INTEGRATION OF VIOLENCE PREVENTION INTO HEALTH PROGRAMMING WITHIN THE IFRC

DISCUSSION PAPER

International Federation
of Red Cross and Red Crescent Societies

CANADIAN
RED CROSS

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1 - BACKGROUND

Violence against women, men, girls and boys is a global problem day-to-day and in disasters and emergencies across continents, countries and communities. Recently there has begun some level of integration of community-based Health and Violence Prevention (VP) projects within the IFRC Secretariat and among a number of National Societies. Program integration is an area of growing focus for the Federation and National Societies as a means to more efficient, effective and relevant support to individuals and communities. Integration is also a way to develop capacities to help individuals and populations to prevent or mitigate risks related to violence that threaten their ability to achieve and maintain a state of healthy and safe living.

In 2010 the IFRC developed its guiding framework document, Strategy 2020, which provides the basis for the strategic plans of all National Societies. The three strategic aims are considered to be mutually reinforcing. This discussion paper builds on IFRC's current efforts to link all three of its strategic aims, and is coherent with the IFRC's work to strengthen sectoral integration as seen in the previous development of a similar paper on Disaster Risk Reduction and Health.

STRATEGY 2020 STRATEGIC AIMS

- Save lives, protect livelihoods and strengthen recovery from disasters and crisis
- Enable healthy and safe living
- Promote social inclusion and a culture of nonviolence and peace

This discussion paper contributes to advancing these strategic aims by presenting current examples and future directions for integration between health and violence prevention in emergency/recovery and development situations.

A list of additional IFRC strategies, frameworks and pledges that support integration between Health and VP are listed in appendix 1. Lessons learned from not supporting integrated programing include, but are not limited to; less effective programmes; mixed messages to the community; duplication of financial and technical support; inconsistent messaging; and perception of fragmentation and incoherence of IFRC work to internal and external partners.[i]

INTENDED OBJECTIVES OF THIS DISCUSSION PAPER

This paper has three key intended objectives for the IFRC and its National Societies in order to better serve beneficiaries:

- To present linkages between Health and Violence Prevention within emergency/recovery and development situations
- To highlight current examples of integration and strategies to replicate/scale-up these initiatives; and
- To propose new areas of integration where they are viable and appropriate. (More detailed, specific actions for integration into various health programming can be defined as a next step).

The IFRC, and its National Societies, has a distinct advantage and added value for addressing violence through its Health programs: its operational experience, grass-roots health response presence through volunteers and external partners, role as auxiliaries to government, and global position and credibility as leaders in health programming.

This paper builds on the idea of a distinct IFRC added value. The paper provides definitions of key terms, context of violence as a health priority, and then outlines the global agreements between the WHO and IFRC to address violence. Following these, an overview of the health consequences of violence is provided, as are risk and protective factors for violence in various health settings and situations and a summary of sample projects where health and violence prevention, mitigation or response activities are being integrated in various locations around the world. . The paper concludes with suggestions for how health programs can further and more effectively integrate issues around violence.

> Like cholera, malaria, malnutrition, or other public health problems associated with disasters, the factors that put people at risk of violence can, and must, be addressed."

SECRETARY GENERAL, IFRC[ii]

2 - DEFINITIONS

HEALTH

Strategy 2020 states "good health" - "the state of physical, mental and social well-being – enables us to enjoy our human rights." This definition is largely based on the 1948 World Health Organization (WHO) definition of health, *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*, but includes a rights and equity perspective and positions the individual clearly as actor in that process. WHO also posits that *whether people are healthy or not, is determined by their circumstances and environmen*t.[iii] The WHO determinants of health include, but are not limited to[1]:

- the social and economic environment
- the physical environment
- the individual's characteristics and behaviours
- education levels and gender

VIOLENCE

Violence is defined by the IFRC as: *"the use of force or power, either as an action or omission in any setting, threatened, perceived or actual against oneself, another person, a group, a community that either results in or has a high likelihood of resulting in death, physical injury, psychological or emotional harm, mal-development or deprivation.*[iv]The IFRC specifically addresses interpersonal (physical, sexual, psychological violence and neglect in homes, schools, institutions, communities, online, etc.) and self-directed violence (self-harm, suicide). See appendix 2 for the categories, types and forms of violence.

RESILIENCE

The IFRC defines resilience as, "*the ability of individuals, communities, organizations or countries exposed to disasters and crises and underlying vulnerabilities to anticipate, prepare for, reduce the impact of, cope with and recover from the effects of shocks and stresses without compromising their long-term prospects"*.[v]

EQUITY IN HEALTH

Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. This refers to everyone and not just to a particularly disadvantaged segment of the population. Efforts to promote social equity in health and reduce disparities are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill.[vi]

> Public health has made some remarkable achievements in recent decades, particularly with regard to reducing rates of many childhood diseases. However, saving our children from these diseases only to let them fall victim to violence or lose them later to acts of violence between intimate partners, to the savagery of war and conflict, or to self-inflicted injuries or suicide, would be a failure of public health."

Gro Harlem Brundtland, Past Director-General, WHO[vii]

3 - CONTEXT
VIOLENCE PREVENTION AS A HEALTH PRIORITY

WHO initiated its work on linking violence and health almost 30 years ago in 1996 declaring violence a major health issue (See Appendix 3 for the of the 1996 WHO resolution. The timeline below highlights key policy statements by WHO and the United Nations to draw attention to the issue of violence in relation to health.

In 2002, the WHO ground-breaking report *World report on violence and health* called for violence to be seen as a health problem that is preventable and for the health sector to take a leading role in violence prevention. Subsequently, in 2004, WHO created the Violence Prevention Alliance (VPA), a network of WHO Member States, international agencies and civil society organizations working to prevent violence, with WHO providing technical guidance.[viii]

VPA participants, including the IFRC, are committed to adopting elements of a health perspective, as part of a multi-sectoral approach to violence. This includes applying an evidence-based / scientific approach to interpersonal violence prevention and to implement the recommendations of the World report on violence and health.

The VPA approach to violence prevention consists of four steps as outlined in the text and diagram below:[ix]

1. To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.

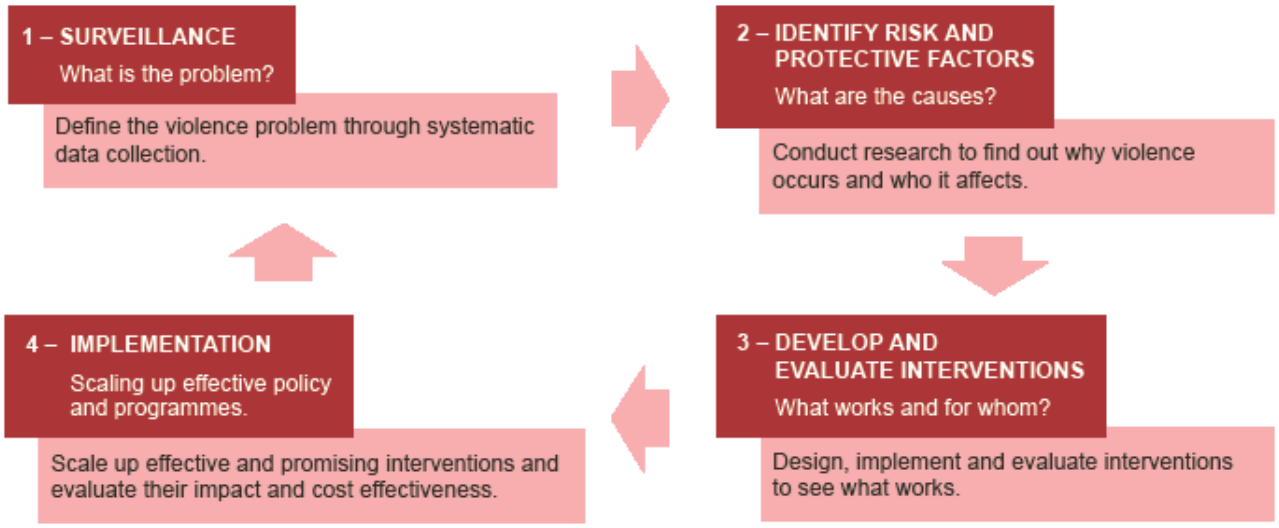
2. To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.

3. To find out what works to prevent violence by designing, implementing and evaluating interventions.

4. To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

DIAGRAM 1- THE WHO VIOLENCE PREVENTION ALLIANCE (VPA) PUBLIC HEALTH APPROACH

THE STEPS OF THE SCIENTIFIC/ HEALTH APPROACH



4 - GLOBAL AGREEMENTS ON HEALTH AND VIOLENCE BETWEEN THE WHO AND IFRC

The IFRC is a member of the VPA network, signaling its commitment to be part of a global effort to highlight violence prevention as a health issue. Over the last several years there has been increasing cooperation between WHO and IFRC on violence prevention as demonstrated below. These agreements have helped define the IFRC approach to violence prevention as a multi-sectoral problem with key health elements while consistently reinforcing IFRC's approach to achieving global standards.

2005: Cooperation Framework

In 2005, the WHO, through its Department of Injuries and Violence Prevention, Cluster of Non-communicable Diseases and Mental Health, and the IFRC through its Health and Care Department developed a Cooperation Framework on Injury Prevention and Management (Cooperation Framework with the World Health Organization). This framework includes provisions for Violence Prevention.

2011: IFRC strategy on violence prevention, mitigation and response

In 2008, the WHO was invited to join over twenty National Societies, the IFRC, ICRC and several international and UN agencies to begin a process to develop the first ever IFRC strategy on violence prevention, mitigation and response. The strategy was completed and approved in 2011.

Violence Prevention Alliance

In May 2011, the IFRC became a formal participant of the WHO global Violence Prevention Alliance (VPA). This was reinforced in September 2011 at the WHO's fifth Milestones Meeting for VPA held in South Africa. (Joint letter with the World Health Organization).

Zonal

The global partnership with WHO has also been reinforced at the regional level. IFRC Regional Offices for Africa; the Eastern Mediterranean Countries; Europe; South East Asia and the Western Pacific all have additional agreements with WHO (https://fednet.ifrc.org/en/resources-and-services/external-relations/international-relations/partnerships/agreements/).

PAHO

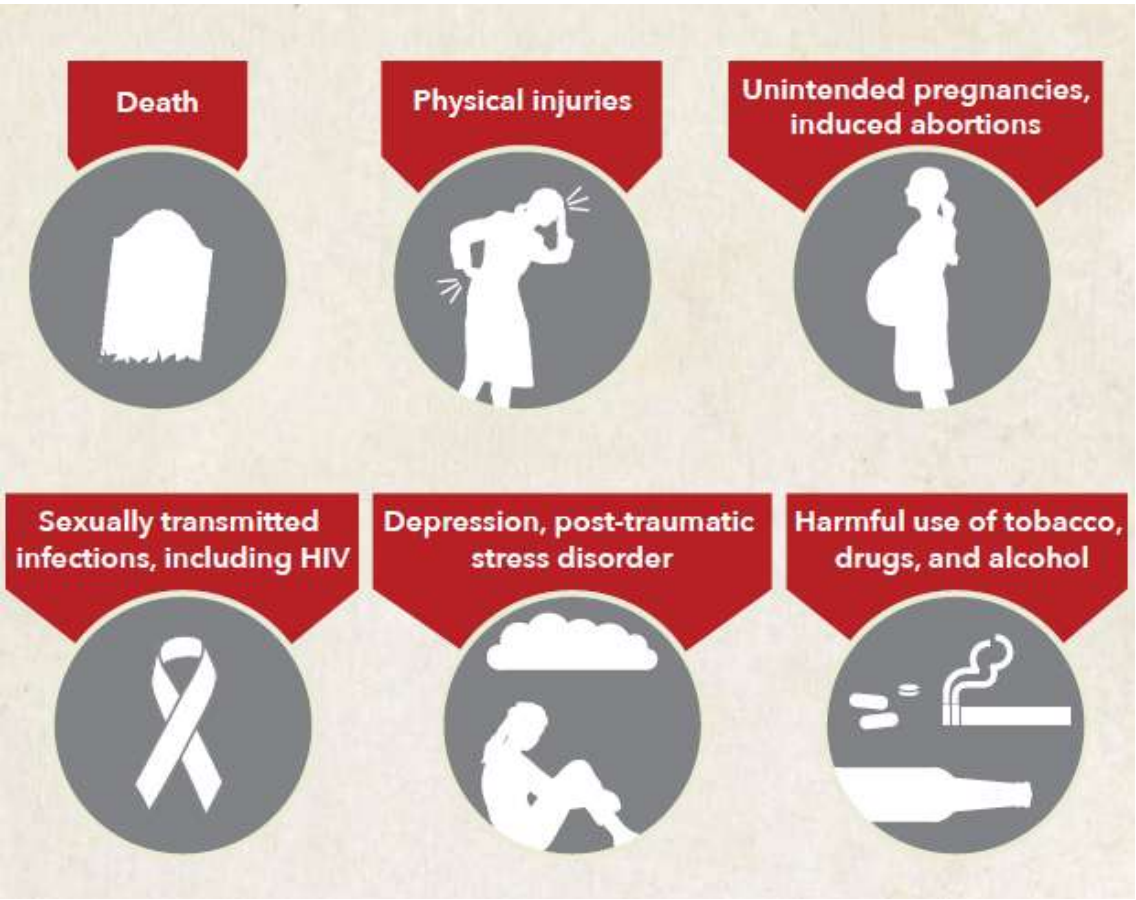
In the Americas, the IFRC and various National Societies interact with PAHO. A MoU between the IFRC and PAHO covering health and health related disaster response and post-disaster situation in the Americas was signed in 2002 (http://www.ifrc.org/en/who-we-are/governance/working-partners/agreements/). Aside from this, PAHO has also integrated the prevention of violence as one its pillars of Mother and Newborn Child Health programming (see: PAHO web page).

Violence prevention continues to be a priority for IFRC and as stated above will be a key strategic aim for the organization until 2020.

5 - DEFINING THE PROBLEM

Global literature reveals that violence in several forms has an impact on health related to mortality and morbidity. Below are some examples that clearly demonstrate that relationship and indicate the cost implication to health.

GRAPHIC 1 – THE HEALTH CONSEQUENCES OF VIOLENCE



SOURCE: WHO. (2013). *VIOLENCE AGAINST WOMEN: THE HEALTH SECTOR RESPONDS*[x]

TABLE 2 - EXAMPLES OF STATISTICS ON THE CONSEQUENCES OF VIOLENCE ON HEALTH

CONSEQUENCE	EXAMPLES OF EVIDENCE
Mortality	Violence in its various forms is among the most prominent causes of mortality in the world – higher than TB or road accidents or malaria.[xi] Each day 4,200 people die from violence (1.6 million a year); more than 90 per cent of them in low and middle income countries; 58% die from suicide, 36% from interpersonal violence and 6% from collective violence.[xii] Worldwide approximately one million individuals die of suicide each year.[xiii] Annually, even more individuals, 10-20 million, attempt suicide and 50-120 million are profoundly affected by the suicide or attempted suicide of a close relative or associate[xiv]. Suicide accounts for 54% of all violence related deaths in the world.[xv] The World Bank estimates that in industrialized countries, sexual assault and domestic violence take away almost one in five healthy years of life for women aged 15-44.[xvi]
Injury, Disease, Trauma & Addiction	Each year, 16 million cases of injury, due to violence, are severe enough to receive medical attention in hospitals.[xvii] The damaging effects of violence on health include physical consequences such as brain injuries, bruises and scalds, chronic pain, irritable bowel syndrome, infertility, pregnancy-related complications, unsafe abortions, pelvic inflammatory disorders, HIV and other STDs, unwanted pregnancies, cancer, heart disease, and chronic lung disease.[xviii] The United Nations reports the impact of child abuse on health includes higher risks for: cancer, lung disease, heart disease, bowel problems, liver disease, and reproductive health problems.[xix] According to a study of 17,000 middle class patients, adults who experience child abuse, compared to those who have not, are: 103% more likely to become smokers, 95% more likely to become obese, 103% more likely to become alcoholics, 192% more likely to become addicted to drugs, and 43% more likely to become suicidal.[xx]

Work by the US based Institute of Medicine and National Research Council Forum on Global Violence Prevention Bard on Global Health and others have recently begun to position violence using an epidemiological/infectious disease model to highlight how violence naturally fits within a health framework.[xxi]

> Although violence does not have a readily observable biological agent as an initiator, it can follow similar epidemiological pathways. Just as with those infected by microbial agents, those exposed to violence have varying levels of resilience and susceptibility. In addition, the influence of the environment can play a major role not only in symptomology, but also in transmission.

National Research Council Forum on Global Violence Prevention Bard on Global Health [xxii]

EXAMPLES OF THE IMPACT OF VIOLENCE ON HEALTH WITHIN KEY IFRC PROGRAM AREAS

Mothers, newborns and children

As the IFRC increases its profile in maternal, newborn and child health (MNCH) there exist clear opportunities for comprehensive and strategic program integration that will prevent women and children becoming either victims or perpetrators of violence. Recent evidence shows that early health and other interventions are shown to be effective in preventing children from developing into perpetrators of violence.[xxiii] Data on linkages between experience of violence and the health of women, men, girls and boys is also growing[xxiv]. The box below provides examples of the ways in which violence against women impacts the health of mothers and of their girls and boys.

SAMPLE STATISTICS

- Compared to their non-abused peers, abused women have higher rates of unintended pregnancies and abortions; sexually transmitted infections, including HIV; and mental disorders such as depression, anxiety, sleep and eating disorders. When this violence occurs during pregnancy, it is associated with adverse pregnancy events – such as miscarriage, pre-term births and stillbirths.[xxv]

- Children of women who experience physical or sexual violence – whether before, during or after pregnancy – are significantly more likely to die before age 5.[xxvi]

- Children of abused mothers have lower rates of immunization and higher rates of diarrhoeal disease, and are more likely to die before the age of five years.[xxvii]
  The odds of losing a child, among women who had ever been physically or sexually abused, were 2-4 times as high as they were among women who had not been abused. The type and severity of the violence was probably more relevant to the risk than the timing, and violence may cause impact on child health through maternal stress or care-giving behaviours, rather than through direct trauma itself.[xxviii]

- Data signifies a link between short birth intervals (less than two years) and the mother's experience of violence. The association between short birth intervals and infant health and survival is well documented. This link additionally illustrates the disintegration of reproductive autonomy amongst those who experience violence.[xxix]

- Mothers exposed to physical or emotional stress are more likely than others to have low birth-weight infants, who, in turn, have an increased risk of dying during childhood.[xxx]

- The capacity of women to raise a child may be diminished because of emotional issues associated with abuse, like depression, anxiety and post-traumatic stress, and they may even be physically prevented from obtaining care for their children.[xxxi]

- Children of mothers who have experienced violence are disadvantaged in their access to life-saving routine immunisations.[xxxii]

Health and Emergencies

Although it remains a neglected problem, the risk of violence after disasters, including health emergencies, has IFRC developed its guiding framework document, Strategy 2020s begun to be acknowledged and documented. For example, the IFRC's "Predictable, Preventable" advocacy report[xxxiii] highlights four key messages: through a combination of shocks, violence increases after disasters; the risk is highest for populations who are already at risk, such as children and women; a scientific approach is needed and it needs to be made a priority; and best practices to integrate violence prevention can be built across the disaster management cycle.

The report notes that whether through food distribution, building shelter, providing clean water, generating livelihoods, giving medical treatment or mobilizing communities on health or psychosocial issues, VP needs to be a cross-cutting issue because those who experience violence are subject to a number of negative consequences, including the obvious physical consequences (injuries, STIs including HIV, and death in extreme cases), as well as psychological effects (shock, PTSD, depression, suicidal thoughts, fear, shame, betrayal, loss of trust, etc.), and social consequences (stigmatization, neglect, social isolation, further violence, etc.).

The cross-cutting/minimum standard nature of VP in emergencies necessitates that practitioners employ a multi-sectoral approach with a clear evidence-based/scientific basis for their interventions. At its core, a multi-sectoral approach encourages a coordinated, multi- sector method that engages in multiple strategies at various points of interaction and is part of the responsibility, vision and action of all disaster responders which includes in health emergencies.

SAMPLE STATISTICS

Americas

Haiti

After the earthquake in 2010, reports based on assessments from a number of Haitian and international agencies revealed that interpersonal violence, especially sexual violence, within the camps for internally displaced people (IDP) in Port-au-Prince posed an extreme humanitarian threat. The threat was highest for children (girls and boys) and women, with the risk continuing even one and a half years after the earthquake. In one survey, 14 percent of women in the IDP camps reported one or more experiences of sexual violence since the disaster.[xxxiv]

Another study found that 60 percent of women and girls interviewed said that they feared sexual violence against them or members of their household; the same study found that 70 percent of respondents reported fearing sexual violence more now than before the earthquake.[xxxv]

Nicaragua

27 percent of female survivors and 21 percent of male survivors reported that violence against women in families and communities had increased following Hurricane Mitch.[xxxvi]

United States of America

In 2005, after Hurricane Katrina hit the states of Louisiana and Mississippi, allegations of intimate partner violence in the affected areas increased up to three times the national

rate.[xxxvii] There was also an increase in allegations of emotional and physical violence found in Louisiana.[xxxviii]

In 1999, six months after Hurricane Floyd in North Carolina, brain injuries were five times more common in the areas hardest hit by the disaster. The researchers concluded the increase was due to elevated stress among parents, leading to higher incidence of child abuse.[xxxix]

Africa

Great Lakes region

In the Great Lakes Region of Africa following disasters and conflicts in 2006, more than 50% of children in displacement camps reported experiencing some form of sexual abuse, in one camp the rate was 87%.[xl]

Kenya

In July 2011 after an influx of refugees from Somalia, reported cases of sexual and gender-based violence in the Dadaab refugee camps increased from 75 between January and June 2010 to 358 during the same period in 2011.[xli]

Asia Pacific

China

Following the 2008 earthquake in Sichuan, all types of family violence were reported to increase. Psychological aggression was reported to grow by over 80% while physical violence between partners increased by 16%.[xlii]

New Zealand

Following the 2010 earthquake in Christchurch, provisional reports showed an increase of 53% in domestic violence cases in the earthquake affected areas.[xliii]

Philippines

Following typhoon Yolanda / Haiyan in 2013, women and children were at increased risk of sex trafficking and transactional sex in order to survive or provide the basic necessities for their families.[xliv]

Middle-East and North Africa

Syria Crisis

In Syria, research by ABAAD and the International Rescue Committee found that sexual violence, including rape, is the most extensive form of violence faced by women and girls in Syria since the conflict began.[xlv] In November 2011, a joint study by the government and the UN Population Fund (UNFPA) reported that one in three women suffers domestic violence in Syria.[xlvi]

Among refugees in Jordan in 2013, twenty-eight per cent of households surveyed left Syria due to specific fears of violence, including sexual and gender-based violence.[xlvii] In addition, early marriage among girls and domestic violence and sexual violence among girls, boys and women were reported as risk factors.[xlviii]

In Lebanon, human rights and women's organizations have reported high levels of conflict-related violence, including sexual violence, as well as a greater prevalence of domestic violence and child marriage.[xlix]

HIV and AIDS transmission

Violence is often a neglected, but important aspect, related to HIV transmission and the safety and health of people living with HIV. This is particularly true for women, as violence against women is seen as both a cause and consequence of HIV/AIDS.[l] The health service delivery must include a comprehensive service for survivors of rape that provides at a minimum treatment of physical injuries, pregnancy prevention, treatment for sexually-transmitted infections, and, where appropriate, HIV post-exposure prophylaxis.

Over a decade of research from countries in different regions of the world documents an undeniable link between Violence against Women (VAW) and HIV infection. The relationship between VAW and HIV risk is complex, and involves multiple pathways, in which violence serves both as a driver of the epidemic, and at times a consequence of being HIV positive.

Rape is one potential cause of direct infection with HIV through violence for some women. However, the primary burden of HIV risk from VAW and gender inequality arises through longer-acting indirect risk pathways. These involve both chronically abusive relationships where women are repeatedly exposed to the same perpetrator, as well as the long-term consequences of violence for women who have experienced prior, but not necessarily on-going, exposure to violence (in childhood or as adults). Addressing both VAW and gender inequality jointly in programmes will contribute to effective HIV prevention. Such synergistic linking forms an important element of effective combination prevention for HIV.

WHO [li]

Health Equity

Research on violence has shown a definite relationship between violence and equity with less economically resourced populations as more vulnerable to violence, this is particularly true for women. Evidence shows that *poor people in almost every society bear a disproportionate share of the public health burden of violence*.[lii]

The literature demonstrates that both violence and a fear of violence may undermine the health status of individuals and populations and increase health disparities. Specifically, in the absence of the underlying determinants of health, (i.e. adequate income, social status, education, social support, health services) environments where inequality, poverty and racism can prosper and violence can be fostered.

If violence is understood as a learned human behaviour and a problem that can be understood and changed[liii], then the prevention of violence should be seen as a necessary precursor of health.

SAMPLE STATISTICS

A recent retrospective study in 54 countries to assess equity levels in MNCH care found "*substantial variations in coverage levels between interventions and countries*" and concluded that the "*most inequitable countries need additional efforts to reduce the gap between the poorest individuals and those who are more affluent.*"[liv] Another study revealed that women *who were emotionally or financially dominated by their partner were 52 per cent more likely to be infected than those who were not dominated*.[lv]

Resilience

Violence Prevention is an essential component of resilient communities. When people experience psychological and physical injuries from violence; or feel unsafe to access helping resources; or have impediments that limit their ability to contribute to their community, community resilience and health are diminished.

The importance of violence is highlighted in the IFRC framework for Resilience.[lvi] Within the framework Violence Prevention is specified as a cross-cutting issue / minimum standard across programs to promote community resilience. Violence Prevention is also noted as part of building social cohesion within communities with specific indicators to reduce the incidence of violence in communities and to raise awareness son VP among communities to increase overall health.

6 - IDENTIFICATION OF RISK AND PROTECTIVE FACTORS

Violence is the result of complex dynamics and factors between individuals, their families, communities and societies. Each of the factors is connected together and can combine to increase vulnerability to experience violence. The ecological model highlights the diverse factors that increase risk, and those needs to be addressed in order to effectively prevent violence. By identifying the factors of risk, it becomes possible to define specific interventions.

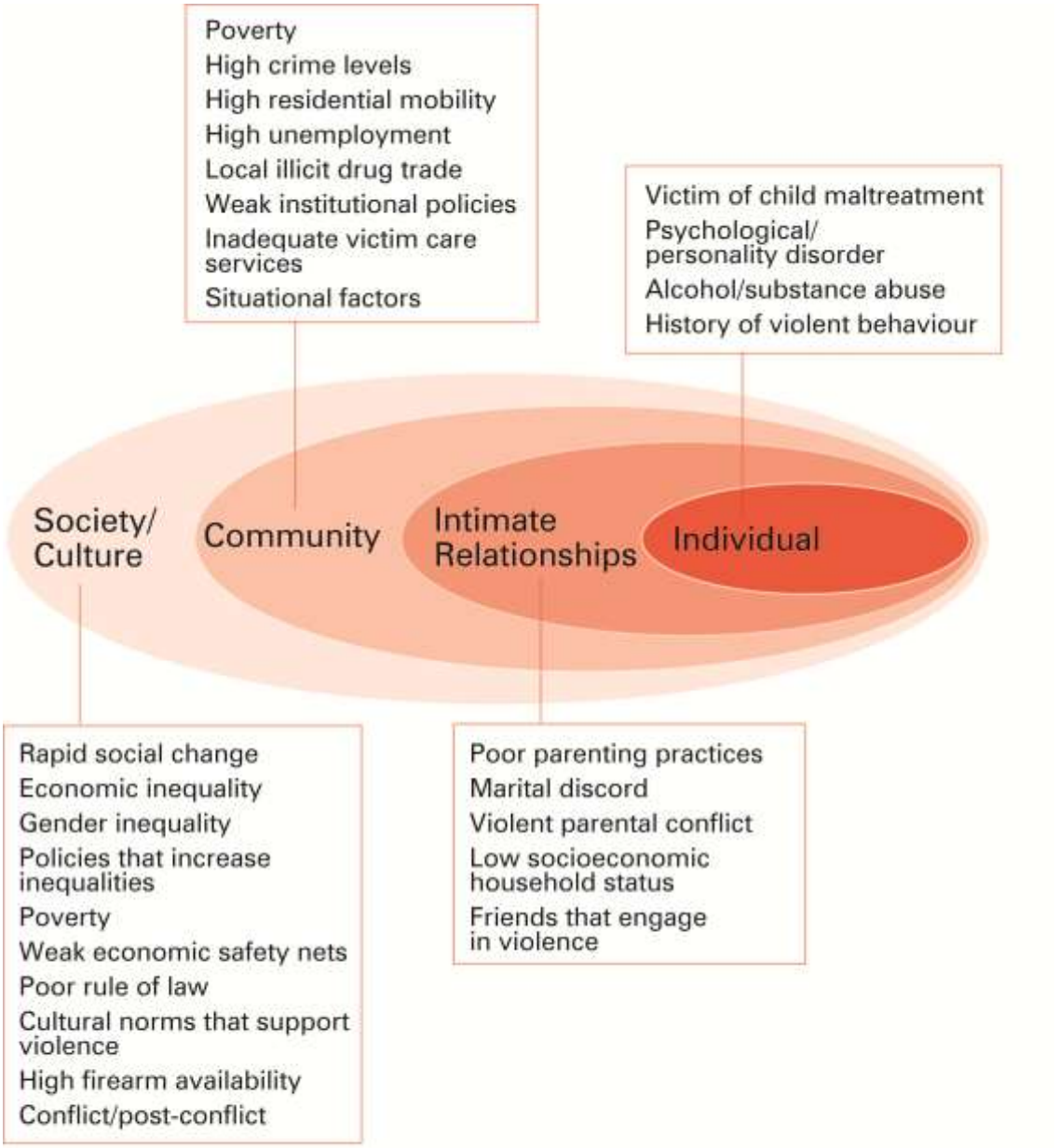
The risk factors can be intensified during disasters and emergencies. During the assessment phase it is of paramount importance that vulnerable populations have full and equal participation to ensure that specific needs are not overlooked. It should be noted that the same factors at the individual, family, community and societal levels that can be a risk, if inverted, can become protective factors such as relationships within families, gender equality, support systems within communities, institutional policies, economic equality, and cultural norms, etc. Each of these can support community resilience.

> The most prevalent vulnerabilities arise not only from disasters and diseases but also from complex factors such as grievances that are born from deprivation and unfairness, marginalization that is rooted in inequality, alienation and injustice, or despair that comes from loneliness, ignorance and poverty. All too often, these are expressed through violence against oneself and others, and may be magnified into wider conflict within and between communities and nations.

IFRC Strategy 2020[lvii]

FIGURE 1: THE ECOLOGICAL MODEL OF VIOLENCE[lviii]

The ecological model highlights the diverse factors that increase risk, and those needs to be addressed in order to effectively prevent violence.



World Health Organization. (2002). World Report of Violence and Health. Geneva: WHO.

7 - SAMPLE INTERVENTIONS

Globally within the IFRC there are a growing number of VP projects (see appendix to IFRC Strategy on Violence Prevention, Mitigation and Response), and the clear advancement on various fronts has demonstrated the capacity of the IFRC and its National Societies to effectively integrate VP within health programing.

This advancement is driven by the capacity of National Societies to have a grass-roots presence; and a large, committed volunteer-base; and the ability to build meaningful and influential partnerships with communities, governments, and other key actors.

While there is good progress, the scale of integration remains limited, geographically focused and the quality of implementation varies. As a result, the reach and impact is not being optimized and there are significant gaps at a global level.

TABLE 3: CURRENT PROJECTS AND PILOTS

TYPE OF INTEGRATION	LOCATION	DESCRIPTION
Care Settings	Austria	Austrian RC has coordinated the EU funded project “Breaking the taboo” (2007–09) aimed at preventing violence against older women in care settings, through awareness-raising activities and empowerment of health and social service professionals to detect risks and prevent violence.
Community based health	India	Since 2009 India RC has integrated VP as part of its community health programming, including through schools, in the state of Tamil Nadu.
Community-Based Health and First-Aid (CBHFA)	Various across regions	The IFRC and CRC have developed a CBHFA VP module (2013). It will be piloted globally until 2016 and then formally included in the revised CBHFA toolkits. The module is currently being piloted in numerous National Societies in Africa (Kenya in Dadaab refugee camp and Tana Delta peace building projects), the Americas (12 National Societies trained in 2013; Haiti implementing), Asia/Pacific (India, Maldives, Myanmar, Pakistan, Philippines) and the Middle-East and North Africa (Palestine Red Crescent and

TYPE OF INTEGRATION	LOCATION	DESCRIPTION
		Palestine Red Crescent in Lebanon).
Community-Based Health and First-Aid (CBHFA) (cont'd)		In Ireland, the CBHFA module benefits over 4,000 prisoners directly every year and 12,000 indirectly including staff and the families of the prisoners. The program operates under a partnership of the Irish Red Cross, the Irish Prison Service and Education & Training Boards (ETB's). Initially piloted in June 2009 in Wheatfield prison it has since been implemented in all 14 prisons throughout Ireland.[lix]
Health Emergency Response Unit (ERU)	Canada Philippines	A VP learning module (piloted in 2011) is now part of core curriculum; a plan is now being developed for comprehensive integration across other ERU Health modules, tools and processes. VP was included as part of the Philippines Typhoon response in 2013.
Emergency Response Unit (ERU) Community Health and Psychosocial support training	IFRC: Denmark and Zimbabwe	VP content integrated into standard IFRC PSS training (2011) and PSS and CHM field school (2012).
Psychosocial Intervention Emergency Immediate Response Team (ERIE)	Spain	Specialized teams are activated in disasters *or* to provide support to prevent potential suicides, when the victim has no other support or when the victim is an adolescent or a young adult.
First Aid	Canada	VP content integrated into Instructor Guide (2009), Babysitting manual (2009), and re-certification orientation (2012).
HIV	Cambodia Jamaica Ethiopia Malawi Uganda	In Cambodia, the HIV programme promotes greater understanding among male police officers on gender roles; their responsibilities to their wives and other sexual partners; gender equality; and the reduction of sexual and gender-based violence.

TYPE OF INTEGRATION	LOCATION	DESCRIPTION
		In Jamaica, a VP learning module has been piloted (2012) for the CHAP program for men who have sex with men and for youth HIV peer educators. A case study on women, HIV and violence has been developed.
Malaria	IFRC: Africa zone	Canadian RC developed a pilot VP learning module (2008) which has become a part of IFRC's core curriculum (2009).
MNCH	Nicaragua	The Canadian Red Cross-supported "Enlace" (2009–12) MNCH project included elements for awareness-raising on gender-based violence.
ICRC's work in Health and emergency		The ICRC has been documenting violence against health-care facilities and personnel, and against patients, since 2008 in 16 countries where it is working. Its recent publication "Making the Case", draws attention to one of the most crucial yet overlooked humanitarian issues of today: violence against health care. This global initiative will last four years and aims to make concrete recommendations to prevent attacks against health care workers.
Collaboration between IFRC and John Hopkins Bloomberg School of Public Health	Global	*The Johns Hopkins and International Federation of Red Cross and Red Crescent Societies Public Health Guide for Emergencies* (2008) A practical guide for humanitarian aid workers from international organizations to support their response to technical and management challenges related to natural and man made disasters including complex humanitarian emergencies. Responding to violence, a key theme, places particular emphasis on: Sexual and Gender based violence as a part of reproductive health, the need to address violence as a priority from the beginning of an emergency and engaging men in mobilization against gender-based violence.

Measuring cost benefit

As the old proverb states: “an ounce of prevention is worth a pound of cure.” This proverb is increasingly being reinforced by academic studies that show when communities invest in preventing violence, the benefits for health and economies can be significant. This underlines the need to ensure Violence Prevention projects meet global best practices and are effectively evaluated to measure reductions in violence.

SAMPLE COST – BENIFITS OF VIOLENCE PREVENTION PROGRAMMING

A study in the USA found that the cost of a program to prevent child abuse equalled 5% of the cost of intervening in child abuse.[lx]

Investment in quality prevention and intervention initiatives (for domestic violence) can be very cost effective, returning as much as $20 for every dollar invested.[lxi]

Research on the cost-benefits of a specific nurse visitation program in the USA revealed that cost savings and benefits derived from implementing the prevention program yielded a cost-benefit ratio of 5.7:1. In other words, for every dollar spent, nearly $6 of benefits in a wide range of health, education, child maltreatment, domestic violence and employment outcomes for women and children is realized by both the government and society at large.[lxii]

Evidence strongly suggests that responding to, and trying to remedy the effects of child maltreatment after it occurs through care, support and treatment are both less effective and more costly than preventing it in the first place (Kilburn and Karoly, 2008).[lxiii] "In the brain, as in the economy, getting it right the first time is ultimately more effective and less costly than trying to fix it later."[lxiv]

8 - INTEGRATION AND IMPLEMENTATION
WAY FORWARD

The IFRC and its member National Societies have begun a few health projects that successfully integrate VP. There are opportunities to improve, measure for impact and scale-these up. There are also opportunities to develop new linkages in order to enhance human health and safety. The following points of integration could be pursued by the IFRC or National Societies where it is viable and appropriate.

1 - INCLUSION IN STRATEGIC FRAMEWORKS

Embed VP as a cross-cutting issue into key existing and future Health strategic frameworks and documents. For example, existing documents such as the Holistic Health and Resilience Approach (HHRA) and the Strategic Plan for Behavioural Change Capacity-building.

2 - TRAINING ON VP FOR HEALTH PERSONNEL

Conduct cross-disciplinary training between Health and VP, e.g. provide the IFRC/CRC **"Ten Steps to Creating Safe Environments"** training to all IFRC Health personnel.

3 - INTEGRATION ACROSS HEALTH PROGRAMMING

Continue to systematically strengthen integration of VP as a cross-cutting issue into Health programming such as CBHFA, Disaster Response related to Health (ERUs, FACT, RiTs/NiTs), First Aid, HIV, and MNCH, etc. Integration of VP is best achieved when it is also complemented with integration of gender specific perspectives and beneficiary accountability standards.

3.1 **Define the problem**

A key strategy to effectively integrate the VP and health sectors is to review existing external documentation from governments, police, universities, NGOs, the UN and other sources to gather and analyse information on the magnitude, scope, characteristics and consequences of violence in each project setting to better understand how the issue is being framed.

3.2 **Identify risk and protective factors**

Include standardized, specific questions on VP within VCA's and other Health assessments (such as module three of CBHFA, rapid assessment tools, health surveys, etc.). Develop and provide guidelines to help analyse and interpret findings from assessments so they can be translated into effective integration.

3.3 **Develop and evaluate interventions**

Based on findings and analysis from assessments, VP should be integrated into Health programming. For example, this may include development of new learning modules for beneficiaries (adults, youth and children), integration of VP content into existing learning modules, inclusion in community awareness raising initiatives through media, and support to organizations to build internal protective systems such as VP policies, procedures, services to

people affected by or having experienced violence, treatment of injuries and psychosocial effects,

Piloting can be done in select, focused locations of a larger Health program, in order to test integration and ensure it is done effectively, before scaling-up.

Build VP into the evaluation/lessons learned process for each project where it is integrated. This can include standardized indicators for expected outcomes, tools for analysing results, and identifying strengths, deficiencies and unexpected outcomes.

3.4 **Implement / replicate / scale-up**

Once VP integration is piloted in select locations and evaluated, the integration can be replicated or scaled up and built into the regular program delivery structure, budget and monitoring and evaluation.

4 - CONDUCT HUMANITARIAN DIPLOMACY

Influence key decision-makers to see VP as a Health issue within development and emergencies; and promote examples of successful integration of Health and VP from across zones. This can be achieved through internal IFRC and external platforms using advocacy documents and tools, high-level meetings and conferences, case studies and social media.

Violence is a globally recognized health problem. The IFRC's experience and leadership to create and integrated approach to address violence as a health issue is reflected both in Strategy 2020 and its growing program intervention to this end (i.e. integration of VP in CBHFA). The goal of this integration is to develop capacities to help National Societies support communities to prevent or mitigate risks related to violence that threaten their ability to achieve and maintain a state of healthy and safe living.

This discussion paper contributes to cohesive, strategic integration of VP and health by presenting a framework and background for integration, current examples of practical action and future directions in emergency/recovery and development contexts.

APPENDIX 1 - IFRC FRAMEWORKS TO SUPPORT INTEGRATION BETWEEN HEALTH AND VIOLENCE PREVENTION

IFRC FRAMEWORKS	SPECIFICS
Strategy 2020	"We have consolidated the direction and progress that were initiated under Strategy 2010 by focusing our vision on **three mutually reinforcing aims** for the next decade" Within Strategic Aim two: Health is defined as: "a state of complete **physical, mental and social well-being**..." and notes that resilient individuals are "healthy, educated, wealthy and **safe.**" There is an emphasis on "spreading awareness of a '**culture of safety**'" The strategy highlights that trauma from violence will be a leading worldwide cause of death, disease and disability by 2020 Within Strategic Aim three: notes that the consequences of vulnerability can be: "expressed through **violence against oneself and others**..." and disadvantaged people "may live in circumstances where they are subjected to violence, abuse and exploitation" One of the expected impacts of Strategic Aim three is: "Lower levels of violence..."
Strategy on Violence Prevention, Mitigation and Response (2011)	Defines violence as a health problem that needs to be integrated across key programs including Health
Violence Prevention Pledge (2011)	Sets the following target for 2015: 70% of the existing IFRC appropriate trainings, resources and tools integrates violence prevention, mitigation and response, with a special focus on children, youth and gender-based violence
Inter-Americas Commitments (2012)	Commitment four includes: We will train our staff and volunteers, working in conjunction with government and civil society, to reduce the causes of violence. We will respond to the impact of violence on families and vulnerable communities and promote a culture of peace

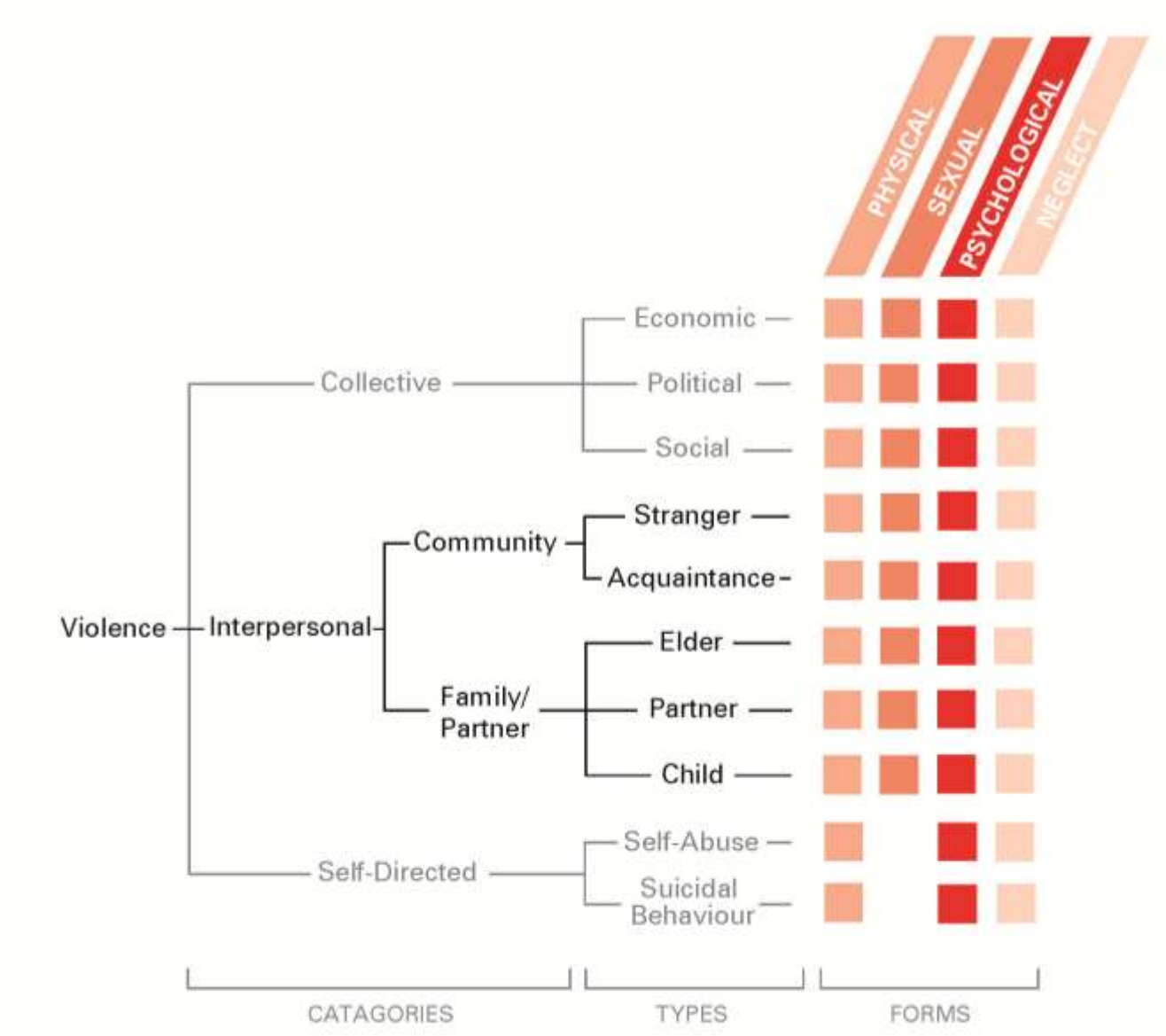
Invest in Africa: Addis Ababa Plan of Action (2012)	Key action 5 includes mainstreaming gender empowerment, violence prevention and promotion of a culture of peace in all areas of our work and activities. Key actions 3 an 8 include, respectively, to invest in strategic partnerships in order to strengthen advocacy and promote non-violence and peace, and to invest in upgrading the capacities and skills of the volunteer base, […], to address humanitarian and development challenges in Africa, with particular focus on […] violence
Vienna Commitments (2010)	National Societies in the Europe Zone commit to advocate at all levels for the public provision of, and access to, adequate services for older people, such as proper living and housing conditions, appropriate health and social care and nursing-in accordance with human dignity and relevant standards, as well as to actively tackle and prevent any mistreatment and abuse against older people
Tehran Declaration (2013)	National Societies in the MENA Zone recognise the expressed challenges National Societies are facing in the area and commit to assess that their programmes are promoting a culture of Peace and Non Violence to reduce vulnerability and include this concept in their planning; encourage increased efforts aimed at bridging cultural divides and promoting cultures of non-violence and peace through peer-to-peer networking such as YABC and exchange among MENA Red Cross and Red Crescent Societies' youth and volunteers and with youth and volunteers from outside the MENA region; and welcome initiatives aimed at strengthening the image, visibility and acceptance of MENA Red Cross and Red Crescent Societies within their local communities and their role in promoting non-discrimination and non-violence within the framework of the Fundamental Principles, utilising traditional and new media channels.
Advocacy report "Predictable, preventable: addressing interpersonal and self-directed violence during and after disasters" (2012)	Outlines the need for Violence Prevention to build into disaster and crisis response (including health disasters). Recommends as a best practice that VP be integrated into CBHFA and other relevant Health resources/tools
Long Term Planning Framework: Health 2012-2015	Goal 1: Build National Society capacity to enable safe and health living and to respond appropriately to health emergencies and crises, by reducing vulnerabilities and building resilient communities. This includes: "the health team will develop a holistic health and resilience approach that takes into consideration the social determinants of health and new emerging threats and that is informed by the research and

	learning agenda"[lxv] Goal 2: Position the Red Cross Red Crescent as a leading strategic partner to improve global health.
IFRC Strategic Framework on Gender and Diversity (2013)	The prevention of gender inequality, gender discrimination and gender-based violence is one of the three outcomes of the strategic framework
Eliminating health inequities. Every woman and every child counts (2013)	Outlines the need to address health inequities through a holistic approach which includes violence prevention. Violence prevention, with a special focus on women and children, is mainstreamed across the document as a consequence of health inequities and the resulting social injustice. It calls governments to mmake a firm commitment to gender equality, non-discrimination and non-violence in constitutions, legislation and national policies, including health policies, and ensure appropriate enforcement mechanisms

APPENDIX 2 - CATEGORIES, TYPES AND FORMS OF VIOLENCE

There are different categories, types and forms of violence. The World Health Organization (WHO) has developed a chart that describes each of the categories—self-directed, interpersonal and collective.[lxvi] Each category includes various types of violence. Cutting across these categories and types are different forms of violence: psychological, physical, sexual and neglect.

Chart: The Categories, Types and Forms of Violence (WHO)[lxvii]



APPENDIX 3 – WORLD HEALTH ASSEMBLY RESOLUTION (2014)

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY A67/A/CONF./1/Rev.1
Agenda item 14.3 24 May 2014

Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children

Draft resolution proposed by the delegations of Albania, Australia, Belgium, Canada, Guatemala, India, Italy, Latvia, Mexico, Moldova, Namibia, Netherlands, Norway, Paraguay, Portugal, Switzerland, Thailand, Turkey, Ukraine, Uruguay, USA and Zambia

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on addressing the global challenge of violence, in particular against women and girls[1];

PP2 Recalling resolution WHA49.25 (1996), which declared violence a leading worldwide public health problem, resolution WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, and resolution WHA61.16 (2008) on the elimination of female genital mutilation;

PP3 Cognizant of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, and against children including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, and all relevant United Nations General Assembly and Human Rights Council resolutions, as well as all relevant Commission on the Status of Women agreed conclusions;

PP4 Noting that violence is defined by the WHO as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation[2]";

PP5 Noting also that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and intimate partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes1;

1 Document A67/22.

2 World report *on violence and health.* Geneva: World Health Organization; 2002.

PP6 Recalling the definition of violence against women as stated in the 1993 Declaration on the Elimination of Violence against Women A/RES 48/104;

PP7 Concerned that the health and wellbeing of millions of individuals and families is adversely affected by violence and that many cases go unreported;

PP8 Further concerned that violence has health-related consequences including death, disability and physical injuries, mental health impacts and sexual and reproductive health consequences, as well as social consequences;

PP9 Recognizing that health systems often are not adequately addressing the problem of violence and contributing to a comprehensive multi-sectoral response;

PP10 Deeply concerned that globally, one in three women experience either physical and/or sexual violence, including by their spouses, at least once in their lives2;

PP11 Concerned that violence, in particular against women and girls, is often exacerbated in situations of humanitarian emergencies and post-conflict settings, and recognizing that national health systems have an important role to play in responding to its consequences;

PP12 Noting that preventing interpersonal violence against children – boys and girls – can contribute significantly to preventing interpersonal violence against women and girls and children, that being abused and neglected during infancy and childhood makes it more likely that people will grow up to perpetrate violence against women, maltreat their own children, and engage in youth violence, and underscoring that there is good evidence for the effectiveness of parenting support programmes in preventing child abuse and neglect in order to halt the intergenerational perpetuation of interpersonal violence;

PP13 Noting also that violence against girls needs specific attention because they are subjected to forms of violence related to gender inequality that too often remain hidden and unrecognized by society, including by health providers, and while child abuse (physical, emotional) and neglect affects boys and girls equally, girls suffer more sexual violence;

PP14 Deeply concerned that violence against women during pregnancy has grave consequences on the health of both the woman and the pregnancy, such as miscarriage and premature labour, and for the baby such as low birth weight, as well as recognizing the opportunity that antenatal care provides for early identification, and prevention of the recurrence of such violence;

PP15 Concerned that children, particularly in child-headed households, are vulnerable to violence, including physical, sexual and emotional violence, such as bullying, and reaffirming the need to take action across sectors to promote the safety, support, protection, health care and empowerment of children, especially girls in child-headed households;

PP16 Recognizing that boys and young men are among those most affected by interpersonal violence, which contributes greatly to the global burden of premature death, injury and disability, particularly for young men, and has a serious and long-lasting impact on a person's psychological and social functioning;

1 Page 6 of *World report on violence and health.* Geneva: World Health Organization; 2002.

2 Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO, 2013.

PP17 Deeply concerned that interpersonal violence, in particular against women and girls, and children, persists in every country in the world as a major global challenge to public health, and is a pervasive violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and a major impediment to achieving gender equality, and has negative socioeconomic consequences;

PP18 Recognizing that violence against women and girls is a form of discrimination, that power imbalances and structural inequality between men and women are among its root causes, and that effectively addressing violence against women and girls requires action at all levels of government including by the health system, as well as the engagement of civil society, the involvement of men and boys and the adoption and implementation of multifaceted and comprehensive approaches that promote gender equality and empowerment of women and girls and that change harmful attitudes, customs, practices and stereotypes;

PP19 Aware that the process underway for the post-2015 development agenda may, in principle, contribute to addressing, from a health perspective, the health consequences of violence, in particular against women and girls, and children, through a comprehensive and multi-sectoral response;

PP20 Acknowledging also the many regional, sub-regional and national efforts aimed at coordinating prevention and response by health systems, to violence, in particular against women and girls and against children;

PP21 Noting with great appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk and protective factors[1], consequences, prevention of and response to violence[2], in particular against women and girls[3], and against children, in the development of norms and standards, in advocacy and in supporting efforts to strengthen research, prevention programmes and services for those affected by violence[4];

PP22 Also noting that addressing violence, in particular against women and girls and against children is included within the leadership priorities of WHO's Twelfth General Programme of Work 2014–2019 in particular to address the social, economic and environmental determinants of health;

PP23 Recognizing the need to scale up interpersonal violence prevention policies and programmes to which the health system contributes and that while some evidence-based guidance exists on effective interventions, more research and evaluation of these and other interventions is required;

PP24 Stressing the importance of preventing interpersonal violence before it begins or reoccurs, and noting that the role of the health system in the prevention of violence, in particular against women and girls, and against children, includes supporting efforts to: reduce child maltreatment, such as through parenting support programmes; address substance abuse including the harmful use of alcohol; prevent the reoccurrence of violence by providing health and psychosocial care and/or rehabilitation for victims and perpetrators and to those who have witnessed violence; and, collect and disseminate evidence on the effectiveness of prevention and response interventions;

1 Protective factors are those that decrease or buffer against the risk and impact of violence. While much of the research on violence against women and violence against children has focused on risk factors, it is important for prevention also to understand protective factors. Prevention strategies and programmes aim to decrease risk factors and/or to enhance protective factors.

2 Including the World Report on Violence and Health (2002).

3 Including the WHO Multi-country Study on Women's Health and Domestic Violence against Women (2005); Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013); Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013).

4 This work is carried out mainly by the Department of Violence and Injury Prevention and Disability, the Department of Reproductive Health and Research, the Department for Mental Health and Substance Dependence and the Department for Emergency Risk Management and Humanitarian Response, in close collaboration with Regional and Country Offices.

PP25 Affirming the health system's role in advocating, as an element of prevention, for interventions to combat the social acceptability and tolerance of interpersonal violence, in particular against women and girls, and against children, emphasizing the role such advocacy can play in promoting societal transformation;

PP26 Recognizing that interpersonal violence, in particular against women and girls, and against children, can occur within the health system itself, which can negatively impact the health workforce, the quality of health care provided and lead to disrespect and abuse of patients, and discrimination to access of services provided;

PP27 Affirming the important and specific role that national health systems must play in identifying and documenting incidents of violence, and providing clinical care and appropriate referrals for those affected by such incidents, particularly women and girls, and children, as well as contributing to prevention and advocating within governments and among all stakeholders for an effective, comprehensive, multi-sectorial response to violence;

OP1. URGES Member States1:

(OP1.1) to strengthen the role of their health systems in addressing violence, in particular against women and girls, and against children, to ensure that all people at risk and or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO's work related to this resolution;

(OP1.2) to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs, and child development, in order to promote and develop an effective, comprehensive, national multi-sectorial response to interpersonal violence, in particular against women and girls, and against children, by, inter alia, adequately addressing violence in health and development plans, establishing and adequately financing national multi-sectoral strategies on violence prevention and response including protection, as well as promoting inclusive participation of relevant stakeholders;

(OP1.3) to strengthen their health system's contribution to ending the acceptability and tolerance of all forms of violence against women and girls, including through advocacy, counselling and data collection, while promoting the age-appropriate engagement of men and boys alongside women and girls, as agents of change, in their family and community, so as to promote gender equality and the empowerment of women and girls;

(OP1.4) to strengthen the national response, in particular the national health system response, by improving the collection and, as appropriate, dissemination of comparable data disaggregated for sex, age, and other relevant factors, on the magnitude, risk and, protective factors, types, and health consequences of violence, in particular against women and girls, and against children, as well as information on best practices, including the quality of care and effective prevention and response strategies;

(OP1.5) to continue to strengthen the role of their health systems so as to contribute to the multi-sectoral efforts in addressing interpersonal violence, in particular against women and girls, and against children, including by the promotion and protection of human rights, as they relate to health outcomes;

(OP1.6) to provide access to health services, as appropriate, including in the area of sexual and reproductive health;

1 And, where applicable, regional economic integration organizations

(OP1.7) to seek to prevent reoccurrence and break the cycle of interpersonal violence, by strengthening, as appropriate, the timely access for victims, perpetrators and those affected by interpersonal violence to effective health, social and psychological services and to evaluate such programmes to assess their effectiveness in reducing reoccurrence of interpersonal violence;

(OP1.8) to enhance capacities, including through appropriate continuous training of all public and private professionals from health and non-health sectors, as well as caregivers and community health workers, to provide care and support, as well as other related preventive and health promotion services to victims and those affected by violence, in particular women and girls and children;

(OP1.9) to promote, establish, support and strengthen standard operating procedures targeted to identify violence against women and girls, and against children, taking into account the important role of the health system in providing care and making referrals to support services;

OP2. REQUESTS the Director-General:

(OP2.1) to develop, with the full participation of Member States[1], and in consultation with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence in particular against women and girls and against children, building on existing relevant WHO work;

(OP2.2) to continue to strengthen WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence, in particular against women and girls and against children, and update the data on a regular basis, taking into account Member States input, and to collect information on best practices, including the quality of care and effective prevention and response strategies in order to develop effective national health systems prevention and response;

(OP2.3) to continue to support Member States, upon their request, by providing technical assistance for strengthening the role of the health system, including in sexual and reproductive health, in addressing violence, in particular against women and girls, and against children;

(OP2.4) to report to the Executive Board at its 136th session on progress implementing this resolution, and on the finalization in 2014 of a global status report on violence and health which is being developed in cooperation with UNDP and UNODC, and reflects national violence prevention efforts, and to report also to the Executive Board at its 138th session on progress in implementing this resolution, including presentation of the draft global action plan, for consideration by the Sixty-ninth World Health Assembly.

1 And, where applicable, regional economic integration organizations

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