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The health system response to violence against women in the WHO European Region: a baseline assessment

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ABSTRACT

This report provides a baseline assessment of how violence against women is addressed in national health systems in the WHO European Region, in line with commitments made by Member States of the WHO European Region in the *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* and the *Strategy on women's health and well-being in the WHO European Region*. The report analyses quantitative findings from a survey carried out among WHO European Region Member States in 2018 and qualitative findings from the content analyses of documents that were either supplied by Member States who took part in the survey or identified by WHO staff.

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The analysis contained in this report was conducted by Daria Ukhova, PhD fellow, Bremen International Graduate School of Social Sciences, Germany, under the technical coordination of Åsa Nihlén, Technical Officer, Gender and Human Rights, WHO Regional Office for Europe.

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Acronyms

FGM	female genital mutilation
GP	general practitioner
IPV	intimate-partner violence
IRIS	Identification and Referral to Improve Safety (programme)
STI	sexually transmitted infection
SV	sexual violence
UNAIDS	Joint United Nations Programme on HIV and AIDS
VAW	violence against women
VAWG	violence against women and girls

Executive summary

This report provides a baseline assessment of how violence against women (VAW) is addressed in national health systems in the WHO European Region. It serves as a key input to monitoring of the commitments made by Member States of the WHO European Region in the *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* and the *Strategy on women's health and well-being in the WHO European Region*.

The aim is to provide an overview of work carried out in Member States on the role of the health sector in preventing and responding to VAW, highlight achievements to date and identify directions for future progress.

The report analyses quantitative findings from a survey carried out among WHO European Region Member States in 2018 and qualitative findings from the content analyses of national policies and plans, health sector guidelines and protocols, and health-care provider training curricula supplied by Member States who took part in the survey or which were identified by WHO staff.

In total, 35 (out of 53) Member State responses provide the basis for the analysis. This represents an effective response rate of 66%.

The analysis is structured along the four strategic directions of the global plan of action:

1. strengthen health system leadership and governance
2. strengthen health service delivery and health workers´/providers´ capacity to respond
3. strengthen programming to prevent interpersonal violence
4. improve information and evidence.

The report concretely monitors the achievements to date of Member States in each strategic direction against performance criteria agreed within the accountability framework of the global plan of action.

In sum, the results show that at policy level, WHO European Region Member States demonstrate a high level of commitment to addressing VAW through their health system. Nearly 83% of the surveyed countries already address VAW in their health policies and strategies, and 71.4% have developed national guidelines, protocols or standard operating procedures for the health system response to VAW. Many of the surveyed Member States are also investing in building health-care providers' capacity to respond to VAW. Pre-service training is provided in nearly half of the surveyed countries, and in-service training in almost 70%.

Significant room for improvement nevertheless remains. Further strengthening of the health system role in VAW prevention and response across the WHO European Region would require:

- increasing investment in human resources working on VAW response, including VAW focal points;
- increasing and better earmarking of financial resources for VAW-related work; and
- strengthening integration of the health system response into countries' multisectoral plans on VAW.

While analysis of existing health sector protocols from across the Region suggests generally high levels of compliance with WHO guidelines on provision of women-centred care and clinical care for survivors of sexual assault, it is important to note that availability of safe abortion as an essential element of post-rape care is still not universal across the Region. Further, only a minority of the surveyed Member

States currently comply fully with WHO's recommendations against universal screening and mandatory reporting of intimate-partner violence (IPV).

Further capacity-building and technical assistance for Member States in developing relevant guidelines, protocols and standard operating procedures will therefore be required to ensure successful implementation of the global plan of action. Health-care providers in all Member States should receive training at pre- and in-service stages. Coverage of topics, especially those related to data collection on VAW, could be improved.

WHO intends to build on these results in its current and future collaborations with Member States in strengthening the health system response to IPV and sexual violence.

This report can be used as a resource for partners and stakeholders in monitoring Member States' commitments to eliminating all forms of violence against women and girls, particularly in relation to United Nations Sustainable Development Goal 5, the 25-year review of the Beijing Declaration and Platform for Action, and the Council of Europe Convention on Preventing and Combatting Violence against Women and Domestic Violence (Istanbul Convention).


1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS

SECTION 1. CONTEXT

1.1. Introduction and background

Violence against women (VAW)[1] is a major global public health problem and a violation of women's human rights. It leads to negative physical, sexual and reproductive, and mental health outcomes (WHO, 2013a). While VAW may take various forms, WHO has identified intimate-partner violence (IPV) and sexual violence (SV) (see Box 1) as key areas for prevention and response, as they are prevalent in all settings (WHO, 2016a).

Box 1. Definitions

Violence against women (VAW) is defined as "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 private life. It encompasses, but is not limited to: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."

Intimate partner violence (IPV) 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."

Sexual violence (SV) is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."

Source: WHO (2016a).

The prevalence of IPV and SV varies internationally. WHO estimates that globally, 35.6% of women have experienced either non-partner sexual violence or physical or sexual violence by an intimate partner, or both (WHO, 2013a). In the WHO European Region, it is estimated that 27.2% of women have experienced any of those forms of violence at least once in their lifetime (WHO, 2013a).

Taking into account the complexity of underlying causes and risk factors of VAW, it is now widely recognized that the response to VAW should be multisectoral, with the health sector having an important role (UN Women, 2013). Health-care providers are often the first professionals with whom survivors of IPV and SV come into contact, and are also identified by abused women as those they would trust most to disclose abuse to (WHO, 2013b). WHO has developed specific evidence-based clinical and policy guidelines (WHO, 2013b), a clinical handbook (WHO, 2014) and a manual for health managers (WHO, 2017) to raise health-care providers' awareness of VAW and support them in their responses.

[1] The term violence against women (VAW) is used throughout this report rather than gender-based violence, following the approach taken in the WHO *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* (WHO, 2016a). The more specific term violence against women and girls (VAWG), also used in the global plan of action, is not used to avoid terminological confusion. Findings in this report, however, also concern the health system response to the needs of girls who become victims of violence because of their gender.

In further recognition of the health sector's commitment to preventing and responding to IPV and SV, WHO Member States endorsed the *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* (WHO, 2016a) (hereafter referred to as the global plan of action) in 2016. The global plan of action has been endorsed by Member States of the WHO European Region and operationalized for the European context in the framework of the *Strategy on women's health and well-being in the WHO European Region* (WHO Regional Office for Europe, 2016a), the *Action plan for sexual and reproductive health* (WHO Regional Office for Europe, 2016b) and the *Strategy on the health and well-being of men in the WHO European Region* (WHO Regional Office for Europe, 2018).

Implementation of the global plan of action is monitored through a number of indicators (discussed in Section 3). WHO conducted a baseline assessment survey across its regions to help countries track implementation of the "violence against women and girls" component of the global plan of action. The WHO European Region survey was carried out between December 2017 and March 2018.
In addition to an invitation to participate in the survey, Member States were also asked to provide relevant documents (such as plans, strategies, guidelines and protocols). This report analyses quantitative findings from the survey and qualitative findings from the content analyses of the documents that were either supplied by Member States who took part in the survey or identified by WHO staff and the international consultant through Internet searches and analysis of grey literature.

The report is presented in three main sections. Section 2 discusses the study methodology. Section 3, which relies on both quantitative findings from the baseline survey and results of the qualitative document analysis, analytically discusses the WHO European Region's performance in relation to the key indicators of the global plan of action. Section 4 discusses how the WHO European Region Member States' response to IPV and SV against women could further be strengthened as part of the realization of the global plan of action. Annex 1 presents a summary of responses received from countries.

SECTION 2. METHODOLOGY

2.1. Baseline survey

WHO conducted a baseline assessment survey (in English and Russian languages) to support countries in tracking implementation of the "violence against women and girls" component of the global plan of action. The survey was carried out in the WHO European Region between December 2017 and March 2018. The invitation to participate in an online survey was distributed by the WHO Regional Office for Europe to national counterparts in ministries of health.

2.1.1. Response rate

Thirty-seven of the 53 WHO European Region Member States responded to the survey. Of these, 32 completed the survey, while five did not complete. Three of the five incomplete responses were partially useful for the study's purposes and were included in the final analysis. The two remaining incomplete responses contained only personal information from the respondents and were discarded. The final analysis therefore included answers from 35 countries.

In summary:

- the total response rate was 69.8% (37 of 53 countries)
- the completion rate was 86.5% (32 of 37 countries)
- the effective response rate (all usable responses) was 66.0% (35 of 53 countries).

Data on compliance with WHO guidelines on clinical care for victims of sexual assault indicated whether there was a systematic bias in non-response (such as non-respondents having lower performance in the domains on which the survey focused) (see Section 2.3). Those data were collected as part of the Joint United Nations Programme on HIV and AIDS (UNAIDS) survey on the national composite policy index (UNAIDS, 2019). Analysis of the level of compliance with WHO guidelines among the 16 WHO European Region Member States that participated in the UNAIDS survey but did not respond to the WHO survey did not identify evidence of systematic bias. All but two of the 16 Member States had a 100% compliance rate with WHO guidelines. The fact that the 16 countries did not participate in the WHO survey was therefore likely not to be related to poorer performance in the domains on which the survey focused.

2.1.2. Missing values

Some questions in the survey had a relatively high proportion of missing answers. This particularly was the case with questions from the second part of the survey, in which countries were asked about specific contents of their multisectoral plans/guidelines/protocols/standard operating procedures and training programmes. The questions were very detailed, and a significant number of respondents appear to have decided to skip them. Pairwise deletion was applied in such cases. Percentages in the text therefore refer to percentages of valid responses only. The "*I don't know*" answers, the proportion of which reached 31% in some cases, were retained as a category.

2.2. Document content analysis

Along with the invitation to participate in the survey, VAW focal points were asked to provide policy documents (such as plans, strategies, guidelines and protocols) addressing the health system response

to IPV and SV in their countries. The international consultant responsible for analysing survey results, with support from WHO staff and interns, analysed grey literature and performed online searches of relevant documents for Member States that did not participate in the survey.

A multilingual group consisting of the international consultant, WHO Regional Office for Europe staff and an intern carried out documentary content analysis. It was not possible to perform the analysis in all cases because of a lack of specific language capacities. The goal of the analysis was to validate country survey responses and gain an in-depth qualitative understanding of the actions countries currently are taking to improve their health sector response to IPV and SV.

Content of the following three types of documents (from the specified number of countries) was analysed:

1. national (or subnational) multisectoral action plans for VAW or, if the latter were not available, national health plans or other relevant health plans, policies and strategies (such as sexual and reproductive health, HIV and maternal health) that referenced VAW (33 countries);
2. guidelines, protocols and/or standard operating procedures on how the health sector should provide care or services to address VAW (14 countries); and
3. training programmes to strengthen the capacity of health-care providers to respond to VAW (four countries).

2.3. Estimation of compliance with WHO guidelines and standards

Calculations for the compliance figures referenced in Section 3 were based on countries' responses, even if answers could not be validated or evidence to the contrary was found. This decision was motivated by several considerations.

First, the inability to validate countries' answers could have been related to the preventive strategies and elements of clinical care on which the survey focused being covered by other policies to which the respondents did not refer, but could nevertheless be aware of.[2] Secondly, cases where countries responded negatively but written evidence of the opposite was found could indicate that those strategies or elements of clinical care actually are not being implemented. Lastly, the fact that VAW focal points were not aware of the aspects of existing policies may also indicate limited implementation. "*I don't know*" responses were treated as "*No*". Similarly, subquestions on specific contents of multisectoral plans/guidelines/protocols/standard operating procedures and training programmes that were skipped selectively were recorded as "*No*". Compliance was not calculated in cases where countries skipped an entire question.

[2] The only case in which this principle was not applied related to Ireland's answer that they provided access to safe abortion, since the survey was carried out prior to the national referendum on abortion that took place in May 2018.

SECTION 3. ANALYSIS OF SURVEY RESPONSES ACROSS STRATEGIC DIRECTIONS OF THE GLOBAL PLAN OF ACTION

The global plan of action has two key objectives focusing on the response to, and prevention of, VAW (WHO, 2016a:11):

- to address the health and other negative consequences of VAW "by providing quality comprehensive health services and programming, and by facilitating access to multisectoral services"; and
- to prevent VAW.

To achieve these objectives, Member States are expected to carry out work in four strategic directions:

1. strengthen health system leadership and governance
2. strengthen health service delivery and health workers'/providers' capacity to respond
3. strengthen programming to prevent interpersonal violence
4. improve information and evidence.

Building on the WHO guidelines discussed above, the global plan of action specifies actions Member States could take in each of the four domains (see WHO, 2016a:17–22). The survey was constructed to collect specific data on whether, and to what extent, countries are implementing the actions recommended by WHO.

The global plan of action also proposed indicators for monitoring Member States' progress at global level (Table 1).

Table 1. Global plan of action proposed indicators for monitoring Member States' progress at global level

No.	Indicator
A1.1	Number of Member States in the WHO European Region that have included health-care services to address IPV and comprehensive post-rape care in line with WHO guidelines in their national health or sexual and reproductive health plans and policies
A2.1	Number of Member States that have developed or updated their national guidelines or protocols or standard operating procedures for the health system response to women experiencing IPV or SV, consistent with international human rights standards and WHO guidelines
A2.2	Number of Member States that provide comprehensive post-rape care in a medical facility (department) in every territorial and/or administrative unit, consistent with WHO guidelines
A3.1	Number of Member States that have a national multisectoral plan addressing VAWG (which includes the health system) and which proposes at least one strategy to prevent VAWG
A4.1	Number of Member States that have carried out a population-based, nationally representative study/survey on VAW or that have included a module on VAW in other population-based demographic or health surveys within the past five years, disaggregated by age, ethnicity, socioeconomic status, etc.

Based on the results of the survey and analysis of the policy documents provided by countries, the remainder of this section analyses the current performance of Member States of the WHO European Region against each of the strategic directions and presents baseline data on relevant global plan of action indicators. As monitoring of the global plan of action will be carried out at aggregate level, most of the data presented are aggregated at regional level.

3.1. Strengthening health system leadership and governance to address VAW

Indicator A1.1 of the global plan of action

Number of Member States in the WHO European Region that have included health-care services to address IPV and comprehensive post-rape care in line with WHO guidelines in their national health or sexual and reproductive health plans and policies (yes/no)

Twenty-nine (82.9%) of the 35 WHO European Region Member States that responded to the survey[3] indicated that they address VAW in their health plans and policies.

Ensuring that the response to VAW is clearly articulated in health strategies and policies is a primary condition for strengthening health system leadership and governance in this area. Among WHO European Region Member States that replied to the survey, 82.9% included references to VAW in their national health strategies and policies.

The global plan of action includes promotion of gender equality and women's empowerment through adoption and reformation of legislation as an important action Member States should take to address VAW within the health system and beyond. Twenty-three Member States (out of 27 that replied to this question, 85.2%) indicated that their multisectoral action plans on VAW include promotion/enforcement of laws on gender equality.

Appropriate human and financial resources need to be allocated for the health system response to VAW. Although the survey did not ask directly whether the Member States had VAW focal points in their ministries of health, it is known that only 18 respondents (51.4%) were VAW focal points, only two of whom worked on VAW full-time; more than half (10) spent less than 25% of their working time on VAW topics. Several VAW focal points appeared to have had a rather low level of knowledge of the health system response in their countries. Depending on the survey question, the share of "*I don't know*" answers varied from 0% to 31.4%.

Financial resourcing of the health system response to VAW appears to be an area with significant room for improvement in the European Region. Only 14 of the 35 Member States (42.4%) that responded indicated that they costed their health system's response. A specific budget line for such response exists in only five of the 35 countries (14.3%) (Belgium, Israel, Italy, Sweden and the United Kingdom). Nineteen countries (54.3%) indicated that while there is no specific budget line, the costs of the health system response are integrated within the overall budget of ministries of health. In the remaining cases, the health system response to VAW is either not financially resourced (five countries, 14.3%) or the respondent was not aware of how it was done (six countries, 17.1%).

Effective mechanisms for collaboration and coordination between the health and other sectors, such as police and social services, are essential for ensuring victims of VAW receive timely and appropriate support. Among the surveyed Member States, 30 (out of 35, 85.7%) have national or subnational multisectoral action plans specifically for VAW, and four (11.4%) include VAW issues in multisectoral gender equality plans. The health sector response, however, is covered in only 29 of these action plans. The extent of health sector involvement in multisectoral responses to VAW varies across the Member States, with some, such as Spain (see Box 2), having a much stronger and more comprehensive focus on health sector-related activities than others.

[3] This figure comprises the 32 countries that completed the survey and the three incomplete responses that were partially useful for the study's purposes and were included in the final analysis.

Box 2. Health sector response in the 2013–2016 national strategy for the eradication of violence against women in Spain

The integration of the health sector response in Spain's national strategy for the eradication of violence against women (Ministry of Health, Social Services and Equality, 2013) demonstrates how wide-ranging a health system response can be, and how many functions the health sector can undertake in the overall multisectoral effort to address VAW.

First, the strategy allocated an important role to the health sector in breaking the silence about VAW and its early detection. This included developing awareness-raising materials for health centres and primary health-care centres, prioritizing related training for health-care professionals and improving their knowledge of the protocol for health-care procedures in gender-based violence. The protocol was further developed to strengthen health-care providers' ability to identify and respond to the needs of victims from disadvantaged groups, such as minors, women with disabilities, elderly women and immigrant women.

Secondly, the strategy emphasized the importance of sectors working jointly. It had a strong focus on promoting knowledge among health-care professionals about how to communicate cases of VAW to police and judicial authorities, and on improving referral mechanisms. Improving the availability of non-residential resources provided by different sectors (including the health sector) for victims of VAW over the full length of their recovery process was also prioritized.

Thirdly, Spain's strategy recognized the hugely important role the health sector could play in collecting statistical data on VAW and advancing knowledge on best practices for VAW prevention within the sector and as part of multisectoral efforts. The strategy included a commitment to improving collection of VAW-related data, including data on women who were seriously injured as a result of VAW and had to be admitted to hospital as a result. It also focused on studying primary health-care providers' experiences of VAW prevention, assistance and referral.

Lastly, the strategy included measures targeted at identification, collection and dissemination of good practices in dealing with VAW within the national health system.

3.2. Strengthening health services delivery and health workers'/providers' capacity to respond

Indicator A2.1 of the global plan of action

Number of Member States that have developed or updated their national guidelines or protocols or standard operating procedures for the health system response to women experiencing IPV or SV, consistent with international human rights standards and WHO guidelines (yes/no)

Twenty-five (71.4%) of the 35 WHO European Region Member States that responded to the survey indicated that they have guidelines, protocols and/or standard operating procedures on how the health sector should provide care or services to address VAW.

3.2.1. Women-centred care

WHO recommends that women who disclose any form of IPV or SV should be offered immediate support. In such cases, health-care providers should, at a minimum, offer first-line support, which implies provision of services "in a way that ensures that a woman gives her fully informed consent,

respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives" (WHO, 2013b:12). Ensuring that health-care services are sensitive to, accessible to and affordable for all victims of VAW, especially those who may be facing multiple forms of discrimination, is crucial (WHO, 2016a).

Nearly all the Member States that responded to the questions on the contents of the standard operating procedures/guidelines/protocols indicated that they cover the following elements of women-centred care comprehensively:

- ensuring privacy during the consultation;
- ensuring confidentiality (in providing and recording care, for instance);
- providing a nonjudgemental, supportive and validating response to disclosure; and
- providing referrals and strengthening linkages between services and sectors through intersectoral collaboration.

Average levels of compliance with these women-centred care principles was 3.88 (on a scale from 0 (minimum) to 4 (maximum)) across 24 Member States that indicated they have such guidelines and answered the related follow-up questions on their contents. Further content analysis of the guidelines confirmed the validity of these responses in virtually all cases.

Although issues of equity were not directly covered in the survey, qualitative analysis of the national action plans on VAW suggests that some countries of the WHO European Region are actively trying to ensure equitable access to health-care services for women from discriminated groups who might be affected by IPV and SV. Slovenia's 2009–2014 national programme on prevention of family violence (National Assembly of the Republic of Slovenia, 2009), for example, had a significant equity focus and included adjustment or establishment of new safe houses and crisis centres for older people, those with physical impairment, people with mental health issues and those with special needs. Spain's national strategy for the eradication of VAW 2013–2016 (see Box 2) included specific measures targeted at minors, women with disabilities, women living in rural areas, elderly women and immigrant women.

3.2.2. Identification of IPV

WHO recommends against universal screening or routine enquiry for IPV (asking women about violence in all health-care encounters), as there is no evidence to suggest that universal screening leads to reduction in IPV incidence or improved health outcomes (WHO, 2013b). Instead, WHO recommends the more selective approach of clinical enquiry or case-finding, where only women presenting with conditions that may be caused or exacerbated by IPV are asked by health-care providers about their potential exposure (WHO, 2013b).

Some countries, however, strongly advocate for universal screening (WHO, 2013b). The results of this survey suggest that approaches to identification of IPV in the WHO European Region vary significantly. Ten Member States (out of 23 that responded to the set of questions, 43.5%) indicated that they practise universal screening for IPV, while only eight (34.8%) stated that they do not. The selective/clinical enquiry approach appears to be used in most of the surveyed countries (18, 81.8%). Nine indicated that both universal screening and selective/clinical enquiry are used as IPV victim identification strategies. This may partially be explained by the fact that different approaches are applied in different health services. The content analysis showed, for example, that routine enquiry into domestic abuse in the United Kingdom is practised only in maternity and mental health services (HM Government, 2016). Lack of detail in the question therefore raises concerns over the validity of the answers.

A significant number of respondents seemed to have been somewhat confused about the terminology. Five respondents indicated that they "*don't know*" whether universal screening is being implemented as an identification strategy in their country (one of the highest relative shares of "*I don't know*" answers in the entire survey). Content analysis of the countries' guidelines revealed several instances in which respondents' positive answers to the question about universal screening were directly contradicted by the guidelines.

Overall, only four of the surveyed Member States (Belgium, Ireland, Norway and Slovenia) indicated that they follow WHO recommendations in this domain coherently. Analysis of the guidelines suggests adherence to WHO recommendations in a further five cases, but the answers of VAW focal points contradicted this evidence.

Whichever strategy is chosen for identification, the global plan of action recommends that identification and care for women experiencing IPV should be integrated into existing health-care services (WHO, 2016a). Some of the surveyed Member States already are doing this: Norway, for example, has developed clinical guidance on addressing violence during pregnancy in primary health services (Justice and Public Security Department, 2014).

3.2.3. Clinical care for survivors of sexual assault

Indicator A2.2 of the global plan of action

Number of Member States that provide comprehensive post-rape care in a medical facility (department) in every territorial and/or administrative unit, consistent with WHO guidelines

Ten (45.5%) out of 22 WHO European Region Member States that responded to this question provide fully comprehensive post-rape care consistent with WHO guidelines.

WHO recommends that survivors of sexual assault should be provided with comprehensive health-care services available 24/7, which should **at a minimum** include:

- psychosocial support, including psychological first aid
- emergency contraception within five days of sexual violence
- access to safe abortion in the case of rape or incest
- prophylaxis against sexually transmitted infection (STI)
- HIV post-exposure prophylaxis.

The average level of compliance with the WHO guidelines on comprehensive post-rape care among the 22 Member States that indicated they have relevant guidelines and answered the related follow-up questions on their contents was **5.05** (on a scale from 0 (minimum) to 6 (maximum)). As Table 2 shows, safe abortion is the least comprehensively covered service in the WHO European Region, followed closely by provision of emergency contraception. Provision of psychosocial support, an element of post-rape care services that was not covered in the UNAIDS survey discussed above (see Section 2.1) (UNAIDS, 2019), appears to be integrated in post-rape care in a large majority of the surveyed Member States (see Box 3 for an example from Malta).

Female genital mutilation (FGM) is recognized in the global plan of action as a form of violence against women and girls, and WHO explicitly recommends that countries "offer services to manage the health complications of women and girls who have undergone female genital mutilation" (WHO, 2016a; see

Table 2. Provision of post-rape care services in the WHO European Region

	Psychosocial support, including psychological first aid	24/7 availability of sexual assault services	Emergency contraception within five days of sexual assault	Access to safe abortion in cases of rape or incest	STI prophylaxis for survivors of sexual assault	HIV post-exposure prophylaxis
Service provided (countries)	19	19	18	15	19	19
Service not provided (countries)	3	2	2	5	1	2
I don't know (countries)	0	1	2	1	2	1
Missing (countries)	13	13	13	14	13	13
Total responses (countries)	35	35	35	35	35	35

Box 3. Psychosocial support in post-rape care in Malta

Guidelines for the management of cases of alleged rape or sexual assault in the Mater Dei Hospital in Malta developed in 2017 (Ministry for Health, 2017) represent a good example of how psychosocial support can be integrated into post-rape care.

Accident and emergency staff are obliged to contact a specially trained support person (social worker) from victim-support services as soon as a victim of alleged or suspected sexual assault presents to the department. On-call support people for such cases are available on a 24/7 basis. Following initial management for physical injuries or trauma, the support person will offer to speak with the victim in a private room set aside for the purpose. The support person will explain to the victim how her case will be dealt with and the legal implications, and ensure that her wishes are established and the repercussions explained to her. The support person is also responsible for obtaining the victim's consent for examinations and will offer follow-up psychological counselling, if deemed necessary.

also WHO (2016b) for guidelines on the management of health complications from FGM). Although the survey did not contain questions on FGM, results of the document analysis suggest that a number of Member States that participated in the survey have either fulfilled this recommendation or plan to do so in the near future. Spain, for example, has developed a common protocol for a health-care response to FGM (Ministry of Health, Social Services and Equality, 2015). The United Kingdom is implementing FGM safeguarding pathways for health-care professionals dealing with suspected and actual cases of FGM as part of its 2016–2020 strategy on ending violence against women and girls (Department of Health, undated). Action plans in Belgium, Finland, France, Italy, Norway, Portugal and Sweden also contain FGM-related interventions.

3.2.4. Training health-care providers on VAW

Training of health-care providers is central to ensuring an effective health system response to VAW (García-Moreno et al., 2015). WHO recommends integrating content on identification and response to VAW in pre-service and in-service training of health-care providers (medical, nursing and midwifery). The training should address providers' attitudes to VAW (such as victim-blaming) and their knowledge of legislation and services available to victims. It should also develop their skills to provide first-line support, enquire about violence and respond to disclosure (WHO, 2013b; WHO, 2016a).

Training on VAW is not provided in a significant number of European Region countries. Among the countries responding to the survey, 16 (out of 35, 45.7%) indicated that they provide pre-service training and 24 (68.6%) in-service training. Both types of training are available only in 13 of these countries (37.1%). While most of the surveyed countries include capacity-building/skills-training for service providers in their multisectoral action plans on VAW, content analysis revealed several instances of health-care providers not even being mentioned in capacity-building activities.

Training programmes implemented by some of the Member States, however, have proved to be highly efficient and cost–effective (see Box 4 on the Identification and Referral to Improve Safety (IRIS) programme in the United Kingdom) and could be drawn upon as other countries in the Region develop their programmes over the coming years. There are also positive signs that more Member States are becoming aware of the need to act on this issue, including the recent introduction of highly comprehensive training programmes in a number of countries in the Region (see Box 5 on recent policy developments in Italy).

Box 4. The Identification and Referral to Improve Safety (IRIS) programme in the United Kingdom primary health-care system

IRIS is a programme developed to support general practitioners (GPs) to identify and appropriately refer cases of VAW. It was launched in 2007 initially as a randomized control trial in 48 GP practices in Hackney (London) and in Bristol. Twelve intervention and 12 control practices were selected in each location. Two consecutive two-hour training sessions that were open to all health-care providers were carried out in each of the intervention practices. A separate one-hour session was offered to the practices' reception and administrative staff.

The first session was delivered by an experienced GP and the domestic violence advocate for each site, and the second by the clinical psychologist and domestic violence advocate. The sessions covered a range of topics and included practical enquiry and referral exercises.

Importantly, the intervention also included provision of technical support in the form of an electronic popup template in the patient's medical record. When health-care providers entered particular coded symptoms (such as depression, chronic pain or tiredness), the template would appear as a reminder of the links to abuse and prompt enquiries about potential exposure to violence. Provision of the training by the local domestic violence advocate also ensured that referral pathways were strengthened (Johnson, 2010).

The trial finished in 2010 and proved to be highly cost–effective and efficient. Women patients in the intervention practices were 22 times more likely than those in the control practices to have a discussion with their GP about a referral to an advocate. This resulted in them being six times more likely to be referred. Women attending the intervention practices were also three times more likely than those attending the control practices to have a recorded identification of VAW in their medical record (University of Bristol, 2012).

The IRIS model has been scaled up since the trial, and by 2016 was running in 33 areas. The Government set out plans to further promote the programme to local commissioners as part of its *Strategy on ending violence against women and girls: 2016–2020* (HM Government, 2016).

Box 5. Italy's new national guidelines on training health-care providers on VAW

New Italian guidelines on primary and secondary health-care services' response to VAW were issued in the form a Decree of the President of the Council of Ministers on 24 November 2017 (Decree of the President of the Council of Ministers, 2018).

The guidelines stipulate that professional training and continuous updating of health-care providers' knowledge are indispensable to ensuring provision of first-line support, identification of risks and prevention of VAW, and request the introduction of an in-service training course on VAW. The guidelines also very clearly specify the structure of the course, which is expected to consist of at least eight modules and to last between 20 and 50 hours. It could be taken in person or as a distance-learning option with some interactive activities, such as round tables, discussion forums, group work and simulation of clinical cases. The guidelines also include detailed learning objectives the course should achieve and a description of the contents to be covered in each learning module. In particular, the course is expected to focus on:

- providers' knowledge of the phenomenon of VAW and addressing VAW-related stereotypes
- improving their understanding of the dynamics of VAW
- health consequences of VAW
- identification of VAW
- principles of women-centred care
- principles of first-line support
- referrals and providers' knowledge of existing intersectoral networks of support
- FGM
- violence against women with disabilities
- providers' knowledge of legal frameworks
- interprofessional knowledge exchange on VAW.

Quality and comprehensiveness of training on VAW for health-care providers also varies across the surveyed Member States. The survey asked which VAW-related topics are covered in training programmes (see Table 3). The average comprehensiveness of training activities was **5.6** (on a scale from 0 (minimum) to 7 (maximum)) across the 23 Member States that replied to those questions. The aspect that has received relatively less attention is follow-up and quality supervision of providers after they complete their training on VAW – this is being carried out in fewer than half of the countries that responded to this question, and the large proportion of missing or "*I don't know*" answers suggests that a number of respondents were not familiar with the concept. Data collection on VAW is another area that appears not to be covered by training programmes in a significant number of the Member States. Considering how important information and evidence are for effective responses to VAW (see Section 3.5), it is crucial to address this gap in training programmes.

Among the different types of health-care providers, doctors most commonly receive training on VAW (in 19 out of 20 countries that replied to the question, 94.4%), followed by nurses (18 countries, 88.9%). Training of midwives is somewhat less common – it is implemented in 16 countries (80.0%). Some of the countries in the Region provide training to a wider range of health-care specialists in addition to these groups: Sweden, for example, also trains dentists, as they often come into contact with women who may potentially be exposed to VAW (survey response). In Ireland, training is open to all front-line health-service staff (survey response).

Table 3. Training of health-care providers on VAW

	Definition of VAW	Where and how to enquire about VAW	Best ways to respond to disclosure	Offering information on VAW and available services	Addressing providers' attitudes towards VAW survivors and gender equality	Data collection on VAW	Follow-up and quality supervision of providers
Topic covered (countries)	20	21	20	22	19	17	10
Topic not covered (countries)	2	1	1	1	2	4	6
I don't know (countries)	1	1	2	1	2	1	5
Missing (countries)	12	12	12	11	12	13	14
Total responses (countries)	35	35	35	35	35	35	35

3.2.5. Mandatory reporting for IPV

WHO recommends against mandatory reporting of IPV to the police by health-care providers, but recognizes that if the woman expresses that she wishes the incident to be reported and is aware of her rights, health-care providers should offer to report the incident to relevant authorities (WHO, 2013b).

The survey results suggest large variation in Member States' approaches to mandatory reporting. Fifteen countries (out of 23 that replied, 65.2%) answered "*Yes*" to the question on whether guidelines, protocols or standard operating procedures include mandatory reporting as an element of clinical care for survivors of violence against women/gender-based violence, with only seven (30.4%) indicating that reporting is not required. One respondent replied with "*I don't know*".

Closer examination of respondents' comments to this question and content analysis of the provided documents reveals, however, that this reportedly high level of noncompliance with the WHO recommendation could at least partially be explained by the design of the survey question. The question was formulated very broadly and did not take into account the potential complexity of reporting requirements and mechanisms existing in the countries. In some countries that answered positively to this question, mandatory reporting is applied only in specific cases (such as minor-age victims in Sweden (National Board of Health and Welfare, 2014)), for specific types of injuries (such as "grievous injuries" in Malta (Department of Primary Health Care, 2017)) and/or only from certain health-care actors. In Czechia, for example, health emergency call centres alert police automatically when violence is reported (police are alerted due to concerns about safety of medical teams), but health-care providers in health facilities are not required to report VAW cases to the police (Vaníčková et al., 2017). The validity of the results is therefore limited.

3.3. Strengthening programming to prevent interpersonal violence

Indicator A3.1 of the global plan of action

Number of Member States that have a national multisectoral plan addressing VAW (which includes the health system), and which proposes at least one strategy to prevent VAW

Twenty-eight (80%) of the 35 WHO European Region Member States that responded to the survey have a national multisectoral plan addressing VAW (which includes the health system) and which proposes at least one strategy to prevent VAW.

The global plan of action identifies that the health sector may play an important role in prevention and reduction of VAW as part of a wider multisectoral collaboration effort (WHO, 2016a). Although most primary prevention actions take place outside of the health sector and the evidence to guide health-care organizations in primary prevention remains scarce, certain types of VAW prevention programmes could be delivered through the health system (García-Moreno et al., 2015). These may include support programmes for children exposed to IPV and those addressing risk factors of IPV, such as alcohol and substance use and maternal depression. Messages on egalitarian and non-violent gender norms and consensual and respectful sexual relations could be integrated into health promotion campaigns (WHO, 2016a).

As was discussed in Section 3.2, multisectoral action plans specifically for VAW or multisectoral gender equality plans that include VAW exist in the vast majority of surveyed Member States (34 out of 35, 97.1%). The health system response, however, is not covered in all such plans; in fact, it is covered in 29 of 35 plans (82.9%).

Strategies to prevent and reduce VAW form an important part of multisectoral action plans (see Table 4). The document analysis suggests that some Member States are trying to involve the health sector in realizing preventive strategies. For example, to ensure access to specialized therapeutic services for people affected by VAW (including children), the Government of Czechia plans to negotiate with health insurance companies to ensure these services are paid for by the companies (Office of the Government of the Czech Republic, 2015).

The VAW strategy in Slovenia included a number of interventions addressing alcohol and drug abuse delivered with participation of the health system (National Assembly of the Republic of Slovenia, 2009) (see Box 6).

The health sector is also involved in developing school-based sexual education programmes across the countries of the Region (Ketting & Ivanova, 2018). To date, only a few countries cover IPV and SV comprehensively in these programmes; this represents a missed opportunity, considering that school-based programmes that address dating violence remain one of the most effective approaches to addressing IPV (WHO & London School of Hygiene and Tropical Medicine, 2010).

Table 4. Selected VAW prevention and reduction strategies applied in the WHO European Region

	Social and gender-norm change strategies, including community mobilization	Perpetrator programmes/ interventions	Mass media campaigns/ awareness-raising initiatives	Healthy relationship skills to manage conflicts	Parenting programmes to prevent child abuse or improve parent–child communication	Interventions and/or policies addressing alcohol or other substance misuse	Promoting/ enforcing laws on gender equality
Applied (countries)	20	23	24	18	23	19	23
Not applied (countries)	4	2	4	6	5	6	3
I don't know (countries)	3	2	0	2	0	2	1
Missing (countries)	8	8	7	9	7	8	8
Total responses (countries)	35	35	35	35	35	35	35

Box 6. Alcohol- and drug-related interventions to prevent VAW in Slovenia

As part of its national programme on prevention of family violence 2009–2014 (National Assembly of the Republic of Slovenia, 2009), Slovenia focused on reduction of risky and harmful use of alcohol and illegal drugs, which are recognized by WHO as factors strongly associated with risk of IPV (WHO & London School of Hygiene and Tropical Medicine, 2010; WHO, 2016a). The health sector, jointly with the social welfare and education sectors, implemented a number of programmes to address this issue.

The first type of interventions focused on awareness-raising about the relationship between alcohol and drug abuse and violence. Implementing agencies (ministries of health, and labour, family and social affairs) organized awareness-raising campaigns to improve the population's knowledge of the issues and promote support for intervention programmes.

Secondly, the programme focused on improving the evidence base on ways to limit the use of alcohol and reduce its harmful consequences. The Ministry of Health, in cooperation with other governmental and nongovernmental agencies and experts, implemented target-research programmes on the relationship between alcohol and drug abuse and VAW in the country and developed a proposal on reducing alcohol- and drug abuse-related VAW.

Thirdly, the programme prioritized work with perpetrators of VAW. A network of VAW perpetrator assistance programmes was established through collaboration involving the ministries of health, labour, family and social affairs, and education and sport. The programme stipulated that if family violence occurs in connection with excessive consumption of alcohol or illegal drugs, the perpetrator should be directed to treatment for alcohol dependence or drug addiction and to programmes in the area of violence.

Lastly, the programme included the establishment of assistance programmes for children and adolescents whose parents were users of alcohol and/or illegal drugs.

3.4. Improving information and evidence

Indicator A4.1 of the global plan of action

Number of Member States that have carried out a population-based, nationally representative study/survey on VAW or that have included a module on VAW in other population-based demographic or health surveys within the past five years, disaggregated by age, ethnicity, socioeconomic status, etc. (yes/no)

Thirty-four (64%) of the 53 WHO European Region Member States have a nationally representative survey on VAW or have included a module on VAW in a population-based demographic, health or other type of survey within the past five years.[4]

Knowledge about the phenomenon of VAW and recognition of what prevention and intervention strategies work is fundamental to an informed decision-making process and effective response. It is for this reason that in the framework of the global plan of action, WHO calls on countries to strengthen routine reporting of VAW statistics and monitoring of implementation of the health system response by including indicators and collecting data on VAW in their health information and surveillance systems. It also urges countries to integrate modules on VAW into population-based surveys and collect data disaggregated by factors such as age, ethnicity, socioeconomic status and education. Countries are encouraged to conduct and support research to develop, pilot and evaluate interventions to address VAW (including within the health system) and fill other knowledge gaps related to VAW (WHO, 2016a).

Improving information and evidence on VAW has already been prioritized by most WHO European Region Member States. As of 2017, national prevalence survey data were available for 43 of the 53 Member States of the Region (81%), but only 34 (64%) had conducted surveys between 2010 and 2017. Most of the surveyed Member States (21 of 28 that responded to the question, 75%) indicated that their multisectoral plans include actions related to standardizing data collection and documentation of VAW, and conducting research on this topic. The comprehensiveness of countries' efforts in this area, however, varies significantly.

Some of the analysed action plans, such as those from Denmark, Finland, Portugal, Spain and the United Kingdom, paid particularly strong attention to improving the evidence base on VAW. This, however, has not yet become a universal approach across the Region. Approaches to gathering information and evidence on VAW among Member States that responded to the survey also differ in terms of the roles countries allocate to the health sector in this process, with some already recognizing the multiple possibilities the health system provides for furthering knowledge and understanding of ways to address the phenomenon of VAW (see Box 2 and Box 7 for examples of how it is done in Spain and Finland).

Providing training on how to collect and record VAW-related data is essential for improving routine reporting of VAW statistics and monitoring of interventions. As discussed in Section 3.3, however, topics related to data collection of VAW are still not included in training programmes for health-care providers in some of the surveyed Member States (four of 22 that replied to the question, 18.2%).

[4] These data were not collected by the survey of Member States, but instead through regular mapping of demographic, health or other surveys by WHO. The data presented here relate to surveys undertaken between 2010 and 2017.

Box 7. Improving information and evidence on VAW with involvement of the health sector in Finland

Finland has committed to strengthening data collection and research on VAW as part of its 2018–2021 action plan for the Istanbul Convention (Committee for Combating Violence Against Women and Domestic Violence, 2017). The health sector will be involved in implementing a number of measures to meet this objective, including:

- developing new health-care and welfare information systems to ensure that the type of violence patients/clients were exposed to is registered;
- surveying the prevalence of forms of violence among disabled people and availability of services;
- performing regular surveys of child victims as part of national school health promotion surveys; and
- estimating the extent of costs arising from IPV in Finland.

Twenty surveyed Member States (out of 28 that replied to the question, 71.4%) indicated that they carry out monitoring and evaluation of VAW programmes as part of their multisectoral action plans. Content analysis of the action plans, however, reveals that the quality of monitoring and evaluation plans varied substantially. In only a few cases were they sufficiently specific and contained goals and outcome indicators.

SECTION 4. STRENGTHENING WHO EUROPEAN REGION MEMBER STATES' RESPONSE TO IPV AND SV

Based on the analysis undertaken of both the quantitative findings from the baseline survey and the results of the qualitative document analysis, the following can be concluded for WHO European Region Member States.

4.1. Priorities for progress

At policy level, WHO European Region Member States demonstrate a high level of commitment to addressing VAW through their health system. Nearly 83% of the surveyed countries already address VAW in their health policies and strategies. This commitment should become universal across the Region in the coming years. As the report demonstrates, some Member States already have seen significant achievements in this area. Further strengthening of the health system role in VAW prevention and response across the WHO European Region would require:

- increasing investment in human resources working on VAW response, including VAW focal points;
- increasing and better earmarking of financial resources for VAW-related work; and
- strengthening integration of the health system response into countries' multisectoral plans on VAW.

The Region's performance in relation to health service delivery for victims of VAW can also be assessed positively, with 71.4% of the surveyed Member States having developed national guidelines, protocols or standard operating procedures for the health system response to VAW. There remains, however, a tangible number of Member States that still need to take this step. Analysis of existing guidelines/protocols/standard operating procedures from across the Region suggests generally high levels of compliance with WHO guidelines on provision of women-centred care and clinical care for survivors of sexual assault. It is important to note, however, that availability of safe abortion as an essential element of post-rape care is still not universal across the Region.

Approaches to identification of victims of IPV (universal screening versus clinical enquiry) and reporting of IPV cases (mandatory versus non-mandatory) vary widely across the countries. Only a minority of the surveyed Member States currently comply fully with WHO's recommendations against universal screening and mandatory reporting of IPV. Further capacity-building and technical assistance for Member States in developing relevant guidelines, protocols and standard operating procedures will therefore be required to ensure successful implementation of the global plan of action.

Many of the surveyed Member States are investing in building health-care providers' capacity to respond to VAW. Pre-service training is provided in nearly half of the surveyed countries and in-service training in almost 70%. Significant room for improvement nevertheless remains. Health-care providers in all Member States should receive training both at pre- and in-service stages. Coverage of topics, especially those related to data collection on VAW, should be improved. More attention should be paid to follow-up and quality supervision of health-care providers once they complete training, and countries should not limit training provision to defined groups of health-care providers.

The role health systems could play in primary prevention of VAW is widely recognized in the WHO European Region. Eighty per cent of the multisectoral VAW and gender equality plans of the surveyed Member States include a health system response and propose prevention strategies, some of which are driven by, or involve, the health sector. More active involvement of the health sector in VAW prevention across the countries of the Region nevertheless is both possible and necessary to ensure effective realization of the global plan of action.

WHO European Region Member States have started investing in improving knowledge on the phenomenon of VAW and, importantly, appear to recognize the role the health sector could play, but the health sector's role in this area could further be strengthened through:

- further implementation and development of health information and surveillance systems on VAW;
- inclusion of topics related to data collection on VAW in training programmes of health-care providers across all the countries of the Region;
- expanded research programmes on VAW; and
- improved monitoring and evaluation of health sector and multisectoral action plans on VAW.

4.2. Moving forward

The goal of this report was to provide a baseline assessment of how VAW is addressed in national health systems in the WHO European Region. In view of the implementation of the global plan of action (WHO, 2016a), it aimed to overview work in this area that has been carried out by Member States, highlight their achievements to date and identify the directions for future development of their health system response to VAW.

WHO aims to use the results included in this report in its monitoring activities related to the global plan of action and the strategy on women's health and well-being in the WHO European Region. WHO further intends to build on these results in its current and future collaboration with Member States in strengthening health system responses to IPV and SV in years to come.

This report can be used as a resource for partners and stakeholders in monitoring Member States' commitments to eliminating all forms of VAWG, particularly in relation to United Nations Sustainable Development Goal 5, the 25-year review of the Beijing Declaration and Platform for Action, and the Council of Europe Convention on Preventing and Combatting Violence against Women and Domestic Violence (Istanbul Convention).

REFERENCES [5]

Committee for Combating Violence Against Women and Domestic Violence (2017). Action plan for the Istanbul Convention for 2018–2021. Helsinki: Ministry of Social Affairs and Health (https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160403/18_2017_Istanbulin%20sopimuksen%20tps%202018-21%20englanti.pdf).

Decree of the President of the Council of Ministers (2018). Linee guida nazionali per le Aziende sanitarie e le Aziende ospedaliere in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza [National guidelines for primary health services and hospitals on provision of help and social-health assistance to women victims of violence]. Gazzetta Ufficiale Della Repubblica Italiana 24:18–30 (in Italian).

Department of Health (undated). FGM safeguarding pathway. London: Department of Health (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/542650/FGM_Flowchart.pdf).

Department of Primary Health Care (2017). Standard operational procedure for suspected or alleged cases of domestic violence attending health centres. Floriana: Department of Primary Health Care.

García-Moreno C, Hegarty K, D'Oliveira AFL, Koziol-Mclain J, Colombini M, Feder G (2015). The health-systems response to violence against women. Lancet 385(9977):1567–79.

HM Government (2016). Strategy on ending violence against women and girls: 2016–2020. London: HM Government (https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020).

Johnson M (2010). "Herding cats": the experiences of domestic violence advocates engaging with primary care providers. Domestic Abuse Quarterly winter:14–17 (http://www.irisdomesticviolence.org.uk/iris/uploads/documents/Herding_cats_SAFE.pdf).

Justice and Public Security Department (2014). Et liv uten vold. Handlingsplan mot vold i nære relasjoner 2014–2017 [A life without violence. Action plan against violence in close relationships 2014–2017]. Oslo: Justice and Public Security Department (https://www.regjeringen.no/contentassets/97cdeb59ffd44a9f820d5992d0fab9d5/hplan-2014-2017_et-liv-uten-vold.pdf) (in Norwegian).

Ketting E, Ivanova O (2018). Sexuality education in Europe and central Asia: state of the art and recent developments. Cologne: Federal Centre for Health Education (https://www.ippfen.org/sites/ippfen/files/2018-05/Comprehensive%20Country%20Report%20on%20CSE%20in%20Europe%20and%20Central%20Asia_0.pdf).

Ministry for Health (2017). Guideline for management of cases of alleged rape or sexual assault which come to Mater Dei Hospital. Valetta: Ministry for Health.

Ministry of Health, Social Services and Equality (2013). National strategy for the eradication of violence against women (2013–2016). Madrid: Ministry of Health, Social Services and Equality (http://www.violenciagenero.igualdad.mpr.gob.es/planActuacion/estrategiaNacional/docs/Estrategia_Nacional_Ingles.pdf).

Ministry of Health, Social Services and Equality (2015). Common protocol for a healthcare response to female genital mutilation. Madrid: Ministry of Health, Social Services and Equality (http://servicios.mpr.es/VisorPublicaciones/visordocumentosicopo.aspx?NIPO=680151644&SUBNIPO=).

National Assembly of the Republic of Slovenia (2009). Resolution on the 2009–2014 national programme on prevention of family violence. Ljubljana: National Assembly of the Republic of Slovenia (http://www.mddsz.gov.si/fileadmin/mddsz.gov.si/pageuploads/dokumenti__pdf/resolution_prevention_familiy_violence_09_14.pdf).

National Board of Health and Welfare (2014). Våld i nära relationers [Violence in close relationships]. Stockholm: National Board of Health and Welfare (in Swedish).

Office of the Government of the Czech Republic Department for Human Rights and Minority Protection Government (2015). Czech Republic – action plan for the prevention of domestic and gender-based violence 2015–2018. Prague: Office of the Government of the Czech Republic.

UN Women (2013). Elimination and prevention of all forms of violence against women and girls. Commission on the Status of Women. Agreed conclusions. New York (NY): UN Women (http://www.unwomen.org/-/media/headquarters/attachments/sections/csw/57/csw57-agreedconclusions-a4-en.pdf?la=en&vs=700).

UNAIDS (2019). Welcome to GAM online reporting tool! In: UNAIDS online reporting tool [website]. Geneva: UNAIDS (https://aidsreportingtool.unaids.org/).

[5] All weblinks accessed 10 April 2019.

University of Bristol (2012). About IRIS. In: IRIS – Identification and Referral to Improve Safety [website]. Bristol: University of Bristol (http://www.irisdomesticviolence.org.uk/iris/about-iris/about/).

Vaníčková E, Hanaček J, Krpalková J, Papežová H, Prokopová R, Seblová J et al. (2017). Domácí a genderově podmíněné násilí: manuál pro lékaře [Domestic and gender-based violence: a manual for physicians]. Prague: UK–3. LF (http://www.mzcr.cz/dokumenty/domaci-a-genderove-podminene-nasili-manual-pro-lekare_15189_3844_3.html) (in Czech).

World Health Organization (2013a). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization (https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/).

World Health Organization (2013b). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization (https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/).

World Health Organization (2014). Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization (http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/).

World Health Organization (2016a). 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. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/252276/1/9789241511537-eng.pdf?ua=1).

World Health Organization (2016b). WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization (https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/).

World Health Organization (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: World Health Organization (https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/).

World Health Organization, London School of Hygiene and Tropical Medicine (2010). Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization (https://www.who.int/reproductivehealth/publications/violence/9789241564007/en/).

WHO Regional Office for Europe (2016a). Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO Regional Office for Europe (https://www.who.int/gender-equity-rights/knowledge/strategy-on-women-health/en/).

WHO Regional Office for Europe (2016b). Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/2016/action-plan-for-sexual-and-reproductive-health-towards-achieving-the-2030-agenda-for-sustainable-development-in-europe-leaving-no-one-behind-2016).

WHO Regional Office for Europe (2018). Strategy on the health and well-being of men in the WHO European Region. Copenhagen: WHO Regional Office for Europe (EUR/RC68/12; http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/68th-session/documentation/working-documents/eurrc6812).

ANNEX 1

SURVEY RESPONSES BY COUNTRY

Responses by country are shown in Table A1.1.

Table A1.1. Responses by country

WHO European Region Member State	Response received
Albania	No
Andorra	Yes
Armenia	Yes
Austria	No
Azerbaijan	Yes
Belarus	Yes
Belgium	Yes
Bosnia and Herzegovina	No (only the representative of Republika Srpska sent the response on behalf of the subregion)
Bulgaria	No
Croatia	Yes
Cyprus	Yes
Czechia	Yes
Denmark	Yes
Estonia	Yes
Finland	Yes
France	Yes
Georgia	Yes (partial)
Germany	Yes
Greece	No
Hungary	Yes
Iceland	No
Ireland	Yes
Israel	Yes
Italy	Yes
Kazakhstan	Yes
Kyrgyzstan	No
Latvia	Yes
Lithuania	Yes
Luxembourg	Yes (incomplete – only personal data)
Malta	Yes
Monaco	No

Table A1.1 contd

WHO European Region Member State	Response received
Montenegro	No
Netherlands	No
North Macedonia	No
Norway	Yes
Poland	Yes (partial)
Portugal	Yes
Republic of Moldova	No
Romania	Yes
Russian Federation	No
San Marino	Yes
Serbia	No
Slovakia	Yes
Slovenia	Yes
Spain	Yes
Sweden	Yes
Switzerland	Yes
Tajikistan	No
Turkey	Yes (partial)
Turkmenistan	Yes
Ukraine	No
United Kingdom	Yes
Uzbekistan	Yes (incomplete – only personal data)

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
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int