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The strategic role of healthcare professionals in early detection of victims: what hinders and what helps

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I will present

- Some data : repeated over time and consistent over Europe
- Some tools: tested in our country
- Some principles: that have proved their worth

Robust & consistent data

- Screening & detection most powerful for early recognition & treatment of health problem
- Violence against women & children public health problem (WHO 2002)
- Health care professionals, frequently in close and intimate contact with women
- Women who were physically abused used more than others health services
- Screening increases the identification of women experiencing IPV in healthcare settings

Robust & consistent data

- 1/5 -1/3 women victim of violence in Europe
- 75% of European women in close contact at least once a year with a health professional
- Women trust health professional to respond to their needs in case of violence
- ED, gynaecologist, general practitioner main gateway for women victims, to access support and orientation
- Pregnant women are more likely to disclose IPV when screened in antenatal clinic

A huge potential

If violence was screened and/or detect **at least by**

- emergency department nurses
- perinatal professionals (midwife & MD)
- gynaecologists
- general practitioner (GP)

A country could guarantee almost **complete detection** of women at risk




Detection paradox

Prevalence of type II diabetes in population: 3-5%
Screening for blood glucose test in ED : 90%

Prevalence of IPV in ED : 12-36 %
Screening ?

Prevalence of pre-eclampsia in prenatal ward 2%
Screening for hypertension: 100 %

Prevalence of IPV third trimester of pregnancy : 15%
screening ?

Detection of PV by MD what's going on ?

- Women victims of violence **prefer to discuss** their experiences with their **doctor** rather than the police, the courts or voluntary organisations
- 75% of women **wish to be systematically asked** by their doctor about any violence in their relationship

65% of doctors are against detection, for fear of **offending their patients**, because they **feel incompetent**, because they don't know the **local resources**.

Reasons given

- **“It is not a medical problem ”** Frequency & impact on health largely underestimated
- **“Not my patients”** False representation & stereotypes
- **“I have not time”** False representation of time needed for actual screening
- **“I don’t want to offend my patient”** whereas women are willing to be asked about violence and trust their GP
- **“I don’t know what to do “** Guidelines & training may overcome medical inaction

Some way to overcome inertia

- Commitment and engagement of responsible for health policy & academic politics
- Properly coordinated multi-agency partnerships & clear referral pathways
- Integration of all health professional into the local network
- Expert advice available on the long term « *medical Concilium* »
- Structural and financial incentives to change clinical pratice
- Guidelines & Training

Protocols should be short and simple

- **D** Detect and welcome
- **O** Offer a clear message of support
- **T** Treat and report
- **I** Inform on right and resources
- **P** Protect and prevent recurrences

DOTIP Guidelines

D	Detect & welcome	Systematically screen for Partner violence *"add PV to your DD"* , indicate your readiness to welcome without confronting *« PV is frequent in any social context, I am ready to talk about the situation without judging»*
O	Offer a clear message of support	Give a simple supportive message *«Whatever the circumstances, violence is always unacceptable. Nobody deserves it. It is prohibited by law»*
T	Treat & report	Complete the necessary treatment and make a **medical report** with photos *« A medical report is independent of a criminal complaint »*
I	Inform on rights & resources	Clarify rights and duties, inform about local resources and how to reach them *« Specialized services exist that can help you and protect your children Both parents are responsible for children's safety »*
P	Protect & prevent recurrences	Assess risk of recurrence and immediate **danger** for the victim and the children, if necessary, refer to a shelter, call the police *« If nothing is done, the situation will not change, it will get worse, your health is in danger as well as that of your children »*

The DOTIP protocol* is recognized as a model of good practice

*BEFH_DOTIP_actu2019_web_PS.pdf (vd.ch)








Same DOTIP
adapted to each frontline professional practice & context

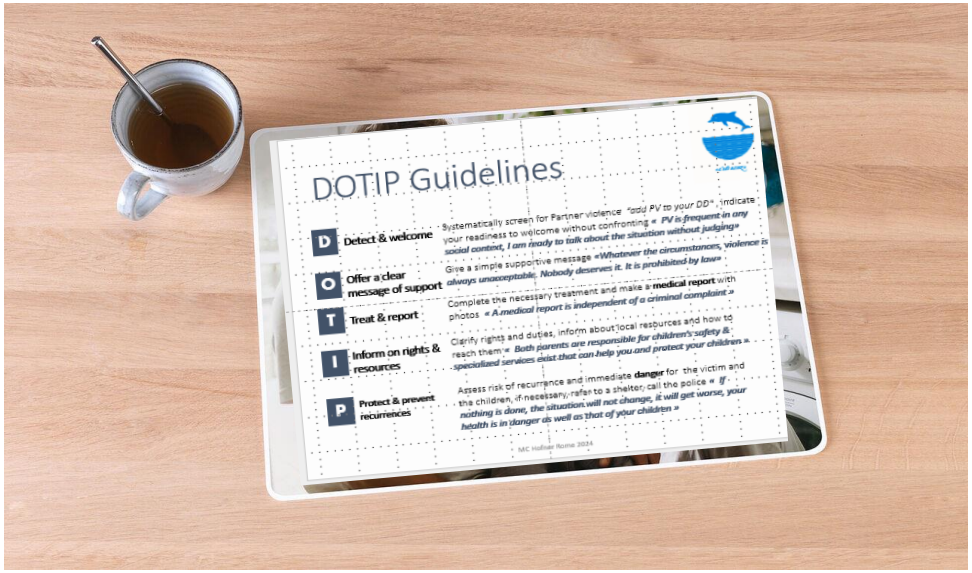
Other practical tools

- **Updated online** Dbase of local resources:
  what, for whom, when and under what conditions
- Annual **network day :** *meeting partners in person*
- **Micro exchange placement**: *discovering reality of other practices*
- Continuing **training:** *learning to practice & questioning one's representation*

Tailored training

Online teaching for the pharmacists

Tailored training



Repeated mini teaching for the ED at lunch time with plastic DOTIP place mat

Some principals

- Taking account of the **beliefs and values** of each profession is the only way to **change professional culture**
- The problem is **complex**. Neither a unique discipline, nor a unique profession can address it alone. So, the program must be **interdisciplinary & interprofessional**
- **All political economic and social sectors** are concerned and must make their contribution. It is not the duty of a single sector.
- A new problematic **should not** automatically lead to the creation of **a new structure**, lets use and support efficiently the **existing experienced resources (often NGO)**

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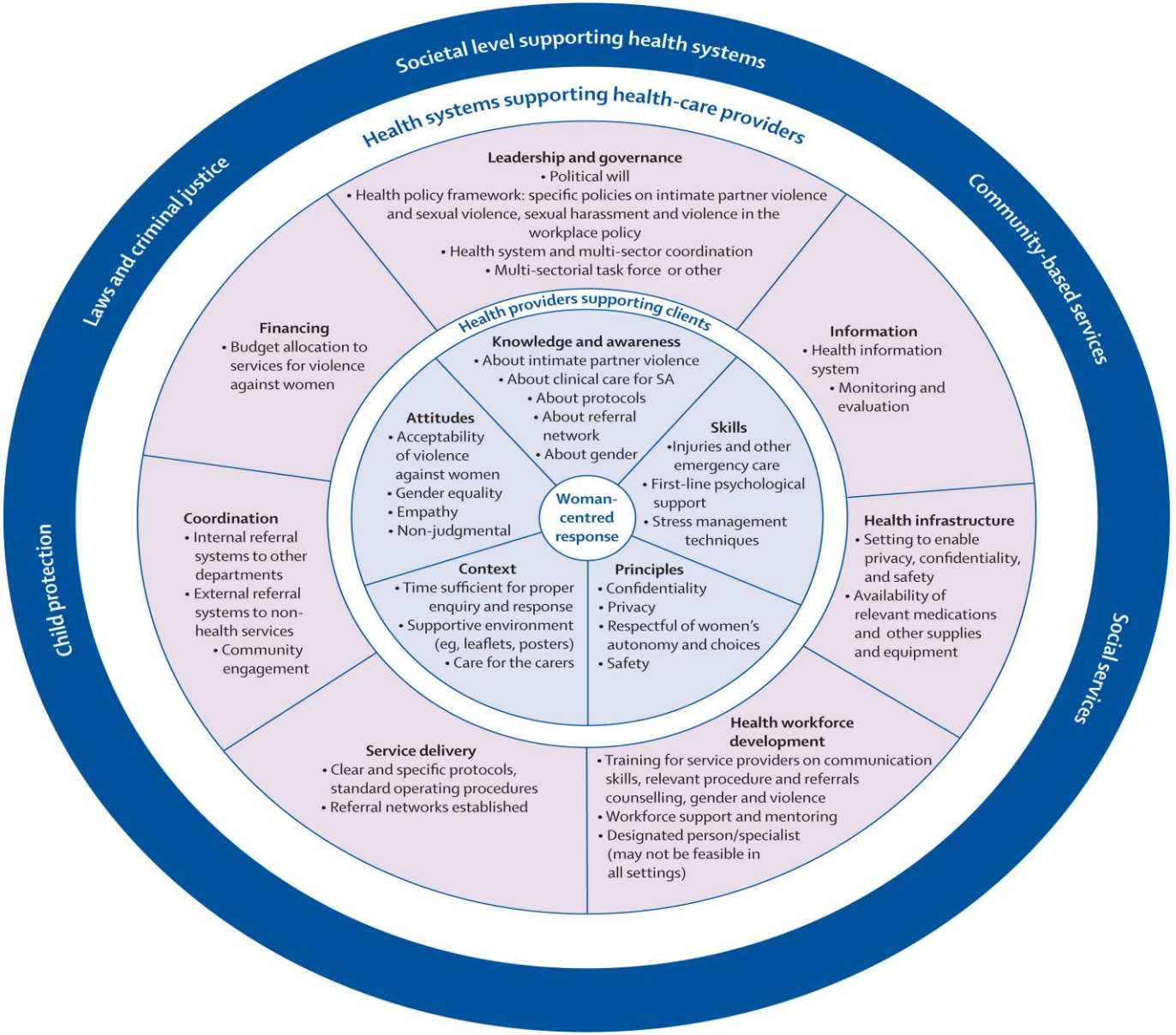
GREVIO findings about health sector in Europe

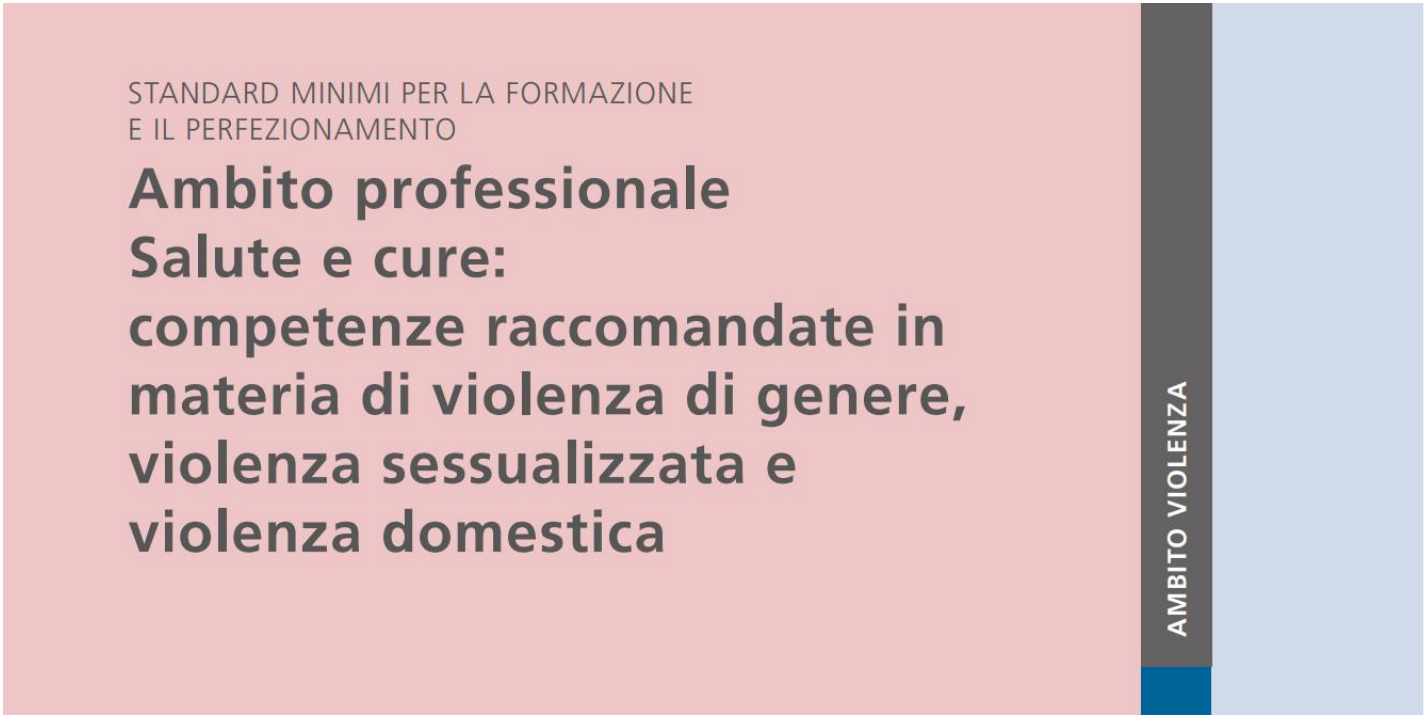
- Often not integrated **in the public policies coordinating bodies** however public health sector is a central part of the answer
- State parties **introduced protocols** but badly implemented, and **not interprofessional**
- **Training** of health care professionals not a priority related to health sector being poorly included in **strategic plans**
- Growing number of **mandatory reporting obligations** whereas Istanbul Convention aims to ensure **professional secrecy and reporting with the victim consent**

The horizon we want to believe in



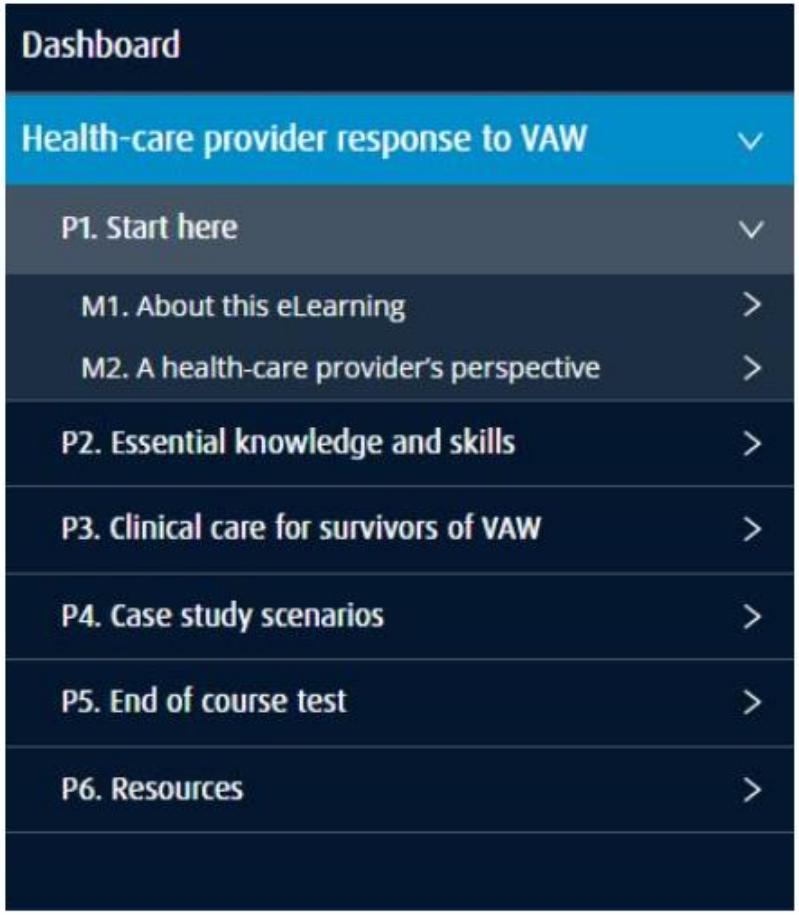
García-Moreno, Claudia, et al. "The health-systems response to violence against women." *The Lancet* 385.9977 (2015): 1567-1579.

Educational minimum standards



[Ambito professionale Salute e cure: competenze raccomandate in materia di violenza di genere, violenza sessualizzata e violenza domestica (admin.ch)]

WHO online learning resource



Health sector response to violence against women (VAW)

Health sector response to violence against women (VAW) (vawhealthresponse.org)

A WHO e-Learning for health care providers to respond to violence against women (VAW). Geneva: World Health Organization; 2023.

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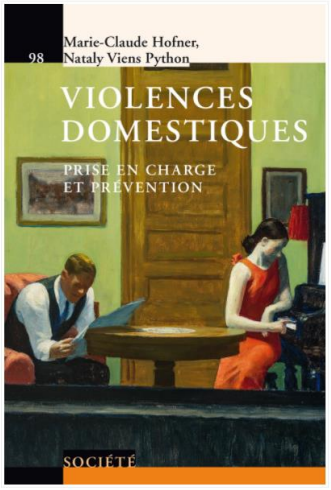

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