VIPROM

European Webinar Series 2025

Victim Protection in Medicine

Handout collection from all 10 webinars

Co-funded by the European Union

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Words of the coordinator

Dear participants,

It is my great pleasure to introduce this collection of handouts from the VIPROM European Webinar Series (4 March 2025 - 8 July 2025). Over the course of ten interactive sessions, we have explored the critical topic of Domestic Violence in healthcare from various angles, equipping medical professionals across Europe with the knowledge and tools needed to better support those affected.

This webinar series was designed to raise awareness, enhance clinical skills, and encourage the integration of the EU training platform's modules into everyday medical practice. Through expert insights, case studies, and best practices, we aimed to create a valuable learning experience that fosters meaningful change.

This collection of handouts serves as a practical resource, summarising the key points from each session. Whether you attended the live webinars or are accessing these materials as a reference, we hope they will support your ongoing efforts in addressing Domestic Violence within your professional field.

Thank you for being part of this important initiative. Your commitment to learning and advocacy makes a difference.

Sincerely, yours

Bettina Pfleiderer

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Forms and Dynamics of DV

European Webinar Series - Webinar 1

Importance of the Medical Sector

- Medical professionals are often the first professional point of contact for victims of Domestic Violence.
- Surveys showed that victims name medical staff as the professionals they are most likely to trust when it comes to disclosing abuse.

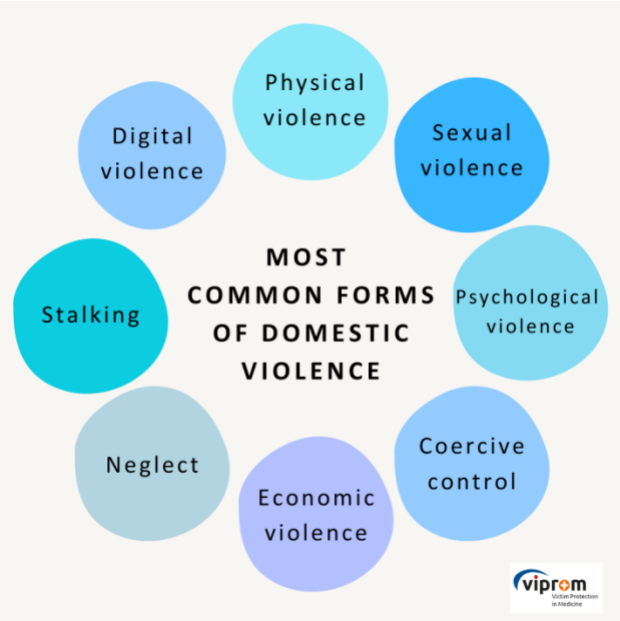
What is Domestic Violence (DV) and what is Intimate Partner Violence (IPV)?

Domestic Violence is defined by the United Nations as "a pattern of behaviour *in any relationship* that is used to *gain or maintain power* and *exert control* over an individual within a family or household."
Intimate Partner Violence refers to violence committed by *current or former intimate partners* – most commonly committed by men against their (former) female partners.

- DV/IPV can happen to anyone – there is neither a ‚typical victim', nor a ‚typical perpetrator'.

Common forms of DV/IPV

Different forms of violence are not mutually exclusive, but rather reinforce each other.



Physical violence: Threat and/or use of physical force

Sexual violence: Sexual activity without consent

Psychological violence: Psychological tactics to exert control or manipulate; including c**oercive control**

Economic violence: Causing economic harm

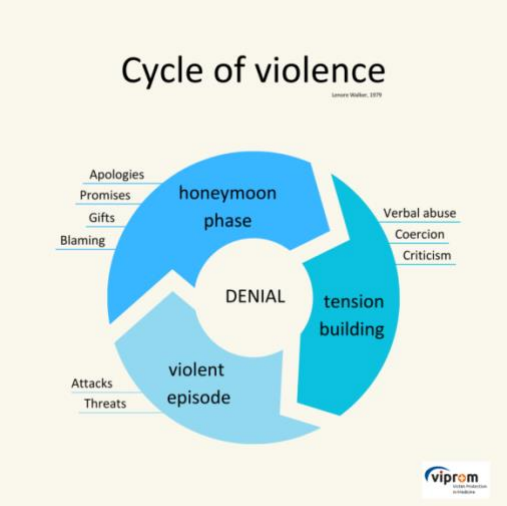
Neglect: Lack of due care (e.g. elderly, children)

Stalking: Repeated unwanted contact, pursuit or observation (including digital forms)

Digital violence/Cyberviolence: Use of digital tools to harm, harass or humiliate the victim.

Dynamics of violence in partnerships

Cycle/Spiral of Violence



I. Tension building

Tension rises over ordinary issues, often including verbal abuse; often victims attempt to prevent further escalation by adapting their behaviour.

II. Violent episode

The escalation is mostly triggered by factors beyond the victims' control (e.g. external events, emotional state of the perpetrator).

III. Honeymoon phase

Often perpetrators feel shame or remorse and show love and kindness towards the victims, trying to convince them that the violence will not occur again.

Not all violent relationships follow this pattern, but it is a helpful framework to understand typical dynamics and especially why victims often find it hard to leave the situation.

Wheel of Power and Control

The 'wheel' represents tactics commonly used by perpetrators to achieve dominance over their partners. It was developed in Duluth, Minnesota in the early 1980s.

Further information:
High resolution image
Video by TheDulutModel on Youtube

This Webinar is based on Module 1 of the VIPROM learning platform. It has been adapted for different national context: Austria, Germany, Greece, Italy and Sweden.

Beyond Bias – Exploring Cultural Responsiveness in DV Trainings

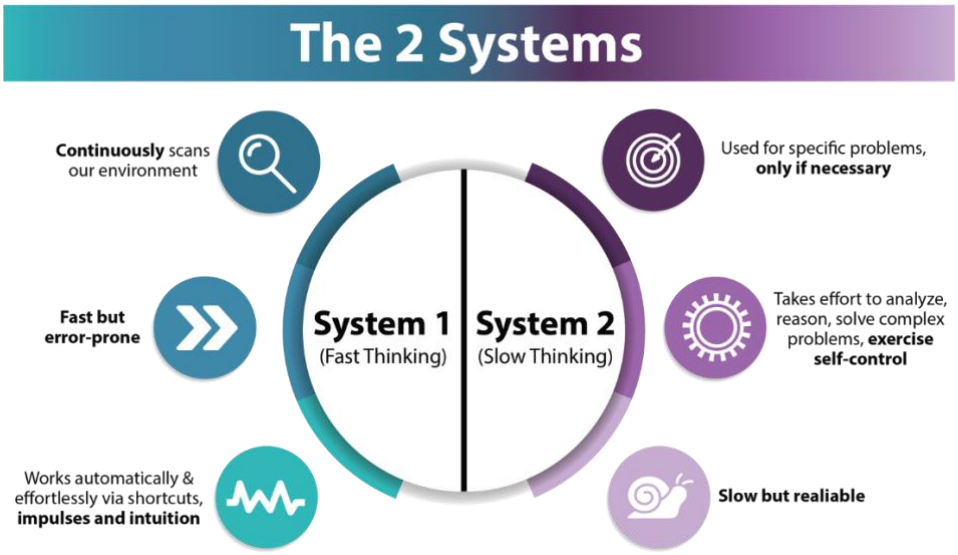
European Webinar Series – Webinar 2

Bias, Blind Spots and De-Biasing

Awareness, Bias & Microaggressions

Bounded awareness = the common tendency to exclude important and relevant information from our decisions, results in the systematic failure to see information that is relevant to our personal lives and professional obligations.

Our individual biases are influenced by our systems of thinking and our experiences. **System 1** (unaware of/ unconscious / implicit): enables us to act quickly based on stored experiences and **System 2** (aware of / conscious / explicit): slower and requires conscious effort.



Bias = a systematic error or distortion in judgment, perception, or reasoning leading to skewed judgments and decision-making, often occurring unconsciously.

What exactly is a stereotype, prejudice, discrimination – for definitions see: **VIPROM Module 8**

… and particularly harmful in the everyday professional context are **microaggressions** (= **brief, subtle, commonplace indignities** that can be delivered verbally, behaviourally, or environmentally. They can be **intentional or unintentional** and are rooted in implicit or explicit prejudice, or racial, ethnic, gender, sexuality, religious, disability, or other stereotypes, see: **ICC (Intercultural Competence for DV Trainers) VIPROM**

Biases in the Context of DV resulting from societal norms and gender role expectations: Men as Victims, Objectification of Women in the Media and Victim Blaming (i.e. the tendency to hold victims of Domestic Violence responsible for the abuse). See: **VIPROM Module 8**

Perception & De-biasing

Perception: An individual's history of perceptions gives her/him a socio-cultural database, a kind of foundational bias, on which s/he builds her/his assumptions. What's unsettling there is that the power of stereotypes and prejudice, for example, seems to be already rooted in perception.

De-biasing strategies:

- **Stereotype replacement** – replacing your stereotypical responses with non-stereotypical ones.
- **Counter-stereotypic imaging** – imagine counter-stereotypical diverse people in detail.
- **Individuation** – getting specific information about members of other ethnic & racial groups.
- **Perspective taking** – put yourself in the shoes of the other, it increases closeness and prevents automatic assumptions.
- **Increase contact** – make more of an effort to encounter and engage in positive interactions with members of other racial & ethnic groups, e.g. work in diverse teams.

Culture in the context of Health

Bias-conscious healthcare arises from the intersection between (inter)cultural competence and healthcare. It happens when **we invite different perspectives to challenge our attitudes and thereby minimize or 'block' our biases**.

Cultural bias is the interpretation and judgment of phenomena by the standards of one's own culture. Our brains encode some people as more human and others as less human. To counter this bias it is necessary to build inclusive mindsets.

'Cultural responsivity' = the extent to which people can understand, embody and feel 'culture' and communicate effectively (i.e. make sense of other people's realities and encourage certain behaviours) in multicultural environments.

5Rs of Cultural Humility

The practice of cultural humility helps mitigate implicit bias, promotes empathy, and aids the provider in acknowledging and respecting patients' individuality: The 5Rs include **reflection, respect, regard, relevance, and resiliency**.

Indicators of Domestic Violence

European Webinar Series – Webinar 3

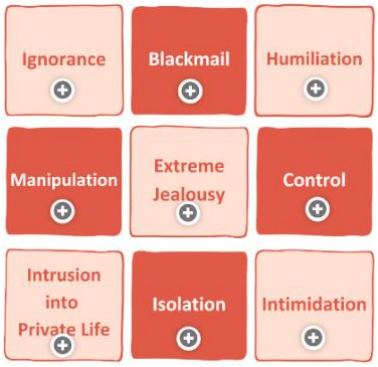
1. The role of medical professionals in identifying Domestic Violence

"As health professional, you will be the first and only contact for many victims."

Victims may not always want to report Domestic Violence to the police or speak to a counsellor, but when they definitely need help, they will finally have to see a physician. Consequently, **healthcare professionals are often the first** beside friends and family, who either hear about the presence of DV or they are the first **ones recognising indicators** and **symptoms** pointing towards DV.[1]

2. Signs of unhealthy relationships

Every relationship differs and so does relationships where violence occurs. However, there are some patterns and signs necessary to recognise and to identify.



To find information on red flags in unhealthy relationships please follow the link here Module 2

3. Impact of Domestic Violence

"Experiencing violence or abuse by an intimate partner increases the risk of developing a mental health disorder by almost three times and the risk of developing a chronic physical illness by almost twice."[2]

While each individual will experience Domestic Violence uniquely, there are many common consequences of living in an environment with violence and/or living in fear. Please find more information about impacts of DV in Module 2.

[1]Stiles, Melissa. (2003). Witnessing Domestic Violence: The effect on children. American family physician. 66. 2052, 2055-6, 2058 passim.

[2] Mellar, B. M., Hashemi, L., Selak, V., Gulliver, P. J., McIntosh, T. K. D., & Fanslow, J. L. (2023). Association Between Women's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. JAMA network open, 6(3), e231311.

4. Possible indicators of violence

"Often, there are no visible indicators – therefore, it is crucial to ask the patient about Domestic Violence in the anamnesis."

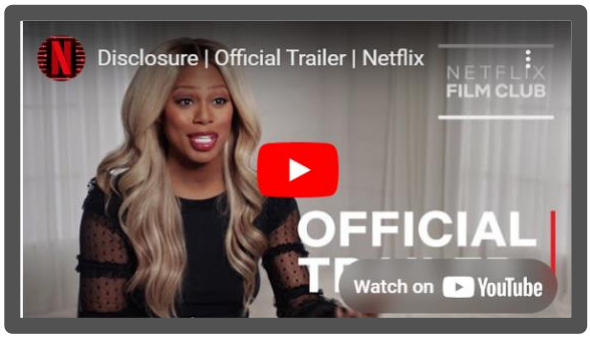
There is a whole range of indicators to serve as "red flags" to health professionals that a patient may be experiencing Domestic Violence. Some of these are quite subtle. Thus, it is important that professionals remain alert to the potential signs and respond appropriately. In Module 2 you will find a range of potential general indicators, and specific indicators pertaining to vulnerable groups including children.

5. Biases in the context of Domestic Violence and their consequences

Last but certainly not least, every patient must be addressed as an individual and not as a representation of a certain community.

As human beings we all have biases. They are helpful in the sense that they help us make quick judgments but then again, they can be highly harmful as the judgments we make can be discriminatory and ignorant. Historically, the existence of LGBTIQ+, has largely been ignored and the majority of content that featured the experiences of LGBTIQ+ have been full of outdated stereotypes.

The movie "Disclosure: Trans Lives On Screen" showcases the contributions of the trans community to media and the history of transgender representation.



Reflection task:

- What consequences can a lack of or incorrect representativeness have on the perception of cases of Domestic Violence in LGBTIQ+ relationships?
- How can diverse media representativeness help to break down stereotypes?

For further information on biases in the context of DV please see Module 8.

Communication in cases of Domestic Violence

European Webinar Series – Webinar 4

The importance of effective communication

Providing comprehensive care to patients experiencing Domestic Violence (DV) requires a nuanced understanding of the **complexities surrounding disclosure**. Many individuals hesitate to disclose their experiences due to fear, shame, or uncertainty about how to seek help. Therefore, employing **effective communication strategies** is essential. This involves creating a safe and supportive environment where patients feel heard and respected. It's also crucial to craft responses that are empathetic and nonjudgmental, ensuring that the patient feels empowered and in control of their decisions.

Effective care for survivors of Domestic Violence must be **multifaceted, incorporating trauma-informed, patient-centered, and gender-sensitive approaches**. A trauma-informed approach recognizes the lasting effects of abuse and emphasizes emotional and physical safety. A patient-centered framework focuses on respecting the individual's needs and preferences, offering care that is tailored to their unique circumstances. Gender-sensitive care acknowledges the specific challenges faced by survivors of different genders, creating a more inclusive and supportive environment for healing. By combining these approaches, healthcare providers can offer **compassionate, effective support** to those in need.

Image: AI generated by ChatGPT

Visual Communication

Often, individuals experiencing Domestic Violence find it challenging to access information or support services. Visual communication plays a crucial role in **raising awareness** about Domestic Violence in medical settings such as hospitals and medical practices. Utilising tools like **posters** (e.g., with QR codes), **leaflets**, or pamphlets display strategically placed in waiting rooms, bathrooms, and other visible areas is essential. Place information with support services in washrooms (with appropriate warnings about not taking them home if the perpetrator could find them).

These visual aids serve to communicate that the facility is a **safe space for discussing Domestic Violence** and make support services readily apparent. By creating a visual environment that openly addresses Domestic Violence, individuals are more likely to feel **encouraged to speak up** and seek help. This proactive approach contributes to **breaking the silence** around Domestic Violence and fostering a **supportive atmosphere** within healthcare settings.

For more information and images of visual communication tools, please refer to Module 3.

As a healthcare provider you can make the difference for DV victims!

Barriers to effective communication

For more information on barriers to effective communication, please refer to Module 3.

The **key barriers to effective communication** include fear of consequences, personal limitations, feelings of shame and stigma, and a lack of trust in medical professionals. Additionally, dependence on the perpetrator, cultural and religious factors, lack of awareness, gender and sexual identity, and language barriers can further hinder disclosure and the ability to seek help.

Effective Communication Strategies

For more information on practical conversation techniques in case of suspected violence please refer to https://training.improdova.eu/wp-content/uploads/2024/02/PWT_PDF_GES_FIN.pdf

For more information on effective communication strategies, please visit Module 3.

Responding to Disclosure

Empowering individuals who are experiencing Domestic Violence is a vital step in their recovery journey. It is essential to create an **environment that fosters trust and shows empathy**, allowing survivors to feel understood and supported. Building trust is key to ensuring that the individual feels safe in disclosing their experiences and is more likely to seek help. By **validating their feelings**, caregivers help reinforce that their emotions are real and justified, which can significantly reduce feelings of isolation or self-blame.

Offering **consistent support is crucial**, ensuring that survivors **have access to the resources and guidance** they need as they navigate their healing process. It is important to avoid confrontation, as this can create barriers to communication and escalate the situation. Instead, caregivers should provide **clear and non-threatening ways** for individuals to seek help, **empowering them** with the tools they need to **regain control** over their situation.

Medical Assessment and securing of evidence

European Webinar Series – Webinar 5

How to document Domestic Violence

Medical professionals are often the first or only professionals interacting with individuals affected by Domestic Violence, but documenting Domestic Violence injuries is not easy.

- A thorough physical examination should be carried out. Findings and observations should be recorded clearly and concisely with the help of body maps.
- The findings in the patient's medical records are to be documented in the patient's own words, but further questions should be also asked if necessary.

More information can be found in Module 4

Screening for Domestic Violence

Conducting in-person screening for Domestic Violence proves effective, especially when utilising a valid and reliable screening tool in a private, one-on-one environment. Find more information on communication in Module 3. In Module 2, you will find both general indicators and specific indicators for gynaecology/obstetrics, surgery (emergency room), and paediatrics.

Documentation of Domestic Violence

Documentation of notes related to the experienced violence should include:

- Patient's responses to screening questions and minimal, but relevant details if more information is shared;
- Your objective observations of the patient's appearance, behaviour and demeanour;
- All recent and old injuries should be recorded and described in detail, recording any pertinent negative findings.
- Your plan of care, recommendations for medical follow-up, and efforts to provide additional resources and referrals without including details of work with advocates and safety planning.
- Any limitations to the examination (lighting, cooperation etc.) should also be documented.

Special Aspects of Documenting Sexual Violence

- Specific consent to each procedure should be obtained from the individual or their guardian, particularly for the genital examination, the release of findings and specimens, and to any photography.

- All recent and old injuries should be recorded and described in detail, recording any pertinent negative findings.
- The victim should be informed that some injuries might become more visible after some days and that, if this happens, she/he should return for examination and documentation

For more detailed information click here.

Medical Forensic documentation

A comprehensive examination and forensic documentation of physical injuries as well as securing any traces of sexual violence are an essential part of primary care.

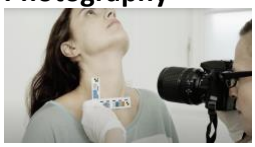
Physical Assessment

Comprehensive assessment should include:

- Physical assessment as dictated by the patient's presenting complaint
- Patient's general appearance, behaviour, cognition, and mental status
- Evaluation of body surfaces and oral cavity for physical findings
- Additional testing, including laboratory specimens and imaging

For more detailed information click here.

Photography

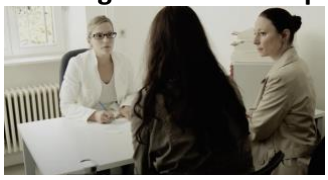


- Capture images of injuries discreetly, prioritizing confidentiality. Avoid photographing the breast(s) and genitalia unless there are evident injuries in those areas.
- Ensure that the photographs maintain anonymity, preventing direct identification of the individual.

Sample/Evidence Collection

Sample/evidence collection may coincide with the physical assessment, but patients can decline, and it should be emphasised that this is their right without impacting the quality of healthcare services they receive. For more detailed guidance, please click here

Discharge and Follow-Up



- Provide the patient with a copy of the documentation sheet and photos if requested.
- Address security issues regarding storage , children's safety and protection need.
- Inform the patient about psychosocial counselling services

Risk Assessment & Safety Planning

European Webinar Series – Webinar 6

The role of the medical sector in risk assessment & safety planning

Risk management includes a range of strategies and interventions aimed at promoting the well-being of the victim, while reducing or eliminating the likelihood of the perpetrator committing further acts of violence[3]. Risk management can include **facilitating access to support and services, accessing secondary counselling** and **ongoing risk assessment**. Making a safety plan following the disclosure of Domestic Violence is an essential part of any risk management effort.

Risk assessment means making a professional judgement about the risk factors present, in conjunction with the victim's own risk assessment, to determine the likelihood of future violence and the potential for harm, including serious injury or death, from future violence[4]. Further information on risk assessment can be found in Module 10 & Module 5.

Main goals of safety planning include the following:

- Identify the presence of risk factors which increase likelihood of escalating the violence that can lead to 'reassault'
- Psychological and psychosocial traits of perpetrators and victims
- Dynamics within the victim-perpetrator relationship
- Risk factors are not causal factors, may not be direct triggers of Domestic Violence
- Risk factors can vary between individuals, relationships, communities, and societal levels
- Certain risk factors are consistently found across studies, others are context-specific, and varying between and within countries (e.g. rural/urban settings)

Let the victim know that you are available to meet again to talk about these issues!

[3] "Risk Assessment." Gippsland Family Violence Alliance, November 9, 2023. Accessed 31.01.2024 https://gippslandfamilyviolencealliance.com.au/risk-assessment/#what-is-risk-management

[4] 1800 Respect, national domestic family and sexual violence counselling service. Accessed: 01.02.24, https://www.1800respect.org.au/resources-and-tools/risk-assessment-frameworks-and-tools/risk-assessment

Important to remember!

Victims of Domestic Violence come from all social, cultural, economic and religious backgrounds and are of different ages, genders and sexual orientations, including people with disabilities. It affects people from all socio-economic and educational backgrounds. It is important to understand that there is **NO 'typical victim'**.

Risk factors and challenges

The strongest indicator of future risk/violence is the perpetrator's current and past behaviour. It is important that the patient is asked about their perception of risk as well as their safety management in the past and the future. Victims often recognise that they are in imminent danger and are afraid to return home.

It is important to take their safety concerns seriously!

The primary goal is to determine if there is a specific and immediate risk of serious harm. **If there is an immediate high risk,** you might express your concern for their safety and have a conversation about protective measures. You can say, **"I'm worried about your safety. Let's discuss what needs to be done to prevent you from being harmed."**[5]

Making a safety plan

Safe place to go	*"If you need to leave your home in a hurry, where could you go?"*
Planning for children	*"Would you go alone or take your children with you?"*
Transport	*"How will you get there?"*
Items to take with you	*"Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?"*
Financials	*"Do you have access to money if you need to leave? Where is it kept? Can you get to it in an emergency?"*
Support of someone close by	*"Is there a neighbour you can talk to about the violence, who can call the police or come help you if they hear sounds of violence coming from your home?"*

[5] WHO (2014) Clinical handbook Health care for women subjected to intimate partner violence or sexual violence, p. 25-26

Working together! Key institutions in cases of Domestic Violence

European Webinar Series – Webinar 7

A key role in violence intervention

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For the victim, opening up about the experienced violence and deciding to seek help can mean that **their whole life might change**. They are confronted with questions such as …

- Is it safe for me to go home now? Are my children safe?
- Is this conversation really confidential?
- Should I apply for a ban order?
- Where do I get financial support?

Moreover, there can be additional barriers like lacking language skills, dependence on a care person, or the fear of losing their residence status, pregnancy or the fear of losing home. It is therefore important to refer the victim to **specialised services**, so that they can conduct a proper **risk assessment** and clarify all open questions. In your local network, you can find specialists on DV who exactly know what to do. Cooperation & referral can therefore not only support you as medical professionals, it is also **crucial for the victims!**

Who are the main actors in violence intervention?

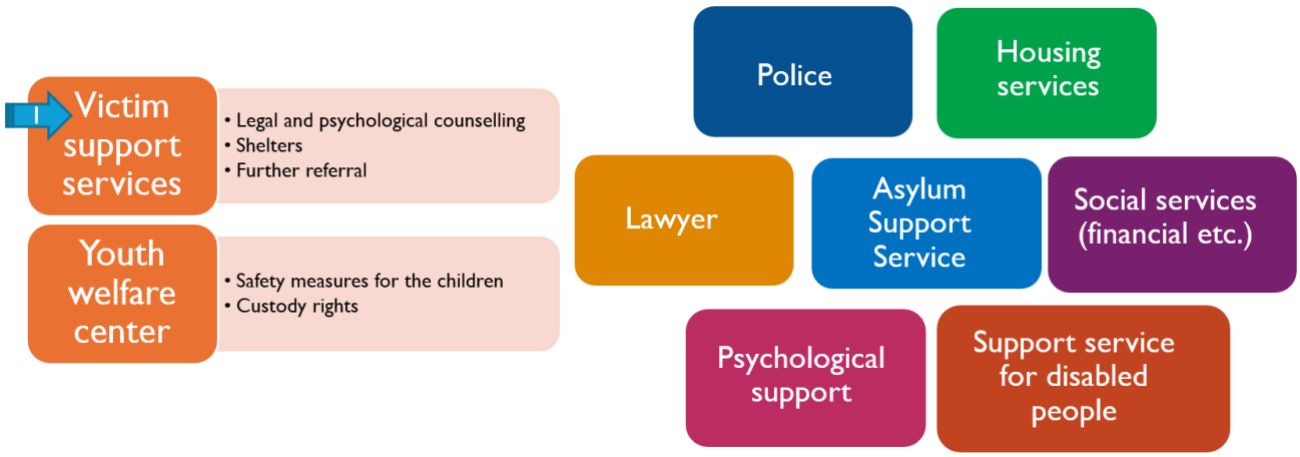
There are numerous institutions that can or should be involved in cases of Domestic Violence. This depends on the life circumstances (as described above). For example, a victim with children will need support from the youth welfare office; victims with addiction problems will need a counseling center for drug users. Asylum seekers affected by violence also face the additional problem that their right of residence often has to be reassessed after separation[6]. Due to their workload, medical professionals can neither provide detailed advice nor link up with several institutions. It is therefore recommended that the victim be referred to the regional victim counseling center. They not only carry out a risk assessment and detailed safety planning, but also discuss - with the victim's consent - which other institutions should be involved. As a medical professional, you can relieve your daily routine by referring the victim to such a victim counseling center. **An example is given here:**

Reminder:

Make sure that you have the victim's consent when involving a third party.

Please respect the victim's refusal to contact the police for reporting or to get in touch with a victim support service.

[6] Depending on the national laws. Refugee help centers can help out.



"What about the Police?"

Reporting to the police can not only be scary for the victim, it can put the victim at high risk and also cause a lot of damage. Most Femicides happen in the context of separation and also perpetration of physical violence and stalking rises significantly. Unfortunately, the most reported cases are dropped and this might expose the victim to an even more dangerous situation or financial problems. Moreover, negative experiences with the police or an insensitive behaviour of insufficiently trained police officers might lead to retraumatisation. Thereby we recommend a confidential talk in a victim support service first. Attention: In countries like Germany, some files cannot be taken back once reported!

This helps you…

- Find out who can be your **local ally** (e.g. victim support service)
- Find out who can be your **ally inside of your institution**
  - ➢ **Sometimes one good working contact is sufficient!**

Checklist for your institution:

- Do I know my local victim support service, e.g. a women counselling center?[7]
- Do I know if there is a search engine for women's shelters in my country?[8]
- Do I have a contact person for Domestic Violence within the local police?
- Do I know what kind of country-wide or local associations exist within my country?
- Did I engage an ally within my institution?

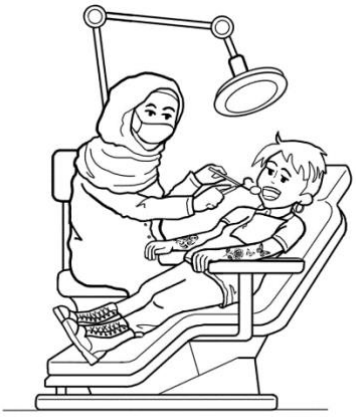
For more information on this topic, please check Module 7 on our European Training Platform.

[7] Tip: In case you just get started, check if there is a WAVE Member organisation in your country.
[8] One example from Germany: https://www.frauenhaus-suche.de/

Theory meets practice: Identifying and responding to Domestic Violence in the medical sector by using dentistry as an example

European Webinar Series – Webinar 8

Dentistry: Important Frontline Responders



Dentists are well placed to identify victims of Domestic Violence (DV) because they **spend more time with patients** (30-60 minutes vs. 7-10 minutes for primary care physicians), allowing them to build rapport and notice behavioral changes. Victims **often attend dental appointments** despite avoiding medical visits due to head, neck, or facial injuries, which are common in DV cases (40-75%). Visible injuries in these areas may indicate violence, with a one in three chance of a facial injury being linked to Domestic Violence.[9]

For more information on the **most common forms of Domestic Violence**, **victim profiles**, or **health impacts**, please refer to Module 1 or the Factsheet from Webinar 1 (04.03.25) – 'Forms and Dynamics of Domestic Violence'.

Recognising the Signs of Domestic Violence - Indicators in Dentistry

For more information on **general indicators** of Domestic Violence, please refer to Module 2 or the Factsheet from Webinar 3 (01.04.25) – 'Indicators of Domestic Violence.'

Indicators in Adults

Dentists are often in a unique position to identify signs of Domestic Violence in adults. Key indicators include **facial trauma** such as bruises or fractures, **unexplained injuries**, and **oral trauma** like broken, subluxated, or knocked-out teeth. Additionally, **poor dental health** or **neglect** may also signal abuse. In addition to physical signs, there are psychological indicators such as **depression**, **stress**, and **emotional withdrawal**, as well as behavioral signs like **anxiety**, **fear**, **evasiveness**, **reluctance to share information**, or a **controlling partner** accompanying the patient. For a more comprehensive list of indicators, please refer to Module 2: Dentistry.

Indicators in Children

[9] More information can be found in Module 1.

Neglect is the most common form of child endangerment. In the dental practice, possible indicators of physical abuse include:

- Frenulum tears: Heavy bleeding may lead parents to seek emergency care. If healing appears inflamed, ask for a plausible explanation.
- Injuries to teeth: Fractures, dislocations, and tooth trauma, especially from forceful removal of pacifiers or hitting with objects, may indicate maltreatment.
- Atypical injury patterns: Injuries at different healing stages or unusual locations (e.g., bilateral lip injuries) are red flags.

Child Neglect:

- Signs include malnutrition, poor hygiene, inadequate clothing, and emotional neglect.
- Dental neglect often shows as untreated caries, which are eight times more frequent in neglected children. If caries or dental trauma occur, assess the child's and guardian's awareness of the issue, willingness, and ability to treat it.

Early Childhood Caries (ECC):

Also known as "teat bottle caries," this is caused by sugary drinks in bottles and poor oral hygiene, common in cases of child neglect.

Stereotypes and Unconscious Bias in Practice

In dentistry, unconscious bias and stereotypes can affect how patients are perceived and treated, impacting the quality of care. Biases based on appearance, socioeconomic status, or cultural background may lead to assumptions about oral health habits or treatment willingness. For example, a dentist may assume a patient from a lower socioeconomic background is less likely to maintain good oral hygiene. In cases of Domestic Violence, biases may also cause dentists to overlook signs of Domestic Violence. Recognising and addressing these biases through ongoing training is crucial to providing fair, respectful, and empathetic care to all patients. For more detailed information please refer to Module 8.

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Effective Communication in Domestic Violence Disclosure

Effective communication is crucial when a patient discloses Domestic Violence in a dental setting. Dentists should create a **safe**, **non-judgmental environment** where patients feel comfortable sharing sensitive information. **Active listening**, **clear language**, and **empathetic responses** are key to ensuring the patient feels heard and supported. It's important to ask **open-ended questions** and give patients time to speak, while also respecting their boundaries. By fostering trust and confidentiality, dental professionals can play a vital role in recognising signs of violence and guiding patients towards appropriate help and resources. For more detailed guidance, please refer to Module 3 and the Factsheet of Webinar 4 (15.04.25) – Communication in Cases of Domestic Violence.

You are a key person in disclosing DV, your action can make a difference, asking one question can change a victim's life!

Spotlight on domestic abuse and sexual violence within sexual health settings

European Webinar Series – Webinar 9

IRISi Our vision and mission

- Our vision is a world in which gender-based violence is consistently recognized and addressed as a health issue.
- Our mission is to promote and improve the healthcare response to gender-based violence by working side by side with health and specialist services.

IRISi's IRIS intervention

- IRIS: Our evidence-based intervention which seeks to improve the general practice response to domestic abuse, launched as a commissionable model in 2011 and has grown significantly since then supporting nearly 44,000 patients since its inception.
- IRIS came from research and was found to be an effective intervention through a randomized controlled trial.
- IRIS is now considered the gold-standard DA intervention for general practice.

IRISi's ADViSE Intervention

- We adapted the IRIS model for sexual health settings, to reach even more survivors. It uses the same basic model as the IRIS intervention.
- ADViSE offers comprehensive, specialist training to sexual health clinic teams to help them to recognise DA, ask about DA, respond to disclosures, risk-check, make referrals for support, and record information about DA on medical records.

DA and SV in sexual health settings

Women who experience DA are **three times** more likely to present with gynecological issues than non-abused women (WHO, 2012). Large numbers of patients who attend sexual health clinics will be presenting with symptoms associated with DA and SV. For this reason, it is important that clinicians have DA and SV enquiry as part of your routine assessment.

What our data says

- We see many more referrals for LGBTQIA+ individuals through our ADViSE programme than we do through our IRIS programme.
- **1 in 2** service users in ADViSE is seeking support around sexual violence
- We see a much younger cohort of service users in ADViSE than we do in IRIS.
- The majority of service users in both our programmes report that they had not previously accessed support for DA or SV showing **we are meeting an unmet need.**
- The majority of service users from both our programmes indicate that they have a mental health condition.

Your response to DA and SV within sexual health

- Be aware of the language that you use when asking/responding, consider age/sexuality/gender
- Do not assume the gender of your patient/their partner/if they have one partner/if the person who is abusive is a partner (consider family members, carers, child to parent abuse)
- Think about young people and that they often don't live with intimate partners so only asking 'how are things at home' isn't enough
- Young people may be experiencing DA indirectly (in the home e.g. one parent abusing another) and can also be experiencing it directly in their own intimate or familial relationships

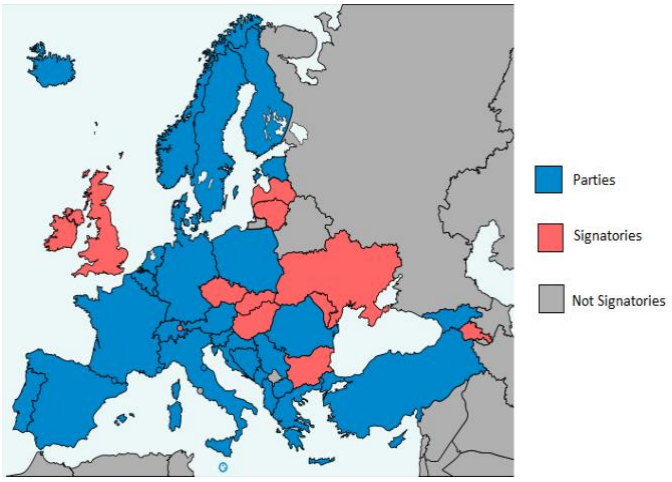
What do survivors want from healthcare professionals?

- To feel comfortable and supported to disclose
- To be asked directly- low threshold for clinical questioning
- An immediate response to disclosure
- A response in later consultations for continuity of care

Council of Europe legal framework: Guidelines for medical professionals in accordance with the Istanbul Convention

European Webinar Series – Webinar 10

Crucial contributions of the Istanbul Convention



The **Istanbul Convention** is the first legally binding regional instrument addressing violence against women (VAW), providing a comprehensive framework for **prevention, protection, prosecution, and integrated policies**. Ratified by 38 states and acceded to by the EU, it reaffirms a gendered understanding of VAW and embeds intersectionality, recognising the specific challenges faced by women experiencing multiple forms of discrimination. The Convention establishes clear legal standards, incorporates the due diligence principle, and aligns with decisions from the European Court of Human Rights (ECHR) and CEDAW Committee. It promotes multi-agency cooperation among state institutions and NGOs, include medical professionals, and acknowledges the critical role of women's organisations in combating VAW. By setting **high standards and requiring gender-sensitive policies**, it remains the **most far-reaching international treaty** on this issue. GREVIO is the body of independent experts responsible for monitoring the implementation of the Istanbul Convention. For more information on different international and national frameworks related to VAW, please refer to Module 6: International standards and legal frameworks in Europe.

Multi-agency cooperation

VAW is best addressed by **coordinated efforts of numerous state agencies and NGOs**. The Istanbul Convention emphasises the need for multi-agency cooperation to eliminate violence, requiring coordinated policies and effective implementation through clear guidelines and training. It mandates legislative measures to protect victims, with cooperation among the judiciary, law enforcement, authorities and NGOs providing **specialist support services** (such as shelters, helplines, and rape crisis or sexualised violence referral centres). This cooperation

must **prioritise gender-sensitive approaches and victims' rights and safety**. Under Article 18 of the Convention, states should ensure appropriate mechanisms for effective cooperation, such as round tables and agreed protocols that enable professionals to address individual cases in a standardised manner.

The key role of medical professionals

Medical professionals play a critical role in responding to and preventing VAW. Under **Article 28 of the Istanbul Convention**, professionals are required to **report cases of suspected VAW** to competent authorities when they have reasonable grounds to **believe a serious act of violence has been committed or is likely to occur**, while still respecting confidentiality rules. However, challenges arise when mandatory reporting requirements conflict with providing victim-centred, gender-sensitive support. For further reading on the role of medical professionals in supporting victims of VAW, please consult WAVE's multi-country research studies.[10]

Challenges of mandatory reporting

In many countries, such as Andorra, Italy, Malta, Montenegro, the Netherlands, and Spain, concerns have been raised about mandatory reporting laws. While these laws aim to protect victims, they can have unintended consequences. Victims may be deterred from seeking support if they fear that their personal information will be disclosed without their consent. The risk is that the obligation to report may undermine the trust between victims and healthcare providers, thus preventing them from accessing the support they need. For medical professionals, it is essential to find a **balance between the protection of adult victims and respecting their autonomy**. They should be trained to understand the complexities of mandatory reporting and be equipped to provide informed support to victims in a way that minimises harm.

Role of forensic practitioners and other medical professionals

Beyond reporting, medical professionals, especially **forensic experts**, play an essential role in identifying and supporting victims of violence. **Forensic experts are responsible for documenting injuries, providing certificates of injuries, and producing high-quality forensic reports that are essential for legal proceedings.** These reports must be robust enough to be used in courts and contribute to gathering evidence necessary for prosecution. Additionally, medical professionals should be involved in multi-disciplinary teams, collaborating with law enforcement, social services, and other stakeholders, to contribute to a coordinated and efficient response to VAW. This **multi-agency approach is a fundamental requirement of the**

[10] Brankovic and Saidlear (2021). Promising practices of establishing and providing specialist support services for women experiencing sexual violence. A legal and practical overview for women's NGOs and policy makers in the Western Balkans and Turkey
Brankovic (2022). Regional assessment: Cooperation between women's NGOs and healthcare providers. A comparative study in the Western Balkans and Turkey

Istanbul Convention and aims to ensure that victims are supported throughout the entire process, from reporting to recovery. Medical professionals can also **assist in specialised services** for victims, such as **sexual violence referral centres** in hospitals. These services offer immediate support to victims while minimising the risk of re-traumatisation. By providing expert assistance in these settings, medical professionals help ensure that victims receive the necessary medical and psychological support while avoiding further harm.

Promising practices

GREVIO Baseline Evaluation Reports have highlighted some **promising practices in relation to medical and forensic support for victims of VAW**. For example, Denmark offers specialised hospital-based centres for sexual violence victims, Austria has introduced standardised injury documentation to strengthen forensic evidence in court, and Sweden trains healthcare professionals to ensure consistent forensic evidence collection.