Abstract

Recent surveys have shown a prevalence of domestic violence during pregnancy. In order to explore possibilities of a joint activity linking gender inequality and mother and child health, the WHO Regional Office for Europe Making Pregnancy Safer initiative and the Gender Mainstreaming programme developed a joint approach. The Republic of Moldova, pilot country for Making Pregnancy Safer in Europe, was chosen as a model to verify if maternity care could address the needs of pregnant women experiencing abuse. In April 2005, the WHO Collaborating Centre on Gender Mainstreaming, Glasgow conducted a training of trainers with the objective of involving family doctors and other primary health care providers in identifying and managing domestic violence. It was concluded that awareness of violence against women is growing in Moldova, as is a gathering momentum for change. The health service is in a unique position to address abuse, given its engagement with women, however, while central to women experiencing abuse, meeting their needs will require a co-ordinated, multisectoral response to maximise health gain and integrate policy planning and service delivery.

World Health Organization
Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18. E-mail: postmaster@euro.who.int
Web site: www.euro.who.int

ISBN
WHOLIS number

O
r
i

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia and Montenegro
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

WORLD HEALTH ORGANIZATION
EUROPE

Making Pregnancy Safer & Gender Mainstreaming

Response to domestic violence in pregnancy

Republic of Moldova

12-13 April 2005

Making Pregnancy Safer

Making Pregnancy Safer
Gender Mainstreaming

The Republic of Moldova

Response to domestic violence in pregnancy

Report

12-13 April 2005

Abstract

Recent surveys have shown a prevalence of domestic violence during pregnancy. In order to explore possibilities of a joint activity linking gender inequality and mother and child health, the WHO Regional Office for Europe Making Pregnancy Safer initiative and the Gender Mainstreaming programme developed a joint approach. The Republic of Moldova, pilot country for Making Pregnancy Safer in Europe, was chosen as a model to verify if maternity care could address the needs of pregnant women experiencing abuse. In April 2005, the WHO Collaborating Centre on Gender Mainstreaming, Glasgow conducted a training of trainers with the objective of involving family doctors and other primary health care providers in identifying and managing domestic violence. It was concluded that awareness of violence against women is growing in Moldova, as is a gathering momentum for change. The health service is in a unique position to address abuse, given its engagement with women, however, while central to women experiencing abuse, meeting their needs will require a co-ordinated, multisectoral response to maximise health gain and integrate policy planning and service delivery.

Keywords

DOMESTIC VIOLENCE
PREGNANCY
INTERPERSONAL RELATIONS
MATERNAL WELFARE
MATERNAL HEALTH SERVICES
REPUBLIC OF MOLDOVA

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the WHO/Europe web site at http://www.euro.who.int/pubrequest.

Abbreviations

CP	Child protection
GBV	National Action Plan on the Prevention and Elimination of Gender-Based Violence
GEM	Gender Mainstreaming
IEC	Information education and communication
IMCI	Integrated Management of Childhood Illnesses
MCH	Maternal and child health
MDA	Republic of Moldova
MoH	Ministry of Health, Republic of Moldova
MPS	Making Pregnancy Safer
NGO	Non-governmental organization
NMCH	National Mother and Child Health Care Programme 2005-2010
RH	Reproductive health
SIDA	Swedish bi-lateral agency
ToT	Training of trainers
UNFPA	United National Population Fund
UNICEF	United Nations Children's Fund
WHO GEM CC, Glasgow	WHO Collaborating Centre on Gender Mainstreaming, Glasgow
WHO-Europe	World Health Organization Regional Office for Europe

Contents

1 Executive Summary 3

2 Background 3

2.1 Definition of domestic violence 3
2.2 Health Consequences of Domestic Violence 3
2.3 Prevalence of domestic violence in the Republic of Moldova 3
2.4 Response to domestic violence 3

3 Developing a model for integrating domestic violence into health care services 3

3.1 Stage 1: Strategic and policy context for addressing domestic violence 3
3.2 Stage 2: Improving service delivery 3

4 Training of Trainers Course 3

4.1 Participants 3
4.2 Methodology 3
4.3 Course content 3
4.4 Proceedings 3
4.5 Issues and recommendations 3
4.6 Conclusions 3

5 Implementation plan 3

6 Participants 3

7 Programme 3

1 Executive Summary

This report outlines the outcome of the Training of Trainers (ToT) on domestic violence and pregnancy undertaken on 13 and 12 April 2005 in Chisinau, the Republic of Moldova. The ToT was organised by WHO Regional Office for Europe (WHO-Europe) and facilitated by the WHO Collaborating Centre on Gender Mainstreaming, Glasgow. The report contains recommendations for the implementation of the training programme and for the wider implementation of measures to address domestic violence in the ante-natal and post natal period.

In 2003, the WHO-Europe Making Pregnancy Safer (MPS) initiative and Gender Mainstreaming (GEM) identified the need for closer collaboration in their work. Given the prevalence of domestic violence during pregnancy and the fact that domestic violence is one of the most sensitive indicators of gender inequality, this was considered to be an area in which collaboration would be productive. As a pilot country for the MPS initiative, the Republic of Moldova presented the opportunity for developing such an approach. Following discussions between WHO-Europe and the Ministry of Health of Moldova (MoH), it was agreed that integration of this issue into maternity care could address the needs of pregnant women experiencing abuse and, if successful, could provide a model for other countries where women experience similar levels of abuse.

To explore the potential for developing an integrated model, a field visit was organised in June 2003[1]. Given its expertise in the field of gender-based violence, the WHO GEM CC, Glasgow, was invited to undertake this mission. The report from this visit contained a number of recommendations, including the provision of a training of trainers (ToT) workshop for national trainers to ensure that family doctors and others involved in primary care were trained on identification and management of domestic violence.

It was concluded that awareness of the issue of violence against women is clearly growing in Moldova and there is a gathering momentum for change. The health service is in a unique position to address abuse, given its engagement with women over their lifespan and particularly during pregnancy. While of central importance to women experiencing abuse, it cannot meet all of their needs, which requires a co-ordinated, multisectoral response to maximise health gain and integrate policy planning and service delivery. The health sector accordingly has to work in partnership with other key agencies to realise the goal of tackling gender-based violence.

2 Background

2.1 Definition of domestic violence

Domestic violence is understood as abuse occurring within intimate relationships and encompasses a range of different behaviours, including physical violence, emotional and psychological abuse, sexual abuse and financial abuse. It is predominantly women who experience such abuse and predominantly men who perpetrate this violence. This prevails across all countries, cultures, religions and sectors of society. Whilst acknowledging that violence occurs within same sex relationships and that some men are abused by female partners such cases are in the minority.

Domestic violence is understood to be part of a wider range of abusive behaviours to which women and girl children are subjected, such as rape, sexual assault, childhood sexual abuse, sexual harassment, female genital mutilation, forced marriage and so on. The United Nations incorporates domestic violence into its definition of gender-based violence thus:

Any act of gender-based violence 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[2].

2.2 Health Consequences of Domestic Violence

The health consequences for women experiencing abuse are considerable and include injury, depression, substance abuse, anxiety, stress, post-traumatic stress disorder, chronic pain problems, gynaecological problems, and poorer general health than women who do not have to cope with abuse. In relation to pregnancy, this can also include obstetric complications, for example increased risk of uterine rupture, "abruptio placentae", pre-term spontaneous rupture of membranes, premature labour and intrauterine death[3,4,5,6]. Women who have experienced abuse are four times more likely to give birth to low birth weight infants.

Although for some women pregnancy can be a protective period, either in terms of abatement of pre-existing violence or delay in its commencement, for others it is a risk period during which abuse may begin or escalate. Consequently, it is important to encompass the pre-pregnancy, pregnancy and post-pregnancy periods in designing both research studies around this issue and in developing appropriate care management interventions for health care providers.

Similarly, awareness of the impact of domestic violence on children and their health is growing. Many children will witness or be aware of domestic violence being committed. One study found that over 90% of children were in the same or next room when their mother was being abused[7]. Children can be hurt themselves, either by trying to intervene to protect their mother or being physically abused by the perpetrator. A summary of the effects on children charted sleep disturbances, temper tantrums, disruptive behaviour and an inability to concentrate in children subjected to such abuse. Aggression, anxiety and feelings of powerlessness were also noted[8]. The correlation between domestic violence and child abuse has also been highlighted in research[9].

2.3 Prevalence of domestic violence in the Republic of Moldova

Domestic violence is reportedly endemic in Moldova[10,11,12]. Despite the paucity of official statistics on the prevalence and nature of abuse, it has been recognised as a significant problem by the government[13]. The available evidence suggests that almost 1:4 women have experienced abuse, with higher levels of violence being reported in rural areas[14]. Given the relative invisibility of this issue, however, and the poor reporting mechanisms for collection of data, it is probable that the prevalence of abuse is higher still.

The connection with other forms of abuse, such as sexual violence and child abuse, is emerging within Moldova, despite the lack of accurate figures. The correlation between abuse and subsequent victimisation is also slowly beginning to be realised. For example, according to UNICEF, of 1,400 victims of trafficking who have been assisted following repatriation to Moldova approximately 70% have a history of abuse – including witnessing or experiencing domestic violence, child sexual abuse or sexual violence. Clearly such women and children are more vulnerable to targeting by traffickers.

The precariousness of the economic position in Moldova, coupled with the high levels of poverty and disadvantage, has inevitably placed constraints on the availability of resources to address domestic violence. Additionally in Moldova, as in other countries, domestic violence has largely been perceived as a personal, private matter rather than a criminal act. As such tolerance of abuse has been embedded in the culture of the country and its norms and social mores reflect an acceptance of this abuse.

2.4 Response to domestic violence

Recent years have witnessed a growing awareness in Moldova of both domestic violence and its significance as one component of a wider problem of gender-based violence. This has occurred at various levels and has been facilitated by non-governmental organizations (NGOs) who have worked to raise this awareness and by external pressures on the government to recognise the nature and extent of the issue. Below are some of the key initiatives developed at a national level and service level.

2.4.1 Government initiatives

Recognition of the need to develop a more systematic response to abuse has been articulated by the government. This has been located primarily within the emerging frameworks on tackling gender equality and human rights. In relation to the former, the government has acknowledged the pervasiveness of gender inequality and the extent to which the economic and social dislocation have disproportionately affected and disadvantaged women. It has developed a national plan to address gender inequality[15], which is driven primarily by the Ministry of Labour and Social Protection.

Criticism of the failure by the Government of Moldova to fulfil its obligations as a signatory to the Convention on the Elimination of All Forms of Discrimination against Women[16] and the need to improve its observance of human rights, has prompted a range of measures by the government. One of these is the National Human Rights Action Plan of the Republic of Moldova 2004-08, which includes a commitment to improving the protection of women experiencing violence and the opportunities for legal redress. It further commits the government to the provision of adequate support services for victims of abuse, responsibility for which has hitherto been assumed by NGOs. As part of the implementation of the Plan, a law on domestic violence has been drafted and is shortly to be ratified. This law seeks to identify the responsibilities of agencies in supporting victims of abuse.

As the legislative and normative framework on violence against women begins to take shape, there is awareness of the role of the different sectors in realising a genuine multidisciplinary and multisectoral partnership to maximise resources and tackle gender-based violence. Although a National Action Plan on the Prevention and Elimination of Gender-Based Violence has yet to be established, there is evidence of support for its development.[17]

2.4.2 Partner initiatives

Many of the developments within Moldova in relation to violence against women and children have been initiated by UN agencies, particularly UNICEF and UNFPA and NGOs Gender Centru and Soros, who have established considerable experience in this field. A brief summary of some of the key developments is given below:

- **UNICEF**

UNICEF is engaged in a range of activities covering three key areas:

1. Maternal and Child Health

Work in this area includes the provision of technical and financial support to health staff, including training. Of particular relevance to the work on domestic violence is their key role in training nurses to work with families as part of the WHO-Europe Integrated Management of Childhood Illnesses (IMCI) programme.

2. Child protection

There are a number of significant developments in this field, for example:

- National Centre for Child Abuse Prevention – 'AMICUL'

- Maternal Centre to support vulnerable mothers and prevent child abandonment
- Temporary shelter for street children – Casa Gavrosh
- Establishment of a child friendly Centre of Child Victims of trafficking

Initiatives on child protection are taking cognisance of this fact and beginning to explore the extent to which this issue needs to be incorporated into measures to improve the protection and welfare of children recognising that to help many children you must also help their primary caregiver, generally their mother.

3. Youth Health and Participation

The preventive work with which UNICEF is engaged in this area is important in IEC activities. Moldova has emerged in recent years as a key country in the origin and transition of trafficking. UNICEF is part of the national committee to address this problem and has been an integral part of attempts to stem this tide and assist victims of trafficking. As noted earlier, most of the victims helped by this organisation experienced some form of abuse prior to being further exploited and abused through trafficking.

➢ **UNFPA**

UNFPA has a pivotal role in the provision of family planning and reproductive health services. It has three women's centres – in Cahul, Chisinau and Drochia – which provide a range of services to women, including counselling and support. UNFPA has extensive experience in training and development in this field and is actively engaged in educating health staff. The production and dissemination of publications and awareness raising material is also a large part of their work as is the proactive health promotion and public awareness campaigns in which they are involved. UNFPA is also a key partner in the ASTRA network on sexual and reproductive health.

UNFPA, like UNICEF, is a major stakeholder in working with MoH to realise national strategies in reproductive health within which it is promoting the need to combat gender-based violence. Of particular importance is the proposal developed by UNFPA in conjunction with the Gender Centre that it is hoped will be funded this year. Within this two-year proposal, a number of progressive and well-defined strategic and operational activities are set out, which have the potential to make a significant contribution to the advancement of a national, coherent response to gender-based violence. The project seeks to provide information and support to national and district level facilities in each of the 33 administrative rayons in Moldova, including family planning clinics, police, education, social assistants, support services for women, and NGOs.

The key components involve building national capacity, through a combination of training, co-ordination and information support, to develop a skilled workforce across agencies able to address this issue. It envisages integration in all programmes regarding family planning and reproductive health services as well as education, social assistance and police. It will be characterized by a partnership approach, involving joint work with central government through the MoH and the ministries of Education, Labour and Social Protection. Through a robust programme of awareness raising campaigns and IEC activities, it will seek to change public attitudes to gender-based violence.

Amongst the key activities outlined in the proposal are:

- Development of a National Action Plan on the Prevention and Elimination of Gender-Based Violence (GBV).
- National conference on GBV.
- ToT on gender-based violence – a comprehensive seven-day training course to form a group of 20 national trainers on issues relation to gender-based violence.

- Workshops on prevention of GBV for Family Planning doctors, police, education and social assistance specialists at local level.
- Workshop on GBV counselling for FP doctors and social assistants.
- Workshop on combating GBV for police.
- Public awareness campaign to prevent and combat gender-based violence.

If successful in its funding bid, this initiative has the potential for taking a lead role in the formulating national policy and in co-ordinating existing work in this area.

3 Developing a model for integrating domestic violence into health care services

The transition to a market economy following independence in 1991 has been fraught with difficulties for Moldova. The beleaguered nature of the economy has unavoidably impacted on the health status of the population and on the resources available to provide health care. The re-organisation of the health system to one in which primary care has a pivotal role has been a substantial undertaking requiring major restructuring and reorganisation. Although this is a more effective and efficient means of providing healthcare, it has necessitated a huge programme of training and re-education for health care providers. In relation to maternity care, family doctors have responsibility for providing antenatal care, with maternity houses having a much-reduced role.

Against this backdrop, it has been difficult to identify the resources and capacity for addressing domestic violence, particularly since it has not been perceived as a health issue in Moldova. Rather, the focus has been very much on a medical model of health care with little public health perspective on the determinants of poor health. Additionally, the perception of this as a private, personal matter has contributed to its relative invisibility. Nonetheless, there have been attempts to incorporate the issue into training for staff working with pregnant women, for example there is a basic module on domestic violence in the training for family doctors.

Following the recommendations of the initial field visit in 2003 to develop a model for addressing domestic violence in pregnancy within Moldova, it was agreed that a TOT course would be held for national trainers, and that there would be a plan developed for rolling out a programme of training for health staff involved in antenatal care. It was recognised, however, that the training of family doctors can only be one dimension to this and that other action needed to be taken to create a system that is conducive to disclosure and support, and which does not leave health staff struggling to cope with the issue in isolation. A systems approach would therefore require the maximization of existing resources to strengthen capacity both in the healthcare system and that of the community based network of services.

During the ToT course, a meeting was held between Dr Maria Taurus, Head of Department of Mother and Child Health of the MoH, Ms Mercedes Juarez of the Gender Mainstreaming programme, WHO-Europe, Ms Katie Cosgrove of the WHO GEM CC, Glasgow, Professor Stratulat, Head of the Perinatal Programme, Dr Pavel Ursu, WHO-Europe Liaison Officer, and representatives of UNICEF and UNFPA. The objective was to explore the options for implementing this work most effectively following the ToT workshop. It was agreed that an implementation plan be developed that identified the action needed to improve health service response to women experiencing abuse. It was further agreed that, since this issue cannot be divorced from the need to develop an intersectoral response, it would be part of a wider framework looking at the strategic and policy context, as well as the implications for improving service delivery.

The strategic and policy context are outlined below and their implications for assisting the response to abuse considered. The key elements for improving service delivery are

discussed, particularly in relation to issues that emerged during the course of the ToT and recommendations for tackling these.

3.1 Stage 1: Strategic and policy context for addressing domestic violence

In the context of antenatal and postnatal care, the two key strategic documents are: The National Mother and Child Health Care Programme (NMCH) 2005-2010, and the National Strategy for Reproductive Health 2005-15.

3.1.1 The National Mother and Child Health Care Programme 2005-2010

This key document outlines the role of health services across four priority areas identified as:

- Health care during the pre-conception and inter-conception period.
- Perinatal health care (pregnancy and neonatal period).
- Health care provided to the infant and young children (28 days-5 years).
- Health care during adolescence.

Within these four areas, health care is provided through a range of national strategies and programmes implemented by the MoH with the support of donors such as UN agencies UNICEF, WHO, UNFPA, and international donors SIDA, SDC. These programmes are: National Programme Promoting Quality Perinatal Care 2003-07, IMCI, National Programmes of Assistance in Family Planning and Reproductive Health Care, National HIV/AIDS Programme, and Single Compulsory Health Insurance Programme.

Although the issue of domestic violence is mentioned within the NMCH and there is attention given to child abuse, the plan does not detail what work is required to address these, nor outline any actions to be taken as a result other than a reference to training health staff on domestic violence and pregnancy.

During a review of this plan, one of the areas identified as needing strengthening was the section on families and communities. A consultant was engaged to assist in fulfilling this task and produced a report in March 2005[18]. Although making a series of recommendations that could implicitly or indirectly improve the situation for women and children experiencing abuse, this document also fails to clarify the actions required. It makes a tentative suggestion for the possible development of a plan to combat 'family violence' but does not explore this option sufficiently to determine whether it will be presented as a full recommendation. In addition, this issue is raised only under the heading of 'social assistance' and is therefore limited in its application. There are a number of recommendations that could have been made, for example, in relation to education or the provision of health services to young people.

3.1.2 National Strategy for Reproductive Health 2005-15

This ten-year plan contains a comprehensive series of measures to improve sexual and reproductive health. It recognises the need to prevent and address domestic and sexual abuse, and trafficking and the importance of such factors in limiting the exercise of freedom of choice in this arena. A commitment to improving healthcare, strengthening the legal framework and developing support services for victims, is articulated in this strategy.

➢ **Recommendations**

- Improvement of the healthcare response to domestic violence should incorporate three key areas i.e. antenatal and postnatal care, child protection and reproductive health, given the interconnectedness of the issues. A coordinating group should be established to address the issue across the three areas and to oversee the implementation plan for improving the healthcare response.

- The recommendations of the consultancy report on families and communities[20] should be reviewed to incorporate the issue of domestic violence and other forms of abuse across the areas of IEC and not confined to the section on social assistance, since this removes the issue from the healthcare arena. This could also be used to highlight the need for a national strategy on gender-based violence.

3.2 Stage 2: Improving service delivery

As part of the move towards primary health care led services, there has been a huge training programme. To facilitate the training, a cadre of national trainers has been established to provide training to family doctors and obstetricians/gynaecologists on antenatal care in the primary care setting. To date, 1800 staff has undergone training. A further 23 sessions is planned for 2005 and will continue to be rolled out in subsequent years.

In relation to domestic violence, a brief module was developed for inclusion in the training. One of its shortcomings, however, is the lack of attention given to understanding the dynamics of abuse and the centrality of identifying providers' own values and prejudices that may impact on the nature of service delivery. As an issue requiring time for reflection, this can create tensions around time and availability, given the scope of the training programme overall. Whilst separate training on domestic violence would be preferable, time and funding constraints made this unfeasible and it was therefore agreed that it should be incorporated into the existing training for family doctors. To facilitate this, a ToT course on domestic violence was organised as part of the MPS initiative.

Guidance for staff in understanding their roles and responsibilities was also highlighted as important during the initial field visit by the consultant in 2003. At that point, staff had indicated a lack of clarity around their roles and responsibilities and a lack of awareness about appropriate interventions with abused women. As part of the ToT, a protocol on domestic violence was drafted by the consultant and refined in discussion with participants in the ToT. This protocol seeks to assist staff in the appropriate identification and management of domestic violence.

4 Training of Trainers Course

The TOT Course on Domestic Violence and Pregnancy was held in Chisinau on 12-13 April 2005. The WHO Collaborating Centre on Gender Mainstreaming provided the facilitator for the course, given its expertise in this area.

4.1 Participants

Participants were drawn from the national trainers of family doctors who have responsibility for training family doctors, obstetricians, gynaecologists and nursing staff. It was also considered important to widen the range of participants, both to provide alternative perspectives in terms of the roles of different agencies and to help in the gradual realisation of a multi-agency approach. Participants therefore included psychologists and social assistants who have a key role in supporting women referred by medical and nursing staff. UNFPA and the NGO Gender Centre also attended the training, given their pivotal role in promoting awareness of this issue and their stake holding role in key national health and social assistance strategies.

Participants on the course came from a variety of backgrounds and this was reflected in the ways in which they perceived the issue. Some had a fairly sophisticated grasp of the problem – particularly the NGOs and social assistants; whereas others were less clear conceptually on this. Many viewed it through the lens of disease pathology – for both the

perpetrators and victims of abuse – which is unsurprising given the medical training they have received.

4.2 Methodology

Since the course was only of two days' duration, the focus was primarily around materials designed to increase knowledge, change attitudes and promote awareness of the role of healthcare workers in the appropriate identification and management of domestic violence. Domestic violence does not fit comfortably within a *'diagnosis→treatment→cure'* model, and since the medical model is the dominant paradigm for understanding health and the role of health services, it requires a considerable shift in perspective to meet the need for a more holistic, woman-centered approach that takes into account the determinants of poor health. Consequently, a lot of the course was devoted to challenging the various misconceptions about domestic violence.

Participants from the health sector agreed that they would benefit from further support on this issue to assist delivery of the training. This is particularly pertinent in relation to cross-over with other issues such as child protection and legal frameworks. In addition, they are less clear on community-based resources to help women and children.

4.3 Course content

The following issues were included: definition of abuse; understanding domestic violence; impact on children and child protection; why women stay; domestic violence and pregnancy; consequences of abuse; role of health worker; identifying and responding to abuse; legal position re domestic violence; and the responsibilities of health staff around reporting, safety planning and risk assessment. A variety of methods were utilised: interactive role-play, scenario discussion in large and small groups, presentations. A training manual and CD-ROM were also provided.

4.4 Proceedings

The protocol on domestic violence was finalised. Participants were also consulted on their views around implementation of the training and protocol, and what issues still required to be addressed. The course was well attended despite the pressures of work on participants, many of whom were based in the centre and therefore on call. Participants engaged well with the subject and were receptive to the materials provided. All worked hard over the two days and appeared committed to improving practice in this area.

4.5 Issues and recommendations

A number of issues emerged during the training, however, which needs to be taken into account in planning the subsequent roll out of training, and which have implications for the future work on domestic violence within health care services.

- **Issue 1: Existing awareness of trainers**

Since domestic violence is a complex issue, generally people participating in a ToT are expected to have a thorough knowledge and sound understanding of the matter. Since many people share the common misconceptions in society about the nature and reasons for abuse, it can take a considerable time to assist people explore their own prejudices and values to understand fully the dynamics of abuse and the way in which it is supported at a societal level and is intrinsically linked to gender inequality. For example, adherence to beliefs around the

rights of men to control/chastise their partners, a conviction that this is personal and private issue between couples, attribution of domestic violence to alcohol, childhood experiences, unemployment, etc., or provocation on the part of women.

- **Recommendation**

Training on domestic violence for family doctors, etc., should be provided jointly with one of the NGOs who can contribute expertise in this field and a wider breadth of knowledge. It will additionally assist in offering a wider perspective of abuse and understanding of other agencies roles. A mentoring system should therefore be established to facilitate this process.

- **Issue 2: Referrals to police**

There were a number of difficulties raised in relation to the proposed law on domestic violence that makes it mandatory for all health staff to report domestic violence to the police. Given the acknowledged shortcomings within the criminal justice system, and the recognition of the need for police services to be more sensitised to the plight of women being abused, this could potentially compromise the efficacy of the health care response. Women have articulated their reluctance to approach the police – in the 1997 survey only 7% had done so[19] – and it is likely that they will be dissuaded from disclosing violence to their health care provider if they know it will be reported to the police regardless of their wishes. It may also compromise the safety of women who are fearful of their partner's response should he learn of this referral. Participants expressed concern that this could potentially undermine the trust required in working with women, violate principles of confidentiality and impact adversely on their attempts to address domestic violence sensitively and effectively.

- **Recommendation**

The requirements of the draft law on domestic violence in relation to reporting obligations of health staff should be reviewed to ensure that they do not jeopardise the safety of women or compromise efforts of staff to intervene appropriately.

- **Issue 3: Communication with patients**

Participants felt that many staff will struggle with broaching the subject of domestic violence and being able to respond non-judgementally and in a non-directive manner. They noted that traditional training of health staff has not included communication and counselling skills, thereby creating a serious deficit in interpersonal skills that will work to detriment of the training programme. This issue was echoed in the Consultancy Report on family and community[20] and appears to be a serious shortcoming in the anticipated rollout of a number of health promotion and public health messages to the population.

- **Recommendation**

A range of measures to develop interpersonal skills has been included in the aforementioned Consultancy Report. Skills in asking about abuse and responding appropriately to disclosure should be incorporated into the training recommended in this document on dealing with sensitive issues.

- **Issue 4: Shortfall in numbers of psychologists and social assistants**

Despite the order issued by the Ministry of Health in 2003 to provide psychologists and social assistants in maternity houses, it has proven difficult to recruit adequate numbers of staff. Additionally, the training for social assistants is reportedly fairly basic and has not included training on interventions in areas such as domestic violence and child protection. Poor wages and the high number of caseloads may have been further disincentives to attracting and retaining staff to these posts. This has implications for the programme to improve healthcare

responses to domestic violence since these professionals have a pivotal role to play, particularly in rural areas where specialist support services for women are non-existent.

- **Recommendation**

This situation should be reviewed as part of the commitment to improving services to victims of abuse.

- **Issue 5: Links with child protection**

Although the overlap with child protection was included in the course materials, time constraints did not allow for fullest examination of the ways in which health workers could and should intervene in cases where this was a concern. There was a clearly identified need for better integration of the issue since a number of participants appeared unclear on their role and responsibilities in this respect.

- **Recommendation**

There needs to be clarification of the role of family doctors and nurses in relation to child protection per se, as well as in cases of domestic violence. The training should incorporate a specific section on this issue and be provided by an agency such as UNICEF with expertise in this field. It was unclear whether there is an existing protocol on child protection for health staff in primary care. If not, this should be developed and cross-referenced with the protocol on domestic violence.

- **Issue 6: Working in rural areas**

There were a number of concerns about the particular difficulties facing staff in rural areas. The concentration of support services in Chisinau means that many women will not have access to specialist help and there will be little services to which staff can refer.

- **Recommendation**

This issue is clearly one that needs to be addressed at a national level. The rollout of training, however, should include discussion on the limitations of interventions in such circumstances, since it is important that health staff do not contribute to a worsening of the situation. Nonetheless, there is the potential for providing information on women's legal rights, assistance to seek support externally and validation of her experience. In these areas, a multi-agency approach will be even more crucial.

- **Issue 7: Implementing the Protocol on Domestic Violence**

The lack of clarity for health staff on their role and the need for guidance was addressed through the development of the domestic violence protocol. Implementation of this protocol, however, needs to be planned. Whilst it will be included in the training programme, there is also a need to identify where responsibility will lie for ensuring that staff is aware of its existence and that they have access to it and use it.

- **Recommendation**

Staff within primary care should be given a copy of the protocol. A readily accessible, shorter version should be disseminated. Within maternity houses, there should be a nominated senior member of staff with responsibility for raising awareness of the protocol.

4.6 Conclusions

Awareness of the issue of violence against women is clearly growing in Moldova and there is a gathering momentum for change which is encouraging, particularly in view of the ongoing

economic crisis. The health service is in a unique position to address abuse, given its engagement with women over their lifespan and particularly during pregnancy. While of central importance to women experiencing abuse, it cannot meet all of their needs. This requires a co-ordinated, multisectoral response to maximise health gain and integrate policy planning and service delivery. The health sector accordingly has to work in partnership with other key agencies to realise the goal of tackling gender-based violence.

There are two components to be addressed in seeking to improve the healthcare response:

- Harmonization of the different levels of initiatives and strategies/plans which impact on this issue and have direct or indirect relevance for healthcare providers. An intersectoral collaboration will yield the best results, bringing together different areas of expertise and widening what potentially could be a very narrowly focused medical model of care. This should be in relation to the three areas identified earlier: maternal and child health, child protection, and sexual and reproductive health.
- Identification of the specific activities that need to be undertaken within the health sector regarding training on domestic violence and implementation of the protocol.

Given the expertise and lead role of NGOs in this area, it would be useful for them to co-ordinate this activity. UNICEF has indicated its willingness to perform such a role. The key areas for targeting efforts to improve the situation for women will encompass:

- building capacity into systems to respond;
- improving service responses;
- strengthening communication and networking;
- developing materials and information to educate both service providers and communities;
- advocating for change and campaigning to raise awareness of the public health and human rights context of gender-based violence; and
- robust monitoring and evaluation mechanisms.

The next section details an Implementation Plan designed to assist in identifying the key components for such change. This outlines the aims and objectives of the work, and the action required to achieve progress these.

5 Implementation plan

Improving the health care response to domestic violence in MCH, reproductive health and child protection

Aim	Objective	Action	Lead agency	Partners	Resources/ Donor
(i) To develop intersectoral collaboration in fields of MCH, RH and CP on domestic violence.	To integrate the issue of domestic violence into ongoing work in the fields of MCH, RH and CP	Convene a working group with representatives from the 3 areas to facilitate this integration.	UNICEF	WHO UNFPA MoH Gender Centru Police Social Assistance Department Municipal Child protection Department	UNICEF
	To review existing national and local strategies and polices across all 3 areas to ensure inclusion of domestic violence and other forms of gender-based violence	Identify the gaps and/or areas of ambiguity in existing policies and strategies in this area and make recommendations to address these.	All		
	To lead on developing a systems approach to domestic violence within health and social services				

(ii)To incorporate domestic violence into a wider definition of gender-based violence and contribute to the development of a national policy on gender-based violence.	To make the connection between domestic violence and other forms of abuse as part of a larger problem of gender-based violence.	Develop a clear definition of domestic violence and gender-based violence.	All	All	
		Identify and describe the inter-connectedness of the different forms of abuse and the relevance for service providers	UNFPA		
		Provide a lead on facilitating an understanding of gender-based violence at national level to assist in the development of a coherent policy and planning framework for addressing this issue	UNFPA Gender Centru		
		Make links with existing work on trafficking through the National Committee on Trafficking in Human Beings	UNICEF MoH		

(iii) To strengthen the capacity of MCH, RH and CP services to respond to the needs of women experiencing domestic violence	To identify the organizational development issues that have to be addressed to support effective intervention on domestic violence.	Review existing structures, policies and resources to identify the enabling and constraining factors in supporting services to respond.	MoH, WHO	All	
		Ensure that there is a clearly defined responsibility for the organization in responding to abuse.	MoH, WHO		
	To identify the multidisciplinary and multi-agency structures required for facilitating increased capacity on this issue.	Clarify mechanisms for increasing capacity within and across organizations e.g. through joint working arrangements; closer liaison	MoH, WHO, Social Assistance Department		
	To support the development of services for women and children experiencing abuse	Provide guidance on the nature of support services required.	Municipal Child Protection Department		

(iv)To improve the health service response to domestic violence	To increase healthcare providers' identification and management of domestic violence in maternity care.	Co-ordinate joint training on domestic violence to Family Doctors, Obs/Gyn & nurses providing antenatal care as part of existing programme of FD training	WHO Family Doctors Managers MoH UNICEF	National Trainers UNFPA Gender Centru	WHO UNFPA UNICEF
		To assist Medical College at Orhei in developing appropriate training modules on domestic violence	MoH	UNICEF UNFPA WHO	
	To standardise good quality of care by family doctors and nurses in relation to reproductive health and maternity care	Implement the protocol on domestic violence and ensure staff are trained in its utilization	MoH FD Managers	UNICEF UNFPA WHO	UNICEF UNFPA
		Use monitoring tools routinely to assist in implementation of quality control mechanisms			
	To increase understanding of domestic violence in staff dealing with child health, particularly in relation to roles developed	Integrate domestic violence into existing training where this is absent	MoH UNICEF		

		Include responding to domestic violence in the role of nursing staff visiting families		WHO UNFPA	
	To clarify the roles and responsibilities of staff in relation to domestic violence and child protection	Include in training on domestic violence	UNICEF/ MoH		UNICEF
		Develop a protocol on child protection which includes domestic violence	Municipal CP dept		
	To ensure staff are equipped to deal sensitively with issues such as domestic violence	Include domestic violence in the proposed training on interpersonal, communication and counselling skills outlined in Families and Communities component of National Maternal and Child Health Care Programme	MoH Social Assistance Department		
	To increase knowledge about effective interventions to address domestic violence and other	Train staff on risk assessment, and safety planning	MoH WHO		

		Develop modules on interventions – guides & tools to use	UNICEF UNFPA		UNICEF UNFPA
	To link with ongoing work on sexual and reproductive health	Include in training on family planning & sexual health where this is not currently being done	UNFPA		
		Ensure education materials for young people in this area are gender sensitive and include information on rights and responsibilities	UNFPA		UNICEF UNFPA
		Improve the accessibility of emergency contraception for women, particularly where abuse is suspected or disclosed	UNFPA		
	To improve the communication & networking between agencies to promote multi-agency collaboration	Develop clear referral pathways to support services and promote development of shared protocols	UNFPA UNICEF MoH		

		Create opportunities for staff to meet with other agencies to share information and develop understanding of other roles locally		UNICEF UNFPA	
		Provide a directory of services / leaflets etc for staff to increase their knowledge of existing resources and improve referrals			
	To support staff with experience of abuse	Facilitate access to support services	MoH UNICEF UNFPA		
		Identify capacity within health services or other agencies to help staff			
		Develop plan for dealing with burnout amongst staff			
	To create a welcoming service in which women can disclose abuse	Display posters etc on abuse, highlighting its unacceptability	WHO UNICEF UNFPA		UNICEF UNFPA

		Provide information on services for women to service users			
	To identify whether services have improved	Undertake a baseline study with FDs and maternity houses to establish current levels of prevalence	WHO		UNICEF UNFPA
		Create a framework for monitoring and evaluation. Include use of routine audit data, KAP surveys pre & post training, staff surveys and interviews with service users	UNICEF UNFPA MoH		
(v) To raise awareness in the community of domestic violence as a public health problem and a human rights problem	Challenge prevailing views on domestic violence and gender-based violence	Develop an advocacy and information strategy	UNICEF UNFPA		
	Increase women's awareness of their rights	Produce and disseminate information and educational materials on domestic violence			UNICEF UNFPA

	Create a climate of unacceptability around violence against women and children	Develop campaigns on abuse, and contribute to existing initiatives e.g.16 days of action			
	▪	Incorporate into the awareness raising components of the Family and Communities Report on Maternal and Child health care Programme	MoH		

6 Participants

Ala Bernic
Lecturer, Postgraduate Medical College, Balti

Ion Bologan
Lecturer, OB&GYN Dept., State Medical University (National Perinatal Programme trainer)

Ala Burlacu
Researcher, Mother and Child Health Care Research Institute, lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Tatiana Buzdugan
Lecturer, Postgraduate College for Medical Assistants, Chisinau (National Perinatal Programme and UNFPA trainer)

Aliona Carjau
Psychologist, Perinatal Centre, Cahul

Larisa Catrinici
Assistant, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Ludmila Ciorcala
Lecturer, Neonatology Dept., State Medical University, (National Perinatal Programme trainer)

Ludmila Chitic, Lecturer, la Colegiul de pregatire a cadrelor medicale medii, Chisinau judet

Nadejda Codreanu
Assistant, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Vera Corcimari
Lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Maria Cornea
Lecturer, Medical College, Orhei

Magdalina Delejuc
Psychologist, Municipal Perinatal Centre, Balti

Ana Doros
Social Assistant, Municipal Perinatal Centre, Chisinau

Valentina Diug
Lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Program trainer)

Maria Dunas
Women Health Centre 'Virginia', Cahul (UNFPA trainer)

Rodica Gram
Psychologist Centrul Perinatal municipal Chisinau

Stelian Hodorogea
asistent universitar , catedra obstetrica si ginecologie, USMF 'N. Testemitanu'

Anastasia Madan
Lecturer, Medical College, Orhei

Angela Marian-Pavlenco
Researcher, lecturer, Postgraduate Ob&Gyn Dept., Mother and Child Health Care Research

Institute, lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Vera Melniciuc
Women Health Centre 'Dalila', Chisinau (UNFPA trainer)

Olesea Misininteva
Social Assistant, Municipal Perinatal Centre, Balti

Maria Moreac
Assistant lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Elena Pascal
Psychologist, Mother and Child Health Care Research Institute

Victor Petrov
Researcher, Mother and Child Health Care Research Institute, lecturer, Postgraduate Ob&Gyn Dept., State Medical University (National Perinatal Programme trainer)

Marina Petrova
Lucrator social Mother and Child Health Care Research Institute

Simion Sarbu
Women Health Centre, 'Ana' Drochia (UNFPA trainer)

Galina Scerbacova
Assistant, Neonatology Dept., State Medical University, (National Perinatal Programme trainer)

Dumitru Siscanu
Head, Consultative Dept., Municipal Perinatal Centre, Chisinau

Victoria Tintiuc
Lecturer, Medical College, Orhei

Natalia Zarbailov
Assistant, Family Medicine Dept., State Medical University (UNFPA trainer)

- **UN Agencies**

WHO Regional Office for Europe

UNICEF

UNFPA

- **Partners**

Valentina Bodrug
NGO Gender Centre

Ludmila Zmuncila
NGO Gender Centre

- **Facilitator**

Katie Cosgrove, WHO Collaborating Centre on Gender Mainstreaming, Glasgow, United Kingdom

7 Programme

- **Day 1**

09.00 Welcome and introductions

09.10 Setting the scene:
- Ground rules
- Overview of objectives
- Outline of course

09.30 Definition of abuse (naming exercise)
- Physical & sexual abuse
- Psychological & emotional

10.30 What do you know about domestic violence?

11.05 Why does it happen?

13.15 Why do women stay?

14.00 Impact on children

14.30 Women's experiences

15.00 Domestic violence and pregnancy

15.45 Recap. Summary & evaluation

➢ **DAY 2**

09.00 Outline of focus for today
Feedback on any issues arising from yesterday

09.20 Role of health worker: Part of the problem or part of the solution?

09.40 How to ask/ how to deal with disclosure: role play

11.00 Assessing women's safety

11.20 Recording & documentation

13.00 The New Law on Domestic Violence – 'Gender Centru'

13.30 Input from UNICEF - Domestic violence & child protection

14.00 Input from women's services (UNFPA)

15.20 Draft protocol – go through & feedback

16.00 Evaluation

---

[1] *'Addressing Domestic Violence in Women Using Maternity Services in Moldova'* Field Report August 2003, Glasgow Collaborating Centre on Women's Health

[2] *Declaration on the Elimination of Violence against Women*, UN General Assembly, Dec 1993

[3] *Abuse of Pregnant Women and Adverse Birth Outcome.* Journal of the American Medical Association 267: 1992.

[4] *Physical Abuse of Women Before, During, and After Pregnancy* **JAMA** 285 (2001)

[5] *Domestic violence and pregnancy*. Bacchus, L., Bewley, S., Mezey, G. (2001). *Obstetrics and Gynaecology*, 5, 2, 56-9

[6] *Crime* Prevention*: an issue for midwives?* James-Hanman, D and Long, L. (1994*)* British Journal of Midwifery vol. 2 (1): 29-32.

[7] Mullins A. *Making A Difference - Working with women and children experiencing domestic violence.* NCH Action for Children 1997

[8] Jaffe P, Wolfe D, Wilson S. *Children of Battered Women.* London: Sage, 1990

[9] Bowker L H, Arbitell M, McFerron J. On the relationship between wife beating and child abuse in Yllo K, Bograd M (eds) Feminist Perspectives on Wife Abuse. Newbury Park, CA:Sage 1988.

[10] *The Situation of Children and Family in the Republic of Moldova: Assessment and Analysis.* UNICEF , Chisinau 2002

[11] *Domestic Violence in Moldova* , Minnesota Advocates for Human Rights, December 2000

[12] *Status of Women in the Republic of Moldova*, United Nations Development Programme (UNDP) 1999

[13] *National Human Rights Action Plan*, Republic of Moldova 2004-08 (decision of the Parliament of the Republic of Moldova No.415-XV, October 24 2003)

[14] *Reproductive Health Survey Moldova,* U.S. Department of Health and Human Services, Centres for Disease Control and Prevention 1997

[15] '*National Plan for Promoting gender Equality in Society for the Period 2003-2005'* (decision of the Government of the Republic of Moldova No 218, February 28 2003)

[16] *Committee on the Elimination of Discrimination Against Women, Concluding Observations: Republic of Moldova* CEDAW/C/2000/II/Add6, 27 June 2000

[17] Proposal UNFPA

[18] Support to the National Working Group to Develop the 'Working with Individuals, Families and Communities Component of the National Plan for Maternal, newborn and Child health in the Republic of Moldova' Feb-Mar 2005

[19] *Reproductive Health Survey Moldova,* U.S. Department of Health and Human Services, Centres for Disease Control and Prevention 1997

[20] *'Support to the National Working group to Develop the 'Working with Individuals, Families and Communities Component of the National Plan for Maternal, newborn and Child health in the Republic of Moldova' Feb-Mar 2005 , pages 20, 26*