Section

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Background and Epidemiology

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Chapter

1

Current Scenario of Sexual Violence

Vaishali Korde-Nayak

Sexual violence affects millions of women globally and its management had been out of the preview of health practitioners in the private sector. With the wide publicity of the Nirbhaya case in Delhi in December 2012, this issue has been brought center stage with a huge movement backed by political will. New laws have been brought into place with standardization of reporting and collection of medical evidence. All health providers are covered by these laws and it has become the responsibility of every doctor, whether in the public or private sector, to offer all medical support to the survivors of sexual abuse. Hence, it is important for doctors, especially gynecologists, to be updated and be aware of all legal, criminal, judicial, jurisprudence and health-related procedures, which will assist them in managing survivors of sexual abuse and also prevent themselves from facing difficulties with the law.

Definition of Sexual Assault, Related Acts and Laws

The World Health Organization (WHO) defines sexual violence as: "Any sexual Act, attempt to obtain a sexual Act, unwanted sexual comments/advances and Acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim on any setting, including but not limited to home and work.

The definition of rape (Section 375 of IPC)[1] as per the recent amendment (The Criminal Law (Amendment) Bill, 2013 as **passed by Lok Sabha on 19 March, 2013)** apart from peno-vaginal sexual intercourse includes other forms of sexual assault like oral penetration, urethral/anal penetration, fingering, use of objects (other than penis) for vaginal, urethral and anal penetration.

It also includes manipulation of any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any other part of body and application of mouth to the vagina, anus, urethra of woman and regards it as a 'rape' under the various circumstances explained in the law (for details please *see* Section II of Relevant Laws).

Section 354 of IPC deals with "criminal assault on a woman with intent to outrage her modesty" and Section 377 of IPC deals with "carnal intercourse against the order of nature". Immoral Traffic Prevention Act deals with human trafficking.[2]

WHO estimates that 150 million girls and 73 million boys under the age of 18 years are sexually abused every year.[3] Every second child is facing some form of sexual violence somewhere in the world!

The Important Terms

1. *Survivor* recognizes that the person is capable of taking decisions despite being victimized, humiliated and traumatized due to the assault. Use of the term survivor is important—believe the person and not pity her.
2. "*Victim*" is understood as a person who is not fully capable of comprehending situation at hand because of the victimhood faced, usually brought in by police. Victim also means a person is in need of compassion, care, validation, and support. The belief is that the person is so victimized that she may not be in a frame of mind to make decisions independently.
3. *Patient*, if a person comes on her own, term patient can be used.
4. *Accused* can be an adult or child. According to Protection of Children from Sexual Offences (POCSO) Act, 2012, any person both male and female, above the age of 18 years is an adult [IPC 2013]. Any person below 18 years, according to POCSO Act, 2012, is child.
5. *Sexual violence* is a significant cause of physical and psychological harm and suffering for women and children. Although sexual violence mostly affects women and girls, boys are also subject to child sexual abuse. Adult men, especially in police custody or prisons may also be subject to sexual violence, as also sexual minorities, especially the transgender community.

The perpetrators range from strangers to state agencies to intimate partners; evidence shows that perpetrators are usually persons known to the survivor.

Doctors have a dual role to play in terms of the Sexual Violence and Assaults and POCSO Act, 2012.

> *"Violence against women is perhaps the most shameful violation of human rights. It knows no boundaries of geography, culture or wealth. As long as it continues, we cannot claim to be making real progress towards equality, development and peace."*
>
> **—Kofi Annan, United Nations General, Assembly, New York, 5–9 June, 2000**

Culprits

More than 95% of sex offenders are relatives, neighbors, and friends. Hence, a majority of the cases go unreported.[3] Amongst those which are reported, 90% do not get justice because of lack of evidence.

Failure of Medical Profession

95% of victims do not get justice because doctors do not document correctly, nor do they collect the evidence correctly. The most important apathy of doctors is, the private sector of the medical profession does not want to get involved.

The two-finger test (TFT): Doctors still continue to use the 2-finger test as evidence. It is a judgemental and invalid test.

Widely performed across India, TFT checks the elasticity of a victim's vagina. A doctor gives his opinion on whether a woman is "habituated to sex" or not. Does that mean that "married women cannot get raped?" Does this mean that a woman who is in a consensual relationship deserves to be raped by others?

Most countries have scrapped it as archaic, unscientific and invasion of privacy and dignity.

In 1997, the law stipulated that only female doctors handle medical exam of rape victims.

In 2005, **ALL** registered medical practitioners (RMPs) were legally empowered to handle such cases.

These changes have introduced more physicians, to these sensitive examinations.

Problems in the Current Response of the Medical Profession to Sexual Assault to India

- Overemphasis on presence of injuries in medical examination. Absence of injuries interpreted as sexual assault did not take place.
- Poor history taking, nonrecognition of nonpeno-vaginal assaults.
- Mandatory police requisition for examination of sexual assault.
- Doctors attitudes—fear of appearing in court, avoidance, stereotypes about rape.
- Inadequate update on current situation that now it is **mandatory for all doctors approached by the survivor to collect evidence**.

Changes in the Acts after Nirbhaya

Amendments to the Indian Penal Code, Section 375 in 2013.[1]

- Expanded the definition of rape which also includes voyeurism, stalking, acid attacks and on proven guilty.
- Severe punishment of more than 7 years of imprisonment.

The POCSO Act, 2012

- The Protection of Children from Sexual Offences (POCSO) Act, 2012. It is applicable to whole of India and protects all children below 18 years from sexual harassment, sexual assault (penetrative and aggravated) and from using a child for pornographic purposes.
- Abetment or even an unsuccessful attempt to commit these offences are also punishable under the Act.
- Mandatory obligation to report the matter—media, hotel staff, hospital staff, clubs, photographic facilities, etc.
- Mandatory for police to register a FIR.
- Child's statement can be recorded at the child's home or place of his choice, preferably by a female police officer, not below the rank of sub-inspector.
- Amendments in the POCSO Act were passed in the Rajya Sabha on 24th July, 2019 including death penalty for aggravated sexual assault on children. Stringent punishment for other crimes against minors. Fines and imprisonment to curb child pornography.

The Manodhairya Yojana of the Maharashtra Government

- Initiated on 2nd October 2013, offers compensation to survivors of sexual abuse and acid attacks by the Government Amendment to the code of Criminal Procedure in 2009 that mandated state governments to have schemes for compensation of victims. Compensation—varies from ₹ 50,000 to ₹ 3 lakhs.
- Government to set up support services such as counseling, medical and legal aid.

FIGO Recommendation[4]

- Every gynecologist who is responsible for conducting medical forensic examinations should be trained, equipped and willing to present evidence in court of law. This is a duty towards sexually abused women, of all ages. Professionalism requires be discharged.
- If specialized rape crisis centers are unavailable, private locations should be provided.
- Consent needed to conduct medical forensic examination and all tests.
- While respecting their choice, doctors should stress advantages of this examination.

FIGO's priority is to address the barriers for clinicians to respond to violence against women through the use of advocacy, training and services.

How can we correct the present scenario?

- Training of medical students and sensitization of medicos.
- Change in medical (MBBS) curriculum by MCI/NMC. At least one question related to this subject should be included in the examination for undergraduate as well as postgraduate certification.
- To educate on uniform protocols for:
  - Examination of the victim
  - Collection of evidence
  - Referrals to other units
  - Management of the victim following abuse.

Violence Against Women

The United Nations defines violence against women as "any Act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such Acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[5]

Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Almost one-third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. The prevalence estimates of intimate partner violence range from 23.2% in high-income countries and 24.6% in the WHO Western Pacific region to 37% in the WHO Eastern Mediterranean region, and 37.7% in the WHO South-East Asia region.[6]

Globally as many as 38% of all murders of women are committed by intimate partners. In addition to intimate partner violence, globally 7% of women report having been sexually assaulted by someone other than a partner, although data for nonpartner sexual violence are more limited.[6] Intimate partner and sexual violence are mostly perpetrated by men against women.

In May 2014, the Sixty-seventh World Health Assembly (WHA) adopted resolution WHA67.15 on "strengthening the role of the health system in addressing violence, in particular against women and girls, and against children." It requests the Director-General "to develop, with the full participation of Member States, and in consultation

with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate; a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, building on existing relevant WHO work."[6]

The scope of the global plan of action is guided by resolution WHA67.15. The plan focuses on violence against women and girls, and against children, while also addressing common actions relevant to all types of interpersonal violence. It also addresses interpersonal violence against women and girls, and against children, in situations of humanitarian emergencies and post-conflict settings, recognizing that such violence is exacerbated in these settings.

CONCLUSION

Violence is preventable and is not inevitable. There is a need to address the economic and sociocultural factors that foster a culture of violence against women (VAW). Health care systems can reinforce interventions for prevention and management of gender-based violence particularly against women and girls. The health care system is the only institution that interacts with almost every woman at some point in her life and women living with violence are likely to visit health facilities more frequently than nonabused.

Interventions by health providers can potentially mitigate both the short- and long-term health effects of gender-based violence on women and their families.

REFERENCES

1. Central Government Act. Section 375 in The Indian Penal Code. https://indiankanoon.org/doc/623254/(accessed 02/01/2021).
2. MoHFW Guidelines and protocols: Medico-legal care for survivors/victims of sexual violence. 2013;23–7.
3. World Health Organization. Global status report on violence prevention 2014. https://www.who.int/publications/i/item/9789241564793 (accessed 02/01/2021).
4. Benagiano G. The role of FIGO in addressing violence against women: International journal of gynecology and obstetrics: 2002;78(1):S125–27.
5. World Health Organization. Violence against women. https://www.who.int/news-room/fact-sheets/detail/violence-against-women (accessed 02/01/2021).
6. WHO clinical and policy guidelines: Responding to intimate partner and sexual violence against women 2013.

Chapter

2

Domestic Violence in COVID Crisis

Padmini Murthy

Abstract

The ongoing COVID-19 crisis has brought affected the global community in more ways than one. Not only has it resulted in the loss of millions of lives globally but has contributed to the dramatic rise in violence globally. Unfortunately, women are at greater risk of domestic violence and the silent pandemic as it is termed has increased during a pandemic especially during COVID. It is aptly as termed a shadow pandemic as many times the abuse is not evident to others but is present and is sometimes all pervasive, i.e. the girls and women in the family may be subject to ongoing Acts of violence. This chapter discusses the reasons why COVID-19 crisis has exacerbated domestic violence/gender-based violence (GBV) globally. The importance and positive outcomes of multi-sectoral approach in addressing DV/GBV during the current crisis will be mentioned in addition to highlighting examples of gender focused best practices in the context of addressing domestic violence globally.

Introduction

If we are to fight discrimination and injustice against women, we must start from the home for if a woman cannot be safe in her own house then she cannot be expected to feel safe anywhere.

Aysha Taryam

There has been a "horrifying global surge in domestic violence" since the start of the COVID-19 lockdowns, said United Nations secretary-general António Guterres in early April.

It is interesting to note the regional or global nature of despair associated with fear and uncertainty of pandemics provides an enabling environment that may exacerbate or spark diverse forms of violence against women including domestic violence. These which have described and documented an increase of violence against women during or post-pandemic are unfortunately scarce. On the other hand, media reports and anecdotal accounts of domestic violence are widespread. To illustrate this when the Ebola outbreak hit West Africa, an "epidemic" of "rape, sexual assault and violence against women and girls" was reported and this caused considerable collateral damage on many fronts.

Malaysia, for example, reported 57% more calls to domestic abuse helplines between 18 March and 26 March. Moreover, sexual and reproductive health clinics are closing worldwide.

In the United States, the National Domestic Violence hotline was proactive in releasing information in early March 2020 just as the pandemic started in the USA. The agency released a publication on "Staying Safe" during COVID-19, including anecdotal evidence of how perpetrators were using the virus as a scare tactic to threaten or isolate victims, and advising those at risk (i.e. women and girls) to have a safety plan, practice self-care and to reach out for assistance.[1]

Another challenge being faced globally is the closure of sexual and reproductive health clinics during COVID and lack of shelters for women to seek refuge as victims of domestic violence and this is a double burden they are facing.

Contributing Factors

Some of the contributing direct and indirect factors to domestic violence and gender-based violence globally are:[1]

1. Economic insecurity and poverty-related stress
2. Quarantine and social isolation
3. Disaster and conflict-related unrest and instability
4. Exposure to exploitative relationships due to changing demographics
5. Reduced health service availability and access to first responders
6. Inability of women to temporarily escape abusive partners
7. Virus-specific sources of violence (example mentioned above)
8. Exposure to violence and coercion in response efforts
9. Violence perpetrated against health care workers—especially female health care workers suffer a double burden in the homes and at work.

In addition, lack of gender equity and cultural practices which stifle women including mechanisms which deny women from expressing their opinion also contribute to the shadow pandemic, namely domestic violence/gender-based violence.

Challenges due to Pandemics including COVID-19

During the current and ongoing COVID crisis women have been affected disproportionately economically and socially.

Economic Hardship

According to a report released by the United Nations earlier this year, the crisis has precipitated disproportionally more layoffs among women, and this has impacted the rolling back of the slim gains made in female labor force. In addition, the economic hardship brought on due to the crisis has severely limited women's ability to support themselves and their families. Their hardships in many instances have further been compounded by the loss of employment of their male spouses or partners which has put them and their daughters at an increased risk for violence. The economic impact has been even more pronounced in female headed households as well.

Unfortunately, the current social protection systems and nets fall short and as mentioned in the brief, majority of women in S. Asia, sub-Saharan Africa, Latin America and The Caribbean work in the informal sector and in addition to facing an increased risk due to domestic violence do not have access to health care services.[2]

Health Challenges

In addition to economic hardships women have faced health challenges. For example, women may be at risk or exposure due to the occupational sex-segregation and it is important for the global community to note that 70% of health workers are women. Most of the nurses globally are women and have been the frontline workers during the current pandemic as are midwives, laundry workers and community health workers who have an increased risk of being exposed to the virus. They also often do not have access to personal protective equipment such as masks, caps, gloves, and gowns and this is another illustration of gender-based violence and domestic violence. To further illustrate this many women are not allowed to wear PPE by their male partners at home since the masks may be used by the men as women and girls are not considered valuable and disposable in many instances. Women continue to be shut out of global decision making and this impacts their reproductive and sexual health and general health as well. The UN policy brief further estimated that an additional 18 million women will lose regular access to modern contraceptives, given the current context of COVID-19 pandemics.[3]

There has been an increased incidence of unwanted pregnancies since girls cannot go to school due to crisis and the quarantine restrictions and many of them have been forced into early marriage by their parents. The pandemic has seen a rise in the number of unwanted teenage pregnancies, globally.

After the recent Ebola outbreak in Sierra Leone in 2014, some studies estimated that teenage pregnancies were 23% higher than in the previous year.[3]

For example, in Kenya authorities in the country have been registering thousands of additional cases of pregnant underage girls during the current pandemic. This is because they lack access to birth control and in many instances have been sexually abused often by strangers because of rape. In sub-Saharan Africa, a report released in October 2020 alone, 608,000 additional girls are thought to be at risk of child marriage, and 542,000 additional girls at risk of early pregnancy. As we are aware adolescent pregnancies have grave consequences for women's health. Teenagers are often at a higher risk for maternal morbidity and mortality. Which is even more exacerbated during the present. As mentioned earlier the number of girls dropping out of school has increased and one of the contributing factors has been pregnancy. This will have not only a short-term impact but a long-term impact as well.

Unfortunately female health care providers globally are at an increased of abuse when they give the patient or relatives news that the patient has tested positive for COVID and are often blamed. This is illogical as these frontline workers whether a physician, nurse or a laboratory technician give information about a positive test but are not responsible for the disease. This is an example of institutional violence and further contributes to the burden of violence against women which has resulted in "burn out" and exhaustion.

In addition to the physical injuries sustained because of women being in proximity with their male partners who are abusive they also experience severe mental trauma and often as already mentioned do not have access to the necessary support and health care services. Due to the lack of safety nets these women often have no where to go and are also at an increased risk for suicide. They are unfortunately unable to enjoy

good health which according to the World Health Organization is a complete state of physical, mental, and social well-being. Often women and girls who are affected by COVID may be denied access to supportive treatment as often their lives due to the all pervasive gender inequality.

The lack of feminine hygiene products during the pandemic has been a major challenge. Girls and women do not have access to sanitary pads, tampons, and menstrual cups. Access to these products is further compounded by economic hardship, social restrictions, and lack of availability. Furthermore, girls and women with physical deformities and mental health issues who are often marginalized face even more challenges in access to feminine hygiene products.

Social Hardships

In addition, the lack of access to clean running water for women and the girl child is an illustration of gender-based violence/domestic violence. To illustrate this further the chore of fetching water is mostly regarded as the responsibility of the women or girls and during the pandemic this task has become even more challenging due to the risks of getting exposed to the virus or raped. Very often women and girls do not have the freedom to use the water they have brought, and this is another illustration of violence against women and girls since they are often forced to go out without protection in unsafe conditions during the pandemic. Restrictions due to gender norms being enforced, need to obtain permission to access health care services and not being able to access social support as they are often isolated and threatened by their abusers and since most of the male partners are at home due to quarantine or being unemployment the incidence of physical and emotional violence against women and girls increases. To sum up the various challenges faced by these women are many fold.

Tracking the Gender Impact of COVID-19

The use of a gender lens in tracking COVID-19 is a valuable tool in addressing the disproportionate effects of COVID. Unfortunately, at present the available data to track primary health effects by sex on cases and deaths is incomplete for most of the global population and is practically. Nonexistent for low income countries. It is also unavailable for reference even for health care workers, and the data is available only in a few handful of countries.

1. Countries such as the US which are affluent or rich and mid-incomes countries such as Brazil have not clearly reported infection rates by sex/gender (although they report deaths by sex).
2. The lack of recent data is a problem for most indicators to track secondary effects, as is the regularity with which they are reported since 2015 when the sustainable development goals were adopted the UN member states.
3. At present there is adequate data to track secondary health effects on maternal health and adolescent births, but ironically there is insufficient data to document effects of lack of access and the well-being of girls. The available data on women's mental health have adequate coverage and frequency but are based on estimates with large gaps in underlying data. This unfortunately is not an accurate picture as estimates are used.

4. The economic indicators often inadequate to track the secondary effects of the pandemic on economic well-being by gender. Neither job losses nor increases in unpaid care work by sex can be fully monitored with the available data. In contrast, sex-disaggregated education indicators are most abundant with available time series. One of the reasons could be lack of data on number of women working in the informal sector.
5. "Indicators like social protection coverage, personal ID coverage, and mobile phone ownership, which can monitor whether short-term mitigation measures exacerbate pre-existing gender inequalities, have been incorporated only recently into international data sets and have low coverage. This is a significant data gap in need of immediate attention."
6. "Gaps in frequency and timeliness for most indicators selected to track the gender effects of the pandemic are greater for rich than for poor countries, constraining rich countries' abilities to monitor the effects of the pandemic on gender inequalities."[4]

Examples of Best Practices Globally

1. Kenya and Trinidad and Tobago are making use of technology in their judiciary to address the issue of GBV.
2. Pharmacies and supermarkets in France and Spain are a part of a safety network and have put into place emergency warning systems to provide counseling services to victims of GBV and assist with reporting abuse during the current crisis.
3. In another move, almost 20,000 hotel rooms across France have been designated as safe spaces.
4. The police department in Odisha is using telephone services to reach out to those women who lodged complaints about abuse pre-COVID crisis.[2]
5. The United Nations Development Program (UNDP) in Somalia has partnered with local communities to implement neighborhood watch initiatives in local communities and to make them alert to any incidents of GBV in their area.
6. Similarly, in Mexico, UNDP, is working with another UN agency, namely UN women to use phones and online platforms to support vulnerable women via the LUNA centers, which have been created as safe spaces for women and girls.
7. In the Dominican Republic, UNDP and BHD Bank recently created a partnership to facilitate referral services of domestic violence cases that are reported by the bank's customers. This is a great illustration of public–private partnership in addressing the silent pandemic of GBV.
8. In addition, UNDP is coordinating with other UN sister agencies, development partners, and governments on Spotlight Initiative, a joint EU–UN partnership to end violence against women and girls. This global, multi-year initiative aims to assist 50 million direct beneficiaries across five regions and more than 25 countries.[2]

Recommendations by World Health Organization for health systems and abused women: Please refer to the enclosed Figures 2.1 and 2.2.

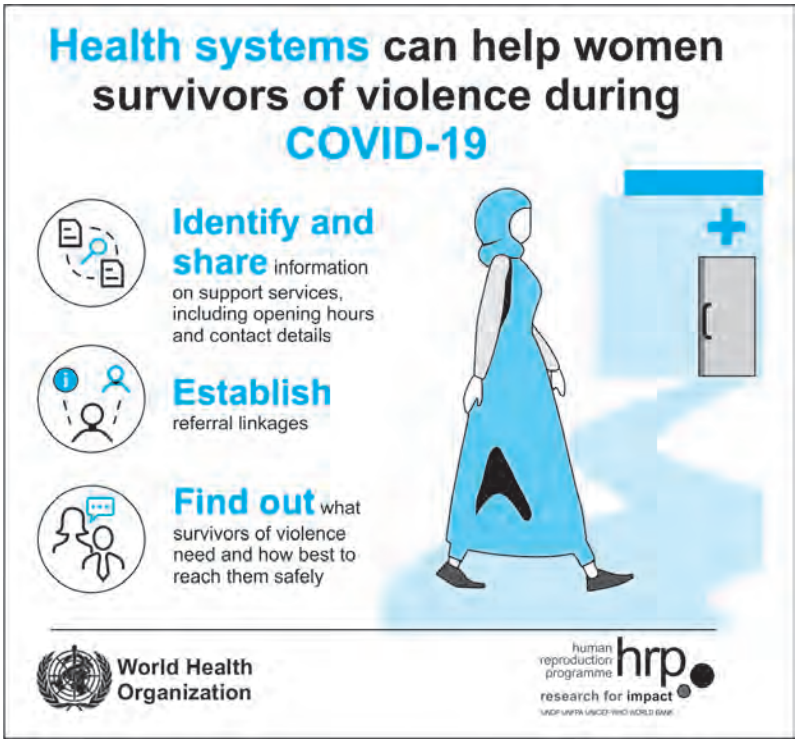

Figure 2.1: WHO recommendations

Figure 2.2: WHO recommendations

Double Pandemic: *Please refer to the enclosed Figure 2.3.*

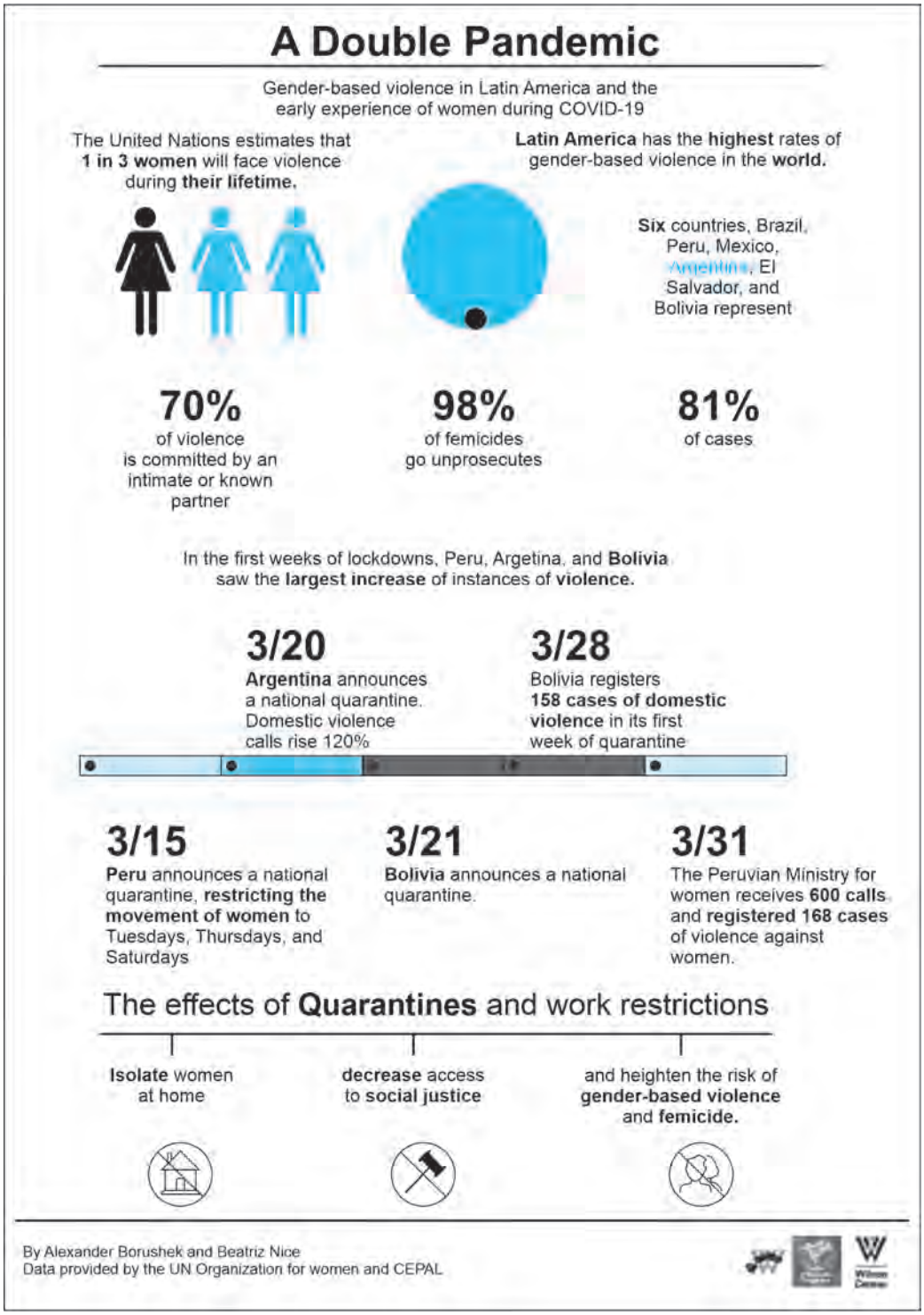

Figure 2.3: Shadow pandemic

CONCLUSION

The shadow or silent pandemic as gender-based violence is known which includes domestic violence has unfortunately reached enormous proportions and according to estimates by UN women is 243 million women have been subjected to gender-based violence which includes domestic violence since the past 12 months. Unfortunately, COVID crisis has stretched the health care systems globally to the breaking point and has reduced the available resources to address the shadow pandemic. The way forward that if we as a global community want to promote health and well-being for all in social and recovery efforts and strengthen our existing health care systems and delivery especially for women and girls they need to be included in the front and center of decision making and response.

REFERENCES

1. Center for Global Development (2020). Pandemics and Violence Against Women and Children. Working Paper 528 Accessed October 4 https://www.cgdev.org/sites/default/files/pandemics-and-vawg-april2.pdf
2. UN Women. 2020. UN Secretary-General's Policy Brief: The Impact Of COVID-19 On Women |Digital Library: Publications. [online]. Accessed October 4 Available at: https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women.
3. United Nations Population Fund (2018) Recovering from the Ebola Virus Disease: Rapid Assessment of Pregnant Adolescent Girls in Sierra Leone. Accessed October 4 https://sierraleone.unfpa.org/en/publications/recovering-ebola-virus-disease-rapid-assessment-pregnant-adolescent-girls-sierra-leone.
4. Data 2 X Buvinic M, Noe L, Swanson E. Tracking the gender Impact of COVID-19 https://data2x.org/tracking-the-gender-impact-of-covid-19/. Accessed October 4.

Chapter

3 European Online Training Platform on Domestic Violence—Improving Frontline Responses to Domestic Violence and Sexual Assault

Bettina Pfleiderer, Paulina Juszczyk

Abstract

Health professionals are often the first point of contact for victims of domestic violence and thus play a major role in the detection and intervention of domestic violence. Interviews with professionals from the medical sector within the EU IMPRODOVA research project (www.improdova.eu) indicated that they are not sufficiently trained in domestic violence and that they are not aware of their role as frontline responders in cases of domestic violence. It also became clear that interagency collaboration was lacking. IMPRODOVA designed therefore training formats and materials not only for the health sector but also for the police and the social sector to improve frontline responders' competencies to prevent, investigate and mitigate domestic violence. In this article, we are presenting the IMPRODOVA online training platform (www.training.improdova.eu) with a focus on the medical sector.

The IMPRODOVA Project and its Methodology

The IMPRODOVA project (https://www.improdova.eu)—improving frontline responses to high impact domestic violence—is a search and innovation project funded by the European Union. It involves a group of experienced researchers and practitioners from eight European countries: Austria, Finland, France, Germany, Hungary, Portugal, Slovenia, and UK (Scotland) working together to provide solutions for an integrated response to high impact domestic violence (HIDV), based on comprehensive empirical research of how police, medical and social work professionals respond to domestic violence in European countries. IMPRODOVA's operational definition of high impact domestic violence (HIDV) is serious violence within the family, against children, spouses and elderly family members. Seriousness can be intensity, duration and consequences of violence.

IMPRODOVA started in May 2018 with a duration of 36 months. Due to the current COVID-19 situation, the project will be extended by four months. In **phase 1**, IMPRODOVA started with the analysis of policy implementation, legislation, data, risk assessment, case documentation, cooperation, and trainings, including the status quo of the medical profession related to domestic violence (DV). In **phase 2**, 296 interviews with different frontline responders from the police, the health sector, and the social sector in eight European countries were conducted to investigate frontline responder

practices with a special emphasis on interagency cooperation to assess the extent to which standards are converted into practice and the actors being involved in multi-professional approaches to tackle DV. In **phase 3**, the project developed tool kits addressing for example risk assessment practices and a training platform with various training materials was designed to improve a multi-agency collaboration. All those tools and the training platform are currently being evaluated, and the feedback given will be used to further optimize them to the need of the practitioners being part of DV frontline response. Figure 3.1 summarizes the timeline of the project.

In theory, we know very well how to prevent, detect and mitigate domestic violence. However, in daily practice these recommendations and guidelines are not always implemented. Across Europe, there are examples of good practices from which we can learn. For instance, in some countries (e.g. Germany) programmes exist that promote the involvement of the medical profession in domestic violence fighting networks (e.g.https://training.improdova.eu/en/training-modules-for-the-social-sector/module-7-principles-of-interorganisational-cooperation-and-risk-assessment-in-cases-of-domestic-violence-in-multi-professional-eams/2/) and have received good outcomes. This best practice examples have been collated by the IMPRODOVA consortium and are shared via the training platform.

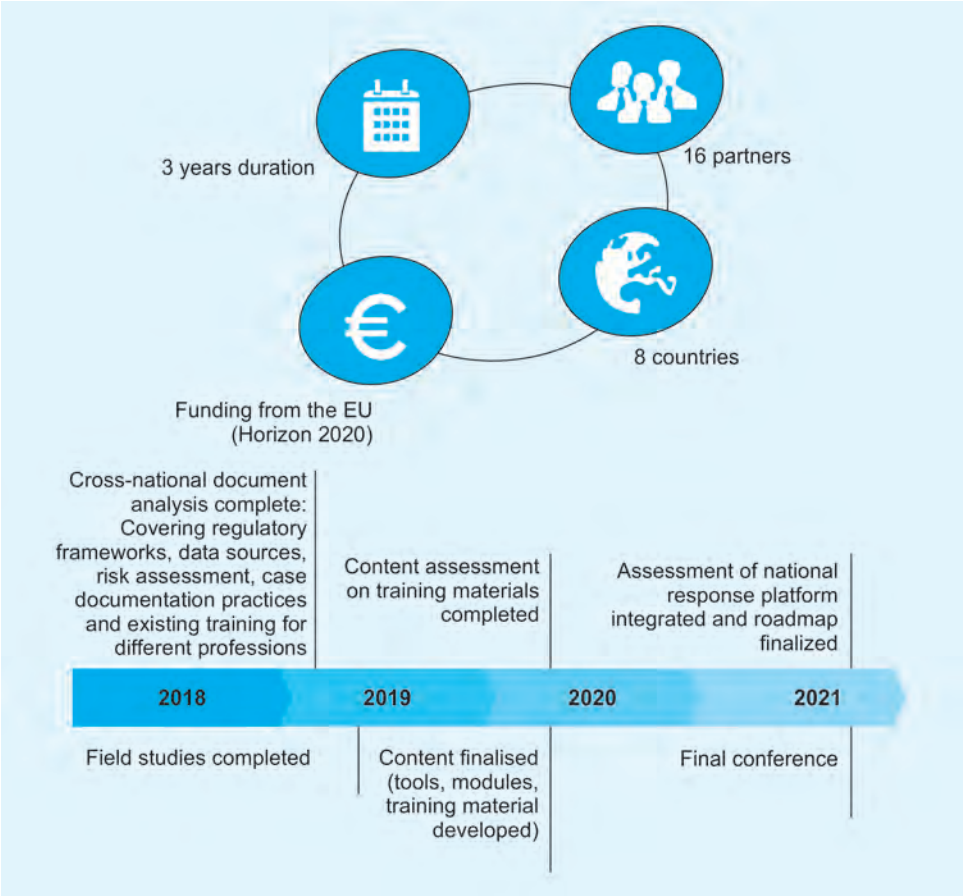

Figure 3.1: Timeline of the IMPRODOVA project

Why the Health Sector Needs Training on Domestic Violence?

Domestic violence can lead to short- and long-term health consequences, prompting victims of domestic violence to seek help from the medical profession. For this reason, health professionals are often the first point of contact for victims of domestic violence and thus play a major role in the detection and intervention of domestic violence. General practitioners, emergency physicians, emergency paramedics, gynecologists, midwives and nurses as well as dentists[1] are the health professionals who most frequently encounter victims of domestic violence and thereby among those who first hear about an incident or perceive indicators or symptoms of domestic violence. The medical profession is not only considered by the Istanbul Convention;[2] (Article 18 (114); Article 20 (127); Article 22 (132); Article 25 (141)) to be an important stakeholder, but its role is also highlighted by numerous authors in research studies.[3–5]

However, based on the interviews with health professionals in the IMPRODOVA countries, it has become apparent that they are not sufficiently trained in domestic violence. Knowledge about domestic violence, symptoms and red flags are often not part of the mandatory curriculum for physicians or at medical school for medical students in most European countries. Therefore, many health professionals are not aware of the important role they play in the network. They see their role primarily in taking care of the medical needs of their patients and rarely consider themselves as frontline responders to domestic violence. A better understanding of their own role, but also of the roles of other frontline responders is necessary in order to work together against domestic violence and to help victims. First studies show good results regarding the identification of domestic abuse following trainings.[6]

Therefore, IMPRODOVA designed training formats and materials to optimize frontline strategies by providing scenario-based learning, material of workshops, educational videos tailored to the various frontline responders, as well as guidelines to enhance frontline responders' cooperation across different professions. These outputs aim at improving frontline responders' capacities and competencies to prevent, investigate and mitigate domestic violence. An online training platform was drafted to make the training formats and materials publicly available (Figure 3.2).

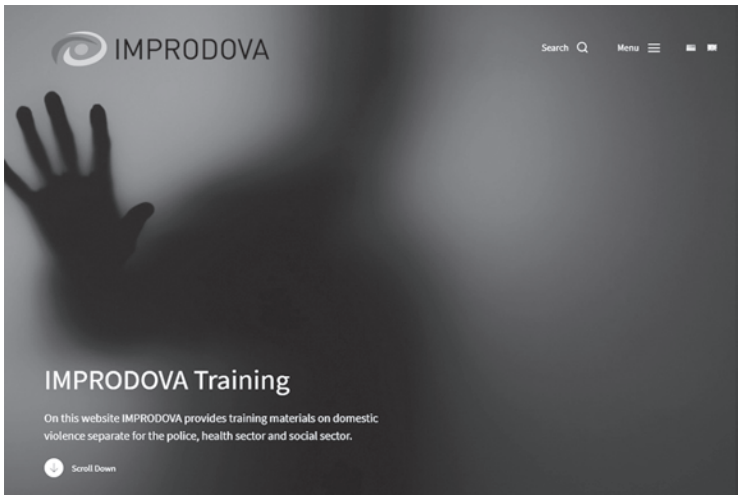

Figure 3.2: Screenshot of the homepage of the IMPRODOVA training platform (https://training.improdova.eu/)

Training Modules on Domestic Violence or Why Knowledge is Power

The IMPRODOVA training platform addresses three main frontline responder groups: The police, the health sector and professionals from NGOs and the social sector. It is modular and consists of seven modules for each frontline responder group, which are thematically the same, but with adapted content to the sector (Figure 3.3). **Module 1 (forms and dynamics of domestic violence)** aims at gaining a better understanding of domestic violence and its forms and consequences. Knowledge is transmitted about the specific contexts and the impact of domestic abuse that can be a helpful step in understanding the individual needs of victims. The objective of **Module 2 (indicators of domestic violence)** is to become familiar with the various indicators for domestic violence, their related risks and to be sensitised to them. As one of the first points of contact, health professionals have the opportunity to identify victims of domestic violence at a relatively early stage and ensure that victims receive the individual support they need quickly. **Module 3 (communication in cases of domestic violence)** presents the different ways of asking about domestic violence in situations where a frontline responder suspects the presence of domestic violence. Furthermore, first steps after the disclosure of domestic violence are presented. Especially, medical staff can stay in contact with victims afterwards and follow-up their situation. **Module 4 for the police (police investigation and legal proceedings)** presents the most important aspects to be considered in police investigations and subsequent legal proceedings after the disclosure of domestic violence. **Module 4 for the health sector (medical assessment and securing of evidence)** presents the most important aspects to be considered after the disclosure of domestic violence and how to document domestic violence injuries for legal trials. It explains in particular how the securing of evidence by a physician can be done in such way that it can be used as evidence in court. **Module 4 for the social sector (support services of the social sector)** presents the help offered by social services after the disclosure of domestic violence. Different contact points are introduced to the reader. **Module 5 (risk assessment and safety planning)** presents why risk assessment is such an important step when tackling domestic violence and what needs to be considered when assessing the risk of victims of domestic violence and what steps are necessary to improve the safety of victims. Knowing these facts, health professionals could intervene long before victims would make the decision to leave the perpetrator or report the incident to the police. **Module 6 (international standards and legal frameworks in Europe)** introduces the international framework in which the work of frontline responders takes place and also presents country-specific regulations in order to gain an impression of how other European countries tackle

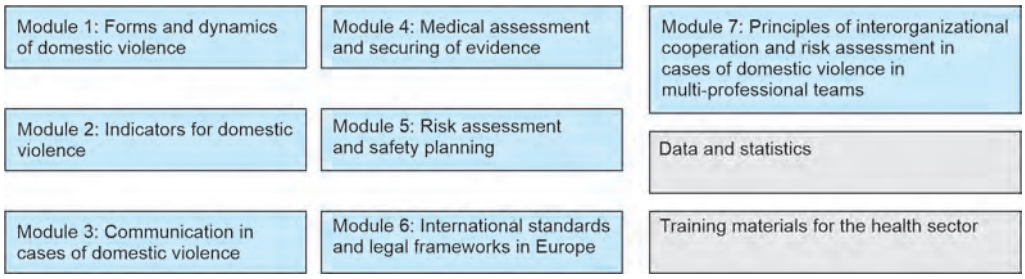

Figure 3.3: Training modules being included in the IMPRODOVA training platform on domestic violence for the health sector

domestic violence. The aim of **Module 7 (principles of interorganizational cooperation and risk assessment in cases of domestic violence in multi-professional teams)** is to understand how frontline responders work and why cooperation in multi-professional teams is most successful in tackling domestic violence.

The Recurring Problem of Limited Time Resources

15 minutes sections are implemented for the police, the health sector and the social sector, where the most important information for the three frontline responder groups is summarized hereby considering the limited time resources of practitioners. Because of the tight schedule and the shortage of human resources, speaking with victims about domestic violence is usually considered as almost impossible by physicians. The aim of this tailored section for the medical sector **"Domestic violence in the health sector in 15 minutes"** is to support practitioners in identifying patients and their children who have been victims of domestic violence and to respond to them appropriately in a very short time. It gives an overview of possible indicators for domestic violence and its physical and psychological consequences. Beyond that, it includes guidelines for patient care and some legal information.

The Necessary Tools

In addition to the seven modules and 15 minutes sections, information regarding **data and statistics** is presented for all frontline responder groups in a separate section. The section includes information about victimization surveys and police data in the EU as those sources have produced most reliable and extensive data available. Additionally, recommendations on good data harmonization and consolidation that should be regarded, are summarized.

Training videos, case studies and **scenario-based learning, knowledge assessments**, and downloadable **factsheets** and **presentations**, as well as an exemplary **workshop concept** for the health sector, that can be adapted by trainers, can be found in the various modules or can be selected separately from the teaching materials. The training videos were produced on the following topics:

- Domestic violence in times of disasters.
- The UN and their role in combating violence against women.
- Why is cooperation in cases of domestic violence important?
- Who are the perpetrators of domestic violence?
- Who are the victims of domestic violence?
- What happens when you contact a victim protection shelter?
- What happens when you call the police?
- How to respond to a disclosure?
- Domestic violence in health services.

Case studies and **scenario-based learning** of the health sector deal with the disclosure of domestic violence to the primary care physician or in medical practice, domestic violence affecting mental health, elder abuse, the negative impact of domestic violence on children and violence during pregnancy. The section also includes the IMPRODOVA risk assessment integration module that explains the whole risk assessment procedure for a specific case (Figure 3.4).

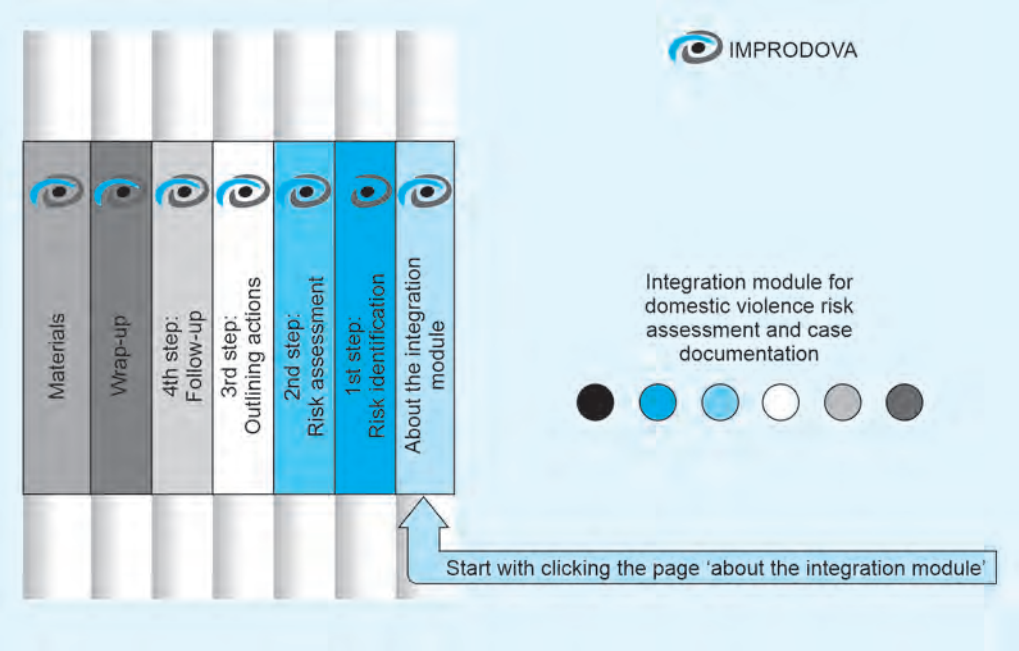

Figure 3.4: Screenshot of the integration module for domestic violence risk assessment and case documentation on the platform. Online link: https://training.improdova.eu/wp-content/uploads/2020/08/Improdova_Risk_Assessment_Integration_Module_Final.pptx

The Missing Pieces

As mentioned before, the IMPRODOVA training platform presents an overview of domestic violence on the EU level and corresponding policies, but does not necessarily reflect national or local contexts. Therefore, as a best practice model for a national version of the international training platform a German IMPRODOVA training platform was developed (https://training.improdova.eu/de/). The whole IMPRODOVA training platform and related materials were translated into German and adapted to the German context.

Assessment of the IMPRODOVA Training Platform or Getting Better and Better

The assessment of the IMPRODOVA training platform serves to further optimize the training materials offered. Both the English and the German training platforms are currently being evaluated. An elective student course has been developed (28 hr) and was held already twice—due to the Corona Pandemic online—on the topic "Domestic violence in an International Context" at the medical faculty in Münster. The course was based on the German training platform. First feedback results revealed that the training platform, including its teaching materials, has resulted in a significant learning and competence progress of the students in all subject areas (Figures 3.5 and 3.6). Also, the students' interest in regional cooperation with other frontline responders, which was lower as compared to other topics prior to the student class, increased after the class. Our students were particularly interested in the communication with victims in cases of domestic violence and in the case studies offered on the training platform.

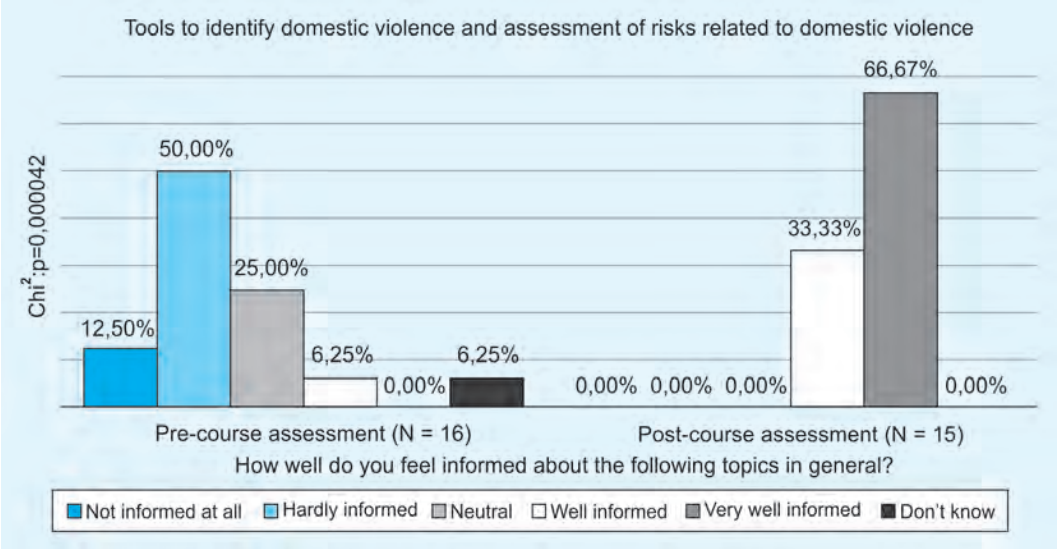

Figure 3.5: Feedback of students indicated that they felt much better informed about tools to identify domestic violence and assessment of risks related to domestic violence after the student course

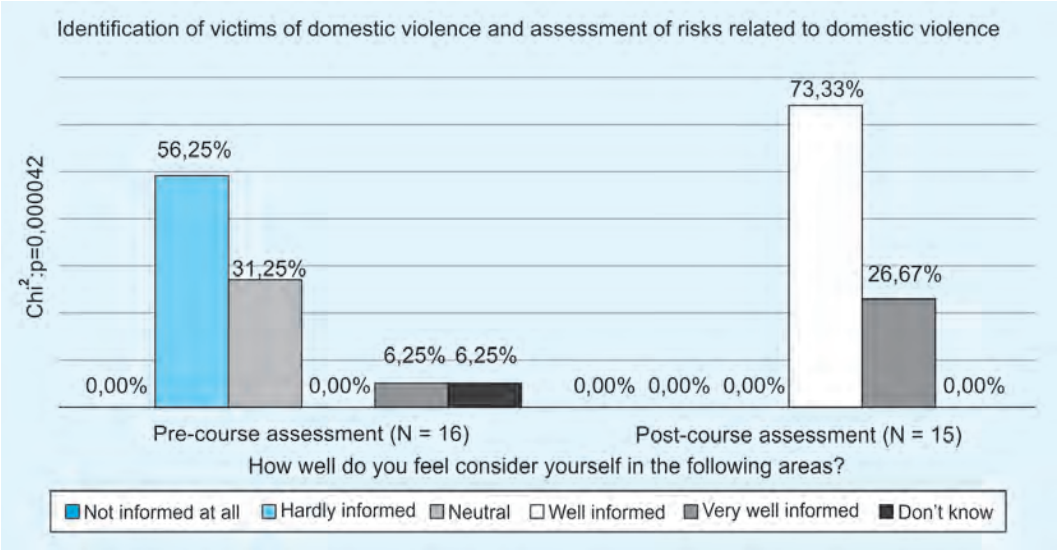

Figure 3.6: Feedback of students showed they felt more competent about the identification of victims of domestic violence and assessment of risks related to domestic violence after the student course

The feedback also indicated that there are still some gaps in the content of the platform that need to be filled. For this reason, work is already underway on supplementary content on domestic violence in the media, domestic violence in times of COVID-19 and information tailored to school teachers.

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only the authors' view and the European Commission is not responsible for any use that may be made of the information it contains.

REFERENCES

1. Ellis TW, Brownstein S, Beitchman K, Lifshitz J. Restoring More than Smiles in Broken Homes: Dental and Oral Biomarkers of Brain Injury in Domestic Violence. J Aggress Maltreat Trauma [Internet]. 2019 Apr [cited 2020 Dec 9];28(7):838-847. Available from: https://doi.org/10.1080/10926771.2019.1595803.
2. Council of Europe. Convention on preventing and combating violence against women and domestic violence. Council of Europe Treaty Series-No. 210. 2011 [cited 2020 Nov 27]. Available from: www.coe.int/conventionviolence.
3. Alsaedi JA, Elbarrany WG, Al Majnon WA, Al-Namankany AA. Barriers that Impede Primary Health Care Physicians from Screening Women for Domestic Violence at Makkah ALmukarramah City. Egypt J Hosp Med [Internet]. 2017 Oct [cited 2020 Dec 9];69(8):3058–3065. Available from: https://doi.org/10.12816/0042856.
4. Jenner SC, Etzold SS, Oesterhelweg L, Stickel A, Kurmeyer C, Reinemann D, Oertelt-Prigione S. Barriers to active inquiry about intimate partner violence among German physicians participating in a mandatory training. J Fam Violence [Internet]. 2015 Jul [cited 2020 Dec 9];31(1):109-117. Available from: https://doi.org/10.1007/s10896-015-9754-2.
5. Piterman L, Komesaroff PA, Piterman H, Jones KJ. Domestic violence: it is time for the medical profession to play its part. Intern Med J [Internet]. 2015 May 8 [cited 2020 Dec 9];45(5):471-473. Available from: https://doi.org/10.1111/imj.12738.
6. Edwardsen EA, Horwitz SH, Pless NA, le Roux HD, Fiscella KA. Improving identification and management of partner violence: examining the process of academic detailing: a qualitative study. BMC Med Educ [Internet]. 2011 Jun [cited 2020 Dec 9];11(36). Available from: https://doi.org/10.1186/1472-6920-11-36.

Chapter

4

WWWCON—The Way Forward

Meera Agnihotri

A new journey was started with WWW Foundation (Women Health Wellness for Women Empowerment) in collaboration with ARTIST (Asian Research and Training Institute for Skill Transfer) and IHW Council (Integrated Health and Wellbeing Council), details of which are discussed here as the way forward to help survivors.

Background

Prof Meera Agnihotri, Chief Patron, Kanpur ObGy Society (KOGS) received the most prestigious Women Empowerment National Award at AICOG (All India Conference of Obstetrics and Gynaecology) on 21st Jan 2018 at Bhubaneshwar, Odisha. There after she was bestowed with the honor to organize WWWCON International Conference, FOGSI (Women Health and Wellness for Woman Empowerment) as Organizing Chairperson. We were really blessed that for the first time in the history of FOGSI Hon'ble President of India Shri Ramnath Kovind Ji had agreed to inaugurate this conference. In this event, women's health issues from womb to tomb were discussed. Health sanitation, hygiene, medical, social, spiritual all aspects were covered by Stalwarts, including 200 national and international faculty. Representatives of state including UP ministers and Mayor of Kanpur participated in the Public Forum held on the issue of prevention of violence against women.

Mission and Message of Dr Meera Agnihotri (Founder)

Being Medical Doctor — Treating Patience is my Profession
Being Medical Teacher — Teaching is my duty and Privilege
Women Empowerment is my Passion

Being inspired by recognition of my work for Women Empowerment activities we have transformed WWWCON blessed by President of India and Union Health Minister into WWW Foundation. With the same aims and objectives to empower our women and transform the status of females in our country.

The issue of **Women Empowerment** is a **Global Concern and one of the prime agendas** of WHO (World Health Organization) and it is one of the greatest concerns of our country. The Global scenario of women health wellness is well-known; it needs a

U-turn to empower our women with the different health agendas including **medical health, maternal diet and nutrition, empowering women the motherhood, spiritual evolution, making them disease free, vaccination against preventable diseases, improving reproductive health of women and many more.**

In India, although a number of policies are provided **by central and state governments** and many more are in pipeline will be met, yet women in our country are still looked upon as 2nd grade in the man dominated (patriarchal society).

Figure 4.1: WWWCON 2018 Inauguration by Hon President of India

Figure 4.2: WWWCON 2018 Panel discussion with FOGSI Stalwarts, Politicians and Media

Figure 4.3: WWWCON Public Forum Dr Meera Agnihotri and Dr Reena Wani

Six "S" are Basically Needed to Empower the Women

Shiksha = Education
Swasthya = Health
Swavlamban = Self Reliance
Samajik Nyay = Justice
Samvedan = Sensitivity
Samta = Equality

Social Obstetrics is one of the most important 7th tools Empowering Women.

It can change the basic concept of all the **SIX "S" needed to empower women**. This book covers **each and every aspect right from "Womb-to-tomb"**. The journey of humanity in womb starts right from two different cells; ovum from mother and sperm from father, zygote implanting *in utero* and the transformation into a complete human being in short span of nine months is most fascination. Fetus is our second patient who is privileged with "Right of unborn child". It is entirely the jurisdiction of obstetricians to **protect the unborn legally, medically, socially, and spiritually**.

Therefore, the face of antenatal care has undergone revolutionary change and a paradigm shift in the last couple of decades with the advent of fetal medicine. Obstetrics has now diversified into a dual care pathway addressing the needs of mother and the fetus as two different patients rather than common entity. It needs further Empowering Mother.

FOGSI focus was released at WWWCON: In this book efforts are made to include and discuss the latest **concept in health issues related to women** in an attempt to empower than as it carries all the issues of **obstetrics and gynecology including social obstetrics. This received best Publication Award in AICOG, Lucknow 2020**.

Plans for Implementation

Initially 4 geographical zones (N, S, E, W) were identified but the need to have activities in each state was felt to be pressing hence decision has been taken to have a coordinator in each state to take forward the activities for Women Empowerment.

She will restart a new life, new mission, new commitment
She needs our support in addition to government support