Expert meeting on

Health-sector responses to violence against women

17–19 March 2009
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Contents

Abbreviations

CEHAT	Centre for Enquiry into Health and Allied Themes
CFPS	Child and Family Protection Services
CSA	childhood sexual abuse
FPU	Family Protection Unit
GBV	gender-based violence
GO	government organization
HAVEN	Hospital Assisted Crisis Intervention for Women Survivors of Violent Environment (Philippines)
IGMH	Indhira Gandhi Memorial Hospital (Maldives)
IPV	intimate partner violence
MCGM	Municipal Corporation of Greater Mumbai
MOH	Ministry of Health
NGO	nongovernmental organization
OSCC	one-stop crisis centre
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
SV	sexual violence
UNPF	United Nations Population Fund
VAW	violence against women
WCCCPU	Women and Children's Crisis Centre and Protection Unit (Philippines)
WHO	World Health Organization

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Introduction

Violence against women and girls (VAW) is a major public health and human rights issue, with sexual violence (SV) and intimate partner violence (IPV) being among the most pervasive. Research, initially from North America and Europe, but increasingly from other settings, has demonstrated the high prevalence of violence against women globally and its negative physical and mental health outcomes, in both the short and long term (Heise et al., 1999; Campbell, 2002). Health professionals frequently, and often unknowingly, come into contact with women affected by abuse, as they make extensive use of health-care resources.

Health professionals have been identified as being in a unique position to create safe and confidential environments for facilitating disclosure of violence and offering appropriate support and referrals to community and other resources. Although much of the evidence for health-sector interventions to address IPV originates from North America (Feder et al., 2009), many low- and middle-income countries are actively seeking to address intimate partner and sexual violence, by integrating specific services into the health-care setting. Approaches to this were outlined in a background paper that was disseminated prior to the World Health Organization (WHO) expert meeting on health-sector responses to IPV and SV, March 2009.

Despite the opportunities for greater health-sector involvement in responding to VAW, and the range of promising models being implemented in a diverse range of settings, this remains a challenge in most settings, particularly where resources are limited. It is important to consider the range of issues that need to be addressed to enhance service provision. These include: how to ensure that the response becomes institutionalized (i.e. changing individual behaviour and organizational culture); how to maintain multisectoral collaboration and collaboration with women's nongovernmental organizations (NGOs); how to ensure that women are not placed at further risk by any intervention; the range of forms of violence it is realistic to address in different health-care settings; which health-care settings are most appropriate for offering these services; should there be routine screening for partner violence or more selective enquiry for improved clinical management; and what are the key lessons about provider training in terms of minimum content and duration.

The meeting aimed to review current evidence and models of provision of care and address the range of challenges identified in providing services for victims of violence against women, particularly intimate partner and sexual violence, in order to initiate the process of developing guidelines for the health sector response to these problems. (See agenda and participants list.) Following a review of the evidence, models of care from different countries were presented. This led to the identification of key themes that need to be addressed by the health sector and a list of themes to be addressed by the guidelines on Health Sector Response to Violence against Women to be developed by WHO.

Aims of the meeting

1. To review the evidence and experiences of implementation and evaluation of health-sector interventions for VAW.

2. To identify key elements of an appropriate health-sector response, with a focus on resource-poor settings.

3. To explore the potential advantages and disadvantages of different models of health-sector responses, and the implications for the replication and scale-up for these models.

4. Building on the above, to develop a detailed outline for guidance to the health sector on an appropriate response to women suffering violence.

Summary of evidence on effectiveness of health-sector interventions

Professor Gene Feder presented an overview of the evidence for health-sector interventions to address partner violence, from two systematic reviews that he has led. (Feder et al., 2009; Ramsay, Rivas & Feder, 2005). Ramsay et al. (2005) published a systematic review of controlled evaluations of interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner violence. The review concluded that advocacy interventions can reduce the levels of abuse, increase social support and quality of life, and lead to increased use of safety behaviours and accessing of community resources. This form of intervention is particularly beneficial to women who have left the abusive relationship, who are actively seeking professional help or are in a refuge setting. However, it is not clear whether advocacy is an effective intervention for abused women identified in health-care settings, due to the lack of studies and their relatively poor design. There is also some evidence that psychological interventions are likely to improve women- and child-centred outcomes for women who have disclosed partner violence. System-based interventions involving changes within the health-care system, for example, can, with some degree of staff training and supportive materials, increase the rates of referral to specialist agencies in the short term. However, from studies with longer-term follow-up, there is evidence that reinforcement and training of new staff is needed to sustain this effect. There is no clarity from studies about whether reinforcement and structural changes help to improve outcomes for women.

Other recently published systematic reviews by Feder et al. (2009) and Ramsay et al. (2002; 2005) explored the question of whether screening for partner violence fulfils the public health criteria for a screening programme. The reviews found that even at the lower prevalence estimates of partner violence, morbidity and mortality show that it is a major public health problem and potentially an appropriate condition for screening and intervention. There are several short screening tools that are relatively valid and reliable for use in health-care settings. There is sufficient evidence that screening for partner violence is acceptable to women. However, the acceptability of partner violence screening among health-care professionals varies widely, and the overall evidence showed that the UK National Screening Committee criteria for implementing a universal screening programme were not met.[1] In terms of the effectiveness of interventions for women who have been identified through screening, there is insufficient evidence to implement a screening programme for partner violence against women in health services, with the possible exception of screening in antenatal settings. The question of when clinicians should ask about partner violence is a major issue. The focus should be on getting a low threshold for asking, by thinking about "clinical enquiry" as opposed to routine screening. Health professionals should be trained to ask directly about partner violence when women present with certain conditions, such as injuries; symptoms of anxiety, depression or substance abuse; sexually transmitted infections (STIs); repeat non-specific symptoms; recurrent gynaecological symptoms; and during the course of antenatal/prenatal care. The way the questions are asked is important as it can discourage women (e.g. "you're not a victim of domestic violence are you?"). Screening tools have been developed and tested and coupled with training in how to ask they have been shown to increase the identification of women suffering violence.

1 The US Preventive Services Task Force similarly reviewed the benefits and harms of screening for family violence evidence and found no studies examining its effectiveness. (U.S. Preventive Services Task Force, 2004; Nelson et al., 2004).

There have been some concerns about routine screening in the context of mandatory reporting of partner violence to authorities. Mandatory reporting is on the statute books in some states of the United States of America and in several countries. Studies of women's views show that women do not want mandatory reporting and that it may deter them from seeking health care. (Rodriguez et al., 1998) Mandatory reporting is a breach of patient confidentiality and autonomy when a competent person does not want the violence reported. It also requires strong evidence of potential benefit, which at present is absent. Studies show that what women want from health-care providers is: (i) before disclosure or questioning: to try and ensure continuity of care; (ii) to make it possible for women to disclose current and past abuse; (iii) when the issue of partner violence is raised, not to pressurize women to fully disclose; (iv) that the immediate response to disclosure is to ensure that women feel they have control over the situation and to address any safety issues; (v) that in later consultations, the health-care provider should understand the chronic nature of the problem and provide follow-up support.

Professor Jacqueline Campbell presented an overview of the largely North American evidence for the adverse health consequences associated with partner violence (see Campbell, 2002). Professor Campbell discussed a new surveillance system that has been implemented in the USA, where men and women are asked about IPV.

There was discussion within the group about the need to clarify the debate around gender symmetry, i.e. that women and men are equally violent. This is an issue in the developed world where surveillance systems ask men and women the same questions about partner violence. It is important to include questions about fear, injury and contextual factors that may help to improve the understanding of the differences as well as the similarities in the experiences of women and men. For example, in the British Crime Survey, although the reported prevalence of intimate partner violence was similar for men and women, a question on living in fear of the partner demonstrated clearly how the experiences were qualitatively different for women and men. Women reported experiencing more threats and fear, as well as injuries (Mirrlees-Black, 1999).

Key themes emerging

The meeting reviewed different models of health care provision for violence against women (see Annex 1 for a more detailed presentation of case-studies). The discussions of the models presented led to the identification of the key themes discussed below.

National policy context

The importance of having national policy directives underpinning strategies to address violence against women was evident in many of the presentations. Some countries had specific policies in place for addressing VAW (e.g. Mexico, Romania and Scotland) or linked violence against women to related issues such as sexual health, safer pregnancy, gender equality, human rights and child protection. In countries such as China, Iraq and Yemen, violence against women is not recognized as a priority issue, making it difficult to develop a national response within the health sector. For example, in Yemen violence against women is framed within the wider context of violence and injuries, as opposed to gender-based violence (GBV).

One of the challenges identified was securing high-level "buy-in". Having prevalence data, from national or local surveys, on the extent of different forms of violence against women gives the issue greater visibility and the data can be used as a tool to encourage governments to address the issue. Government has to be engaged at the highest level in order to make sure that health-sector responses to the problem are monitored and accountable. In many examples, ministries of public health were responsible for approving and funding intervention models, while setting national targets (e.g. Mexico's programmes to address IPV, Scotland's National Gender-based Violence Programme and the one-stop crisis centres (OSCCs) in Thailand.)

The development of networks and partnerships

Partnerships between the health-care sector and other statutory bodies and NGOs are critical to the success of VAW interventions, since many women will present with complex multiple needs. In the Romanian case-study, a basic protocol outlining the roles and responsibilities of different organizations was developed and the Romanian Ministry has used this as a national standard for multisectoral working.

Mutual respect of institutional and organizations' needs and resources is necessary for successful government organization (GO)/NGO collaboration. In Malaysia, a health-advocacy network brings together women, NGOs and ministries of health. However, historically there has been a lack of acceptance of women's NGOs as partners in responding to VAW. In the Hospital Assisted Crisis Intervention for Women Survivors of Violent Environment (HAVEN) in the Philippines, the model is a collaboration between government and nongovernment agencies. In Thailand, network strengthening is a key component of the one stop crisis centres.

In Mexico, there are different referral pathways depending on the severity of the violence. Women are initially provided with medical treatment and counselling within the health-care setting. However, those at high risk, requiring immediate safety or "death prevention", are referred to specialized VAW services such as refuges. However, one of the challenges of multisectoral working is the documentation and sharing of information across organizations for the purposes of documenting the woman's experiences and coordinating support plans.

Forms of violence addressed

Some intervention models had a broad focus in terms of the types of VAW being addressed. In the Scottish National Gender-based Violence Programme, the definition of VAW includes intimate partner violence, rape and sexual assault, child sexual abuse, commercial sexual exploitation, harmful traditional practices, and sexual harassment and stalking. Broadening the scope to include all forms of VAW helped to engage health-care professionals. This approach also facilitates linkages between the intervention programme and a range of national policies and legislative frameworks. Levers at a national level include the National Strategic Framework on Violence Against Women (formerly the Domestic Abuse Strategy); National Training Strategy on Domestic Abuse (now Violence Against Women); National Strategic Approach for Survivors of Childhood Sexual Abuse; National Domestic Abuse Delivery Plan for Children and Young People (developed under the auspices of Getting it Right for Every Child); and a legislative obligation under the Public Sector Duty for Gender Equality Act 2006; and a commitment to addressing inequalities (Better Health, Better Care).

Other models, such as the HAVEN case-study from the Philippines, the one stop crisis centres in Thailand and Malaysia, and the Romanian case-study also address a broad spectrum of VAW. The Hong Kong case-study focused on partner violence during pregnancy, while other models, mainly from African countries, focused on sexual violence, particularly post-rape care.

Approaches to training health-care professionals

Tthe Indian case-study on the Centre for Enquiry into Health and Allied Themes (CEHAT) presented an interesting approach to delivering training, based in a hospital setting. A core group of trainers was established, consisting of doctors and nurses who have undertaken intensive training. This approach helps to promote a sense of ownership of the work and their roles within the project. The core team then trains their own colleagues and the training has been well received compared to training provided by non-health-care providers. A training cell consists of core groups of trainers from different hospitals. The training is a nine-day educational programme on violence against women. The content includes domestic violence awareness, the health implications and role of health-care providers in responding to patients, and a follow-up module that focuses on the skills needed for screening women for domestic violence.

In the Romanian case-study, a joint training programme was developed for the police, health-care providers, social workers and other service providers. This approach fits well with the overarching philosophy of the Romanian intervention model, which is to develop partnerships between organizations so that there is a supportive multisectoral network that promotes communication between organizations and facilitates support for women.

Approaches to the identification of violence against women

Approaches to the identification of abused women ranged from screening all women to selective screening. In the Mexican case-study, the focus of the intervention is early diagnosis to target women in the early stages of the abuse trajectory. The approach to identification of abuse is made through identification of symptoms as opposed to routine screening – for example, if a woman presents with depression, anxiety or repeat STIs.

There must be a supportive environment in order for routine screening for abuse to take place – for example, with regard to confidential space, staff training, clinical guidelines and protocols, as well as ongoing monitoring of routine screening. In the Malaysia one-stop centres, there is no routine screening due to the lack of infrastructure (e.g. lack of financial support and staff shortages, lack of commitment at all levels, and a lack of regular review of the work protocol). Similarly, in Hong

Kong, routine screening for partner violence during the antenatal period was discontinued when the project did not received ongoing funding. The Scottish case-study provides an example of the kind of infrastructure needed to support a routine enquiry programme. Under Scotland's National Gender-based Violence Programme, routine enquiry will be introduced in a staged and incremental way by targeting priority settings such as mental health, maternity, sexual health, addictions, community nursing and accident and emergency. There will be monitoring and evaluation of routine enquiry using a paper-based system in all health-care settings. The national programme is run by a national team consisting of a programme manager, three regional advisers, a research manager, an information and performance manager and an administrator. There is national guidance in terms of a set of tools and resources on gender-based violence and routine enquiry, as well as local training consortia. There are also funds for dissemination of information and to raise staff awareness.

Documentation of abuse and forensic evidence collection

Accurate and meticulous documentation of abuse is needed in order to enable a woman to obtain the protection she needs. Careful documentation and photographs of injuries provide compelling evidence and may increase the likelihood that a perpetrator is brought to justice. It is also critical that each professional involved in the woman's care understands the potential role that the abuse plays in any presenting medical conditions. Records containing documentation of abuse should be kept in a confidential environment, but easily accessible to professionals involved in the woman's care. It is also important to recognize that documenting violence against women in an unsafe way can create unintended harmful outcomes.

In the Thailand case-study, part of the medical record goes to the OSCC and the other part stays in the health-care facility. This procedure is detailed in the clinical guidelines for health professionals. Furthermore, only professionals involved in the case can access the part of the medical record that contains documentation of the violence. However, there can be disadvantages to this approach, for example if health professionals do not look at the background medical records and are therefore not aware of the violence. In the Maldives case-study the hospital-based Family Protection Unit (FPU) has two different forms for documenting violence experienced by an adult or a child. Medical-legal forms are completed for each client and sent to the police through the chief executive officer's office. The case notes of all clients who come into contact with the FPU are stored in the FPU database. A monthly report is sent to concerned authorities at the end of each month. Hospital staff are trained and orientated to FPU activities. In the Mozambique case-study, general practitioners and surgeons are being trained to undertake high-quality medico-legal assistance. Similarly, in the Maldives case-study, medical staff receive training in collecting forensic medical evidence.

Framework for recommendations for health-sector responses to violence against women

Participants reflected on the case-studies and discussion groups of the previous days to identify key elements of a health-sector response to VAW, with a focus on resource-poor settings. These will inform the development of WHO recommendations. The themes identified are presented next.

1. Enabling environment

- National policies and procedures should be in place, as it may be difficult to work in an environment where laws and policies do not recognize violence against women as a problem or may even sanction, for example, men "disciplining" their wives.
- Before embarking on training health professionals, it is necessary to engage and managers to address the issue and secure organizational "buy-in" at a senior and strategic level within the health-care setting.
- Existing initiatives should be used to transform health systems, for example by linking violence against women to existing priorities such as HIV counselling and testing, and making pregnancy safer.
- Basic service-provision principles include: privacy and confidentiality; good communication skills; and policies for addressing institutional violence such as sexual harassment, bullying, and providers' own experiences of violence.
- Care pathways for abused women must be available.
- There must be a budget allocation for VAW.

2. Training

- Training providers should consider the intrinsic motivations for health professionals to learn about violence against women. For example, in the Romanian case-study, health professionals are motivated to attend training because they accumulate credits to continue to practise in their role. However, a core motivation for clinicians is to effectively respond to the health-care needs of their patients and this can be linked to the prevalence and health consequences of VAW.
- Minimum components should include: awareness raising to sensitize clinicians to the issue; listening to women and how to ask about partner violence; how to support and validate disclosure; care pathways within and external to the system; ethical issues (safety and confidentiality); legal issues (situation and rights); child protection; and documentation and record keeping.
- Electronic or paper audits of disclosure, documentation and referral should be maintained, which can be fed back to health professionals.
- Gender inequalities must be part of the training, since part of the aim is to change organizational culture as well as raise individual awareness.
- Integral to any training response is consideration of how to address violence in the health-care system itself.
- Agencies involved in the care pathway should be named and involved in the training process. The care pathway, both internal and external, must be clearly defined during the training.
- Models of training may vary according to the aims of the intervention and what health professionals are expected to do after the training.

- The training needs to be adjusted according to the needs of personnel and reflect the clinical context in which they are working.
- Training must recognize time limitations and what can realistically be achieved.
- There is a need to consider how the training is delivered, by whom, and the advantages and disadvantages of different models. For example, it may be beneficial for the trainer to be a health professional, in order to gain more acceptance for policy changes among staff.
- Multidisciplinary training may be beneficial in terms of enabling different professionals to understand each other's roles and responsibilities, and it can promote coordination of care and information sharing within the health-care setting. However, unidisciplinary training might be preferable if there are time constraints and health professionals are required to enquire about different forms of VAW.
- It may also be beneficial to consider joint training between the health-care organization and external agencies, in order to facilitate the referral process and promote an understanding of what kinds of support different organizations can provide. In South Africa, multisectoral training has been used, which was lengthy, but it was possible to cover many issues.
- There is a need to include administrative workers, cleaners, porters and security staff in some training, in order to raise awareness and sensitivity around the issue of violence against women, as these workers often have close contact with patients.
- Supervision and reinforcement are necessary after the initial training, in order to sustain the competencies health-care professionals acquire. This may include case conferences or updates at staff meetings. It is important to identify and use all existing opportunities to provide support to staff.
- Midlevel management needs training in order to be convinced about the importance of the issue and understand what is needed.
- Training should be included in undergraduate curricula, induction programmes, and in-service sessions for continuing professional development.
- Obtaining accreditation for the training will give it credibility and get "buy-in" from health-care managers and policy-makers.

3. Systems and services

- The minimum response that any health-care setting should provide, regardless of whether it is in a low- or high-resource country, is: listening; documentation of what the woman is saying, any injuries, and, if sexual violence has occurred, documentation of any forensic evidence; validation of the woman's experiences and a non-judgemental response; medical treatment; information about what services can assist immediately if there is a crisis, and in the long term. Support must be based on what the woman wants and continuity of care should be maintained whenever possible.
- The next level of support should include: safety planning; referrals within the health-care facility to professionals who have more experience of dealing with partner violence, or to external specialist organizations.
- It may be possible to have a core group of heath and social care professionals within the facility who receive additional training, in order to provide more in-depth emotional support after women have disclosed abuse. The core group can provide more ongoing support and risk assessment, ensure continuity of care and make referrals to external organizations. There may be more resources within the health sector than in external NGOs.
- Depending on one "champion" within the health-care facility will not ensure long-term sustainability of the service if the burden falls

on one person. It is important to define what we mean by "champion". The role has to be built into the management system of a health-care system so that it becomes part of someone's remit. Therefore, if that person leaves, the role still has to be fulfilled.

- Developing networks must be led by the government and should include the women's unit, ministries of health, NGOs, criminal justice system, police, internal affairs and health-care service. In order to establish the network, it may be necessary to rely on allies and interested persons in the first instance until it becomes institutionalized or part of core business.
- The health-care-delivery system should identify existing services and compare them with the guideline or standard. Any gaps should be filled by systematic implementation of these services to improve their accessibility, quality, efficiency and effectiveness.

4. Accountability and monitoring

- A monitoring system must be part of any health-sector response to VAW, to demonstrate that the problem exists and provide data on the number of cases.
- There should be regular case reviews to monitor the quality of service and support health professionals in responding to VAW.
- Debriefing support should be made available to health professionals.
- A system should be in place to learn from women's experiences of the service in order to improve quality.
- Interagency meetings should occur at a local and national level.
- Clinical guidelines for responding to VAW must be in place and their implementation should be monitored.

5. Research and surveillance

- There is a need for more research on the effectiveness of interventions in relation to outcomes for women and children, as well as on their cost effectiveness.
- Surveillance tends to focus on injury and will not provide accurate information about the health burden of violence. Other approaches are needed to get a more complete picture of the problem.
- Existing injury-surveillance systems make the underlying issue of gender-base violence difficult to identify. It is important to ensure that the sex of the victim and the relationship of the probable perpetrator to the victim can be documented.
- When developing surveillance systems, care must be taken to ensure that they are not cumbersome and time consuming. The smaller the amount of surveillance data collected, the better the quality.
- There may not be enough data on VAW in some countries to convince governments to address the issue. However, prevalence studies do not have to be large and it is possible to collect and use local data on prevalence to develop advocacy.
- It is important to recognize that there is limited research funding, and intervention studies should be prioritized over studies that only measure prevalence or health consequences of partner violence. Therefore, it may be more cost effective to include additional research questions in intervention studies. For example, it is possible to collect data on baseline prevalence of partner violence and cost-effectiveness within intervention studies, as well as doing nested qualitative studies on health professionals' views and experiences of the intervention.

6. Approaches to psychosocial and emotional support

- In the guidelines it is important to distinguish between what is psychosocial support given by a health-care professional that has first contact with the woman, and longer-term support that comes later from other professionals.
- Women experiencing IPV will need different types of support at different points in time. Therefore, a ladder approach may be necessary spanning basic emotional support and more specialized counselling and therapy. Health-care facilities should be prepared for and develop services for women who may need more intensive support.
- The starting point for psychosocial support is recognizing women's resilience. At a minimum, emotional support should include listening in a non-judgemental way. (Research from the Hong Kong case-study has highlighted the importance of listening to women's experiences.) The health professional must assess the risk to the woman and evaluate her expectations and intentions, and seek to provide women with some options based upon this information.
- It is important to clarify what are useful messages to convey to women when providing emotional support. In the USA clinicians are told to say "you are not to blame", but no one has tested whether this is a helpful thing to say to abused women, although survivors of partner violence believe that it is. If there is limited time within the consultation then it is important to know what messages to convey to women.
- For more specialized service provision, counsellors in the health-care facility should receive specialized training on how to manage cases of violence. This includes, for example, nurses who provide counselling services, psychologists and psychiatrists working in mental health teams or wards. Professionals should be equipped to deal with both partner violence and sexual violence. In South Africa, a new training curriculum is providing doctors with training to provide cognitive behavioural therapy, but this is still to be evaluated.
- The approach to service provision needs to be considered carefully, as the establishment of specialized counselling services that are known to be related to violence can be stigmatizing and provide a barrier to access. While it is important to create linkages with existing services, it is also important to avoid stigma that can be associated with certain types of counselling, such as for HIV.
- Health professionals should be prepared for some women to ask for help for their abusive partner, or a health professional may have contact with the partner of a woman who has disclosed violence to them. Due to safety concerns, health professionals should not seek to contact the woman's partner, and the provider should not refer the couple for traditional couple counselling or therapy. There is some evidence that low-level couple violence can be addressed by couple counselling, but this is specialized treatment for low-level violence, with both partners assessed separately about what they want to do. This should not be confused with traditional marital therapy. In general this approach is contraindicated.
- It is important to recognize that psychosocial and emotional support may differ for partner violence and sexual violence, although cognitive behavioural therapy has been shown to be effective for both IPV and SV. Post-traumatic stress disorder intervention for sexual violence victims is quite specialized and traditionally provided by psychologists, which presents challenges for settings where there is a lack of trained psychologists or other mental health specialists.
- The WHO guidelines should consider whether the response to partner violence and sexual violence will differ, how this will be addressed and at what level of health care different interventions are to be provided.

- Crisis-intervention models have been shown not to be effective. Programmes for men who perpetrate abuse only work if they want to change. Identifying these men can be difficult.

7. Non-negotiable issues and principles (ethical and safety issues, documentation)

- It is important to address contradictions between medical ethics and the laws of the country, particularly those related to mandatory reporting.
- It is important to consider the unintended harmful consequences that may occur as a result of badly implemented interventions.
- There should be absolute confidentiality, and information should only be shared with other professionals if there is a real risk to the woman's life, a child is being abused, or a person discloses that they intend to harm or kill someone else. While it is always preferable to do this with the consent of the woman, in some cases it may be necessary to do this without her consent. However, she should always be informed of what information is being shared, with whom and why.
- There is a need to consider how to deal with confidentiality in rural areas. For example, in small towns it may be safer to submit a mandatory report to the police in another town.
- The safety of the woman disclosing abuse, and her children, is always the main priority. It is important to believe what the woman is saying, empathize, and not belittle her experiences. The health professional must listen carefully to the details, to be able to assess the risks and support the woman to have a safety plan.
- The woman's decision should prevail and she should be allowed to take action when she wants to. The woman should have the right to treatment irrespective of whether a criminal case is pursued.
- Health professionals must document cases accurately and meticulously without judgement. They should not interpret what the woman says, but provide an accurate account of what she says and what is observed by the health professional (e.g. injuries etc.). The medical record should be kept somewhere confidential and should not be accessible to the perpetrator or family members.
- Personal details of the woman that can help to identify her should not be shared for any form of surveillance or monitoring.
- Health professionals should not take actions that will stigmatize a person suffering from violence.
- With regard to the perpetrator, he must be made responsible for his actions, but there may be scope to address other issues such as alcohol or substance abuse.

8. Screening

- Using the public-health model, there is not enough evidence to recommend screening for IPV across all health-care settings. In the context of antenatal care, it is possible to make a case for asking at least once based on trial evidence, if it can be done in a safe way without the partner present. It may also be appropriate to screen in the context of pregnancy termination.
- The high prevalence of violence experience in women with mental health problems may justify screening women who present with depression and anxiety disorders.
- It may be more appropriate to ask women about IPV (or SV) if they present with certain health conditions. For example, an accident and emergency department asking every woman who attends with an injury, or, in a primary care setting, every woman who presents with recurrent non-specific symptoms (like "tired all the time"). This constitutes appropriate clinical enquiry as opposed to screening all women.

9. The development of networks

- Multi-agency collaboration is necessary, since the health-care facility will not be able to meet women's multiple and complex needs.
- In order for networks to be successful, there should be an understanding of each partner's roles and responsibilities.
- Health-care facilities should be part of a network of organizations that can assist women affected by intimate partner violence and/or sexual violence.
- There is a need for networks to meet regularly to review issues, strengthen networks and integrate responses across sectors. (In the Romanian case-study, integration was critical to support local partnerships and activities focused on strengthening service provision across services. In the Malaysia case-study, they have state-level committees for the one-stop crisis centres, with regular joint training that is cosponsored by different agencies.)
- It is important to consider what can be done if there are no referral services within the country or there are limited resources. It may be necessary to have a core group of professionals within the health-care facility who receive more intensive training (e.g. basic counselling skills, risk assessment and safety planning), to whom women can be referred.
- Components of a successful network include: broad partnerships between agencies; active local core groups; joint training; integrated systems of referral; integrated information systems; and common behaviour-change-communication activities.

10. How to link violence against women with child protection in the guidelines

- Responding to cases of child abuse requires additional competencies that need to be provided in addition to training for intimate partner violence.
- It is important to keep a gender equality perspective and recognize the danger of blaming the mother.
- It may not be an efficient use of resources to separate out services for intimate partner violence and childhood abuse.
- It is important to explore with women how their children are being treated by the perpetrator, in a non-judgemental way.
- If a health professional is aware that a child is being abused, this should always be reported for the necessary actions to be taken.
- When reviewing a woman's situation in follow-up consultations, it is also important to consider the safety of her children.
- Health professionals may see different patterns of child abuse.
- Children living in domestic violence situations should not always be interpreted as child abuse and will not necessarily require mandatory reporting. Each case must be assessed individually in order to make a judgement. Mandatory reporting of all cases can result in unintended harmful consequences. This form of reporting may deter women from disclosing violence and could jeopardize their safety. However, it is also important to recognize that persistent witnessing of serious forms of domestic violence is a child-protection issue.
- In order to assess the impact on children, try to speak to them on their own to get more information and try to assess potential sources of support for children from

significant others. Offer referral of children to therapeutic support services. Report children at risk according to mandatory laws, and consider the woman's level of fear about children being removed.

- In the USA there is a principle of keeping children safe by ensuring the safety of the mother. It is important to support the non-abusing parent. Professionals working in the child-protection system need to receive training on domestic violence and vice versa.
- It is not clear whether the WHO guidance should recommend asking women using health services about childhood sexual abuse (CSA). There is very little time during a consultation to deal with a traumatic event that happened many years ago. However, the guidance should at least provide information on the link between intimate partner violence and CSA to ensure that this is not ignored. A woman may spontaneously disclose CSA while she is disclosing IPV and should be given the space to discuss this. It should be acknowledged that she has been disempowered by her experiences of past abuse. The population of women experiencing IPV overlaps substantially with the population of women who have experienced CSA. Therefore, although the guidelines should not recommend asking about CSA, they should state that health professionals should be prepared to respond to disclosures of child sexual abuse.
- Health professionals working in mental health services should receive extra training on child sexual abuse, as they are more likely to encounter women who are affected.

11. Mandatory reporting

- As noted in point 7, "Non-negotiable issues and principles", there should be absolute confidentiality and information should only be shared with other professionals if there is a real risk to the woman's life, a child is being abused, or a person discloses that they intend to harm or kill someone else. While it is always preferable to do this with the consent of the woman, in some cases it may be necessary to do this without her consent. However, she should always be informed of what information is being shared, with whom and why.
- The laws and legislation around mandatory reporting are likely to vary between countries and should be known to health-care providers.

12. The role of health-care services in responding to men as victims and perpetrators

- The health sector may have a role in assisting perpetrators of violence, as most men will not approach social services or criminal justice for help to address their violence. They are more likely to be present in general practice and alcohol abuse services. The health sector should work collaboratively with other agencies and refer men externally, where any services exist, rather than providing support within the health-care facility.
- The recommendations need to consider what response should be offered to men who are victims of sexual violence.
- If men's violence is linked to alcohol or illicit drug abuse, then it is necessary to consider what kinds of services are available to deal with both issues or how to integrate violence issues within substance-abuse programmes.
- If a health-care professional refers a male patient for help with violence, then it may be necessary for the partner to be aware of this.

13. The role of the health sector in prevention and the role of health promotion

- The health-care sector also has a role in primary prevention and health promotion, in coordination with other agencies.
- It is possible to integrate messages about violence as part of routine health-promotion activities. For example, in Moldova, family doctors provide mother and child classes and are able to do prevention work as this is part of their job description. In Hong Kong, prevention work is undertaken in antenatal classes (e.g. talk about care of the newborn, impact on relationship dynamics, etc.). In Mozambique, nurses in health centres do a 15 minute session on health promotion with all patients, not just women, and the issue of domestic violence is included. The health consequences and impact on children are also discussed.
- Other opportunities for primary prevention and health promotion include positive parenting and positive fathering, as in the Hong Kong case-study.
- It is also important to think about prevention work with adolescents and young people who use health-care services.
- Health-care professionals need to consider the language they use with women, and use gender-sensitive language. The issue of communications skills links with recommendations for point 2, "Training component".

References

Campbell JC. Health consequences of intimate partner violence. *Lancet*, 2002, 359(9314):1331–1336.

Feder G et al. How far does screening women for domestic (partner) violence in different health care settings meet the UK National Screening Committee criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 2009, 13:16. http://www.hta.ac.uk/1501 (accessed 10 March 2010).

Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Population Reports*, 1999, Series L(11):1–14.

Mirrlees-Black, C. *Domestic violence: findings from a new British Crime Survey self-completion questionnaire*. Home Office Research Study 191. London, United Kingdom, Home Office, 1999.

Nelson HD, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine* 2004, 140:387-396.

Parker B, McFarlane J, Soeken K, Silva C, Reel S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing & Health*, 1999, 22(1):59-66.

Ramsay J et al. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal,* 2002, 325:314–326.

Ramsay J, Rivas C, Feder G. *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner violence: a systematic review of controlled evaluations*. London, Department of Health, 2005.

Rodriguez, MA et al. Patient attitudes about mandatory reporting of domestic violence – implications for health care professionals. *The Western Journal of Medicine*, 1998, 168:337-341.

Tiwari A et al. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *British Journal of Obstetrics and Gynaecology*, 2005, 112(9):1249–1256.

U.S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. *Annals of Internal Medicine* 2004, 140:382-386.

Country case-studies

Case-study from Thailand

Dr Chanvit Tharathep presented the one-stop crisis centres (OSCCs) in Thailand. In 2000, the government cabinet approved OSCC implementation. In 2001–2002 there was a pilot project by the Ministry of Public Health for OSCCs in 20 regional and general hospitals. The OSCCs were expanded to 104 hospitals in 2004, and after the Domestic Violence Act in 2008 they were expanded to 250 hospitals in 2008. Treatment includes history taking, rape examination, HIV/STI testing, pregnancy prevention, antiretroviral drugs, and the provision of home shelter. A hotline has been set up in every province, which goes directly to the hospitals. Other key components of the intervention model include: training and skills improvement provided to all staff; network strengthening; community empowerment; and anti-violence socialization. In 2003, OSCCs were seeing five cases of IPV daily across 17 hospitals (or 1825 cases of violence against women and children). In 2008 OSCCs were seeing 73 cases of IPV daily across 582 hospitals (or 26 565 cases of violence against women and children).

Challenges encountered/lessons learnt

- Intimate partner violence is the most common form of violence experienced by women.
- In 50% of cases alcohol was involved.
- A multidisciplinary approach and management is helpful.
- Network strengthening is helpful.
- Integrated information management is important.
- There is a need to consider how different sectors can work together. Integrated strategic formulation among all participants is necessary.

Case-study from Mexico

Dr Aurora del Rio Zolezzi highlighted the importance of national-level policy and guidance on responding to VAW, which include statements about responsibility. In Mexico there are a number of national strategies and legislative frameworks in place: (i) 2007 Article 6, General Law for Women's Access to a Life Free of Violence; (ii) 2000 Mexican guidelines for addressing family violence in health-care services. Although very little was done in response to these guidelines, in 2002 the Federal Government assigned 7.5 million dollars to address VAW. In 2003 a national survey on IPV found that 33.3% of women had experienced some form of partner violence in the previous 12 months. By 2005 all 32 states in Mexico had begun developing or consolidating programmes to address IPV. Additionally, since 2006 VAW has been included in the social health insurance system as a way of scaling-up.

In Mexico the approach to intervention is the public-health model and health promotion (violence prevention in adolescence), where violence is portrayed as an unnatural behaviour. The focus of the intervention model is on early diagnosis and detection (not through routine screening, but through clinical enquiry) to target women in the early stages of violence. Support offered to women may include: (i) counselling and psychological treatment that focuses on helping women to find a way out of the cycle of violence and assess different options; (ii) medical attention to STI/HIV prevention; (iii) attention to injuries and to diseases associated with VAW; (iv) emergency contraception; (v) medical abortion and legal advice in cases of rape; and (vi) death prevention through referral to refuges. Dr del Rio Zolezzi described three levels of attention that match different levels of severity of violence: (i) essential first-contact units, e.g. emergency rooms; (ii) specialized VAW

services; and (iii) highly specialized VAW services such as refuges. In Mexico, health professionals favour diagnosis of partner violence through symptoms detection as opposed to routine screening (e.g. if a woman presents with depression, anxiety, repeat STIs, etc.). If a woman discloses partner violence, then further in-depth questions are asked before referring her to the appropriate organizations or professionals. If a woman reports "no violence", but the health-care professional suspects that she is a victim of violence, the suspicion will be documented and she will be asked again at her next visit.

Challenges encountered/lessons learnt

There is a need for:

- more preventive work;
- more detection at first-level contact;
- improved quality of services;
- more epidemiological surveillance;
- financial sustainability.

Case-study from Scotland[2]

Katie Cosgrove presented Scotland's National Gender-based Violence Programme 2008–2011. Scotland's national guidelines on health-sector responses to IPV, published in 2005 were largely ignored and there was an identified need for structural change. The Healthcare Policy and Strategy Directorate at the Scottish Government is responsible for overall management and direction. The programme will be implemented across the NHS in Scotland, which comprises 14 local health boards and 8 special health boards that have a national remit.

In order to engage health-care providers, it was necessary to broaden the scope to all forms of VAW, including IPV, rape and sexual assault, child sexual abuse, commercial sexual exploitation, harmful traditional practices, and sexual harassment and stalking. Levers at a national level include the National Strategic Framework on Violence Against Women (formerly the Domestic Abuse Strategy); National Training Strategy on Domestic Abuse (now Violence Against Women); National Strategic Approach for Survivors of Childhood Sexual Abuse; National Domestic Abuse Delivery Plan for Children and Young People (developed under the auspices of Getting it Right for Every Child); and a legislative obligation under the Public Sector Duty for Gender Equality Act 2006 and a commitment to addressing inequalities (Better Health Better Care). The work programme has four key deliverables: (i) implementation of routine enquiry in key priority settings; (ii) guidelines for health-care providers; (iii) production of an employee policy on GBV; and (iv) improved multi-agency collaboration, particularly in relation to child protection and homelessness.

The approach to routine enquiry will be staged and incremental, by targeting key priority health-care settings such as mental health, maternity, addictions, sexual and reproductive health, accident and emergency, and community nursing services. Targets have been set that are measurable. There will be monitoring and evaluation of routine enquiry using a paper-based system in all settings, case tracking of some women, and evaluation of staff perceptions. However, routine enquiry will not be introduced until the right physical environment is secured (e.g. having policies in place etc.). There will also be annual reporting of results to the Scottish Government. The programme is run by a national team consisting of a programme manager, three regional advisers, a research manager, an information and performance manager and an administrator. There is national guidance in terms of a set of tools and resources on GBV and routine enquiry, as well as local training consortia. The programme includes funds for dissemination of information and to raise staff awareness.

[2] A web site for the programme and its materials is in the process of being established. The main document outlining the programme can be found at: http://www.sehd.scot.nhs.uk/mels/CEL2008_41.pdf

Women who disclose abuse in these settings may be offered counselling or therapy if required. Where there is an ongoing relationship, e.g. with a health visitor, there may also be advocacy and emotional support. In all settings, however, women would be offered information on local services for women experiencing abuse, and referred on to them as appropriate. In the implementation of the programme, it is also expected that staff will undertake risk assessment with each woman and support her in creating a safety plan. Although there is variation across the country, every health board area has a multi-agency partnership on VAW, which offers different support to women, and health services would refer women to these local initiatives. There is a national helpline for domestic abuse and another for rape and sexual assault, and women would be given details of how to access these.

Lessons learnt in the development and implementation of the intervention

- There is a need for communication across the health directorates within the Scottish Government to ensure appropriate inclusion of this issue in strategic and operational developments.
- There is a need to ensure that information on the evidence base for this work is clear and readily available to staff.
- It is important to identify where the differential responsibilities lie and harness support, e.g. the policy for employees will be developed nationally through the staff governance team and then disseminated to the 22 health boards rather than the boards individually creating their own.
- Each board has been asked to identify a senior executive lead for the work and an operational manager – this has been important in achieving "buy-in" for the programme and a clear line of accountability for its implementation.
- There are two main reporting mechanisms into the Scottish Government. This is important in helping boards to understand where and how information on their progress is being reported.

Challenges encountered

- The geography of Scotland has required the programme to be developed in a way that meets the different needs of urban, rural and island communities. The number of boards and their hugely varied demographics mean there is a need to design and agree individual targets and performance measures against which to measure progress.
- Lack of national datasets for recording of disclosures, etc., is a major problem and one that is difficult to resolve within the timescale of the programme. Accurate data will consequently be difficult to gather. Given the above, the development of the monitoring and evaluation framework presents a key challenge in seeking to reflect adequately the implementation of the programme.
- At a conceptual level, it has been crucial to help boards understand that the programme is not interested merely in identifying the numbers of service users who have been abused, and that routine enquiry is a means to an end not an end in itself. It is designed to improve the health-care assessment and response – the process has therefore had to be slowed down in some areas where there is inadequate preparation for its implementation.
- There are competing priorities within boards that are focusing on meeting national health targets.
- There is some degree of anxiety about the impact of routine enquiry on staff, both personally and professionally.
- There is concern about the capacity of external agencies to absorb the anticipated increase in referrals.

- There are difficulties linking in to all the national developments that have relevance for this work, e.g. in workforce development, strategic frameworks for mental health, addictions, others, and identifying mechanisms to ensure its integration and mainstreaming.
- The scale of the training programme and planning across 22 health boards, which has to be undertaken before the implementation of routine enquiry, also presents a challenge.
- There is a variation in availability of services for women across the country.

Case-study from Malaysia

Dr Siti Hawa Ali presented the one-stop crisis centre (OSCC) in Malaysia . In the last two decades, the Ministry of Health (MOH) of Malaysia has shown greater interest in the area of VAW. Although the MoH did not emerge as one of the key players at the outset, they have shown greater interest in recent years. Their effort has been supported and encouraged by women's NGOs, particularly since the 1990s.

OSCCs as an intervention model to respond to VAW began at Kuala Lumpur Hospital, the main government tertiary-level hospital in the country in 1993. This was subsequently replicated by Penang General Hospital in 1995, and by 1996 all general hospitals at the state level were instructed to set up an OSCC within their emergency departments. In 1997, all district hospitals were instructed to set up OSCCs and provide the services accordingly. At present there are about 128 OSCCs in government hospitals nationwide.

Basically, an OSCC provides integrated support to survivors of violence, within a hospital set-up. This includes physical, forensic, and social as well as emotional support services. Follow-up support for both medical and non-medical needs is also given to the survivors as and when needs arise. The integration of services is carried out both at organizational level and among relevant agencies that deal with the issue of VAW directly and indirectly. The interagency committee/network plays the role of the community arm for the OSCC. The interagency committee will examine issues faced by survivors, work on the support system between agencies, and also recommend policy changes at relevant levels. The members of the interagency committee come from all relevant government agencies as well as NGOs. In some set-ups, the interagency meeting is held on a monthly basis to resolve any issues regarding the survivors and services, but most commonly they will meet once or twice a year to discuss overall issues pertaining to the operation of the OSCC. This set-up exists at all levels from federal to district level.

Challenges encountered/lessons learnt

At a conceptual level:

- There is still an ongoing debate on the involvement of medical personnel and the MOH in the issue of VAW. Some of the questions regularly raised are: Are emergency departments the appropriate entry points for VAW? Will social-health intervention become a required approach in dealing with this issue specifically and other health issues generally? Does a multidisciplinary approach challenge the dominance of the medical profession? What would be the status of partnership of women's NGOs and the MOH in dealing with the issue? Should gender perspective in health intervention and health policy be given importance?
- The sustainability of services and models has also become one of the major issues that the OSCC programme has to deal with. The model started with the intention of supporting survivors of VAW in the capital city of Malaysia; the MOH was not prepared with a blueprint on how such a model should be replicated at different levels or health set-ups. The fact that it was strongly supported by women's NGOs from the outset, especially in providing training and volunteers, has left the model in a situation

where it depends on the interest of individual medical or health personnel, or continuous support from a women's NGO. In other words, it has become "champion dependent", and without these key "champions" the services may not be provided satisfactorily.

At service level, OSCC services can be tremendously improved if the following challenges are dealt with:

- Development of a dedicated team of staff, or improvement in the level of commitment from medical/health staff to dealing with the issue of VAW at all levels, is necessary to ensure the effectiveness of OSCCs.
- Appropriate allocation of a budget would not only assist the running of OSCCs, but also supply the necessary recognition and accountability of the service.
- The justice system relies heavily on the medical documentation. An integrated approach towards medical reporting and documentation is necessary not only to assist the justice system but also to reduce the burden for a single medical unit/department such as the obstetric and gynaecology department. At the same time, it will also increase the importance of other medical assessments such as those done by psychiatrists and medical social workers.
- The OSCC model needs to keep abreast not only of medical procedures but also of the whole discussion on VAW and gender perspectives of the health sector. The work protocol requires regular review, so that services can fulfil their objective of being sensitive towards the needs of survivors of interpersonal violence.
- One of the greatest challenges faced by this model is to give an effective follow-up service to survivors. In many situations survivors do not return to the emergency department. . In cases where survivors are suspected to be in danger of contracting HIV or STIs they may not be traced or may refuse a follow-up appointment. This may enhance the silent growth of such illnesses.

Measures taken

- Given the challenges, several steps have already been taken to ensure that the OSCC model survives. These include:
- Reactivating the involvement of women's NGOs in supporting the OSCC services. This is currently done in two ways, with a third project planned:
  - By involving them in research on the health impact of violence (2007–2010). This research is conducted by the Women's Health Development Unit of Universiti Sains Malaysia, which has invited the women's NGOs that deal with violence to be their research partners. The aim of this partnership is to bring both the MOH and women's NGOs back onto the same platform in promoting OSCC.
  - By developing the health-advocacy network. The information based on the research will be used to help promote awareness of the relationship between VAW and health. Women's NGOs and researchers from universities will be the core group in this work.
  - Another country-wide research project on health impact will also be carried out by the Women's Development Research Centre of Universiti Sains Malaysia. In this study, about 400 nurses will be trained on the issue of VAW, as they will take part as data collectors in the research.
- Improving medical and health sciences curricula:
  - as part of the accreditation process, all medical schools in the country must indicate that they have included the subject of gender and health as well as violence on their curriculum;
  - some health sciences and medical schools have already included specific subjects such as interpersonal violence as part of the regular curriculum they offer.

- Developing an integrated model at local level:
  - the OSCC service at the Hospital Universiti Sains Malaysia is currently a regular reference for local practitioners. It has a dedicated nursing team and a committed team of medical and social workers, as well as piloting an electronic documentation system that ensures confidentiality and reduces the practice of repeating questions to survivors of violence. It also carries out monthly case reviews with supervision.
- Improving networking:
  - OSCCs rely on a multidisciplinary approach to be effective; therefore, strengthening the collaboration of the network is critical to ensuring that survivors of violent experiences receive the necessary support. The efforts made include regular collaborative training and regular meetings either during the monthly case conference or by meeting annually at district or state level;
- Reviving OSCCs at local level:
  - at least three major hospitals from different states in the country have shown interest in reviving their OSCC services. This may be the beginning of a revival that may be followed by other states and district hospitals. This process will not only provide a revival for the OSCCs that are less active, but will also provide an opportunity for a comprehensive evaluation of OSCCs in the country.

Since the introduction of OSCCs throughout the country in 1996, the OSCC as a model has shown that it is not easy to attract health-sector involvement in VAW. It takes a long time to change the mindset of medical and health personnel and to convince them that they are part of the detection, treatment and prevention team. However, having an OSCC set up in all hospitals has helped thousands of women and children who experience violence, and it speeds up the development of an awareness about the issue among medical and health-sector personnel. Indeed, one is able to observe more genuine interest among these personnel.

Case-study from India: the Centre for Enquiry into Health and Allied Themes (CEHAT)

Ms Padma Deosthali presented work undertaken by the Centre for Enquiry into Health and Allied Themes (CEHAT). Dilaasa, India's first hospital-based crisis department was established at KB Bhabha Hospital, Bandra to make the public health-care system take account of the issue of domestic violence. It was set up in 2001 as a collaboration of the public health department of the MCGM (Municipal Corporation of Greater Mumbai) and CEHAT (the research centre of the Anusandhan trust). Another such department was initiated at Kurla Bhabha Hospital in 2006. The strategic location of Dilaasa in a hospital has helped around 1500 women facing domestic violence to access services easily. Dilaasa means "reassurance", and it seeks to provide psychosocial support to women survivors of domestic violence. The objectives are to: (i) provide social and psychological support to women coming to the department; (ii) assist the key trainers of the five hospitals to train their hospital staff on an ongoing basis; (iii) build capacity of the training cell members to train the staff of the 16 hospitals and work towards making the hospital patient friendly; and (iv) network with other organizations working on women's issues, for mutual support and sharing.

Training at Dilaasa is aimed at improving the response of hospital staff to women facing domestic violence. The training programmes, such as gender-sensitization training of the entire staff, are conducted mainly by health professionals, i.e. doctors, nurses and social workers, and target those screening women patients reporting for treatment in various departments of the hospital. The training activities have now been expanded to five hospitals across the city of Mumbai. This training is conducted by trained hospital staff

with support from CEHAT staff. Methods include: (i) an orientation module that aims to develop an understanding of domestic violence as a health-care issue, and the role of health-care providers in responding to patients; and (ii) a follow-up module that aims to build skills in screening women for domestic violence and also provides an understanding of the cycle of violence and specific needs of women living in violent homes.

Within the intervention, a core group of trainers has been established, consisting of doctors and nurses who have undergone intensive training. This helps to promote a sense of ownership of the work and their roles within the project. The members of the core team train their own colleagues, and the training is well received compared with non-health-provider training. Having the core group develop their own proposal and set up their own intervention in the hospital proved to be successful, as it guaranteed their investment in the project. A training cell consists of core groups of trainers from different hospitals. They have developed a nine-day VAW educational programme. Additionally, some nurses have been trained as counsellors to provide support to women in the hospitals. Hence, there is potential for nurses to play a large role, but this requires changes in national policy. Key intervention components include a crisis-counselling model based on feminist counselling principles, suicide-prevention counselling, and education of mainstream health providers.

In the counselling impact study, the focus of the counselling was removing blame. Safety plans were useful, though not always effective. It was important for women to have a space where someone listened and believed them and where they could get immediate help in an emergency. Even women facing extreme restrictions on their mobility were able to get help on the pretext of going to the hospital.

In addition to the counselling intervention, the Sexual Assault Care and Forensic Evidence or SAFE Kit is a "model kit for comprehensive care and documentation of evidence in cases of sexual assault". The kit was designed to address issues of care and documentation in relation to sexual assault. Critical components of sexual assault intervention include: (i) consent; (ii) collection of evidence; (iii) documentation; and (iv) medical and psychological support.

Challenges encountered/lessons learnt

- Difficulties have been encountered with health professionals not wanting to document forensic evidence, in order to avoid appearing in court.
- A lack of institutional policies and guidelines has been found.
- There is a perception among some health professionals that VAW is not a health problem.
- Health professionals are reluctant to become involved in cases of torture and conflict, particularly when they involve the State.

The SAFE kit does not ensure a sensitive response:

- partial evidence collection is not offered with SAFE;
- there is mandatory reporting of sexual assault and rape to the police, which may deter some women from seeking help from health-care professionals;
- there is a lack of confidentiality and privacy, e.g. examinations for sexual assault and rape take place on the labour ward;
- admission is mandatory.

Case-study from Romania

Ms Ionela Cozos presented Romania's strategy to address VAW. This model was selected by the United Nations Population Fund (UNFPA) as one of 10 case-studies of successful programming for addressing VAW, and a similar model is being adopted in Moldova. She highlighted the importance of the national policy context, as Romania

has many national strategies and legislative frameworks that support work on VAW. These include the Law on Equal Opportunities Between Men and Women and the Law on Preventing and Combating Domestic Violence, in addition to the provisions under criminal law. Key actors involved in work on VAW include: national government institutions; local administration institutions; civil society; and international partners such as WHO and UNFPA. VAW is also a priority area for the Sexual and Reproductive Health Strategy (e.g. safe motherhood making pregnancy safer; family planning; abortion services; prevention and management of STIs and HIV/AIDS; prevention and management of infertility; sexual health of ageing people; sexual and reproductive health of adolescents and youth; and early detection of genital and breast cancer). The programme has a broad remit and addresses all forms of VAW. The objective of the programme is to enhance the capacity of governmental institutions at national and local levels, and of civil society, to formulate, implement and evaluate policies to combat VAW. There is identified service provision for victims and perpetrators, and referrals are made within a network of statutory organizations and NGOs.

Historically, the challenges encountered at a political and financial level included: varying levels of involvement of national and local authorities; difficulties in identifying local partners; limited local resources; and conflicting local priorities. Challenges encountered at a technical level included: the lack of specialized services; a lack of common protocols; training needs; infrastructure; and monitoring (e.g. in terms of multiple definitions, events versus cases, aggregation/reporting, and multiple entry points).

The solution was to develop an integrated approach involving a national framework and policies, with local partnerships. The philosophy of this model is to integrate services for victims with prevention efforts and build a network for communication and support. The components of this approach include: broad partnerships between institutions; active local coordination groups that develop action plans and meet regularly; a joint training programme for health-care professionals, police, social workers and other experts; an integrated system of referrals and services where everyone in the network understands the roles and responsibilities of other members; and an integrated information system. What works well with regard to this approach is the grass roots working at the highest levels of government, taking a multisector approach; building the technical and management capacity of professional staff; introducing an integrated information system, important not only for defining and quantifying the problem, but for tracking cases; and using the media as an ally.

Challenges encountered/lessons learnt

- Partnerships are critical to the success of VAW projects and local authorities must be part of the process.
- Efforts to combat VAW must address victims and perpetrators.
- Quality – high standards set by the lead institution tend to be adopted by partners.
- High-quality training and follow-up stimulates involvement by other partners.

Case-study from Hong Kong

Dr Agnes Tiwari presented health-sector approaches to addressing VAW in Hong Kong. In terms of a health-sector response to VAW, there is no national strategy, no budget allocation, no training for health professionals, and no integration between services. The first population-based survey of pregnant women in Hong Kong was conducted in 2005–2006. The sample consisted of 3245 patients. Of these, 296 (91%) reported being abused by their partners in the previous year; 216 (73%) reported psychological abuse; and 80 (27%) reported physical or sexual abuse. Dr Tiwari presented the results of a published study of a randomized controlled trial of an intervention tested on 110 pregnant Chinese women between 2002 and 2003. (Tiwari et

al., 2005). Women who received the empowerment intervention (which was adapted from an intervention in the USA by Parker et al., 1999) reported reduced psychological and minor physical abuse, reduced symptoms of postnatal depression, and improved health-related quality of life post-delivery compared to the control group (Tiwari et al., 2005).

Unfortunately, the intervention did not receive ongoing funding, so there is no practice of routine screening for IPV in Hong Kong. The focus therefore of Dr Tiwari's research is now on primary prevention. Dr Tiwari referred to two new primary prevention projects that she is involved in: (i) the positive fathering project; and (ii) the positive parenting project. In the positive fathering project the emphasis is on couple communication, coping with Chinese and western expectation and beliefs about childbirth and the postpartum period. The positive parenting project focuses on the family as a whole, with trained voluntary workers to support parents and children. The project also emphasizes child-friendly parenting in order to decrease physical punishment and negative verbal messages.

Capacity-building strategies include: (i) having a "champion" within the health-care setting, which is immensely helpful to raise the profile of the research team, create open lines of communication, make public their recognition of the research, and provide financial back-up when needed; (ii) providing exposure to the issue for faculty through practice in shelters for abused women and providing health assessment and education; (iii) designing and implementing courses for undergraduate and postgraduate students on partner violence prevention and intervention; and (iv) providing continuing education sessions at the College of Obstetrics and Gynaecology.

Challenges encountered/lessons learnt

- It is not necessary to reinvent the wheel when researching interventions, but they should be culturally appropriate.
- Interventions should be theory based, evidence based and protocol driven.
- It is important to have a well-trained and committed research team.
- Clinicians and practitioners should be involved in the research.
- Close monitoring is necessary to ensure intervention fidelity and adherence.
- It is unethical and unsafe not to give the control group any treatment.

Case-study from the Philippines: Project HAVEN (Hospital Assisted Crisis Intervention for Women Survivors of Violent Environments)

Ms Teresa Balayon presented project HAVEN (Hospital Assisted Crisis Intervention for Women Survivors of Violent Environments), which was established at the hospital-based crisis centre at East Avenue Medical Centre in the Philippines Women and Children's Crisis Centre and Protection Unit (WCCCPU). The model utilizes a holistic and integrated approach to addressing VAW, underpinned by collaboration between government and NGOs. The original purpose of the intervention was to (i) mainstream and institutionalize experiences of NGOs in the health-care-delivery system, to provide medical, health and psychosocial services for women-victim survivors, in an environment that is gender sensitive and woman friendly; and (ii) institutionalize government and NGO collaborative response, with the long-term goal of replicating the hospital-based crisis centre in all government hospitals.

The intervention model addresses a broad spectrum of violence, including IPV, sexual assault and trafficking. Current objectives within the intervention model include: (i) to provide gender-sensitive and holistic health care to women and children victims/survivors of violence; (ii) to create and sustain a woman- and child-sensitive environment within the hospital; (iii) to

sensitize and reorient personnel at all levels and departments of the hospital, to the issue of VAW; (iv) to develop a career path or subspecialty in health and GBV; (v) to develop a systematic and gender-sensitive documentation and monitoring system; (vi) to develop training materials that have evolved from experiences of staff of the WCCCPU; and (vii) to assist the Department of Health in developing a model for replication in government hospitals.

Services provided to victims include crisis intervention, counselling, medical treatment, legal referral and temporary shelter. Support programmes include education and training, survivors' support, policy advocacy and monitoring, documentation, and generation of knowledge. Ms Balayon also referred to the context in which the intervention occurred. There was a strong demand for woman-centred approaches to VAW, responsive national machinery for women's concerns, receptive government officials and hospital administrators, committed women's organizations, and commitment from governments to international standards of responses to VAW.

Challenges encountered/lessons learnt

- There have been shifts in policy regarding government/NGO collaboration.
- Periodic turnover of medical personnel can cause difficulties.
- Lack of access to services among poor and disadvantaged women is challenging.
- Problems have been encountered with implementation of the WCCCPU protocol within the hospital system.
- Inappropriate implementation of national laws and local government ordinances has caused problems.
- It is important to eliminate vestiges of unequal power relations at interpersonal, institutional and structural levels.
- Responses to VAW must recognize the inherent capacities of victim-survivors to cope with a failure of social institutions to eliminate conditions that create abuse and violence.
- Holistic, complementary, and integrated victim-centered perspectives and approaches as well as interdisciplinary and multidisciplinary studies of GBV are critical to responses of the health sector to VAW.
- Health services must continuously improve their response to VAW through education and training, environmental scanning, coordination with the community, periodic organizational assessment, and planning involving survivors and other service providers.
- Mutual respect of institutional and organizational needs and resources is necessary to successful government and NGO collaboration.
- Compliance with international standards requires appropriate complementary mechanisms at mid and local levels.

Key gaps and issues that remain

- Provision of after-care for survivors of VAW.
- Conceptual and values clarification of stakeholders.
- Assessment of current responses to VAW.
- Improving compliance to intervention standards.
- Management of knowledge generated from current responses to VAW.
- How to create a culture that is free of violence and abuse.

Case-study on services for sexual violence in selected African countries

Dr Jill Keesbury presented a review of services for sexual violence in selected African countries. Generally, services to meet the needs of survivors

are weak and poorly understood. There is a lack of documented experiences about what works, and the focus is on prosecuting the perpetrator rather than caring for the survivor. Furthermore, the needs of survivors vary greatly depending on sex, age, the nature of the assault, disease epidemiology, legal options available and sociocultural context.

Most African countries are characterized by a lack of dedicated medico-legal services or by poorly organized and separate services. The African regional sexual and gender-based violence (SGBV) initiative of the Population Council incorporates 9 countries and 20 partners. Key elements included in the response are: (i) medical (e.g. management of SV at first point of contact with the survivor, sensitive approaches to managing child survivors of SV, and encouraging and enabling presentation by male survivors, screening for signs and symptoms of violence during consultations); (ii) justice system (e.g. collection of forensic evidence and creation of a chain of evidence that can be used during prosecution, strong links between medical and police facilities to enable incidents to be referred in either direction); and (iii) community (e.g. psychological counselling, new or strengthened community-based prevention strategies that are relevant and appropriate for the local context, to convey messages about IPV in prevention strategies).

The objectives of the SGBV network are to: (i) pilot innovative approaches to SGBV service strengthening; (ii) document the feasibility of these approaches; and (iii) promote evidence-based policies and programmes across the region.

Challenges encountered/lessons learnt

- Legislation and policies, multisectoral frameworks, guidelines, protocols and validated training curricula are essential for ensuring coordinated responses to SGBV. Medical management is quite well developed. Police protocols for evidence collection and treatment of survivors are available. However, psychological support and treatment of children and males remains weak.
- One-stop shops are not the only way, or the ideal model for delivering SGBV services. One-stop shops are resource intensive, there are issues around sustainability, there is urban bias and questions about what works in rural areas, and they have not been evaluated in low-resource settings. Alternative models include integrated care within existing health facilities, linking to the police; strengthening police services and linkages to health centres; and a victim advocate or "buddy system" where integrated services are not available.
- Legal concerns can serve as a barrier to accessing medical and other management services. Public barriers include: not wanting to prosecute family members, transportation costs may act as a disincentive to visiting a second point of contact, and limited or incorrect awareness of the requirements for receiving care. Health-care-provider barriers include: limited or incorrect awareness of the requirements for delivering care, limited awareness of forensic evidence-collection procedures, and unwillingness or inability of health-care providers to present evidence in court.
- The majority of survivors reporting sexual assault are children or adolescents, yet services are commonly designed for adults.
- Very little is know about addressing the immediate and long-term psychological needs of survivors in Africa, and the feasibility, safety and effectiveness of addressing intimate partner violence in low-resource health services.
- While the need for a multisector response is clear, how best to organize cooperation and collaboration between sectors for policy and for delivery is not clear. At facility level there is the question of where to situate services; at systems level, links with police and judiciary, and links with prevention services need to be addressed; and at policy level, decisions need to be made about involvement of ministry of gender or social services.

Case-study from Maldives: the Family Protection Unit (FPU)

Dr Aseel Jaleel presented the work of the Family Protection Unit (FPU) at Indhira Gandhi Memorial Hospital (IGMH) in the Republic of Maldives. Qualitative research conducted in 2004 highlighted the need to establish a support service in the health sector to address GBV. The aims of the intervention model are to: (i) improve the responsiveness of the health sector to GBV and child abuse; (ii) establish a dedicated FPU to deal effectively and sensitively with cases of abuse at the hospital; (iii) develop specific hospital protocols and procedures for dealing with abuse cases; (iv) develop and display advocacy materials; (v) train/sensitize all hospital staff on GBV, identifying signs and symptoms of GBV, following protocols, effective documentation of abuse and appropriate referrals; (vi) train medical staff personnel in collecting forensic evidence; (vii) develop a confidential database of all abuse cases that can produce data on the number of cases; (viii) have dedicated staff working for the FPU at IGMH; (ix) offer a safe, child-friendly and comfortable space for examinations and private counselling; and (x) offer on-site counselling and referral to outside support services.

Between 15 August 2005 and 27 February 2009, the total number of cases referred to the FPU included 105 GBV, 270 child-protection issues, 47 other cases and 95 unmarried pregnancy cases, giving a total of 517 cases. The FPU has two different forms for documenting violence experienced by an adult or a child. Child-abuse cases are referred to the Child and Family Protection Services (CFPS) using a referral form, and adult clients are provided with the contact numbers of counselling agencies. Medical-legal forms are completed for each client and sent to the police through the chief executive officer's office. Case notes of all clients who come into contact with the FPU are filed at the FPU. Information about the client, including name and address, are stored in the FPU database. A monthly report is sent to concerned authorities at the end of each month.

A total of 188 staff at IGMH have been trained and orientated to FPU activities, including 41 doctors, 117 nurses and 30 paramedical staff. Various staff members have attended external training courses, conferences and workshops on GBV and health-sector responses, including a workshop on the forensic investigation of rape cases. Advocacy materials for health-care professionals include information on the services provided by the FPU, referral procedures and the responsibilities of health-care professionals. Advocacy materials for patients include information on the services provide by the FPU, location of the service and issues of confidentiality.

Challenges encountered/lessons learnt

- Strengthening institutionalization of FPU services at IGMH
- Designating a FPU coordinator
- Improving the physical capacity of the FPU
- Improving the pathway of care
- Developing guidance and information material to raise staff awareness
- Screening for gender-based violence and child abuse
- Strengthening the capacity building of health personnel on identification and management of victims of abuse
- Strengthening the referral system between the hospital and other sectors in providing support services to abused women and children
- Raising public awareness about the existence of FPU services and the unacceptability of GBV and child abuse

Case-study from Yemen

Dr Eman Alkobaty presented the Violence and Injury Prevention Programme in Yemen that was initiated by the Ministry of Public Health and Population in 2004. However, the programme was not active for some time due to the lack of resources. In 2008,

the programme merged with the Injury Prevention Programme funded by the WHO (Injury and Violence Prevention Department). The Ministry of Public Health implemented a surveillance system on violence and injuries in 10 major hospitals that were equipped with computers. Doctors are trained to use a special form to document cases of violence, and a training manual on diagnosis of violence cases will be developed by a multidisciplinary team of health-care professionals (e.g. forensic doctors, gynaecologists, paediatricians). Guidelines for addressing violence against children and adults were developed. The surveillance system has been implemented since July 2009, when doctors in the emergency departments in the 10 hospitals were trained. Since Yemen has no data on the extent of different forms of VAW, the new system will generate data.

The presentation highlighted how difficult it is to develop work on VAW in a country where the national policy context does not recognize VAW as an abuse of human rights. VAW is not considered as a significant issue in itself, but is framed within a wider context of violence and injuries, which makes it more difficult to give it any visibility.

Challenges encountered/lessons learnt

- VAW is not a priority issue and there is a lack of awareness about the issue.
- VAW is not an explicit component in the programme.
- There is a lack of local/national data on the extent of VAW.
- There is a culture of silence, which creates further stigma around the issue of VAW.
- There is a lack of systems.
- Resources are deficient.
- There is a lack of services to support abused women in terms of legal support and social and medical care.
- There is poor coordination between the relevant partners at government level and NGOs who work on the issue of VAW (e.g. Ministry of Public Health and Policy, Ministry of Justice, Ministry of Interior Affairs, Ministry of Social Affairs and Labor and NGOs).

Case-study from Iraq

Dr Faiza A Majeed presented the challenges of addressing VAW in Iraq. The status and situation of Iraqi women has deteriorated with three wars since the mid-1980s, which resulted in a decade of sanctions. The Iran–Iraq war, with an estimated one million soldiers killed, created a segment of "traumatized women and girls" who suffered over the loss of their families. Different forms of VAW exist apart from IPV, for example sexual harassment, detention, and torture for political reasons. The events in Iraq after the 2003 war, particularly the sectarian conflicts, led to an increase and emergence of new forms of VAW that are continuously threatening Iraqi women's rights to security, mobility and access to health care and education, as well as employment. This includes targeted killings of women to settle political, ethnic or family scores; threats by militant groups to force women to restrict their movement in public; and violation against women's rights, such as forced early marriage of young girls, induced by economic and sociocultural factors.

The social stigma attached to sexual violence crimes prevents many women from accessing medical treatment or seeking psychosocial counselling, as reporting can also lead to other social and cultural consequences such as rejection or even honour-related murder for having caused shame to the family. Vulnerability and exposure to violence has increased among internally displaced women. Women may be forced into trading sex for food and shelter for their families, especially in refugee situations (among widows). The extent of sexual assault of female prisoners is unknown.

The Iraq Family Health Survey measured the extent of domestic violence and found that among women

surveyed, 83.1% experienced controlling behaviour from their husbands, 33.4% emotional violence, 21.1% physical violence and 13.9% physical violence during pregnancy. In the past five years, there have been 21 000 reported cases of VAW, 400 reported rape cases between 2004–2005, and 150 women beheaded in 2006.

Dr Majeed discussed a new victim-assistance project in Kurdistan. Four pilot injury-surveillance projects have been implemented. There is a joint project on combating VAW in three areas – northern, central and southern Iraq. Stakeholders include various government ministries, NGOs and civil society. The project outcomes are to ensure that: (i) VAW is integrated within the government's policies, as well as civil society organizational programmes, services and activities; (ii) the institutional, technical and operational capacities of key government ministries and civil society are strengthened to adequately respond to the needs of VAW survivors; and (iii) positive change in perceptions and attitudes among community leaders and local communities, especially adolescents, in relation to gender equity and equality, including VAW, is achieved.

Challenges encountered/lessons learnt

- The sociocultural context in Iraq makes it difficult to address the issue of VAW.
- There are ongoing efforts in Iraq to improve the country's performance on human rights, especially women's rights.
- There is a lack of legislative frameworks to protect women from violence and regulate and institutionalize the fight against VAW.
- There is a lack of services for survivors of VAW in Iraq.
- There is a shortage of human resources and financial support.
- There needs to be improved coordination between different United Nations agencies and NGOs, to avoid duplication.

Case-study from Mozambique

Dr Francelina Romao presented the health-sector response to VAW in Mozambique. A survey conducted in 2005 showed that 54% of women had been victims of physical or sexual violence at some point in their lives. In 2002, nurses and doctors working in health units providing 24 hour services in Maputo town received training. The objectives were to improve the quality of care and documentation of violence. The central hospital of Maputo developed a standard protocol to assist victims of sexual violence. National surveillance on trauma, of which violence is a component, was introduced in 2008 in every provincial and central hospital.

In 2008, GBV was discussed at a national annual meeting with all hospital managers, where the standardized protocol was discussed and approved. This council is chaired by the Minister for Health. Medico-legal specialists exist in only three central hospitals. In 2009, general practitioners and surgeons will be trained to undertake high-quality medico-legal assistance. Health-care professionals coordinate with NGOs that can provide counselling and support related to psychological and legal matters. However, most of these activities are being implemented in major urban areas only. In 2009, there was comprehensive training of nurses working in mother and child care covering 300 nurses in Maputo. They are also developing a programme where women can obtain assistance in the health unit (like a one-stop shop) to prevent revictimization. The next step is to improve coordination between health care and the police.