23 WHO 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

Contents

In focus

The Global Plan of Action (A69.9) was adopted in 2016 (WHA69.5). In A69.5 the WHA asked for an interim report at WHA71 and a full report on implementation at WHA74. A74/21 provides the full report as requested.

The original Global Plan of Action was conceived as guiding WHO's work through to 2030. In para 57 of A74/21 the Secretariat suggests the Assembly consider further initiatives to progress the approaches set out in the Global Plan of Action.

Background

PHM's comment on this item at WHA69 provides an overview of the origins and structure of the Global Plan of Action.

The interim report requested in WHA69.5 was provided as Progress Report E in (A71/41 Rev.2). It is quite thin.

PHM Comment

There is much to appreciate in the Global Plan of Action. The role of the health system in relation to a multisectoral response to interpersonal violence (Box 1) is nicely presented. The four strategic directions provide a useful way of thinking through both analysis and strategy. The guiding principles are unimpeachable.

However, in our PHM comment on the Global Plan of Action at WHA69 we highlighted:

- the invisibility of sexual orientation, in relation to analysis, programming and data collection;
- the importance of addressing structural analyses of violence in the development of data collection systems, including appropriate disaggregation;
- the need to address cultural (and structural) barriers to accessing services and information;
- the quality of post-discharge services for women in danger; and
- sexual violence as a weapon of war.

The failure to address the structural *determination* of interpersonal violence is a major weakness of the Global Plan of Action and of the current report (A74/21). In particular there are no analyses or actions directed towards:

- **patriarchy, misogyny and homophobia,**
- **casteism, or**
- **internal colonialism.**

There is no analysis in the GPA of the role of patriarchy, misogyny and homophobia in generating violence nor the structural factors in different societies which reproduce patriarchy, misogyny and homophobia.

Patriarchy thrives when men and boys are encouraged (by custom and ideology) to project their fears and disappointments onto women and girls, including through violence. Homophobia thrives when heteronormative people are encouraged (by custom and ideology) to project their fears and disappointments onto people of diverse sexualities and orientations, including through violence. What does 'public health perspective' mean if it does not shine a light on these dynamics?

Recognising the role of patriarchy and homophobia in driving violence points to the need to build respect, to encourage listening across difference and to ensure security for all, not at the cost of others but as a shared dispensation. This project of reshaping custom and ideology is not a challenge for the health sector alone but ignoring it in health system advocacy can only help to perpetuate such attitudes and the violence they sanction.

There is no analysis in the GPA of the role of casteism in generating violence nor the structural factors which reproduce casteism in different societies.

Casteism naturalises inequalities in power and privilege. Casteism thrives when the powerful and privileged are encouraged (by custom and ideology) to project their fears and disappointments onto the powerless and marginalised, including through violence.

The role of the health sector in reshaping the institutions, practices and expectations which reproduce casteism is complicated by the presence of caste related oppressions within the

health system itself. However, bringing a rigorous public health perspective to the prevalence and drivers of caste related violence can only help to build the movement for change.

There is no recognition in the GPA of the concept of ‘internal colonialism’ as a way of understanding structural violence. ‘Internal colonialism’ recognises that violence against indigenous people and communities in white settler societies does not simply cease when the colonising power relinquishes formal political control. ‘Internal colonialism’ recognises that violence against slave-descended people in post slavery societies does not simply cease when slavery is abolished.

Recognising internal colonialism points to the need for justice, respect, and truth. It points to the need for reconciliation based on a new living covenant which is owned with pride by the whole society.

Box 1 of the GPA describes the role of the health systems as advocating for a public health perspective in relation to interpersonal violence and advocating with other sectors to address risk factors and determinants of such violence. However, there is nothing in A74/21 which suggests that national health systems are being encouraged to encompass patriarchy, homophobia, casteism and internal colonialism in their implementation of a public health approach or in their advocacy with other sectors.

If the health system is not deploying a structural analysis in understanding violence and advocating with other sectors it is thereby helping to obscure these structural determinants and enabling them to continue to operate unchallenged.

This report does nothing to hold governments accountable for implementing the actions identified in the GPA as the primary responsibilities of member states

A74/21 is almost entirely about what WHO has done by itself or with international partners.

However, the Global Plan of Action specifically identified actions which are the primary responsibilities of member states (including national and subnational governments). See paras 8-10 and Section 3 of A69/9.

Further, the Global Plan of Action includes a monitoring and accountability framework (Section 4, from page 33) including a raft of indicators and targets including for actions which are identified as the responsibilities of governments. However, most of the indicators listed are yet to be defined (TBD).

(The suggested indicators all take the form of “Number of member States that have …” which might provide some indication of global progress but do nothing about holding governments to account. This style of indicator based on self-report against flexible criteria is weak.)

However, there is very little information in A74/21 about member state actions as set out in Sections 3A - 3C of A69/9. There is no information in A74/21 on any progress achieved in finalising and implementing the monitoring and accountability framework.

This report fails to hold governments accountable for their action or inaction on interpersonal violence, including against women and children.

The failure of this report to acknowledge the impact of WHO's funding crisis on the implementation of the GPA is a critical weakness

The original Global Program of Action and the current report are in many ways admirable documents, notwithstanding the criticisms above.

However, Outcome 3.1 ('Countries enabled to address social determinants of health across the life course') is notoriously underfunded and avoided by the big donors. Two questions this report does not answer:

- What is **not** being done in progressing the Global Program of Action because of WHO's dire funding crisis?
- To what extent is the implementation of the Global Program of Action held hostage to the preferences of the few donors who are willing to support action on the social determinants of health?

Notes of discussion at WHA74