and that stigmatize survivors” (16). The sub-indicators contributing to the indicator on inclusion of transformation of norms in policies assessed whether one of the following gender norm transformation interventions was included in policy: community mobilization, and group education. We also assessed whether public awareness raising campaigns were included, even though these have not been shown to be effective in changing gender attitudes or behaviours related to violence, to assess how many countries were including ineffective prevention approaches in policy. These three intervention categories were identified as ones that were the most evaluated types of norm-change interventions in the *Respect women* framework. It is to be noted that evidence indicates that community mobilization and group education interventions are promising with regard to changing attitudes (16).

Similar to the empowerment (E) indicators, multisectoral VAW policies were the only type of policy document reviewed to assess the indicators for “T” (see rationale in the subsection above on Empowerment). The health sector is not expected to play a substantial role in changing community norms and, therefore, health policies were deemed unlikely to include relevant content for these indicators.

In relation to the two interventions with promising evidence of effectiveness, only a quarter of countries (25%, n=44/174) included community mobilization interventions, and nearly a third (31%, n=53/174) included group education interventions (Figure 19). Across all WHO regions, 30% or more of countries included at least one of these two interventions in policy. Regionally, the WHO Eastern Mediterranean Region had the highest proportion of countries (24%) with both community mobilization and group education included in policy, while the European Region had just 4% of countries that included both types of intervention (see Figure 19, and Web annex 4.6, Table 4.6c).

**Figure 19: Proportion of countries with eligible policy documents that include community mobilization, group education, or both, by WHO region and globally (n=174)**



Despite the evidence of ineffectiveness, nearly three quarters of countries (74%, n=129/174) included awareness raising interventions, and for one third of countries (33%, n=58/174), awareness raising was the only intervention mentioned for changing gender norms (Web annex 4.6, Table 4.6d).

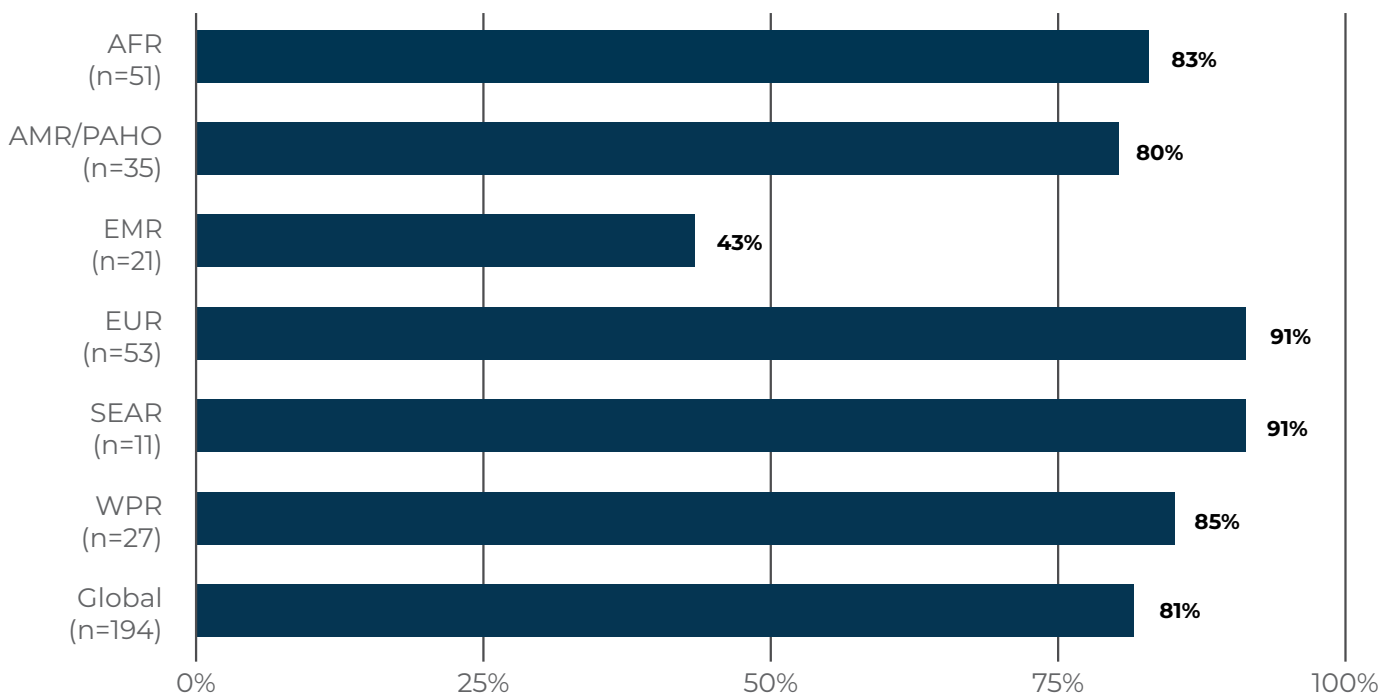
### 3.6 Availability of prevalence data

Alongside the activism of feminist movements, the availability of evidence – particularly prevalence data – on VAW has been one of the most powerful factors in placing VAW on the policy agendas of many governments (39). Prevalence data have also been instrumental in placing VAW on global health and development agendas, including the Sustainable Development Agenda. The SDGs include a target (SDG target 5.2) on the elimination of VAW with two indicators including one on prevalence of recent (last-12-months) IPV (SDG indicator 5.2.1) and one on prevalence of recent (last-12-months) sexual violence by someone other than an intimate partner (SDG indicator 5.2.2).<sup>43</sup>

<sup>43</sup> Meta-data including definitions of these indicators are available with United Nations Statistics Division at: <https://unstats.un.org/sdgs/metadatas/?Text=&Goal=5&Target=5.2>

The recently published WHO VAW prevalence estimates (7) and data analysed from the Global Database on the Prevalence of VAW (28) show that the availability of nationally representative population-based prevalence surveys on VAW, or that include questions on VAW, has dramatically increased within the last 20 years. Data on past 12 months prevalence of IPV, in particular, are available from 157 countries, although this varies across WHO regions (Figure 20).

**Figure 20: Proportion of countries with availability of population-based survey data (conducted between 2000 and 2018) on last 12 months prevalence of intimate partner violence, by WHO region and globally (n=194)**



Source: Based on data from the Global Database on Prevalence of VAW (28).

Overall, four fifths of countries (81%, n=157/194) have conducted at least one survey between 2000 and 2018 with data on the prevalence of recent IPV (Figure 21). The WHO South-East Asia Region has the highest proportion of countries (91%) while the Eastern Mediterranean Region has the lowest proportion of countries with prevalence surveys (43%), highlighting the need for a concerted effort to improve the availability of prevalence data in countries from this region.

## 4. Conclusion and implications

In a world where almost one in every three women experiences violence, mostly by an intimate partner, evidence-informed policies urgently need to be put in place. Policies are necessary, but they are not sufficient unless they are adequately resourced and subsequently implemented in full. While this report does not convey the extent of implementation of the policies in countries, it does reflect an assessment of governments' commitments and stated intentions in setting an agenda for VAW programme implementation and service delivery and an assessment of the alignment of existing policies with principles of gender equality and human rights. Health and multisectoral policies that address VAW play a crucial role in setting this agenda for the health sector. This report calls for policy dialogues with policy-makers across sectors, but particularly those from the health sector, to strengthen specific aspects of policy as follows.

### 4.1 Implications for policy strengthening

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A majority of countries have at least one type of policy that addresses VAW. Globally, while over three quarters of countries have a multisectoral VAW policy, health sector policy frameworks are less developed. More effort is needed from ministries of health to fully integrate VAW prevention and response interventions into a range of health sector policies, including, but not limited to general national health strategies and policies specific to sexual and reproductive health (SRH) and HIV. Additional types of policies where response to VAW needs to be integrated include maternal health, adolescent health and mental health policies, even though these are currently excluded from the VAW Policy Database and this report. Going beyond integration, these policies need to ensure VAW is a strategic priority for the sector and that clinical protocols/guidelines or standard operating procedures are in place for the provision of services and support for survivors. The relatively low number of countries reporting budget allocation(s) for VAW highlights the need to resource policies adequately so that programmes and services addressing VAW can be implemented.

Encouragingly, most countries recognize the human rights principles of privacy and confidentiality in their policies when it comes to woman-centred care. However, translating these human rights principles into practice-based operational guidance needs to be strengthened. More countries need to articulate a clear commitment to privacy during consultations and fulfil their obligation to ensure confidentiality and communicate any limits to it where these exist, particularly in contexts where there are legal obligations to report violence to the police or other authorities.

Over half of countries do not include specific information about requirements to report VAW to relevant authorities in their policies, making it unclear what guides health-care providers' practice. In the small number of countries that do make it mandatory to report VAW to the police, there are challenges for providers and survivors alike. More dialogue is needed with governments to identify ways in which women can be supported to report in ways that uphold their safety, respect their rights to autonomy and consent, and lead to meaningful changes.

In relation to health services, more than three quarters of countries recognize the criticality of first-line support for survivors. While there are variations in how this is included in policy and the level of detail included, a number of countries are using WHO's recommendations to guide the content of their own national policies, including specifying WHO mnemonic "LIVES" in provision of first-line support. First-line support is also the service element of post-rape care that countries most frequently report to be available. Of concern, however, is that a majority of countries did not include in policy any approach to the identification of women subjected to intimate partner violence (IPV), even though this is by far the most common form of violence experienced by women (1). Two aspects of post-rape care – emergency contraception (EC) and sexually transmitted infection (STI and HIV prophylaxis, although less frequently mentioned in policies, are more widely reported as being available in post-rape care services. Abortion services, on the other hand, continue to be a major gap in post-rape care policies and service availability, highlighting the need for continued advocacy for the alignment of policies and service provision with the available evidence and international human rights standards (40).<sup>44</sup> Also of concern is the less frequent mention of mental health assessment, referrals and/or treatment for survivors of IPV or sexual violence, highlighting another area requiring dialogue with governments.

In addressing some of the gaps in health policy frameworks identified in this report, WHO has produced a resource package of its guidelines and implementation tools to support countries – including through dialogue – to integrate VAW into their health policies and to develop, update and align their national guidelines or protocols with WHO's recommendations for health sector response to VAW (15, 19, 20). In addition to providing direct technical support to ministries of health as part of its mandate, WHO is part of a joint United Nations initiative – together with UN Women, the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP) and the United Nations Office on Drugs and Crime (UNODC) – on strengthening essential services for women and girls subjected to violence, which has been implemented in approximately 60 countries in the last five years or so (17).<sup>45</sup> The health sector component of this initiative is based on WHO guidelines and has been used to strengthen national clinical guidelines or protocols for responding to violence against women (15, 20).

There is evidence of the disproportionate impacts of violence faced by adolescent girls and young women and women with disabilities (1, 23). In addition, WHO estimates of the health burden of IPV also highlight the particular harms of such violence during pregnancy (2). In assessing the inclusion of these populations in policy, the mandate to "leave no one behind" requires not only that they be recognized but that, beyond this, there are specific strategies or services to reach them and meet their needs. Unfortunately, this report highlights major gaps in VAW policies. A majority of countries have a long way to go in this regard and need to dedicate more concerted attention to the inclusion of these and other populations that are disproportionately impacted by violence. Of particular concern

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44 For example, the in the WHO African Region, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol), which is the main legal instrument for protection of the rights of women and girls in Africa, recognizes access to safe, legal abortion as a woman's human rights (41).

45 The number of countries is based on personal communication as documented in an unpublished 2019 UN Women report titled: *Assessment of pilot countries' implementation of the United Nations Joint Programme on Essential Services Guidance for Women and Girls Subject to Violence (2017–2018)*.

is that, despite the high levels of violence experienced by adolescent girls and young women, very few countries have recognized their particular needs and included specific strategies to reach them, highlighting an urgent area in need of policy action.

Addressing the prevention of VAW in policies is relatively new, as historically much more attention has been paid to response services. The findings in this report focused on three of the seven prevention strategies contained in RESPECT: empowerment of women (E), services ensured (S), and transformed gender attitudes, beliefs and norms (T). Unsurprisingly, the highest proportion of countries included response service (S) interventions, though not always the types of services that are evidence-informed. Strategies to empower women economically and socially need much more emphasis as fewer countries have included these in their VAW-related policies. Finally, while the majority have included at least one intervention aimed at transforming gender norms, the most frequently included one – awareness raising – has been shown to be ineffective as a stand-alone intervention. This highlights the need to focus on the evidence-informed gender norm transformation interventions in policies, such as community mobilization and group education interventions with women and men, girls and boys (16).

Such alignment and strengthening of policies with more evidence-based VAW prevention approaches needs to be a key area for intersectoral policy dialogue with and among relevant ministries, to ensure better integration of evidence-based strategies in sector-specific policies alongside national multisectoral VAW plans. A promising start has been made towards such an effort by several United Nations agencies, which have come together to make a collective commitment on scaling up evidence-informed prevention in 25 countries by 2025, in the context of the Generation Equality Forum's action coalition roadmap on gender-based violence, guided by the framework presented in *RESPECT women: preventing violence against women*.<sup>46</sup> Together, all the agencies that have endorsed the framework are collaborating on rolling out the *RESPECT women* framework and implementation package (16, 18) to strengthen capacities of intersectoral policy-makers to integrate evidence-based prevention strategies into their national policies and programmes.

This report has highlighted that progress in policy content is uneven, not only across indicators, but also across WHO regions. While some regions have placed greater emphasis on multisectoral VAW policies (e.g. the WHO European Region), others have put greater emphasis on the integration of VAW specifically in health policies (e.g. the WHO African Region). While some countries have addressed mental health more frequently in their policies (e.g. in the WHO South-East Asia and Eastern Mediterranean Regions), others have done better on addressing populations living in vulnerable situations (e.g. in the WHO Region of the Americas) and on inclusion of evidence-based interventions to transform gender norms (e.g. in the WHO Western Pacific Region). These regional disparities are illustrative of different countries' differing priorities when it comes to addressing VAW, and between prevention and response services; this information can be useful in dialogues at the regional level about where policy frameworks can be strengthened to better align with WHO recommendations and other evidence-based guidance. At the

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46 See the Gender-Based Violence Action Coalition Collective Commitments on Prevention, at the Paris Generation Equality Forum on Beijing25 Commitments website: <https://focus2030.org/Generation-Equality-Forum-overview-of-the-commitments>



same time, this report provides illustrative good practice examples from selected countries (one from each of the six WHO regions) that have well articulated and elaborated prevention and/or response interventions addressing specific aspects of VAW, which can serve as models and inspiration for other countries.

### ***Implications for policy strengthening at the regional level***

#### **Strengthening health sector policies, including clinical guidelines**

- Countries from the WHO African, European and Western Pacific Regions in particular need to place a greater emphasis on developing health sector-specific policies, including both integrating VAW interventions into health policies and developing clinical protocols/guidelines. However, even in the South-East Asia Region and the Region of the Americas, some countries need to make more progress on health sector-specific VAW policies, including clinical guidelines, to complement the emphasis placed on multisectoral plans of action.

#### **Inclusion of health services in policies**

- Countries from the WHO European and Western Pacific Regions need to make a greater effort to specifically include first-line support and immediate post-rape care services – such as emergency contraception (EC), STI prophylaxis, and HIV post-exposure prophylaxis (PEP) – in their policies. Similarly, countries in the WHO African Region also need to emphasize the inclusion of immediate post-rape care in policies. All WHO regions need to strengthen the inclusion of abortion as part of post-rape care services in their policies.

#### **Adolescent girls and young women**

- Recognizing and addressing the specific needs of adolescent girls and young women must be strengthened in policies, particularly in countries from the WHO Eastern Mediterranean, South-East Asia and Western Pacific Regions.

#### **Transformation of gender norms**

- While interventions to change gender norms are frequently mentioned in policy, community mobilization in particular – a more promising intervention – is not sufficiently emphasized in the policies of countries from the WHO European and Western-Pacific Regions, as compared with the WHO African Region, representing an area of policy dialogue on VAW prevention interventions. The same applies with respect to group education interventions, which need to be better reflected in national-level policies in the WHO Region of the Americas and the South-East Asia Region.

### **Summary of areas for policy strengthening**

1. Interventions to address VAW need to be included as a strategic priority in national health policies, with accompanying budget allocations.
2. More countries need to develop clinical guidelines and protocols or standard operating procedures (SOPs) to guide health-care providers in caring for VAW survivors.
3. Clinical guidelines/protocols or SOPs need to be aligned with WHO evidence-based recommendations, particularly in the areas of IPV identification, mental health care and comprehensive post-rape care.
4. Effective responses to the specific violence-related risks facing adolescent girls and young women and women with disabilities need to be more clearly articulated in policies. IPV during pregnancy also needs specific attention given the opportunities that antenatal care provides for identification and a supportive response.
5. Prevention interventions, particularly those focused on the empowerment of women, need greater attention in VAW policies, as do group education and community mobilization interventions for gender norm transformation.

## **4.2 Implications for policy advocacy and implementation**

While the data in this report provide a rich framework that can guide programme design and implementation as well as service delivery, they do not in any way reflect the reach, depth or quality of existing programme implementation. The data presented do, however, provide a useful tool for holding governments accountable to policy commitments. They also provide a baseline against which to track progress in the implementation of various commitments that governments have made on addressing VAW, including most recently at the Generation Equality Forum in 2021. The information in this report can be used effectively in advocacy and programming efforts by civil society, United Nations agencies and donors to urge governments – sectoral ministries and parliamentarians – to align their policies with evidence and with international norms and standards related to human rights and gender equality. The indicators for monitoring the implementation of the Global Plan are well reflected among the indicators included in the VAW Policy Database as discussed in this report and there is evidence of progress in some areas and gaps in others. The next report on the implementation of the Global Plan will be presented at the World Health Assembly in 2025 with the final report due in 2030 to coincide with the end of the SDG monitoring period.<sup>47</sup> The data in this report provide a useful baseline against which to track progress.

This report provides data that can be used by youth groups, women's rights organizations and disability rights groups to highlight the limited progress made in addressing the vulnerable situations and needs of adolescent girls, young women and women with disabilities in policies. It is a wake-up call for accelerating the agenda on "leaving no one behind" when it comes to VAW.

<sup>47</sup> This was elaborated in the World Health Assembly (WHA) resolution 74.8, which calls for reporting on WHO resolution 69.5 (2016) and the Global Plan in 2025 and 2030 (42).

These data also highlight the need for continued advocacy and technical support efforts by United Nations agencies, including WHO, not only encouraging ministries of health to implement a stronger health systems response to VAW as mandated in the Global Plan, but also facilitating dialogue among other sectoral ministries to strengthen policies and coordination of essential, evidence-based response services and prevention programmes across justice, the police, social services, education, labour and social protection. This report calls on parliamentarians – and the advocacy forums that reach them, such as the Inter-Parliamentary Union – to place greater emphasis on strengthening budgetary allocations for implementing evidence-informed policies. The gap in this area has been highlighted in this report, with very few countries “walking the talk” when it comes to allocating domestic resources towards responding to VAW.

While VAW interventions should ideally be resourced through the domestic funding of policies, the reality is that external donors have played an important role in financing policy strengthening and programming for VAW prevention and health systems responses, including through integrated health and development programmes.<sup>48</sup> This report’s findings call on donors to strengthen their investments in policies that guide large-scale sectoral programmes, be they health, education, justice, social protection or law enforcement programmes, by including or strengthening the policy elements that are highlighted at the end of section 4.1. In the health sector, there is a particular need to focus on the integration of VAW prevention and response in policies on mental health, adolescent health, sexual and reproductive health, maternal health and HIV.

COVID-19 has once again shone a light on the exacerbation of VAW during times of crisis. While this report did not specifically look at how emergency preparedness or humanitarian response plans respond to VAW during a crisis, the report highlights the need for including VAW in these plans and policies. Recent analyses by other United Nations agencies highlighted that only 52 countries have integrated VAW measures – considering them as essential – in COVID-19 response plans (43). Donors and governments that are planning their investments in the area of humanitarian response need to pay particular attention to ensuring that VAW services are included, integrated and financed as essential services during crises (22).

### 4.3 Implications for policy research

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This report reflects a work in progress. While much effort has gone into extracting as much meaningful information as possible from several types of policy documents to populate a large number of indicators, there is more to be done. Specifically, additional types of policies need to be added to the inclusion criteria, such as mental health policies, emergency preparedness and response plans for

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48 This has included financing by the United States Government to include gender-based violence through the United States President’s Emergency Plan For AIDS Relief (PEPFAR) as part of HIV/AIDS programming (see: <https://www.state.gov/preventing-sexual-violence/>), the World Bank’s financing of stand-alone and integrated GBV interventions through infrastructure and health loans (see: <https://www.worldbank.org/en/topic/socialsustainability/brief/violence-against-women-and-girls>) and the Government of the United Kingdom’s “What Works” to prevent VAW initiative, which concluded its first phase in 2020 focusing on generating research and evaluation on effective prevention interventions and in its second phase will focus on taking evaluated promising approaches to scale, which also require greater attention to national plans, policies and strategies to guide large scale sectoral programmes to integrate VAW prevention (see: <https://www.gov.uk/guidance/funding-for-what-works-to-prevent-violence-against-women-and-girls>).

humanitarian settings and outbreaks/epidemics, and maternal and adolescent health policies. Sectoral plans or policy documents obtained from the justice, police and social sectors may also be useful.

More importantly, with regard to the information already available, there is a need to validate the country-level data through policy dialogues that include representatives from across sectoral ministries and also individuals from diverse and representative communities and disciplines. Such dialogues serve a dual purpose. The first is to more deeply understand the myriad policy frameworks that countries use to guide their VAW prevention and response efforts. For example, in some countries, laws, government orders, policy circulars, operational plans or subnational policies may provide more precise and detailed guidance to practitioners and implementers than the national-level policy documents used in the VAW Policy Database and analysis for this report. The second purpose of dialogue about country-level data is to further extend the discussion with governments and other stakeholders – such as civil society advocates, programme implementers, service providers, donors and United Nations agency partners – into the area of how to strengthen the policy frameworks that guide provision of VAW prevention and response services, both on paper and in practice.

The data on policy content presented herein have value as a complement to a variety of other data types and analysis methods, such as policy surveys undertaken with government representatives; prevalence estimation; content analysis of laws on violence; and data on the availability of health or other services. While each approach has its shortcomings, there are complementarities that offer the potential for triangulation of information to provide a more complete and holistic picture on how policies are formulated by policy-makers, interpreted by other decision-makers and programme planners, operationalized and implemented on the ground.

This report focuses on the intent of policies, but there is a need to go further by comparing intent against actual implementation of policies in practice. This would require researching how policies are perceived or interpreted by the implementers; how they are translated into operational plans; and how programmes and services are resourced, managed, and monitored and evaluated for quality and coverage. Ideally, to complement the data collected for this report, an in-depth analysis focusing on a number of countries would be valuable, to further analyse the implementation of national-level policies and frameworks.

### **Summary of areas for advocacy, research and programme implementation**

1. Civil society groups (e.g. women's rights groups, youth advocates and disability rights groups) can use this report to advocate that greater attention be given in policies to populations with increased risks or in vulnerable situations, particularly with respect to adolescent girls, young women, and women and girls with disabilities.
2. United Nations agencies can use these findings in their advocacy efforts for better-coordinated multisectoral prevention and response services, by bringing together sectoral ministries within countries and using this report to encourage the implementation of an essential VAW services package and use of the *RESPECT women* prevention framework to guide VAW policies and programmes.
3. Parliamentarians can introduce, endorse and vote in laws and policies that effectively address VAW, including ensuring that budgetary allocations are made for implementation of evidence-informed VAW policies and programmes.
4. Donors can use this report's findings to guide their sectoral and multisectoral investments to integrate evidence-informed strategies for VAW prevention and response, with particular attention to investments in sexual, reproductive, maternal, adolescent and mental health plans and emergency preparedness and response plans, among others.
5. Policy researchers can use these data to assess and compare implementation of policies against government intentions, and to highlight areas of strength and weakness in both policy-making and implementation. They can also identify methods to gather and track policy data with respect to VAW.

Numerous commitments have been made by national and international policy-makers to prevent and respond to VAW. The increase in reports of VAW during the COVID-19 pandemic makes it ever more urgent that policy commitments are strengthened, monitored and implemented. The findings in this report present a picture of a glass half full. They act as an urgent call to action for WHO Member States – not only for their ministries of health, but for several other sectoral ministries and also legislators, policy-makers and others who allocate budgets, design, plan, implement and monitor programmes that can contribute to ending VAW. These results provide a tool for advocates to hold all duty bearers accountable to their policy commitments. They also help donors, United Nations agencies and others to target their support to specific areas of VAW prevention and response policies and programmes that need to be further strengthened. Every woman has a right to live a life free of violence and coercion, and duty bearers have the responsibility to ensure that policies are designed and implemented to respect, protect and fulfil this human right.

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