Addressing Firearms as a Critical Blind Spot in Global Efforts to Prevent Violence Against Women and Femicide

The Need for the World Health Organization to Take Action

Naeemah Abrahams, Bettina Borisch, Natalie Briggs, Jacquelyn Campbell, Elizabeth Dartnall, Pierrette Kengela, Ruti Levtov, Monica Meltis, Cristina Neme, Dean Peacock, Natalia Pollachi, Natalia Ruiz, Itzel Soto, Claire Somerville, and Claire Taylor

Global Coalition for WHO Action on Firearm Violence

CO-PUBLISHING ORGANISATIONS

2026

Addressing Firearms as a Critical Blind Spot in Global Efforts to Prevent Violence Against Women and Femicide

The Need for the World Health Organization to Take Action

Contributors (listed alphabetically): Naeemah Abrahams, Bettina Borisch, Natalie Briggs, Jacquelyn Campbell, Elizabeth Dartnall, Pierrette Kengela, Ruti Levtov, Monica Meltis, Cristina Neme, Dean Peacock, Natalia Pollachi, Natalia Ruiz, Itzel Soto, Claire Somerville, Claire Taylor.

Co-publishing organisations (listed alphabetically):

Data Cívica, Mexico; Division of Social and Behavioural Sciences, School of Public Health, University of Cape Town; Gender Centre, Geneva Graduate Institute; Gender Equality Network for Small Arms Control; Global Coalition for WHO Action on Firearm Violence; Gun Free South Africa; Instituto Sou da Paz, Brazil; International Federation of Social Workers; Prevention Collaborative, Global; Sexual Violence Research Initiative, Global; Women's Institute for Alternative Development (WINAD), Trinidad and Tobago; World Federation of Public Health Associations.

CONTRIBUTOR AFFILIATIONS

1. Naeemah Abrahams — Chief Specialist Scientist, Gender and Health Research Unit, South African Medical Research Council

2. Bettina Borisch — Professor of Global Health, University of Geneva; Executive Director, World Federation of Public Health Associations

3. Natalie Briggs — Gender Equality Network for Small Arms Control (GENSAC)

4. Jacquelyn Campbell — Anna D. Wolf Chair and Professor, Johns Hopkins University School of Nursing

5. Elizabeth Dartnall — Executive Director, Sexual Violence Research Initiative (SVRI)

6. Pierrette Kengela — Coordinator, Global Coalition for WHO Action on Firearm Violence

7. Ruti Levtov — Senior Associate, Prevention Collaborative

8. Monica Meltis — Executive Director, Data Cívica

9. Cristina Neme — Projects Coordinator, Sou da Paz, São Paulo, Brazil

10. Dean Peacock — Division of Social and Behavioural Sciences, School of Public Health, University of Cape Town; Co-Director, Global Coalition for WHO Action on Firearm Violence

11. Natalia Pollachi — Director of Projects, Instituto Sou da Paz

12. Natalia Ruiz — Data Analyst, Data Cívica

13. Itzel Soto — Data Analyst, Data Cívica

14. Claire Somerville — Executive Director, Gender Centre, Geneva Graduate Institute

15. Claire Taylor — Consultant, Gun Free South Africa

Global Coalition for WHO Action on Firearm Violence

**The protea in our logo symbolises resilience, regeneration, and hope—core principles of a public-health approach to preventing gun violence. Native to South Africa and fire-adaptive, the protea survives cycles of stress and emerges renewed, reflecting prevention, healing, and long-term wellbeing.*

CONTENTS

Background 4

Acknowledgements 4

Executive Summary 5

Introduction: firearms and gender-based violence 9

Current evidence as the tip of the iceberg: Inadequate surveillance and global data systems 11

Firearm violence, care burdens, and gendered health system impacts 12

Firearms, GBV, and country-level evidence 13

Brazil: Firearms, non-lethal IPV, and a visible prevention window 13

Mexico: The proliferation of firearms and the transformation of lethal violence against women 16

Western Balkans: Domestic violence as the most lethal firearm context 18

South Africa: Firearm regulation, femicide reduction, and the costs of weak enforcement 20

Implications of findings from Brazil, Mexico, the Western Balkans, and South Africa for global health policy and practice 23

Identifying blind spots in WHO and other UN agency work on IPV 25

The declining visibility of firearms within WHO violence-prevention frameworks 25

WHO data, guidance, and the visibility of firearm violence in UN approaches to GBV and femicide 25

UN Women's Firearms Violence and GBV Blind Spot 27

Firearms, gender-based violence, and the Women, Peace and Security agenda: implications for WHO leadership 28

Implications for policy and practice: integrating firearm risk into GBV prevention 29

The feasibility of WHO leadership on femicide data 33

Conclusion 38

Works Cited 40

Annex 1: Mandates, resolutions, and authoritative calls relevant to WHO action on firearm-related GBV and femicide 45

Background

This report is one of a set of companion analyses by the Global Coalition for WHO Action on Firearm Violence (WHO Action) and its member organisations addressing firearm violence across overlapping population groups: women and girls; men and boys; and children and youth. WHO Action and its 120 member organisations across more than forty countries are calling on the WHO to strengthen its work on firearm violence. Together, these companion papers seek to illuminate how gun violence operates across gender and age, while also speaking directly to advocacy constituencies that remain institutionally organised around these gender categories. We recognise, though, that gun violence rarely conforms to neat demographic boundaries. An intersectional lens reminds us that identities and exposures overlap, and that harms experienced by one group are rarely isolated from others.

Acknowledgements

The authors acknowledge the thoughtful review and suggestions by Hana Salama, MA, and Fatima Marinho, MD, MPH, PhD, Visiting Professor at the GBV research group at the Federal University of Minas Gerais, Brazil.

We also acknowledge the generous copy-editing and layout support provided by the Gender Equality Network for Small Arms Control (GENSAC).

> **“Firearm access shapes whether violence becomes fatal.”**

Executive Summary

This report has two overlapping objectives. First, it seeks to engage the broader GBV prevention and response field by showing that firearms are both instruments of homicide and tools that intensify fear, threats, injury, sexual violence, and coercion, heightening the risk that abuse becomes fatal. Second, it urges WHO to use its existing public health mandate, normative authority, and technical capacities to ensure that firearm-related risk is more consistently reflected in GBV surveillance, clinical guidance, prevention frameworks, trauma care, and support to Member States. The argument advanced here is therefore directed both to GBV practitioners and researchers, who can strengthen prevention by integrating firearm risk into existing work, and to WHO, whose guidance powerfully shapes what becomes visible, measured, and acted upon in global and national health policy.

Gender-based violence (GBV), including intimate partner violence (IPV), sexual violence, and femicide, remains one of the most pervasive causes of injury, disability, and death among women globally (Flor et al., 2026). Despite sustained global attention, this report identifies inadequate attention to firearms as a critical gap in the way GBV is understood and addressed.

Drawing on a review of World Health Organization (WHO) publications and World Health Assembly resolutions from 1996–2025, analysis of UN Women guidance on national action plans to address GBV, and evidence from Brazil, Mexico, the Western Balkans, and South Africa, the report argues that firearms have not been systematically integrated into major GBV prevention, surveillance, and response frameworks. It situates this within a broader institutional and geopolitical context, recognising both the pioneering contributions of WHO violence-prevention teams and the political, institutional, and resource constraints under which they operate (Peacock et al., 2025).

Firearms as a driver of lethality, severe injury, and fear

Firearms are implicated in a substantial proportion of femicides globally - and, beyond how often they are used, they sharply raise the odds that a given assault ends in death, functioning not only as instruments of homicide but as tools that intensify fear, coercion, injury, and trauma. For women, firearm violence is most likely to be fatal in the home, at the hands of intimate partners or family members, and is typically preceded by histories of abuse, threats, and escalating violence (UNODC & UN Women, 2022, 2023). Campbell's landmark US study identified firearm access as one of the strongest predictors of intimate partner femicide, increasing the odds of lethality more than fivefold (Campbell et al., 2003); South African, Balkan, Latin American, and global studies reach consistent conclusions (Abrahams et al., 2013; Nowak, 2012; SEESAC, 2016; World Health Organization, 2012).

The harm extends well beyond fatalities. Non-lethal firearm threats create credible fear of death, suppress disclosure, constrain mobility, and may prevent women from leaving abusive relationships (Sorenson & Schut, 2016). Firearms are also used to facilitate sexual violence in both domestic and conflict-related contexts, though these dynamics remain significantly under-documented in global surveillance systems (Machisa et al., 2017; Salama, 2023). Available evidence indicates a disproportionate and under-documented impact on lesbian, gay, bisexual, transgender, queer, intersex, and other diverse sexual orientations and gender identities (LGBTQI+) populations, particularly transgender women.

Women also disproportionately shoulder the burden of long-term care for survivors of firearm injury and constitute the majority of the health and care workforce responding to gun violence, meaning firearm violence deepens gendered inequalities at both household and health-system levels (International Labour Organization, 2018; Mohammed et al., 2023).

Evidence for prevention

A substantial international evidence base demonstrates that stronger firearm legislation—including licensing systems, firearm relinquishment in domestic violence contexts, background checks, and safe-storage measures—is associated with reductions in firearm homicide and intimate partner femicide (Díez et al., 2017; Santaella-Tenorio et al., 2016; Zeoli et al., 2018). The country case studies reinforce and extend these findings:

- **Brazil**: health-sector notification systems reveal clear escalation pathways from non-lethal firearm violence to femicide, demonstrating that health systems already identify high-risk cases long before lethal outcomes occur.
- **Mexico**: rising firearm availability has transformed lethal violence against women, with firearms now the dominant mechanism of female homicide in both public and domestic settings.
- **Western Balkans**: domestic violence has emerged as the most lethal firearm context—more deadly than criminal or public violence—yet receives the least regulatory attention.
- **South Africa**: strengthened firearm regulation and enforcement were associated with substantial declines in gun-related femicide; weakened enforcement contributed to subsequent increases (Abrahams et al., 2013; Matzopoulos et al., 2019).

Across all four settings, institutional failures to remove firearms from men known to pose a risk to women repeatedly contribute to preventable deaths—and health systems consistently encounter women at high risk early enough to intervene (García-Moreno et al., 2015; Sharps et al., 2001; Vital Strategies, 2025).

In each setting, firearm access emerges as one of the strongest and most modifiable predictors of whether violence against women becomes fatal, making it a particularly important target for public health intervention.

Two implications follow. First, although health systems are well placed to identify risk early, sustained reductions in femicide ultimately depend on legal and regulatory restriction of firearm access among those who pose a risk; where comprehensive reform is politically constrained, mandatory firearm removal in domestic-violence contexts is the highest-impact priority (Santaella-Tenorio et al., 2016; Zeoli et al., 2018). Second, such regulation cannot stop at national borders: restrictive domestic laws are undercut when neighbouring states remain permissive—as in Mexico, where most firearms recovered at crime scenes originate in the United States—and recent US rollbacks of export controls deepen this regional risk (Everytown for Gun Safety, 2025; Martínez-Villalba, 2024; Thrush, 2025). Crucially, protections reduce harm only when they are actionable: for undocumented, economically dependent, or disabled women, and in settings where enforcement institutions are themselves sites of impunity, formal systems must be redesigned and paired with community-based mechanisms so that the women at greatest risk are not left unprotected (Ellyson et al., 2026; Lynch et al., 2025; Tobin-Tyler, 2023).

WHO, UN frameworks, and the visibility of firearm-related GBV

WHO plays a uniquely important agenda-setting role within the UN system through its authority over injury surveillance, epidemiology, evidence synthesis, and normative guidance. What WHO measures and prioritises strongly influences what becomes visible within global GBV policy frameworks—and, downstream, within the guidance of other UN agencies and the national action plans of Member States.

WHO's mandate to address firearm-related harm is already established: successive World Health Assembly resolutions identify violence as a major public health issue requiring surveillance, prevention, and multisectoral response, and WHO's 2016 Global Plan of Action explicitly names firearm availability as a cross-cutting determinant of interpersonal violence (World Health Assembly, 1996, 2003, 2014, 2016; World Health Organization, 2016). Just as WHO addresses harmful alcohol use, unsafe roads, and poverty without regulating them, it can address firearm access as a determinant of injury, lethality, and death—without assuming an arms-control mandate or duplicating the work of UNODC and UNODA.

Yet a recent multi-partner review finds that firearm violence has received only occasional attention within WHO's work, with visibility steadily decreasing over the last fifteen years (Peacock et al., 2025). WHO frameworks such as RESPECT Women and INSPIRE represent major advances in evidence-based violence prevention but were built on systematic reviews drawn predominantly from settings where firearms are not the main driver of violence. The first edition of RESPECT, published in 2019, includes mention of weapons but does not specifically name firearms. RESPECT's second edition of 2025 does name firearm access among its risk factors, but that recognition has not been carried through into the surveillance, risk assessment, and clinical guidance needed to act on it where firearms are prevalent. The femicide evidence base has since matured considerably and now demonstrates clearly that firearms are a critical determinant of lethality where they are prevalent. The limited integration of firearm-related risk in global GBV frameworks is mirrored downstream. Firearms are one of several risk factors for severe and lethal violence against women, alongside prior abuse, controlling behaviour, separation, and threats. However, UN Women's most recent guidance on national action plans does not mention firearms, nor do the national GBV action plans of several countries with high burdens of gun-related femicide, and the Women, Peace and Security agenda acknowledges firearms only inconsistently. The omission is precise: the flagship femicide-data frameworks disaggregate killings by age, sex, and victim–perpetrator relationship but not by the means of killing—leaving the weapon, one of the most significant and potentially modifiable determinants of lethality, the one variable global guidance does not systematically request (Šimonović, 2021; UNODC & UN Women, 2022b).

The gap is disciplinary as well as institutional. The violence against women prevention field and the firearm violence prevention field have developed largely in parallel, each maturing around a blind spot that is the other's core strength: firearm violence research has historically under-attended to domestic and intimate partner contexts, while the violence against women field has engaged only intermittently with the literatures on lethal means, injury severity, and regulatory evaluation. More systematic engagement with the firearm field's evidence—on the legal design features that reduce intimate partner homicide, on lethal means restriction, and on trauma-care-based intervention models—offers the violence against women field an under-utilised resource for reducing femicide, while that field's global reach and contextual depth addresses gaps in a firearm literature that remains heavily concentrated in high-income settings.

Opportunities for WHO leadership

The report concludes that WHO has both the mandate and the comparative advantage to strengthen global attention to firearm-related GBV and femicide. Within its existing mandate, WHO can:

- build on the advances in the second edition of RESPECT Women by operationalising its existing recognition of firearm-related risk—through surveillance guidance, risk assessment, and clinical protocols—and extend comparable attention to firearm-related risk across INSPIRE in future iterations;
- strengthen normative guidance on femicide and GBV reporting, including support for countries to use existing ICD-11 codes for weapon type and victim–perpetrator relationship;
- develop clinical and trauma-care guidance for health system responses to firearm injury;
- synthesise evidence on effective prevention interventions; and
- convene technical consultations and research partnerships.

WHO also possesses well-established mechanisms for supporting member states to strengthen health data systems—including injury surveillance, ICD classification, verbal autopsy, and mortality-review processes—demonstrating that limitations in existing national data are not barriers to action but areas in which WHO has longstanding technical expertise. Objections that national data are too weak therefore mistake the nature of the constraint. WHO has overcome the same limitations in other domains—civil registration, verbal autopsy, and maternal-death surveillance—and its standards have repeatedly

mobilised external financing at no cost to its core budget (de Savigny et al., 2017; Gostin et al., 2015; World Bank & WHO, 2014). The binding constraint is not mandate, money, or Member State appetite, each of which is already present; it is prioritisation within WHO's normative agenda—the one input only WHO can supply.

Integrating firearms into WHO's violence-prevention agenda is essential to advancing global commitments to end GBV and femicide. Without systematic integration of firearm-related risk into GBV frameworks, health systems, surveillance systems, and national action plans, a major determinant of women's injury and death will remain insufficiently addressed within the very systems intended to prevent violence and protect survivors.

> **“Firearms function not only as instruments of homicide but as tools that intensify fear, coercion, injury, and trauma.”**

Introduction: firearms and gender-based violence

Firearms constitute a critical, yet systematically neglected, cause of fear, trauma, injury, disability, and death among women in abusive relationships.

For a number of years, the Secretary-General, in his reports on conflict-related sexual violence (CRSV), has recognised that the proliferation of small arms and light weapons (SALW) is a key driver and enabler of CRSV. He has repeatedly called on member states to “adopt national legislation on arms control and ammunition management and implement the Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects and the Arms Trade Treaty and other relevant instruments, to bolster prevention of conflict-related sexual violence” (United Nations Secretary-General, 2024, p. 30). In his 2025 report on the Women, Peace and Security Agenda, the UN Secretary-General noted that “The spread of arms and ammunition contributes directly and decisively to sharp increases in gender-based violence in conflict-affected countries” (United Nations Secretary-General, 2025, p. 18). In 2024, the Fourth Review Conference (RevCon4) of the UN Programme of Action on Small Arms and Light Weapons (UNPoA) included significant new language linking armed violence, gender, and health, explicitly recognising “the intricate linkages between armed violence associated with illicit small arms and light weapons and the health of women, men, girls and boys,” and affirming that such violence “constitutes both a public health and a mental health concern.” (United Nations, 2024, para. 134). The document further calls for prevention strategies and comprehensive support for victims and survivors (Bjerten & Briggs, 2025).

Despite this emerging recognition within parts of the UN of the devastating gendered effects of firearm violence on public health, firearm-related risks have not yet been systematically integrated into WHO violence-prevention and GBV frameworks.

Addressing firearm-related violence against women falls within WHO's established public health mandate: successive World Health Assembly resolutions recognise violence as a major public health challenge, and WHO has repeatedly identified firearm availability as a determinant of interpersonal violence and femicide (WHO, 2012, 2016). The scope and basis of this mandate are set out below.

This gap has major consequences. The role firearms play varies across settings, reflecting differences in prevalence, legal regulation, trafficking, conflict exposure, and social norms around weapon ownership. But where they are present, firearms reconfigure power and heighten fear, trauma, and risk within intimate relationships across five dimensions:

Since RESPECT was developed, the femicide evidence base has grown substantially. It now demonstrates clearly that firearm access is a critical determinant of lethality in settings where firearms are prevalent--but this evidence was not yet prominent in the global systematic reviews on which RESPECT was built, most of which drew on a literature where firearms are not the main driver of intimate partner violence (IPV). This is not a criticism of RESPECT. It is an argument for ensuring that future iterations of WHO and UN violence-prevention frameworks integrate firearm-related risk in a way that is sensitive to context and reflects this maturing evidence base.

First, **firearm access substantially increases the risk of femicide**. Globally, an estimated 45,000 women and girls are killed each year by intimate partners or other family members, accounting for more than half of all female homicides (UNODC & UN Women, 2022a, 2023). Women are several times more likely to be killed by an intimate partner when a firearm is present in the home, and firearms are disproportionately used in domestic homicides, including murder-suicide (Abrahams et al., 2024; Nowak, 2012; UNODC & UN Women, 2022a). Campbell’s landmark 2003 study identified gun ownership as one of the strongest risk factors for intimate partner homicide, over and above intimate partner violence (IPV) in

the US, with the odds of lethality increasing 5.4-fold where the abusive partner owns a gun (Campbell et al., 2003). In Mexico, official data covering the period 2004–2024 show that the rate of murders of women involving firearms increased by 375%, reflecting both rising gun availability and growing lethality in domestic and community contexts (Martínez-Villalba, 2024). A 2021 study by the United Nations Development Programme (UNDP) on the use of guns in situations of domestic violence and femicide in Serbia, reports that: “In families and relationships in which perpetrators have access to firearms, the risk of misusing the weapon and the risk of violence escalation is increased up to five times and the consequences of the misuse are severe” (Stevanović Govedarica, 2021, p. 5).

These killings are rarely spontaneous. They are typically preceded by documented histories of abuse, threats, and escalation. In the United States, intimate partner murder-suicides of women are also usually preceded by perpetrator threats of suicide, as well as prior IPV and gun ownership (Koziol-McLain et al., 2006). Murder-suicides comprise 30-40% of the intimate partner homicides in the ; of these, 95% of victims were women killed by their male intimate partners, and 93% were perpetrated with a gun (Violence Policy Center, 2023).

Firearm-related intimate partner homicide has emerged as a leading cause of death during pregnancy and the postpartum period in the United States, with Black women facing markedly elevated risk—a pattern that underscores the nexus of gun violence, maternal health, and structural inequality (Soares et al., 2024; Tobin-Tyler, 2023). Other research points to similar dynamics in Latin America and the Caribbean (Soares et al., 2025).

Gun violence against lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people is a significant but under-documented public health concern. Available evidence indicates a clear concentration of lethal violence among transgender women. The most comprehensive global dataset on killings of gender-diverse people—the Trans Murder Monitoring project—shows that over 90% of documented victims are transgender women or transfeminine people, with the majority of cases occurring in Latin America and the Caribbean and frequently involving firearms (Transgender Europe, 2023).

Second, **beyond fatalities, firearms are used by perpetrators as a means of exerting control**. Evidence from perpetrator self-reports indicates that one in eight men convicted of IPV has used a gun to threaten a partner, creating a credible fear of death and, for some, preventing relationship exit (Tobin-Tyler, 2023). The very presence of a gun in an abusive situation is profoundly harmful, and non-lethal firearm use—threatening with a gun, displaying a weapon, or firing shots without causing injury—is widespread. Such acts heighten fear and may suppress disclosure, restrict mobility, and can prevent women from leaving abusive partners (Sorenson & Schut, 2016; SEESAC, 2025). However, in some cases, abused women say that the threat with a gun was the incident that persuaded them to leave (Campbell et al., 1998).

Emerging evidence increasingly recognises firearm-related abuse as a distinct form of violence rather than simply a precursor to homicide. Survivors report that firearms are frequently used to intimidate, monitor, coerce, facilitate sexual violence, threaten suicide, and create a persistent fear of death. In many cases, these behaviours occur without a firearm ever being discharged, yet profoundly constrain women's autonomy, mobility, help-seeking, and ability to leave abusive relationships (Hope and Heal Fund & Battered Women’s Justice Project, 2025; Sorenson & Schut, 2016).

Third, **evidence linking perpetrators of IPV to mass shootings further undermines the artificial distinction between “private” domestic violence and “public” gun violence**. A majority of mass shootings in the United States are linked to domestic violence; analysis of Gun Violence Archive data found that 59.1% were domestic violence–related and 68.2% involved either family victims or a perpetrator history of domestic violence (Geller et al., 2021; White House, 2023). Failure to intervene in IPV contexts therefore represents a missed opportunity for broader firearm-violence prevention (Tobin-Tyler, 2023; Geller et al., 2021).

Fourth, **firearms intersect with sexual violence**. While the role of firearms in femicide is sometimes documented, their role in sexual violence remains significantly under-examined within global health policy and surveillance systems. Evidence from South Africa indicates that among the relatively small proportion of women who reported a rape to police, 7% indicated a gun was used to threaten them—second after knives at 18% (Machisa et al., 2017). Similar research is hard to find and urgently needed.

Fifth, **available data from a small number of contexts indicate that 70–90% of recorded incidents of conflict-related sexual violence involved weapons, especially firearms**. Publicly available data on CRSV, and on the weapons involved, remain sparse, but the limited disaggregated evidence that exists is consistent on this point (Salama, 2023). In a companion paper, Kengela and Peacock (forthcoming) illustrate how in conflict and post-conflict settings, the nexus of land dispossession, extractive industries, armed security companies (sometimes paramilitaries), and the subsequent proliferation of firearms often contributes to generalised violence, with sexual violence against women a common feature.

Current evidence as the tip of the iceberg: Inadequate surveillance and global data systems

Despite the role firearms play in various forms of violence against women, global data systems remain limited in their ability to capture these firearm-related harms.

A significant proportion of female homicides—estimated at roughly four in ten globally—cannot be classified as gender-related killings due to missing contextual information, including relationship to the perpetrator and weapon type (UNODC & UN Women, 2022a). This limits the ability to identify risk factors, track trends, and design targeted prevention strategies.

A further limitation is the near absence of systematic data on non-fatal firearm violence in GBV contexts. Evidence suggests that millions of women have experienced firearm threats from intimate partners, yet these incidents are rarely captured in official statistics (Sorenson & Schut, 2016). As a result, the burden of firearm-related GBV is substantially underestimated, and critical opportunities for early intervention are missed. This is true, too, even for WHO reports on IPV during pregnancy and the postpartum period (WHO, 2011).

Sexual violence datasets often do not disaggregate by weapon type, and firearm surveillance systems typically focus on fatal or non-fatal gunshot injuries rather than threats. Where firearm involvement in sexual violence is not recorded, it is unlikely to be integrated into risk assessment tools, protection-order protocols, or prevention guidance. Recognising firearm-enabled sexual violence as part of the continuum of coercive control strengthens the case for integrating firearm risk into health-sector guidance, multisectoral GBV responses, and emergency and trauma care.

Existing data systems do not routinely disaggregate violence by sexual orientation, gender identity, and weapon type, limiting the ability to assess patterns of risk and to design targeted prevention strategies (United Nations Human Rights Council [UNHRC], 2018). The absence of sexual orientation and gender identity variables in violence surveillance systems, combined with limited attention to firearm risk, results in the systematic exclusion of LGBTQI+ populations from GBV and injury-prevention frameworks.

Strengthening data systems to capture firearm involvement across the full continuum of GBV is therefore essential to improving prevention and reducing femicide. The WHO is well positioned to support Member States in addressing these gaps by promoting more inclusive surveillance systems and by incorporating firearm-related risk into GBV and violence-prevention guidance.

Firearm violence, care burdens, and gendered health system impacts

The effects of firearm violence on women extend well beyond direct victimisation and reflect broader structural relations of inequality. Consistent with global evidence that women perform most unpaid care and are the majority of care workers (International Labour Organization, 2018), women overwhelmingly shoulder long-term care for survivors of firearm injury. Daily care tasks like bathing, toileting, turning to prevent pressure sores, managing medications, and transporting survivors to clinics are most often provided by mothers, partners, or daughters. When families lose a member to gun violence, women are also disproportionately responsible for grief care, household stabilisation, and engagement with institutions such as police, courts, and health services (Mohammed et al., 2023). These burdens are not evenly distributed. Women in low-income households, in communities with chronically under-resourced public services, and in settings where caregiving falls outside formal support systems bear a disproportionate share—often with little institutional recognition or relief.

Within health systems, firearm injuries add to already heavy workloads borne primarily by women. Nursing, emergency care, trauma care, mental health services, and physical rehabilitation are female-dominated professions. In communities, the social workers, mental health professionals, and non-governmental organisation workers are also mostly women. As firearm injuries surge, women providers experience increased exposure to severe trauma, burnout, and secondary stress (Engel et al., 2020; Barnard et al., 2023). Health care systems occupy a uniquely exposed position within firearm violence ecosystems. They are the institutions responsible for treating gunshot injuries, yet they are also workplaces in which armed individuals sometimes enter emergency departments, threaten staff, or commit acts of violence (Agard et al., 2025; Dorn de Carvalho et al., 2025; MSF, 2025). Even when firearms are not discharged inside hospitals, the cumulative exposure of clinical teams to severe gunshot trauma functions as an occupational hazard in its own right (Ward et al., 2006).

Gun violence thus reinforces gendered care burdens at both household and system levels and does so most severely where existing inequalities leave women with the least capacity to absorb them.

Firearms, GBV, and country-level evidence

We turn now to examine the extent of firearm involvement in femicide and intimate partner violence in Brazil, Mexico, the Western Balkans, and South Africa. We have selected these four settings because recent detailed reports have been released on specific aspects of gun violence and GBV in each, and also to contribute to an existing research base that typically foregrounds studies from the global north.

Brazil: Firearms, non-lethal IPV, and a visible prevention window

Brazil provides one of the most detailed national pictures globally of how firearms shape both lethal and non-lethal violence against women, largely because firearm violence is captured not only through mortality statistics but also through mandatory health-sector notification of interpersonal violence. This dual data architecture allows unusually clear insight into escalation pathways from psychological abuse including coercive and controlling tactics and non-lethal firearm IPV to femicide.

Using national mortality data (SIM), Instituto Sou da Paz estimates that approximately 1,877 women were killed by firearms each year between 2020 and 2024, accounting for around half of all female homicides. In 2024, 47% of all women murdered in Brazil were killed with a firearm (Instituto Sou da Paz, 2026).

It is worth distinguishing two things these figures capture. The proportion of femicides involving a firearm reflects how often guns are used; it is a separate question, addressed below, whether a gun makes a given violent act more likely to prove fatal. The São Paulo comparison of attempted and completed femicides speaks directly to the latter, and it is this lethality effect - rather than prevalence alone - that makes firearm access a modifiable determinant of femicide even where guns are not the single most common method of killing.

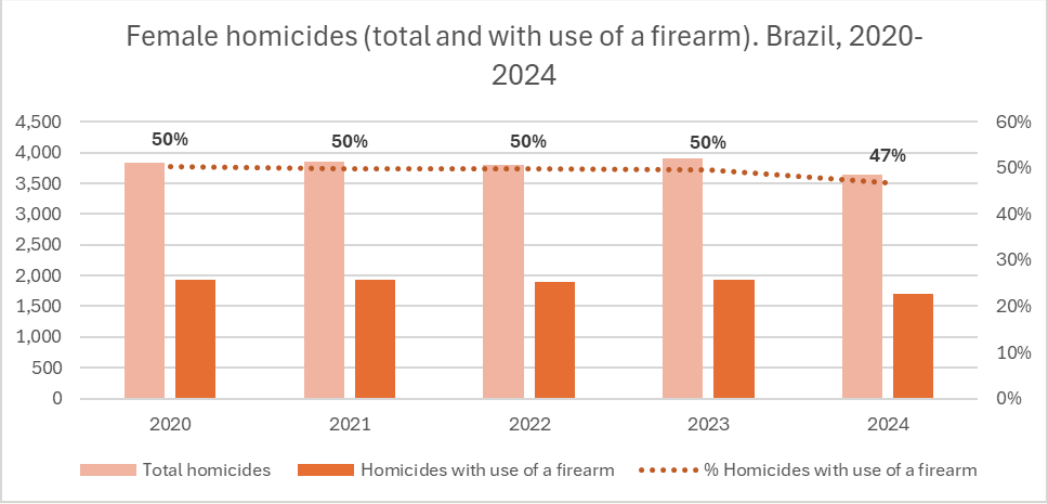

Figure 1. Source: National Mortality Information System (SIM)

Although firearm homicide is often framed as a public-space phenomenon associated with organised crime, the domestic sphere is a central site of risk for women: 25% of female firearm homicides occur in the home, compared with 12% among men, and 41% of female homicides in the home involve a firearm (Instituto Sou da Paz, 2024).

The gendered nature of firearm risk becomes even clearer when non-lethal violence is examined. A comparison of attempted femicides in which the victims survived and femicides in which the victims died, using data from the Public Security Department of São Paulo State, found that the use of firearms increased the lethality of the cases by 85%, leaving almost no chance of rescue and little chance for those women to seek help and change their lives (Instituto Sou da Paz, 2026; Sousa, 2026).

Drawing on the national notifiable disease surveillance system (SINAN), Sou da Paz also documented nearly 4,400 cases of non-lethal firearm violence against women in 2024 alone, 44% of which occurred in the home.

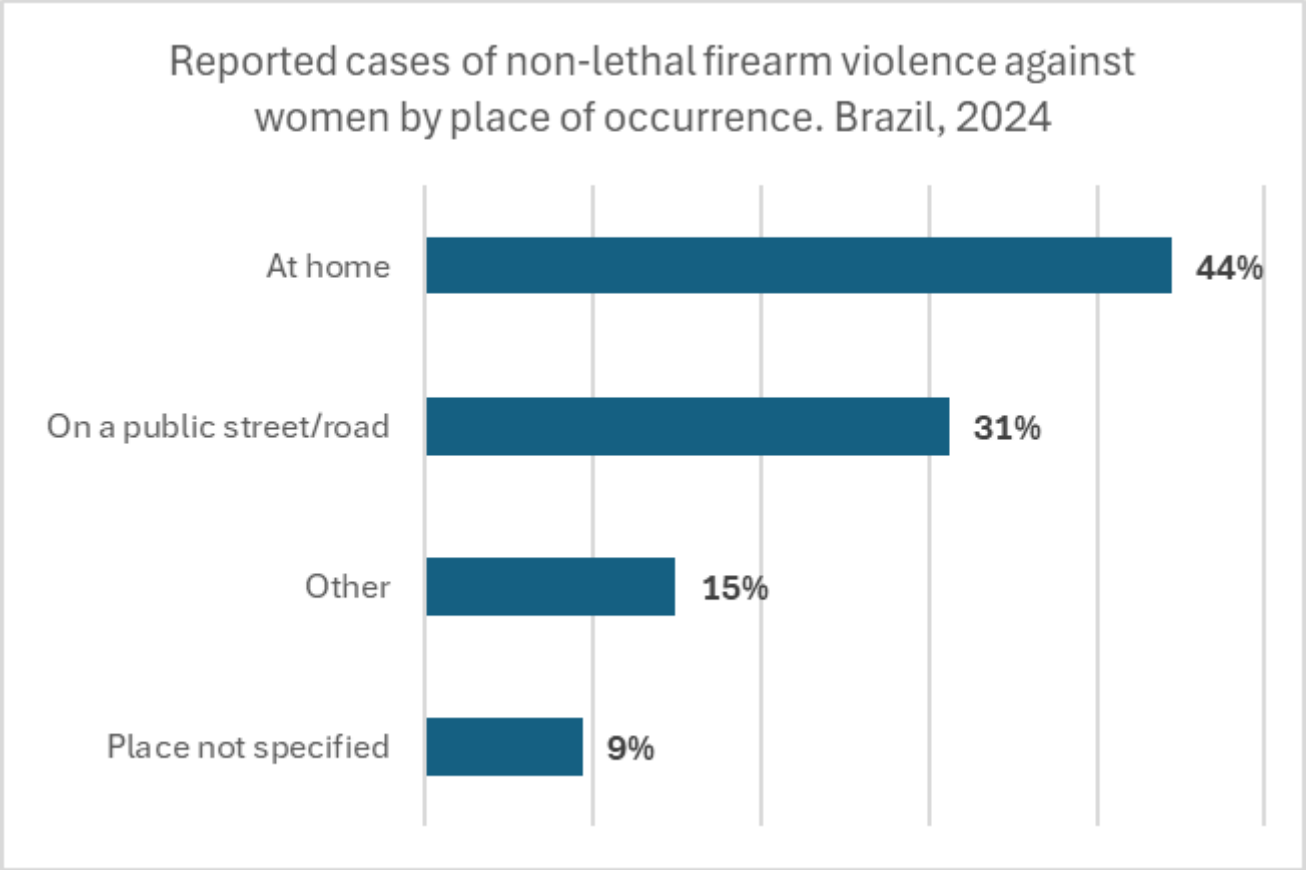

Figure 2. Source: National Notifiable Disease Surveillance System (SINAN)

Intimate partners or ex-partners accounted for about a quarter of identified perpetrators, making them the largest known perpetrator category. Firearms were frequently used to threaten, intimidate, and enforce psychological and sexual violence, not only to inflict physical injury (Instituto Sou da Paz, 2026).

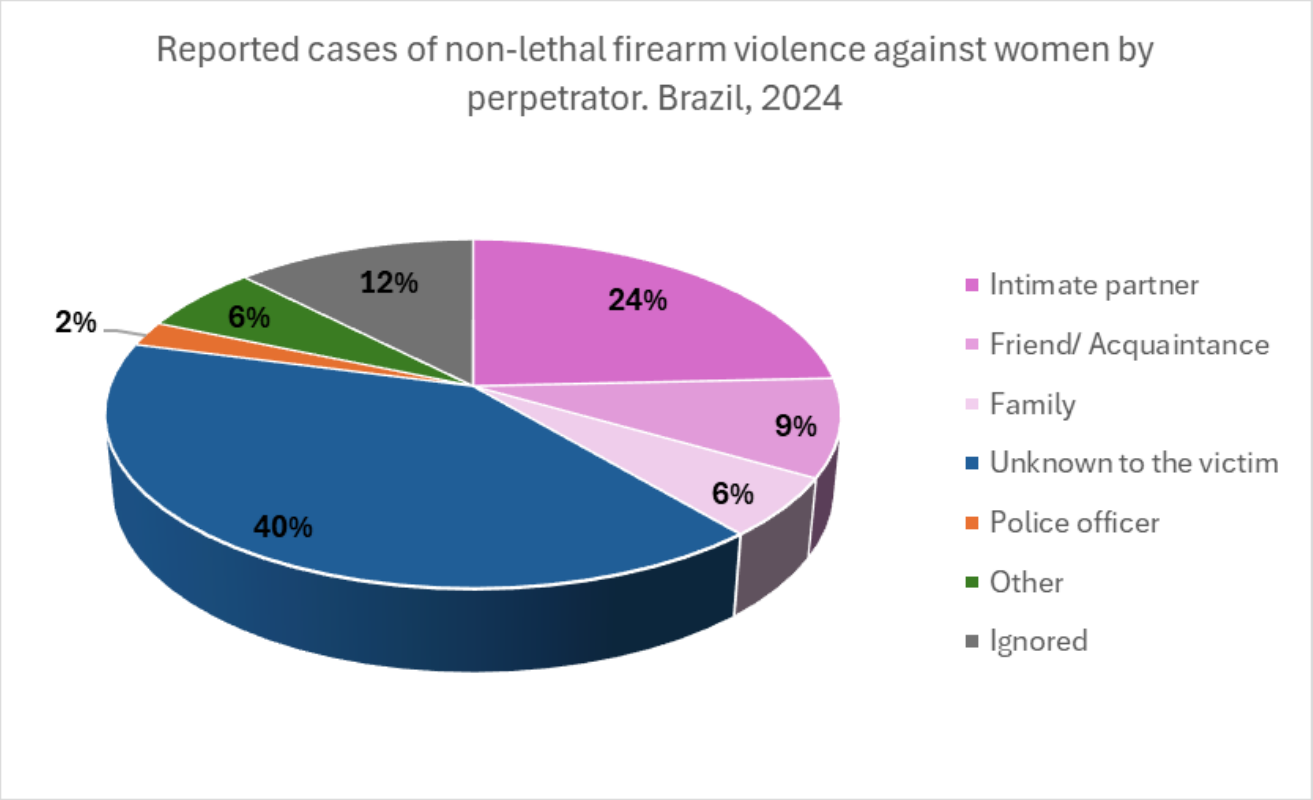

Figure 3. Source: National Notifiable Disease Surveillance System (SINAN)

One-third of cases involved repeat violence, a defining feature of the severest forms of intimate partner violence and an important predictor of escalation to lethal harm. Longitudinal analyses linking health and mortality databases show that women with a documented history of intimate partner violence face a substantially higher risk of subsequent homicide, with firearms posing the greatest risk of death compared with other means (Barufaldi et al., 2017; Pinto et al., 2021; Pinto et al., 2025).

These findings highlight the central role of health services in identifying escalation risk. A pilot project mapping care trajectories of women victims of violence in a Brazilian state capital found that most cases were only formally reported when victims reached hospital emergency services, despite earlier contacts with primary care. This underscores the unrealised prevention potential of health systems in interrupting cycles of firearm-related IPV before they culminate in femicide (Vital Strategies, 2025). This potential was also noted in US research (Sharps et al., 2001).

A sample analysis using data from the Public Security Department of the Federal District in Brazil found that, of all femicides committed with firearms, 51% were committed with legally registered firearms (Rivers, 2024). These data underscore the role of legally registered firearms in violence against women, and thus the importance of integrating this perspective into national regulation on firearms access and cautionary measures, such as preventive seizure of aggressors' firearms.

Brazil's data thus demonstrate that the health system is already identifying high-risk firearm-related IPV well before femicide occurs. Despite existing legal guidance for medical staff to make a formal police record when identifying a case of violence against women, in practice such records are uncommon, owing both to a lack of resources and to a culture of preserving the victim's right to choose whether or not to report formally. The prevention gap, then, lies not in health sector detection, but in the absence of institutionalised pathways linking health-sector notification to the offer of information on women's rights, the provision of safe spaces and social assistance, support in laying charges, and formal police consequences for aggressors, including firearm removal and licensing review. As a result, women's rights

advocates have trained and supported medical staff to know how to approach an identified victim and have social service professionals available to talk with them about their rights and the importance of a formal police report, but such efforts need to be expanded and institutionalised.

Mexico: The proliferation of firearms and the transformation of lethal violence against women

Mexico's security crisis, which intensified with the campaign against cartels that began in 2006, has resulted in more than 450,000 alleged homicides between 2006 and 2025. The scale of this crisis is reflected in the national homicide rate, which more than doubled over this period, rising from 10 homicides per 100,000 inhabitants in 2006 to 25 per 100,000 in 2024[2]. This security crisis has directly influenced the proliferation of firearms and their widespread use in Mexico.

This is particularly significant given that civilian firearm ownership in Mexico is severely restricted by law. With only one legal gun store in the entire country, operated by the military and strict regulations limiting civilian access, the widespread use of firearms in homicides points to the scale of illegal arms trafficking and the failure of regulatory frameworks to contain it. The proliferation of illegal weapons has fundamentally altered the landscape of lethal violence, making firearms accessible not only in organised crime contexts but increasingly in domestic and interpersonal settings.

Despite major legal advances in Mexico, such as recognising femicide in 2012 and adding gender-based aggravating factors, policies addressing violence against women and marginalised groups rarely consider the role of firearms. This omission leaves a critical gap in prevention efforts, compounded by ongoing problems in how violence is recorded and classified.

Between 2005 and 2024, the proportion of female homicides committed with firearms more than doubled, rising from 31% to 63%. This increase reflects not only a quantitative change but also a displacement of other methods: in 2005, homicides of women were distributed across several means, such as hanging (22%) and sharp weapons (18%), whereas by 2024, firearms alone account for nearly two-thirds of cases, with all remaining methods combined representing less than 40%.[3]

> **“Health and justice systems can identify risk before lethal outcomes occur.”**

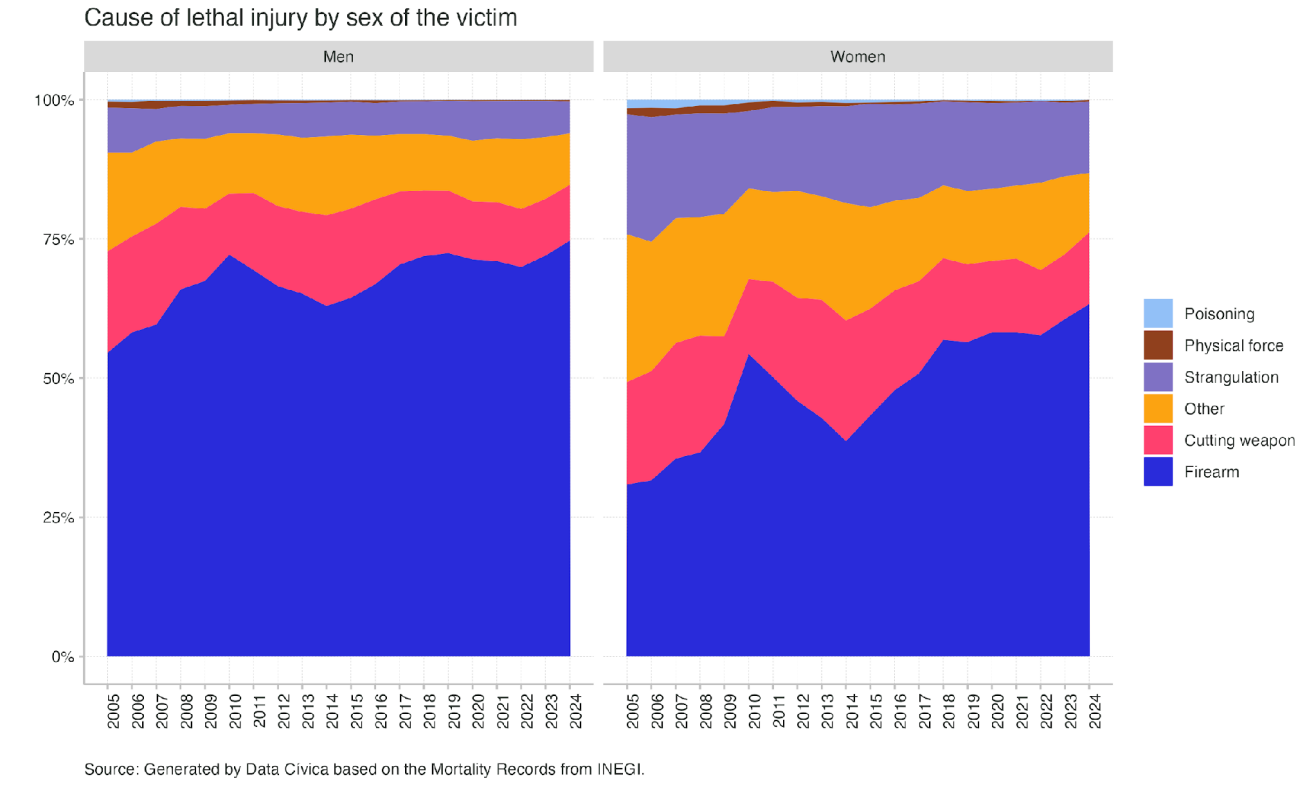

Figure 4: Cause of fatal injury by sex of victim in Mexico

This shift also suggests changes in the contexts in which violence against women occurs, including an escalation in the severity and lethality of attacks. Firearms, due to their deadly efficiency, drastically increase the likelihood that violent encounters result in death, which poses significant challenges for prevention and intervention efforts. Understanding this evolving pattern is crucial for developing targeted public policies and strategies that address the specific risks posed by firearms in the context of gender-based violence.

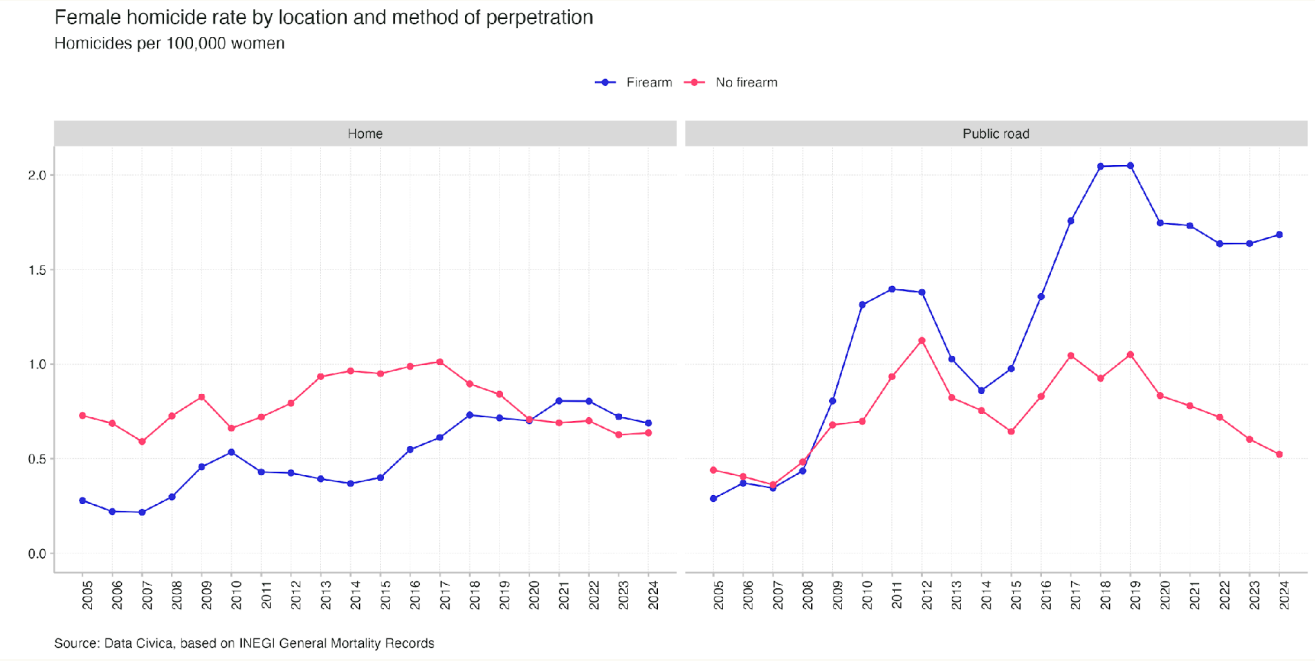

Figure 5: Homicide rate for women by location and method of perpetration in Mexico

Another pattern that has shifted over time is the method of homicide by place of occurrence. Prior to 2021, the majority of female homicides occurring within private residences were carried out using methods other than firearms. However, beginning in 2021, firearm use in household homicides exceeded 50% for the first time, reaching 54%, reflecting a notable shift in the dynamics of domestic violence. In public spaces, firearms had already been the leading method since at least 2005, consistently accounting for more than half of all cases.[4]

This convergence indicates that the lethality of violence against women is no longer strongly determined by the context of the attack: whether a homicide occurs at home or in public, firearms are now the most likely instrument of perpetration. The growing presence of firearms in household settings highlights how lethal firearm violence has expanded into domestic environments, where violence against women has traditionally been associated with other forms of aggression.

Together, these trends suggest that the proliferation of firearms in Mexico has reshaped the patterns of lethal violence against women, increasing both the lethality of violent incidents and the likelihood that domestic or interpersonal conflicts escalate into fatal outcomes. The centrality of firearms in both public and private contexts underscores the urgent need for targeted policies and interventions that address gun availability and regulation as a key component in preventing lethal violence against women.

Despite ongoing efforts to produce data disaggregated by sociodemographic characteristics, significant gaps remain. Key variables such as skin colour, occupation, sexual orientation, and the relationship between victim and perpetrator continue to suffer from substantial under-registration, limiting our ability to fully understand how these factors shape exposure to firearm-related violence.

Firearm violence in Mexico illustrates that national regulatory frameworks are insufficient when they are not accompanied by regional arms-control mechanisms and serious enforcement of illegal trafficking. The failure to contain gun violence in Mexico is not primarily a failure of domestic law design; it is a failure of bilateral and multilateral arms governance. Available evidence indicates that the overwhelming majority of firearms recovered at Mexican crime scenes originate in the United States, where purchasing regulations are substantially more permissive and cross-border trafficking has proceeded largely unchecked for decades. We address the broader implications of this later in this report.

Western Balkans: Domestic violence as the most lethal firearm context

Research conducted by the South Eastern and Eastern Europe Clearinghouse for the Control of Small Arms and Light Weapons (SEESAC) shows that between 2019 and 2023, firearm incidents linked to domestic violence resulted in more deaths than incidents associated with criminal activity or public disputes (SEESAC, 2025). Policy attention continues to prioritise public and criminal gun violence, while domestic settings account for the highest lethality for women.

> **“Firearm access is not fixed or inevitable; it is shaped by licensing systems, firearm removal mechanisms, safe-storage requirements, enforcement practices, and broader regulatory environments.”**

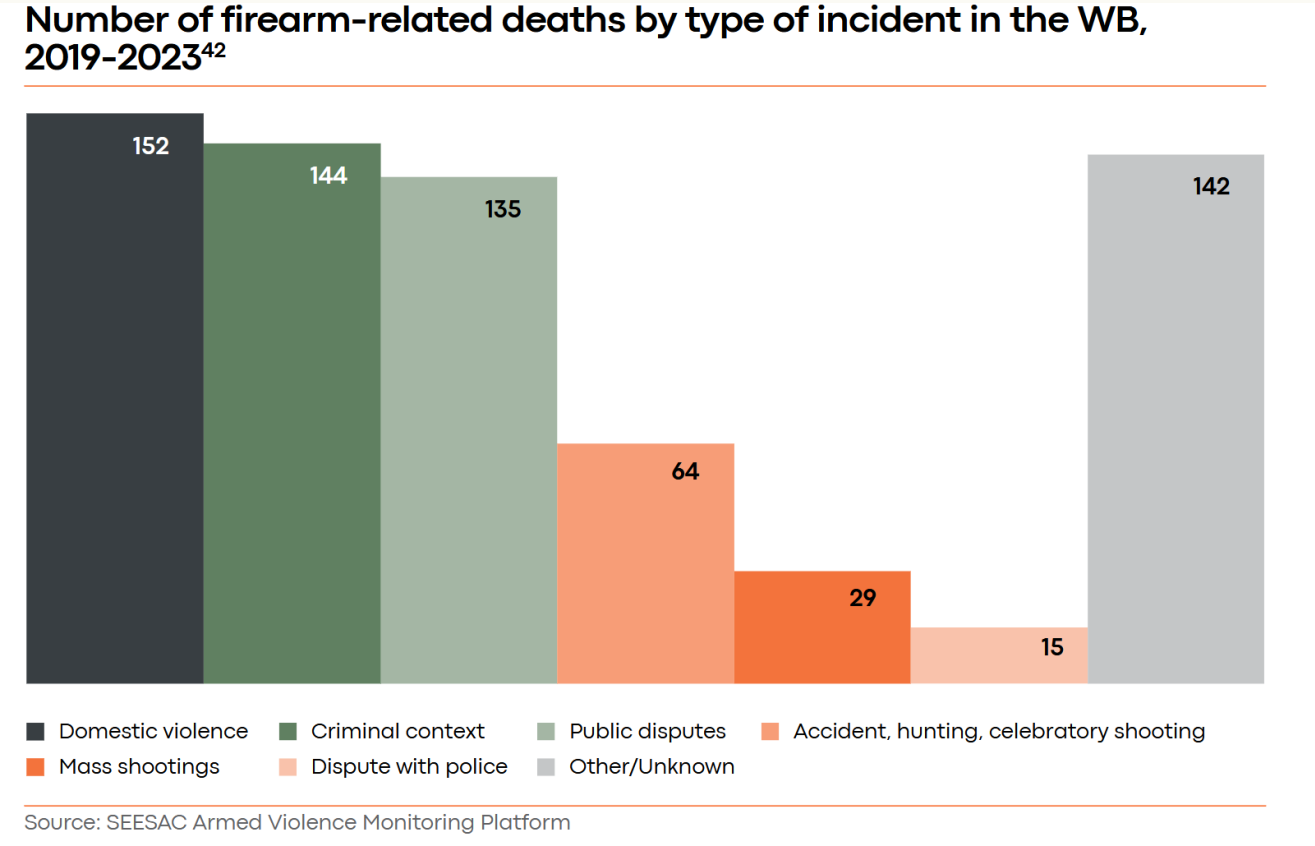

Figure 6: Number of firearm-related deaths by type of incident in the Western Balkans, 2019-2023

The gendered nature of this risk is stark. Approximately two-thirds of women killed with firearms in the region are killed in domestic-violence contexts, most often by current or former intimate partners or family members (SEESAC, 2025). Men are more likely to be shot in public or criminal settings.

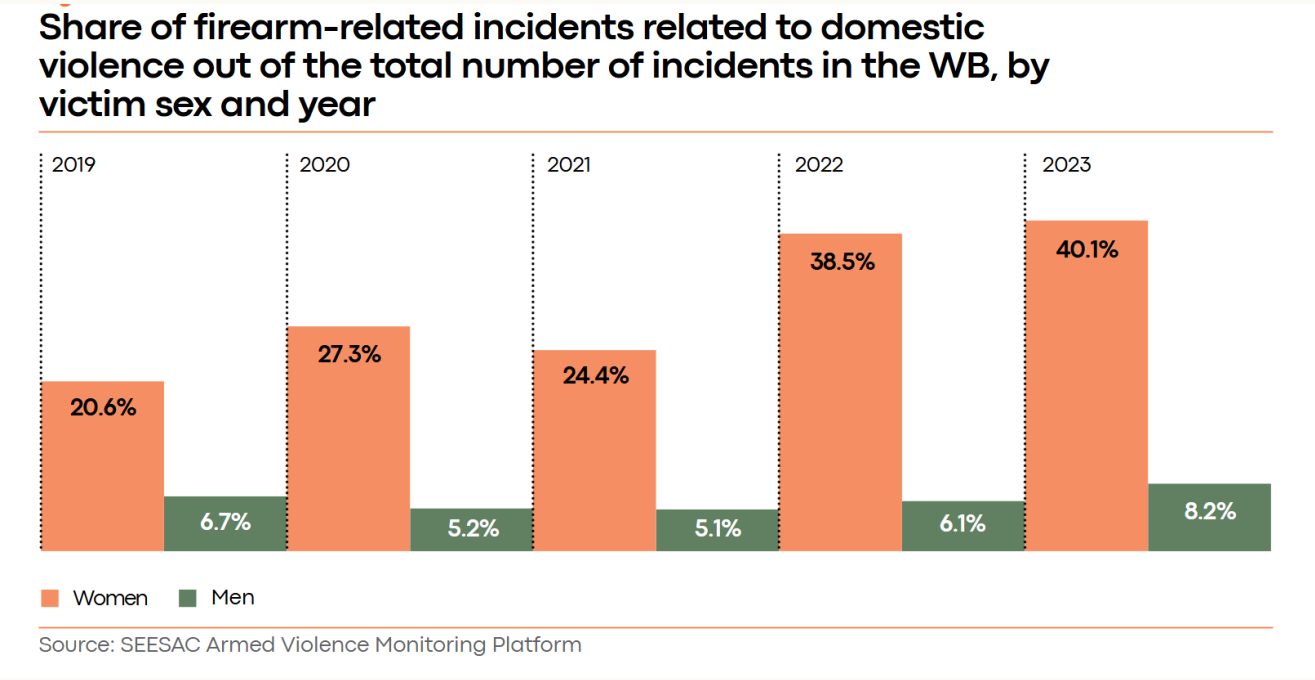

Figure 7: Firearm-related domestic violence incidents

This divergence reflects broader global patterns but is intensified in the Western Balkans by the legacy of armed conflict and the continued circulation of small arms within households.

Firearms in these contexts function as instruments of lethal violence and as tools to assert control. Survivors report that the presence of a firearm creates a persistent and credible threat that suppresses disclosure, constrains mobility, and prevents exit from abusive relationships. Non-lethal firearm threats—such as brandishing or verbal threats involving a weapon—are widespread but poorly captured in official data, rendering much of the harm invisible until it becomes fatal.

A key structural factor underlying these dynamics is institutional fragmentation. Responsibilities for small-arms control, domestic violence prevention, and women's protection are often distributed across separate ministries, legal frameworks, and data systems. This fragmentation allows firearm-related risk in domestic settings to fall between policy silos, limiting both prevention and accountability (SEESAC, 2025).

Taken together, the Western Balkans case highlights a critical policy failure: the contexts in which firearms are most lethal for women receive limited regulatory and programmatic attention. Addressing firearm-related GBV in the region therefore requires stronger enforcement of existing laws and the systematic integration of firearm risk into domestic violence prevention, protection, and response frameworks.

South Africa: Firearm regulation, femicide reduction, and the costs of weak enforcement

South Africa's rate of intimate partner femicide is one of the highest in the world, almost five times higher than the global average (Abrahams et al., 2025). A 2024 review of femicide in South Africa indicates that guns were "the most common manner of death in which women were killed" whereas previously it had been stab wounds or blunt force (Abrahams et al., 2024, p. 4).

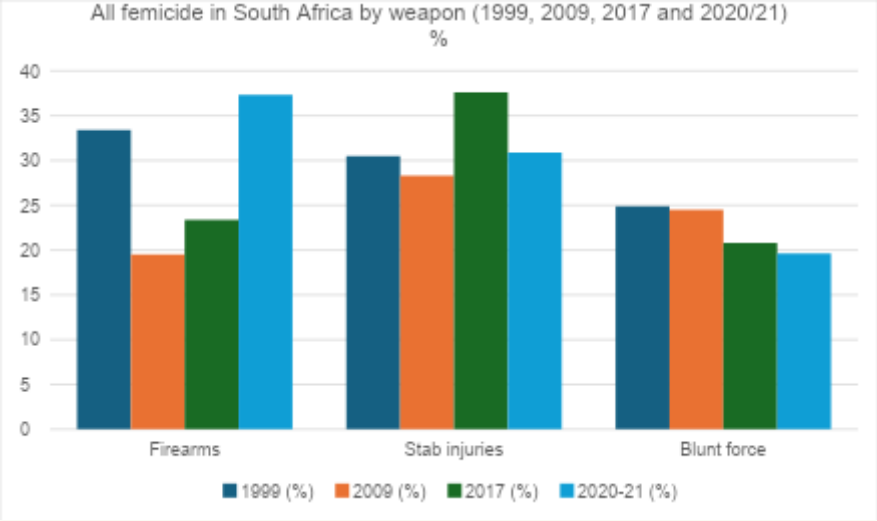

Figure 8: All femicide in South Africa by weapon (1999, 2009, 2017 & 2020/21) %

South Africa provides some of the strongest longitudinal evidence globally that firearm regulation can reduce femicide at scale, while also illustrating the consequences of weak implementation. Four nationally representative femicide studies conducted by the South African Medical Research Council (1999, 2009, 2017, 2020/21) document a substantial decline in overall femicide between 1999 and 2017, with the largest reductions occurring in gun-related killings (Abrahams et al., 2025). During this period, gun-related femicide declined from approximately one-third of cases to around one-fifth.

This decrease coincided with the implementation of the Firearms Control Act (FCA) of 2000 and a period of active enforcement of adherence to its regulations. This included strengthened licensing requirements, competency testing, firearm recovery operations, and amnesties (Taylor, 2019). Analyses attribute thousands of lives saved to reduced firearm availability, consistent with international evidence that limiting access to highly lethal means yields disproportionate reductions in mortality (Matzopoulos et al., 2019; Santaella-Tenorio et al., 2016).

These gains have proven reversible. From 2017 onwards, gun-related femicide increased sharply, catching up with earlier increases in male firearm homicides. By 2020/21, gunshots accounted for more than one-third of femicides, the highest proportion recorded in two decades (Abrahams et al., 2025).

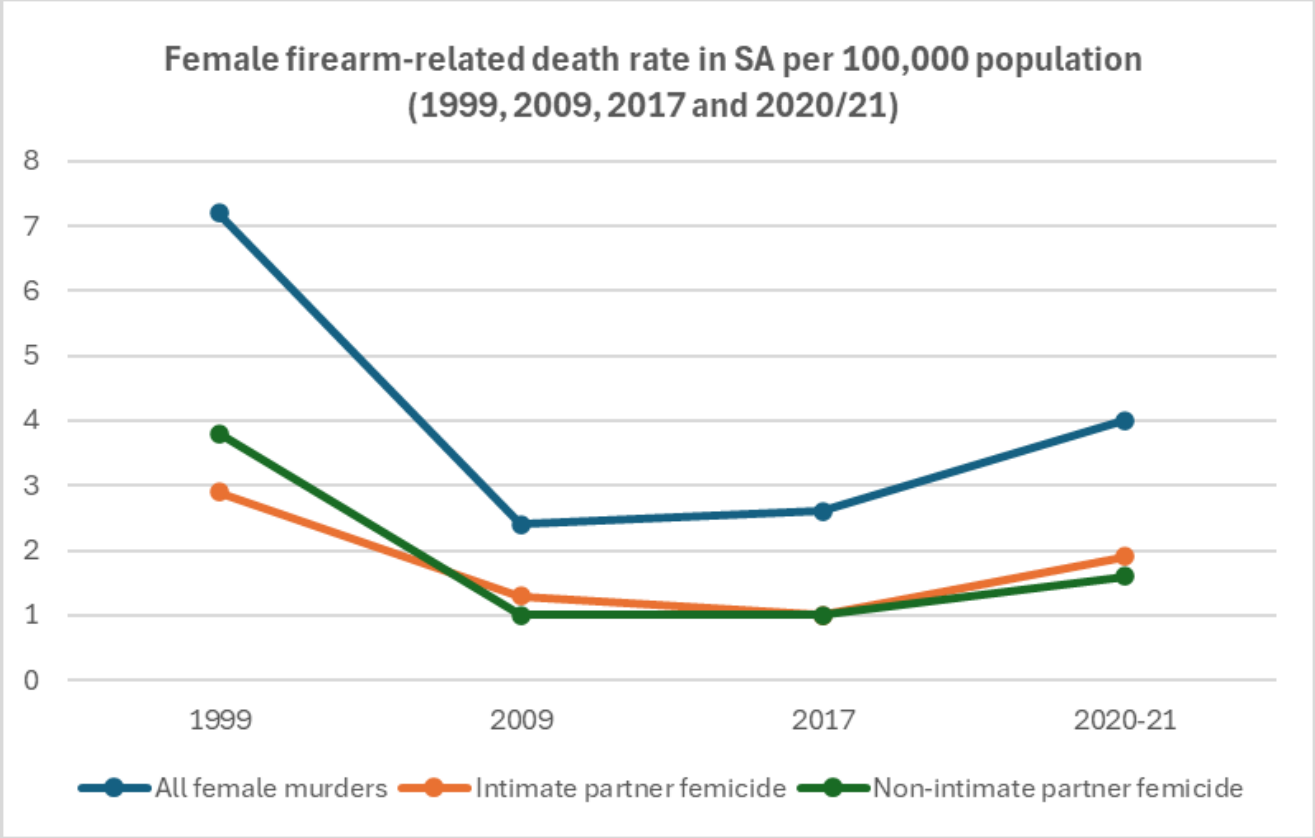

Figure 9: Female firearm-related death rate in South Africa per 100,000 population (1999, 2009, 2017 & 2020/21)

This shift reflects both increased firearm availability and systemic failures in regulation and enforcement, including dysfunction in the Central Firearms Registry, growth in applications for and granting of firearms licenses– which are disproportionately used in intimate partner femicide-suicide, and persistent failures to remove firearms in IPV contexts (Gun Free South Africa, 2025).

“Firearm regulation can produce substantial and sustained reductions in femicide when effectively implemented.”

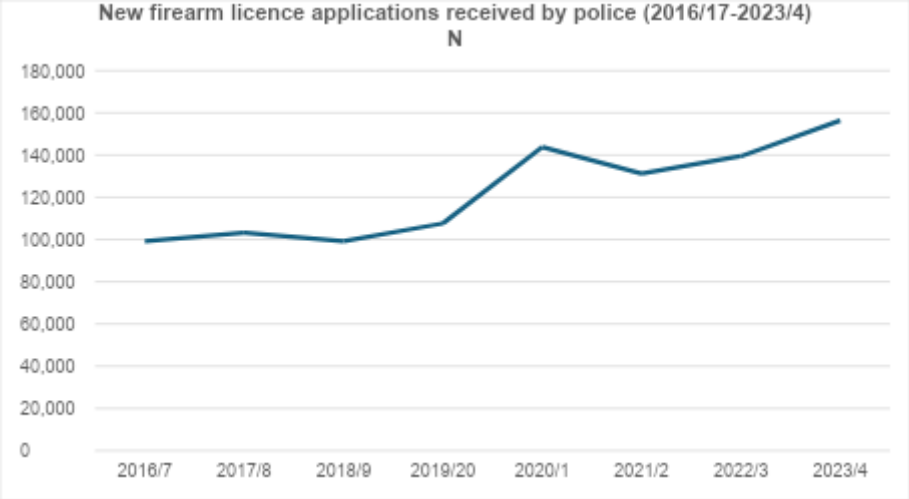

Figure 10: New firearm licence applications received by police (2016/17-2023/24) N

Institutional responses to firearm-related domestic violence reveal a critical gap between policy and practice. When firearms are identified in protection-order applications and IPV complaints, removal is inconsistently ordered and poorly enforced. Courts retain broad discretion, and police implementation is uneven, even in cases involving credible threats. Occupational firearms, including those held by security personnel, who are disproportionately represented as perpetrators of IPV, are often exempted despite this elevated risk (Vetten, 2025). These failures allow known risks to persist within domestic environments.

At the same time, national GBV policy has not systematically integrated firearm risk. South Africa's 2020-2030 National Strategic Plan on Gender-Based Violence and Femicide (Department of Women, Youth and People with Disabilities, 2020) does not include a substantive focus on firearms, despite strong national evidence of their role in femicide. This omission reflects a broader pattern in which firearm regulation and GBV prevention operate in parallel rather than in coordination.

In response to these gaps, the South African Medical Research Council has developed a draft National Integrated Strategy on the Prevention of Femicide that embeds firearm risk within prevention and response. The strategy includes several elements with broader applicability.

First, it proposes specialised femicide units with end-to-end responsibility for investigation and case management, supported by trained multidisciplinary teams. These units are designed to ensure rapid response, consistent oversight, and integration with surveillance systems such as Femicide Watch.

Second, it integrates prosecutorial and social support functions within investigation teams, strengthening both legal outcomes and engagement with affected families. This model recognises that femicide cases require coordinated responses across justice and social systems.

Third, it standardises investigative and training protocols, including danger assessment, recognition of coercive control, and the identification of femicide patterns. These elements address known gaps in risk recognition and institutional bias.

Fourth, and most critically, it embeds firearm-specific prevention measures. These include stricter enforcement of licensing criteria, systematic identification of firearm access in domestic violence cases, and a shift from discretionary authority to a clear obligation to remove firearms where there is a history of abuse, credible threat, or protection order. The strategy also calls for strengthened training for police, prosecutors, and judicial officers on firearm law and IPV-linked risk (South African Medical Research Council, 2023).

The South African case demonstrates two central findings. First, firearm regulation can produce substantial and sustained reductions in femicide when effectively implemented. Second, these gains are contingent on consistent enforcement, institutional coordination, and the integration of firearm risk into GBV prevention and response systems. Where these elements weaken, lethality increases.

These findings have broader implications for global health policy. They show that firearm access is a modifiable determinant of femicide, that health and justice systems can identify risk before lethal outcomes occur, and that failure to act on this information results in preventable deaths. Integrating firearm removal, risk assessment, and surveillance into GBV frameworks is therefore essential to effective prevention.

Implications of findings from Brazil, Mexico, the Western Balkans, and South Africa for global health policy and practice

The findings from Brazil, Mexico, the Western Balkans, and South Africa reveal consistent patterns in how firearm access shapes the trajectory and lethality of violence against women. Across diverse legal systems and levels of firearm regulation, three interrelated dynamics emerge: the central role of firearms in escalating violence to fatal outcomes, the persistence of non-lethal firearm threats as part of psychological IPV and controlling behaviour, and recurring institutional failures to remove firearms from men who pose a known risk to women. Together, these point to two critical actions: integration of firearm risk into GBV prevention frameworks and the need for national, regional and global regulations restricting access to firearms, especially in those countries with easy access to firearms.

The central role of firearms in escalating violence to fatal outcomes: evidence shows that firearm access functions as a critical escalation mechanism. In each context, lethal violence is typically preceded by documented histories of abuse, threats, and repeated violence. Where firearms are available, these patterns are more likely to culminate in femicide. This underscores the importance of recognising firearm presence as a high-risk indicator within the continuum of GBV, rather than treating lethal outcomes as isolated events.

Health systems detect risk, but detection is not linked to prevention : In Brazil, routine health-sector notification data reveal clear escalation pathways from non-lethal firearm violence to femicide. Similar patterns are evident in other settings, where survivors frequently report threats involving firearms prior to lethal incidents. However, these signals rarely trigger coordinated responses involving law enforcement, firearm removal, or protection services. This gap reflects a broader failure to translate risk detection into risk reduction.

Institutional fragmentation undermines firearm removal: Institutional fragmentation consistently undermines prevention. Across all four contexts, responsibility for firearm regulation, GBV prevention, and victim protection is distributed across separate systems with limited coordination. This fragmentation allows firearm-related risk in domestic settings to fall between policy domains, weakening accountability and delaying intervention. Even where legal frameworks permit firearm removal in cases of domestic violence, implementation is inconsistent, discretionary, or poorly enforced.

From a public health perspective, these findings have important implications for priority setting. Public health institutions routinely focus attention on risk factors that are both strongly associated with adverse outcomes and amenable to intervention. Across multiple settings, firearm access emerges as one of the most powerful predictors of whether violence against women becomes fatal. At the same time, firearm access is not fixed or inevitable; it is shaped by licensing systems, firearm removal mechanisms, safe-storage requirements, enforcement practices, and broader regulatory environments. If the objective is reducing femicide, firearm access therefore warrants attention not simply because it is associated with lethal outcomes, but because it represents one of the most significant and potentially modifiable determinants of lethality currently identified in the evidence base (Abrahams et al., 2013; Campbell et al., 2003; Santaella-Tenorio et al., 2016; UNODC & UN Women, 2022).

Taken together, these findings point to two clear implications for global health policy.

First, reducing femicide requires the integration of firearm risk into GBV prevention frameworks at both the clinical and population levels. Health systems play a critical role in identifying and responding to risk. However, it is important to be clear about what constitutes the most effective strategy to address the role of firearms in lethal and non-lethal violence against women. Sustained reductions in lethal violence depend on legal and regulatory frameworks that restrict access to firearms among individuals at risk of perpetrating violence, particularly in intimate partner contexts (Santaella-Tenorio et al., 2016). The role of safe-storage regulation also warrants further investigation: cross-national differences in regulatory regimes—for example, between Canada and the United States, which differ markedly in safe-storage requirements as well as in rates of female homicide—suggest a plausible but as yet under-examined contribution that merits dedicated comparative research.

Second, regulatory frameworks cannot be limited in their scope to national laws. Countries with restrictive domestic laws remain exposed to lethal harm when neighbouring states maintain permissive regimes. As we have seen, the crisis of firearm violence in Mexico illustrates this clearly. Restrictive domestic laws in Mexico—and in other countries in the region—are unlikely to achieve their protective potential while large volumes of weapons continue to flow across the border from the United States, where purchasing regulations are substantially more permissive. Recent US policy developments point in the opposite direction, including the rollback of export due-diligence rules, reductions in the capacity of federal firearms oversight bodies, and active promotion of international gun sales (Everytown for Gun Safety, 2025; Muggah, 2022; Thrush, 2025).

“In each setting, firearm access emerges as one of the strongest and most modifiable predictors of whether violence against women becomes fatal.”

Identifying blind spots in WHO and other UN agency work on IPV

Over the past three decades, WHO's violence-prevention teams have played a pioneering role in establishing violence against women and violence against children as global public health priorities, helping to develop influential frameworks including the World Report on Violence and Health, INSPIRE, RESPECT Women, and WHO clinical guidance on intimate partner and sexual violence. These achievements have often been realised despite limited staffing, chronic resource constraints, and complex geopolitical dynamics within the World Health Assembly and broader UN system.

As documented elsewhere, efforts to elevate firearm violence within WHO have faced sustained resistance from some Member States—notably the United States—as well as ambivalence from several firearm-manufacturing states and concern within WHO about entering politically polarised terrain (Peacock et al., 2025). WHO staff working on violence prevention and emergency care have, in recent years, engaged constructively with researchers and advocates seeking stronger attention to firearm violence within public health frameworks. The analysis that follows should therefore be understood not as a critique of WHO programmes or staff, but as an examination of how institutional, political, and governance dynamics have contributed to a persistent blind spot in global health policy.

The declining visibility of firearms within WHO violence-prevention frameworks

The research report *Tracking the WHO's Attention to Firearm Violence, 2000–2025* documents a steady decline in WHO engagement with firearms as a public health issue over the past fifteen years (Peacock et al., 2025), including in areas where firearms are clearly implicated in violence against women and femicide. This decline has institutional roots worth naming. World Health Assembly Resolution 49.25 (1996)—the founding mandate for WHO's violence prevention work—called on WHO to develop science-based approaches to violence prevention as a public health priority. That mandate has always encompassed the full range of means by which violence is perpetrated, including firearms, as subsequent WHO publications in the early 2000s made clear (WHO, 2012). Over the following decade, WHO publications reflected this mandate, acknowledging firearms in discussions of homicide, injury, and intimate partner violence. Over time, however, firearms have been increasingly under-represented in GBV guidance, surveillance recommendations, and prevention frameworks—a retreat from, rather than an extension of, the original mandate. This omission shapes what health systems measure, what clinicians are trained to recognise, which interventions are prioritised and what laws and regulations are implemented.

In this way, the limited integration of firearm-related risk within WHO frameworks may contribute to broader blind spots in how women's firearm-related injury and death are recognised within global GBV prevention systems.

WHO data, guidance, and the visibility of firearm violence in UN approaches to GBV and femicide

The WHO has played a foundational role in establishing violence against women and violence against children (VAC) as core public health concerns. Over the past three decades, WHO has generated influential epidemiological research, clinical guidance, and multisectoral prevention frameworks that

have shaped national policy and practice globally. Frameworks such as RESPECT Women and INSPIRE represent major advances in evidence-based violence prevention and have helped mobilis e governments, donors, and civil society around coordinated responses to GBV and VAC.

Within the United Nations system, WHO plays a central role in shaping how violence is defined, measured, and addressed as a public health issue. Responsibilities relating to firearm violence, however, are distributed across multiple agencies and frameworks. UNODC and UNODA hold primary mandates relating to arms trafficking, criminal justice, disarmament, and implementation of international small-arms agreements, including the Firearms Protocol, the Programme of Action on Small Arms and Light Weapons, and the International Tracing Instrument. WHO's role is distinct but complementary: rather than regulating weapons, it contributes expertise in epidemiology, injury surveillance, violence prevention, emergency care, rehabilitation, mental health, and health-systems strengthening. WHO is also a member of the UN Coordinating Action on Small Arms (CASA), reflecting recognition within the UN system that firearm violence has important public health dimensions (Peacock et al., 2025).

WHO has repeatedly articulated within its own constitution, resolutions, reports, and technical guidance that violence prevention—including firearm-related violence—falls within its public health mandate. WHO's Constitution identifies the organisation as the directing and coordinating authority on international health work. World Health Assembly resolutions WHA49.25 (1996), WHA56.24 (2003), WHA67.15 (2014), and WHA69.5 (2016) all identify violence as a major public health issue requiring evidence generation, prevention, surveillance, and multisectoral response; the 2014 resolution, on strengthening the role of the health system in addressing violence, in particular against women and girls and against children, affirmed the responsibility of health systems to strengthen surveillance, provide clinical care, improve prevention, and collect evidence on effective interventions. WHO's *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*, endorsed by the World Health Assembly in 2016, explicitly identifies firearm availability as a cross-cutting determinant of interpersonal violence alongside harmful alcohol use, poverty, and weak law enforcement (WHO, 2016). Earlier WHO guidance on femicide also explicitly identified firearm access as a major risk factor for intimate partner homicide (WHO, 2012). The issue, therefore, is not whether WHO has a mandate to engage firearm violence as a health issue, but rather the extent to which firearm-related risks have been systematically integrated into WHO's more recent GBV, femicide, and violence-prevention frameworks and operational guidance. Annex 1 consolidates these and the other resolutions, mandates, and authoritative calls on which the present analysis rests.

WHO routinely addresses social, commercial, environmental, and behavioural determinants of health without assuming primary responsibility for regulating them. Harmful alcohol use, unsafe roads, poverty, adverse childhood experiences, harmful gender norms, and environmental pollution all fall within WHO's work because they shape health outcomes, injury, disability, and mortality. Firearm access can be understood in the same way: not as an arms-control issue per se, but as a determinant of injury severity, lethality, disability, trauma, and death. From this perspective, WHO's role is not to regulate weapons directly, but to generate evidence, strengthen surveillance, support prevention, improve clinical and public health responses, and make firearm-related harms visible within health policy and practice.

Through its authority over disease classification, injury surveillance, global estimates, and evidence-based guidance, WHO frameworks establish the technical foundations that inform the work of other UN agencies and the design of national policies. This agenda-setting function is particularly influential in the field of GBV, where WHO guidance has helped shape multisectoral prevention and response strategies adopted by Member States and UN partners, including UN Women, and has helped mobilise governments, donors, and civil society around coordinated responses to violence against women and children.

The RESPECT Women framework, jointly developed by WHO, UN Women, and other partners, illustrates this influence (WHO, 2019, 2025). In both its 2019 and 2025 editions, RESPECT synthesises evidence across seven domains and is widely used as a reference point for national GBV strategies. It demonstrates how WHO's epidemiological analysis and public health framing can be translated into policy-relevant guidance that is subsequently taken up and amplified across the UN system.

Because WHO guidance frequently establishes the technical and epidemiological baseline for subsequent UN frameworks and national strategies, gaps in how firearm-related risk is addressed within WHO guidance are likely to reduce its visibility across the wider GBV policy ecosystem. RESPECT illustrates both the progress made and the gap that remains. Its first edition (2019) drew attention to the availability of weapons as a community-level risk factor but did not identify firearm access as a specific risk factor for heightened control or lethal violence against women, nor include firearm-related prevention measures, surveillance considerations, or implementation guidance. The second edition (2025) goes notably further: it names reducing access to alcohol and firearms as protective factors and identifies the proliferation of "weapons" as a risk factor in humanitarian settings. That recognition is an important advance. What it does not yet do is integrate firearms into the rest of the framework—the surveillance that records weapon type, the risk- and danger-assessment tools, the clinical and safety-planning guidance, and the intervention examples—needed to support action in settings where firearms substantially shape patterns of injury, control, and femicide.

The importance of firearm-related risk is likely to vary across contexts depending on firearm prevalence, accessibility, legal regulation, and patterns of violence. In settings where firearms are widely available, however, evidence increasingly suggests that they function as major determinants of lethality and severe injury.

Between the first and second editions, the evidence linking firearm access to femicide, severe injury, coercive control, and threats against women continued to expand, and the second edition's explicit naming of firearms reflects part of that shift.

UN Women's Firearms Violence and GBV Blind Spot

UN Women's guidance on national action plans (NAPs) to address violence against women mirrors WHO's limited attention to guns over time. The *Handbook for National Action Plans on Violence against Women* (2012) does include firearms as a risk factor for GBV, but the 2023 update, *Together for Prevention: Handbook on Multisectoral National Action Plans to Prevent Violence against Women and Girls*, and the 2015 *Framework to Underpin Action to Prevent Violence Against Women*, as well as the Beijing+30 review processes (UN Women, 2015, 2025a, 2025b; UN Women & The Equality Institute, 2023), do not mention firearms at all. Other than in the 2012 guidance on national action plans, they are not systematically integrated into risk assessment, protection measures, prevention design, or monitoring frameworks, even as femicide is increasingly recognised as a critical policy priority. With the inclusion of firearms in the 2025 RESPECT framework, UN Women has evidence readily available to strengthen its guidance on firearm regulations and firearm violence prevention and care.

While no direct line can be drawn between WHO's limited attention to firearm violence in the context of GBV and the relative absence of firearms in UN Women's guidance, the relationship between upstream technical guidance and downstream policy visibility is well established. Where data are not systematically collected, and where risk factors are not clearly articulated in global guidance, they are less likely to be incorporated into national policy frameworks. In this context, stronger WHO attention to firearm-related GBV—including improved data collection, classification, and guidance—would support more consistent integration of firearm risk into UN Women's GBV NAP guidance and Member State implementation.

> **"RESPECT illustrates both the progress made and the gap that remains."**

This gap is particularly consequential in the context of femicide. UN Women's global reviews recognise the scale and urgency of femicide but rarely analyse the means by which women are killed, despite evidence from UNODC and national studies showing that firearms are frequently the dominant method. The absence of comparable global estimates of firearm involvement in femicide and non-lethal firearm use in domestic violence constrains the ability of UN agencies and Member States to design targeted prevention strategies.

Firearms, gender-based violence, and the Women, Peace and Security agenda: implications for WHO leadership

The Women, Peace and Security (WPS) agenda provides a widely recognised global framework for addressing gendered violence, prevention, and protection in conflict and post-conflict settings. Established through UN Security Council Resolution 1325 (2000) and subsequent resolutions, the agenda emerged through sustained advocacy by feminist peacebuilding and women's rights organisations, including those working in conflict-affected contexts, alongside supportive Member States (Davies & True, 2019). It is structured around four pillars: participation, prevention, protection, and relief and recovery, and is implemented primarily through national action plans adopted by Member States.

While initially developed in response to the gendered impacts of armed conflict, the WPS agenda has increasingly been applied to peacetime and internal security contexts, including violence against women and girls and femicide. This expansion creates clear entry points for public health engagement, particularly in relation to prevention, risk assessment, and survivor support. For instance, the UN Secretary General's 2025 Report on Women, Peace, and Security noted that the spread of arms and ammunition contributes directly and decisively to sharp increases in gender-based violence in conflict-affected countries (United Nations Secretary-General, 2025). In the same report, he noted that reporting under the Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons shows that the number of States integrating gender considerations in national arms control has consistently and substantially increased over time (74% of reporting States in 2024).

Despite this potential, the WPS agenda has engaged only unevenly with the governance of weapons that drive gender-based violence. Analysis by the United Nations Institute for Disarmament Research shows that references to arms control and small arms within WPS resolutions remain limited and highly selective, with little attention to domestic or intimate partner violence involving firearms (Myrttinen, 2020). Where weapons are addressed, the emphasis is primarily on conflict-related sexual violence, disarmament processes, and post-conflict settings. As a result, the role of firearms in coercive control, escalation, and lethality within intimate relationships remains under-addressed within WPS implementation.

Gaps are also evident at the national level. While an increasing number of WPS national action plans include references to small arms and light weapons, these references seldom mention IPV. Recent analysis released by UNIDIR shows that 62 WPS NAPs mention small arms and light weapons (SALW) and/or weapons and ammunition management (WAM), representing 31% of analysed NAPs between 2020-2024. The steady attention to SALW highlights a sustained recognition of their gendered impacts, yet with only about a third of WPS NAPs mentioning SALW there is room for further improvement. Notably, despite having the highest per capita levels of firearm violence, only a few States in the Latin America and the Caribbean region explicitly address SALW in their WPS NAPs, and mostly in conjunction with illicit trafficking, such as in Argentina (2022) and Mexico (2021) (Myrttinen et al., 2025).

These patterns mirror those identified in WHO and UN Women frameworks. Across all three domains, firearms are acknowledged in principle but are not systematically integrated into prevention, surveillance, or response strategies. This convergence points to a broader structural gap, and therefore opportunity, in global governance, where firearms are treated primarily as instruments of conflict or crime rather than as determinants of health and mechanisms of increased control and lethal violence.

Implications for policy and practice: integrating firearm risk into GBV prevention

The evidence across diverse settings shows that firearms are a consistent and modifiable determinant of lethality in gender-based violence (GBV). Reducing femicide and severe injury among women requires integrating firearm risk into health, legal, and governance responses—aligning existing GBV prevention frameworks with the evidence on how violence escalates and becomes fatal.

Integrating firearm-related risk into GBV prevention does not require abandoning or replacing existing WHO frameworks. The evidence reviewed here suggests that firearms function as a cross-cutting determinant of escalation, severe injury, and lethality, intersecting all seven RESPECT strategies.

RESPECT Strategy	Examples of firearm-related integration
R—Relationship skills strengthened	Address firearm threats, intimidation, escalation risk, and conflict resolution in relationship and perpetrator interventions; incorporate firearm-related risk into counselling and family support programmes.
E—Empowerment of women	Strengthen housing, income support, legal assistance, firearm-related safety planning, and protection for women facing armed abusive partners.
S—Services ensured	Integrate routine enquiry about firearm access and threats, firearm-inclusive danger assessment, trauma-informed care, referral pathways, and documentation of firearm-related violence into GBV services.
P—Poverty reduced	Address the links between poverty, household insecurity, firearm acquisition for perceived protection, and barriers to leaving high-risk relationships.
E—Environments made safe	Firearm licensing, background checks, safe-storage measures, temporary off-site storage, firearm relinquishment, enforcement of protection orders, and trafficking prevention.
C—Child and adolescent abuse prevented	Address children's exposure to firearm threats, domestic firearm violence, parental homicide, and firearm-related trauma.
T—Transformed attitudes, beliefs and norms	Challenge harmful norms linking firearms with power, control, protection, and dominant forms of manhood; promote non-violent models of masculinity and conflict resolution.

Emerging evidence suggests that firearm-related prevention extends beyond firearm removal alone. Additional measures may include safe-storage interventions, temporary off-site firearm storage during periods of heightened risk, integration of firearm-related risk into perpetrator programmes, community-based support for survivors navigating protection-order processes, and efforts to address harmful norms linking firearm ownership with power, control, and protection. The strength of evidence varies across these approaches, and additional research is needed to determine which combinations are most effective across different settings. Together, however, they illustrate a growing toolbox of interventions that can complement existing GBV prevention strategies and strengthen implementation of the RESPECT framework (Ellyson et al., 2026; Lynch et al., 2025; SEESAC, 2025; Stevanović Govedarica, 2021).

Two fields, mirror-image blind spots: the case for cross-disciplinary learning

The argument advanced to this point has run in one direction: firearm-related risk should be integrated into violence against women prevention frameworks, guidance, and services. But the integration case runs the other way as well—the violence against women prevention and response field stands to gain

from more systematic engagement with the evidence produced by firearm violence prevention and injury research. The two fields have developed largely in parallel, and each has matured around a blind spot that is the other's core strength. Firearm violence research has historically framed gun violence as a predominantly public, community-level phenomenon affecting young men, with domestic and intimate partner contexts under-represented in research investment and policy attention until comparatively recently—a gap mirrored in the policy patterns documented in the Western Balkans, where domestic settings account for the highest firearm lethality for women yet receive the least regulatory focus (SEESAC, 2025). The violence against women prevention and response field, conversely, has built deep and globally grounded expertise in perpetrator dynamics, social norms, and survivor-centred response, while engaging only intermittently with the literatures on lethal means, injury severity, and regulatory evaluation.

This parallel development means the violence against women prevention field has substantial evidence available to it that remains largely untapped. Three bodies of work are particularly relevant. First, firearm policy research has produced a mature quasi-experimental literature evaluating which specific legal design features reduce intimate partner homicide—including the relative effects of relinquishment requirements, the scope of relationship categories covered by prohibitions, and ex parte versus final protection orders (Díez et al., 2017; Ellyson et al., 2026; Zeoli et al., 2018). This regulatory evaluation science offers GBV prevention a level of specificity about legal mechanism design that the field's own evidence base, centred on social-norm and relationship-level interventions, does not currently provide. Second, the suicide prevention field has developed a substantial evidence base on lethal means restriction—including safe storage, temporary out-of-home storage during periods of elevated risk, and clinician-delivered counselling on firearm access (Barber & Miller, 2014). Its core insight—that restricting access to highly lethal means during high-risk periods prevents deaths even where underlying risk is unchanged—transfers conceptually to IPV safety planning, although this application remains under-evaluated in VAW contexts and should be framed as a tested model warranting adaptation rather than established VAW evidence. Third, hospital- and trauma-care-based violence intervention models developed primarily in response to community gun violence offer an institutional template—embedding violence intervention and social support functions at the point of medical contact—that speaks directly to the prevention gap identified in Brazil, where health systems detect firearm-related risk but lack institutionalised response pathways (Vital Strategies, 2025).

Two caveats apply. Much of this evidence originates in the United States and other high-income settings, and its mechanisms presuppose institutional infrastructure—functioning firearm registries, courts, and enforcement agencies—that, as discussed below, cannot be assumed in many high-burden settings. Translation therefore requires adaptation and evaluation, not transplantation. These caveats, however, argue for structured engagement between the two fields rather than continued separation: the VAW field's global reach and contextual sophistication is precisely what the firearm prevention literature lacks, just as the firearm field's evaluation methods and means-restriction evidence address the VAW field's gap on lethality. WHO is distinctively well placed to convene this synthesis, as it has done in other domains where previously separate evidence communities—such as road safety and alcohol harm reduction—were brought into a common public health framework.

Health systems and early identification

At the level of health systems, firearm access should be treated as a high-impact risk factor within routine GBV screening, assessment, and response. Health services are often among the first institutional points of contact for women experiencing violence, and in many contexts already identify patterns of repeat abuse and escalation. Integrating routine enquiry about firearm access, threats, and prior use into clinical protocols would strengthen early identification of high-risk cases. Non-lethal firearm threats should be recognised as sentinel events that trigger enhanced protection, safety planning, and referral pathways. Safety planning can include safe storage for survivors who want to remain in the relationship but to do so more safely. Surveillance systems should also capture weapon type, prior violence, and non-fatal firearm use to support more complete risk identification and more targeted prevention strategies (SEESAC, 2025; Sorenson & Schut, 2016; WHO, 2019).

Evidence from Brazil, the United States, South Africa, and the Western Balkans suggests that firearm-related risk can be incorporated into existing violence-against-women services through a relatively small number of practical additions. These include routine enquiry about firearm access, firearm threats, and firearm ownership; firearm-inclusive danger assessment; safety planning that addresses access to firearms; and referral pathways linked to protection, legal support, and firearm relinquishment where appropriate. Such measures build on existing GBV practice rather than requiring the creation of entirely new service systems (SEESAC, 2025; Sharps et al., 2001; Stevanović Govedarica, 2021; Vital Strategies, 2025).

Realising this potential requires that health-sector responses are accessible to women whose circumstances compound their exposure to firearm-related harm. Undocumented migrants, women with disabilities, Indigenous women, and those in situations of economic dependence often face the greatest barriers to disclosure and the greatest risks of retaliation (Tobin-Tyler, 2023). Clinical protocols should be designed with these realities in mind: enquiry about firearm access must be conducted in conditions of genuine safety and confidentiality, without automatic referral to police or immigration authorities in ways that deter disclosure. Referral pathways should include community-based and culturally safe options, and health providers should receive training that addresses how intersecting vulnerabilities shape both exposure to firearm-related violence and barriers to seeking help (WHO, 2019).

The integration of firearm risk into GBV responses should extend explicitly to sexual violence. Available evidence indicates that firearms are used to facilitate coercion, enforce compliance, and suppress resistance in both domestic and conflict-related contexts, yet these dynamics remain largely absent from surveillance and clinical guidance (Salama, 2023, 2025). In fact, health professionals are potentially critical in both the response and prevention of CRSV as they are often the first point of contact for survivors. They play a crucial role in identifying cases of sexual violence, providing medical care, and documenting injuries and evidence for legal purposes (Salama, 2026). Strengthening health-sector responses requires the routine inclusion of firearm-related variables in sexual violence risk assessment, forensic documentation, and administrative data systems. Non-lethal firearm threats in sexual violence cases should be recognised as high-risk indicators requiring coordinated protection and, where applicable, firearm removal. Current data systems frequently lack disaggregation by weapon type and relationship context,limiting the ability to identify risk and design targeted prevention strategies (UNODC & UN Women, 2022a, 2023). Incorporating firearm-enabled sexual coercion into WHO normative guidance would support more comprehensive prevention and response strategies across the continuum of GBV (World Health Organization, 2019).

These approaches align particularly closely with the “Services ensured” and “Relationship skills strengthened” domains of the RESPECT framework by strengthening early identification, safety planning, and coordinated response within health systems.

Legal protection and firearm removal

Legal and regulatory frameworks play a central role in determining whether identified risks translate into protection. Evidence from multiple contexts shows that firearm removal in cases of domestic violence is one of the most effective mechanisms for reducing femicide. This requires establishing clear, enforceable obligations for firearm removal where there is a history of abuse, a credible threat, or the issuance of a protection order. Licensing systems should incorporate risk-based criteria that account for histories of violence, with mechanisms for suspension or revocation that do not depend solely on criminal conviction. These measures are most effective when supported by strong enforcement systems and coordination between police, courts, and administrative authorities (Abrahams et al., 2024; Matzopoulos et al., 2019; Santaella-Tenorio et al., 2016).

These findings suggest a hierarchy of regulatory priorities for contexts where comprehensive reform is politically constrained: mandatory firearm removal in domestic violence contexts, accompanied by strong enforcement mechanisms, is likely to yield the greatest reduction in femicide per unit of policy effort. Licensing reform, background checks, and illegal weapons recovery address broader population-level risk. Both levels of intervention are necessary; neither is sufficient alone.

Evidence from South Africa, Serbia, Brazil, and other settings indicates that legally owned firearms frequently feature in domestic violence, attempted femicide, and femicide. This suggests that firearm licensing systems should be understood not only as administrative mechanisms but also as violence-prevention interventions. Effective approaches may include background checks that incorporate domestic violence histories, review of firearm licences following protection orders or credible threats, periodic licence renewal, safe-storage requirements, and mechanisms for temporary or permanent firearm relinquishment when risk is identified (Abrahams et al., 2025; Rivers, 2024; SEESAC, 2025; Stevanović Govedarica, 2021).

However, legal protections are only meaningful if they are actionable. For many women at elevated risk—including those without secure immigration status, those who are economically dependent on a perpetrator, those with disabilities that limit mobility or communication, and those from communities with well-founded distrust of police and courts—the formal legal system may be inaccessible, unsafe to approach, or actively harmful (Tobin-Tyler, 2023). Protection-order processes and firearm-removal mechanisms should be designed to function without requiring women to navigate systems that expose them to secondary harm. This includes ensuring that immigration consequences do not attach to GBV-related contacts with police or courts, that accommodations for people with disabilities are embedded in legal processes, and that legal aid and advocacy support are available to women who cannot navigate these systems alone.

Legal protections are also less effective in places where capacity to enforce them is limited. In many of the highest-femicide settings globally—including parts of sub-Saharan Africa, Central America, and conflict-affected states—enforcement institutions are themselves sites of impunity, corruption, or active danger for women seeking protection. This does not make regulatory approaches unimportant in these contexts, but it does mean they must be designed differently.

Community-based and civil society mechanisms can partially substitute for state enforcement where institutional trust is low. Trained advocates can accompany survivors through protection-order proceedings, provide safety planning, facilitate access to services, and help survivors communicate information relevant to firearm possession and risk. Compliance monitoring and enforcement of firearm relinquishment orders are typically undertaken by courts, specialised firearm-relinquishment units, prosecutors, and law-enforcement agencies working in collaboration with victim advocates (Ellyson et al., 2026; Lynch et al., 2025).

Health systems can also serve as a relatively trusted institutional entry point even where justice systems are not. In contexts where women are reluctant to approach police or courts, health facilities—particularly primary care and emergency services—may represent the most viable site for risk identification, safety planning, and referral (García-Moreno et al., 2015).

The specifics of laws and policies shape enforcement success. Simpler, more observable requirements—such as a presumptive obligation to remove firearms when a protection order is issued, rather than discretionary judicial authority—reduce the scope for institutional failure and make non-compliance more visible and accountable (Díez et al., 2017; Wallace et al., 2021).

The fundamental insight is that weak institutional capacity is an argument for more carefully designed regulation, not for abandoning the regulatory framework. The absence of effective enforcement is itself a modifiable determinant of femicide, and addressing it requires both institutional reform and the development of community-based alternatives that do not depend on state functionality as a precondition.

These legal measures correspond most directly with the RESPECT strategy focused on making environments safe, while also strengthening women’s ability to safely exit abusive relationships.

Data, surveillance, and accountability

Across both health and justice systems, improved data integration and accountability mechanisms are essential. Current data systems frequently operate in isolation, limiting the ability to track escalation

pathways or identify missed opportunities for intervention. Linking health-sector data, mortality data, and criminal justice records would enable more accurate identification of firearm involvement in femicide and intimate partner violence. The establishment or strengthening of femicide observatories and review mechanisms can support this process by systematically examining cases to identify points at which intervention could have prevented death. These approaches are particularly important given the classification gaps in femicide data described earlier.

Domestic Violence Fatality Review Teams provide a particularly useful model. By bringing together health, law-enforcement, judicial, social-service, and community actors to systematically review individual deaths, these multidisciplinary mechanisms can identify missed opportunities for intervention, institutional failures, and recurrent risk factors that are often invisible in routine surveillance data alone. Their experience suggests that systematic case review can strengthen both accountability and prevention and offers important lessons for the design of Femicide Watch mechanisms and related mortality-review systems (Hope and Heal Fund & Battered Women's Justice Project, 2025; Šimonović, 2021).

WHO is well placed to supply these capabilities through instruments it already maintains—the ICD's existing capacity to record weapon type and victim–perpetrator relationship, injury surveillance (Holder et al., 2001), verbal autopsy, mortuary- and facility-based surveillance, and femicide death reviews modelled on the maternal death surveillance and response cycle. The feasibility of these measures, the precedents on which they rest, and the international calls they would answer are addressed in a dedicated section below.

Improved surveillance and accountability systems also strengthen the evidence base necessary to operationalise and evaluate RESPECT-aligned prevention strategies across sectors.

The feasibility of WHO leadership on femicide data

The data and surveillance measures proposed above raise obvious questions of feasibility. Reliable cause-of-death registration remains concentrated in a minority of countries, and criminal-justice data are often delayed, incomplete, and contested. These constraints are real, but they are not reasons for inaction: they are neither new nor unique to femicide, and WHO has spent two decades building the machinery to overcome them in other domains. We treat them at length deliberately, because measurement is where this report's central argument—that what WHO measures and prioritises shapes what becomes visible—translates into practice, where WHO's comparative advantage is clearest, and where objections to WHO engagement are most common.

The limits of death registration have been documented most authoritatively by WHO-led research itself (Mathers et al., 2005; Mikkelsen et al., 2015), and WHO has treated them not as a boundary on its work but as a focus of it, through its role in the global agenda to strengthen civil registration and vital statistics (CRVS) and through tools such as the SCORE for Health Data technical package (WHO, 2020).

Where physician certification is absent, WHO maintains the global standard verbal autopsy instrument, explicitly designed to capture deaths caused by injuries (WHO, 2022)—and injury deaths are among the causes most reliably ascertained in verbal autopsy validation studies (Murray et al., 2011).

Where routine registration undercounts deaths of particular concern, WHO has institutionalised dedicated surveillance and response: Maternal Death Surveillance and Response, launched with partners in 2012, was motivated explicitly by the unreliability of vital registration for maternal deaths, and established notification, review, analysis, and response cycles since adopted in national policy across most low- and middle-income countries (WHO, 2013, 2021).

The feasibility of such systems in middle-income settings is demonstrated within this report: South Africa's national femicide studies were built on mortuary-based surveillance rather than complete vital registration, and Brazil's SINAN system shows that mandatory health-sector notification of non-lethal violence can operate at national scale.

Extending this established machinery to femicide and firearm-related GBV would also answer a decade of convergent calls from UN human rights mechanisms—and from Member States themselves.

Since 2015, the Special Rapporteur on violence against women has called on all States to establish femicide watches or observatories publishing data disaggregated by victim–perpetrator relationship—a call that her 2021 review documented as substantially taken up and that her successor has carried forward (Šimonović, 2016, 2021; Alsalem, 2025). The CEDAW Committee has framed such data collection as part of States' due diligence obligations (CEDAW Committee, 2017); Member States endorsed the same approach through the Beijing+25 regional review (UNECE, 2019); the 2020 renewal drew more than forty special procedures mandate holders, the CEDAW chairperson, GREVIO, and the Inter-American Commission's Rapporteur for Women's Rights (OHCHR, 2020); and the Special Rapporteur on the right to health has framed comprehensive health-system responses to violence as a right-to-health obligation (Mofokeng, 2022). These instruments are consolidated in Annex 1.

While UN Women has not focused on firearms as a risk factor for lethality, fear, and control in its most recent publications on national action plans, it has done substantial work on femicide in partnership with UNODC—including updating the global epidemiological estimates of gender-related killings and convening expert consultations on their measurement, such as the 2025 global meeting in Vienna (UNODC & UN Women, 2025a, 2025b). The statistical framework for measuring gender-related killings developed by UNODC and UN Women, endorsed by the UN Statistical Commission in 2022, now supplies agreed definitions and counting rules (UNODC & UN Women, 2022b). Yet even within this body of work, the pattern this report documents recurs. The data modalities recommended under the femicide watch initiative—disaggregation by age, sex of the perpetrator, and the relationship between victim and perpetrator (Šimonović, 2021, paras. 18–19)—do not extend to the means of killing.

The weapon, one of the most significant and potentially modifiable determinants of lethality, is the variable that global guidance does not yet systematically request, within the flagship femicide data initiative just as within WHO, UN Women, and Women, Peace and Security frameworks. WHO can make a significant contribution to changing that.

Data gaps are not merely technical problems. When firearm-related femicides and IPV-related deaths are misclassified or remain unidentified, the resulting evidence base can distort public understanding, obscure preventable causes of death, and divert attention and resources away from interventions most likely to protect women. What is not measured is less likely to be prioritised, funded, or addressed through policy (Hope and Heal Fund & Battered Women’s Justice Project, 2025).

Research agenda

Addressing firearm-related gender-based violence and femicide requires a focused research agenda to close persistent gaps in definition, measurement, and implementation.

First, there is an urgent need to establish consistent and policy-relevant definitions of femicide and attempted femicide, including approaches that capture both lethal and life-threatening violence. Without shared definitions, cross-country comparison remains weak and prevention strategies are difficult to target or evaluate.

Second, non-fatal firearm use—including threats with firearms and display of firearms as a means of threat—must be systematically measured, as these dynamics often precede lethal outcomes but remain largely invisible in current surveillance systems.

Third, improving prevention depends on integrating data across health, police, court, and social-service systems, and systematically capturing prior victim contact with institutions. Evidence shows that many victims had previous interactions with services, suggesting missed opportunities for intervention that are not currently analysed in a coordinated way.

Fourth, further research is needed to determine which protection-order frameworks and enforcement models most effectively trigger and sustain firearm removal, particularly in low-capacity or low-trust settings where formal legal mechanisms may not translate into protection in practice.

Fifth, comparative analysis is required to identify firearm licensing, renewal, and risk assessment provisions that best prevent high-risk individuals from retaining access to firearms, including among security-sector personnel who are often excluded from standard controls.

Sixth, there is a need to better understand the interaction between firearm access and other structural drivers of violence, particularly alcohol use and availability, which are consistently associated with escalation but rarely integrated into GBV prevention strategies.

Seventh, research should identify which combinations of legal, health, and community-based interventions—including safe-storage mechanisms supported through safety planning, public health encouragement, and law—are most effective in preventing escalation from non-lethal violence to femicide, including the role of multidisciplinary case review mechanisms in identifying system failures.

Eighth, structured translational research is needed to adapt and evaluate evidence from the firearm violence prevention and suicide prevention fields—including lethal means restriction, safe and temporary off-site storage, clinician counselling on firearm access, and the comparative evaluation of legal design features in relinquishment and prohibition regimes—within violence against women prevention programmes and guidance, particularly in low- and middle-income settings where this evidence has rarely been tested.

Ninth, standardised and validated risk assessment tools that incorporate firearm-related risk require development, adaptation for context, and scaling across diverse contexts to enable earlier and more consistent intervention.

Tenth, and finally, strengthening global accountability depends on improving the availability, quality, and comparability of femicide data, including addressing persistent gaps and recent declines in national reporting.

Together, these priorities define a clear agenda for WHO, Member States, and research partners to advance more effective, evidence-informed prevention of firearm-related violence against women. Several of these research priorities are particularly important for strengthening the evidence base underpinning future iterations of the RESPECT framework and related WHO guidance.

Core implication

Across all levels, the central implication is consistent: firearm access shapes whether violence becomes fatal. Addressing this reality requires recognising firearms as part of the continuum of GBV and incorporating firearm-related risk into prevention and response systems. This approach provides a clear pathway to reducing femicide, strengthening protection for survivors, and improving the coherence of global and national responses to violence against women.

WHO is uniquely positioned to provide leadership and guidance on firearm-related violence against women—not by duplicating the arms-control work of other UN agencies, but by more consistently addressing firearm-related harm within the public health mandate established above.

No new resolution, treaty, or formal expansion of powers is required: as set out earlier in this report, WHO's constitutional mandate and successive World Health Assembly resolutions already direct it to address violence prevention, surveillance, clinical care, and the determinants of interpersonal violence—

explicitly including firearm availability. As Gostin and colleagues note, WHO derives unusually strong normative authority directly from its Constitution, which empowers it to establish global standards, guidance, and reporting frameworks through the World Health Assembly (Gostin et al., 2015; WHO, 2006). These capacities position WHO to address dimensions of firearm-related harm—injury epidemiology, violence prevention, trauma care, rehabilitation, mental health, and multisectoral public health action—that remain largely outside the scope of existing arms-control and security frameworks. The WHO's existing mandates for this work are consolidated in Annex 1.

Within these existing mandates, WHO can act immediately across the areas set out above. More formalised and sustained forms of engagement—including dedicated staffing, regularised reporting mechanisms, a comprehensive global strategy, or the negotiation of a framework convention on firearm-related harms—would be significantly strengthened by explicit Member State endorsement and dedicated financing through the World Health Assembly. At the same time, implementation of upstream prevention measures such as firearm licensing reform, safe-storage regulation, firearm removal in IPV contexts, and restrictions on harmful commercial practices ultimately depends on national political will. WHO's contribution is to strengthen the evidence base, improve surveillance and prevention guidance, support health systems, and make firearm-related harms more visible within global GBV and femicide prevention frameworks.

Similarly, strengthening cause-of-death classification, expanding injury surveillance to capture weapon type and prior violence, and documenting non-lethal firearm use as part of perpetrator attempts to assert control would significantly strengthen the evidence base for GBV prevention. Translating this evidence into clear guidance for health systems and multisectoral responses would support earlier identification of risk and more effective intervention.

Incorporating this evidence into WHO guidance could support more consistent integration of firearm risk into UN Women's national action plan guidance (UN Women, 2012, 2025a; World Health Organization, 2012, 2019). Similarly, WHO guidance on integrating firearm-related risk into WPS implementation would strengthen the translation of these commitments into measurable outcomes, particularly in settings where small arms remain widely available and domestic violence is a major contributor to women's mortality (Davies & True, 2019; Myrttinen, 2020). It would also drive attention to the need for WHO clinical guidance and support to the health systems needed to respond to gunshot injury.

Strengthening WHO leadership would also enable more consistent integration of firearm-related GBV risk across UN frameworks, including Beijing and Cairo Platform for Action reviews, as well as those focused on arms control such as the Arms Trade Treaty, the Firearms Protocol, the UN Programme of Action on Small Arms and Light Weapons, and the Global Framework for Ammunition, amongst others.

The femicide watch initiative itself demonstrates what normative leadership alone can catalyse. Within five years of a single mandate holder's call—issued without budget, country presence, or any instrument beyond annual appeals—femicide observatories or watch bodies were established across more than twenty countries by governments, national human rights institutions, universities, and civil society coalitions, with consolidated regional data published for twenty-one countries in Latin America and the Caribbean (Šimonović, 2021, paras. 33–46). If a special procedures mandate can catalyse institutional change of this breadth through normative appeal alone, the conclusion follows a fortiori for WHO, whose constitutional authority, Member State governance, country presence, and technical machinery exceed those of any individual mandate holder by orders of magnitude. Nor does reliance on Member State implementation or constrained budgets distinguish this agenda from the rest of WHO's work.

The bottom line, then, is that normative guidance whose implementation rests with Member States is not a limitation of WHO's role; it is WHO's role. Indeed, the same dependence characterises RESPECT, INSPIRE, WHO's clinical guidelines on intimate partner and sexual violence, and the ICD itself, and derives from the constitutional design that gives WHO its distinctive standard-setting authority (Gostin et al., 2015).

The recent history of mortality data demonstrates that such standards mobilise resources rather than requiring WHO to supply them: the World Bank–WHO Global CRVS Scaling Up Investment Plan (World Bank & WHO, 2014) and the philanthropically financed Data for Health Initiative channelled implementation support to some twenty countries, embedding WHO's verbal autopsy standard within routine national registration systems at no cost to WHO's core budget (de Savigny et al., 2017; Hazard et al., 2020).

Standards are what external financing organises around; absent the standard, there is less clarity about what to finance. The marginal cost of the present agenda is further reduced because its vehicles are already in motion: Member States themselves adopted ICD-11 through World Health Assembly resolution WHA72.15 (World Health Assembly, 2019) and are now undertaking national transitions—the natural, low-cost window in which coding guidance on weapon type and victim–perpetrator relationship can be embedded—while the femicide statistical framework, developed through consultation with national institutions in more than fifty countries, is already being piloted with UNODC and UN Women support across Latin America, Africa, and Asia (UNODC & UN Women, 2025). The binding constraint, in short, is not mandate, money, or Member State appetite, each of which is demonstrably present; it is prioritisation within WHO's normative agenda—and prioritisation is the one input only WHO can supply.

“WHO's role is not to regulate weapons directly, but to generate evidence, strengthen surveillance, support prevention, improve clinical and public health responses, and make firearm-related harms visible.”

“What is not measured is less likely to be prioritised, funded, or addressed through policy.”

“Normative guidance whose implementation rests with Member States is not a limitation of WHO's role; it is WHO's role.”

Conclusion

GBV and femicide represent one of the most pervasive and preventable causes of injury and death among women globally. This report has demonstrated that firearms fundamentally alter the risk environment of abusive relationships. The evidence is extensive, consistent, and global: firearm access substantially increases the likelihood of femicide, enables prolonged psychological abuse through credible threats, and transforms domestic settings and intimate relationships into spaces of lethal danger for women.

The evidence reviewed here—consistent across international syntheses and national case studies—shows that strong firearm legislation is particularly important to femicide prevention in settings where firearms are widely available and frequently used in interpersonal violence, while health systems play a critical complementary role in prevention, detection, care, and advocacy.

Yet firearms remain systematically marginalised within the global health policy frameworks that guide prevention, surveillance, and response to violence against women. As documented in *Tracking the WHO's Attention to Firearm Violence, 2000–2025*, WHO engagement with firearms as a public health issue has declined markedly over the past fifteen years—precisely when evidence of their role in femicide has grown stronger. This retreat matters because WHO's technical guidance, data collection systems, and normative frameworks shape what health systems measure, what clinicians are trained to recognise, and which interventions are prioritised across the UN system and within Member States. The incomplete integration of firearms—now named as a risk and protective factor in influential frameworks such as RESPECT Women, but not yet carried through into surveillance data recommendations, risk assessment, and GBV prevention guidance—means that a critical mechanism of women’s fear, injury, and death remains insufficiently visible in the very systems designed to prevent harm.

The evidence from Brazil, Mexico, the Western Balkans, and South Africa demonstrates that this invisibility has consequences. Across all four settings, health and justice systems encountered women at risk early enough to intervene, yet failures to act on firearm access allowed preventable deaths to occur.

Reintegrating firearms into WHO's violence-prevention agenda is essential to fulfilling global commitments to end violence against women and to advance health equity. WHO's contribution—within its existing mandate, and complementary to arms-control and criminal-justice frameworks—lies in strengthening the public health dimensions of prevention, surveillance, care, rehabilitation, and multisectoral response. From a public health perspective, firearm access warrants particular attention because it is both one of the strongest predictors of femicide currently identified and one of the most amenable to intervention through policy, institutional practice, and prevention programming.

In settings where firearms substantially shape patterns of severe injury and femicide, WHO frameworks should more systematically address firearm access as a high-impact risk factor for violence-related harm. In practice, this means:

- strengthening global data collection on firearm involvement in femicide and IPV, building on WHO's longstanding experience supporting Member States through injury surveillance systems, mortality reviews, verbal autopsy, disease classification, and health information system strengthening;
- improving injury and cause-of-death classification to capture weapon type and relationship context;
- documenting non-lethal firearm threats and firearm related coercion as forms of violence requiring health-sector response;

- translating this evidence into clear guidance for health systems, protection services, and multisectoral GBV prevention;
- supporting Member States to operationalise firearm removal in IPV and domestic violence contexts as a core component of violence-against-women prevention.

Doing this would deepen the work of UN Women, the Women, Peace and Security agenda, and arms-control bodies—grounding their frameworks in more complete evidence on how women are coerced, injured, and killed. It would ensure that Beijing+30 reviews, national action plans, and femicide-prevention strategies address the mechanisms through which violence becomes fatal, not only its consequences. It would reposition health systems—already encountering survivors of firearm-related violence every day—as early-warning sites capable of interrupting escalation before it culminates in death. Without this integration, even the most comprehensive gender-based violence frameworks will continue to overlook the pathway that makes violence lethal. That is a structural failure, and its cost is measured in women's lives.

Limitations

Several limitations should be considered when interpreting the findings presented here. The country case studies are illustrative rather than globally representative, and the availability and quality of data on firearm-related GBV vary substantially across settings. In many countries, health, police, and mortality data systems do not systematically record weapon type, relationship to the perpetrator, or prior violence, limiting comparability and likely underestimating the scale of firearm-related harm. In addition, while substantial evidence links firearm access to increased lethality in intimate partner violence and femicide, the evidence base for some specific prevention interventions—particularly outside high-income settings—remains uneven and requires further development. The analysis presented here should therefore be understood as identifying important and under-addressed patterns, policy implications, and research needs rather than providing a comprehensive global epidemiological assessment.

The paper is also limited in its ability to explain precisely why firearm violence has received comparatively limited attention within WHO GBV frameworks and programmes over time. Although broader geopolitical resistance to firearm-related work within WHO has been documented elsewhere (Peacock et al., 2025), this report did not include interviews with current or former WHO staff, Member State representatives, or participants involved in the development of frameworks such as RESPECT Women. As a result, it is not possible to determine the relative influence of geopolitical pressure, donor priorities, staffing and resource constraints, internal institutional dynamics, disciplinary boundaries within GBV research, or differing assessments of the available evidence base in shaping WHO priorities. The paper therefore focuses primarily on the observable consequences of limited integration of firearm-related risk within global GBV guidance and surveillance systems, rather than making definitive claims about institutional intent or causation.

Works Cited

Abrahams, N., Mathews, S., Martin, L. J., Lombard, C., & Jewkes, R. (2013). *Intimate partner femicide in South Africa in 1999 and 2009*. PLoS Medicine, 10(4), e1001412.

Abrahams, N., Chirwa, E., Mhlongo, S., Dekel, B., Ketelo, A., Lombard, C., Shai, N., Ramsoomar, L., Mathews, S., Labuschagne, G., Matzopoulos, R., Prinsloo, M., Martin, L. J., & Jewkes, R. (2024). 20 years of femicide research in South Africa *(Research brief)*. South African Medical Research Council, Gender and Health Research Unit.

Abrahams, N., Chirwa, E., Mhlongo, S., Dekel, B., Ketelo, A., Lombard, C., Shai, N., Ramsoomar, L., Mathews, S., Labuschagne, G., Matzopoulos, R., Prinsloo, M., Martin, L. J., & Jewkes, R. (2025). Two decades of tracking femicide in South Africa: An analysis of four national surveys from 1999 to 2020/2021. *Glob Public Health*, *20*(1), 2576753. https://doi.org/10.1080/17441692.2025.2576753

Agard, J. Anderson, S. Fabre AS, Garcia-Joseph, M. Norville, K. Schroeder, M. Joseph, C and Florquin. N. (2025). Pathway to Policy: Firearms Trafficking and Public Health in the Caribbean. Port of Spain, Cave Hill, and Geneva: CARICOM IMPACS, CARPHA, GA-CDRC at The UWI, and Small Arms Survey.

Alsalem, R. (2025, November 21). *Confronting emerging forms of femicide* [Keynote address]. International High-Level Conference against Femicide, Rome. Office of the United Nations High Commissioner for Human Rights.

Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine, 47*(3, Suppl. 2), S264–S272.

Barnard, N. B., Rothmann, S., De Beer, L. T., & Lubbe, W. (2023). *Burnout of emergency nurses in a South African context: The role of job demands and resources, and capabilities*. Frontiers in Psychology, 14, 1119063. https://doi.org/10.3389/fpsyg.2023.1119063

Barufaldi, L. A., Souto, R. M. C. V., Correia, R. S. B., et al. (2017). Violência de gênero: comparação da mortalidade por agressão em mulheres com e sem notificação prévia de violência. *Ciência & Saúde Coletiva, 22*(9), 2929–2938.

Bjerten, E. and Briggs, N. (2025) Advancing Gender and Inclusivity in Small Arms Control: Key Takeaways from RevCon4, Women's International League for Peace and Freedom and the Center on International Cooperation at New York University

Campbell, J.C., Rose, L., Kub, J., & Nedd, D. (1998) Voices of strength and resistance: A contextual and longitudinal analysis of women's responses to battering. *Journal of Interpersonal Violence 13*:743-762.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*(7), 1089–1097.

Committee on the Elimination of Discrimination against Women. (2017). *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19* (CEDAW/C/GC/35). United Nations.

Davies, S. E., & True, J. (2019). *Women, peace and security: A critical introduction*. In S. E. Davies & J. True (Eds.), *The Oxford handbook of women, peace, and security* (pp. 1–18). Oxford University Press.

de Savigny, D., Riley, I., Chandramohan, D., Odhiambo, F., Nichols, E., Notzon, S., AbouZahr, C., Mitra, R., Cobos Muñoz, D., Firth, S., Maire, N., Sankoh, O., Bronson, G., Setel, P., Byass, P., Jakob, R., Boerma, T., & Lopez, A. D. (2017). Integrating community-based verbal autopsy into civil registration and vital statistics (CRVS): System-level considerations. *Global Health Action, 10*(1), Article 1272882.

Department of Women, Youth and People with Disabilities. (2020). *National Strategic Plan on Gender-based Violence and Femicide*. Pretoria: Department of Women, Youth and People with Disabilities, Republic of South Africa.

Díez, C., Kurland, R. P., Rothman, E. F., Bair-Merritt, M., Fleegler, E., Xuan, Z., Zawitz, C., Cook, P. J., & Siegel, M. (2017). State intimate partner violence–related firearm laws and intimate partner homicide rates in the United States, 1991 to 2015. *Annals of Internal Medicine, 167*(8), 536–543.

Dorn de Carvalho, J. M., McGuire, S. S., Oliveira, L. L. R., Bellolio, F., Ranzani, O. T., Pinheiro Besen, B. A. M., Guimarães, H. P., Lunardi, M. C., Mullan, A. F., Hajjar, L. A., & Maia, I. W. A. (2025). Prevalence and Impact of Violence Against Healthcare Workers in Brazilian Emergency Departments: A National Survey. *The western journal of emergency medicine*, *26*(6), 1769–1780. https://doi.org/10.5811/westjem.45138.

Ellyson, A. M., Kafka, J., Adhia, A., Shanahan, S., Bowen, D., & Rowhani-Rahbar, A. (2026). Crime reductions after enhanced implementation of Washington state's domestic violence protection order firearm relinquishment law. *Journal of Criminal Justice, 102*, 102591. https://doi.org/10.1016/j.jcrimjus.2025.102591

Engel, R. J., Lee, D. H. J., & Rosen, D. (2020). Psychiatric Sequelae Among Community Social Service Agency Staff 1 Year After a Mass Shooting. JAMA network open, 3(8), e2014050. https://doi.org/10.1001/jamanetworkopen.2020.14050

Everytown for Gun Safety. (2025, September 29). *Trump administration rescinds Department of Commerce rule that tightened restrictions on U.S. gun exports abroad, delivering gift to gun industry and increasing likelihood of guns being diverted to international cartels*.

Flor, L. S., Spencer, C. N., Cagney, J., *et al.* (GBD 2023 Intimate Partner Violence and Sexual Violence against Children Collaborators). (2026). Disease burden attributable to intimate partner violence against females and sexual violence against children in 204 countries and territories, 1990–2023: A systematic analysis for the Global Burden of Disease Study 2023. *The Lancet, 407*, 31–52.

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet, 385*(9977), 1567–1579.

Geller, L. B., Booty, M., & Crifasi, C. K. (2021). The role of domestic violence in fatal mass shootings in the United States, 2014–2019. *Injury Epidemiology, 8*(1), Article 38. https://doi.org/10.1186/s40621-021-00330-0

Gostin, L. O., Sridhar, D., & Hougendobler, D. (2015). The normative authority of the World Health Organization. *Public Health, 129*(7), 854–863. https://doi.org/10.1016/j.puhe.2015.05.002

Gun Free South Africa. (2025). *Gun-related femicide in South Africa over 25 years: A call to action*.

Hazard, R. H., Buddhika, M. P. K., Hart, J. D., Chowdhury, H. R., Firth, S., Joshi, R., Avelino, F., Segarra, A., Sarmiento, D. C., Azad, A. K., Ashrafi, S. A. A., Bo, K. S., Kwa, V., & Lopez, A. D. (2020). Automated verbal autopsy: From research to routine use in civil registration and vital statistics systems. *BMC Medicine, 18*, Article 60. https://doi.org/10.1186/s12916-020-01520-1

Holder, Y., Peden, M., Krug, E., Lund, J., Gururaj, G., & Kobusingye, O. (Eds.). (2001). *Injury surveillance guidelines*. World Health Organization.

Hope and Heal Fund, & Battered Women's Justice Project. (2025). *Gender inequities: The erasure of women's lives through the absence of data*. Hope and Heal Fund and Battered Women's Justice Project.

Instituto Sou da Paz. (2024). *The role firearms play in violence against women* (3rd ed.).

Instituto Sou da Paz. (2026). *Pela vida das mulheres: O papel da arma de fogo na violência de gênero* (5ª ed.).

International Labour Organization. (2018). Care work and care jobs for the future of decent work. Geneva: ILO.

Kengela, P. & Peacock, D. (forthcoming). Guns, Gender and the Ground Beneath Our Feet: How the Extractive Sector and the Informal Economy Fuel a Hidden Gun Violence Crisis Against Women, Global Coalition for WHO Action on Firearm Violence.

Koziol-McLain, J., Webster, D., McFarlane, J., Block, C. R., Ulrich, Y., Glass, N., & Campbell, J. C. (2006). Risk factors for femicide-suicide in abusive relationships: Results from a multi-site case control study. *Violence & Victims, 21.* 3-21. https://doi.org/10.1891/vivi.21.1.3

Lynch, K. R., Gusmano, M. K., Temple, J. R., & Lane, S. (2025). It takes a village: Addressing community needs to implement firearm prohibitions for domestic violence protective order respondents. *Journal of Interpersonal Violence*. Advance online publication. https://doi.org/10.1177/08862605251363616

Machisa, M., Jina, R., Labuschagne, G., Vetten, L., Loots, L., Swemmer, S., Meyersfeld, B., & Jewkes, R. (2017). *Rape justice in South Africa: A retrospective study of the investigation, prosecution and adjudication of reported rape cases from 2012.* Gender and Health Research Unit, South African Medical Research Council.

Martínez-Villalba, L. (2024). *Femicide and Gun Control: The Application of Symbolic Penal Law in The Mexican Criminalization of Femicide*. Int J Semiot Law 37, 1755–1775.

Mathers, C. D., Fat, D. M., Inoue, M., Rao, C., & Lopez, A. D. (2005). Counting the dead and what they died from: An assessment of the global status of cause of death data. *Bulletin of the World Health Organization, 83*(3), 171–177.

Matzopoulos, R., Prinsloo, M., Bradshaw, D., & Abrahams, N. (2019). *Reducing homicide through policy interventions: The case of gun control*. South African Medical Journal, Vol 109, No. 11b (pp. 63-68).

Mikkelsen, L., Phillips, D. E., AbouZahr, C., Setel, P. W., de Savigny, D., Lozano, R., & Lopez, A. D. (2015). A global assessment of civil registration and vital statistics systems: Monitoring data quality and progress. *The Lancet, 386*(10001), 1395–1406. https://doi.org/10.1016/S0140-6736(15)60171-4

Mofokeng, T. (2022). *Violence and its impact on the right to health: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (A/HRC/50/28). United Nations Human Rights Council.

Mohammed RS, Boateng EA, Amponsah AK, Kyei-Dompim J, Laari TT. (2023). Experiences of family caregivers of people with spinal cord injury at the neurosurgical units of the Komfo Anokye Teaching Hospital, Ghana. PLOS ONE 18(4): e0284436.

MSF (Médecins Sans Frontières). (2025, May 5). *Haiti violence pushes MSF trauma hospital to its limits.*

Muggah, R. (2022, June 24). America is the world's gun store. *Foreign Policy.*

Murray, C. J. L., Lopez, A. D., Black, R., et al. (2011). Population Health Metrics Research Consortium gold standard verbal autopsy validation study: Design, implementation, and development of analysis datasets. *Population Health Metrics, 9*, Article 27. https://doi.org/10.1186/1478-7954-9-27

Myrttinen, H. (2020). *Connecting the dots: Arms control, disarmament and the Women, Peace and Security agenda.* UNIDIR. https://doi.org/10.37559/GEN/20/01

Myrttinen, H., Mondesir, A., & Terreros Lozano, M. (2025). *Closing gaps: Strengthening the Women, Peace and Security agenda through arms control and disarmament.* UNIDIR.

Nowak, M. (2012). *Femicide: A global problem* (Research Note No. 14). Small Arms Survey.

Office of the United Nations High Commissioner for Human Rights. (2020, November 23). *Urgent action needed to end pandemic of femicide and violence against women, says UN expert* [Press statement]. https://www.ohchr.org

Peacock, D., et al. (2025). *Tracking the WHO's attention to firearm violence, 2000–2025.* Global Coalition for WHO Action on Firearm Violence.

Pinto, I.V. et al. (2021). *Fatores associados ao óbito de mulheres com notificação de violência por parceiro íntimo no Brasil*. Ciência & Saúde Coletiva, 26(3):975-985.

Pinto, I.V.; Marinho, F.; Malta, D.C. (2025). *Risk of mortality by aggression: A retrospective cohort study in women with notification of interpersonal violence in Brazil*. Public Health, 240: 12-17.

Rivers, A. (2024, January 16). *DF teve mais feminicídios cometidos com armas legais do que ilegais*. Metrópoles. https://www.metropoles.com/distrito-federal/df-teve-mais-feminicidios-cometidos-com-armas-legais-do-que-ilegais

Salama, H. (2023). Addressing Weapons in Conflict Related Sexual Violence: The Arms control and Disarmament Toolbox, UNIDIR, Geneva.

Salama, H. (2025). *Deploying the arms control and disarmament toolbox: Strengthening the role of United Nations peace operations to prevent sexual violence.* UNIDIR.

Salama, H. (2026). Gendered consequences: Conflict-related sexual violence. In M. Birch & A. Hagopian (Eds.), *De Gruyter handbook of conflict and health* (pp. 509–522). De Gruyter. https://doi.org/10.1515/9783111250144-028

Santaella-Tenorio, J., Cerdá, M., Villaveces, A., & Galea, S. (2016). What do we know about the association between firearm legislation and firearm-related injuries? *Epidemiologic Reviews, 38*(1), 140–157. https://doi.org/10.1093/epirev/mxv012

SEESAC. (2016). *Gender and SALW in South East Europe*. South Eastern and Eastern Europe Clearinghouse for the Control of Small Arms and Light Weapons.

SEESAC. (2025). *The misuse of firearms in domestic violence in the Western Balkans*.

Sharps, P. W., Koziol-McLain, J., Campbell, J. C., McFarlane, J., Sachs, C., & Xu, X. (2001). Missed opportunities for prevention of femicide by health care providers. *Preventive Medicine 33,* 373-80.

Šimonović, D. (2016). *Report of the Special Rapporteur on violence against women, its causes and consequences* (A/71/398). United Nations General Assembly.

Šimonović, D. (2021). *Taking stock of the femicide watch initiative: Report of the Special Rapporteur on violence against women, its causes and consequences* (A/76/132). United Nations General Assembly.

Soares, M. Q., Melo, C. M., e Silva, E. F., Pinto, I. V., & Bevilacqua, P. D. (2025). Survival and risk of death among women with reports of intimate partner violence during pregnancy: A national cohort study in Brazil. *BMC Public Health, 25*, 2025.

Sorenson, S. B., & Schut, R. A. (2016). Nonfatal gun use in intimate partner violence. *Trauma, Violence, & Abuse*, 19(4), 431–442.

Soares, M. Q., de Melo, C. M., & Bevilacqua, P. D. (2024). Femicide during pregnancy and postpartum period by an intimate partner: An integrative review. *Aggression and Violent Behavior, 76*, Article 101919.

Sousa, A. (2026, March 8). *Arma de fogo eleva em 85% o risco de morte em casos de violência doméstica, aponta estudo*. Folha de S.Paulo.

South African Medical Research Council. (2023). *National integrated strategy on the prevention of femicide*.

Stevanović Govedarica, G. (2021). Small arms and light weapons, gender-based violence and domestic violence: Analysis of regulatory framework and practice in Serbia. United Nations Development Programme. https://www.undp.org/sites/g/files/zskgke326/files/migration/rs/undp_rs_SALW_and_DV.pdf.

Taylor, C. (2019). Gun control and violence: South Africa's story. Gun Free South Africa.

Thrush, G. (2025, June 18). *Justice Dept. to cut gun-sale inspectors by two-thirds as it moves to downsize A.T.F.* The New York Times.

Tobin-Tyler, E. (2023). *Intimate partner violence, firearm injuries and homicides: A health justice approach to two intersecting public health crises*. Journal of Law, Medicine & Ethics, 51, 64–76.

Transgender Europe. (2023). *Trans Murder Monitoring 2023: Violence against trans and gender-diverse people in a global context*.

United Nations. (2024). *Final report of the Fourth United Nations Conference to Review Progress Made in the Implementation of the Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects* (A/CONF.192/2024/RC/3).

United Nations Economic Commission for Europe. (2019). *Report of the Beijing+25 Regional Review Meeting* (ECE/AC.28/2019/2). United Nations Economic and Social Council.

United Nations Human Rights Council. (2018). *Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity* (A/73/152). United Nations.

United Nations Secretary-General. (2024). *Conflict-related sexual violence: Report of the Secretary-General* (S/2024/292). United Nations Security Council.

United Nations Secretary-General. (2025). *Women and peace and security: Report of the Secretary-General* (S/2025/556). United Nations Security Council.

United Nations Security Council. (2000). *Resolution 1325 (2000) on women, peace and security* (S/RES/1325).

UNODC & UN Women. (2022). *Gender-related killings of women and girls (femicide/feminicide): Improving data to improve responses*.

UNODC & UN Women. (2022). *Statistical framework for measuring the gender-related killing of women and girls (femicide/feminicide)*. United Nations Office on Drugs and Crime.

UNODC & UN Women. (2023). *Femicides in 2023*.

UNODC & UN Women. (2025). *Femicides in 2024: Global estimates of intimate partner/family member femicides*. United Nations Office on Drugs and Crime and UN Women.

UN Women. (2012). *Handbook for national action plans on violence against women*. United Nations Entity for Gender Equality and the Empowerment of Women.

UN Women. (2015). *A framework to underpin action to prevent violence against women.* United Nations Entity for Gender Equality and the Empowerment of Women.

UN Women. (2025a). *Beijing+30 action agenda: For all women and girls*. United Nations Entity for Gender Equality and the Empowerment of Women.

UN Women. (2025b). *Beijing+30: From words to action – National action plans to end violence against women and girls*. United Nations Entity for Gender Equality and the Empowerment of Women.

UN Women, & The Equality Institute. (2023). *Together for prevention: Handbook on multisectoral national action plans to prevent violence against women and girls*. United Nations Entity for Gender Equality and the Empowerment of Women.

Vetten, L. (2025). *Losing liberty and life: Firearms and domestic violence in South Africa*.

Violence Policy Center. (2023). *American roulette: Murder-suicide in the United States* (8th ed.).

Vital Strategies. (2025, January 2). *Mulheres vítimas de violência mudam o padrão de visitas às unidades de saúde cerca de 90 dias antes do agravamento do caso*. Vital Strategies. https://www.vitalstrategies.org/mulheres-vitimas-de-violencia-mudam-o-padrao-de-visitas-as-unidades-de-saude-cerca-de-90-dias-antes-do-agravamento-do-caso/

Wallace, M. E., Vilda, D., Theall, K. P., & Stoecker, C. (2021). Firearm relinquishment laws associated with substantial reduction in homicide of pregnant and postpartum women. *Health Affairs, 40*(10), 1654–1662.

Ward, C. L., Lombard, C. J., & Gwebushe, N. (2006). Critical incident exposure in South African emergency services personnel: prevalence and associated mental health issues. *Emergency medicine journal : EMJ*, *23*(3), 226–231. https://doi.org/10.1136/emj.2005.025908

White House. (2023). *U.S. national plan to end gender-based violence: Strategies for action.*

World Bank & World Health Organization. (2014). *Global civil registration and vital statistics: Scaling up investment plan 2015–2024*. World Bank.

World Health Assembly. (1996). *Prevention of violence: A public health priority (WHA49.25)*. World Health Organization.

World Health Assembly. (2003). *Implementing the recommendations of the World report on violence and health (WHA56.24)*. World Health Organization.

World Health Assembly. (2014). *Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children (WHA67.15)*. World Health Organization.

World Health Assembly. (2019). *Eleventh revision of the International Classification of Diseases* (Resolution WHA72.15). World Health Organization.

World Health Organization. (2006). *Constitution of the World Health Organization.* In *Basic documents* (45th ed.).

World Health Organization. (2011). *Intimate partner violence during pregnancy* (WHO/RHR/11.35). World Health Organization.

World Health Organization. (2012). *Understanding and addressing violence against women: Femicide*. World Health Organization.

World Health Organization. (2013). *Maternal death surveillance and response: Technical guidance*.

World Health Organization. (2016). *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*. World Health Organization.

World Health Organization. (2019). *RESPECT women: Preventing violence against women* (WHO/RHR/18.19). World Health Organization.

World Health Organization. (2020). *SCORE for health data technical package*.

World Health Organization. (2021). *Maternal and perinatal death surveillance and response: Materials to support implementation*.

World Health Organization. (2022). *Verbal autopsy standards: Ascertaining and attributing causes of death tool*.

World Health Organization. (2025). *RESPECT women: Preventing violence against women* (2nd ed.). World Health Organization.

Zeoli, A. M., McCourt, A., Buggs, S., Frattaroli, S., Lilley, D., & Webster, D. W. (2018). *Analysis of the strength of legal firearms restrictions for perpetrators of domestic violence and their association with intimate partner homicide*. American Journal of Epidemiology, 187(11), 2365–2371.

Annex 1: Mandates, resolutions, and authoritative calls relevant to WHO action on firearm-related GBV and femicide

The instruments consolidated below fall into two tiers: those by which Member States have directly instructed WHO (the WHO Constitution and World Health Assembly resolutions), and those by which the wider United Nations human rights and statistical system has converged on the same agenda. Neither tier requires new authority; together they leave the question not whether WHO may act, but why it has not yet prioritised doing so.

Instrument (year)	Adopting/issuing body	Key provision
WHO Constitution (1946)	WHO Member States	Establishes WHO as the directing and coordinating authority on international health work
Resolution WHA49.25 (1996)	World Health Assembly	Declares violence a leading worldwide public health problem; requests the Director-General to develop science-based public health approaches to prevention
Resolution WHA56.24 (2003)	World Health Assembly	Calls for implementation of the recommendations of the World Report on Violence and Health
Resolution WHA67.15 (2014)	World Health Assembly	Strengthening the role of the health system in addressing violence, in particular against women and girls and against children
Resolution WHA69.5 and Global Plan of Action (2016)	World Health Assembly	Endorses the Global Plan of Action, which explicitly identifies firearm availability as a cross-cutting determinant of interpersonal violence
Resolution WHA72.15 (2019)	World Health Assembly	Adopts ICD-11, with national transitions under way since 2022
General Assembly resolutions 68/191 (2013); 70/176 (2015)	UN General Assembly	Action against gender-related killing of women and girls (see Šimonović, 2021, para. 18)
General Recommendation No. 35 (2017)	CEDAW Committee	Frames collection, analysis, and publication of violence data —disaggregated by victim–perpetrator relationship, including through femicide observatories—as part of States' due diligence obligations
A/71/398 (2016)	Special Rapporteur on violence against women	Establishes femicide watch modalities and data-collection methodology
A/76/132 (2021)	Special Rapporteur on violence against women	Stocktake of the femicide watch initiative; recommends that UN agencies continue and expand their support to States in establishing femicide information systems and watch bodies (para. 82)
Beijing+25 regional review outcome, (2019)	UNECE Member States	Recommendation 31(j): all countries should establish multidisciplinary national bodies such as “Femicide Watch”

Joint statement of 23 November (2020)	40+ special procedures mandate holders; CEDAW Committee chairperson; GREVIO; Inter-American Commission Rapporteur for Women's Rights	Renews the femicide watch call, with comparable data disaggregated by victim–perpetrator relationship and other characteristics
A/HRC/50/28 (2022)	Special Rapporteur on the right to health	Clarifies the legal obligations that arise under the right to health framework in addressing violence, including comprehensive health-system responses
53rd session decision (2022)	UN Statistical Commission	Endorses the UNODC–UN Women statistical framework for measuring the gender-related killing of women and girls
Reports of the UN SG on CRSV (2024) and on the WPS agenda (2025)	UN Secretary-General	Identifies the proliferation of small arms and light weapons as a driver and enabler of conflict-related sexual violence and gender-based violence

Resources:

https://justassociates.org/all-resources/ep-7-women-who-dream-of-a-world-without-gun-violence/

Notes

1. This information was derived from the General Mortality Records of INEGI for the period 2005-2024.↩
2. This information was derived from the General Mortality Records of INEGI for the period 2005--2024.↩
3. This information was derived from the General Mortality Records of INEGI for the period 2005--2024.↩

CO-PUBLISHING ORGANISATIONS

Data Cívica
Mexico City, CDMX, Mexico
www.datacivica.org

Division of Social and Behavioural Sciences, School of Public Health, University of Cape Town
Falmouth Building, Level 1, Anzio Road, Observatory, Cape Town, South Africa
health.uct.ac.za/school-public-health

Gender Centre, Geneva Graduate Institute
Maison de la Paix, Chemin Eugène-Rigot 2, 1202 Geneva, Switzerland
www.graduateinstitute.ch/gender

Gender Equality Network for Small Arms Control (GENSAC)
Global network / Secretariat
www.gensac.network

Global Coalition for WHO Action on Firearm Violence
Global coalition
www.whoaction.org · info@whoaction.org

Gun Free South Africa
P.O. Box 3048, Killarney, 2193, Johannesburg, South Africa
www.gfsa.org.za

Instituto Sou da Paz
Rua Cardeal Arcoverde 359, 13th floor, São Paulo, CEP 05508-000, Brazil
www.soudapaz.org

International Federation of Social Workers (IFSW)
Maiengässli 4, 4310 Rheinfelden, Switzerland
www.ifsw.org

Prevention Collaborative
Global
www.prevention-collaborative.org

Sexual Violence Research Initiative (SVRI)
2nd Floor, Lourie Place, 179 Lunnon Street, Hillcrest, Pretoria, Gauteng 0083, South Africa
www.svri.org · svri@svri.org

Women's Institute for Alternative Development (WINAD)
P.O. Box 10134, San Juan, Trinidad and Tobago
www.winad.org · winad1999@yahoo.com

World Federation of Public Health Associations (WFPHA)
Institute of Global Health, University of Geneva, Campus Biotech - G6, Chemin des Mines 9, 1202 Geneva, Switzerland
www.wfpha.org · secretariat@wfpha.org