**UNFPA Consolidated Submission to the Call for contributions: *Violence and its impact on the right to health*, by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health**

January 17th 2022

UNFPA welcomes the opportunity to provide this submission for the forthcoming report on the impact of violence on the right to health by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.

The right to live free from violence and to enjoy the highest attainable standard of physical and mental health are deeply intertwined. UNFPA recognises that a complete state of physical, mental and social wellbeing cannot be achieved in a context of violence, conflict, discrimination or abuse.

UNFPA operates in over 150 countries to advance gender equality and to empower women to decide freely on their fertility and sexuality free from coercion, discrimination and violence, including by preventing and addressing gender-based violence (GBV), female genital mutilation (FGM) child, early, and forced marriage and Gender -biased Sex Selection (GBSS). Indeed and in recognition of the criticality of the right to health in the context of GBV, UNFPA invests in health system strengthening in over 90 per cent of the countries in which it supports GBV interventions.

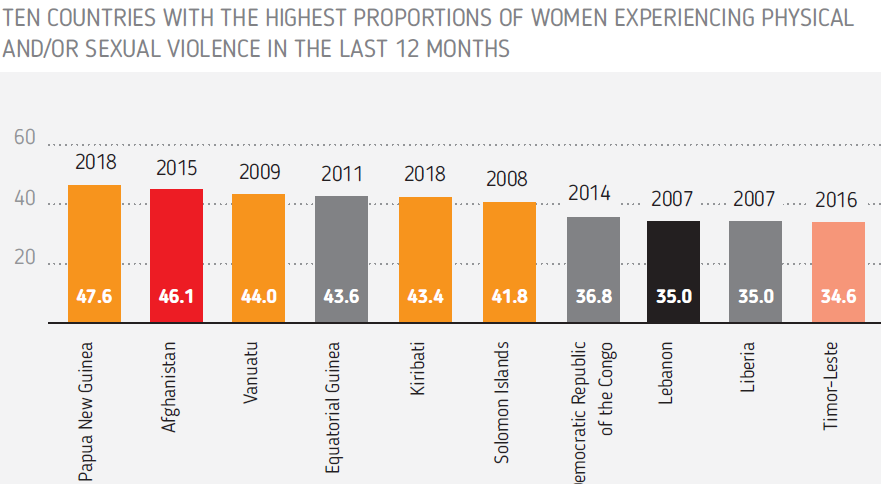
Through a range of programmes, including the EU-Spotlight Initiative, a global multi-year partnership to eliminate all forms of violence against women and girls, UNFPA is working with UNWomen, UNDP, UNICEF and other UN agencies to implement comprehensive response and prevention programs. Further UNFPA supports implementation and roll out of joint UN programmes and frameworks, including the Essential Services Package for Women and Girls Subject to VIolence, the RESPECT framework, the Interagency Minimum Standards for GBV in Emergencies as well as a range of specific international guidance and tools (including the frameworks and tools to support gender and social norm change), to ensure quality programme interventions.

UNFPA commends the Special Rapporteur for bringing into focus the devastating impact of violence upon women and girls’ right to health.

**1.Please describe, share data and information on the characteristics, number of cases, and the profile of victims and perpetrators in your country/ies or region(s) regarding:**

* 1. **Gender-based violence against women**

In a first of its kind, [the UNFPA geospatial dashboard](https://www.unfpa.org/geospatial-dashboard-intimate-partner-violence)[[1]](#footnote-1) [p](https://www.unfpa.org/geospatial-dashboard-intimate-partner-violence)rovides national and subnational statistics on the experience of intimate partner violence (IPV), disaggregated by age , education, wealth and employment[[2]](#footnote-2) across 119 countries from the global north and the global south. This is a rich source of data supporting the opportunity for strong statistical analysis of the prevalence and drivers of IPV as highlighted in the UNFPA publication, “Prevalence Rates, Trends and Disparities in Intimate Partner Violence: Power of Data in the Geospatial Dashboard.”[[3]](#footnote-3) The dashboard shows that IPV not only varies between countries, but it can vary widely within countries, by district or province as well as across different age groups. Indeed, it shows that in more than 75 per cent of countries that reported on IPV by age, women under age 35 experienced the greatest risk of IPV.[[4]](#footnote-4)



Data from nationally representative surveys and UNFPA data at country and regional levels reveal these staggering statistics:

* In most countries with available disaggregated data, IPV prevalence among women and girls aged 15-49 differs significantly across administrative areas.In Afghanistan, where national 12-month IPV prevalence was 46.1 per cent according to the 2015 Afghanistan DHS, rates vary widely across the country. They range from 4.5 per cent in Helmand province to 90.3 per cent in Ghor. Similarly, the 2015–2016 Tanzania Demographic Health Survey estimated that prevalence of intimate partner violence varied from 4.6 per cent in Pemba South to 56.8 per cent in Mara province while the national estimate was 29.6 per cent.
* Data from 54 countries with available data disaggregated by educational level showed that in 79.6 per cent, IPV rates were highest among women with the lowest level of education i.e. primary only or no education
* Data from **Ukraine** indicates that 1.1 million women experience intimate partner violence every year. The numbers of reported cases of domestic violence have increased in recent years: the 115,000 reports in 2018 increased by almost 25 per cent in 2019, by 50 per cent in 2020 and reached 326,000 complaints in 2021.[[5]](#footnote-5)
* Results from **Turkmenistan’s** first-ever Domestic Violence Survey will be published in early 2022 but existing evidence shows that increasingly more women justify GBV: 58.4 per cent in 2019 compared to 35 per cent in 2016.
* Data from UNFPA **Burundi** indicates an average of 4,165 GBV cases per month in the country. Sexual violence is the most common form of violence reported.
* **Latin American and the Caribbean** (LAC) is the only region worldwide where child marriage and early unions have not reduced in the past 25 years: estimates suggest that 1 in 4 women were married or in early union before the age of 18.
* For **Turkey**, data indicates that the lifetime experience of physical and/or sexual intimate partner violence among ever married women is at 38% while the experience of physical and/or sexual intimate partner violence in the last 12 months is 11%. [[6]](#footnote-6)

Women and girls in all regions across the world are affected by femicide. With an estimated 18,600 victims, Asia is the region with the highest number of victims in absolute terms, while Africa is the region with the highest level relative to the size of its female population.[[7]](#footnote-7) Femicide[[8]](#footnote-8) is a key area of attention in the LAC region where 14 of the 25 countries in the region record the highest rates of femicide in the world. In 2019 for example, there were at least 4,640 cases of femicide in the region. Some of the recorded rates are below:

* **Honduras:** 6.2 per 100,000 women
* **El Salvador:** 3.3 per 100,000 women
* **the Dominican Republic:**  2.7 per 100,000 women
* th**e Plurinational State of Bolivia**: 2.1 per 100,000 women
* **Argentina**: 251 documented victims (2020)[[9]](#footnote-9)
* **Peru:**  5,131 reported femicides, of which 83 per cent were of adult women and 13 per cent were of adolescents and girls.[[10]](#footnote-10)
* **Brazil:** approximately 3 femicides per day, 68 per cent of which are Afro-descendant women
  1. **Gender-based violence and other forms of violence against children**

T[he UNFPA geospatial dashboard](https://www.unfpa.org/geospatial-dashboard-intimate-partner-violence)[[11]](#footnote-11) provides disaggregated data by age as dictated by the standard Demographic Health Survey and Multi Indicator Cluster Survey. The age group categories are 15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49. As such, data collected from standardised population prevalence surveys on violence against children is not readily available for children under the age of 15. A range of safety and ethical considerations must be taken into account for interviewing and collecting data relating to children. More specific guidelines are available to guide this work.[[12]](#footnote-12) That said, UNFPA has the following data available:

**Ukraine** reports 2,756 complaints registered by the National Police on behalf of children (2020).[[13]](#footnote-13)

In **Peru,** 63 per cent of the 18,044 cases of sexual violence reported in 2019 involved children below 18, and 91.5 per cent of victims were girls and adolescents. Between 2013 and 2018, 63,131 acts of rape were reported nationwide, of which 28.5 per cent of the victims were children (0-12 years old) and 54.9 per cent were adolescents (13-17 years old). Women’s Emergency Centres reported 47,781 cases of violence against children and adolescents (0 to 17 years) from January to November 2021, with 68.9 per cent of survivors being girls. The majority of cases of rape reported during the same period involved children or adolescents (6,350 or 67.6 per cent of the total). [[14]](#footnote-14)

UNFPA also supports global progammes on ending harmful practices including female genital mutilation (FGM), child marriage and the practice of son preference and gender-biased sex selection for which data is available.[[15]](#footnote-15) FGM has been performed on at least 200 million girls and women in 31 countries across three continents, with more than half of those subjected to it living in Egypt, Ethiopia and Indonesia. Over 4 million girls are at risk of undergoing FGM annually.

While the prevalence of child marriage has decreased worldwide – from one in four girls married a decade ago to approximately one in five today – the practice remains widespread. Before the COVID-19 pandemic, more than 100 million girls were expected to marry before their eighteenth birthday during the next decade. Of the countries contributing to this Call, Peru reports recent survey data revealing that 28 per cent of married women between the ages of 15 and 49 entered into early unions before age 18; regional rates within the country range from 20 per cent to as high as 50 per cent.[[16]](#footnote-16)

There are an estimated 140 million missing girls as a result of the practices of gender-biased sex selection (GBSS). In addition to the demographic impacts of son preference and GBSS leading to a marriage squeeze and trafficking, women may be subjected to intimate partner violence if they fail to give birth to a son. They may also experience reproductive coercion, carrying multiple pregancies or undergoing selective abortion, often unsafe and against their will. Additionally, in the context of son preference, first born girls are more likely to experience different forms of violence, such as neglect, maltreatment, violence and, in extreme cases, death.

* 1. **Gender-based violence against LGBTQI or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity**

The standard Violence Against Women survey tools, including the WHO Multi-country Study on Women’s Health and Domestic Violence and the Domestic Violence module in the Demographic and Health Survey (DHS)[[17]](#footnote-17) do not contain questions to determine the sexual orientation, sex characteristics or gender identity of the survivor or perpetrator.[[18]](#footnote-18) As such, widespread data relating to LGBTQI populations is limited.

Between 2014 and 2020, 3,514 LGBTQI people were murdered in 11 countries in **Latin America and the Caribbean**, and 40 per cent of these homicides were related to prejudice against sexual orientation or gender identity of the victims. In 2019, 327 cases were identified, and 351 cases were found in 2020. A total of 350 trans and gender diverse people were reported killed in Central and Latin America from October 2019 to September 2020.[[19]](#footnote-19)

**In Brazil,** data from 20 of 27 states shows 1,679 cases of willful bodily harm, 121 homicides and 88 rapes against LGBTQI individuals in 2020. According to data from the civil society organization ANTRA, there were 175 murders of transgender individuals. It is noteworthy that 65per cent of the murders were directed at sex workers and at least 78per cent of the victims were Afro-descendant people.

**Violence against persons with disabilities, including GBV**

Standard Violence Against Women survey tools, including the WHO Multi-country Study on Women’s Health and Domestic Violence and the Domestic Violence module in the Demographic and Health Survey (DHS)[[20]](#footnote-20) do not contain questions related to disability as drawn from the Washington Group Questions.[[21]](#footnote-21) As such, widespread data relating to disability is limited. While this is changing in some countries through adaptation of the tools, it is still limited in uptake.

Regardless, global evidence suggests that women with disabilities are up to 10 times more likely to experience sexual violence, and estimates are that 40 per cent to 68 per cent of young women with disabilities will experience sexual violence before the age of 18. **[[22]](#footnote-22)**

In Brazil, there were 7,613 cases of violence against persons with disabilities, of which 58.5 per cent were cases of domestic violence. Cases involving survivors with intellectual disability constituted almost 40 per cent of these, followed by physical disability (30.2 per cent), visual impairment (9.4 per cent) and hearing impairment (7.3 per cent).

* 1. **Gender based violence against men**

Gender-based violence disproportionately impacts women and girls and data collected is reflective of this. However, Ukraine notes 27,676 complaints by men of domestic violence in 2020, constituting 13 per cent of total domestic violence complaints. [[23]](#footnote-23)

* 1. **Conflict gender based violence, including sexual violence**

UNFPA, in partnership with other UN and International NGOs, lead a steering comittee whcih supports collection of the incidence of GBV through the multi sectoral Gender-based Violence Information Management System (GBVIMS).[[24]](#footnote-24) This system supports the collection of incident data in humanitarian settings (and increasingly in development settings), including conflict related gender-based violence and sexual violence, to support GBV practitioners in understanding where and how to target responses and monitor effectiveness of referral and case management systems. This includes understanding levels of reporting to or referral to and from health services. This data collection system is implemented to the highest level of ethical and safety standards to maintain confidentiality of survivors. In some settings the data collected under the GBVIMS supports reporting under the Monitoring, Analysis, and Reporting Arrangements (MARA)[[25]](#footnote-25) in compliance with Security Council 1312 and its sister resolutions. Reports are made public depending upon national agreements between contributing services and data is reported in trends and percentages in order to protect survivor reporting.

Armed conflict, such as that ongoing in eastern **Ukraine,** exacerbates sexual and gender-based violence. Women whose partners participate in armed conflict are more likely to experience physical or sexual abuse.[[26]](#footnote-26) Increased risk of GBV is also attributed to increased tolerance of violence in society and negative coping mechanisms used by partners involved in the hostilities[[27]](#footnote-27). Women and girls from front line communities, both government-controlled and non-government controlled, experience higher risk of sexual harassment and other forms of sexual violence.[[28]](#footnote-28) While sexual violence is often documented as a weapon of case, based on the cases documented in Ukraine, a dedicated OHCHR report[[29]](#footnote-29) finds there are no grounds to believe that sexual violence is being used as a strategy against civilians in Ukraine. Regardless, women and girls caught up in armed conflict are known to be at increased individual risk for sexual violence solely due to their gender.[[30]](#footnote-30)

* 1. **Please share analysis and available evidence on the impact of COVID on the above.**

In April 2020, UNFPA estimated that 31 million cases of GBV could be expected in the first 6 months of mobility restrictions to prevent the spread of COVID-19, with an additional 15 million cases for every 3 months of continued lockdown.[[31]](#footnote-31) However, the exact rise in prevalence of GBV as a result of COVID-19 cannot be quantified in precise terms because the collection of national prevalence data is not recommended in such situations as it would risk the safety of women.[[32]](#footnote-32) A decision tree was developed by the kNOwVAWdata initiative (UNFPA) in consultation with UNWomen and WHO to help guide decisions around data collection during the pandemic.

Information about the uptake of services by women and girls experiencing violence during COVID must be interpreted through the lens of the barriers to access. Fear of acquiring or transmitting the virus, suspension of public transportation, and reduction in family income to pay for mobile and internet services made it more difficult for survivors to reach assistance. Shutdown of services deemed “non-essential,” community lockdowns, and overwhelmed health facilities created physical barriers to seeking help. With less access to women’s shelters, disrupted court processes for protective orders and hearings, and economic stress from loss of work, survivors had reason to question whether it was possible to leave their situations. At the same time, GBV hotlines proliferated and remote case management became newly accessible for some. In **Latin America and the Caribbean**, there was an increase of calls to helplines in most of the countries of between 50 per cent (Economic Commission for Latin American and Caribbean) and 80 per cent (Inter-American Commission of Women). Significant increases in helpline demand during the first months of 2020 were reported in **Argentina** (67 per cent increase), **Mexico** (60 per cent), **Chile** (70 per cent), and **Colombia** (130 per cent).

A UNFPA and UNWomen survey across nine African countries[[33]](#footnote-33) indicated that most women reported higher levels of gender-based violence. Big data analysis conducted by UNFPA and UNWomen in Asia [[34]](#footnote-34) showed that internet searches related to violence against women and help-seeking rose significantly during COVID-19 lockdowns in eight Asian countries, buttressing evidence of the particular dangers faced by women confined to homes or restricted in their movements.

In **Ukraine**, figures indicate that incidence of GBV is rising and compounded by the conflict in eastern Ukraine and the COVID-19 pandemic. Data shows a drastic increase in the number of complaints related to domestic and intimate partner violence, increasing by 50 per cent in 2020 compared to 2018, and numbers continued to rise in 2021. [[35]](#footnote-35)

COVID fueled the existing phenomenon of technology-facilitated gender-based violence as women and girls become more reliant upon online services and technology for social and professional reasons. In LAC, UNFPA developed a continuum of violence concept to understand the transformation of certain forms of violence in the context of the pandemic. There was an increase in cases of digital violence, crimes related to online sexual extortion and child pornography, and sexual harassment. It is estimated that during the pandemic, girls, young women, and LGBTQI young people have been exposed to increased cyberbullying and digital violence in various forms. UNFPA also released a technical paper on “Making All Spaces Safe: Technology-facilitated Gender-based Violence” in recognition of the increasing impact and continuum of violence between online and physical spaces.[[36]](#footnote-36)

**2. Please describe whether the legal framework prohibits and sanctions these forms of violence and the definitions and forms of violence included in the legal system. Please explain redress options for survivors of violence, (the pathway they go through if they decide to file a complaint), levels of impunity and if access to comprehensive physical and mental care for GBV-survivors is recognized as a form of reparation.**

Support for the development of national legislation that complies with international laws and agreements is a critical area of work for UNFPA globally, with 96 per cent of UNFPA offices reporting significant investment in this effort.

Countries are increasingly strengthening legislation to criminalise GBV but there are notable gaps. The table below provides information on the legal frameworks for select countries contributing to this report.

|  |  |  |
| --- | --- | --- |
| **Country** | **Law** | **Year** |
| Argentina | Law to “prevent, punish and eradicate violence against women in all areas in which they develop their interpersonal relationships." Recognizes VAW types and modalities (domestic, institutional, labor, against reproductive freedom, obstetric, media, public-political and violence exercised in the public space) . | 2009 |
| Bolivia | Law to Guarantee a Life Free from Violence for Women. Aims to establish mechanisms for prevention, care, protection and reparation for VAW and prosecution of aggressors. | 2013 |
| Brasil | Law N. 13.104 on Femicide | 2015 |
| Law No. 11.340, “Law Maria da Penha” forbids domestic and family violence against women. | 2006 |
| Burundi | Article 554 of Law No. 1/05 prohibits rape, including marital rape. Article 535 addresses spousal abuse. Legal framework excludes LGBTQI people from this protection. | 2009 |
| Chile | "Law Gabriela" on femicide | 2020 |
| "Law of Intrafamily Violence" | 2005 |
| Colombia | Law 1719 guarantees access to justice to survivors of sexual violence, particularly sexual violence in a context of conflict. | 2014 |
| Law 1257, Comprehensive Law of Protection | 2008 |
| Costa Rica | Law No. 7586, Law against Domestic Violence | 1996 |
| Law No. 9.877 on street harassment | 2020 |
| Cuba | Articles 298 and 300 of the Penal Code typify rape and sexual violence | 1987 |
| Ecuador | Law to Prevent and Eradicate Violence Against Women. Prohibits physical, psychological, sexual, patrimonial, political, gynecological-obstetric, and symbolic forms of VAW. Establishes protection and reparation mechanisms. | 2018 |
| El Salvador | Ley Especial Integral for a Life Free from Violence for Women | 2012 |
| Guatemala | Law against femicide and other forms of violence against women | 2008 |
| Law against sexual violence, exploitation and human trafficking | 2009 |
| Honduras | Executive Decree 23-2013 incorporates femicide into the Penal Code | 2013 |
| Law against Domestic Violence. Decree 132-97 | 1997 |
| México | General Law on Women’s Access to a Life Free from Violence | 2007 |
| “Law Olimpia,” aimed at punishing crimes that violate the sexual intimacy of people through digital means | 2020 |
| Nicaragua | Comprehensive Law against Violence Against Women | 2014 |
| Panamá | Law 82, typifies femicide and violence against women | 2013 |
| Paraguay | Law No. 5777 on Comprehensive Protection to Women, Against all forms of Violence | 2017 |
| Peru | Law No. 26.260 on Protection Against Family Violence | 1997 |
| Law No. 30.068. Incorpora al Código Penal el tipo especial del feminicidio | 2013 |
| Dominican Republic | Law to facilitate access to Justice for women victims of violence | 2011 |
| Turkey | Law No. 6284 on the Protection of Family and Prevention of VAW | 2012 |
| Ukraine | Law on Prevention and Combating Domestic Violence No. 2229-VIII of 07.12.2017 | 2017[[37]](#footnote-37) |
| Amendment of Criminal Code and the Criminal Procedural Code of Ukraine including the criminalization of domestic violence (Article 126-1) No. 2227-VIII of 06.12.2017 | 2017[[38]](#footnote-38) |
| Uruguay | Law on GBV Against Women | 2018 |
| Venezuela | Organic Law on the Right of Women to a Life Free from Violence | 2007 |

In **Turkmenistan**, the government has approved the second National Action Plan for Gender Equality (2021-25) but has not adopted GBV legislation to address domestic violence. The Criminal Code does not include an offence of domestic violence.

In **Turkey**, four consecutive GBV National Action Plans have been adopted and the final one is for the years between 2021-25 which was announced on July, 1 in 2021. This date is also the official date for Turkey’s withdrawal from Istanbul Convention. There are concerns that Turkey’s withdrawal from the *Istanbul Convention* will lead to watering down of domestic legislation and institutions for combating violence.

**Ukraine** is a signatory of the Istanbul Convention, but it remains unratified. In 2019, Ukrainian legislation criminalized domestic violence, forced marriage, and illegal abortion or sterilization. Restraining measures and criminal liability for perpetrators of domestic violence were instituted. The legal definition of rape was amended in line with international standards. In 2021, accountability for DV perpetrators was further strengthened. Data shows 921 people sentenced in 2020 for domestic violence, compared to 225 in 2019. [[39]](#footnote-39)

In the **Arab States**, there is a lack of dedicated mental health legislation in 30 per cent of countries, leaving survivors without adequate response services.

In **Turkmenistan**, international clinical protocols for rape survivors are not endorsed, and HIV PEP and emergency contraception for survivors are not available. Standard Operating Procedures for multisectoral GBV response have been developed with the support of UNFPA, but not yet endorsed by the Government as comprehensive GBV legislation is a prerequisite for it.

In a positive development, Guatemala established an observatory to register crimes against women, making evident the legal framework for accountability to survivors.

**3. Please share examples of the types of structural and institutional violence with origins within the State, (perpetrated or condoned by the State) or perpetrated by those not representing or affiliated to the state in your country/ies of region, and who is affected. In particular, describe structural/institutional violence in medical settings against women and girls, LGBTQI persons and persons with disabilities or any other individuals or groups relevant in your country/ies or regions.**

Violations of bodily autonomy are common forms of structural violence and discrimination against women and girls, particularly those with disabilities, in medical settings. UNFPA brought focus to this issue in the 2021, State of the World Population Report.[[40]](#footnote-40)

Data on **harmful practises and violence in obstetric care** is not widely available but the issue is increasingly coming to public attention in countries such as **Ukraine** where **t**hese actions are prohibited under general regulation of criminal offences, and Peru, where the Ministry of Women and Vulnerable Populations included obstetric violence in the National Plan against GBV 2016-2021.[[41]](#footnote-41) In **Ecuador**, 47.5 percent of women over the age of 15 have experienced gyneco-obstetric violence during their lifetime. This includes receiving sexual advances, humiliating comments, and receiving medical examinations in front of a third person without consent. Forty-one per cent of Ecuadorian women have experienced obstetric violence during childbirth. These rates are higher among rural and indigenous women.[[42]](#footnote-42) Notable cases of institutional violence against women in **gyneco-obstetric services** were reported in Argentina, prior to the 2021 abortion law. In March 2014, a 24-year-old girl was diagnosed with a miscarriage, but was sentenced to eight years in prison for aggravated homicide [[43]](#footnote-43) In March 2019, a 12-year-old girl who was pregnant as a result of rape was denied her request of access to a legal abortion. She underwent a caesarean section at 6 months of pregnancy.

In **Turkmenistan**, there have been reported cases of women with **disabilities**, especially women with mental illness and intellectual disabilities, who have been encouraged by medical personnel to have abortions. Women and young persons with disabilities cannot fully access reproductive health services in the country due to a variety of factors, including stereotypes about persons with disabilities, discrimination, and insufficient training of healthcare staff. This exclusion only increases the vulnerability of women and young persons with disabilities to violence, sexually transmitted infection, undiagnosed and untreated illnesses and unintended pregnancy.

In the **Arab States** region, data indicate **limited levels of women’s and girls’ autonomy in decisions about their own health**: fewer than half of decisions regarding a woman’s health are made by the woman herself. Despite legislation and policies that guarantee a level of autonomy in decision making, surveys conducted in Arab States suggest that permission is often required from male relatives or husbands to access healthcare. Furthermore, stigma and discrimination limit access to and utilization of services for mental health issues, HIV testing, and menstrual health needs. In some settings, health care providers offering clinical management of rape services may prioritize virginity testing and pregnancy testing, mirroring wider social norms that stigmatize survivors. Women also face procedural obstacles, such as being required to report within a designated time period (e.g., three months from the incident for Palestinian women), and must show proof of significant injury to proceed to prosecution.

**4. Please also share information on the impact of criminalization of sex work, same sex relations, transgender persons, abortion, drug abuse, harmful practices in obstetric care, female genital mutilation on the violence experienced by the affected individuals and their enjoyment of the right to health.**

The criminalization of **sex work** in Turkmenistanhas been found to contribute to irregular migration of sex workers to Turkey and the Arab Emirates, where they become victims of trafficking and lack health and social protection due to their undocumented status.

Regarding **same-sex sexual activity,** Burundi criminalizes the practice and regularly prosecutes LGBTQI persons. In several countries within the Arab States region (Brunei, Qatar, Saudi Arabia, United Arab Emirates, and Yemen) the death penalty is a legal option for punishment of consensual same-sex sexual activity.[[44]](#footnote-44) Reports from Turkmenistan reflect general social pressure, hate and violence, including by police, directed at LGBTQI populations even when their status is not criminalized. The cumulative impact of legal and social sanctions against LGBTQ individuals discourages uptake of health care services, including reproductive health care and life-saving treatment for sexual violence.

Women and girls seeking abortion, even when the procedure is not criminalized, still face barriers in access and experience forms of violence when trying to obtain it. In **Ukraine** late-term abortions are allowed until the 22nd week in some circumstances of medical and non-medical nature, and must be cleared by a Prenatal medical Concilium, and, in case of rape, require police statements. In **Turkmenistan**, abortion is only allowed until the fifth gestational week, when many women do not even realize they are pregnant, leading them to seek abortion services in alternative settings where there is increased risk of health complications. **Argentina’s** recentlyapproved Law on the Voluntary Interruption of Pregnancy established a system for regulating abortion with various criteria, but women and girls continue to face barriers to voluntary and legal termination of pregnancy. For example, in 2020 a 12-year-old girl was denied a legal termination of pregnancy and underwent a micro-caesarean section during her second trimester of pregnancy with twins.[[45]](#footnote-45)

Although **Bolivia** has regulations that guarantee access to interruptions of pregnancy (ILE) forvictims of sexual violence, compliance is not guaranteed. A report prepared by the Ombudsman in 2020 reveals that only 8 per cent of 277 health providers in 44 health centres know in which cases the ILE pertains. In October, an 11-year-old victim of sexual violence who wished to legally interrupt her pregnancy faced public pressure from a range of organizations to continue with the pregnancy, resulting in the family’s acquiesence. Girls in Bolivia whose pregnancy is detected after the fifth month are not permitted to access ILE, with 686 girls found to be in this circumstance in 2021 according to the National Health Information System.[[46]](#footnote-46)

Abortion in **Brazil** is prohibited except in cases of rape, risk to the mother´s life or anencephaly. However, the Ministry of Health acknowledges that about one million abortions are performed annually in Brazil, and of these, 250,000 women require hospitalization. In **Honduras**, abortion is prohibited in all cases including rape, serious malformation of the fetus and to save the life of the mother.

In the context of total criminalization of abortion against women who suffer obstetric emergencies, their right of access to justice and due process is violated. Many of the cases are reported by health personnel, due to the uncertainty about their legal duty. **El Salvador** has prosecuted 181 cases of abortion (2010-2019) by women who have suffered obstetric emergencies, in some instances bringing charges of aggravated homicide, which carries a custodial sentence of up to 50 years. An emblematic case was taken to the Inter-American Court of Human Rights, in which the Salvadoran state was found responsible for the arrest, conviction and death of a woman who experienced arbitrary detention while seeking urgent medical attention for an obstetric emergency .[[47]](#footnote-47)

**FGM** is usually criminalized through specific legislation in countries with high prevalence rates. Countries in **the Arab States** region with high prevalence rates have banned the practice. For example, the Kurdistan Region of Iraq banned FGM in 2011, and has seen dramatic decreases in girls subjected to the practice, from 44.8 per cent to 10.7 per cent. In **Ukraine,** there is no specific legislation against FGM but it is prosecuted as a felony under statues prohibiting intentional grievous bodily harm. In recent years, FGM has become increasingly medicalized and performed by health care providers in a clinical setting, which lends legitimacy to the practice despite it being a violation of medical ethics. This trend is most common in Egypt and Sudan, where nearly 80 per cent of women and girls who have undergone FGM had it performed by a health care provider.

**5. Please share information on the health and other type of responses provided by the State and/or other actors in your country/ies or regions in focus to survivors of each/some of the aforementioned forms of violence. Please assess what works well and not so well, and whether COVID-19 impacted the response and how.**

UNFPA offices invest in health system strengthening to support survivors of violence in 102 countries. UNFPA is working in approximately 73 countries to advance the integration of GBV response and prevention as priorities within the Universal Health Coverage framework and policy. UNFPA relies upon international best practices and standards including the Essential Services Package for Women and Girls Subject to Violence (ESP), supporting implementation in 94 countries.[[48]](#footnote-48) Also underlying all UNFPA interventions to support health responses are the human rights principles ensuring of accessible, acceptable, quality and available services.

UNFPA support GBV response and prevention interventions in over 110 countries globally across health, justice, policing, legal and justice sectors to support and prevention violence for women and girls in all their diversity. This work continues to be supported and scaled up through a range of global programmes including the Joint UN Programme for the Essential Services Package for Women and Girls Subject to VIolence and the joint UN and EU led Spotlight Initiative.

As well as supporting nationally led policy and programmes to respond and prevent GBV, programme and policies place individual women at the centre of the intervention to ensure survivor centred approaches are paramount. Couples, families and communities as systems in which the survivor is situated are also engaged to ensure comprehensive and human rights based approaches to GBV response and prevention. Some example of interventions include the following:

In conflict areas in **Eastern Ukraine**[[49]](#footnote-49) UNFPA supports psychosocial support mobile teams, safe accommodations, and healthcare service delivery points for GBV survivors.

In **Turkmenistan**, survivors of domestic violence in two cities receive care through local NGOs that are piloting integrated services including a new shelter. A hotline service introduced in 2021 refers survivors to medical and other response services.

**Peru** has focused on strengthening the health response to GBV through development of a framework of technical standards for GBV care, [[50]](#footnote-50) including mental health care.[[51]](#footnote-51)

In **Burundi**, responsibility to prevent and respond to GBV is situated in the Ministry of Gender, the Police and Justice Ministries, and health structures that are reinforced with SRH kits and training such as clinical management of rape.

Across the Pacific, including in **Solomon Islands and Kiritbati,** Standard operating Procedures and Guidelines accompanied by training packages are in place to support quality responses for survivors of GBV.

In **Turkey**, hospital-based Child Monitoring Centers have been introduced and child-friendly interview rooms in courthouses have been upgraded. Legislation has established special interview techniques for children.

Despite these advances, UNFPA continues to identify and address gaps in health and other service provision for GBV survivors.

* Fees for GBV healthcare remain in place in many Arab States, among others
* Exclusion of non-nationals (e.g. refugees, migrants) blocks access to GBV care for entire subpopulations
* Decentralization of health services in countries such as Ukraine is being closely watched to determine the effect on survivors living in rural or conflict zones
* Low national capacity and lack of institutionalisation of GBV services in countries including Turkmenistan require ongoing technical and financial support to NGOs to scale up and adequately meet survivor needs in addition to the government based services.
* Mandatory reporting of injuries consistent with violence from health services to the legal and justice system (which serves as an impediment for survivors seeking treatment).

While COVID-19 caused unprecedented disruption in government and social services globally, UNFPA was able to maintain or expand GBV services in 65 per cent of the countries providing data. Of the individual GBV service points supported by UNFPA, 80 per cent report managing to maintain at least a basic level of services over the course of the pandemic. However, the COVID 19 pandemic revealed systemic weaknesses and resulted in public policies that negatively impacted GBV services including in the following ways:

* Life-saving healthcare for GBV survivors (clinical management of rape and mental health support) was frequently suspended when health systems became overburdened with COVID-19 cases. Often these services were not considered ‘essential’ despite indications of a surge in GBV during the pandemic
* SRH was deprioritized within health systems, putting women and girls at higher risk of unwanted pregnancy and obstetric emergencies
* Shelters and safe spaces were often designated non-essential, reducing access to specialized support
* Measures to limit public mobility frequently lacked consideration of the need for survivors to relocate and to reach safety and services
* Justice systems in some cases failed to prioritize protective orders and hearings for GBV survivors who required immediate relief.

These obstacles drove UNFPA offices to develop mitigation strategies, with 99 per cent reporting that innovative approaches during COVID-19 including the following:

**Remote/mobile service delivery:**

Remote GBV services accelerated due to movement restrictions. In **Belize,** remote service provision was strengthened with online counselling services and a toll free GBV Hotline. Twenty-four SRH mobile clinics were set up in priority districts to reach individuals with contraceptives, counselling, and safe GBV identification and referral. In many countries including **Tajikistan**, the services of existing GBV hotlines were expanded to ensure 24/7 coverage.

Mobile clinics were established in **Niger, Mozambique**, and **Liberia** with teams equipped with the skills and vehicles to go where needed. Mobile GBV response teams in **Kyrgyzstan** included police, health, and social service providers. In **Malawi,** GBV responders receive mobile credit in order to support remote case management.

**Information Technology:**

In **Belize,** WhatsApp/SMS text options for support were launched during the pandemic. GBV responders in countries including **Nigeria, México, Belize, Honduras,** and **Trinidad and Tobago** were trained and equipped with ICT equipment to provide psychosocial support and referrals.

In **Kyrgyzstan,** technical support was provided to the government to develop a unified algorithm for GBV cases in the context of COVID-19. This facilitated coordination among health, social services, law, police, and justice sectors. UNFPA supported implementation of Youth Connect in **Trinidad and Tobago,** a mobile application to increase access to SRH information and telemedicine during lockdowns.

In **Turkey**, the mobile application called KADES is developed by the Ministry of Interior. It is an emergency support application for women which directs security units to the place of violence in just minutes upon notification. It has been downloaded by more than 3 million women since 2018. In addition to this, the UNFPA Turkey office has developed an online mobile app called AMBER to increase women’s awareness of their right to bodily autonomy. It is designed both as a calendar which facilitates women's menstrual cycle tracking and pregnancy planning as well as supporting a diary where women can record important dates and situations concerning their physical and mental health. AMBER also aims to facilitate women's access to necessary information and support mechanisms to lead healthy and safe lives.

**Strengthening local response and coordination capacity:**

In **Tajikistan** UNFPA supported the coordination of a Gender Theme Group (GTG) to ensure a unified response to COVID-19. The GTG established an [on-line action plan](https://drive.google.com/file/d/1M6EIVX1HT22XrmB_9-VaF0w_s9kmp27_/view?usp=sharing) to build response and monitoring capacity, support selected CSOs, and develop knowledge and information products addressing the impacts of COVID-19.

In **Guyana,** UNFPA facilitated the establishment of local networks among authorities and communities to support safe GBV identification, link individuals to response services, and provide GBV psychosocial support.

In **Turkmenistan,** where UN agencies supported the Government to develop and implement National Plans for Preparedness, a key element was to ensure that even during a pandemic the right to family planning and safe pregnancy and childbirth was safeguarded. UNFPA also strengthened the capacity of local NGOs to provide GBV information, psychosocial support, and legal counselling services.

In Turkey, electronic handcuffs system has been launched by the Ministry of Interior to track the perpetrator and the survivor. This system prevents perpetrators under court order to be within a certain distance of the complainant/survivor. The use of these handcuffs is currently limited.

**Resourcing health services:**

In **Liberia** UNFPA established a maternity unit to ensure that pregnant women in quarantine or diagnosed with COVID-19 received necessary care. UNFPA **Egypt** identified nurses and medical practitioners from NGOs who were available to staff four Safe Women clinics In the absence of staff to address GBV incidents during peak COVID periods, and to provide case referral to legal and social services. UNFPA contributed supplies needed during the COVID-19 pandemic such as personal protective equipment and hygiene kits to support healthcare response.

**6. Please specify the budget allocated in your country/ies in focus, to health related response to survivors of all/some forms of violence mentioned above. Please indicate the percentage of the national budget devoted to this; the percentage of the international aid provided or received for this. Please explain the impact of Covid 19 to the funding of responses to all/some forms of violence in your State/institution.**

A key focus of joint UN work in supporting gender responsive budgeting to ensure sufficient resources to support responses to GBV is the implementation of Module 7 of the Essential Services Package for Women and Girls Subject to VIolence (UNFPA, UNWomen, WHO, UNDP, UNODC) . This module will support countries in the costing of responses for survivors of GBV to enable increased focus and advocacy on gender-responsive budgeting.

**Ukraine** has allocated 274.2 million UAH from the state budget to develop available specialized services for survivors of GBV in 2021, and comparable amounts are planned for 2022-2024. These specialized services cover various sectors, and not only the health sector response.

**7. Please describe the needs of survivors of the above mentioned forms of violence as identified by your State/institution. Please share survivor-self identified needs and those of their families, with a focus on health emergency and long-term needs.**

In order to effectively respond to health emergencies, **national systems must be responsive to the needs of survivors.**  They must recognise the need to integrate **systematic approaches to health care from the national laws and policies to community level** care and referral. Research and programme implementation experience of UNFPA suggests that where trust in institutions exists, GBV reporting increases because survivors feel protected in coming forward.

UNFPA supports the process of national/local system integration through the implementation of health care responses in compliance with the Essential Services Package for Women and Girls Subject to Violence as well as other WHO, UNFPA and UN agency guidelines. There are also a range of relevant tools for use in emergency and humanitarian settings that establish best practices, including the UNFPA Minimum Intial Services Package for Sexual and Reproductive Health (MISP). The MISP prescribes a set of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis, and it has been successfully launched in multiple locations. The Ministry of Health of **Turkmenistan**, for example,endorsed the Minimum Initial Service Package (MISP) for reproductive health during emergencies to prevent and manage the consequences of sexual violence, among other sexual and reproductive health services. Based on the MISP, Turkmenistan identified psychological and medical needs of survivors during health emergencies, including the need for shelters, HIV post-exposure prophylactic kits and emergency contraception.

Given that **structural discrimination, reinforced by gendered and social norms,** perpetuates and sustains violence, key interventions within the health system require increased inclusion of women as senior health system administrators, managers, doctors and decision makers in addition to community based workers and nurses. Gender parity across the health system, along with foundational training on gender and GBV for all healthcare workers, will begin to mitigate the structural challenges to supporting survivors of violence.

Practices such as mandatory reporting of domestic violence or rape to authorities, publication of survivor names, and collection and sharing of sensitive data without consent can reduce trust and depress reporting rates. UNFPA centres GBV programming on principles of **confidentiality, safety, consent, and nondiscrimination.**  To the extent these principles are integrated into national policies regarding survivors’ rights, including within healthcare systems, and local practitioners are supported in their implementation, survivors will be empowered to identify and seek assistance in addressing both emergency and long-term needs.

There are many states with significant gaps in resources (human and financial) and policies which hinder access to quality services for survivors. These gaps are context-specific; in **Burundi** for example, UNFPA identified four key needs to respond to GBV: improved transportation infrastructure to reach GBV service points, reduced justice fees, socio-economic reintegration programs, and increased protection mechanisms for survivors.

**8. Please share examples of good practices and examples of comprehensive health responses to survivors of violence and indicate efficient multi-sectoral efforts at the community, national, regional and international levels by State or non-State actors.**

At the country level, UNFPA supports State actors in developing comprehensive services for survivors of GBV both in development and humanitarian contexts. Support for multi-sectoral response services, and health services in particular are guided by international standards including the Essential Services Package for Women and Girls Subject to Violence (ESP),[[52]](#footnote-52) the Inter Agency Minimum Standards for GBV Programming in Emergencies[[53]](#footnote-53), and guidelines for health system responses produced by WHO in partnership with UNFPA and other UN agencies.[[54]](#footnote-54)

The ESP, developed under the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, was launched by UNFPA and UN Women in 2013 to support countries in providing services for survivors of violence in a broad range of settings. The ESP was produced through a global consultation process with experts in the fields of health, law enforcement, justice, and social services. It includes sector-specific modules outlining minimum standards and characteristics of GBV services.

UNFPA advocates at global, regional and national levels for the adoption of the ESP and supports implementation of comprehensive, human-rights based and survivor-centred GBV services. This involves coordination and development of multisectoral standard operating procedures, policies and training to service providers.

At the regional level, UNFPA and the Pan American Health Organisation have developed a virtual course on clinical management of sexual and intimate partner violence aimed at health personnel in the LAC region. The course will be launched in March 2022 within the framework of the Spotlight Initiative.[[55]](#footnote-55)

Some good practices at the national level:

* In **Argentina**, health services were adapted to the COVID-19 emergency context. Response services to GBV and access to contraceptive methods were recognized as essential.[[56]](#footnote-56)
* In **Ecuador**, the Ministry of Public Health developed the Technical Standard of Care for GBV, establishing guidelines for providing care to survivors with specific guidelines for girls and adolescents, LGBTQI individuals, and people with disabilities.[[57]](#footnote-57)
* In **Lebanon**, UNFPA collaborated with the Ministry of Public Health to integrate GBV into SRH services. In collaboration with UNICEF and UNFPA, the Minsitry of Public Health launched a national strategy for clinical management of rape (CMR) and formed a coordination taskforce co-led co-led by UNFPA and involving key actors in health and GBV.
* In **Peru**, UNFPA supported the Ministry of Health in a pilot for health services and protection services for survivors of violence that includes SRH and mental health.[[58]](#footnote-58)
* **Turkmenistan,** with UNFPA support, conducted an assessment of existing services to GBV survivors. Results informed about the pathways to the development of the national GBV response system with international standards and principles.
* Since 2017, emergency sexual and reproductive health service delivery points have been established within existing health care facilities in **Ukraine**. These delivery points provide confidential, free 24/7 access to SRH care for women, girls, and survivors of GBV. UNFPA has trained personnel on comprehensive medical and psychological care and referral of GBV survivors.
* **Uruguay** was the first country in the LAC region to adapt the WHO Clinical Management Guidelines for Intimate Partner Violence to the national context.
* Local governments in Ukraine have been supported in establishing daycare centers, psychosocial support points and 86 specialized police units for urgent response to domestic violence which are operational in 67 cities. A national free 24/7 Governmental Call Centre for survivors was launched in 2019.
* In **Tajikistan**, the ESP was adapted and made easily accessible through a GBV pocket guide to strengthen referral systems and improve the quality of service delivery.
* In **Mexico**, UNFPA coordinated a local adaptation of the ESP through a participatory process that included local services providers and CSOs.
* In **Turkey,** the mobile application KADES, supports instant reporting of GBV by survivors to police into six languages. This also facilitates multisectoral partners in response and referrals for refugees and migrants.

Coordinated service provision requires provider mapping and development of referral pathways and standard operating procedures. UNFPA routinely supports this process as a foundation for quality multisectoral response, as shown by these recent examples:

* Mapping of referral pathways was accomplished in Malawi, Uganda and Jamaica and directories of GBV services were produced. Vulnerable populations were considered, to ensure provision of care leaves no one behind
* In Kyrgyzstan a participatory mapping survey of essential services from the survivors` perspective was conducted, based on global methodology
* Following service mapping in Niger, Nigeria and Malawi, standard operating procedures for GBV response and prevention were established, specifying the roles and responsibilities of each actor in the areas of health/psychosocial, justice and security. Coordination structure and referral mechanisms were also put in place.

**9. Please describe State and other actors initiatives and measures to prevent these forms of violence, specific budget allocated to prevention, and good practices in this regard.**

UNFPA, in partnership with UNWomen, WHO, UNODC and UNDP, is supporting the global roll out of the **RESPECT[[59]](#footnote-59) framework** and implementation plan. This framework aims to prevent GBV through a set of interventions including strengthening the capacity of policy makers and implementers to design, deliver, and monitor GBV initiatives.

Specific measures and good practices UNFPA is engaging in with State and other actors for GBV prevention include:

**Social and gender norm change**, identified as a key output of UNFPA’s 2022 - 2025 Strategic Plan for gender equality and GBV prevention. Programming will address the discriminatory gender and social norms that impede equality and inhibit women’s rights and decision-making power within their families and societies. Negative social and gender norms expose women and girls to harmful practices and obstruct their use of services that safeguard their health, rights, and dignity. Building capacity at individual, community and national levels to address root causes of structural inequality is foundational to progress toward reducing GBV. For example, UNFPA is developing guidance to engage health workers in recognising and addressing their own social and gendered norms and the ways in which this impacts clinical treatment and practice when responding to survivors of violence.

UNFPA supports **integration of GBV prevention into Comprehensive Sexuality Education** as a global strategy to reduce violence against adolescents, a critical population given the impact felt across their life course. Following a 2020 literature review of the evidence,[[60]](#footnote-60) technical support and implementation plans will be published in 2022.

Examples of current CSE integration work include:

* UNFPA **Honduras** has developed a CSE and GBV toolbox for the Education Secretary, targeting parents and guardians for social norms change
* In **Belize**, CSE delivery for out-of-school youth has been strengthened through development of a CSE Peer Education Curriculum and Training Resource Manual
* **EL Salvador** produced educational materials to raise awareness of GBV and CSE for women and girls with disabilities
* In **the Pacific**, the 2020 International Technical and Programmatic Guidance on Out-of-School CSE was launched to inform national strategies on CSE/Family Life Education. This is an important political advance for CSE in the Pacific and may be instructive for South-South learning.
* In **Papua New Guinea**, UNFPA supports the first-ever CSE Steering Committee to build momentum behind Spotlight-supported CSE interventions.
* In **Samoa,** as an adaptation to the COVID-19 pandemic, UNFPA supported the conversion of the CSE curriculum into an online multimedia learning platform.

**Disability inclusion** as an essential component of UNFPA’s GBV prevention work. Recognizing the increased risk of violence faced by women and girls with disabilities, UNFPA is leading an initiative in **Eastern Europe and Central Asia** to mainstream disability rights and awareness across GBV service sectors. Through collaboration with government and CSOs, products including Standard Operating Procedures used by police and clinical protocols for medical treatment of GBV are being updated to equip responders to provide inclusive services. Assisted communication materials are being developed for those with visual and auditory impairments to empower them to understand their options and rights in accessing GBV and health services.

Programming to encourage **positive parenting and transform harmful masculinities** offers a promising approach to GBV prevention. Ninety-six per cent of UNFPA offices report working with men and boys as a prevention strategy. In **Argentina,** training for security forces has been reformed to introduce diverse forms of masculinity. In **Tajikistan**, parenting and positive masculinity are taught through theatre-based performances on street harassment, dating violence, early marriage, and SRHR. In **Uganda,**  100 male mentors have been trained to conduct community engagement on SRHR and GBV prevention, reaching almost 60,000 community members to date.

**Alliances with faith based organizations (FBOs)** represent another of UNFPA’s prevention approaches. In **El Salvador,** partnership with FBOs has grown through training religious leaders on the linkages of sexual violence, child marriage and early unions with teen pregnancy. This promotes family acceptance of GBV prevention and response practices.

In **Tajikistan** UNFPA supported the development of comprehensive training modules for religous officials and leaders of commmunity mosques on Islam and Gender, together with the Committee of Religious Affairs and Regulations of Traditions. In the **Pacific,** UNFPA is a member of a technical coordination group that supports the Pacific Conference of Churches as a strategy to engage with FBOs on GBV prevention activities

UNFPAwill expand access to **safe spaces for girls and women.** These spaces increasingly integrate SRHR education and services, in keeping with needs expressed by users, and are a primary venue for sharing prevention information. **Mentorship programmes and girls’ social networks** offer avenues to educate youth on GBV, SRHR, harmful practices, gender perspectives and life skills. In **Malawi** a mentorship program successfully provided support for mentees to report child marriage cases. No girl attending mentorship programmes became pregnant during the pandemic, demonstrating the impact of prevention approaches using concepts of bodily autonomy.

**Engagement with media, business, and financial organizations** isincreasingly strategic for GBV prevention. In **Burundi,** a Bank for Women has been established to support economic projects that will improve women’s social status and decision making power. UNFPA **Argentina** is working with journalists, social communicators, publicists, union representatives and business chambers to raise awareness on GBV and their role in promoting social norms transformation. In **Trinidad and Tobago,** UNFPA supports the National Trade Union Centre with policy development and workshops to sensitise business leaders on establishing grievance procedures for GBV, harassment, and violence at work.

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