Violence Against Women – A Public Health Perspective
Project Report – Fiji 2010

December 2010

Department of Public Health and Primary Care – College of Medicine, Nursing and Health Sciences (Fiji School of Medicine) Fiji National University

World Health Organization
Western Pacific Region

Fiji School of Medicine

FNU Fiji National University

Ministry of Health
Shaping Fiji's Health

VIOLENCE AGAINST WOMEN: A PUBLIC HEALTH PERSPECTIVE – FIJI 2010

Joint Project between College of Medicine, Nursing and Health Sciences (Fiji School of Medicine) - Fiji National University and World Health Organization, in association with Ministry of Health Fiji

Report prepared by:
Dr Timaima Tuiketei and Ms Avelina Rokoduru - December 2010

Fiji VAW Project Team: Mr Navitalai Litidamu, Ms Iloi Rabuka, Dr Viema Biaukula, Dr Roman Chute, Ms Rusieli Taukei and Ms Violet Prasad

WHO Project Team: Dr Li Dan, Dr Krishnan Rajan, Dr Wang Xiangdong and Mr Shalvindr Raj

MINISTRY of Health
Shaping Fiji's Health

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i. FOREWORD

As the Head of the Department of Public Health and Primary Care (DPHPC) and a member of the VAW Project Team 2010 Fiji, I am pleased to share a few thoughts and to greet those that would go through this Violence Against Women (VAW) Project Report Fiji 2010.

Violence against other fellow humans - women, children, other men and self, is a universal phenomenon. While the contexts might be different – they can be political, socio-economic or cultural; they can be resource and resource-distribution-based; gender-based; poverty-based or religious-based – violence and acts of violence know no physical or human boundaries and have been part of the human civilization throughout the ages.

The VAW project team was commissioned by the World Health Organization (WHO) South Pacific office in July 2010, to conduct a host of VAW activities as components of the Project in Fiji. This report is one of the main outcomes of that partnership between the College of Medicine, Nursing & Health Science (formerly known as Fiji School of Medicine) /Fiji National University, Ministry of Health Fiji and WHO. A lot of work on VAW has been implemented by various NGOs and CSOs in particular the Fiji Women's Crisis Centre with other stakeholders & I applaud them for their tremendous efforts. Health professionals are frontline service providers to VAW patients. This report is DPHPC's contribution to the multi-pronged approach to ending violence against women in our society. Using a public health approach, this report is a pilot project in providing evidence to facilitate how VAW can be best addressed. I am proud to note that through this report, the VAW Project Team has established a new milestone in providing research evidence on how VAW is addressed at health care facilities in Fiji by health care workers.

Most of the findings support the general discussions and trends already established by statistics and reports compiled by the Fiji Women's Crisis Centre as well as the Fiji Police Force. What is unique about this report is that it now establishes that VAW is a disease burden in Fiji which should be appropriately addressed. The report also provides insights into how health care workers address individual cases of VAW presented to them in the workplace. The majority of the health workers while confident to handle VAW patients, simultaneously acknowledge the need for further training in specific areas such as VAW counseling, medico-legal issues, clinical management amongst others. Indeed, this is a health workforce that is ready to take on tasks to address VAW in their workplace.

The recommendations arising from this report demand commitment from various sectors of society so that the public health response is informed, concerted, targeted and therefore effective. One such recommendation is to design a relevant gender and culturally- sensitized VAW curriculum for health professionals at recognized training institutions. This could become the forte for DPHPC, CMNHS and therein see the Department contribute not only to the national VAW response but to the Pacific's regional response to ending VAW.

I salute and commend the efforts of the VAW Project Team towards achieving the outputs. I must express my deep appreciation to Dr. Li Dan and the WHO team for the funding and believing in DPHPC to deliver something that will be instrumental in facilitating the effective reduction of VAW in society. *Vinaka Vakalevu.*

Navitalai Litidamu
Head - Department of Public Health and Primary Care
College of Medicine, Nursing and Health Sciences – Fiji National University

ii. ACRONYMS

A&E	Accidents and Emergencies
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CMR	Consolidated Monthly Return
DD	Domestic Duties
DEVAW	Declaration on the Elimination of Violence Against Women
DPHPC	Department of Public health and Primary Care
FSMed	Fiji School of Medicine
FNU	Fiji National University
FWCC	Fiji Women's Crisis Centre
HC	Health Centre
ICPD	International Conference on Population Development
MOH	Ministry of Health
NS	Nursing Station
PATIS	Patient Information System
PSHRC	Pacific STI/HIV Research Centre
VAW	Violence Against Women
VHW	Village Health Worker
WHO	World Health Organization

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IV. ACKNOWLEDGEMENTS

The Violence Against Women Project Fiji 2010 was funded by WHO and executed by the VAW project team based at the Department of Public Health and Primary care (DPHPC) and the Pacific STI/ HIV Research Centre (PSHRC) of the Fiji School of Medicine/Fiji National University

The involvement of members of the following government agencies, non government organisations, individuals and other stakeholders were critical to the completion of this project are hereby acknowledged for their active participation and contributions:

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FSMed/FNU VAW Project Team: Dr Timaima Tuiketei, Ms Avelina Rokoduru, Mr Navitalai Litidamu, Ms Iloi Rabuka, Dr Viema Biaukula, Dr Roman Chute, Ms Rusieli Taukei, Ms Violet Prasad and Ms Loata Serau

Executive Summary

1. Introduction

WHO launched the Global Report on "Violence and Health" in 2002. The recommendations include a call on member countries to: *create, implement and monitor a national action plan for violence prevention; enhance capacity for collecting data on violence; define priorities and support research on prevention of violence; promote primary prevention responses; strengthen responses for victims of violence; integrate violence prevention into social and educational policies, and thereby promote gender and social equality; and increase collaboration and exchange of information on violence prevention.* In the Western Pacific Region, about 57 000 deaths occur annually because of violence (Global Burden of Disease, WHO, 2004). Many more are injured and suffer a range of physical, sexual, reproductive and mental health problems. Moreover, violence places a massive burden on national economies because of expenditure on health care and law enforcement, and lost productivity.

The gender sensitization and creating awareness activities with prevention strategies in violence against women (VAW) have been remarkably covered and championed by the NGO support groups in Fiji over the years – in particular the Fiji Women's Crisis Centre, the Council of Women and its affiliates, the church and religious groups, Department of Women, Fiji Police Force, Ministry of Health and other stakeholders. Since 2008, these activities in VAW have been strengthened taking a new turn in advocacy and policy interventions, commenced the annual 16 days of awareness program including the reclaiming the night marches in Suva and around the main cities in Fiji. The no drop policy adopted and implemented by the Fiji Police Force in all VAW reported cases since 2008 has also made positive impact and strengthened this program.

Most of the data now available on VAW in Fiji are from those that report it to the Fiji Women's crisis centre from the records of the Fiji Police Force – voluntarily done so by those affected in VAW. However, one of the gaps identified is the number of cases of Injuries and other sustained impacts on VAW seen in the health facilities in Fiji. Literature review shows that the last data collected in Fiji on VAW was obtained in 1994-1999 from NGOs & other stakeholders. There is no data available from Fiji MOH in health services and on service providers on VAW patients that are managed and treated in the government health facilities. What is also not known are:

- Are these data easily captured in PATIS, or hospital records or CMR or nurses reports
- What types of injuries are sustained and which ones are commonly seen
- What type of treatment is given: at A&E/GOPD, admitted or referred to base hosp
- What are the outcomes of these injuries
- How are the health professionals managing injuries from VAW
- Are the health professional staffs adequately trained to address these VAW issues?

Hence, the rationale for this project.

2. Project Components - Has three components implemented in July to Dec 2010

Component 1: Conduct research on VAW situation analysis from PH perspective through data collection from selected health facilities & self administered questionnaire from health staff

Component 2: Conduct a VAW Prevention BCC materials competition for FSMed/FNU students on 3 categories: pamphlet, poster & TV Spots – in Sept – Nov 2010 period

Component 3: Conduct a stakeholder's workshop to disseminate research findings: 16/12/10

3. Objectives

component	objectives
1: research	1. To ascertain what type of injuries sustained from VAW are seen and recorded in the selected health facilities in Fiji
	2. To identify the descriptive characteristics of these injuries
	3. To determine whether the health professional staff are appropriately managing these patients in the various health facilities
2: BCC materials	To create awareness and share experiences on VAW issues to students and staff of tertiary institutions at the Fiji National University/Fiji School of Medicine
	To develop some new BCC materials on preventing VAW as prevention strategies
3:workshop	To discuss and disseminate the results of components 1 and 2 to stakeholders

4. Methodology

Component 1: This is a selective cross-sectional retrospective study with convenient sampling of the Fiji MOH health facilities to obtain data from medical records in A&E/GOPD registers, PATIS & police record files on Injuries sustained in VAW from January 2005 to December 2009. The selected health facilities were: 5 in Central Eastern, 6 in Western and 5 in the Northern Divisions & included 10 hospitals, 4 Health Centres and 2 Nursing Stations. Permission was granted first by the Minister for Health, Dr Neil Sharma, the MOH head office and National Ethics Committee approval was obtained before the study was commenced. Specific variables were identified and lifted out from the medical records. Data was entered and analyzed by SPSS. Component 2 – VAW BCC material competition organized for FSMed/FNU students and sessions on VAW issues for students and staff in Sept –Nov 2010 period. Component 3 will be conducted in workshop mode.

5. Results and Analysis – Main Findings Only

A- Questionnaire responses

5.1 – Descriptive Characteristics: Total sample size: 98 health professional staff; Total health facilities sites: 16; Gender:17% Males, 83% females;

- Health staff by designation: Doctors – 14%; Dentists – 17%; Registered nurses - 69%
- Work locations: GOPD/A&E (20%); Hosp (39%); Specialist Hospitals (12%); HC (20%; NS (3%).

5.2 Self Impressions and assessment:

- 70% of health professionals are comfortable in managing VAW patients
- 78% have very good Knowledge on definition of VAW
- 50% state there is low content on basic medical or nursing training to manage VAW patients
- 80% have good confidence in consulting and managing women who are victims of violence
- 88% need VAW clinical management and other specified training needs

5.3 Clinical Practice & Management

- 67% of health professionals sometimes ask VAW patients whether this is a repeated experience. 32 - 75% of health staff think about VAW in female patients who present with Symptoms such as abnormal menses, anxiety, chronic pain & weight loss. 95% think of VAW if she presented with Physical marks of injury - bruising or bleeding
- From Jan 2005 - Dec 2009: 95% of the health professionals have treated patients on VAW - 69% treated up to 10 patients; 14% treated 20 patients; 12% treated more than 20 patients.
- Of these patients: 83% had more than one violent attack in the past

5.4 Assailants

- 96% of the VAW patients know the assailant: 45% were current boyfriend; 43% were close family relative; 32% were their divorced husbands; 29% were victim's neighbor; 27% were separated husbands; 26% were ex-boyfriend; 15 -16% were others.
- Common methods used by the assailant to cause physical or psychological injury to the women victims of violence: 74% had Verbal abuse; 86% punching; 69% kicking; 67% slapping, 49% blunt object, 37% sharp object; 19% burning; 1-3% others including forceful sex & rape.
- 70% of the assailants were sober, 74% had alcohol intoxication during the violent act.

5.5 VAW patients

- Commonest way in which the VAW patient arrives at the health facility: 70% brought by relatives; 61% were brought in by the Police; 61% came by herself; 22% were brought by the assailant; 38% brought in by parents; 35% by friends; 6-15% by others.
- First time of arrival to the health facility for treatment. 61% Less than 6 hours after the violent attack; 48% arrive between 6-12 hours after the attack 55% arrive after 24 hours
- Main injuries seen in these VAW patients of violence: 85% facial & scalp, 59% Jaw injuries, 50% head injuries, 51% Upper limb injuries, 30% Attempted Rape, and others
- Treatment offered: 56% only require Minor First Aid; 73% had moderately severe injuries; 45% had severe injuries- which required Inpatient Treatment; 17% had life threatening injuries which required emergency surgery or intensive care treatment

5.6 Health professionals – made many suggestions in improving the services for VAW patients

- 93% of the health professionals stated there is no MOH Written Policy or guideline on the Management of Women who received injuries from any form of violence
- Notification of VAW patients: 39% of health professional always report it to police; 49% refer VAW patients for counseling; Only 6% report it and refer patient to FWCC, 34% have filled a police medical report; 5% of them have been summoned to Court for testimony on a VAW case.

B- Health facility data

5.7 Descriptive Characteristics: Total Sample size: 3027 data for women; Total no. health facilities: 16 Ethnicity: F (54%) I (43%) O (3%); Marital status: 49% married, 13% single, 38% did not state & others; Age: majority (39%) were in 21-30 yrs, 23% were in 31-40yrs, then 12% each for the 16-20 yrs and 41-50yrs. Vulnerable age groups: 6% in 1-15years and 1% in 61-90yrs. Occupation: 67% did not state, 22% DD, 2% C/S, 9% others; Address: 44% rural, 43% urban, 13% no record;

5.8 Total No. of cases – There was steady increase of recorded cases over the 5 years from 2005-9 but slight decrease in 2008: 2005 -532 cases, 2006 -579 cases, 2007 -607cases, 2008 -584 cases, 2009 – 674 cases; 51 cases were not dated in the records.

5.9 Presenting Complaints - h/o assault to body injuries: 58%, head & neck: 25%, body- head & neck: 14%, other – 3%

5.10 Type of Injuries: 2 abuse types – physical, sexual and others. Of the 3027 cases: 83% were physical, 5% were reported sexual, 0.5% other and 12.5% not clearly classified.

5.11 Police report - 62% (1868) of the cases were reported to the police. This included all the girl child (6%) assault cases reported in this study.

5.10. Final Diagnosis – 25% of the final diagnosis were assault cases, 76%of the cases did not have any diagnosis, 0.5% were recorded as other cases.

5.12 Assailants - The highest number of perpetrators of violence in this study was male spouses: husbands (1189 – 39%); boyfriends (295 -10%) and de-facto partners (65 – 2.1%). They made up 1,549 of the 3,027 cases (51%). The second highest category of perpetrators were only listed as 'an Indian male/s 6 %); a Fijian male/s' (28%) in the record books at the various health facilities. Women assailants -3%.

C- BCC Materials – Total of 3 video clips, 4 posters and 3 brochures were submitted

D- Stakeholders Workshop was conducted on 16/12/10 and results were disseminated.

6. Conclusions – Objectives were attained

The VAW disease burden is in existence in the MOH health facilities in the 3 Divisions. A lot of insights on VAW from the three perspectives: VAW patients, assailants and the clinical service providers have been revealed. Health staff have made self impressions and assessments on their practice and identified interventions strategies to improve their clinical management in the service provision for VAW patients. 10 new original and dynamic BCC VAW materials were developed and now available for printing and dissemination.

7. Recommendations

- Establish a specialized counseling unit within the health facility premises where a counselor, social worker, religious personnel and others can be available 24 hours to attend to VAW patients.
- Strengthen/formalize referral networks with NGOs on counseling/follow up of VAW patients and with the Police to improve case reporting by health staff and VAW patients.
- Develop VAW policy and clinical management guidelines in MOH
- Develop/strengthen curriculum on Injury for VAW patients for health professionals
- Conduct training on VAW clinical management, medico-legal issues, counseling & other areas
- Develop more VAW BCC materials and accessibility in providing information to women.
- Conduct more community awareness programs on VAW issues. VHW to play a lead role in this.
- Develop & maintain a proper information system integrating it within the existing HIS in MOH on timely and accurate records at health facilities to effect wholesome treatment and to assist in behavior change interventions for patients and perpetrators, health care workers, violence and gender-based NGOs, government and the general public.

VIOLENCE AGAINST WOMEN: A PUBLIC HEALTH PERSPECTIVE – FIJI 2010

1. INTRODUCTION

WHO launched the Global Report on "Violence and Health" in 2002. The recommendations include a call on countries to: create, implement and monitor a national action plan for violence prevention; enhance capacity for collecting data on violence; define priorities and support research on prevention of violence; promote primary prevention responses; strengthen responses for victims of violence; integrate violence prevention into social and educational policies, and thereby promote gender and social equality; and increase collaboration and exchange of information on violence prevention.

Reproductive Health and Women – Since Cairo (1994 ICPD), the concept of health has moved away from a narrow, purely biomedical view to one of health as a right to emotional, social and physical well-being[1]. This shift focuses on the cultural and economic environments within which women from many different cultures receive RH services. As well, the initial biomedical model allowed the service provider to decide what was best for women clients and was more successful in curative care because it sought to relieve pain and physical distress rather than facilitate promotive and preventive care (Ibid). This same approach must now be used to address violence against women in Fiji's health system.

For more than a decade intimate-partner violence and sexual violence against women have been recognized as major global public health problems, as well as serious human rights abuses. The impact of these forms of violence on acute and long-term health and well-being has been documented in publications such as WHO's World report on violence and health (Krug et al. 2002), the WHO Multi-country study on women's health and domestic violence against women (Garcia-Moreno et al., 2005), and various other population-based studies. Intimate-partner violence and sexual violence have a damaging impact on physical, mental and reproductive and sexual health, with consequences such as physical injuries, depression, post-traumatic stress disorder, suicide attempts, substance abuse, unwanted pregnancy, gynecological disorders, sexually transmitted infections, increased HIV/AIDS risk, and others.

Intimate-partner violence, sometimes called domestic violence or spouse abuse, includes acts of physical aggression, sexual coercion, psychological/emotional abuse and controlling behaviors by a current or former partner or spouse (Heise & Garcia-Moreno, 2002). It can happen within marriage, long-term partnerships or short-term intimate relationships, and can be perpetrated by ex-partners when these relationships have ended. It has been documented as largely perpetrated by men against women, although such violence also occurs in same-sex couples and can be perpetrated by women against men. As a category of interpersonal violence, intimate-partner violence includes dating violence that occurs among young people,

[1] **Raghavan-Gilbert, P** Gender Issues in Reproductive Health: Let's Get Serious, in, Reflections, UNFPA, Country Support Team for the South Pacific, (1), 1999; 2.

although the pattern of such violence may be different to that experienced in the context of long-term partnerships, and studies often examine the two issues separately.

Sexual violence occurs both within intimate partnerships and outside them. It has a significant impact on both girls and boys, although among adults women are at substantially greater risk of victimization than men. Sexually violent acts can be perpetrated by intimate partners, family members, friends, acquaintances, authority figures such as teachers or clergy, or strangers. In most communities however intimate partners and people known to the victim are by far the most common category of perpetrator. Sexual violence takes different forms over the life course, from child sexual abuse to forced sexual initiation to sexual coercion within and outside intimate.

In the Western Pacific Region, about 57 000 deaths occur annually because of violence (Global Burden of Disease, WHO, 2004). Many more are injured and suffer a range of physical, sexual, reproductive and mental health problems. Moreover, violence places a massive burden on national economies because of expenditure on health care and law enforcement, and lost productivity.

2. BACKGROUND AND RATIONALE

The gender sensitization and creating awareness activities with prevention strategies in violence against women (VAW) have been remarkably covered and championed by the NGO support groups in Fiji over the years – in particular the Fiji Women's crisis centre, the Council of women and its affiliates, the church and religious groups, Department of Women, Fiji Police Force, Ministry of health and other stakeholders. For the past decades, these activities in Violence against women have been strengthened taking a new turn in advocacy and policy interventions, commenced the annual 16 days of awareness program including the reclaiming the night march in Suva and around the main cities in Fiji. The reconciliation stand and no drop policy adopted and implemented by the Fiji Police Force in all VAW reported cases since 2005 has also made positive impact and strengthened this program.

Most of the data now available on VAW in Fiji are from those that report it to the Fiji Women's crisis centre from the records of the Fiji Police Force – voluntarily done so by victims of VAW. However, one of the gaps identified is the number of cases of Injuries and other sustained impacts on VAW seen in the health facilities in Fiji. There is no data available from Fiji MOH in health services and on service providers on VAW patients that are managed and treated in the government health facilities. What is also not known are:

- whether injuries sustained through VAW come to the hospitals or health facilities,
- are these data easily captured in the PATIS, or hospital records or CMR or nurses reports
- what types of injuries are sustained – which ones are commonly seen,
- what type of treatment was given – whether they were treated as outpatients, admitted or referred to a higher health facility
- What are the outcomes of these injuries

- Are these type of injuries given a special attention in the health facilities
- How are the health professionals managing injuries from VAW in the remote centres
- Are the health professional staffs adequately trained to address these VAW issues.

Hence the rationale for this study and the project as a whole.

There were 3 components to this project:

1. **Component 1:** Conduct research on situation analysis – through data collection from identified health facilities from 2005-9 and self administered questionnaires by health professionals	• Literature review shows that the last data collected in Fiji on VAW was obtained in 1994-1999 from NGOs & other stakeholders • Since 2008 – NGOs & Fiji Police have been collaborating strategies to address this such as: the annual program of reclaiming the night, no drop policy, and so forth. • Nil data available from MOH in health services and on service providers on VAW patients • This is an Identified gap – which is the niche for this project component
Methodology	Lifting out data from GOPD & A/E registers using the designed template, in the identified health facilities: 6 in west, 6 in CE & 5 in North. SA Questionnaire survey conducted for doctors, nurses & dentists
Commenced from	26/7 t0 1/9/10. *Data analyzed &* Preliminary report ready by Dec 2010
2. **Component 2:** Conduct a VAW Prevention BCC materials competition for FSMed/FNU students on 3 categories: pamphlet, poster & TV Spots	• Competition commenced from 16thSept to November • Series of lunch hour sessions from various experts on VAW were conducted weekly/fortnightly at Pasifica and Tamavua Campuses from 16th September 2010 • Competition closed on 29/11/10 • Prizes awarded on 13/12/10 together with the launch of the VAW project results
3. **Component 3**: Conduct a stakeholders workshop to disseminate research findings	• Launch of the VAW project results was on 13/12/10 • Stakeholders workshop was conducted on 16/12/10 • Stakeholders reviewed the research findings & strengthen their strategies based on these findings

3. OBJECTIVES

The research objectives for component 1 are:

1. To ascertain what type of injuries sustained from VAW are seen and recorded in the selected health facilities in Fiji
2. To identify the descriptive characteristics of these injuries
3. To determine whether the health professional staff are appropriately managing these patients in the various health facilities.

The objectives for component 2 are:

1. To create awareness and share experiences on VAW issues to students and staff of tertiary institutions at the Fiji National University/Fiji School of Medicine
2. To develop some new BCC materials on preventing VAW as prevention strategies

The objectives for component 3 are:

1. To discuss and disseminate the results of components 1 and 2 to stakeholders
2. To utilize these findings in the stakeholders activities and programs on VAW prevention strategies in Fiji

4. LITERATURE REVIEW

4.1 Definition of Violence Against Women and Girls

The Declaration on the Elimination of Violence Against Women adopted by the United Nations General Assembly in 1993 provides an internationally accepted definitions of VAWG. **It notes the relationship between the Declaration and CEDAW:**

> *"Recognizing that effective implementation of the Convention on the Elimination of All Forms of Discrimination against Women would contribute to the elimination of violence against women and that the Declaration on the Elimination of Violence against Women, set forth in the present resolution, will strengthen and complement that process."*

Article 1 of the Declaration defines "violence against women" as: "*any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."*

Article 2 states: "*Violence against women shall be understood to encompass, but not be limited to, the following:*

> *(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;*
>
> *(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;*
>
> *(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."* [2]

The term **violence against women** refers to any act that results in, or is likely to result in, physical, sexual and/or psychological harm to women and girls, whether occurring in private or

[2] General Assembly Resolution 48/104, 48 UN GAOR Supp. (N.. 49) at 217, UN Doc. A/48/49.

in public. Violence against women is a form of gender-based violence and includes sexual violence (UNFPA, 2008:9)[3].

The definition of Violence Against Women contained in the United Nations Declaration on the Elimination of Violence Against Women (DEVAW) as: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats or such acts, as coercion or arbitrary deprivation of liberty, whether occurring in public or in private life", (UNIFEM, 2002:27)[4]. It is important to note that both definitions include violence perpetrated both in the public and private spheres of life.

4.2 Gender based violence

Now, "gender-based violence is an umbrella term for any harmful act that is perpetuated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/child marriage; and harmful traditional practices such as female genital mutilation, honor killings, widow inheritance, and others (UNFPA, 2008:10)."[5]

Gender-based violence is an issue associated with the spread of HIV and other STI across the Pacific. Fear of violence reduces the power of women to negotiate safe sex. Violence by men towards women is a serious problem in all Pacific island countries and territories. Gender-based violence includes beating of wives and girlfriends, sexual coercion of girls and women, rape (including rape of wives and girlfriends), violence to sexual minorities, and sexual abuse of children. In at least one Pacific Island country the police are complicit or involved in this kind of violence [6]

4.3 Sexual Violence

Sexual violence, including exploitation and abuse, refers to any act, attempt or threat of a sexual nature that results, or is likely to result, in physical, psychological and emotional harm. Sexual violence is a form of gender-based violence (UNFPA,2008,10)

A piece of work done by AusAID (2008;4), combines all of the above to provide a general descriptive detail of VAW in Fiji, PNG, Solomon Islands, Vanuatu and East Timor as encompassing and including *physical violence* – e.g. slapping, kicking, hitting or use of weapons; *emotional abuse* –e.g. systematic humiliation, controlling behavior, degrading treatment, insults and threats; *sexual violence* –e.g. including coerced sex or being forced into sexual

[3] UNFPA, (2008), AN ASSESSMENT OF THE STATE OF VIOLENCE AGAINST WOMEN IN FIJI 2008 UNFPA Pacific Sub Regional Office, Suva, FIJI

[4] UNIFEM, (2003), Actions to End Violence Against Women; a regional scan of the Pacific 2002 - A Study for UNIFEM, UNIFEM, Suva

[5] USAID and UNICEF: Strategic Framework for the prevention of and response to gender based violence in Eastern, Central and Southern Africa, in pp 10 of UNFPA, (2008), An assessment of the state of violence against women in Fiji 2008 UNFPA Pacific Sub Regional Office, Suva, FIJI

[6] UNDP 2009, Gender and HIV in the Pacific Islands region - A review of evidence, policies and strategies with recommendations, UNDP Pacific Centre,

activities considered degrading or humiliating; and, *economic abuse* – such as restricting access to financial or other resources with the purpose of controlling or subjugating a person[7].

Studies conducted in different Pacific Island countries show that violence against women is prevalent. The Fiji Women's Crisis Centre, which does training, counselling and research on family violence throughout the Pacific, reports that violence against women and children is prevalent throughout the region, across all ethnic and socio-economic groups.[8]

4.4 Reasons for Sexual Violence and Abuse in the Pacific

1. A common cause of violence by men against their wives and girlfriend appears to be refusal or reluctance to have sexual relations. It also seems to be widely believed in different Pacific cultures that a married woman does not have the right to refuse intercourse with her husband. When girls and women are beaten for refusing sex or are forced to have sex, their risk of becoming infected with HIV increases, not only because of greater physical vulnerability but also because they are unable to negotiate safe sex under such circumstances. Women who been beaten by their husband or partner are less likely to report rape even if the rapist is not their husband or partner and more likely to fear HIV testing even if they have not engaged in pre-marital, extramarital or transactional sex.
2. On-going WHO-sponsored research using methodology to produce comparable results is investigating intimate partner violence in different countries around the world. In the Pacific a study was completed in Samoa in 2003, while studies conducted in 2008 are nearing completion for Kiribati and Solomon Islands, using comparable methodology. For Samoa, of the random sample of women aged 15-49 in the survey, 41% of women reported that they had experienced physical violence from an intimate partner, 20% reported experiencing sexual violence from an intimate partner, and 46% have experienced either or both. Twenty four percent of Samoan women surveyed reported that they had experienced severe physical violence (defined as being hit with a fist, kicked, dragged, threatened with a weapon or having a weapon used)[9]. Comparison with 12 other countries showed the rate of violence against women was in the mid range in Samoa.
3. Preliminary data from the Solomon Islands survey shows two out of three women who had ever been in a relationship had experienced violence by their husband or boyfriend. One out of four had experienced violence from someone who was not their boyfriend. One out of 10 experienced beating during pregnancy, and of these one out of five experienced being punched or kicked in the stomach. The findings suggest that the rate of violence against women there is third highest out of 12 other countries surveyed.

[7] AusAID, (2008), Violence Against Women in Melanesia and East Timor: Building on Global and Regional Promising Approaches, Office of Development Effectiveness, AusAID, Canberra. – (A study on Fiji, PNG, Sol. Is, Vanuatu and East Timor).

[8] UNDP 2009, Gender and HIV in the Pacific Islands region - A review of evidence, policies and strategies with recommendations, UNDP Pacific Centre

[9] WHO, 2003. *The Samoa Family Health and Safety Study*. Secretariat of the Pacific Community.

4. Preliminary data from Kiribati survey shows that physical violence was the most prevalent form of partner violence followed by emotional abuse and closely by sexual partner violence. Sixty percent of women reported that they had experienced physical partner violence and 46% of women reported that they had experienced sexual partner violence. Overall, 68% of women reported that they had experienced physical or sexual partner violence, or both. Twenty three per cent of women who had ever been pregnant reported being beaten by a partner during their pregnancy. Seventeen per cent of women who reported experiencing violence during their pregnancy had been punched or kicked in the abdomen while they were pregnant, and 18% of women aged 15–49 reported that they had experienced sexual abuse when they were under the age of 15. [10]

4.5 Forms of VAW in Melanesia

According to AusAID (2008), VAW is severe and pervasive in Melanesia and East Timor. The two most common forms of violence against women in East Timor, Fiji, PNG, Solomon Islands and Vanuatu are: i) physical, psychological and economic violence against women by intimate partners; and ii) all forms of sexual violence perpetrated by intimate partners or others. This is consistent with global trends (ibid; vii);

Fiji

In Fiji, the common forms of violence against women are domestic violence, rape within marriage, sexual violence, and prostitution and trafficking (UNFPA, 2008:11)

Domestic violence refers to violence occurring within a relationship and includes intimate partner violence, violence between family members and sometimes, this extends to other domestic relationships. Domestic violence is not just limited to physical violence but includes sexual violence, emotional/ psychological violence and economic violence (UNFPA, 2008:11). Domestic violence stems from the unequal power relations between partners and involves the use of power and control of one person over another within the relationship.

Accordingly, Fiji Police Force statistics indicated 13% of all Crimes Against the Person in the period from 2003 to 2007 being attributed to domestic violence (UNFPA, 2008; 11). During this time, there were about 82% women victims and 18% men victims. For e.g. in 2007 alone, the Fiji Police recorded a total of 457 cases of domestic violence throughout the country. During the period from 2003-2007, there were fifteen murders committed in a domestic violence setting and of this total 13 of the victims were women. Overall, the Fiji Police Force data indicates a downward trend in cases of domestic violence over the past six years from 2001 to 2007 with a reduction in reporting from 941 cases in 2001 to 457 cases in 2007 (Ibid; 12). However as noted elsewhere, there are differences in VAW incidence reporting to the Fiji Police against those reported to the Fiji Women's Crisis Centre (FWCC) as in Table 1 below.

[10] UNDP 2009, Gender and HIV in the Pacific Islands region - A review of evidence, policies and strategies with recommendations, UNDP Pacific Centre

Table 1: FWCC – New Clients seen 1984 to February, 2010

YEAR	Domestic Violence	Rape	Sexual Harassment	Child Abuse	Others	TOTAL
1984	5	3	0	0	0	8
1985	26	3	0	3	39	71
1986	35	3	0	2	83	123
1987	58	7	0	1	92	158
1988	123	9	0	1	180	313
1989	175	5	0	1	211	392
1990	212	10	0	0	203	425
1991	245	4	0	11	244	504
1992	248	10	0	8	259	525
1993	240	13	0	14	391	658
1994	257	33	0	14	566	870
1995	331	30	0	33	490	884
1996	469	26	0	29	469	993
1997	405	18	5	19	505	952
1998	484	20	15	53	559	1131
1999	544	21	19	24	661	1269
2000	361	25	8	28	595	1017
2001	449	23	10	28	722	1232
2002	429	21	10	33	766	1259
2003	394	26	23	20	643	1106
2004	572	20	12	35	508	1147
2005	480	17	18	42	371	928
2006	420	19	18	41	314	812
2007	441	12	10	27	293	783
2008	386	17	6	38	309	756
2009	373	21	7	57	305	763
Feb 2010	89	4	6	11	48	158
TOTAL	**8251**	**420**	**167**	**573**	**9826**	**19237**

Source: FWCC website: www.fwcc.org accessed 15 Nov., 2010.

In Fiji national research on domestic violence and sexual assault found that 80% of survey respondents had witnessed violence in their home. 66% of women surveyed reported abuse by their partners, 30% of these suffered repeated physical abuse, and 44% reported being hit while pregnant. 74% of female victims did not report violence to the Police or seek medical attention. 13% of survey respondents reported that they had been raped. 74% of perpetrators were known to the victim, and over 30% being relatives. [11]

[11] UNDP 2009, Gender and HIV in the Pacific Islands region - A review of evidence, policies and strategies with recommendations, UNDP Pacific Centre

Sexual assault and harassment was found to be prevalent across all age groups in the Pacific. In Fiji, but the largest group of victims was 11-15 years old. Both Fiji Women's Crisis Centre and Police records show that 95% of perpetrators of domestic violence are male. In the small number of cases where women were violent to men, it was usually in self-defense. Fiji Police Statistics also show that of nine murders committed in the context of domestic violence, seven of the victims were women.

Counselors at the Fiji Women's Crisis Centre said that the number of women who condone violence or believe men have the right to physically punish their wives is higher than reported in the survey. The counselors believe that Fiji Police records are not representative; assault of women is a commonly recorded offence but most women who have been assaulted do not report it, because they have been taught to accept violence, or because of family pressure, or because of fear of reprisals if a complaint is made.[12]

As this study is focused on incidences of violence against women in Fiji in the past 5 years, data provided by FWCC show as in *Table 2* that there is a noted trend for a high incidence of repeat cases which have been reported over the last 10 years (1999 – 2009).
The Fiji Women's Crisis Centre provided assistance 10,353 new clients and 11,978 repeat clients visited all centres from July 1999 to June 2004, in addition to 2,556 counselling sessions by telephone. This includes 3,868 new cases of domestic violence and 543 new cases of sexual assault. Child abuse cases continued to increase with a total of 262 new clients seen for the same period. [13]

[12] Cited in Asian Development Bank (Penelope Schoeffel), 2006**.** *Country Gender Assessment: Republic of the Fiji Islands*. Pacific Regional Department and Regional and Sustainable Development Department, Asian Development Bank, UNDP Manila

[13] 2009, Gender and HIV in the Pacific Islands region - A review of evidence, policies and strategies with recommendations, UNDP Pacific Centre

Table 2: FWCC – New & Repeat Cases of VAW, 1999 – 2009

Yr	D/Violence Cases		Rape Cases		Sexual Harassment Cases		Child Abuse Cases		Sub Totals		Grand Total
	New	Repeat	New	Repeat	New	Repeat	New	Repeat	Tot New	Tot Rpt	G/Tot
1999	544	724	21	41	19	2	24	21	608	788	**1396**
2000	361	368	25	19	8	0	28	24	422	411	**833**
2001	449	391	23	13	10	4	28	27	510	435	**945**
2002	429	377	21	21	10	6	33	38	493	442	**935**
2003	394	448	26	52	23	7	20	19	340	526	**866**
2004	572	472	20	47	12	4	35	21	504	544	**1048**
2005	480	353	17	23	18	1	42	24	557	401	**958**
2006	420	334	19	44	18	4	41	16	498	398	**896**
2007	441	384	12	32	10	2	27	30	490	448	**938**
2008	386	471	17	2	6	0	38	22	447	495	**942**
2009	373	718	21	9	7	3	57	76	458	806	**1264**
Total	**4849**	**5040**	**222**	**303**	**141**	**33**	**373**	**318**	**5327**	**5694**	**11021**

Source: Adapted from statistics on FWCC website: www.fwcc.org accessed 15 Nov., 2010.

4.6 Costs of VAW to Society

There are general costs of VAW that are felt within a society. Violence against women increases health care, social service, policing and justice system costs and results in loss of productivity from both paid and unpaid work (AusAID, 2008: vii)

Recommendations for addressing VAW: Internationally, efforts to reduce VAW must be long-term and focused on addressing structural inequalities together with providing victim support and access to justice. This is a multisectoral approach and there are three main strategies which have proven successful in other countries of the world – increasing women's access to justice, increasing women's access to support and the general prevention of violence[14].

Recommendation to do VAW Research: It has been noted that there is little published, quantitative research on violence against women in the region (AusAID, 2008: vii). Sexual violence, abuse and exploitation in relation to the transmission of HIV amongst Pacific women and girl children has been identified as a priority topic that has remained a gap in HIV research in the region (Buchanan-Aruwafu, 2007). Researchers may wish to collect and analyse data on women's health in the Pacific from the perspective of women. This is because diseases affect men and women differently, may be unique to women, may have different risk and exposure factors and may require different interventions. All of which have long-term health planning implications.[15]

[14] AusAID, (2008), Violence Against Women in Melanesia and East Timor: Building on Global and Regional Promising Approaches, Office of Development Effectiveness, AusAID, Canberra. – (A study on Fiji, PNG, Sol. Is, Vanuatu and East Timor) – Exec summary, viii-ix

[15] **Raghavan-Gilbert, P.,** Gender Issues in Reproductive Health: Let's Get Serious, in, Reflections, UNFPA, Country Support Team for the South Pacific, (1), 1999; 4.

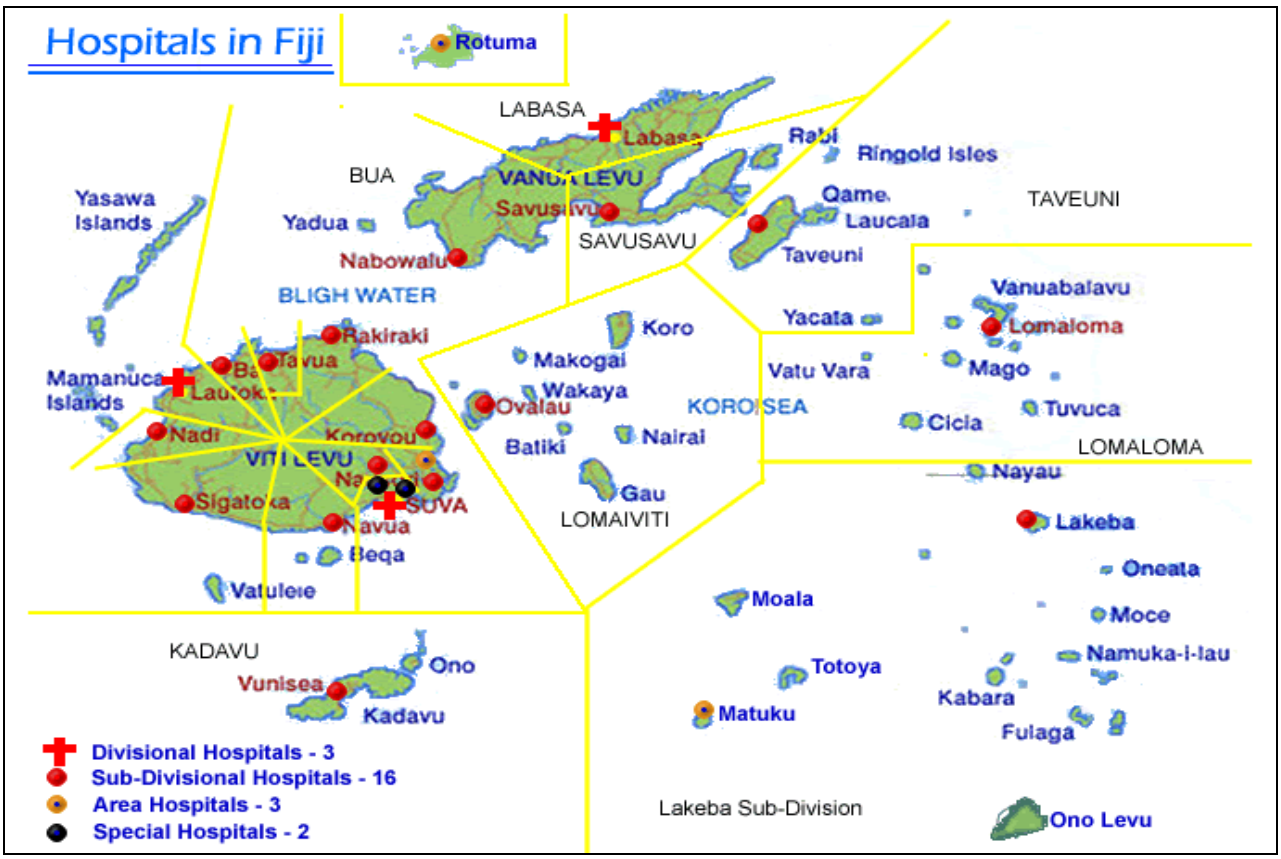
I: COMPONENT 1 – CONDUCT BASELINE PUBLIC HEALTH RESEARCH

5. THIS STUDY

Fiji at a Glance

The general population of the Fiji Islands according to the 2007 census is approximately 837,271 of which 427,176 are males and about 410,095 are females (Bureau of Statistics, 2010)[16]. Of the total population, the indigenous Fijians (475,739) compose the ethnic majority, followed by Indo-Fijians (313,798), followed by other Pacific Islanders (15,311) and Part Europeans, (10,771) - Ibid.

Figure 1: Map of Fiji showing the MOH health facilities



Source: Fiji HIT Report 2010.

Fiji's Health System - Organization of health services and delivery systems

According to the World Health Organisation (WHO, 2008)[17], Fiji's Health services are delivered through 900 village clinics, 124 nursing stations, three area hospitals, 76 health centers, 19 sub

[16] Fiji Islands Bureau of Statistics, (2010), Key Statistics June 2010, Population,
[17] Information adapted from the WHO Western Pacific website:

divisional hospitals and three divisional hospitals and three specialized hospitals for TB, leprosy and Medical Rehabilitation units at Tamavua Hospital and St Giles Mental Hospital. Fiji plays a key role in the development of public health surveillance of eight priority infectious diseases (Pac NET), public health laboratory networks (Lab NET) and targeted outbreak response (Epi NET) under the Pacific Public Health Surveillance Network (PPHSN).

Health policy, planning and regulatory framework

The Ministry of Health Strategic Plan 2007-2011 was developed through extensive consultations with major stakeholders, including the private sector, nongovernmental organizations, central government agencies and senior staff of the Ministry of Health. The Strategic Plan has been developed in recognition of the Government's international commitments, the Government's Strategic Development Plan 2007 to 2011, the major health priorities for the people of Fiji and the planning requirements of the Ministry of Finance and National Planning. The Strategic Plan is also expected to form the framework for the development of annual corporate plans for the Ministry of Health for each successive year, from 2007 to 2011 inclusive.

Table 3: Fiji Health Care Workers (Human Resources) 2006.

Human Resources for Health	Total Number	Rate per 1000
Physicians	315	0.37
Dentists	42	0.05
Pharmacists	40	0.05
Nurses	1,673	1.96
Midwives	-	-
Paramedical Staff	-	-
Community Health Workers	-	-

Source: Adapted from WHO Western Pacific website: www.wpro.who.int/NR... Accessed 15/11/2010

www. wpro.who.int/countries/2008/fj/national_ health priorities.htm – site accessed 15/11/2010

6. METHODOLOGY

This is a selective cross-sectional retrospective study with convenient sampling of the health facilities to obtain data from their A&E and GOPD registers, PATIS and admission registers on Injuries sustained in Violence against women from January 2005 to December 2009.

The selected health facilities were: CWM Hosp, St Giles Hosp, Levuka Hosp, Valelevu HC and Nausori HC in the Central and Eastern Division: Lautoka Hosp, Nadi Hosp, Ba Mission Hosp, Tavua Hospital, Korolevu HC & Naqalimare NS in the Western Division; Labasa Hosp, Savusavu Hosp, Taveuni Hosp, Seqaqa HC & Dogotuki NS in the Northern Division. Permission was requested first to the Minister for Health and the Ministry of Health head office and Ethics Committee approval was obtained before the study was commenced.

Variables that were lifted out from the records were as follows: Age; Ethnicity; Address: rural or urban; Occupation: DD, civil servant, private, other; Presenting complaints; Physical, sexual, emotional or other; Type of Injury: physical assault, burn, use of objects, other; Final diagnosis: types of classification: head Injury, Dental, chest or other; Outcome: treated as GOPD, or admitted as In patient or referred or died; and whether this was reported as Police case.

A Data base was created on the above variables; Analysis of data was made using SPSS and other statistical calculations. The timelines were as follows: from 26/7/10 – 20/9/10 – data collection from the health facilities; from 23/8/10 – 15/10/10 – data entry was completed; from Nov – Dec 2010 analysis & interpretation was done and the report writing in Dec 2010.

7. DATA LIMITATIONS

The data collected may not be representing the true picture of the cases seen of VAW in the MOH health facilities in Fiji but this is an indicative of the disease burden. The data also did not include any patients with VAW from the General Practitioners and the private sector facilities. Double reporting and repeat visit of data may have occurred on VAW patients and this could not be picked up from the records as they are not indicated in the registers.

Detailed accounts of injuries were also not properly documented as they were just generalized. There was also poor record noted from the referral at A&E/GOPD for admission in that same hospital or to a higher health facility. There is limited information on the VAW patients available at the A&E/GOPD records.

The VAW pregnant patients could not be picked up in this study because the ANC registers were not included. There are also no records of deaths obtained from these data as they were not reflected in the data sources.

8.0 RESULTS - FINDINGS & DATA ANALYSIS

A. HEALTH PROFESSIONALS RESPONDENTS TO QUESTIONNAIRE

8.1 Descriptive Characteristics

The Total sample size that answered the questionnaires was 98 health professional staff from a total of 16 health facilities sites. There were 17% males and 83% females; with 63% Ethnic Fijians, 27% Indo Fijian; 9% of other ethnic origin and 1% did not state their ethnicity.
In terms of religious beliefs: there were 74% Christian, 20% Hinduism, 2% Islam and 45 come from other religious groups.
In the health professionals by designation: there were 14% Doctors, 17% Dentists and 69% Registered nurses. Their work locations are from: GOPD/A&E section was 20%; Sub divisional Hospitals were 39%; Specialist Hospitals was 12%; HC was 20% and 3% in NS. With their years of service in that particular health facility : 56% were employed for up to 3 years, 23% in 4-6 years, 6% in 7-10 years, 9% in 11-14 years, and 6% were employed for more than 15 years.

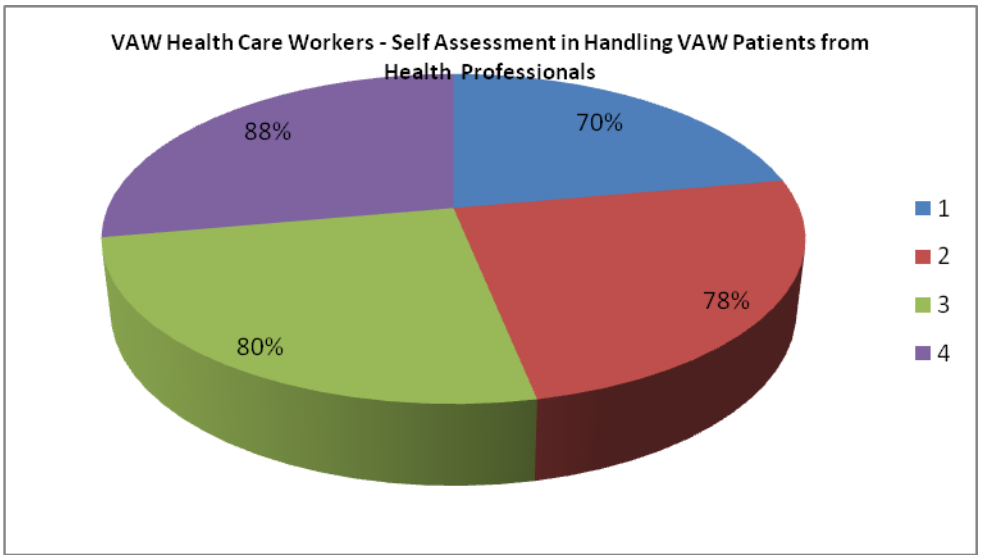
8.2 Self Impressions and assessment:

With Clinical perceptions, 70% of health professionals are comfortable in consulting and examining a woman who is a victim of violence; 13% very comfortable; 6% uncomfortable and 10% were very uncomfortable in consulting VAW client.

In terms of the knowledge on definition of VAW: 15% of the health staff defined it as violence against women; 4% - state Violence directed at a woman in the home by an intimate partner e.g. husband, boyfriend, etc; 3% - Violence directed at women outside the home by an intimate partner e.g. husband, boyfriend, etc; and 78% of them included all the above definition.
Their impression: on the content of basic medical or nursing training to consult and manage women victims of violence, 40% state there is Low content and 10% very low content; 42% state good content and 8% say there is very good Level of content on VAW clinical management and other related issues in the medical & nursing curriculum.

Regarding their impression of their self-confidence in consulting and managing women who are victims of violence, 71% have a Good Confidence Level and 9% have very good Level of Confidence; 17% have low Confidence and 3% with very Low Confidence is 3%.
In their Self Assessment regarding the VAW clinical management training needs analysis, 88% said in that they needed some kind of capacity building and 12% stated that they did not need any training. Of those that stated yes, 21% require training in - Medico legal aspects, 13% on Clinical management aspects, 29% on psychological Counseling techniques and 64% require training in all of the above mentioned areas.

Figure 2: Self Assessment of Health Professionals in Handling VAW Patients



Key:

1-	70%	Comfortable in Managing VAW Patient
2-	78%	Very Good Knowledge & Definition VAW
3-	80%	Good Confidence in Consulting & Managing VAW Patient
4-	88%	Need VAW Clinical management & Other Training

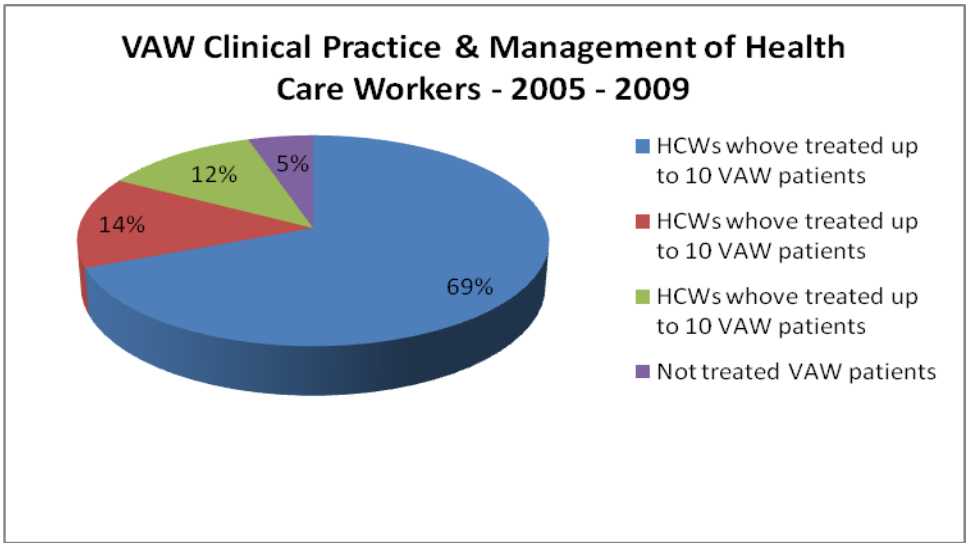
8.3 Clinical Practice and Management

67% of health professionals only sometimes ask every women in VAW consultation if she had had a repeated experiencing of any form of violence in the past; 14% asked about it most of the time; 10% asked all the time and 9% of them never asked.

For specific presenting complaints: 32% of health professionals will think of VAW when a woman present with abnormal menstrual bleeding, 55% will not think about VAW and 13% were unsure. 75% of health professionals will think of VAW if the woman presented with mental symptoms of anxiety, 19% will not think about it and 6% were unsure. 61% of the health professionals will think of VAW if the woman presented with Chronic pain, 32% will not think about it & 7% were unsure whether they will think about it or not. 51% of health professionals will think of VAW if she presented with weight loss, 41% will not think about it and 8% were unsure. 95% of health professionals will think of VAW if she presented with physical marks of injury such as bruising or bleeding, 2% will not think about it and 3% were unsure.

Since 2005, 66% of the health staff has professionally attended to women who are patients of violence and 34% have not. From Jan 2005 - Dec 2009: 95% of the health professionals have treated VAW patients with 69% o them treating up to 10 patients, 14% treated up to 20 patients, 12% treated more than 20 patients, 2% cannot remember and 3% of the health professionals did not state anything about treating VAW patients. Of these patients: 7% of the health professional staff state that all the VAW patients they had treated had more than one violent attack in the past, 76% state that some of them had more than 1 violent attack and 17% of the patients were first timers.

Figure 3: VAW Clinical Practice by Health Care Workers in MOH



8.4 Assailants

The health professionals stated that 96% of the VAW patients know the assailant under these categories: 45% were their current boyfriend, 43% were close family relative, 32% were their divorced husbands, 29% were VAW patients' neighbors, 27% were their separated husbands, 26% were ex-boyfriend, 16% were their current female sexual partner, 16% were the VAW patients work mate, 16% were friends who have no intimate relationship with the VAW patients, 15% were children of the VAW patients, and 8% were former female sexual partner. In 4% of the VAW patients, the assailant was a stranger to the VAW patient.

The common methods used by the assailant to cause physical or psychological injury to the women in these acts of violence are as follows: 86% from physical abuse as in assault: punching; 74% had verbal abuse – as in swearing; 67% were hit with slapping; 68% were assaulted through kicking; 49% were assaulted through a blunt object –such as wood, rope or belt; 36.7 % were hit or stabbed with sharp objects - e.g. knife, broken bottle; 19.4% were due to burning; 1-3% were due to other injuries such as: forced to sleep outside house, refused to be given food, refusal to breastfeed child by husband and family, psychological trauma - (critics), forceful sex, rape, sexual intercourse, sexually abuse, sexually violence, using embarrassing words to VAW patients in front of people and Verbal threats.

With the status of their mind, the assailants or perpetrators at the time in causing the violent injuries: 70% of them were sober; 74% had alcohol intoxication; 30% were intoxicated with drugs; 38% were intoxicated with yaqona; 9% were known mental patient or of unsound mind.

8.5 VAW patients:

With the state of mind of the victims in the consultation period at the health facilities: 68% were crying; 50% were blank and in state of shock; 50% were calm and cooperative; 17% were combative, abusive and uncooperative; 14% the woman was a known mental patient of unsound mind.

The Commonest way in which the VAW patient arrives at the health facility are: 70% brought by relatives; 61% came by herself; 61% were brought in by the Police; 38% brought in by parents 35% by friends; 22% were brought by the assailant; 15% by fellow workers; 12% not sure how they arrive; 11% by health workers; 9% by social/NGO workers; and 6% by religious workers.

In the time of arrival to the health facility for treatment for the first time, the VAW patients came: 61% Less than 6 hours after the violent attack; 48% arrive between 6-12 hours after the attack; 55% arrive after 24 hours; 30% arrive several days after the attack; 18% arrive week after the attack; and 19% arrive more than 1 week after the attack.
The main injuries that were seen by the health professionals in these VAW patients were: 85% facial & scalp, 59% Jaw injuries, 51% Upper limb injuries, 50% head injuries, 31% Lower limb injuries, 30% Attempted Rape, 21% Chest injuries, and 13% were Abdominal injuries.

The Treatment offered by health professionals in the health facilities from Jan 2005 to Dec 2009 were: 56% only require Minor First Aid (include ice packs and analgesics); 73% had moderate severity injuries requiring frequent return Outpatient Visits (stitching, dressing); 45% had severe injuries, require Inpatient Treatment (Altered Conscious levels, require head injury observation, fractures major bones, bleeding; 17% would be classified as - life threatening injuries require emergency surgery or intensive care treatment. The ordering of further blood and radiological investigations were only done by 47% of the health professionals who will only do it if absolutely necessary.
93% of the health professionals stated there is no Written Policy available on the Management of Women who receives injuries through violent acts within MOH.

8.6 Notification of VAW

For the notifications of VAW patients: 39% of the health professionals always report it to the police and 33% does it only at times; 29% do not report it at all. 49% of the VAW patients are referred to counselors for counseling with: 20% to WCC, 7% to religious organization, 5% to St Giles Hosp, 13% to others. Only 6% report it and refer patient to WCC, 20% report it sometimes only and 74% never report it.
34% of health professional has filled a police medical report. 60% keep a Copy of the report in the patients' folder; 14% in the Police record book, 3% in the A&E Register and others. 5% of the health professionals have been summoned by the Court to give testimony on a VAW case.

B. DATA FROM FIJI HEALTH FACILITIES

8.7 Descriptive

This research component involved the collection of data on cases of violent incidents which were presented at the A&E, GOPD, PATIS and inpatient registers in selected MOH health facilities in Fiji. The data collected were records written committed on women and girls from the ages of 1 to 90 years, in the last 5 years, i.e. January 2005 to December 2009. Data was collected from sixteen (16) health facilities in the 4 national health divisions of Fiji – the Northern, Western, Central and Eastern divisions; specifically from the divisional and sub-divisional hospitals, health centres and nursing stations (*Table 4 and refer Figure 1*).

Table 4: Selected Health Facility Sites by Division – VAW Study, 2010)

Health Facility	Divisions			Total Facility No.
	Northern	Western	Central and Eastern	
National & Divisional hospitals	Labasa Hospital	Lautoka Hospital	Colonial War Memorial Hospital, St. Giles Hospital	4
Sub-divisional hospitals	Savusavu; Taveuni	Nadi Hosp; Ba Mission; Tavua Hospital,	Levuka Hospital;	6
Health centres (HC)	Seaqaqa HC	Korolevu HC,	Nausori HC, Valelevu HC	4
Nursing stations (NS)	Dogotuki NS	Naqalimare NS	-	2
Total	5	6	5	16

Source: Fieldwork, Aug-Sept, 2010

The type of data collected for this part of the study involved tallying the total number of individual cases presented at each of the facilities. For each of the sites, tallies were recorded for each patient's age, ethnicity, marital status, urban or rural residence, occupation, complaints presented at the health facility, the types of abuse and injury presented, the outcome for the patient, whether the case was reported to the police or not and, the identification of the perpetrator of the injury. These variables were chosen because they were the common information required of each patient at the facilities.

The information was collected from various handwritten physical records kept at each of the facilities and were manually counted for this study. It is important to note at the outset that the quality and accuracy of the data gathered for this study largely depended on the recording methods adopted by the health facilities. While there were instances where all of the variables were recorded for each case, there were many more where the information about each patient (including the types of injuries and abuses suffered) was sketchy and brief therefore not providing much needed information.

Furthermore, there was also the issue and possibility of repeat cases presented at the health facilities. Where FWCC has meticulously noted the number of repeat cases presented to their organization over the years (*Table 2*), there is no such indication appearing in the health facility records to facilitate accuracy in record keeping and importantly, to effect sound treatment and care for a VAW patient. Therefore there is likelihood that there had been double, triple or more counting for a single patient in this study because the study did not record the names of VAW patients.

The importance of accurate record and data keeping must not be underestimated. There is a need to maintain timely and accurate records at the health facilities to effect wholesome treatment and to assist in behavior change interventions for health care workers, violence and gender-based NGOs, government and the general public.

As this was a pilot project and situational analysis for only the last 5 years, the results below have been compiled from an initial foray into record books that were made available to the research team.

8.8 Number of Cases Presented

For the period of January, 2005 to December, 2009, there were 3,027 recorded incidences of injuries and/or abuse inflicted on women and girls that were presented at the seventeen health facilities in this study (*Table 5*).

Table 5: Total Number of VAW Cases Presented at Selected Health Facilities – 2005 - 2009

Health Facility	Name of Facility	Total Number of Cases	Percentage (%) of Total
Divisional hospitals	*Colonial War Memorial Hospital (CWMH)*	99	3.3
	Lautoka Hospital	370	12.2
	Labasa Hospital	93	3.3
	St.Giles Hospital	0	0
Sub-divisional hospitals	*Levuka Hospital*	106	3.5
	Nadi Hospital	866	28.6
	Ba Hospital	476	15.7
	Tavua Hospital	90	3.0
	Savusavu Hospital	214	7.1
	Taveuni Hospital	206	6.8
Health Centres	*Valelevu Health Centre*	416	13.7
	Nausori Health Centre	0	0
	Korolevu Health Centre	62	2.0
	Seaqaqa Health Centre	28	0.9
Nursing Station			
	Naqalimare Nursing Station	0	0
	Dogotuki Nursing Station	1	.0
Total		**3,027**	**100**

Source: Fieldwork, Aug-Sept, 2010

There are many interpretations for the figures in Table 5 above. While the majority of cases of violence were reported from health facilities located in the western and northern divisions of Fiji, this could also mean that records were better kept at those same facilities. The numbers for the main hospital in Fiji – CWMH (99) – and those recording 0 or very low statistics indicate existence of issues of record keeping, issues of reporting at health facilities and even issues of under-reporting.

There is a need to conduct further studies on the issues of VAW reporting and recording at health facilities such as identification of cases, reporting of those cases, their treatment and follow up.

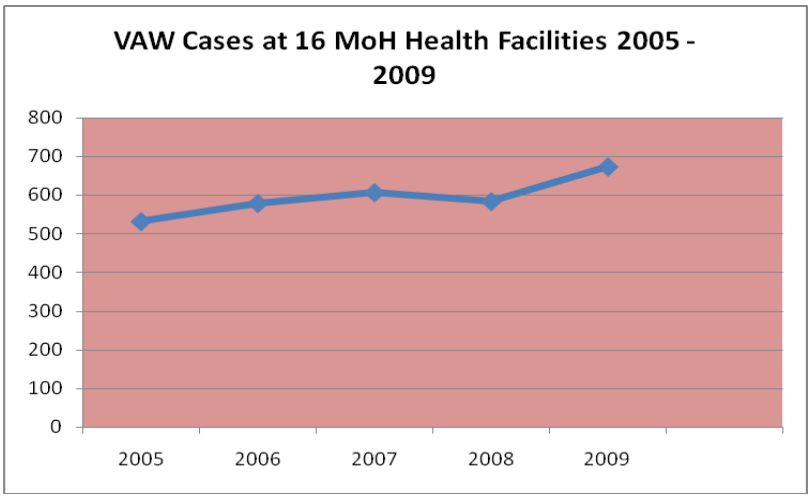
The total number of cases recorded in these 16 health facilities in the past 5 years from 2005 to 2009 showed a steady increase over the 5 years from 2005 to 2009 with a slight decrease in 2008. In 2005 there were 532 cases, 2006 had 579 cases, 2007 had 607cases, 2008 had 584 cases, there were 674 cases recorded for 2009; 51 cases were not dated in the records.

Table 6: No. of VAW Cases Presented to Fiji's Selected Health Facilities 2005 - 2009

Year	Total No. of Cases
2005	532
2006	579
2007	607
2008	584
2009	674
Sub-total	2,976
Cases Not Dated	51
Total	3,027

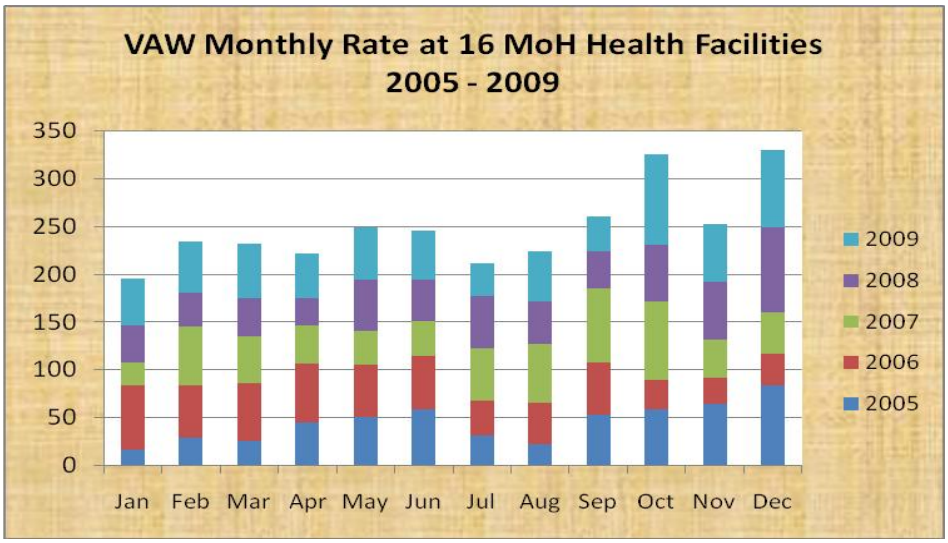
Source: Fieldwork, Aug – Sept., 2010.

Figure 4: VAW Cases 2005-9 in 16 MOH facilities



Source: Fieldwork, Aug – Sept., 2010.

Figure 5: VAW monthly rate at selected MOH facilities 2005-2009



Source: Fieldwork, Aug – Sept., 2010.

Table 7: VAW Record by Month 2005 - 2009

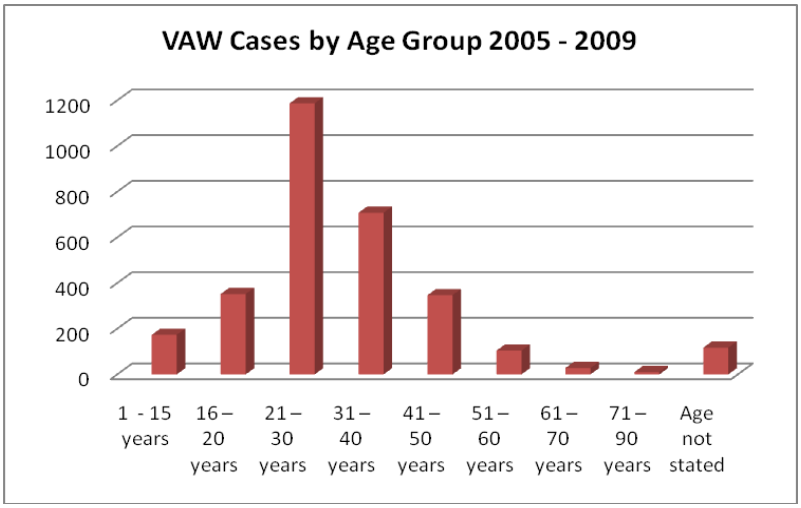
Months/Years	2005	2006	2007	2008	2009	Total
January	16	67	24	39	49	195
February	28	55	62	35	54	234
March	25	60	49	40	57	231
April	45	61	40	28	47	221
May	50	55	35	54	55	249
June	58	56	37	43	51	245
July	31	36	55	55	34	211
August	22	43	61	45	53	224
September	52	55	78	38	37	260
October	58	31	82	59	95	321
November	64	27	40	60	61	252
December	83	33	44	89	81	329
Total	532	579	607	585	674	3027

Source: Fieldwork, Aug-Sept., 2010.

8.9 Age & Ethnicity of Patients

Of the total patient records, 91 records did not include the age of the patient and 2 records did not include the ethnicity of the patient. These were variables that were commonly recorded into the records used at the General Outpatients Department (GOPD), the Accidents & Emergencies (A&E), Patient Information System (PATIS) & police records at the health facilities. Patients in the age groups of from 1 to 90- years of age presented their injuries at the selected health facilities in this study. Ethnicity: F (54%) I (43%) O (3%); Marital status: 49% married, 13% single, 38% did not state & others; Age: majority (39%) were in 21-30 yrs, 23% were in 31-40yrs, then 12% each for the 16-20 yrs and 41-50yrs. Vulnerable age groups: 6% in 1-15years and 1% in 61-90yrs. The majority of VAW patients (31%) were between the ages of 21 and 30 years had visited a health facility with some form of physical and/or sexual violence and abuse in the last 5 years.

Figure 6: VAW cases by Age group 2004-9 in selected MOH Facilities



Source: Fieldwork, Aug – Sept., 2010.

Table 8: Age Range by Ethnicity by Mean of VAW Patients from Selected Health Facilities 2005 – 2009

Age Range	Ethnicity				Total No. of VAW Patients per Cohort	
	Indo-Fij	Fijian	Others	Not stated	Number	Mean Age
1 - 15 years	73	89	13	0	175	10.4
16 – 20 years	119	221	13	0	353	18.2
21 – 30 years	500	660	27	1	1,188	25.6
31 – 40 years	287	401	21	0	709	35.0
41 – 50 years	180	149	19	0	348	44.8
51 – 60 years	64	38	3	0	105	54.8
61 – 70 years	17	12	0	0	29	64.5
71 – 90 years	8	3	0	0	11	78.2
Age not stated	6	11	1	0	18	0
Total	**1254**	**1584**	**97**	**1**	**2,936**	

Source: Fieldwork, Aug – Sept., 2010.

8.10 Girl Children

There were 175 girl children between the ages of 1 – 15 years who had presented physical and/or sexual violence and abuse injuries at the selected health facilities in the last 5 years. At least 70 of those children were aged less than 10 (*Case Study A*).The instance of violence reported for this age group seemed to increase as children grew older.

8.11 Marital Status

The marital status of a good number of patients (36%) was not reported. The majority of those recorded were married patients (49%) with an equal distribution of married women living in urban areas (44%) and in the rural areas (45%) of Fiji. About 13% of the women stated they were single and there were a few involved in de-facto relations (1.5%), divorced (.4%) or widowed (.2%). The majority of those living in de-facto relations were reportedly living in urban areas.

8.12 Occupation

About one fifth of the VAW patients did domestic duties (22%) while some were civil servants, (46 - 1.5%), working in the private sector (0.7%) or other (9.1%). The records did not state the majority of the patients' occupation (67.1) and this could have included students, toddlers and house helps, amongst others. Whether the occupation of the patient bears significance as a health record needs to be further considered. While the occupation variable might be convenient to assess medical insurance for medical costs, there is little benefit for this variable appearing in general health and medical records.

However, the occupation variable can be put to good use if violence versus socio-economic status study or profiling of VAW patients was done to link socio-economic status to violence incidence and prevalence from a public health perspective is held. The degree and intensity of violence perpetrated however cannot be determined by the socio-economic status of a woman alone and must be considered against many other factors.

Case Study A: The Girl Child Presenting Violence at a Health Facility. There were 175 reported cases of violence against girl children who were aged between 1 and 15 years old in this study of which 70 were aged below 10. 106 of the recorded cases were of physical abuse and 59 were of a sexual nature. The types of injury presented recorded 22 of the children suffering head and neck injuries, another 118 suffered general body injuries, 14 recorded both, head and neck and body injuries while 21 records did not state the type of injury at all. There were 16 cases of sexual abuse and 38 cases of physical abuse amongst this group whose final diagnosis was noted as 'assault', in this study. 16 of the total 137 reported cases of sexual assault and 38 of the total 2,499 cases of physical abuse in this study, was recorded for this age group. Of the 175 total cases of child violence recorded, 115 were reported to the Police. Of that total, 93 cases were treated at the GOPD, 1 was admitted the final outcomes for 21 were not recorded. In 44 of the 175 cases, girls or women who were friends, mothers or mothers in law (11 cases) were perpetrators of violence. The rest of the cases recorded male friends, husbands (2), relatives and in-laws as perpetrators of violence.

8.13 Urban & Rural Distribution

There was an equal distribution of VAW patients living in urban areas (44%) and rural areas (43%) of Fiji. There was no record of addresses for the remaining 13% of patients. Again, the relevance and importance of the residential or work address being supplied and noted in a health record is brought into focus. In its current use, this information (like ethnicity, occupation and age) is only used as an identification marker.

This information (and other identification markers in medical record keeping) could be used by health care workers to profile distribution/prevalence of violence cases by geographic location, by occupation, by age groups, etc to design and implement appropriate interventions to address VAW issues and effect behavior change in society. Should this avenue be considered to address VAW issues in the community, triangulating this information from public health records, with those available at the various Police Stations against those statistics provided by the various branch offices of FWCC can be beneficial for all stakeholders.

8.16 Presenting Complaints

The women presented at all the health facilities with a history of assault: with 58% due to body injuries: 25% were due to head & neck, 14% were body, head & neck injuries and 3% were due to other injuries.

Presenting complaints are those complaints that patients go with to the health facilities. The majority of the complaints presented at the various health facilities in this study were those of body injuries (58%). The second most common presented complaint was that of head and neck injuries (25%), followed by 14% of patients complaining about both, body and head and neck injuries. The remaining 3% of complaints were not stated in the health records perused in this study and appeared only as 'assault' cases.

Typical record entries would note the following phraseology as presenting complaints:

"Slapped by father"...;
"Assaulted by: husband; ...father; ...Indian male;...brother; ...Indian woman; ...
punched in face; "
"beaten by electric wire..."
"assaulted, cut upper lip..."

8.15 Types of Violence & Final Outcomes

For this study, there were two major types of violence that were considered – physical and sexual violence. There were other forms of violence that were noted in the records of patients. Of the total 3027 cases, 83% of patients had suffered physical abuse, 4.5% had experienced sexual abuse and 0.3% had experienced other forms of abuse. The remaining 12.5% of VAW cases were not clearly classified under any of the above categories in the records (Table 9).

Table 9: Health Facility by Abuse Type 2005 – 2009

Health Facilities	Physical abuse	Sexual Abuse	Not stated	Total
CWM Hospital	78	18	3	99
Valelevu Health Centre	408	2	6	416
Levuka Hospital	85	5	16	106
Nadi Hospital	706	30	130	866
Lautoka Hospital	299	6	65	370
Ba Hospital	409	16	51	476
Tavua Hospital	51	3	36	90
Korolevu Health Centre	40	1	21	62
Labasa Hospital	80	1	12	93
Savusavu Hospital	146	19	49	214
Taveuni Hospital	170	35	1	206
Seaqaqa Health Centre	26	1	1	28
Dogotuki Nursing Station	1	0	0	1
TOTAL	**2499**	**137**	**391**	**3027**

Source: Fieldwork, Aug – Sept., 2010.

Noting the limitations of the data collected for this study, there were higher numbers of physical than sexual abuse recorded at all the selected health facilities. The difference between the numbers of physical and sexual violence raises issues on a number of things; whether there was sufficient awareness and/or training to acknowledge the possibility of sexual violence generally associated with physical violence; whether health care workers can detect signs of sexual violence and abuse for each case and whether there are existing definitions of physical and sexual violence in place to assist health care workers treat and manage patients of violence for women and the general public.

It is recommended that further research be conducted to address the questions of VAW awareness, treatment and management in public and clinical health within Fiji's health system.

The general final outcomes for any patient at a hospital include treatment at GOPD and being sent home, admittance into the hospital, referral to a higher health facility within the divisional health system, or one dies. In the context of this study, of the 3027 records of patients, the majority (2119 – 70%) were treated at GOPD and sent home on the same day. About 5% were admitted into hospital while there was a recorded case of a patient being referred to a higher facility. Unfortunately, about 26% of patients' final outcomes were not recorded. There were no recorded cases of death for VAW patients and this may be interpreted in a number of ways; that the proper record book for this outcome would have been elsewhere and not at GOPD, A&E, PATIS or within the police reports held at the facilities, or, that the VAW patient was brought in dead so that there was no record of the case at the beginning.

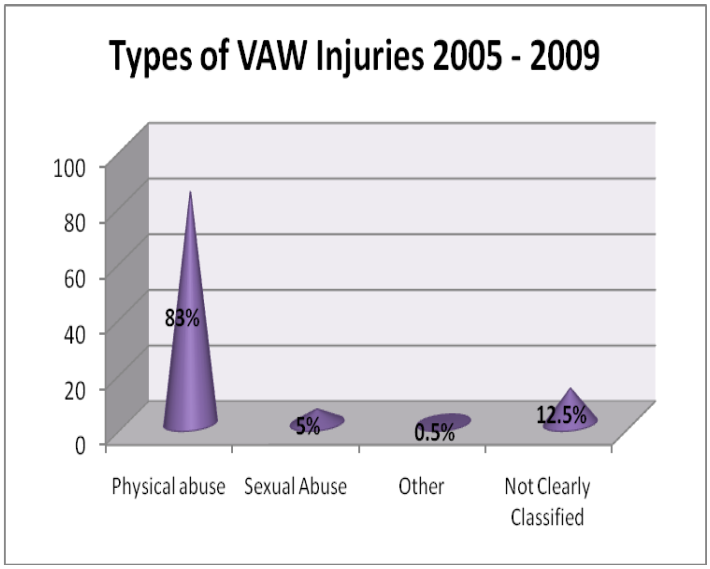
8.16 Physical Abuse & Outcomes

There were 2499 patients who presented complaints of physical violence and abuse. Of these about 1902(76%) of the patients presented their complaints at GOPD and were sent home after treatment. Another 105 patients were admitted and 1 was referred to a higher health facility. There were 491 entries which did not state the final outcomes for those respective patients. Furthermore, there were about 21 cases of patients suffering both, physical and sexual violence who presented their complaints at GOPD in this period while there was 1case of a physical and sexual violence patient, being admitted.

8.17 Sexual Abuse & Outcome

There were 137 cases of sexual violence recorded in this study. Of these, 87 patients presented at GOPD. About 21 of those 87 cases were both, sexual and physical violence in nature. Another 22 patients were admitted into the hospital and 28 records did not note the final outcome for those respective patients.

Figure 7: Types of VAW Injuries 2005-9 selected MOH facilities



Source: Fieldwork, Aug – Sept., 2010.

8.18 Types of Injury

The general classifications of injuries used in this study were head and neck injuries, body injuries and those that reported both, head and neck injuries as well as body injuries. Therefore, the total 3027 VAW reported cases included 43% of body injuries; 25% of head and neck injuries, 14% of both head and neck and body injuries, and 18% of cases that did not specify the type of injury inflicted upon the patient.

8.19 Final Diagnosis

There were 717 VAW cases of assault, 12 cases that were reported as 'other' than assault, and a very high number (2298) of records that did not state the final diagnosis for those patients. The recorded assault patients displayed head and neck injuries (158), body injuries (453), both, head and neck and body injuries (95) and others (11). However, there were 586 head and neck injuries, 857 body injuries, 324 patients inflicted with both classifications of injuries and another 532 patients whose status for final diagnosis was not recorded. There is a possibility that a good portion of this bulk of patients' cases would have also been classified as assault cases. Hence, 25% of the final diagnosis were due to assault, 76% of the cases did not have any diagnosis, and 0.5% were recorded as other diagnosis.

8.20 Perpetrators of Violence

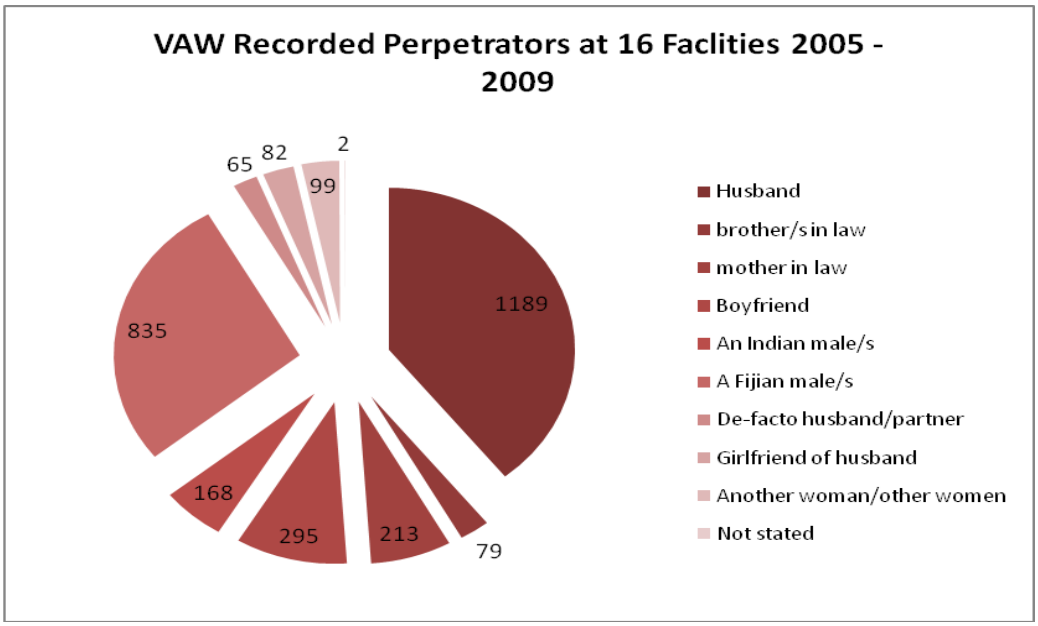
It has been reported in most literature that perpetrators of violence, whatever its form, is known to the victim (in this case the patient); the findings from this study have revealed a similar trend. Perpetrators have mostly been the spouses, partners, in-laws, friends, and relatives of the VAW patients (*Table 10*).

While most reports have listed males to be most likely perpetrators of violence against women, it is interesting to note the high numbers of female perpetrators. This point is raised here so that appropriate interventions addressing VAW do not only target men but include women and girls as well.

The highest number of perpetrators of violence in this study was male spouses: husbands (1189 – 39%); boyfriends (295 -10%) and de-facto partners (65 – 2.1%). They made up 1,549 of the 3,027 cases (51%). The second highest category of perpetrators were only listed as 'an Indian male/s 6 %); a Fijian male/s' (28%) in the record books at the various health facilities. The 'indian male' or 'fijian male' labels could be hiding real identities such as brothers, husbands, partners, fathers, and others who are linked in some way to the patient of violence.

There is a need to change reporting methods for VAW patients' records so that the two ambiguous categories may become specific. This change is suggested to facilitate interventions that are targeted at specific sections of society and therein bring about behavioral change.

Figure 8: Assailants for VAW Patients 2005-9 in selected MOH facilities



Source: Fieldwork, Aug – Sept., 2010.

8.21 Reporting of Case to the Police

Given the implementation of the reconciliation and 'No- Drop Policy' by Fiji Department of Police, it would be interesting to establish the implementation and effectiveness (or otherwise) of this policy within the health system in Fiji. There was a probe to establish whether incidents of violence against women & the girl child were reported to the Police, included into this study. According to the findings of this study, about 589 of the total 717 assault cases were reported to the police. The same can also be said of the other 1151 cases that were not recorded as 'assault' in the records. The fact that those cases were referred to the Police despite not being recorded as assault cases in the health facility records implies the severity of the violence, abuse and eventually, the injury. Therefore, of the total 3.027 patient records of VAW, a total of 1,868 (62%) cases were reported to the Police in the period of this study. It is heartening to note that more than half of the cases had been reported to the Police. This is an indication that advocacy and prevention work by government and some NGOs such as the FWCC are working and effecting change in society. Simultaneously, the high number of cases not reported to the police (1286) should remain a high concern and steps should be taken to address this.

The high number of non reported cases indicates the need for effective counseling and treatment for the patients to empower them to make a decision to report those cases to the Police and therein cease or reduce the instances of violence they are experiencing. There is also need to provide clinical treatment along with sound and timely counseling to VAW patients to facilitate and manage wholesome treatment. It is important to remember that physical and sexual violence are largely accompanied by verbal and emotional violence and abuse.

All forms of abuse have lasting effect (if not managed and treated properly over time) on the physical, psychological and mental health of a patient. Violence negatively impacts the self esteem, identity and dignity of a human being and their effect and impacts seep into the family and communities of affected people. Policies, programs and activities in the health and clinical management and treatment of patients of violence whether women, children or men are needed to address all the issues surrounding violence. Indeed, violence and its impacts and effects can be directly linked to the health of a person, family, community and nation.

Increasing Rate of Violence with Increasing Age of Children: 2005 – 2009

Table 10: Children's Age by Physical & Sexual Abuse 2005 – 2009

Child's Age	Physical Abuse	Sexual abuse	Total
1	3	0	3
2	2	1	3
3	7	1	8
4	3	2	5
5	0	2	2
6	6	1	7
7	3	7	10
8	4	6	10
9	4	3	7
10	6	2	8
11	9	2	11
12	10	0	10
13	11	9	20
14	20	14	34
15	18	9	27
Total	**106**	**59**	**165**

Please note: The 10 not noted here did not state the type of abuse suffered by the child.

9. COMPONENTS 2 AND 3

II: COMPONENT 2 OF VAW PROJECT FIJI 2010 - BCC MATERIALS STUDENT COMPETITION

The VAW Prevention BCC materials competition was conducted for the FSMed/FNU students on 3 categories: pamphlet, poster & TV Spots. A series if VAW lectures were also conducted in the 3 campuses at Pasifika, Tamavua and at the Fiji School of Nursing during the September – October 2010 period to create more awareness on VAW issues amongst the staff and students of the College of Medicine, Nursing and Health Sciences/Fiji National University.

Ten (10)applicants were received from the students and the winners are:

- TV Spot – Wilisoni Tigarea – MBBS 4 student from Fiji
- Poster – Simon Wale – MBBS 6 student from Solomon Islands
- Brochure/pamphlet – Wilisoni Tigarea - MBBS 4 student from Fiji

Copies of the winning Poster and brochures are in Annex 2
Evidence of the 2010 VAW Project launch on 13/12/10 is in Annex 3

III: COMPONENT 3 OF THE VAW PROJECT FIJI 2010 – STAKEHOLDERS' WORKSHOP TO DISSEMINATE THE RESULTS OF COMPONENTS 1 AND 2

A workshop was conducted on 16th December 2010 at the Tanoa Plaza Conference room, Suva for 30 participants representing the various VAW stakeholders. These included the FWCC, Fiji Women's Action for Change, Soqosoqo Vakamarama, Ministry of Women and Social Welfare, Church and religious groups, PCASS, Ministry of health, Fiji School of Nursing, Fiji School of Medicine/College MNHS and World Health Organization.

The objectives of the workshop were attained.
The detailed information of this activity is in Annex 4

10. CONCLUSION

The VAW disease burden is in existence in the MOH health facilities in the 3 Divisions. A lot of insights on VAW from the three perspectives: VAW patients, assailants and the clinical service providers have been revealed. Health staff have made self impressions and assessments on their practice and identified interventions strategies to improve their clinical management in the service provision for VAW patients.
Ten (10) new original and dynamic BCC VAW materials were developed and now available for printing and dissemination.

Detailed results on findings and discussions were shared in the VAW Stakeholders workshop held on 16/12/10.

11. RECOMMENDATIONS

The recommendations are mainly Issues identified to improve the clinical management of VAW patients more effectively by the health professionals such as to:

WHO or donor agency

1. Conduct a more in depth secondary analysis of this existing data to triangulate and cross tabulation with literature review data from the FWCC and FPF.
2. Conduct further VAW related researches given the findings of this baseline study

Ministry of Health

1. Establish a specialized counseling unit within the health facility premises where a counselor, social worker, religious personnel and others can be available 24 hours to attend to VAW patients.
2. Develop VAW policy and clinical management guidelines in MOH in a holistic approach
3. Develop & maintain a proper information system integrating it within the existing HIS in MOH on timely and accurate records at health facilities to effect wholesome treatment and to assist in behavior change interventions for patients and perpetrators, health care workers, violence and gender-based NGOs, government and the general public.

4. Maintain timely and accurate records at the health facilities to effect wholesome treatment and to assist in behavior change interventions for health care workers, violence and gender-based NGOs, government and the general public.
5. This information (and other identification markers in medical record keeping) could be used by health care workers to profile distribution/prevalence of violence cases by geographic location, by occupation, by age groups, etc to design and implement appropriate interventions to address VAW issues and effect behavior change in society. Should this avenue be considered to address VAW issues in the community, triangulating this information from public health records, with those available at the various Police Stations against those statistics provided by the various branch offices of FWCC can be beneficial for all stakeholders.

Fiji School of Medicine/FNU

1. Conduct further secondary analysis of the primary baseline data collected in this research to cross tab with other existing data available from the literature to develop and strengthen VAW intervention strategies.
2. Conduct training on VAW clinical management, medico-legal issues, counseling in all aspects including spiritual & other related areas
3. Conduct further studies on the issues of VAW reporting and recording at health facilities such as identification of cases, reporting of those cases, their treatment and follow up.
4. Conduct further secondary analysis of the primary baseline data collected in this research to cross tab with other existing data available from the literature to develop and strengthen VAW intervention strategies.
5. Develop/strengthen curriculum on Injury for VAW patients for health professionals in both undergrad and post grad courses offered at FNU

MOH, FWCC and other Stakeholders

1. Conduct and strengthen more community awareness programs on VAW issues. VHW to play a lead role in this at the community level.
2. Strengthen/formalize referral networks with NGOs on counseling and proper follow up of VAW patients, and also with the Police to improve case reporting by health staff and VAW patients
3. Develop more VAW BCC materials and accessibility in providing information to women including the need to seek medical attention early at post injury period.
4. Conduct evidence based interventions to educate boyfriends and on the harmful use of alcohol based on the results of this study.
5. Develop BCC materials to prevent Facial and scalp injuries and preserve the facial and beauty of the females which is very important to women as well as the husbands. The evidence highlighted in this study that 85% of injuries received are head and scalp is relevant. This will also boost self confidence of women and wives.
6. Slogans such as 'Never touch the face" or "prevent low IQ a brain development in children" or "Boost self confidence" would be ideal.

12. ANNEX 1 - Fiji - Demographic and Country overview.

Fiji is a small island state at the hub of the south-west Pacific midway between Vanuatu and the Kingdom of Tonga. The 2007 Fiji population census[18] was 837,271 comprising 475,739 Indigenous Fijians, 313,789 Indo-Fijians and 47,734 of other ethnic groups. Overall, the rural population was 49% and the urban 51% with urban growth rate being 1.7%[19]. The average annual growth rate is 0.8% (the natural increase of 1.2% minus migration) with crude growth rates being higher in the Fijian than in the Indo-Fijian population. Areas with noticeably increased population over the past few years are the Western Division (55,266) and Central Division, where the population of the Suva and Nausori urban and peri-urban areas has increased by 32,300. Thirty nine percent of the population is less than 20.

Fiji's Economic Exclusive Zone contains 332 islands covering a total land area of 18,333 sq km in 1.3 million sq km of the South Pacific. It is a multi-cultural and multi-religious country where different cultures meet and to some extent merge. Literacy rate is around 94%, with English being the official language and Fijian and Hindi the languages of daily use.

Economic Situation.

Fiji's housing and employment crises are pervasive and will be compounded over time by high rates of school drop-out. As land leases expire and food costs rise, squatter settlements now number 200 with an estimated population of 100,000 people. Sixty eight percent of the workforce earns less than $7,000 per year. Main sources of revenue are tourism, sugar, mining, agriculture and bottled water. National GDP at constant price was $3.505 billion in 2000 and had grown to $5.826 billion in 2007.

The country has a relatively good infrastructure to support its development but the overall standard of living is declining. It is rated on the UNDP Human Development Index (HDI) as being one of the medium developed countries, being ranked 92nd among a listing of 177 nations in 2006. However this represents a decline from position 46 in 1995. There is poverty, as reflected by the drop in ranking on the HDI, but it is not overtly apparent as seen in Africa, and some other Melanesian countries. The economy has become increasingly dependent on tourism, remittances from overseas, gold and forestry exports.

The current Interim Government has been in place since December 2006. They have identified certain conditions to be in place prior to Fiji proceeding to a general election. These include adoption of the People's Charter, within which Pillar 10 addresses issues of the health sector and proposes to '*increase the proportion of GDP allocated to health by 0.5% per annum for the next 10 years to achieve a level of 7% of GDP*'. The achievement of this objective would result in significantly increased funding for the health sector, this will require continued advocacy for health developments in the face of competing demands; and the MoH to demonstrate that it uses its resources effectively.

Estimates of poverty in Fiji are that 29% of the rural population and 40% of the urban population are poor; and that poverty (35% of the overall population) is distributed across the nation. The poor often live in unsafe and overcrowded houses in under-served peri-urban shanty towns where exposure to pollution and other health risks are greatest. They are most likely to indulge in risky behaviors out of circumstances rather than by choice, often going hungry or eating poor quality foods, living stressful lives, indulging in personal habits such as drinking of kava and smoking tobacco to obtain comfort and to socialize. It is estimated that by 2006 the Suva/Nausori corridor will have 15,000 squatter households with a population of 90,000-100,000 people. This will place a large strain on the entire urban infrastructure, such as water supply, sewerage, electricity, roads, traffic congestion and social services.

[18] Fiji Islands Bureau of statistics Fiji MOH 2008 Annual Report
[19] Roberts, Lingham; Fiji Health Situational Analysis report 2008

Key health Indicators

A comprehensive set of population health indicators is presented in Table 1 below. Overall the Figures show no real improvement in the health status of the people of Fiji over the past 5 years, although there have been some improvements in areas of post neonatal mortality and contraceptive coverage rates.

Table 1: Fiji's key health indicators

	2003	2004	2005	2006	2007	2008
Population (Census estimates)	866,099	848,647	849,361	868,488	868,107	879,301
Total Live Births	17,910	17,714	17,826	18,394	19,298	18,944
Crude Birth Rate/1,000 Population	20.68	20.87	20.99	21.20	22.2	21.5
Crude Death Rate/1,000 Population	7.06	6.63	7.02	7.1	9.8	7.4
Rate of Natural Increase	1.36%	1.42%	1.4%	1.4%	1.2%	1.4
Under 5 Mortality Rates/1000 live Births	23.73	22.52	25.81	25.8	22.4	23.6
Infant Mortality Rate/1000live Births	18.87	17.84	20.76	19.5	18.4	13.1
Perinatal Mortality (stillbirth and early neonatal deaths/1,000Live Births)	16.4	19.3	22.05	19.4	15.8	15.4
Early Neonatal Deaths (0-7days)/1,000 live Births	7.54	8.13	10.43	8.0	N/A	N/A
Neonatal Mortality (Deaths 0-28days) 1000 Live Births	9.27	10.05	15.37	11.3	11.9	9.0
Maternal Mortality Ratio/100,000 LBs	22.3	33.9	50.5	43.5	31.1	31.7

Source: Fiji MOH Annual Reports 2008

COMPARISON WITH PACIFIC NEIGHBORS.

Table 2 below presents comparative indicators for some pacific states and shows that the Fiji rank in the UNDP Human Development Index, trails behind Tonga and Samoa. There are many other clear differences for example Fiji exhibits double the rate of urbanization than its neighbors; its teenage pregnancy rate (15-19) is high, partly accounted for by the young age of marriage of many Indo-Fijian females.

Table 2: Selected regional comparative indicators

Indicator	Fiji	Samoa	Solomon Is	Tonga	Vanuatu
Human Dev. Index Rank:	92	77	129	55	120
% population urbanised	51	23	17	24	24
Under 5 mortality rate 2006	18	28	73	24	36
Life expectancy at birth 2006	69	71	63	73	70
% of pop. using improved drinking water sources 2004	47	88	70	100	60
% of pop. using improved adequate sanitation 2004	72	100	18	96	50
Age specific fertility rate (15-19) births per 1000 women	45	23	69	42	38

Sources: 1. UNDP Human Dev. Report 2007/08, 2. UNICEF: http://www.unicef.org/infobycountry

Morbidity and Mortality.

Table 51 reveals the triple burden of morbidity in Fiji stemming from injury, infectious diseases and chronic non-communicable diseases. It also shows that non-communicable diseases account for the greatest part of mortality.

Table 3: The ten major causes of morbidity and mortality in 2007

No	**MORBIDITY Cause**		**MORTALITY Cause**
1	Injury	1	Diabetes mellitus
2	Influenza and pneumonia	2	Other forms of heart diseases
3	Intestinal and infectious disease	3	Ischemic heart diseases
4	Infection of skin & subcutaneous tissues	4	Hypertension
5	Ischemic heart disease	5	Septicaemia
6	Other conditions originating in peri-natal period	6	Cerebrovascular Disease
7	Chronic lower respiratory disease	7	Other conditions originating in perinatal period
8	Other forms of heart diseases	8	Chronic lower respiratory disease
9	Hypertension	9	Renal failure
10	Diabetes mellitus	10	Influenza and pneumonia

Source: Fiji MOH - hospital admission Source: Fiji MOH -Death certificate

Non- communicable diseases such as diabetes, heart disease, high blood pressure and respiratory diseases have now replaced infectious and parasitic diseases as the principal causes of mortality and morbidity in Fiji.

Key Lifestyle and other issues impacting on health of the people

Lifestyle: The socio cultural differences on health, the migration to urban areas and the transition from the consumption of local produce to imported refined food items, has resulted in an increase in obesity and non-communicable diseases in recent decades. Secular fashion and behavioral trends are powerful influences on young people while the breakdown of traditional social controls have allowed behaviors such as binge drinking, cannabis consumption, an active nightclub scene, sexual promiscuity and commercial sex, the consumption of 'fast foods' and the increase in street kids and homelessness all of which are readily visible phenomenon of lifestyle change. The greatest challenge is youth unemployment. Young people of productive working age are commonly seen on the urban and suburban streets of Fiji during working hours.

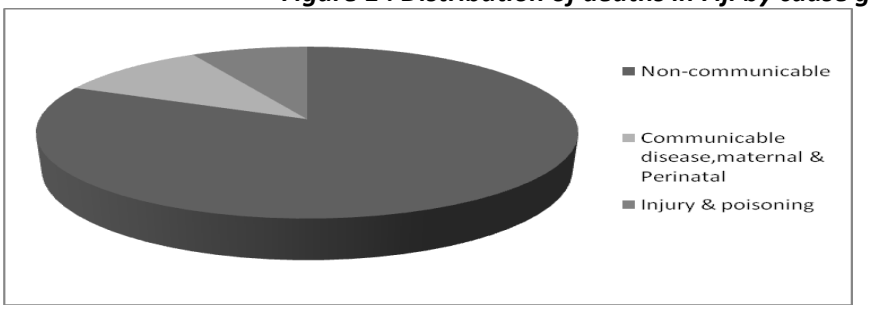
Water and sanitation: Many of the rural water supply systems built during the colonial period are now deteriorated to the degree that village water systems are sources of diarrheal diseases and other water borne diseases.

NCD BURDEN IN FIJI

The obesity and non communicable disease problem in Fiji is a serious one. 82% of deaths are now due to heart disease, heart failure, stroke and hypertension, and these have been recognized as an important health problem[20]. 10% of deaths are due to communicable diseases, maternal & prenatal and 8% due to injury & poisoning.

[20] Fiji Ministry of Health Report, 2007

Figure 1 : Distribution of deaths in Fiji by cause groups, 2007



VAW is under NCD within the components of Injury and Poisoning. It is also reflected in the National NCD Strategic Plan 2011-2014 under Injuries.

The last national NCD STEPS Survey 2002 [21] *found that of the 6783 individuals sampled:*
The overall population of overweight (BMI 25-29.9) in the Fiji population between the ages of 15-64 years was 29% and for obesity 18%. Generally the females had higher BMI than males (mean BMI 26.7 vs 24.2) Fijians more than Indo Fijians. There is also a rapid increase in the proportion of overweight/obesity in both genders prior to the age of 30years. By measurement of waist – hip ratio (WHR) there was a significantly higher rate of high risk central obesity among females (45%) than males (4%). The prevalence of diabetes in Fiji among 25-64yrs old was 16 %, & among them the proportion of newly diagnosed cases was 53.2%.There is a much higher proportion of diabetes among the Indo Fijians (21.2%) as compared with Fijians (11.5%) There is also difference in the overall prevalence of diabetes by locality with a prevalence of 24.7% in the urban & 12.8% in the rural.
The prevalence of hypertension in the population 15-64years was 19.1% and 63% of them were newly diagnosed. There is a higher proportion of hypertension among Fijians ((21%) as compared with Indo-Fijians (16%) and the proportion of uncontrolled previously diagnosed cases is higher among Fijians (81%) than among Indo-Fijians (58%). There was generally low consumption of fruits and vegetables with 66% of survey participants eating less than one serving of fruit per day and 26% eating less than one serving of vegetables per day.

There was also a higher proportion of urban males (49%) in the high-risk triglycerides group (>=1.70mmol/L) as compared to either rural males (24%) or urban females (28%). HDL cholesterol levels were used to categorize individuals into a high risk group (<= 0.90 mmol/L) was 31% and for females was 35%, a difference that was not statistically significant; 37% currently smoke tobacco; There is a low rate of physical activity (25%); A high rate of binge drinking (77.3% of current drinkers).

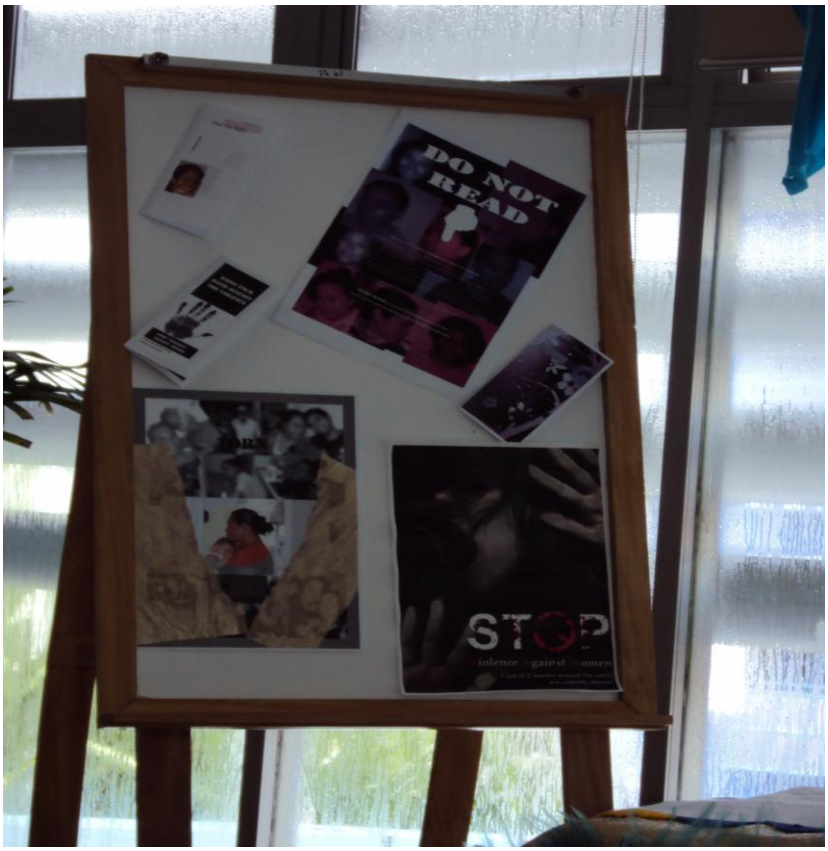
The Fiji National NCD Strategic Plan is overseen by the national multisectorial NCD Committee which is chaired by the Hon Minister of Health with membership from all stakeholders including representatives from the 3 Divisions; Northern, Western and Central Eastern, who have their own Divisional NCD Committees. The national NCD Committee meets once every quarter and monitors & evaluates the progress of the implementation of this strategic plan at various levels. Following the submission of the NCD Strategic Plan to cabinet in 2004, the Fiji Government also increased its specific NCD budget allocation from 60,000 FJD in 2003 to 280,000 FJD in 2004 and continued annually to date. This reflects the government commitment to address NCD issues and interventions following the World Health Assembly Resolutions and the Pacific Island Ministers of Health meetings culminating the 2003 Tonga Commitment, 2005 Samoa Commitment and the 2007 Vanuatu Commitment.

[21] Fiji NCD STEPS Survey 2002 Report

Annex 2 – Winning poster and pamphlet

Winning Poster by Simon Wale

Pamphlets and Brochures



Annex 3 – Launch of the VAW Results on 13/12/10 – Tanoa Plaza Conference Room

Dr Li Dan, Dr I Tukana (MOH) & Prof Ian Rouse (FSMed) Dr Tukana launching the VAW Project results

Dr Li Dan & some of the VAW Team Project members

Dr Timaima Tuiketei presenting the findings at the launch

Annex 4 - Summary of the VAW stakeholders Workshop on 16/12/10

Workshop was attended by nine (9) out of the 14 stakeholders that were invited with 17 participants. The results were shared with the stakeholders followed by the group discussions sharing their concerns and issues to develop and strengthen strategies in the prevention of VAW in Fiji based on these evidence. A lot of healthy discussions and exchanges were made in taking the recommendations forward.

The FWCC rep Ms Edwina Tikoisuva also shared an overview and insights on the 16 days activism against VAW and the work of the FWCC.

The following issues were presented by he stakeholders on how they will utilize the VAW project results:

Stakeholder	*Response on Activities/ Comments*
FWCC	*Use this new information in community outreach activities* *Conduct more study on economic perspectives as highlighted by RBF that the Health costs of VAW in Fiji was $300 million* *Provide this VAW project report in their Library as a resource material to facilitate the empowerment of women*
SSV	*The perceived definition on what violence is needs to be addressed at all levels. Have programs already in place in the community. This new information will strengthen their outreach work.* *Verbal abuse is a concern as highlighted in the report and will now target families on VAW issues as people respond to the SSV programs – will use this information.* *VAW training to be also brought down to secondary and primary students*
PCASS	*Strengthen counseling already offered to families in their centres* *Valued the work of this VAW research* *Concern with Stigma that is related to VAW reporting esp in communities. Most women prefer to have the violence stopped rather than reporting the matter to the police of health workers.* *Would like to be included in the future VAW researches*
Church group	*Use the data in church through the male/female reconciliation programs.* *Use the perspectives of love, families, roles and responsibilities in the church*
WHO	*Officially very useful – this Fiji study and Mongolia were selected by WHO to represent the WPRO region – so very important report* *Could be able to link VAW with HIV esp. in the sexual abuse versus HIV transmission as this may be crosscutting with the HIV program.* *Supports the secondary analysis and will commit in funding it* *Recommendations to be more direct and action orientated based on the evidence esp. in community education and BCC materials development and creation in the prioritized intervention areas as in boyfriends, parents and children*

	WHO invites FSMed in the follow up of VAW programs with NGOs & stakeholders in Fiji.
UNIFEM	*There are many MOH recommendation & will require special presentations to them. Will need to strategize the implementation of these as they are the line service providers including reporting system.* *Can fund small VAW projects for NGOs and other agencies.* *Will be calling for proposals soon in the media for further studies in VAW* *VAW patients and stigma issues in the communities esp. with VHW* *Need to conduct further research on: looking at the disease burden of VAW in the private sector, children of VAW patients who are affected, the impact of violence in male child or gay men.* *Interested in the follow up of recommendations with the MOH and will support FSMed with funding and activities as per recommendations. Also interested in the VHW training.* *UNIFEM would like to be included in the follow up researches*
FSN	*FSN curriculum currently does not include much content in VAW issues. The curriculum should be strengthened to allow interlinked between what is taught at the academic institutions and the communities outreach.* *Evidence is important to design curriculum* *Changes already made to the BPHN curriculum commencing in 2011*
FSM	*Changes to be included in the undergrad MBBS curriculum in PH component – incorporate VAW issues*

The workshop was closed by HOD DPHPC Mr N Litidamu and Dr Li Dan of WHO.

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