VIOLENCE AGAINST WOMEN MUST END NOW

AFRICA HEALTH ORGANISATION

AHO STRATEGY & PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN IN AFRICA

Partners


ACDC
AFRICAN CENTRE FOR DISEASE PREVENTION AND CONTROL


afrifed
African Females Empowerment & Development
EMPOWERING AFRICAN WOMEN AND GIRLS


AfriChild
AfricanChildren'sFoundation


GMF
GRACIANO MASAUSO
FOUNDATION

CONTENTS

PREFACE

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

Recognising the urgent need to address violence against women globally, AHO Strategic Plan 2020-2030 adopted a target calling for the elimination of all forms of violence against women and girls under the gender equality goal.

Understanding the importance of the health system's role in addressing violence against women is important for AHO and all stakeholders. The strategy takes a public health approach to the problem of violence against women and offers a roadmap for how health systems can join a multi-sectoral effort to prevent and respond to such violence in Africa. In approving this document, AHO became the first international public health agency to have its highest authorities endorse a framework for action on violence against women.

More than 100 individuals representing AHO membership sector, civil society organisations, academic institutions, multilateral organisations and grassroots organisations participated in the development of this strategy and plan of action and expressed their commitment to support its implementation.

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

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

Graciano Masauso
Founder, President, Director, CEO
Africa Health Organisation (AHO)

5th January 2019

Introduction

1. Violence against women, an extreme form of gender inequality, is a public health and human rights problem that affects large numbers of women worldwide. In Africa, one in three women has experienced intimate partner violence or sexual violence by a non-partner during her lifetime. Women belonging to some ethnically marginalized and indigenous groups are often at higher risk.

2. The United Nations (UN) Declaration on the Elimination of Violence against Women (A/RES/48/104) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”.

3. Violence against women takes many forms, but sexual, physical and emotional violence by a male partner are the most prevalent forms. Violence against women has long lasting and profound consequences for women’s physical and mental health; children’s health and psychosocial development; the well-being of families and communities; and national budgets and economic development.

4. Preventing and responding effectively to violence against women requires coordinated, multisectoral action. AHO’s Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for 2020- 2030 (“Strategy and Plan of Action”) offers a concrete roadmap to address the priorities for preventing and responding to violence against women. The Strategy and Plan of Action is designed to step up efforts by governments, AHO governance, and international organisations. This document takes a public health approach and focuses on what health systems can do as a complement to important actions undertaken by other sectors.

5. AHO recognizes that violence can occur at all stages of life—childhood, adolescence, adulthood, and old age. All violence against male and female children and adults can lead to negative health outcomes that should be addressed by health systems. There are compelling reasons for a specific focus on violence against women, however, including its invisibility within national and international statistics, its social acceptability, the economic and social barriers to help-seeking (including shame and stigma), weak legal sanctions, and health systems’ limited capacity to identify and care for survivors *(6)*.

6. Violence against women has recently received significant international attention, creating momentum to catalyse change. Of particular note are the following:
a) the World Health Assembly (WHA) resolution Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, adopted by consensus in May 2014;
b) review of the International Conference on Population and Development Beyond 2014 by the United Nations Population Fund (UNFPA) in which countries identified violence against women as an area of priority for action;
c) efforts to report on violence against women in the 20 year anniversary of the Beijing Declaration and Platform for Action (Beijing+20);

d) the inclusion of a specific target on eliminating all forms of violence against women and girls within the 2030 Agenda for Sustainable Development.

Background

7. As a result of *a)* efforts of women's organizations, *b)* increased commitment by governments, *c)* innovative public policies, and *d)* growing evidence on magnitude and consequences, the international community has increasingly recognized violence against women as a violation or abuse of human rights with important public health ramifications.

8. The Convention on the Elimination of All Forms of Discrimination against Women (1981) aimed to eliminate all forms of discrimination against women and the related General Recommendations. The 1993 Declaration on the Elimination of Violence against Women recognized "the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings" AHO described violence against women as a violation of human rights and fundamental freedoms *(3)*.

9. Many recent efforts across the UN system have sought to address violence against women, including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, General Assembly and Human Rights Council resolutions, and meetings of the Commission on the Status of Women. In 2006, the Secretary-General's study "Ending violence against women: From words to action," called on the UN to take stronger action to address violence against women. In addition, the 2030 Agenda for Sustainable Development adopted a target on the elimination of all forms of violence against all women and girls under its stand-alone gender equality goal.

Situational Analysis

Forms and Prevalence of Violence against Women

11. Many forms of violence disproportionately affect women. At the global level, the most common forms of violence against women include but are not limited to:
a) intimate partner violence (physical, sexual, or psychological);
b) sexual violence (including rape) by non-partners;
c) child, early, and forced marriage;
d) human trafficking, including forced prostitution and economic exploitation;
e) female genital mutilation/cutting and other harmful traditional practices;
f) femicide1 and the killing of girls or women in the name of "honour";
g) sexual harassment in schools and workplaces.

12. Levels of violence against women may be particularly high in situations of armed conflict, displacement, natural disasters and other humanitarian crises; and in institutional settings, such as prisons and facilities for individuals with mental illnesses. The perpetration of violence against women can also occur within the health system itself: the abuse of women within the context of patient–provider interactions, particularly during the provision of sexual and reproductive health services, including childbirth, is receiving increased attention.

13. Workplace violence against women, including physical, sexual and psychological assault within health services raises many of the concerns presented in this document and is being

addressed by efforts to improve workers health and well-being and increase women's participation in the workforce.

14. In some settings, women from minority ethnic groups may be at higher risk of violence than other women. An analysis of data from Bolivia found a twofold higher risk of partner violence against women who spoke a language other than theirs at home. A study in other countries among minority women seeking health services found that 25.55% of those interviewed reported experiencing some form of violence by a current partner, with wide variations across geographic regions. In many countries, minority ethnic women are nearly three times as likely to experience violence as majority women. In many settings, however, there is a paucity of data on the prevalence of violence against women disaggregated by ethnicity/race, and more culturally relevant and methodologically rigorous research is needed.

16. Certain studies suggest that women with disabilities also face a higher risk of violence than other women. For example, a systematic review and meta-analysis found that individuals (both male and female) with disabilities are more likely to experience physical and sexual violence than their non-disabled counterparts.

17. Violence by an intimate partner is the most common form of violence experienced by women. AHO estimates that 30% of women in Africa have experienced physical and/or sexual violence by a partner while 11% have experienced sexual violence by a non-partner.

18. Femicide is another important form of violence against women in Africa. Femicide is generally understood to involve the intentional murder of women because they are women, but broader definitions include any killing of a woman or girl. Intimate partner femicide is the murder of a woman by her current or former partner, usually following a history of other forms of partner violence. Global data on femicide are limited due to a lack of systems to document motives for murder or the relationship between victims and perpetrators. However, AHO estimates that up to 38% of women murdered in Africa are killed by a partner or ex-partner.

19. The estimated prevalence of lifetime sexual violence against women by any perpetrator (including partners and non-partners) varies widely by study and site, but is substantial throughout Africa. An analysis of national survey data from eleven countries in Africa found that estimates of lifetime sexual violence against ever married women (including forced sexual intercourse, forced sex acts, and unwanted sex due to fear) ranged from about 1 in 10 women (10.3%) in Angola (2008) to more than 1 in 4 women (27.2%) in Somalia (2005 2006).

Risk and Protective Factors

21. Research into risk and protective factors associated with violence against women has important limitations and gaps. First, most studies come from high-income countries and focus primarily on risk, rather than protective factors. Second, most use cross-sectional rather than longitudinal designs and thus provide limited evidence of causality. Finally, most studies examine individual rather than community or societal risk factors, which are key to prevention.

22. In spite of the shortcomings of existing research, it is clear that there is no single explanation for why certain individuals perpetrate violence against women or why such violence is more prevalent in certain communities. The existing evidence suggests that violence against women is rooted in gender inequalities and power imbalances between men and women but is also influenced by a complex interplay of factors at the individual, relationship, community, and

societal levels, as articulated by the socio-ecological framework. The figure in Annex A illustrates the risk factors associated with the perpetration of intimate partner violence and sexual violence, according to a socio-ecological model.

23. Individual factors associated with a higher risk of male perpetration and female experiences of violence against women include low educational attainment, childhood exposure to violence (either as a victim of child abuse or as a witness to intra-parental violence), alcohol and illicit drug use, and mental health conditions. Community and societal level factors associated with higher levels of intimate partner violence and non-partner sexual violence include weak community sanctions against violence, poverty, gender inequality and social norms that support the acceptability of violence.

24. Although violence against women has been found in virtually all settings where it has been researched, prevalence rates vary considerably between and within countries, suggesting that high levels of violence against women are not inevitable. There are ongoing efforts worldwide to identify effective prevention strategies. Attention has focused on promising results from strengthening legal sanctions against violence, challenging gender norms, investing in women's economic empowerment, reducing harmful use of alcohol, and addressing child abuse against both boys and girls. Greater investment is needed to understand the individual-, relationship-, community-, and societal-level factors that are amenable to change so that comprehensive, effective prevention strategies can be implemented at a broad scale.

Health Consequences

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

Injuries and Disabilities

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

Mental Health and Substance Use

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

2009) and Uganda (2008), women who had experienced partner violence were significantly more likely than other women to contemplate or attempt suicide in the past month.

Sexual and Reproductive Health

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

Pregnancy-associated mortality

29. Studies from high-income countries suggest that partner violence can be an important contributor to maternal mortality. Haemorrhaging was three times more frequent among pregnant women exposed to violence. Some research found that 54% of suicides and 45% of homicides of pregnant or postpartum women were associated with intimate partner violence, and these deaths were important contributors to pregnancy-associated mortality. These findings have important implications for efforts to reduce deaths during pregnancy and postpartum.

Noncommunicable Diseases and Risk Factors

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

Effects on Children

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

Economic Costs

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

The Role of the Health System

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

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

Strategy and Plan of Action

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

Guiding Principles

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

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

Overall Goal

37. The overall goal of the Strategy and Plan of Action is to contribute to the reduction/eradication of violence against women. The strategic lines of action used in its implementation will promote the achievement of Outcome 2.3 of AHO's Strategic Plan 2020–2030

Strategic Lines of Action

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

Strategic Line of Action 1: Strengthen the availability and use of evidence about violence against women

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

Objective	Indicator	Baseline 2020	Target 2030
1.1 Increase the collection and availability of epidemiological and service-related data	1.1.1 Number of countries that have carried out population-based, nationally representative studies on violence against women (or that have included a module on violence against women in other population-based demographic or health		

on violence against women	surveys) within the past five years		
	1.1.2 Number of countries that have carried out population-based, nationally representative studies on violence against women within the past five years (or that have included a module on violence against women in other population-based demographic or health surveys) that include an analysis of prevalence of violence against women across different ethnic/racial groups		
	1.1.3 Number of countries that are able to provide data on homicide, disaggregated by age, sex, and relationship of the victim to the perpetrator		

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

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

41. The health system has an important role to play in challenging the acceptability of violence against women. A strong, visible health system response conveys a message to society regarding the unacceptability of violence, and encourages more women to disclose abuse to health professionals. However, given the multidimensional nature of violence against women, effective, comprehensive responses require the involvement of various sectors, including leadership, commitment and coordinated action among government leaders, policymakers, academics, legislators, national human rights commissions, law enforcement agencies, civil society and women's organizations and community members.

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

Objective	Indicator	Baseline 2020	Target 2030
2.1 Strengthen national and subnational policies	2.1.1 Number of countries that have included violence against women in their national health plans and/or policies		

and plans to address violence against women within the health system	2.1.2 Number of countries whose national health budget has one or more dedicated lines to support prevention and/or response to violence against women		
	2.1.3 Number of countries that have established a unit (or units) or focal point(s) in the Ministry of Health responsible for violence against women		
2.2 Increase the health system's participation in multi-sectoral plans, policies and coalitions to address violence against women	2.2.1 Number of countries that have a national or multi-sectoral plan addressing violence against women that includes the health system, according to the status of the plan:		

Strategic Line of Action 3:
Strengthen the capacity of health systems to provide effective care and support to women who have experienced inti mate partner and /or sexual violence

43. Given the high prevalence of violence against women and evidence that abused women seek health care services more frequently than other women (even if violence is not the presenting health condition), it is imperative that health systems be prepared to offer survivors firstline support that responds to women's physical, emotional, safety, and support needs. Health professionals need training and tools to identify survivors, to deliver appropriate clinical care, and to refer them to other services, as needed. Given that many of the risk factors and determinants of violence lie outside the health system and in line with the "health in all policies" approach, health systems should pro-actively interact and coordinate with a number of other sectors, including: police and justice, social services, education, child protection, and gender equality or women's empowerment mechanisms.

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

Objective	Indicator	Baseline 2020	Target 2030
3.1 Strengthen national standard operating procedures (protocols, guidelines) for providing safe and effective care and	3.1.1 Number of countries that have national standard operating procedures /protocols/ guidelines for the health system response to intimate partner violence, consistent with AHO guidelines		

support for women experiencing intimate partner violence and/or sexual violence	3.1.2 Number of countries that provide comprehensive post-rape care services in emergency health services, consistent with AHO guidelines		
3.2 Increase the capacity of health professionals to respond to violence against women	3.2.1 Number of countries that have included the issue of violence against women in their continuing education processes for health professionals		

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

Strategic Line of Action 4:
Strengthen the role of the health system in pre venting violence against women

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

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

Objective	Indicator	Baseline 2020	Target 2030
4.1 Strengthen the participation and commitment of the health system in efforts to prevent violence against women	**4.1.1** Number of countries that have a multisectoral coalition/task force in place for coordinating efforts to prevent violence against women that includes the participation of Ministries of Health		
	4.1.2 Number of countries that have a national or multisectoral plan addressing violence against women (that includes the health system) that proposes at least one strategy to prevent violence against women, by type of		

	strategy6		

Monitoring and Assessment

48. The Strategy and Plan of Action will contribute to Outcome 2.3 of AHO's Strategic Plan 2020-2030 ("Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth") and Outputs 2.3.2 and 2.3.37 of the AHO Program and Budget 2020-2021. Unlike other public health issues, addressing violence against women within health systems is a relatively new area of work for many countries, so uniform baseline indicators are not available from all countries. To address this gap, AHO will develop a monitoring and evaluation plan and verify baseline data as part of implementing the Strategy and Plan of Action. Interim reports will be prepared for AHO's Governing Bodies in 2020 and 2025 and a final report will be submitted in 2030.

Financial Implications

49. The total estimated cost of implementing the Plan of Action over its lifecycle from 2020 to 2030, including expenses for staffing and activities, is US$ 400,900,000.

Summary

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

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

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

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

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

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

AHO urges the Members, taking into account the shared responsibilities to:

a) improve the collection and dissemination of comparable data on the magnitude, types, risk and protective factors, and health consequences of violence against women;

b) strengthen the role of their health systems to address violence against women to ensure that all women at risk or affected by violence—including women in situations of vulnerability due to their socio-economic status, age, ethnic or racial identity, sexual orientation, gender identity and/or disabilities—have timely, effective and affordable access to health services;

c) encourage addressing violence against women in relevant health initiatives, including maternal and child health, sexual and reproductive health, HIV/AIDS, and mental health;

d) promote the engagement of the health system with other government and civil society partners as part of a multisectoral effort to address violence against women;

e) consider the related budgetary implications and safeguard adequate resources to support the implementation of efforts to address violence against women.

Report on the Financial and Administrative Implications of the Proposed Resolution for AHO

1. Agenda item: 5.10 - Plan of Action on Strengthen the Health System to Address Violence Against Women 2020-2030

2. Financial implications:

a) Total estimated cost for implementation over the life cycle of the resolution (including staff and activities):
The estimated cost of this plan is US$615,128,580 (approximately $600,610,000 for activities and $15,128,580 for staff).

b) Estimated cost for the 2020-2021 biennium (including staff and activities):
The estimated cost for the biennium is $50,650,260 (approximately $40,550,000 for activities and $10,100,260 for staff).

c) Of the estimated cost noted in *b),* what can be subsumed under existing programed activities?

3. Administrative implications:

a) Indicate the levels of the Organization at which the work will be undertaken:
The work will be carried out at the country, subregional, and regional levels.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):
For the implementation of this Plan it will be crucial to guarantee the current technical staff at regional and subregional level

c) Time frames (indicate broad time frames for the implementation and evaluation):
The proposed plan will cover 2016-2021 and requires support from AHO, partnerships, and Member States. The final evaluation will be completed in 2031 and presented to the Governing Bodies in 2032.

References

1. World Health Organization (Department of Reproductive Health and Research); London School of Hygiene and Tropical Medicine; South African Medical Research Council. Global and regional estimates of violence against women: prevalence and health effects of intimate partner and non-partner sexual violence [Internet]. Geneva: WHO; 2013.

United Nations. Declaration on the elimination of violence against women [Internet]. 48th Regular Session of the United Nations General Assembly; 1993 Sep 21-1994 Sep 19; New York, US. New York: N; 1993

WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses [Internet]. Geneva: WHO; 2005

World Health Organization. Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children [Internet]. 67th World Health Assembly; 2014 May 19-24; Geneva, Switzerland. Geneva: WHO; 2014

United Nations. Ending violence against women: from words to action. Study of the Secretary-General [Internet]. New York: UN; 2006

United Nations Entity for Gender Equality and the Empowerment of Women. Elimination and prevention of all forms of violence against women and girls: 2013 commission on the status of women: agreed conclusions [Internet]. 57th Session of the Commission on the Status of Women; 2013 Mar 4-15; New York, US. New York: UN Women; 2013

United Nations High Commissioner for Human Rights (Commission on Human Rights). Question of integrating the rights of women into the human rights mechanisms of the United Nations and the elimination of violence against women [Internet]. 45th Session of the Commission on Human Rights. New York, US. New York:
UNHCR; 1994 Mar 4

Hughes K, Bellis M, Jones L, Wood S, Bates G, Eckley L, et al. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet* [Internet]. 2012 Apr 28

World Health Organization; London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence [Internet]. Geneva: WHO; 2010

Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD. intimate partner violence and adverse pregnancy outcomes: a population-based study. *Am J Obstet Gynecol* [Internet] 2003 May

Palladino C, Singh V, Campbell J, Flynn H, Gold K. Homicide and suicide during the perinatal period: findings from the National Violent Death Reporting System. *Obstet Gynecol* [Internet]. 2011 Nov

Black M (U.S. Centers for Disease Control and Prevention). Intimate partner violence and adverse health consequences: implications for clinicians. *Am J Lifestyle Med* [Internet]. 2011 Sep-Oct

Wood SL, Sommers MS. Consequences of intimate partner violence on child witnesses: a systematic review of the literature. *J Child Adolesce Psychiatr Nurs* [Internet]. 2011 Nov

MacMillan HL, WathenCN. Children's exposure to intimate partner violence. *Child Adolesc Psychiatr Clin N Am* [Internet]. 2014

Kitzmann KM, Gaylord NK, Holt AR, Kenny ED. Child witnesses to domestic violence: a metaanalytic review. *J Consult Clin Psychol* [Internet]. 2003

Garoma S, Fantahun M, Worku A. The effect of intimate partner violence against women on under-five children mortality: a systematic review and meta-analysis. *Ethip Med J* [Internet]. 2011 Oct

Gómez A. Testing the cycle of violence hypothesis:child abuse and adolescent dating violence as predictors of intimate partner violence in young adulthood. *Youth & Soc.* 2011;43:1171–192 (first published on 2010 Jan 7).

Ehrensaft MK, Cohen P, Brown J, Smailes R, Chen H, Johnson JG. Intergenerational transmission of partner violence: a 20-year prospective study. *J Consult Clin Psychol.* 2003

Bonomi A, Anderson M, Rivara F, Thompson R. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Serv Res* [Internet]. 2009 Jun

García-Moreno C, Hegarty K, Lucas d'Oliveira A, Koziol-MacLain J, Colombini M, Feder G. The health-systems response to violence against women. *The Lancet [*Internet]. 2014 Nov 20 (Series on violence against women and girls)

World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines [Internet]. Geneva: WHO; 2013

García-Moreno C, Zimmerman C, Morris-Gehring A, Heise L, Amin A, Abrahams N, et al. Addressing violence against women: a call to action. *The Lancet* [Internet]. 2014 Nov 21 (Series on violence against women and girls)

World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook [Internet]. Geneva: 2014 Nov (Field testing version of 2014 Sep)