The Responsiveness of the Health Sector in Kampong Thom Province to victims of Domestic Violence

GTZ Promotion of
Women's Rights
Cambodia
August 2008

gtz

Written by Emilia Roig
Interview translations by Annie Nut

Acknowledgements

I would like to express my very special thanks to Ms Annie Nut, who provided valuable guidance and support throughout the study. She helped me to better understand the Khmer culture and its implications for domestic violence issues and was an outstanding translator.

I also would like to thank Licadho, Adhoc, TPO, CoDeC, COWS, and BFDK for their time and support in arranging the fieldwork and making their resources available to assist GTZ-PWR in any way.

To the Kampong Thom Provincial Health Department, I would like to express special appreciation for their cooperation and support in providing all the necessary official documents.

And last but not least, I am particularly grateful to the respondents, who gave their free time to provide us with important information about their personal and professional experience related to domestic violence.

Table of Contents

List of Appendices

Acronyms

ADHOC	Cambodian Human Rights and Development Association
BFDK	Buddhist for Development Kampong Thom
CODEC	Cooperation Development for Cambodia
COWS	Cambodian Organization for Women's' Support
CPA	Complementary Package of Activities
DV	Domestic Violence
DV Law	Law on the Prevention of Domestic Violence and the Protection of Victims
HC	Health Centre
HI	Handicap International
HIS	Health Information System
ISS	Injury Surveillance System
KT	Kampong Thom
LICADHO	Cambodian League for the Promotion and Defense of Human Rights
MCD	Medical Certificate with Diagnosis
MoH	Ministry of Health
MoI	Ministry of the Interior
MoJ	Ministry of Justice
MPA	Minimum Package of Activities
NGO	Non Governmental Organization
OD	Operational District
PH	Provincial Hospital
PHD	Provincial Health Department
RH	Referral Hospital
RTAVIS	Road Traffic Accident and Victim Information System
RTOTIF	Road Traffic and Other Type of Injury Form
ToT	Training of Trainers
TPO	Transcultural Psychosocial Organization

Executive Summary

Health services provide a unique window of opportunity to address the needs of abused women. Although battered women use health services more than non-abused women, a very small percentage of them are identified as battered by health workers. Health providers are typically reluctant to ask women about experiences of violence – either from fear of offending women or reluctance to open a vast array of issues to which they will not know how to respond.

In Kampong Thom province, especially in remote rural areas, access to the health system for victims of DV is rather limited. Geographical distance, financial limitations and the shame associated to such violence are the main obstacles which prevent the victim from reaching the health system at every level – provincial, district, and commune.

Health workers often do not recognize DV as a public health problem and do not see it as part of their role to ask patients about DV or provide any kind of support for victims. As health workers have limited access to information on the non-medical services available to the victim and lack knowledge on national legislation, it greatly lowers their ability to provide the necessary support (advice, information, referral, etc.). Furthermore, while providers offer appropriate medical treatment to the victims, they feel that they do not have the skills to further address DV. NGOs play a tremendous role in this respect, as victims of DV accompanied by NGOs are automatically identified by health workers as battered women and benefit from more adequate services than victims coming by themselves.

Obtaining a medical certificate for subsequent Court prosecution is a complicated and lengthy process, for which legal NGOs offer valuable support. Information on the use of the medical certificate is not systematically provided by health workers as DV has not yet received the same amount of attention as other types of gender-based violence such as rape – for which doctors always ask the patient whether s/he wants to obtain a medical certificate.

There are no specific record-keeping procedures for DV in Kampong Thom province, but the injury surveillance system (ISS), which is in the process of being piloted in Kampong Thom, provides new opportunities for monitoring of DV and for greater awareness of health workers on DV issues, and in turn a better response of the health sector towards DV.

1. Introduction

a. Background of the survey

The health sector and domestic violence are intrinsically linked as the health sector can often be the first contact point for women experiencing domestic violence (depending on the nature and gravity of their injuries). Although women's treatment varies enormously, contact with the health sector is the only possibility for victims to obtain the official document which can later serve as medical proof for potential Court proceedings.

Hospitals vary in their record-keeping policies and in most cases medical certificates are difficult to obtain. The health sector is an important actor in data collection for the national statistic on DV. As there is no common and uniform definition of DV within the health system, and as little awareness on the subject exists among health professionals, registering cases of DV is a difficult task.

Regarding linkages with social services, since health care providers have little means of protecting patients from violent partners, they are often reluctant to provide any other assistance than the medical treatment. To obtain a medical certificate, the victim needs to follow tedious procedures and since they are not aware of the role of such documents in the first place, this represents a double obstacle.

b. Objectives of the report

The objective of the report is to provide information on:

- Attitudes and awareness regarding DV among health professionals
- The impact that attitudes and awareness levels have on the intervention and prevention of DV
- The resources available to health professionals to support the victims (both internal and external resources)
- The procedure for obtaining official medical documents for legal proceedings
- The record-keeping procedures and their relevance for monitoring of DV

In light of the findings of the study, I will provide recommendations on how to improve the access to the heath sector for victims of DV on the one hand, and on how to improve the response of the health staff on the other. With improved access to and response of the health sector, more victims will have the option of legal action and awareness in the general public on DV will in turn be increased[1]. More victims will consider the health sector as potential support, and more health staff will disseminate information on DV and thus prevent it from happening, or provide support in ending it.

c. Research design

To evaluate the access to and the response of the health sector, I mostly used qualitative research methods, such as semi-structured interviews, field observations, key informants interviews, visits to hospitals and health centres, and attendance to community meetings. These research methods enabled me to draw heavily on the context, on local perceptions, and provided a holistic understanding of domestic violence in this particular setting. Individual interviews were deemed the best method to deal with such a sensitive topic. Even though the qualitative technique of focus group discussions is especially suited to exploratory research investigating people's attitudes, knowledge, problems and practices in health-related issues, such settings would have not enabled the same level of openness as individual interviews. Additionally, it would have been difficult to gather victims of DV for that purpose due to the reluctance to disclose such personal information in public. Individual interviews avoided inhibitions, enable us to collect more detailed responses, and shed light on the lack of common understanding of DV issues among health professionals. Health professionals from various health facilities in the province of Kampong Thom were interviewed on their perceptions, knowledge, and attitudes towards DV issues.

Victims of DV were identified and selected by NGOs dealing with DV from various perspectives such as Adhoc and Licadho as legal NGOs, TPO, COWS, BFDK and CODEC as psychosocial NGOs. This approach is justified by the fact that most victims of DV who access the health sector and who manage to obtain medical certificates are supported by NGOs. ADHOC and Licadho provide support for legal action such as complaint and divorce. The other NGOs provide psychological support to victims and perpetrators and conduct activities which promote sustainable change in the

[1] Indicator 1 of the PWR-Offer: "Increasing the percentage of the population aware that all forms of violence against women are criminal acts and wrongful behavior to 30%".

community. The interviews with the victims supported by the legal NGOs informed us about the response of the health sector, while the interviews with the victims supported by the other NGOs provided greater information on the access to the health sector.

Respondents

1 KT Provincial Health Deputy Director
1 KT Provincial Hospital Director
1 KT Provincial Hospital Dep. Director
2 Doctors
2 Nurses (trauma ward)
1 Nurse-in-chief (maternity ward)
3 Health Centre Directors
1 Kru Khmer (traditional healer)
9 Victims of domestic violence
1 Perpetrator
10 NGO staffs
2 Village chiefs
2 Policemen
Total 35 respondents

Limitations and challenges

Due to the setting of the research this report does not provide general, but rather case-specific data. The selection of the respondents and their relative small number fails to represent the population under study. It is difficult to infer the data gathered to the rest of the population as it only concerns a limited number of people who were not selected on a random basis. All the victims have one characteristic in common: they benefitted at one point from the support of NGOs. Their socio-economic background is relatively homogeneous as they all come from rural communities.

In most of the interviews, it was very difficult to collect the information I was initially looking for. Interviews with the victims of DV were more sensitive than expected and many questions could not be answered due to emotional reasons. All the interviews with victims of DV were conducted in the presence of the representative from the NGO which introduced us, which sometimes redirected the focus of the interview on the services provided by the NGO rather than on their access to health care. They also may have given information they believed the NGO representative would have wanted to hear. In other cases, family members were in the same room and this created unease and reduced the quality of the interview. Another challenge was the low level of education of some respondents, which made it difficult to express abstract concepts and follow structured reasoning.

2. Health professionals' response to DV

To assess the response of the health sector to DV, it is essential to determine to what extent health professionals (at all levels) are sensitised to DV issues. We interviewed health staff from: Kampong Thom **Referral Provincial Hospital** (Director, Deputy Director, Nurse-in chief of the maternity department, Nurse from the traumatology department, Nurse from the internal injury ward), Stung **Referral Hospital** (Administrative staff), and four **Health Centres** across Kampong Thom province (directors, doctors, nurses).

Three major findings came out of these interviews[2]:

- Health professionals are **not aware that there exists a uniform nationally agreed-upon definition of DV**. There is no common definition of DV among health professionals within and between health facilities.
- **DV is considered a social problem** (or as a private family matter), which does not enter the realm of the health sector
- Health staff consider **intervention in DV** cases the exclusive **role of the police and the Courts**

a. Accessibility of the health sector for victims of DV

The health system in Kampong Thom province is organised as follows:

Provincial level (PH)
Kampong Thom provincial referral hospital[3]

District level (RH) and commune level (HC)
3 Operational Districts (OD)
- Kampong Thom referral hospital (21 health centres)
- Stong referral hospital (10 health centres)
- Baray Santuk referral hospital (19 health centres)

[2] Similar results came out of the 1999 study conducted by PADV. Domestic Violence In Cambodia: A Study Of Health Care Providers Perceptions And Response, 1999
[3] Kampong Thom referral hospital was upgraded provincial hospital in 2007.

Each level offers different services, known as “packages of activities”. The minimum package of activities (MPA) is available at each level (from provincial hospital to health centres). Complementary packages of activities (CPA) are delivered in addition to the MPA at the district and provincial levels. Additional treatments requiring better equipment are dispensed at the provincial hospital only.

In theory all patients should be referred by the health centre to the referral hospital, and then from the referral hospital to the provincial hospital[4]. Referral slips are available in health centres for referral to RH and PH. In practice these forms are rarely used. Over the past six months, from January to June 2008, 67 referrals from health centres to referral hospitals and 969 referrals from RH to provincial hospitals have been registered. The first figure proves that the link between health centres and hospitals is not systematic and lacks coordination.

The health centres located near referral hospitals are more likely to refer patients than very remote health centres. However, in practice, many patients – if they can afford it – go directly to the RH or PH because they expect better services.

Private services are also available at the provincial, district, commune, and village levels. Traditional doctors (Kru Khmer) are very popular in villages as access to modern medicine can be limited and more costly. Private practice (doctor, nurse, drug seller) is also widely used at all levels. Little information was available on the responsiveness of private health care providers to DV.

- Access to the health sector greatly varies depending on the geographical location of the victim, on her level of education, on income, and on whether she has supportive relatives. In the past six months (January to June 2008), 81 female patients were admitted in the trauma ward of Kampong Thom PRH, and 36 female patients were admitted in the small surgery ward, which in total amounts to 117 women. All 117 cases have been registered in the register book both in the small surgery and trauma wards. But as nothing indicates whether injuries were caused by DV, it is impossible to establish the number of victims of DV out of the 117 patients.

[4] See **Appendix A**: Referral slip

According to the 2005 Cambodian Baseline Survey on violence against women, DV mostly occurs in the form of cursing or insulting, throwing something, pushing, shoving, or grabbing the other, knocking on the head, slapping or spanking, kicking, biting, shaking, and pulling hair. Injuries caused by the aforementioned acts leave in most cases minor injuries such as bruises, superficial cuts or burns, superficial wounds, which do not necessarily require urgent treatment. For minor injuries, victims of DV mostly resort to self-treatment and/or Kru Khmer, bone setter, and TBA[5]. Since little can be done against such injuries, victims of DV would rather avoid going to the health centre to save money and time.

"I did not think of going to the health centre because my neighbours told me that I would have to pay for fees", victim of DV

"Going to the health centre costs me more than double the price I would have to pay for the Kru Khmer. And at the health centre, you never know how much you will have to pay", victim of DV

"I don't want to be asked questions by the health staff, so I would rather use self-medication", victim of DV

"I am too ashamed of what is happening with my husband. So I'd rather remain discreet about it. And going to the health centre is not the best way", victim of DV

According to the 2005 Baseline Survey, respectively 59%, 66%, 92% responded "yes" the questions: *do you know a husband who knocks (on head), slaps, kicks, bites, shakes, pulls hair or punches his wife? Do you know a husband who throws objects, pushes, shoves, or grabs his wife? Do you know a husband who curses or insults his wife?*

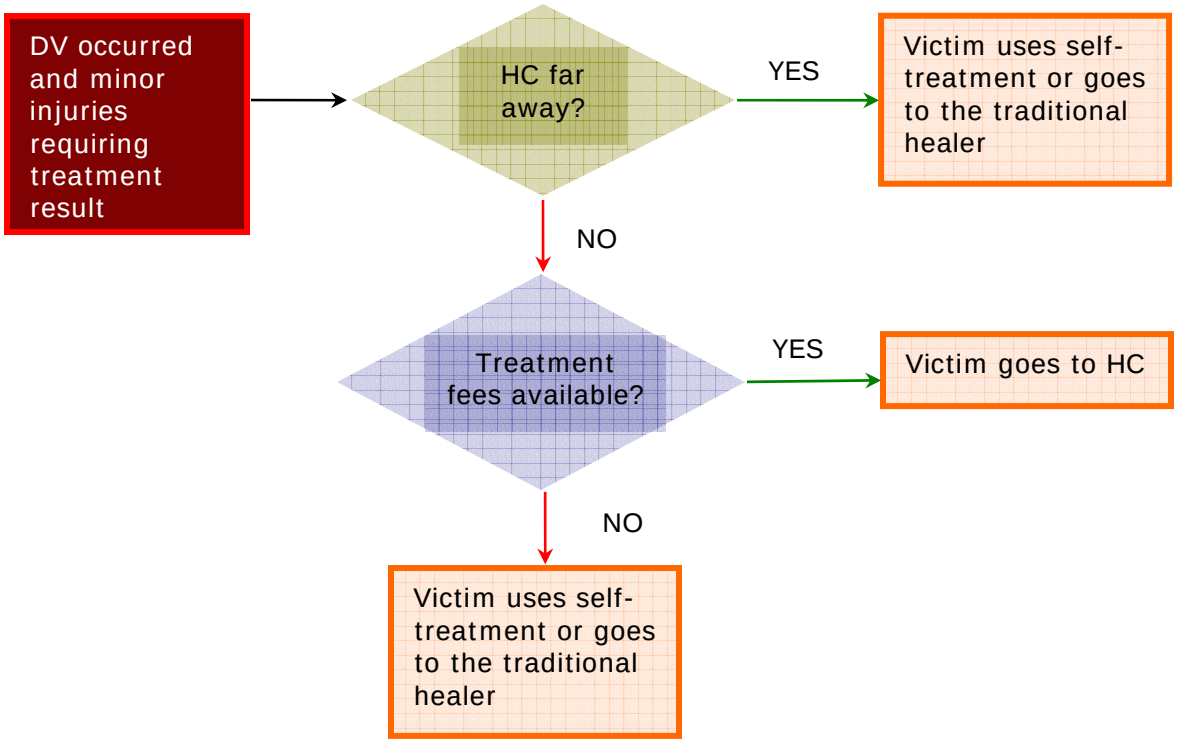
DV mostly leaves minor injuries for which the victim uses self-treatment. The vast majority of DV cases thus never come in contact with the health system.

These percentages show that these kinds of DV are widespread and yet not easily identifiable as no record keeping can be done. 50% of the women interviewed went to the health centre or hospital because of injuries caused by DV such as broken arm, serious wound at the head, serious injuries on the

[5] Traditional birth attendant

whole body. The remaining 50% of the interviewees have never been to the health centre because of DV because their injuries could be self-treated. The women who accessed the health sector were supported by legal NGOs and obtained (or are in the process of obtaining) a medical certificate for legal action to prevent further DV.

The following simplified flowcharts summarise the processes followed by victims:



Still according to the 2005 Baseline Survey, the following forms of DV are less common but still widespread. Injuries due to punching, tying up and hitting, hitting with objects, threatening with a knife or gun, burning or choking, throwing acid, raping, stabbing or shooting are generally serious and require emergency treatment.

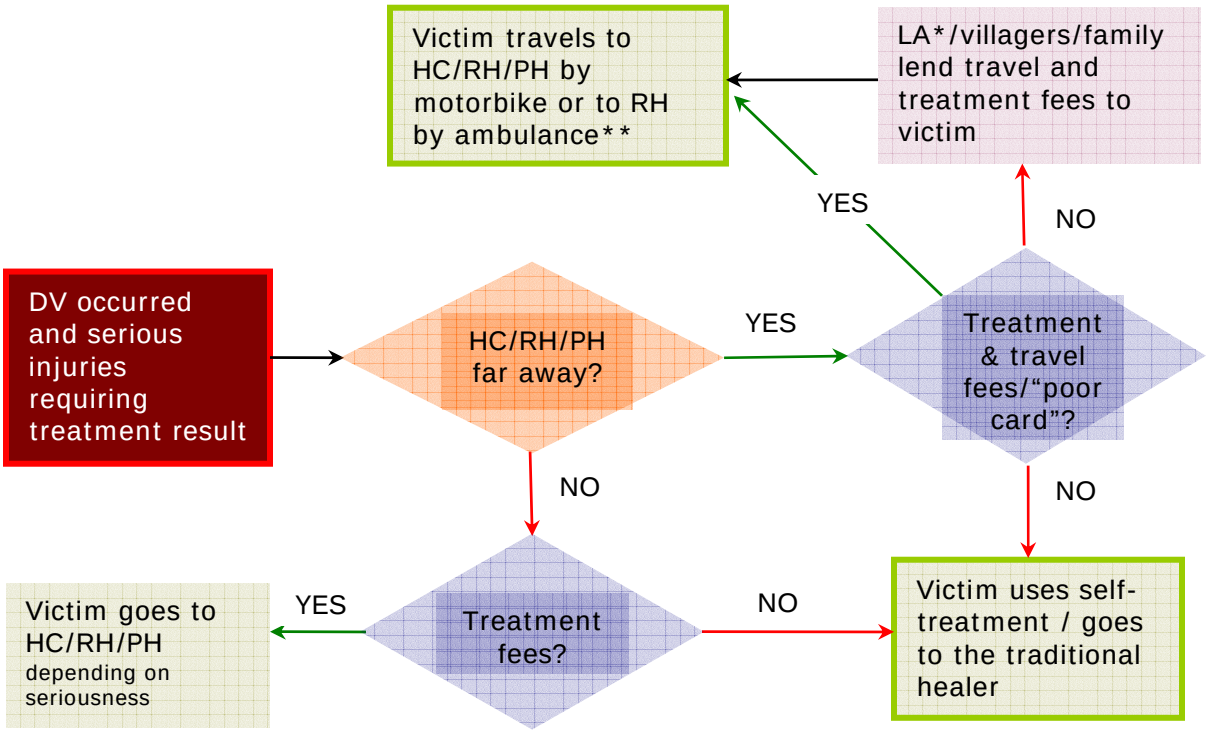
One out of six respondents went to the hospital by herself. The typical obstacles which prevent access to the health sector for victims of DV (financial constraints, remoteness, intimidation and threats from husband) did not exist in her

Victims benefitting from the support of NGOs have better access to the health system as they are offered logistical and financial support.

case: she is a "poor card[6]" holder, which dispenses her from paying the treatment fees; she lives at a walking distance from the provincial hospital; and her husband left the marital home. Another victim resorted to a private doctor as she had just delivered and could not leave her house. She received support from her sisters and neighbours to look after the children left at home and walk her to Kampong Thom provincial hospital.

In case of emergency, some victims used traditional medicine (for a broken arm). Although some respondents reported to have better treatment with the Khmer Kru than at the health centre, victims of DV most commonly go to the health centre, or directly to the provincial hospital. Access is made easier for victims benefitting from the services of NGOs, as financial and logistical support is often provided.

The following simplified flowcharts summarise the processes followed by victims:



* Local authorities

** An ambulance service is available at the referral hospital

[6] The ID poor card is delivered to poor household according to various criteria determining the level of poverty. Each holder of a "poor card" is entitled to free health treatment. However, patients coming with these cards are often neglected by the staff of the health facility as they have no incentive to provide quality services – the treatment fees constitute part of the salary of the health workers.

The role of NGOs and local authorities

- **NGOs** play a tremendous role in channelling victims of DV to the health sector. In most cases, victims coming to the provincial hospital because of DV benefit from the support of NGOs. Among other kinds of help, they receive support in obtaining medical certificates with diagnosis for Court prosecution[7]. NGOs reduce the obstacles preventing victims from accessing the health sector by providing financial and logistical assistance. Legal NGOs have a more automatic approach when it comes to requesting medical certificates and bringing the victim directly to the hospital, whereas NGOs primarily providing social services favour counselling activities (individual counselling, men's and women's self-help groups, etc.) as a tool for sustainable change in attitudes, behaviour, and representations in the community.

"I did not want to go to the health centre, but I thought that NGOs could help me", victim of DV.
"Almost all victims of DV coming to the trauma department are supported by NGOs", Nurse

- The fourth chapter of the DV law (prevention and protection of victims) stipulates that victims should be receiving the appropriate assistance such as "urgent medical assistance" by the authorities in charge[8]. Practices of **local authorities** greatly vary. In 50% of the cases observed for this study, local authorities intervened and provided support in accessing the health centre or the hospital, as well as other type of support such as shelter, counselling, mediation with the husband[9]. In the remaining half, local authorities did not intervene at all for various reasons: either family or friendship ties existed between the husband and the police and/or the village chief, or they considered DV as a family matter which should be solved in the internal sphere of the household and did not require any outside intervention. In many cases, the victim did not dare reporting to the local authorities because of threats from the perpetrator. The response of the *nearest authorities in charge* greatly varies depending on the size of the town or village where the victim lives, on

[7] See **Appendix B**: Request letter by Licadho sent to the Court to obtain an official request for a medical certificate with diagnosis.
[8] Chapter 4, Article 13, section3, Law on the Prevention of Domestic Violence and the Protection of the Victims
[9] See **Appendix C**: Contract between wife and husband

the level of awareness of local authorities on DV, and on other factors such as corruption, special ties between the protagonists. Villages were NGOs are active seem to provide better protection to victims of DV. TPO and BFDK initiated men's self-help groups in several villages involving local authorities, village chiefs and abusive husbands. These groups seem to have built awareness on DV among the members and within the wider community, DV is no longer considered a family matter but concerns the whole community. Local authorities intervened in cases of DV and group pressure plays a positive role in preventing DV.

"I told the village chief that I was scared of my husband and he told me to be a good wife and not blame my husband", victim of DV

"When I went to the police to explain my case, I knew they would not listen and help me as one of them is a very good friend of my husband's", victim of DV

"When my husband is too violent, the village chief offers me to stay at his house with his family", victim of DV

"I know that if I am violent with my wife, the other members will intervene and disapprove of my behaviour", member of a men's self-help group

"I used to be the most violent man of the village, and now I talk the other men into stopping being violent with their wives", member of a men's self-help group

b. Awareness of health professionals on DV

Different profiles came out of the interviews:

- health worker is aware of DV but has no means to intervene (no information on the non-medical services available, on legal procedures, and on the DV law)
- health worker is aware and willing to provide the appropriate response (refer to social services, provide information on the rights of the victim, and on the MCD) but feels s/he does not have the mandate to do so
- health worker is unaware of DV issues and considers DV the domain of the police

Very few of the staff we interviewed had a precise and accurate idea of what DV was. Confusion on the definition of DV exists at all levels. The form of DV to which respondents mostly referred to is rape. As some interviewees believed rape could be

considered an act of DV between wife and husband, others did not recognize that rape could be considered a type of DV between wife and husband. Confusion existed between gender-based violence (which also includes rape) and DV. In all cases, domestic violence was referred to as "quarrel" or "fight" between wife and husband, which strongly differs from the accurate definition of DV. In the section "history" of the hospitalisation file, "accident par querelle" (accident due to quarrel) was the term used to refer to DV[10]. The term "querelle" also appeared in the admission form[11].

There is no common understanding among the staff from the same hospital and between hospitals/health centres. In the same department, two nurses had widely diverging understandings of DV. Staff exposure to development partners (through workshops and seminars) increases the level of awareness, and as this exposure is greater at the provincial and district levels, the commune level is where the awareness is the lowest.

"I have been working in this health centre for almost ten years, and have never seen any case of domestic violence", Doctor from a HC

"I heard on TV that domestic violence is the use of power of a family member on another member of the family. It can be physical and verbal. So, for example, when my boss despises me and shows no respect, this is domestic violence", Nurse from KT PH

"Do you mean quarrels and fights between wife and husband?", Doctor from KT PH

Awareness on the DV law and on the legal options available for the victim was also rather limited among the interviewees. This assessment goes hand in hand with the fact that DV is still considered a private matter by many health professionals. However, all the respondents were well-informed about the procedure for issuing a medical certificate. They are aware about the procedure for issuing medical certificates but lack information on the use which can be made of it. A holistic understanding of the DV law is thus missing. The interviewees seem to have been sensitised about rape, as in most cases they associate medical certificate to rape.

[10] See **Appendix D**: "Dossier d'hospitalisation", Kampong Thom Provincial Hospital
[11] See **Appendix E**: Admission form, Kampong Thom Provincial Hospital

b. Perception on their competence and role towards victims

Many of the respondents felt they had no particular role to play with victims of DV other than providing medical treatment. The 2005 Baseline Survey suggests that there is a significant gap between what Cambodians deem as "acceptable" and as "legal" with respect to acts of DV.[12] The high level of acceptance of DV suggests that it may be more challenging for health professionals to recognize DV as a national problem and feel they have a role to play in its prevention.

The boundaries set by the perceived competence of health professionals are an obstacle for appropriate intervention and support to victims of DV by health providers.

"It is the role of the police to investigate, not the one of doctors and nurses", Nurse

"Sometimes I give advice on divorce procedures, but I usually wait for the women to ask me. Because when the couple reconcile, they blame me for interfering in their private life", Nurse

Medical certificates

An important area where the limited competence of health professionals is a major obstacle to the implementation of the DV law is the issuing of medical certificates. According the Operational Guidelines for Clients' rights and providers' rights-duties[13], the right to information and health education (article 2) stipulates that "clients have the right to request and be given a written summary of their diagnosis, treatment and care and the result of other examination on discharge from a health care facility".

High ranking officials from the provincial health department explained that the cause of the injury cannot be displayed on the medical certificate. The medical certificate is limited to injury assessment, i.e. it only *describes* the type of injury or illness (location, size, seriousness, etc.), and does not mention the cause. For example, "open wound on the head", but it will not be said that this injury was caused by DV, even though the patient explicitly tells the doctor that the injury is the result of DV. The very relevance of this document is thus largely diminished. This

The medical certificate is limited to injury assessment, and does not mention the cause of injury. The very relevance of this document is thus largely diminished.

[12] Violence Against Women: A Baseline Survey (2005).
[13] Operational Guidelines for Clients' Rights and Providers' Rights-Duties, Ministry of Health, supported by GTZ, February 2007

practice does not result from an official governmental guideline, but has been followed as a common practice within the profession. The respondents justified this practice by saying that investigation is under the competence of the police.

As we will see later, medical certificates can only be issued after an official written request from the Court (See 3.a., p 20). The procedure can seem very complicated, long, and costly to most victims of DV. As doctors and nurses cannot make the decision to issue the medical certificate themselves, they have a very important role to play when it comes to informing the patients about the procedure and use of the medical certificate. The doctors interviewed reported that they systematically ask the patient whether s/he wants to obtain a medical certificate in case of rape. Victims of other forms of DV are rarely asked whether they want a medical certificate.

"It is not the competence of the doctor to write the cause of the injury. How can I write it if I did not witness the act?", Doctor

"If a patient was a victim of rape, then I always ask if she wants to have a medical certificate", Doctor

Referrals to the legal sector and to social services

Health workers do not consider referring the patient to non-medical services part of their duties and responsibilities.

Referrals to social services are not a regular practice among the staffs interviewed. However, links between NGOs and the health sector do exist but the channelling is reversed. The referrals occur the other way around from NGOs / social services to hospitals and/or health centres. Lack of knowledge about the services offered by NGOs and lack of awareness on DV are the main obstacles to adequate referrals.

The main tool for facilitating referrals to the legal sector is the medical certificate, whereby it is the only pragmatic link between the legal sector and the health sector with DV issues. What typically comes out of the interviews is that the linkages with the legal sector are usually made by NGOs and/or the police and not by the health facility.

"Most patients who ask for a medical certificate are supported by NGOs", Nurse

"My job is to provide medical treatment but I do not have the capacity to offer more than this. The only thing I can do is trying to comfort the patient and listen to her story", Nurse

3. Linkages with the legal sector

a. Procedure for issuing a medical certificate with diagnosis

The medical certificate with diagnosis[14] (MCD) is the official document required by the Court to serve as official proof of the violence for the trial. They can be issued by the provincial hospital (PH) and the referral hospital (RH) by a committee consisting of health officials from the provincial health department (PHD) and the doctor in charge of the patient. Another document also named medical certificate can be issued by the doctor in charge alone, but this document has no legal value.

MCD are not easy to obtain. As they cannot be issued at the commune level, patients need to be referred to the PH or to the RH to make the request of the MCD. Obtaining a MCD is thus particularly difficult for victims of DV living in remote rural areas.

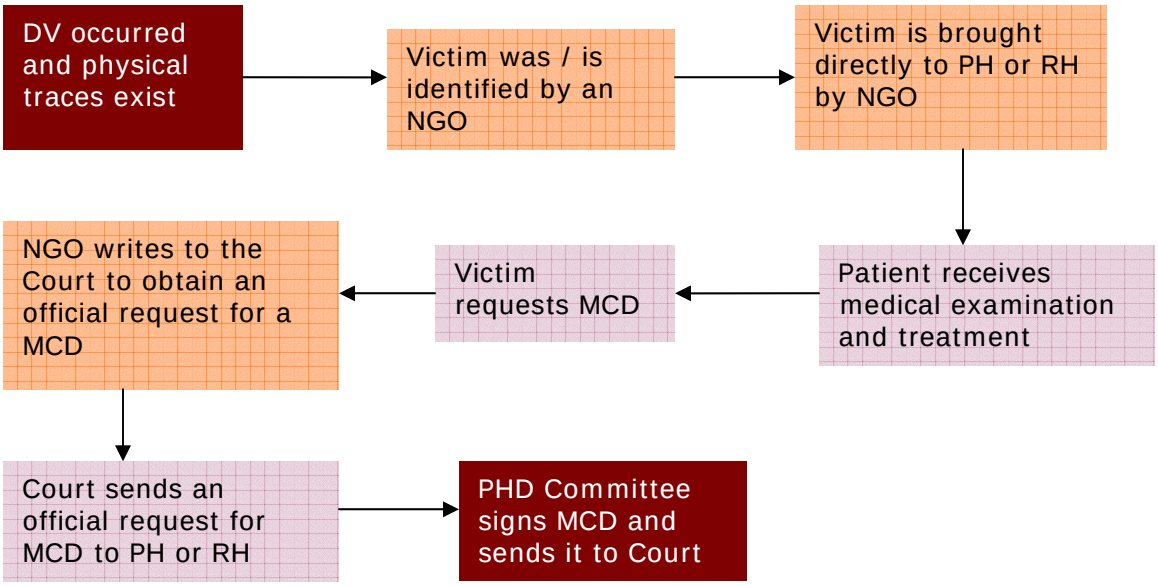
If victims are not benefitting from the support of NGOs, they are often discouraged by the complexity and length of the process. Over the past six months very few MCDs were delivered as very few patients made the request.

Kampong Thom Referral Provincial Hospital tracks the number of medical certificates issued by reporting to the PHD every semester[15]. Over the past six months (January to July 2008), very few MCDs were delivered as very few patients made the request. Between May and July 2008, there were 10 discharged letters issued by the trauma ward, and there were no records before May 2008.

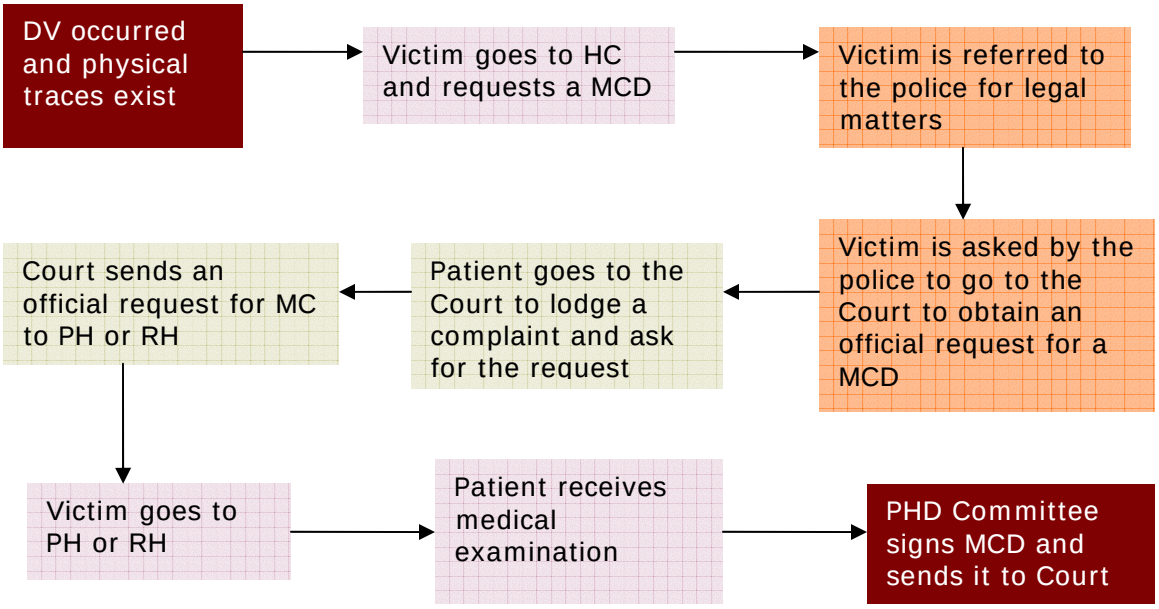
- Among the interviewees, the victims who did not go to the health centre or to the hospital ignored that a medical certificate could be delivered as a proof of the abuse for further legal action. This can be explained by the fact that legal proceedings within the family – and particularly in rural areas – are not yet accepted as a solution to DV. In remote rural areas, awareness is lower because of the lack of exposure to NGOs and other campaigns.

[14] See **Appendix F**: Medical certificate wit diagnosis (MCD)
[15] See **Appendix G**: Semester report of medical certificates with diagnosis

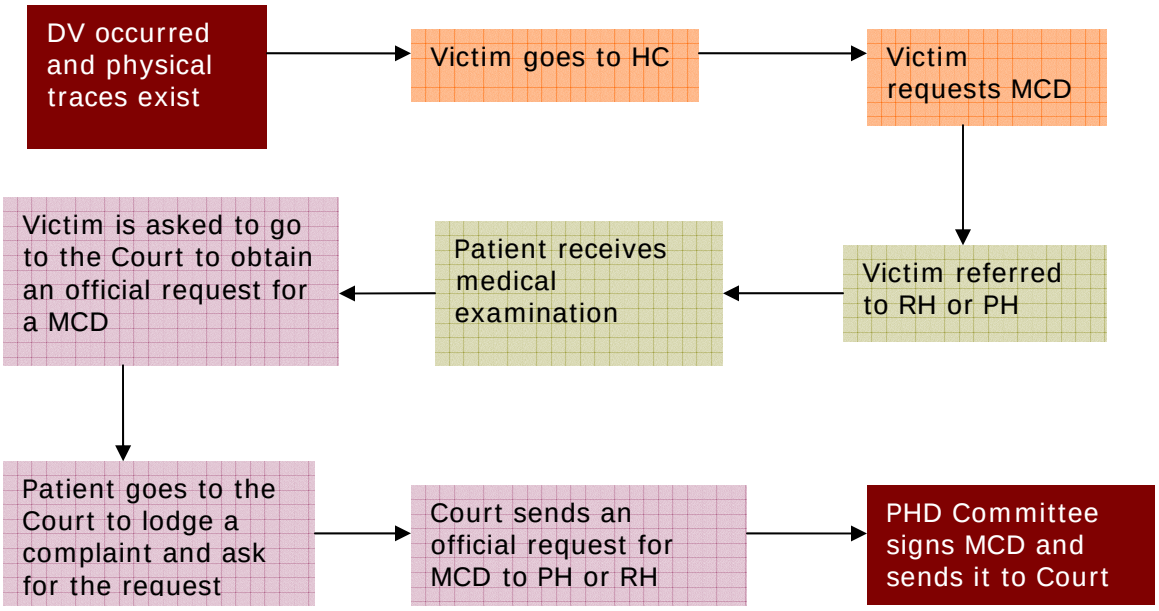
***Scenario 1*:** This scenario is the most common. Throughout the process the victim receives the support from a legal NGO (Licadho, Adhoc). Victims seeking support with NGOs typically require help with obtaining a divorce (or protection order) or with lodging a complaint. NGOs direct them through all the necessary steps to fulfill their request. They provide technical, logistical, and financial support.



***Scenario 2*:** The police provide the link between the patient and the health and legal sectors. In such cases the health sector directly refers the patient to the police for legal matters. This scenario only happens in a handful of cases. The lack of awareness on the use of the MCD, and the lack of knowledge on the procedures prevents the victims for undertaking this task by themselves. Victims of DV often give up halfway because they encounter financial difficulties (arbitrary and non-official fees are often requested throughout the process), and are simply discouraged. By the time they obtain the official letter from the Court, the traces on their bodies may have disappeared, and the document loses its relevance.



***Scenario 3*:** This scenario only happens extremely rarely. The patient is following all the steps without any outside support – apart from relatives. This suggests that the patient is very well informed on the procedures, is aware of the use of the MCD, may have special ties to the Court, and above all, is determined to obtain it. Without special ties with the legal profession, entering in contact with the Court is the most difficult step. We have not met any victim of DV who followed this scenario 3.



b. Main obstacles faced by victims of DV in obtaining the MCD

As we have seen in the section above, obtaining a MCD can be a tedious enterprise, without the help of a specialised NGO. The main obstacles preventing the victims from obtaining them include:

The MCD is delivered to the Court directly, and the patient does not have the right to hold a copy for her/himself.

- Geographical remoteness (no access to the RH/PH)
- Lack of knowledge on legal procedures and on the DV law
- Lack of awareness on DV (DV is accepted by the victim)
- Emotional manipulation by husband / family
- Financial limitations (for official and unofficial fees)
- Threats from husband / family

4. The health sector and national statistics on DV

a. Record-keeping and compatibility with DV monitoring and statistics[16]

There is no existing specific record-keeping procedure for DV in the health sector. All patients admitted to the hospital or health centre are registered in a general registry. However some elements in the existing forms would make it possible to recognise and include DV for monitoring and statistics.

At all levels of the health system, cases of DV are registered in the general registry, where the personal details of the patient, the reason of venue, and the type of injury/disease are mentioned. An admission form[17] relates this type of information at the HC level, and a hospitalisation file[18] provides more detailed information at the provincial level. The hospitalisation file ("dossier d'hospitalisation") contains one section entitled "history" ("histoire de la maladie") where the cause of the injury (DV) is mentioned (see § 3.b.).

Forms and registers are filled at the facility level. Health centres and RH send a summary report to the operational district every month (see appendix M&N). The operational district then sends a summary report to the Provincial Health Department (PHD). A final report is sent by the PHD to the Ministry of Health (MoH), which maintains a central database focused primarily on prevalence of medical conditions and disease.

A new comprehensive computerized health data collection system called the Health Information System (HIS) will ultimately integrate both facility level and population level data. Injuries resulting from DV are not separately tracked at the Ministry level and are not

Although no specific section is available for DV under the current forms, DV is sometimes recorded as "quarrel between husband and wife" under the section "history" of the hospitalization file at the district and provincial levels. However in most cases, DV is simply recorded as "quarrel".

[16] For this section, I collected information from the report "Establishing a National Statistic on Domestic Violence: Existing Mechanisms, Opportunities and Strategies", July 2006, Allison Shwartz, GTZ-PWR.
[17] See **Appendix H**: Admission form at the health center level
[18] See **Appendix D**: "Dossier d'hospitalisation", Kampong Thom Provincial Hospital

registered in the current version of the HIS. Under the current system, injuries resulting from DV are not identified.

"If the patient agrees, it can be written in the hospitalization file, under the section "history" that the injury was caused by quarrel with the spouse", Deputy Director of Kampong Thom PH

Unlike with rape[19], there is no specialized intake form for examining victims of DV. Following treatment, the victim is given a form that notifies the name of the hospital, the treatment, and the date of admission[20]. Currently, there is no separate tracking of medical certificates issued for injuries resulting from DV. Although no mechanism is currently in place to track injuries caused by DV, several opportunities exist.

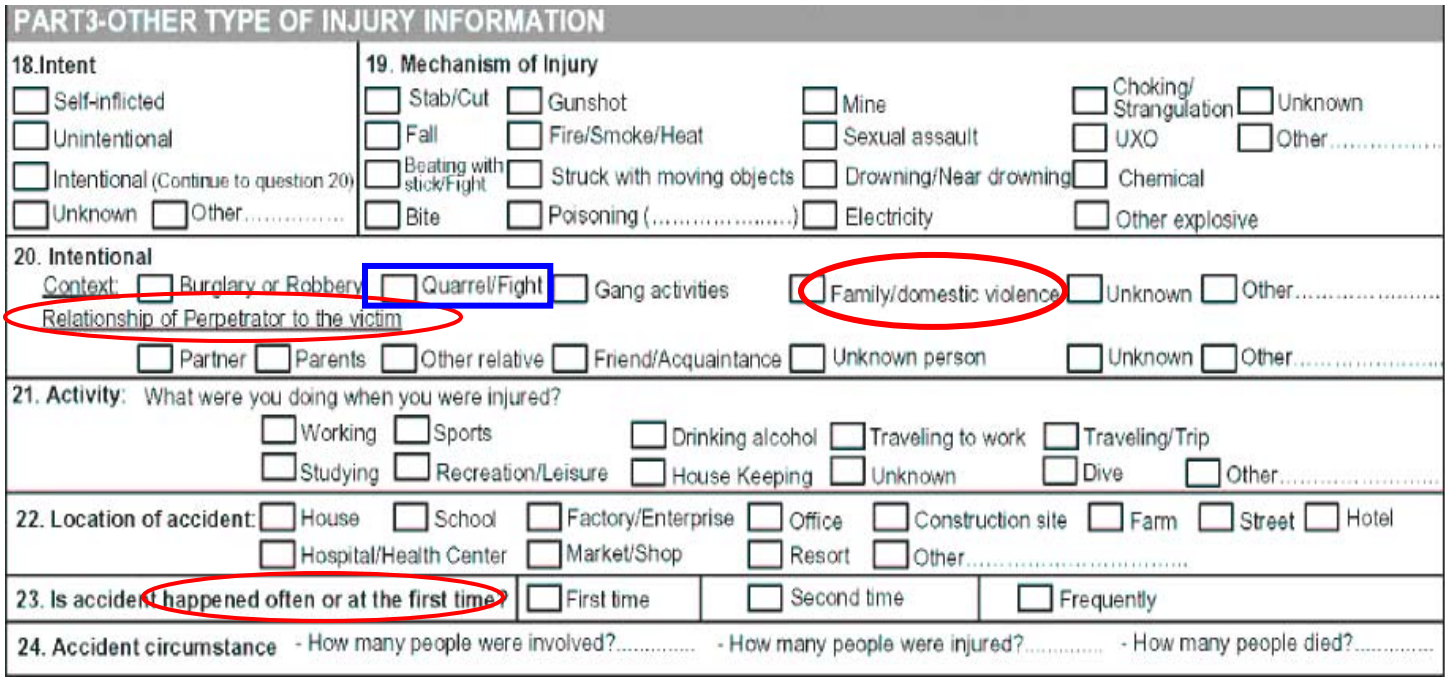
b. The Road Traffic and other type of injury form: an opportunity for ongoing national monitoring system of DV

The latest injury monitoring tool is now in the process of being piloted in Kampong Thom province. It was developed by MoH with the support of various development partners. This system provides comprehensive information on the victim's identity, on the nature and *cause* of the injury, and most importantly on the perpetrator(s). Injuries will be tracked using the **Road Traffic and Other Type of Injury Form** (RTOTIF).

While the emphasis for the injury information system (ISS) is on developing a straightforward and concise form that health practitioners will be likely to fill out completely and regularly, MoH has agreed to create separate sections for some types of injuries, such as those resulting from traffic accidents.

A DV indicator was proposed for the Health Information System (HIS) two years ago but ultimately tabled because DV lacked a clear and uniform definition. Modifications on the form meant to include DV are currently under discussion at the national level. Under the current version of the Road Traffic and Other Type of Injury Form[21], DV is not registered under a specific section, but it could either be tracked as a field on the common form or under a separate section devoted to DV-related injuries. GTZ-PWR project coordinator Sui Sakkunthea is currently submitting these suggestions to MoH.

[19] See **Appendix I**: Specialized intake form for rape cases
[20] See **Appendices E & H**: Admission forms HC and PRH
[21] See **Appendix J**: Road Traffic and Other Type of Injury Form



PART3-OTHER TYPE OF INJURY INFORMATION

18.Intent
- Self-inflicted
- Unintentional
- Intentional (Continue to question 20)
- Unknown
- Other.....

19. Mechanism of Injury
- Stab/Cut
- Gunshot
- Mine
- Choking/ Strangulation
- Unknown
- Fall
- Fire/Smoke/Heat
- Sexual assault
- UXO
- Other.....
- Beating with stick/Fight
- Struck with moving objects
- Drowning/Near drowning
- Chemical
- Bite
- Poisoning (.....)
- Electricity
- Other explosive

20. Intentional
Context: Burglary or Robbery; Quarrel/Fight; Gang activities; Family/domestic violence; Unknown; Other.....
Relationship of Perpetrator to the victim
Partner; Parents; Other relative; Friend/Acquaintance; Unknown person; Unknown; Other.....

21. Activity: What were you doing when you were injured?
Working; Sports; Drinking alcohol; Traveling to work; Traveling/Trip
Studying; Recreation/Leisure; House Keeping; Unknown; Dive; Other.....

22. Location of accident: House; School; Factory/Enterprise; Office; Construction site; Farm; Street; Hotel
Hospital/Health Center; Market/Shop; Resort; Other.....

23. Is accident happened often or at the first time? First time; Second time; Frequently

24. Accident circumstance - How many people were involved?..... - How many people were injured?..... - How many people died?.....

Such a system heavily relies on the willingness and on the capacity of local data collectors. Most importantly, health workers need to be able to recognize DV.

A national monitoring system was successfully established and implemented. While past experiences provide interesting insights into developing a similar mechanism to monitor DV, some important differences between these systems should be noted. First, DV-related statistics are more elusive than traffic accident statistics as DV is generally underreported. In Cambodia, DV is largely considered an internal family matter and tends to be justified under multiple circumstances. Moreover, as we have seen in this report, victims are less likely to report incidents of DV because of the shame associated with such violence. As a result, incidents of DV are more difficult to recognize and record than are traffic accidents.

The form can also seem ambiguous for data collectors. In the section 20, two boxes can correspond to DV in the current state of awareness among health workers: “family/domestic violence”, and “quarrel/fight”. DV does not clearly stand out in the current form and could easily be underreported because of confusion.

However, despite these limitations, the form represents a valuable opportunity for DV monitoring, as it explicitly includes DV. Should this form be used and filled in appropriately, the outcome would be considerably positive both for DV monitoring and for the responsiveness of the health sector towards DV.

5. Recommendations

As we have seen throughout this report, awareness of health professionals is rather limited on DV issues. In order to promote better responses of the health sector towards victims of DV, it is thus essential that health professionals be trained on how do deliver non-medical services to victims of DV coming to their departments such as counselling, referral to non-medical services, providing information on the procedures to obtain a MCD, and most importantly, on how to recognise DV and register the case accordingly. In this respect, consciousness raising strategies and institutional strengthening training programmes should be developed specifically for the health sector.

The survey indicates that most DV cases do not go through the public health sector as injuries typically suffered by battered women do not necessitate urgent medical treatment. As traditional healers are in direct and regular contact with victims of DV, including the private and traditional health sector in awareness raising activities would yield considerable results.

The survey indicates that most DV cases do no go through the public health sector. As traditional healers are widely exposed to victims of DV, including the private and traditional health sector in awareness raising activities would yield considerable results.

As the response of the health sector also strongly depends on the general level of acceptance of DV and on awareness on the rights of the victim, efforts to raise consciousness on DV issues with the general public should be further strengthened. If the victims are reluctant, scared, or ashamed to share their experience with heath professionals, their capacity to help the victim will be considerably reduced.

Core priority recommendations

- Create a **flowchart outlining the different steps to be taken when a victim of DV is admitted to the health facility** (treat, assess, inform, refer, document, etc.) and disseminate it in all health facilities (after ToT is completed with at least one or two staffs from each health facility
- Advocate for **easier access to the medical certificate with diagnosis** with MoH and MoJ
  - To make the MCD available upon simple request from the patient, without the formal request of the Court.
  - To allow the victim to obtain her/his own copy of the MCD
  - To include the cause of the injury in the MCD
- Foster close cooperation with **GTZ programme Support to the Health Sector Reform** in the long run, especially for the aforementioned activities.

a. General recommendations to MoWA and GTZ/PWR

- Disseminate the Kampong Thom **service directory** at all levels (HC, RH, PH) to health workers that are in closest contact to the victim and who are most likely to provide advice to her (nurses)
- Closely monitor the use of the ISS form **Road Traffic and Other Type of Injury Form** to ensure that DV is correctly recognized and registered
- Foster **communication and coordination** between **MoWA** and **MoH** and amongst **health care providers**, **women's groups**, the **legal sector** and other service providers. Information sharing and exchanges of best practices are key for the improved implementation of the DV law
- As most victims do not reach the health sector as the traces left by DV are mostly minor injuries not requiring medical intervention, it is essential to **encourage NGOs to extend their support to victims of DV**, be it legal (Adhoc, Licadho) or psychosocial support (TPO, BFDK, COWS, CODEC)

b. Recommendations on awareness-raising activities with health professionals

- Train health professionals – especially those who are in close contact to the victim (nurses) – **on the use of the service directory** and emphasise on the need to refer victims of DV to psychosocial and legal services
- Conduct a **ToT with health professionals** from HC, RH and PH to fill in the **Road Traffic and Other Type of Injury Form** (RTOTIF), with a strong **emphasis on DV** (definition of DV, ways to recognize signs of DV, etc.).
- Jointly with the aforementioned training, conduct a session on **how to recognize medical signs of (suspected) DV**[22], and on **routine and selective screenings** of female patients.
- In parallel, conduct another **ToT** on the use of the **flowchart** outlining the different steps to be taken when a victim of DV is admitted to the health facility (treat, assess patient's safety, inform, refer, document the case, etc.)
- **Actively include health sector professionals and traditional health practitioners** in the facilitation of public forums and other awareness-raising activities. This approach is meant to make them feel part of the common effort to prevent DV and increase their effectiveness in tackling the issue.
- Conduct a training of nurses on **basic counselling skills**. This training could be facilitated by **TPO** or **BFDK**, as they have demonstrated excellent psychological skills.

[22] When it is not recognized or accepted by the victim. clinical signs which give suspicion of DV include injury to the head, neck, torso, breast, abdomen, genitals, bilateral or multiple injuries, delay between onset of injury and seeking treatment, explanation by the patient which is inconsistent with the type of injury, any injury during pregnancy, prior history of trauma, chronic pain, symptoms for which no etiology is apparent, psychological distress such as depression, suicidal ideation, anxiety and /or sleep disorders, a partner that seems overly protective and who will not leave the patient's side.