



# Health Sector Response to Gender-based Violence

Case Studies of the Asia Pacific Region

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# **Health Sector Response to Gender-based Violence**

## **Case Studies of the Asia Pacific Region**

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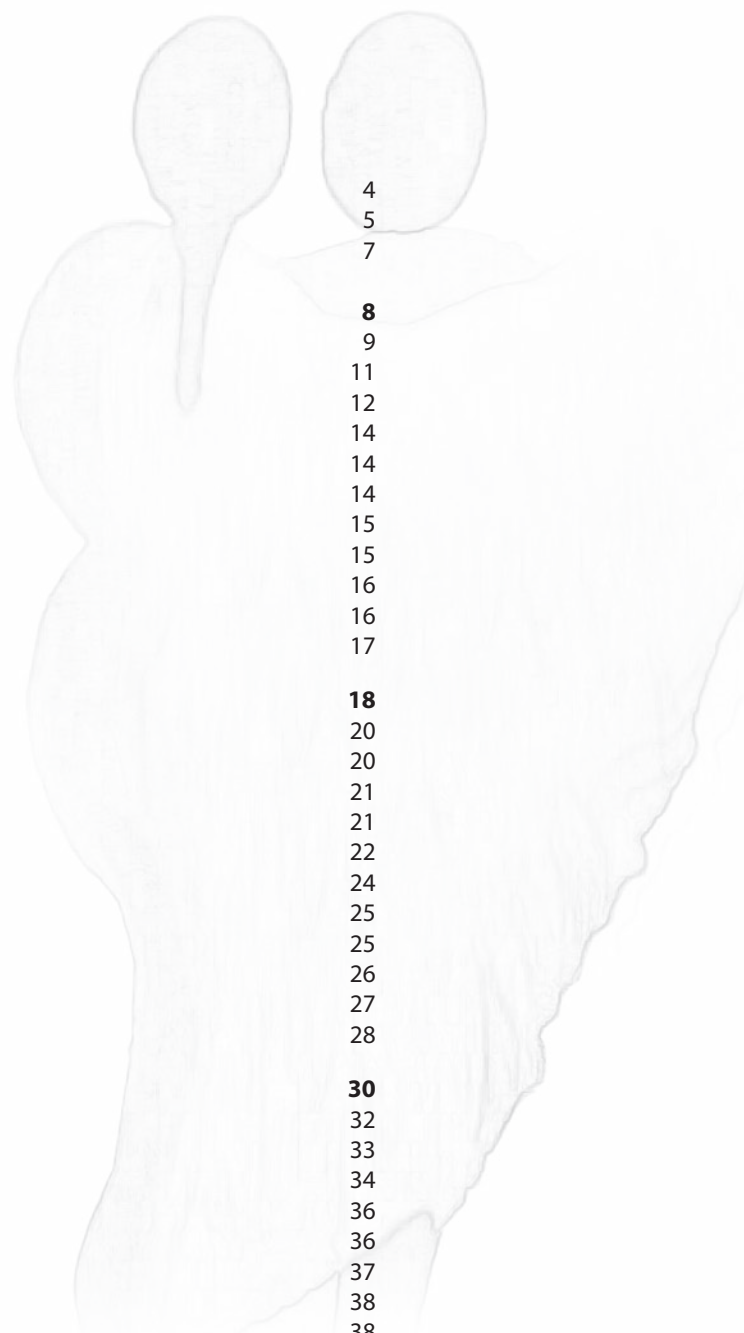
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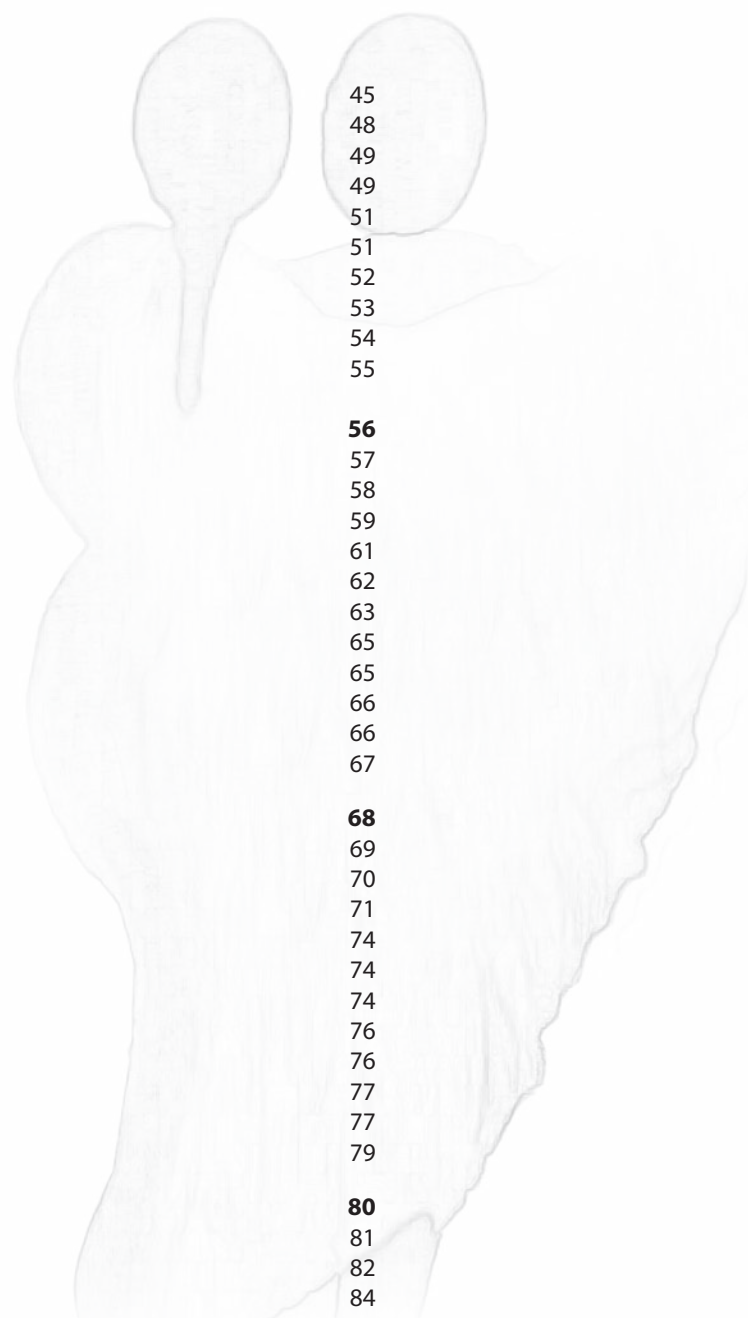
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# Acronyms and abbreviations\*

|                |  |
|----------------|--|
| <b>A&amp;E</b> | Accident and emergency   |
| <b>AIDS</b>    | Acquired Immune Deficiency Syndrome  |
| <b>APRO</b>    | Asia Pacific Regional Office   |
| <b>CEDAW</b>   | Convention on the Elimination of All Forms of Discrimination Against Women                       |
| <b>CEO</b>     | Chief executive officer  |
| <b>DNA</b>     | Deoxyribonucleic acid  |
| <b>DV</b>      | Domestic violence  |
| <b>GAD</b>     | Gender and Development   |
| <b>GBV</b>     | Gender-based violence  |
| <b>GDI</b>     | Gender Development Index   |
| <b>GEM</b>     | Gender Empowerment Measure   |
| <b>GNI</b>     | Gross National Income  |
| <b>HDI</b>     | Human Development Index  |
| <b>HIV</b>     | Human Immunodeficiency Virus   |
| <b>INGO</b>    | International non-governmental organisation  |
| <b>IPV</b>     | Intimate partner violence  |
| <b>MDG</b>     | Millennium Development Goals   |
| <b>MoH</b>     | Ministry of Health   |
| <b>MoJ</b>     | Ministry of Justice  |
| <b>MoU</b>     | Memorandum of Understanding  |
| <b>NGO</b>     | Non-governmental organisation  |
| <b>OSCC</b>    | One-stop crisis centre   |
| <b>PPP</b>     | Purchasing power parity  |
| <b>RH</b>      | Reproductive health  |
| <b>SRO</b>     | Sub-regional office  |
| <b>STI</b>     | Sexually transmitted infection   |
| <b>ToT</b>     | Training of trainers   |
| <b>UNDP</b>    | United Nations Development Programme   |
| <b>UNFPA</b>   | United Nations Population Fund (formerly United Nations Fund for Population Activities)          |
| <b>UNICEF</b>  | United Nations Children's Fund (formerly United Nations International Children's Emergency Fund) |

|            |                           |
|------------|---------------------------|
| <b>VAW</b> | Violence against women    |
| <b>WHO</b> | World Health Organisation |

## Bangladesh

|                   |  |
|-------------------|--|
| <b>DGHS</b>       | Directorate General of Health Service          |
| <b>GES</b>        | Gender Equity Strategy                         |
| <b>HNPSP</b>      | Health Nutrition and Population Sector Program |
| <b>MMR</b>        | Maternal mortality rate                        |
| <b>MoH&amp;FW</b> | Ministry of Health and Family Welfare          |
| <b>MoW&amp;CA</b> | Ministry of Women and Children Affairs         |
| <b>RPiP</b>       | Revised Programme Implementation Plan          |
| <b>WFH</b>        | Women Friendly Hospital                        |
| <b>WFHI</b>       | Women Friendly Hospital Initiative             |

## Malaysia

|              |   |
|--------------|---|
| <b>KLH</b>   | Kuala Lumpur Hospital   |
| <b>OBGYN</b> | Obstetrics and gynaecology  |
| <b>KPWKM</b> | Ministry of Women, Family and Community Development (Kementerian Pembangunan Wanita, Keluarga dan Masyarakat) |

## Maldives

|             |                                 |
|-------------|---------------------------------|
| <b>FPU</b>  | Family Protection Unit          |
| <b>IGMH</b> | Indira Gandhi Memorial Hospital |
| <b>MGF</b>  | Ministry of Gender and Family   |
| <b>SHE</b>  | Society for Health Education    |
| <b>TEH</b>  | Total Expenditure on Health     |

\* Included in this list are only those acronyms, abbreviations and initialisms which occur more than once in the text. These acronyms, abbreviations and initialisms are listed according to the case study in which they are found, with those occurring in more than one case study listed together.



## Papua New Guinea

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|              |  |
|--------------|--|
| <b>FHS</b>   | Family health services                             |
| <b>FSC</b>   | Family support centre                              |
| <b>FSVAC</b> | Family and Sexual Violence Action Committee        |
| <b>LRC</b>   | Law Reform Commission                              |
| <b>MSF</b>   | Médecins Sans Frontières (Doctors Without Borders) |
| <b>NDoH</b>  | National Department of Health                      |
| <b>NHPS</b>  | National HIV Prevention Strategy                   |
| <b>PEP</b>   | Post-exposure prophylaxis                          |
| <b>PNG</b>   | Papua New Guinea                                   |
| <b>VCT</b>   | Voluntary counselling and testing                  |

## The Philippines

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|              |   |
|--------------|---|
| <b>DoH</b>   | Department of Health  |
| <b>DSWD</b>  | Department of Social Welfare and Development                            |
| <b>EAMC</b>  | East Avenue Medical Center  |
| <b>GGI</b>   | Gender Gap Index  |
| <b>HAVEN</b> | Hospital-Assisted Crisis Intervention for Women in Violent Environments |
| <b>ILO</b>   | International Labour Organisation                                       |
| <b>NCRFW</b> | National Commission on the Role of Filipino Women                       |
| <b>PNP</b>   | Philippine National Police  |
| <b>PPGD</b>  | Philippine Plan for Gender-Responsive Development                       |
| <b>RA</b>    | Republic Act  |
| <b>VAWC</b>  | Violence Against Women and Children                                     |
| <b>WCC</b>   | Women's Crisis Centre   |
| <b>WCPU</b>  | Women and Children Protection Unit                                      |

## Sri Lanka

---

|             |                                  |
|-------------|----------------------------------|
| <b>CMoH</b> | Central Ministry of Health       |
| <b>FHB</b>  | Family Health Bureau             |
| <b>IDP</b>  | Internally Displaced Person      |
| <b>PHM</b>  | Public health midwives           |
| <b>PHNO</b> | Public health nursing officers   |
| <b>SGBV</b> | Sexual and gender-based violence |

## Timor-Leste

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|               |  |
|---------------|--|
| <b>PRADET</b> | Psychosocial Recovery and Development in East Timor            |
| <b>RHRCC</b>  | Reproductive Health Response in Conflict Consortium            |
| <b>SEPI</b>   | Office of the Secretary of State for the Promotion of Equality |



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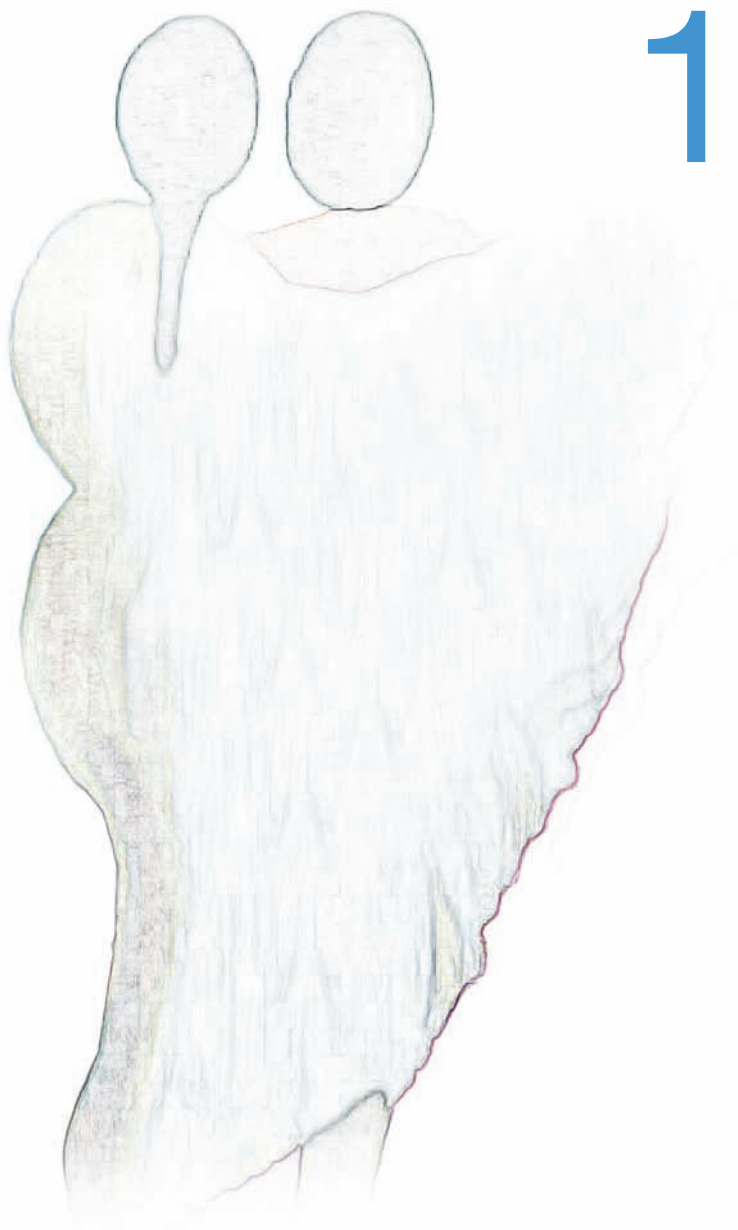
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# Bangladesh

## Country Profile:

|  |                |
|--|----------------|
| Total population (in thousands):                       | 155,991 (2006) |
| GNI per capita (PPP Intl \$):                          | 1,230 (2006)   |
| Total health expenditure per capita (PPP Intl \$):     | 26 (2006)      |
| Life expectancy at birth male/female (years):          | 64/64 (2007)   |
| Maternal mortality ratio (per 100,000 live births):    | 320 (2007)     |
| Infant mortality ratio (per 1,000 live births):        | 52 (2006)      |
| Births attended by skilled health personnel (%):       | 20 (2006)      |
| Total fertility rate:                                  | 2.9 (2006)     |
| Human Development Ranking 2009 (out of 182 countries): | 146            |

Source: World Health Statistics 2008

**B**angladesh has a population of 155 million people living in an area of 147,570 square kilometres, which makes it the country with the highest density of people per square kilometre. The rural population forms 76 per cent of the population [1].

Bangladesh has made remarkable progress in recent decades as measured by social development indicators, particularly in the area of health [2]. Life expectancy had risen to 64 years by 2007, and, for the first time, the life expectancy of females has surpassed that of males. The adult literacy rate has increased to 54 per cent with the enrolment of females at both primary and secondary level being greater than that of males.

The maternal mortality rate (MMR) has decreased from 570 per 100,000 live births in 2005 to 320 per 100,000 live births in 2007. These achievements have been made while the country is still considered a relatively low resource country with a Gross National Income (GNI) per capita of \$470 (PPP \$1,230) [3]. In addition, Bangladesh is extremely vulnerable to natural disasters such as floods, cyclones, storms and mudslides, as well as being prone to conflict and civil disturbances, all of which have a major negative impact on the health and economy of the country. Furthermore, sporadic conflict has taken place in parts of Bangladesh for several years. It is widely acknowledged that conflict and post-conflict settings as well as displacement oftentimes lead to an increased prevalence of gender-based violence (GBV) in the affected areas.

Hospital services are the most visible and important component of the health care delivery system. Functionally, public sector hospital services are divided into three levels – primary, secondary and tertiary. There are 30 to 50-bed Upazila Health Complexes (UHC) at the

Upazila (*upojela* or subdistrict) level. They, together with union-level ('urban-ward' level) hospitals, provide primary care, i.e. the 'Essential Services Package'. District (*zila*-level) hospitals range from 50 to 250-bed hospitals and provide specialised care in addition to primary care. Presently, upgrading of district hospitals from 50 to 100-250 beds is ongoing. At the tertiary level, medical college hospitals and specialised hospitals provide specialised care while some function as teaching hospitals. The secondary level and tertiary level hospitals are also linked with other hospitals as referral centres [7].

## Prevalence of GBV

GBV is common both in urban and rural areas of Bangladesh and is prevalent across regions and classes. The reported prevalence rates range from 40-70 per cent [5], although various studies have found considerable underreporting of the data. For example, it appears that only the most severely beaten women consider their problem worthy of mentioning in an interview or surveys while some others accept beating and abuse as commonplace and do not report it [6].

The WHO Multi-country Study on Domestic Violence (DV) and Women's Health was carried out in one urban and one rural site in Bangladesh in 2004. It showed that in the group of ever married women aged 15-49 years, 40-42 per cent reported physical violence and 37-50 per cent reported sexual violence purportedly by their husband ever in their lifetime [4]. It also showed that sexual violence was more frequent in provincial areas of Bangladesh in comparison to urban areas [4]. The same study found that 14 per cent

of ever pregnant women reported experiencing physical partner violence during pregnancy.

Another recent study of intimate partner violence (IPV) suggests that: 'violence against women (VAW) is endemic in Bangladesh: about three-fourths (74 per cent) of the rural and more than half (58.8 per cent) of urban women reported having been physically abused by their husbands any time during their married life, while 35.4 per cent of rural and 29.7 per cent of urban women were physically abused anytime during the last 12 months preceding the survey' [6].

Reports of VAW in the media have been on the rise in the last decade [6]. However, it should be noted that at least a

part of this trend may be due to increased reporting rather than increased prevalence.

The direct health consequences of IPV include various forms of injuries. In regards to IPV, 93 per cent of rural women and 89 per cent of urban women have suffered from one to two injuries per incidence of violence, however, very few abused women have utilised formal services. Only 9.6 per cent of women who reported violence had used a health service and virtually no women had sought help through the police or the courts [6, 7]. The WHO Multi-country Study also found statistically significant associations between IPV and various negative physical, mental and reproductive health (RH) consequences [4].

**Table 1: Number of cases of different types of GBV reported in the media (1997-2008)**

| No.          | Category               | 1997 |            |              | 2000 |              | 2005 | 2006         |              | 2007 | 2008 |              |
|--------------|------------------------|------|------------|--------------|------|--------------|------|--------------|--------------|------|------|--------------|
| 1            | Rape                   | 434  |            |              | 286  |              | 491  | 549          |              | 458  | 307  |              |
| 2            | Gang rape              | -    |            |              | 179  |              | 271  | 248          |              | 201  | 132  |              |
| 3            | Attempt to rape        | -    |            |              | 38   |              | 142  | 141          |              | 114  | 111  |              |
| 4            | Murder after rape      | -    |            |              | 30   |              | 142  | 170          |              | 126  | 114  |              |
| 5            | Homicide               |      | 192        | 353          |      | 1,010        |      | 1,086        | 837          |      |      | 720          |
| 6            | Suicide                |      | -          | 281          |      | 563          |      | 478          | 337          |      |      | 281          |
| 7            | Physical violence      |      | -          | 94           |      | 1,350        |      | 1,118        | 481          |      |      | 269          |
| 8            | Dowry related violence |      | 127        | 57           |      | 131          |      | 112          | 148          |      |      | 102          |
| 9            | Dowry related murder   |      | -          | 79           |      | 208          |      | 274          | 176          |      |      | 170          |
| 10           | Forced marriage        |      | 50         | -            |      | 6            |      | 4            | 10           |      |      | 5            |
| <b>Total</b> |                        |      | <b>803</b> | <b>1,397</b> |      | <b>4,314</b> |      | <b>4,180</b> | <b>2,888</b> |      |      | <b>2,211</b> |

Source: Bangladesh Mahila Parishad, based on 14 National Dailies. [6]

It is important to note that in Bangladesh, 14 per cent of the maternal deaths are considered to be due to violence [8]. The contribution of violence to maternal deaths equals that of abortion and is only surpassed by haemorrhages. The relatively large contribution of violence towards the MMR is possibly due to high rates of fatal forms of violence such as acid throwing or burning as well as the deliberate murder of women. Therefore, it is understandable that the health sector is attempting to address GBV by linking it to the reduction of maternal mortality.

## Overarching policy framework

According to article 15(a) of the Constitution of the country, the health of all citizens is one of the fundamental responsibilities of the State. Bangladesh has ratified all the conditions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and has committed to achieve the Millennium Development Goals (MDG) by 2015.

The Government of Bangladesh has undertaken a number of legal reforms to address the issue of GBV including the Suppression of Violence Against Women and Children (Amendment) Act (2003) and the Acid Crimes Control Act (2002). The Law Commission of Bangladesh has also recently taken the initiative of drafting a Bill on DV which is an important step towards the legal recognition of DV in Bangladesh. The draft bill not only recognises psychological violence in the eyes of the law but recommends that the provision of counselling for victims and perpetrators should be provided.

The National Health Policy (Draft) recognises the significance of GBV under the topic of emerging issues stating that: 'Emerging and Reemerging with risky diseases such as arsenic related diseases, avian flu, childhood disabilities,

mental health problems, road-railway-river accidents and violence (particularly against women) are being considered as major challenges for the country' [1]. The subject of GBV is not specifically included in any of the goals but under the section of principles it is recognised in broad terms:

- '12. Determine the priority regarding health sector strategy and innovative programmes on the basis of epidemiological data and the socio-cultural context.
13. Tackle emerging and reemerging diseases caused by demographic transitions and environment reasons as well as the changing pattern of diseases.'

Although GBV cannot be considered a 'disease', given the aforementioned preamble, these principles could be seen as relating to VAW. Furthermore, under strategy 32 of the National Health Policy it is mentioned that:

*'A coordinated prevention, cure and rehabilitation health care service management along with the help and assistance from other concerned ministries ... will be formed for addressing health of the victims of violence, attack, road-rail-water accidents specially women and children. The centres that do not have this kind of service will be improved so that these kinds of victims get medical treatment from there.'*

Although the health policy admirably attempts to recognise the issue of GBV, the importance of GBV seems to merge with other issues such as road-rail-water accidents, which have different implications. Specifically targeted strategies to address GBV including acid injuries would have been more desirable in addressing GBV in the health sector.

**The Gender Equity Strategy (GES)** developed by the Ministry of Health and Family Welfare (MoH&FW) in 2001 identifies VAW as an important issue on the backdrop of high levels of VAW. Strategic objectives developed to address the issue include:

- Strengthening existing health facilities to include preventive and curative care for violence victims;
- replicating one-stop crisis centres (OSCCs) at Upazila (subdistrict) level; and
- addressing VAW and gender-based discrimination in the work place [13].

**The Programme Implementation Plan (PIP)** has identified the Women Friendly Hospital Initiative (WFHI) at primary, secondary and tertiary level hospitals as priority areas. One of the four key areas to be addressed under this initiative is GBV [7]. The document notes that: *'Although no formal statistics/study is available to portray the incidents of violence against women and children, the newspaper coverage is enough to understand the severity of the problem. The Government has already established two One-stop Crisis Centres at the Dhaka and Rajshahi Medical College Hospitals on a pilot basis to provide services to the women victims of violence. During HNPSP, this service will be expanded and training will be given to the providers to make them capable of handling such cases. Child victims will also be covered through this service.'*

**The Revised Programme Implementation Plan (RPIP) of the Health Nutrition and Population Sector Program (HNPSP) of the MoH&FW (2003-2011)** addresses the topic of gender mainstreaming in the health sector. While accepting the existing inequalities, the document indicates the commitment of the health sector towards GBV: *'MoH&FW's goal is to ensure that its policies and programmes are gender equitable and reduce the existing inequalities in the health status of women and men in Bangladesh which is the basis for formulating a HNPSP'*. It refers to the MoH&FW GES as a tool to mainstream a gender perspective in sector policy, planning, programming, implementation and evaluation so that gender equality in working lives and service delivery is achieved.

The RPIP identifies actions such as equitable recruitment (Government of Bangladesh [GoB] quota), fast-

tracking measures (to get women to senior positions), professional development and ensuring that female staff are represented and participate in decision-making forums. MoH&FW has a Gender Advisory Committee (GAC), chaired by the Secretary, a Gender Issue Office (GIO) and Gender, NGO and Stakeholder Participation (GNSP) section, for mainstreaming gender, participation issues and enhancing Government-NGO partnership. The MoH&FW also adopted a Maternal Health Strategy (MHS) in 2000 and a GES in 2001 and relevant actions are being implemented [7].

## Description of the health response

### **Women Friendly Hospitals Initiative**

In 1997-98, the Government of Bangladesh and UNICEF took steps to upgrade hospitals so that women could access their services easily [6]. The main objectives of this activity were to decrease the MMR and to provide support to survivors of violence. At that time the main activities conducted were training of doctors and nurses on how to deal with patients in a sensitive manner [6].

Presently, with funding from organizations such as UNICEF, the Directorate General of Health Service (DGHS) in collaboration with Naripokkho (a national NGO) has launched an initiative named WFHI. The initiative aims to address the high MMR by addressing four key areas, one of which is 'management of violence against women victims'. With violence contributing to 14 per cent of maternal deaths it is strategic to address both issues in one initiative.

While providing care to victims, the initiative attempts to institutionalise the care of GBV into the health system by first conducting an initial assessment of hospitals based on a set of pre-determined criteria. This is followed by



orientation and capacity building of the hospital staff on WFHI, and the development and implementation of a hospital action plan. Hospitals are being regularly assessed for accreditation based on approved criteria. Once the hospital develops this initiative it can be accredited as a Women Friendly Hospital (WFH) based on the criteria which includes GBV care. Regular monitoring and mentoring is being carried out by Naripokkho. The first phase of the initiative included establishing the intervention in seven hospitals namely Cox's Bazar, Fotikchori, Bahirob, Jaipurhat, Manikgonj, Rajbari and Chowgsa.

The initial evaluation done by Naripokkho [6] shows that the scores based on the criteria of service provision for GBV victims have nearly doubled in most hospitals. The achievements include availability of a separate examination room, identification of a dedicated team including a medical officer and nurse that is often headed by an obstetrician, availability of medical instruments, immediate attention for victims, maintenance of privacy, availability of a list of supportive services, maintenance of a separate register for victims, as well as ensured adequate documentation. The initiative also attempts to ensure the availability of necessary equipment and facilities to care for the victims of violence. A counselling service is provided by counsellors recruited by the NGO in most instances, and the NGO also provides assistance for legal support. An extensive support mechanism with three committees functioning at three levels has been developed to assess and strengthen the initiative. Subsequently, within the last year, the initiative has been extended to five more district hospitals: Thakuragoan, Jamalpur, Moulavi Bazar, Gaibandha and Nilfamari.

Capacity building, however, has been limited to training the hospital core teams on the use of the protocol and how to run the initiative, including clinical management. Inclusion of sensitisation and training on GBV issues, particularly on ethical and compassionate aspects, and extension to the rest of the hospital staff would improve

the quality of care provided. The main challenges identified were the lack of infrastructure and lack of human resources, however the presence of committed care providers at a higher level within the institution has been key to success in establishing these units.

### ***One-stop crisis centres***

In Bangladesh there is a GBV Multi-sectoral Programme led by the Ministry of Women and Children Affairs (MoW&CA), with the MoH as an important implementing partner. Under this activity, seven OSCCs have been established in the tertiary level medical college hospitals located in Dhaka, Rajshahi, Chittagong, Sylhet, Khulna and Barisal districts.

In addition to having a trained team of care providers led by a senior doctor, the centres have an eight-bed facility to admit women for a defined period in order to provide medical treatment, counselling services as well as legal services on-site free of charge. The centres are supported by forensic facilities including a laboratory for DNA analysis. The health sector provides the space and health care personnel. There is also a police unit attached to the centre and the OSCC is backed up by a shelter for victims established by the MoW&CA. There is a steering committee headed by the Secretary, MoW&CA, with members from eight relevant ministries, six directors of medical college hospitals and six principals of medical colleges. The role of this committee is policy formulation and project monitoring. There is a coordination committee headed by the Joint Secretary (Planning and Development) and MoW&CA, with members from the selected eight ministries. This committee is mainly responsible for the effective implementation of the project. In each hospital where OSCC services are available there is a hospital working group formed with doctors from different departments, including the social welfare department, to ensure the quality of the OSCC's services is continually improved.



This is a good example of a coordinated response from multiple sectors with the provision of medical, counselling and legal services in a space identified within a hospital. However, it is important to ensure that the coordinating mechanism is institutionalised into the hospital management for long-term sustainability of the activity. Between August 2001 and June 2009, a total of 7,791 women and children were received by the six OSCCs. Twenty-seven per cent of these women availed themselves of legal help and filed cases, of which nearly a quarter, 23 per cent, had a penalty imposed against the perpetrator.

## Policy and protocols

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As part of the WFHI, a comprehensive national level protocol was developed by the DGHS of the MoH&FW and UNICEF dealing with GBV as one of the four thematic areas of the initiative. Part one of the document gives an introduction covering the foundation, definitions, goals and objectives of the initiative. Thereafter, the document describes the criteria for recognition of the hospitals, services and monitoring mechanisms [8].

Part two of the document is a handbook on developing WFH with the objective of ensuring quality of care with regard to the four thematic areas including VAW. Training, recognising, documenting and reporting of VAW is dealt with in this section along with much emphasis being placed on recognising challenges and solutions [8]. Part three is designed to help institutions to prepare an action plan to implement the initiative.

This document attempts to give guidance on both the managerial aspects of the initiative and the clinical aspects of responding to VAW. However, taking up the two areas separately may have improved the impact of the training conducted on the module.

An operational manual called 'Operational Manual for One-stop Crisis Centre in Medical College Hospitals' has also been developed by the Multi-sectoral Programme coordinated by the MoW&CA and is available at the OSCCs.

## Referrals and screening

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Although some isolated studies on prevalence have been conducted in different settings, no screening programmes are being conducted.

The OSCCs are providing a comprehensive service, which includes legal and counselling services. No forward referrals mechanism is needed from the OSCC as all service needs are provided. Assistance by way of shelter provision is available within the same district as a part of the same programme.

The WFHI provides medical care and basic counselling conducted by health personnel. Arrangements have been made for referral for legal services to NGOs, identified in each district. Linkages with the community health care workers and other health institutions in the district are not established at present.

## Capacity building

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In terms of capacity building for the WFHI, this has been limited to training the hospital core teams on the use of the initiative protocol including clinical management. However, sensitisation and training on GBV issues, particularly on the ethical and compassionate aspects, for the rest of the hospital staff has been lacking.

### ***A training manual for doctors and nurses on VAW [9]***

This document published in the local language offers the care provider 'in depth' information on different aspects of management, documentation and reporting of GBV. Developed by the DGHS of the MoH with UNFPA in 2006, it includes a large resource pool comprising experts in different disciplines such as forensic pathology, obstetrics and public health. The module also includes 30 hours of training covering subjects such as prevention, management of sexual violence (including rape), forensic management of violence, gender issues and long-term management. Evidence collection formats and guidance is also provided. A training programme that included hospital core staff involved with VAW was conducted.

### ***Introduction to forensic DNA profiling [10]***

This document has been developed by the Multi-sectoral Programme on VAW of the MoW&CA with the assistance of the National Forensic DNA Profiling Laboratory of Dhaka Medical College. This user friendly manual gives the care provider an introduction to DNA technology as well as providing clear instructions on sample collection and transport of specimens.

There is no documented information to suggest that the topic of GBV has been included in medical curricula.

## **Documentation and data management**

Data collection and data management in the OSCCs are being conducted in a systematic manner while maintaining confidentiality. A detailed information collection format is being used which is available in the local language. These documents are kept in locked storage within each centre. Summary reports of the monthly review meetings

are maintained and information on client numbers is submitted to the programme management office where a national database has been created. Some of this information has been published in the newsletter of the Multi-sectoral Programme.

Although a separate register is maintained for victims of GBV in the outpatient departments of the WFIHs, the maintenance of document confidentiality becomes a challenge when the patients are admitted to a common ward where admission notes and other related documents are treated in a similar manner to the documents of other patients. No formal data management system related to data on GBV has been established.

## **Positive outcomes/successes**

The inclusion of GBV in the maternal mortality reduction exercise has worked well in Bangladesh. Given the high priority of reducing maternal mortality in the country, linking GBV to this programme has provided a launching pad to address GBV in the health sector. Once GBV care is institutionalised in the health sector through this initiative, it is important to review and modify the programme in order to address the aspects of care particularly relevant to GBV.

The response to GBV through the health sector by way of opening 18 service points under the two programmes described above certainly has been a success. Some of these centres have been providing care for more than eight years. 'Up-scaling' of the Women Friendly Initiative (WFI) to include five more hospitals indicates the practicality of establishing this response although, as discussed below, there are a number of potential challenges.

The state health sector of Bangladesh, like in most countries in the region, has a shortage of trained care

providers including doctors. In spite of this, all 18 hospitals have made arrangements to allocate care providers to manage the centres. The commitment of the hospital administration and the care providers has been key to this success.

The development of national level documents such as the protocol for the WFH and the instruction on forensic DNA profiling are important steps taken by the MoH in institutionalising a health sector response implementing the policy of the state as indicated in the GES of the MoH. The inclusion of a specific activity, namely extending OSCCs into the GES, has been a major success by way of institutionalising GBV care in the health sector.

## Primary issues and challenges

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The presence of committed care providers at a high-level has been key to the success of the WFHI, however they continue to face challenges such as a lack of infrastructure and human resources. Lack of medical staff also remains a major challenge. Most hospitals have been understaffed for many years and recruitment of new staff is minimal at present. Furthermore, the staff involved in both the WFHI and the OSCCs appear to have had only one session of training which included managerial and documentation as well as clinical management issues. No training on the area of gender issues or areas outside clinical care has been included.

Both programmes depend at present on resources from outside the health sector. In the case of OSCC, infrastructure establishment and staffing as well as working arrangements have been incorporated into the day-to-day functioning of the hospital. However, coordination and leadership comes from the MoW&CA

with funds from donors. Plans to administratively institutionalise the centres should be considered in the event that the project mode ends.

Overcrowding of the hospitals makes maintenance of privacy a major challenge, as patients who seek care in the WFHI have to be admitted to the gynaecology ward. Although doctors try to identify beds for this purpose, the woman is likely to feel stigmatised when special attention is given in the common ward. Maintenance of confidentiality is also a challenge under these conditions.

Although it is advantageous to include GBV care provision at a programmatic level with other areas of RH as with the WFHI, at the institutional level, the care providers may not recognise the sensitivities with which the victims need to be cared for, unless special effort is taken by way of training on GBV.

Finally, lack of national protocols is common to the region and Bangladesh is no exception.

## Lessons learned and recommendations

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- The provision of beds at the OSCCs makes it practical to provide care for very ill victims while maintaining confidentiality and privacy. It is suggested that provision be extended to the hospitals where the WFHI has been established.
- While some training for health care workers on GBV has been conducted, capacity building requires greater attention. It is important for more sensitisation and capacity building of the care providers in the centres to be conducted, with particular emphasis placed on the guiding principles of GBV care. It is recommended as an initial step that a programme of ongoing training specifically on GBV be developed

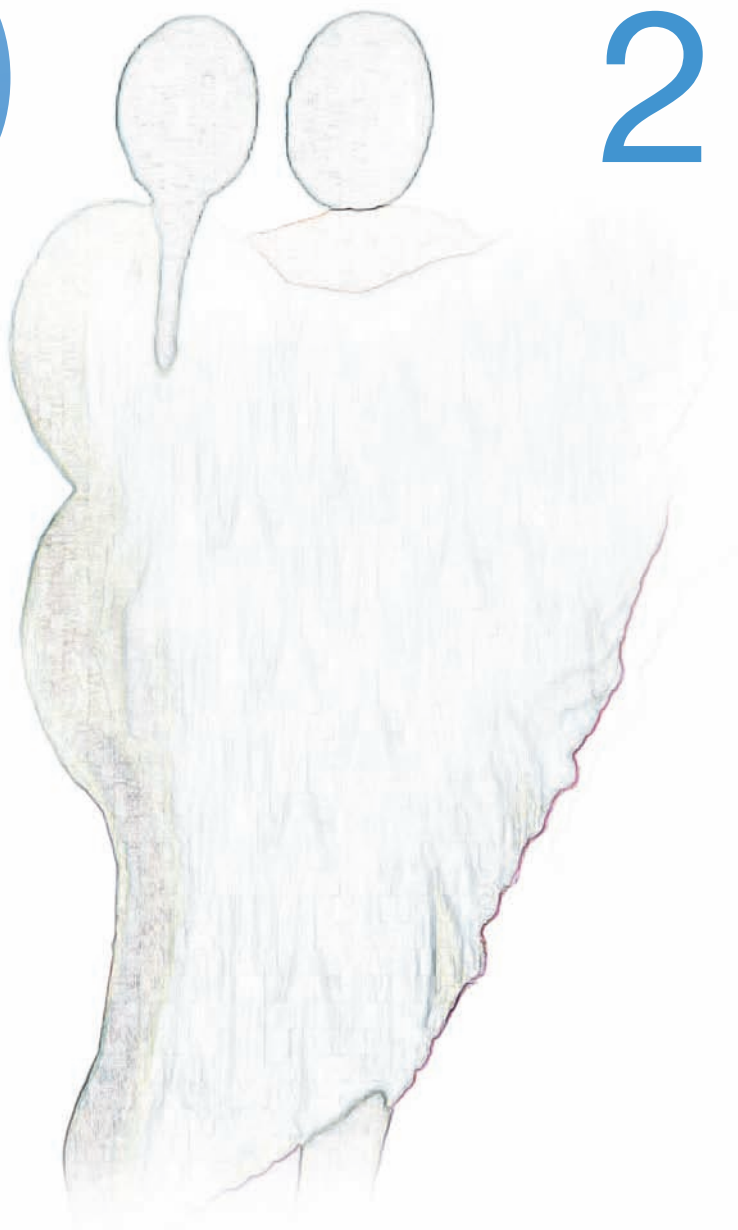
targeting care providers including medical officers of the 18 institutions which provide GBV care under the two programmes. Although these hospitals are under two programmes, pooling of resources and conducting training using one module will both streamline the services as well as give care providers an opportunity to share their experiences. International NGOs (INGOs) may be able to support such initiatives.

- Medical officers, often at a senior level, are providing care in the centres in addition to their routine duties, taking on an additional responsibility. In order to support this extra work and encourage their ongoing participation in GBV care it may be useful to provide them with overseas training or study tours which will enhance their skills and in turn will benefit the centres.
- It is recommended that forward planning to ensure the sustainability of these programmes from both a budgetary and an administrative point of view be conducted. This is all the more important as withdrawal of assistance from supportive mechanisms outside the health sector is likely.
- Many policies in the health sector have addressed GBV together with other issues (often unrelated). A more focused approach is recommended in drafting policies in order to effectively address GBV in the health sector.
- Development and dissemination of national protocols and guidelines for management of GBV is recommended. This would not only streamline the services provided by these 18 hospitals but give visibility to the importance of addressing GBV in the health sector.
- A formal mechanism for collecting and managing data from the service points should be established. This data would provide credible evidence to prove that the health sector is able to successfully address GBV within the health sector and encourage other hospitals to join up.

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# 2



## Malaysia

### Country Profile:

|  |               |
|--|---------------|
| Total population (in thousands):                       | 26,743 (2006) |
| GNI per capita (PPP Intl \$):                          | 10,613 (2004) |
| Total health expenditure per capita (PPP Intl \$):     | 226 (2006)    |
| Life expectancy at birth male/female (years):          | 69/74(2007)   |
| Maternal mortality ratio (per 100,000 live births):    | 30 (2002)     |
| Infant mortality ratio (per 1,000 live births):        | 10 (2006)     |
| Births attended by skilled health personnel (%):       | 100 (2005)    |
| Total fertility rate:                                  | 2.7 (2006)    |
| Human Development Ranking 2009 (out of 182 countries): | 66            |

(Source: World Health Statistics 2008)

Malaysia is a federal constitutional monarchy consisting of peninsular Malaysia and East Malaysia. Its total population is more than 26 million [1]. Malaysia is a multi-ethnic country where Malays, Chinese, Indians and indigenous groups live in cohabitation.

Although about 88.5 per cent of Malaysian people live within five kilometres of a health facility, 60 per cent of those in Sarawak and 76 per cent of those in Sabah live within five kilometres of a health facility [2]. In addition, the richest quintile groups live closer to health facilities than do the poorest quintiles (Rozita Hussein 2000).

The Malaysian health care system is reputed to be among the best in the region. The health care system considers women's health an important issue, but has begun to shift its focus through placing greater emphasis on the role of men and the family [2].

Female life expectancy has improved significantly in the last few years by increasing from 75.1 years in 2002 to 76.4 years in 2005, while male life expectancy rose from 70 years to 70.6 years over the same period [3].

The maternal and child health programme implemented in the 1990s contributed to an improvement in the health of women and increased access to safe delivery (99.5 per cent in 2005) and antenatal coverage (77 per cent in 2005) [3]. Despite the greater emphasis placed on HIV/AIDS in health education and greater awareness of HIV/AIDS, the proportion of women living with HIV increased from 7.9 per cent in 2001 to 11.6 per cent in 2005 (June) [3].

Health education has also been given great attention in respect to cervical and breast cancers, the incidence of which has increased from 52.8 per 100,000 population in 2002 to 56.8 per 100,000 population in 2005 [3].

**Table 1: Statistics for rape and domestic violence cases of three organisations: OSCC, Police Department and Welfare Department from years 2004 – 2006**

| Organisation/year  | 2004  |       | 2005  |       | 2006  |       |
|--------------------|-------|-------|-------|-------|-------|-------|
|                    | Rape  | IPV*  | Rape  | IPV   | Rape  | IPV   |
| OSCC               |       |       | 1,099 | 1,851 | 1,454 | 2,159 |
| Police Department  | 1,765 | 3,101 | 1,931 | 3,093 | 1,561 | 2,171 |
| Welfare Department |       | 560   |       | 421   |       |       |

\* Intimate Partner Violence

Source: Ministry of Health and Ministry of Women and Community Development

## Prevalence of GBV

Violence is a major public health problem in Malaysia, where violence-related injury accounted for 4.6 per cent of all injury cases admitted to government hospitals in 2003 [4].

In Malaysia, gender-based violence (GBV) is believed to be largely underreported. National prevalence data on violence against women (VAW) is unavailable, though the University Sains Malaysia is undertaking a national study of VAW in order to measure its prevalence. So far, the only survey of GBV was conducted by a women's NGO in the early '90s. According to this study, 1.8 million or 39 per cent of women over the age of 15 years 'were beaten' by their husbands or boyfriends. However, only 909 women actually reported violence to the police [5].

According to national data compiled by the Ministry of Women, Family and Community Development (Kementerian Pembangunan Wanita, Keluarga dan Masyarakat [KPWKM]), in 2004, 3,101 cases were reported to the police, while only 560 cases were reported to Social Welfare departments [6].

The incidence of rape reported to the police has increased in the past three years. Its incidence has increased from 1,217 in 2000 to more than 1,931 in 2005 [6]. More than half of the female victims (56 per cent) reporting being raped were younger than 16 years of age [7].

Marital rape also appears to be a concern. According to a national research investigation of domestic violence (DV) conducted between 1989 and 1992, more than half of the women who sought help reported their husbands had used physical force during sexual intercourse [5].

## Overarching policy framework

Malaysia was the first Muslim country, as well as one of the first states in the region, to adopt a law on violence, the Domestic Violence Act of 1994. This law came into force in 1996 [8]. It has had a major impact by raising public awareness of GBV. Anti-rape laws have existed since the late '80s and were reformed in 1989.

In the Sixth Malaysia Economic Plan (1991-1995) – a five-year blueprint incorporating policies and key programmes for the 1991-1995 development period – GBV was recognised for the first time. GBV constrains women from participating in development [9]. Moreover, in 1996, the Malaysian Cabinet approved a Plan of Action for the Advancement of Women. This Plan recognised the elimination of VAW as a national priority which would lead to a strengthening of the position of women [10].

Reducing VAW has also been included in the Ninth Malaysia Plan for 2006-2010, with a focus on raising public awareness (through conducting national campaigns against VAW), training on gender roles for agencies involved in handling cases, and creating new shelters [3].

Although the KPWKM is responsible for issues related to VAW, several groups have played a role in providing services to abused women [4,11]. These groups range from ministerial agencies such as the Ministry of Health (MoH) to the Police Department and NGOs. There is no National Ministerial Committee on VAW. Instead, each institutional agency takes on different tasks. For instance, the role of the MoH is in secondary and tertiary prevention in respect to identifying and managing cases of DV [4]. However, recently, with the creation of a Violence and Injury Prevention Programme (VIPPP) within the MoH in 2004, more prevention activities are being carried out



with the collaboration of all stakeholders both within and outside the MoH. Such activities include 1) collaborating in the planning and strengthening of all activities pertaining to violence prevention within the Ministry; 2) establishing a DV, rape and sodomy database; 3) carrying out gender sensitisation training for all health personnel concerned with violence prevention and management in order to increase recognition and reporting in addition to enhancing the quality of treatment for victims of GBV.

## Description of health responses

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One-stop crisis centres (OSCCs) began slowly in Malaysia with the first being established in 1994 at the General Hospital, Kuala Lumpur. This was in response to a nationwide campaign against DV initiated by women's groups. After women's organisations lobbied the MoH to make the service more widely available, in 1996, the Minister directed all state hospitals to establish OSCCs for women victims of violence [12]. In 2003, there was a total of 96 OSCCs across the country [13]. Medical social workers in hospitals and volunteers from women's organisations (when available) provide counselling, and coordinate further assistance.

OSCCs aim to provide integrated services to abused women at the same location. The main principles upon which OSCCs are based are respect for women's needs and privacy as well as confidentiality. There is a focus on a holistic approach and not just physical treatment for physical abuse. This approach is a multi-disciplinary approach in which the hospital is the first place women may go to (after family and friends) [11].

Based on a multi-sectoral approach, OSCCs provide comprehensive services such as counselling, medical

care, support services, provisions for police collection of forensic evidence, legal aid and temporary shelter, all in one site. The OSCCs are based at the accidents and emergency (A&E) departments of almost all public hospitals, and thus benefit from the round-the-clock operational hours of these departments. The rationale behind the implementation of an OSCC model was to provide comprehensive services at one site, with the potential benefit of geographical proximity to all services, reduced or no delays for examinations, additional referrals for specialised services, and more patient-centred care. Counselling is often offered on-site by counsellors at tertiary hospitals and by medical social workers at secondary hospitals and upon referral by women's NGOs or social workers from the Department of Social Welfare. Internal referral systems are created to refer cases at the OSCC level to other specialised services on-site, while the provision of an interagency network, including police and social workers, is considered crucial for external referrals.

## Policy and protocols

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In 1988, the MoH developed a protocol on the management of rape that was disseminated to all hospitals [14-15]. It took nearly ten years for the MoH to develop a specific circular for the management of abuse cases in general (in 1996) within OSCCs. Apart from the 1996 circular, the MoH has failed to develop a formal policy on health sector response to VAW.

Specific guidelines on the management of GBV cases by OSCCs were formulated at the Kuala Lumpur Hospital (KLH) in 1994. These guidelines were later used in hospitals throughout Malaysia. However, not many

hospitals are using these guidelines as a whole, but have instead adopted specific clinical protocols for rape and child abuse contained in the guidelines. The national guidelines (developed by KLH) are divided into two parts. The first part describes the aims and objectives of the OSCC model, the types of services to be put in place and the layout of the infrastructure. The second part focuses on standard clinical procedures for treating abused women. In addition, it describes the role of each person and agency involved in managing such services, including medical assistants at the triage counter of the A&E (at the entrance), the counsellor, and the NGOs. This part also contains a medical booklet containing all the various clinical forms needed for recording OSCC cases. Among them are checklists for battered women, a rape protocol, and forms for child abuse and the collection of specimens. However, there are no specific clinical protocols for DV.

According to the guidelines, the main objectives of the OSCC are to provide the following services:

- Identification;
- examination and medical treatment;
- documentation and processing of evidence;
- basic counselling and extending emotional support;
- multi-level crisis intervention;
- legal and court activities;
- temporary shelter; and
- medical reporting.

The OSCC philosophy is based on respect for women's needs and privacy in addition to confidentiality. The model is characterised by a multi-disciplinary approach, where the health care system, and particularly the hospital, is conceived as the first place where women may go to after being abused (after family and friends) [11,16].

Interagency networking, shared responsibility and precise task distribution are also behind the teamwork philosophy of the OSCCs [16]. Professionalism is thus shown through expert medical examinations and interventions in order to provide the best care for women, care which involves total quality management focused on the patient [16]. One-stop also means that integrated services are provided to all women and children for any type of abuse, including IPV, rape and sexual assault, child abuse, and sodomy.

The guidelines explicitly mention the A&E department as the main location of the OSCC because of its 24-hour accessibility. Moreover, the location of the OSCC was chosen on the assumption that abused women did access A&E services when in need of care.

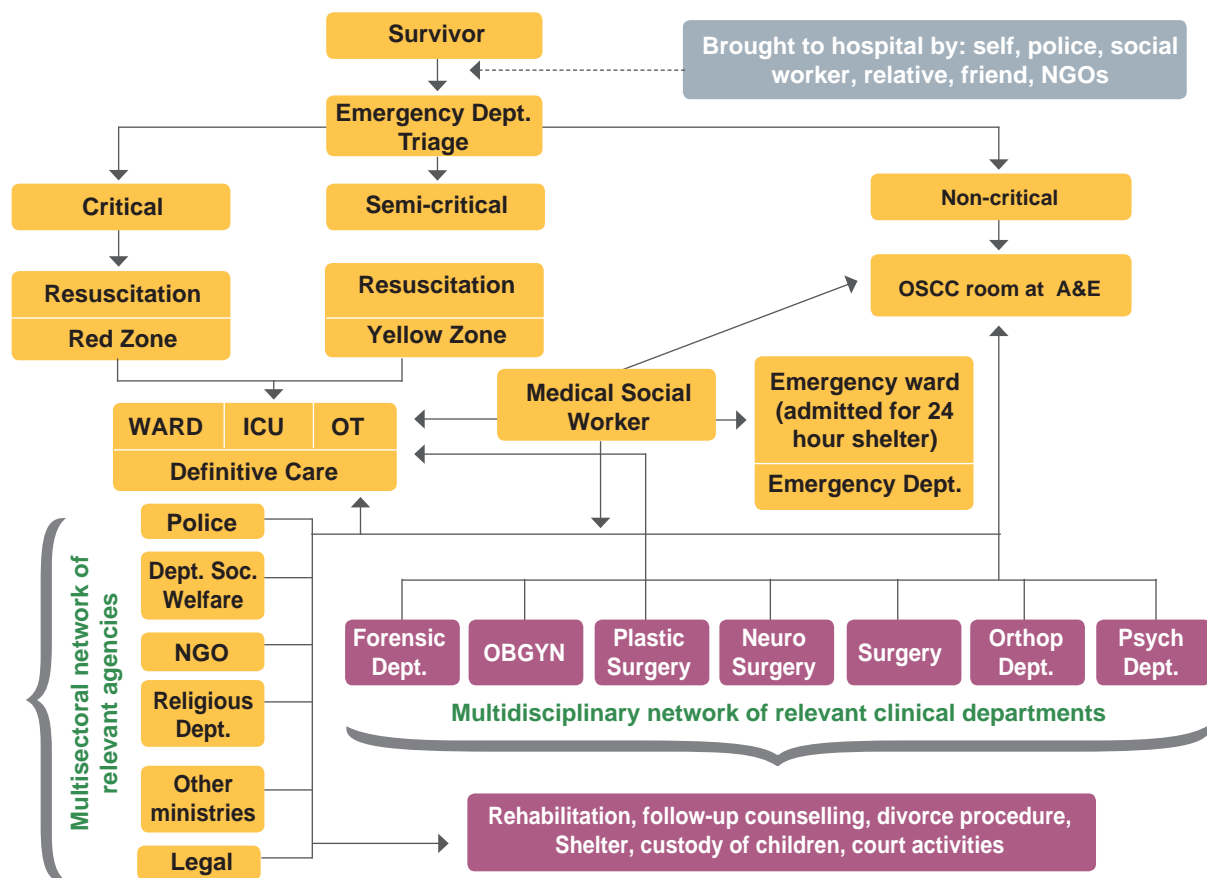
## Referrals and screening

Not only do OSCCs provide integrated medical services at one location through the presence of an intra-hospital medical team (OBGYN, psychologists and medical officers), but they also benefit from the presence of support and police teams present on-site (e.g. policemen and social welfare officers), all of whom converge at the OSCC so that a woman does not have to be moved unnecessarily. OSCCs should usually be governed by a multi-disciplinary committee coordinated and chaired by a representative of a public hospital even though this has proven to be a challenge. A formal referral system is in place between hospital departments (e.g. OBGYN and medical social worker) and across agencies (e.g. police, social welfare, women's shelters and counselling services). However, at district level hospitals, such referrals are not always in place as only limited support services are available outside the capital cities.

There is no formal screening procedure in Malaysia for all women who come through the health system. Nevertheless, the clinical guidelines state that screening for potential victims of abuse should be carried out at the hospital level. This screening should be done by means

of an interview with a medical officer, or a brief screening can be conducted at the triage phase. Then, once identification of the nature of the case is made, referral can be made so that a more detailed medical interview can be conducted. In addition, to assisting doctors in

**Figure 1: Step-by- step hospital procedures used in managing OSCC abuse cases**



Source: Hassan, 1994.

identifying abuse cases, the guidelines also enumerate some potential health problems or behaviours that may help health providers to recognise a woman who has been abused. Such women may appear evasive and will perhaps evince an apologetic attitude or passivity. They may make frequent visits to hospitals or give evidence of physical injury during pregnancy. Despite appearing in the guidelines, no specific screening policy for IPV has been developed by the MoH. Nor have such interventions been implemented at the hospital level. Although referred to in the statement of the contents of the guidelines, a risk index form has not been developed for the use of staff members in abuse cases.

The primary responsibility of the Family Health Development Division of the MoH is to deal with all activities pertinent to family health, nutrition, and primary health care [17]. In 2004, funded by UNFPA, the Family Health Development Division initiated a violence screening pilot programme in two primary health clinics – one for antenatal and the other for maternal and child health (MCH) services – in Kelantan State [18]. The aim of the programme was to help health providers detect early signs of violence so as to be able to take immediate action. In addition, these clinics provided the means whereby data could be collected on the rates of incidence of violence and related risk factors. The implementation of this project involved the cooperation of the three main agencies responsible for reproductive health (RH) services. They are the MoH, the National Population and Family Development Board, and the Federation of the Associations of Family Planning Malaysia. A training manual for health providers has also been developed by the Division. This manual contains guidelines and principles for conducting screening for IPV amongst women, methods for managing IPV cases, and

standard operating procedure for health care workers in primary health care facilities in addition to a system for documentation, monitoring and evaluation of cases.

## Capacity building

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Training is an important element in the raising of practitioner awareness and developing knowledge of OSCC procedures. Besides a national training course offered annually by KLH, very few specific courses are available in other states. The state hospital in Kelantan organises annual training courses in collaboration with the university hospital at Kota Bharu. At the tertiary level, A&E staff members are sent for training on rotation and so all personnel are trained in OSCC procedures. However, medical assistants, junior doctors and assistant nurses who do not directly deal with OSCC are not sent to such courses. In Malaysia, very little training is available to regional staff – usually a one-off short training session – and only a few providers at district levels ever attend any seminars.

There have been some attempts to incorporate GBV into the curricula of medical and nursing colleges in the country and in some cases training has taken place. However, it has tended to be dependent on committed individual professors, teachers and trainers rather than having become institutionalised. GBV is not usually included in medical curricula. However, the University of Sains Malaysia in Kelantan has integrated it into its medical curricula.

The VIP Programme of the MoH also organises specific training for health providers at primary health care level on GBV and its prevention and treatment.

## Documentation and data management

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In general, there is no national database that integrates and monitors data on GBV from the various agencies [11, 19]. Different sectors collect different information, and so there is no unified collection of data. Existing data collection mechanisms are mainly client-based and very much influenced by organisational needs and functions, and therefore the results of these data compilation systems vary. Hospital admission data uses the International Classification of Diseases - 10th Revision (ICD-10) code and only captures those admitted who die after admission. Emergency cases are not included in this database. Existing OSCC data only show the number of cases seen for rape, DV, child abuse and sodomy. Cases seen at OSCCs are clerked in a special 'OSCC book' using a standard format capturing the demographic details of the victim and perpetrator, history of the incident and the management details of the victim. However, there is no system for the compilation and routine analysis of OSCC data. Each OSCC sends the statistics to the MoH every six months. However, the collected data are not published or used in any specific training.

At OSCCs, there are forms for collecting evidence for rape and child abuse cases in which the details of the physical examination and referrals are recorded. As for IPV, there is only a checklist form for battered women to guide doctors on how to interview and record cases of domestic abuse. This includes questions about the woman's personal details, generic information concerning the perpetrator, the current as well as past history of the abuse (within the last year), past illnesses, previous violence, information from the physical examination and the management of the case.

Great emphasis is given to ensuring patient privacy and maintaining confidentiality during the entire clinical process. This requires close attention to the physical infrastructure of the room, the recording of basic information and the history of abuse, examination, and counselling. Moreover, in some OSCCs, privacy and confidentiality issues have been faced and subsequent improvements made through the use of colour coding systems and stamping on registration files. However, by placing OSCCs in A&Es, some aspects of privacy and confidentiality are sacrificed as patients are brought to one of the busiest areas of hospitals.

## Positive outcomes/successes

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- A strong legal framework on VAW (a law, a policy and clinical guidelines) has been an important factor for the integration of GBV services into the health sector, without which OSCCs could not have been created and scaled up.
- Initial strong support and collaboration between NGOs and hospitals led to the creation of OSCCs and the Interagency Working Group. However, the sustainability of such multi-sectoral collaboration across agencies is difficult in the long run, especially at district level.
- Institutional senior-level support, at both ministerial and hospital level, was crucial for the development of OSCCs. Without MoH support, the scaling up of OSCCs at all state hospitals would not have been possible.
- The integration of a health response through OSCCs is an important achievement as holistic care located in one centre is offered to women who experience abuse.

- Clear guidelines and pathways of care – and systematic training of their use – are also an important element in the delivery of care to abused women, without which health providers would not be able to offer quality care.
- The presence of ‘individual champions’ supporting the OSCCs at hospital level was crucial for the running of the services, though organisational support is needed to continue to run a violence response program in the long-term.
- The creation of a IPV Unit at the MoH has demonstrated its support for efforts to prevent GBV and the delivery of quality care to abused women.

## Primary issues and challenges

In Malaysia there has been a discrepancy between the stated national procedures for GBV and their actual implementation through OSCCs. Findings from a study of OSCCs and their challenges in Malaysia [19] show that organisational and policy barriers limit the full integration of OSCC services:

- Training is not sufficient and is focused on clinical interventions for rape;
- no protocol for IPV cases, only for rape and child sexual abuse;
- shortage of trained and designated staff, especially at district level;
- weak referrals between hospital units and limited coordination across agencies; and
- IPV not prioritised by senior policy-makers because of other competing health priorities.

Challenges and factors at different systems and levels are interlinked and, therefore, they cannot be addressed separately.

OSCC care is often fragmented and not always provided at one site, especially at district level [19], where there is a lack of resources both within the hospital and externally, thereby limiting options for comprehensive service provision. Despite some of the strengths related to interagency networks and geographical proximity of all services, several challenges exist in relation to the integration of comprehensive care through OSCCs. These challenges range from lack of staff sensitivity and awareness to time shortages, staff rotation, limited collaboration with agencies, little training, no IPV protocols and budget constraints. Among many other untoward factors, lack of knowledge of violence prevention among health personnel and the public and inability to recognise cases early and manage them appropriately have been noted as reasons for the underreporting of cases.

Despite the support of MoH and women’s groups, several issues are of concern when it comes to the sustainability of OSCCs. For instance, the high staff turnover at hospitals may lead to a weakness stemming from a lack of trained personnel. Another issue is the shortage of personnel, especially in district hospitals, where specialised staff members are not available (e.g. forensic officers) or women’s groups are not available to provide volunteers and referrals for shelters. Some concerns exist regarding the multi-sectoral collaboration between the hospital and other agencies, as the absence of follow-ups to referred cases appear to be a challenge, particularly at district level where few support services are available. There should be more coordination with Social Welfare and other agencies.

In addition, each agency should be aware of the protocols of other agencies in order to ensure coordination. The protocols for all agencies should be made clearer and all teams should be aware of them.

Besides interagency collaboration and lack of training and human resources, another problem is engendered by inadequate financial resources. As described in the MoH circular and in the national guidelines, the OSCC model is based on the services and resources of the Kuala Lumpur tertiary hospital system. It is thus based on the assumption that infrastructure and support services would be available. In reality, when extended to different hospital facilities, the implementation of the policy inevitably encounters problems when attempts are made to extrapolate the comprehensive model of OSCC services to settings where only basic care and limited support services are available.

Adaptations of the model vary depending on the local context and level of hospital care. As such, the OSCCs at the tertiary level are the most developed and comprehensive, a state of affairs reflective of the higher availability of human resources and services. Moreover, because of higher exposure to training, tertiary hospital personnel are more aware of procedures than those at lower levels of hospital care. Referral hospitals have medical officers in charge of OSCCs, while medical assistants or staff nurses are in charge at smaller district hospitals. Only some referral hospitals have medical social workers or counsellors, and so in most district hospitals, informal counselling is very often offered by staff nurses or medical officers and women are then referred to psychiatric clinics at tertiary hospitals for specific psychological support. Therefore, even with political will and a framework giving guidance, policy implementation is constrained by local

resources, with the existing health service structure and capacity determining the true effectiveness of integrated OSCC care.

Despite the official scale-up of OSCCs at all facilities, even at district level, none of the hospitals received any additional budget for the creation and running of the centres, and so each facility was forced to make use of A&E budgets for OSCC expenditures.

## Lessons learned and recommendations

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Having governmental support has helped institutionalise the creation of OSCCs in state hospitals throughout Malaysia. In addition, the strong national women's movement has also acted as a catalyst to implementation.

OSCC services can be a protective factor guarding against GBV since these services provide an entry point and an opportunity for women to come forward and get help. Having specific services located at one site helps to ensure privacy in care and confidentiality, thereby ensuring greater responsiveness to women's needs. The geographical proximity of all services at one site and the interagency network are important elements of the OSCC model.

OSCCs must be made visible and accessible and, therefore, OSCCs should be established in all government hospitals. In addition, their activities should also be promoted.



### ***Specific recommendations:***

- Ensure top-level commitment to GBV;
- conduct public awareness campaigns to help raising public awareness of the existence of OSCCs and the need to condemn GBV;
- help creating a supportive environment for health care staff by ensuring financial and human resources at OSCCs (e.g. by strengthening current hospital service infrastructure and enhancing human resources);
- develop specific standard protocols for IPV through creating a training system, especially at district levels;
- develop in-service training and training curricula at medical schools aimed at fostering core skills in counselling and communication in respect to sensitive topics (including GBV) so as to enhance staff awareness and understanding of GBV and gender issues;
- strengthen collaboration and referrals within hospital units and across agencies; and
- develop a comprehensive database for GBV cases across agencies.

A national action plan for violence prevention is fundamental to sustaining violence prevention efforts. It should include objectives, priorities, strategies and assigned responsibilities, as well as a timetable and an evaluation mechanism. The plan should be based on a consensus established by a wide range of stakeholders and include elements such as reviewing and reforming existing legislation and policy if necessary, building data collection and research capacity, strengthening services for women who experience abuse, and developing and evaluating prevention responses.

Training of health personnel in GBV prevention and its management requires emphasis. Those working in other agencies concerned with the prevention of violence should also be involved in this training. The capacity and funding required for the provision of quality care for victims should also be heightened. GBV prevention and treatment modules should be incorporated into medical and nursing curricula.

The links with existing support services, which consist of counselling, shelter, financial aid, and skill development programmes for those at risk and the women themselves, should be strengthened and expanded.

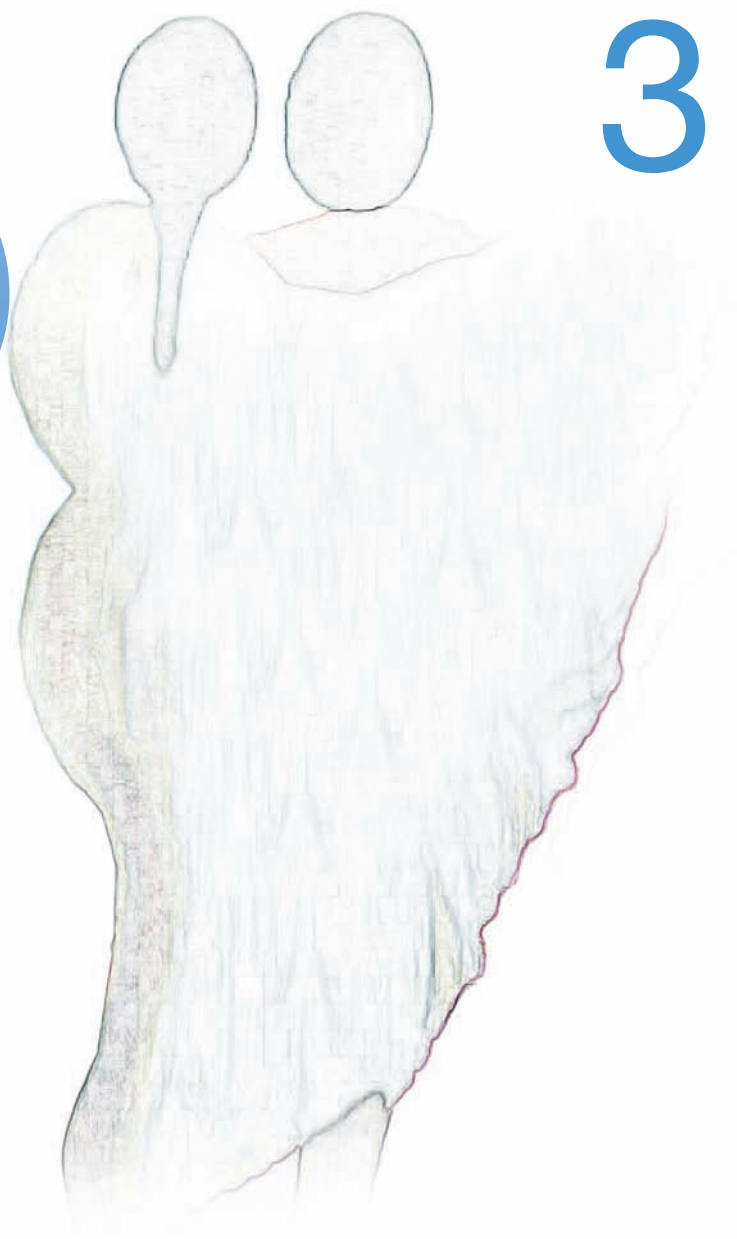
Besides A&E and OSCC facilities, antenatal and postnatal health services are also important contributors to the prevention of violence. Home visits during pregnancy and the early postnatal period provide the opportunity for health personnel to offer support to new mothers and detect cases of abuse, thereby being preventive of further abuse. Accordingly, providers of primary health care should be trained and made sensitive of GBV issues.

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# 3



## Maldives

### Country Profile:

|  |              |
|--|--------------|
| Total population (in thousands):                       | 300 (2006)   |
| GNI per capita (PPP Intl \$):                          | 4,740 (2006) |
| Total health expenditure per capita (PPP Intl \$):     | 742 (2006)   |
| Life expectancy at birth male/female (years):          | 72/73 (2006) |
| Maternal mortality ratio (per 100,000 live births):    | 43 (2005)    |
| Infant mortality ratio (per 1,000 live births):        | 26 (2006)    |
| Births attended by skilled health personnel (%):       | 84 (2006)    |
| Total fertility rate:                                  | 2.6 (2006)   |
| Human Development Ranking 2009 (out of 182 countries): | 95           |

(Source: World Health Statistics 2008)

**T**he Republic of Maldives is a country formed by a double chain of twenty-six atolls stretching in a north-south direction. The atolls of Maldives encompass a territory spread over 90,000 square kilometres and features 1,192 islets, of which 200 islands are inhabited. With a population of 300,000 (2007), Maldives is the smallest Asian country in both population and area. With an average ground level of 1.5 metres (4 ft 11 in) above sea level, it is the lowest country on the planet [1].

The burgeoning tourism industry along with multi-lateral and bilateral aid has promoted high rates of economic development over the past three decades and Maldives has recorded significant achievement in human development indicators. Life expectancy at birth stood at 46 years of age in 1978, and it has now risen to 72 years of age for males and 73 years of age for females. Infant mortality has declined from 127 per thousand in 1977 to 12 per thousand in 2005, and adult literacy stands at 96 per cent [2]. The maternal mortality rate stands at 43 per 100,000 live births.

The Total Expenditure on Health (TEH) as a percentage of Gross Domestic Product (GDP) was 6.2 per cent in 2003 [2]. It is important to note that Public Expenditure on Health (PEH) as percentage of TEH is quite high, reaching 89 per cent.

On the other hand, Maldives has a large adolescent population, amounting to 25 per cent of the total population, and has a high unmet need for family planning, reaching 37 per cent. It is of relevance to note that Maldives has a high divorce rate and has a high rate of female headed households, reaching 42 per cent [3].

The Maldivian population is highly dispersed. More than one third of the inhabited islands have a population of less than 500 people and 70 per cent of the inhabited islands have a population of less than 1,000 people (Ministry of Planning and National Development [MPND] 2008c). This creates challenges for the provision of basic services and for women's access to support for gender-based violence (GBV). Health services in Maldives are organised and promoted through the primary health care approach, which emphasises the overall health needs of the community. These services are provided through a countrywide referral network of Family Health Workers (FHWs) (at least one on each inhabited island), 27 Atoll Health Centres, four regional hospitals and a tertiary level hospital – the Indira Gandhi Memorial Hospital (IGMH) – in the capital. Inaugurated in 1994, the 200-bed hospital is a well-equipped medical service facility providing a wide range of specialised services. As of April 2008, more than 70,000 foreign employees live in the country and a considerable proportion of the professional health care workers are expatriates.

Despite the existence of a gender divide in Maldives, women have historically held a relatively high position in society compared to neighbouring countries. Girl babies or children do not face sex selective abortion or malnutrition because they are girls and they are valued as highly as boy children. This is reflected by the equal sex ratio. Women play a relatively significant role in society and currently Maldives has the highest Gender Development Index (GDI) in South Asia (UNDP 2007:327). This reflects equal primary and lower secondary educational enrolment levels of boys and girls, no evidence of discrimination against girl children in terms of access to health and relatively equal life

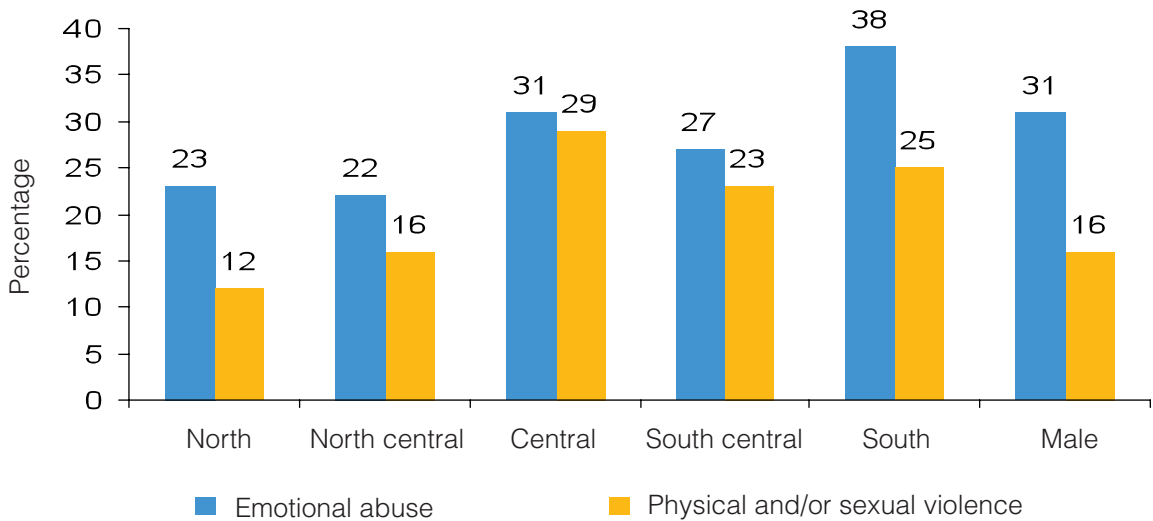
expectancy. The literacy rate in Maldives of both men and women is also the highest in the region at 98 per cent. Education of women is valued as highly as the education of men. In fact, the ratio of female to male adult and youth literacy and primary enrolment is exactly equal at one. Secondary and tertiary enrolment rates are now higher for females than males (UNDP 2007:335). The Gender Empowerment Measure (GEM) is based on the percentage of seats in parliament held by women, the percentage of female legislators, senior officials and managers, the percentage of female professional and technical workers and the ratio of estimated female to

male earned income. By this measure, Maldives ranks 76th, also the highest in the region with a value of 0.437 (UNDP 2007:331).

### Prevalence of GBV

GBV and child abuse have been recently identified as issues of concern in Maldives, though their extent has not always been fully acknowledged by the community

**Figure 1: Percentage of ever-partnered women aged 15-49 years reporting intimate partner violence, by region**



Source: The Maldives Study on Women's Health and Life Experiences. Ministry of Gender and Family, 2007, p. 34.

and some of the stakeholders. According to a national study on women's health and life experiences [9], based on the WHO Multi-country Study on Women's Health and Domestic Violence (DV) methodology, 1 in 5 women aged 15-49 (19.5 per cent), who have been in a relationship, have experienced at least one form of physical or sexual violence – or both – during their lifetime. The study also reports that 12 per cent of women surveyed reported that they had been sexually abused before the age of 15 years [9].

While the prevalence of GBV is lower in Maldives than in most of the other countries in the region, the study revealed that GBV is not only a social, legal and educational issue, but the physical, sexual and mental health consequences of abuse of women and girls makes it a major public health concern.

Women who have experienced violence were significantly more likely to have health problems, emotional distress and thoughts of suicide. Of those women who have experienced physical or sexual partner violence, 35.5 per cent reported being injured at least once, although many of these women did not receive the health care that they needed for injuries. Furthermore, women who have experienced intimate partner violence (IPV) were found to be hospitalised more often and had more operations in the past 12 months than women who have not experienced violence. Overall, women who had experienced IPV visited health professionals more often than women who had not, but often did not reveal the real cause of their injuries.

## Overarching policy framework

Several policy documents illustrate the high level commitment of the government to addressing GBV.

GBV is a priority concern for the Maldivian Government, as stated in the country's 7th National Development Plan that calls for the adoption '*of an integrated, zero-tolerance approach to gender-based violence*' and '*advocates for the elimination of violence against children*' and the establishment of support services for vulnerable children and women [5].

The Ministry of Health (MoH) has committed to addressing GBV in several policy documents. In particular, the integration of GBV care for women and girls into health services has been included among the strategic actions of the Health Master Plan (2006-2015) [6]. In addition, the thematic areas of the National Reproductive Health Strategy (2005-2007) [7] identify GBV as an important area for action. In particular, the latter calls for the strengthening of the prevention and management of GBV cases of women and girls in health care settings through: 1) development of protocols for GBV care and referral; 2) training of health care workers on management of cases of abuse; and 3) an inter-sectoral network for prevention and management of GBV among women and adolescents.

Prior to restructuring in 2008, the Ministry of Gender and Family (MGF) was the responsible body for providing support to women, children and families who experienced abuse. Under its leadership, several steps towards addressing GBV across sectors had been undertaken. For instance, an action plan on GBV was drawn up by the MGF to implement the recommendations of the national study on violence against women (VAW) [12]. The plan recommended the institutionalisation of family protection services in all hospitals in the country and the need for strengthened and integrated networks across all sectors addressing GBV.

Further policy measures were taken by the Government towards the development of a multi-sectoral framework

to address GBV and child abuse. In its Second and Third Periodic Report on the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the CEDAW Committee of the Government of Maldives expressed its commitment towards the establishment of a multi-sectoral support system to help victims of GBV [4]. As a follow up, covering the period 2007-2009, a draft Action Plan on implementing CEDAW in Maldives was formulated in consultation with relevant stakeholders [5]. The Action Plan includes VAW amongst its key issues and, in particular, calls for: 'the development of professional guidelines on addressing GBV for service providers in each relevant sector; training and sensitisation on GBV for health professionals and policy makers within the health sector.'

Despite the high level political support for enhancing responses to GBV amongst women and girls, much still remains to be done. There is currently no law on GBV, although in 2008, the MGF drafted a Domestic Violence Bill, based on a Concept Paper developed by the NGO Hama Jamiyya. Under the draft Domestic Violence Bill, a legislative framework is provided for victims of DV to obtain effective remedies, including emergency services such as immediate medical attention and long-term rehabilitation.

The election of a new government in 2009 led to significant structural changes in administration. The Ministry of Women and the MoH have been brought under one Minister, which should enhance cooperation and coordination of the activities addressing GBV in the health sector. However, there is an equal danger that gender and GBV will become a marginalised issue in the MoH. Moreover, the impact of the proposed initiative to privatise the health sector on the response to abused women and girls needs to be carefully considered.

## Description of the health response

GBV has only been recognised as a serious issue in Maldives in recent years and the response from the health sector is at the early stages. The Family Protection Unit (FPU) was established at the IGMH in August 2005 as a pilot project. It was a collaborative effort between the MGF and the MoH, with the support of UNFPA, UNICEF and WHO. The FPU has one room which functions as an office and private counselling room. This space is located within the Casualty (Outpatients) Department of the IGMH, which enables a faster and effective referral mechanism between the hospital departments and the Unit (10).

The FPU represents the first Maldivian model of integrated care for abused women and children, offering services for physical, sexual and emotional violence within health services. Being the main hospital providing health care to people in Malé, IGMH may also serve as the first point of contact for most people who experience GBV or child abuse. The main aim of the FPU is to improve the health sector responsiveness to cases of GBV and child abuse by providing the following services:

- Medical examination of suspected, reported and referred GBV or child abuse cases in a sensitive and appropriate manner;
- provision of in-hospital, individual, confidential and short-term counselling for those in need, so that they can explore their feelings, get emotional support and examine their options for further support in a safe and private environment; and
- referral to outside agencies that can offer long-term support to victims of abuse.



Doctors working in the Obstetrics and Gynaecology (OBGYN) unit are rostered to be on call for the FPU and effectively provide care to the patient on arrival. Two full-time dedicated counsellors are located at the FPU and offer professional counselling during office hours. After office hours, the two counsellors provide a 24-hour on call service. Although there is no designated coordinator, the FPU benefits from the voluntary contribution of the services of a few committed doctors, who have been instrumental in the creation and sustainability of the FPU. However, despite the presence of local 'champions', the long-term sustainability of the FPU can only be ensured with greater institutionalisation including a designated coordinator. No budget has been allocated to the FPU, but the salaries of the two counsellors are presently being paid by the hospital administration.

Since inception, more than 550 patients have received

care from the FPU. The cases are not limited to GBV but include many issues concerning women and children such as neglect, substance abuse, runaway children, abortion and unwanted pregnancies [13]. Table 1 outlines the number and types of GBV cases seen by the FPU between its set up in 2005 and August 2008 [8].

An evaluation of the FPU was carried out in August 2008 as funded by WHO and UNFPA. The evaluation was intended to assess the effectiveness of the FPU model and to suggest an appropriate institutional framework suitable to Maldives to allow for the development of a model that will serve the specific needs of women and children within the given socio-cultural realities. The evaluation concluded that the Unit has been successful in improving the health sector response to GBV in Maldives, but that it requires strengthening in a number of areas, particularly to prepare for eventual 'up-scaling' to other islands [8].

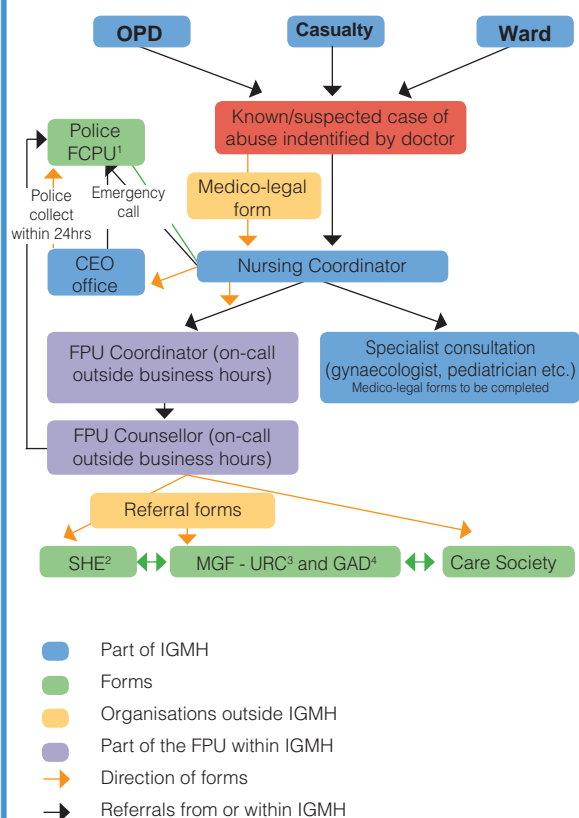
**Table 1: Cases seen by the Family Protection Unit at IGMH up to June 2008 [8]**

|             | Physical | Sexual excluding rape | Rape   | Unmarried pregnancies | Others including suicide |
|-------------|----------|-----------------------|--------|-----------------------|--------------------------|
| 2005        | 11 (74%) | 0                     | 1 (6%) | 0                     | 3 (20%)                  |
| 2006        | 14 (22%) | 3 (5%)                | 4 (6%) | 33 (52%)              | 9 (14%)                  |
| 2007        | 19 (31%) | 1 (2%)                | 4 (6%) | 26 (41%)              | 12 (19%)                 |
| 2008 (June) | 11 (38%) | 1 (3%)                | 0      | 12 (41%)              | 5 (18%)                  |
| Total       | 65       | 5                     | 9      | 71                    | 29                       |

Source: FPU data

**Figure 2: Pathways of referral for survivors of GBV in IGMH**

The following table illustrates the new system of referral for suspected or reported cases of GBV or child abuse.



- 1: Family and Child Protection Unit
- 2: Society for Health Education
- 3: Unit for the Rights of Children
- 4: Gender and development

## Policy and protocols

Although there are no national guidelines or protocols available on GBV in Maldives, IGMH has developed its own guidelines for FPU [10] which clearly identifies the roles and responsibilities of different health care providers and outlines the pathway of care to manage such cases – see Figure 2. It is important to note that these guidelines contain a binding statement that health providers should act in accordance with them.

However, these guidelines are not widely disseminated across staff in other departments, meaning they are not always followed.

IGMH has also developed a medico-legal form, with the assistance of international experts. The medico legal form is very comprehensive, includes body maps and is being used in other hospitals as well.

## Referrals and screening

Most of the cases referred to the FPU are either brought in directly by parents or self-directed, referred by the police or by staff from MGF. Internally, most cases are referred by the Casualty or the Outpatients Department.

Once treated and counselled, the FPU Counsellor refers cases to either social workers at MGF or to counsellors from the Society for Health Education (SHE), or a local NGO, which also provides a telephone helpline offering confidential information and assistance on child abuse issues. The external referral of a case from the FPU to social support and counselling services is not immediate.

It usually takes place by way of a letter posted to the support organisation, which will subsequently contact the patient by phone and an appointment will be offered. However, there is no information about the outcome of the referral relayed back to the FPU staff.

There is no referral to legal aid support, which is offered by Hama Jamiyya, a local NGO based in Malé. Legal aid by Hama Jamiyya is a recent introduction, which could be strengthened and networked to provide comprehensive services to victims of GBV and child abuse.

At present, screening for GBV is not conducted at IGMH or any other health facility in the country. Screening was not included in the initial objectives of the FPU because of ethical considerations concerning being able to effectively respond to positively identified cases. However, it may be considered as an opportunity to increase the number of cases detected at IGMH at a later stage, but should only be introduced as a hospital policy after adequate training (and provision of information material) of medical officers at the Outpatients, RH Department and Casualty Department.

**Table 2: Number of staff trained**

| Category of staff trained | Number trained |
|---------------------------|----------------|
| Doctors                   | 41             |
| Nurses                    | 117            |
| Paramedical staff         | 30             |
| Total                     | 188            |

Source: FPU data

## Capacity building

It was with the establishment of the FPU that capacity building in the health sector in the area of GBV started in Maldives. A workshop was conducted as a preliminary activity to the establishment of the FPU in order to train some of the staff, both medical and paramedical, regarding GBV and the FPU procedures. Thereafter, further training programmes have been conducted at IGMH. Between 2005 and 2006, a total of 188 health providers were trained (see Table 2). However, due to the rapid turnover of care providers in Maldives, some of the doctors and nurses who underwent the initial training have left the hospital [8].

In addition, training in the UK in forensic medicine has been provided to one medical specialist to support the FPU.

The establishment of the FPU has brought visibility to the issue of GBV within the institution of the IGMH. At the beginning of the project, the FPU Focal Points were able to conduct specific awareness and monitoring activities such as progress reviews of the project, or share their experience during case conferences within IGMH. Furthermore, FPU activities were presented at fora outside the IGMH, such as the midterm review of the UNFPA and the multi-sectoral Child Protection Working Group. Unfortunately, such activities stopped after March 2006. The lack of formal institutionalisation of the FPU by the hospital administration and the lack of a designated coordinator, as well as time and resource constraints may have contributed to the gradual cessation of such awareness activities.

## Documentation and data management

An effective medical recording system for the FPU has been developed after much effort with the assistance of international experts. Specific medico-legal forms – commended for being very detailed and accurate by various stakeholders such as the police and the Attorney General’s Office – are completed for every patient, irrespective of the type of abuse, and are kept on the premises of the hospital administration. All child abuse cases are automatically reported to the police. On the other hand, GBV cases are reported to the police only if the patient wishes to do so. Otherwise, they will be kept in the hospital for future reference. The responsibility of ensuring the dispatch of the medico-legal forms to the hospital administration lies with the Nursing Coordinator.

The FPU case notes are identified by name, but are kept locked at the FPU office, and thus they can be accessed only by the FPU Counsellor. Soft copies are stored in the computer, which is password protected.

However, some providers did not complete them correctly or in full, probably because of lack of training on how to detail the injuries, their length, and possibly the lack of awareness of the importance of these forms for providing evidence in court. Moreover, although data regarding the performance of the Unit are regularly submitted to the Hospital Administration, clear steering or monitoring mechanisms for improving FPU services have not been established.

Beside the data collection done by the FPU, there is no national systematic data collection system in place for GBV cases to give evidence of the scale and scope of GBV cases coming through the health system.

## Positive outcomes/successes

The Maldives Study on Women’s Health and Violence against Women has provided well-documented evidence that VAW is an issue in the country with serious public health consequences. This has been effective in carrying out advocacy to initiate an effective health sector response to GBV.

The commitment of the Ministry of Gender and Family towards eliminating GBV was crucial for the establishment of the FPU at IGMH, which has in turn brought visibility to the issue of GBV within the health sector in Maldives.

The FPU represents the first Maldivian model of integrated care for abused women and children. In spite of many challenges the FPU faced over the years, it continues to provide services within the health services system for those who have experienced physical, sexual and emotional violence, thereby confirming the fact that such programmes are sustainable with commitment by dedicated staff. The institutionalisation of the FPU with the official recruitment of two counsellors by the hospital management has contributed to the long-term sustainability of the intervention.

The FPU experience is currently being taken positively and a training programme is planned to initiate the replication of the model at the private hospital in Malé [13]. Plans are also underway to adapt the FPU model and set-up similar service centres in the hospitals in some of the islands although more capacity building is required for this to be effective.

## Primary issues and challenges

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While the establishment of the FPU at IGMH has been an important first step in improving the health sector's response to GBV, in order for it to become more integrated and institutionalised, high-level support from the hospital administration, as well as from MoH is needed. Although the FPU is located at IGMH and the counsellors are provided and paid by the hospital, there is no policy statement regarding the integration of the care of abused women and children or other evidence of any official endorsement of the FPU by the hospital administration. The FPU therefore faces a challenge with the 'buying in' of the services by other hospital departments, and the coordination between them is made more difficult due to the lack of an established mechanism of communication.

Despite the availability of hospital guidelines on the management of abuse cases at IGMH, not all health personnel are aware of their existence, their content or the responsibilities of the care providers indicated in them. This is in part due to the rapid turnover of health care providers. The lack of formal orientation on FPU services and its guidelines for new health providers, who join the hospital in rapid succession, is affecting the quality of care provided.

Although there is general high-level consensus on the need for collaboration across sectors to respond to violence, coordination at an operational level still remains a challenge, probably due to the numerous commitments and the time constraints experienced by the different partners.

GBV and child abuse are sensitive and complex human rights, social and public health issues which need the

support of many actors, besides the health service providers. Limited multi-sectoral collaboration appears to hinder the functioning of the FPU and limits the options of care that could be offered to women and children. Over the past year, limited discussions and formal meetings took place across agencies to review progress or address coordination issues around the provision of services for GBV and child abuse. While the FPU makes referrals to outside services, there is a lack of back referral which makes it difficult to monitor the outcome for women and children who come through the hospital.

The lack of specialised or trained doctors in forensic medicine is another challenge, as the medical officers are expected to collect and document findings. Finally, recent political changes may have an impact on these GBV programmes, which is difficult to predict.

## Lessons learned and recommendations

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Institutionalisation of the response to GBV into the state health delivery mechanism in a sustainable manner should be the ultimate goal of any programme addressing GBV in the health sector. This needs to be kept in mind particularly at the planning stage.

High-level support from the hospital administration, as well as from the MoH, is essential for the integration of FPU services and its functioning within IGMH. Such support is crucial in GBV care provision, as well as in building up hospital recognition – by all departments.

Advocacy activities should be conducted with high-level stakeholders on the importance of GBV as a public

health issue and the importance of service provision for victims of GBV, particularly considering the fact that major health policy changes are envisaged in the near future.

While the FPU has its own guidelines, it is important to develop national level guidelines on the management of GBV, including the management of victims of rape in order to institutionalise a response and ensure consistency of care across health institutions.

To ensure the ongoing sustainability and quality of the health sector response to GBV, it is necessary to conduct sensitisation and training programmes on a regular basis and incorporate them into the Continuing Medical Education (CME) programmes for care providers. GBV and sensitisation on FPU activities should be included in the familiarisation training of the new care providers, particularly that of doctors, to compensate for the rapid turnover of care providers. The sensitisation and training programmes should highlight the humanitarian and ethical aspects of providing care for GBV in the health sector. Furthermore, capacity building of the medical officers on evidence collection and documentation is important as no forensic pathologists or judicial medical officers are available.

Sharing experiences and information about GBV services provided by the FPU with other departments in the hospital could be effective in promoting better coordination and 'buy-in' and should be given priority.

A multi-sectoral referral system for GBV is essential in providing comprehensive care to women and children receiving care at the FPU. In Maldives, this system should be strengthened and formalised. It would also be ideal to develop a system for back referral and follow-up of victims attending the FPU.

Considering the sensitive nature of the issue, limited facilities and resources available as well as the experiences of the FPU at IGMH, it is recommended that replication should happen in stages. At atoll level, the structure and objectives of the services provided may differ from the FPU model at IGMH. The FPU model would need to be reviewed in view of the availability of local resources and support services. For instance, as most health care providers outside IGMH and Malé are not prepared to respond to abuse cases effectively, training would need to be conducted at the local level.

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# 4



## Papua New Guinea

### Country Profile:

|  |              |
|--|--------------|
| Total population (in thousands):                       | 6,202 (2006) |
| GNI per capita (PPP Intl \$):                          | 1,630 (2006) |
| Total health expenditure per capita (PPP Intl \$):     | 111 (2006)   |
| Life expectancy at birth male/female (years):          | 60/64(2006)  |
| Maternal mortality ratio (per 100,000 live births):    | 733 (2005)   |
| Infant mortality ratio (per 1,000 live births):        | 60 (2006)    |
| Births attended by skilled health personnel (%):       | 38 (2005)    |
| Total fertility rate:                                  | 4.0 (2006)   |
| Human Development Ranking 2009 (out of 182 countries): | 148          |

(Source: World Health Statistics 2008)

**P**apua New Guinea (PNG) is one of the least developed countries in the world and is ranked 148 on the Human Development Index (HDI). Average life expectancy is the lowest in the Pacific region at 60 years for men and 64 years for women. Infant mortality of 60 per 1,000 births and maternal mortality of 733 per 100,000 live births are also some of the highest in the region.

PNG is also prone to natural disasters. In the last decade alone, PNG has experienced multiple incidences of earthquakes, tsunamis, volcanic eruptions, floods, droughts and extreme frost. These disasters have resulted in a loss of lives; displacement of families; destruction of crops, property and livelihoods; and disruption to social services, such as health care and education. In addition, PNG has experienced armed conflict over several years. Evidence indicates that violence against women (VAW) perpetrated mainly by Bougainville men and soldiers increased dramatically during the crisis and post-conflict period.

The population of six million is widely dispersed and the majority of the country is not accessible by road. Many people have little contact with or access to the police or the formal justice system and are largely beyond the reach of government services including health care. In fact, the health system is failing and experts argue that the health services have declined over the last 30 years [1]. There is a country-wide system of health aid posts out of which half are closed, and the Catholic Church is the largest supplier of health care in rural communities. The latest statistics from 2000 indicate that there are only about five doctors per 100,000 people in PNG and most are in Port Moresby

or the larger towns, leaving the majority of people without access to a doctor [2].

Since HIV was first recorded in PNG in 1987, the trend in reported HIV infections has shown a significant and steady growth [1]. In 2004, PNG became the fourth country in the Asia Pacific region to declare a generalised epidemic after HIV prevalence surpassed one per cent among women attending the antenatal clinic at the Port Moresby General Hospital. Based on modelling of available data, the national prevalence is estimated to be 1.6 per cent with an estimated 60,000 people living with HIV in 2007 [3]. However, others suggest that the rate of infection is much higher.

Available behavioural surveillance data and social research indicate that HIV is primarily sexually transmitted in PNG, through unprotected vaginal and anal sex between men and women and unprotected anal sex between men [4]. Gender inequities greatly influence the sexual transmission of HIV in PNG [5, 6]. Women and girls are more vulnerable to HIV infection than men and boys and less able to protect themselves because of the many economic, social, legal, political and cultural disadvantages they face [1].

## Prevalence of GBV

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The rates of VAW in PNG are thought to be some of the highest in the world. In PNG, the socialisation processes of men and women right from birth puts men in a

position of absolute authority over women, who are expected to be obedient and submissive to men. The PNG Law Reform Commission (LRC) conducted the first nationwide research on domestic violence (DV) in PNG in the 1980s and found that approximately two-thirds of all PNG women reported being victims of physical partner violence. There was evidence of some provincial variation with almost 100 per cent of women in two highland provinces (Chimbu and Western Highlands) reporting DV, while the rate was closer to 50 per cent in Oro (coastal province) and Western New Britain (island province) [7]. A follow-up to the LRC study is currently underway and will provide longitudinal data on VAW in PNG.

Sexual VAW in particular has reached epidemic levels in PNG and has significant implications for the health and well-being of women and girls, particularly with the high rate of HIV/AIDS. The PNG Institute for Medical Research conducted a study on sexual violence in 1993 which indicated that 55 per cent of wives had been forced to have sex against their will by their husbands. Of married women surveyed, 50 per cent reported that their husbands had used beatings and threats to force them into sex. The study also revealed an alarming prevalence of gang rape (known as *lainap* in PNG) with 60 per cent of the men interviewed admitting that they had participated in gang rape [6].

An Amnesty International report on VAW in PNG published in 2006 found that the injuries women suffer as a result of gender-based violence (GBV) can be, and often are, serious. It also found that DV accounts for 80-90 per cent of injuries in women presenting at some hospitals [8]. According to Miranda Darling Tobias, 'health workers at Kundiawa hospital estimated that 8 out of 10 patients in their surgical ward were there as a result of domestic violence' [1]. Hospital and health care clinic staff reported to Amnesty International that they frequently treat injuries such as broken arms, facial bruises and fractures,

kick marks on the back and lacerations caused by bush knives. In the most serious cases, women are killed by their partners. A member of the hospital staff in Wewak told Amnesty International that she often warns women who present with serious injuries that 'next time' they face a real risk of being killed, because the nature and/or severity of their injuries is such that it is more a matter of luck than intent whether their partner's abuse results in death [8].

## Overarching policy framework

In the late 1980s, PNG was a leader in the developing world in terms of action on VAW with the first national study on DV and the first national programme of action on DV of any developing country [9]. This was in part due to strong leadership from the LRC, however, with a lack of continued leadership the majority of the progress was lost until 2000 when the issue of GBV was again brought into the spotlight and the Family Violence Action Committee (now the Family and Sexual Violence Action Committee [FSVAC]) was formed.

PNG does not have a DV act, however, amendments to the Criminal Code and Evidence Act were passed in 2002 and include:

- Clearly defined sexual offences against children;
- definition of incest expanded to cover more categories of relationships;
- court procedures improved to protect survivors' safety and dignity;
- definition of rape expanded to cover penetration of the mouth or anus and use of objects, requirement for medical corroboration removed, victim's previous sexual conduct not admissible as

- evidence; and
- rape in marriage became illegal [10: 109].

PNG has developed a comprehensive National Strategy and Action Plan for ending family and sexual violence (2008-2012), which is the output of extensive community consultation and research [11]. Significantly, the strategy is based on an ecological model recognising that interventions must take place at individual, family, community and societal levels and that there must be a multi-sectoral approach to address VAW. The plan outlines clear roles and responsibilities for government, social service providers, the health care system, the justice system, the education system, clergy, media and employers. Health related activities in the plan include:

- Ensuring the construction, quality and utilisation of family support centres (FSCs) in hospitals in all provinces, which includes training provincial FSC staff at Lae FSC, an FSC considered to be a Centre of Excellence;
- increasing survivor access to comprehensive health care, which includes completing the medico-legal protocol, incorporating curricula on the protocols into medical schools and nursing programmes, and eliminating all hospital fees for survivors of family and sexual violence; and
- integrating family and sexual violence into HIV/AIDS plans, policies and programmes.

The FSVAC plays a coordinating role in ensuring the implementation of such activities.

The current health plan does not include GBV as a strategic area, however, the 2010 National Department of Health (NDoH) Draft Strategic Plan has, for the first time, included family and sexual violence as a Strategic Area within Family Health Services (FHS). GBV has also become a programme area under the FHS section of the

NDoH and a GBV programme officer was placed at the Department last year. The NDoH GBV programme officer has been working to get directors in the various health sectors to understand the importance of GBV within the current plan because it affects Strategic Directions 3 and 4: Safe Motherhood and STI/HIV respectively. The programme officer is assisting directors to do their planning and advocating for the inclusion of GBV in the Annual Activity Plans for 2010 to ensure the GBV activities receive funding. According to the NDoH GBV programme officer, by 2012 every provincial health department will have a GBV programme under FHS.

The United Nations' system in PNG is also taking a lead role in GBV, including within the health sector. The United Nations has one country programme including a five-year strategic plan on gender (2008-2012). There is good collaboration and joint programming on GBV in the health sector with almost all agencies involved at some level with the FSVAC, a national NGO, and the FSCs.

## Description of the health response

One of the most significant elements of the health sector's response to GBV in PNG is the introduction of hospital-based one-stop crisis centres (OSCCs) for family and sexual violence, otherwise known as FSCs.

The health system offers the most practical entry point for creating a coordinated response to GBV in PNG because injuries from GBV and other symptoms such as poor health, STIs and high-risk pregnancies bring women to hospitals and medical facilities. In recognition of this, PNG's first national strategy on family and sexual violence (2001) prepared by the FSVAC, a national NGO, recommended that an OSCC be set up at Port

Moresby General Hospital. In 2003, a centre was opened which was a collaboration between FSVAC and the hospital. At the same time, Lae's Angau Hospital took the initiative to establish their own centre in partnership with Soroptomists International (an international NGO). In recent years, Doctors Without Borders (Médecins Sans Frontières [MSF]) funded a separate building for the Lae FSC and now manages the Lae centre as well as a new centre in Tari. Centres have also been set-up at Goroka Base Hospital, Kainantu District Hospital and Kundiawa Hospital with several other centres in preparation at both provincial and district hospital level. Since 2003, UNICEF has been involved in strengthening services for women and child protection activities in the centres, and has provided funding for the renovation of facilities in Port Moresby, Kundiawa, Mt Hagen, Aloau, Kiriwine and Anglimp South Wagi.

Historically, the centres have been run by various NGOs in collaboration with the hospital management with little overall ownership and coordination from the NDoH. However, in recent years the NDoH has demonstrated its commitment to, and responsibility for, improving health care for survivors of GBV through hospital-based centres. In October 2005, the Secretary for Health sent a circular to all CEOs of public hospitals directing them to establish FSCs in all government hospitals, to provide care for victims of family and sexual violence. Furthermore, in 2009, guidelines and protocols were finalised that clarify the core mandate of the centres and the responsibilities of the hospitals. These guidelines will replace the Memorandum of Understanding (MoU) previously agreed between hospitals and the civil society organisations. All centres will now be under the responsibility of the hospitals, the provincial health authorities and the NDoH, although the support and collaboration of other organisations continues to be essential to the success of the centres (guidelines discussed in more detail below).

FSCs are generally the first point of entry for survivors of GBV, with clients being able to access the centres directly without having to wait in Outpatients or Accident and Emergency (A&E). Clients can also be referred by staff of the hospital. The purpose of the centres is: *'to provide client-centred care for the medical and psycho-social needs of victims/survivors of family or sexual violence in one location with respect and empathy, and to assist in preventing family violence through advocacy, community education and increased access to justice for survivors.'*

Under the new guidelines, all FSCs will provide the following services:

- Initial assessment for category of violence and level of injury;
- physical examination and recording of history;
- medical treatment in the centre (where injuries are minor), or referral to specialist medical care within the hospital;
- follow-up medical care;
- accompanying patients to referred services;
- documentation of injuries and provision of medical report to client and collection and storage of evidence for possible criminal proceedings;
- provision of medical report to the police if required, using format approved by NDoH, Health Improvement Branch;
- STI diagnosis and treatment and/or prevention of STIs, tetanus, Hepatitis B and rape-related pregnancy (if within 72 hours of rape);
- provision of post exposure prophylaxis (PEP) for HIV (with voluntary counselling and testing [VCT]) in-line with NDoH approved protocols;
- crisis counselling and assessment of current safety issues, crisis management and trauma counselling, and development of a plan for case management, including follow-up counselling;
- counselling for children who have witnessed abuse

- of their mother;
- information on legal options and assistance with obtaining protection orders, including liaising with village courts;
- liaising with police for laying criminal charges, child protection services, child welfare, etc;
- emergency accommodation where needed (max. 48 hours);
- regular support group for those clients who want it;
- referral to other safe accommodation where needed and other community support services;
- provision of emergency clothing, food and assistance with transportation;
- community outreach and advocacy including

informing community about the centres, educating community about laws and rights, public events; and

- data collection and management.

The officer in charge of the FSCs is a full-time nurse coordinator (funded by the NDoH through the hospital) whose role is to oversee the daily operations of the centre, provide management, training and supervision to centre staff and volunteers, provide training to other health staff, develop activity plans, maintain a referral network and maintain the community outreach programme. Other staff will include a female community health worker, a female volunteer, a receptionist as well as a physician

**Figure 1: From the National Department of Health checklist on clinical guidelines for domestic violence**





and medical social worker who will be on call for more serious cases. Staff and volunteers will be trained through a programme recognised by the NDoH, which is in the process of setting up a Centre of Excellence, a system of clinical attachments and performance criteria for staff and volunteers, as well as a detailed procedural manual containing pro formas, protocols, referral trees, templates for client records, and formats for collecting and reporting on case data and centre performance indicators.

The functioning of the centre and its officer in charge will be supervised by a management committee consisting of senior hospital staff, FSVAC, the AIDS committee, a representative from NGOs, police and financial sponsors.

## Policy and protocols

In PNG, there has been concern that while some health workers provide comprehensive and compassionate services to survivors of GBV, the majority only treat physical injuries and even pass judgement about the victim's role in the assault. The national strategy and action plan for ending family and sexual violence notes that a 'system' with protocols and training is vital so that health care workers do not simply act on their own biases [11].

In response to such concerns, PNG became the first country in the Pacific to introduce a formal protocol and training on DV for primary health care providers in urban and rural areas in 2003. The NDoH Protocol on Domestic Violence requires health workers to ask about DV with

certain presenting conditions, ensure privacy, inform the client she has the right to be protected, provide treatment, carry out safety planning and record injuries.

PNG is also in the process of finalising more detailed Clinical Practice Guidelines for Medical Care and Support of Survivors of Sexual and GBV. These were developed by a working group and based on WHO guidelines. They are designed to work together with the guidelines for the FSCs (discussed below). The comprehensive protocol outlines entry points for patients, information and consenting procedures, security of client records, mental health trauma counselling, safety planning, completing a medical record pro forma, examination procedures, collecting forensic evidence, PEP and pregnancy prevention.

Furthermore, as mentioned above, the NDoH recently finalised guidelines for hospital-based OSCCs for family and sexual violence. The NDoH guidelines note that the centres have interpreted their mandate in different ways and in some cases there is considerable divergence from the original concept. The new guidelines clearly set out the purpose, rationale and core principles of the centres. They also outline the staffing needs and responsibilities, the management of the centres, physical space requirements and operations, as well as partnerships between the hospital and other agencies. The new guidelines are very thorough and based on core principles of human rights and dignity.

The only exceptions to this are the MSF-run centres at Lae and Tari which have their own guidelines and protocols and have a more medicalised focus and a particular concentration on sexual violence. However, the new NDoH guidelines and protocols have been designed in collaboration with MSF to ensure consistency.



## Referrals and screening

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There are no formal referral systems in place for survivors of GBV although a number of different organisations have good working relationships and informal referral practices. Furthermore, the DV clinical guidelines include a referral network template for each health centre/post to develop their own relevant, localised referral network. Training with health service providers has included a session on building a referral network by making personal contacts with relevant services in the area including village health volunteers, church or women's groups, community leaders, church counsellors, welfare offices, hospital social workers, village court magistrates, public solicitors and others.

There are no formal screening procedures in PNG for all women who come through the health system, however, the clinical guidelines on DV require health workers to ask about DV with women and children with physical injuries. This is also the case for female clients who have:

- Chronic complaints with no obvious cause;
- an STI, especially re-infection;
- chronic pelvis pain;
- delay in seeking treatment;
- many children, or children too close; and
- a young child who is not growing well.

In the health care worker training programme, workers are encouraged to ask in a non-judgmental way saying something like, 'We see a lot of patients with health problems because of being beaten by their husbands, and I'm wondering if this is happening to you.'

However, with the decline in the health system in recent

years, key informants suggested that it is likely that very few health service providers on the ground are still using the DV checklist and asking about violence. The new protocol and guidelines and training manual are an attempt to re-establish a comprehensive system of response for survivors of GBV.

## Capacity building

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Over the last eight to ten years, a number of sensitisation workshops and other training has been conducted with health service providers on GBV, including the use of the clinical guidelines on DV. However, the approach has been somewhat ad hoc and there has been little success in fully incorporating GBV training into relevant health professional curricula. For example, an in-service training package on DV with a six-step protocol was created in 2003 and relevant tutors responsible for teaching this topic from all the colleges of community health work and nursing were trained. However, when the new health care worker curriculum was developed, DV was only partially integrated. In response, there was an additional one-day training workshop conducted on how colleges could work on integrating the materials themselves. Since then work has continued and pre-service training for community health workers now includes coverage of DV and rape.

There have been some attempts to incorporate GBV in the curricula of medical and nursing colleges and in some cases training has taken place. However, whether such actions were taken tended to be dependent on committed individual professors, teachers and trainers rather than having become institutionalised.

A comprehensive training manual for HSPs is currently being developed (waiting to see draft) to support the newly developed medical protocol and FSC guidelines. The NDoH ran a seven-day training of trainers (ToTs) on GBV and health with approximately 30 provincial HSPs in Port Moresby in late 2009. The trainers then returned to their provinces and conducted training with community health workers in their districts.

WHO also provides training for staff of the FSCs around the country and will continue to train health workers on the new medical protocol. In addition, the Lae FSC, which

is considered the best example of service provision on GBV in the country, will provide training and mentoring support to FSCs being established in other provincial hospitals. However, it must be acknowledged that because this centre is run by an international NGO, it has extensive resources and capacity including full-time medical staff, medical supplies and a well-equipped building. MSF themselves acknowledge that this model is not sustainable for the rest of PNG. While other centres must operate with fewer resources and technical expertise, the Lae centre still has valuable lessons to share in terms of systems and operating procedures.

## Integrating Gender into HIV and AIDS Activities: *A Guide for Implementers*



The National Gender Policy and Plan on HIV/AIDS 2006-2010 has been adapted into user-friendly tools by *the Sanap Wantaim* (Stand Together) programme and have been disseminated to HIV/AIDS implementing partners with significant success [5].

PNG is also developing a competency based training and mentoring programme for GBV staff to increase the local capacity to respond to, mitigate the effects of, and reduce the twin epidemics of GBV and HIV/AIDS. A certification package at a university level for GBV programme staff, volunteers and HIV/AIDS civil society partners is currently being developed. The aim is for the certification package to be also integrated into related coursework for social workers and counsellors. Initial training will include the NDoH's OSCC staff.

## Documentation and data management

In 2001, a report was commissioned by the FSVAC on the nature, extent and causes of family and sexual violence in PNG. The report found that: 'in PNG, major improvements to the data collection systems of all agencies are desperately needed, requiring specific provisions for recording the main forms of family and sexual violence.'

Previously, there has been no system to collect data on the number of GBV cases going through the health system. This is one of the main reasons for underreporting of GBV seen in the health facilities. However, 'suspected DV' and rape of adults (male and female) and children (male and female under 16 years of age) has just been added to the list of information to be recorded at the health facilities and then sent in monthly to the National Health Information System (NHIS). Figures from 2009 were the first recorded, but they are not yet available. It should be noted that there is some concern amongst experts in the GBV field that because many of the facilities still charge the punitive DV fee, women often do not tell the truth about the cause of their injuries and, as such, any data collected will be misleadingly low.

## HIV/AIDS

PNG is taking a lead in the region in terms of integrating GBV and HIV activities within the health sector.

A lack of sexual autonomy has made women increasingly vulnerable to HIV/AIDS in PNG. Even those women who are reached by HIV/AIDS awareness and education campaigns are rarely in a position to act on the information they receive. For example, women repeatedly told Amnesty International that if they refused sexual intercourse with their partners or insisted on condom use, they would face violence and/or desertion by their partners [8].

Girls aged 15-19 years of age are the most vulnerable to HIV infection in PNG, particularly because older men have sex with them. The low status of women means that they are subjected to sexual violence and rape, and can't negotiate safe sex. Women are also often blamed for spreading HIV and are exposed to more violence [1, 12].

PNG has a National Gender Policy and Plan on HIV/AIDS 2006-2010 that recognises the importance of a gendered approach to HIV by stating that GBV is both a cause and consequence of HIV infection. GBV has been identified as a key policy issue and the policy states that gender is the single most significant factor affecting a person's risk of contracting HIV and suffering the consequences of infection [12]. The plan recommends the integration of FSV prevention and response activities into HIV-related programming at all levels, moving beyond awareness raising and into the development of programmes, services and skills.

Pre- and post-test guidelines and a checklist have been developed for VCT for HIV Units to reduce negative consequences for women linked with HIV testing. Training

of VCT counsellors on GBV issues is being undertaken by the National HIV/AIDS Training Unit. PEP for HIV has also been included in the GBV medico-legal protocols.

In consultation with partners involved in the national response, the PNG Government has developed a new National HIV Prevention Strategy 2010-2015 (NHPS) [3]. The NHPS provides the strategic framework for guiding and expanding HIV prevention efforts within the overarching framework of the PNG National Strategic Plan (NSP) on HIV/AIDS 2006-2010 and its companion documents, the National Gender Policy and Plan (NGPP) on HIV/AIDS 2006-2010, the National Research Agenda (NRA) for HIV and AIDS 2008-2013, and the Health Sector Strategy (HSS). The strategy acknowledges that: 'gender is a key aspect of the HIV prevention framework, with relevant strategies from the National Gender Policy integrated into NHPS priority areas. Comprehensive implementation of the National Gender Policy will be critical for underpinning the successful implementation of HIV prevention strategies.'

## Positive outcomes/successes

- PNG has made a number of achievements in terms of the health sector response to GBV in recent years. The first step towards opening the hospital-based OSCCs has been determining that VAW was indeed a health crisis. This has taken many years of coordinated advocacy with the government from United Nations' agencies including UNICEF and UNFPA, local and international NGOs, researchers and dedicated medical professionals. It is a significant achievement that, as of early 2007, the NDoH has recognised the need to improve its

response to GBV and is taking a lead on the issue.

- Even though the effectiveness and capacity of the FSCs varies, the introduction of these hospital-based OSCCs has been a success in terms of national level commitment and a multi-sectoral strategic approach to addressing GBV with a health sector focus. Significantly, the NDoH has recently agreed to fund the operating costs of FSCs in all provincial hospitals.
- Multi-sectoral responses to GBV through OSCCs based in hospital settings can be very effective because women who have experienced violence seek health care more frequently than women who have not experienced violence. Furthermore, women often seek treatment at health care facilities for injuries and less defined but related symptoms of violence before seeking help from other agencies such as police or even women's NGOs. Hence, the PNG example shows that even when the health system is limited, women and girls come in large numbers when the centres are run well with trained staff.
- Having a national action plan on VAW that outlines the roles and responsibilities for each sector including the health system is very positive and can be effective in promoting a multi-sectoral response to GBV.

Other major achievements include:

- The inclusion of GBV in the annual plans of the HIV/STI section and the FHS section, supported by a specialist advisor.
- The FHS creating the position of GBV Programme Officer.
- The development of comprehensive national guidelines and protocols on the health sector response to GBV, in line with WHO standards.
- The integration of GBV and HIV activities being

carried out through the health sector. The adoption of a gender policy in the HIV strategy and creating user-friendly tools for implementers–this has been very successful through Non-governmental Organisation/Community Based Organisation (NGO/CBO) work.

## Primary issues and challenges

Arguably the most significant challenge for PNG in addressing GBV through the health sector is the fact that there has been a significant decline in health service delivery in recent decades. The decline in service provision means that most health staff are no longer using the checklist and other tools in their day-to-day work on the ground. For example, the person who developed the DV checklist reports that they have heard of only two health facilities run by the Catholic Church where the checklist is still being used. In this sense there has been a significant issue in sustainability which must be understood within the context of a collapsing health service, a stagnant NDoH, and a complicated devolution of powers to provincial health authorities that is at different stages in different provinces.

Given the collapsing health system, there is a serious question about how the new FSCs and protocols will function. In the PNG context it makes sense to have OSCCs that are connected to hospitals but have their own dedicated resources so that survivors of GBV can side-step the major issues of overcrowding, long waiting times and lack of confidentiality in the hospitals. This is particularly important given the high prevalence of VAW in PNG. However, for the response to be successful, the centres need to be well funded and have dedicated full-

time staff. Furthermore, it must be remembered that the majority of people living in remote rural communities do not even have access to provincial hospitals.

While the NDoH has taken a number of important steps to start addressing GBV through the health sector, there is a lack of capacity within the department when it comes to expert knowledge on GBV. There is also a weakness in communication and coordination between the branches of the NDoH, particularly between the central office and the provinces, which is reflected in that fact that, according to some key informants, the Health Promotion Unit has stopped re-printing and supplying the DV checklist, leaflets and posters to the provinces.

Existing FSCs have faced many challenges and have had varying degrees of success. An ongoing issue in many of the centres, particularly those being run by NGOs, is a lack of support by the hospital management. In fact, two centres have ceased functioning due to a lack of support from the hospitals to which they are attached. And in Lae, although MSF has an MoU with Angau Hospital, the system of referral between the hospital and the centre is not running smoothly due to communication problems and strained relationships. The centre is missing out on treating a number of GBV cases that are not being referred from the hospital. In response, MSF is starting to work on outreach to improve awareness of the centre in the community and improve referrals to it.

In the forthcoming process of ‘scaling up’ the FSC system there is always a concern about the quality of services, but to address this there is concerted effort to institutionalise training of HSPs at all levels. Nevertheless, it remains a major challenge to incorporate GBV training modules in the health worker curricula. Getting good, committed staff to work in the FSCs will also be an ongoing challenge. While the national level guidelines and protocols will

assist in ensuring consistency and quality, there must be ongoing training and sensitisation of these tools at all levels for them to be effective. Ensuring that all women who have experienced physical or sexual violence receive treatment directly from the FSCs will take time and training of all hospital staff as well as conducting community outreach promoting awareness of the services.

It is particularly important to advocate at the management levels as key informants noted that the quality of the service is in many ways dependent on the hospital management, particularly the CEO and his or her commitment to the service.

As yet there have been no detailed evaluations done of the FSCs, so there is no information on the outcomes of interventions, particularly in terms of what works and what does not. This is a gap that needs to be addressed. Furthermore, data collection and management remains another major gap.

## Lessons learned and recommendations

- The hospital-based OSCC model can be effective, particularly because it promotes a multi-sectoral response and gets all partners working together. A good multi-sectoral response requires coordination and an effective referral system between the three domains of prevention, treatment and support, and justice for victims.
- Success in developing a multi-sectoral response to GBV through the health sector does not happen overnight. Getting the NDoH on board and committed to addressing GBV as a public health issue has taken years of advocacy at various levels

by NGOs, medical professionals and the United Nations. As such, any health sector response requires advocacy and sensitisation at various levels, particularly with the government.

- For interventions to be sustainable, ultimately the government needs to take responsibility for GBV as a public health issue by funding operational costs and staffing. This is now happening in PNG through the national strategy and government consultation.
- It is necessary to have strong leadership and a strong driver to promote GBV as a public health issue. In this respect, it is effective to have a central coordinating agency to lead the response to GBV to ensure a multi-sectoral response – while the FSVAC plays this role in PNG, a lack of resources and capacity limits their ability to fulfill this role properly.
- For hospital-based OSCCs to be effective there needs to be training at multiple levels including strong advocacy with hospital management to ensure a good collaborative relationship between the hospital management and those running the OSCC. Ongoing training is vital to ensure continued quality and sustainability of services and it is necessary to institutionalise training of HSPs by incorporating it into curricula.
- Adequate staffing of centres is vital – women should be seen by women – and there is a need for dedicated, well-trained staff. Work must be done to motivate and take care of staff to retain them and avoid burn out, especially where they are dealing with so many difficult cases.
- Having infrastructure for the care and treatment of GBV cases is the most effective approach to managing the issue.
- The OSCCs offer a good entry point for HIV messaging and services including voluntary counselling and testing (VCT) and PEP.



- There needs to be more monitoring and evaluation of services including receiving feedback from clients. It is also important to collect reliable data on the number and types of cases of GBV coming through the health sector to continue to justify work and improve services.

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# The Philippines

## Country Profile:

|  |               |
|--|---------------|
| Total population (in thousands):                       | 86,264 (2006) |
| GNI per capita (PPP Intl \$):                          | 3,430 (2006)  |
| Total health expenditure per capita (PPP Intl \$):     | 88 (2006)     |
| Life expectancy at birth male/female (years):          | 64/71(2006)   |
| Maternal mortality ratio (per 100,000 live births):    | 230 (2005)    |
| Infant mortality ratio (per 1,000 live births):        | 24 (2006)     |
| Births attended by skilled health personnel (%):       | 60 (2003)     |
| Total fertility rate:                                  | 3.3 (2006)    |
| Human Development Ranking 2009 (out of 182 countries): | 105           |

(Source: World Health Statistics 2008)

**T**he Philippines is one of the most populous countries in Southeast Asia. With a population greater than 86 million, it is a diverse country with a rich multi-linguistic, multiethnic, and geographically dispersed population. Its land area of approximately 300,000 square kilometres is spread over more than 7,000 islands. As such, the country has a large number of remote communities whose inhabitants have only the most exiguous means of life. This untoward state of affairs is often exacerbated by the fact that the quality of transportation and communication systems is highly uneven in many areas. The upshot is that many remote communities are unable to have proper access to goods and even basic services. [1]

Since the restoration of democracy in 1986, the number of civil society groups and peoples' organisations has grown considerably. Civil society, particularly the women's movement, has increasingly exerted a formidable influence [1]. However, the Philippines is confronted with political and economic uncertainty, as well as conflict and natural disasters, all of which converge so as to put women and girls at increased risk of violence and exploitation.

The country scores relatively well on international gender equality measures and indices. For instance, in 2006, out of 157 developing countries, the Philippines ranked 47th in respect to the percentage of females enrolled at the primary, secondary and tertiary levels. In 2008, the country maintained its rank as the 6th country on the Swiss-based World Economic Forum's Gender Gap Index (GGI). The GGI examines differential gaps in outcomes between women and men in four fundamental categories: economic participation and opportunity, educational attainment, political empowerment, and health and survival. Furthermore, at a value of 0.560, the

Philippines ranks 61st out of 108 countries on the basis of the Gender Empowerment Measure (GEM), an indicator that measures to which extent women take an active part in economic and political life.

However, in the 2008 Joint Country Gender Assessment for the Philippines, it is revealed that there is much to be done if what has been achieved can be sustained. There is a clear need to implement policies and programmes conducive to the empowerment of women and gender equality in a much more efficacious manner. In any event, it must be recognised that this state of affairs is inseparable from underlying social structures and wide-scale social practices that form the bedrock of cultural acceptance of gendered violence.

## Prevalence of GBV

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The prevalence of gender-based violence (GBV) in the Philippines is difficult to estimate. Official statistics show a very limited number of reported cases per year if considered in proportion to the size of the population.

A 2003 survey by the NGO Social Weather Station (SWS) found that 12 per cent of men admitted having physically harmed women. Of these respondents, 39 per cent admitted using violence against their wives, while 15 per cent said they used violence against their girlfriends and 4 per cent against their partners. On the other hand, in the same survey, women cited the following reasons for not reporting violence: embarrassment, not knowing how or to whom to report, believing that the violence was unimportant, or believing that nothing would be done.

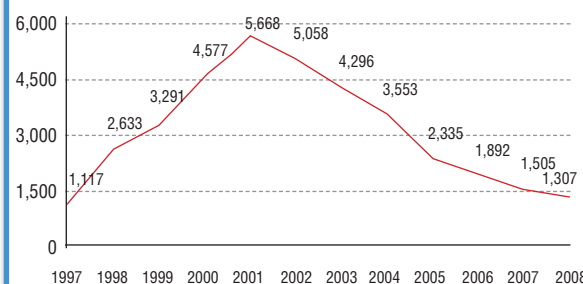
In the 2002 Cebu Longitudinal Health and Nutrition Survey, researchers examined the prevalence of and factors associated with intimate partner violence (IPV) perpetrated by husbands and wives in Cebu City. The researchers found that about 26 per cent of the wives reported that either they or their husband had perpetrated at least one physically aggressive act during the past year, while 22 per cent reported sexual coercion used by their husbands in the course of their relationship. The most common reasons cited for using violence against spouses were alcohol consumption, nagging, the wife fighting back, or jealousy.

In terms of reported cases, 'physical injury/wife battering' accounted for approximately half (49.6 per cent) of all reported cases of violence against women (VAW) nationwide in the period between 1997 and 2008. The peak was in 2001 with 5,668 reported cases (see Figure 1). Reported rape cases accounted for about 13.8 per cent of the total of reported VAW cases in the period between 1999 and 2008. However, a downward trend occurred in reported rapes with 946 reported rapes in 1999 in comparison to the 811 reported rapes in 2008 with the peak being reached in 2000 at 1,121 reported cases.

## Overarching policy framework

As a signatory to international conventions and declarations upholding gender equality and the human rights of women, the Philippines has passed several laws protecting women from GBV. The Philippine Plan for Gender-Responsive Development (PPGD) of 1995-2025 summarises the impact of VAW: '(VAW) is in direct contradiction to national and social development goals. It exacts grave consequences on women's lives as individuals, and denies them options... It jeopardises their health, human rights and capacity to participate, as well as contributing freely in society.' As promulgated

**Figure 1: Number of physical injuries/ wife battering cases reported to the PNP: 1997-2008**



by the PPGD, the Philippine Framework Plan for Women (a three-year directional plan) stresses the economic empowerment of women, women's human rights, and gender-responsive governance as the keys to gender equality and the overall empowerment of women.

Some of the significant laws include:

- The Anti-Rape Law of 1997 (Republic Act [RA] 8353) redefines and expands on what constitutes rape from its original formulation as a crime against chastity to that of being a crime against the person. It further broadens the definition by not restricting the act of rape to penile penetration by including the insertion of any object. It explicitly recognises marital rape when it refers to cases when the offender is the legal husband of the woman raped. However, it nullifies criminal action or penalty if the wife-victim subsequently forgives the offender.
- The Rape Victim Assistance and Protection Act of 1998 (RA 8508) mandates the establishment of rape crisis centers in every province and municipality to provide counselling and free legal assistance while ensuring the privacy and safety of rape survivors/victims. It also tasks the government with the

training of law enforcement officers, public prosecutors, lawyers, medico-legal officers, social workers and *barangay* (village) officials on human rights and duties, gender sensitivity and the legal management of rape cases.

- The Anti-Violence Against Women and Their Children Act (RA 9262) was enacted in 2004. In the course of promulgating implementing rules and regulations (IRR), the Act outlines the specific duties and responsibilities of the Department of Health (DoH) as a Member of the Inter-Agency Council on Violence Against Women and Children (IAC-VAWC).
- The Philippines Republic Act 9710 provides the Magna Carta for Women by saying that 'The State shall, at all times, provide for comprehensive, culture-sensitive, and gender-responsive health services and programmes covering all stages of a woman's life cycle and which addresses the major causes of women's mortality and morbidity. In cases of VAW and children, victims and survivors shall be provided with comprehensive health services that include psychosocial, therapeutic, medical, and legal interventions and assistance towards healing, recovery, and empowerment.'
- This follows on from the Department of Health Administrative Order issued in 1997 institutionalising the establishment of a Women and Children Protection Unit (WCPU) in all DoH hospitals for victims/survivors of domestic violence (DV), rape, incest, torture, sex trafficking, and other abusive and exploitative acts.
- Pursuant to the annual General Appropriations Act, agencies are tasked to formulate a Gender and Development (GAD) budget and to implement the same by utilising at least five per cent of their total budget appropriations as a GAD budget. In accordance with the Framework Plan for Women, agencies are encouraged to promote gender-responsive governance, protect and fulfill women's human rights, and promote women's economic empowerment.

## Description of the health response

In 1995, the Women's Crisis Centre (WCC), a women's NGO that pioneered crisis intervention for women victims/survivors of abuse, proposed to the National Commission on the Role of Filipino Women (NCRFW) a project entitled Project Hospital-Assisted Crisis Intervention for Women in Violent Environments (HAVEN). NCRFW incorporated Project HAVEN into its larger proposal entitled 'Policy Development and Advocacy for Women's Health (PHI/96/P13),' which was funded by UNFPA in 1996. The DoH identified the East Avenue Medical Center (EAMC) as the government hospital where the project would be piloted. The project was later renamed Women and Children's Crisis Care and Protection Unit when it was institutionalised. A National Steering Committee was formed with nine government agencies as shown below [2].

A year after Project HAVEN commenced operations, the DoH piloted purely government-based Women's Desks in five government hospitals. In 1997, then Philippine president, Fidel V. Ramos, issued a memorandum entitled 'A Call to Action Against Domestic Violence.' That directive led to the issuance of an Administrative Order (AO No. 1-B s) by the DoH mandating all hospitals retained by the Department to establish WCPUs [3].

To date, there are 44 out of 72 DoH regional and specialty hospitals with WCPUs established by the DoH throughout the country [3]. They are usually located near the emergency rooms of hospitals and have a separate room for interviews, crisis counselling and medical examination. The WCPUs should have trained service providers, including at least one on-call obstetrician or gynaecologist, one paediatrician, a nurse, a psychiatrist/psychologist/counsellor, and a social worker. Seed funding was provided for the establishment of such facilities, but the funding for their continuous operation is shouldered by the respective hospitals, which translates into the

continuous provision of financial and technical resources, as well as the development of enabling operational policies such as the allocation of a certain portion of the GAD budget (Section 64 of RA 9262) for the use of these facilities [4].

The goal of the WCPUs is to provide holistic, gender-sensitive care to women and children who are victims of violence. The specific objectives are as follows:

- To ensure that women and children who consult the DoH hospitals due to violence are treated with the utmost care, concern and understanding (attitude);
- to create and sustain an environment within the hospital setting that is sensitive and friendly to women and children (attitude);
- to develop a systematic, gender-sensitive documentation and monitoring system; and
- to coordinate with other governmental and non-governmental institutions and organisations to develop a better organised approach to addressing the other, non-medical needs of victims of violence [2].

Ideally, the WCPUs should have five main components in recognition of their multidisciplinary and collaborative approach to VAWC:

- 1 Medical, surgical, psychological and other health services that feature 24-hour service, a holding and processing area for victims of violence, a standard clinical protocol for their examination and management, and a gender-sensitive recording system;
- 2 a networking mechanism fostering links with other government organisations and NGOs to ensure an holistic and integrated approach to VAWC;
- 3 a training programme that addresses human resource development, which the DoH undertakes

**Figure 2: National Steering Committee for WCPU**



- 1 : National Commission on the Role of Filipino Women
- 2 : National Bureau of Investigation
- 3 : Commission on Population
- 4 : Department of Social Welfare and Development
- 5 : Department of Interior and Local Government

with the University of the Philippines, viz., the Philippine General Hospital (UP-PGH) Child Protection Unit (CPU) and Women's Desk;

- 4 research and documentation of experiences to serve as input leading to further studies and for policy and programme improvement; and
- 5 information and advocacy campaigns conducted on the basis of communication materials aimed at raising awareness and prevention of VAWC.

Generally speaking, the following services are available at WCPUs:

- Medical examination and treatment;
- laboratory tests;
- issuance of medical certificate;
- forensic interview;
- crisis counselling;
- psychological/psychiatric care if needed;
- provision of food, transportation, and medicine;
- home visit;
- surgery if needed;
- other medical services; and
- court testimony.

Either through its own resources or through a referral system, these services may be supplemented by the WCPU with social, economic, legal, police and related forms of assistance. For the social services, the WCPU may provide such assistance as risk assessment and management, home visits for continued support of the client, livelihood assistance, educational support, parenting classes, and the formation of support groups for the clients and their family members. Involving all service providers, while case conferences are regularly held at all WCPUs.

Under new standards (see Guidelines and Protocols Section below), the prevention of all forms of gender violence and the elimination of all instances of VAW are held to be the most strategic component of the WCPU service package. The WCPU should have easy-to-read, culture- and gender-sensitive information materials available to clients and their families. It should ensure that awareness-raising in respect to VAW is part and parcel of the psycho-social services extended to clients and is complementary to the caring and concern shown to them. WCPUs are also expected to participate in advocacy activities and to hold orientation seminars on the WCPU for other hospital personnel. The vision,

mission and goals and policy guidelines of the WCPU should be displayed prominently in the unit for easy reading by clients and as a constant reminder to WCPU personnel.

## Policy and protocols

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While much progress has been made in responding to GBV in the Philippines, it has been felt that the lack of gender sensitivity in general as combined with such problems as a lack of resources, operational difficulties and the need for coordinated action against VAW have prevented agencies from providing more responsive VAW services to victims/survivors. There is also a great deal of work remaining, not to speak of the need to map out strategies for eliminating VAW. In response to this, in 2005, the NCRFW and its primary partner agencies in the anti-VAW effort – the Department of the Interior and Local Government (DILG), the Department of Social Welfare and Development (DSWD), the DoH, the Department of Justice (DoJ) and the Philippine National Police (PNP) – started developing performance standards for the service category they represent, so as to set a benchmark for anti-VAW services. The standards are anchored in international and national instruments promoting women's human rights, in particular the Anti-Violence Against Women and Their Children Act of 2004 (RA 9262), and the Anti-Trafficking in Persons Act of 2003 (RA 9208), along with the Anti-Rape Law (RA 8353) and its twin, the Rape Victim's Assistance Act (RA 8505).

In 2008 the DoH published performance standards and assessment tools for services addressing VAW. Developing the standards took almost a year. Extensive research, involving a review of existing literature, especially agency mandates, along with fieldwork and consultations preceding the actual drafting. A consultant for each



agency was engaged to review protocols and facilities, facilitate the assessment of services rendered to VAW victims/survivors, and draft the performance standards and assessment tools. To validate the consultant's baseline report and the draft standards and tools, focused group discussions were conducted by the NCRFW with the participation of direct service providers from each agency and some local government units (LGUs). The drafts were then endorsed by the individual agencies through their respective focal persons for review and adoption [4].

The standards are particularly designed to work with the women and children protection units and health services. The standards were developed for the following reasons: (1) as a tool for direct service providers to respond effectively to cases of VAW; (2) as a means to gauge the level of compliance with national policies; (3) as a basis for generating concrete data needed for programme development and policy formulation; and (4) as an advocacy tool for protecting women's human rights, especially those of VAW victims/survivors. They specify what gender-responsive service to VAW victims/survivors entails by virtue of falling within the following parameters: policy, physical facilities, services, monitoring, evaluation and research, information and advocacy, and resources [4]. The standards also include an assessment tool for ensuring compliance with the standards as well as to generate data for monitoring and evaluation purposes. The data generated is also a tool for prioritising and planning, particularly in regard to the use of the GAD budget.

## Capacity building

As a first step, Project HAVEN initially sent two counsellors from WCC and the head of EAMC's WCPU to Australia to attend a short university course on women's health

and to observe the operations of a hospital-based crisis centre. The Project then provided training in VAW-related counselling, and in gender-sensitive handling of victims for project staff and ninety other health professionals from EAMC and other government hospitals.

Now, GBV capacity building is taking place at multiple levels in the Philippines. All hospital employees are given gender sensitivity training and VAWC specific training is provided to various medical specialties. Since they are relevant to their specialisation, personnel are trained in the principles and methods of gender-sensitive medical and health care and treatment, in crisis and long-term counselling and support, in investigative interview techniques, and in the collection of forensic evidence. In addition, they are familiarised with the laws related to the handling of VAW cases.

In the WCPU, a training orientation is held for new residents every year. Included are such topics as VAW as a health issue, the nature and dynamics of abuse, and the clinical skills required in following the hospital protocol for such cases. Non-medical personnel are likewise given an orientation on how to be sensitive to victims-survivors. The WCPU also undertakes continuous capacity building for its service providers. This is done through in-house training, participation in scientific conferences or short-term training programmes in the Philippines and abroad, and inter-agency meetings. Debriefing sessions are also regularly held to respond to the emotional needs of service providers.

According to the new standards, the following training packages are deemed necessary to the fostering of skills and knowledge required for WCPU operations:

Basic skills in gender-sensitive delivery of health services:

- Health care principles and methods;
- crisis counselling;



- development of forensic specimen collection skills to provide evidence and ensure preservation (minimum of 10 hours);
- interviewing for collection of forensic evidence;
- woman- and child-sensitive communication/ interview techniques and methods of investigation; and
- investigation.

Basic training on the VAW issue (minimum of 30 hours):

- Gender analysis of the nature, extent and causes of VAWC;
- analysis of the different forms of VAWC;
- power dynamics;
- gender sensitivity training;
- gender-sensitive crisis intervention (minimum of 30 hours);
- crisis theory in the context of VAWC;
- crisis intervention in the context of VAWC;
- networking; and
- qualities of a gender-sensitive service provider.

Gender-sensitive crisis intervention (minimum of 30 hours):

- Crisis theory in the context of VAWC;
- crisis intervention in the context of VAWC;
- networking;
- qualities of a gender-sensitive service provider;
- medical and legal literacy related to VAWC (minimum of 30 hours);
- laws on women and children;
- procedures; and
- basic medico-legal information.

Self-care training (minimum of 15 hours):

- Stress management and stress management techniques.

## Referrals and screening

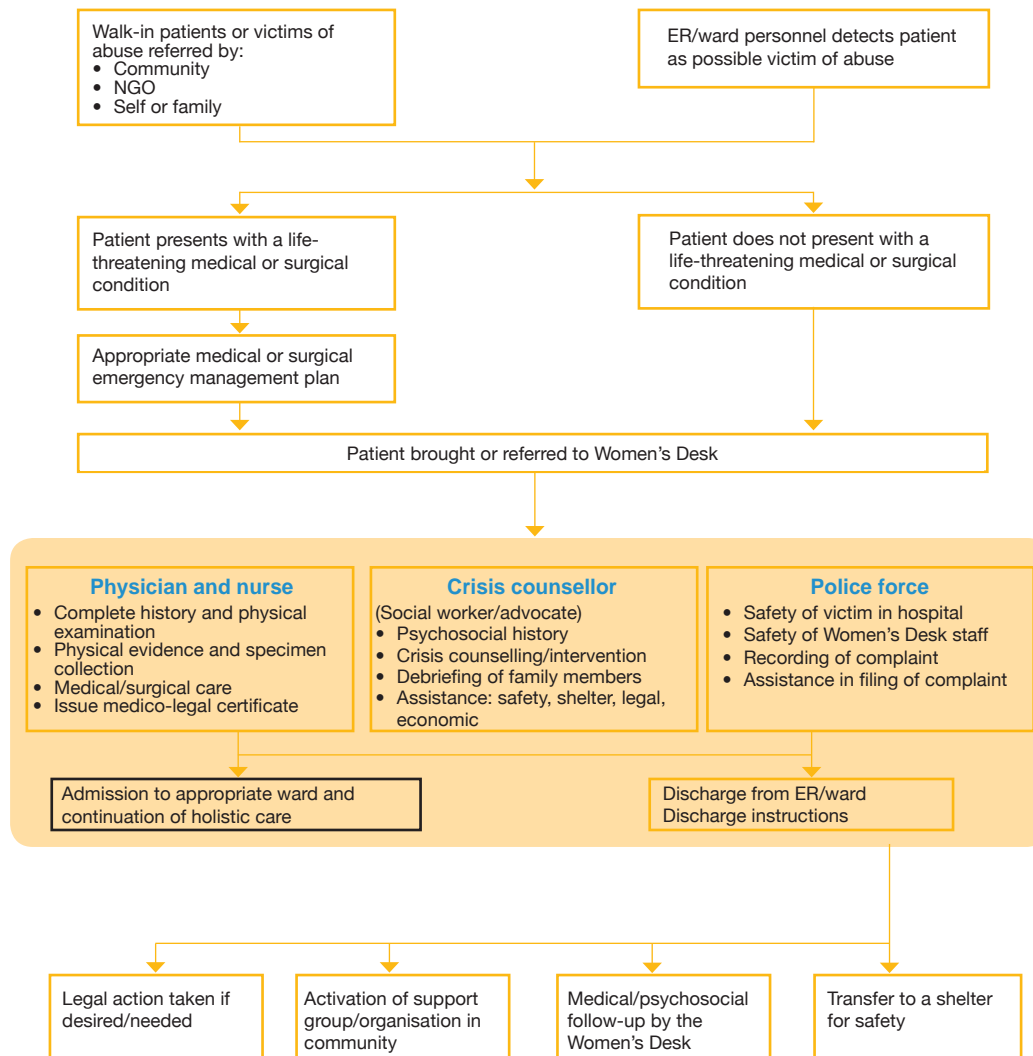
In the WCPUs, once victims are admitted to specific areas, the team is also responsible for following up on the victims until they are discharged, followed up on and/or properly referred. Continuity of care for the victims is stressed.

The WCPU makes referrals to other service units of the public and private sectors, including the NGOs providing special services for VAW victims/survivors. The important referral links include legal and paralegal assistance, police support, shelter (short- and long-term), and financial as well as livelihood support. Additionally, the service providers are linked with various professional organisations (e.g. associations of psychiatrists, social workers and physicians) allowing for access to new approaches and information on VAWC interventions. The list of collaborating organisations should be updated regularly, and cooperation agreements reached with them reviewed and strengthened periodically. Figure 3 represents the pathway of care for victims/survivors of GBV at the WCPUs.

Health service providers in hospitals that have WCPUs are trained to screen for violence as based on the following questions:

- Have you ever had an injury caused by a violent encounter?
- Have you ever been emotionally, physically or sexually abused (as an adult or as a child)?
- Have you ever been hit, slapped, kicked or otherwise physically or sexually hurt within the last year?
- Have you ever been hit, slapped, kicked or otherwise physically or sexually hurt during any of your pregnancies?

**Figure 3: Pathway of care for the management of cases of VAW**



Source: [5]

*All questions should end with: ‘ “by your spouse/partner/boyfriend, or by anyone important to you?” ’*

## Documentation and data management

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The VAW registry form is a uniform intake form on which is recorded the salient details of a VAW case. It serves as a full documentation of the medical and psycho-social interventions given to each client. These records, as well as the master list of VAW clients, are kept in the WCC office. The WCPU operates and maintains a database system not only for the safe and secure storage of records but also for the easy retrieval and processing of data for case conferences, case management, service performance review, and for planning and programme evaluation and improvement. The database includes the profiles of the client and the perpetrator, the services provided and the results of the interventions. Service providers are able to use the data system readily to conduct research or studies that can enhance the work of the facility.

Under the new set of standard operating procedures, the WCPU should maintain an efficient system of monitoring the performance of personnel and the status of clients. This is done through regular case management meetings. An effective database can generate adequate information allowing the assessment of the effectiveness of WCPU services and their results and impacts.

These facilities, together with those established in provincial and municipal hospitals, are monitored by the DoH through the submission of a quarterly accomplishment report containing the following information: (1) activities completed (e.g. organisational/policies/development, training/seminars/orientation, advocacy and, networking activities); (2) target groups; (3) number of participants; and (4) comments. For the VAWC incidence report, the information

sought by the monitoring questionnaire includes the number of victims/survivors and perpetrators, type of abuse, age of victims/survivors and referral data. Because of lack of personnel and funds, however, these quarterly reports have not been consolidated into an annual report.

Most reporting of VAW occurs at the women and children's desks at the *barangay* (village) level, social welfare offices, police precincts, and NGOs that provide services to victims/survivors. However, inadequate coordination among providers has led to the compilation of inaccurate statistics. To address this, the Joint Multi-Stakeholder Programme to Eliminate VAW in the Philippines plans to augment and further develop the existing database of the DSWD with funding provided by the International Labour Organisation (ILO) and UNICEF. The National Recovery and Reintegration Database of the DSWD currently captures only trafficked person cases. On the basis of the funding provided by the ILO and UNICEF, data from additional areas will be incorporated into the web-based software in order to capture other forms of VAW, viz., DV, rape and sexual harassment cases.

## Positive outcomes/successes

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In comparison to other developing countries, it is indubitably the case that the Philippines can be said to be in the lead in initiating services addressing both medical and legal concerns in the care of female and child victims/survivors of violence.

The Philippines has a very comprehensive legislative framework and high-level political will supportive of responses to GBV. The country has been very successful in institutionalising an integrated health sector responsive to GVB since DoH Administrative Order 1-B was issued in 1997 leading to the establishment of multiple hospital-

based WCPUs. One of the strengths of the approach has been the effective collaboration between the government and local NGOs.

The recent development of standard procedures by the health sector governing responses to VAW constitutes a high-level achievement. These highly comprehensive standard procedures were grounded in extensive research, consultation and collaboration. Particularly valuable is the fact that they have become a tool of assessment, which can be used to encourage greater monitoring and evaluation so as to assure compliance with the standards themselves. This has been a relatively weak area in the past, so this development is a positive step forward.

## Primary issues and challenges

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Despite the success of the response in the Philippines, there are still a number of challenges.

Firstly, as with almost all countries in the region, there is a lack of research and documentation on interventions that work. There is also a need for improved data collation and processing so that data can be utilised for such purposes as advocacy, education or training, and fund raising.

The second major challenge is the effective implementation of policies and protocols. While the new standard procedures are excellent, in the past implementation of guidelines and the monitoring of services have demonstrated the huge gap between policy and reality. The DoH admits that it lacks a monitoring team or any system to ensure proper implementation of its commitment to the hospital based-crisis centres. There have been reports that some hospitals do not comply with Administrative Order AO No. 1-B even when they claim to have a women's desk [5].

In terms of service delivery, there are also a number of challenges. Aside from a lack of resources, problems identified by DoH personnel are as follows: a lack of direct authority to monitor the performance of DoH-devolved facilities; severe lack of medical personnel and financial resources preventing hospitals from completely complying with the requirements for setting up WCPUs; the low level of gender awareness or lack of gender sensitivity of WCPU personnel; and the lack of public concern for VAW as an issue [4].

Some doctors still hesitate or refuse to testify in court. They hesitate to perform medico-legal examinations knowing that they may well be called to testify in court in the future. Doctors should take account of the value of testifying in court. What is needed in this instance is the provision of support mechanisms fostering this type of service for survivors.

Compared with others in the emergency room, some victims/survivors may not appear to need immediate attention. As such, this leads to a tendency to make them wait for service. It is important for HSPs to recognise that they may have safety and security concerns that need to be immediately addressed.

Because the hospitals are now in the process of being privatised, financial assistance is becoming scarcer for those victims/survivors who are poor. There is a need for sustained financial support for indigents, especially women and children who are victims/survivors of violence and abuse [4].

## Lessons learned and recommendations

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- It is necessary to construct and use a knowledge base. It is recommended that VAW interventions should be evaluated so as to ascertain what

approaches are most effective and if women are ultimately benefited. New indicators are needed that move beyond simply measuring identification and referral rates and focus instead on measurements of women's well-being and satisfaction with services. It is also recommended that sufficient resources should be allocated to put in place rigorous monitoring and evaluation systems (M&E) systems for policies/programmes.

- More work is needed on advocacy, policy dialogue and awareness-raising campaigns on GBV so as to foster strong commitments to continue addressing this issue.
- It is recommended that partnerships between different agencies involved in GBV response continue to be strengthened, including inter-agency referral mechanisms.
- Abundant evidence exists to show that training alone has no appreciable effect on provider behaviour unless it is accompanied by changes in procedures and systems. Institutional change must include implementation of new procedures with regard to patient flow, documentation, measures to ensure privacy and confidentiality, and the creation of referral networks.
- Given that the Philippines already has a well established and integrated system, the next step is to ensure the quality, accountability and sustainability of the services provided. This has started with the development of standard procedures and the use of assessment tools. However, more work is needed to develop systems for improving performance. To this end, Pagaduan-Lopez et al. (2006) recommend the following:
  - Development of a professionally competent human resource pool;
  - standardisation of professional practice codes with penalties for malpractice;
  - creation of regulatory and certifying boards;
  - formulation of requirements for continued

accreditation;

- provision of continuing medical and legal education;
- development of systems and structures for ensuring standardised and adequate services and training, as well as strict adherence to rules and regulations at all levels;
- creation of a national council that is multidisciplinary and multi-sectoral in nature to direct and coordinate policy and advocacy on both preventive and restorative levels, as well as setting standards monitoring implementation within the devolved structure of relevant government agencies; and
- making adequate logistical support available [3].

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## Sri Lanka

### Country Profile:

|  |               |
|--|---------------|
| Total population (in thousands):                       | 19,207 (2006) |
| GNI per capita (PPP Intl \$):                          | 3,730 (2006)  |
| Total health expenditure per capita (PPP Intl \$):     | 105 (2006)    |
| Life expectancy at birth male/female (years):          | 69/76 (2006)  |
| Maternal mortality ratio (per 100,000 live births):    | 38 (2005)     |
| Infant mortality ratio (per 1,000 live births):        | 11 (2006)     |
| Births attended by skilled health personnel (%):       | 97 (2000)     |
| Total fertility rate:                                  | 1.9 (2006)    |
| Human Development Ranking 2009 (out of 182 countries): | 102           |

(Source: World Health Statistics 2008)

Sri Lanka is a small country, relative to its neighbours, with a population of 20 million people living within an area of 65,742 square kilometres. Women form 51 per cent of its population. The Demographic and Health Survey (DHS) conducted in 2006 found that of ever married women aged 15-49 years, 81 per cent live in rural areas, 13.1 per cent in urban areas and another 5.5 per cent in estate areas [1]. The same survey showed that out of married women aged 15-49 years, 6.4 per cent were either widowed or divorced at the time of the survey. The legal age of marriage in Sri Lanka is 18 years under Common Law provisions.

Sri Lanka ranked 102nd on the Human Development Index [HDI] (0.759) and 98th on the Gender Development Index [GDI] (0.735) for 2007-2008, which is one of the highest in the South Asian region. In contrast, the Gender Empowerment Measure (GEM), which reveals whether women take an active part in the economic and political life, is 0.389, which gives Sri Lanka a low rank of 98th out of 109 countries [21].

Since 1987 the Sri Lankan Government has provided free health care to all citizens of the country and health care provision has been one of Sri Lanka's strengths, leading to a relatively low maternal mortality rate of 38 per 100,000 live births (2005) and an infant mortality rate of 11 deaths per 1,000 births (2006). Women of Sri Lanka have a literacy rate of 92 per cent and life expectancy of 76 years [1, 2]. At present, nearly 97 per cent of deliveries take place in health institutions and Sri Lanka is considered to be a low prevalence country for HIV/AIDS with a prevalence of less than 0.1 per cent. The strength of the health system offers an opportunity to address gender-based violence (GBV) in a holistic and integrated manner.

The state provides free health care with equal emphasis on both preventive and curative care. The Central Ministry of Health (CMoH) is responsible mainly for policy formulation and management of major health institutions of the country. Devolution of power by constitutional changes made in 1987 resulted in the creation of provincial ministries of health responsible for servicing the health institutions in the nine provinces. The Family Health Bureau (FHB) was established in 1968 to address maternity and child health issues and it presently addresses all reproductive health (RH) issues including GBV.

Sri Lanka has had its share of natural and manmade disasters which have had a gendered impact, including increasing vulnerability of women to GBV. In 2004 the tsunami affected the coastal areas of the island and a subsequent increase in the incidence of GBV was recorded. The armed conflict that lasted nearly 26 years generated a culture of violence which in turn had effects on the incidence and severity of incidents of GBV in the country. Fortunately, the conflict has come to a conclusion, although it has generated yet another group of women whose status as Internally Displaced Persons (IDPs) has increased their vulnerability to GBV [3].

## Prevalence of GBV

In Sri Lanka the most common form of GBV is domestic violence (DV). On the other hand, practices such as witch hunting, widow burning and honour killings found in some parts of South Asia are not seen in Sri Lanka [9].



With regard to GBV, while there is no nationally representative data, several micro-level surveys indicate that the prevalence of GBV is high and widespread across all classes, ethnic and religious groups. One of the earliest studies conducted in 1991 found a surprisingly high incidence of GBV ranging from 54 per cent in the city of Colombo to 71 per cent in Halmillawa, a very rural setting [4]. In 2003 another study among the sub-population of estate workers found a relatively high incidence of GBV amounting to 83 per cent of women interviewed.

It is interesting to note that as early as 1992 a general practitioner conducted a study among his patients on GBV issues and found that 27 per cent of women suffered DV with 9 per cent of them requiring admission to hospital. He also documented that nearly 20 per cent of the women who had suffered DV were prevented from seeking treatment by the perpetrator [5]. A study conducted among the patients attending the outpatients department of one of the teaching hospitals in the suburbs of Colombo found that 41 per cent of women had been abused by their partners [8].

A screening project conducted over a period of one year among pregnant mothers attending the antenatal clinics of a major hospital in Central Province in 2002 found that 40 per cent of women had experienced violence by a partner at some time during their life and of those 36 per cent suffered from physical violence [6]. Another study conducted in the same year among pregnant women in another district found that 18 per cent of women had been abused by a partner some time during their cohabitation [7].

Health consequences of GBV have not been well documented in Sri Lanka. However, the study conducted by a general practitioner analysed the physical injuries of the victims and recorded that 26 per cent of them claimed to have lost consciousness or fainted. He also recorded that 8 per cent were admitted to a hospital as an emergency case [5].

Similarly, there is little documentation of the mental health consequences of violence in Sri Lanka, although international research suggests a close association between intimate partner violence (IPV) and suicidal ideation and attempts [10, 11]. Sri Lanka has one of the highest suicide rates in the world (between 18-30 per 100,000) and one report identified that in the year 1991, 210 women either committed or attempted to commit suicide in Sri Lanka as a result of DV [11].

## Overarching policy framework

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The enactment of the Prevention of Domestic Violence Bill in 2005 heralded the State's recognition of violence within the family as a violation of rights [18]. This Act, which provides for the issue of a protection order by a magistrate in order to ensure the safety of a victim, has incorporated two important concepts from a health perspective: the Act recognises mental/emotional violence before the law and provides counselling services. Furthermore, the law identifies specific health care providers who are considered suitable to provide this service [15]. In addition, the Penal Code of Sri Lanka also provides for sexual harassment and rape with stringent penalties and minimum sentences identified.

The Women's Charter, developed in 1992 by the Ministry of Women's Affairs, categorically states under the topic Right to Protection from Gender Based Violence, that: *'the state shall take all measures to prevent the phenomenon of GBV. Such measures shall include provision of support to programmes which provide support and counselling services to women victims of violence'* [13]. The Charter identifies health as an area which needs to be represented in the National Committee of Women (NCW), which is an advisory body on women's issues.

As early as 1998, the Population and Reproductive Health Policy of Sri Lanka identified 'achieving gender equality' as an important goal. The policy reasoned that: *'the position of women in family and community, their reproductive health and their participation in public life is being increasingly threatened by the alarming increase in gender-based violence and intimidation and harassment of women in the community'* [12].

The Health Master Plan of Sri Lanka 2007–2016, developed by the Ministry of Health (MoH), identifies VAW and IPV as important issues that need to be addressed. It identifies the expected output as *'recognition of various forms of violence against women as a major health issue by the health system and improvement of the capacity to address the issue'* [14].



**One of the posters developed for the Pilot Project 2002. The poster reads “Father! When you hit our mother we feel the pain.”**

The National HIV/AIDS Strategic Plan 2007-2011 under the section on guiding principles for the National HIV/AIDS response recognises the important relationship between VAW and HIV/AIDS and recommends that: *'all planning, service delivery and research should be done with gender equality in mind'* [16].

The formation of the National Committee on Violence of the MoH under the leadership of a high-level health administrator indicates the commitment of the state to addressing violence. The mandate of the committee includes addressing GBV and it has been successful in publishing the National Report on Violence, which has two chapters dedicated to GBV issues [9]. The designation of the FHB as the focal point for GBV issues as a part of the MoH was another important policy decision. The appointment of a Consultant Community Physician (CCP) for this post showed the importance of GBV in the agenda of the MoH.

Whilst these laws and policies are in place, there are still major gaps in their implementation and enforcement. There is no separate allocation of funds for GBV activities in the state health budget, however, financial support is provided through the allocation of space, staff and infrastructure. The United Nations' system has been supporting the state, particularly in the area of capacity building. WHO has supported the MoH in developing and publishing the National Report on Violence and Health in Sri Lanka [9].

## Description of the health response

Piloting the UNFPA Programme Guide for Health Care Providers and Managers (Option B).

Subsequent to the International Conference on the 'Role of the Health Professionals in Addressing Violence Against Women' in 2002, Sri Lanka agreed to pilot Option B of the

UNFPA Programme Guide for Health Care Providers and Managers. This included sensitisation of the Health Care Workers and the community in addition to conducting a screening programme for GBV in a health care setting.

The pilot was conducted in the North Central Province in two hospitals. The response from the CMoH and the Provincial MoH was encouraging. All women attending the antenatal clinic and the gynaecological clinic were identified for the screening. Data collection was done by two social science graduates who were specially trained for this purpose. Every woman who attended these clinics within the period of study was screened. Those found positive were offered counselling at a facility managed by Sarvodaya (a national NGO).

As a part of capacity building, training was conducted for institutional and community health care staff. Training for two days was given to nearly 300 health care workers such as public health midwives who do home visits, medical health officers, public health inspectors, and doctors and nurses of different sections of the hospitals. At the same time, sensitisation of the community on GBV was carried out in the form of posters, leaflets and advocacy. Participants for the sensitisation programmes included administrative officials of the province, members of the police and armed forces, and members of the media. An important feature of this exercise was that sensitisation and training was carried out in both the curative (hospital) and preventive sectors (community) at the same time and with equal emphasis. There was a very positive response rate to the screening with only four per cent of women refusing to answer the four screening questions.

The programme was funded by UNFPA and the implementing partner was Sarvodaya. The contribution from the MoH was limited to allowing the intervention to take place within the state hospital and providing the space to conduct the study. The hospital staff was not directly involved as a part of their duties.

### ***Service Centre in a State Hospital (Option C): 'Mithuru Piyasa' at the District General Hospital Matara***

Experiences gained through piloting the UNFPA Programme Guide were shared with nine other countries. The conclusion was that the Programme Guide was useful and Sri Lanka would progress to Option C, which was to establish a dedicated GBV service point within the hospital providing medical care, counselling and legal services. This programme was started as part of the tsunami response. A whole year of consensus building with government was required to get them on board, a process which included environmental scanning and identification of 'champions'.

In an attempt to institutionalise the treatment of GBV into the state sector hospitals, a service point was established in 2007 at a district hospital in one of the highly populated districts of southern Sri Lanka. An Memorandum of Understanding (MoU) was signed with the MoH at the central level which formalised arrangements for funds to be directed from the MoH to the provinces and districts. Space and staff were provided by the hospital although no additional budget was allocated to the hospital for this. The initial costs of equipment and minor refurbishing was provided by UNFPA. Funds were also made available for training programmes by UNFPA, and the hospital staff arranged and conducted capacity building with the help of external expert resource persons.

Initial training of the core staff identified to run the centre was for five days. The training included basic befriending skills, basic concepts of gender, the role of health care providers and the health consequences of GBV. At the end of the workshop, participants were encouraged to develop a plan for the running of the facility with the guidance of the consultant. In the presence of the hospital administrators, the duties of different postings were discussed and agreed upon. This exercise gave the core staff a very positive feeling of ownership. In addition, two-day training in befriending was given in 2009 to the staff of Mithuru Piyasa.

All services are provided on-site except in-depth counselling and legal advice, for which referral is given. Women can visit the centre under their own volition or they can be referred by a health worker from any health institution or the community. Women can revisit the centre as the need arises for follow-up. Behaviour change communication (BCC) materials which have been adapted from the pilot are distributed in the hospital and posted in other strategic sites in the community.

The documentation and data management mechanism has been developed with particular emphasis on ensuring confidentiality. However, the health management information system still requires strengthening.

It is important to note that UNFPA conducted a needs assessment of the key districts inclusive of the available

services and is supporting the MoH in replication of the one-stop crisis centre (OSCC) model in 2010 in five more districts namely Anuradhapura, Vauniya, NuwraEliya, Kalmunai and Batticaloa. Provision of space, staff and other infrastructure will come from the MoH.

#### *Help desks in selected hospitals*

Women in Need, an NGO dedicated to the care of victims of GBV, has been successful in cooperating with the local hospital authorities and establishing counselling services in eight selected hospitals in different parts of the country. They essentially provide a counselling service and legal assistance. The NGO has been proactive in developing this service. For instance, if they recognise that there is a high prevalence of GBV in a particular area they approach the hospital administration and offer their services.



***Training of Public Health Midwives and Public Health Inspectors at a session coinciding with the opening of Mithuru Piyasa.***

Whether this is accepted or not has been dependent on the outlook of the individual administrator and their prioritisation of the issue.

Help desks were established in several hospitals in the north and the east as a part of the response to the 2004 tsunami. Priority has been given to cases of child abuse and the help desks are managed by the NGOs with minimal involvement of the hospital staff. At present sustainability is a problem as funding is coming to an end.

## Policy and protocols

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There are no national protocols or guidelines on GBV developed so far in Sri Lanka, however, National Guidelines on Management of Rape Victims are being developed with the assistance of Sri Lanka College of Forensic Pathologists and other relevant experts.

A proposal to develop National Guidelines for Management of GBV victims which targets medical officers has been accepted by the National Committee on Violence.

## Referrals and screening

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Two isolated programmes of screening have been carried out in Sri Lanka. The first was as part of the piloting of the UNFPA Programme Guide as discussed earlier.

The second, a screening tool for physical abuse, was developed and validated among pregnant women in the community in 2004. The researchers designed a

questionnaire with six questions specifically to survey the incidence of physical violence among a cohort of pregnant women. The questions attempted to determine whether the woman had heard of VAW, whether she knew of anyone who had been exposed to violence and whether she herself had been exposed to violence [7]. A total of 991 patients were screened of which 45 per cent reported verbal abuse, 36 per cent reported physical abuse and 44 per cent reported different forms of sexual violence such as offensive touching on public transport, indecent proposals and gross sexual abuse. Those found positive were referred for counselling to a centre a few kilometres away, but most did not make use of this option.

As a part of the establishment of Mithuru Piyasa, a mechanism was established for referral of victims for legal assistance which was provided by Women in Need or Legal Aid, the welfare arm of the Ministry of Justice (MoJ). The training of community health care personnel concurrently helped in setting up a forward referral mechanism of patients to the centre.

## Capacity building

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As discussed above, a number of training sessions have been carried out with health care providers and the community as part of the UNFPA pilot project and the development of the service centre in Matara. Other areas of capacity building include:

### *Development of a training module for primary health care workers*

The FHB of the MoH, which has a very successful maternity care service programme with a wide coverage of domiciliary care, is planning to address GBV through



grass roots level health care workers. It has developed a module on the roles and responsibilities of the primary health care worker in prevention and management of GBV, which has been included in the basic curriculum of the public health midwives (PHM) and public health nursing officers (PHNOs). The adaptation of the same module for in-service training for the Primary Health Care Team (PHCT) has been undertaken to ensure that all PHMs and PHNOs serving in the country undergo the training. The training of trainers (ToT) has been completed as described below.

#### ***Training of trainers***

A team comprised of Primary Health Care Supervisory Officers, namely the Medical Officer of Maternal and Child Health, two Medical Officers of Health, the Regional Supervisory Public Health Nurse, the Public Health Nurse and the Supervising Public Health Inspector, have been identified for each province. These provincial teams

serve as trainers and have undergone a four day ToT on the module mentioned above. Four such training programmes to cover the whole country have so far been conducted.

These teams are expected to conduct a training programme in the division of every Medical Health Officer. Fifty training programmes have been scheduled for 2009 of which 35 have been completed up to this date.

#### ***Integration of sexual and gender-based violence (SGBV) into health sector emergency preparedness and response***

A national resource pool comprised of six personnel was given ToT as part of the Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East, Southeast Asia and the Pacific (SPRINT) initiative in Malaysia at the beginning of 2009. There is a tripartite agreement between the Health Emergency and Disaster



***Doctors and other care workers being trained together.***

Management Training Unit (HEDMaTC) of the Faculty of Medicine, MoH and UNFPA to build health sector capacity to integrate sexual and reproductive health (SRH) and gender into emergency preparedness and response. In-country training is of three days duration and allocates half a day to discussing SGBV with an emphasis on Inter-Agency Standing Committee (IASC) guidelines and guiding principles.

#### ***Update on GBV for doctors providing care for IDPs***

A one-day programme for all doctors providing care for IDPs on the importance of prevention and management of GBV was conducted in Vavuniya and Anuradhapura. Sixty doctors from refugee camps located in the north and east of the country participated in the programme. This was coordinated by the FHB and supported by UNFPA.

#### ***Contribution by the health related professional organisations***

The Sri Lanka Medical Association, which is the academic organisation of doctors, has formed a Women's Health Committee to address issues concerning women's health. Two publications have been developed on the issue of GBV. One is the *Review of Research Evidence on GBV* [19] which summarises the available research in a user friendly manner. The other important publication is *Recommendations for Addressing GBV by the Health Sector in Sri Lanka* which provides guidance to the health sector in addressing GBV [20].

The same committee has initiated a dialogue among the medical faculties of five universities to identify the ways and means of including GBV in the medical curriculum. The Board of Study in Obstetrics and Gynaecology of the Post Graduate Institute of Medicine has already included the topic of GBV in curriculum of the Diploma in Reproductive Health.

#### ***Development of a sensitisation package for 'Newly Married Couples'***

A sensitisation package has been developed by the FHB of the MoH to sensitise newly married couples on different aspects of family life, in order to improve their health and well-being. One of the objectives in developing this package is the prevention of DV in the community. It is designed to highlight the value of family harmony and healthy marital relationships based on understanding, as well as to show the negative effects of violence within the family. The document is in print and will be ready for dissemination soon. Family Health Workers are to take it to the community.

## **Documentation and data management**

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No formal documentation or data management mechanism for GBV is available in Sri Lanka. However, data collection formats including body maps have been developed for Mithuru Piyasa and are being used. Confidentiality is ensured by maintaining one master register which is kept under lock and key. After the initial visit, the victim is identified only by a number. Although plans were made to set-up a database, it was not started due to lack of funds. With the up-scaling of the programme to other districts it would be essential to design a data management mechanism.

## **Positive outcomes/successes**

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The Sri Lankan health sector has addressed the issue of GBV at multiple levels at once, corresponding to



a systematic approach. Establishing a service point within the government hospital serviced by the staff including doctors and nurses has been a success. The fact that it was able to sustain itself for more than three years in spite of the UNFPA project having ended after one year shows that once GBV management had been institutionalised the state could carry it on.

On the policy level, inclusion of GBV and the appointment of a focal point helped in the setting up of the service centre. The appointment of a violence committee has also helped by publishing an important report which could be used for advocacy. The FHB through its grass roots level care providers is propagating a prevention strategy which is another positive step.

The development of a training module for family health workers and the subsequent training, which has the objective of training all family health workers on the island, is very positive, particularly with those officers who conduct regular home visits, as they are in a key position to offer help.

## Primary issues and challenges

Despite a number of successes, challenges remain in the health sector response to GBV in Sri Lanka. Firstly, there is still a reluctance of some health care workers to intervene in issues related to GBV, although this is less among the Public Health Midwives who have a closer linkage with families. Women are also reluctant to access counselling services when the centre is based outside the hospital. For example, in the UNFPA pilot project Option B, screening was carried out and positive cases were referred to a counselling centre located about two kilometres from the hospital. However, many women who agreed to go

for counselling when offered did not access the centre because of the distance, indicating that the hospital is the crucial place to provide counselling.

Screening was carried out in the pilot, but it was not continued because the pilot was a time-bound project and the data collection was done by a specially trained person paid by the project. Continuation and sustainability is a challenge in such a situation. The involvement of NGOs in service provision in the health sector was also seen by some hospital staff as encroaching on their territory.

One of the major challenges in the development of the Matara service centre was related to funding for capacity building including sensitisation. Funding was initially provided by UNFPA, however, for a number of reasons, the funding was delayed after the first year. Even though the service carried on, for a period of time, the project lost momentum and staff lost enthusiasm. This is reflected in the fewer number of cases that were seen by the centre during this period.

State sector staff are liable to be transferred after serving two to four years in one institution. This is a major challenge because trained staff are likely to move elsewhere within a short time. At one stage only one doctor – out of nine who had been trained – remained. The lesson learned is to train as many doctors as possible within the section where the OSCC is located in order to ensure sustainability.

## Lessons learned and recommendations

- The involvement of Deputy Director General Medical Services with the gender focal point of the FHB from the early stages of the activity was one of the reasons for its success. Involvement of both

central and provincial administration from the response planning stage is essential. A high-level advocacy activity is suggested to coincide with the planned up-scaling of the response.

- In selecting staff for the centre, it is important to recognise those who are committed to the issue of GBV rather than give preference to seniority. In establishing Mithuru Piyasa, those who volunteered from the hospital staff were given preference.
- It is well-known that dedicated leadership provided by individuals is often the driving force for such initiatives. This was true in this activity, where strong leadership from two dedicated doctors was crucial to establishing the centre. However, it is important to draw others into the programme as the activity progresses so that more and more committed people are available in case others move elsewhere. The development of a second generation of such committed persons is a key to the long-term sustenance of a programme.
- The example of the pilot project in Sri Lanka, which ceased to function after the project ended and was later re-established, demonstrates that budgeting should be designed so that there is strong support in the initial phases. Nevertheless, budgeting should account for a planned and gradual withdrawal of the external organisation such as UNFPA in order to eventually institutionalise the service into the state health system. This indicates that for a service to be sustainable, the means of continuing after the end of the project should be considered at the beginning of the project. It is recommended that building the capacity of the institution should take place long before the project ends and should be incorporated into the original project design.
- While the primary responsibility of responding to GBV within the health sector rests with the state, it must be recognised that the services of capable NGOs should be utilised to bridge the gap in service

provision of GBV.

- Ongoing sensitisation of care providers on the existing policies of the health sector which recognise GBV as a health issue is needed and should emphasise their roles and responsibilities.
- The experience of Sri Lanka demonstrates that a combined training programme for community and institutional health workers is very useful in building bridges and facilitating referrals. It is also has the advantage of building confidence among the care providers, which flows onto acceptance of the service in the community. Therefore, it is recommended that the capacity building of the care providers in institutional and community care is conducted concurrently.
- Institutionalising GBV training for all health care providers by incorporating it into medical curricula is the ultimate goal. As such, advocacy with universities and professional organisations should be undertaken to promote the incorporation of GBV in both undergraduate and postgraduate medical curricula.
- As mentioned above, counselling provided outside the hospital setting was rarely accessed by women and so every effort should be made to ensure that all aspects of care are available within the health institution, preferably in one location. The only exception is legal assistance, which may need to be referred outside.
- In Sri Lanka, data from the screening was used effectively for advocacy with parliamentarians. It is recommended that data collection and management of the data from the service centres are formalised and regularly published through mechanisms such as the *Annual Health Bulletin*.
- Development of national guidelines on GBV management should be a high priority issue.
- An evidence-based advocacy strategy should be established.

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# Timore-Leste

## Country Profile:

|  |              |
|--|--------------|
| Total population (in thousands):                       | 1,114 (2008) |
| GNI per capita (PPP Intl \$):                          | 480 (2007)   |
| Total health expenditure per capita (PPP Intl \$):     | 150 (2006)   |
| Life expectancy at birth male/female (years):          | 64.0/69.0    |
| Maternal mortality ratio (per 100,000 live births):    | 660 (2007)   |
| Infant mortality ratio (per 1,000 live births):        | 88 (2009)    |
| Births attended by skilled health personnel (%):       | 9.8 (2003)   |
| Total fertility rate:                                  | 6.95 (2004)  |
| Human Development Ranking 2009 (out of 182 countries): | 162          |

(Source: World Health Statistics 2008)

**T**imor-Leste, one of the youngest states in the world, gained full independence in 2002. It has a population of just over one million people, with 44 per cent under the age of 15 years and 62 per cent under the age of 25 years. Approximately 75 per cent of the country's infrastructure was destroyed in the fight for independence and Timor-Leste is the poorest country in Asia, ranking 162nd out of 182 countries in the 2009 United Nations Development Programme-Human Development Index (UNDP-HDI).

Average life expectancy is 64 years for men and 67 years for women. The fertility rate is estimated at 6.95 lifetime births per woman, one of the highest in the world. Maternal mortality also remains amongst the highest in the world.

Timor-Leste has a number of cultural groups, most of which are patriarchal, and there are at least 25 indigenous languages in the country. Approximately 90 per cent of the population is Catholic and the Church has great influence in the country.

The primary economic activity is subsistence agriculture and rural populations live in small, scattered villages often isolated by mountainous terrain and poor roads.

The health system is still relatively young and Safe Motherhood has been a priority of the Ministry of Health (MoH) since it was established in 2002 [2]. In 2004, a comprehensive reproductive health (RH) strategy was developed, however, providing a full range of RH services remains challenging due to the lack of infrastructure, incomplete supply of health commodities and limited capacity of the health workforce. Since gaining independence, Timor-Leste has remained prone to conflict.

During the 24 years of Indonesian occupation, human rights abuses, oppression and intimidation were common. Women faced violations of reproductive rights, rape, sexual harassment, enforced slavery and forced or coerced prostitution. Women were also active in the resistance movement as fighters, spies and messengers [3]. As a post-conflict country, violence has continued to manifest with periods of renewed conflict and continued instability such as the 2006 crisis, greatly increasing women's vulnerability to violence and exploitation [1].

## Prevalence of GBV

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The most common types of gender-based violence (GBV) in Timor-Leste include domestic violence (DV), including *barlake* (bride-price related violence), sexual assault, child abuse, human trafficking and sexual exploitation and GBV suffered during the Indonesian occupation.

From January to November 2009, 817 GBV cases were reported to the National Vulnerable Persons Unit of the Police Force of Timor-Leste, of which 465 related to DV cases. However, most incidents are unreported. Statistics from NGOs vary, nevertheless, it has been reported that referral support services attended to 220 emergency medical assistance/trauma counselling cases in 2009 (provided by the NGO sector).

Among women reporting intimate partner violence (IPV) in the RHRCC survey, 42 per cent suffered physical injuries. The most common health consequences resulting from DV according to the survey are 'psychological difficulties such as nightmares, intrusive memories, significant

### Box 1: Results from the Reproductive Health Response in Conflict Consortium (RHRCC) Survey (2002)

According to a population-based survey on violence against women (VAW) conducted by the RHRCC in 2002:

- Forty-three per cent of women reported some form of intimidation or control, verbal abuse, physical assault or sexual coercion by their partner in the year preceding the interview;
- one in four women reported being physically assaulted by their partner in the year preceding the interview;
- sixteen per cent of women reported sexual coercion by their husbands in the year preceding the interview;
- one in ten women had been beaten during pregnancy;
- forty per cent of women reporting abuse in the year before the interview reported that their partner had demanded sex after they had been beaten; and
- violence from perpetrators outside the family was significantly lower post-1999 crisis with a 76 per cent decrease in physical violence and a 57 per cent decrease in sexual violence; 23 per cent of women reported sexual violence during the crisis versus 10 per cent post-crisis; and 24 per cent of women reported physical violence from outsiders (militias and military) whereas the post-conflict rate was 6 per cent [1].

changes in sleep pattern, feeling constantly afraid or scared' (22 per cent of those reporting abuse); loss of consciousness (13 per cent); bruises, scrapes or welts (12 per cent); deep wounds or cuts (11 per cent); and unwanted pregnancy (9 per cent). Half of those beaten during pregnancy experienced a negative pregnancy outcome.

Of those reporting injuries from violence, only 30 per cent sought treatment from a healthcare provider. However, it is not surprising that few women seek medical treatment given that the average walking time to a health centre is 70 minutes according to UNDP Human Development Report 2002.

A number of factors contribute to the issue of GBV in Timor-Leste, including high rates of poverty, large families and a history of violence at a society level, primarily as the result of occupation and colonialism. Box 2 outlines some of the entrenched values that play a role in the prevalence of GBV in Timor-Leste.

### Overarching policy framework

Gender equality is guaranteed in the Timor-Leste Constitution and the government is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and has adopted the Millennium Development Goals (MDG) targets and indicators in national planning. The Government has a stated commitment to mainstreaming gender in its national programmes and has targeted the education, health, justice and police sectors as priorities. The Office of the Secretary of State for the Promotion of Equality (Secretaria de Estado Para a Promoçã da Igualdade [SEPI]) has been established to assist in the coordination of this process and to advise the various ministries and departments.

The Government of Timor-Leste recognises that GBV is a human rights abuse and a public health issue as reflected in a number of policy documents. The CEDAW Treaty Specific Document states that: *The Government recognises that gender-based violence in all its forms greatly hinders the ability of women to enjoy their basic human rights and*



## Box 2: Entrenched values that contribute to prevalence of GBV in Timor-Leste include:

- The notion of male guardianship over women;
- tolerance of male violence;
- the bride price (*barlake*) system and traditional systems of law and conflict resolution (*adat*);
- problematic behaviour such as alcohol abuse, gambling and betting on cockfights;
- the strong social taboo on any third parties intervening in DV;
- women's lack of education and economic independence;
- the lack of recognition of rape within marriage;
- the separation of women from their own kin caused by patrilineal inheritance systems;
- the inescapability of marriage due to the taboo of divorce;
- the lack of property rights upon separation;
- heavy expectations of obedience; and
- the performance of particular gendered roles within marriage.

*can be considered a health problem. Not only are women at physical risk and possible death, they are susceptible to trauma and other disorders such as depression and anxiety' [4].*

The first National Women's Congress in 2000 identified DV as a priority issue and, as a result, the drafting of new legislation on DV began. The draft Law Against Domestic Violence provides a broad definition of DV that includes both direct and indirect physical, mental or sexual maltreatment, although there is no provision for situations of economic abuse. The legislation covers civil and criminal law issues and recognises a broad array of 'domestic' relationships, including common law relationships, extended family members, household servants and people living in the household. The legislation is wide-ranging in

its provisions and progressive in its reference to principles of gender equality, sexual autonomy and human rights [3]. The draft Law Against Domestic Violence consists of a package of three laws and also includes a Decree Law on Support Services as well as a Law on the Provision of Maintenance for Victims of Domestic Violence. The draft Law was just recently adopted by the Council of Ministers on 19 August 2009 and is pending final approval by the National Parliament.

Article 19 of the Law Against Domestic Violence outlines hospital-assisted services responsibilities, including providing immediate and follow-up medical assistance, collecting forensic evidence, informing the victims of his/her rights, communicating with public authorities, preparing a situation report and guiding the victims to shelter if warranted.

Though still pending approval by the National Parliament, crimes of VAW are covered, to a lesser extent, by the National Penal Code promulgated in early 2009. Here, under Art. 154, 'Maltreatment of a Spouse', physical or mental mistreatment of a spouse or partner is a criminal offence, punishable with a sentence of between two and six years in prison. Similarly, Art. 155, 'Maltreatment of a Minor', carries the same sentence. There are further provisions on sexual coercion and rape which carry increased sentences if the victim is under 17 years, or particularly vulnerable, due to sickness or disability.

The National Police Force of Timor-Leste has special units for addressing GBV – Vulnerable Person Units. First established in 2000, the units continued to function, albeit limitedly, in the districts during the socio-economic crisis of 2006. The Protection Working Group established a subgroup to monitor and address GBV in response to the crisis [2]. The Women's Justice Unit of the Judicial System Monitoring Programme was formed in 2004 to monitor the treatment of women within the formal justice system, particularly cases of DV and sexual assault. The main



government body working on GBV is the SEPI, supported by the UNFPA since 2001.

The MoH's new RH policy includes a cross-cutting consideration of GBV and its impact on women's health [3]. It emphasises improving women and men's knowledge, screening and support services to respond to GBV as part of overall RH services across the country [4: 29]. The Government has also identified DV as a priority issue in the National Development Plan, the Justice, Rights and Equality Sector Investment Programme (SIP) and the Consolidated Support Programme (CSP). It is also identified as a basic indicator in the achievement of the third MDG process, although the mental health strategy and HIV report do not mention the associations with GBV.

## Description of the health response

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The MoH has supported efforts to address GBV but has not initiated these efforts on its own, rather NGOs have played a dominant role in the health sector response to GBV in Timor-Leste [3]. However, a more clearly defined response to GBV will soon be enshrined in legislation once the Law Against Domestic Violence is finally approved by the National Parliament, although it remains to be seen how this will be implemented and how strong a role the MoH will play (see discussion under challenges).

In 2002, Psychosocial Recovery and Development in East Timor (PRADET), an NGO specialising in mental health counselling, established a facility at Dili Hospital where survivors can receive medical treatment and other forms of assistance in a safe environment. The service centre is called *Fatin Hakmatek* meaning 'safe place' and is supported by UNFPA and other donors. All staff at Fatin Hakmatek are health workers (mostly nurses

and midwives), which has helped them maintain a good linkage and working relationship with the MoH.

Fatin Hakmatek is a good example of a one-stop service centre (OSCC) model with the purpose of having a building facility, offering medical treatment, counselling, legal advice, overnight accommodation, follow-up medical care and referrals to other sources at a single site. PRADET also recently signed an Memorandum of Understanding (MoU) with the Marie Stopes Foundation to provide STI testing for clients that have been referred to PRADET. Forensic examination is performed in some cases; however, there is only a single Cuban forensic pathologist located at Dili National Hospital and one Timorese doctor trained in forensic examination.

While Fatin Hakmatek is located in Dili, PRADET counsellors make regular visits to the districts to attend to new referrals and follow-up on existing case-work.

## Policy and protocols

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Currently, there are no national level protocols to guide clinical responses to DV or sexual assault in Timor-Leste. However, PRADET, the NGO carrying out the only integrated response to GBV in the country, has its own internal guidelines and protocol in the local language, Tetum.

PRADET with the MoH and supported by UNFPA has recently developed a Medical Forensic Protocol for Examination of Victims of Domestic Violence, Sexual Assault and Child Abuse, while piloting a standard pro forma to facilitate the collection of medical evidence for legal prosecutions. According to UNFPA, the protocol is comprehensive and can be used for cases of physical abuse, including DV, sexual assault and child abuse in

a single protocol. It is also designed to be appropriate for the Timorese context because it does not involve complicated testing such as DNA testing and presents information in a clear manner in locally appropriate languages [3].

Currently, only a doctor can document injuries, which is a challenge because of the lack of doctors in the country, particularly in rural areas. However, once the Medical Forensic Protocol finally comes into force, training for health workers to document injuries can take place.

## Referrals and screening

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In 2007, Timor-Leste participated in a global training programme on referral systems for health care workers, law enforcement and community leaders, which initiated the establishment of linkages between the health, police, social and legal sectors, NGOs, government and churches. PRADET links with other service providers as part of a local referral network, mostly in the NGO sector including the Judicial System Monitoring Programme (JSMP); Victim Support Services (legal assistance); the Vulnerable Persons Unit of the local police force; MoH (Emergency Services at the Dili National Hospital [DNH]); Fokupers Safe House in Dili (longer-term stay). They have an MoU with the MoH and the Ministry of Justice (MoJ), which has helped institutionalise their respective roles and responsibilities and ensure close relationships.

Pradet also makes daily visits to the emergency room at Dili Hospital to build relations with medical staff and to enquire whether there are any victims of GBV needing support and to promote internal referral within the health sector. PRADET is working to change the referral process between police and the hospital with regards to authorisation for medical forensic examinations because

currently the police, not the victim, determines whether such a forensic examination should be carried out. This can lead to delays in medical attention and collection of evidence [3].

While informal linkages exist, there is currently no formalised national referral system to support victims of GBV in Timor-Leste. Follow-up by individual service providers on referrals made is somewhat ad hoc and there are no clear guidelines on protecting client confidentiality which remains a concern. However, there are plans to strengthen and expand these informal networks of support services (mainly NGO sector) with support from MDG Achievement Fund for Gender (Spanish Government) in 2010.

## Capacity building

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Currently, in Timor-Leste there is no institutionalised national level training programme for health service providers on GBV. It is not incorporated into in-service, pre-service training or medical curricula. However, PRADET has conducted a number of workshops for health care workers to help them with better screening for GBV and knowing how to respond. The training workshop is usually for two days with a focus on trauma response, including definitions of DV, impact of DV, needs of victims and how to get help. In 2002, PRADET also facilitated training for health care workers on forensic examination after sexual assault [3].

Pradet has carried out awareness-raising training on GBV and the medical forensic protocol on a number of occasions for health care workers (mainly nurses), local community leaders, community police and members of the Vulnerable Persons Unit of the local police. Formal training on the medical forensic protocol for health care

**Figure 1: Referral to support services for survivors of GBV**



workers is planned for late 2009/early 2010 once the protocol is approved by the MoJ.

## Documentation and data management

As in many countries in the region, documentation and data management is relatively weak in Timor-Leste. PRADET keeps a record of the number of its cases; however, although there is no consistent system at the national level to identify and document cases of GBV. The MoH has collected statistics on the number of GBV cases

received by emergency room staff but the quality of this is not clear and statistics are not shared widely [3]. The new medical forensic protocol will hopefully promote consistent documentation of cases.

The Ministry of Social Solidarity has a Women and Children's Unit that collects some data on 'vulnerable people'. There is some discussion about including a GBV question into their data collection from the districts. This would hopefully give a better idea of the scale and scope of GBV cases in the country. However, it should be remembered that collecting data on GBV is challenging and there are a number of ethical factors that should be considered including the training of data collectors (see WHO guidelines).

## Positive outcomes/successes

All reports indicate that Fatin Hakmatek is an excellent centre that provides comprehensive services to survivors of GBV within the health sector. Being linked to the hospital has resulted in a well integrated response. Furthermore, ongoing mentoring and capacity building of Fatin Hakmatek staff is continuing with the useful assistance of an international consultant who knows the local context but who can yet bring in 'best practice' examples from other countries.

Community outreach in the districts and working from the ground up has been effective in the Timor-Leste context. PRADET believes that its approach of responding to GBV within a trauma framework has been successful, especially by virtue of its integrating of related issues such as mental health, drug and alcohol abuse.

When the Law Against Domestic Violence is finally promulgated (optimistically in 2010), this will provide a

strong policy and institutional environment on which to base a health sector response to GBV. It will legislate for greater state involvement; however, it remains to be seen how this will be actually implemented in practice. There will be a steering committee established to look at implementation of the law, which is positive.

The development of the medico-legal protocol is a success story and when it is approved by the MoJ it will become a regulation that is linked to the criminal procedure code. This is important for institutionalising a response and it is hoped that it will be a useful tool that ensures consistency of documentation of GBV cases in a culturally appropriate way.

It is positive to note that through the MDG Achievement Fund, Timor-Leste will be conducting an evaluation of GBV interventions at the end of 2010, which will include client satisfaction surveys. This is vital in developing a better understanding of what works and what does not in order to be able to improve and expand the response to GBV through the health sector in an appropriate and sustainable way.

## Primary issues and challenges

One of the biggest issues in responding to GBV through the health sector in Timor-Leste is that there are so many competing issues and priorities for this new nation, in particular the high total fertility rate and high maternal and child mortality. As such, GBV is often considered less important and receives less funding and commitment. Furthermore, the belief that GBV is a family matter that should be dealt with privately persists, and promoting an understanding that GBV is a public health issue remains difficult.

Currently, the health sector response to GBV is led by a local NGO. The MoH is supportive of efforts to respond to GBV but limited resources constrain its ability to respond independently, which poses a number of challenges in terms of institutionalisation and sustainability of services. While the NGO response has been excellent, they are unable to respond to all the country's needs on their own. The most significant challenge reported by PRADET is the lack of consistent, long-term funding. While they receive financial support from UNFPA and other agencies, the funding is often short-term, causing difficulties in developing long-term strategic plans. It is not sustainable in the long-term for an NGO to run the health sector response without financial and institutional support from the MoH.

The lack of institutionalisation and high level of centralisation in Timor-Leste means that the health sector response to GBV is focused mainly in Dili, although PRADET does conduct community outreach work. Coordination between the Dili-based MoH and the districts remains a challenge. Also, providing an accessible service to the majority of the rural population is further challenged by the limited infrastructure and resources. There are no social workers in the country and existing mental health workers have limited training. In such situations, there is the potential for staff to become overwhelmed by the extent of the need coupled with a lack of resources.

While it is very positive to note that the DV law will probably be passed in 2010 which will legislate for a health sector response to GBV and specify the state's roles and responsibilities in this response, there may be challenges with implementation. In particular, the government may not fully appreciate the budgetary implications of the new law. There is a need for strong political will to ensure that adequate funds are allocated to GBV treatment and prevention services within the health sector in order to be able to fully implement the law.

Data collection systems remain weak in Timor-Leste and more effort is required to collect reliable data to be able to respond from an evidence-base, and also to monitor and evaluate the impact of GBV responses within the health sector.

## Lessons learned and recommendations

- It is important for the Government to take more ownership of the health sector response to GBV for it to be sustainable in the long-term including the provision of funding and institutional support.
- While theoretically RH would be a good entry point to respond to GBV in Timor-Leste, in reality this will be very challenging because of the number of competing interests. This sector is already overwhelmed and will not necessarily prioritise GBV. However, it is important to continue to advocate at a high-level for the acknowledgement of the proven linkages between GBV and Timor-Leste's priority issues such as the high total fertility rate (TFR) and high levels of maternal and infant mortality.
- Using mental health as an entry point to address GBV may be more effective as there is an already established resource of mental health workers in all of the districts, although more sensitisation and training is required to respond to this issue. Accident and emergency (A&E) could be another entry point for a response, however, resources and capacity remain an issue and furthermore there is a shortage of long-term support services for survivors to be referred to.
- It is necessary to strengthen and expand the referral network, especially in the districts. This requires training and sensitisation of referral partners on how to deal with and refer cases of DV, sexual assault and child abuse. It may also be useful

to lobby with government ministries (the Ministry of Social Solidarity [MSS], MoH and Ministry of Education [MoE]) to allocate funding for referral support services (e.g. shelters and advocacy).

- NGO-led responses like Fatin Hakmatek require long-term support to be able to conduct long-term strategic planning and they also need capacity building and support in administrative areas such as finances, transport, report writing and proposal writing.
- It is important to focus not only on the medical needs of survivors of GBV but to find a balance between their medical and psychosocial needs.
- It is important to use research and rigorous data to inform the focus of programmes so that they are evidence-based.

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