



Health Sector Response to Gender-based Violence

An assessment of the Asia Pacific Region



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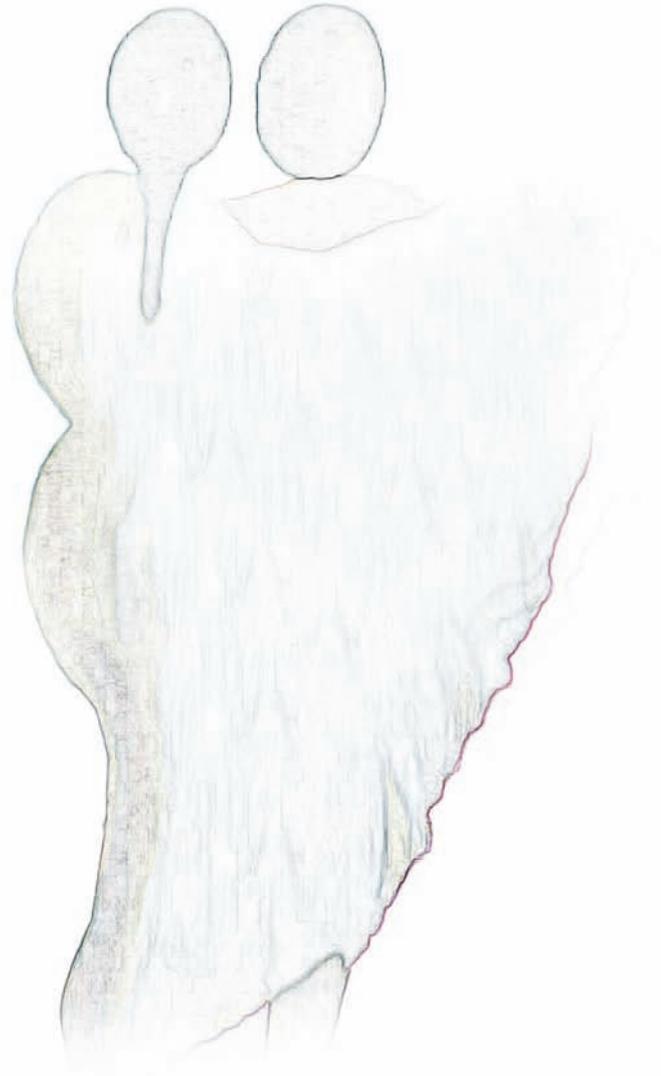
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Acronyms and abbreviations*

A&E	Accident and emergency	NGP	National gender policy
AIDS	Acquired Immune Deficiency Syndrome	NAP	National Action Plan
APRO	Asia Pacific Regional Office	NHPS	National HIV Prevention Strategy
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women	OBGYN	Obstetrics and gynaecology
CEDPA	Centre for Development and Population Activities	OPD	Outpatient department
CEHAT	Centre for Enquiry into Health and Allied Themes	OSCC	One-stop crisis centre
CHC	Community Health Centre	PEP	Post-exposure prophylaxis
CO	Country office	PIC	Pacific Island Country
CPD	Continuous (Continuing) professional development	PID	Pelvic inflammatory disease
DHS	Demographic and Health Survey	PNG	Papua New Guinea
DoH	Department of Health	PPT	Pusat Pelayanan Terpadu (Integrated Service Centre)
DV	Domestic violence	PRADET	Psychosocial Recovery and Development in East Timor
FCC	Family counselling centre	PSRO	Pacific Sub-Regional Office
FPU	Family protection unit	PTSD	Post-traumatic stress disorder
FSC	Family support centre	RH	Reproductive health
GBV	Gender-based violence	SDC	Swiss Agency for Development and Cooperation
HIV	Human Immunodeficiency Virus	SGBV	Sexual and gender-based violence
HMIS	Health Management Information System	SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East, Southeast Asia and the Pacific
HSP	Health service provider	SRH	Sexual and reproductive health
IASC	Inter-Agency Standing Committee	SRO	Sub-Regional Office
ICPD	International Conference on Population and Development	STI	Sexually transmitted infection
ICRW	International Centre for Research on Women	ToT	Training of trainers
IEC	Information, education and communications	UNFPA	United Nations Population Fund (formerly United Nations Fund for Population Activities)
IGMH	Indira Gandhi Memorial Hospital	UNHCR	United Nations High Commissioner for Refugees
INGO	International non-governmental organisation	VAW	Violence against women
IPV	Intimate partner violence	VAWC	Violence against women and children
KPI	Key Performance Indicator	VAWG	Violence against women and girls
MCH	Maternal and Child Health	WCC	Women's crisis centre
MDG	Millennium Development Goals	WCPU	Women and children protection unit
MGF	Ministry of Gender and Family	WHO	World Health Organisation
MISP	Minimum Initial Services Package		
MoH	Ministry of Health		
MoU	Memorandum of Understanding		
MSF	Médecins Sans Frontières (Doctors Without Borders)		
MSI	Marie Stopes International		
NGO	Non-governmental organisation		

* Included in this list are only those acronyms, abbreviations and initialisms which occur more than once in the text.

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Foreword

Gender-based violence (GBV) is well recognised as a human rights violation and a public health problem with legal, social, cultural, economic and psychological dimensions. Violence against women and girls cuts across class, race, religion and ethnicity and is today no longer viewed as a private matter. Decades of advocacy spurred by the women's movement and global research provide ample evidence on the manifold forms and consequences of GBV limiting the choices and curtailing the rights of women and girls in all spheres and throughout their lives. Among the impacts are a wide range of health consequences including sexually transmitted infections (STIs), HIV and AIDS, unintended pregnancies, psychological disorders, deprivation of sexual and reproductive rights and diminished well-being. The severe costs of violence against women incurred by children, families, communities and the state are thus well demonstrated and thoroughly documented by the data.

A multi-sectoral response is required to offer comprehensive support to women who suffer violence. In particular, it is probable that no other sector has a greater opportunity to aid women survivors of violence than the health sector. The institutionalised health care system is probably the only institution that interacts with every woman at some point in her life. For many women, a visit to a health facility may be her first effort to seek help and the only chance to receive support and care, as well as to escape a situation of abuse. Even in the remote and marginalised areas most women are likely to seek family planning or antenatal care services at least once in their lifetime, thereby making reproductive health facilities a critical entry point for GBV-related information and services. The health care system is therefore well placed to detect, refer and care for women and girls living with violence, and, as such, it can indubitably perform a critical function in preventing and managing GBV.

Over the years, UNFPA has played a pivotal role in supporting programmes that aim at strengthening health

sector responses to GBV. It is one of the six pillars of UNFPA's *Strategic Framework on Gender Mainstreaming and Women's Empowerment 2008-2011*. A centrepiece of UNFPA's corporate strategy is to address GBV through its Sexual and Reproductive Health (SRH) programmes and make it an integral part of the essential SRH package, a state of affairs which is in keeping with the goals of the International Conference on Population and Development (ICPD)¹.

In partnership with national counterparts, several UNFPA country offices in Asia and the Pacific have ongoing efforts designed to strengthen the capacities of health sectors to respond efficaciously to GBV. While these initiatives present varying models, are at different stages of implementation and enjoy different levels of success, they have created a body of knowledge and experience that would benefit from regional assessment and sharing. Accounts of "lessons learned" can indeed provide data and analyses of great value to countries that are planning on up-scaling successful interventions and others in the region which are at the stage of providing technical assistance to governments for developing new health sector interventions on GBV.

In view of what has just been mentioned and as part of the Regional Programme on Gender, UNFPA Asia and the Pacific Regional Office (APRO) commissioned an assessment and review of existing approaches to and models of health sector responses to GBV in the region. This twin publication is the outcome of this assessment, and includes a main publication, largely devoted to the assessment report and a supplementary publication comprising seven case studies. The assessment report analyses and documents various models and approaches of health system responses to GBV, including normative frameworks for protocols, management and referral; provision of services; capacity building and multi-sectoral linkages to GBV. It also identifies existing gaps with regard to health sector responses to

1 "UNFPA Strategic Plan 2008-2011: Accelerating Progress and National Ownership of the ICPD Programme of Action", para. 58 and Outcome 4, para. 74.

GBV, documents lessons learned and presents key findings and recommendations under the following sub-headings: *Approaches and models of service; Capacity building; Protocols and guidelines; Collaboration and referral; Screening; and Documentation and data management.*

The supplementary publication of seven case studies allows for the documentation of best practices and provides in-depth analyses of country-level experiences in Malaysia, Maldives, Papua New Guinea, Philippines, Sri Lanka and Timor-Leste. Whilst serving as a supplement to the assessment report, this compilation of case studies is simultaneously an independent stand-alone publication.

Both publications have been prepared with significant input from UNFPA Country Offices in the region. In December 2009, the assessment and case studies were shared at a four-day technical and capacity building regional workshop with UNFPA Gender and Reproductive Health Officers from twenty-one country offices. The workshop provided an excellent opportunity to share and validate the findings of the assessment and obtain further input from the country offices. These publications fill a long standing gap in the availability of analytical information on the region, and provide a strong advocacy tool for UNFPA country offices

and the regional offices to strengthen government and health sector commitment to address GBV as a public health priority in the region. They also contain comprehensive reference materials useful for advocacy groups as well as policy makers and donors.

Disseminating these good practices is one step towards sharing and learning from one another.

The UNFPA-APRO will continue to support South-South collaboration and technical assistance for national efforts to improve their health sector response to violence. We hope that this comprehensive account and analysis of health sector response to GBV in the Asia and the Pacific region and the in-depth case studies provide not only solid evidence but also guidance and encouragement in addressing GBV as a public health priority.



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Director
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1 Introduction to the Assessment

'Addressing GBV through UNFPA-supported SRH programmes is the minimum standard to which all UNFPA operations should be held accountable. Fundamentally, UNFPA should play a leadership role in ensuring that GBV is addressed as an integral part of the essential SRH package.'

Source: UNFPA Strategic Plan 2008-2011: Accelerating Progress and National Ownership of the ICPD Programme of Action, para. 58 and Outcome 4, para. 74.

In the past few decades gender-based violence (GBV) has been recognised as a worldwide problem, crossing cultural, geographic, religious, social and economic boundaries. In 2006, the United Nations Secretary General released an in-depth study on all forms of violence against women (VAW), which highlighted that: 'VAW persists in every country in the world as a pervasive violation of human rights and a major impediment to achieving gender equality' [11].

United Nations Population Fund (UNFPA) has a long history of supporting GBV programmes worldwide. The 2001 publication, *A Practical Approach to Gender Based Violence: A Manual for Health Care Providers* was a major step forward by UNFPA in piloting the prevention and assessment of GBV

into its reproductive health (RH) services. The guide was tested in ten countries in five regions with overwhelmingly positive results¹. Building on lessons drawn from the pilot projects, UNFPA has mainstreamed the prevention and management of GBV into its policies and programming more comprehensively and is supporting many more countries to strengthen the health sector response to GBV. UNFPA's commitment to addressing GBV is well-entrenched in its corporate policies, which include a specific Strategy and Framework for Action to Addressing GBV – 2008-2012. The framework is explicit in its acknowledgment that addressing GBV through UNFPA's sexual and reproductive health (SRH) programmes is 'the centrepiece of the agency's corporate strategy on GBV'. Accordingly, GBV has been identified as a key priority in UNFPA's overall Strategic Plan 2008-2011.

In recognition of the widespread prevalence of GBV and its health consequences, several UNFPA country offices (COs) in Asia and the Pacific, including India, Sri Lanka, Maldives, Nepal, Philippines, Indonesia and Timor-Leste have initiated programmes and projects that aim at strengthening the capacity of the health sector to respond to GBV. These initiatives follow different strategies and models, are at different stages of implementation and have enjoyed different levels of success. They have, however, created a body of knowledge and experience that needs to be assessed and shared across the region. Furthermore, while many of these countries are planning on up-scaling these interventions, others in the region are planning on developing new health sector interventions on GBV (e.g. China and Mongolia) and would benefit from the experiences of those who already have such programmes.

The Regional Programme of Asia Pacific Regional Office (APRO) and the Pacific Sub-Regional Office (PSRO) also have a strong focus and a specific output on GBV. As part of the Regional Programme on Gender, APRO and PSRO are supporting a programme that builds the capacity of COs and

Box 1: UNFPA role and accountability

As the lead United Nations organisation on SRH, UNFPA has a natural and strategic entry point to address this issue, given the intrinsic linkages with GBV and the critical opportunities that SRH services represent. As the organisation with primary responsibility for designing and promoting the International Conference on Population and Development (ICPD) Programme of Action, UNFPA has an ethical, programmatic and fiscal responsibility to redouble its efforts in addressing GBV. This is also the case regarding its efforts to reduce poverty and achieve the Millennium Development Goals (MDG). Moreover, as an organisation that follows a human rights-based approach (HRBA) to programming, UNFPA has an obligation to tackle this systematic and universal violation of fundamental human rights via its policies and programmes. Furthermore, the Inter-Agency Standing Committee (IASC) designated UNFPA as the lead agency for addressing GBV in humanitarian situations. Hence, UNFPA is at the forefront in dealing with this issue and coordinating systems of multi-sectoral response in all conflict, post-conflict, natural disaster and recovery settings.

UNFPA Strategy and Framework for Action to Addressing GBV, 2008-2011, p. 7

their partners, strengthening the health sector response to GBV within a multi-sectoral framework. As a first step of this initiative, UNFPA – APRO engaged two consultants to carry out this assessment of the health sector response to GBV in the Asia and Pacific region in coordination with COs.

¹ Cape Verde, Ecuador, Guatemala, Lebanon, Lithuania, Mozambique, Nepal, Romania, Russia and Sri Lanka.

1.1 Objectives of the assessment

- 1 To learn from existing interventions and health sector responses to GBV and identify and promote evidence-based health sector interventions within a multi-sectoral framework that are appropriate for the region/sub-regions.
- 2 The assessment forms the basis for identification of models, policies, protocols, guidelines and tools appropriate for adaptation by COs.
- 3 The assessment will guide the design and development of capacity building programmes for staff of COs and health care workers.

1.2 Workshop on Strengthening the Health Sector Response to GBV

From 1-4 December 2009, UNFPA APRO held a Workshop on Strengthening the Health Sector Response to GBV in Bangkok, Thailand. The workshop brought together more than forty UNFPA staff, both RH and gender programme officers, from more than 25 COs and sub-regional offices (SROs). The aim of the workshop was to share the results of the assessment, strengthen the capacity of the participants to respond to GBV from a health system perspective, enhance the synergy and integration of GBV and SRH issues in UNFPA responses as well as strengthen South-South cooperation by promoting knowledge and experience sharing between COs.

Participants presented their country experiences of responding to GBV through the health sector, learned from expert resource people, participated in one of two field visits to hospital-based One-stop crisis centres (OSCCs) near Bangkok, and had the opportunity to carry out practical forward planning, defining the next steps for policy and programme development in their COs.

Participants were encouraged to provide feedback on the assessment which has been incorporated into this report, along with information from the country presentations, group discussion and annual work plan development (see Annexes 1 and 2 for a copy of the workshop agenda and list of participants).

1.3 Report structure

This report presents the findings of the Assessment of the Health Sector Response to GBV in the Asia Pacific region. The report first outlines some of the definitional issues related to GBV and why it is considered a public health issue. It then details the assessment methodology and provides a brief background of the Asia Pacific regional context and women's experiences of violence. The report then presents the key findings of what is happening in South Asia, Southeast Asia and the Pacific with regards to the health sector response to GBV, broken down into the following concept areas:

- Models of service;
- capacity building;
- guidelines and protocols;
- referral systems;
- screening; and
- documentation and data management.

A brief definition of each concept is provided, as understood for the purposes of this assessment and report. These should not be considered all-encompassing or technically perfect definitions but rather practical meanings to clarify the focus of the discussion. Discussion and analysis of each concept are also presented in a text box at the end of each section.

The key findings are followed by an analysis of the challenges and lessons learned. Finally, recommendations are provided based on the analysis of the challenges and lessons learned.



2 Methodology

The assessment was carried out by two consultants engaged by UNFPA APRO. In total, 27 countries from South Asia, Southeast Asia and the Pacific were included in the assessment (see Figure 1).

The assessment was conducted primarily as a desk review and included the following methodological approaches:

2.1 Literature review

The literature review was conducted as an initial step for gathering evidence on GBV as a public health issue and evaluating the health sector response to GBV in the region.

An online search was conducted on the following databases: Poplin, Cochrane, Expanded Academic ASAP, Web of Science, JSTOR and PubMed. In addition, the common search engines Google, Google Scholar and Yahoo were searched using key words. The following key words were used:

Figure 1: Countries included in the assessment, grouped by sub-region



- For databases:
- VAW
 - GBV + health
 - DV + health
 - Sexual violence + health
 - Health responses to VAW
- For search engines:
- Health responses + GBV + (country by name)
 - Health sector responses + GBV
 - Health responses + VAW
 - GBV + health
 - DV + health
 - Sexual violence + health
 - Health responses to VAW

Most of the publications included in the review were published within the last ten years. However, some older articles and reports were included if they were considered significant or if more recent material was not available.

Overall, more than 200 reports, articles and documents were reviewed.

Note: A separate document with a list of all relevant literature has been prepared for easy reference by COs.

2.2 Material from UNFPA COs

The APRO team received extensive support from PSRO and UNFPA COs who provided relevant information and documentation on country level practices and experiences. In order to ensure consistency of the methodology and comparability between countries and regions, a framework was developed by the consultants to guide the collection of information and material from

UNFPA COs and other sources. All COs and the PSRO completed the framework and the information has been collated into a user-friendly form and shared with the participants at the aforementioned workshop.

All information and documents provided by COs have been reviewed and assessed and, where necessary, follow-up interviews were conducted with other relevant stakeholders by phone and email. As mentioned above, the PSRO and COs also contributed to the assessment through the workshop and their inputs during this process are incorporated into the report.

Relevant documents provided by the PSRO and COs have been included in the aforementioned document list.

2.3 Focus on health system responses

The assessment focused on health system responses to GBV. While considering the structural variations of the health care systems that exist in different countries, an assessment tool was developed by the consultants to guide the health system focus. The development of the tool was based on information already available from similar assessments and with input and advice from a number of RH and gender experts (see Annex 3).

2.4 Country case studies

As part of the assessment, seven case studies have been developed to provide in-depth analysis of country

level experiences, key issues and lessons learned. The case studies were developed based on the information gathered in the desk review, supplemented by field visits, phone and email interviews, as well as discussions with stakeholders. The following case studies were undertaken and are included as Annex 1 to this report: Bangladesh, Malaysia, Maldives, Papua New Guinea (PNG), Philippines, Sri Lanka and Timor-Leste.

2.5 Limitations of the assessment

The focus of this assessment is on the health system response to GBV, in particular looking at initiatives led by the health sector. However, it is important to recognise that civil society has and continues to play a strong role in responding to GBV from a health perspective in many countries. Non-governmental organisations (NGOs) have initiated a number of responses and have also worked in collaboration with governments in this regard. Furthermore, as will be discussed later, the role of NGOs in the provision of other GBV services such as shelters, long-term counselling, advocacy, education and prevention activities is vital to the multi-sectoral framework in which the health sector must respond.

It is important to note that this document may not include all health sector responses to GBV in the region but, rather, attempts to highlight the key practices and initiatives. It is also acknowledged that while every effort has been made to gather all relevant information from the various countries, this has been predominantly a desk review conducted within a limited time frame, and as such there may be some gaps in the information.



3

Definitions

3.1 What is gender-based violence?

The United Nations Declaration on the Elimination of Violence Against Women [12] defines the term GBV as:

Any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

In this document and throughout the assessment the term GBV is used, however UNFPA's focus is on violence against women and girls (VAWG), as explained in Box 2.

Root causes for GBV are gender inequality and discrimination. However, it is also shaped by the interaction of a wide range of factors, including histories of colonialism and post-colonial domination, nation-building initiatives, armed conflict, displacement and migration. Furthermore, the specific expressions of VAW in different contexts are influenced by economic status, race, ethnicity, class, age, sexual orientation, disability, nationality, religion and culture [11].

Box 2: Gender-based violence or violence against women – which is it?

GBV can apply to women and men, girls and boys. The UNFPA focus remains on tackling VAWG, since it is they who are overwhelmingly affected. This is not to say that sexual abuse of adolescent boys and the sexual exploitation of young men are not of grave concern to UNFPA.

The primary targets of GBV are women and adolescent girls, but not only are they at high risk of GBV, they also suffer exacerbated consequences as compared with what men endure. As a result of gender discrimination and their lower socio-economic status, women have fewer options and less resources at their disposal to avoid or escape abusive situations and to seek justice. They also suffer SRH consequences, including forced and unwanted pregnancies, unsafe abortions and resulting deaths, traumatic fistula, and higher risks of sexually transmitted infections (STIs) and HIV – issues at the core of the UNFPA programming mandate.

Source: UNFPA Strategy and Framework for Action to Addressing GBV, 2008-2011, p. 7

GBV takes on many forms including intimate partner violence (IPV)² and marital rape; sexual violence; dowry-related violence; female infanticide; sexual abuse of female children; female genital mutilation/cutting and other traditional practices harmful to women; early marriage; forced marriage; non-spousal violence; violence

perpetrated against domestic workers; and other forms of exploitation and trafficking.

The most common form of violence experienced by women and girls globally is Domestic Violence (DV), which is most often perpetrated by a male partner against a female partner. The World Health Organisation (WHO) Multi-Country Study of Women's Health and DV showed that lifetime prevalence of physical or sexual partner violence, or both, varied from between 15 per cent and 71 per cent in ten countries. It is evident that women also perpetrate violence against men and that violence can occur in same-sex couples [13-17]. However, the overwhelming burden of partner violence is borne by women at the hands of men [18-21]. Furthermore, women are much more likely to suffer injuries as a result of violence by a male partner than men are from a female partner.

This assessment of the health sector response to GBV focuses on IPV or DV and sexual abuse of women and girls, particularly as these are the most prevalent forms of VAW in the Asia Pacific Region and the most common types of violence present in the health sector.

3.2 Why is GBV a public health issue?

'Worldwide, it is estimated that VAW is as serious a cause of death and incapacity among reproductive-age women as is cancer, and it is a more common cause of ill-health among women than traffic accidents and malaria combined' [22].

2 While most countries use the term DV, the term intimate partner violence, or IPV, is increasingly used because it specifically refers to, without confusion, violence between partners rather than violence involving other family members.

GBV is a major but preventable public health problem. The health care system is the only institution that interacts with almost every woman at some point in her life and international research has consistently shown that women exposed to violence visit health services more frequently than non-abused women. Health service providers (HSPs) – especially those serving in accident and emergency (A&E) wards and in women’s health settings such as reproductive and sexual health, maternal child health and prenatal settings – have a critical role to play in detecting, referring and caring for women living with violence. Interventions by health providers can potentially mitigate both the short- and long-term health effects of GBV against women and their families.

It is also vital to remember that the health system in any country is not immune from GBV internally. UNFPA has highlighted that reproductive rights violations in the health sector (such as unavailability or disruption of contraceptive supplies, judgemental or biased treatment based on reproductive status or choice, coercive family planning counselling, denial of contraceptives and forced sterilisation) are forms of GBV [23]. This should be considered when undertaking institutional capacity building related to GBV.

However, despite the increasing evidence of the serious health consequences of GBV, health systems in many countries are not geared towards addressing the issue. Studies show that health professionals in many countries have not received training or professional development on GBV and responding to violence is not seen as part of their role [21, 24]. HSPs are members of a given society and reflect the dominant socio-cultural attitudes within the community that may contribute to GBV. Within the

health system, like anywhere else, there will inevitably be both victims and perpetrators of GBV. There is therefore a great need to sensitise HSPs about gender and GBV and enhance the capacity of health systems to respond effectively and sensitively to GBV.

Recognising that GBV is a public health issue does not mean that the health sector can be expected to deal with it alone. Reducing and responding to GBV takes concerted and coordinated effort from a range of sectors including social services, religious organisations, the judiciary, police, media and business. The health sector therefore needs to play an important role within a multi-sectoral framework.

GBV has a wide range of physical, mental and RH consequences which often last long after the abuse has ended [8].

3.2.1 Physical health

GBV, particularly physical violence by intimate male partners, often causes serious bodily injury, including bruises, cuts, black eyes, burns, concussion, broken bones, injuries from knives and other objects, as well as permanent injuries such as physical disfigurement from burns or bites. VAWG in families may even be fatal. In fact, data from a range of countries demonstrates that the majority of women murdered are killed by present or former partners [25]. In addition, women may commit suicide as a last resort to escape a violent situation.

Women who are physically abused often also have a host of less-defined somatic complaints, including chronic headaches, abdominal and pelvic pains, and muscle aches [19, 26-29].

3.2.2 Mental health

Recurrent abuse can erode women's resilience and place them at risk of psychological problems such as fear, anxiety, fatigue, sleeping and eating disturbances, depression and post-traumatic stress disorder (PTSD). Links have also been found between physical abuse and higher rates of psychiatric treatment, attempted suicide, and alcohol and drug dependence [8, 26, 30-32].

Rape survivors commonly experience psychological difficulties such as heightened fear, anger, anxiety, depression, guilt, self-blame, loss of trust, flashbacks, withdrawal and PTSD [33].

3.2.3 Reproductive health

Physical and sexual abuse have important RH consequences either directly through risks incurred by forced sex, or indirectly through psychological effects that lead to risk taking behaviours [3: 6]. Studies in the US indicate that women beaten during pregnancy run twice the risk of miscarriage and have four times the risk of having a low birth weight baby than women who are not beaten [34]. In a number of other countries, physical abuse has also been found to be associated with higher rates of abortion, miscarriages, stillbirths and delayed entry into antenatal care [3, 8, 19, 35]. Research has also shown that women who experience IPV during pregnancy are at greater risk of having attempts made on their lives than non-childbearing women [36].

Abused women have more unwanted pregnancies, higher fertility levels and a lessened ability to consistently use contraceptives [6-8, 19]. This indicates that women who have experienced violence have less control over their RH choices [37-39].

Women who have experienced sexual violence are at increased risk from unwanted pregnancy, unsafe

Box 3: The links between GBV and HIV

Recent research on HIV in intimate partner relationships in Asia highlights that women are particularly vulnerable to HIV/AIDS and pervasive gender inequalities undermine women's ability to negotiate safe sexual practices [1]. Furthermore, GBV can interfere with women's ability to access treatment and care, maintain adherence to antiretroviral treatment, or carry out infant feeding choices. Evidence also exists that living with HIV can constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV status, or even following admission that HIV testing has been sought [4].

The demographic and health survey in India showed that HIV prevalence was more than four times higher among married women who experienced both physical and sexual violence by an intimate partner than among non-abused women [9]. Additional analysis of these data indicated that abusive men were almost twice as likely to acquire HIV infection outside their marital relationships and that their wives are consequently at a greater risk of HIV infection. IPV appears to facilitate transmission of HIV within marriage. Women exposed to IPV from husbands exposed to HIV through regular unprotected sex with multiple partners had a seven-times higher HIV risk compared with women not exposed to IPV and whose husbands did not have sex with multiple partners [10].

abortion, STIs including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), infertility, pelvic pain or pelvic inflammatory disease (PID) and urinary tract infections. Such violence is also associated with severe sexual problems and mental health disorders [25, 40].

3.2.4 Health costs to children

Studies have consistently shown that girls who experience sexual abuse may suffer from a range of mental health issues, including depression, PTSD, low self-esteem, anxiety, self-harming and suicidal ideation [41]. Research also indicates that there may be other long-term consequences of girl child

sexual abuse such as poor physical health, substance abuse, and difficulties with interpersonal relationships including an increased risk of DV and adult rape [42-45].

The impact of DV is also significant on children. Children who witness DV may suffer significant negative social, emotional, behavioural and academic repercussions [46-49]. Impacts

Table 1: Health consequences of VAWG

Physical

Abdominal/thoracic injuries
Bruises and welts
Lacerations and abrasions
Fractures and breaks
Eye injuries
Rupture of the eardrum
Burns
Chronic pain syndromes
Disability
Gastrointestinal disorders
Fibromyalgia
Reduced physical functioning

Psychological and behavioural

Alcohol and drug abuse
Depression and anxiety
Eating and sleep disorders
Feelings of shame and guilt
Phobias and panic disorders
Physical inactivity
Poor self-esteem
PTSD
Psychosomatic disorders
Smoking
Suicidal behaviour and self-harm
Unsafe sexual behaviour

Sexual and reproductive

Gynaecological disorders
Pregnancy complications
Miscarriage/low birth weight
Pelvic inflammatory disease
Sexual dysfunction
STIs, including HIV/AIDS
Unsafe abortion
Unwanted pregnancy

Fatal health consequences

AIDS-related mortality
Maternal mortality
Homicide
Suicide

Source: [21: 101]

may include development and learning problems, poor concentration, and limited social skills, aggressive and non-compliant behaviour, low self-esteem, depression and anxiety [46, 49-51].

A number of studies including recent research in the Solomon Islands [6] and Kiribati provide strong evidence for the theory of 'intergenerational transmission of violence', which argues that witnessing and experiencing violence as a child has the potential to create future 'victims' and 'perpetrators' [52-61].

3.2.5 Other costs of violence

VAWG is now widely recognised as a serious human rights abuse with far-reaching consequences for women, their children and for the community and society as a whole. On International Women's Day 2009 the United Nations Secretary-General, Ban Ki-moon, made the following statement:

VAW stands in direct contradiction to the promise of the United Nations Charter to 'promote social progress and better standards of life in larger freedom.' The consequences go beyond the visible and immediate. Death, injury, medical costs and lost employment are but the tip of an iceberg. The impact on women and girls, their families, their communities

and their societies in terms of shattered lives and livelihoods is beyond calculation. Far too often, crimes go unpunished and perpetrators walk free. No country, no culture, no woman, young or old, is immune.

VAW clearly violates women's rights to be free from violence and constrains other rights. For example, a woman cannot exercise her rights to livelihood, education, mobility, health or participation in governance if she is prevented from leaving her home under threat of violence or death. In addition, a woman cannot fulfil her right to choose whether, when or how often she will have children if she is routinely denied the opportunity to consent to sexual relations, or to choose whether and whom she marries [62: 9].

VAW also severely constrains development, obstructing women's participation in political, social and economic life [63]. The impacts include escalating costs in health care, social services, policing and an increased strain on the justice system. It lowers the overall educational attainment and mobility of victims/survivors, their children and even the perpetrators of such violence [64]. VAW undermines and constrains the achievement of the MDG, including those set in the areas of poverty, education, child health, maternal mortality, HIV/AIDS and overall sustainable development [11].



4 The Asia Pacific regional context

The culturally diverse Asia Pacific Region has approximately 3.7 billion people, more than 60 per cent of the world's population. It encompasses two of the world's largest economies (China and India), countries experiencing economic transition (China, Mongolia and Viet Nam), middle income countries (Indonesia, Malaysia and Thailand) and countries facing or recovering from conflict (Afghanistan, Cambodia, Indonesia, Pakistan, Philippines, Nepal, PNG, Solomon Islands, Sri Lanka, Thailand and Timor-Leste).

One major challenge facing the region is the fact that it has more than half of the world's young people, aged 10-24, and is also home to the majority of the world's older people [65]. Urbanisation and internal and international migration are occurring at unprecedented rates and Asia will soon house the world's largest urban population, over half of whom will live in slums and informal settlements.

In many countries, access to high-quality health services is uneven, and there is a large unmet need for family planning and RH services. In particular, the poor are least able to implement their family size and spacing choices effectively and to deliver their children safely [66: 4-5].

The Asia and Pacific region has more than 6.5 million people living with HIV/AIDS, with some five million in China and India alone. The region shows wide variation in epidemic trends among different countries. For instance, Cambodia, Myanmar and Thailand show declining HIV prevalence, but the epidemic is growing at a particularly high rate in Indonesia, Viet Nam and PNG [66: 4-5].

Gender disparities persist in health, literacy, education, political participation, income and employment. Although most countries in the region have signed or ratified the United Nations' Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), not all ensure equal rights for women in their own constitutions. Traditional gender norms, stereotypes and practices allowing discrimination, son preference, antenatal sex selection, forced marriage, GBV and exclusion from political, social and economic participation all continue.

4.1 The Pacific

The Pacific is a diverse region usually grouped into three divisions: Melanesia, Micronesia and Polynesia. The Pacific has some of the least-developed countries in the world ranked between 55th (Tonga) and 148th (PNG) on the Human Development Index (HDI). The majority of Pacific Islanders live in rural villages which are often separated by rugged terrain or large stretches of ocean. Some countries are particularly prone to natural disasters. In addition, a number of countries, including PNG, the Solomon Islands and Fiji, have recently experienced conflicts which have particular implications for women's security.

Among the Pacific Island Countries (PICs) that have a Gender Development Index (GDI) ranking, Samoa has the highest at 72nd and PNG the lowest at 124th. The gender gap remains obvious in education and literacy levels,

although the gap has decreased over recent years [67]. It is concerning to note the particularly low proportion of female parliamentary members in the Solomon Islands, PNG, Tonga and Vanuatu. Women's lack of economic empowerment is also reflected in a lack of access to and control over economic resources in the form of land and personal property.

In countries such as the Solomon Islands, Vanuatu and PNG, the cultural practice of 'bride price' has been distorted over time. While it used to be an exchange of goods between families that recognised the value of women, it is now a common belief that with the payment of bride price women are effectively purchased by their husbands who are therefore entitled to control and 'discipline' their wives as they think necessary [6, 7, 68]. Where bride price has been paid it is very difficult for a woman to leave a violent relationship [69].

Physical punishment is often used as a form of disciplining women who are seen as stepping outside of their prescribed gender roles. For example, in the Solomon Islands, Family Health and Safety Study and the Kiribati Family Health and Support Study, the majority of women interviewed also believed that a husband is justified in hitting his wife under some circumstances, such as disobeying him or being unfaithful [6, 7]. Similarly, in Fiji, according to the Fiji Women's Crisis Centre (WCC), there is a high-level of tolerance for DV.

In recent years there has been a concerted effort to conduct in-depth research on the prevalence, causes and consequences of VAW in the Pacific region. Samoa, the Solomon Islands, Kiribati, Vanuatu and Tonga have all conducted (or are in the process of conducting) nationally representative, household-based population surveys derived from the WHO Multi-Country Study on Women's Health and DV. This has provided robust data on the prevalence of different types of VAW as well as the physical, mental and RH consequences of such violence.

Box 4 summarises the most significant findings from Samoa, the Solomon Islands and Kiribati.

In the Solomon Islands and Kiribati, this concrete data on the prevalence and health consequences of GBV has proven useful in a) getting funding to support health system responses to GBV, b) convincing relevant government partners of the need for a GBV response within the health sector and c) sensitising HSPs about GBV as a public health issue.

4.2 Southeast Asia

With its population of over half a billion people, Southeast Asia is one of the most populous regions of the world. It has a diverse range of faiths, cultures, and economic and political systems (e.g. socialist systems in Cambodia, Lao People's Democratic Republic and Viet Nam and democracies in the other countries). Some countries have experienced relatively recent conflict and political unrest (Timor-Leste, Thailand, Philippines, Cambodia and Viet Nam) and security concerns continue to create uncertainty and make women more vulnerable to violence. Natural disasters such as the 2006 tsunami or, more recently, rising food and oil prices, pose threats to the security and well-being of the population, especially women. The rise of religious fundamentalism (e.g. in Indonesia and Malaysia) threatens women's human rights and security. Of particular concern has been the growing realisation of the degree to which decentralisation (e.g. in Indonesia and Thailand) allows local authorities to pass local laws that have little consideration for women's rights or that reinforce traditional and/or illegal practices that have a negative impact on women [70:10-11].

Women in the region face traditional gender norms, stereotypes and practices that allow for discrimination and many forms of GBV. According to a number of reports, the subservient role of women within the marital relationship is often accepted by both men and women in society and results in women being more vulnerable to partner violence. For example, according to the WHO Multi-Country Study Methodology in Thailand, almost all women felt that they could not refuse sex with their husband or partner under any circumstances [71]. A survey in several provinces of China revealed that 44 per cent of respondents thought that there were justifiable reasons for a husband to hit his wife [quoted in 72] and according to the Cambodian Demographic and Health Survey (DHS), 35 per cent of women aged 15-49 agreed with at least one justification for a husband hitting his wife [73]. In Myanmar, a Baseline Data Collection and Behaviour Study on Male Involvement in RH (2005) revealed that 23.8 per cent of urban and 17.9 per cent of rural married men reported use of violence against wives/partners.³

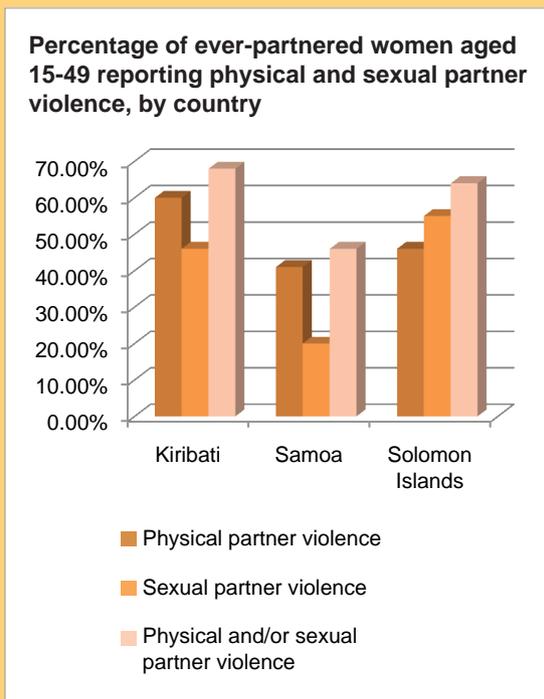
DV and sexual assault remain the most common forms of GBV in Southeast Asia although violence perpetrated against domestic workers as well as other forms of exploitation and trafficking are of particular concern in this region.

Given that partner violence is the most common form of violence, Table 2 collates data from various population-based studies in the region. It shows the relative prevalence rates of physical and sexual partner violence based on available data for countries that have conducted population-based surveys, including basic information on the methodologies of the respective surveys. As the data shows, the prevalence of physical partner violence ranges from 10-34 per cent. Sexual violence within the last 12 months ranges from 2-17 per cent.

3 From UNFPA Myanmar Country Office presentation at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

Box 4: Summary of significant findings on prevalence of VAW in Samoa, the Solomon Islands and Kiribati, based on population surveys using the WHO Multi-Country Study Methodology [5-7]

- The prevalence of VAW in the Pacific region appears to be relatively high compared to data from other countries who have conducted the WHO Multi-Country Study [8]. See table below.



- In Samoa and Kiribati physical partner violence was found to be more prevalent than sexual partner violence. However there is a significant overlap between these forms of abuse with

many women experiencing both forms of violence.

- In the Solomon Islands sexual partner violence is more common than physical partner violence which has important implications for health sector interventions.
- While in most countries women are at greatest risk of violence by an intimate partner, this was not the case in Samoa where 62 per cent of respondents reported that they had been physically abused by someone other than a partner and 11 per cent reported being raped by a non-partner. The Samoa report suggests that the prevalence of physical abuse primarily reflects physical punishment of children by their parents, teachers and others.
- In the Solomon Islands 18 per cent of women aged 15-49 reported physical violence by a non-partner and 18 per cent reported non-partner sexual violence. Being a post-conflict country where exposure to sexual assault and rape has been high it is necessary for the health sector to respond to the immediate and long-term consequences of sexual violence.
- Sexual abuse of girl children is also of relatively high prevalence in the Pacific region. For example, in the Solomon Islands 37 per cent of women aged 15-49 reported that they had experienced sexual abuse when they were under the age of 15. In Kiribati it was 19 per cent.
- In Kiribati 23 per cent of ever-pregnant women had been beaten during pregnancy and in the Solomon Islands 11 per cent of women reported this to be the case.

Table 2: Intimate partner violence prevalence, selected population-based studies in Southeast Asia

Country or area	Year of study	Coverage	Sample			Proportion of women physically abused by partner (%)			Proportion of women sexually abused by partner (%)		
			Size	Study population	Age (years)	During previous 12 months	In current relationship	Ever	During previous 12 months	In current relationship	Ever
Thailand [71]	2000	Bangkok	1536	III	15-49	8		13	17		30
	2000	Nakhon-sawan (70% rural province)	1282	III	15-49	13		34	16		29
Indonesia ⁴	1999-2000	Central Java	765						13		22
Philippines	1993	National	8481	V	15-49			10			
	1998	Cagayan de Oro City and Bukidnon Province	1660	II	15-49			26			
Vietnam [74]	2002	Fila Bavi (rural)	883	III	17-60	8		31	2		7
Cambodia [18]	1996	Six regions	1374	III	--			16			
China [75]	1999-2000		1665		20-64		34				
Timor-Leste [76]	2002	Dili (urban) & Alieu (rural)	256	III	18-49	25			16		

Study population: I = all women; II = currently married/partnered women; III = ever married/partnered women; IV = married men reporting on own use of violence against spouse; V = women with a pregnancy outcome; j- perpetrator could be family member or close friend

4 SEHATI Study, using WHO Multi-Country Study questionnaire

4.3 South Asia

South Asia is home to 1.7 billion people, well over one-fifth of the world's population, making it both the most populous and most densely populated region in the world. It is also home to nearly half of the world's poor, has the highest illiteracy rate in the world and the schooling of females still lags behind that of males, despite the economic progress that has taken place in some countries. In addition, one-third of the world's maternal deaths occur in South Asia [77].

There is significant diversity within South Asia in terms of language, ethnicity, political and economic systems as well as religious and cultural practices. Despite a vibrant women's movement and great strides made towards gender equality, patriarchal structures and values remain deeply entrenched across the diverse communities of South Asia.

Despite the fact that the world's first female prime minister came from the region, women's empowerment is low and a large number of women still suffer from various forms of GBV. The practices of antenatal sex selection and infanticide of female babies are still prevalent in South Asian countries. Furthermore, many children suffer from malnutrition, with girls being disproportionately affected [78:53]. The region is also marked by conflict and political instability which increases women's vulnerability to GBV.

The issue of dowry continues to play a role in GBV in the region despite anti-dowry laws enacted in countries such as India, Bangladesh and Pakistan. Disputes about dowry in parts of South Asia have been highlighted as instigating serious incidents of DV, including murder

and suicide. Witch hunting is also a concern in some parts of India and has been found to be associated with socioeconomic factors. Honour and shame complexes and reverence for female virginity and sexual purity also contribute to women's experience of violence in the region. Regulation and control of female behaviour may involve VAW and in extreme cases even 'honour killings'. Other forms of indirect and subtle control are exercised in some countries in the region through threats of violence or withdrawal of family benefits and security [79:xi]. Child marriage, leading to both physical and mental trauma, is also prevalent in some countries in South Asia.

Within this cultural context, DV still remains the most prevalent form of GBV. A study from Maharashtra, India, showed that 38 per cent of women were verbally abused and more than half of these had experienced physical abuse by an intimate partner. In Bhutan, a study commissioned by the National Commission of Women showed that violence is prevalent in most women's lives, independent of being single or married. It also indicated that alcohol and financial matters were common triggering factors. One of the higher prevalence rates of VAW was reported in Nepal where 80 per cent of the women reported psychological violence, 32 per cent reported physical violence and 10 per cent reported sexual violence.⁵

Table 3 shows the prevalence of partner violence for various South Asia countries based on the most recent population-based studies available. It shows that women's lifetime experience of physical partner violence ranges from 18-47 per cent and 7-50 per cent for lifetime experience of sexual partner violence. Sri Lanka and Pakistan have also recently conducted population-based studies using the WHO Multi-Country Study Methodology, although the results have not yet been published.

5 From presentation by UNFPA Nepal Country Office at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 3 December 2009, quoting UNFPA study called 'Samta' conducted in 2005.

The health consequences of violence have been recorded in many countries, and research conducted throughout India has linked VAW to greater risk of infections, unwanted pregnancies, HIV infection

and maternal deaths. Also see Box 6 for information on injuries likely related to violence reported in female medico-legal forms at a tertiary hospital in Maharashtra, India.

Table 3: Intimate partner violence prevalence, selected population-based studies in South Asia

Country or area	Year of study	Coverage	Sample			Proportion of women physically abused by partner (%)			Proportion of women sexually abused by partner (%)		
			Size	Study population	Age (years)	During previous 12 months	In current relationship	Ever	During previous 12 months	In current relationship	Ever
Afghanistan [80]	2006	National (16 provinces)	4700	III	10-50	39		52			17
Bangladesh [81]	2002	Dhaka	1603	III	15-49	19		40	20		37
	2002	Matlab (rural district)	1527	III	15-49	16		42	24		50
India	1993-1994	Tamil Nadu	859	III	15-39		37				
	1993-1994	Uttar Pradesh	983	III	15-39		45				
	1995-1996	Uttar Pradesh, five districts	6695	IV	15-65		30				
Maldives [82]	2006	National	1900	III	15-49	6		18	2		7

Study population: I = all women; II = currently married/partnered women; III = ever married/partnered women; IV = married men reporting on own use of violence against spouse; V = women with a pregnancy outcome



5

Key findings

There is growing recognition of the public health burden resulting from GBV and the need for the health sector to identify and support abused women in the region. There is particularly a need for health providers to be better able to identify women experiencing violence, provide care and refer them to specialised services.

Overall, the assessment shows that the majority of countries in the Asia Pacific Region are actively seeking to respond to the issue of violence. Most countries have initiated or are initiating at least some health sector responses to GBV, which is promising. However, there is understandably wide variation in the scale, scope, quantity and quality of the responses across countries and the level of integration that has been achieved in each country's national health system. Figure 2 illustrates the different stages that countries in the region are at with regards to their response to GBV through the health sector.

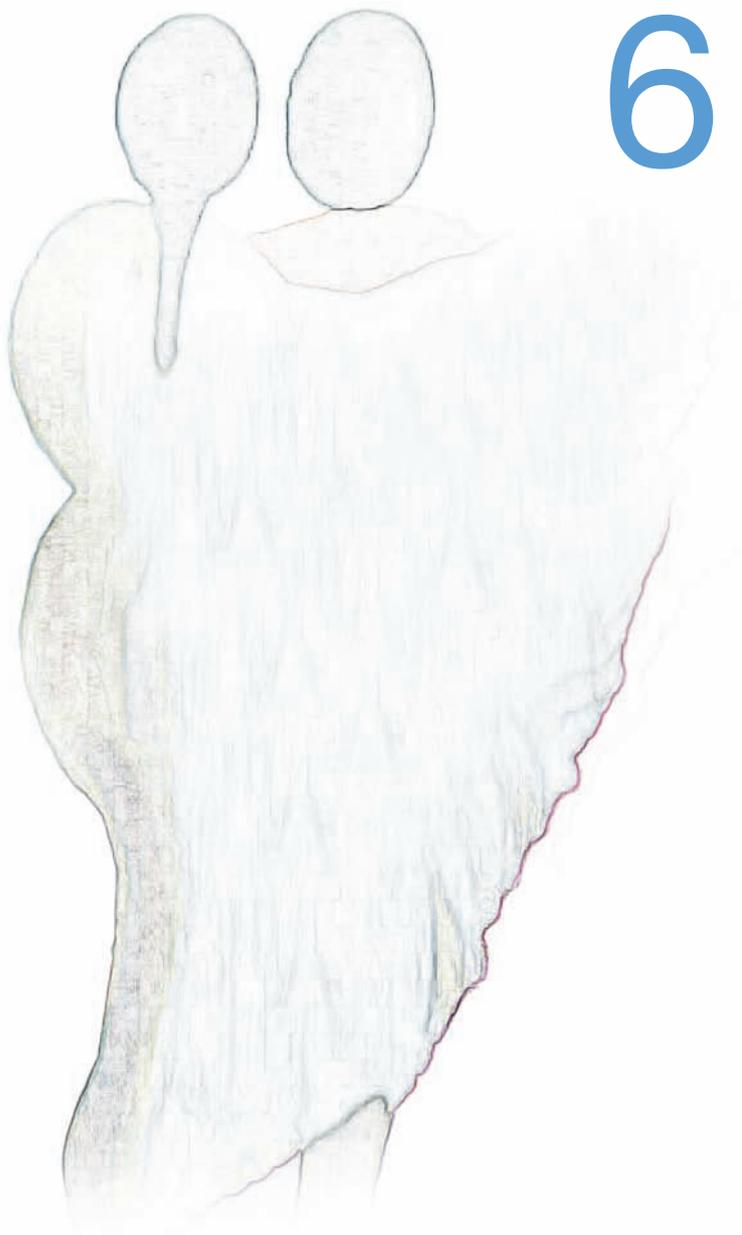
Some countries have been addressing GBV through the health sector for more than ten years (e.g. Malaysia and Indonesia), and have therefore had some success in 'scaling-up' pilot projects to integrate a GBV response into their national health system. Other countries are just starting interventions (e.g. Mongolia and China) focusing on one particular area, such as capacity building of HSPs, or carrying out pilot projects in a small number of regions and learning lessons on next steps.

Figure 2: Stages of countries in responding to GBV through the health sector



Other countries have not yet established formal systems of response but have made progress by sensitising stakeholders, capacity building, research and evidence building activities (e.g. Kiribati and Laos). On the other hand, some countries met with resistance despite attempts to develop GBV interventions within the health sector

and continue working on advocacy efforts (e.g. Iran). For a number of countries in the region, responding to GBV within the context of serious socio-political upheavals remains a huge challenge, although it is important to recognise that conditions such as conflict increase women's risk of experiencing GBV and need particular attention.



6

Overarching legislative and policy frameworks

Definition: For the purposes of this assessment and report, 'legislation and policy' refers to relevant laws on GBV such as family violence or DV legislation, as well as government approved plans such as national action plans (NAPs) on GBV which outlines the roles and responsibilities of different sectors, including the health sector, in responding to violence. Relevant policy initiatives also include the incorporation of GBV into national level health policies such as national health plans, RH policies and HIV/AIDS policies. Documents can also refer to circulars and directives from state administration regarding issues related to GBV and health, for example, the request for the establishment of OSCCs in all government hospitals in Thailand.

6.1 GBV legislation and NAPs

Figure 3 shows the countries in the region with DV legislation, those in drafting or bill phase and those where no action has taken place yet. It can be seen that the majority of countries in the region have such legislation, although the implementation of legislation remains inconsistent.

Figure 3: DV legislation in the Asia Pacific region

Countries with Domestic Violence Acts	Countries with DV bills or developing bills
Afghanistan: Elimination of Violence Against Women law, 2009	Bhutan
Bangladesh: The Prevention of Oppression Against Women and Children Act 2000 and Suppression of Violence Against Women and Children (Amendment) Act (2003)	Fiji
Cambodia: Prevention of Domestic Violence Against Women Law, 2005	Maldives
China: Law of the People's Republic of China on the Protection of Rights and Interests of Women (2005)	Timor-Leste
India: Protection of Women and Domestic Violence Act, 2005	
Indonesia: Law of Republic of Indonesia No 23/2004 regarding Elimination of Violence in Household	Countries without DV bills
Laos: Law on Development and Protection of Women, 2004	
Malaysia: Domestic Violence Act, 1994 Act 521	Kiribati
Mongolia: Domestic Violence Act (2004)	Myanmar
Nepal: Domestic Violence (Crime and Punishment) Act, 2008 ⁶	Papua New Guinea
Pakistan: Domestic Violence (Prevention and Protection) Act, 2009	Samoa
Philippines: The Anti Domestic Violence Republic Act, 2002	Solomon Islands
Sri Lanka: Prevention of Domestic Violence Act No 34, 2005	Tonga
Vanuatu: Family Protection Act No. 28 of 2008	
Vietnam: Law on Domestic Violence Prevention and Control, 2008	

6.1.1 The Pacific

In the Pacific, despite efforts by women's NGOs, there has been minimal legislative change in the area of DV. Some of the main issues are:

- DV not being recognised as a crime and with the consequence that general assault laws are used;
- police and court officials are often unsympathetic to survivors of partner violence and do not encourage legal solutions;
- non-molestation orders and protective injunctions can only be made for married women, not de facto wives or girlfriends, they are made sparingly and inconsistently, and they are difficult to enforce, partially because there is no legislation setting out

6 The Nepal Civil Code for Gender Balance was amended in 2006 to criminalise marital rape.

- clear guidelines; and
- courts usually refuse to imprison a ‘breadwinner’ even when a further crime is committed [83].

PNG and Fiji have each developed a NAP for ending GBV which can be effective in promoting a multi-sectoral response and sustaining violence prevention efforts. The plans outline clear roles and responsibilities for government, social service providers, the health care system, the justice system, the education system, clergy, media and employers.

6.1.2 Southeast Asia

In Southeast Asia a number of countries including Malaysia, Mongolia, Viet Nam, Philippines, Indonesia and Thailand have DV or family violence legislation. Legislation is often accompanied by steering committees to guide implementation, circulars guiding the implementation and/or NAPs. For example, in Viet Nam a circular guiding the implementation of the Law on DV Prevention and Control was issued by the Ministry of Health (MoH) in 2009 and other circulars are being developed by relevant ministries, including the Ministry of Justice (MoJ). A NAP to implement the law has also been developed and was approved in 2009.

Bills have been drafted in other countries and are pending parliamentary approval. In Timor-Leste, DV legislation has been drafted and is pending parliament’s approval of the new penal code. The legislation is wide-ranging in its provisions and progressive in its reference to principles of gender equality, sexual autonomy and human rights [84]. An example of how DV legislation was developed in Indonesia is presented in Box 5.

6.1.3 South Asia

The CEDAW recommendation that legal changes are necessary to recognise DV has been adopted by most

countries in South Asia as shown in Figure 3. Maldives and Bhutan are currently in the process of drafting DV bills. In addition, countries such as Bangladesh and India have enacted laws to deal with some forms of violence particularly common in their countries.

- The Bangladesh Dowry Prohibition Act 1980;
- The Bangladesh Cruelty to Women (Deterrent Punishment) Ordinance, 1983 and 2003;
- The Bangladesh Women and Child Repression (Special Provision) Act of 1995 of Bangladesh;
- India Dowry Prohibition Act 1986; and
- India Antenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act PNNDT 1994 amended in 2003 health policies.

6.2 Health policies, decrees and circulars

6.2.1 The Pacific

Most PICs do not yet recognise GBV in their health plans and policies. However, the PNG 2010 National Department of Health Draft Strategic Plan has, for the first time, included family and sexual violence as a Strategic Area within Family Health Services.

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. In consultation with partners involved in the national response, the PNG Government has developed a new National HIV Prevention Strategy 2010-2015 (NHPS). The strategy acknowledges that: ‘gender is a key aspect of the HIV prevention framework, with relevant strategies from the National Gender Policy (NGP) integrated into NHPS priority areas. Comprehensive implementation of the

NGP will be critical for underpinning the successful implementation of HIV prevention strategies.’ (see PNG case study for further discussion)

6.2.2 Southeast Asia

In recent years, commitment to the integration of GBV into national health systems has been welcomed by a number of governments in the Southeast Asian region at the highest levels.

In particular there have been a number of government policies and circulars on the implementation of a medical response to GBV, which are potentially strategic tools for stimulating greater sensitivity among health providers. Some of the most recent initiatives include:

- In Viet Nam, gender equality and GBV are explicitly mentioned in various policy and legislative documents including the National Strategy on RH Care, Population Strategy and Family Building Strategy (2005-2010).
- Timor-Leste’s new RH policy includes a cross-cutting consideration of GBV and its impact on women’s health [84] (see case study for more information).
- In Indonesia, in October 2002, an agreement on the establishment of an integrated service system for victims of violence against women and children (VAWC) was signed between the MoH, the police, the Ministry of Social Affairs and the Ministry of Women’s Empowerment. Based on the agreement, the MoH established hospital-based Integrated Service Centers (Pusat Pelayanan Terpadu [PPT]) at public hospitals (district level) and public health centers (subdistrict level). To enforce the October 2002 agreement, the MoH issued a circular mandating sub-national public hospitals

and public health centers to establish and locally finance the services at the PPT including the Hospital Information Management System.

- In 2009, Indonesia developed Minimum Standard Health Services for VAWC under the decentralised system which requires that victims of VAWC receive health services by trained health personnel at an Integrated Service Centre. The two target indicators in five years (2010-2014) are:
 - Of public hospitals, 60 per cent in each district to establish a PPT for VAWC and each hospital should be staffed with a minimum of three trained personnel; and
 - each district to establish Qualified for VAWC Service at Primary Health Centres with a minimum of two trained personnel.⁷
- The Philippines Republic Act 9710 providing for the Magna Carta of Women was passed on 14 August 2009. Section 17: Women’s Right to Health states that: ‘in cases of VAWC, 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 (DoH) Administrative Order issued in 1997 to institutionalise the establishment of a Women and Children Protection Unit (WCPU) in the DoH hospitals for victims/survivors of DV, rape, incest, torture, sex trafficking, and other abusive and exploitative acts.
- In Mongolia, on 22 September 2009, a Joint Order from the MoH and Minister for Social Welfare was issued to establish a one-stop service centre for GBV victims at the Forensic Hospital, District Health Centre.

7 From UNFPA Indonesia CO presentation, Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

Box 5: The process of enacting DV legislation in Indonesia

In 1997, in Indonesia, an NGO movement consisting of 15 organisations began to create a draft law on DV. They believed that before any practical improvements were likely to occur, a clear statement by the parliament outlawing VAW, including in the home, was needed.

The movement promoted the draft bill throughout Indonesia to bring attention to its importance for all stakeholders. After thorough lobbying for four years, the draft was finally submitted to the House of Representatives in July 2001. On 13 May 2003, the plenary of the House of Representatives agreed to use the draft as the House of Representatives' proposal to be discussed and processed as a law [2]. The draft bill was then at the second stage of the law-making process, however Indonesia was holding elections for new representatives in 2004 and it took some time before the bill was passed into law.

In September 2004, after years of effort, the parliament passed the law on VAW in the home (Law No. 23/2004). The new law outlaws four forms of violence – physical, psychological, sexual (including marital rape) and economic neglect. Significantly, the law makes 'criminal' violence against all members of the household, including husbands, wives, children and extended family members.

According to this law, the government is committed to the following:

- Preventing occurrences of DV, punishing the perpetrators and protecting the victims;
- establishing policy on eliminating DV through communication, information and education on the topic;

- making public announcements and promoting discussions and advocacy on eliminating DV;
- conducting gender-sensitive training on issues of DV; and
- establishing standards and accreditation for gender sensitive services.

In order to become a law, the bill had to pass through the following steps:

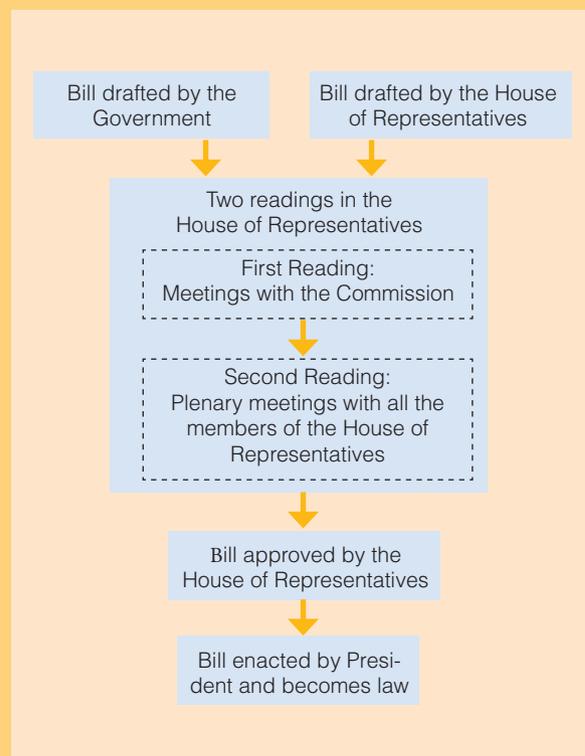


Diagram taken from [2]

- In China, there is ongoing health sector reform, but no inclusion of gender or VAW into the mandate for Maternal and Child Health (MCH) institutions or Community Education Departments (CEDs).

6.2.3 South Asia

In South Asia, a number of health policy documents have highlighted the importance of addressing GBV. Some specific examples include:

- In Maldives, GBV and child abuse have been included among the strategic actions of the Health Master Plan (2006-2015), and within the thematic areas of the National RH Strategy (2005-2007) (see Maldives case study for more information).
- In Sri Lanka, achieving gender equality was an important goal identified as early as 1998 in the Population and RH Policy. VAW and IPV is also identified in the Health Master Plan of Sri Lanka 2007-2016 as important issues that need to be addressed (see Sri Lanka case study for more information on other relevant policies).
- In Afghanistan, the Essential Package of Hospital Services (2005) mentions sexual assault, however, related medications such as post-exposure prophylaxis (PEP) kits and diagnostic facilities are not addressed in the document. Furthermore, while gender inequality is mentioned in the Health and Nutrition Sector Strategy (2007-2008) and the National RH Strategy (2006-2009), GBV and its relationship to health and RH has not been reflected. Also in Afghanistan, as in a number of other countries including Cambodia, there have been guidelines and training manuals developed on mainstreaming gender into the health sector.

However, they often fail to specifically address GBV as one of the most significant gender issues relevant to the health sector.

- In India, a strategy paper on gender in reproductive and child health has been developed by the MoH.⁸

6.3 Reflections

While DV legislation is not necessarily directly related to the health sector, it reflects the commitment of the government to the issue as a whole and it is therefore positive to see so many countries in the region with DV legislation. Legislation also often includes some reference to the responsibility of the health sector in provision of care for survivors of violence.

This assessment shows that GBV should be included as a cross-cutting issue in all relevant health policies such as HIV/AIDS policy, youth policy, RH policy and mental health policy. High-level policy commitment to GBV as a public health issue is necessary to ensure an institutional and sustainable response. Some countries, particularly the middle income countries in Southeast Asia such as Thailand, have had strong support for GBV as a health issue from policy makers at the highest level which has contributed to their success in developing integrated responses to GBV.

On the other hand, a number of countries, including Afghanistan, Myanmar and Iran, are struggling to get GBV recognised as a public health issue and incorporated into national health plans. Without political will and

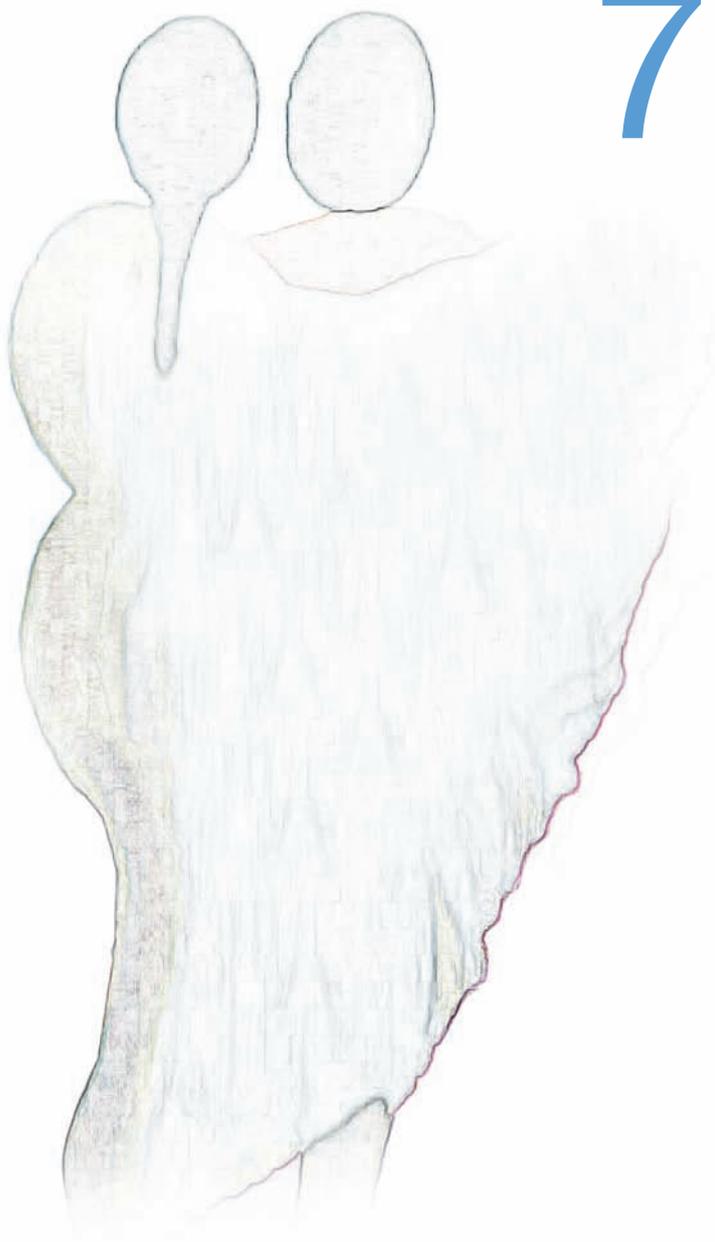
⁸ From presentation by UNFPA India Country Office at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

leadership, programme implementation is a challenge. For example, the Maldives Family Protection Unit (FPU) struggled with high-level commitment within hospitals in part because, at the time of establishment, there was no inclusion of GBV in health policies even though there was strong support from the Ministry of Gender and Family (MGF).

In other countries, such as Bangladesh, references to GBV are made in health policies. While this is encouraging, it needs to be noted that the issue is frequently linked to a number of unrelated difficulties such as road-rail-water accidents. This shifts the focus away from GBV and dilutes the response. Furthermore, even in countries that have achieved relative success in policy reform related to GBV as a health issue, implementation remains a challenge (see Timor-Leste and PNG case studies for more discussion on this).

It is evident from the experience of many countries that incorporating GBV into health policies is not easy and does not happen overnight. The mainstream health sector is sometimes reluctant to recognise GBV as a cross-cutting issue. For example, in PNG it took years of targeted advocacy by multiple partners, including the United Nations, NGOs, international non-governmental organisations (INGOs) and medical professionals, to finally get family and sexual violence included as a strategic area in the 2010 Department of Health Draft Strategic Plan. These advocates finally became successful through focusing their attention on defining GBV as a public health 'crisis'. The lesson is that when governments start developing relevant health policies, such as a National Health Policy or RH policies, United Nations agencies including UNFPA and WHO, as well as medical professionals, should lobby for the inclusion of GBV.





7 Approaches and models of service

Various countries in the region are implementing different approaches to addressing GBV through the health sector. However, the assessment found that a few models of integration are being replicated in many settings. These often focus on service provision at a secondary or tertiary level through A&E or women's health services; or at a primary level through reproductive or family planning health services.

Table 4 outlines the various approaches evident in the Asia Pacific region. The different responses to GBV at the national health sector level have been distinguished for the purposes of this assessment and report by the level of integration:

- 1 Selective provider and/or facility level integration (same site): Implemented at both primary and secondary level of health care, this type of model is characterised by the integration of one or two service components for abused women (e.g. counselling or psychological therapy) in vertical programmes.
- 2 Comprehensive provider level or facility level integration (same site): Another model that includes a comprehensive range of IPV and sexual assault services delivered in one setting. This is found most commonly in industrialised settings (particularly in the United States of America) and primarily at secondary or tertiary levels of care [85]. The hospital-based OSCC is one such model that has become popular in the region.

Table 4: Different country approaches to addressing GBV through the health sector

Country	Approach/ model	Start year	Services offered	Location/scale	Entry point	Responsible agency/ies	Staff
Service provider and/or facility level integration (same site)							
India	FCC	2004	Counselling, referral to hospital departments for immediate medical care & outside services, hospital provides beds for short-term stays	Separate room in 8 district hospitals in Rajasthan; extending to 8 more districts	Varies from district to district (i.e. OBGYN or HIV/AIDS ward)	Led by local NGOs in districts, supported by hospital admin.	NGO coordinator & 2 counsellors
Sri Lanka	Help desks	2000	Counselling and legal advice	Eight selected hospitals	A&E & (OPD)	Women in Need (NGO)	Counsellors
Bhutan	Forensic Medical Unit	2005	On-site counselling, documentation of findings, referral to police etc	JDWNR Hospital in Thimphu	Forensics	Royal Government of Bhutan	
Comprehensive provider level or facility level integration (same site)							
Malaysia	OSCC	1994	Varies between sites but generally counselling, medical care, forensic evidence, legal aid, temporary shelter & referral	More than 95% of all state hospitals. In 2003 there were 96 centres with OSCCs	A&E of all public hospitals	Led by MoH with support from women's NGO, police & social welfare department	Hospital medical social worker & volunteers
Thailand	OSCC	1999	Varies between sites but generally medical care, counselling, social welfare, hotline, referral, community outreach & advocacy	All general & regional hospitals (95) and most provincial level hospitals (approx. 500)	Varies but usually in the Social Welfare Department	Led by Ministry of Public Health	3 full-time staff (incl. social worker & psychologist)
India	Dilaasa (OSCC)	2004	Medical care, psychological support, legal assistance & shelter services	Mumbai Hospital	Close to Casualty Department	Public Health Department with CEHAT (NGO)	1 full-time social worker, part-time doctor & clinical psychologist

Country	Approach/ model	Start year	Services offered	Location/scale	Entry point	Responsible agency/ies	Staff
Sri Lanka	Mithuru Piyasa (OSCC)	2007 - on-going	Medical care, counselling & referral to legal advice, & longer-term counselling	District Hospital, Matara; replication of OSCC planned for 5 more districts	OPD	MoH with support from UNFPA	1 medical officer, 1 nursing officer available 8-5
Maldives	FPU	2006	Medical care, counselling & referral	Indira Gandhi Memorial Hospital (IGMH)	Separate room in OPD	MoH with support from UNFPA	2 full-time counsellors
PNG	FSC	2005	Medical care, forensic examination, counselling, social support, legal advice, short-term shelter & referral	5 centres with plans to expand to all state hospitals	Separate centre usually located on hospital grounds	National DoH, MSF, local NGOs, hospital administration	Full-time doctors, nurses & counsellors
Bangladesh	OSCCs	2000	Medical treatment, incl. forensic facilities, counselling & legal services and referral	7 tertiary level medical college hospitals in 6 districts		Ministry of Women and Children's Affairs with hospital admin.	Trained team led by a senior doctor
Philippines	WCPU	1995	Screening, medical care, forensic evidence, temporary shelter, legal advice & referral	Piloted at East Avenue Medical Centre; since 1998 up-scaled to all DoH hospitals	Separate room in the women only ward	National Council on the Role of Filipino Women, WCC & DoH	Social worker and counsellor
Indonesia	PPTs	1998	Varies but usually provides medical treatment, counselling, legal advice & referral	90 hospitals & 100 PHC; 5-year target to have 60% of public hospitals with PPTs	Separate room usually in Emergency Department	MoH, Ministry of Women's Empowerment; Ministry of Social Affairs & police	Minimum of 3 trained personnel



Government-led response



NGO-led response



Combined government and NGO response

Country	Approach/ model	Start year	Services offered	Location/scale	Entry point	Responsible agency/ies	Staff
Nepal	OSCC	2001	Screening, medical care, forensic evidence, psychosocial support, counselling & follow-up	Kirtipur Centre	Separate room	Phect-Nepal	Doctor and nurse
Timor-Leste	Fatin Hakmatek-OSCC model	2002	Medical care, documentation, counselling, legal advice, temporary shelter & referral	Purpose built facility at Dili Hospital with outreach to districts	Separate centre on hospital grounds	PRADET (NGO) with support from donors	Dedicated health professionals

System level integration (multi-site linkages)

Bangladesh	Women's Friendly Hospital Initiative	1998	Medical care, documentation, counselling, external referral	Identified rooms in 12 hospitals	RH services	Director General of Health Services with NGO support	Team headed by senior doctor
China	Pilot – Effective health sector response to VAW	2008	Routine screening in MCH hospitals (MoH), medical care, documentation, psychosocial support, prevention & multi-sectoral referral for victims, IEC activities	Pilot in 2 counties in 2 provinces expanding to additional 3 counties in 2010	MCH hospitals	MoH, ACFE, UNFPA	
Vietnam	Screening and referral pilot ⁹	2008	Screening, medical treatment & referral	Piloted in 5 district hospitals and 12 CHCs in 2 provinces	Examination department	Provincial DoH with funding from UNFPA & SDC	All hospital staff trained for screening

 Government-led response
  NGO-led response
  Combined government and NGO response

9 Refer to Screening section for more detailed discussion.

- 3 System level integration (multi-site linkages): Systems level integrated approaches still offer a comprehensive range of services for victims of violence but differ from the other two models in that the services are not offered at the same site. For example, at secondary and tertiary levels a range of medical IPV services have been integrated, mainly into maternity hospitals, with external referrals for other specialised services [85].

in Rajasthan, India, the centre at Zanana Hospital is located in the HIV/AIDS ward; at Karauli, it is located in the obstetrics and gynaecology (OBGYN) department, which is easily accessible, and in Alwar it is within the outpatient department (OPD). It has been suggested that the success of the centres can to some extent be attributed to their location. Finding the right location is a balancing act: on the one hand it should be easily accessible and without stigma, but on the other hand it should offer privacy.

7.1 Entry points

GBV service points can be located in different sections of the health institution. For example, among the centres

Table 5 outlines the pros and cons of different entry points for responding to GBV in the health sector and could be a useful tool for countries carrying out a situational analysis of what entry point would best suit their needs and country context.

Table 5: Pros and cons of different entry points for responding to GBV in the health sector¹⁰

Accident and Emergency	
PROS	CONS
<ul style="list-style-type: none"> • easy access 24/7 • first place of contact in the hospital • OPD has linkages <ul style="list-style-type: none"> - internal - external • allows access to young people as well • staff familiar with legal cases and procedures • geographical proximity to all medical services 	<ul style="list-style-type: none"> • staff oriented to bio-medical, know little about <ul style="list-style-type: none"> - privacy - confidentiality • accidents/injuries receive priority over others – focus on medical injuries, which may cause delays for women to be treated (as moderate injury may not be seen as important) • no continuity of care • busy environment (impact on privacy)

¹⁰ Table created from Workshop on Strengthening the Health Sector Response to GBV, Day 2 Group work, Bangkok, 2 December 2009, and Colombini, M., S. Mayhew, C. Garcia-Moreno, J. Cottingham and C. Watts, *Health sector responses to intimate partner violence and sexual violence*. Background paper to a WHO expert meeting (organised in March 2009).

Adolescent Sexual and Reproductive Health (ASRH)

PROS

- youth focused services
- young people often victims of street violence/rape, coerced sex
- can reach youth at the age when relationships start or when they have first sexual experience
- can reach girls and talk about sexual violence
- large youth population in the region
- providers may have some counselling skills
- often services offer medical and non-medical support (counselling)

CONS

- difficult to tap them
- unwanted pregnancy/diseases
- judgmental attitudes of providers
- requires sensitisation of staff
- requires external referral to support services

Family Planning

PROS

- high opportunity for health worker to screen
- no 'GBV' stigma
- accessible/women focused
- providers may have some counselling skills
- often services offer medical and non-medical support (counselling)
- ongoing relationship with women (continuity of care)

CONS

- high caseload
 - time constraints
 - limited staff
- may be difficult to ensure confidentiality
- different 'field'
 - family planning
 - GBV
- may only reach married women who use family planning
- requires active screening
- still requires change in providers' attitudes
- requires external referral to support services

Maternal and Child Health

PROS

- flagship programme on health reform (e.g. systems approach = integrated service delivery, with financing/regulation)
- easy access to other services
- good linkage with primary health care
- can have high coverage
- can enhance detection of cases

CONS

- lack of awareness/appreciation of importance of addressing GBV as a public health concern
- difficult to integrate into external agencies or institutions
- increased workload/burden for health personnel
- still requires active screening and sensitised staff
- requires strong referral systems for non-health support services

Mental Health/Psychosocial Care

PROS

- response to most excluded
- addresses visible forms of GBV
- addresses core causes of GBV
- offers immediate to long-term emotional support (follow-up)

CONS

- stigma towards psychological care may limit access
- Isolation
- disempowered
- morbidity dependency
- challenges and rehab (re-integrated)
- limited coverage as found primarily at regional specialised centres
- very specialised service (limited in scope)
- high costs for patients

Primary Health Care

PROS

- cover all female patients, victims (large coverage)
- entire country – rural/urban coverage
- close to community thus easy to access
- public/community awareness
- local linkage/networks
- continuity of care, thus can enhance detection

CONS

- capacity building/more training to sensitise staff
- requires resources for referral to medical and non-medical support (linkages to upper levels of care are needed)
- close to community/confidentiality is difficult to maintain
- referral might not be there/have to travel far
- limited number of staff/overworked/time constraints
- requires active screening

STIs/HIV

PROS

- get tested for STIs/HIV and counselling
- opportunity to involve partners (usually male) for further intervention (e.g. testing, counselling, anger management, pre-marital/marriage counselling)
- opportunity for men, youth (schools) to get information on SRH/STIs/HIV
- providers trained and familiar with discussing sensitive issues
- may enhance discussion and strategies around disclosure
- providers may have some counselling skills

CONS

- lack of awareness/trained staff to carry out STIs/HIV testing
- fear of disclosure of information from client/GBV survivors
- stigma/fear preventing people from accessing services/information
- strategy for settings where epidemics are generalised
- quite specialised and often stigmatised (limiting access to it)
- focus on specific target group (limited coverage)
- difficulties in adherence to PEP
- requires referral to non-health support services

7.2 Reflections

There are a number of different approaches that have been applied in the region to address GBV through the health sector. The commonality between them is that they recognise GBV as a health issue, the health sector is often the first place where women seek help (after family and friends), and it is the health sector's responsibility to move beyond mere provision of medical treatment of injuries for women who have been abused.

7.2.1 OSCC model

The majority of regional approaches fall under the definition of system level integration, in particular the OSCC model. The OSCC model aims at providing integrated services to abused women at the same location. These operational centres offer a wide range of integrated services to address IPV, including health, legal, welfare and counselling services in one location – usually the A&E departments of urban public hospitals. Some of these centres have dedicated staff working at the centres at all times, others have core staff members and a list of contacts, such as for psychologists and medical social workers, who can be called upon to provide specialised services on-site when needed. The main principles upon which OSCCs are based are the respect for women's needs and their privacy and confidentiality, focusing on a holistic approach [86].

While the OSCC model can be effective, one common issue in the region is that despite the availability of the service, demand remains relatively low. This is in part because not all hospital staff are sensitised to detect and refer cases, but also in countries including Indonesia, Thailand, Malaysia and PNG, community awareness-raising is needed to increase the demand for the service. In some countries, services for victims are not always free and this needs to be addressed as a priority to ensure that

abused women and children have access to medical care and are not further victimised by having to pay (see PNG case study for more details).

7.2.2 Lead agency

It is noteworthy that the majority of the health sector responses to GBV in the region are being led by each country's health ministry, which contributes to the institutionalisation of interventions at a national level. However, there are also a number of examples of INGOs and NGOs that are carrying out responses either on their own or in collaboration with government agencies, as illustrated in Figure 2.

NGO-led models are more common in countries where the state health system is weak or under-resourced, or where NGOs have a strong presence such as in conflict and post-conflict settings. For example, in Myanmar, Médecins Sans Frontières (MSF) and Marie Stopes International (MSI) are providing medical care and treatment for victims of GBV including the provision of STI, HIV, Hepatitis B Virus treatment and emergency contraceptive pill. In Pakistan, the World Population Foundation is working on capacity building of local NGOs in relation to GBV and RH in the districts of Jacobabad and Kashmore. The American Refugee Committee (ARC) International is also implementing a GBV Local Partnership Project for Afghan refugees focused on providing health care to GBV survivors. While the ultimate aim is for the Government to take responsibility, in such countries, health sector interventions may not be possible without the support of NGOs (see case studies).

On the other hand, where the state health sector is well established and strong the response tends to be led by the MoH and has been scaled-up (e.g. Thailand and Malaysia). However, even when a service is run by the state health sector, if there is not a long-term and high-level commitment, sustainability is not guaranteed.

Models that adopt a combined approach of government-led with NGO support can often be successful because they draw on the strengths of each institution (e.g. India). However, there needs to be diplomatic and effective communication and collaboration between the partners, including a clear distinction of roles and responsibilities. The success of the service is often dependent on the relationship between the partners. For example, MSF working with hospital management in PNG has struggled because they are seen as outsiders infringing on the authority of the administration.

Other countries such as Mongolia and Bhutan are just starting an approach and could benefit from learning from other country experiences through South-South collaboration.

7.2.3 'Up-scaling'

Up-scaling from one pilot or service centre to many around the country is the ultimate aim of a national level, integrated health sector response to GBV. This has proven successful where government has taken a strong lead and policy directives are given by the MoH, for example in Malaysia and Thailand. The mainstream health systems in these middle income countries are relatively strong with human resources and capacity, which is an important factor in the 'up-scaling' process.

In countries where the mainstream health system is weak or where the capacity of services ranges between provinces or districts, 'up-scaling' has been challenging (see PNG and Sri Lanka case studies). This is because in most countries, the first system/model/pilot is carried out in the tertiary hospital. 'Up-scaling' is thus based on the assumption that the infrastructure and support

services are similar in other regions/settings. In reality, when translated to different hospital facilities, the implementation of the service inevitably encounters problems. Even with political will and a guidance framework, 'up-scaling' is constrained by local resources and the capacity of the existing health service structure. For example, with regard to 'up-scaling' to an atoll level in Maldives, a review of the FPU found that replication should happen in stages and consider the limited facilities and resources available. It was recommended that a number of activities, including the development of national level policies and protocols and ensuring the availability of basic services in the new site, were necessary before any expansion could be considered (see Maldives case study for more detail).

The different capacities of the hospitals must be considered – for example in Indonesia the police hospitals have been more successful in establishing integrated services centres than public district hospitals. This is because they have a clear line of command, do not depend on local government support, and they have more trained staff as well as forensic units already located there.¹¹

7.2.4 Monitoring and evaluation

Despite the multitude of responses to GBV taking place in the health sector in the region there is a serious dearth of formal evaluations, meaning little evidence of what is in fact happening is being recorded. There is also very little ongoing monitoring of how services are performing, how they could be improved, and whether or not they are actually addressing the needs of survivors of violence. There is a serious need for greater accountability, greater emphasis on quality of care, case reviews and debriefing for support staff.

11 From presentation by Dr Anwarul of Indonesia at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.



8

Capacity building

Definition: For the purposes of this assessment and report, capacity building refers to building the capacity of health care providers and other actors in the health sector to respond to GBV in an effective, compassionate and sensitive manner. It includes (but is not limited to):

- Sensitisation of MoH staff, policy makers, administrators and community leaders on gender, GBV and appropriate response;
- sensitisation of all health care providers and administrators at an institutional level on GBV as a health issue;
- training of care providers dealing directly with survivors to identify, provide appropriate care (e.g. injury treatment, counselling and documentation), and offer referral to additional internal and external services (e.g. social work and legal);
- regular in-service training of care providers to accommodate the rapid turnover of staff;
- in-depth training on GBV management for leading care providers through study tours, sharing experiences and overseas training;
- specific training and continuous professional development (CPD) on relevant GBV policies and protocols to ensure their implementation; and
- incorporation of GBV training into undergraduate, postgraduate and technical training curricula of care providers.

Capacity building is a vital component of any response to GBV in the health sector and needs to be carried out at multiple levels. Also, the type of capacity building may vary in length, focus and design depending on the target group and their role in responding to GBV (see Table 5). Health care worker basic competencies include:

1. Identify, assess and document abuse;
2. intervene to secure safety and reduce vulnerability;

3. recognise that cultural and value factors influence VAW;
4. recognise legal and ethical issues in intervening and reporting VAW; and
5. engage in activities to prevent VAW.

As mentioned in Section 3.2, it must be recognised that health care workers are members of a society and community just like other citizens and have similar beliefs and attitudes towards women and GBV as reflected in society as a whole. A good example of this is the recent workshop with HSPs carried out in the Solomon Islands. Table 6 shows the results of a participant pre-test using questions on attitudes to IPV and compares them to a recent national survey. The HSPs' attitudes to IPV were similar to (and sometimes worse) than in the general population. These attitudes will without doubt impact on the HSPs' ability to respond to victims of GBV effectively and sensitively in their work. As such, any capacity building must first address the underlying issue of gender inequality and providers' attitudes and the inevitability that some health care workers are victims or perpetrators of violence.

Figure 4: Levels of health worker competency for addressing family violence (Source: Brandt 1997)¹²



8.1 The Pacific

The majority of PICs are yet to carry out capacity building on GBV with health care providers. However, training has been a recent first step in some countries, namely PNG, the Solomon Islands and Kiribati, in order for health care workers to develop a better understanding of GBV as a public health issue and their role in responding to and preventing violence.

12 Quoted in presentation by Jane Koizal-McLain at Workshop on Strengthening Health Sector Response to GBV, Bangkok, 1 December 2009.

Table 6: Attitudes to VAW, HSPs versus general female population, Solomon Islands

Does a man have a good reason to hit his wife under the following circumstances?	% of HSPs in workshop pre-test who agreed (n=58)	% of women aged 15-49 in Family Health and Safety Study who agreed (n=2882)
If she doesn't complete housework to his satisfaction	34%	22%
If she disobeys him	41%	41%
If she refuses to have sex with him	12%	20%
If he suspects that she is unfaithful	39%	27%
If she is unfaithful	58%	63%

In PNG, over the last 8-10 years, a number of training and sensitisation workshops have been conducted with health care workers on GBV, including the use of the clinical guidelines on DV. However, the approach has been ad hoc and there has been little success in fully incorporating GBV training into relevant health professional curricula (see PNG case study).

In the Solomon Islands and Kiribati, capacity building of health care workers (HCWs) has just started with support from UNFPA. As aforementioned, UNFPA had supported research on GBV in these two countries using the WHO Multi-Country Study Methodology. The results indicated that GBV was highly prevalent and that it had far reaching health consequences for women and their children.

Table 7: Capacity building workshops in Kiribati and Solomon Islands

	Kiribati Pop – 93,000 19-21 October	Solomon Islands Pop – 484,000 9-11 November
Participants	21	58
Role	21 nurses & midwives, 0 doctors	38 nurses & midwives, 13 doctors
Sex	19 females, 2 males	33 females, 25 males

Building the capacity of health care providers to respond to GBV in an effective, compassionate and sensitive manner was the first step in what will be an ongoing response. Three-day workshops were held with health care workers in each country, conducted by an international consultant. Given that Solomon Islands and Kiribati are at the beginning stage of a response, the workshop aim was to begin networking and sensitisation for the development of a strategy for a health system response to VAWC in collaboration with UNFPA, the MoH and the Secretariat of Pacific Communities (an INGO). Among the outcomes of the workshops were draft strategic action plans which included recommendations. The process demonstrated that it is first important to identify what is currently being done and by whom, to identify health and gender champions among service providers and community leaders, and arrange for monitoring and follow-up to mitigate risk of losing momentum when interventions are just beginning.¹³

8.2 Southeast Asia

In the Southeast Asian region, capacity building of health care workers to respond to GBV cases has taken place in many countries often in connection with the establishment of OSCCs, however the focus of the training varies from country to country.

In Malaysia, the MoH trains staff of agencies on OSCC management guidelines and critical pathways. Women NGOs train medical providers and social workers on gender-sensitisation. Volunteer counsellors are also

recruited and trained to assist OSCCs. Only doctors and staff nurses from the A&E and gynaecology receive in-depth training as they are the most involved in GBV service provisions [85]. In Thailand, sensitisation is provided to all staff at institutions where OSCCs were being established with more in-depth training for staff of the OSCCs.

In the Philippines, there are a number of entry points for abused women including the OBGYN department, the emergency section, different OPDs and the counselling department. As such, health care providers including midwives, nurses and doctors have been trained to identify and assess DV. Training is now integrated into the medical and nursing school curricula [87].

In Indonesia, there are four guidelines that form the basis for conducting GBV capacity building for health personnel:

- 1 2002 guideline for VAW prevention and management at primary health centre (subdistrict level);
- 2 2002 guideline for establishing and functioning of an integrated service (PPT) for victims of VAWC at the hospital (district level);
- 3 2004 training manual on VAW management in conflict and emergency situations; and
- 4 2006 training manual for health professionals on VAW prevention and care (MoH and PULIH, an Indonesian NGO addressing psychological protection in disaster and conflict-affected communities).

Training of HSPs in relation to the establishment of an integrated service centre includes:

13 Information taken from presentation by Dr Jane Koizal-McLain, resource person for Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

- Awareness raising on basic concept of gender; definition of VAW, understanding concept of GBV and types of violence, including trafficking; effects of VAW (health, psychological and social effects);
- training on GBV management including how to provide medical services and basic counselling to the survivors of violence in every stage of medical services (prevention, assessment, diagnosis and treatment); and
- training on how to build a multi-sectoral network including the importance of integrated services (health, psychosocial and legal aspects), how to build a referral system with other providers, and how to build a reporting and recording system of VAWC cases.

Among countries that do not yet have well-established approaches such as OSCCs, some capacity building is still taking place:

- China has carried out initial sensitisation with HSPs and following the development of the VAW Medical Intervention Protocol, in-depth training will be conducted.
- Mongolia has recently conducted training with HSPs. Mongolia also organised a study tour to the Philippines (December 2008) to learn best practices in setting up OSSC, improved knowledge and practice in OSSC services, and the ways of working in a multidisciplinary team in providing legal, medical and mental health services.
- WHO Myanmar is working on capacity development of health staff at the MoH on GBV issues. As a response to the humanitarian crisis following Cyclone Nargis, Myanmar is training 230 HSPs in GBV issues and has developed a trainer pool list.

- UNFPA Viet Nam with the Swiss Agency for Development and Cooperation (SDC) has recently developed a training manual for health workers on prevention of VAW to be piloted in two provinces.

However, there is still a gap in integrating GBV into medical curricula in the Southeast Asian region, with Indonesia and the Philippines as exceptions. In Indonesia, GBV capacity building is not yet fully institutionalised into health personnel curricula, however one of the midwifery academies has integrated knowledge into sexual and RH, including management of VAW.

8.3 South Asia

In South Asia, most capacity building on GBV in the health sector has been training for HSPs, usually in connection with a pilot or project intervention. For example, in Sri Lanka, in 2002, the health sector started piloting option B of the UNFPA Programme Guide which included sensitisation and capacity building with nearly 400 health care personnel (see Sri Lanka case study for more information on capacity building). Similarly, in Maldives, when the FPU was piloted at Indhira Ghandi Memorial Hospital in 2005, nearly 200 health care providers were trained in GBV. Subsequently, many programmes have been conducted by the FPU in other island hospitals. Pakistan piloted a community-based intervention programme on GBV and HIV in 10 districts with support from UNFPA. This included development of a training module in Urdu and Sindhi and training of more than 300 facility trainers and 240 lady health supervisors. In Bhutan, the forensic medicine unit (FMU) of the hospital and the MoH conducted sensitisation of

health workers on management of GBV in health care settings in 2008 and 2009.

Capacity building efforts have been facilitated by the development of training manuals and guidelines in a number of countries in the region. In Bangladesh a training manual for doctors and nurses on VAW has been developed. Also, a manual on the introduction of forensic DNA profiling has been published by the Multi-sectoral Programme on VAW. Capacity building in India has been facilitated by the development of guidelines on GBV for an accompanying facilitator's guide for medical officers by

the National Commission of Women, Centre for Enquiry Into Health and Allied Themes (CEHAT) and UNFPA.

Other alternative forms of capacity building have taken place in Maldives by the FPU, including: FPU staff writing columns for the Maldivian Medical Association newsletter, *Prescription*, on issues related to GBV and child protection; FPU development of a health education forum for all pregnant women and spouses on GBV and child protection and the work of FPU; the FPU presented classes at the Faculty of Health Sciences to share their experience; and students studying counselling spend

Figure 5: Sri Lanka's public health staff who have had GBV training



a few hours doing a field visit to the FPU as part of their work experience.

Meanwhile, more long-term, institutionalised capacity building has been lacking. As in the Pacific and Southeast Asia, incorporating GBV into medical curricula remains a challenge, although Sri Lanka has been successful in integrating a GBV module into public health orientation training for public health staff who are taking up preventive health positions (Medical Officers of Health) and the in-service curriculum of public health midwives.

8.4 Reflections

As the definition of capacity building highlights, sensitisation and training is required at multiple levels within the health system. Many countries have done at least some capacity building on GBV with health care providers, often as a first step in their response (i.e. Solomon Islands and Kiribati), which is promising. However, most countries in the Asia Pacific region have tended to focus on only one or two elements of capacity building rather than implementing a holistic, integrated plan. For example, many countries have conducted short-term, one-off training with doctors and nurses, usually in connection with a pilot or project, often supported by United Nations' agencies or INGOs. On the other hand, sensitisation of policy makers and administrators, in-service training, CPD, and incorporation of GBV into medical curricula has been sorely lacking.

There is often a lack of follow-up or refresher training. The assessment indicates that one possible reason for this is that training is usually arranged as part of a project rather than being institutionalised into the system. There also tends to be a lack of coordination and information sharing between agencies regarding these activities.

There has been little success in incorporating GBV into medical undergraduate and postgraduate curricula despite concerted effort on the part of many countries. Some reasons for this are lack of prioritisation of GBV among academics, a lack of targeted advocacy and a lack of clarity as to which department should be responsible (i.e. forensic, community health, gynaecology, etc). The Women's Committee of the Sri Lanka Medical Association recently convened a meeting of representatives of the six medical colleges to discuss ways of incorporating GBV into the medical curricula. There was consensus that it should be done but it has not been implemented yet.

One of the important aspects of the Sri Lankan capacity building was the concurrent capacity building of the care providers including doctors in both institutional and community care. This facilitated referrals and confidence building among the care providers which flowed on to acceptance of the service in the community.

There is abundant evidence 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.

9

Protocols and guidelines



Definition: For the purposes of this assessment and report the simplest definition that can be applied to protocols from a health perspective would be: 'precise and detailed plans for the study of a medical or biomedical problem and/or plans for a regiment of therapy.' (1)

GBV protocols can exist at an institutional level and at a national level but generally include:

- Receiving, history taking, examination, investigation and treatment of GBV/DV survivors;
- maintaining patients' privacy and confidentiality, including document storage;
- identification and management of situations of high risk (for suicide, homicide or extreme emotional distress);
- management of rape and sexual abuse, including reporting forms and body maps;
- provision of STI/HIV prophylaxis and emergency contraception to rape survivors; and
- prevention and management of sexual and gender-based violence (SGBV) in humanitarian emergency settings.

(1) <http://www.find-health-articles.com/msh-clinical-protocols.htm>

A number of countries in the region have protocols on the management of OSCCs included with their clinical protocols such as in Bangladesh, Maldives, PNG and Thailand.

9.1 The Pacific

In 2003, PNG was the first country in the Pacific region to introduce a National Department of Health Protocol on DV and training for primary health care providers in urban and rural areas. The protocol 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, safety planning and recording of injuries.

PNG is in the process of finalising a more detailed Clinical Practice Guidelines for Medical Care and Support of Survivors of Sexual and Gender-Based Violence. These were developed by a working group and based on WHO guidelines. They are designed to work together with the guidelines for the Family Support Centres (FSCs). 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.

The Solomon Islands' MoH is also currently engaged in writing clinical guidelines for health care practitioners on GBV.

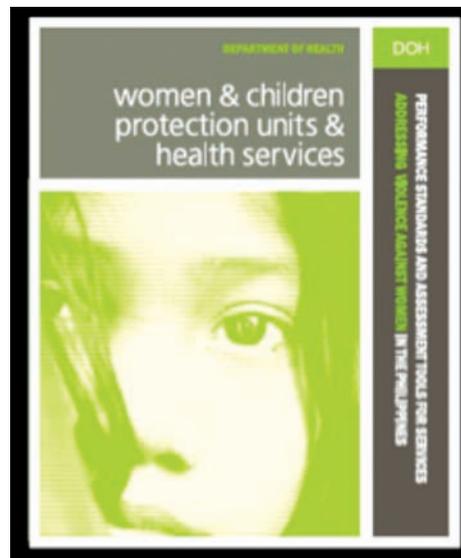


9.2 Southeast Asia

In Southeast Asia, most countries with OSCCs have policies and protocols to guide their implementation. In several cases where these approaches have been up-scaled to many hospitals, the protocols have been formalised by the national MoH and are institutionalised at the national level. For example, in Thailand, the Ministry of Public Health developed a manual for guiding the implementation of the OSCCs at the hospitals (see Malaysia and Philippines case studies for details of their protocols and guidelines).

China MoH with UNFPA support started developing a VAW Medical Intervention Protocol in 2007. It integrates sexual, physical and psychological DV and has undergone four rounds of revision with English and Chinese translations. National and international expert reviews have taken place and the English (draft) and Chinese final version became available for piloting in November 2009. The first specialised training on the protocol was conducted in the third quarter of 2009. A basic evaluation of the protocol and a second round of psychological training and counselling with local supervision and a case review by an international consultant is planned for the second quarter of 2010.

China has also developed a comprehensive intervention strategy as part of its pilot project which is very positive. Often the specifics of implementation are not considered so comprehensively at the beginning and therefore more challenges are faced. It has also been noted that in China, the local institutions where the pilot is taking place, develop their own localised implementation plans based on the strategy. This has reportedly increased ownership and accountability.¹⁴



In 2002, Indonesia's MoH issued guidelines for the establishment of PPT integrated service centres – one guideline for the establishment of PTTs at the hospital district level and another for establishment at the primary health centre at the sub-district level. These guidelines are currently being revised and cover the following:

- Gender and GBV;
- counselling techniques;
- general and forensic examination, including OBGYN examination for sexual violence related cases;
- laboratory requirements;
- emergency contraception;
- reporting and recording, including coding; and
- networking and referral.

Timor-Leste's Fatin Hakmatek is in the process of finalising an innovative protocol that can be used to document injuries arising from sexual assault, DV and child abuse all on one form. It is also appropriate for the Timor context

14 From UNFPA China Country Office presentation at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

as it does not involve complicated testing which is expensive and unavailable (i.e. DNA testing). However, in other countries in the region, in the absence of clear guidelines and protocols, clinical services related to GBV remain inconsistent and ad hoc.

In Viet Nam, the MoH is reviewing guidelines for health providers working on GBV/DV. The guidelines will be revised to become the national guidelines on working with GBV/DV victims and will be applied in the whole country in 2010.

In Mongolia, a working group was formed in October 2008, which is composed of representatives from various ministries, National Forensic Institute, Police Department, Trauma and Orthopaedics Centre of Ulaanbaatar, and Mongolia Family Psychological Centre under the leadership of the MoH to provide technical guidance in establishing and developing regulations and standards for the OSCC.

9.3 South Asia

In Sri Lanka there are no national protocols or guidelines developed so far, but 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, targeting medical officers, has been accepted by the National Committee on Violence.

When the FPU was established in Maldives, a hospital protocol for the functioning of the unit was established including responsibilities of care providers and pathways of care. A medico-legal form was also developed, however these have not yet been institutionalised at a national level.

Bangladesh has developed a comprehensive protocol for the Women Friendly Hospitals Initiative (WFHI), 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 the objectives of the initiative. Part two is a handbook on developing women friendly hospitals in order to ensure quality of care with regard to the four areas including GBV. Training, recognising, documenting and reporting of GBV is dealt with in this section along with much emphasis being placed on recognising challenges and solutions. Part three is designed to help the institution to prepare an action plan.

The Indian Medical Association in collaboration with United Nations Children's Fund (UNICEF) and the Ministry of Human Resource Development has developed an examination kit for victims of sexual abuse. It contains guidance and material required for examination. Dilassa, one of the counselling centres in India, has also developed comprehensive guidelines on responding to violence for health professionals, which include a documentation format.

In Bhutan the Forensic Medicine Unit of the MoH has developed a protocol on GBV, which is under discussion. Similarly, in Afghanistan, a standard GBV treatment protocol is in draft form, however there are concerns that it is more like a GBV training manual rather than a clinical treatment protocol.

9.4 Reflections

The development and implementation of specific protocols are necessary for institutionalising a GBV response into health institutions and for ensuring consistency of care. A number of countries do not have any protocols to guide

health care providers' responses to GBV. This means that there is a lack of consistency and uniformity of care. Without protocols, there is some concern that many health care workers will only treat physical injuries and even pass judgement about the victim's role in the abuse. For example, this has been reported as a problem in the Solomon Islands and Kiribati.

In other countries, guidelines and protocols for a single institutional response have been developed, such as the FPU in Maldives; or protocols have been developed as part of a pilot project, as in China and Mongolia. In other countries again, protocols have been institutionalised at a national level through the MoH and are supposed to guide responses across all government health institutions. In a number of settings the protocols combine guidance on project management (i.e. running of OSCCs) and clinical management of GBV. This can dilute the focus on issues such as confidentiality, sensitivity and gender awareness which are very important in effective provision of GBV care.

Although many countries recognise the importance of protocols and have developed them, their formalisation and implementation remains relatively weak. One major issue is that even where protocols exist they are not easily accessible or visible in the institution.

There is often a gap in ongoing training and orientation on protocols as discussed in a number of case studies. Another concern is that if protocols are simply developed by external consultants then they will not necessarily be relevant to the country context or accepted by local health institutions. The example of Timor-Leste shows how protocol development in line with the local context has been effective. There should be a balance between developing protocols based on international best practices such as WHO guidelines, and being appropriate and realistic for the country context with strong local ownership.

Protocols and guidelines should be:

- 1 Developed through extensive consultation and consensus building with stakeholders such as forensic pathologists, gynaecologists, police and social welfare so that there is widespread acceptance of the tool;
- 2 developed at national level and accompanied by some sort of directive from the health ministry to ensure implementation;
- 3 user friendly to ensure implementation;
- 4 accompanied by a guidance document and/or training for all relevant hospital departments (including paediatrics, OBGYN, laboratory, emergency etc); and
- 5 made easily accessible and available in the place of work.





10 Collaboration and referral

Definition: *Effective treatment of survivors of GBV requires internal and external collaboration and referral.*

Internal: *Women may access the health system at a range of potential entry points for service provision and may have a range of presenting health needs as discussed in Section 7.1. Some women experiencing IPV will present at primary care, while women experiencing serious injuries may present to hospital emergency services. Given that coerced sex and violence resulting in pregnancy is widespread, ante- and postnatal care, family planning or post-abortion care are also potentially important entry points. Internal referral means a coherent and effective method of two-way communication and referral between different departments within the health institution (i.e. gynaecology, surgery, forensic and counselling centre).*

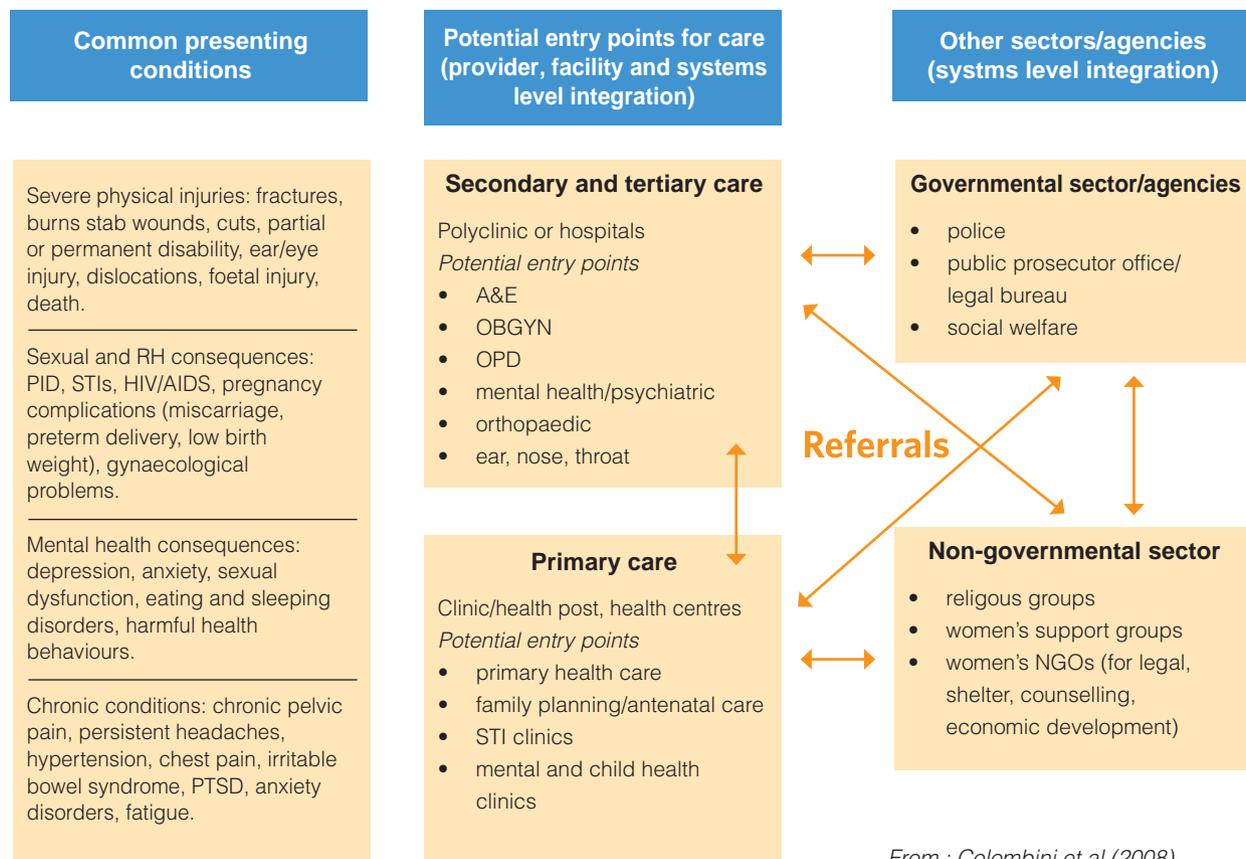
External: *As discussed throughout this report, the health sector is not the only sector involved in the care of survivors of violence. The health sector response must take place within a multi-sectoral framework. Therefore, it is important that the health sector ensures not only the efficient delivery of health related services to victims of violence, but also facilitates these women's access to non-health services. External referral means a coherent and effective method of two-way communication and referral between the health sector and other sectors that respond to GBV such as NGOs, courts, police and social services.*

inevitably, there will be multiple actors involved in a health sector response to GBV, therefore it is important for each player to have a clear understanding of their respective roles and responsibilities. It is also vital to have an effective coordination and collaboration mechanism between these groups. An example of a possible effective pathway of referral is outlined in the figure below (Source: [85]):

10.1 The Pacific

In the Pacific, victims are generally treated through the A&E departments and there are no formal referral services either internally or externally. However, there are some exceptions to this:

Figure 6: Potential entry points for delivery of health care to abused women



From : Colombini et al (2008).

- In Fiji, while there is no formally established health sector response to GBV, the Fiji WCC is one of the leading one-stop style NGO support centres in the region and they have a good working relationship with doctors and hospitals who make referrals.
- The Solomon Islands has recently developed a referral network called SAFENET. This has been formalised through a Memorandum of Understanding (MoU) between the MoH, police, women's shelters, relevant NGOs and Public Solicitor's Office. The MoU outlines procedures and clarifies the role of the parties in responding to GBV incidents.
- In PNG, DV clinical guidelines include a referral network template for each health centre/post to develop their own relevant, localised referral network. Training with HSPs 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.

Some OSCCs in the region also benefit from the presence of support and police teams present on-site (e.g. policemen and social welfare officers) so that a woman would not have to be moved unnecessarily. However, at district level hospitals such referrals are not always in place as limited support services are available outside the capital cities. Multi-sectoral collaboration and referrals are areas that need to be strengthened in most countries.

In Thailand, the OSCCs have a multi-disciplinary team including nurses, physicians, specialists (counsellors), laboratory technicians, medial registrars, chiefs of sections, counselling nurses, social workers and psychiatrists/psychologists. These multi-disciplinary teams then function within the multi-sectoral framework as illustrated in Figure 7. The hospital-based OSCCs have particularly good working relationships with the police and public prosecutors and conduct complex case conferences with internal

10.2 Southeast Asia

In Southeast Asia, a number of countries that have OSCCs have integrated medical services at one location through the presence of an intra-hospital medical team (consisting of OBGYN, psychologists, medical officers, etc). In such cases a formal referral system is usually in place between hospital departments (e.g. OBGYN and the medical social worker) and across agencies (e.g. police, social welfare, women's shelters and counselling services), however the implementation of such systems often remains weak.

Figure 7: Thailand's OSCC multi-disciplinary referral network



and external partners to ensure effective coordination. Thailand has acknowledged that intergovernmental and multi-sectoral collaboration has been a key factor in their successful implementation of an OSCC system. In fact, Thailand has recommended that a training manual for multi-sectoral teams be developed and that multi-sectoral teams should be trained in communication techniques and in the use of relevant guidelines and protocols. Collaboration is vital to the sustainability and up-scaling of the OSCC services according to Thailand (see Timor-Leste, Malaysia and Philippines case studies for more detail on their referral systems).

10.3 South Asia

The majority of OSCCs and other approaches in South Asia have referral mechanisms for services that are not available on-site, particularly legal support, long-term counselling and shelter, for example in Maldives, Sri Lanka, India, Nepal and Bangladesh. Most of the referrals are for legal support.

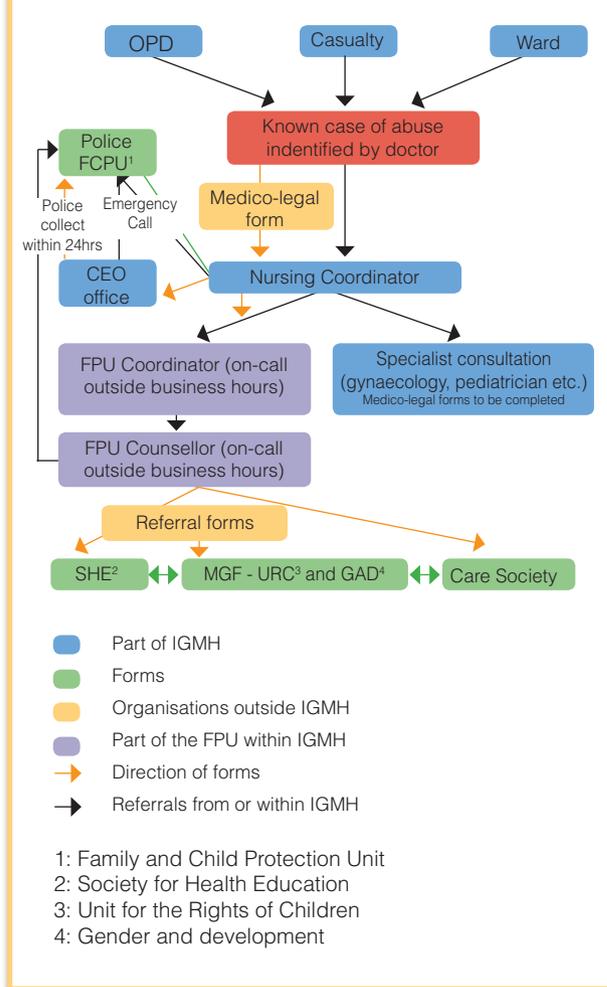
However, back referrals and follow up of patients is conducted only in a few centres. The collaboration between these organisations is often limited to acceptance of cases for service provision, but a closer linkage between them is lacking.

While most countries that have developed a response have guidelines to promote coordination between medical departments and define pathways of care for victims of violence, implementation remains relatively weak.

For example, the FPU in Maldives established a protocol with the pathway of care as outlined in Figure 8. However a review of the unit found that despite the availability of hospital guidelines on the management of abuse cases,

Figure 8: Maldives FPU pathway of care

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



not all health personnel were aware of their existence, their content, or their responsibilities when such patients present to the hospital. As such, internal coordination and referral was breaking down and patients in need were not necessarily being referred to the FPU.

11

Screening

Definition: For the purposes of this assessment and report, screening within the health system is technically defined as the examination of a group of usually asymptomatic (non-complaining) individuals to detect those with a high probability of having or developing a given disease or condition.

Universal screening refers to a policy of asking all women about violence in every programme and on every visit. This system is the most far-reaching, however it is also the most costly and difficult one to implement, particularly in low-resource settings.

Routine screening can be defined as carrying out screening in selected settings such as emergency services, mental health programmes and antenatal clinics. Important components of a screening programme include:

- 1 Privacy;
- 2 trained and empathetic staff;
- 3 the ability to listen;
- 4 support with basic counselling; and
- 5 referral. [3]

The decision to implement a screening system must consider the capacity of the institution/country to provide adequate care in the event of positive identification (either within the institution or through

referral) of GBV. The objective of screening is to identify victims of abuse early and provide needed care, rather than collecting data for advocacy, although this may be an added benefit.

Most victims will not spontaneously disclose that they have experienced GBV and therefore routine screening allows for the early identification of abused victims who may otherwise be asymptomatic. Studies show that most victims are never asked about GBV by their providers [88]. Yet, in studies that have asked women whether they would, for example, disclose sexual assault to their provider if they were asked about it, 70 per cent said 'yes', but only six percent of the women in this study said they had been asked. 90 per cent of the women said they felt their physicians could help them with problems they were experiencing because of the sexual assault [89]. Victims report that although this disclosure would initially be difficult, they would be prepared to talk about this, in private, with a health care provider who asked questions about GBV in a caring, non-judgmental manner.

While a number of countries in the region have conducted training with health care providers to encourage them to screen for abuse with the presentation of injuries and symptoms often associated with violence, universal or routine screening for GBV has only been tried in Malaysia, Viet Nam, China, Sri Lanka and Nepal. They have tended to be pilot attempts at screening in a limited number of settings rather than universal, and a number of them were not carried past the pilot phase and are no longer continuing. Therefore, there are no sub-regions contained in this section of the assessment.

In Malaysia in 2004, the Family Health Development Division of the MoH, which deals primarily with activities related to family health, nutrition and primary health

care [90], initiated a violence screening pilot, funded by UNFPA, in two primary health clinics, one in antenatal and MCH services and the other in an Family Planning Association (FPA) clinic in Kelantan State [91]. The aim of the programme was to help health providers conduct early detection of violence and take immediate action; and collect information on DV incidence rates and related risk factors (see case study on Malaysia for more detail).

Under the project Improving Health Care Response to GBV in Viet Nam which began in 2002 supported by the Hanoi Health Department, Population Council, Centre for Applied Studies in Gender and Adolescence, and the Ford Foundation, procedures have been developed to screen and document cases. Screening of all women aged 15 years and older is undertaken at the emergency department of five district hospitals of which two are supported by UNFPA/SDC and 12 Community Health Centres (CHCs) in two provinces. 87 per cent of female clients screened at Ben Tre District Hospital in October 2009 were asked three questions on DV, childhood sex abuse and rape and ticked information on a screening form. If the health worker identified GBV, they recorded the patient's information on a GBV Victim Information Form and transferred the patient to the counselling room after providing treatment. If a woman did not disclose GBV, but the health worker felt she may be experiencing violence, they provided her with information on GBV including contact details of support services. The screening system requires that service providers ensure privacy; respect and keep confidential patients' information; do not ask patients in front of strangers; ask about GBV with a sympathetic attitude; be friendly; and not judge or blame.

However, not all health providers strictly follow DV procedures and, as a result, not all women are screened during their visits to health facilities. Providers do not screen frequently for sexual abuse, and it is reported that it remains a challenge to identify victims and provide

appropriate services as many clients are still reluctant to report violence [92]. Ongoing refresher training and monitoring is needed to ensure high-quality screening and referral services.¹⁵

Viet Nam's Family Planning Unit at Tu Du Hospital provides pre-abortion counselling that includes screening for GBV, although it has been identified that counsellors do not have much GBV training or adequate time to deal with positive responses. Duc Giang Hospital in Viet Nam also provides screening of clients and counselling through the Gia Lam Women's Centre for Counselling and Health Care, based at the hospital. However, according to a recent UNFPA report, 'not all health staff is motivated to screen all clients because there is no formal requirement from the MoH or Hanoi Health Department nor material benefit for doctors. Screening depends solely on their sense of responsibility, which may be compromised by the five minutes allocated for each client examination.' [92]

In China, the National Centre for Women and Children Health, which is an affiliated agency of the MoH, is partnering with UNFPA for a VAW Medical Intervention Pilot. In Phase One (2004-2005), a VAW resource book for medical professionals was developed and in Phase Two (2007-ongoing), they are piloting a medical intervention model which includes screening in MCH hospitals. China has developed a comprehensive screening protocol that is currently being finalised and will be tested over the coming six months. Subsequently, it will be revised, printed and disseminated. The rolling out of the screening protocol will be done in conjunction with

extensive training for ALL medical staff to be comfortable and able to ask the screening questions. This is vital because based on the protocol, health professionals are encouraged to adopt their own approach and wording to screening.

In Sri Lanka, one isolated example of screening has been carried out as part of the piloting of response B of the UNFPA manual for health care providers. This was conducted over a period of one year and is described in detail in the case study.

11.1 Reflections

Very few countries in the region are carrying out routine screening. Some of the reasons for this include:

- Lack of time;
- lack of privacy;
- lack of resources;
- lack of screening protocols and training;
- no system for responding to positive cases; and
- legal concerns about eliciting a response and whether to report to police.

Currently, with the aforementioned constraints, screening in an effective and ethical way is not feasible for many institutions. However, in time, with more services being available and as capacity develops, it could become part of a routine inquiry to enhance early detection and care.

15 From UNFPA Viet Nam Country Office presentation at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.



12 Documentation and data management

Definition: Documentation is one of the most important, but often neglected, components of a health sector response to GBV. Documentation means a clear and specific record of the history including details of the incident as well as providing a description of injuries, preferably diagrammatically (i.e. on body maps). To ensure consistency and uniformity, it is necessary to develop and make available formats for documentation (such as a medico-legal report).

Data management refers to the collection, safe storage and collation of data on the number and type of GBV cases presented at health institutions. This should include adding types of GBV such as DV and rape to national medical information systems (MIS), and publishing the results in relevant reports.

Documentation and data management are a clear gap area in the Asia Pacific region. Due to the few examples of documentation and data management of GBV in the health sector, this section is not separated by subregion. Many countries in the region do not have clear and systematic methods for documenting and recording cases of violence that present in the health sector. An example from India (Box 6), explores the gaps that are often present in reporting practices, illustrates the significant burden of GBV cases on the health system

Box 6: Health records and DV in India¹

To document the role of the health care system in addressing the problem of DV, from 1997-1999, the Department of Medical and Psychiatric Social Work at the Tata Institute of Social Sciences (TISS) in Mumbai undertook a study of medical data from the Thane District, Maharashtra state, in western India. The primary goal of the study was to determine both how and the extent to which DV (verbal, physical and emotional abuse against adult women in a family setting) cases are addressed in health care settings.

The researchers used a combined qualitative and quantitative methodology that included:

- Examination of health records from an urban hospital with 350 beds, a rural primary health centre serving eight villages and three urban outreach health centres;
- brief exit interviews with 29 female patients at the community health posts and at the corporation

hospital who were likely victims of DV;

- 18 in-depth interviews with women identified through the exit interviews;
- four Focus Group Discussions (FGDs) with women from geographically and culturally diverse communities; and
- interviews with 21 doctors from five different health facilities.

From studying the records from community-based health facilities and the corporation hospital the researchers found:

- Women comprised a larger proportion of the 718 prenaternal cases than did men (54 per cent versus 44 per cent);
- there were serious gaps with regard to the identification and recording of abuse in health records with information critical for understanding the extent of DV (such as type of injury and perpetrator) often missing;

Table 8: Distribution of records in community based health facilities

Community-based health facilities	Total data collected	Total no. of prenaternal cases
Urban clinic	563	219
Urban maternity hospital	2,929	229
Urban health post	1,276	167
Rural health post	780	103
Total	10,616	718

1. Information for this box was compiled from:

a) International Centre for Research on Women (ICRW) and Centre for Development and Population Activities (CEDPA), Examining health records for evidence of DV: A research study in Maharashtra, India: Department of Medical and Psychiatric Social Work, Tata Institute of Social Sciences. 1999, ICRW and CEDPA;

b) Dr. Surinder Jaswal, presentation at UNFPA Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 2 December 2009.

- the researchers hypothesised that 82 per cent of all female patients with preternatural causes of injury may have come to the health clinics as a result of DV;
- fourteen per cent of the women's medico-legal cases recorded some type of violence as the direct cause of injury (i.e. suicidal burns, attempted suicide, assault and homicidal strangulation);
- thirty-nine per cent of the women's medico-legal cases were probably cases of violence (i.e. burns, falls, poisoning, accidental burns, accidental falls and accidental poisoning);
- thus the researchers concluded that as many as 53 per cent of female medico-legal cases brought to the corporation hospital represented situations of DV; and
- the results of the self-reporting questionnaire

indicated that more than 60 per cent of respondents suffered from severe psychosocial stress and nearly 39 per cent reported thoughts of suicide, highlighting the severe mental health consequences of DV.

This information was used as an advocacy tool for the following: to recommend for more rigorous, detailed and sensitive recording formats at all levels of the health sector to adequately reflect the prevalence of DV; for the adoption of a basic protocol for screening suspected victims of DV by health facilities; to strengthen the identification and support of women with injuries from DV; to train HSPs to recognise signs and symptoms of violence and how to respond; to improve accessibility of services; and to better track cases involving violence.

that are not being recognised, and also highlights the power of data in terms of advocacy and programme development to address GBV.

There are, however, a few examples of documentation and data management systems in the region:

- Data from OSCCs or other similar initiatives is being collected in a number of countries including India, Bangladesh, Maldives and Sri Lanka. Most OSCCs have designed their own information collection formats but the use of computer databases, regular analysis and publication of data is rare. India, in 2007, released a report, Documentation of Interventions, which published some of the data from six family counselling centres (FCCs) in Rajasthan. Similarly, Bangladesh published some of the data from the six OSCCs in the newsletter of the multi-sectoral programme on VAW.

- In Malaysia in 2004, the MoH created a Violence and Injury Prevention Programme which includes activities establishing a DV, rape and sodomy database, as well as carried out sensitisation training for all health personnel related to violence prevention and management.
- Cambodia also has a Sexual Violence Recording and Reporting System at the hospital level that was started in 2005 and expanded to the whole country in 2007.
- In Afghanistan, the Ministry of Public Health with technical support from UNFPA has incorporated indicators on GBV, including self-immolation, rape and DV into the Health Management Information System (HMIS). The data collection forms are currently being revised accordingly and the plan is for the revised forms to be used with the implementation of the revised Basic Package of Health Services. However, it would be advisable

to pilot the new forms and make any necessary revisions before full implementation. Furthermore, health personnel at the provincial level are not trained in data collection on GBV which would need to be addressed in order for the HMIS to be able to gather accurate information on GBV indicators.

- In Viet Nam, UNFPA is supporting the integration of GBV/DV into the existing HMIS over 2010-2011.

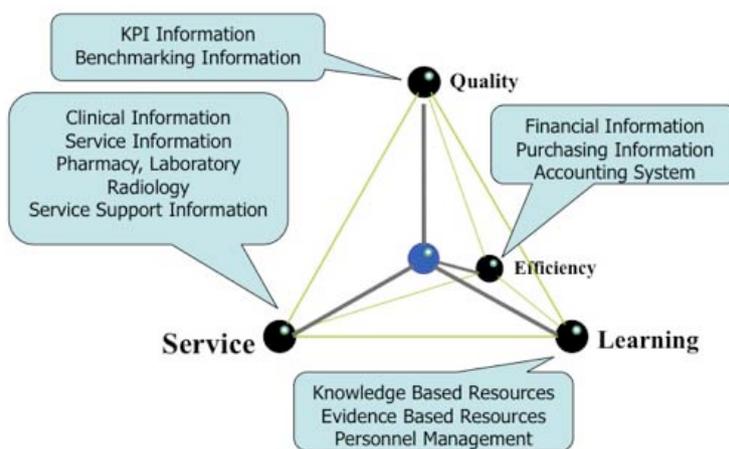
Thailand is leading the way when it comes to data management of GBV cases in the region. They have a comprehensive, nationwide, computer database. The effectiveness of their system stems from the fact that they developed a comprehensive strategic analysis of the situation and their goals before starting. The MoH

recognised that good information management can improve quality, effectiveness and efficiency of patient care. The HMIS is illustrated in Figure 9.

To collect data on GBV the Bureau of Health System Development, the MoH developed a Women and Child Violence Information Management Programme for the OSCCs. The principles of the database development were:

- Input data at the place of data origin (single entry, single site, real time);
- person who enters the data must check, edit and verify data themselves;
- using technology to create complete reports;

Figure 9: Model of Thailand's health management information system¹⁶



16 From the presentation by Dr Chanwit Tharathep, Director, Bureau of Health Service System Development, Department of Health, at Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 3 December 2009.

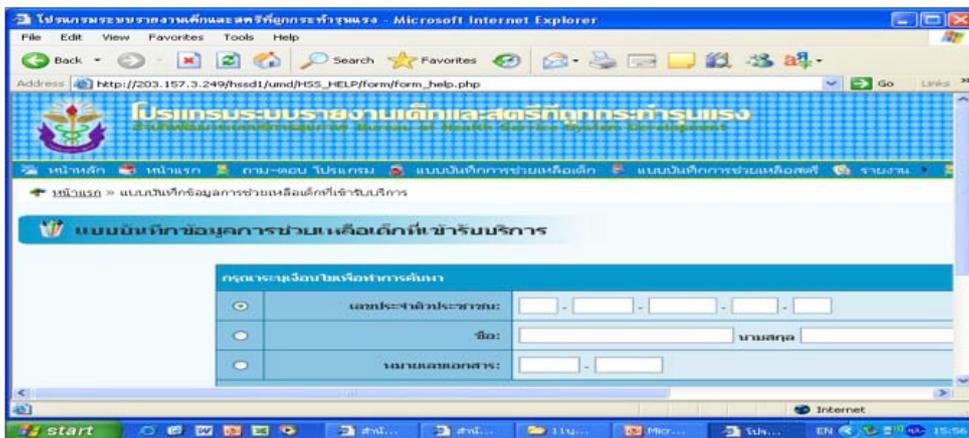
- using technology to reduce repeated work;
- using technology to carry out fast analysis (in seconds); and
- using technology to explore the database over many sessions and answer as many question as possible.

1. Victim's data;
2. perpetrator data;
3. incident data;
4. type of violence data;
5. medical service data; and
6. support and treatment plan data.

There is a primary internet database for all health records in the country and a sub-programme specifically on cases from the OSCCs. This secondary database requires a personal ID and password. Information on victims of violence can be searched in the database in three ways: a person's 13-digit National Identification Number; first name and surname; and document identification numbers. There are six parts to the reporting form on the database:

Approximately 500 out of 800 hospitals in Thailand are currently reporting on GBV and 50 per cent of hospitals report using the internet system. When the information is reported publically it removes all identifying information to protect client confidentiality. Data analysis from the programme provides knowledge on the magnitude and severity of the problem, distribution of the problem (time, place and person), trend of a disease or health

Figure 10: Image of sub-database for recording cases of VAWC¹⁷



17 Ibid.

Table 9: The number of cases of VAWC seen by OSCCs in Thailand, 2005-2008

Year	Number of Hospitals	No. of child victims of violence	No. of female victims of violence	Average no. of cases per day
2005	109	5,886	5,656	32
2006	91	7,981	7,901	39
2007	250	9,598	9,469	52
2008	582	13,036	13,595	73

problem, surveillance for abnormal changes and possible preventive measures/hypotheses.

Data from the database on the number of GBV cases seen by the OSCCs in Thailand is represented in Table 9. This indicates that over the past five years the number of cases has increased almost four times.

12.1 Reflections

Comprehensive and systematic documentation and data management is a major gap in the region. Many countries have no specialised recording systems for GBV. The example of India illustrates that when special measures are not taken to train HSPs how to document cases of GBV properly, cases with even obvious injuries are not recorded or have large gaps of information even in medico-legal documents. This is a serious problem because it means that accurate medical histories are not being recorded, women are not receiving the treatment they need, evidence is not collected or recorded for possible prosecution and there is no accurate record of the burden of GBV on the health system to guide interventions and resource allocation. On the other hand, when data is collected, managed, analysed

and used well it can be a powerful advocacy tool.

Although most OSCCs in principle have a methodology to ensure confidentiality of data, the centres face many constraints due to a lack of space, suitable infrastructure and overcrowding. Where victims are admitted to a common ward as in Bangladesh or Sri Lanka it is a challenge for the care providers to ensure confidentiality.

Data management is an area that requires strengthening and may require technical assistance, particularly in the field of information technology. Countries in the region could learn from well-established system examples like that in Thailand. The example of Thailand illustrates that leadership by the MoH and effective coordination between regions is required for a data management system to function at a national level.

Ideally, it would be useful to have GBV indicators included in the HMIS of all countries, although it must be recognised that GBV is not like other diseases that are easy to identify and record. For the inclusion of GBV indicators into HMIS to be effective and reflect the number of cases presenting in the health system, all health providers need training and sensitisation to be able to recognise such cases. This could be effective with screening protocols for countries that have the capacity to do this.



13

GBV and humanitarian response

ICPD, para. 4.1 states:

'Countries are urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation.'

There is growing awareness of, and global attention to, the atrocities committed against women and girls during conflicts, notably reflected in the historic Security Council Resolution 1325 and more recently in Security Council Resolution 1820 on sexual violence as a threat to peace and security [23]. The United Nations clearly acknowledges that the general breakdown in law and order which occurs during conflict and displacement leads to an increase in all forms of violence [93, 94] as women's bodies become 'battle grounds' where opposing forces fight to gain control. Women and girls also face increased vulnerability to rape, sexual exploitation and other forms of GBV during natural disasters.

- Sexual violence and abuse are increasingly being used as systematic weapons of war by bandits, insurgency groups, the military, border guards, host communities, refugees and others.

- Women and girls of all ages are raped and abducted to serve as sexual slaves, pregnant women are physically assaulted and many women have been murdered or infected with HIV.
- Women and girls face sexual violence and discrimination in the distribution of everything from food to plastic sheeting.
- Many women and girls are trafficked through borders that are not staffed. Since there is a breakdown of law and order, border patrols and the police are either non-existent or act as collaborators in the trafficking.
- The tensions of conflict and the frustration, powerlessness and loss of traditional male roles associated with displacement may be manifested in an increased incidence of domestic VAW.
- For refugees and internally displaced persons (IDPs), violence within the family often increases as a result of the lack of jobs, shelter and basic services and is exacerbated by the availability of weapons. This is especially prevalent in communities where there are men returning from war who frequently transfer their entitlement to commit violence in a military situation from the battlefield to their homes and communities.

The issue of GBV therefore requires an expanded response in any humanitarian effort, particularly from a health sector perspective. UNFPA is positioned to play a leading and expanded role to coordinate interventions in this regard, particularly as the lead agency responsible for GBV, RH and gender mainstreaming within United Nations' IASC [23].

Two examples where UNFPA played a key role in the health sector response to GBV in humanitarian emergency situations are Cyclone Nargis in Myanmar and the Indian Ocean Tsunami in Sri Lanka.

13.1 Cyclone Nargis, Myanmar ¹⁸

The delta region of Myanmar was hit by Cyclone Nargis on 2-3 May 2008, with high tidal waves of up to three to four metres and wind speeds of up to 240 km per hour. The disaster affected 2.4 million people and caused up to 140,000 deaths.

Perhaps fortuitously, at the time Nargis struck Myanmar, two representatives from Myanmar had just completed a training of trainers (ToT) course on integrating sexual and RH into crisis response (facilitated by International Planned Parenthood Federation's [PPF] Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East, Southeast Asia and the Pacific [SPRINT] Initiative). These representatives, one from UNFPA and one from United Nations High Commissioner for Refugees (UNHCR), tried to overcome the challenges and immediately initiated SRH response activities of the Minimum Initial Services Package (MISP), including GBV, in order to meet the RH needs of people in the affected areas. A number of orientation sessions, training sessions and ToTs on the MISP, GBV, psychosocial support and women's protection were organised and attended by more than 3,000 humanitarian actors. A GBV Trainer Pool list was developed and the majority of trainees also completed a MISP online course. In addition, five staff from UNFPA, UNHCR, Myanmar Medical Association and MSI attended the regional training on Clinical Management of Rape Survivors, organised by UNFPA and UNHCR in Chiang Mai in July 2008. Knowledge on clinical management and related legal issues was shared with medical staff of partner agencies.

As part of the response to women's protection in the aftermath of Nargis, seven women friendly spaces were

18 Information from UNFPA Myanmar Country Office presentation

established and they provided psychological counselling, vocational training and micro-loans.

The activities were implemented in coordination with the MoH, the Department of Social Welfare, United Nations' agencies, local and international NGOs, community-based organisations (CBOs) and youth volunteers. To finance the SRH and women protection project activities, money was raised through various channels including a Flash Appeal, Central Emergency Response Fund (CERF), UNFPA core fund and from donor countries including Norway and Australia.

Addressing the issue of GBV was difficult, particularly during the acute phase primarily because of:

- Insufficient service provision for SGBV survivors;

- lack of proper mechanism for referring sexual violence cases;
- low prioritisation of SRH and women's protection by local authorities and international agencies;
- sexual violence and protection are culturally and politically sensitive issues, and difficult to discuss openly and to disseminate messages about;
- inadequate coordination especially at the field level; and
- overlapping of support provided by different organisations in some areas.

However, despite these challenges, the protection of vulnerable groups in crisis situations is an issue which has greater support and visibility. UNFPA in collaboration with the Department of Social Welfare is currently developing a NAP for Protection of Women in Emergencies.

Figure 11: Women Friendly Space established in response to Cyclone Nargis, Myanmar



13.2 Tsunami, Sri Lanka¹⁹

The government health system in Sri Lanka is robust and the overall health response was very quick. Although somewhat delayed, UNFPA supported the government through:

- Provision of dignity kits;
- provision of emergency RH kits;
- rebuilding damaged RH facilities;
- establishing psycho-social support;
- establishing women's centres in the community; and
- initiating hospital GBV management centre.

UNFPA identified integrating SRH and gender into emergency preparedness and response as a key activity



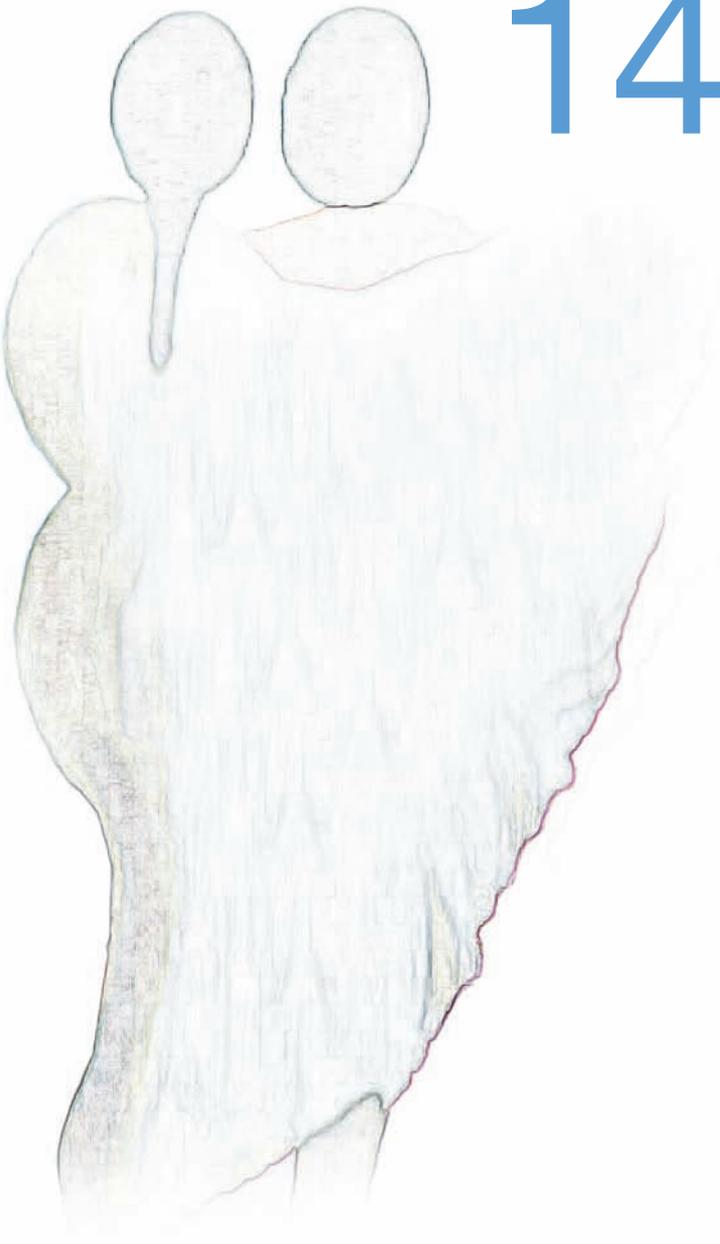
in its country programme and adopted the following strategies:

- Advocated for establishing all components of MISP on RH (including sexual violence and STI/HIV prevention);
- advocated to integrate SRH and gender into national health disaster preparedness plan; and identified the need for national capacity building on SRH and prevention and management of SGBV in crisis and conducted training on SPRINT;
- continued advocacy with policy makers and decision makers, both health and non-health, to include prevention and SGBV in the response;
- promoted national ownership for sustainability and bridging gap between crisis, early recovery and development; and
- developed partnerships with other United Nations' agencies, academic institutions, professional colleges and Civil Society Organisations (CSOs).

Some of the major challenges included the rapidly changing scenario at the ground level, the need for strengthening of the focal points/agencies within the MoH, UNFPA CO and the lack of availability of sufficient agencies to manage referrals.

Despite these challenges, the tsunami experience strengthened UNFPA Sri Lanka's capacity to respond to GBV from a health sector perspective and was instrumental in re-establishing and expanding the OSCC model in Matara (see Sri Lanka case study for more details).

19 Information from UNFPA Sri Lanka Country Office presentation, SGBV linkages in emergency response in Sri Lanka at UNFPA Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 1 December 2009.



14 GBV and humanitarian response

In this section, the key regional issues and challenges are identified in terms of developing an integrated health sector response to GBV within a multi-sectoral framework. In this assessment the following key gap areas in the health sector response to GBV in the Asia Pacific region are identified.

Monitoring and evaluation of interventions

Institutional data on GBV burden

Institutionalisation of capacity building

Prevention strategies

Multi-sectoral collaboration and referral

Formalisation of care through protocols

14.1 Political will and leadership

14.1.1 Lack of support from high-level government officials

In many places it has been a challenge to receive the support of the government in addressing GBV as a

health issue. For example, in countries such as Bhutan, Iran and Pakistan, despite concerted effort, interventions have been difficult to get off the ground with high-level political will. In addition, there are victims of GBV within the health system and yet most countries still do not have sexual harassment policies within the health sector.

14.1.2 Lack of support from hospital management

In a number of countries there continues to be a lack of support from hospital management for health sector interventions on GBV. This leads to a failure to prioritise GBV in allocating resources, space and staff. For example, a major challenge faced by the FPU in Maldives was apathy of hospital management to the issue. Even after the hospital management initially agreed to allocate a separate space for a confidential woman/child-friendly sexual abuse examination room, it was later re-allocated to another area that was given more priority.

14.1.3 Lack of support from other HSPs

As most state sector health institutions are under-resourced and overcrowded with many competing demands, HSPs are likely to feel that allocating space and staff to GBV is a 'waste' unless they are sensitised to understand the health implications of GBV and need for the service. This was observed in Sri Lanka where HSPs' resistance lessened when they were made aware of the successes and benefits of having an OSCC in the hospital.

14.2 Institutionalisation of GBV response into the mainstream health system

14.2.1 Lack of incorporation of GBV issues into health policies

Some country health master plans have included addressing GBV as an important goal, however many others have struggled with this. Even where GBV has been mentioned in health policies such as in Bangladesh it often only receives broad recognition rather than serious consideration as a cross-cutting issue.

14.2.2 Challenges with formalising care through policies and protocols

Although there are a number of GBV service provisions in the health sectors in the region, the establishment of formal protocols to guide the provision of care is relatively weak. Often protocols are developed for single institutions that are running as a pilot or project but have not been institutionalised across the board. This means that there is a lack of consistency and uniformity of care.

14.2.3 Challenges with implementation of policies and protocols

Even when countries have managed to incorporate GBV into health policies comprehensively and have protocols to guide interventions, there is often a discrepancy between the stated national GBV procedures and their actual implementation. Protocols are often not made easily accessible or visible in institutions and there is a failure to provide ongoing training for staff as well as orientation on the guidelines for new staff.

14.2.4 Challenges facing institutionalising GBV capacity building into health systems

While many countries have conducted training for HCPs at different levels, there is still a concern that health care workers continue to 're-victimise' women by discounting their stories and dealing only with the physical symptoms of abuse. The majority of training with health care providers has been brief and conducted in a somewhat ad hoc manner, often by different agencies, with a lack of follow-up or refresher training. There has been limited success in institutionalising GBV training into the mainstream national health systems by incorporating it into the curricula for doctors, nurses and other medical professionals. There have been attempts to do this, however as the case studies from PNG and Malaysia attest, this has tended to be dependent on committed individual professors, teachers and trainers.

14.2.5 Challenges in 'up-scaling' from a pilot/project to an integrated systematic response

While some countries such as Sri Lanka, Malaysia, Indonesia and Thailand have had success in scaling-up and extending GBV programmes into their mainstream health systems, other countries are facing challenges in this regard. Refer to Table 4 for a more detailed explanation of the reasons for this.

14.2.6 Financial challenges

Financial constraints are a challenge in integrated models, particularly stand-alone, hospital-based OSCCs where funds depend mainly on local hospital boards. This leads to poor infrastructure, lack of adequate staffing and a lack of private examination and counselling rooms. There is a challenge with the continuation and ownership of responses at the national level, particularly through the provision of budgets, such as is the case with India's FCCs. Furthermore, this can be particularly challenging when

approaches are run by NGOs, or in low income countries where health systems are already financially constrained (see PNG and Timor-Leste case studies). The bureaucratic mechanisms that exist in most countries make it difficult for the service providers to access funds even when they are available from INGOs and NGOs.

14.2.7 Staffing challenges

There is a lack of human resources in many countries, particularly doctors, nurses, counsellors, psychologists and social workers who are necessary in the response to GBV. For example, in Bangladesh, no new cadres have been recruited for many years. The high turnover of staff in Maldives and Sri Lanka makes it difficult to maintain a base of well-trained staff on GBV in those countries.

14.2.8 Challenges reaching survivors of violence

The majority of responses to GBV through the health sector in the region are based at tertiary level hospitals, which may result in more limited coverage than services located at a primary care level [85], such as at RH clinics with routine screening. It must be noted that for many countries in the region, particularly in the Pacific, and in island nations like Maldives, rural communities do not have easy access to tertiary level health care. In such cases, many women continue to miss out on treatment and support.

14.2.9 Long-term sustainability

Most interventions are project-based and supported primarily by a small number of 'champions'. When the project ends or if the 'champion' leaves, then the intervention often falls over. This is of particular concern when interventions are led by the NGO sector with little buy-in from government. Furthermore, if the interventions are not appropriate for the country context (i.e. OSCCs are resource demanding), then they have less chance of long-term success.

14.3 Multi-sectoral collaboration and referral

14.3.1 Lack of information sharing and collaboration between different partners, ministries, INGOs and NGOs working on GBV in the health sector

In some countries, there are a number of different agencies running different OSCCs in different sites. For example, in PNG, MSF is running two, a local NGO is running one and the social worker department of a state hospital is running another. The lack of coordination between these different agencies leads to issues with consistency of care. However, it is positive to note that this is currently being addressed in PNG with the introduction of national level policies, guidelines and systems. There is often a lack of sharing and collaboration between different agencies and donors who are supporting a mainstream health sector response to GBV.

14.3.2 Lack of effective multi-sectoral referral between the health sector and other service providers for GBV survivors

It is well-documented and reported that addressing GBV requires multi-sectoral collaboration because abused women have multiple needs that must be addressed. In many countries this collaboration has been a challenge. Although countries often report having some sort of informal referral system between the health sector and other services, it is generally not well-institutionalised or systematised. This can be particularly challenging when external support services are minimal or lack capacity, for example in the PICs.

14.3.3 Challenges with referral within health institutions

Given the variety of locations where abused women may present and the range and potential severity of presenting

health problems, there is an urgent need for coherent, effective referral within the health institution. However, the state health sector in most countries is overstretched with innumerable departments dealing with different activities, and coordination among the departments for GBV care remains a serious challenge.

14.3.4 Lack of community awareness of services

It has been found that referral is often not enough to promote use of GBV services in the health sector. There is a need for advocacy, outreach and awareness-raising of the services so that women can come directly for care. This was reported to be the case in many countries including Malaysia, Maldives and in PNG with the MSF-run centre in Lae.

14.3.5 Gap in working with men and boys

Actively engaging men and boys as partners and agents for changes is vital in any effort to end VAWC. This, however, is a major gap in the region, particularly in the health sector. Even though a number of health care providers are male and there are some strong male medical 'champions' such as in Maldives and Sri Lanka, there has been little concerted effort to promote their involvement.

14.4 Evidence-based responses to GBV

14.4.1 A lack of monitoring and evaluation of services

Very few health sector GBV programmes in low and middle income countries have been systematically evaluated which means that there is little evidence on what actually works well on the ground and what does not. Even

countries that have been operating well-integrated, scaled-up interventions have had little if any evaluations conducted.

14.4.2 Variation in quality of response

With inadequate monitoring and evaluation, the quality of responses varies significantly from country to country and even from site to site. There has been little emphasis on outcomes such as client satisfaction in the region and there is a gap in supervision and accountability that should be addressed.

14.4.3 Screening remains a significant gap

While there continues to be ongoing debate internationally as to the effectiveness of screening for GBV, it is important to note that very few countries in the region are carrying out routine screening for GBV in health care settings (with the exception of China and Viet Nam, as discussed in Section 11). This is likely due to the fact that screening requires extensive training, resources and commitment. In addition, health care workers often report that they do not have the time to take on this extra role, as mentioned in the example of Viet Nam. Furthermore, there is always the ethical imperative that before screening takes place there should be enough local support services available to refer victims who are identified in the screening process.

14.4.4 A lack of documentation and data management

A number of countries have identified a lack of official data on the nature, prevalence and incidence of the various types of GBV as a significant barrier to effective policy making. In particular, a lack of data on the burden of GBV cases in the health sector makes it difficult to advocate for integrating the GBV response into the health sector. Most

MISs are not yet geared towards empirically measuring and demonstrating the value added by the interventions in terms of health outcomes.

14.5.5 Lack of prioritisation of prevention

Currently, there are few GBV prevention programmes initiated by the health sector, and this requires greater attention. Some exceptions include China, Sri Lanka and Thailand who are taking a preventative approach with their screening processes and providing materials on 'healthy relationships'. The establishment of the service centre in Sri Lanka was accompanied by sensitisation and training of community health workers (public health midwives) and doctors working in the community servicing the hospital. This encouraged early identification and referral of GBV cases. Sri Lanka also has developed a public health booklet for newly married couples which has a section on GBV.

14.5 Internal UNFPA challenges

14.5.1 Lack of support for GBV as a public health issue

Even within the United Nations' system there can sometimes be a lack of support for addressing GBV as a public health issue. It is sometimes still defined exclusively as a gender issue and thus marginalised.

14.5.2 Lack of coordination between RH and gender

In UNFPA, there is often a lack of coordination between RH and gender programmes when addressing an issue such as GBV which cuts across both.



15

Lessons learned

15.1 Developing an integrated health sector response requires political will and leadership

As seen in Malaysia and other countries, institutional senior-level support, at both the ministerial and hospital level, is crucial for the development of an integrated health sector response to GBV. In Malaysia, the scaling up of OSCCs to all state hospitals would have not been possible without leadership from the MoH.

In other countries such as PNG, developing political will has taken many years of coordinated advocacy with the government from United Nations' agencies, INGOs, researchers and dedicated medical professionals. Thailand successfully promoted the up-scaling of their OSCCs by linking the initiative to the Queen's 72nd birthday celebrations which reflected high-level support.

The Mongolian joint United Nations initiative has also demonstrated that with good ownership and commitment by national counterparts, both governmental and non-governmental, progress on GBV in the health sector can be achieved with relatively few resources, within a relatively short space of time.

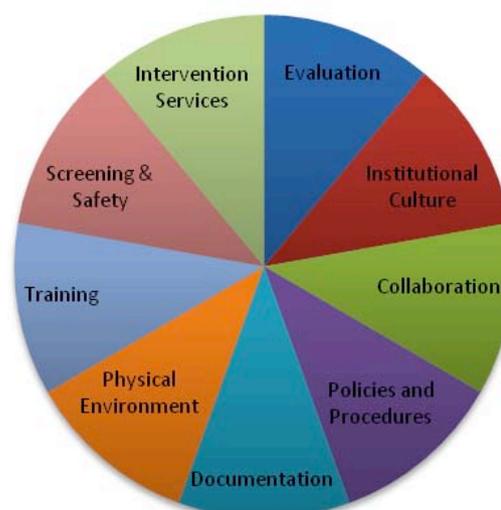
15.2 Developing an integrated health system response to GBV takes time

Countries are at varying levels in terms of the development and integration of GBV services in the health sector as illustrated in Figure 2. Countries that have been working on this issue the longest (i.e. for more than 10 years) have the most well-developed systems. This is not surprising, however, it is important for countries in the early stages of their interventions to remember that progress takes time. Even interventions in industrialised countries that have been well-integrated into the health system must continue to evaluate, learn, adapt and improve their services for survivors of violence.

15.3 The health sector should ultimately institutionalise a systematic response into routine health care

It is not possible to instate nationwide, multi-level responses to GBV all at once. Nevertheless, the ultimate aim should be to institutionalise a health sector response to GBV so that it becomes part of routine care. This requires that components such as capacity building, policies, protocols and multi-sectoral collaboration are developed and formalised at a national level and integrated into the mainstream health system as illustrated in Figure 12. All of these elements also require ongoing monitoring and evaluation.

Figure 12: System response to GBV in the health sector, based on Delphi Agency for Healthcare Research and Quality (AHRQ)²⁰



Many countries in the region have started with one intervention in one site as a pilot. Such projects can be very useful as a first step for countries to build capacity, learn lessons and evaluate what works and what does not in their specific context. However, it is also important to focus not only on project/event-oriented interventions and concentrate on capacity building to integrate into national health systems. While 'scaling-up' has been a challenge for many countries, others in the region have been relatively successful. They provide lessons on how

²⁰ Quoted in the presentation by Dr Jane Koizal-McLain, at UNFPA Workshop on Strengthening the Health Sector Response to GBV, Bangkok, 1 December 2009.

this can be done effectively. For example, extensive advocacy from the women's movement was instrumental in getting OSCCs institutionalised in government hospitals throughout Malaysia, comprising 95 per cent of urban government hospitals nationwide [92].

15.4 Finding an appropriate entry point and integrate horizontally

In order to have an effective health sector response to GBV one must try to reach the most number of women in need. This means that countries need to think carefully about the most appropriate entry points for their interventions, based on the pros and cons outlined in Table 5. It is also important in the long-term to integrate horizontally across multiple health levels and entry points (i.e. HIV/AIDS prevention, A&E and SRH services) to reach the most people. For example, China notes that under their current pilot at MCH hospital settings, the impact may be limited and that they will need to consider expansion to other departments such as OBGYN and the family planning department to reach more women.

15.5 Developing an integrated response requires collaboration and coordination

It is well-documented and reported that addressing GBV in the health sector requires an integrated multi-sectoral collaboration to be developed because abused women have multiple needs that must be addressed. It is also vital to have effective collaboration and coordination mechanisms not only between partners, but also internally, between medical departments.

15.6 Evidence-based responses are vital to address the needs of survivors

Health sector responses to GBV must be targeted to the specific and evolving needs of the community, such as a greater prioritisation of prevention, or a focus on rape as in the case of PNG. This requires systematic documentation and data management, evidence-based advocacy and research to understand the successes and operational lessons to be learned for improving services and scaling-up in different settings. It needs to be known what approaches are most effective and if women are ultimately benefited. Building this evidence is vital for continued commitment of national and local leaders.

In this regard it is essential to integrate monitoring and evaluation into any project or programme plans at the initial stage. Developing baseline data is also important to be able to measure progress against. New indicators are needed that move beyond simply measuring identification and referral rates and focus instead on measures of women's well-being and satisfaction with services.

15.7 Countries in the region have a lot to learn from each other

The experiences of the countries in the region offer a wealth of information and lessons that other countries can learn from, so it is important to promote South-South collaboration. There are a number of countries that have similar cultural contexts and are at similar stages in their responses and could benefit from working together.

Some examples could include:

- Mongolia learning from China's comprehensive implementation strategy;
- China, Mongolia and other piloting countries learning from Viet Nam's Toolkit for Monitoring Domestic Violence Prevention Activities at Healthcare Facilities;
- countries like Iran, Pakistan and Afghanistan conducting a study tour together;
- countries like Bangladesh, Sri Lanka and India working on regional advocacy with medical associations and universities to institutionalise GBV training into medical curricula;
- countries like Thailand, Malaysia, Indonesia and Philippines sharing evaluation tools and methodologies for their OSCC models and sharing findings; and
- countries like Timor-Leste and China sharing experiences from Maldives, Thailand, Solomon Islands and Kiribati on conducting population-based research on VAW using the WHO Multi-Country Study Methodology.



16

Recommendations

These recommendations should be considered in the context of the lessons and challenges outlined above. They may appear broad, however, this is because UNPFA COs are at very different stages in supporting a health sector response to GBV. For some countries these recommendations will be short-term goals while for others they will reflect longer-term goals. These recommendations must therefore be considered within the diverse and evolving socio-cultural, political and economic contexts of each country.

Given that this assessment is of the health sector, these recommendations present what is needed for a holistic health sector response to GBV for multiple actors. However, recommendations that could be particularly relevant for UNFPA to lead or support have been the focus. At the same time it is acknowledged that UNFPA is only one player amongst many in this area and it is important for UNFPA to work to its strengths in SRH and identify where it can best add value to already existing, ongoing and planned interventions at the country level.

1 Assessing the situation

- 1.1 Carry out environmental scanning and situational analyses to understand what is happening in the country and where the gaps are.
- 1.2 Support programmes based on in-depth analysis of the most suitable and sustainable intervention approaches for the country.
- 1.3 Respond to GBV in the health sector by linking to existing programmes and establishing new programmes where UNFPA has particular strength.

2 Building political will and leadership

- 2.1 Carry out sensitisation and advocacy with policy makers and high-level government officials to promote an understanding that GBV is a public health issue. Research and collect data on the impact of GBV on women's health, hospital utilisation, the cost to the health system and costs of inaction. This data can be useful for advocacy, for example, as seen in Solomon Islands and Kiribati where UNFPA has supported such research and advocacy.
- 2.2 The health ministry to appoint a focal point for addressing GBV within the health sector at a decision-making level, for example, as done in Bangladesh and Sri Lanka. UNFPA can advocate for this.
- 2.3 Support the development of national multi-sectoral GBV action plans and strengthen the institutional capacities required for inter-ministerial coordination, implementation and monitoring (including women's machineries).

3 Health policies and protocols

- 3.1 Support health policy development processes, including sexual harassment policy within the health sector, to ensure that GBV is included where necessary as a cross-cutting issue. This could include funding policy development consensus meetings, and running training and workshops for policy makers – such as the GBV toolkit developed in Nepal.
- 3.2 The health ministry to develop, disseminate and ensure implementation of national level guidelines and protocols – including standards on clinical management, ethical and legal issues – for GBV. UNFPA can advocate for this and facilitate the exercise by sharing relevant country examples of protocols, funding study tours and workshops to develop protocols, and funding external expert resources.
- 3.3 Identify health professionals sensitive to the issue of GBV and utilise them in advocating with the government for the inclusion of GBV into health policies (MoHs tend to be more receptive to guidance given by health professionals).

4 Capacity building

- 4.1 Carry out awareness raising and capacity building with UNFPA staff to ensure that they understand their key role in promoting a response to GBV within the health sector, in particular by systematically ensuring that GBV issues receive high priority along with such other areas of UNFPA focus as population and development dynamics analysis; SRH, including STIs and HIV; adolescents and youth; and gender equality, more broadly.

- 4.2 Carry out capacity building with health care providers at all levels. Include information about identification and management of abuse cases, issues around gender and power relations and abuse, ethical issues, and counselling skills. Such awareness training sessions should be regular and be integrated into the orientation programme for new medical staff.
- 4.3 Give priority to ensuring that all health providers have received Clinical Management of Rape Survivors Training and training in implementing the MISP.
- 4.4 Advocate with universities, post-graduate institutions and boards of study for the integration of GBV into pre- and in-service training and curricula of health care providers such as nurses, paediatricians, OBGYN, psychiatrists, community health workers and skilled birth attendants. This includes the development of national level health care training manuals on GBV so that they are institutionalised and used regularly. UNFPA can advocate and support this process.
- 4.5 Build up a local resource pool of experts who can conduct a sustainable GBV training programme in the health sector. UNFPA can provide technical assistance, and support ToTs and study tours in this regard.
- 4.6 Support professional medical associations and organisations (such as the Sri Lanka Medical Association) to sensitise health professionals regarding GBV. They are likely to have more influence and sway within the medical community than NGOs or United Nations' agencies.
- 4.7 Support institutionalising GBV provider training in pre- and in-service curricula by advocating with health professional associations at the global and regional level – i.e. the Commonwealth Medical Association, the International Federation of Medical Students Associations, the Medical Women's International Association, and the International Federation of Gynaecology and Obstetrics.

5 Strengthening the institutional response

- 5.1 Carry out sensitisation and advocacy with health administrators and hospital staff to ensure that programmes addressing GBV are accepted and supported on the ground. This could include informal presentations during existing lunch-time seminars or during regular departmental meetings and regular newsletter or email newsheets. This is particularly important where projects/programmes are being carried out.
- 5.2 Equip health centres for quality care, such as separate rooms for private consultations and medical exams in cases of rape and other forms of physical abuse; this also includes advocating for, providing technical assistance to and supporting access to PEP in order to prevent HIV transmission for all women and adolescent girls who have been raped and others who have engaged in unprotected sexual intercourse.
- 5.3 Ensure the availability of emergency contraception supplies, post-rape kits and demand-creation strategies. These services are integral to UNFPA-supported SRH programmes and are part of its response to sexual coercion and sexual violence. They are also in line with its leading role in RH commodities security.

6 'Up-scaling' and institutionalisation

- 6.1 Before up-scaling or replicating a pilot/model, carry out situational analyses to evaluate the functional capabilities of the new setting and adapt the model as necessary.

- 6.2 Support countries to have a long-term vision for an integrated health sector response, thinking beyond the project models.
- 6.3 Plan for the long-term financial viability of a project at the beginning of its development, for example by advocating with the MoH to provide for staffing, space and infrastructure in the long-term.
- 6.4 Consider time lags for donor funds to go through the bureaucratic mechanisms of the ministries when planning activities.
- 6.5 Develop horizontal integration of GBV into other areas of the health sector such as HIV/AIDS, maternity care, child care, family planning, youth clinics as well as domiciliary care.

7 Screening

- 7.1 More developed GBV services in the health sector to consider the feasibility of routine screening in terms of time, resources and availability of support services. If feasible, then develop, test and utilise routine GBV screening tools to promote early detection, care and referral of cases.
- 7.2 Carry out research into the effectiveness of screening for GBV in low and middle income country context.

8 Multi-sectoral collaboration

- 8.1 Establish a central steering committee to take the lead in developing a health sector response to GBV within a multi-sectoral framework. The MoH should ideally take the lead in this committee, however

this decision will depend on the capacities and policies of the relevant stakeholders in different country contexts.

- 8.2 Identify forums which bring together different actors such as the GBV Forum of Sri Lanka and encourage the state sector to participate and advocate for representation in appropriate bodies.
- 8.3 Promote collaboration between United Nations' agencies to address GBV at the national health system level – for example, a number of United Nations' Joint Programme initiatives have proven successful such as in PNG and Mongolia's Joint Programme on Prevention of VAWC.

9 Internal and external referral mechanisms for survivors

- 9.1 Health institutions to develop a formal system for coherent, effective referral between the health sector and external, non-health services such as legal, police and long-term counselling. For referral practices to be effective they need to be systematised and include a formal mechanism that defines roles and responsibilities of agencies (i.e. MoUs); to have a formal mechanism for directing the survivor to the relevant service points (i.e. through a letter or referral form); and they need to have a mechanism for inter-sectoral coordination (i.e. a multi-sectoral committee that meets regularly).
- 9.2 Develop a system to obtain follow-up information about patients referred to other agencies.
- 9.3 Establish a formal internal system of referral for GBV survivors within health institutions through guidelines that identify the roles and responsibilities of different departments/

HSPs, flowcharts on pathways of care and so forth. Ensure that such guidelines are easily accessible, that all new staff are trained on this during orientation, and that the referral system is continuously reinforced through newsletters and meetings.

10 Documentation and data management

- 10.1 Collect reliable data on the number and types of GBV cases coming through the health sector in a systematic way in order to understand the trends, plan effective interventions, and advocate for expanded and ongoing services. This data should be published and shared widely to generate awareness of GBV as a public health issue.
- 10.2 Support DHS modules on DV and national/sub-national surveys on this and other forms of violence (especially sexual violence, GBV in conflict/post-conflict situations and harmful practices).

11 Monitoring and evaluation

- 11.1 Monitor and evaluate GBV services in the health sector including receiving feedback from clients to improve and expand services and provide evidence of what works.
- 11.2 Promote greater accountability and focus on impact, evaluating and using indicators that look for tangible evidence of improvement in women's

lives, not only numbers on training and units.

- 11.3 Support baseline data collection to assess progress of interventions.

12 Prevention and involvement of men and boys

- 12.1 Link institutional interventions with community-based health activities to promote GBV prevention. For example, conduct concurrent GBV sensitisation with the community health providers in the surrounding area of the institution to promote referral and early identification of victims.
- 12.2 Address the link between GBV and RH issues, including maternal mortality and HIV/AIDS. UNFPA can advocate for public programmes and budgets to address VAWG in the context of health sector-wide approaches and reforms, and in the formulation and monitoring of national HIV/AIDS plans, providing follow-up technical assistance and support, engaging associations of women living with HIV and AIDS in the process.
- 12.3 Systematically integrate sensitisation on VAWC in sexuality and RH education programmes (formal and non-formal), particularly in terms of prevention of GBV through the health sector by way of tailored interventions and messages for men and adolescent boys on GBV in SRH programmes including those related to HIV prevention.
- 12.4 Strengthen the role of male advocates and opinion leaders in the health sector to raise awareness about GBV as a public health issue, foster a culture of non-violence and advocate for policy and institutional change.

- 12.5 Launch public awareness education and mobilisation campaigns by and for men opposed to GBV, highlighting the health implications.
- 12.6 Link with regional and national networks of men opposed to VAW such as the White Ribbon Campaign and the Men Engage Alliance to address GBV and health.

13 Addressing GBV in humanitarian emergency responses

- 13.1 Advocate with national governments, peacekeeping missions and other actors to ensure that RH and GBV prevention and response programmes are integrated into health care provisions for humanitarian emergencies.
- 13.2 Support and provide technical support to

incorporate GBV in crisis and post-crisis situations (e.g. emergency preparedness plans; consolidated appeals; humanitarian action plans; post-conflict needs assessments and transition frameworks; disarmament, demobilisation and reintegration (DDR) plans; security sector reform initiatives and peace-building programmes; and national plans to implement and monitor actions under Security Council Resolution 1325 and 1820).

- 13.3 Strengthen health services and provider competencies to render a comprehensive response to sexual violence and its consequences, including counselling, shelters, hotlines, prevention and treatment of STIs, HIV, PEP, emergency contraception, treatment and care for women with traumatic fistulas, pregnancy-related care, as well as the collection of forensic evidence as part of legal procedures to bring perpetrators to justice and document human rights violations.



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Annex 1: Regional workshop agenda

APRO Workshop on Strengthening the health sector response to GBV Bangkok, Thailand 1-4 December 2009

Objectives:

- 1 To learn from existing interventions on health sector response to GBV and identify and promote evidence-based health sector interventions within a multi-sectoral framework that are appropriate for the region/sub-regions.
- 2 To strengthen COs' and national partners' response to GBV from a health system perspective within a multi-sectoral framework.
- 3 To enhance synergy and integration of GBV and SRH issues in UNFPA responses at the country and regional level.
- 4 To strengthen South-South cooperation by promoting knowledge and experience sharing between COs.

Day 1 – December 1, 2009: Understanding the issue: reaching common ground

	Time	Session	Facilitation
1	8:30 - 9:00	Registration	
2	9:00 - 9:10	Welcome	Najib Assifi
3	9:10 - 9:40	Introductions	Kiran Bhatia (APRO)
4	9:40 - 10:30	Key concepts: Gender & GBV GBV as a public health issue	Riet Groenen (Pacific SRO) Chair: Salman Asif (Pakistan)
Coffee break 10:30 - 10:45, Group photo			
5	10:45 - 11:30	Key concepts: the integration of GBV into the health system	Resource person: Jane Koizal-McLain Expert Comments: Saramma Mathai (APRO) Chair: Zaman Ara (Bangladesh)
6	11:30 - 12:00	UNFPA corporate policy and history of approaches to GBV as a public health issue	Interactive Exercise: Kiran Bhatia (APRO)
7	12:00 - 1:00	Highlights of the Assessment of Health Sector Response to GBV in the Asia Pacific Region	Presenters: Emma Fulu & Lakshmen Senanayake Chair: Wassana Im-em (Thailand)
Lunch 1:00 - 2:00			
8	2:00 - 2:45	Group discussion of issues raised in the assessment presentation	South Asia group leader: - Venkatesh Srinivasan (India) Southeast Asia group leader: - Pamela Marie Averion (Philippines) Pacific/Timor group leader: - Caroline Meenagh (Timor-Leste) - Venkatesh Srinivasan (India) Health Systems Perspective group leader: Munire Bassir (Iran)
9	2:45 - 3:15	Group presentations to plenary	Chair: Gilbert Hiawalyer (PNG)
Coffee break 3:15 - 3:30			
10	3:30 - 5:15	RH linkages with GBV HIV/STI, Pregnancy related and GBV linkages with emergencies.	Panel: - Jane Wilson (UNAIDS) - Chaiyos Kunanusont (APRO) - Wame Baravilala (Pacific SRO) - Wame Baravilala (Pacific SRO) with CO presenters (Sri Lanka and Myanmar TBC) Chair: Saramma Mathai (APRO)
11	5:15 - 5:45	Gallery walk	COs share and dialogue on products and programmes

Day 2 – December 2, 2009: Skill building

	Time	Session	Facilitation
1	8:30 - 9:00	Day 1 review	Kiran Bhatia (APRO)
2	9:00 - 10:15	Models of services; analysis of different approaches by health systems to address GBV	Resource person: Manuela Colombini Chair: Lakshman Senanayake

Coffee break 10:15 - 10:35

Panel discussions: Best practices & challenges: Skill building Panel discussions on four key dimensions with three relevant country examples for each panel			
3	10:35 - 11:35	Introduction: the case of India; historical analysis of strategies and interventions	Venkatesh Srinivasan (India) Anuja Gulati (India) Chair: Professor S. Jaswal
4	11:35 - 1:00	Panel 1: Policy and Protocols Opening Presentation: Country 1: Philippines Country 2: PNG Country 3: China	Resource person: Dr. Anwarul, Chair: Nigina Abaszade (Afghanistan)

Lunch 1:00 - 2:00

5	2:00 - 3:30	Panel 2: Capacity building approaches for the health sector Presentation: Jane Koizal-McLain Parallel Group Presentations & Discussions: Country 1: Indonesia Country 2: Sri Lanka Country 3: Myanmar	Resource person: Jane Koizal-McLain Chair: Dechen Chime (Bhutan)
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Coffee break 3:30 - 3:50

6	3:50-5:00	Panel 3: Referral and screening Country 1: Malaysia Country 2: Vietnam Country 3: Timor-Leste	Commentator: Manuela Colombini Chair: Chandy Chea (Cambodia)
	6:00 onwards	Party time	

Day 3 – December 3, 2009: Linkages and field realities

	Time	Session	Facilitation
1	8:30 - 9:00	Day 2 review	Facilitators Team
2	9:00 -10:30	Panel 4: Documentation and data management Presentation: Wassana Im-em & Dr. Chanvit Tharathep (Thailand) Country 1: Maldives Country 2: Bangladesh Country 3: Nepal	Chair: Prof. S. Jaswal
3	10:30 -11:00	Field visit briefing	Dr. Chanvit Tharathep (Thailand) Rizvina de Alwis

Lunch 11:00 - 12:00

4	12:00 - 4:00	Field visit to: 1 Thammasat Chalermprakiet Hospital Child and Women Protection Unit 2 Saraburi Hospital OSCC	Rizvina and Thailand CO team
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Day 4 – December 4, 2009: UNFPA forward planning

	Time	Session	Facilitation
1	8:30 - 9:00	Field visit debriefing	Dr. Chanvit Tharathep (Thailand) Lakshmen Senanayake Rizvina de Alwis
2	9:00 - 11:00	Creating an integrated health sector response to GBV: Critical linkages	Simulation exercise Facilitator: Kiran Bhatia (APRO)

Coffee break 11:00 - 11:20

3	11:20 -12:00	Forward planning by country and regional teams: learning from CO AWP's	Kiran Bhatia (APRO) Rizvina De Alwis (APRO) Chair: Banzragch Oyun (Mongolia)
4	12:00 - 1:00	Defining next steps for policy and programme development for COs	Group Work

Lunch 1:00 - 2:00

5	2:00 - 3:00	Gallery walk	Participants and Facilitation team
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Coffee break 3:00 - 3:30

6	3:30 - 4:00	The next steps for 2010: Plans for follow-up	Chair: Saramma Mathai (APRO)
7	4:00 - 4:30	Closing ceremony and evaluation	Najib Assifi

Annex 2: List of participants

APRO Workshop on Strengthening Health Sector Response to GBV, 1-4 December 2009, Bangkok, Thailand

List of participants

No.		Given Name	Last Name	Title	Country
Country Offices					
1	Ms.	Nigina	Abaszade	Programme Analyst	Afghanistan
2	Dr.	Zaman	Ara	National Programme Officer-RH	Bangladesh
3	Ms.	Dechen	Chime	National Programme Officer	Bhutan
4	Ms.	Chandy	Chea	Gender Programme Officer	Cambodia
5	Mr.	Sochea	Sam	National Programme Associate	Cambodia
6	Ms.	Maja	Hansen	Professional Officer	China
7	Mr.	Venkatesh	Srinivasan	Assistant Representative	India
8	Ms.	Anuja	Gulati	State Programme Officer	India
9	Ms.	Ramot Nurlela	Aritonang	Programme Associate on Gender and monitoring and evaluation systems (M&E)	Indonesia
10	Ms.	Monire-Therese	Bassir	Programme Specialist	Iran
11	Ms.	Ghazal	Chegini	National Project Assistant	Iran
12	Ms.	Pafoualee	Leechuefoung	National Programme Officer	Lao PDR
13	Ms.	Viengthong	Manivone	National Programme Officer	Lao PDR
14	Ms.	Tengku Aira Tengku	Razif	Programme Assistant (Gender Focal Point)	Malaysia
15	Ms.	Shadiya	Ibrahim	Assistant Representative	Maldives
16	Dr.	Aseel	Jaleel	Consultant, OBGYN	Maldives

No.		Given Name	Last Name	Title	Country
17	Ms.	Banzragch	Oyun	National Programme Officer-Gender/PD	Mongolia
18	Ms.	Khorloo	Enkhjargal	National Programme Officer-RH	Mongolia
19	Dr.	Myat Pan	Hmone	Women's Protection Coordinator	Myanmar
20	Dr.	Mya	Thet		Myanmar
21	Dr.	Badri Maya	Manandhar	Medical Officer	Nepal
22	Ms.	Lubna	Tajik	Provincial Coordinator	Pakistan
23	Mr.	Salman	Asif	Gender Advisor	Pakistan
24	Mr.	Gilbert	Hiawalyer	Assistant Representative	PNG
25	Mr.	Hendry	Plaza	National Programme Officer	Philippines
26	Ms.	Pamela Marie	Averion	National Programme Officer-Gender and Culture	Philippines
27	Ms.	Chandani	Galwaduge	Programme Advisor	Sri Lanka
28	Ms.	Shamila	Daluwatte	National Programme Officer-Gender	Myanmar
29	Dr.	Taweesap	Siraprapasiri	Programme Officer	Thailand
30	Ms.	Sukanya	Thongthumrong	National Programme Associate	Thailand
31	Ms.	Caroline	Meenagh	GBV Project Manager	Timor-Leste
32	Dr.	Domingas	Bernardo	National Programme Officer-RH	Timor-Leste
33	Ms.	Do Thi Minh	Chau	National Programme Analyst, Gender Manager	Viet Nam
34	Ms.	Phan Thi Thu	Hien	National Programme Analyst, Ethnic Minority and Safe Motherhood	Viet Nam

No.		Given Name	Last Name	Title	Country
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APRO

35	Ms.	Kiran	Bhatia	Adviser, Gender	APRO
36	Ms.	Rizvina	De Alwis	Programme Specialist	APRO
37	Ms.	Saramma	Mathai	Adviser, Maternal Health	APRO
38	Dr.	Chaiyos	Kunanusont	Adviser, HIV	APRO

Pacific SRO

39	Mr.	Wame	Baravilala	Advisor, R.H.	Pacific SRO
40	Ms.	Riet	Groenen	Adviser, Gender	Pacific SRO

Resource Persons and Consultants

41	Mr.	Anwarul Amin	Mars	Head of Sub Directorate Health Technology Directorate of Medical Services Specialist, MoH	Indonesia
42	Dr.	Chanwit	Tharathep	Director, Bureau of Health Service System Development, DoH	Thailand
43	Ms.	Emma	Fulu	Consultant	Australia
44	Ms.	Jane	Koziol-McLain	Co-Director, Interdisciplinary Trauma Research Unit, School of Health Care Practice, Auckland University of Technology	New Zealand
45	Ms.	Jane	Wilson	Regional Programme Advisor, UNAIDS Asia Pacific Intercountry Team	Thailand
46	Dr.	Lakshmen	Senanayake	Consultant	Sri Lanka
47	Ms.	Manuela	Colombini	Research Fellow, Centre for Population Studies, London School of Hygiene and Tropical Medicine	England
48	Ms.	Surinder	Jaswal	Professor & Dean, School of Social Work, Tata Institute of Social Sciences	India
49	Ms.	Wassana	Im-em	Assistant Representative	Thailand

Annex 3:

Detailed outline on the content and focus of the assessment from a health system perspective

While considering the different structural variations of the health care systems that exist in different countries, this tool was developed by the consultants to guide the assessment of the health system responses to GBV. The tool was developed drawing on evidence and experience from similar assessments with input and advice from a number of RH and gender experts.

<p>Incorporation of GBV in policies of the MoH</p>	<ul style="list-style-type: none"> • Health Policies <ul style="list-style-type: none"> - Ex: National health policy, specified health policies MCH, mental health, HIV/STD policy, youth policy • Availability of policies specifically addressing GBV issues <ul style="list-style-type: none"> - Ex: policy on reporting of GBV - Policy on patients privacy and confidentiality - Policy on discrimination against women/GBV survivors - Policy on screening all women/special groups such as pregnant mothers - Sexual harassment policy
<p>Policy on incorporating GBV into data collection mechanism such as DHS</p>	<ul style="list-style-type: none"> • Availability of information on GBV in DHS or other national publication of the MoH • Inclusion of GBV data in routine HMIS, both preventive and treatment services
<p>Mechanism for implementation of national policies related to GBV</p>	<ul style="list-style-type: none"> • Responsible directorate such as MCH identified to address GBV • Focal points appointed at different levels of the health system • Availability of national level committee on GBV/violence in MoH to support and monitor such activities
<p>Budgetary allocation/financial availability for addressing GBV from the national/provincial budget</p>	<ul style="list-style-type: none"> • Separate budget line for the programmes/projects • Allocations through other programmes

National protocols/guidelines for addressing GBV issues	<ul style="list-style-type: none"> • Protocols on patient privacy and confidentiality • Protocols on management of GBV/DV • Protocols for risk assessment in GBV/DV • Protocols for management of situations at high risk (high risk of suicide, homicide, injury or extreme emotional distress) • Protocols for management of rape and sexual abuse Reporting forms, body maps developed at national level • Protocols available in prevention and management of SGBV during crises • Availability of these documents at different levels of institutions
Mechanism for national (including provincial) MoH capacity building	<ul style="list-style-type: none"> • Sensitisation activities for high-level policy makers and high-level officials of the MoH conducted • Incorporation of GBV training into undergraduate/ post graduate curricula of medical school • Incorporation of GBV training into curricula of nurses, midwives and other health staff • Regular short courses on GBV including refresher training/skills development of doctors/nurses (CPD) • Recruitment, training and availability of counsellors to work with highly sensitive persons in specific health settings
Referral networks and alliances with other governmental and NGO service organisations	Referral networks and linkages with other relevant service providers social services, NGOs at all levels (national, provincial, district and service delivery point level)
Provision of dedicated services to survivors of GBV	<ul style="list-style-type: none"> • Service points for GBV survivors in different models established as a part of the MoH response (may or may not be supported by outside funds but initiated by the state) • Integrated approach within the existing MCH/family planning/women's health programmes and in the OPDs and in other specialties (e.g. OBGYN, surgical, medical)
National level preventive strategies led by health sector	<ul style="list-style-type: none"> • Incorporation of GBV into community health • Inclusion GBV into the curricula of community health workers • Development of Information, education and communications (IEC) materials addressing community • Preventive health programmes on GBV with the community • Incorporation of GBV into RH programmes such as school health, adolescent health and youth programmes • Addressing through social marketing campaigns • Active involvement of the professional colleges (i.e. OBGYN, surgeons, physicians, psychiatrists, community physicians)
GBV research	<ul style="list-style-type: none"> • Support GBV research • Operational research on health sector response to prevent and manage GBV



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