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Health care of women victims of intimate partner violence
– a policy perspective –

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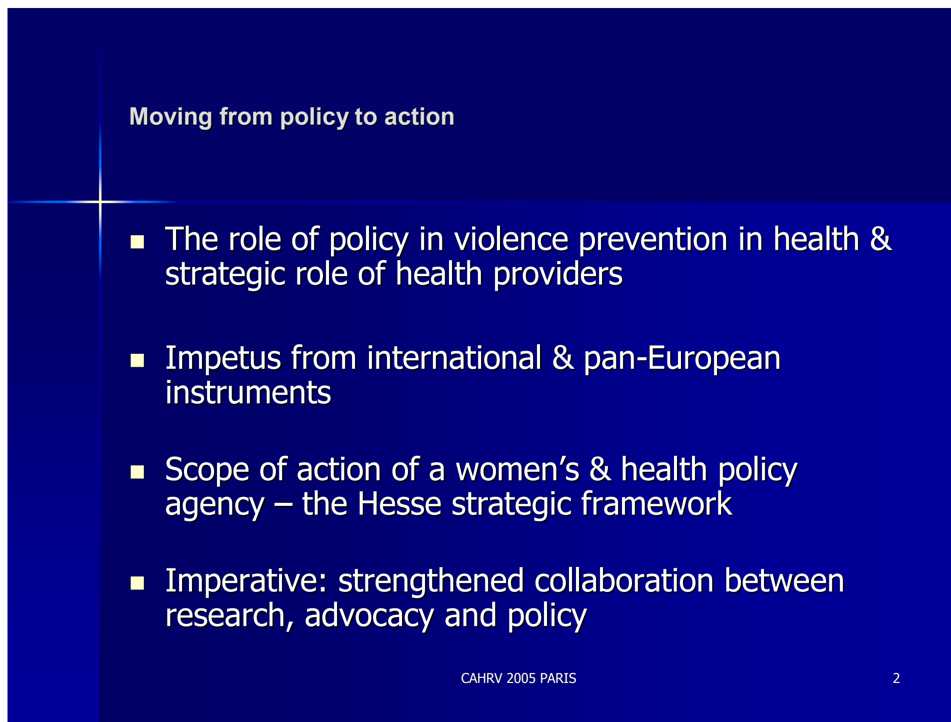
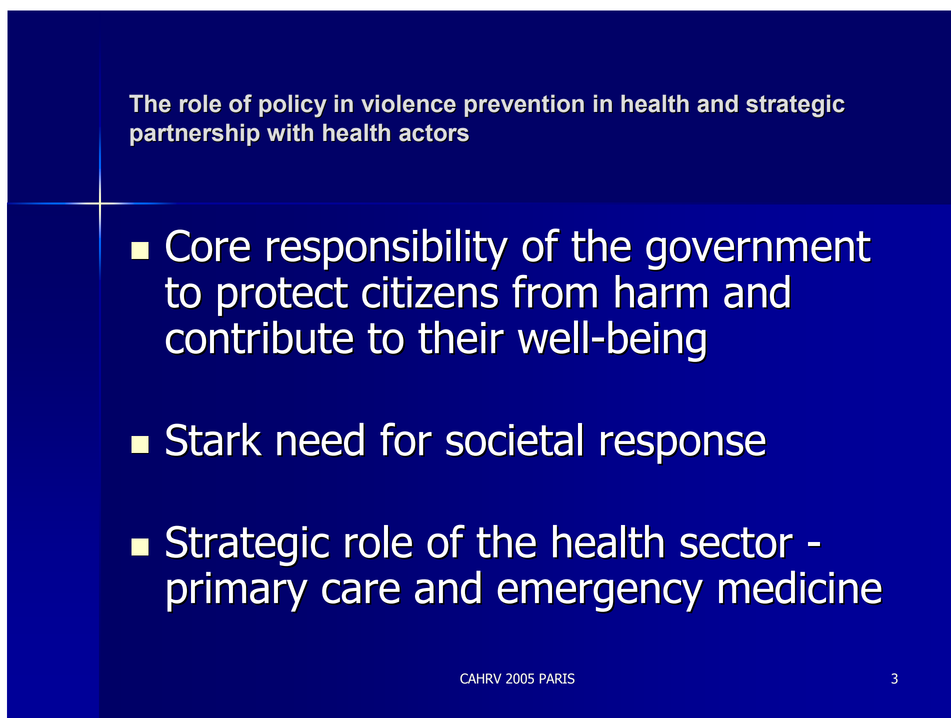
Hesse and European Violence Prevention in Health Networks

Introduction:
My topic today is the health care of women victims of intimate partner violence from a policy perspective.
First, I want to be sure you know what I mean when I use the term "policy" as it can mean different things in different places.
My use of the term reflects the German system that is my professional home. Elsewhere I have heard the term used to describe the work of NGOs involved in opinion-building and defining standards for good practice. In Germany, policy-makers are all either in the government or in self-governing bodies entrusted with public responsibilities. We include professional associations among self-governing entities. Medical associations are such policy-makers and are increasingly focussing on violence in health. They have a broad range of public health policy issues to attend to and to a certain degree define the state of the art of medical care. All German physicians belong to a medical association and therefore have a vested interest in the opinion-building and standard writing accomplished by medical associations.
In sum, when I use the term "policy" I mean the standards and structures a public agency or self-governing body develops. And, as the case may be, binding law passed by parliament, often first drafted in agencies and ministries.

In my presentation I will address the following points:



The role of policy in violence prevention in health and strategic partnership with health actors:



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The government has a core responsibility to protect citizens from harm and contribute to their well-being. This is especially true where violence is concerned. Violence poses a threat both to individuals and the community at large.

The health consequences are directly related with significant impairment, including of mental health in the short and long-term. As Carol Hagemann-White and Sabine Bohne determined after a thorough review of the literature and qualitative interviews with health actors in Germany, every health issue could potentially be connected to violence. As studies by several members of the CAHRV network and elsewhere have shown, intimate partner violence is the most common form of abuse women experience. The World Health Organization's review of the literature revealed that between 40-70% of female murder victims are killed by their husband or boyfriend.
And as Sylvia Walby among others has demonstrated, its social and human costs are staggering.

Health has a key role to play in providing adequate care and preventing additional harm. Considerably more cases of interpersonal violence come to the attention of health-care providers than to the police, other authorities or women's advocates. The outcome of an injury resulting from violence depends not only upon its severity, but also on the speed and appropriateness of treatment. Appropriate treatment includes systematic referrals to suitable organizations who will meet the individual's non-medical needs - for psychological, social and legal support. Regrettably, this is not yet normal practice. It is imperative that we systematically include health in our violence protections.
It makes STRATEGIC SENSE TO FORMULATE POLICY that will enable health professionals to be active in comprehensive violence prevention and protection efforts. Health training and working conditions need to be such that health professionals can act as key gatekeepers. They have the skills and arguably also an ethical responsibility to monitor, identify, treat and intervene in cooperation with other professions and sectors.

What authority can public policy draw on to involve health in violence prevention?

Impetus from international and pan-European instruments, the missing link:

Eradication of violence against women is key to gender equality

- International treaties and conventions
  - International Human Rights Treaties
  - 1949 Geneva Convention and their 1977 Protocols
  - Treaties of Rome (1957) and subsequent development of social protections / civil rights in the European Union
  - The Convention on the Elimination of All Forms of Discrimination against Women (1979)

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The body of international law on human rights and equal rights is abundant and has contributed to gender equality standards across the world. However, none of the treaties and conventions listed here on this slide has connected the eradication of violence against women with gender equality.

International consensus can help civil society to obtain change:

International consensus can help civil society to obtain change

- International consensus documents specifically addressing gender violence
  - Vienna World Conference on Human Rights (1993)
  - U.N. Declaration on the Elimination of Violence against Women (1993)
  - Fourth World Conference on Women in Beijing (1995)
  - World Health Assembly resolutions declaring health a leading public health problem (1996) and adopting the WHO recommendations for public health action (2003)

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The Vienna world conference on human rights in 1993 was a breakthrough. This meeting recognized that women's rights are human rights. That traditions denying women a healthy and safe life must never prevail over human rights.
Another big moment in international consensus building was the Beijing conference in 1995, calling for monitoring and the elimination of violence against women world-wide. Since then, policy has consistently cited the Beijing conference to justify taking action. The research community also relies heavily on Beijing.
The World Health Assembly, the annual meeting of ministers of health, soon after Beijing declared violence a leading public health problem. The WHO followed through with a world-wide investigation of interventions and programmes. They looked at what has been done to reduce interpersonal violence, and what is known about effectiveness. The results and recommendations were published in 2002.

Global and European foundations for strategies to establish violence prevention in health as a state-of-the-art standard of care:

Global and European foundations for strategies to establish violence prevention in health as a state-of-the-art standard of care

- World health report on violence and health (2002) and subsequent Global campaign for violence prevention
- Daphne initiative (1997-1999) and Daphne programmes to combat violence against children, youths and women (since 2000)
  - priority for health sector 2003
  - continued focus on monitoring, surveillance, validation of promising practice in Daphne II 2004-2008

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The World health report on violence and health provides impetus for making use of the health sector's capacity to define, understand, and address the health challenges which violence imposes.
In fact, the WHO sees health actors and therefore ministries of health as being the leaders in the field of violence prevention. I am not so sure health policy is quite ready to run the show.
In Europe, since 1997 the Daphne initiative and programmes have provided a platform for multi-national efforts. Perhaps in response to the WHO report in 2002, the European Commission put health intervention on top priority for Daphne funding in 2003.

Scope of action of a policy-making agency in Germany:

Scope of action
- Hesse Department of Social Welfare

- Long-term goal: overcome fragmented initiatives, achieve effective results through cohesion
- Strategic framework for public policy to combat violence against women
  - facilitator & coordinator roles
  - guidance and empowerment tools

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Now to get to the role of women's and health policy agencies in Germany:

Be it a ministry at the federal or regional level, our long-term goal is to be more effective at protecting women from violence. To close gaps in protection, to overcome fragmentation of responses and responsibilities. To reach this goal, we typically taken on facilitator and coordinator roles.

- Typically, a women's policy unit will head up task forces involving all relevant institutions. This way policy can facilitate stakeholder involvement, help overcome institutional barriers and co-ordinate responsibilities.
- Public policy helps install guidance and empowerment tools – in Germany we have been relying on action plans and law reforms.
  - An action plan to combat gender violence provides a framework for cohesive responses. actors in the community are entrusted with clear-cut roles. In the best of all worlds this results in co-ordinated intervention, rehabilitation and prevention.
  - Law reforms can be particularly empowering for the individual. A violence protection act that guarantees individuals' rights, potentially will replace the victim role with self-determination.
  - Community actors who participate in continuous analysis/monitoring of the application of action plans and legal framework empower civil society. This contributes to societal recognition of responsibility to protect women from violence. And it is a good way to move from policy to action.

- Much of women's and health policy in Germany has devised schemes to involve health actors. We have been pretty successful at doing this in my region and have contributed to national policy debate. We have also ventured into the great European debate that a Daphne project engenders. What came out of this is the European Violence Prevention in Health Network. This slide delineates our immediate and long-term goals:

Daphne Project goals and accomplishments:

Action radius of a women's & health policy agency
- Hesse Department of Social Welfare
(2)

Daphne Project 03/175/WC - 2003-2004

- Immediate-term goals:
  - gather first pan-European, multi-centre medico-legal evaluation data on violence against women and children
  - situational analysis of medico-legal health services throughout Europe
  - concerted and diverse practice development at community level
- Long-term goal:
  - provide the basis for a sustainable European violence prevention in health network – multi-sectoral approach

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Daphne project results (1)

- Preliminary prevalence findings in medico-legal community
  - first European multi-centre pilot-study
- First overview of medico-legal services for surviving victims of interpersonal violence
- Sustainability and growth at community-level

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– Our multi-centre epidemiological study involved 6 medico-legal institutes using a common data base. The data covers the magnitude, scope, characteristics and consequences of violence against women and children.

– Our pan European medico-legal practice survey: addressed 2003 medico-legal institutes throughout Europe (including Eastern European countries outside the Union.) With 91 responders, we had a response rate of 44,8%. We learned that over 90% of these respondents are involved in evaluation and care of surviving victims primarily of intimate partner violence and child abuse.

– The network capacity-building focus of the project has had an impact locally, regionally and internationally.
  - Most of the participating medico-legal institutes have become immersed in networks in their own communities.
  - On the European regional level we created new links. Hesse could link up with two of its European partner regions – the Aquitaine in France and Emilia Romagna in Italy. This was a first opportunity to connect our efforts to combat violence against women. And the pan-European practice survey identified potential for expanding collaboration in the medico-legal community.

- On a global level, collaboration with WHO has been close. This includes support and cooperation through the global networking initiative Violence Prevention Alliance. My ministry is a founding member of this initiative which works to facilitate the implementation of the recommendations of the World report on violence and health.

Daphne project results (2)

- Established specific potential of the medico-legal community to contribute to
  - national and European violence and health observatories
  - co-ordinated health evaluation and care of survivors of interpersonal violence
  - strategic efforts to involve health actors in community-based violence prevention networks

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In sum, this one-year Daphne project was very ambitious. It was able to establish the specific potential of the medico-legal community to contribute to violence prevention in health in three ways.

1. Medico-legal institutes are able to contribute valuable data to national and European violence and health observatories.
2. Medico-legal victim emergency services are able to *co-ordinate* health evaluation and care in their clinics as well as community responses. This helps to avoid repeated exams and interviews, speeds up emergency care where time is of an essence, and community support can kick in more readily. All of this in turn helps to prevent secondary victimization. Finally,
3. when a medico-legal institute immerses itself in community networks, there can be at least two positive outcomes. Forensic physicians contribute to knowledge transfer by sharing their unique evaluation and documentation skills, and they help create an environment which encourages

other health actors to get on board.

Daphne project results (3)

Expansion to date of the European Violence Prevention Network

- Vienna/Austria
- Liège/Belgium
- Tartu/Estonia
- Bordeaux/France
- multiple actors throughout Germany
- Bristol/GB
- Emilia Romagna/Italy
- multiple actors in Spain
- Bern/Switzerland
- Cardiff/Wales
- global community through WHO & the Violence Prevention Alliance

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One of my roles as the sole policy-maker in this project was to facilitate expansion of the network. I have been able to help link the participating institutes with advocacy and policy in their communities. This effort continues as the network expands.

The European Violence Prevention in Health Network has great potential for being sustainable. We stay in contact with each other as sounding boards and help each other present research findings and practice development results at such conferences as these – seldom in settings such as this one, albeit. And we have written grant proposals to be able to do more funded project work together. We are hoping for the best.

Conclusion:

TO CONCLUDE:

- Lessons learned
  - Pivotal position of policy agencies to facilitate multi-sectoral intervention and violence prevention
  - Health actors have a key role to play in bridging the gap between care needs and services available to victims
- Imperative:
  - strengthen collaboration between research, advocacy and policy
  - achieve science based, sustainable violence prevention in health throughout Europe

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I hope to have brought home the point that

- Public policy is in a pivotal position to facilitate multi-sectoral intervention and violence prevention,
- health actors have a key role to play in bridging the gap between care needs and services available to victims. And finally,
- if we want to obtain science-based, sustainable violence prevention in health throughout Europe, and I think we do, we would be well advised to strengthen collaboration between research, advocacy and policy.

I believe the European Violence Prevention in Health Network is a very good forum for pursuing that goal. I also am convinced it makes good strategic sense to link our networks.

Thank you for today's opportunity to do just that. Thank you all for your attention.