

ADDRESSING VIOLENCE AGAINST WOMEN IN HEALTH POLICIES AND PROTOCOLS IN THE AMERICAS

A regional status report



PAHO



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

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Washington, D.C., 2022

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ABBREVIATIONS AND ACRONYMS

GBV	gender-based violence
HIV	human immunodeficiency virus
IPV	intimate partner violence
LGBTI	lesbian, gay, bisexual, transgender/transsexual, and intersex
MCH	maternal and child health
MoH	Ministry of Health
NCD	noncommunicable disease
NCPI	National Commitments and Policy Instrument
NHPSPs	National Health Policies, Strategies and Plans
PAHO	Pan American Health Organization
PEP	post-exposure prophylaxis
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PTSD	post-traumatic stress disorder
RESPECT	acronym used for framework for prevention of violence against women
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
SDGs	Sustainable Development Goals
SRH	sexual and reproductive health
SRMNCAH	sexual, reproductive, maternal, newborn, child, and adolescent health
STI	sexually transmitted infection
SV	sexual violence
UN	United Nations
VAC	violence against children
VAW	violence against women
WHO	World Health Organization

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PREFACE

Violence against women and girls is a serious public health and human rights problem in the Region, with devastating consequences – for the health, well-being and lives of women and girls, their families and communities. According to estimates by the World Health Organization (WHO), one in three women in the Americas has suffered physical or sexual violence in her lifetime. This situation is unacceptable and must change.

The sheer numbers of women and girls affected by violence in this Region are particularly shocking because we know that violence is preventable. Today we know more than ever before about what works to prevent violence against women. The Governing Bodies of the Pan American Health Organization, made up of Ministers of Health of its Member States, were the first WHO region to adopt a Regional Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women in October 2015. Since then, substantial progress has been made in developing and implementing health policies and protocols, in improving quality of and access to essential services for survivors and in strengthening multisectoral collaboration in line with evidence-based standards and targets designed to advance the prevention and response to violence against all women and girls. It is essential that the status described in this report is not lost, but rather built upon and expanded in order to empower women and girls across the Americas to enjoy long and healthy lives.

Attention to this topic is especially timely right now, as we come together to build back better in the context of COVID-19. The pandemic has not only increased the urgency for action to prevent violence in all its forms as well as the visibility of this important agenda with policymakers, program managers, civil society representatives and communities themselves. The findings and lessons learned documented in this report can help guide future efforts to sustain and expand progress in the Region.

PAHO stands ready to work with countries and partners to expand the evidence base on what works, to improve health system responses, to strengthen prevention and response capacities, and to continue to monitor and report on advances to prevent violence in all its forms.

Together, we will end violence against all women and girls in the Americas.

Dr. Anselm Hennis

Director, Department of Noncommunicable Diseases and Mental Health
Pan American Health Organization

EXECUTIVE SUMMARY

Violence against women (VAW) is a persistent and wide-ranging public health, social justice, and human rights problem in the Region of the Americas. From young girls to older women, one out of every three experiences physical and/or sexual violence in her lifetime, mostly by an intimate partner. Twenty-eight Member States in the Region of the Americas rely on VAW estimates, with prevalence rates for lifetime intimate partner violence ranging from 14% in Cuba to 42% in the Plurinational State of Bolivia. The importance of having quality prevalence data on VAW is underlined by the Strategic Plan of the Pan American Health Organization 2020–2025, the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, as well as the Sustainable Development Goals (**Box EX1**).

BOX EX1. Sustainable Development Goals (SDGs) and violence against women



Violence against women cuts across multiple SDGs, including but not limited to Goals 3 (health), 4 (education), 10 (inequality), 11 (cities and safe spaces) and 16 (peace and justice). It is explicitly highlighted in Goal 5.



Goal 5 Achieve gender equality and empower all women and girls.

Target 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

The SDGs are also noteworthy as they include for the first time globally agreed, measurable indicators related to violence against women that countries are committed to achieving and monitoring. These include:



Indicator 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age.



Indicator 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence.

Source: United Nations. Transforming our world: the 2030 agenda for sustainable development. New York: United Nations; 2015 [Accessed 1 July 2022]. Available from: <https://sdgs.un.org/2030agenda>

The consequences of VAW in all its forms are significant. Studies have linked violence to a broad range of physical, sexual, reproductive, and mental health problems. These range from deaths to injuries requiring emergency treatment, unintended pregnancies, sexually transmitted infections and gynecological problems, as well as mental illness and the adoption of unhealthy behaviors that can increase the risk of noncommunicable diseases. Beyond the costs for women's health and well-being, violence affects their children, families, and communities. Exposure to or witnessing violence in the home not only has an impact on a child's emotional health and behavior, it can also increase the risks of a child experiencing or perpetrating violence later in life.

The burden of violence on women and girls, their families and communities is especially challenging because these costs are preventable. Evidence shows that violence against women and girls can be prevented and its consequences can be mitigated. The health sector plays a vital role in identifying, responding to and preventing VAW in collaboration with other sectors and partners. This role includes helping to identify abuse early and providing survivors with quality care, anchored in evidence-based health protocols and clinical guidance, showcasing leadership and advocating for a public health approach, informed by strong health policy agendas that address violence, and collaborating with other government sectors and partners to advance multisectoral action on VAW.

Violence against women is not a new topic in the Region. The Americas is the Region that developed and approved the first international human rights treaty specifically addressing violence against women—the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, known as the Belém Do Pará Convention, signed on 9 June 1994.

The Governing Bodies of the Pan American Health Organization (PAHO), made up of Ministers of Health of its Member States in the Americas, were the first WHO region to adopt a regional Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women during the 54th Directing Council and the 67th Session of the Regional Committee for the Americas of the World Health Organization (WHO), on 1 October 2015 (see Box EX2).

One year later, the Strategy informed the development of a WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence against women, girls and children. Both the regional and global strategies apply a public health approach to the prevention of violence against women and offer a roadmap for how health systems can join a multisectoral effort to prevent and respond to such violence.

The Region is home to many examples of national policies and laws, strategies and plans, programs and action across countries, regions and communities to prevent and respond to violence against women and girls. Progress in the Americas has been supported by years of advocacy, social mobilization, and related efforts by civil society organizations, including women's organizations and movements. Given this experience and the burden of violence on the population, the Region has an important perspective to contribute to this topic. Member States from the Region have repeatedly stressed the need to give more visibility to regional examples of progress, and this report is a direct response to this request.

BOX EX2. PAHO Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, 2015–2025

The Strategy includes four strategic lines of action, as well as specific indicators to measure progress under each:

STRATEGIC LINE OF ACTION 1: Strengthen the availability and use of evidence about violence against women

Selected indicators include:

- 1.1.1 Number of Member States that have carried out population-based, nationally representative studies on violence against women (or that have included a module on violence against women in other population-based demographic or health surveys) within the past five years

STRATEGIC LINE OF ACTION 2: Strengthen political and financial commitment to addressing violence against women within health systems

Selected indicators include:

- 2.1.1 Number of Member States that have included violence against women in their national health plans and/or policies

STRATEGIC LINE OF ACTION 3: Strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or nonpartner sexual violence

Selected indicators include:

- 3.1.1 Number of Member States that have national standard operating procedures/protocols/guidelines for the health system response to intimate partner violence, consistent with WHO guidelines
- 3.1.2 Number of Member States that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines

STRATEGIC LINE OF ACTION 4: Strengthen the role of the health system in preventing violence against women

Selected indicators include:

- 4.1.2 Number of Member States 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 strategy

Source: Pan American Health Organization. Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women [Internet]. Washington (DC): 2015 [Accessed 9 October 2022]. Available from: <https://www.paho.org/en/documents/strategy-and-plan-action-strengthening-health-system-address-violence-against-women-0>

OBJECTIVES, METHODS, AND AUDIENCE

The report is particularly noteworthy as it is the first of its kind in the Region of the Americas allowing a closer look at key indicators of progress in line with commitments made under the Strategy and Plan of Action. It addresses health policymakers, including Ministry of Health focal points on violence prevention, as well as those working with the health sector, including representatives of other government sectors, civil society organizations, academia and partners at the national, subregional, and regional levels engaged in strengthening the prevention and response to violence against women and girls. The report specifically aims to:

- **Highlight challenges and achievements in the Americas in the prevention and response to violence against women in line with selected indicators of the Strategy and Plan of Action on violence against women and related PAHO/WHO guidance;**
- **Analyze Region-specific lessons learned to inform future policy and practice in countries; and**
- **Mobilize stakeholders in the Region to deepen dialogue, strengthen partnerships and act on findings to prevent and respond to violence against women and girls.**

The report draws on data collected as part of the progress monitoring on the Strategy and Plan of Action on VAW and expands the analysis with a focus on indicators that would benefit from a more in-depth document review, including those related to health policies and plans, health system protocols and guidelines and national multisectoral policy.

Findings from the policy review are complemented by information collected as part of a PAHO survey of Member States, as well as data from the National Commitments and Policy Instrument (NCPI) survey, which is administered by the Joint United Nations Programme on HIV and AIDS (UNAIDS) as a component of the Global AIDS Monitoring platform. This report is also informed by a collaboration with WHO to develop a global policy database on VAW and related global analysis of data on indicators in the WHO global plan of action and draws on data from the global database.

SUMMARY OF FINDINGS

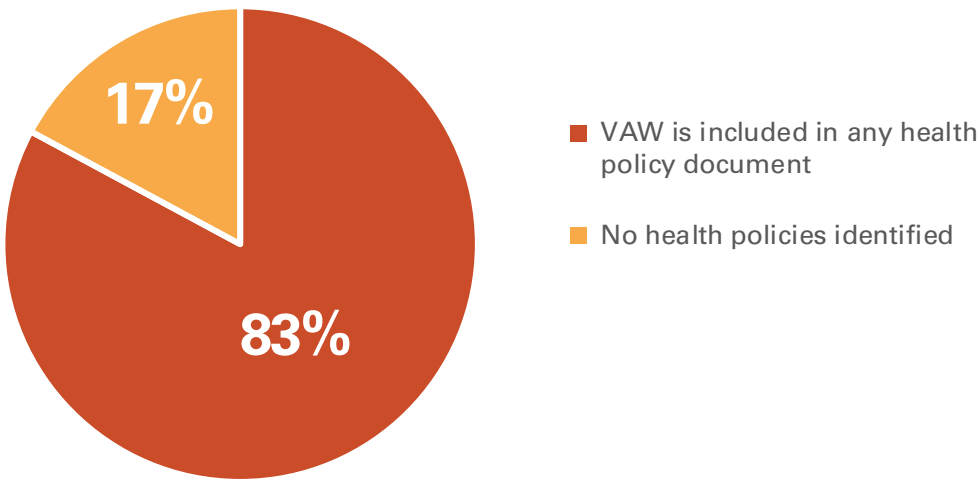
While the multidimensional nature of VAW requires the involvement and commitment by various actors, effective leadership by the health sector is a critical factor in advancing countries’ prevention and response efforts. A strong, visible health system response conveys a message to society regarding the unacceptability of violence and encourages more survivors to seek help.

As highlighted by the Strategy and Plan of Action on VAW, a key starting point for strengthening health sector leadership is the integration of content, evidence, and responses relating to VAW into national and subnational policies and plans within the health system, including national health strategic plans.

As this report highlights, 83% of Member States have included VAW in their health plans or policies (see **Figure EX1**). Such a reference in a policy document can set the tone for the future engagement of health actors on VAW, establish a mandate, and set goals and targets for action, including priorities for strengthening access to and the quality of health services for survivors.

The depth of references to violence differs greatly across policy documents, with only 63% of Member States recognizing VAW as a strategic priority in their health policies. This points to an important policy agenda item for the Region to keep strengthening attention to VAW in national health policies, strategies, and plans.

Figure EX1. Percentage of Member States that have included VAW in their national health plans and/or policies



When women and girls experience violence, the health system plays a key role in responding to their needs, preventing further harm, and mitigating the consequences of violence. Survivors of violence often name health workers as the first professional contact to whom they would go for help. Evidence further suggests that even when violence is not the presenting condition, survivors seek healthcare services more frequently than other women.

It is therefore imperative that health systems be prepared to offer survivors comprehensive trauma-and violence-informed care and support that responds to women's physical, emotional, safety, and support needs. This is underlined by the Strategy and Plan of Action, which includes a strategic line of action on strengthening the capacity of health systems to provide effective care and support to women who have experienced intimate partner and/or sexual violence.

A milestone for a strong health system response to VAW is the existence of at least one health sector protocol on VAW, offering information on services and care to be provided to survivors of violence. Sixty percent of Member States have national standard operating procedures, protocols or guidelines for their health system's response to VAW. These protocols are critical for guiding good quality health service delivery and can also be useful in the training and professional development of health workers. Countries may have one national health sector VAW protocol or several ones focusing on specific forms of violence, specific settings or specific groups of survivors.

While the sheer number of protocols is a substantial achievement for the Region, more efforts are needed to strengthen the quality of documents and their alignment with current evidence. A closer look at the content of the protocols highlights that only 40% of Member States included all four criteria consistent with WHO guidelines defined in the regional Plan. However, there was some nuance across the four criteria among the Member States: 54% included some aspect of first-line support; 57% mentioned measures to enhance a woman's safety; 49% included referrals to other essential services, (e.g., legal support); and 54% mentioned the provision (directly or via referrals) of mental health care.

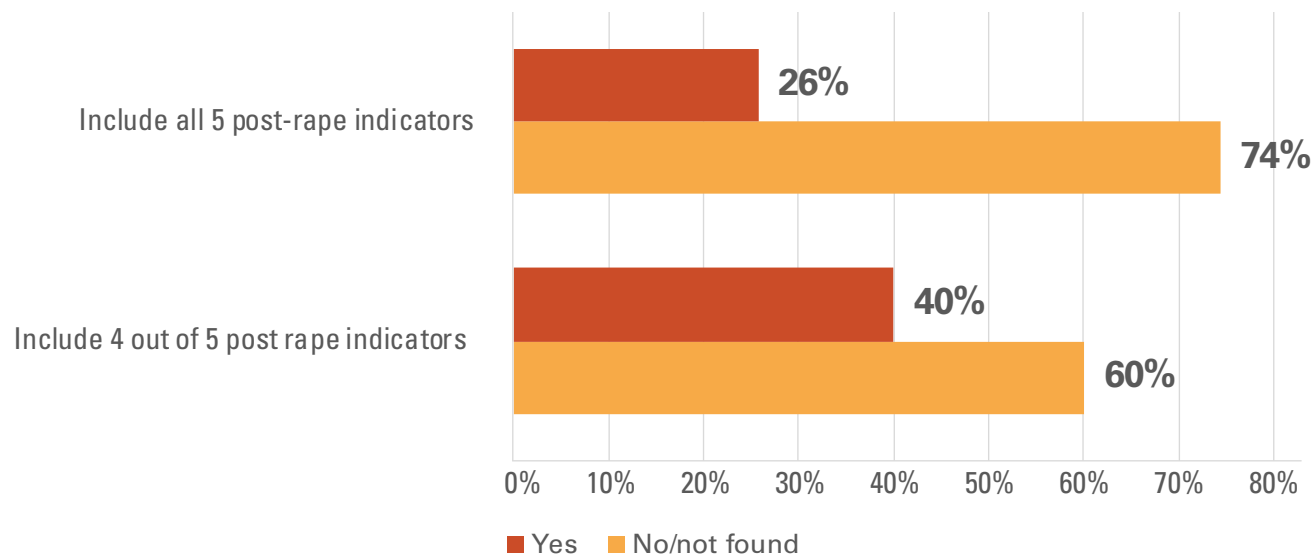
Sexual violence is a particularly severe challenge in the Americas, requiring timely intervention by the health system to mitigate the consequences for survivors’ health and well-being. Comprehensive post-sexual assault (post-rape) care services in emergency health services is defined to include:

- a) First-line support and psychological first aid;
- b) Emergency contraception to women who seek care within five days;
- c) Referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law;
- d) Sexually transmitted infection and/or HIV post-exposure prophylaxis, per applicable protocols; and
- e) Hepatitis B vaccination.

While a text reference to these criteria does not necessarily mean these services are readily available and accessible, it is an important starting point for them to be specifically mentioned in protocols that outline the health system response to VAW.

Figure EX2 shows that 26% Member States include all five indicators that comprise the post-rape care services indicator from the regional Plan. Forty percent of Member States include four out of five of these indicators. Of the five indicators, 54% Member States make reference to first-line support and 49% to emergency contraception and prophylaxis for STIs and/or HIV.

Figure EX2. Percentage of Member States that mention comprehensive post-rape care services in their health sector VAW protocols



Hepatitis B vaccination is mentioned by 43% of Member States in their protocols. One area for improvement relates to abortion in accordance with national law, as under one-third of Member States (29%) mention it in their protocols.

Attention to post-rape care is particularly timely in the context of the COVID-19 pandemic, which increased the visibility of the issue and opportunities for change. There is a need to continuously expand advocacy for the inclusion of post-rape care in health policies and protocols, including its core components and its evidence base, aligned with broader efforts to strengthen capacities among ministries of health and other stakeholders in improving services available to survivors of sexual violence through improved access. Explicit reference to essential post-rape care services in policies and protocols is an important step in meeting survivors' needs and preferences.

Health systems can also play a key role in multisectoral 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; and
- 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, social services, police and justice), and collaborate with national multisectoral coordination mechanisms and civil society organizations.

An important basis for such collaboration can be provided by a national multisectoral plan that brings together the various efforts of different stakeholders engaged in the prevention and response to VAW. Around 80% of Member States have either a multisectoral VAW policy or a national gender policy that includes VAW in a significant way.

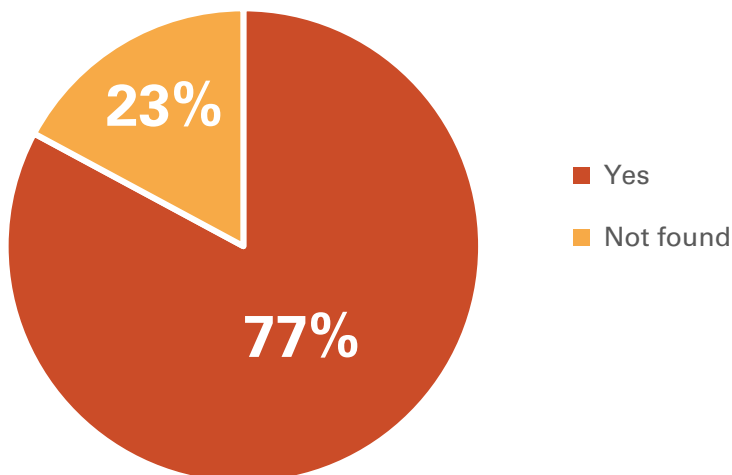
It is crucial that these multisectoral plans be developed with the collaboration of the health sector and that the multisectoral plan/policy be based on the best available evidence with the best potential to prevent and reduce VAW. Accordingly, specific

indicators in the Strategy ask not only about the existence of multisectoral plans but also about plans that propose at least one strategy to prevent violence against women.

RESPECT (see **Box EX3**) refers to a multisectoral and multi-agency framework developed by WHO, UN Women, and partners outlining seven evidence-based strategies to prevent violence against women. In the Region, 77% of Member States include at least one prevention strategy/intervention in their multisectoral plan/policy (see **Figure EX3**). Each Member State that has a multisectoral plan/policy with at least one strategy includes on average seven interventions or approaches associated with RESPECT. However, eight Member States include 1–4 interventions, 13 Member States include 5–9 interventions, and only six Member States include 10 or more interventions.

Ideally, multisectoral plans/policies should include a high number of strategies that when implemented together would work to prevent violence in the short, medium and long term. For this reason, it is important that Member States work not only to meet the regional indicator of having at least one, but also that they move beyond and include many strategies. The level of inclusion of different specific approaches using the RESPECT framework also varies widely, for example with 6% of Member States mentioning couples therapy and 71% of Member States mentioning strategies for raising awareness.

Figure EX3. Percentage of Member States that include at least one prevention strategy/intervention in their multisectoral plan/policy



BOX EX3. RESPECT: seven strategies to end violence against women

Relationship skills strengthened

Empowerment of women

Services ensured

Poverty reduced

Environments made safe

Child and adolescent abuse prevented

Transformed attitudes, beliefs, and norms

Source: World Health Organization. RESPECT women: preventing violence against women [Internet]. Geneva: 2021 [Accessed 9 October 2022]. Available from: <https://www.who.int/publications/i/item/WHO-RHR-18.19>

CONCLUSIONS AND RECOMMENDATIONS

This report is an important milestone on the Region's path toward the goals and targets identified in PAHO's Strategic Plan 2020–2025, the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, as well as related commitments made by Member States. The information analyzed in the report provides an overview of efforts made in countries through the commitment by governments, civil society, professional associations, academia, as well as international partners, and communities.

While substantial efforts have been made to advance the prevention and response to violence against women and girls in the Region, much more remains to be done. As the Region approaches 2025, there is a need to build on these achievements and this knowledge and keep strengthening efforts by that year and beyond.

Key conclusions and recommendations include:

- **Learn from and build on the achievements described in this report and accelerate progress toward the full implementation of the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women and the elimination of all forms of VAW through the development and implementation of evidence-based policies and protocols.**
- **Continue including VAW in new health policies and strengthen integration of VAW in strategic health sector documents, including national health policies, strategies and plans.**
- **Strengthen the scope of information included on VAW in health policies, including framing it as a strategic priority for action by the health sector in collaboration with other sectors.**
- **Strengthen the institutional capacity of the health sector, including MoH focal points on VAW, to implement policy commitments through training, resourcing and ongoing support.**
- **Strengthen the quality of health system protocols and clinical guidelines in line with the evidence base, enshrining the role of health services and health workers in the identification of violence, the provision of first-line support, timely post-rape care and other essential standards.**
- **Strengthen implementation of health system protocols, including through the development of clinical handbooks, job aids and similar reference tools as well as training for health workers.**
- **Continue to strengthen multisectoral policy frameworks and prevention approaches and their alignment with the evidence base and build country capacity on RESPECT, including in the health sector.**

- **Strengthen regional and subregional dialogue across countries and partners in order to boost learning on what works to prevent and respond to VAW in all their diversity.**
- **Improve attention to groups in conditions of vulnerability in policy documents and strengthen guidance for health workers and services based on the circumstances and preferences of each group.**
- **Consider regular service evaluations, including those incorporating the views and preferences of survivors themselves, to monitor progress on the ground and complement policy reviews.**
- **Invest in additional, regular analysis to keep expanding the evidence base on what is known about policies and protocols that prevent and respond to VAW.**
- **Build partnerships across sectors, organizations, and countries to sustain the momentum and take concerted action toward full implementation of the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women and its vision.**

The report should not be seen as the conclusion of, but rather as a key milestone in the process of monitoring and reporting on the status of preventing and responding to violence against women and girls in the Americas. It presents a snapshot of efforts by Member States and their partners, but further and regular analysis would be beneficial to keep expanding the evidence base on what is known about policy and protocols that prevent and respond to VAW.

The report highlights many examples of efforts by governments and their partners in the Region and the great potential for countries and communities to learn from each other, and to help inform the regional and global evidence on violence against women and girls. Attention to violence prevention and response is especially timely in the context of the COVID-19 and the increase in visibility and urgency of action to address this problem. The pandemic has not only increased the risks of violence for many women and girls, it has also exacerbated service gaps, underlining the fundamental role of health systems in contributing to preventing and responding to violence in all its forms. The findings and lessons learned can guide future efforts in sustaining the momentum of the existing achievements and taking concerted action to fill identified gaps vis-à-vis the final years of implementation of the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women.

Violence against women in all its forms is preventable, and its consequences can be mitigated. PAHO is committed to continue working with partners and countries in taking this agenda forward to ensure that women and girls in all their diversity in the Americas are able to live a life without fear and violence, and in health and well-being.



I. BACKGROUND: WHY THIS REPORT IS IMPORTANT

VIOLENCE AGAINST WOMEN AND GIRLS IS HIGHLY PREVALENT IN THE AMERICAS

Violence against women (VAW), defined 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” (1), is an extreme form of gender inequality, and it is a persistent public health and human rights problem in the Region of the Americas.

VAW affects a large portion of the population in the Region. About one in three women and girls have experienced either physical and/or sexual intimate partner violence (IPV) or nonpartner sexual violence in their lifetime (2). VAW takes many forms, all equally unacceptable, IPV being the most common (see **Box 1** and **Table 1** for recent estimates for intimate partner violence and nonpartner sexual violence in the Region). Trends in violence have received new attention in the context of COVID-19.

To understand the true magnitude of violence in the Region, to monitor progress and to inform policy and practice at regional, subregional, and national levels, it is critical that countries regularly conduct population-based studies with representative data measuring the prevalence of VAW and related risk factors and consequences. This has been reiterated by the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, which includes a specific indicator on the number of Member States with prevalence data. According to the latest analysis by the World Health Organization (WHO) and partners, 28 Member States in the Americas rely on VAW prevalence estimates.

BOX 1. Violence against women and girls in the Americas



One in four women aged 15 and older in the Americas has experienced physical and/or sexual violence by an intimate partner in her lifetime.



Almost 1 in 8 (12%) women aged 15 years and older has experienced nonpartner sexual violence in her lifetime.

Source: World Health Organization. Violence against women prevalence estimates, 2018: WHO Region of the Americas fact sheet. Geneva: 2021. Available from: <https://apps.who.int/iris/handle/10665/341592>

Table 1. National prevalence estimates of lifetime and past 12 months physical and/or sexual intimate partner violence (IPV) among ever married/partnered women aged 15–49 years, Region of the Americas, 2018

Region/Member State	Lifetime IPV point estimate (Percentage)	Past 12 months IPV point estimate (Percentage)
Antigua and Barbuda	-	-
Argentina	27	5
Bahamas	-	-
Barbados	-	-
Belize	24	8
Bolivia (Plurinational State of)	42	18
Brazil	23	11
Canada	-	3
Chile	21	6
Colombia	30	12
Costa Rica	27	7
Cuba	14	5
Dominica	-	-
Dominican Republic	19	10
Ecuador	33	8
El Salvador	21	6
Grenada	28	8
Guatemala	21	7
Guyana	31	10
Haiti	23	12
Honduras	17	7
Jamaica	24	7
Mexico	24	10
Nicaragua	23	6
Panama	16	8
Paraguay	18	6
Peru	38	11
Saint Kitts and Nevis	-	-
Saint Lucia	-	-
Saint Vincent and the Grenadines	-	-
Suriname	28	8
Trinidad and Tobago	28	7
United States of America	26	6
Uruguay	18	4
Venezuela (Bolivarian Republic of)	19	8

Note: These estimates were taken from the WHO Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for nonpartner sexual violence against women. For the 95% confidence intervals and for more information on the methodology please see the full report [here](#).

THE CONSEQUENCES OF VAW ARE SEVERE

VAW is rarely an isolated act. For example, IPV tends to escalate and become more severe over time—and without intervention can result in death. The Economic Commission for Latin America and the Caribbean estimates that there were more than 4000 femicides¹ in 2020 across 21 countries of Latin America and the Caribbean. It is important to note that women are at particular risk of violence by someone they know.

Beyond the risk of death, violence—perpetrated by partners or non-partners—can lead to multiple health consequences in the short, medium and long term, including physical, sexual, reproductive, and psychological problems affecting the health and well-being of women and girls (3, 4, 5, 6, 7). Violence can also result in injuries requiring emergency treatment.

It is associated with a range of mental health consequences, including depression, anxiety disorders including post-traumatic stress disorder (PTSD) and self-harm. Experiences of violence increase the likelihood that survivors adopt unhealthy behaviors such as alcohol and drug-use or smoking, behaviors commonly associated with increased risk of noncommunicable diseases. Experiences of sexual violence are moreover associated with a range of negative sexual and reproductive health outcomes, including increased risk of sexually transmitted infections such as HIV, unplanned pregnancy and gynecological problems (8). In the Region, IPV has been shown to be associated with negative health outcomes including increased risk of anemia and lower hemoglobin levels (9), as well as higher tobacco use and reports of sexually transmitted infections (10). As a result, survivors of violence tend to use health services more often (11, 12).

BOX 2. Global deaths at the hands of intimate partners



Globally between **38%** and **50%** of murders of women are committed by intimate partners.

Source: World Health Organization. RESPECT women: preventing violence against women [Internet]. Geneva: World Health Organization; 2021 [Accessed 8 October 2022]. Available from: <https://www.who.int/publications/item/WHO-RHR-18.19>

¹ Defined as annual total number of homicides of women 15 years of age and over killed by gender violence. According to national laws, it is called femicide, feminicide, or aggravated homicide due to gender (33).

In addition, VAW results in substantial socioeconomic costs, including direct economic costs from increased use of services for survivors and their families, as well as the broader negative financial impact on communities and societies. Violence in its various forms affects labor market participation, because abuse can compromise a woman's ability to achieve or maintain employment (13). In the Americas, evidence shows that work-related disruptions including absenteeism and leaving their job are higher among women who experience IPV (13, 14, 15). The Inter-American Development Bank (16) suggests that economic losses between 1.6% and 4.2% of the gross domestic product are seen in some countries as a result of domestic violence. A United States study estimated the costs of intimate partner rape, physical assault and stalking at US\$ 5.8 billion annually, a considerable portion of which was due to direct healthcare costs (17).

The effects of IPV also extend beyond women who experience it. Evidence shows that children who live in homes where violence occurs are also more likely to experience abuse by the perpetrator and be negatively impacted in various ways.

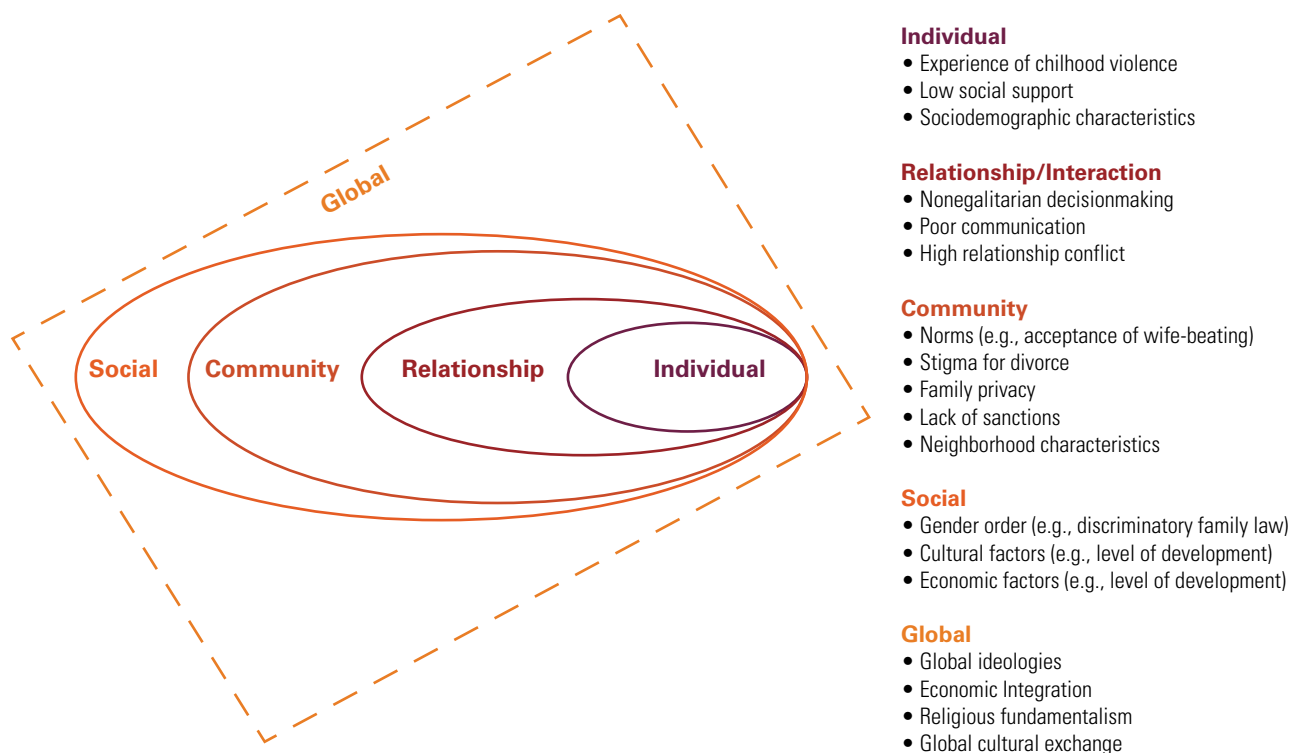


In the Americas, there is a documented negative impact on women who experience physical violence and their children. This starts in utero with women attending fewer prenatal visits than women not experiencing IPV and continues after birth with lower weight among survivor's children as well as lower likelihoods of children being vaccinated (9). Moreover, school attendance of children with mothers subjected to IPV has also been shown to be disrupted and school dropouts have been shown to increase (18, 19).

VIOLENCE HAS MULTIPLE CAUSES

There is no single explanation for why certain individuals perpetrate VAW or why such violence is more prevalent in certain communities. Violence is influenced by a complex interplay of factors at the individual, relationship, community, and societal levels, as articulated by the ecological model, showing risk factors across different levels of social ecology (see Figure 1) (20, 21). VAW is rooted in gender inequalities and power imbalances between men and women, and boys and girls, that must be addressed hand-in-hand with other forms of health and social inequities.

Figure 1. Ecological model with integrated globalized framework through which to analyze violence against women across levels of social ecology



Source: Fulu E, Miedema S. Violence Against Women: Globalizing the Integrated Ecological Model. Violence Against Women [Internet]. 2015 Dec 1 [Accessed 6 October 2022];21(12):1431–55. Available from: <https://doi.org/10.1177/1077801215596244>

VIOLENCE IS PREVENTABLE

The burden of violence on women and girls’ health and well-being alone makes it a public health priority for the Americas. The variation in prevalence of violence within and between countries and settings shows that such violence is not inevitable (2, 22, 23). This significant health burden can be prevented, and its consequences can be mitigated with the active engagement of health workers and health managers, Ministry of Health (MoH) staff and other health sector actors, in collaboration with other government sectors and nongovernmental organizations.

BOX 3. RESPECT: seven strategies to end violence against women

Relationship skills strengthened
Empowerment of women
Services ensured
Poverty reduced
Environments made safe
Child and adolescent abuse prevented
Transformed attitudes, beliefs, and norms

Source: World Health Organization. RESPECT women: preventing violence against women [Internet]. Geneva: 2019 [Accessed 5 October 2022]. Available from: <https://www.who.int/publications/i/item/WHO-RHR-18.19>

Evidence points to a number of proven strategies and interventions with the best potential to reduce VAW (see **Box 3**) (24). Promising results have, for example, been observed related to interventions that strengthen legal sanctions against violence, challenge gender and social norms associated with violence, invest in women's economic empowerment and education, prevent child abuse against both boys and girls, and strengthen access to needed support services, including health services for survivors.

THE HEALTH SYSTEM HAS A CRITICAL ROLE TO PLAY

Health systems play a crucial role in the multisectoral response to violence (25). Given the direct impact of violence on health, women who have experienced violence often seek health care frequently. Women and girls who have experienced violence also identify health workers as the first professional point of contact they would most trust with a disclosure of abuse (26). Health services are usually provided in close contact with communities, including through their disease prevention and health promotion activities, which can help to identify those at risk as early as possible. Health workers, with the skills to know when and how to ask about violence, can make a major difference to survivors' lives and health by providing emphatic, nonjudgmental, and timely care of appropriate quality (27). Health systems and MoH should ensure that providers are prepared to meet the needs of survivors who seek care, because appropriate early intervention can minimize the psychological and physical consequences of violence (26, 28).

Health services can act as a gateway to other essential services for survivors, facilitating appropriate and "warm" referrals to police, justice, protection, shelter, social support, and other services. As trusted professionals, healthcare workers are in a unique position to encourage survivors to seek the type of help that addresses all their needs. This is critical for improving health outcomes in the short and long term, for preventing future violence, and for ensuring safety for women and their children.

Certain services such as sexual and reproductive health services and primary care are especially well positioned to detect cases of violence and provide timely and quality care. Evidence shows that these interventions can strengthen women's readiness to address VAW, increase safety-promoting behaviors, reduce re-exposure to some types of VAW, and improve health (29, 30).



In collaboration with other sectors, health actors can ensure appropriate inclusion of gender equality and human rights-based prevention messaging in its health promotion and disease prevention activities. The health system often has access to critical information, including prevalence and health consequences of violence as well as service use by survivors, which can help to inform policy and action.

VIOLENCE PREVENTION IS NOT NEW TO THE AMERICAS

VAW has been increasingly recognized by the international community as an important public health issue, thanks to various factors including the efforts of women's organizations, the commitment of governments, growing evidence of the magnitude and consequences of violence, and innovative public policies (31).

Various conventions have been signed at the global and regional level, including the Convention on the Elimination of All Forms of Discrimination against Women in 1979 and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, known as the *Convention of Belém do Pará* in 1994, offering a strong human rights framework to guide action in policy and practice (32, 33).

BOX 4. Role of the health sector



While preventing and responding to VAW requires a multisectoral approach, the health sector has a key role to play, including in:

- 1.** Identifying those who are experiencing violence and providing them with comprehensive health services;
- 2.** Facilitating access to other essential support services in other sectors that survivors of violence need and want;
- 3.** Integrating into health education and health promotion activities with patients and communities messages about the human rights violations and harmful health and other consequences associated with violence, and the need to seek appropriate and timely care;
- 4.** Documenting the magnitude of the problem, its causes and consequences, and using this information to advocate for coordinated multisectoral prevention and provision of effective responses; and
- 5.** Contributing to the prevention of violence by addressing risk factors and promoting protective factors of violence in collaboration with other sectors, such as harmful alcohol and substance use, access to education, safe environments, etc.

The Region of the Americas has been a pioneer in the response to VAW as it was the first WHO region to approve a framework for action on VAW. In 2015 the Pan American Health Organization (PAHO) Governing Bodies approved the Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women (34). In 2016 the World Health Assembly approved 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 (35). The global plan is closely aligned with the regional Strategy.

The Strategy and Plan of Action on VAW (see **Box 5**) reflects the priorities and efforts of Member States and of women's movements to draw attention to and catalyze action to address violence in the Americas, incorporating evidence, practice, norms, principles, standards, and technical guidelines developed by PAHO, WHO, and other United Nations system actors (34). This provides a strong organizational mandate for action by PAHO and its Member States and offers a clear framework for analyzing progress in the Region.

BOX 5. PAHO Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, 2015–2025

Strategic lines of action:

- 1.** Strengthen the availability and use of evidence about violence against women.
- 2.** Strengthen political and financial commitment to addressing violence against women within health systems.
- 3.** Strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or non-partner sexual violence.
- 4.** Strengthen the role of the health system in preventing violence against women.

Key indicators of progress encompass the number of Member States that include VAW in their national health plans and/or policies, including national health strategic plans as well as health program-specific policies, such as those on sexual and reproductive health or HIV. Inclusion of VAW in policy documents can take many different forms, thus requiring a more in-depth text analysis to identify the scope and depth of references. Another key tool for Member States to strengthen the health sector response to VAW consistent with the priorities of the Strategy and Plan of Action is the development of national standard operating procedures, protocols, or guidelines for providing safe and effective care and support for women experiencing IPV and/or nonpartner sexual violence. Health systems need to develop protocols to ensure the provision of first-line support that responds to women's physical, emotional, safety, and support needs (36).

A key starting point is the existence of at least one, evidence-based national protocol that guides the response of the health system to survivors of VAW (34). Such a protocol is also important to inform the development of clinical tools and trainings for health workers to enable them to deliver appropriate clinical care and to provide referrals within and outside the health sector. To assist with this important agenda, various tools and guidance documents have been developed by PAHO/WHO and partners (see **Box 6**).

While the health sector has an important role to play, its response to VAW must complement the broader multisectoral response. To guide the collaboration with other government sectors and nongovernmental partners, many countries have developed national multisectoral policies or plans that outline their vision, objectives, and strategic priority actions for addressing VAW across sectors and agencies. It is important that the health sector engages with these broader multisectoral policy frameworks. Global tools such as RESPECT offer useful guidance that can inform the development of such policy frameworks in line with the evidence base.

Similar progress indicators around health policies, health protocols or guidelines and multisectoral plans have also been included in the PAHO Strategic Plan, thus strengthening the mandate for action.

The 2021 progress report on the implementation of the Strategy and Plan of Action on VAW lauded progress in the Region while also recommending the need for more in-depth analysis of selected indicators and related background documents (37). This report is a direct response to this recommendation. It is hoped that the report will help to inform the next steps for strengthening the health sector response to VAW, as the Region moves toward the final years of implementation of the Strategy and Plan of Action. This report is also timely given the increased visibility and renewed urgency of the topic in the context of COVID-19 (see **Box 7**).

BOX 6. Selected tools and guidance documents to assist with the health sector response

[Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines](#)

[Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook](#)

[Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers](#)

[Caring for women subjected to violence: A WHO curriculum for training health-care providers](#)

BOX 7. COVID-19 and VAW policies



Many governments across the Region have developed new policy documents to guide responses to the COVID-19 pandemic. Given the implications of the pandemic for work on violence, there have been opportunities to strengthen guidance that addresses violence in emergencies such as this. For example, in 2020, Ecuador published a protocol for communication and care for cases of gender-based violence and domestic violence during the pandemic: the Communication and care protocol for cases of gender and intra-family violence during the CORONAVIRUS (COVID-19) Health Emergency. This protocol emanated from various sectors and included guidelines for identifying cases, preventing escalating violence, and providing care, as well as on the role of different institutions.

Reference: El Gobierno de Todos, Ecuador. Protocolo de comunicación y atención de casos de violencia de género e intrafamiliar durante la Emergencia Sanitaria por CORONAVIRUS (COVID-19) [Internet]. 2020 [Accessed 6 October 2022]. Available from: <https://www.igualdadgenero.gob.ec/wp-content/uploads/2020/05/Protocolo-de-atenci%C3%B3n-violencia.pdf>

OBJECTIVES AND AUDIENCE OF THIS REPORT

The report aims to:

- Highlight challenges and achievements in the Americas in the prevention and response to violence against women in line with selected indicators of the Strategy and Plan of Action on VAW and related PAHO/WHO guidance;
- Analyze Region-specific lessons learned in order to inform policy and practice in countries; and
- Mobilize stakeholders in the Region to deepen dialogue, strengthen partnerships and act on findings to prevent and respond to violence against women and girls.

The primary target audience is policymakers in the health sector, including MoH focal points on violence prevention and others engaged in developing, implementing, or monitoring health policy responses to violence against women and girls, or individuals managing health programs and directing health services related to violence against women and girls. It also addresses those responsible for violence-related health policy and programs—for example, policymakers and program managers with an interest in women’s and family health, sexual and reproductive health, mental health, and health promotion.

A secondary audience includes policymakers in other sectors with responsibility for violence prevention and response, including policymakers and program managers in women’s and children’s protection, social affairs, justice/police, education, and other sectors with which the health sector regularly collaborates in addressing violence against women and girls. These also include government representatives who sit on a multisectoral mechanism to prevent violence and protect survivors, as well as civil society organizations at the national and regional level, professional associations, academia, foundations, and other non-State actors.

The tertiary audience is subregional, regional, and global organizations, including United Nations partners, bilateral and multilateral actors, donors, and other international networks working to support governments and their communities in ending violence and promoting health and well-being for all women and girls of all ages in the Americas.



STRUCTURE OF THE REPORT

This report presents a summary of regional progress in three areas:

1. Strengthening the leadership of the health sector response to VAW

This includes an overview of available health policies and the extent to which they pay attention to violence against women and girls.



2. Strengthening the quality of health services for VAW survivors

This includes looking at the availability and quality of health system protocols that guide the response to survivors.



3. Strengthening the role of the health sector in the multisectoral response to VAW

This includes an overview of available national multisectoral policies for addressing violence against women and girls and an analysis of the extent to which RESPECT strategies are reflected in these policy documents.



Further details on methodology are provided in the following chapter.

A collection of examples is included in text boxes to showcase experiences from the Region or highlight important issues for consideration.



II. METHODOLOGY OF THIS REPORT

Good information, which includes information on the status of policies and programs, is essential for assessing progress, identifying opportunities and gaps and guiding future policy and practice to prevent and respond to violence against women and girls. In response, PAHO initiated a project in 2020 to inform progress monitoring on the Strategy and Plan of Action on VAW with a view to learning from experiences in the Region and informing discussions with Member States.

A progress report on the implementation of the Strategy and Plan of Action on VAW was presented to PAHO Governing Bodies in 2021 (37). This report draws on data collected as part of the progress monitoring and expands the analysis with a specific focus on indicators that would benefit from a document review, including those related to health policies and plans, health system protocols and guidelines, and national multisectoral policy. Further details of PAHO's methodology, as well as the inclusion and exclusion criteria for health policy documents and indicator definitions, can be found in Annexes 1 and 2.

DATA SOURCES

This report draws on three types of complementary data:

1. Responses from Member States to a survey issued by PAHO

National-level data were collected between December 2020 and February 2021 through the administration of a standardized questionnaire, coordinated by PAHO through its country offices. The questionnaire asked country respondents about the existence of national policies, protocols, governance mechanisms and structures related to VAW in line with the indicators of the Strategy and Plan of Action on VAW. Twenty-seven countries (77% of PAHO Member States) responded to the survey.²

² The following countries responded to the survey: Argentina, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Grenada, Guatemala, Guyana, Honduras, Haiti, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, and Uruguay.



2. Complementary data on post-rape care

Given the challenges of assessing the provision of comprehensive post-rape care, the report also drew on complementary data from the NCPI survey, which is administered by the Joint United Nations Programme on HIV and AIDS (UNAIDS) as a component of the Global AIDS Monitoring platform and has been incorporated into the WHO VAW Policy Database. The NCPI database includes the most up-to-date data available from each country in response to the following question (No. 115): “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 (26): (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.” Data from the latest year in which countries responded to this question are included in this report.

3. Data from a policy review conducted by PAHO

In line with findings of the 2021 progress report, PAHO initiated a more in-depth review of policy documents collected through the survey of Member States to report on progress in the implementation of the Strategy and Plan of Action on VAW. Simultaneously, WHO initiated work globally to create a global database on VAW to house policy documents and present information on indicators based on 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. In 2020, WHO commissioned a consultancy team to develop the VAW Policy Database and review the global status of VAW in national policy documents (38). Given the alignment of the regional and global strategies, PAHO participated as a partner in this process, aligning methodologies, drawing on data from the global database and conducting analyses of indicators based on regional priorities.

In addition to documents shared by Member States, targeted web searches took place between March and June 2021. In addition, the WHO global repository for sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH), which contained all policy documents submitted by countries that completed the SRMNCAH survey in 2018, was searched for any other relevant documents (39). Finally, given the various ways the documents were sourced, PAHO consulted its country offices on the list of documents in the fall of 2021, and, on a case-by-case basis, followed up with national counterparts in Member States to obtain any updated or new documents and to provide any other relevant information. The details of the search strategy are included in the Document Search section. Most of the documents identified were found through web search (47%) or were sent by Member States (23%). A much smaller number of documents were found in the SRMNCAH repository (18%) or through other sources (12%).

POLICY DOCUMENTS

For this report, various types of policy documents were considered, including plans, strategies, protocols, standard operating procedures, and guidelines. The four main categories of relevant policy documents are outlined in **Table 2**. Member States may have more than one of each policy type, and often do.

Table 2. Policy document types and descriptions

Type	Description
National health policy	National health sector-specific policy document. This may be a generic health policy (referred to as national health policies, strategies, and plans), or one specific to SRH, RMNCAH, mental health, NCDs, HIV, or GBV. To be included in the VAW Policy Database, the national health policy must include VAW, though VAW need not be a strategic priority within the document.
Health sector VAW protocol	Health sector-specific on VAW. A policy document that provides guidance for the health sector on the provision of VAW preventive and/or responsive services, care and/or treatment. Documents that fall into this category may be clinical protocols/standard operating procedures or guidance for health professionals, managers and/or administrators involved in the prevention/response to VAW.
Multisectoral VAW policy	Multisectoral policy document on VAW. Contains the country's overall plan for prevention and/or response to VAW and assigns responsibilities to varying ministries and/or other governmental and nongovernmental agencies involved in VAW prevention and response. Gender equality and/or other policies that address the advancement of women and contain a strong VAW component may also be included under this document type.
VAW training manuals	National-level manual or curriculum specific to VAW and targeted at healthcare professionals.

DOCUMENT SEARCH

Internet searches were led by WHO in March 2021³ and by PAHO in June 2021. To begin, a series of search terms was entered (search terms can be provided upon request), which included a set of terms related to the type of document (e.g., policies, protocols, guidelines), a set of terms related to violence against women, and the Member State name. Next, each Member State's MoH website was searched to find VAW/SV protocols. Relevant documents were identified, downloaded, and reviewed to ensure that VAW was included. The documents were selected based on the inclusion and exclusion criteria outlined in [Annex 1](#).

POLICY CONTENT INDICATORS

PAHO selected indicators relating mainly to three strategic regional priorities summarized below and listed in [Annex 2](#).

The first group focused on a set of indicators related to whether there is strong leadership in the health sector response to VAW among Member States.

A second important element of a strong health system response to VAW is the provision of timely, quality care. For these indicators, only health sector VAW protocols were evaluated, based on the priorities in the Strategy and Plan of Action on VAW. These indicators include some important aspects of quality of care such as privacy, confidentiality, and first-line support.

Given the multisectoral nature of violence prevention and response, the third set of indicators focuses on multisectoral policies and strategies that include the health sector, and their alignment with the evidence base—specifically the RESPECT framework.

An additional set of indicators, which relate to vulnerable groups, should be recognized across sectors and could be included in any type of document outlined above.

³ More information on the WHO methodology is available here: <https://www.who.int/publications/item/9789240040458>

It is recognized that, in certain cases, indicators may be found in “unexpected” policies (e.g., a reference to first-line support may be included in a multisectoral VAW policy in the health section, rather than in the health sector VAW protocol). However, while the mention of an indicator in any official government document is a positive step forward, this report focused on the inclusion of the indicator in the most relevant/appropriate document. This is because the type of document matters to the extent to which the text reference has been implemented on the ground. For example, it is far less likely that a hospital director or doctor will regularly consult the national multisectoral VAW policy when looking for guidance, and thus a reference to first-line support in that policy may be slightly less impactful than a reference in the health sector VAW/availability protocol.

For each indicator identified in a policy document, the response was either: (1) included, which is when an indicator is found within a policy document and can be evidenced with text; (2) not included, which is when a policy document explicitly states something is not to be done; or (3) not specified, which is when an indicator is not found within policy document. Descriptive statistics are presented for each indicator, often showing “Yes” and “Not specified” given how uncommon it was to find that something was explicitly not included in a policy.

DATA ANALYSIS

Data were analyzed both at the regional and subregional level. For a select set of indicators, subregional analyses are presented. The indicators selected for subregional analysis are mostly related to the availability of different types of policy documents. It is essential to measure the progress in the development of health policies, health sector VAW protocols, and multisectoral VAW policies because this is a crucial first step to defining the health system role in the multisectoral response to VAW and to providing quality health care to survivors of violence.



These subregional analyses are important given the heterogeneity in the Region and for PAHO to determine which subregions to engage with in different priority areas (a list of the countries of each subregion is given in **Annex 3**). Selected examples from the Region are included in text boxes to showcase progress and related lessons learned.

LIMITATIONS

There are several limitations to the methodology and the scope of this report.

The four types of document included do not cover all available health policies, nor do they include all documents related to VAW and health (see **Box 8**). For example, health policy documents related to health emergency preparedness were not included, nor were plans that addressed very specific types of violence. Other documents that contained information relevant to health and VAW did not emanate from the health sector, but as they were not necessarily multisectoral VAW policies, they were also excluded. Subnational policies were also ineligible, representing another area for future analysis, particularly for federal countries. For future work, it would be pertinent to expand the types of policies for review, including, for example, child and adolescent health policies/plans, and clinical guidelines/standard operating procedures on specific sexual and reproductive health issues, such as family planning and others.

BOX 8. Other important documents (Brazil)



One Member State example of other important policy documents that did not meet the inclusion criteria is Brazil's Plan to combat femicide (Decree No. 10.568) which names the Ministry of Health as part of the multisectoral committee established to deal with health emergencies (14).

This plan is a multisectoral document on femicide, the most extreme form of VAW, but is too specific to fall into the category of multisectoral VAW policy as the search was for documents addressing multiple types of VAW.

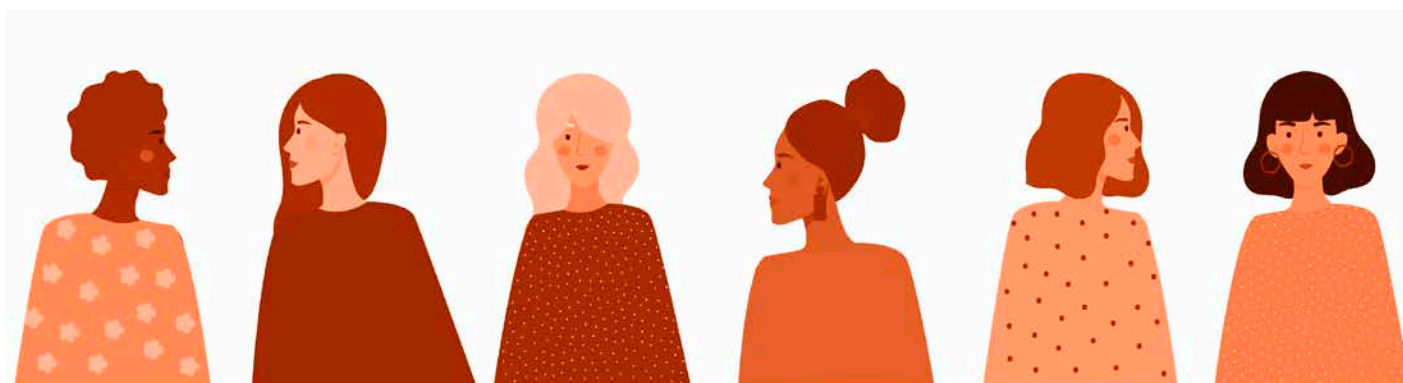
Reference: Presidência da República Secretaria-Geral Subchefia para Assuntos Jurídicos. DECRETO No 10.568 DE 9 DE DEZEMBRO 2020. 2020 [Accessed 7 October 2022].
Available from: <https://legislacao.presidencia.gov.br/>

It is very likely that not all relevant documents were found. Some Member States did not respond to requests for documents, while others did not necessarily post all relevant policy documents online. In certain cases, updated guidelines or policies had not yet been approved and were therefore not eligible or accessible.

Children and adolescents, especially girls, are especially vulnerable to violence. Evidence also suggests that there are important intersections between VAW and violence against children. PAHO/WHO and partners have made important progress in this area with the development of INSPIRE: seven strategies for ending violence against children (VAC), and PAHO is working with Member States to address VAC. The intersections between VAW and VAC and the implications for clinical care were not addressed in this report, but are extremely important (40, 41). It was necessary to exclude policies and protocols on child and adolescent health and VAC based on the scope, but such important policies warrant analysis in future work.

One additional limitation is that what is written in policies does not always translate to practice. The existence of good-quality policy documents is an important first step. However, further work is required to implement these policies in practice to be able to ensure that women experiencing violence have access to quality care.

There must be adequate resources, strong leadership and governance, and political will for implementation (36). Further research is required to explore the extent of implementation across the Region. This work should be complemented by other research highlighting the voices of survivors who have utilized health services as well as of health workers, given their essential role in the provision of women-centered care.





III. FINDINGS

3.1 STRENGTHENING THE LEADERSHIP OF THE HEALTH SECTOR RESPONSE TO VAW

The health sector has a significant role to play in addressing VAW in collaboration with other sectors and partners. PAHO advocates for a public health approach to supporting health systems addressing this multisectoral issue in the Region (34). A strong, visible health system response conveys a message to society regarding the unacceptability of violence and encourages more survivors to seek help. While the multidimensional nature of VAW requires the involvement and commitment by various actors—including government leaders, policymakers across sectors, parliamentarians and legislators, civil society and women’s organizations, and community members—effective leadership by the health sector is a critical factor in advancing countries’ prevention and response efforts.

As highlighted by the Strategy and Plan of Action on VAW, a key starting point for strengthening health sector leadership is the integration of VAW in national and subnational policies and plans within the health system, including national health strategic plans. Such a reference in a policy document can set the tone for the future engagement of health actors on VAW, establish a mandate, and set goals and targets for action, including priorities related to strengthening access to and quality of health services for survivors.

This section reviews the extent to which health policy documents have integrated VAW, including the extent of the reference in the texts. At the same time, while a reference to VAW in health policy documents is an important achievement, it is only a first step. While many governments in the Region have addressed VAW in their health policies, there are often gaps between documentation of commitment and implementation. Effective implementation requires the availability of qualified focal points empowered through training and with designated budgets within the health system to advance implementation of the policy. Data from the policy review are thus combined with data from the survey of Member States about the existence of focal points and budgets, providing an important snapshot of health sector leadership on VAW in the Region.

OVERVIEW OF HEALTH POLICY DOCUMENTS

Some 63 national health policies that included reference to VAW were identified, with 83% (n=29) of Member States having some type of national health policy to address this issue. This generally high number suggests that the large majority of Member States in the Region consider VAW to be an issue requiring health sector intervention. In addition to national health policies, strategies, and plans (NHPSPs), other policies that address VAW in the Region relate to sexual and reproductive health, HIV and mental health (Table 3).

Almost half of all Member States (46%) have an NHPSP that references VAW, representing an important milestone in anchoring a public health approach to violence.

It is also promising that most of the subregions are doing well with the development and approval of health policies that mention VAW, though the types of policies differ. All of the Member States in Central America, plus Cuba, the Dominican Republic, and Mexico, have some type of health policy that mentions VAW. In South America 90% of countries have a health policy that mentions VAW, and in the Non-Latin Caribbean, over three-quarters of the Member States have one.

Although some Member States in the Region have published health policies that specifically address VAW, these were only evident, however, in Central and South America (see Table 4).

Table 3. Percentage of national health policy documents identified (by type)

Type of health policy	Yes (Number of policies)	Yes (Percentage of Member States)
Any national health policy that includes VAW to some extent	29	83
National health policies, strategies and plans (NHPSP)	16	46
National gender-based violence health policy	6	17
National sexual and reproductive health policy	14	40
National reproductive, maternal, newborn, child, and adolescent health policy	5	14
National NCD policy	1	3
National HIV/AIDS policy	18	51
National mental health policy	3	9

Table 4. National gender-based violence health policies

Member State	Policy name (Spanish)	Policy name (English)	Year of publication
Argentina	Plan Nacional de Políticas de Géneros y Diversidad en Salud Pública	National Plan for Public Health Gender and Diversity Policies	2020
Chile	Política de salud en violencia de género	Gender-based violence health policy	2008
Dominican Republic	Estrategia para el fortalecimiento de la respuesta del Sistema Nacional de Salud a la violencia, con énfasis en la violencia de género y contra niños, niñas, adolescentes, mujeres y personas adultas mayores, 2016–2020	Strategy for strengthening the health sector response to violence, with emphasis on GBV and violence against children, adolescents, women and the elderly: 2016–2020	2015
El Salvador	Plan de acción para la operativización de la estrategia de prevención del feminicidio y violencia sexual: prevenir-detectar-atender (pre-detecta)	Operational action plan for the femicide and sexual violence prevention strategy: prevent-detect-care (pre-detection)	2018
Mexico	Programa de Acción Específico Prevención y Atención de la Violencia Familiar y de Género 2013–2018	Specific Action Plan for Care for Family and Gender-based Violence 2013–2018	2013
Paraguay	Plan Nacional de Prevención y Atención a la Violencia Basada en Género desde el Sistema Nacional de Salud 2020–2025	National Plan for Prevention and Attention to Gender-Based Violence from the National Health System 2020–2025	2020

With the exception of those of Chile and Mexico, most of these policies were published between 2015 and 2020. All are about gender-based violence, with the exception of Argentina’s policy, which focuses more broadly on gender, but also contains extensive information on gender-based violence (GBV) and included prevention, early detection, and comprehensive care in the health system as one of five priority objectives (42).

These high-level policies focus specifically on the role of the health sector in responding to VAW. They are an opportunity to spell out the rationale for health sector engagement and often form the basis for strengthening health system leadership in the response to VAW (see **Box 9**).

BOX 9. National plan for prevention and attention to gender-based violence from the national health system 2020–2025 (Paraguay)

Paraguay’s national plan for prevention and attention to gender-based violence from the national health system 2020–2025 stands out for articulating clearly how the health sector needs to take a leading role in the response to VAW.

“Debido a que este problema social es multicausal y complejo, en el que se interceptan además de las razones de género, razones económicas, políticas, sociales, culturales, de etnia, territoriales, que interactúan como factores de vulnerabilidad, el MSPyBS [Ministerio de Salud Pública y Bienestar Social] debe constituirse en un actor protagónico de las respuestas multisectoriales que involucran a otras instituciones como: educación, justicia, policía, servicios sociales y de protección, entre otros” (p. 17).

“Because this social problem is multicausal and complex, in which gender, economic, political, social, cultural, ethnic, and territorial factors interact, to create vulnerabilities, the MSPyBS [Ministry of Health and Social Welfare] should be a leading actor in multisectoral responses that involve other institutions such as: education, justice, police, social and protection services, among others” (p. 17).

Paraguay’s plan is exemplary in that it clearly articulates why VAW is a public health problem, includes key principles of the plan (and for health services), and outlines strategic priorities and actions and a plan for monitoring and evaluation.

Reference: Ministerio de Salud Pública y Bienestar Social, Paraguay. Plan Nacional de Prevención y Atención a la Violencia Basada en Género desde el Sistema Nacional de Salud 2020–2025. 2020 [Accessed 7 October 2022]. Available at http://186.16.40.134/-cepep01/wp-content/uploads/2021/02/Plan-Nacional-de-Prevencion-y-Atencion-a-la-Violencia-de-genero_V4-1.pdf

VIOLENCE AGAINST WOMEN AS A STRATEGIC PRIORITY

BOX 10. National health strategy (Chile)

One example of a country that included VAW as a strategic priority in its NHPSP is Chile—in the National Health Strategy: Towards the Achievement of the 2011–2020 Health Goals.

The strategy included the following text, which clearly indicates that VAW is a strategic priority for Chile.

“Se propone fortalecer los marcos normativos de salud para el mejoramiento de la calidad de la atención de salud a víctimas y agresores derivados por violencia de género, los que serán actualizados, aplicados y evaluados con una periodicidad determinada. También se proponen estrategias relacionadas con la oferta de servicios para brindar una atención a las víctimas, que sea precoz, oportuna y de calidad, incluyendo la atención de mujeres en procesos judiciales y de sus hijos. Para lograr este objetivo, es central la capacitación y sensibilización de los trabajadores del sistema de salud.” (p. 93)

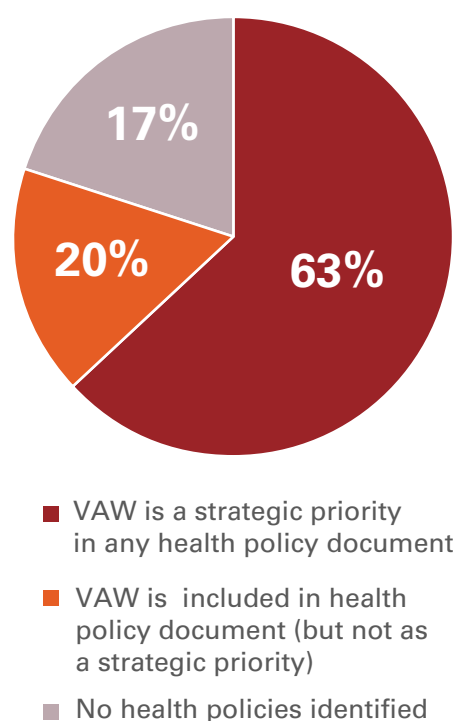
“It is proposed to strengthen the regulatory health frameworks to improve the quality of health care for victims and aggressors derived from gender violence, which will be updated, applied and evaluated with a determined periodicity. Strategies related to the provision of early, timely, and quality care of services to care to victims are also proposed, including the care of women in judicial proceedings and their children. To achieve this objective, training and awareness-raising of healthcare workers is essential.” (p. 93)

Reference: Ministerio de Salud, Chile. Metas 2011-2020 Elige vivir sano. [Accessed 6 October 2022]. Available from: <http://www.bibliotecaminsal.cl/wp/wp-content/uploads/2011/12/Metas-2011-2020.pdf>

Even though 83% of the Member States have some type of national health policy that includes VAW can be considered a substantial achievement, it is important to note that the extent to which VAW was included varies significantly across countries and policy documents. As shown in **Figure 2**, 63% of the Member States have at least one policy where VAW is considered a strategic priority, whereas in 20% VAW is mentioned but not framed as a strategic priority.

This indicates that when countries write or update health policies and plans, there is room for VAW to be included more extensively in line with regional mandates and the global evidence base. Including VAW as a strategic priority in a health policy document allows the MoH to take ownership of the issue and sets the tone for strengthening prevention and response capacities in the health sector and beyond. An example is provided in **Box 10**.

Figure 2. Member States' health policy documents: extent to which VAW is included and/or mentioned



MINISTRY OF HEALTH UNIT (OR UNITS) OR FOCAL POINT(S) RESPONSIBLE FOR VIOLENCE AGAINST WOMEN

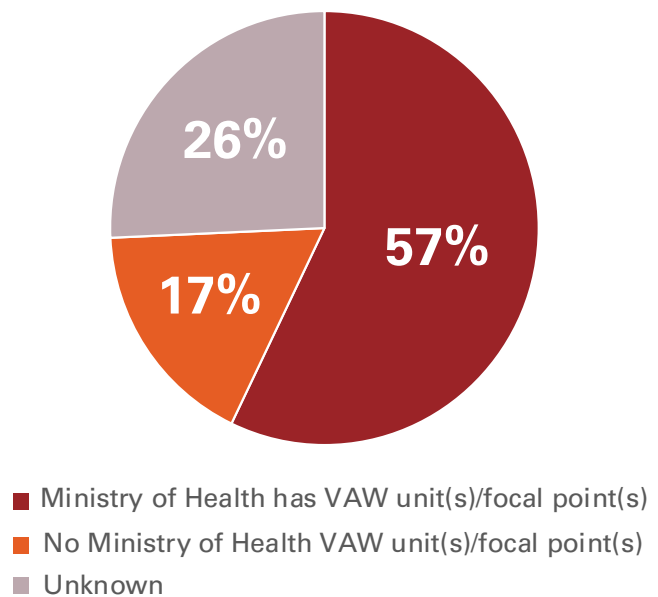
Another indicator to measure strengthening the leadership of the health sector response to VAW is whether the MoH has a unit or focal point responsible for VAW. As seen in **Figure 3**, considerable progress has been made on this indicator in the Americas. Overall, 57% of the Member States reported having one. Differences in the time, resources, and capacity of focal points may limit their ability to advance the work on VAW, and these limitations must be continuously addressed.

NATIONAL HEALTH BUDGET LINES FOR VIOLENCE AGAINST WOMEN

Financing in the form of health sector budget allocation to VAW is crucial to implementing national policies and to ensuring that health systems have the necessary resources to prevent and respond effectively to VAW. The allocation of resources further indicates a commitment from both policymakers and healthcare managers and administrators to address VAW (11). Accordingly, the Strategy and Plan of Action on VAW draws attention to this topic and includes a specific indicator on the number of Member States with at least one national health budget line dedicated to support prevention and/or response to VAW.

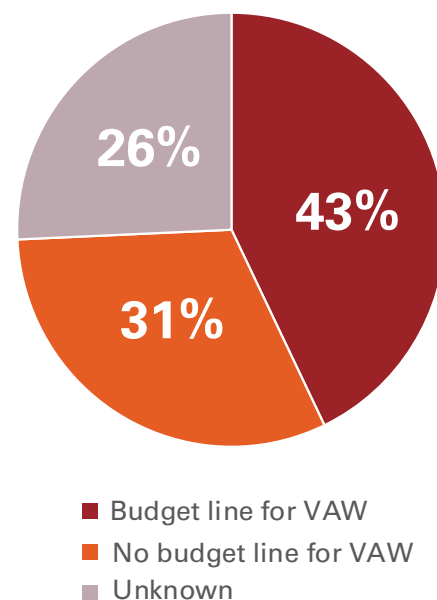
Drawing on survey data as seen in **Figure 4**, only 43% of the Member States reported having a budget line dedicated to supporting the prevention and/or response to VAW. This is problematic given the importance of financing for a strong health system response to VAW and represents an area for future work for the Americas (11).

Figure 3. Number of Member States that report having a unit or focal point in the MoH responsible for violence against women



Note: these data were taken from a PAHO survey administered to all Member States in December 2020. If the Member State did not respond to the survey or a question, then the answer is considered to be “unknown.”

Figure 4. Number of Member States that report having a national health budget with one or more dedicated lines to support prevention of and/or response to VAW



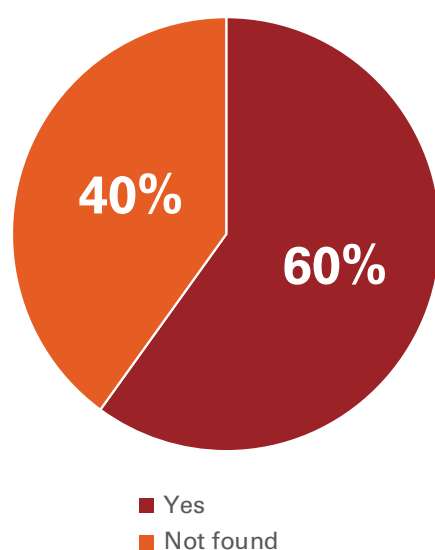
Note: these data were taken from a PAHO survey administered to all Member States in December 2020. If the Member State did not respond to the survey, then the answer is considered to be “unknown.”

3.2 STRENGTHENING THE QUALITY OF HEALTH SERVICES FOR VAW SURVIVORS

The health system plays a key role in responding to violence through the provision of supportive immediate and ongoing care (11). Survivors of violence often name health workers as the first professional contact to whom they would go for help. Evidence further suggests that even when violence is not the presenting condition, survivors seek healthcare services more frequently than other women. It is therefore imperative that health systems should be prepared to offer survivors comprehensive care and support that responds to women's physical, emotional, safety, and support needs. If the interaction between the survivor and the health service is a positive one, women will be more likely to return to seek help from these services and may recommend the health service to others.

Health services can act as a gateway to other essential services, including those in other sectors. Accordingly, one of the strategic lines of action in the Strategy and Plan of Action on VAW is to strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner and/or sexual violence (34).

Figure 5. Member States that have national standard operating procedures/protocols/guidelines for their health system's response to VAW



HEALTH SECTOR VIOLENCE AGAINST WOMEN PROTOCOLS

A milestone for a strong health system response to VAW is the existence of at least one health sector VAW protocol, which provides information on services and care to be provided to survivors of VAW. These protocols are critical tools to guide good-quality health service delivery. They provide standardized guidance that ensures consistency across people, and settings, and over time. Protocols can also be useful to guide training and professional development of health workers, as these documents often set the expectation for the health system response to survivors of violence. Countries may have one national health sector VAW protocol, or several ones focusing on specific forms of violence, specific settings or specific groups of survivors.

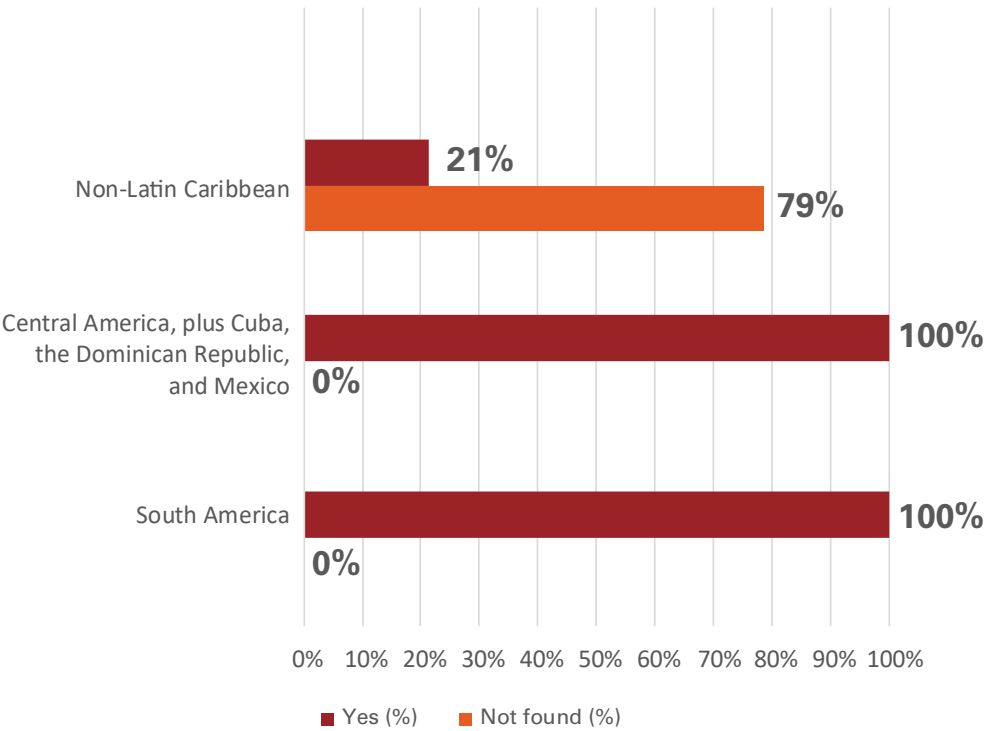
As shown in **Figure 5**, 60% of the Member States have national standard operating procedures, protocols, or guidelines for the health system's response to VAW.

SUBREGIONAL ANALYSIS ON AVAILABILITY OF HEALTH SECTOR VAW PROTOCOLS

The availability of health sector VAW protocols varies significantly between subregions. As seen in **Figure 6**, in Central America, plus Cuba, the Dominican Republic, and Mexico, and South America, 100% of Member States have health sector VAW protocol. The level of detail varies, but this is an important achievement toward providing guidance to health system managers and health providers. However, only 21 % of the Member States in the Non-Latin Caribbean have such a document. Thus, it is important that work continue to improve these numbers, using some of the key guidance from PAHO/WHO clinical and policy guidelines (26).

Given the central role of such protocols in facilitating a strong health system response to VAW, related indicators about their existence have been included in the Strategy and Plan of Action on VAW as well as in the PAHO Strategic Plan. It is critically important that these protocols not only exist, but that they be guided by the best available evidence (26). Accordingly, the following section reviews the content of the protocols in line with selected indicators of quality.

Figure 6. Subregional analysis of availability of health sector VAW protocols



BOX 11. Warning signs that may be associated with violence

Health workers should suspect violence if they note the following:

- Injuries that are repeated or not well explained;
- Ongoing emotional health issues, such as stress, anxiety or depression;
- Harmful behaviors such as misuse of alcohol or drugs;
- Thoughts, plans or acts of self-harm or (attempted) suicide;
- Repeated sexually transmitted infections;
- Unwanted pregnancies;
- Unexplained chronic pain or conditions;
- Repeated health consultations with no clear diagnosis;
- An intrusive partner during health consultations;
- Missed healthcare appointments;
- Emotional and behavioral problems in children.

KEY CONTENT INDICATORS FOR HEALTH SECTOR VAW PROTOCOLS

CLINICAL INQUIRY AND UNIVERSAL SCREENING

Health services are a critical space for the detection of violence. When those at risk for violence or who are experiencing violence are identified in a timely manner, timely and appropriate help can be offered, helping to prevent the (re-)occurrence or escalation of violence. In the WHO Clinical and Policy Guidelines, universal screening is defined as large-scale assessment of whole population groups to identify individuals that have experienced violence (26). An example of universal screening is to ask every woman who comes into contact with health services departments seeking care about her experience of violence. Evidence suggests that universal screening is not recommended (26).⁴ While in certain settings screening has been found to increase identification in certain cases, evidence shows that it neither increases referrals to support services nor serves to reduce IPV (43).

The WHO guidelines recommend selective or clinical inquiry for the identification of women experiencing violence who present to healthcare settings (26). This entails the health worker asking about experiences of violence based on the presenting conditions, history and, where appropriate, examination of the individual presenting for care or services (see Box 11).

As seen in Figure 7, only 3% of Member States explicitly warn against universal screening for IPV (see Box 12 for an example). Most of the Member States (83%) did not specify whether universal screening should occur or not. Given the important role that health workers have in the identification of violence – not only to facilitate access to timely health care but also to assist with referral to other essential services – lack of explicit wording, and more importantly clinical guidance, on this issue is a concern as it leaves decisionmaking with respect to procedures to identify violence against women up to the individual worker, facility, or situation. Moreover, 14% of Member States recommend universal screening, which is currently not supported by the evidence.

The WHO guidelines recommend clinical inquiry as the best strategy for identifying women's experiences of current (or past) violence (26). Only three Member States (9%) explicitly include reference to this approach to violence identification in their health sector VAW protocols (see Figure 8). Four other Member States mentioned clinical inquiry in their multisectoral

⁴ There are some exceptions to this recommendation, as WHO recommends universal screening in certain services and circumstances including antenatal care, HIV testing and counseling, and among women with mental health symptoms or disorders (depression, anxiety, PTSD, self-harm/suicide attempts).

VAW or national health policy. While inclusion of a mention of clinical inquiry in a policy document, compared to the health sector VAW protocol, is a promising first step, it is important that similar language be included in clinical protocols and tools which are often the first point of reference for health workers and the basis for health system capacity-building. The considerable gaps in attention to clinical inquiry in protocols in the Region are an important area for future attention by Member States in collaboration with PAHO.

Figure 7. Member States with a health sector VAW protocol that references universal screening

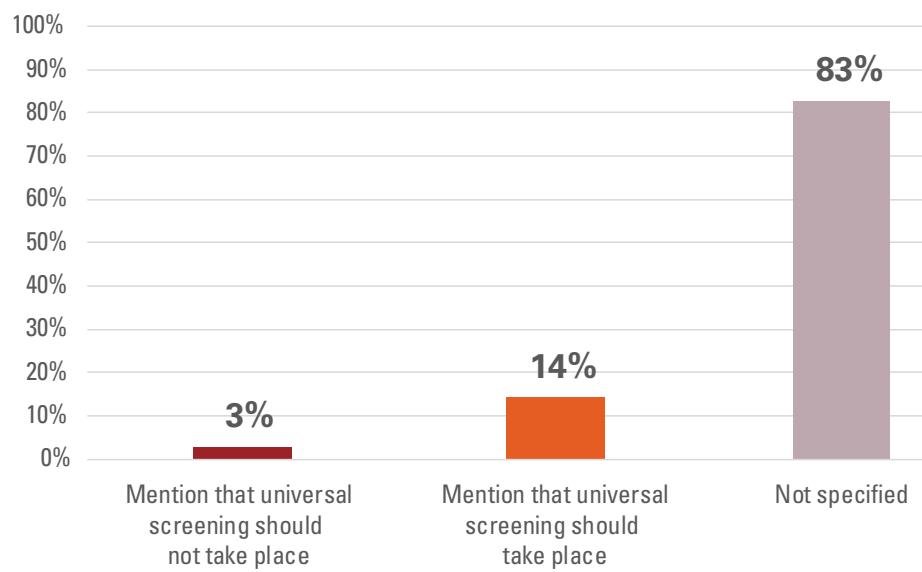
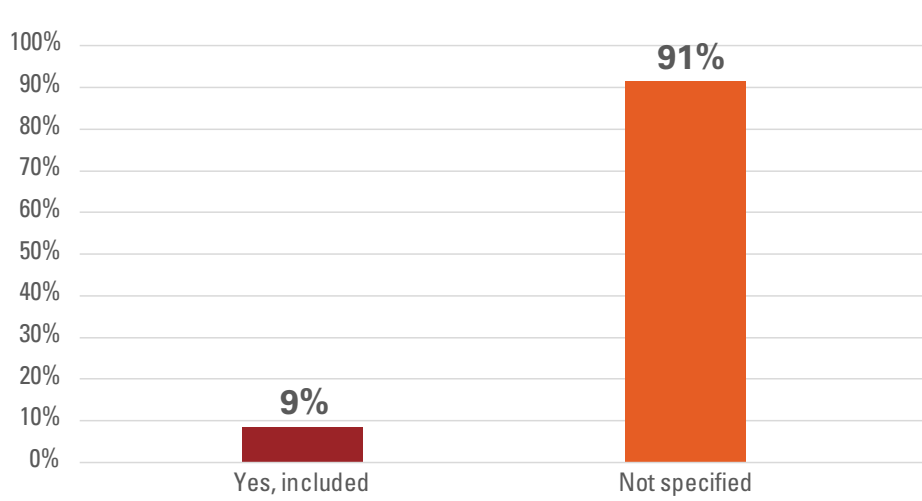


Figure 8. Member States with a health sector VAW protocol that references clinical inquiry



BOX 12.
Language around universal screening (Uruguay)

In its 2018 guidance on health care for women who have experienced intimate partner violence or sexual violence, Uruguay cites the WHO recommendation not to conduct universal screening and to do clinical inquiry instead, based on the presentation of certain injuries and symptoms.

“La OMS alienta a los equipos de salud a mencionar el tema a todas aquellas mujeres que presenten lesiones o trastornos que puedan estar relacionados con la violencia, si bien las directrices del 2013 no recomiendan el método de detección universal o de indagación sistemática.” (p. 31)

“WHO encourages health teams to raise the issue with all women with injuries or disorders that may be related to violence, although the 2013 guidelines do not recommend universal screening or screening.” (p. 31)

Reference: Ministerio de Salud, Uruguay. Atención de salud para las mujeres que han sufrido violencia de pareja o violencia sexual. 2018 [Accessed 6 October 2022] Available from: <https://www.gub.uy/ministerio-salud-publica/sites/ministerio-salud-publica/files/documentos/publicaciones/Manual%20Clinico%20SNIS%20MSP%202018.pdf>

BOX 13. Confidentiality and privacy

Privacy and confidentiality are not new concepts in health care. They are critical human rights principles, and many health systems already enshrine them for all their patients. When it comes to responding to survivors of violence, ensuring privacy and confidentiality is essential to encourage disclosure of violence in healthcare settings. It is also crucial for the safety of survivors, as breaches may put survivors at risk of additional violence or expose them to stigma and discrimination.

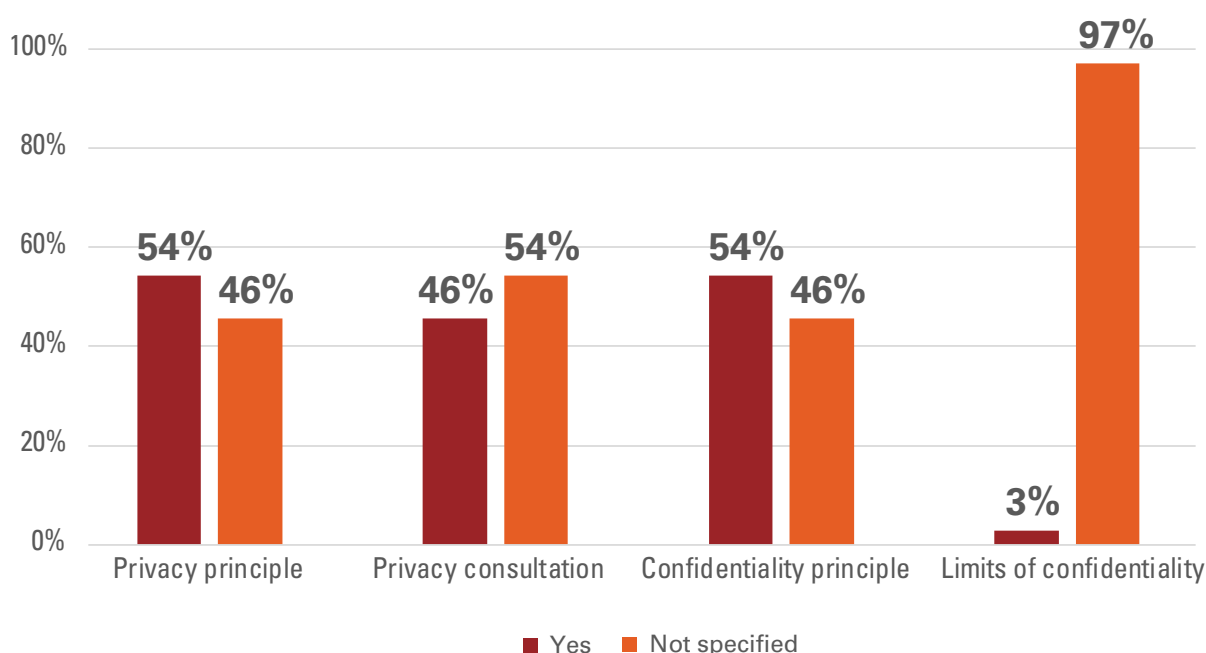
PRIVACY AND CONFIDENTIALITY

Two important aspects to ensuring that survivors of VAW receive quality health care are privacy and confidentiality (see [Box 13](#)).

When reviewing policy documents for their attention to privacy and confidentiality, the search focused on the following. First, privacy should be explained broadly in the text, and a specific reference to having privacy during medical consultations should be included in health sector VAW protocols. For confidentiality, the principle should be referenced in text, for example in relation to the provision of quality care. It is also important for any limitations of confidentiality, for example in case of any mandatory reporting requirements, to be explicitly mentioned, so that the health worker using the protocol can be guided in their approach to the survivor. Including these details can help to avoid any misunderstanding or misinterpretation of principles and ensure privacy and confidentiality are applied in practice.

As seen in [Figure 9](#), 54% of Member States recognize privacy and confidentiality as important aspects of care, and 46% explicitly state that there should be privacy during the consultation with a survivor of VAW. While this points to a considerable level of recognition of these principles in the Region, only one Member State (3%) explained the importance of highlighting the limits of confidentiality.

Figure 9. Member States' mention of privacy and confidentiality in health sector VAW protocol



For both privacy and confidentiality, mentioning the principles as related to VAW is a significant step, but it is not enough. Over half of Member States mentioned privacy as a principle, but the extent to which the principle was explained varied substantially between them. Of the 19 countries that included this principle, eight of them included only one sentence or statement, and it was often on the importance of both privacy and confidentiality. El Salvador went a bit further in its 2019 technical guidelines for healthcare for people affected by violence (see **Box 14**) (44).

In terms of including the importance of privacy during consultation, the 16 Member States that fulfilled this indicator included much more thorough information. While language differed across documents and countries, the additional details provided by these countries was helpful as it unpacked the meaning of the principle and facilitated its implementation by health services and health workers in practice. A few good practice examples are included in **Boxes 15–17**.

Regarding confidentiality (see **Boxes 18 and 19**), and similar to privacy, this principle was most frequently mentioned briefly and in relationship to other principles (such as first-line support). Only three Member States included any mention on the limits of confidentiality (see **Boxes 20 and 21**). The limits of confidentiality are related to situations of mandatory reporting, which far more Member States did include (n=13). If mandatory reporting is stipulated by law, which is not generally recommended for adult survivors, it is important for Member States to instruct health workers on how to discuss the limits of confidentiality with survivors. Without such guidance confidentiality may inadvertently be breached, which may put the survivor at further risk of harm.

BOX 15. Technical guidelines for the care of victims of sexual violence (2016) (Chile)

“Es necesario respetar el pudor de la persona, realizando el examen en condiciones de privacidad suficiente y siempre con la presencia de otra persona del servicio de urgencia, profesional o técnico. Se debe incorporar a un acompañante de la víctima, si ésta así lo solicita.” (p. 38)

“It is necessary to respect the modesty of the person, conducting the examination in conditions of sufficient privacy and always with the presence of another person from the emergency, professional or technical services. A companion of the victim must be involved, if they request it.” (p. 38)

Reference: Ministerio de Salud, Gobierno de Chile. Norma General Técnica para la Atención de Víctimas de Violencia Sexual. 2016 [Accessed 6 October 2022]. Available from https://diprece.minsal.cl/wrdprss_minsal/wp-content/uploads/2016/10/NT_VICTIMAS-VIOLENCIA-SEXUAL_web.pdf

BOX 14. Technical guidelines for health care (El Salvador)

As related to survivors of sexual violence, the national guidelines mention:

“La médica o médico que asista a la mujer afectada, debe hacerlo respetando sus derechos humanos, en un ambiente de privacidad, respeto y confidencialidad, manteniendo su ética profesional.” (p. 74)

“The doctor who assists the affected woman must do so while respecting her human rights, in an environment of privacy, respect and confidentiality, maintaining their professional ethics.” (p. 74)

This description goes beyond a mere mention of privacy to situate it as an important aspect of human rights and professional ethics for doctors.

Reference: Ministerio de Salud de El Salvador, Lineamientos técnicos de atención integral en salud de las personas afectadas por violencia. 2019 [Accessed 6 October 2022]. Available from: <http://asp.salud.gob.sv/regulacion/pdf/lineamientos/lineamientosatencionintegralpersonasafectadasviolencia2019.pdf>

BOX 16. Domestic and sexual violence complaints and response protocol (Saint Kitts and Nevis)

“Complainants of Domestic and Sexual violence have a right to, inter alia, the following: a. Privacy during all interventions, including the nurse assessment, medical examination, counselling and evidence gathering;” (p. 11)

Reference: Government of St. Kitts and Nevis. Domestic and sexual violence complaints and response protocol. Not found online.

BOX 17. Protocol for the clinical management of sexual violence (2020) (Bolivarian Republic of Venezuela)

“De fácil acceso, con una sala de espera dispuesta de tal forma que ofrezca la privacidad necesaria y a su vez fácil acceso a otros servicios que pudieran derivarse del diagnóstico inicial, tales como cirugía y hospitalización.”

(p. 12); “La historia clínica y la evaluación física deben realizarse en un ambiente tranquilo y con privacidad, considerándose los elementos individuales propios de la víctima, tales como sexo, edad, nivel de instrucción, idioma a través del cual se comunica, posibles limitaciones cognitivas, discapacidades entre otros factores, con el propósito de generar vínculos de comunicación adecuados, que permitan un posterior manejo clínico, forense y terapéutico acorde, evitando así la revictimización.” (p. 17)

“Easy to access, with a waiting room arranged in such a way that it offers the necessary privacy and at the same time easy access to other services that could derive from the initial diagnosis, such as surgery and hospitalization.” (p. 12); “The medical history and physical evaluation must be carried out in a quiet and private environment, considering the individual elements of the victim, such as sex, age, level of education, language through which it communicates, possible cognitive limitations, disabilities among other factors, with the purpose of generating adequate communication links that allow a subsequent clinical, forensic and therapeutic management in accordance, thus avoiding re-victimization.” (p. 17)

Reference: Ministerio del Poder Popular para la Salud, Venezuela. Protocolo para el manejo clínico de la violencia sexual. 2020 [Accessed 7 October 2022]. Available from https://venezuela.unfpa.org/sites/default/files/pub-pdf/protocolo_nacional_manejo_clinico_de_violencia_sexual_1.pdf

BOX 18. Manual of comprehensive care for victims of intimate partner, sexual and gender-based violence in the health system (Paraguay)

In Paraguay’s *Manual of Comprehensive Care for Victims of Intimate Partner, Sexual and Gender-Based Violence in the Health System* (2021), the principle of confidentiality is included in a wider context of effective communication and sensitive care, which goes beyond a mere mention of it.

“Una comunicación efectiva se basa en la escucha responsable; por lo que ESCUCHAR – MIRAR • Significa dejar hablar libremente a la persona. • Significa percibir tanto el contenido como los sentimientos. • Requiere sensibilidad. • Ayudar a establecer la confianza entre las partes. • Implica mantener contacto visual (mirar – ser visto – ser oído). CONSIDERACIONES FINALES Respete: El derecho de las personas a la confidencialidad. Guía: No brinde consejos o diga qué debe hacer la persona. Evite: Hacer juicios de valor sobre lo que oye, no juzgue, no critique.” (p. 105)

“Effective communication is based on responsible listening; so LISTENING – LOOKING • Means to let the person speak freely. • It means perceiving both content and feelings. • Requires sensitivity. • Help establish trust between the parties. • It involves maintaining eye contact (looking – being seen – being heard). FINAL CONSIDERATIONS Respect: People’s right to confidentiality. Guide: Do not give advice or tell what the person should do. Avoid: Making value judgments about what you hear, don’t judge, don’t criticize.” (p. 105)

Reference: Ministerio de Salud Pública y Bienestar Social, Paraguay. Manual de Atención Integral a Víctimas de Violencia Intrafamiliar, Sexual y de Género en el Sistema de Salud. 2021 [Accessed 7 October 2022]. Available from <https://data.miraquetemiro.org/sites/default/files/documentos/31%20Manual%20Atencion%20Violencia%20Intrafamiliar%20y%20de%20Genero.pdf>

BOX 19. National health standards for care for people living in violent situations (Costa Rica)

Costa Rica has similarly strengthened language on confidentiality of survivors. In the national protocol, confidentiality of information, especially in cases in which security is at risk, is explicitly enshrined:

“Garantizar la confidencialidad de la información brindada por las personas víctimas de violencia atendidas, principalmente en aquellos casos en los que prive el resguardo de la vida y el patrimonio, así como la seguridad de la persona.” (p. 28)

“Guarantee the confidentiality of the information provided by the victims of treated violence, mainly in those cases in which the protection of the life and heritage are at risk, as well as the security of the person.” (p. 28)

Reference: Ministerio de Salud Costa Rica. Norma nacional para la atención integral a personas en situación de violencia en los servicios de salud. 2019 [Accessed 7 October 2022]. Available from <https://www.binasss.sa.cr/opac-ms//media/digitales/Norma%20nacional%20para%20la%20atenci%C3%B3n%20integral%20a%20personas%20en%20situaci%C3%B3n%20de%20violencia%20en%20los%20servicios%20de%20salud-1.pdf>

BOX 20. Principle and limits of confidentiality (Grenada)

In Grenada, the Health Care Sector Standard Operating Procedures for Gender-Based Violence, published in 2014, include language on both the importance of confidentiality and some of the limitations.

“Confidentiality is an important part in developing trust in a relationship. In cases of domestic violence and sexual abuse, confidentiality is not only a privacy issue but also a safety issue. Codes of practice require all professionals to consider carefully their legal and ethical duties as they apply to patient confidentiality.

The patients need to understand that health care professional may have a legal and professional obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent (WHO, 2003). The issue of confidentiality should be discussed with the patient to ensure awareness of its meaning in the context of health care provision and the relevant laws, protocols, and operations procedures” (p. 52).

Reference: Ministry of Health and Social Security and Ministry of Social Development and Housing, Grenada,. Health Care Sector Standard Operating Procedures for Gender-Based Violence. 2014.

BOX 21. Principle and limits of confidentiality (Trinidad and Tobago)

Trinidad and Tobago’s 2021 health sector VAW protocol, National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence: Trinidad and Tobago, include clear information on both the principle of and the limits of confidentiality.

“Confidentiality is a critical component of the care for survivors of violence. Confidentiality of health records must be maintained, for example by keeping such documents and any relevant notes in a safe place and not anywhere that anyone can see or access them.

It is important that the survivor be informed of any limits to confidentiality at the very start of her interaction with the health-care provider. It is not appropriate for the survivor to be asked to disclose and share her experience in a safe space, but then later be informed that confidentiality cannot be maintained. Survivors should always be informed of what information is being shared, with whom and why (6).”

This information will help healthcare providers interact with patients in a way that is supportive and women-centered, by giving her all of the pertinent information on the limits of confidentiality.

Reference: Ministry of Health, Trinidad and Tobago. National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence: Trinidad and Tobago. 2022.

BOX 22. First-line support for survivors of violence

First-line support involves five simple tasks, as summarized by the letters of the word “LIVES”:

Listen: Listen to the woman closely, with empathy, and without judgment.

Inquire about needs and concerns: Assess and respond to her various needs and concerns.

Validate: Show her that you understand and believe her. Assure her that she is not to blame.

Enhance safety: Developing a plan with her to protect herself from further harm.

Support: Help her to connect to other support services.

Reference: WHO. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. 2014 [Accessed 10 October 2022]. Available from: http://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf;jsessionid=E6507006376612D2A87F6ED75F9D49EB?sequence=1

FIRST-LINE SUPPORT

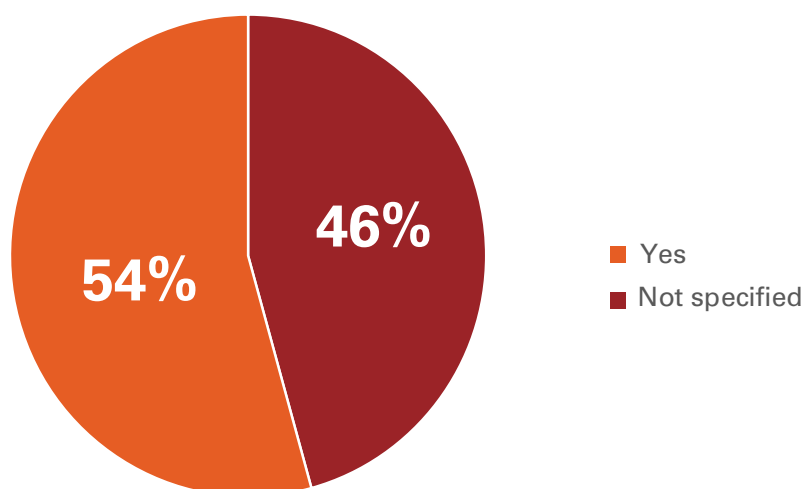
Evidence suggests that first-line support is one of the most important care interventions that can be provided to survivors of violence.

According to WHO guidelines, it should be considered the minimum level of care and include practical care that responds to a woman’s emotional, physical, safety, and support needs, without intruding on her privacy. First-line support should ideally be provided at the first point of contact, as it does not necessarily require many resources or much time (see **Box 22**).⁵

As seen in **Figure 10**, 54% of Member States included some mention of first-line support in their health sector VAW protocols. Eleven additional Member States included first-line support in other types of documents. However, given that protocols tend to be the main reference document for health workers in clinical settings and often the basis for capacity-building, the relatively low percentage that meet this indicator suggested that more work is needed to strengthen attention to and guidance on first-line support in protocols of the Region.

Boxes 23–25 provide some good practice examples of how selected protocols included references to first-line support, establishing an important basis for a quality health system response to survivors of violence.

Figure 10. Member States with health policies that mention first-line support (or some aspect of it) in their health sector VAW protocols



⁵ For the first-line support indicator, a very broad approach was adopted, given the variation in the ways that Member States include it. Even a mention of one of the following four components would suffice as “Yes, included”: 1. Providing practical care and support, which responds to a 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.

BOX 23. First-line support (Panama)

In the manual of norms and procedures for the comprehensive care of violence and promotion of forms of solidary coexistence in the health system, Panama includes an explicit reference to LIVES/ANIMA, along with an explanation of some important elements, and an explanation of the acronym itself.

“Preguntas para la atención

Las siguientes son algunas preguntas sencillas y directas que pueden usarse como punto de partida y que muestran que usted está interesado en escuchar acerca de los problemas de la mujer. Según lo que ella responda, siga indagando y escuchando su relato. Si responde afirmativamente a cualquiera de estas preguntas, ofrézcale apoyo de primera línea “ANIMA” (p. 71).

“Questions for care

The following are some simple and direct questions that can be used as a starting point and showing that you are interested in hearing about the woman's issues. Based on her responses, keep inquiring and listening to her story. If they answer yes to any of these questions, offer first-line support “ANIMA” (p. 71).

Reference: Ministerio de Salud, Panama. Manual de normas y procedimientos para la atención integral de la violencia y promoción de formas de convivencia solidaria en el sistema de salud. 2019 [Accessed 7 October 2022]. Available from: <https://data.miraquetemiro.org/sites/default/files/documentos/manual%20atencionviolencia.pdf>

BOX 24. First-line support (Guatemala)

Guatemala's 2019 Protocol for the Care of Victims/Survivors of Sexual Violence includes a reference to LIVES/ANIMA explicitly, and mentions that this should be used for women who are victims of sexual violence to respond to their physical, emotional and security needs (23).

“5.2.2 Apoyo de primera línea (ANIMA) para mujeres

Utilice «ANIMA» (37) como una intervención para la atención de mujeres VSVS [víctimas/sobrevivientes de violencia sexual]. Esta técnica provee atención práctica y responde a las necesidades de la mujer, tanto emocionales como físicas y de seguridad, así como apoyo sin invadir su privacidad.” (p. 63)

“5.2.2 Front-line support (ANIMA/LIVES) for women

Use «ANIMA» (37) as an intervention for the care of women victims/survivors of sexual violence. This technique provides practical care and responds to the needs of the woman, both emotional and physical and security, as well as support without invading her privacy.” (p. 63)

Reference: Ministerio de Salud Pública y Asistencia Social, Guatemala. Protocolo de atención a víctimas/sobrevivientes de violencia sexual. 2019 https://guatemala.unfpa.org/sites/default/files/pub-pdf/ProtocoloVS_FINAL_baja%20%281%29.pdf [Accessed 6 October 2022].

BOX 25. First-line support (Nicaragua)

In the standards and protocols for the prevention, detection and care of domestic and sexual violence, Nicaragua mentions important aspects for psychosocial support that align nicely with LIVES/ANIMA or first-line support.(24)

“IX. 2. C. Atención Psicosocial -La entrevista psicosocial tendrá aspectos esenciales como: privacidad, confidencialidad, ambiente de confianza y de comunicación, preferiblemente no hacer preguntas, más bien pedir el relato de lo ocurrido. Como regla general no culpabilizar, no juzgar, ni insinuar que está mintiendo y respetar sus decisiones. -La psicóloga o trabajadora social asignada, tendrá la responsabilidad de valorar el riesgo y definir con la persona abusada la red de apoyo y el plan de seguridad de esta.” (p. 118).

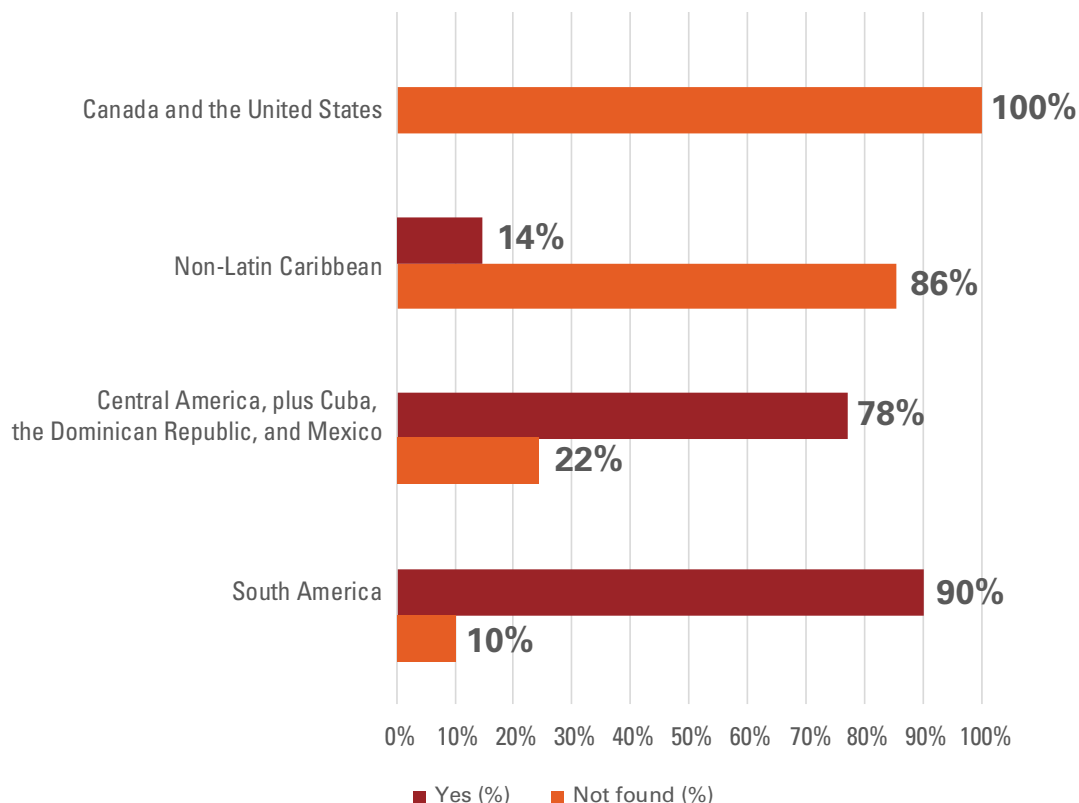
“IX. 2 C. Psychosocial Care -The psychosocial interview will have essential aspects such as: privacy, confidentiality, an atmosphere of trust and communication, preferably not asking questions, rather asking for an account of what happened. As a general rule, do not blame, judge, or imply that you are lying and respect your decisions. -The assigned psychologist or social worker will have the responsibility of assessing the risk and defining with the abused person the support network and their safety plan. “ (p. 118).

Reference: Ministerio de Salud, Nicaragua. Normas y Protocolos para la Prevención, Detección y Atención de la Violencia Intrafamiliar y Sexual. 2009 [Accessed 7 October 2022]. Available from: https://data.miraquetemiro.org/sites/default/files/documentos/N_031_AM_325_2009_Norma_Prot_Prev_Detec_yAten_Violencia.6784.pdf

In terms of the inclusion of first-line support in health sector VAW protocols, as shown in **Figure 11**, South America is doing well with 90% of Member States including some aspect of first-line support. This is most likely because all of the Member States in this subregion have health sector VAW protocols, as without the existence of a health sector VAW protocols, a Member State would automatically not fulfill this indicator.

For Central America, plus Cuba, the Dominican Republic, and Mexico, 100% of Member States have a health sector VAW protocol, yet only 78% include first-line support, which is an area of opportunity for when these protocols are updated/revised or for when new ones are published. Numbers were very low for the Non-Latin Caribbean (14%), pointing to significant gaps in this area. The gap is particularly noteworthy given that many countries do not have any protocol to guide the health system response. This presents an important opportunity for MoHs in the Subregion to not only develop health sector VAW protocols but to also ensure that these protocols are guided by the available evidence, including a reference to first-line support.

Figure 11. Inclusion of some aspect of first-line support in health sector VAW protocols, by subregion

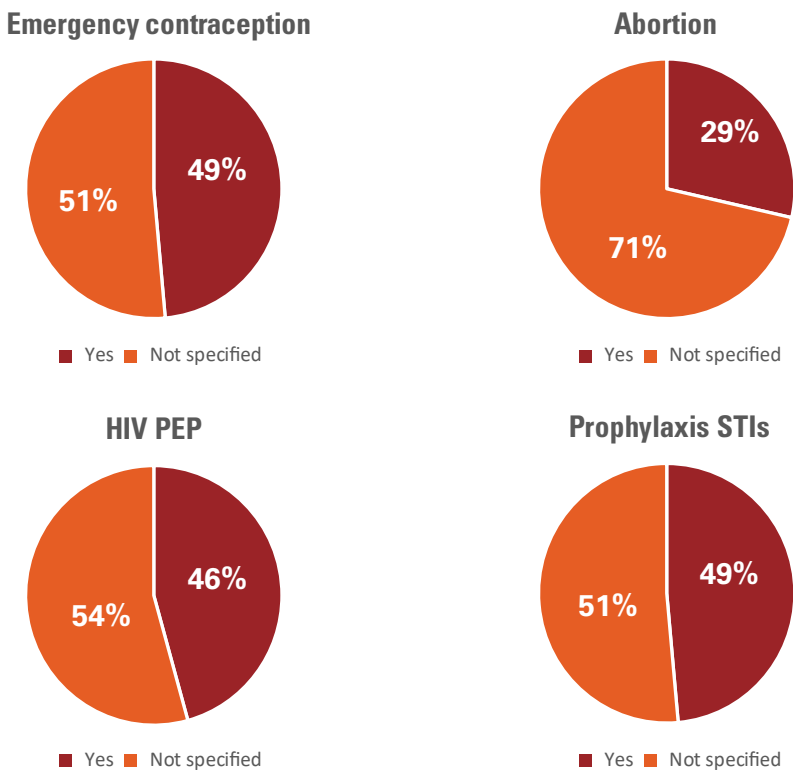


IMPORTANT ASPECTS OF CLINICAL CARE AFTER SEXUAL ASSAULT

Sexual violence has enormous consequences for women and girls, as it is associated with a range of sexual and reproductive health consequences such as unwanted pregnancy, unsafe abortion, and a higher risk of sexually transmitted infections, including from HIV. Health systems play an important role in helping to mitigate these consequences through timely access to high-quality clinical care. This is reiterated in the Strategy and Plan of Action on VAW, which includes an indicator on the provision of comprehensive post-rape care in line with WHO guidelines.⁶

As shown in **Figure 12**, around half of the Member States (49%) stipulate that emergency contraception should be provided in the case of unwanted pregnancies resulting from rape. Around 46% stipulate in their health sector VAW protocol that post-exposure prophylaxis (PEP) to prevent HIV should be provided, while half (49%) mention the need to provide prophylaxis for STIs.

Figure 12. Member States that mention emergency contraception, abortion, HIV post-exposure prophylaxis (PEP), and prophylaxis for STIs in health sector VAW protocols

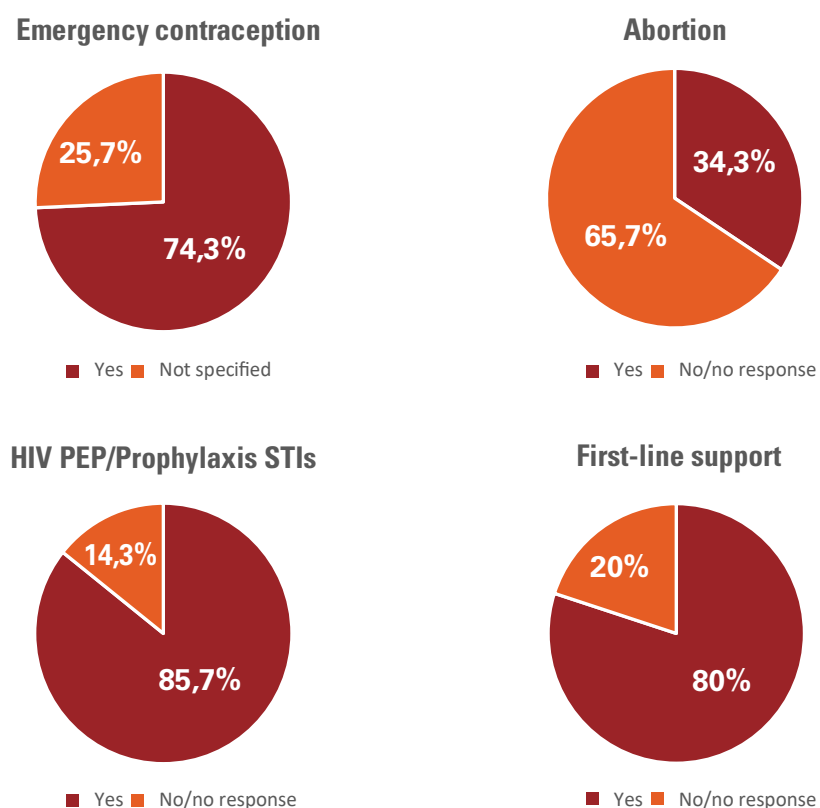


6 Comprehensive post-rape care services include: a) first-line support and psychological first aid; b) emergency contraception to women who seek care within five days; c) referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law; d) STI and/or HIV post-exposure prophylaxis, per applicable protocols; and e) hepatitis B vaccination.

For abortion in accordance with national law, a little under one-third of the Member States (29%) mentioned that this service should be available to survivors of sexual violence when a pregnancy results from the incident.

There were some differences between the policy data and the UNAIDS NCPI survey data, as evidenced in **Figure 13**. Around three-quarters of countries reported having service delivery points that provided emergency contraception, which is significantly higher than what was found in policy, and may be accounted for in the fact that the analysis limited documents to health sector VAW protocols only. The percentage of those that responded that they similarly provide first-line support was also much higher in the NCPI survey data (80% versus 54%).

Figure 13. Countries that report first-line support, emergency contraception, abortion, HIV post-exposure prophylaxis (PEP), and prophylaxis for STIs from the UNAIDS National Commitments and Policy Instrument Survey Data



Data source: UNAIDS National Commitments and Policy Instrument (NCPI) survey data – 2017 or 2019 (whichever data are available for countries).

Overall, as seen in **Table 5**, all Member States in South America and Central America, plus Cuba, the Dominican Republic, and Mexico, responded that they provide at least one aspect of comprehensive post-rape care services. For the Non-Latin Caribbean, and Canada and the United States, only 64% and 50% of Member States included at least one aspect, respectively. This should be addressed urgently given the importance of providing timely and comprehensive post-rape care for mitigating the health consequences that can result from sexual violence.

MENTAL HEALTH ASSESSMENT, TREATMENT, AND REFERRALS

Violence against women is associated with a range of short-, medium-, and long-term mental health consequences, including depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and increased risk of self-harm and suicide attempts. A WHO analysis found, for example, that women who have experienced IPV were almost twice as likely to experience depression and increased alcohol consumption (8).

It is therefore essential that survivors of violence be provided with appropriate mental health care to assist with their short- and long-term recovery. First-line support is informed by psychological first aid and can help considerably with a survivor’s emotional or mental health care needs. Additional support can be provided to survivors by strengthening positive coping methods, teaching stress reduction, and exploring social support. Some survivors will recover quickly with these interventions; others, such as persons

Table 5. Proportion of subregions with at least one aspect of comprehensive post-rape care services available (in line with WHO guidelines)

Region or subregion	Yes (Percentage)	No/No survey completed (Percentage)
Americas	83	17
Canada and the United States	50	50
Non-Latin Caribbean	64	36
Central America, plus Cuba, the Dominican Republic, and Mexico	100	0
South America	100	0

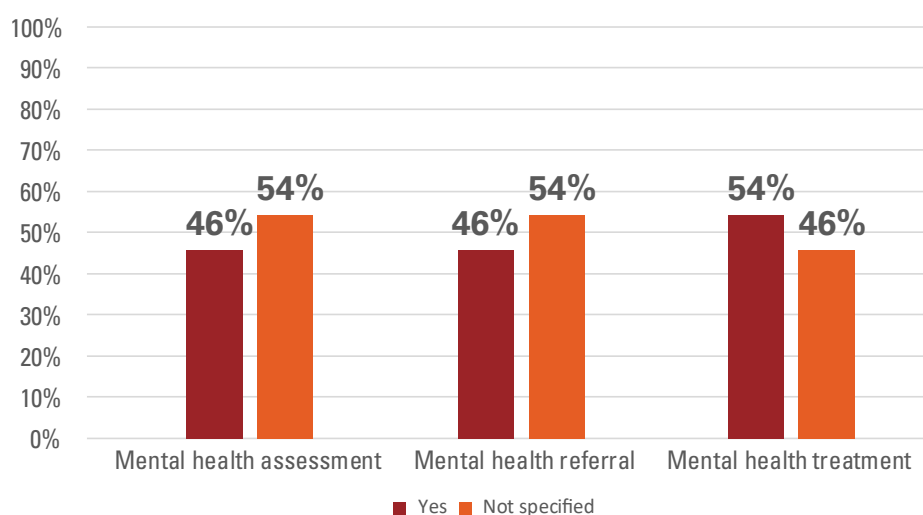
Data source: UNAIDS National Commitments and Policy Instrument (NCPI) survey data – 2017 or 2019 (whichever data are available for countries).

with preexisting mental health conditions, may require additional mental health care. Given the impact of violence on survivor's mental and emotional health and well-being, it is important for all to be assessed for potential mental health needs and offered and/or referred to additional support as needed.

Findings show that 54% of the Member States include a reference to mental health assessment in their protocols, 54% include mental health treatment, and 46% specifically mentioned referral to mental health services/specialists (see **Figure 14**). This points to a significant agenda for the Region to strengthen guidance for health workers on how to respond to the mental health needs of survivors of violence. Attention to this area is especially timely given that the pandemic has considerably impacted both risks of violence as well as the mental health of populations in the Region. Tools such as mHGAP 2.0 and the forthcoming WHO guidance on mental health care for survivors of violence can be useful resources to countries and partners as they take this agenda forward.

In recognition of the close links between violence and mental health, and the importance of giving detailed guidance to health workers, selected countries in the Region have developed specific protocols on the provision of mental health care for survivors of violence (see **Boxes 26 and 27**).

Figure 14. Member States with health sector VAW protocols that reference mental health assessment, treatment, and referrals



BOX 26. Mental health assessment, treatment, and referrals (El Salvador)

In the technical guidelines for healthcare for people affected by violence, published by El Salvador in 2019, the relationship between psychological first aid and psychological care is articulated, as well as the need for referrals, when necessary.

“Atención psicológica

Si la mujer presenta alteraciones en su estado emocional, el personal de salud capacitado debe priorizar la atención brindando los primeros auxilios psicológicos, orientada a mejorar la salud emocional, la autoestima y el empoderamiento de la mujer. Si está en crisis, brindar la atención psicológica si se cuenta con el recurso especializado en el establecimiento, de lo contrario realizar la referencia de inmediato al hospital más cercano, para atención psicológica o psiquiátrica, según la condición de la paciente, además proporcionar atención psicológica a la familia y el seguimiento.” (p. 71)

“Psychological attention

If the woman presents alterations in her emotional state, the trained health personnel must prioritize the attention by providing psychological first aid, aimed at improving the emotional health, self-esteem and empowerment of the woman. If you are in crisis, provide psychological care if you have the specialized resource in the establishment, otherwise make a referral immediately to the nearest hospital, for psychological or psychiatric care, depending on the patient's condition, in addition to providing psychological care to the family and the follow-up.” (p. 71)

Reference: Ministerio de Salud, El Salvador. Lineamientos técnicos de atención integral en salud de las personas afectadas por violencia. 2019 [Accessed 7 October 2022]. Available from: <http://asp.salud.gob.sv/regulacion/pdf/lineamientos/lineamientosatencionintegralpersonasafectadasviolencia2019.pdf>

BOX 27. Mental health assessment, treatment, and referrals (Peru)

Peru has a specific protocol for mental health care for IPV, the technical guide for mental health care for women in situations of violence caused by a partner or ex-partner. In regard to assessment, treatment, and referrals the following text is included:

“b) Diagnóstico: -El diagnóstico es realizado por el personal de salud especializado o personal capacitado. -Posteriormente a la evaluación de la salud física y mental se realiza el diagnóstico establecido en la Clasificación Internacional de Enfermedades (CIE-10), explicando a la víctima de violencia los hallazgos encontrados, así como el tratamiento que requiera. -Motivar a la víctima a que plantee sus dudas e inquietudes y clarifique cualquier información que se requiera, verificando que la persona haya comprendido la información. -Una vez realizado el diagnóstico se procede a brindar el tratamiento según las guías técnicas correspondientes. -Se consigna lo evaluado en la historia clínica y llena la ficha de evaluación de violencia de pareja o expareja (Anexo 9). -Según el caso, proceda a realizar la referencia y articulación intersectorial para asegurar la continuidad del tratamiento, remitiendo la documentación pertinente.” (p. 23)

“B) Diagnosis: -The diagnosis is made by specialized health personnel or trained personnel. -After the evaluation of physical and mental health, the diagnosis established in the International Classification of Diseases (ICD-10) is made, explaining to the victim of violence the findings found, as well as the treatment required. -Motivate the victim to raise their doubts and concerns and clarify any information that is required, verifying that the person has understood the information. -Once the diagnosis is made, treatment is provided according to the corresponding technical guidelines. -The evaluation is recorded in the medical history and the form for the evaluation of partner or ex-partner violence is filled out (Annex 9). -Depending on the case, proceed to make the reference and intersectoral articulation to ensure the continuity of the treatment, sending the pertinent documentation.” (p. 23)

Reference: Ministerio de Salud, Gobierno de Perú. Guía técnica para la atención de salud mental a mujeres en situación de violencia ocasionada por la pareja o expareja 2017 [Accessed 7 October 2022]. Available from: <http://bvs.minsa.gob.pe/local/MINSA/3943.pdf>

BOX 28. Essential services for women and girls subjected to violence

The United Nations Essential Services Package, developed by UN Women, UNFPA, UNDP, UNODC, and WHO, outlines a set of essential multisectoral services for women and girls who have experienced gender-based violence. This includes essential health, police, justice, and social services that together can mitigate the consequences of violence, promote the health and safety of women and girls, assist in their recovery and empowerment, and prevent violence from reoccurring. The package includes a range of health services aligned with WHO guidance, including the identification of survivors by health services, first-line support, clinical care and treatment, including post-rape care and mental health assessment and care, as well as medico-legal documentation. Coordination between essential services, thus also between health and service providers in sectors, is fundamental to ensure comprehensive, survivor-centered care and support.

Reference: United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) World Health Organization (WHO) United Nations Population Fund (UNFPA) United Nations Development Programme (UNDP) United Nations Office on Drugs and Crime (UNODC). United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence. 2015 [Accessed 10 October 2022]. Available from: <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>

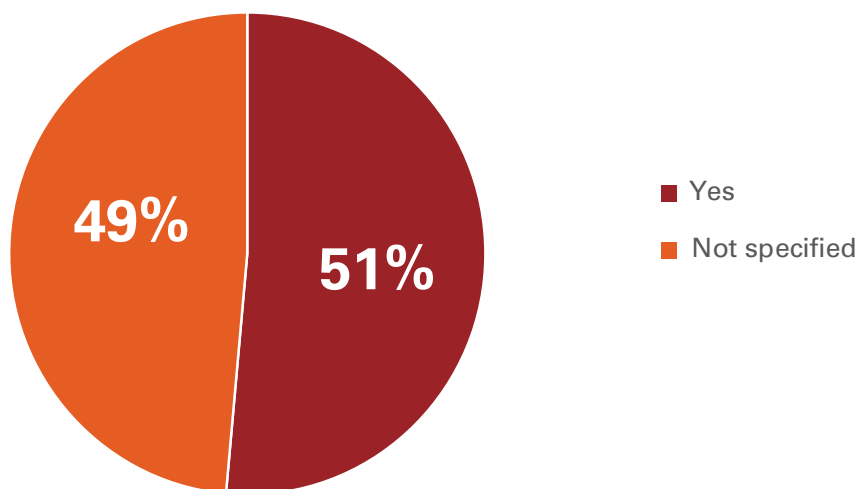
REFERRALS OUTSIDE THE HEALTH SYSTEM

Health services not only provide life-saving care and support to survivors of violence, they are also in a unique position to act as a gateway to other essential support services. Given the multidimensional needs of survivors, health services and health workers must work closely with police and protection services, shelters, social services, legal services and many other providers (see **Box 28**). To facilitate “warm” referrals that respond to survivors’ needs and preferences, it is important to specify the role of health workers with regard to referrals outside of the health system.

In **Figure 15**, it can be seen that that 51 % of the Member States stipulate that referrals to support services outside the health sector should be provided. For example, these may be referrals to formal services, such as shelters or criminal justice services, as well as nongovernmental organizations or informal support.

Selected countries have underlined the importance of a coordinated and integrated approach to the response to survivors of violence (see **Boxes 29 and 30**). The closer the different essential services are working together, the greater will be their collective ability to respond to the survivor’s needs and reduce the chances of

Figure 15. Member States with health sector VAW protocols that mention referrals to support services outside the health sector



revictimization by focusing the survivor to repeatedly retell their story and ask for help. Close coordination and seamless referrals also require health workers to have the needed knowledge of the referral options and pathways in a given community, which underlines the need for appropriate education and related capacity-building of health and other frontline service providers.

BOX 29. Referrals outside the health system (Plurinational State of Bolivia)

The Plurinational State of Bolivia provides an example of referrals and counter-referrals in the Model of Integrated Care for Victims of Sexual Violence, highlighting the need to coordinate between institutions.

“1.11. Referencia y contrareferencia

- *El proceso de referencia y contrareferencia es el conjunto de esfuerzos interinstitucionales e intersectoriales para ofrecer una atención integral a las víctimas de violencia sexual. Para ello, se requiere de la articulación y coordinación entre las instituciones del Estado y la sociedad civil.*
- *Identificar instituciones públicas y privadas (salud, policía, justicia, apoyo psicosocial, etc.) que brinden atención a las víctimas.” (p. 36)*

“1.11. Referrals and counter-referrals

- The referral and counter-referral process is the set of inter-institutional and intersectoral efforts to offer comprehensive care to victims of sexual violence. For this, it requires articulation and coordination between State institutions and civil society.
- Identify public and private institutions (health, police, justice, psychosocial support, etc.) that provide care to victims.” (p. 36)

Reference: Ministerio de Salud y Deportes de Bolivia. Modelo de Atención Integral a Víctimas de Violencia Sexual. 2015 [Accessed 7 October 2022]. Available from: <https://www.comunidad.org.bo/assets/archivos/herramienta/d0fe93060eb1bbcaf7fc40c90ffcd9ea.pdf>

BOX 30. Referrals outside the health system (Saint Kitts and Nevis)

In the Domestic and Sexual Violence Complaints and Response Protocol, Saint Kitts and Nevis outlines the role that service providers have in educating themselves and ensuring referrals through maintaining relationships, which is crucial.

“7.3 All Service Providers have an obligation to educate themselves on the resources/assistance available to complainants of domestic and sexual violence from the various Service Providers.

7.4 It is crucial that Service Providers develop and maintain relationships with each other so that referrals will be more relevant to the needs of the complainants and the resources of the Institution/Agency.

7.5 It is very important to emphasize that the complainants have the choice in all matters but it is the duty of the Service Providers to ensure that the complainants are provided with comprehensive information on the available options.

7.6 Complainants of Domestic and Sexual violence may seek to do nothing, seek medical attention, request police involvement, seek counselling or any combination of actions listed above.” (p. 11)

Reference: Government of St. Kitts and Nevis. Domestic and Sexual Violence Complaints and Response Protocol.

MANDATORY REPORTING

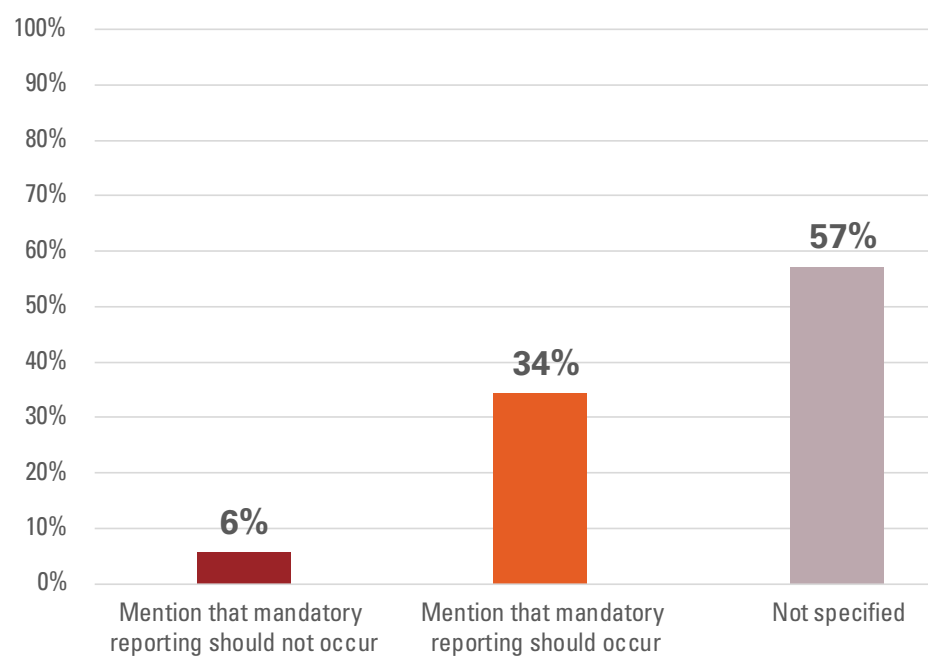
WHO guidelines recommend against mandatory reporting of IPV to the police by health workers (26, 27). This is predicated on the fact that mandatory reporting can infringe on a survivor's autonomy and empowerment. It may also pose new challenges for her safety and well-being, including risk of retaliation and retraumatization as a result of interacting with other service providers and systems.

From a health service perspective, mandatory reporting presents an ethical and professional practice challenge to health workers due to privacy and confidentiality standards related to health care, time, and resource requirements of reporting, and the awareness that this type of response may reduce help-seeking and disclosure of violence to health workers. Evidence suggests that health workers should offer to assist with reporting if the (adult) survivor wishes to do so and has been made aware of her rights. Since mandatory reporting is usually set by national law, rather than health sector guidance, it is important for the health workers to be aware of their obligations with regard to reporting, to enable them to be of the best possible help to the survivor.

This analysis found that only 6% of the Member States stated explicitly that mandatory reporting is not to be included, which is an ideal response for IPV in line with the current evidence (see **Figure 16**). About one-third of the Member States (37%) mentioned that mandatory reporting should occur, including text accordingly in their health sector VAW protocols. A little over half of the Member States (57%) did not specify whether mandatory reporting should occur or not.

It is often helpful for health sector guidelines to include an explanation of any reporting requirements in the health sector VAW protocol, regardless of whether it is legally required or not. Lack of attention to this topic in protocols may leave many questions unanswered and reduce the likelihood of a standardized, evidence-based response by health workers. Explicitly stating the requirements helps the health workers to play their role, reduces the opportunities for errors and offers a good basis for capacity-building (see **Box 31**).

Figure 16. Mandatory reporting by health workers, as mentioned in health sector VAW protocols



BOX 31. Mandatory reporting language (Argentina)

In Argentina, the protocol for comprehensive care for victims of sexual violence includes an explanation that the decision to report is the survivor choice and therefore healthcare workers should not report. The language is clear and affords the survivor autonomy.

“6. LA DENUNCIA. RESPONSABILIDADES LEGALES DE LAS/OS PROFESIONALES DE SALUD Para las personas adultas en nuestro país la violación es un delito de instancia privada. Esto significa que a partir de los 18 años la decisión de instar la acción penal es de la víctima. En estos casos no corresponde que las /os profesionales de salud denuncien” (p. 36)

“6. THE REPORT. LEGAL RESPONSIBILITIES OF HEALTH PROFESSIONALS

For adults in our country, rape is a private crime. This means that from the age of 18, the decision to take criminal action belongs to the victim. In these cases, it is not appropriate for health professionals to report” (p. 36).

Reference: Ministerio de Salud, Argentina. Protocolo para la Atención Integral de Personas Víctimas de Violencia Sexual. 2021 [Accessed 7 October 2022]. Available from: https://bancos.salud.gob.ar/sites/default/files/2021-05/Protocolo_Atencion_Personas_Victimas_Violaciones_Sexuales_2021_5.pdf

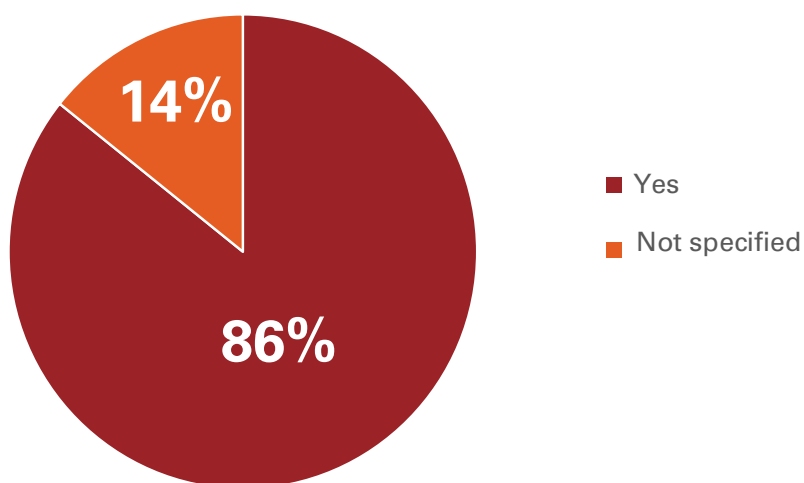
TRAINING

Training health managers and health workers is essential to a strong health system response to VAW (26, 45). The WHO clinical and policy guidelines specify that in and pre-service training should be provided (26). This analysis offers a snapshot of a high-level commitment to train healthcare providers on VAW. As seen in **Figure 17**, 86% of Member States do include these commitments in their policies.

Overall, most subregions demonstrated the commitment to training, with two subregions at 100% of Member States (Canada and the United States, and Central America, plus Cuba, the Dominican Republic, and Mexico). In both the Non-Latin Caribbean and South America, over three-quarters of the Member States expressed a commitment to training in their health and/or multisectoral policy documents.

The review did not, however, collect training manuals and curricula that may exist in Member States to strengthen capacity-building of health workers (see **Boxes 32 and 33** for selected examples of training resources). This is an area for future collaboration between PAHO and Member States, including designing a more rigorous methodological tool to collect, categorize, and analyze different training resources and their implementation, in addition to continuing to strengthen text references to training in health policies and protocols.

Figure 17. Member States that mention a commitment in policy to train healthcare providers in addressing VAW



BOX 32. National training manual (Dominican Republic)

In 2016, the Dominican Republic published the Training Plan for the National System for Prevention and Comprehensive Attention to Violence Against Women, Domestic Violence, and Sexual Crimes (25). This document was published jointly by the Ministry of Women, the Public Ministry, The Ministry of Education, the Ministry of Public Health, the National Police, and the Judicial Branch with the support of UNFPA. The training plan is for the National System for Prevention and Comprehensive Care for Violence Against Women, Intimate Partner Violence, and Sex Crimes. It focuses on incorporating a gender perspective and lasts 119 hours (over 17 weeks). The objective of the training is the following:

“Favorecer la integración de las servidoras y servidores públicos que conforman el Sistema Coordinado Prevención y Atención Integral a la Violencia contra la Mujer, Intrafamiliar y Delitos Sexuales, a través de una herramienta de capacitación-sensibilización sobre género y violencias focalizada en la reflexión crítica sobre las formas en las que socialmente se construyen roles diferenciadores para mujeres y hombres, las implicaciones de estas imposiciones en los actos de violencia, y en particular, en la revictimización de las mujeres en el trayecto de la ruta de atención que conlleva sobrevivir convivir y denunciar un acto violento” (p. 4).

“Promote the integration of the public servants that make up the Coordinated System for Prevention and Comprehensive Attention to Violence against Women, Intrafamily and Sexual Crimes, through a training-awareness tool on gender and violence focused on critical reflection on the ways in which differentiating roles for women and men are socially constructed, the implications of these impositions in acts of violence, and in particular, in the revictimization of women along the path of care that involves surviving coexistence and reporting a violent act ” (p. 4).

Reference: Ministerio de la Mujer, Ministerio Público, Ministerio de Educación, Ministerio de Salud Pública, Policía Nacional de la República Dominicana, Poder Judicial República Dominicana. Plan de Capacitación del Sistema Nacional de Prevención y Atención Integral a la Violencia Contra la Mujer, Intrafamiliar y Delitos Sexuales 2016.

BOX 33. Online training program for healthcare workers (Mexico)

In 2021, the National Center for Gender Equity and Reproductive Health, which is part of the Mexican Ministry of Health, launched a training course called “La NOM-046 y su aplicación en la prevención y atención de la violencia. Aspectos generales” (NOM-046 and its application in the prevention and care of violence. General features).

The course builds capacity on an important Norm that addresses care for survivors of violence, and incorporates best practices/principles from WHO/PAHO. This free, 16-hour online course includes a module on medical care. At the launch event held on November 30, 2021, the National Center for Gender Equity and Reproductive Health convened over 250 actors from the State Ministries of Health as well as high-level national leaders. The course opened on 1 December 2021 and by 2 December 2021 all of the available spots for the first round were taken. This represents an important advancement in strengthening training for health workers in Mexico.

Reference: Secretaría de Salud, México. Educación, Capacitación y Actualización a Distancia en Salud_MD2 [Internet]. 2021 [Accessed 7 October 2022]. Available from: <http://moodle.dgces.salud.gob.mx/moodle/>

3.3 STRENGTHENING THE ROLE OF THE HEALTH SECTOR IN THE MULTISECTORAL RESPONSE TO VAW

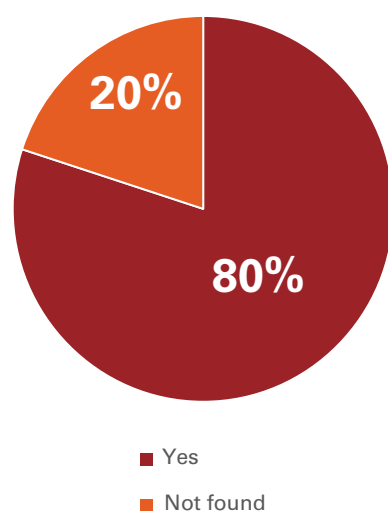
Health systems can also play a key role in multisectoral efforts to prevent violence. The public health approach to prevention involves four key steps:

- 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; and
- 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, social affairs, and justice), as well as collaborate with national multisectoral coordination mechanisms on gender equality and civil society organizations. A solid basis for such multisectoral collaboration can be provided by a national multisectoral plan that brings together the various efforts of different stakeholders engaged in the prevention and response to VAW and outlines their roles and responsibilities.

It is important that multisectoral plans be developed in collaboration with the health sector, and that the policy document be based on the best available evidence with the best potential to prevent and reduce VAW. This section therefore reviews the existence of multisectoral policy frameworks in the Region, together with their content in line with the RESPECT strategies.

Figure 18. Member States that have a national or multisectoral policy addressing VAW that includes the health system



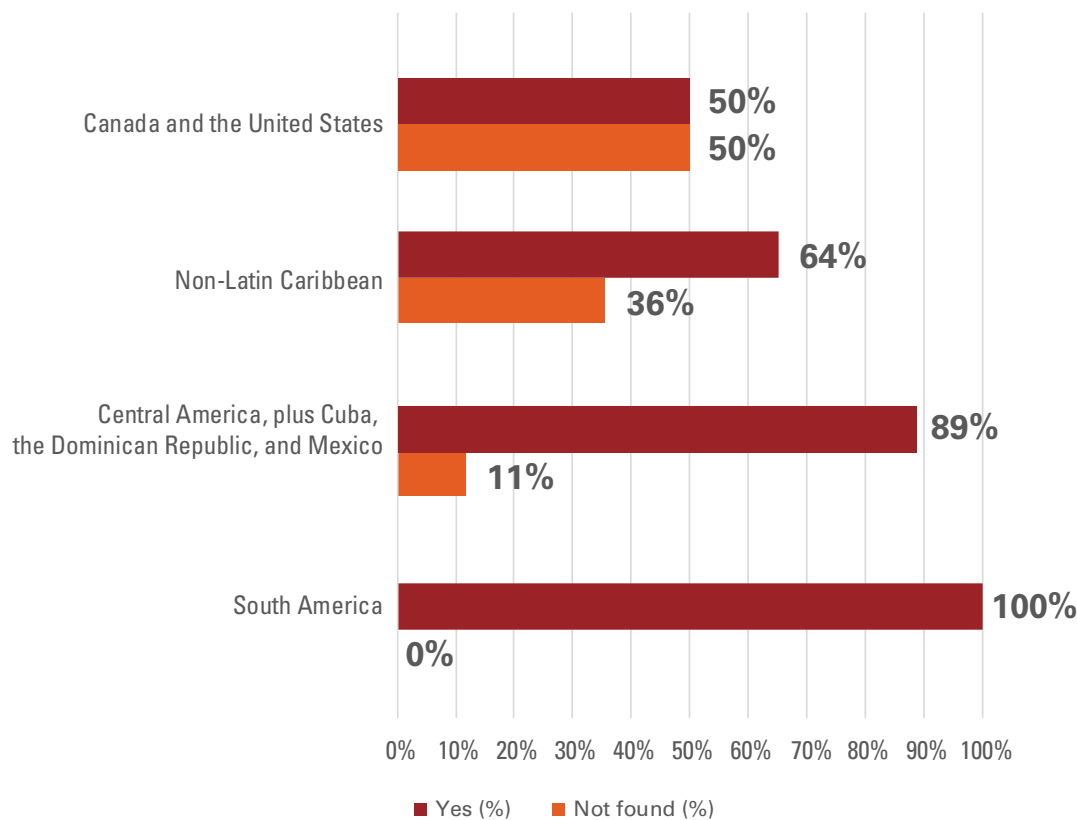
MULTISECTORAL VIOLENCE AGAINST WOMEN POLICIES

Most Member States in the Americas have a national or multisectoral policy addressing VAW. As seen in **Figure 18**, 80% have either a multisectoral VAW policy or a national gender policy that includes VAW in a significant way. These plans usually involve multiple sectors (e.g., justice, education, and social affairs), including the health sector.

SUBREGIONAL ANALYSIS ON AVAILABILITY OF A NATIONAL OR MULTISECTORAL PLAN ADDRESSING VAW THAT INCLUDES THE HEALTH SYSTEM

Central America, plus Cuba, the Dominican Republic, and Mexico, and South America have shown progress on the availability of multisectoral VAW policies (see [Figure 19](#)). However, this represents an area of opportunity for other subregions/countries.

Figure 19. Member States that have a national or multisectoral policy addressing VAW that includes the health system, by subregion



ALIGNMENT OF MULTISECTORAL PLANS WITH THE RESPECT FRAMEWORK

Given the high prevalence of VAW globally and regionally, it is crucial that Member States place a strong emphasis on prevention (46). The RESPECT women framework was created by WHO, UN Women, and various other partners to review and summarize the evidence base on what works to prevent violence against women. RESPECT contains seven strategies (see Box 34) with various action-oriented approaches (24). While the focus of this report is on the inclusion of these strategies in multisectoral VAW policies, they may also be included in other types of documents beyond the scope of this report given the varied nature of the approaches (e.g., national transportation policies or poverty reduction plans).

In the Region, 77% of the Member States include at least one prevention strategy/approach in line with RESPECT in their multisectoral plan. On average, Member States that meet this indicator include around seven interventions or approaches associated with RESPECT.

There was, however, substantial diversity across plans. Findings indicate that eight Member States included 1–4 interventions, 13 Member States included 5–9 interventions, and only six Member States included 10 or more interventions. Ideally, multisectoral plans/policies should include a large number of prevention strategies and approaches that when implemented together would work to prevent violence in the short, medium, and long term.

BOX 34. RESPECT women: preventing violence against women

- R Relationship skills strengthened.** This refers to strategies to improve skills in interpersonal communication, conflict management, and shared decisionmaking.
- E Empowerment of women.** This refers to economic and social empowerment strategies including those that build skills in self-efficacy, assertiveness, negotiation, and self-confidence.
- S Services ensured.** This refers to a range of services including health, police, legal, and social services for survivors of violence.
- P Poverty reduced.** This refers to strategies targeted to women or the household, whose primary aim is to alleviate poverty.
- E Environments made safe.** This refers to efforts to create safe schools, public spaces, and work environments, among others.
- C Child and adolescent abuse prevented.** This includes strategies that establish nurturing family relationships.
- T Transformed attitudes, beliefs, and norms.** This refers to strategies that challenge harmful gender attitudes, beliefs, norms, and stereotypes.

In **Figure 20**, the percentage of Member States that includes different RESPECT prevention strategies is shown by type of intervention or approach. Overall, the level of inclusion of these approaches varied widely—from 6% of Member States mentioning couples therapy associated with the strategy on “Relationship skills strengthened” to 71% mentioning approaches for raising awareness associated with “Transformed attitudes, beliefs, and norms.” There were several areas where multisectoral plans could be strengthened in line with the evidence base, suggesting a need to strengthen governments’ capacity on RESPECT and related prevention evidence to enable them to apply this knowledge as they develop and update their multisectoral plans (see also **Box 35**).

The Non-Latin Caribbean has made significant progress in integrating prevention approaches in multisectoral VAW policies. In the following table, examples from countries across the Non-Latin Caribbean are included to highlight this achievement (see **Table 6**).

BOX 35. Approaches to empowering women (Panama)

Panama includes language of empowering women in its action plan for equality of opportunities for women: 2016–2019. Of note is the inclusion of various strategies designed to support women including self-help groups and shelters.

“Fomentar la creación, mantenimiento y operatividad de albergues temporales para víctimas de violencia domestica hijos e hijas y sus familias, conformando grupos de autoayuda y autonomía económica.” (p. 41)

“Encourage the creation, maintenance and operation of temporary shelters for victims of domestic violence, sons and daughters and their families, forming self-help groups and economic autonomy.” (p. 41)

Reference: Instituto Nacional de la Mujer, Panamá. Plan de acción de igualdad de oportunidades para las mujeres: 2016–2019. 2016 [Accessed 7 October 2022]. Available from: <https://www.scribd.com/document/543358794/plan-de-accion-de-igualdad-de-oportunidades-para-las-mujeres>

Figure 20. Member States with strategies for prevention in line with RESPECT, by type of intervention/approach

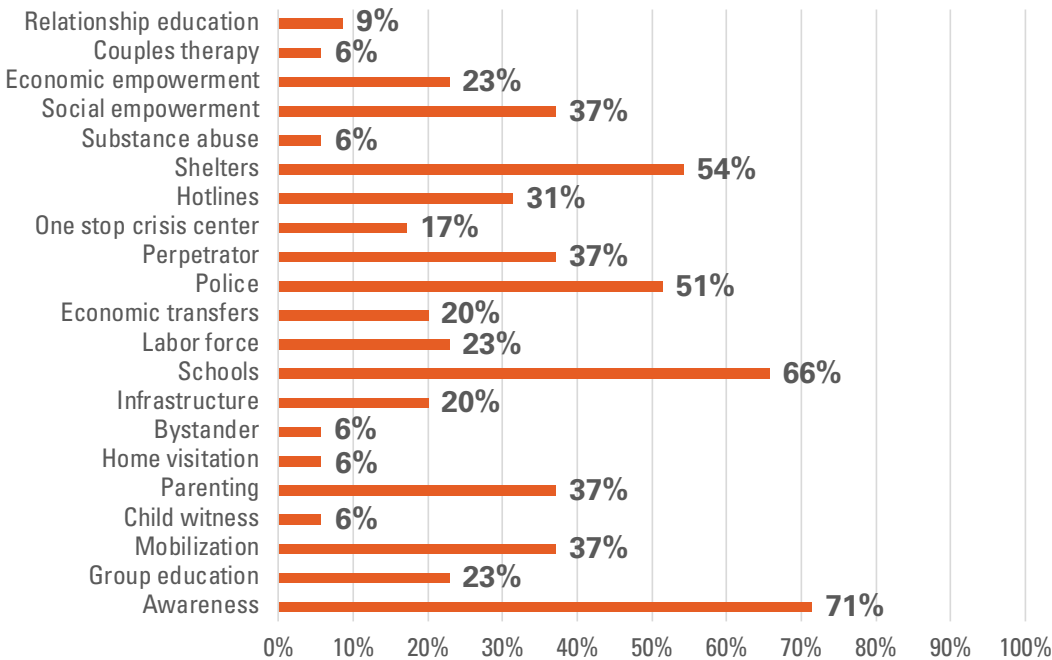


Table 6. Examples of RESPECT interventions from the Non-Latin Caribbean Subregion

RESPECT strategy	Intervention	Country	Document	Example
Relationship skills strengthened	Relationship education	Bahamas	Strategic Plan to Address Gender-Based Violence (2015)	"To involve churches, faith-based organisations and CSOs in prevention initiatives...Develop training for marriage counsellors and pre-marital counsellors on how to encourage couples to exercise mutual respect in intimate relationships and to reject all forms of spousal and relationship abuse." (p. 134)
Empowerment of women	Economic empowerment	Grenada	Gender Equality Policy & Action Plan (2014)	"2. Promote women's economic empowerment and resilience. Short-term actions • Bring together all agencies and groups offering GBV and related services to discuss and develop strategies to promote women's economic empowerment and resilience. Agencies and groups offering GBV and related services consulted on strategies to promote women's economic empowerment and resilience." (p. 149)
Services ensured	Shelters	Haiti	National 2017–2027 plan to combat violence against women	<i>"6.2.3. Action 7 : Encadrer le fonctionnement des centres d'hébergement Les centres d'hébergement ont pour but d'offrir aux femmes et filles violentées un hébergement temporaire dans un environnement sécuritaire, afin de leur permettre de se reconstruire et de reprendre le cours de leur vie."</i> (p. 38) "6.2.3. Action 7: Supervise the operation of the accommodation centers The purpose of the shelters is to provide abused women and girls with temporary accommodation in a safe environment, so that they can rebuild and get on with their lives." (p. 38)
Poverty reduced	Labor force	Haiti	Gender equality policy 2014–2034	<i>"i. Établissement de protocoles d'accord avec les institutions étatiques concernées pour la fourniture d'une assistance sociale devant contribuer à la réhabilitation socioéconomique des femmes et filles violentées (accès à l'éducation, à la formation professionnelle, au crédit, à l'emploi productif, etc.)."</i> (p. 38) "i. Establishment of memoranda of understanding with the state institutions concerned for the provision of social assistance to contribute to the socio-economic rehabilitation of abused women and girls (access to education, vocational training, credit, productive employment, etc.)." (p. 38)
Environments made safe	Safe schools	Saint Vincent and the Grenadines	Saint Vincent and the Grenadines National Gender-Based Violence Action Plan (2014)	"3.1.2 The Ministry of Education The Ministry of Education will assume responsibility for the implementation age appropriate sexuality education and education on GBV violence among school age children. Additional responsibility for this Ministry will include a program of training on gender and GBV for teachers and principals; the organization of nationwide rallies, radio and television programs, and community activities on key days in the international calendar during which the focus is on GBV; and a program of education for children on their rights." (p. 28)

Table 6. Examples of RESPECT interventions from the Non-Latin Caribbean Subregion (*continued*)

RESPECT strategy	Intervention	Country	Document	Example
Child and adolescent abuse prevented	Parenting interventions	Grenada	Gender Equality Policy & Action Plan (2014)	“(iii) Integrate modules on gender-based violence into professional training programs, e.g., nurses, police officers, social workers and teachers; and Health and Family Life Education (HFLE) school curriculum at the primary and secondary levels; parenting/life skills through Parent-Teacher Associations, Health Clinics, and the Youth Division.” (p. 106)
Transformed attitudes, beliefs, and norms	Community mobilization	Antigua and Barbuda	Strategic action plan to end gender-based violence Antigua and Barbuda 2011–2015	“Widespread Community Mobilization and Individual Behavior Change will be undertaken. This includes raising overall community awareness, mobilizing community-based efforts, providing support for evidence-based advocacy; and conducting mass media campaigns that improve knowledge, attitudes, and practices of community members. A key aspect of community mobilization is involving the media to ethically and accurately report on violence issues.” (p. 14); “Use of community-wide meetings, knowledge-building workshops, peer group discussions, and drama to challenge gender inequities related to Gender-Based Violence (GBV)” (p. 24)

BOX 36. Violence against women from ethnic minority groups

In the Americas, violence against women cannot be seen in isolation from various other social factors and trends. Data suggest, for example, that indigenous and Afro-descendant women face higher risks of different forms of violence than other women, while also experiencing greater barriers in access to support, care and justice. Violence intersects with ethnicity, gender, socioeconomic status, (lack of) access to land and income, education, health, and other status, often leading to compound inequities and systemic discrimination faced by certain groups of women and girls.

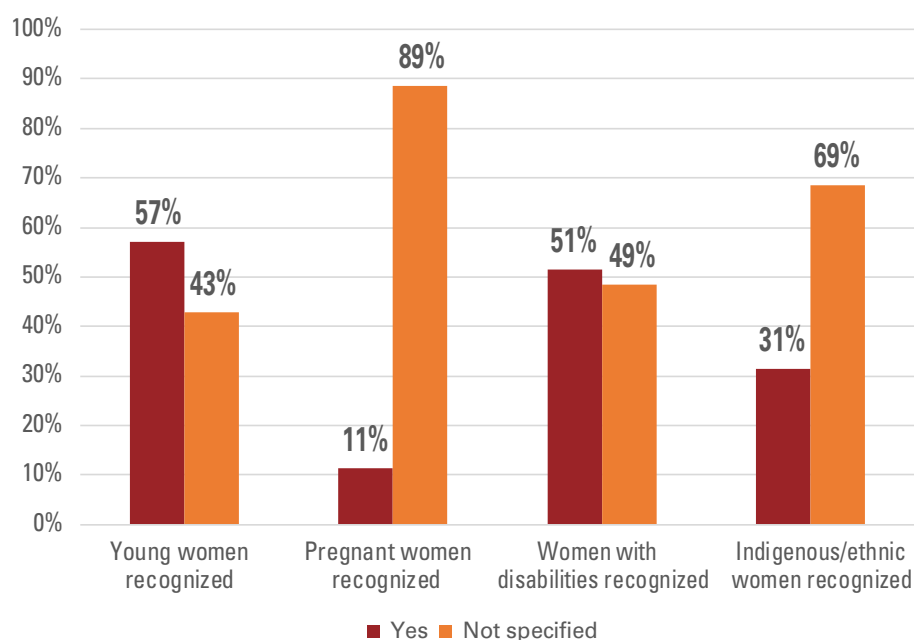
In line with the principle of leaving no one behind, it is essential that efforts to prevent violence pay appropriate attention to the specific risks and barriers faced by women and girls from ethnic minority groups. An important first step is to give visibility to the needs and preferences of these groups in policy and practice. This is underlined by the regional Strategy and Plan of Action on VAW, which stresses the importance of collecting prevalence data disaggregated by ethnicity/race.

3.4 FOCUS ON GROUPS OF WOMEN IN CONDITIONS OF VULNERABILITY

One crucial element to policies and plans is the recognition of populations in conditions of vulnerability. While all women and girls can be at risk of violence, evidence suggests that some groups face heightened risks while also experiencing increased barriers in access to care and support. Thus, in line with the principle of leaving no one behind, explicit recognition of such groups and their specific needs and preferences are important. While this is not an exhaustive list, the choice was made to focus in this analysis on references to young women aged 10–24 years, women with disabilities, pregnant women, and indigenous/ethnic minority/Afro-descendant women (see also [Boxes 36 and 37](#)).

Overall, it can be seen in [Figure 21](#) that the group recognized most often in policy is young women, with 57% of Member States including some language around this. The vulnerable group least often recognized is pregnant women, as only 11% of Member States mentioned vulnerability to different forms of VAW.

Figure 21. Member State recognition of vulnerable groups of women



Beyond recognition of vulnerable groups in policy, ideally the health sector should be providing differentiated services for these groups based on their specific characteristics. Overall, there was far less mention of differentiated services among Member States, as shown in Figure 22.

BOX 37.

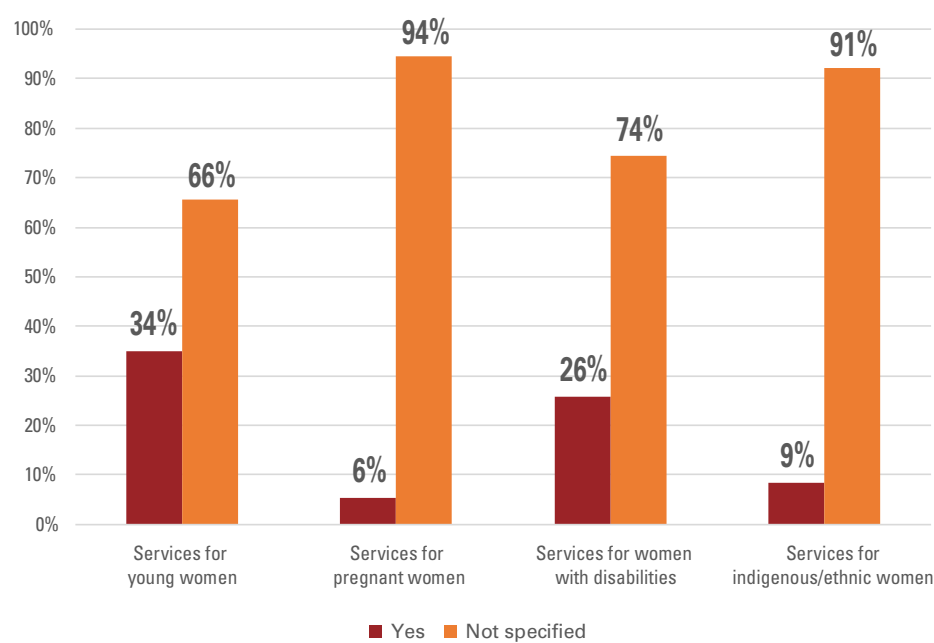
Other vulnerable groups
(Argentina)

The four groups selected in this report (young women aged 10–24 years, women with disabilities, pregnant women, and indigenous/ethnic minority/Afro-descendant women) are not the only vulnerable groups in the Region. While these other groups were beyond the scope of this project, they are worth mentioning. Some of the groups include low-income women or women with no income, and LGBTI populations, including transgender people.

In 2020, Argentina’s Ministry of Health published a protocol called, “Comprehensive health care for trans, transvestite and nonbinary people. Guide for health teams.” This protocol is an important step toward recognizing transgender peoples as vulnerable and to providing differentiated services.

Reference: Ministerio de Salud Argentina. Atención de la salud integral de personas trans, travestis y no binarias. Guía para equipos de salud. 2020 [Accessed 8 October 2022]. Available from: <https://bancos.salud.gob.ar/sites/default/files/2020-10/guia-salud-personas-trans-travestis-nobinarias.pdf>

Figure 22. Member State reference to differentiated services for vulnerable groups of women





IV. CONCLUSIONS AND RECOMMENDATIONS

Violence against women in the Region of the Americas takes multiple, intersecting forms, all of which have substantial health, social, and economic consequences for women and girls, their families, and communities (36). This report offers valuable data on the status of efforts across the Region in developing policies, protocols, and plans to respond to this challenge. The report is the first of its kind, presenting a more in-depth overview of the response of the Region to VAW in line with priorities agreed in the Strategy and Plan of Action on VAW. It complements other progress reporting to PAHO Governing Bodies and related global analysis (37, 38, 47).

As evidenced in the findings of this report, significant progress has been made. This is consistent with existing literature, which shows that many countries in the Region have developed both “first generation laws” (spanning back to the 1990s and often focused on family violence) as well as “second generation laws” that are more comprehensive and account for more types of violence (48). Overall, a major achievement across Member States has been the formulation and approval of policies, protocols, and plans related to both health and VAW. Some 83% of Member States have a health policy that includes VAW in some way, 60% have a health sector VAW protocol, and 80% have a multisectoral VAW policy.

The Region has an opportunity to build on these achievements and accelerate progress toward the elimination of all forms of VAW through developing and implementing evidence-based policies and protocols.

Most Member States have a health policy of some type that includes VAW, and it is important that this trend be continued and built upon in future as countries revise and update their health policies and plans. In addition to integrating VAW in their NHPSP, topic-specific policy documents—including those on sexual and reproductive health, women’s, children’s and adolescents’ health, mental health, and/or HIV—provide additional opportunities to strengthen policy frameworks for a strong health sector response to VAW. Moreover, while many Member States mention VAW in their health policy documents (83%), only 57% of those with such a policy include VAW as a strategic priority.

Further efforts are needed to extend the scope of content on VAW in health policies and plans, framing it as a strategic priority for health-sector action.

Efforts must continue to strengthen the institutional capacity of the health sector to implement these policy commitments and respond to VAW.

Evidence shows that even in countries with comprehensive policy frameworks to address VAW there are still gaps in both current policy and practice that need to be addressed, specifically with regard to governance and leadership, health service organization, and the health workforce (including both health managers and health providers) (49).

The findings in this report show that fewer than half of the Member States reported having a health budget line dedicated to VAW, potentially limiting the implementation of any policy document. Only 57% of Member States reported having a focal point for VAW at the MoH, with likely varying access to resources and learning. Ideally, Member States should have strong leadership at the MoH in the form of a supported, trained, and well-resourced focal person, as well as up-to-date policies and protocols.

When strengthening the quality of health services for VAW survivors, the availability of guidelines and protocols is an important facilitator of a strong response (25).

The findings in this report indicate that substantial progress has been made in the Americas, as evidenced by the number of health sector protocols identified. However, further work is needed to strengthen the quality of protocols and align them with the evidence base.

A close review of the content of protocols has flagged a number of areas for attention. Overall, there is not a single health service indicator where more than 54% of Member States included or met it, pointing to gaps in almost half of all others. The indicators that had been included by most Member States were the principles of privacy and confidentiality, first-line support and mental health treatment.

Substantial work remains to be done in order to build on these achievements and expand the quality of available guidance. For example, the identification of survivors of violence is an essential role of health services. The findings highlight that only 9% of Member States explicitly mentioned clinical inquiry in their protocols, which is what PAHO/WHO recommends instead of universal screening, which only 3% of Member States stated explicitly should not take place.

Similarly, while many Member States included the principles of privacy and confidentiality, only 3% included information on the limits of confidentiality, which is a critical component of enabling the application of these principles in practice. Moreover, only 6% of Member States explicitly stated in their health sector VAW protocols that mandatory reporting should not take place, which suggests that there may be issues around the limits of confidentiality in cases of mandatory reporting.

Around half of the Member States mentioned the need for health services for survivors of sexual violence—including HIV PEP, emergency contraception, and prophylaxis for STIs. However, less than one-third (29%) included information on abortion in accordance with national law.

The level of detail in health sector VAW protocols matters as it can help to address important knowledge gaps in health services and facilitate the implementation of guidelines. The more detailed the guidance included, the easier it is for health workers to understand exactly what is required of them.

These topics—supported by a strong evidence base—represent considerable opportunities for the Region to tackle in their protocols in the future in collaboration with PAHO and partners. Moreover, the evidence base on what works to strengthen health system responses to VAW is continuously expanding, potentially offering new knowledge and know-how to Member States as they advance this agenda. While this is a positive development, it also poses new challenges as it requires sound processes in countries to regularly update existing guidelines/protocols in line with the expanding evidence base.

It is important to note that even the strongest protocol will not have the impact envisaged if not implemented effectively.

In an analysis of health sector responses to IPV in low- and middle-income countries, Colombini et al. identify in addition to the existence of clear protocols and guidelines a number of other facilitators, including “management support; intersectoral coordination with clear, accessible on-site and off-site referral options; adequate and trained staff with accepting and empathetic attitudes toward survivors of IPV; initial and ongoing training for health workers; and a supportive and supervised environment in which to enact new IPV protocols” (50).

While the existence of a protocol and its alignment with the evidence base and related indicators is a critical milestone, it is important that they be implemented and complemented by clinical handbooks, job aids, and similar reference tools, as well as training for health workers to support them in their day-to-day interaction with survivors. For example, two countries in the Region— Argentina and Uruguay—have collaborated with PAHO in adapting to their contexts the manual on health care for women subjected to intimate partner and sexual violence, an important step in strengthening the health system response to violence.

While most Member States in their policy documents recognized the importance of training, very few training manuals were found. One previous study from Colombia showed that health providers had not been trained to address sexual violence, despite their recognition of the importance of the problem and willingness to learn more (51). While more research in this area is needed and concerns about sustainability remain, evidence suggests that training can positively influence providers’ knowledge and attitudes and strengthen access to support (52, 53, 54, 55).

To monitor implementation of any guidance document and ensure continuous health service quality improvements, countries may wish to consider regular service evaluations, including those incorporating the views and preferences of survivors themselves.

They offer valuable intelligence to keep strengthening responses that are evidence-based and centered on the survivor’s experience. In collaboration with WHO, the United States Centers for Disease Control and Prevention and PEPFAR, Jhpiego developed a tool for GBV quality assurance (56). This tool and its facilitation guide are an important resource for Member States as they advance in this area of work. With the support of Canada and the United States of America, PAHO is currently collaborating with selected countries (including Colombia and Peru) in adapting and piloting a rapid service assessment tool with a focus on post-rape care.

While essential, the role of the health sector takes place within a broader multisectoral approach to VAW. When strengthening the role of the health sector in the multisectoral response to VAW, it is important to pay attention to those multisectoral plans and strategies that include the health sector.

Encouragingly, about four out of five Member States have some type of multisectoral VAW policy. While this is a noteworthy achievement, it is important to consider that several policies and strategies will expire and/or be updated in the coming years. It is therefore critical that this progress not be lost but rather built upon in future.

Moreover, in recent years, the evidence base on what works to prevent VAW has been expanded, offering considerable resources to Member States as they continue to strengthen their multisectoral policy frameworks and prevention approaches (57, 58, 24). This analysis looked at the extent to which RESPECT strategies and approaches have been incorporated into multisectoral plans. While 77% of Member States include at least one prevention approach in line with RESPECT in their multisectoral plan, there remains substantial variety across plans and opportunities to strengthen alignment with the evidence base. Given that there is no single cause of violence nor any single solution to prevent it, multisectoral plans/policies should ideally include a combination of strategies and approaches that, when implemented together, will work to prevent violence in the short, medium, and long term.

The findings highlighted that some strategies and approaches were adopted much more widely than others. For example, while 6% of Member States mentioned couples therapy associated with the strategy on “Relationship skills strengthened” in their multisectoral plan, 71% of Member States mentioned approaches for raising awareness associated with “Transformed attitudes, beliefs and norms” in the plans. There are thus several areas where multisectoral plans could be strengthened in line with the evidence base, suggesting a need to strengthen governments’ capacity on RESPECT and related prevention evidence as they develop and update their multisectoral plans.

In an effort to leave no one behind, this report also paid particular attention to certain groups in conditions of vulnerability. While all women and girls across the Region can experience violence, some groups face heightened risks and increased access barriers in seeking needed support. Therefore, the analysis reviewed the extent to which policies and plans on VAW reference certain groups in conditions of vulnerability, specifically young women, women with disabilities, pregnant women, and indigenous, ethnic minority, or Afro-descendant women.

While some progress has been made in policy documents with regard to attention to younger women, greater efforts are needed to enable policy and practice to respond to the needs of more vulnerable populations including women and girls from ethnic/racial minority groups, women and girls with disabilities, and LGBTQI+ groups.

These findings highlight that differentiated services were often not specifically included in any policy identified.

Recognizing these groups explicitly in policies, plans and protocols is a first step toward making their needs and preferences visible. It can then be built upon through more specific guidance for health workers and services based on the circumstances and preferences of each group. Going forward, this is a crucial agenda for action in collaboration with PAHO in line with the Region's commitment to equity and universal health.

This report underlines that Member States in the Americas share many common priorities, interests, and challenges, and there continue to be opportunities to share lessons learned in the Region between and across Member States of the Americas and with other regions.

Given the richness of experiences in the Region, the report underlines the value of regional exchange of information, experiences, and solutions. The report is another contribution to the documentation and dissemination of experiences from the Region so as to inform the regional and global evidence base. At the same time, in order to translate global evidence into practice, there continues to be great value in strengthening regional and subregional dialogue across countries and partners in order to boost learning on what works to prevent and respond to violence against women in all their diversity.

Some differences across countries and subregions were also flagged in this report, requiring targeted follow-up. For example, the Member States in South America are doing extremely well with the development of policies, protocols, and multisectoral plans, many of which meet core indicators identified in this report. While continuing to maintain and improve the quality of policies and guidelines, this subregion can build on these achievements by strengthening implementation, including through developing clinical tools, training health workers and managers, conducting regular service evaluations, and strengthening health information systems.

Central America has also made progress with all types of documents, with few Member States missing any. However, more work is needed to strengthen the content of selected documents, for example, in terms of guidance on first-line support and post-rape care. The inclusion of selected quality indicators in health sector protocols would help this subregion build on existing achievements and strengthen practical responses.

For the Non-Latin Caribbean, tremendous progress has been made toward developing multisectoral policies, although greater efforts are needed to strengthen the role of the health sector in such multisectoral responses and related mechanisms, and to strengthen the institutional capacity of the health sector to advocate for a public health approach. Crucially, there is an urgent need in the Non-Latin Caribbean to strengthen health system protocols and guidance related to violence in line with the evidence base, which are essential for guiding efforts to strengthen health worker skills and improve health service quality.

Given these subregional trends, there are opportunities for countries in all subregions to collaborate and share experiences and tools, as well as for PAHO and partners to provide targeted support to subregions to advance the agenda in line with local needs and opportunities.

This report is an important step on the Region's path toward the goals and targets identified in PAHO's Strategic Plan 2020–2025, the Strategy and Plan of Action on VAW, as well as related commitments made by Member States.

PAHO is ready to work in partnership with Member States and many others to convene stakeholders, review and discuss findings, and disseminate lessons learned in preventing and responding to violence. Partnerships with United Nations agencies, regional and subregional intergovernmental mechanisms, civil society partners, WHO Collaborating Centres, and many others are central to this effort.

As the Region approaches 2025, there is a need to build on these achievements and this knowledge and keep strengthening efforts toward 2025 and beyond. The report should therefore not be seen as the conclusion of but rather as a key milestone in the process of monitoring and reporting on the status of preventing and responding to violence against women in the Americas. It presents a snapshot of efforts by Member States and their partners, but there are opportunities to deepen analysis and build on these findings,

including country- and region-specific validation processes. Moreover, further and regular analysis to monitor policy developments on an ongoing basis would be beneficial to keep expanding the evidence base on what is known about policy and protocols that prevent and respond to VAW.

Attention to violence prevention and response is especially timely in the context of the COVID-19 pandemic and the increase in visibility and urgency of action for this topic. The pandemic has not only increased risks of violence and exacerbated service gaps for many women and girls, it has also underlined the fundamental role of health systems in contributing to the prevention and response to violence in all its forms. The Region now has an opportunity to learn from this experience and strengthen responses to violence through collaborative action across all levels.

Moving forward will require the collaboration and engagement of many—including government ministries and institutions, parliamentarians, civil society organizations, health managers and other essential service providers, academia, professional associations, international and regional partners and donors, and communities themselves. The findings and lessons learned can guide future efforts in sustaining the momentum of the achievements and taking concerted action toward full implementation of the Strategy and Plan of Action on VAW and its vision. Violence against women in all its forms is preventable, and its consequences can be mitigated. PAHO is committed to continuing to work with countries and partners in taking this agenda forward in order to ensure that women and girls in all their diversity in the Americas are able to live a life without fear and violence, and in health and well-being.



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ANNEX 1

INCLUSION AND EXCLUSION CRITERIA FOR HEALTH POLICY DOCUMENTS

Inclusion and exclusion criteria for health policy documents

Criteria	Inclusion	Exclusion
Types of violence	Sexual violence Intimate partner violence	Sexual harassment Human trafficking Femicide
Timeframe	Any document that does not expire that does not have an updated version.	Any document that a Member State stated that was expired or outdated
Level of government	National level	Subnational level
Type of documents	Health policies (including health sector strategic plans, health sector GBV plans, HIV, SRH, NCD, RMNCAH policies) OR Protocols Guidelines Norms Standard operating procedures OR Multisectoral VAW policies including gender policies with a VAW section	Resolutions Training manuals
Survivor characteristics	Adult women or adolescents	Children (e.g., survivors of child abuse)
Responsible institution	National ministry (and for health policies, must be an MoH document or national health authority document)	Documents issued by any other ministry or institution

ANNEX 2

INDICATOR DEFINITIONS

Indicators about strengthening the leadership of the health sector response to VAW

Indicator short name	Indicator
Health policy VAW	Is there a national health policy that includes violence against women?
Health sector strategic plan VAW strategic priority	Is there a health sector strategic plan that includes violence against women as a strategic priority?
Health policy VAW focus	Is there a national health policy (any type) that includes violence against women as a strategic priority?
Training	Is there a commitment in policy to train healthcare providers on violence against women?
Ministry of Health VAW focal point(s)/unit(s)	Does the Member State have a unit (or units) or focal point(s) in the Ministry of Health responsible for violence against women?
VAW budget	Does the Member State have national health budget with one or more dedicated lines to support prevention and/or response to violence against women?

Indicators about strengthening the quality of health services for survivors of VAW

Indicator short name	Indicator
Health sector VAW protocol	Is there a health sector protocol that guides the response to violence against women?
Privacy principle	Does the health sector VAW protocol mention privacy as a principle of women-centered care?
Privacy during consultation	Does the health sector VAW protocol mention respect for privacy during consultation?
Confidentiality principle	Does the health sector VAW protocol mention confidentiality as a principle of women-centered care?
Limits of confidentiality	Does the health sector VAW protocol mention a requirement to inform survivors of the limits of confidentiality?
First-line support	Does the health sector VAW protocol mention first-line support for survivors?
Universal screening	Does the health sector VAW protocol mention universal screening?
Clinical inquiry	Does the health sector VAW protocol mention clinical inquiry?
Emergency contraception	Does the health sector VAW protocol mention emergency contraception provision for survivors?
Abortion	Does the health sector VAW protocol mention safe abortion for survivors?
HIV PEP	Does the health sector VAW protocol mention HIV post-exposure prophylaxis (PEP) for survivors?
STIs	Does the health sector VAW protocol mention STI prophylaxis for survivors?
Referrals	Does the health sector VAW protocol mention referrals to support services outside the health sector?
Mental assessment	Does the health sector VAW protocol mention mental health assessment of survivors?
Mental health referral	Does the health sector VAW protocol mention mental health referral for survivors?
Mental health treatment	Does the health sector VAW protocol mention mental health treatment for survivors?
Mandatory reporting	Is mandatory reporting of violence against women required by healthcare providers in the health sector VAW protocol?

Indicators about strengthening the role of the health sector in the multisectoral response to violence against women

Indicator short name	Indicator
Multisectoral VAW Policy	Is there a multisectoral policy for preventing and/or responding to violence against women (hereafter: multisectoral VAW policy) ?
RESPECT indicators	
Relationship strengthening	
Relationship education	Does the multisectoral VAW policy include individual or group education to strengthen relationship communication skills?
Couples therapy	Does the multisectoral VAW policy include couples therapy?
Empowerment	
Economic empowerment	Does the multisectoral VAW policy include at least one strategy for women's economic empowerment?
Social empowerment	Does the multisectoral VAW policy include at least one strategy for women's social and/or psychological empowerment?
Services	
Substance abuse	Does the multisectoral VAW policy include substance abuse prevention strategies?
Shelters	Does the multisectoral VAW policy include shelters?
Hotlines	Does the multisectoral VAW policy include hotlines?
One stop crisis centers	Does the multisectoral VAW policy include one stop crisis centers?
Perpetrator	Does the multisectoral VAW policy include perpetrator interventions?
Police	Does the multisectoral VAW policy include police interventions?
Poverty reduction	
Economic transfers	Does the multisectoral VAW policy include economic transfers?
Labor force	Does the multisectoral VAW policy include labor force interventions?
Environmental safety	
Schools	Does the multisectoral VAW policy include school based interventions?
Infrastructure	Does the multisectoral VAW policy include public spaces, infrastructure, or transport interventions?
Bystander	Does the multisectoral VAW policy include bystander interventions?
Child abuse prevention	
Home visitation	Does the multisectoral VAW policy include home visitation or outreach?
Parenting	Does the multisectoral VAW policy include parent interventions?
Child witness	Does the multisectoral VAW policy include psychological support for child witnesses to intimate partner violence?
Transformation of attitudes, beliefs, and norms	
Mobilization	Does the multisectoral VAW policy include community mobilization?
Group education	Does the multisectoral VAW policy include group education to promote changes in attitudes and norms?
Awareness	Does the multisectoral VAW policy include awareness raising?

Indicator short name	Indicator
Vulnerable populations indicators	
Young women recognized	Does the health sector VAW protocol/health policy/VAW/multisectoral VAW policy recognize adolescent girls and/or young women as a vulnerable population?
Young women services	Does the health sector VAW protocol/health policy/multisectoral VAW policy provide differentiated health services for adolescent girls and/or young women who are survivors?
Disabled women recognized	Does the health sector VAW protocol/health policy/multisectoral VAW policy recognize women with disabilities as a vulnerable population?
Disability women services	Does the health sector VAW protocol/health policy/multisectoral VAW policy provide differentiated health services for women with disabilities who are survivors?
Pregnant women recognized	Does the health sector VAW protocol/health policy/multisectoral VAW policy recognize pregnant women as a vulnerable population?
Pregnant women services	Does the health sector VAW protocol/health policy/multisectoral VAW policy provide health differentiated services for pregnant women who are survivors?
Indigenous/ethnic women recognized	Does the health sector VAW protocol/health policy/multisectoral VAW policy recognize ethnic/racial minority and indigenous women as a vulnerable population?
Indigenous/ethnic women services	Does the health sector VAW protocol/health policy/multisectoral VAW policy provide differentiated health services for ethnic/racial minority and indigenous women who are survivors?

ANNEX 3

SUBREGIONS

Subregion	Countries	Number of countries
Canada and the United States	Canada	n=2
	United States of America	
Non-Latin Caribbean	Antigua and Barbuda	n=14
	Barbados	
	Bahamas	
	Belize	
	Dominica	
	Grenada	
	Guyana	
	Haiti	
	Jamaica	
	Saint Lucia	
	Suriname	
	Trinidad and Tobago	
	Saint Kitts and Nevis	
	Saint Vincent and the Grenadines	
Central America, plus Cuba, the Dominican Republic, and Mexico	Costa Rica	n=9
	Cuba	
	Dominican Republic	
	El Salvador	
	Guatemala	
	Honduras	
	Mexico	
	Nicaragua	
	Panama	
South America	Argentina	n=10
	Bolivia (Plurinational State of)	
	Brazil	
	Chile	
	Colombia	
	Ecuador	
	Paraguay	
	Peru	
	Uruguay	
	Venezuela (Bolivarian Republic of)	

Violence against women and girls is widespread in the Region of the Americas, resulting in enormous consequences for the health and well-being of women and girls, their families, and communities. These costs are unacceptable and they can be prevented through evidence-based action, including the health sector through its policies and protocols, as well as in collaboration with other sectors.

This report remains the first of its kind and is a major milestone for the Region. It is specifically informed by the commitments of Member States in the regional Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women. The report provides an analysis of efforts to advance the prevention of violence against women through health policies, clinical protocols, multisectoral plans, and related approaches across the Americas.

Attention to this topic is timely, as the COVID-19 pandemic has created new visibility for this area of work. This report offers critical information on efforts in the Region that can be learned from and used to build upon in the future to prevent and respond to violence against all women and girls everywhere.

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