It Takes Health to End Violence Against Children

Assessing alignment of national health policies with the World Health Organization's Global Plan of Action to address interpersonal violence

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Executive Summary

Background
Violence against children affects 1.7 billion children every year, in every community and every country.[1] It includes all forms of physical, sexual and mental violence; neglect or negligent treatment; maltreatment or exploitation; harm or abuse including commercial sexual exploitation; trafficking; and harmful practices such as female genital mutilation/cutting and child marriage. Globally, the economic impact and cost from the consequences of violence against children has been estimated as high as US $7 trillion per year.[2]

It does not have to be this way. Children deserve better. Preventing and addressing violence against children is complex, but it is possible. Recent strides have been made recognising the problem and finding appropriate solutions including the development of *INSPIRE: Seven Strategies for Ending Violence Against Children*, led by World Health Organization (WHO) in collaboration with partner agencies. The adoption of WHO's Global Plan of Action to strengthen the role of the health system within a national multisectoral response regarding interpersonal violence, in particular against women and girls, and against children in 2016 provides a strong mandate for countries and their health systems to address violence against children as a global and urgent public health problem. The global plan provides guidance for Ministries of Health to accelerate the implementation of the health sector's contribution within multisectoral efforts to end violence against children.

World Vision has undertaken a review of 24 countries' national health policies to identify the extent to which these policies are aligned with the global plan, as well as detect promising practices and formulate recommendations for future policy work.

Methodology
This review used a mixed-methods qualitative approach consisting of a desk review of 67 national health policy documents, key informant interviews with World Vision staff responsible for health sector programming, and questionnaires administered to government officials. The review was conducted across 24 countries – one in the Americas, four in Asia, and 19 in Africa. These countries were chosen according to criteria including status of the country as "Pathfinding" within the Global Partnership to End Violence Against Children,[3] and World Vision's work in health and violence at country level.

Findings
In recent years, several global development trends have contributed to a generation of national health policies increasingly sensitive to issues of violence against children and women. These include the growing global movement to promote gender equality and empower women and girls; the promotion of universal health coverage, particularly for children; the recognition that issues like child health and violence require a "whole-of-government" approach; and the recognition that adolescents have specific health needs.

At the same time, resource constraints,[4] lack of standardised age and gender-disaggregated data on violence, diversity of violence topics, traditionally fragmented government responses, and limited attention to mental health have prevented the development and adoption of health policies and plans that fully embrace and address violence against children. Despite these challenges, numerous national health policies showcase promising practices including mainstreaming violence into child health policies and plans, inclusion of violence response service delivery in essential health packages, consistent consideration of the gendered nature of violence and adaptation of responses to the specific situation of women and girls, progressive harmonisation of data collection at all levels, and regular and nationally representative surveys of violence prevalence.

Review findings lead to three prioritised recommendations:

1 Integrate the issue of violence against children into health policies and plans in alignment with WHO global plan including essential health promotion, child health, mental health, emergency response services, and universal health coverage packages.

2 Leverage ongoing health promotion and behavioural change policies and programmes to include social norm changes on violence against children.

3 Ensure regular data collection on violence against children disaggregated by age and gender.

Moving forward, further research into the implementation of these national health policies, plans and programmes will be required to document best practices, jointly address challenges, and report on the implementation of WHO global plan at the World Health Assembly in 2020.

Background

Violence against children affects 1.7 billion children every year. Children are subjected to violence in their communities, schools, and homes – the very places they should feel the most safe and secure. Violence is devastating for children, affecting their health, obstructing their education, and diminishing their chances for a life free from poverty and discrimination. The impact of violence goes beyond individual children, affecting families and communities, slowing economic development, and eroding human and social capital.[5,6,7]

Violence against children includes all forms of physical, sexual and mental violence; neglect or negligent treatment; maltreatment or exploitation; harm or abuse including commercial sexual exploitation; trafficking; and harmful practices such as female genital mutilation/cutting and child marriage.

Preventing and addressing violence against children is a complex task, but it is possible. Recent strides have been made in recognising the problem, and political will to find appropriate solutions is at an all-time high. The Global Partnership to End Violence Against Children, a multisectoral platform launched in 2016, is where all major stakeholder groups come together to focus their words, actions and resources to end violence against children. Pathfinding countries under the Global Partnership commit to accelerating the achievement of the End Violence goals. Currently, 15 countries have committed to adhering to the End Violence principles, monitoring delivery of commitments, reporting annually, sharing learning, and celebrating success during Solutions Summits organised by the Global Partnership.

No single sector can solve the issue of violence against children alone. However, the health sector is strongly positioned to contribute to ending violence, as healthcare workers are often front-line responders for violence against children.[8,9]

In May 2016, at the 69th World Health Assembly, Member States of the WHO adopted the Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. The global plan of Action provides guidance for Ministries of Health to accelerate the implementation of the health sector's contribution within multisectoral efforts to end violence against children.

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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.

The Global Plan of Action is a guidance document developed by WHO following resolution WHA67.15: "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children." The global plan outlines strategies to respond to and prevent violence against women and girls, against children, and cross-cutting all forms of interpersonal violence. It emphasises strengthening the health sector's response to violence across four pillars:

Pillar I: Strengthening health system leadership and governance

Pillar II: Strengthening health service delivery and health workers'/providers' capacity to respond

Pillar III: Strengthening programming to prevent interpersonal violence

Pillar IV: Improving information and evidence

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"Violence against children affects more than one billion children every year... the health sector is strongly positioned to contribute to ending violence against children."

Types of violence against children[10]

Maltreatment (including corporal punishment) involves physical, sexual and psychological violence, as well as neglect by parents, caregivers and other authority figures.

Intimate partner violence includes violence by a current or former partner; this disproportionately affects females, and commonly occurs within child and early or forced marriage.

Sexual violence includes non-consensual completed or attempted sexual contact, non-consensual acts of sexual nature not involving contact, online exploitation, and sexual trafficking.

Psychological or emotional violence includes restricting movements, ridicule, threats and intimidation, discrimination, rejection, and other non-physical forms of hostile treatment.

When directed against girls or boys because of their biological sex or gender identity, any of these types of violence can constitute gender-based violence.

Methodology

This review used a mixed-methods approach consisting of a desk review of 67 national policy documents and 13 intersectoral plans, plus relevant international reports from an online search, key informant interviews with World Vision staff in-country, and completion of a standardised interview by government contacts. Section III reflects findings of the desk review. Fact sheets were built through a combination of secondary research and inclusion of information gathered via interviews with World Vision staff in national offices and questionnaires administered to national government staff in-country.

Twenty-five countries were ultimately selected for review.[II] Due to language constraints, only countries with working capacity in English or French were included. Further criteria including World Vision national office capacity and expertise in relation to health and violence, as well as country pathfinding status, were used to narrow the list of countries to 24. Of the 24 countries reviewed, only two did not have a current health policy or strategic plan, defined as updated in the last five years or in effect. In one case, old policy documents were reviewed; in the second case, the Democratic Republic of the Congo, no policy documents were found, resulting in their exclusion from further study.

Documents were identified through a keyword search and outreach to in-country World Vision staff. Policies, strategic plans and roadmaps were considered. Review of the documents was conducted against an analytical framework developed in line with the global plan indicators. Across the four pillars, or strategic directions, 18 points of analysis were developed. Points 8, 13 and 14 were exceptionally analysed through review of additional sources including the Demographic and Health Survey (DHS), which includes modules on domestic violence, child discipline, and child labour (as well as a question about age of first marriage), the Multiple Indicator Cluster Survey (MICS), which includes a module on child discipline, and the Violence Against Children Survey (VACS), which is wholly designed to evaluate violence against children.

The second phase of research consisted of key interviews and questionnaires administered to World Vision staff and government officials in-country. Interviews were conducted with staff in Rwanda, Ghana and Tanzania. Questionnaires were completed by government officials from Senegal, Solomon Islands, India and Tanzania.

Analytical Framework

Pillar	Indicator
Pillar I Strengthen health system leadership and governance	**1** Actions to address violence against children **a** Establishment of a unit/focal point at all administrative levels to specifically address violence against women, children and adolescents **b** Coordination function between health and other sectors (e.g., police and justice, housing and social services, women's affairs) **c** Codes of conduct within healthcare facilities that prohibit mistreatment of women and girls by health workers **d** Provision of healthcare services to address intimate partner violence and comprehensive post-rape care
	2 Funding and resource allocation for prevention of and response to violence
Pillar II Strengthen health service delivery and health workers'/providers' capacity to respond	**3** National guidelines, protocols or standard operating procedures for health system response to child survivors of maltreatment
	4 Services to manage health complications for survivors of female genital mutilation
	5 Mental health and social services provided by health workforce to address psychological consequences of violence
	6 Health worker training curricula that includes content on identifying and responding to survivors of violence
	7 National guidelines, protocols or standard operating procedures for health system response to women experiencing intimate partner violence and/or sexual violence
Pillar III Strengthen programming to prevent interpersonal violence	**8** National multisectoral plan addressing violence against women and girls (including the health system), which proposes at least one strategy to prevent violence against women and girls
	9 Home visiting and parenting support programs to detect, prevent and respond to violence against women and children (including work done by community health workers)
	10 Programmes that challenge harmful gender norms
	11 Life and social skill interventions among adolescents to prevent peer violence
	12 Awareness-raising programmes in schools or hospitals on maltreatment/violence against children
Pillar IV Improve information and evidence	**13** Conducting a population-based, nationally-representative study/survey or including a module on violence against women in the last five years
	14 Conducting a nationally-representative survey or including a module on child maltreatment in the last five years

Limitations

The policy review undertaken for the drafting of the present review focused on policy documents developed by Ministries of Health and Sanitation; a comprehensive review of policies developed by other ministries was not undertaken. While this serves to develop a clear picture of how well the issue of violence against children is integrated into health policy documents, it does not incorporate actions or strategies identified in secondary ministerial documents.

In addition, the list of policy documents is not exhaustive. There is a strong possibility that existing policy documents were not included in this review, despite an extensive online search and outreach to in-country contacts.

Finally, this report did not attempt to conduct any review of implementation or evaluation of impact of relevant policies. This review focused particularly on pillars I and IV and thus, the majority of promising practices and good examples are derived from these areas.

Findings

Overall, the majority of countries developed health policies addressing violence in some form. There was significant diversity in the national health strategies, particularly for specific actions and targeted populations. Many strategies had a strong gender focus.

Pillar I
Strengthening health system leadership and governance

In the majority of countries, there is a substantial body of health policy related to ending violence against women and girls, and multiple countries have established ministries of gender promotion and child protection, specifically mandated to address violence. All 24 countries outlined general coordination functions between health and other ministries. However, actions to prevent and respond to violence against all children are less defined and the establishment of focal points for inter-ministerial coordination on violence was not identified as a strategy to prevent violence against children.

A significant stride in government leadership that can address violence against children is the rising tide of universal health coverage (UHC) policy. Children are well placed to benefit from the promotion of UHC as a universally recognised vulnerable population and beneficiary group. Integrating violence into UHC services presents a unique opportunity to equitably provide healthcare services to address violence against children.

Promising Practices

1. Specific actions to prevent and respond to violence against children (including boys), encompassed in national health policy documents and plans;
2. Violence issues integrated into child health objectives promoting a holistic approach to child health;
3. Gender consistently considered in national policies and plans, specifically actions to combat all forms of gender-based violence, including female genital mutilation, where relevant;
4. Response services for violence against women and children included in the list of essential services and UHC programmes.

Positive Examples

Mali's *Decennial Plan for Health and Social Development 2014 - 2023* not only explicitly mentions violence against children, but also includes strategies and actions to end violence against children under integrated actions, thereby addressing child health as a whole. It explicitly outlines the need to eliminate female genital mutilation ("excision").

India's *National Health Policy 2017* identifies gender violence as one of seven priority areas for improving the environment for health.

Rwanda's *National Reproductive Health Strategy* identifies prevention and response to sexual violence among its priorities.

Kenya's *Health Policy 2014-2030* contains a specific objective for reducing the burden of violence and injuries, as well as scaling up psychosocial rehabilitation services to address long-term effects of violence and injuries. These services are included in their essential health package, as are pre-hospital care and community management of violence and injuries.

Burundi's *Politique Nationale de Santé 2016-2025* explicitly addresses

violence issues throughout the life course including adolescence, youth, and school-period (six - ten years). Prevention and response to child, early and forced marriage, sexual violence, female genital mutilation, and physical violence are addressed with dedicated strategies under child health.

Tanzania includes information, education, and communication about child protection at the community level as components of their essential health package.

Challenges and Gaps

Few countries mentioned establishing focal points on violence for inter-ministerial coordination.

Codes of conduct within healthcare facilities that prohibit the mistreatment of women and children by health workers are not mentioned, not defined, or not violence-specific.

Few policies or plans reference violence-specific funding or resource allocation beyond general "health promotion" activities.

Explicit definition of services for victims of sexual violence is not often found in national health policies and plans, although it may be regulated at lower levels. In addition, other forms of violence against women, girls and boys, such as corporal punishment, do not have as clearly defined mandatory minimum service packages.

There is a disconnect between violence issues and child health, wherein violence is not often considered a component of child health programming.

"Integrating violence into UHC services is an opportunity to provide healthcare services to end violence against children."

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Spotlight

Women and Children Protection Units in the Philippines

Since 1997, the Philippines has worked to establish Women and Children Protection Units in all Department of Health hospitals. Seventy-eight units have been established across 43 provinces, equipped with staff trained in recognition, reporting, recording, and referral of cases of violence against women and children. These units are permanently situated to provide interviews and crisis counselling, medical examinations and culture– and gender-sensitive information materials on violence against women and children. In response to the introduction of the Aquino Health Agenda (2010), which recognised the need to implement equity to access health services, the Women and Children Protection Program, established under the national Department of Health, aims to achieve the following:

1 Establish at least one unit in every province

2 Ensure that all health facilities have competent and trained gender-response professionals

3 Standardise and maintain quality of healthcare services within the unit

4 Ensure the sustainability of the programme through appropriate organisational and budgetary support

5 Create and maintain a centralised and harmonised database for reports submitted by units

Pillar II
Strengthening health service delivery and health workers' and providers' capacity to respond to violence

Overall, policy related to health service delivery and provider capacity is strong with regard to sexual trauma, particularly for women. In addition, the link between violence, mental health, and the need for psychosocial support is increasingly recognised. However, the standard operating procedures and guidelines for a broader spectrum of gender-based violence and child maltreatment are less readily available.

Promising Practices

1. Population-specific guidelines, standards and/or standard operating procedures for healthcare workers on handling violence developed and included in curricula, which cover both child maltreatment and all forms of gender-based violence;

2. Specific actions related to psychosocial care and victim support included in mental health policies and strategies.

Positive Examples

Kenya has a specific policy objective to reduce the burden of violence and injuries including prioritisation of scaling up psychosocial rehabilitation services to address the long-term effects of violence and injuries.

Malawi's *Health Sector Strategic Plan II 2017-2022* references the provision of psychosocial interventions for people affected by violence, conflict and disasters. It also identified "training service providers in the management of gender-based violence cases in collaboration with other sectors" as a key activity aiming to "reduce environmental and social risk factors."

Challenges and Gaps

More countries outline guidelines for gender-based violence than for child maltreatment. While gender-based programming is significant for the elimination of violence against women and girls, it is vital that other forms of violence, including against boys, are not overlooked. Sexual violence is more frequently mentioned in policy compared to domestic or intimate partner violence, and essential response services often focus on post-rape and sexual trauma care. Service delivery for other forms of gender-based violence is often overlooked.

While most policy documents reference mental health, fewer make explicit linkages between violence and mental health. While there has been progress recognising mental health and reducing stigma in national health policy, there has not been the same advance linking mental health issues resulting from violence, nor a focus on psychosocial support for child survivors of violence in the majority of health policy documents.

Spotlight

Kenya's National Guidelines for Management of Sexual Violence

Kenya released the second edition of their national guidelines in 2009. The document is comprehensive and establishes standards of care regarding:

- Medical management
- Psychosocial support
- Forensic management
- Victims of sexual violence in humanitarian settings
- Quality assurance and improvement for post-rape care

The guidelines cover medical issues of consent, disease prevention and pregnancy prevention. The emphasis on psychosocial care, notably promoting a survivor-centred approach, is striking, and guidelines cover counselling for varied groups, necessary environment for productive counselling, and various types of counselling. Child-specific services are outlined including history taking, examination, post-exposure prophylaxis regimens, and other disease prevention and psychosocial support.

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Pillar III
Strengthening programming to prevent interpersonal violence

Policy documents reflect a broad range of strategies and activities to address violence, particularly programmes challenging harmful gender norms, life and social skill interventions, and awareness-raising and sensitisation programmes. Country policies and plans outline a range of programmatic focus on these issues from singular focus on gender-based violence to holistic violence programming.

Promising Practices

1. Strategies to address harmful cultural and gender norms - including those condoning violence against children as a form of discipline - included in national health plans;
2. Violence prevention included as a critical component of health promotion and non-communicable disease prevention strategies;
3. Multisectoral plans across health, justice and education that outline not only violence response, but violence prevention activities.

Positive Examples

Zambia's policy documents include a comprehensive set of strategies to achieve the goal of improving the health status of adolescents by 2021, comprising cultural and value shifts through changes in social norms and behaviours.

Uganda's *Health Sector Development Plan through 2020* seeks to address gender norms and promote female health by empowering male partners with knowledge about reproductive, maternal and newborn care services, as well as by establishing and functionalising adolescent-friendly corners at all levels of care.

"Health promotion" strategies and activities are widely cited including promotion of healthy living styles, as well as behavioural change in favour of health and school health programmes in locales such as Zambia, Burundi, Mali, Kenya, Malawi, Papua New Guinea, Timor-Leste, Rwanda and South Africa.

South Africa's *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa: 2012-2016* links violence to health promotion—in strategies to address inequity and social determinants—by working with the education sector to encourage comprehensive health education and promotion in schools, which address a range of issues including psychosocial well-being, mental health and violence prevention.

Challenges and Gaps

While most countries acknowledge the need to change gender norms, there is very little focus on changing norms on child maltreatment including corporal punishment at home and in schools.

In addition, although community health is frequently referenced, community work related to violence prevention, including home visiting and parenting support, is not, even in dedicated community health policies.

Finally, while the relationship between, for example, physical activity and physical health is well represented in health promotion strategies, the link between violence and persistent health issues over the life course is not.

Spotlight

Adolescent Health in Zambia's National Health Strategic Plan

Zambia's National Health Strategic Plan includes a goal to "improve the health status of adolescents by 2021." Strategies include:

- Allocation of adolescent-friendly spaces in health facilities;
- Scaling up training of peer educators and deploying them to adolescent-friendly spaces in health facilities and communities;
- Strengthening and scaling up school health programmes;
- Achieving cultural and value shifts through changes in social norms and behaviours such as on sexual and gender-based violence and child marriage, as well as alcohol and substance abuse.

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Pillar IV
Improving information and evidence

The majority of the 24 countries reviewed conducted nationally-representative data collection on violence against women in the last five years, largely by including domestic violence and/or female genital mutilation modules in the Demographic and Health Survey (DHS). Near parity was noted for nationally representative surveys on child maltreatment; however, the scope of data collection on violence against children varied greatly. Only four countries conducted Violence Against Children Surveys (VACS) in the last five years, with one additional country currently in the survey design process. Beyond donor-funded and internationally standardised surveys, several countries also include indicators on violence in their national health plans.

Promising Practices

1. Specific sex- and age-disaggregated indicators on violence included in national health plans;
2. Community, local and national data reporting on violence harmonised;
3. VACS implemented;
4. Modules on domestic violence, female genital mutilation and child discipline included in DHS and Multiple Indicator Cluster Surveys (MICS).

Positive Examples

Multiple countries developed indicators on violence in national strategic health plans:

Kenya
- Annual deaths due to violence/injuries (per 1,000 persons)
- % of new outpatient cases attributed to gender-based violence

Timor-Leste
- No. of facilities providing youth-friendly services

Sierra Leone
- % of currently partnered girls and women aged 15 to 19 years who have experienced physical and/or sexual violence by their current intimate partner in the last 12 months

Tanzania
- No. of communities sensitised on the legal rights of rape victims
- No. of communities sensitised on the importance of child protection

Zambia
- % of survivors (male and female) of sexual violence (10-19, 20+ years) who received post-exposure prophylaxis within 72 hours of sexual assault
- % of adolescents accessing integrated post-gender-based violence services
- % of districts with at least one fully functional one-stop centre for care gender-based violence survivors output

Niger
- Proportion of female and girl victims of physical, sexual, psychological, economic or cultural violence

Challenges and Gaps

Resource constraints remain a major barrier to data and evidence collection.

Multiple countries report difficulty in data harmonisation from local to national levels. One official responsible for monitoring and planning in a Ministry of Child Protection noted the lack of data on the phenomenon of child marriages as a significant barrier to policy development; similar challenges are present for initiatives on other forms of violence.

While current levels of monitoring of sexual assault and gender-based violence, which disproportionately affect women and girls, is imperative, no specific indicators were identified in national plans that monitor violence against boys. Plans may include indicators on violence against adult males, notably on gun violence and conflict, but male children and adolescents are being lost in the data.

> "Currently, the reporting of statistics on gender-based violence cases and programming lacks synchronisation and cohesion from the local to the national level. Without consistent data and a data-sharing mechanism, the effectiveness of gender-based violence prevention and response cannot be quantified, and relevant stakeholders cannot benefit from knowledge on best practices and lessons learned."
>
> World Vision Rwanda employee

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Spotlight

National Surveys on Violence Against Children

The Violence Against Children Survey (VACS) programme, led by Centers for Disease Control (CDC), generates data on prevalence and incidence of physical, sexual and emotional violence, as well as risk and protective factors, consequences of violence, and access to services. They have generated data for nearly 10% of the world's youth population, thus far. Survey topics include gender attitudes, safety, witnessing violence, violence perpetration, health risk behaviours and outcomes, and service-seeking and utilisation rates.

The Demographic and Health Survey (DHS) programme, led by the Centers for Disease Control and Prevention (CDC), is a nationally representative household survey providing data for a wide range of monitoring and impact evaluation indicators vis-à-vis population, health and nutrition. Potential survey characteristics include domestic violence, female genital mutilation and child discipline.

The Multiple Indicator Cluster Survey (MICS) programme, led by UNICEF, represents the largest source of statistically sound and internationally comparable data on women and children worldwide. Potential survey characteristics include female genital mutilation, attitudes towards domestic violence, and child discipline.

The DHS module on domestic violence includes questions on emotional, physical and sexual violence including a question on violence by parents and parents-in-law, siblings, teachers, employers and police officers or soldiers. It includes a specific question on whether the victim sought help, and if so, from where: family, friends, neighbours, religious leaders, medical personnel, police, lawyers or social service organisations. The MICS module is solely focused on attitudes toward domestic violence.

The modules on female genital mutilation for both DHS and MICS, directed towards adult respondents and termed "female circumcision", include questions related to awareness of and attitudes toward the practice, personal experience, experience of the respondents' children and identifying practitioners of female genital mutilation.

Questions on child discipline - directed toward the caregiver - gather information on attitudes toward child discipline including physical and emotional violence.

Conclusion

There have been major strides toward ending violence against children in recent years facilitated by prioritisation of social protection and the promotion of universal health coverage. Consistent consideration of gender in national health policies has promoted addressing violence issues that women and girls face, and there is increasing recognition that a "whole-of-government" approach is required to end violence.

Critical work in the health sector is occurring in both violence prevention and violence response (i.e., health services rendered post-trauma). Mental health and psychosocial support are increasingly considered and included in national plans. Programmes to challenge and change harmful cultural norms are increasingly in place. Even prior to the introduction of the global plan in 2016, countries including Tanzania and the Philippines have been integrating violence prevention and response activities into their health systems with success.

However, a number of gaps and challenges remain. Resource constraints remain a significant barrier to ensuring preventive and responsive health services that address violence are available for all children, at all levels of care. In addition, while gender-based violence, specifically sexual violence against women is well addressed across these 24 countries, child-specific language on violence is less clear. Where child-specific language on violence is included, it may not be considered a component of holistic child health.

In order to strengthen health policy to end violence against children, governments should:

1 Strengthen leadership by ensuring that ending violence against children is integrated into the wider health agenda, including child health, non-communicable disease prevention, mental health and emergency response services. Inclusion of violence-related services within essential health packages and universal health coverage platforms is also recommended.

2 Strengthen programmes by leveraging ongoing behavioural change and health promotion programmes to include social norm changes on violence against children more explicitly. Community health policies should be explicit in their inclusion of violence-related work.

3 Collect and harmonise data and evidence on violence against children, since the problem cannot be solved until its scale and scope are better understood. Ongoing monitoring, as well as the implementation of a nationally-representative population-based survey is crucial, particularly one that is age- and gender-disaggregated, so violence against women, girls and boys is well understood.

Moving forward on a global level, further research into the implementation of these national health policies, plans and programmes will be required to document best practices, jointly address challenges, and report on the implementation of WHO global plan at the World Health Assembly in 2020.

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Endnotes

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Annex I: National Health Policies

Country	Document	Year(s)
Burundi	National Health Development Plan	2011-2015
	Vision Burundi 2025	2011-2025
	Politique Nationale de Santé	2016-2025
	Politique Nationale de Protection Sociale	
	Stratégie de Protection Sociale	2015
Ghana	National Healthcare Quality Strategy	2017-20218
	MDG Acceleration Framework (MAF)	2016-2017
	National Newborn Health Strategy and Action Plan	2014-2018
	Human Resource Policies and Strategies for the Health Sector	2007-2011
	Health Sector Medium Term Development Plan	2014-2017
	Health Sector Gender Policy	2009
	National Community-Based Health Planning and Services (CHPS) Policy: Accelerating Attainment of UHC and Bridging the Access Inequity Gap	2016
	Policy and Guidelines for Hospital Accident and Emergency Services in Ghana	2011
	Child and Family Welfare	2014
	National Strategic Framework on Ending Child Marriage in Ghana	2016-2026
Haiti	Politique Nationale de Promotion de la Santé	2009
	Politique Nationale de Santé	2012
	Plan Directeur de Santé (draft)	2012-2021
India	National Health Policy	2017
Kenya	Kenya Health Policy	2014-2030
	Health Sector Strategic and Investment Plan (KHSSP): Second Medium Term Plan for Health	2013-2017
	National Plan of Action for Children in Kenya	2015-2022
Lesotho	Health Sector Strategy Plan	2012/13-2016/17
	Lesotho Health Policy	2011
	National Strategic Plan on Vulnerable Children	2012-2017
Malawi	National Sexual and Reproductive Health and Rights (SRHR) Policy	2009
	National Community Health Strategy	2017-2022
	Health Sector Strategic Plan II: Towards Universal Health Coverage	2017-2022
	Malawi Health Sector Strategic Plan: Moving Towards Equity and Quality	2011-2016
	Child Protection Strategy	2012-2016
Mali	Politique Sectorielle en Matière de Santé	1996
	Plan Stratégique National pour le renforcement du système de santé	2009-2015
	Plan Decennal de Développement Sanitaire et Social (PDDSS)	2014-2023
Niger		
	Plan de Développement Économique et Social	2017-2021
	Politique Nationale de Protection Sociale	2011
Philippines	Information and Guidelines for the Management of STDs in Children	1998
	Revised National Policy on Violence and Injury Prevention	2014
	Revised Policy on the Establishment of Women and Their Children Protection Units in All Government Hospitals	2013

	National Policy and Strategic Framework on Child Injury Prevention	2006
	All for Health Towards Health for All: Philippine Health Agenda	2016-2022
	Comprehensive Program on Child Protection	2012-2016
Papua New Guinea	National Health Plan	2011-2020
	PNG Community Health Post Policy	2013
Timor Leste	National Health Sector Strategic Plan	2011-2030
	National Action Plan for Children in Timor-Leste	2016-2020
Rwanda	Non-Communicable Disease Policy	2015
	National Food and Nutrition Policy	2014
	National Community Health Policy	2015
	National Human Resources for Health Policy	2014
	Health Sector Policy	2015
	Health Financing Sustainability Policy	2015
	Adolescent Sexual Reproductive Health and Rights Policy	2011-2015
Senegal	Politique Nationale de Santé Communautaire	2014
	Plan Stratégique National de Santé Communautaire	2014-2018
	Plan National de Développement Sanitaire	2009-2018
	Stratégie Nationale de Protection de L'enfant	2013
Sierra Leone	RMNCAH Policy	2017-2021
	RMNCAH Strategy	2017-2021
	National Health Strategic Plan	2016-2020
South Africa	Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa	2012-2016
	Strategic Plan	2015-2020
	National Health Promotion Policy and Strategy	2015-2019
	Integrated School Health Policy	After 2012
	Annual Performance Plan	2017-2020 2013-2016
South Sudan	National Health Policy	2016-2025
Swaziland	Second National Health Sector Strategic Plan [draft zero]	2014-2018
	National Health Sector Strategic Plan	2008-2013
	National Health Policy	2007
	Policy for Human Resources for Health	2012
Tanzania	Health Sector Strategic Plan IV	2015-2020
	National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania	2008-2015
	Tanzania National eHealth Strategy	2012-2018
Uganda	Health Sector Development Plan	2015-2020
	National Orphans and Other Vulnerable Children Policy	2004
	National Social Protection Policy	2015
Zambia	National Health Strategic Plan	2017-2021
	National Health Policy	2012

Annex II: DHS, MICS and VACS Completion

	Conducted a nationally representative survey or included a module on violence against women in the last 5 years (i.e. DHS domestic violence (DV) or FGM module)	**Conducted a nationally representative survey or included a module on child maltreatment in the last 5 years (i.e. DHS, MICS, VACS)**		
		Conducted DHS in the last five years (with a module on child maltreatment: child discipline (CD) and/or child labour (CL))	*Conducted MICS in the last five years (with a module on child maltreatment)*	*Conducted VACS in the last five years*
Burundi	DHS 2016-17 (DV)	DHS 2016-17 (CD, CL)	-	-
Ghana	(2014 DHS did not include module on DV or FGM)	-	MICS 2017-18	-
Haiti	DHS 2016-17 (DV)	DHS 2016-17 (CD)	(never conducted MICS)	(VACS conducted in 2012)
India	DHS 2018-19 (DV)	-	(last national MICS in 2000)	-
Kenya	DHS 2014 (DV, FGM)	DHS 2014 (FGM)	(last national MICS in 2000; 3 regional MICS conducted in 2014)	(VACS conducted in 2010)
Lesotho	(2014 DHS did not include module on DV or FGM)	-	Unknown – survey design in process	In progress
Malawi	DHS 2015-16 (DV)	-	2013-14	2013
Mali	DHS 2013 (DV, FGM)	DHS 2013 (CL, FGM)	2015	-
Niger	DHS 2017 (DV, FGM)	DHS 2017 (CD, CL, FGM)	(last MICS in 2000)	-
Papua New Guinea	DHS 2016-17 (DV)	-	(never conducted MICS)	
Philippines	DHS 2017 (DV)	-	(last MICS in 1999)	National Baseline Survey - Violence Against Children 2016
Rwanda	DHS 2014-15 (DV)	-	(last MICS in 2000)	In progress
Senegal	DHS 2017 (FGM)	DHS 2017 (CL, FGM)	(last national MICS in 2000; 1 MICS conducted in Dakar 2015-16)	
Sierra Leone	DHS 2013 (DV, FGM)	DHS 2013 (CL)	2017	-
Solomon Islands	(never conducted DHS; Family Health and Safety Study conducted in 2009)		(never conducted MICS)	
South Africa	DHS 2016 (DV)	DHS 2016 (CD)	(never conducted MICS)	
South Sudan	(never conducted DHS or nationally representative survey)		(last MICS in 2010)	
Sudan	(last DHS in 1989-90; Survey on the Understanding of Violence against Women and Children conducted in 2009)		2018	
Swaziland	(last DHS in 2006-07)	-	2014	(VACS conducted in 2007)
Tanzania	DHS 2015-16 (DV, FGM)	DHS 2015-16 (FGM)	(last MICS in 1996)	(VACS conducted in 2009)
Timor-Leste	DHS 2016 (DV)	-	(never conducted MICS)	
Uganda	DHS 2016 (DV, FGM)	DHS 2016 (CD, FGM)	(last MICS in 1999)	2015
Zambia	DHS 2015 (DV)	-	(never conducted MICS)	2014
Zimbabwe	DHS 2015 (DV)	-	2018	(VACS conducted in 2011)
Total	**18**	**10**	**8**	**5**
		17		

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World Vision and the Global Partnership to End Violence Against Children believe a world without violence against children is possible. No one person, group or organisation can solve this problem alone. It will take the world to end violence against children.