October 2015

SIGFV Newsletter n° 1 October 2015

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- For further background information: SIGFV Website
- Contact EMAIL: famviolence@gmail.com
- To become an active member: MEMBERSHIP
- Update of meetings schedule and DISCUSSION TOPICS

1. WONCA SPECIAL INTEREST GROUP ON FAMILY VIOLENCE: FROM THE EDITORS.

We are proud to send you the first newsletter of our Special Interest Group on Family Violence providing a summary of discussions during the first period of our network with more extensive summaries of Wonca rural (Dubrovnic) and Wonca Africa (Accra) and due attention to work of the constituting networks.

Upcoming events are during the WONCA Europe in Istanbul: a 4 hours pre-conference course with training good practices on the **22th October** (at 9 am) and different workshops on training, prevention and multidisciplinary collaboration the other days.

We would in particular like to welcome delegates of colleges or academies who want to become involved in training and action against any type of family violence. On the **23th October** we will also meet after the conference time to discuss formal statements on Family Violence (FV) and further activities. You are all warmly invited or can join the discussion online (DISCUSSION TOPICS).

Leo Pas (Belgium) and

Raquel Gómez Bravo (Spain)

2. WONCA SPECIAL INTEREST GROUP ON FAMILY VIOLENCE: AN INTRODUCTION.

Since 2004, the issue of family violence has been raised by numerous researchers and practitioners from different backgrounds during WONCA conferences. At the WONCA World meeting in Prague in 2013

representatives of Europrev, the WONCA Working Party on Women and Family Medicine, the Vasco da Gama Movement, and a core group of researchers from an informal interest group on Family Violence met to constitute the WONCA Special Interest Group on Family Violence, which was endorsed formally in January 2014 by the Executive Board of WONCA WORLD.

Among the specific objectives of the group are: to update and disseminate available scientific evidence on family violence in general practice/family medicine and primary health care and to generate recommendations based on this evidence; if evidence is not sufficiently available we aim to establish a consensus based approach and to share and elaborate new evidence such as for preventive measures, care strategies and policy development worldwide. On these bases was inspired also this newsletter: to share activities, evidence and improve the communication in order to achieve the goals of the SIGFV.

We have been running in collaboration with the WONCA Working Party on Women and Family Medicine, the Vasco da Gama Movement and Europrev workshops in almost all WONCA Meetings since 2014 and prepare our first formal statements during the WONCA ISTANBUL MEETING.

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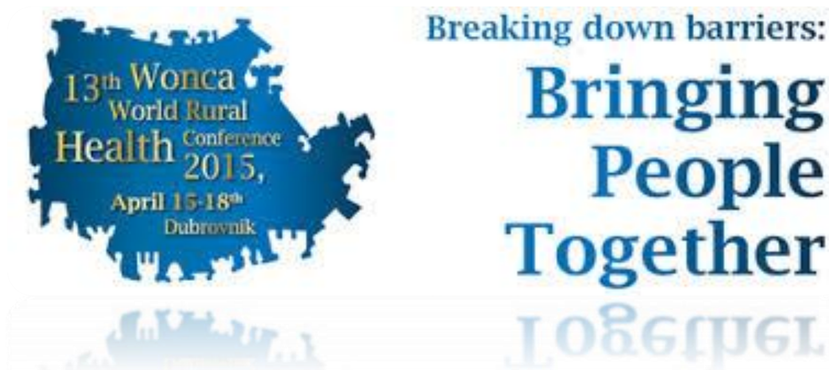
3. WONCA SIGFV ACTIVITIES 2015



WORKSHOPS 17th April Conclusions from Wonca Rural 2015

By Nena Kopcavar Gucek (Slovenia) and Lorraine Bacchus (UK)
Edited: Leo Pas (Belgium), Joyce Kenkre (Uk) and Tanja Pekez-Pavlovski (Cr)

The workshops during this conference looked specifically to the context and the possibilities of action and multidisciplinary collaboration in rural and remote areas.

PRIMARY PREVENTION SHOULD BE GIVEN ATTENTION THROUGH EDUCATION OR COMMUNITY AWARENESS ACTIONS:

- Primary prevention should be implemented, offering education about healthy relationships (maybe starting with students, in school).
- It is important to raise awareness at community level in particular, as well as to realise to highlight risks in a woman's life cycle when DV might be an issue (e.g. pregnancy and postpartum and divorce).
- Awareness should be raised about social norms that maintain and challenge violence.
- Medical school students can form voluntary groups by talking to people in rural environment (project in Brazil).
- Public education should combat denial and minimisation in the community of family violence (FV), such as »There is no violence in my community!«

SUPPORTING VICTIMS:

- Beware of typical health complaints for FV and links with mental wellbeing (stomach pain, reproductive issues, headache, etc. , and of repeating injuries in different stages of healing…)
- In spite of protocols, guidelines and legal frameworks the individualised approach should be assured: different situations need interventions tailored to different contexts and to women's individualised needs.
- Support should not just be oriented to identifying women, but also empowering them through active listening, acknowledging the suffering and informing women they are not alone : FV is common
- Support women expressing themselves and tell you what they need.
- There is a need to recognise the gendered nature of FV
- At the very least ask women "do you feel safe to go home?".

PRACTICE MANAGEMENT:

- Make your clinic a safe place for women to disclose.
- At practice level it should be clear what tools the community has – shelters, hotlines...
- Such information should be available on small contact cards to give to women that they can easily hide from perpetrator.
- A website could be created, offering information and anonymous counselling to the victims.
- Responsibility for the patients and outcomes should be shared within a multi-sector/agency response; rural practitioners should not be the sole responsible experts for the outcomes of cases.

INVOLVEMENT OF DIFFERENT PROFESSIONS IN RESPONDING TO FAMILY VIOLENCE IN RURAL FAMILY PRACTICES:

- Interdisciplinary task groups should be considered to work on specific cases
- Non-governmental organisations should be included in the multidisciplinary teamwork.
- Women support groups have an important role in treatment of family violence.
- Coordination with shelters and safe-houses should be improved.
- In rural communities, involving key power-brokers in the interdisciplinary care for victims of family violence can be very important.
- Social workers should be made aware that they have legal obligations in relation to FV (UK-proposal).
- Guidelines and a clear protocols can help provide support for

medical and other experts in case of family violence.

TRAINING

- There is a general lack of training at undergraduate and graduate level in medical faculties
- Physicians should be trained regarding forensic documentation of abuse – e.g. injuries, how to look for injuries that are not obvious, how to document the mental state of the woman, and of who else accompanied her; although it's simple to take a photograph according to local rules and containing date and time code to be admissible as legal evidence.
- Training of all staff in general practice is needed – even receptionists who can pick up on clues in the waiting room.
- Training, raising awareness and women empowerment should be parts of interdisciplinary approach programs.
- All services need training (e.g. GPs, police, social services)
- It is suggested to train them together so that they provide women consistent responses.

LEGAL FRAMEWORK

- A legal and state background should be defined for interdisciplinary action.
- Obligatory reporting violence to the social services and/or police, which is in some states obligatory by law, may not have the expected benefit: after reporting, the violence can escalate.

A WHOLE FAMILY APPROACH

- As a family physician, you may build a trust relationship with all actors in the relationship.
- Be aware of your role as a family physician dealing with all members of the family, children witnessing violence and – if a dialogues is acceptable to the survivor and possible- the perpetrating partner

AVOIDING VIOLENCE AGAINST CAREPROVIDERS:

- Nurses in rural areas can find themselves exposed and isolated when they work outside and separated from their team. A tool to insure the security/safety of the community nurses should be developed.

Discussions in Workshop WONCA AFRICA 7/5/2015 on Family Violence

Summarised with the help of Ogenna Okeke (Nigeria) and Martin WIllcockx (South Africa) and the original abstract from Abimbola Silva (Nigeria)

The African Communities are in a delicate balance with a high incidence of violence and limited resources. Possibilities for action were discussed.

Community action can work.

Primary care practices are seen as well as care providers and as important leaders for public health and local community education. Following actions were suggested:

A promising initiative against Family Violence in Uganda , the SASA approach, indicates that community action can change the attitude and outcomes in domestic violence in Africa. It is based on the WHO ecological model of domestic Violence embedded in the smaller family, the local communities and society at large. (Ref : BMC Medical 2014 12:122 – Uganda). The steps are based at community level on the stages of change model at individual as well as society levels : **S**tart , raise **A**wareness, provide **S**upport, **A**ction.

The local context is very important

In particular - as violence is largely embedded in cultural views – non-specifically informed services need specific training and raising awareness. It should also be borne in mind that police and law enforcement agents are not oriented towards protecting the victim, but towards getting the truth.

To solve the dilemma between acceptable and unacceptable customs, the human rights and children rights are a useful framework. All actions, through which harm would result, emotionally or in personal development as well as all physically repetitive aggressive behaviour, need to be interpreted as family violence.

The context of violence is in particular important. The example was given for example of a woman calling the police

while her husband phoned the local police chief and told them to go away.

Tasks for Family practice identified during workshop discussions

What can GPs do?

- Distinguish between intentional harm and unintentional : parents may have unrealistic expectations
- Find someone who can support the survivors or the children in violent relationships
- Enlarge the circle of allies in the fight against violence and culturally embedded views

It is confirmed that FP/GP need to actively contribute to change communities' norms, attitudes and practices. The following local initiatives for reducing maternal and child mortality were mentioned which can provide models for action:

- Ghana : primary health centres integrated coordination of care
- Free maternal and child health services
- Free Mama kits
- National immunisation days as action moments
- 'Mothers to mothers' project
- Community post-mortem of maternal deaths in Malawi

Suggested steps to come to such actions:

a. Get community to agree that violence in the family is a problem and agree on how to deal with it
   - Start with case reports, documentation of consequences.
   - Spending a long time in a community and providing a positive role model is important.

b. Raise wider awareness: doctors do have some degree of respect:
   a. Get politicians on board
   b. Get journalists to report cases
   c. Radio programmes (as for HIV/AIDS)
   d. Health talks and dialogues in health centres are useful local enhancements
   e. Work through churches,
   f. In schools :
      i. Take leadership from within – e.g. principal who outlawed caning in her school.
      ii. Changing perception from the basics about relationships

c. Get support from law enforcement agencies

d. Empower women through
   a. Improving education of the girl child

b. Improving socio-economic status of women e.g through loans for small scale businesses, training in crafts which may not need much capital to be productive.

e. Female Gender Mutilation still happens, although illegal, because some women want it – because they won't be considered a woman and will be ostracised if they haven't undergone FGM

Preventive actions:

- Raise awareness in the local communities about the related problems , the consequences and need of changing attitudes in relation to FV
- Involve opinion leaders positively
- Provide education in the community (talks on health centre, in schools,…)

Public actions

- Empower women by access to education
- Educate children to react differently from the usually accepted norms in their surroundings to cope with problems
- Policy development on family violence prevention and care
- Increasing shelters, which are working well

Practice management

- Create an enabling environment in practice (waiting room, private consultation ,posters …)
- Organise team approach
- Coordination of care with other care levels
- Organise sharing information
- Systematically asking about family violence in specific situations (e.g. prenatal care, ….)

Legal provisions :

- Laws are needed to provide more power to clinicians to take action
  - Good practice: in South Africa mandatory reporting is felt to promote change in behaviour when physician take action
  - However WHO guidelines indicate that mandatory reporting is unacceptable
- It was agreed that further comparison and exchange has priority in this area
- A suggestion meriting specific attention was to separate

urt' from other courts
specialised justice officers involved
  - In Belgium this was recently realised
  - Do other examples exist?
- Means of enforcing the laws are also important as there are many laws in place which are not enforced. Collaboration with female lawyers associations may be beneficial to ensure victims/survivors get redress from the law courts.

Other priorities for the near future should be:

- To develop guidelines on identification and appropriate care and safety after disclosure.
- To develop materials for waiting rooms. These materials should be adapted to local cultures and practices.
- To make provisions for sharing data to document the problems met
- A uniform terminology is needed**.** The regularly used term 'Gender based violence' may need broadening systematically to 'Family violence' or 'domestic Violence'; instead of 'Victims' the term 'Survivors' may be preferred (eg. general advise in South Africa)

Summary

- There is a firm resolution that GP/FM can act as role model
- GP should create a longstanding trusted relationship with the community
- They may positively involve community leaders
- GP should document negative health and other consequences of any kind of violence and aggressive acts and
- Combat underlying problems (alcohol, views…)
- To deal with feelings of lack of power a concrete action plan is neede

Forms of family Violence in African Communities

Background paper by Abimbola Silva, GARKI Hospital Abuja.

The Local African Community has traditionally provoked victimisation more than fighting it. These are the reasons why this may be so according to the prevalent forms of family violence in the African Communities :

1. Intimate partner violence and local African communities.

The couple, as a family is often seen in the African context, as a small part of an extended family or generation. They are often not permitted to 'stand alone' and there is often acceptable or expected 'interference' from the extended family especially, the in laws. Such interference is not limited to any part of the couples' life as it may range from fertility or not, to the gender of their children and even to the need to acquire a second wife, if the current one is not productive at all or not productive of the desired child gender, often, male. This interference is primarily partial towards the man as the head or leader of the home, such that the issue of violence against a woman is often regarded as the woman's fault.

In a migrant community in the Southwest of Nigeria many people, women inclusive, support wife beating if she did such things like burn her husband's food (33%), go out without telling him (50%), refuses to have sex with him (36.7%), if she neglects the children (48.5%) or if she argues with him(42.5%).

In some Nigerian societies, violence against a woman is so much condoned that it is accepted as a sign of love. In a qualitative study among Tiv women, one respondent was quoted to have said the following: "*If you are not yet beaten by your husband then you do not know the joy of marriage and that means you are not yet married".*

To make matters worse, what happens between a couple, even if known by relatives like in- laws, is meant to be kept sacred and secret within the family. Hence, many abused African women are advised by their own mothers or sisters to bear the beatings and abuse as part of the married life since ' marriage is not a bed of roses.' Many deaths have occurred, often undocumented and the perpetrators have gone unpunished.

This attitude has so far been the greatest problem of progress or curbing of abuse within the African context. It is as such seen as provocative to violence.

Finally derogatory widowhood rites are imposed on women in some Nigerian societies and should be considered a form of abuse of the wife by the relatives of the late husband.

2. Elder abuse and local African communities

The extended family is an integral part of each family, as already highlighted.

This has generally been the reason why many young couples either live within the 'family or ancestral house'. As these young couples themselves

progress in age and their parents become elderly and dependent on them, elder abuse may then ensue.
This may be in the firm of taking over the property of such aged parents without catering adequately for them.
It may also be in the form of neglect if such children leave the ancestral home to the cities to look for ' greener pastures '. Or even if they just leave the elderly unattended to during the working hours of the day, to make a living.
There are extensive reports of elderly parents being locked inside the house alone to prevent them from wandering off (especially those with behavioural changes from dementia) when the children or caregivers have gone out.
Elder abuse in this form may be attributed to the local communities' lack of faith in homes for the elderly especially in the African context where the elderly are expected to be catered for by their children. Keeping them in an old peoples' Home ' especially since the child has to earn a living, is considered alien, unAfrican and a disrespect to the elderly. As such these homes are not very popular and where available, are very expensive. Hence many children would rather keep their aged parents with house helps who may lock them up alone indoors or the children may themselves lock these aged ones up alone during the day while at work.

3. Child abuse and the local African community

The common form of child abuse in the context of the African local community would be child labour. This is often due to the intense poverty in these communities necessitating the 'extra hands' from these young ones who should be in school.
The scourge of HIV / AIDS in Africa, has also rendered many families fatherless and many children orphans such that the oldest child who should be nurtured but without any support from anyone or the government needs to then provide for his younger siblings. These children are taken advantage of and many are physically and sexually abused, despite the underlying psychological trauma of having their childhood taken away from them.
In the African context, a child is also usually ' only to be seen and not heard'. This makes it difficult for children to express themselves and increases their psychological trauma.

4. Girl child abuse and the local community.

Girl child abuse may be seen as a separate entity in family violence as far as the local African community is concerned. Certain Northern Nigerian communities still practice girl child marriage. Many NGOs are propagating information to discourage this as much as possible and even though a lot has been said, the practise still continues till date.
Girl child marriage is associated with ,any public health issues such as vesicovaginal fistula (VVF) which causes such husbands who sexually violate these children to abandon the girl wife and her child , if alive, causing her to be labelled among the 'unclean', a form of psychological trauma, in itself.
Girl child abuse includes the Male child preference which deprives girls of education, right to inherit land or property and the subsequent belief by the male child or men that the woman is his sole property with which he can do as he pleases.

Female genital mutilation as a cultural and religious tradition among some Nigerian societies is also an indication that the society and local community somewhat condone and provoke family violence and especially violence against women.

Hence the fight against family violence and especially violence against women in the African local community or context is essentially a fight against societal norms, attitudes and accepted cultural practices.

4. SIGFV and other networks

Article by Jan Coles (Australia) in June 2015 WONCA news

Introduction

The WONCA Working Party on Women and Family Medicine (WWPWFM) has, since its inception in 2001, identified
family violence as a major health issue facing women
doctors and their patients WONCA's stance against family
violence has been further strengthened by the Vasco da Gama Young Doctors group work and the formation of the WONCA Special Interest Group on Family Violence (WONCA SIGFV) in 2014.

In 2013, at the WONCA World Meeting in Prague, the WWPWFM ran a workshop led by A/Professor Jan Coles from Australia on "Hidden Violence". At this workshops participants addressed the challenges facing family physicians and then worked on solutions to the challenges they identified. To engage with doctors from more WONCA regions these workshops have been repeated in 2014 with WWPWFM members leading at the WONCA Asia-Pacific Meeting in Kuching, Malaysia (in collaboration with the WONCA SIGFV) and at WONCA Rural meeting in Gramado, Brazil.

Key themes from the Workshops on Hidden Violence:

A number of key themes were identified at all workshops. The universal themes were: the need to improve training for doctors in recognising and responding to family violence, improved strategies within the community to prevent violence and to raise awareness of its health costs; and finally, the value of access to coordinated multidiscipline team response supported by community-based services such as refuges for women and specialist family violence services for women and men, victims and perpetrators.

At the Malaysian conference gendered and cultural behaviours identified as a particular challenge in the Asia Pacific. In Brazil, specific challenges faced by rural family doctors included the lack of confidentiality and anonymity in small rural communities, being the doctor for victims and perpetrators, violence directed towards informers and sometimes the doctor, and the lack of support for the physicians.

Priority Areas for development

Workshop participants shared their ideas and strategies for responding to the challenges posed by responding to family violence in clinical practice. Solutions included developing local referral networks, working with other community based agencies and working as part of a multidiscipline team. In areas where few services were available, up skilling in trauma counselling by doctor and/or other health workers and the formation of self-help women's groups may be innovative sources of support were services are limited.

Improved professional education was the theme that was raised in every workshop. Education was felt to be most effective if it started early with medical students and vertically integrated to progressively improve the doctors' skills as they moved from novice to expert family physicians. Increasing curriculum content in this area of medicinal training was recommended.

5. EUROPREV Working group on Family Violence

Europrev has reorganised in 2013 its activities grouped in several workings groups around a central theme. Family Violence is one of them. During the first Europrev meeting where working groups presented their policy (Ljubljana 13th March 2015) the Implement Daphne training programme to which Europrev participates was presented extending a train the trainers programme for Asia organised by WOMEN AGAINST VIOLENCE (WAVE) to Bulgaria, Romania, Austria and Germany (more in the next issues).

The session also reviewed literature and agreed to a provisional statement on prevention of family violence which will be further debated during a **workshop in WONCA Istanbul (23 th October 2015)** with short presentations by Prof Gene Feder (Bristol University) and Carmen Fernandez Alonso (SACYL)

PROVISIONAL STATEMENT ON PREVENTION:

- Further studies are required to improve identification for IPV in PHC
- Such studies need to document outcomes as well as potential harm
- In the mean while the prevalence of IPV and the strong relationship with mental health and the prooven efficacy of mental health interventions requires a casefinding strategy among those at higher risk and in particular among clients with mental health problems

6. SIGFV and Young Doctors Movement

In 2012, after the meeting of the WONCA Working Party on Women and Family Medicine, the Vasco da Gama Movement, started to develop a strategy to raise awareness among the junior doctors about family violence, providing training and promoting research in collaboration with the WWPWFM, the SIGFV and other YDM.

Since the creation of the Family Violence Group under the Beyond Europe network of VdGM, the group has been very active, participating with workshops in each VdGM FORUM, VDGM activities and joint workshops with the SIGFV. The use of the new technologies and the continuous innovation, like the Facebook group that has been set up to share information and improve the communication.

WORKSHOPS:

- "How Should we Approach Family Violence in Primary Care?". II VdGM Forum, 2015, Dublin.
- "Violencia Domestica ¿Cual es el papel de la Atención Primaria?". 4º Congreso Iberoamericano de Medicina Familiar y Comunitaria, 2015, Montevideo.
- "Advocacy in Primary Care Workshop". Oral Communication of advocacy in Gender Violence on a PC setting. 4º Congreso Iberoamericano de Medicina Familiar y Comunitaria, 2015, Montevideo.
- "Round table on Gender Violence in Iberoamerica". 4º Congreso Iberoamericano de Medicina Familiar y Comunitaria, 2015, Montevideo
- Workshop accepted for WONCA Europe 2015, Istanbul.

FUTURE PROJECTS:

- Activities on future meetings, mainly through posters and workshop presentations in collaboration with other WONCA networks.
- Group members will attend to the WONCA SIGFV Preconference on Istanbul 2015.
- Create a profile on Twitter to further dissemination of information.
- Work in collaboration with victim support associations.

7. Good practices

GOOD PRACTICES FROM AFRIWON

From its roots in general practice, family practice in Africa is gaining recognition as a philosophy of care provided by specially trained health personnel: the family physician. Little wonder Dr Sodipo Jimi (a member of AfriWon practising at the Mirabel Centre of Lagos State University Teaching Hospital, Nigeria) gained

recognition as one who was able to provide patient-centered care in a setting which would have otherwise been the exclusive preserve of the Gynaecologist.

In 2013, a sexual assault centre (i.e. Mirabel Centre) was opened at the Lagos State University Teaching Hospital to clients who were victims of sexual assault. Contrary to the earlier expectations, clients who presented included both sexes and all age groups (from infants to the elderly), they all needed wholistic care (gynaecological, mental, spiritual, medical etc) and they also needed continuing and coordinated care. From observing the approach to patient care provided by Dr Sodipo Jimi, it was clear to the Centre manager that more family physicians were needed at this centre.

Read more on YOUNG DOCTORS MOVEMENT IN AFRICA

8. Next newsletter

The next newsletter will focus in particular on results of the course, workshops and statements prepared at the WONCA Europe Congress 2015 in Istanbul, provide a guide of the future meetings and interesting events for those who have a special interest in this field.

The Editior is always looking for more contributions and new contributors so if you would like to write to **famviolence@gmail.com**

We call for specific contributions from all over the world describing the context, forms of family violence, projects, training initiatives and good practices.

Any individual contributions are welcome **before the 15th of November**, please send them to: **famviolence@gmail.com**