

**DRAFT Minutes Workshop Conflict-Related Sexual Violence**

**A World in Transition, 1st June 2012, City Hall, Oslo, Norway, 12.00 – 14.30 hrs**

**1. Agenda**

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| 12.00-12.05 h | Welcome and practical information by organizer |
| 12.05-12.15 h | Ragnhild MathisenDeputy Minister of Health and Care Services, NorwayWelcome, opening and presentation on the Norwegian perspective and response to sexual violence |
| 12.15–12.20 h | Dr Etienne KrugDirector Department of Violence and Injury Prevention and Disability, WHOWelcome, overview of WHO’s and the health sector’s role in preventing violence. |
| 12.20-12.30 h | Self-introduction of participants |
| 12.30-12.35 h | Prof Anthony ZwiUniversity of New South Wales, AustraliaPresentation of key results of a global review of research on effective interventions for the prevention of conflict-related sexual violence |
| 12.35-12.40 h | Dr Claudia Garcia-MorenoTeam Leader, Department of Reproductive Health and Research, WHOOverview of WHO’s past and current efforts to address conflict-related sexual violence. |
| 12.40-12.50 h | Dr Alexander ButchartCoordinator, Prevention of Violence, Department of Violence and Injury Prevention and Disability, WHOPresentation of the draft WHO plan of action to address conflict-related sexual violence. |
| 12.50-14.15 | Discussion(Facilitated by Etienne Krug, WHO)* Discuss and agree on a number of key priorities for the field of prevention and response to conflict-related sexual violence.
* Identify the role and main contributions for WHO over the next 3-5 years.
* Outline further steps for the development of a WHO wide action plan including global, regional and country level.
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| 14.15-14.30 h | Conclusion and Wrap up |

**2. Summary of technical inputs**

The meeting started with technical inputs on addressing conflict-related sexual violence.

**Ragnhild Mathisen**, Deputy Minister of Health and Care Services of Norway, welcomed participants to the meeting, highlighted the importance that Norway attributes to preventing and addressing sexual violence in conflicts and beyond, and highlighted the need for improved multi-sectoral coordination to address sexual violence. She called for increased efforts to prevent sexual violence and to strengthen reproductive and mental health services. She highlighted the role of the health sector in monitoring and documenting violence against women and the collection of forensic evidence; in better documenting good practices for prevention programming and service delivery, and in raising visibility, reducing stigma and shame, and advocating for more action to address such violence. She also stressed the importance of multi-sectoral collaboration.

**Etienne Krug**, Director of the Department of Violence and Injury Prevention and Disability at WHO Geneva, noted that in her acceptance speech on re-election as WHO Director General, Dr Margaret Chan had committed to giving more attention to the prevention of “domestic violence”. He also noted that some progress has been made with respect to services, but they are still not geared up or comprehensive enough to meet the needs of survivors. While the health sector should play a major role in addressing sexual violence (particularly in the areas of prevention and survivor services), public health experts are often absent from discussions when interventions to prevent conflict-related sexual violence are being planned. The health sector can contribute substantially to primary prevention and survivor services in terms of data collection; intervention design, monitoring and evaluation, service provision, support for policy development and advocacy. He outlined WHO activities to build the health sector’s capacity to fulfil its role, and underlined the need for a WHO-wide action plan.

**Eric Goosby**, United States Global AIDS Coordinator, described US government activities to address sexual violence. Addressing gender-based violence is part of PEPFAR’s overall gender strategy. Via PEPFAR, the US has invested US$155 million in the prevention and mitigation of gender-based violence in the past year, including providing at least 47000 women with post-rape care and services. Comprehensive country programming involving scaling up of screening, counselling, and prevention services is being implemented in Tanzania, Democratic Republic of the Congo, and Mozambique. PEPFAR is a partner of the international initiative Together for Girls, which addresses sexual violence particularly against girls. Via the gender challenge fund, PEPFAR also strengthens gender equity initiatives in 18 PEPFAR countries. He commended WHO for its work on violence prevention and services, including its work on estimating the prevalence of intimate partner violence, and highlighted the need to move from data collection and research to implementation and scaling-up of effective interventions at the country level.

**Anthony Zwi**, Professor at the University of New South Wales, presented preliminary results from a systematic review of strategies to reduce risk and incidence of sexual violence in conflict and post-conflict zones. The review examined efforts to address sexual violence as a tactic of armed conflict; opportunistic sexual violence due to situational vulnerability; sexual violence as a form of exploitation by peace keepers/humanitarian staff, and sexual violence as a form of familial or community violence exacerbated by weakened social or legal structures. The review revealed an acute lack of evaluation of interventions. None of the studies examined having measured whether an intervention actually reduced the incidence of sexual violence. Promising interventions for primary prevention include firewood provision / patrols / alternative fuels, and zero tolerance policies for sexual violence on the part of peacekeepers/humanitarian staff. Legal interventions were not associated with reduced risk. Promising interventions for secondary prevention included providing medical care and psychosocial services, and the participation in self-help groups. He highlighted the underlying mechanisms that could contribute to reduced risk: First, that women need to feel empowered to know that they have rights; Second, they need to know that there is help (e.g. services) for the problem, third that rape be de-normatized and made socially unacceptable, and fourth that community members be empowered to find their own solutions.

**Claudia Garcia-Moreno**, team leader for the Sexual Health, Gender, Rights and Adolescence unit in the WHO Department of Reproductive Health and Research, described WHO’s previous and ongoing activities on conflict-related sexual violence. Most work has been conducted within the framework of UN Action, which convenes 13 UN agencies to bridge humanitarian and peacekeeping work on conflict-related sexual violence. WHO leads the knowledge pillar of UN action and contributes to building evidence, establishing data collection methods and developing a research agenda. Several data collection instruments have been developed, including questionnaires to capture information on the prevalence, consequences, and risk and protective factors for sexual and other forms of violence in conflict-affected settings. WHO has also contributed to a gender-based violence management information system that promotes standardized data collection across agencies; developed a research agenda on conflict-related sexual violence, and held expert meetings on mental health and psychosocial support for victims of sexual violence. The WHO work plan on sexual violence in conflicts builds on the on-going collective work of UN Action that has been done with other agencies and across WHO departments.

**Alexander Butchart**, coordinator of Violence Prevention at WHO, presented the draft WHO-wide work plan to address sexual violence in conflict-affected settings. The plan (attached) outlines WHO’s suggested contribution over the next 3-5 years for five results areas. Expected results include an improved understanding of the magnitude and nature of conflict-related sexual violence, and better evidence on what works to prevent and respond to sexual violence. It further aims to strengthen policy response at country level, and improve programmes to prevent sexual violence and provide services for victims. The WHO plan also includes mechanisms to increase visibility and strengthen political commitment to addressing conflict-related sexual violence. Development of a WHO work plan on violence against women more broadly, including, sexual violence in conflict would include a WHO-wide consultation process, aimed at building HQ, regional and country office capacity to support programme design, implementation and monitoring.

**3. Discussion**

The discussion focused on identifying priorities for preventing and responding to conflict-related sexual violence in general, and WHO’s specific role in this regard, including the main outputs that WHO should aim for over the next 3-5 years, and next steps for the development of a WHO wide action plan.

A number of **priorities for the field** were highlighted in the discussion. Participants emphasized the need to move from data collection and guideline development, to country-level implementation. There was some discussion on whether we need to wait for data or should act on what we already know. These efforts should be aligned with existing cooperation mechanisms, such as the WHO country cooperation strategies, humanitarian mechanisms, sector-wide approaches or other partnership frameworks. Building WHO capacity at country level was perceived as a major challenge in this regard. WHO was identified as having a major role to play in stimulating high-level policy dialogues and supporting the dissemination of successful country programmes and best practices. There was also a suggestion to use country partnership frameworks to advocate and engage countries in taking on board the issue of sexual violence. PEPFAR, for example, uses their partnership framework to engage countries in such a dialogue.

Multi-sectoral coordination was identified as another priority area. As violence does not fall into one of the traditional development or humanitarian sectors, new ways of collaboration and multi-sectoral guidance are needed. Any response at country level should focus on sustainable, multi-sectoral, systems-strengthening approaches. Current responses tend to be ad hoc and often are not sustained. The need for increased funding, particularly for sustainable longer-term responses, was highlighted. There is also a need to build evidence on systems approach and on complex interventions to respond to this problem. Moreover, there is a need to have country-specific responses tailored to each country’s needs. It was pointed out that it may be challenging to only focus on conflict-related sexual violence since there is a lot of sexual violence that happens on a day to day basis and should be taken into account as an important driver of conflict-related sexual violence. Using Kenya as an example where there has been traction on response to sexual violence, success was attributed to strong emphasis on policy, research, advocacy and programming. Civil society, for example, can play an important role in moving things forward with the Ministry of Health.

It was suggested to better define and specify the focus of WHO work on conflict-related sexual violence, and to focus on high-risk groups affected by sexual violence independently from their direct involvement in a conflict-situation. It was further suggested to link responses to other agendas, such as WHO’s work on disability. It was noted that increased attention should be paid to men, both as victims and perpetrators of sexual violence, and to children, and to other interrelated forms of violence. There was also a suggestion to use the framework of the women, peace and security resolution (1325) as a framework for multi-sectoral responses.

Several suggestions were made regarding further development and implementation of the **WHO work plan**. Participants were in favour of WHO having a more prominent role in addressing conflict-related sexual violence, and noted that WHO was seen as an important moral authority able to put the issue on global and national agendas, as well as having a normative role.

It was recommended that WHO focus on “low-hanging-fruits”, by identifying and supporting a small number of feasible interventions in settings where success is likely, which can then serve as examples for similar work in other countries.

Participants agreed with the proposed activities for **results area 1**, the collection and dissemination of data on conflict-related sexual violence. However, it was noted that WHO should work increasingly on ways to translate data into action at country-level.

For **results area 2**, strengthened evidence on what works to prevent and respond to sexual violence, participants highlighted the need to increase the evidence, particularly with regard to monitoring and evaluation of existing interventions, and noted that the term evidence-informed was preferable to evidence-based. It was suggested that WHO also focus on sexual violence against children and other interrelated forms of violence, and do more to address alcohol and other risk factors for sexual violence. On intervention research, it was noted that more research is required to identify effective interventions.

**Results area 3** focuses on strengthened policy response and programming. In addition to the proposed activities, it was suggested that WHO provides more guidance for data collection, and indicators. Normative work should be promoted, with an emphasis on ensuring its ownership by other agencies and implementing partners. It was also noted that clinical care is very critical to spark other activities and can be built on including linking with other sectors.

The discussion on **results area 4** about visibility and political will yielded several suggestions that went beyond the proposed activities. Conducting journalist trainings on violence prevention was acknowledged as an important first step in increasing attention to the issue. It was noted that more focus should be placed on interventions to increase country ownership. To increase political will and commitment at the country level, it was suggested that WHO should produce estimates of the economic costs of sexual violence.

To increase global political will and visibility, it was suggested that WHO should be mandated by either a GA resolution or a WHA resolution to implement its work plan on sexual violence. It was suggested that the message should be repeated at different platforms, addressing bilateral and multi-lateral agencies, and potentially the G8 during the UK presidency, and the post-2015 framework.

**Results area 5** was seen as a part of the plan needing further development. It was acknowledged that a WHO-wide plan on violence against women could be a mechanism for strengthening cooperation and accountability across the three levels of the organization. However, questions were raised about how Result 5 would be funded and achieved. It was noted that any funding for WHO to develop this area of work should be provided in a way that enables integration across the three levels of WHO and between different clusters and departments. It was further suggested to strengthen WHO’s role in other coordination mechanisms beyond the organization, and its role in the multi-sectoral response at country-level.

**4. Conclusions and next steps**

The discussion was expected to contribute to discussions on the initial direction of the further development and consultation process for the WHO wide work plan. It was noted that the conclusions should be regarded as a starting point to a broader consultation, and that activities included in the current draft of the workplan ware provisional only. It was suggested to prioritize the following areas in the consultation process:

* Participants were in favour of a stronger role for WHO in addressing conflict-related sexual violence. WHO was seen as adding value in the areas of data collection; generation and dissemination of evidence on what works; global and national advocacy, and country-level policy development.
* WHO’s role and mandate in a multi-sectoral response needs to be further specified, in particular whether it should act as a facilitator and convenor, or just provide authoritative guidance to other sectors in applying a public health approach.
* While it was acknowledged that there is still a lack of evidence and guidance in particular in the area of prevention of conflict-related sexual violence, participants perceived the need to show results at the country level as having utmost importance. How to ensure implementation of WHO norms and standards requires further discussion.
* The need for additional policy discussion with other UN agencies and by WHO governing bodies was emphasized.

*Next steps*

* The development of a WHO plan on violence against women for all three levels of the organization was encouraged. This would involve regional and country consultations.
* Conduct needs assessment on WHO tools and guidance with relevant implementing agencies and government and NGO representatives in conflict-affected countries.

**5. DRAFT WHO Workplan to address sexual violence in conflict-affected settings**

**Overall goal**: To reduce the incidence and mitigate the consequences of conflict-related sexual violence.

This draft plan on conflict-related sexual violence is proposed in the context of strengthened WHO commitment to increase the public health sector's contributions to address violence against women in all countries in order to foster evidence-based prevention and enable access to services for survivors of violence against women more broadly. Efforts to address conflict-related sexual violence are part of this larger WHO initiative, recognizing both, the endemic nature of sexual violence as well as its exacerbation during conflicts.

**Expected Results, Objectives and Key Deliverables for the Draft WHO work plan**

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| **Expected Results/Outcomes** | **Objectives** | **Outputs** | **Key Activities, Products** | **WHO Core Function and whether deliverable is at the Global, Regional or Country level** |
| R1. Improved understanding of magnitude and nature of conflict-related sexual violence | Objective 1: To collect and compile data and evidence on prevalence, risk factors and consequences of conflict-related sexual violence | Strengthened data collection and the evidence base for prevention of sexual violence | 1. Pilot and implement surveys on conflict-related sexual violence with women and men in 1- 2 countries and refine methodologies | **Research, Evidence and Knowledge generation**Global  |
|  |  | Disseminating research and data on global and regional estimates | 2. Publication and dissemination of global and regional prevalence estimates and health consequences of sexual violence based on the Global Burden of Disease estimates | Global |
|  |  |  | 3. Disseminate research agenda for conflict-related sexual violence | Global |
|  |  | Comparative country report on prevalence, policies, laws, capacity and resources for sexual violence | 4.Compile brief comparative country report on prevalence, policies, laws, capacity and resources for sexual violence, based on existing Global Status Report on Violence Prevention data  | Global |
| R2. Strengthened evidence on what works to prevent and respond to sexual violence  | Objective 2: To generate evidence on what works to prevent and respond to sexual violence | Evidence on effective interventions to prevent and provide services for sexual violence | 1. Support to interventions research on addressing sexual violence in selected settings (non-conflict, weak institutional settings) | **Research, evidence and knowledge generation**Global  |
|  |  | Expanded searchable violence prevention evidence-base to include conflict-related sexual violence  | 2. WHO and Liverpool John Moores University searchable violence prevention evidence-base expanded to cover conflict-related sexual violence | Global |
|  |  |  | 3. Support to Sexual Violence Research Initiative and other collaborative research activities | Global and regional |
|  |  | Strengthening sexual and reproductive health and health systems | 4. Evaluate deployment of reproductive health kits, including post-rape kits in crises settings | Country |
| R3. Strengthened policy response and improved programmes and services to prevent and respond to sexual violence, including conflict-related violence | Objective 3: To strengthen policy makers understanding of sexual violence, its costs and consequences, and responses  | National policy dialogues in 2-3 countries with policy makers to raise awareness about sexual violence, its costs and consequences and follow up technical support | 1. National policy dialogues in 2-3 countries using WHO normative tools and evidence on preventing and responding to intimate partner and sexual violence (e.g. stake holder consultations and on-going support for follow up activities) | **Evidence-based advocacy and policy options**Country |
|  | Objective 4: To strengthen capacity of programme planners, implementers, health and humanitarian actors for prevention and response at global, regional and country level | Increased human and institutional capacity across sectors to design, deliver, monitor and scale-up effective interventions  | 1.Conduct training and follow up to identify entry points for possible interventions for prevention and care, across relevant sectors in 2-3 countries | **Technical support, and Institutional capacity** Global, Regional and country |
|  |  | Strengthening sexual and reproductive health and health systems | 2. Provide technical support to follow up activities in 2-3 countries to, e.g., develop national protocols, test new interventions, strengthen delivery of post-rape care | Global, regional and country |
|  |  |  | 3. Support Regional Offices on-going country-based responses to sexual and gender-based violence in crises settings  | Regional and Country |
|  | Objective 5: To develop norms and standards for strengthening the psychosocial, mental, sexual, reproductive and other health responses to survivors of and on primary prevention of sexual violence  | Strengthening the response to the psychosocial and mental health needs of survivors of sexual violence | 1.Intervention guide for non-specialized health care in conflict affected settings, with guidance on care for survivors of sexual violence 2. Guide on simple, manualized psychological treatments | **Norms and Standards**Global  |
|  |  | Updating norms, standards and technical guidance on sexual violence | 3. Develop and/or update, adapt and disseminate Clinical and policy guidelines for responding to intimate partner and sexual violence, and forensic/medico-legal guidance, including to conflict-affected settings  | Global |
|  |  | Updating norms, standards and technical guidance on sexual violence | 5. Develop and disseminate WHO guideline on the primary prevention of sexual violence in conflict- and weak institutional settings | Global |
| R4. Increased visibility and political commitment to addressing conflict- related sexual violence |  |  | 1.Global Policy dialogues on SV during relevant UN days (e.g. international day on elimination of VAW) | Global  |
|  |  |  | 2.Side event during WHA 2013 | Global |
|  |  |  | 3. Training for journalists | Global |
| R5. Strengthened WHO-wide coordinated response | Objective 6: To develop a harmonized WHO-wide action plan on violence against women  | Harmonized WHO-wide action plan on violence against women (including conflict-related sexual violence) and reflecting key deliverables and outputs across all levels of WHO | 1.Regional and country office capacity building workshops | Global, regional and country |
|  |  |  | 2. Regional and global consultation | Global , regional and country |

**6. List of Participants**

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