

# WHO

## Preventing violence: a public health priority (Resolution WHA49.25)

1. DECLARES that violence is a leading worldwide public health problem;

2002

**World report  
on violence  
and health**



World Health  
Organization

# Preventing injuries and violence



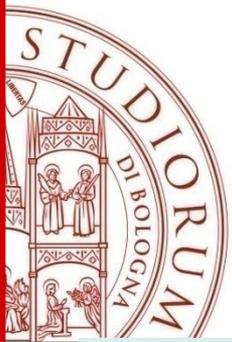
Preventing injuries and violence

A GUIDE FOR MINISTRIES OF HEALTH

2007



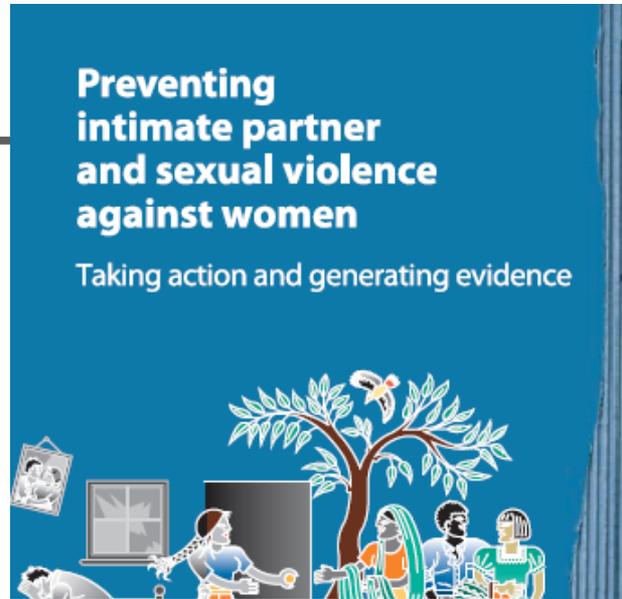
World Health  
Organization



# La violenza rappresenta un vero e proprio problema di salute pubblica

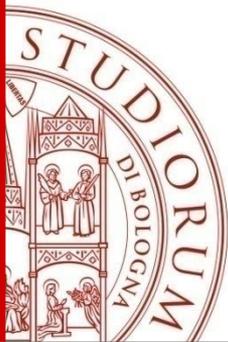
*World Report on Violence and Health, World Health Organization, 2002.*

# Violenza nelle relazioni di intimità e violenza sessuale



■ Intimate partner and sexual violence may affect everyone - though there is a strong gender pattern with the majority of those experiencing it being women and the majority perpetrating it being men; everyone can help to prevent it and can work together to stop the continuation of violence across generations.

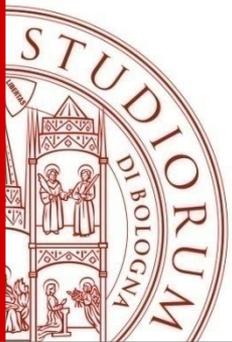




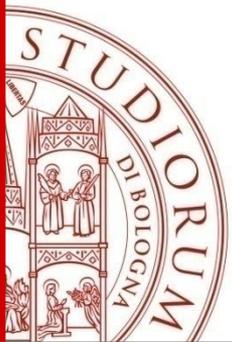
World Health  
Organization



Population-based studies from various countries indicate that 10–69% of women aged 15–49 years experience physical abuse by a male intimate partner at least once in their lifetime (Heise, Ellsberg & Gottemoeller, 1999; Heise & Garcia-Moreno, 2002) while 6–47% of women report attempted or actual forced sex by an intimate partner in their lifetime (Jewkes, Sen & Garcia-Moreno, 2002). The *WHO Multi-country study on women's health and domestic violence against women* found that between 6% and 59% of women reported experiencing sexual violence by an intimate partner in their lifetime, with the figures for most sites falling between 10% and 50% (Garcia-Moreno et al., 2005).



2011



# Child abuse

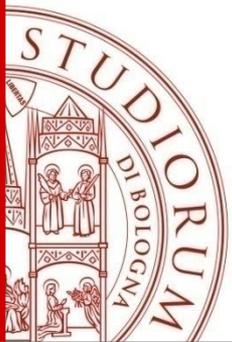
**I FELL OUT OF MY CRADLE**

**CHILD ABUSE AND NEGLECT.** Millions of children are abused and neglected every day by their parents or other caregivers. In some states, 25-50% of children report incidents of frequent physical, sexual, emotional, and verbal abuse. Abuse is a crime against the child and the nation. It is estimated that there are 10 million child abuse and neglect incidents each year. 15 years of child abuse is linked to 100,000 deaths. The 100,000 deaths are not just the child, but also the child's family and the child's community. There are 10 million children in the United States who are abused or neglected every day.

Child Abuse and Neglect. For more information, visit [www.auntie.com/abuse](http://www.auntie.com/abuse)



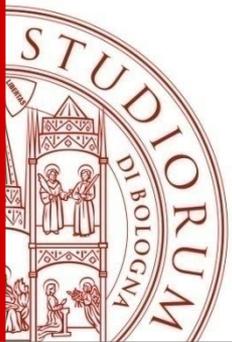
**NATIONAL CAMPAIGN FOR VIOLENCE PREVENTION**  
Creating a Safer Future for All Children

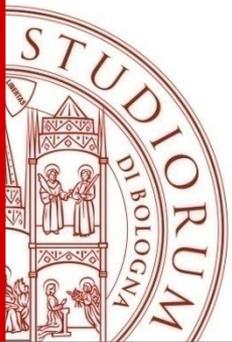


ITALIAN CAMPAIGN FOR CHILD PROTECTION  
CAMPAGNA NAZIONALE PER LA PROTEZIONE DELL'INFANZIA

MILLIONS OF CHILDREN SUFFER ABUSE  
AND NEGLECT AT THE HANDS OF THEIR  
PARENTS AND OTHER CAREGIVERS.

www.ministero.salute.gov.it



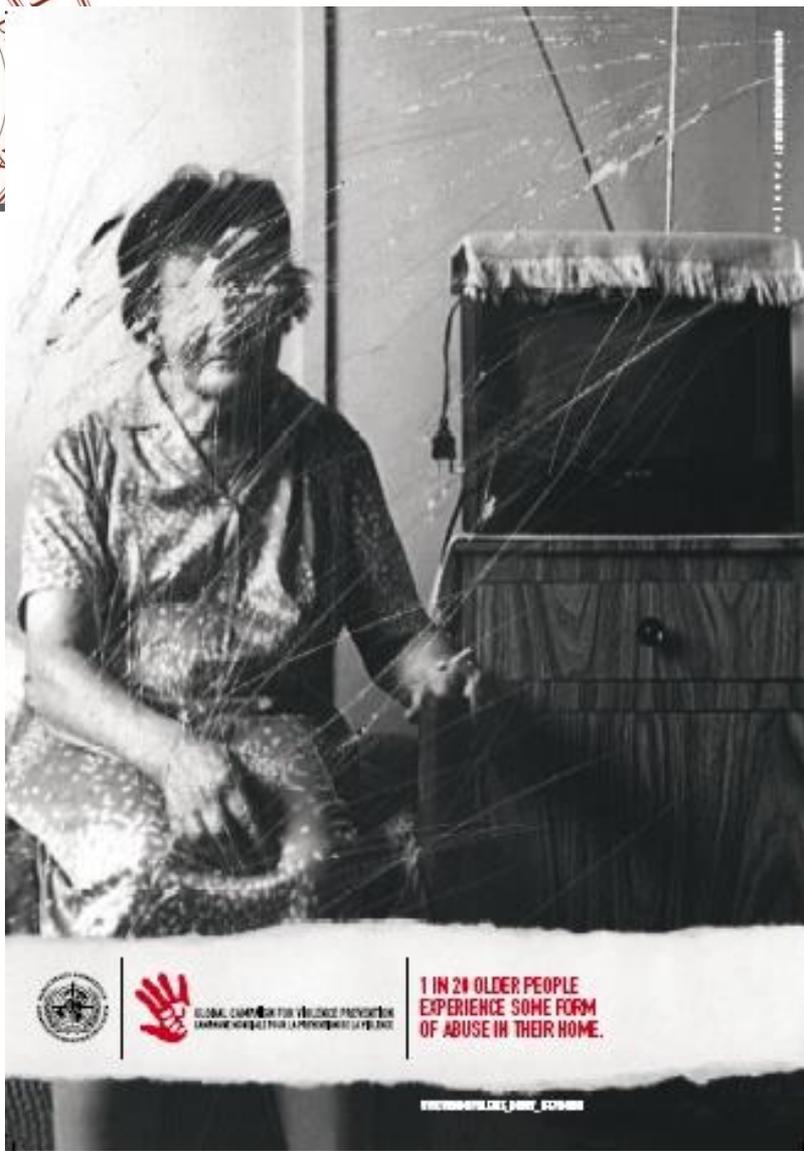


# I FELL DOWN THE STAIRS

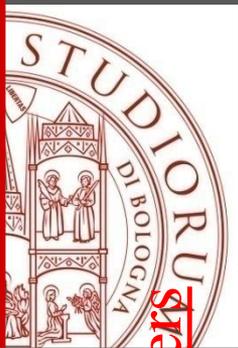
**VIOLENCE BY INTIMATE PARTNERS.** Violence by intimate partners occurs in all cultures, although some people believe it is a greater risk than others. The overwhelming burden of partner violence is borne by women of the world. Studies show that 28-70% of them are injured or killed by their husbands or boyfriends, frequently in a context of an ongoing relationship. In some countries, more than 50% of women report being physically abused by an intimate partner at some point in their lives.

Women by intimate partners can be prevented. For more information, visit [www.ohchr.org/en/ljny\\_prevention](http://www.ohchr.org/en/ljny_prevention)

# La violenza nei confronti della persona anziana



# Violenza contro le donne



Others



Violence by states (e.g. rape in war)

Trafficking

Non-partner rape/harassment/violence

Dowry deaths/honor killings

Differential access to food/medical care Psychological abuse; Coerced sex/rape/harassment; Physical violence; Violence during pregnancy

Female infanticide; FGC/M

Sex-selective abortion

Family members



Differential access to food/medical care

Violence in pregnancy

Physical and sexual violence

Psychological abuse

Intimate partner



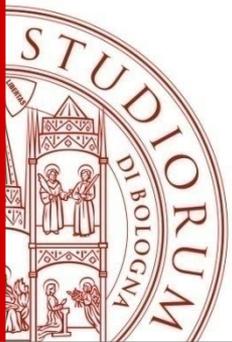
Prebirth/ Infancy

Adolescence

Reproductive

Older

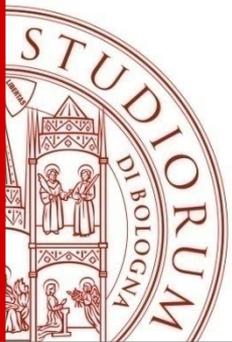
ages



# Il Servizio sanitario

- I servizi sanitari sono spesso i primi a cui si rivolge la vittima di violenza
- Lì risiede quindi il più grande potenziale per identificare la violenza ed iniziare l'aiuto





# Definire il problema

1

Defining the  
problem

Uncovering the size  
and scope of the  
problem

Violenza: **come, quando, dove e quale**

Tipologia della violenza

Relazione tra vittima ed aggressore

Dovrebbe essere descritta in termini di  
numero, percentuale di nuovi casi,  
meccanismo dell'azione violenta, uso di  
armi e sostanze come alcol e  
caratteristiche temporali e geografiche

2

Identification  
of risk and  
protective factors  
What are  
the causes?

# Identificazione dei fattori di rischio e dei fattori protettivi

## Fattori di rischio: il perché della violenza

(esempio è l'isolamento sociale fattore di rischio per il child abuse, la violenza domestica e l'abuso sull'anziano)

**Fattori protettivi:** riducono il rischio e le conseguenze (esempio una società con alto capitale sociale e scarsa differenza di reddito)

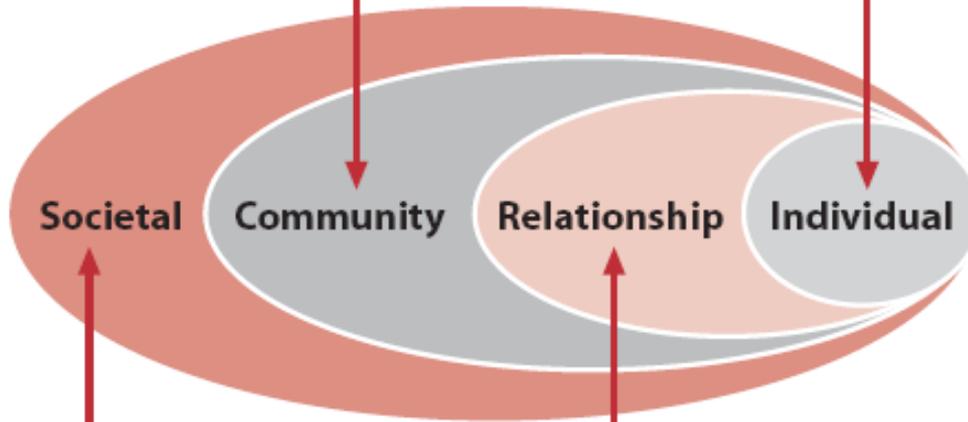
# 3

Development and evaluation of interventions  
What works and for whom?

Assistenza,  
Interventi per evitare la  
recidiva

Reducing alcohol availability  
Changing institutional settings  
Refer people at risk for violence  
Improving trauma services

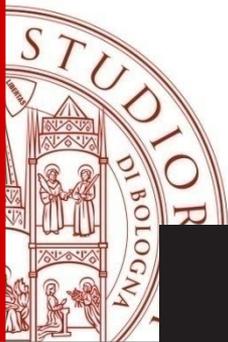
Social development programmes  
Vocational training  
Victim care and support



Public information  
Strengthen police and judiciary  
Reduce poverty and inequality  
Educational reform  
Reduce access to means  
Job creation programmes

Parenting programmes  
Home visitation  
Family therapy  
Mentoring programmes

Fornire assistenza  
e supporto alla  
vittima  
Protocolli  
Linee guida  
Screening  
Formazione medica



# VITTIME DI VIOLENZA:

EMERGENZA-URGENZA MEDICO-LEGALE

**Percorso per un  
Pronto Soccorso  
dedicato alle vittime  
di aggressione**

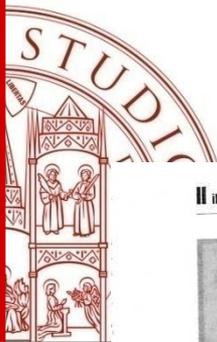
21 ottobre 2006

**TAVOLO INTERISTITUZIONALE**

Oratorio di San Filippo Neri

Via Manzoni 5, Bologna

ore 9.30



**LE IDEE**  
A sinistra, il pm Luigi Persico. A destra, l'assessore comunale Milli Virgilio



**LE MISURE**

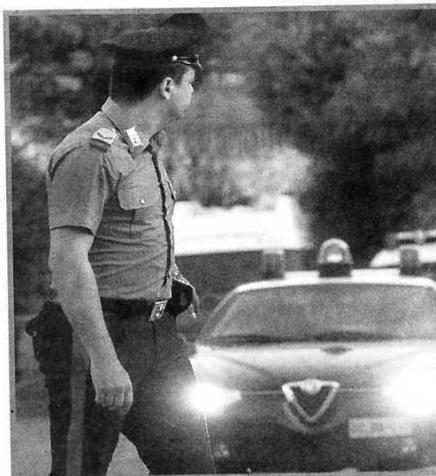
1

Più illuminazione, taxi a tariffa agevolata e collettivi per le donne che escono di sera, sostegno economico alle vittime

2

No a fischietti, pulsanti per sos ai semafori e alla costituzione del Comune parte civile come farà Milano

**La sicurezza in città**



**INDAGINI** Una pattuglia durante i controlli notturni

**IL PIANO** L'assessore Virgilio e il procuratore vicario Persico  
**Summit Procura-Comune**  
**«Ecco cosa fare subito contro l'allarme stupri»**

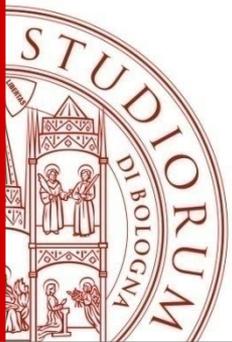
di Renata Ortolani

L'allarme stupri al centro ieri di un vero e proprio summit fra Luigi Persico, vicario del Procuratore capo, e l'assessore alle Pari opportunità di Palazzo D'Accursio, Milli Virgilio. E mentre trapela che i magistrati sono intenzionati a prendere contatto con i primari del Pronto soccorso di Maggiore e Sant'Orsola, da Milano arriva l'eco del piano anti-violenza che il sindaco Letizia Moratti sta mettendo in cantiere: con tanto di costituzione di parte civile del Comune al fianco delle vittime. Milli Virgilio preferisce non anticipare la sostanza del quanto è stato concordato ieri

direzione data dalla Moratti che ci si muoverà a Bologna. E tiene a sottolineare. «Qui la vera novità è far lavorare insieme le realtà che già ci sono e già funzionano sia nel campo della prevenzione che in quello dell'appoggio alle vittime di violenze. Non ci sono misure risolutive, non c'è una ricetta che risolva il problema — incalza l'assessore —. Ciò che serve è più illuminazione, senza risparmi e senza limitazioni non giustificate; e poi il lavoro complessivo, a cominciare dalle scuole fino al Pronto Soccorso degli ospedali. Non abbiamo parlato, in Procura, né di fischietti né di autobus rosa. Io non credo a queste cose. Vigilantes in più? Forse, ma io

za della popolazione con quelli legati al degrado. Quindi: locali aperti e illuminati, cioè attività, vita, presenza della collettività». Virgilio elenca anche gli appuntamenti che ruotano attorno al tema donne e sicurezza: il 12 settembre un incontro sugli omicidi ai danni di donne; il 12 e il 13 ottobre, insieme all'Università, un incontro con alcune giuriste spagnole sulle molte implicazioni che la legge adottata in Spagna potrebbe avere anche da noi. Poi il corso speciale che, in collaborazione con la Medicina legale, fra qualche giorno prende il via al Maggiore: lezioni per il personale sanitario (come abbiamo anticipato ieri), quello che per primo di solito si scontra durante alla donna stuprata

sano di fare a Milano — concorda la vicesindaco Adriana Scaramuzzino —. Sono più favorevole a taxi con tariffa agevolata per le donne e taxi collettivi da mettere davanti a ristoranti, cinema e altri locali. Escluderei anche, per Bologna, la costituzione di parte civile del Comune prevista a Milano. Ogni città ha la sua fisionomia e le sue dimensioni le misure anti-violenza vanno calibrate. Quindi dico sì a più illuminazione, più telecamere, più risorse investite per accompagnare il percorso delle donne che subiscono violenza: anche nel reinserimento sul lavoro». E potenziare il numero dei vigili urbani? «Sì, ma il controllo del territorio va fatto in maniera coordinata: da tutte le forze dell'ordine, non solo da quelle che rispondono al Comune».



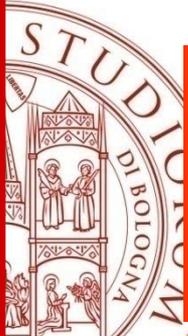
***‘Probably the most important contribution to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse’***

**Council on Ethical and Judicial Affairs,  
American Medical Association**



# Violenza sessuale: miti

- 1) “She asked for it.”
- 2) “It can’t happen to me.”
- 3) Sex offenders are motivated by sexual desire.
- 4) Sex offenders are retarded.
- 5) Sex offenders are a certain race.
- 6) Women frequently “cry rape”.

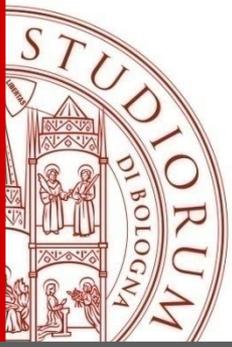


# VIOLENZA DOMESTICA

## Ostacoli per il riconoscimento

- 1) **Mancanza di conoscenza**
- 2) **Mancanza di protocolli**
- 3) **Mancanza di tempo**

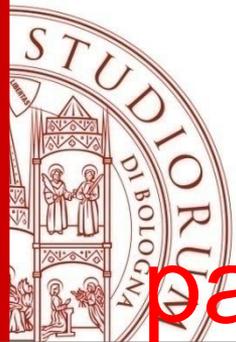




# DOMESTIC VIOLENCE and the Emergency Department

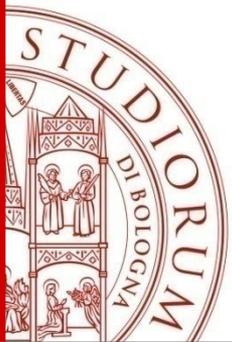
- 30% of all female trauma patients
- 22-35% of all females presenting to the Emergency Department
- most are repeat ED patients
  - 20% 11 or more abuse related visits
  - 23% 6-10 abuse related visits

Amy C. Sisley, MD, MPH  
University of Maryland  
School of Medicine

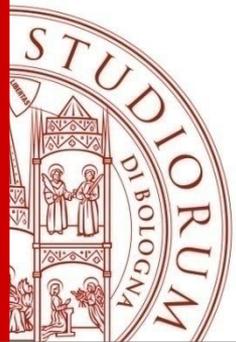


# Opening Pandora's Box: Why physicians do not ask patients about domestic violence

- #1 Not enough time -71%
- #2 Fear of offending the patient-55%
- #3 Powerlessness to intervene -50%



# *What do I do if she says,* *“Yes?”*



WHEN YOU NEED AN  
EXTRA-SENSITIVE TOUCH



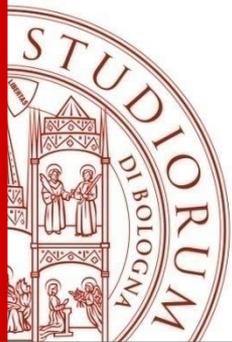
*The softest cleaning routine that's kind to sensitive skin.*



**Cachez**

Gentle skincare for braving relationships

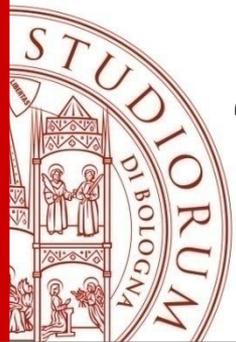
[www.cachez.it](http://www.cachez.it)



# Eliminating Female genital mutilation

An interagency statement

OHCHR, UNAIDS, UNDP, UNECA, UNESCO,  
UNFPA, UNHCR, UNICEF, UNIFEM, WHO



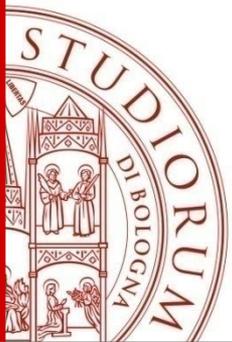
## Legge 9 gennaio 2006, n.7 art. 6

### “Articolo 583-bis Codice penale Pratiche di mutilazione degli organi genitali femminili.

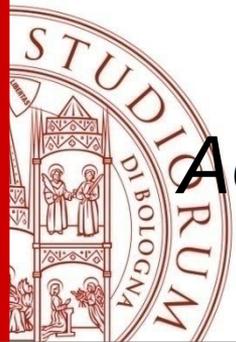
*Chiunque, in assenza di esigenze terapeutiche, cagiona una **mutilazione** degli organi genitali femminili è punito con la reclusione da quattro a dodici anni. Ai fini del presente articolo, si intendono come pratiche di mutilazione degli organi genitali femminili la clitoridectomia, l'escissione e l'infibulazione e qualsiasi altra pratica che cagioni effetti dello stesso tipo.*

*Chiunque, in assenza di esigenze terapeutiche, provoca, al fine di menomare le funzioni sessuali, **lesioni** agli organi genitali femminili diverse da quelle indicate al primo comma, **da cui derivi una malattia nel corpo o nella mente**, è punito con la reclusione da tre a sette anni. La pena è diminuita fino a due terzi se la lesione è di lieve entità.*

*La pena è aumentata di un terzo quando le pratiche di cui al primo e al secondo comma sono commesse a danno di un minore ovvero se il fatto è commesso per fini di lucro.*



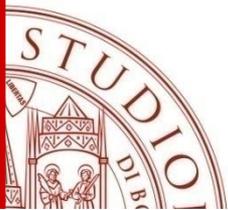
- **Art. 583-ter. – (Pena accessoria).** – “*La condanna contro l’esercente una professione sanitaria per taluno dei delitti previsti dall’articolo 583-bis importa la pena accessoria **dell’interdizione dalla professione** da tre a dieci anni. Della sentenza di condanna è data comunicazione all’Ordine dei medici chirurghi e degli odontoiatri*».



# Decreto del Ministero della Salute *Adozione di Linee Guida di cui all'art. 4 della Legge*

Linee Guida rivolte nello specifico alle **figure professionali sanitarie** nonché ad altre figure professionali che operano con le comunità di immigrati provenienti da Paesi dove sono effettuate le pratiche di mutilazione genitale femminile.

Le Linee Guida hanno lo scopo di realizzare attività di **prevenzione, assistenza, riabilitazione** delle donne e delle bambine già sottoposte a tali pratiche.



### COME È MONITORATA L'APPLICAZIONE DELLA CONVENZIONE?

La Convenzione istituisce un meccanismo di monitoraggio incaricato di verificare l'applicazione delle sue disposizioni. Tale meccanismo si fonda sulle analisi condotte dai due organi che ne costituiscono i pilastri portanti: il *Gruppo di esperti sull'azione contro la violenza nei confronti delle donne e la violenza domestica* (GREVIO), un organismo indipendente composto da esperti, e il *Comitato delle Parti*, un organismo politico composto dai rappresentanti ufficiali degli Stati parti della Convenzione. Le loro conclusioni e raccomandazioni aiuteranno a garantire il rispetto della Convenzione da parte degli Stati e la sua efficacia a lungo termine.

[www.coe.int](http://www.coe.int)

[www.coe.int/conventionviolence](http://www.coe.int/conventionviolence)  
[conventionviolence@coe.int](mailto:conventionviolence@coe.int)

ITA

Il Consiglio d'Europa è la principale organizzazione di difesa dei diritti umani del continente. Include 47 Stati membri, 28 dei quali fanno anche parte dell'Unione europea. Tutti gli Stati membri del Consiglio d'Europa sono segnatari della Convenzione Europea dei Diritti dell'Uomo, un trattato concepito per proteggere i diritti umani, la democrazia e lo stato di diritto. La Corte europea dei diritti dell'uomo supervisiona l'attuazione della Convenzione negli Stati membri.



### CONVENZIONE DEL CONSIGLIO D'EUROPA SULLA PREVENZIONE E LA LOTTA CONTRO LA VIOLENZA NEI CONFRONTI DELLE DONNE E LA VIOLENZA DOMESTICA

Convenzione di Istanbul

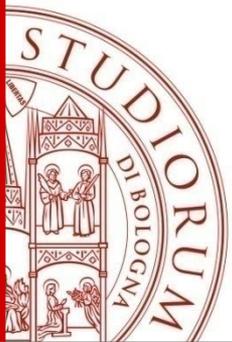
AL SICURO DALLA PAURA  
AL SICURO DALLA VIOLENZA



# 2011

- a “violence against women” is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life;
- b “domestic violence” shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim;





## Article 15 – Training of professionals

- 1 Parties shall provide or strengthen appropriate training for the relevant professionals dealing with victims or perpetrators of all acts of violence covered by the scope of this Convention, on the prevention and detection of such violence, equality between women and men, the needs and rights of victims, as well as on how to prevent secondary victimisation.
- 2 Parties shall encourage that the training referred to in paragraph 1 includes training on coordinated multi-agency co-operation to allow for a comprehensive and appropriate handling of referrals in cases of violence covered by the scope of this Convention.



**Governo italiano**

Dipartimento per le pari opportunità  
Presidenza del Consiglio dei Ministri

Dipartimento

Approfondimenti

Archivio Notizie

Bandi e Avvisi

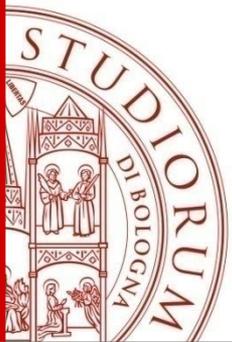
## Notizie

# **01.02.2018 - IN GAZZETTA UFFICIALE LE LINEE GUIDA OSPEDALIERE PER LE DONNE VITTIME DI VIOLENZA**

Sono state pubblicate sulla Gazzetta Ufficiale del 30 gennaio 2018 le Linee guida nazionali di indirizzo e orientamento per le Aziende sanitarie e le Aziende ospedaliere in tema di soccorso e di assistenza socio-sanitaria alle donne vittime di violenza. Le linee guida, previste dalla legge di Stabilità del 2016, tracciano un percorso per le donne che subiscono affinché sia garantita loro un'adeguata e tempestiva presa in carico, dal triage fino all'accompagnamento e/o orientamento, se consenzienti, ai servizi pubblici e privati dedicati presenti sul territorio.

Elaborate dal gruppo di lavoro costituito all'interno dell'Osservatorio nazionale sul fenomeno della violenza sessuale e di genere, insediatosi nel mese di novembre 2016, le Linee guida nazionali coinvolgono nel percorso anche gli eventuali figli minori della donna, testimoni o vittime di violenza.

Le Linee guida nazionali dovranno essere adottate entro un anno dalla loro entrata in vigore con la pubblicazione in Gazzetta Ufficiale.



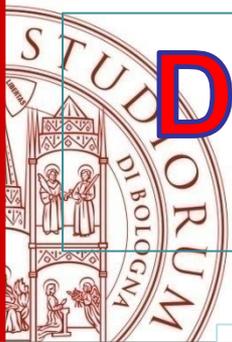
Il *Percorso per le donne che subiscono violenza*, di seguito delineato, dovrà garantire una tempestiva e adeguata presa in carico delle donne a partire dal *triage* e fino al loro accompagnamento/orientamento, se consenzienti, ai servizi pubblici e privati dedicati presenti sul territorio di riferimento al fine di elaborare, con le stesse, un progetto personalizzato di sostegno e di ascolto per la fuoriuscita dalla esperienza di violenza subita.



## Destinatarie

Destinatarie del *Percorso per le donne che subiscono violenza* sono le donne (con il termine “donne” sono da intendersi anche le ragazze di meno di 18 anni come previsto dall’art. 3 lettera f) della Convenzione di Istanbul), italiane e straniere, che abbiano subito una qualsiasi forma di violenza.<sup>1</sup>

Sono coinvolti nel *Percorso* anche le/gli eventuali figlie/i minori della donna, testimoni o vittime di violenza, tenuto conto della normativa riguardante i minori e delle vigenti procedure di presa in carico socio-sanitaria delle persone minorenni.



# Destinatari delle linee guida

Servizi sanitari

Servizi socio-sanitari territoriali

Centri antiviolenza e case rifugio

Forse dell'Ordine e di Polizia locali

Procura della Repubblica

Tribunale Minorenni (civile e penale)

Enti territoriali

## PARTE SECONDA

### **Accesso al Pronto Soccorso e *Triage***

La donna può accedere al Pronto Soccorso:

- Spontaneamente (sola o con prole minore)
- Accompagnata dal 118 con o senza l'intervento delle FF.OO
- Accompagnata dalle FF.OO
- Accompagnata da operatrici dei Centri antiviolenza
- Accompagnata da altri servizi pubblici o privati
- Accompagnata da persone da identificare
- Accompagnata dall'autore della violenza

Il personale infermieristico addetto al *triage*, con un'adeguata formazione professionale, procede al tempestivo riconoscimento di ogni segnale di violenza, anche quando non dichiarata. A tal fine può avvalersi di informazioni relative ad eventuali precedenti accessi ai Pronto Soccorso del territorio da parte della donna.

Si raccomanda alle Regioni di adeguare i sistemi informatici aziendali e regionali per consentire all'azienda sanitaria o all'ospedale di riferimento di essere in rete con tutte le altre strutture della regione di appartenenza.

# TRIAGE AREA

24 HOUR

Domestic & Sexual Violence Helpline

FREEPHONE

**0808 802 1414**

Open to *all women and men* affected by domestic & sexual violence

☐ text support to 07797 805 839 ✉ 24hrsupport@dvhelpline.org

The Philadelphia  
Domestic Violence Hotline

Confidential • Toll-Free • 24-7

**1-866-723-3014**

TTY: 215-456-1529

EVERYONE  
DESERVES TO **BE SAFE**  
Safety, information and support for you or someone you know

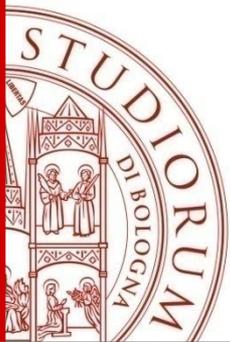
National  
Domestic  
Violence  
Helpline

**CALL  
1560  
FREE** 24 HOURS



Nella zona del *triage* deve essere presente materiale informativo (cartaceo e/o multimediale) visibile e comprensibile anche da donne straniere, relativo a:

- Tipologie di violenza;
- Effetti della violenza sulla salute di donne e bambine/i;
- Normativa di riferimento;
- Indicazioni logistiche sui servizi pubblici e privati dedicati presenti sul territorio;
- Servizi per il sostegno a figlie/i minori testimoni e/o vittime di violenza;
- Indicazioni relative al numero di pubblica utilità 1522<sup>3</sup>.

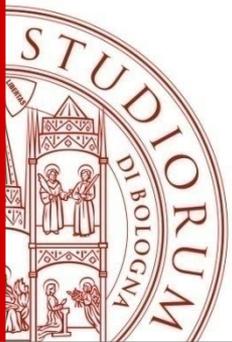


**L'assegnazione del codice giallo o equivalente determina l'attivazione del *Percorso per le donne che subiscono violenza.***

Nel caso in cui la donna abbia fatto accesso al Pronto Soccorso con figlie/i minori è opportuno che le/gli stesse/i restino con la madre e che siano coinvolti nel suo stesso *Percorso.*

# Codice rosa



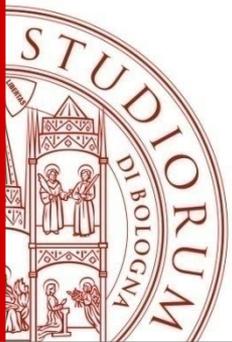


## **Trattamento diagnostico - terapeutico**

La donna presa in carico deve essere accompagnata in un'area separata dalla sala d'attesa generale che le assicuri protezione, sicurezza e riservatezza.

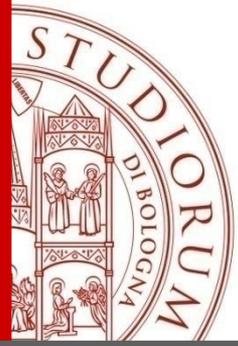
Eventuali accompagnatrici/accompagnatori, ad eccezione delle/dei figlie/i minori, dovranno essere in un primo momento allontanati; successivamente, e solo su richiesta della donna, potranno raggiungerla nell'area protetta.

L'area protetta rappresenta, possibilmente, l'unico luogo in cui la donna viene visitata e sottoposta ad ogni accertamento strumentale e clinico, nonché il luogo di ascolto e prima accoglienza (ove anche reperire il materiale utile per una eventuale denuncia/querela), nel pieno rispetto della sua privacy.



# Unico luogo

*“L'area protetta rappresenta, possibilmente, l'unico luogo in cui la donna viene visitata e sottoposta ad ogni accertamento strumentale e clinico, nonché il luogo di ascolto e prima accoglienza (ove anche repertare il materiale utile per una eventuale denuncia/querela), nel pieno rispetto della sua privacy”.*



# Trattamento diagnostico-terapeutico

*I medici che entrano in contatto con la donna che ha intrapreso il Percorso per le donne che subiscono violenza, a partire dal medico che fara' la prima visita, dovranno refertare in modo dettagliato e preciso tutti gli esiti della violenza subita.*



## PARTE TERZA

### **Attivazione della rete antiviolenza territoriale**

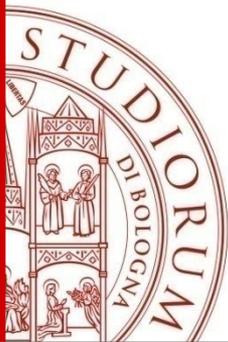
Al termine del trattamento diagnostico-terapeutico, l'operatrice/operatore sanitaria/o che ha preso in carico la donna utilizza lo strumento di rilevazione "*Brief Risk Assessment for the Emergency Department - DA5*"<sup>4</sup>, indicato dal Ministero della Salute, per essere coadiuvata/o nella elaborazione e formulazione di una corretta e adeguata rilevazione in Pronto Soccorso del rischio di recidiva e letalità e per adottare le opzioni di dimissioni di seguito suggerite:

#### **a) Rilevazione del rischio in Pronto Soccorso basso:**

L'operatrice/operatore sanitaria/o informa la donna della possibilità di rivolgersi ai Centri antiviolenza, ai servizi pubblici e privati della rete locale e la rinvia al proprio domicilio; qualora la donna acconsenta, attiva la rete antiviolenza territoriale.

#### **b) Rilevazione del rischio in Pronto Soccorso medio/alto:**

L'operatrice/operatore sanitaria/o informa la donna della possibilità di rivolgersi ai Centri antiviolenza, ai servizi pubblici e privati della rete locale e, qualora la donna acconsenta, attiva la rete antiviolenza territoriale.



# VIOLENCE AGAINST WOMEN: GUIDELINES FOR HEALTH SECTOR RESPONSE

WHO's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:



#### Women-centred care:

Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).



#### Training of health-care providers on intimate partner violence and sexual violence:

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.



#### Identification and care for survivors of intimate partner violence:

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.



#### Health-care policy and provision:

Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.



#### Clinical care for survivors of sexual violence:

Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.



#### Mandatory reporting of intimate partner violence:

Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.

All statistics can be found in the report entitled Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, by the World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council, found here: <http://www.who.int/reproductivehealth/publications/violence/vi16/en/index.html>

- Collaborazione fattiva con la rete territoriale intra ed extra ospedaliera;
- Lettura della rilevazione del rischio in Pronto Soccorso di recidiva e letalità;
- Promozione condivisa e sinergica di un sapere comune, volto al confronto e alla conseguente crescita professionale.

Per obiettivi, struttura e contenuto dei moduli formativi, si rinvia all'Allegato D) Formazione professionale delle presenti Linee guida nazionali.

La formazione professionale e l'aggiornamento continui di operatrici e operatori sono indispensabili per una buona attività di accoglienza, di presa in carico, di rilevazione del rischio e di prevenzione.

I moduli formativi dovranno fornire una adeguata conoscenza di base del fenomeno della violenza maschile contro le donne in merito a:

- Dinamiche della violenza da parte dei soggetti autori di violenza: come nasce e si sviluppa, il ruolo degli stereotipi e degli atteggiamenti sessisti;
- Conseguenze della violenza sulla salute e sul benessere della donna e delle/dei sue/suoi figlie/i;
- Tutela delle categorie vulnerabili, quali sono, specifici obblighi e possibili percorsi per donne disabili, in gravidanza, minori ecc.;
- Criteri e metodologie per instaurare con la donna una relazione fondata sull'ascolto e sull'accoglienza;
- Conoscenza delle risorse economiche e professionali disponibili sul territorio;



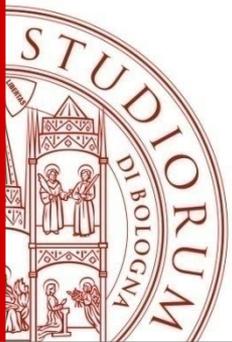
## PARTE QUARTA

### **Aziende sanitarie**

Le Aziende sanitarie locali e le Aziende ospedaliere, anche attraverso i propri distretti, presidi e servizi territoriali, devono adoperarsi affinché, nel prestare assistenza socio-sanitaria a donne che subiscono violenza, siano rispettate tutte le indicazioni contenute nelle presenti Linee guida nazionali.

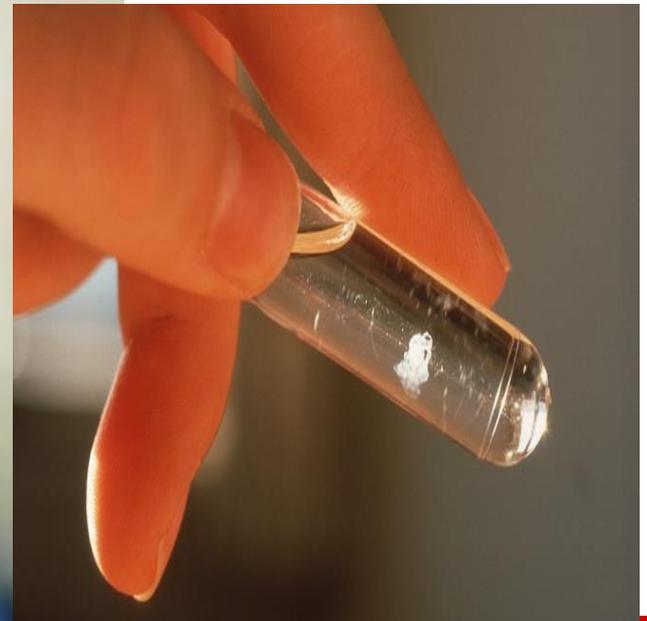
Dovranno di conseguenza impegnarsi a:

- ➔ - Realizzare al loro interno percorsi e procedure di accoglienza e presa in carico che prevedano e garantiscano, tra l'altro, il raccordo operativo e la comunicazione con tutti gli attori della rete antiviolenza territoriale;
- ➔ - Garantire una regolare e continua attività di formazione e aggiornamento del personale - compreso quello convenzionato -, partecipando alla progettazione e alla organizzazione di moduli formativi, anche avvalendosi delle competenze specifiche e operative maturate negli anni a partire dal proprio territorio;
- ➔ - Partecipare a tavoli di confronto periodici con istituzioni e soggetti pubblici e privati della rete antiviolenza territoriale;
- ➔ - Assicurare il monitoraggio costante del fenomeno della violenza maschile contro le donne, attraverso la rilevazione e il controllo degli strumenti in uso (scheda del *triage*, schede di dimissione);



**Barbara Kiwak  
Illustration Inc.**

# Genetica forense



- Ricerca e repertazione, nell'ambito della visita stessa, delle tracce di materiale biologico, avendo cura di adottare tutte le procedure capaci di evitare eventuali fenomeni di contaminazione (operatore-reperto, reperto, ambiente-reperto, ecc.),

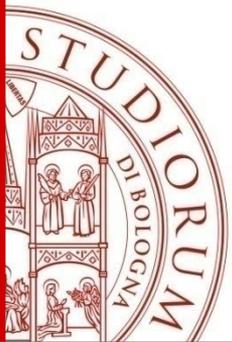




# Informazione → Consenso

- Il consenso alle procedure di repertazione di eventuali tracce biologiche dovrà essere formalizzato nella documentazione sanitaria



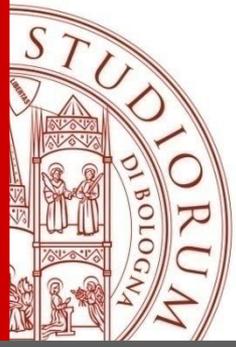


# SEXUAL ASSAULT KIT TESTING: WHAT VICTIMS NEED TO KNOW

FINGERPRINTING  
FORENSIC  
EXAMINATIONS

JUSTICE  
TESTING BACKLOG  
DEBRIS WITH A  
COLD HITS  
OFFENSE INDEX  
EXONERATION  
VINE  
STATISTICS  
JOHN DOE WARRANTS

THE NATIONAL CENTER FOR  
**Victims of Crime**



## What is a sexual assault kit (SAK)?\*

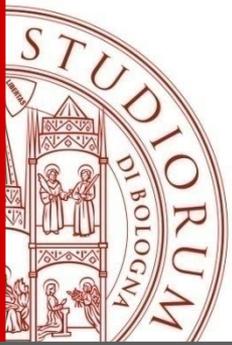
A sexual assault kit, or SAK (pronounced "sack"), is a set of swabs, slides, envelopes, instructions, and forms specifically designed to collect and preserve physical evidence that can be used in a criminal sexual assault investigation.

## What is collected in a SAK?

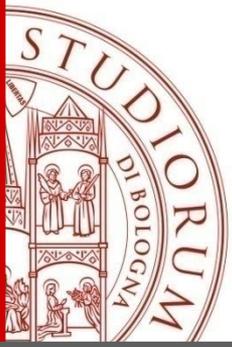
- DNA evidence, including blood, semen, and saliva, is collected from the victim's body to aid in identifying the perpetrator and to demonstrate that physical contact occurred.
- Other physical evidence, including clothing fibers, fingernail scrapings, and hairs, may be collected.
- The victim's clothing, particularly undergarments or clothing that have biological stains, may also be collected and considered to be part of the SAK.
- Blood will be collected from the victim to determine if blood stains belong to the victim or someone else.
- Urine may be collected for testing if a victim suspects she may have been drugged by the assailant.
- The victim's account of the assault will be documented and







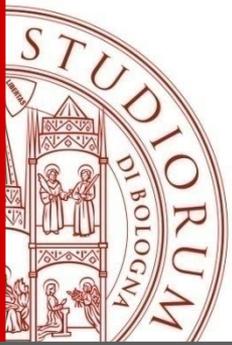
Non-genital injuries were noted in over a third of all cases in which the crime lab received the sexual assault kit. Common locations of non-genital injuries included the back (13.5%), the arms (15.1%), the legs (14.6%), and the neck (9.7%). A number of cases also had documented pattern injuries and bite marks (27%). Genital injuries were noted in almost half of all cases (41.4%), including redness (25.3%), abrasions (14.9%), and swelling (9.5%).



# DNA e condanna

## 57,1% vs 9,1%

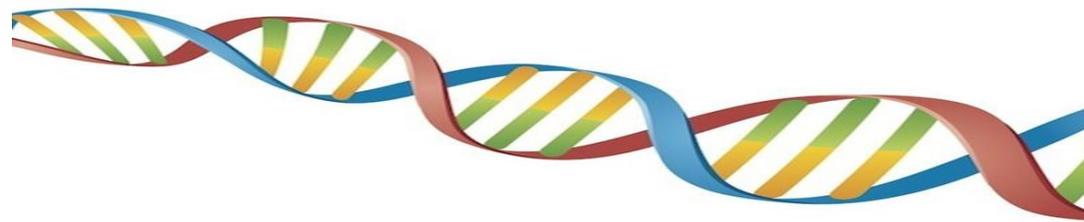
**DNA and Conviction.** Over half of cases (57.1%) with a DNA match to the suspect ended in conviction compared to 9.1% with crime laboratory results but no DNA match and 17.6% of cases without crime laboratory results. Conviction was also significantly more likely when there was clothing evidence and when there was blood evidence (though these forms of evidence were found in only 6 cases and 3 cases respectively) and when law enforcement collected more types of evidence. There was a greater likelihood of conviction when victims



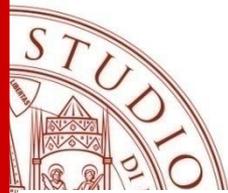
# Intervista al PM

## Findings from Prosecutor Interviews

Our interviews with prosecutors helped illuminate their strategies for using injury evidence and biological evidence and the prosecutors' assessment of their effects. Prosecutors stated that victims' undergoing forensic medical examinations was helpful in itself, because it helped support victims' credibility. They felt that juries would perceive victims' decisions not to get medical examinations as atypical for someone who was truly sexually assaulted. Prosecutors



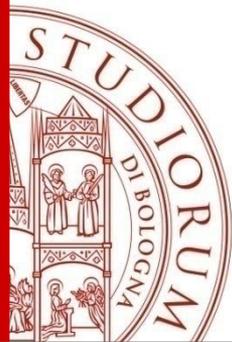
Prosecutors endorsed the value of biological evidence for establishing that there was a sexual act, for identifying suspects in stranger cases or when the victim's ability to identify the assailant is compromised, and for confirming that the correct person is being prosecuted, even if additional evidence exists linking the suspect to the assault. Findings from forensic analyses can be used in interrogations to confirm sexual contact when suspects deny it, and confront them about inconsistencies in their stories. Specific information about what biological evidence was found in which location on the body or in the room may confirm victims' account and contradict defendants' accounts. Some prosecutors felt that such evidence was particularly helpful in cases in which the defense may question the victim's credibility. Biological evidence tends to be



# La difesa

Defendants may even use the consent defense when victims are below the age of consent in hopes of obtaining jury nullification, in which juries refuse to apply the law because they believe a conviction to be unjust. One ADA speculated that suspects may use the consent defense more now than in the past because they know that DNA evidence will rebut claims that the victim fabricated their account.

Another defense strategy was to provide alternative explanations for why DNA was recovered from the victim or crime scene (e.g., a physical fight in which the offender spat on the victim's chest rather than placing their mouth there), particularly in child and adolescent victim cases in which consent is not a defense. Although a less common and less reliable tactic, defense attorneys were occasionally successful in challenging the integrity of procedures (e.g., chain of custody) or questioning crime laboratory conclusions on purportedly scientific grounds.



## **The Importance of an Effective System of Biological Evidence Collection and Analysis**

This study's findings underline the importance of DNA in sexual assault cases. They suggest that DNA is an important factor in prosecutors' decision to accept cases and carry them forward. They suggest that prosecutors, at least in the office we studied, value DNA evidence in prosecuting sexual assault and consistently make efforts to obtain it in cases they carry forward, to the point that it seems to be a practice standard. These results strengthen the case for providing victims access to quality forensic medical examinations and effective DNA analysis,



# Tossicologia forense





**Drug analysis**

**Blood spatter**

**Toxicology**

**Fingerprints**

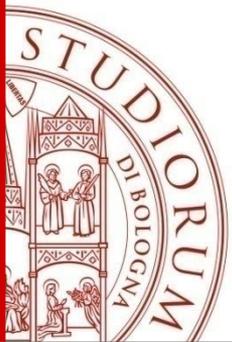
**Forensic pathology**

**Bite marks**

# Forensics on trial

Science used in court found to be wanting by the





# Codice penale

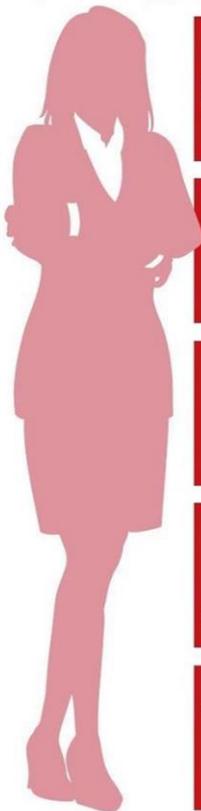
- **Art. 572** Maltrattamenti contro familiari o conviventi
- **Art. 570** Violazione degli obblighi di assistenza familiare
- **Art. 643** Circonvenzione di persone incapaci
- **Art. 591** Abbandono di persone minori o incapaci

## OBBLIGO DI DENUNCIA



# Il codice rosso

Proposta di legge per il contrasto alla violenza sulle donne



## CODICE ROSSO

La vittima di violenza, molestia dovrà essere sentita dal magistrato entro 3 giorni dalla iscrizione della denuncia.



## BOTTE IN FAMIGLIA

Reclusione da 3 a 7 anni (invece attuali). Pena aumentata se fatto in danno di un minore.



## STALKING

Reclusione da 1 a 6,5 anni dal minimo di 6 mesi a 5 anni.



## SFREGI

Da 8 a 14 anni per sfregio per il viso. Più difficile ottenere misure di prevenzione.



## VIOLENZA SESSUALE

Carcere da 6 a 12 anni, aggravata se con violenza di denaro o favori.

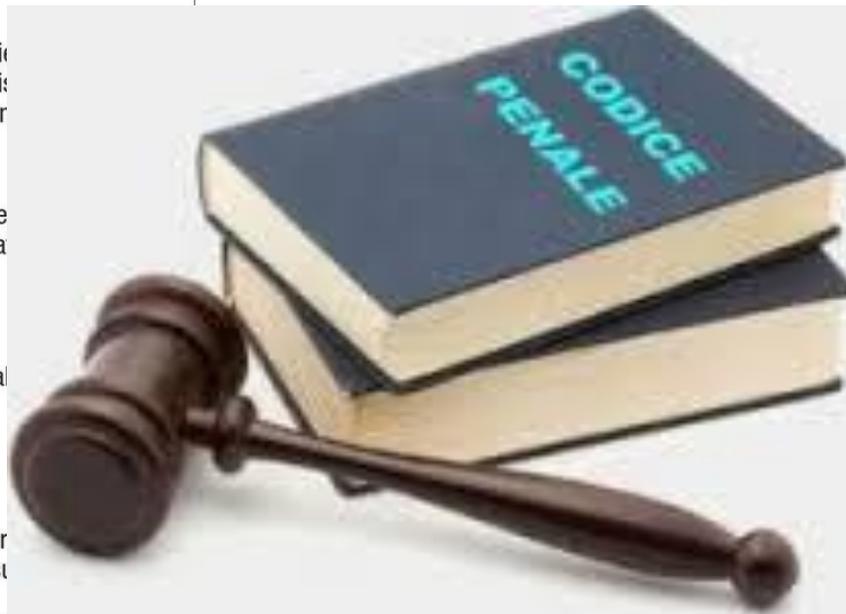
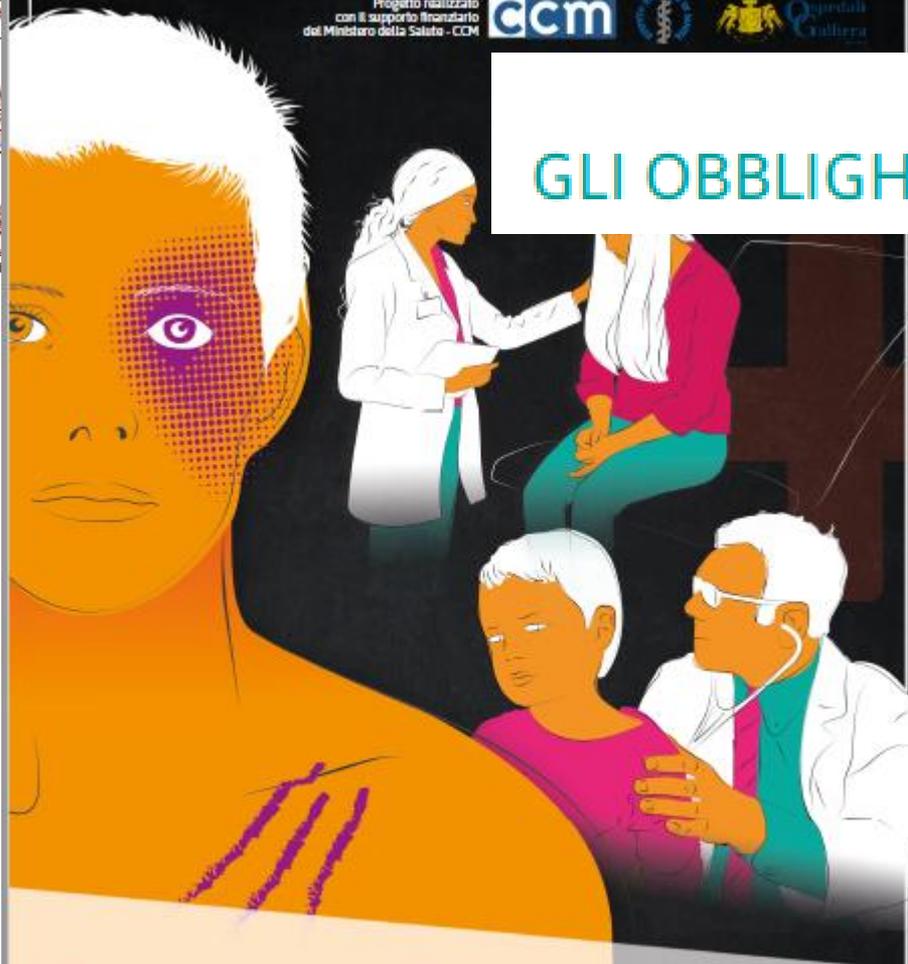


Figura professionale	di segnalazione	sottraggono all'obbligo di segnalazione	la notifica all'autorità giudiziaria	modalità di apprendimento del reato
Libero professionista (ESPN)	Referto	- Esporre il paziente a procedimento penale - Esporre a documento se stessi o un congiunto	Entro 48 ore	<b>Diretta:</b> il medico deve aver prestato personalmente assistenza a vittima e/o maltrattante.
Dipendente o convenzionato SSN (PU)	Rapporto	Nessuna	Senza ritardo	<b>Diretta e indiretta:</b> anche quando il medico è venuto a conoscenza del reato da terzi nell'esercizio della sua professione

Tabella 1

## GLI OBBLIGHI DI LEGGE PER IL MEDICO



Riconoscere, accogliere e accompagnare  
le persone vittime di violenza relazionale  
donne e minori in particolare

**MANUALE** per operatori di Pronto Soccorso

### DELITTO DI VIOLENZA SESSUALE PERSEGUIBILE D'UFFICIO

- Se il fatto (Ex Art. 609 bis, violenza sessuale) è commesso nei confronti di una persona che all'epoca dei fatti non aveva compiuto gli anni 18;
- Se il fatto è commesso dall'ascendente, da genitore, anche adottivo o dal di lui convivente o da altra persona cui il minore è affidato per ragioni di cura, di educazione, di istruzione, di vigilanza o di custodia o che abbia con esso una relazione di convivenza;
- Se il fatto è commesso da un pubblico ufficiale o da un incaricato di pubblico servizio nell'esercizio delle proprie funzioni;
- Se il fatto è commesso con altro delitto per il quale si deve procedere d'ufficio (es. lesioni personali dolose, superiori ai 20 gg, maltrattamenti in famiglia);
- Se il fatto è commesso nell'ipotesi di cui all'art 609 quater, ultimo comma (con minori di anni 10);
- Se attuata violenza di gruppo.

DELITTI CONTRO LA VITA (art. 575 c.p. e seg)

DELITTI CONTRO L'INCOLUMITÀ INDIVIDUALE (art. 582 c.p. e seg) (Lesioni personali dolose lievi, gravi o gravissime o colpose gravi e gravissime da violazione delle norme per la prevenzione degli Infortuni sul Lavoro e Malattie Professionali). Secondo un'interpretazione prevalente, anche le lesioni colpose da incidente stradale rientrano - se gravi - tra quelle procedibili d'ufficio.

ABUSO DEI MEZZI DI CORREZIONE O DISCIPLINA (art. 571 c.p.)

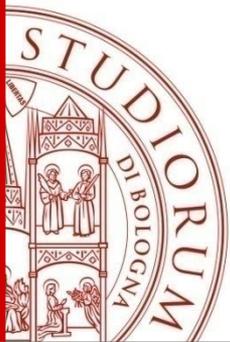
MALTRATTAMENTO IN FAMIGLIA O VERSO FANCIULLI (art. 572 c.p.)

SEQUESTRO DI PERSONA (art. 605 c.p.)

VIOLENZA PRIVATA (art. 610 c.p.)

MINACCE (art. 612 c.p.) (Se grave, con uso di armi, da più persone, etc ... vedi art.339 c.p.)

ATTI PERSECUTORI (art. 612 bis c.p.) (Nei confronti di minori o disabilità art. 3 L. 104/92)



# Childhood maltreatment is associated with distinct genomic and epigenetic profiles in posttraumatic stress disorder

Divya Mehta<sup>a,1</sup>, Torsten Klengel<sup>a</sup>, Karen N. Conneely<sup>b</sup>, Alicia K. Smith<sup>c</sup>, André Altmann<sup>a</sup>, Thaddeus W. Pace<sup>c,d</sup>, Monika Rex-Haffner<sup>a</sup>, Anne Loeschner<sup>a</sup>, Mariya Gonik<sup>a</sup>, Kristina B. Mercer<sup>e</sup>, Bekh Bradley<sup>c,f</sup>, Bertram Müller-Myhsok<sup>a</sup>, Kerry J. Ressler<sup>c,e,g</sup>, and Elisabeth B. Binder<sup>a,c</sup>

<sup>a</sup>Max Planck Institute of Psychiatry, 80804 Munich, Germany; <sup>b</sup>Department of Human Genetics, <sup>c</sup>Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA 30322; <sup>d</sup>Winship Cancer Institute, Emory University, Atlanta, GA 30322; <sup>e</sup>Howard Hughes Medical Institute, Chevy Chase, MD 20815-6789; <sup>f</sup>Veteran's Affairs Medical Center, Decatur, GA 30033; and <sup>g</sup>Yerkes National Primate Research Center, Atlanta, GA 30322

Edited by Bruce S. McEwen, The Rockefeller University, New York, NY, and approved March 19, 2013 (received for review October 12, 2012)



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Published online 20 February 2009 | Nature | doi:10.1038/news.2009.113

**News**

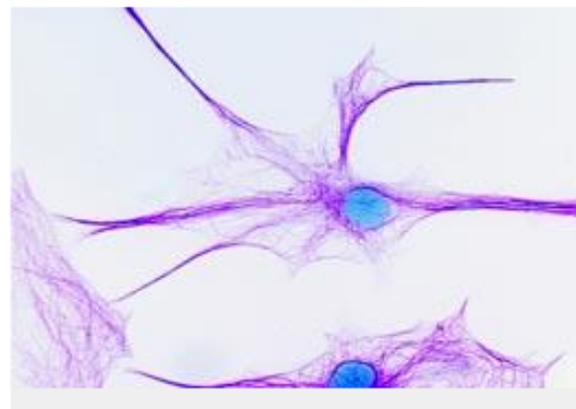
## Child abuse leaves lasting 'scars' on DNA

**Lingering marks on DNA could amplify stress responses.**

Heidi Ledford

Suicide victims with a history of abuse during childhood are more likely to carry chemical changes to their DNA that could affect how they respond to stress as adults, a study has found.

Those with no history of childhood abuse did not





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## Violence and Injury Prevention

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Data collection

Care of the injured

Disability and rehabilitation

Policies

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Publications

### Elder abuse



WHO/Sergey Volkov

The abuse of older adults occurs all too frequently but remains a largely hidden problem. It is predicted to increase as many countries are experiencing rapidly ageing populations. Elder abuse can lead to serious physical injuries and long-term psychological consequences, increased risk of nursing home placement, use of emergency services, hospitalization and death. Promising prevention and response strategies include:

- professional awareness campaigns to help health care workers recognize elder abuse
- caregiver support to reduce stress and training on dementia
- residential care policies to define and improve standards of care

**16%**

of older people were abused in the past year

**Only 4%**

of elder abuse is reported

**41%**

of WHO Member States report having a national action plan for preventing elder abuse

# MISSING VOICES

# 2002

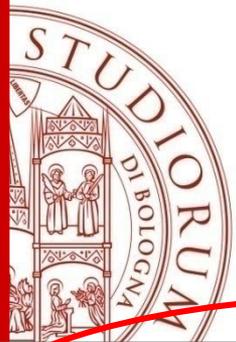
Views of older persons on elder abuse



World Health Organization  
Geneva

The conclusions contain recommendations for action, some of which are already being implemented, with others to follow in the near future. These recommendations can be summarised as follows:

- To develop a screening and assessment tool for use in primary health care settings
- To develop an education package on elder abuse for primary health care professionals
- To develop and disseminate a research methodology 'kit' to study elder abuse
- To develop a Minimum Data Set concerning violence and older people
- To ensure dissemination of the research findings through scientific journals
- To develop a global inventory of good practice
- To mobilize civil society through raising awareness of the widespread magnitude of elder abuse



**2008**

As a result, elder abuse continues to be a taboo, mostly underestimated and ignored by societies across the world.

Evidence is accumulating, however, to indicate that elder abuse, which includes the pervasive issue of neglect, is an important public health and societal problem that manifests itself in both developing and developed countries. As such, it demands a global orchestrated response. From a health and social perspective, unless the primary health care (PHC) and social services sectors are well equipped to identify and deal with the problem, elder abuse will continue to be underdiagnosed and overlooked.

## A Global Response to Elder Abuse and Neglect:

Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report



### The project objectives are:

- To develop and validate a reliable instrument applicable in different geographical and cultural contexts in order to increase awareness among PHC professionals to the problem of elder abuse and neglect.
- To build the capacity of PHC workers to deal with elder abuse and neglect through evidence-based education for the development of prevention strategies.

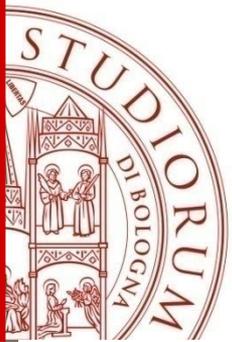


# 2011

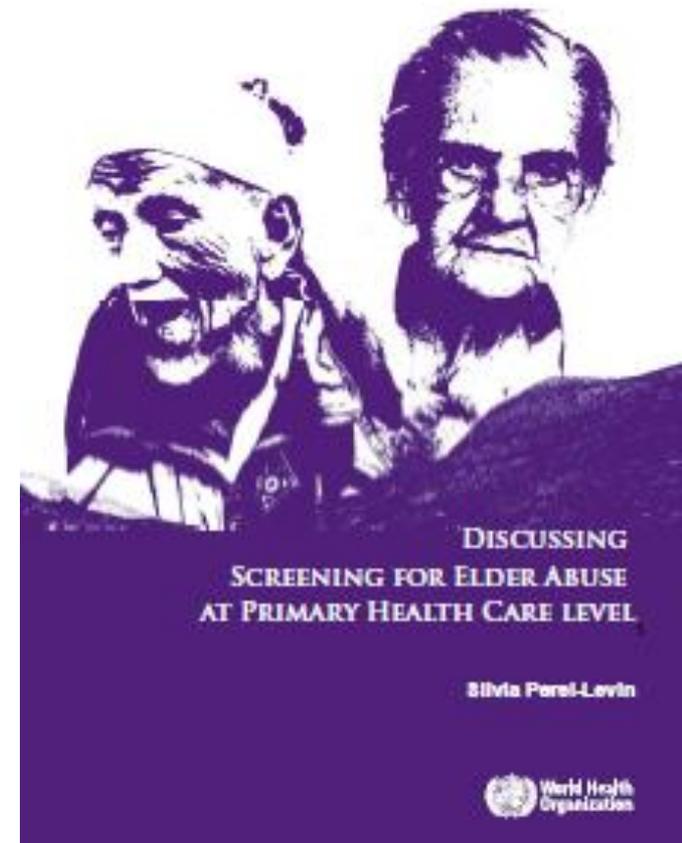
*The problem of elder maltreatment is a common challenge across government departments and a shared problem that cuts across the activity areas of many sectors. Health systems have a key role to play in providing services for victims of maltreatment who have been harmed physically and mentally. The health sector is also best placed to advocate for preventive approaches with an evaluative framework. Decisive action is needed now to fill these gaps in research and to take effective steps to secure the safety and well-being of older people in the European Region. Prevention and social justice for older people can only be achieved by mainstreaming the response into other areas of health and social policy.*

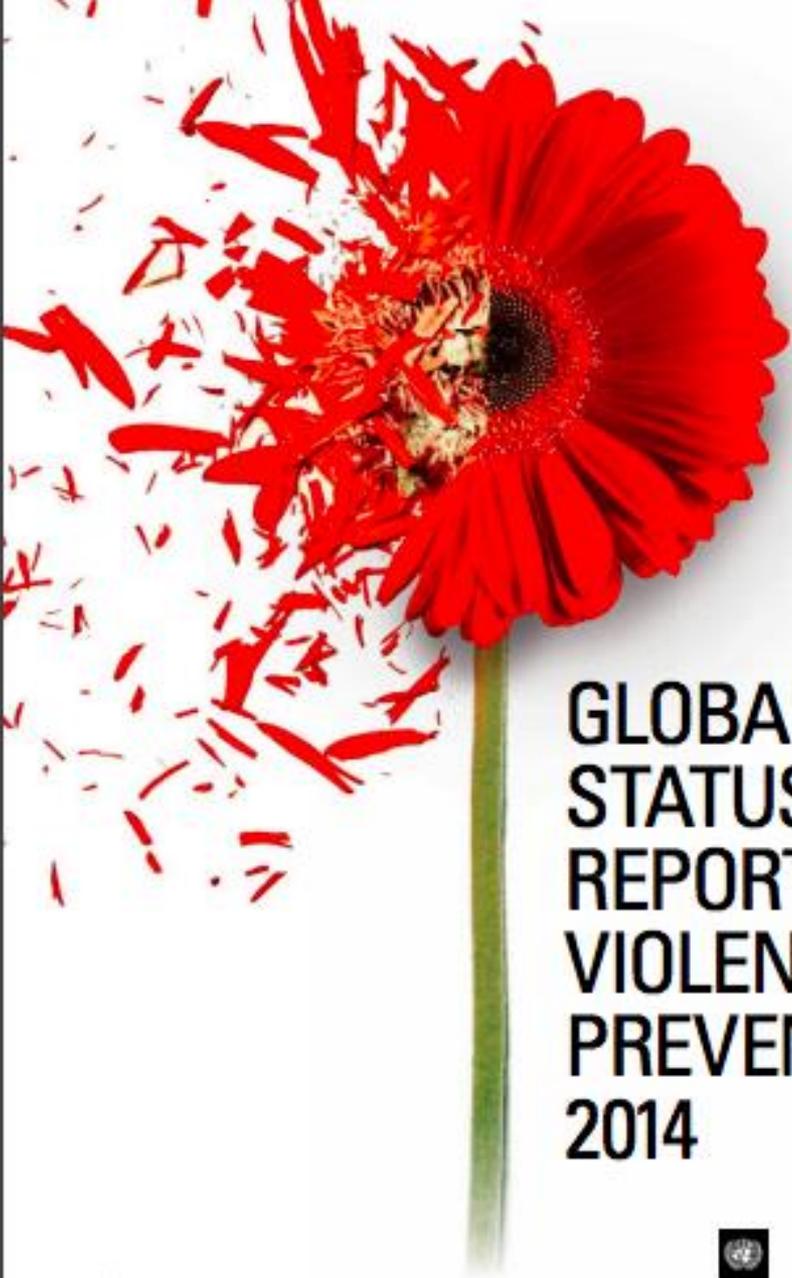
*We invite Member States of the European Region to join the global effort to reduce a leading health and social problem and to create safer and more just societies for older people. We at WHO hope that this report will provide policy-makers, practitioners and activists with the facts needed to integrate the agenda for preventing elder maltreatment both within and outside the health sector.*

European report  
on preventing elder  
maltreatment



Although women have the advantage of longevity, they are more likely than men to experience domestic violence and discrimination in access to basic services, such as education, health care and social security, resulting in a cumulative status of ill-health, which, due to women's second-class status, is often neglected or ignored (1). Therefore, it is critical to analyse the abuse of older women not only within the context of population numbers where women outnumber men but also in the context of a life-course of discrimination, oppression and abuse.





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# GLOBAL STATUS REPORT ON VIOLENCE PREVENTION 2014



World Health  
Organization



UNODC

United Nations Office on Drugs and Crime



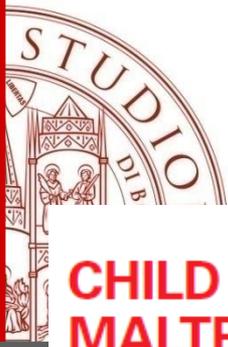
UN  
DP

United Nations  
Development Programme

Approximately  
800,000 victims

STUDIORUM - UNIVERSITÀ DI BOLOGNA

FOI AI TERMINI DI LEGGE DA ALTRE PERSONE O PER FINI NON ISTITUZIONALI



## CHILD MALTREATMENT

Millions of children suffer abuse and neglect at the hands of their parents and other caregivers.

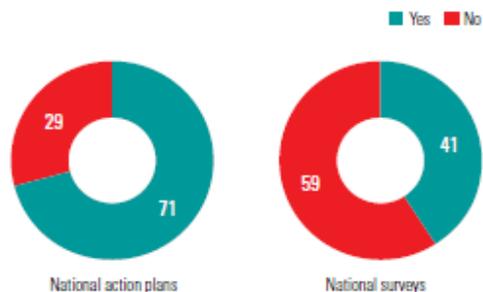
### Findings from the survey

The majority of countries report having adopted national action plans to address child maltreatment. Many countries report that prevention programmes for child maltreatment are being implemented. However, only a minority of countries report implementing these measures at scale.

### Prevention approaches

There are a number of evidence-based programmes designed to help strengthen early relationships and interactions between children and their caregivers, promote healthy development and prevent child maltreatment.

### Proportion of countries with national action plans and surveys



## INTIMATE PARTNER VIOLENCE

Globally, one in three women has been a victim of violence by an intimate partner.

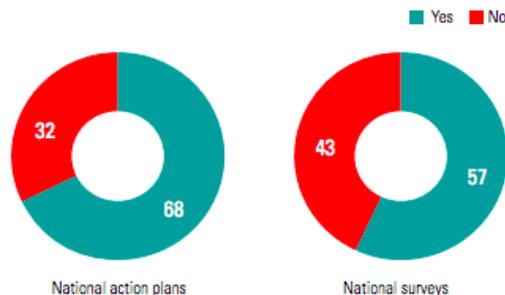
### Findings from the survey

A majority of countries report having conducted national surveys on intimate partner violence and two thirds report having national action plans to address it. Far fewer report implementing school- and community-based programmes to change attitudes and behaviour directly.

### Prevention approaches

Promoting gender equity, creating a climate of non-tolerance for violence and starting prevention efforts at a young age are some of the key strategies for preventing intimate partner violence.

### Proportion of countries with national action plans and surveys



## ELDER ABUSE

Many older people experience some form of abuse in the home.

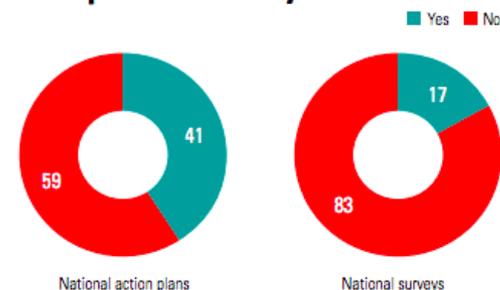
### Findings from the survey

Although public and professional information campaigns to raise awareness about elder abuse are reported in many countries, elder abuse is one of the least-investigated types of violence in national surveys, and one of the least addressed in national action plans.

### Prevention approaches

Strategies to prevent elder abuse include efforts to raise professional awareness and train practitioners; inform the public about how to identify the signs and symptoms of elder abuse and where help can be obtained, and improving policies and practices in residential care facilities for elderly people. There is, however, very little research on the effectiveness of any such programmes in preventing elder abuse, and this is a critical gap to fill.

### Proportion of countries with national action plans and surveys



# New WHO Violence Prevention Information System, an interactive knowledge platform of scientific findings on violence

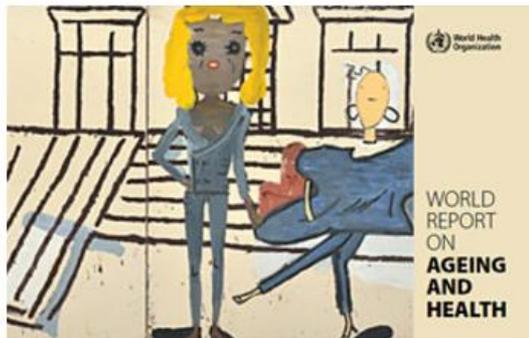
Stephanie Burrows,<sup>1</sup> Alexander Butchart,<sup>1</sup> Nadia Butler,<sup>2</sup> Zara Quigg,<sup>2</sup> Mark A Bellis,<sup>3,4</sup>  
Christopher Mikton<sup>5</sup>

Updated information and services can be found at:  
<http://injuryprevention.bmj.com/content/24/2/155>



Figure 1 WHO Violence Prevention Information System, an interactive knowledge platform of scientific findings on violence.

## World report on ageing and health 2015



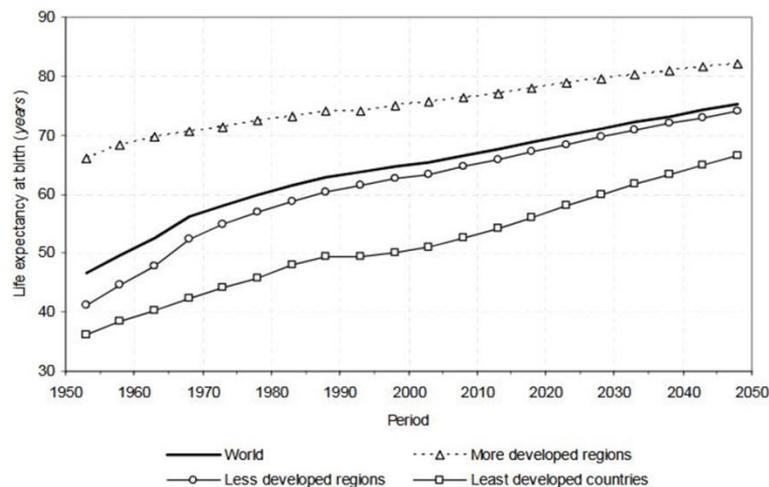
Rose Willey

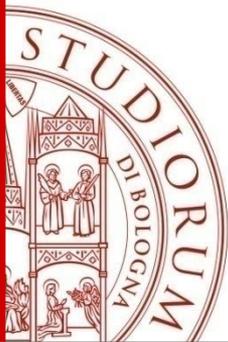
30 September 2015 - Comprehensive public health action on population ageing is urgently needed. This will require fundamental shifts, not just in the things we do, but in how we think about ageing itself. The *World report on ageing and health* outlines a framework for action to foster *Healthy Ageing* built around the new concept of functional ability. Making these investments will have valuable social and economic returns, both in terms of health and well-being of older people and in enabling their on-going participation in society.

WHO news release: Number of people over 60 years set to double by 2050; major societal changes required

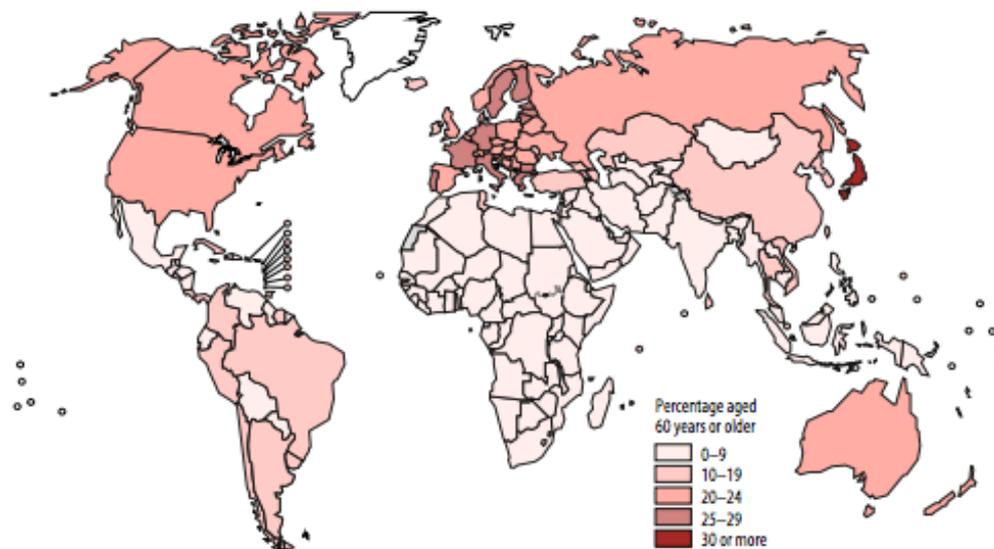
*The Gerontologist* Special Supplement on the *World report*

# Progressivo invecchiamento della popolazione (nel 2050 gli anziani raddoppieranno: dai 900 milioni di oggi a quasi due miliardi)

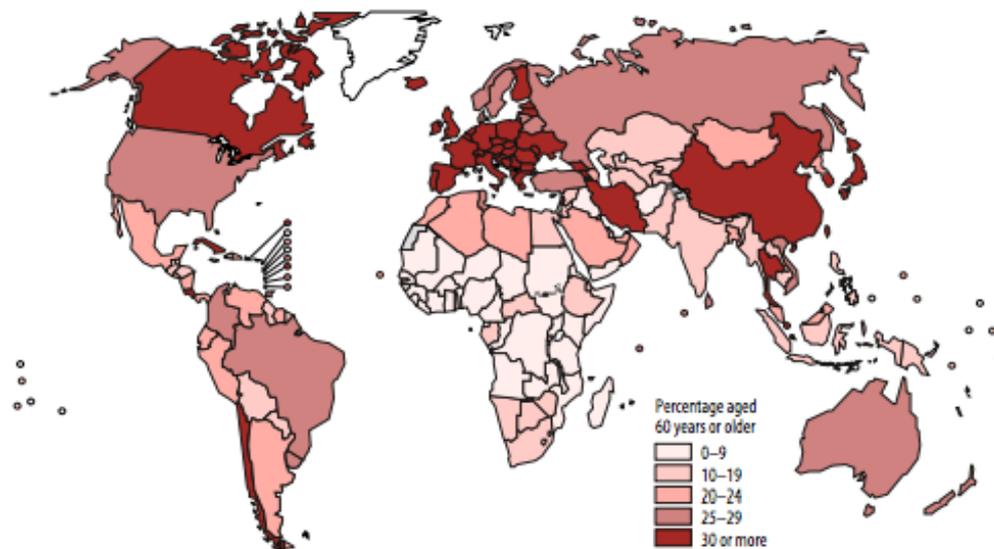




**Fig. 3.1.** Proportion of population aged 60 years or older, by country, 2015



**Fig. 3.2.** Proportion of population aged 60 years or older, by country, 2050 projections



# AUMENTANO GLI ANZIANI E SI ALLUNGA LA VITA MEDIA

## POPOLAZIONE ANZIANA

Anni 2007 e 2017. Valori assoluti e percentuali

Popolazione anziana. 1° gennaio, anni 2007 e 2017



2007

2017

11,7 milioni  
20,1% della popolazione

13,5 milioni  
22,3% della popolazione

90 ANNI E PIÙ

466.700  
0,8% della popolazione

727.000  
1,2% della popolazione

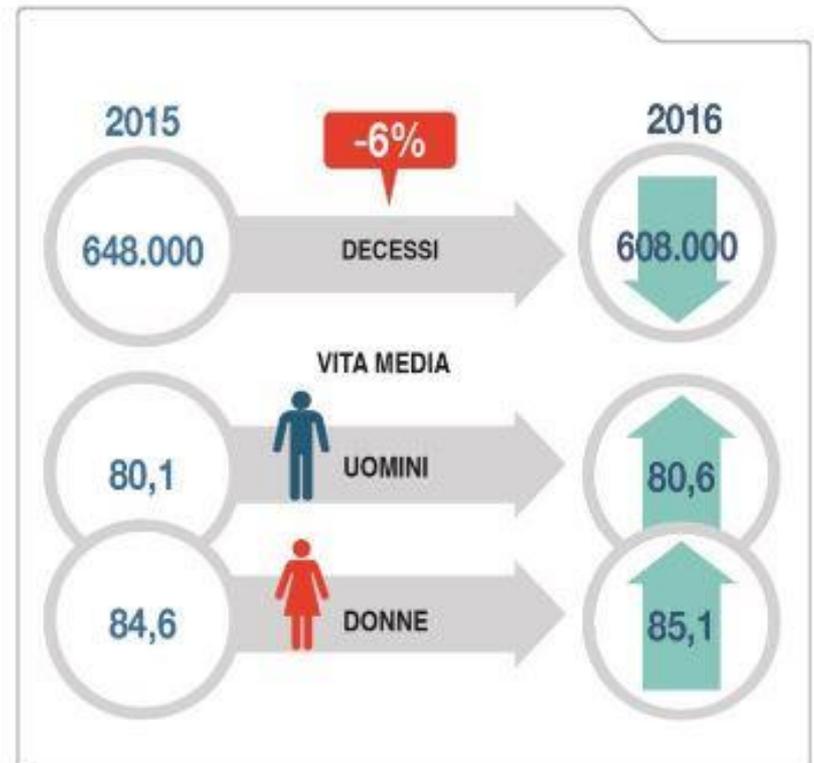
ULTRACENTENARI

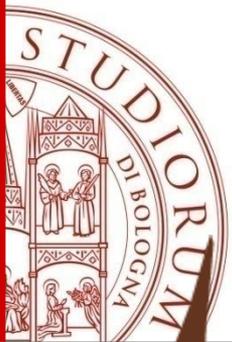
10.386  
0,02% della popolazione

17.000  
0,03% della popolazione

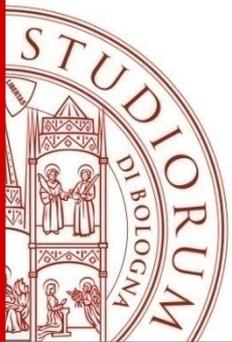
## DECESSI E VITA MEDIA

Anni 2015 e 2016. Valori assoluti e percentuali



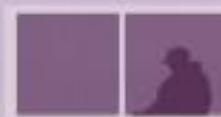


Elders who experience  
even modest abuse had a  
**300 percent  
higher risk  
of death**



# Elder Abuse

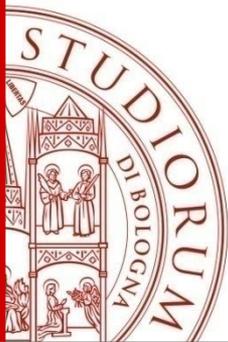
The Health Sector Role in Prevention and Response



Elder abuse is a hidden problem.  
**1 in 6** older adults worldwide  
have been abused in the past year.



World Health  
Organization



## What is elder abuse?

It's the abuse and neglect of older people. **It takes many forms.**



### Physical abuse

- Hitting, pushing, kicking
- Inappropriate use of drugs or restraints



### Psychological or emotional abuse

- Insults, threats, humiliation, controlling behavior, confinement and isolation



### Sexual abuse

- Sexual contact without consent



### Financial exploitation

- Misusing or stealing a person's money or assets



### Neglect or abandonment

- Not providing food, housing, or medical care

Elder abuse **can happen just once or repeatedly.**

People who commit elder abuse are **often in a position of trust.**



Family members

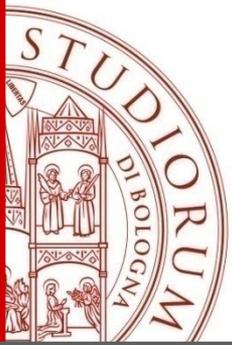


Health care workers



# World Health Organization

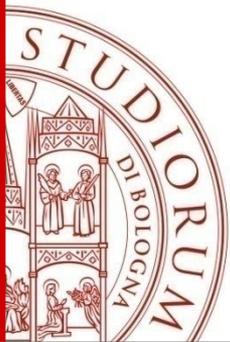
	Elder abuse in community settings (1)	Elder abuse in institutional settings (2)	
Type of abuse	Reported by older adults	Reported by older adults and their proxies	Reported by staff
<b>Overall Prevalence</b>	<b>15.7%</b>	<b>Not enough data</b>	<b>64.2% or 2 in 3 staff</b>
Psychological abuse:	11.6%	33.4%	32.5%
Physical abuse:	2.6%	14.1%	9.3%
Financial abuse:	6.8%	13.8%	Not enough data
Neglect:	4.2%	11.6%	12.0%
Sexual abuse:	0.9%	1.9%	0.7%



# Abuso finanziario

- Disturbi cognitivi
- Associato ad altri tipi di abuso o neglect

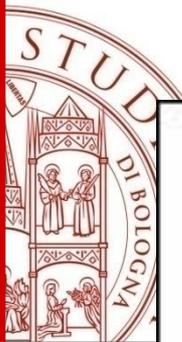




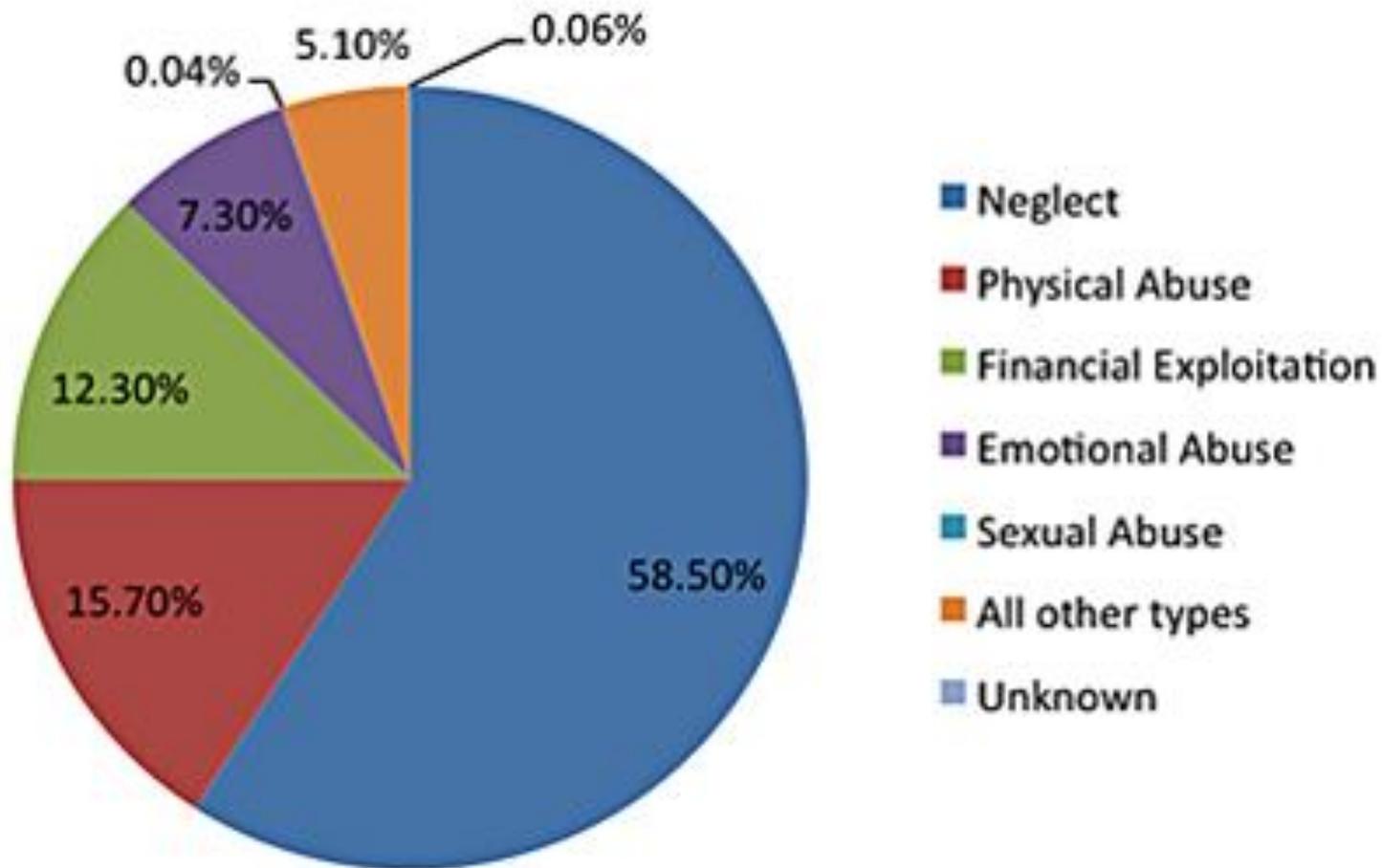
# Abuso “by system”

- Da trattamenti disumanizzanti nei luoghi di ricovero
- Da emarginazione dovuta alla mancanza di politiche in favore dell’anziano

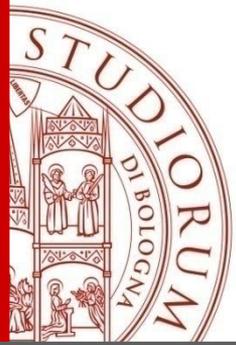




## Types of Elder Abuse

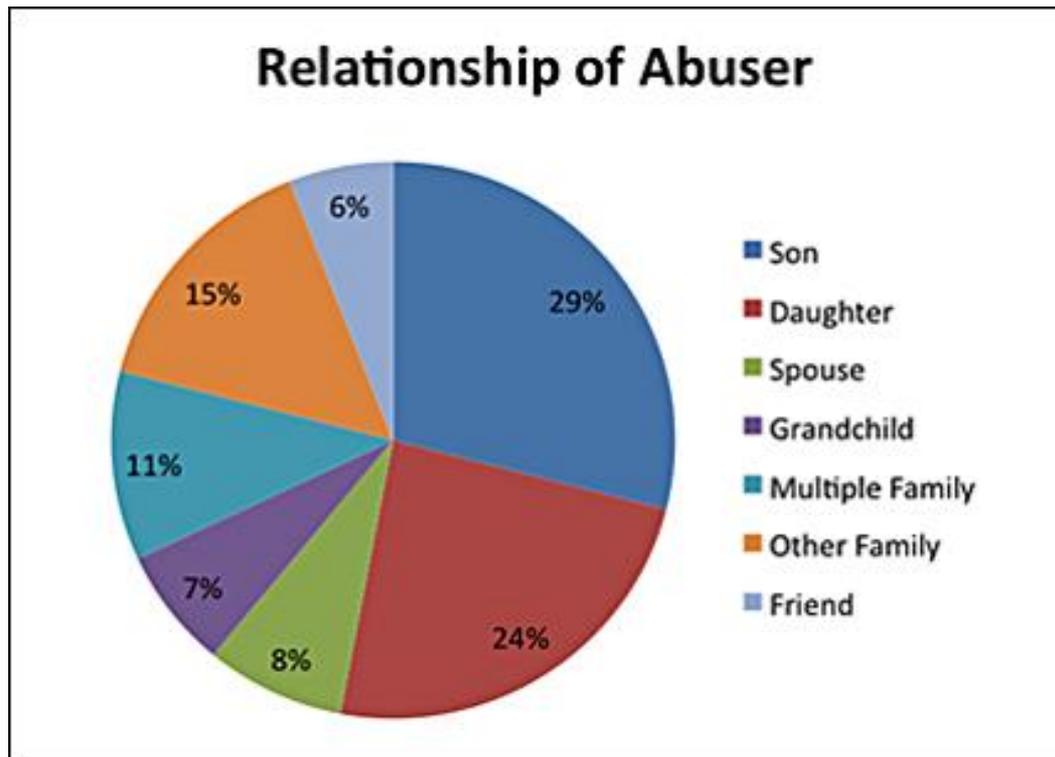


National Center on Elder Abuse, Bureau of Justice Statistics. 2012



# Dove avviene l'abuso

- Circa i 2/3 dei casi avviene in famiglia





# Elderly Domestic Abuse

### Do older people seek help?

Research shows that older people are less likely to report abuse than younger age groups; they do not access third sector specialist services and they also want help for the abuser.

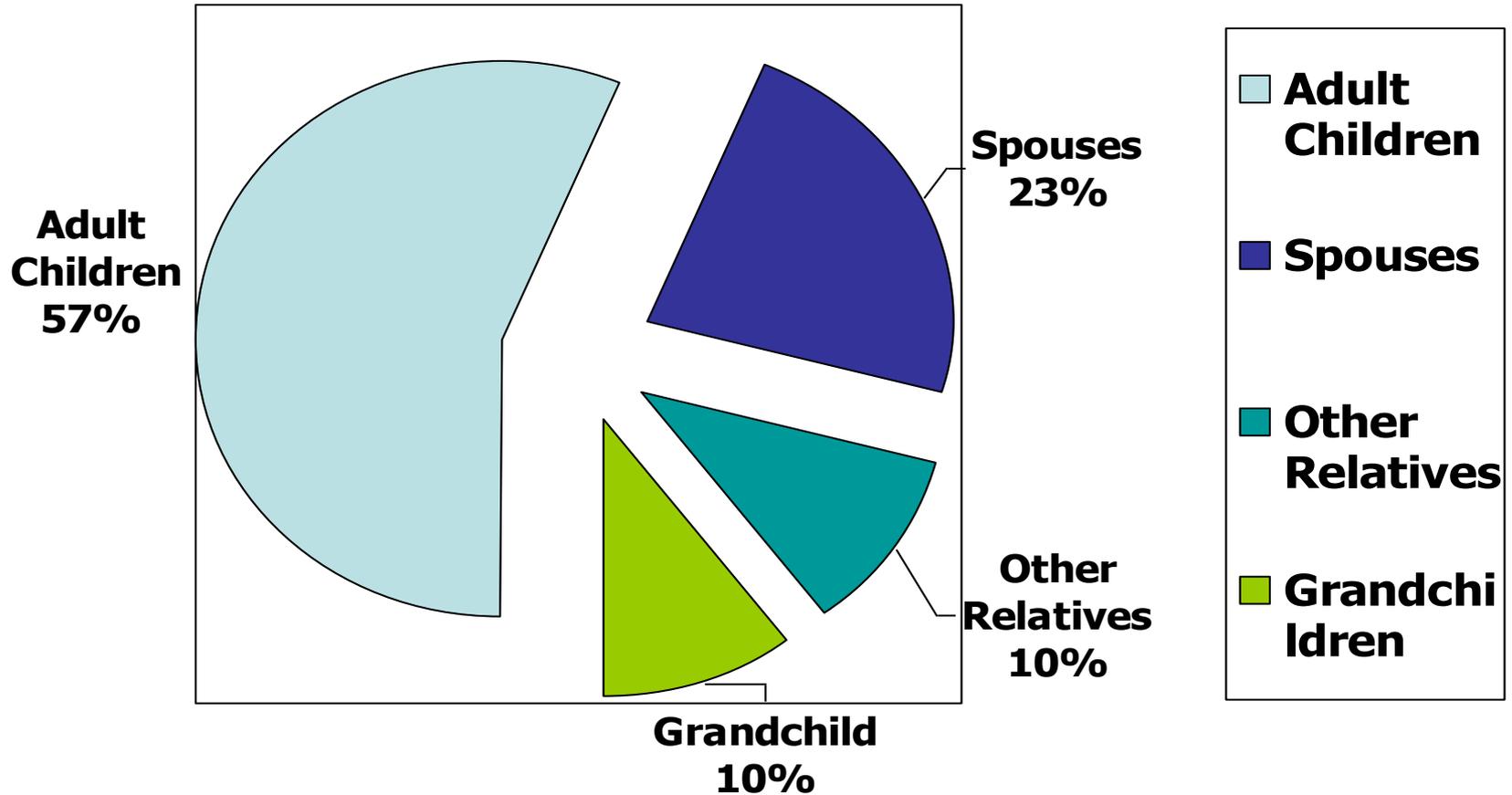
### Why is there a lack of reporting?

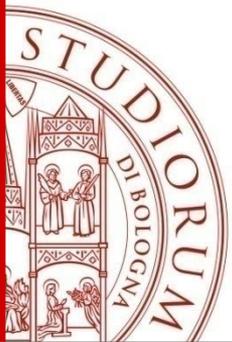
- A misguided feeling that they are somehow responsible for the abuse;
- Fear of repercussions from the perpetrator;
- A greater level of emotional, financial and physical dependence on their perpetrator than their younger counterparts;

- They do not want to criminalise the abuser, who may well be a child or grandchild.

### On an organisational level:

- Our research shows that existing services are not suitable for older victims.
- Services are often tailored towards safely removing the victim-survivor from the harmer through relocation from the family home and the community.
- Decision-makers frequently view older people as a homogenous vulnerable group of adults that are unable to make their own decisions.

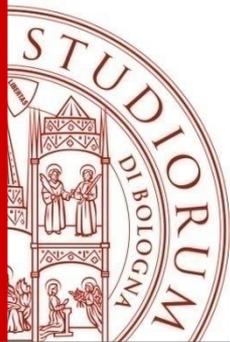




# L'aggressore

- **Gli uomini sono più frequentemente autori di abuso fisico, finanziario e psicologico**
- **Le donne sono in più del 50% dei casi responsabili di abbandono nell'assistenza**





# Breaking Point

Is this the face  
of a victim or a  
perpetrator?



# Quali sono i fattori di rischio

#NoticeMe

The strength of evidence is strong - risk factors for elder abuse include: significant disability, poor physical health, depression, low socioeconomic status\*. But not always.

\* World Health Organisation. 2015 World Report on Ageing and Health

## FATTORI DI RISCHIO

## FATTORI PROTETTIVI

Fattori legati alla persona anziana	Decadimento cognitivo	Fattori individuali	Sesso maschile
	Problemi comportamentali		Buona condizione psico-fisica
	Malattie psichiatriche		Buona condizione socio-economica
	Basso reddito		
Fattori legati al perpetratore dell'abuso	Caregiver sovraccaricato o stressato	Fattori legati alle relazioni	Far parte di una rete sociale ampia e con legami forti
	Problemi psicologici/ di dipendenza		
	Disarmonie familiari/relazioni conflittuali		
Fattori legati all'ambiente	Scarso supporto sociale	Fattori legati all'ambiente	Coordinazione delle risorse e dei servizi tra i vari enti della comunità
	Disagio socio/economico		



# Elder Abuse and Animal Cruelty

Elder abuse and animal abuse go together so often that when I see one I automatically look for the other.



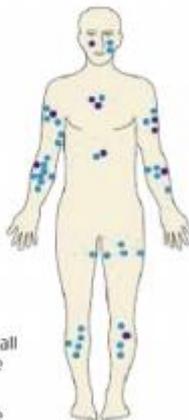
Barbara Fabricant

25 year investigator of animal abuse

## Anterior Comparison

PART I: ACCIDENTAL

PART II: PHYSICAL ABUSE



### ORIGIN OF ACCIDENTAL BRUISES

- Not able to recall cause of bruise
- Able to recall cause of bruise

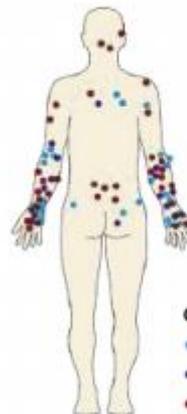
### ORIGIN OF BRUISE

- Unknown
- Accidental
- Inflicted

## Posterior Comparison

PART I: ACCIDENTAL

PART II: PHYSICAL ABUSE



### ORIGIN OF ACCIDENTAL BRUISES

- Not able to recall cause of bruise
- Able to recall cause of bruise

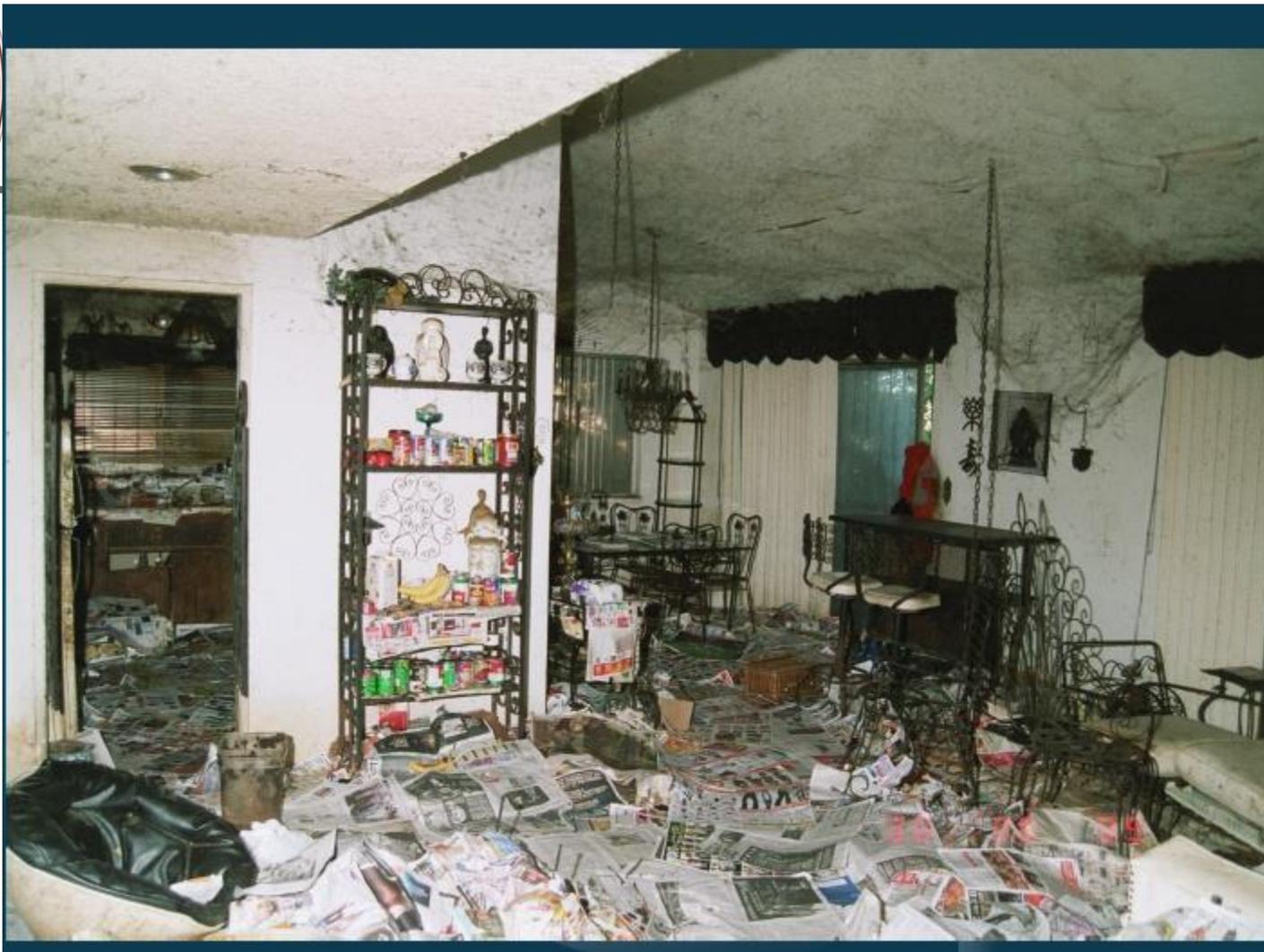
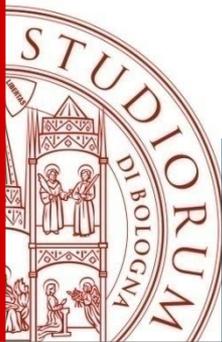
### ORIGIN OF BRUISE

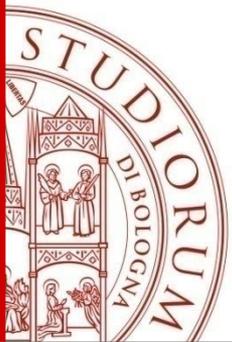
- Unknown
- Accidental
- Inflicted

# Auto-trascuratezza “Self-neglet”

- Non vi è una persona che abusa. è l'anziano non si prende cura di se stesso
- Non tutti concordi nel fare rientrare questa forma nell'abuso







## Elder abuse has devastating consequences.

It has **physical effects.**



Injuries



Lasting disabilities



Worsened health conditions

It has **psychological effects.**



Anxiety



Loneliness



Loss of dignity, trust, and hope

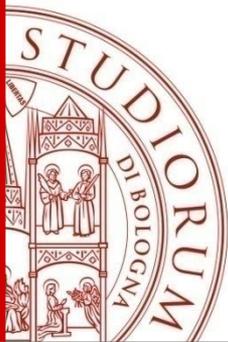
One study from the United States tracked older people over 13 years and found:

**Victims of elder abuse were twice as likely to die** compared to older people who did not report abuse.

## Elder abuse has high costs.



In the United States:  
**US\$5.3 billion**  
each year in medical costs from violent injuries to older people



## Elder abuse is **preventable** – and everyone has a role to play.

We can help ensure that older people live in safety – **without fear of being hurt, exploited, or neglected.**



### The public can:

- ✓ Watch for signs of elder abuse
- ✓ Learn how to get help and report abuse



### Older people can:

- ✓ Stay connected to family and friends
- ✓ Learn more about their rights
- ✓ Use professional services for support where available
- ✓ Make sure their financial and legal affairs are in order



### Family and informal caregivers can lower their risk of committing abuse by learning ways to cope:

- ✓ Get help from family or friends
- ✓ Take breaks
- ✓ Get support from local health and social services



# 11 Things that Anyone Can Do to Prevent Elder Abuse

**1** Learn the **signs of elder abuse and neglect**



**2** **Call or visit an elderly loved one** and ask how he or she is doing

**3** Provide a respite **break for a caregiver**



**4** Ask your bank manager to train tellers on **how to detect elder financial abuse**

**5** **Ask your doctor** to ask you and all other senior patients about possible family violence in their lives



**6** **Contact your local Adult Protective Services or Long-Term Care Ombudsman** to learn how to support their work helping at-risk elders and adults with disabilities

**7** Organize a **“Respect Your Elders” essay or poster contest** in your child’s school

**8** Ask your religious congregation’s leader to **give a talk about elder abuse** at a service or to put a message about elder abuse in the bulletin

**9** **Volunteer to be a friendly visitor** to a nursing home resident or to a homebound senior in your neighborhood

**10** Send a letter to your local paper, radio or TV station suggesting that they cover **World Elder Abuse Awareness Day** (June 15) or **Grandparents Day** in September



**11** Dedicate your **bikeathon/marathon/other event** to elder mistreatment awareness and prevention

# 1. Detection Tool – EASI

## Elder Abuse Suspicion Index - (EASI)

- Developed by Dr. Mark Yaffe, Maxine Lithwick and Christina Wolfson – Montreal/McGill
- **6 question tool for use by physicians to assess suspicion of potential cases of abuse of older adults**
- Designed for use with mentally capable older adults
- Other uses being explored
- Adapted for use in different countries (Israel, England)



### ELDER ABUSE SUSPICION INDEX © (EASI)

#### WHAT IS EASI?

The EASI was developed\* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated\* for use by family practitioners of cognitively intact seniors seen in ambulatory settings.

\*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 276-300. Haworth Press Inc: <http://www.HaworthPress.com>

© The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459)

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Maxine Lithwick, MSW CSSS Cavendish, Montreal, Canada  
[maxine.lithwick.cd@ssss.gouv.qc.ca](mailto:maxine.lithwick.cd@ssss.gouv.qc.ca)

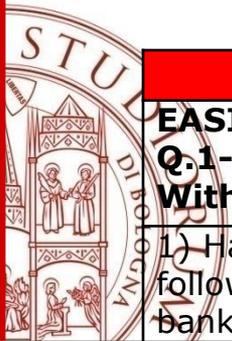
Christina Wolfson, PhD McGill University, Montreal, Canada  
[christina.wolfson@mcgill.ca](mailto:christina.wolfson@mcgill.ca)

### EASI QUESTIONS

Q.1-Q.5 asked of patient; Q.6 answered by doctor

#### Within the last 12 months:

- 1 Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? Yes  No   
Did not answer
- 2 Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? Yes  No   
Did not answer
- 3 Have you been upset because someone talked to you in a way that made you feel shamed or threatened? Yes  No   
Did not answer
- 4 Has anyone tried to force you to sign papers or to use your money against your will? Yes  No   
Did not answer
- 5 Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? Yes  No   
Did not answer
- 6 Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? Yes  No   
Not Sure



## ELDER ABUSE SUSPICION INDEX © (EASI)

### EASI Questions

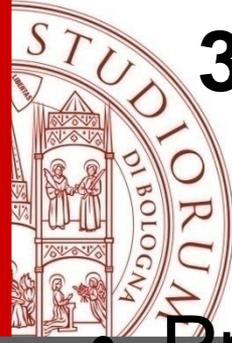
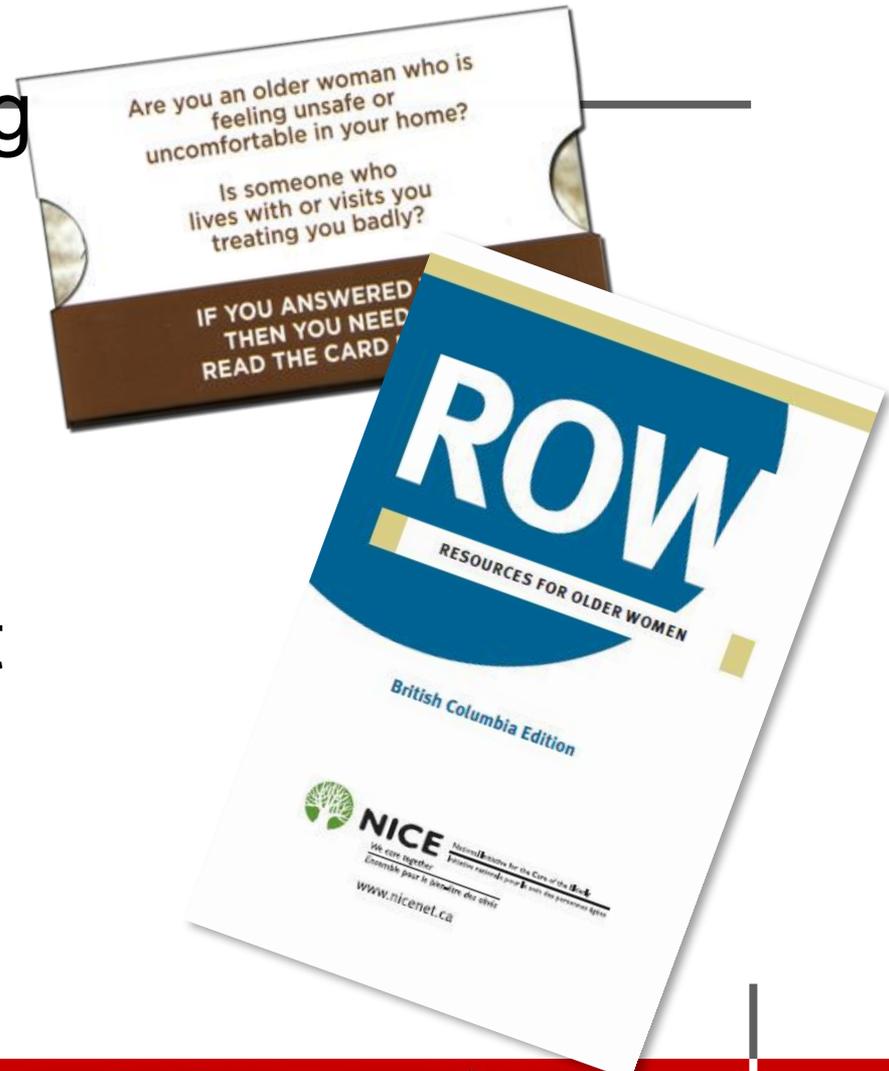
Q.1-Q.5 asked of patient; Q.6 answered by doctor

Within the last 12 months:

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse <u>may</u> be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

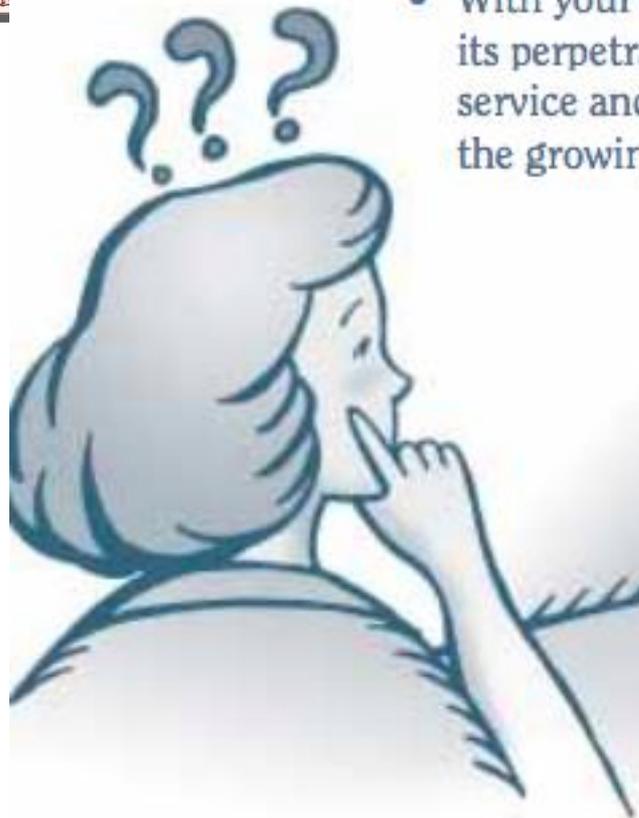
# 3. Detection Tool – Resources for Older Women

- Produced by “Bridging Aging and Women Abuse Project”
- Covers rights information and numbers to call to get help once safe
- 2 formats and 2 different distribution plans



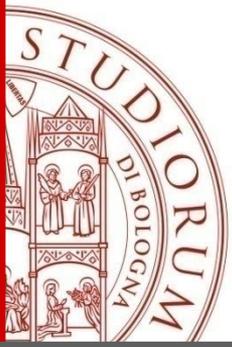
Thus, it may take the courage of a caring family member, friend or caretaker to take action when the victim may be reluctant.

- With your vigilance, care and cooperation, elder abuse can be stopped and its perpetrators arrested and prosecuted. In the past four years alone, social service and law enforcement resources have expanded dramatically to meet the growing need. **HELP IS AVAILABLE.**



***Remember:***

**If you suspect abuse,  
report it.**



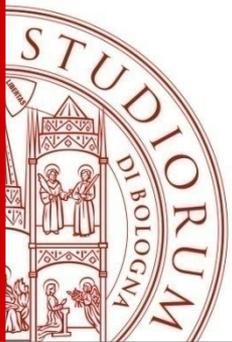
Aging Clin Exp Res

DOI 10.1007/s40520-014-0277-0

ORIGINAL ARTICLE

# Elder abuse awareness in Italy: analysis of reports to the Prosecutor Office of Bologna

Giancarlo Salsi • Maria Carla Mazzotti •  
Grazia Carosielli • Francesca Ingravallo •  
Susi Pelotti



**Time to  
screen**





## Time to Screen



1. Are you afraid of anyone in your family?
2. Has anyone close to you tried to hurt or harm you recently?
3. Has anyone close to you called you names or put you down or made you feel bad recently?
4. Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
5. Has anyone forced you to do things you didn't want to do?
6. Has anyone taken things that belong to you without your OK?



If abuse is suspected, report concerns to the appropriate authorities. Document this suspicion and any evidence of abuse.

Dong X. Screening for Elder Abuse in Healthcare Settings: Why Should We Care, and Is It a Missed Quality Indicator? *J Am Geriatr Soc.* 2015;63(8):1686-1688.

# Time to screen

adaptation, avec leur permission, de l'ouvrage de Myma Reis et Daphne Nahmiash, *Les mauvais traitements à l'égard des personnes âgées*. Un manuel d'intervention, Québec, Les Presses de l'Université Laval, 1998.

Le présent document est l'un des nombreux outils de détection, d'intervention ou de prévention en matière de maltraitance envers les aînés. Pour obtenir plus de renseignements sur le présent outil ou sur tout autre outil du réseau NICE ou encore sur toute activité de formation connexe, veuillez visiter le site: [www.nicenet.ca](http://www.nicenet.ca)

Février 2010

# LISA

LISTE DES INDICES DE SITUATIONS ABUSIVES

Canada

Programme Nouveaux horizons pour les aînés  
Ressources humaines et Développement des compétences Canada

New Horizons for Seniors Program  
Human Resources and Skills Development Canada



Gouvernement du Canada  
Réseaux de centres  
d'excellence

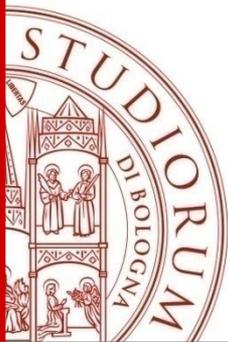
Government of Canada  
Networks of Centres  
of Excellence



**NICE** Initiative nationale pour le soin des personnes âgées  
National Initiative for the Care of the Elderly

Ensemble pour le bien-être des aînés  
We care together

[www.nicenet.ca](http://www.nicenet.ca)



# Studio «LISA»



RILEVAZIONE DI POSSIBILI SITUAZIONI DI ABUSO SUGLI ANZIANI E INDIVIDUAZIONE DI UN MODELLO DI CONTRASTO

***LISA → Liste des indices de situations abusives***

- 13 domande per valutare il caregiver
- 24 domande per valutare la persona anziana

**Questionario somministrato a volontari AUSER in forma anonima**

Valutazione in scala Likert da **0 a 4**

[inesistente, lieve, discreto, probabile e grave, si e grave]

**0-6 → NON ABUSO**

**7-21 → POSSIBILE ABUSO**

**22-148 → SOSPETTO ABUSO**

## LISTA DEGLI INDICI DELLE SITUAZIONI ABUSIVE (LISA)

Per determinare la presenza o l'assenza di situazioni abusive

**PER IL CAREGIVER**

Età \_\_\_\_\_

Sesso M / F

- 1 Ha problemi di comportamento 

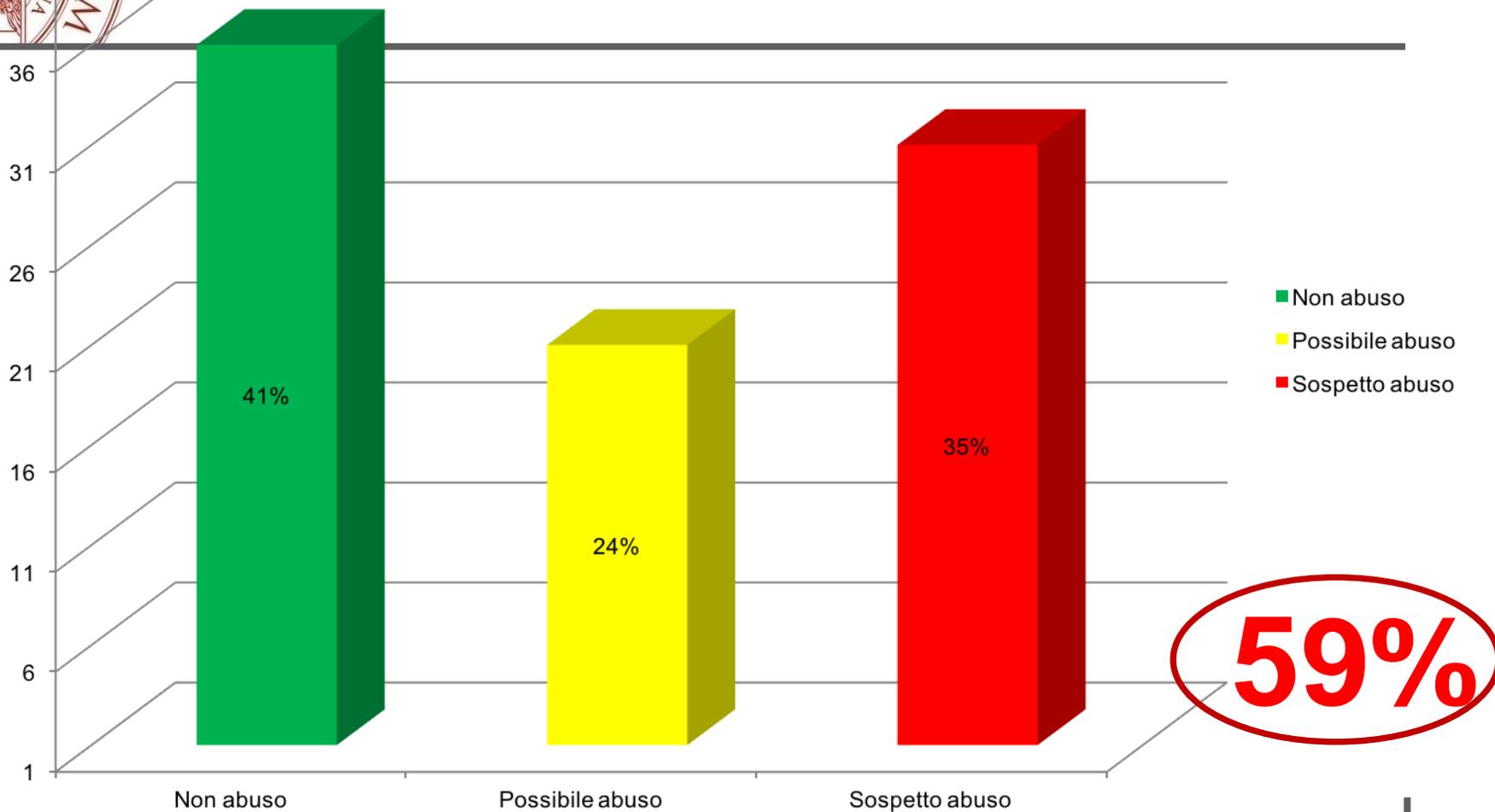
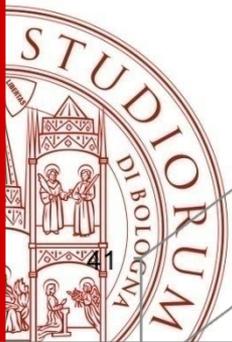
	0	1	2	3	4	00	000
--	---	---	---	---	---	----	-----
- 2 E' dipendente sul piano finanziario
- 3 Ha difficoltà affettive o mentali
- 4 Abusa di alcol o sostanze stupefacenti
- 5 Fatica a capire lo stato della persona anziana
- 6 Ha attese irrealistiche
- 7 È restia a prestare assistenza
- 8 Ha conflitti coniugali o familiari
- 9 Non ha una buona relazione con la persona anziana
- 10 Ha difficoltà ad esprimersi in italiano e scarsi rapporti con la persona anziana
- 11 Ha difficoltà a cucinare e a fornire i farmaci prescritti
- 12 Rimprovera continuamente
- 13 Aveva avuto cattivi rapporti in passato con la persona anziana

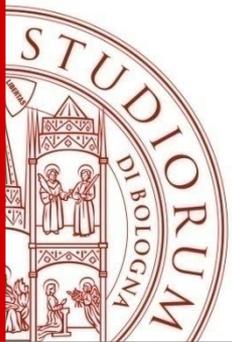
## PER LA PERSONA ANZIANA

Età \_\_\_\_\_

Sesso M /F

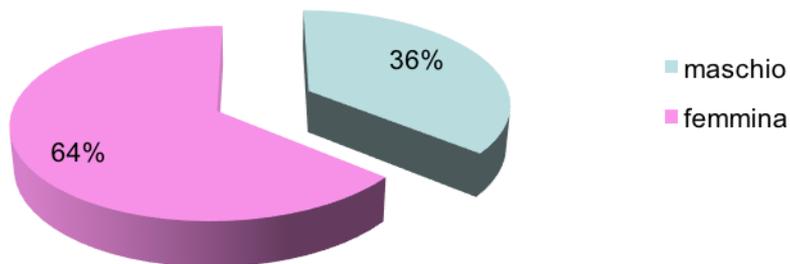
- 1 Ha subito maltrattamento in passato
- 2 Ha conflitti coniugali o familiari
- 3 Vive da sola con il caregiver
- 4 E' poco consapevole delle sue condizioni
- 5 Risponde poco alle domande o mostra ansia alla risposta
- 6 È isolata socialmente
- 7 E' priva di assistenza sociale
- 8 Ha problemi di comportamento
- 9 Ha una demenza
- 10 E' dipendente finanziariamente
- 11 Ha attese non realistiche
- 12 Abusa di alcol o di farmaci
- 13 Non ha una buona relazione con il caregiver
- 14 Mostra i segni di cadute o ferite sospette
- 15 Mostra scarsa igiene personale
- 16 E' presente scarsa pulizia della casa
- 17 Ha vestiti inadeguati o impropri
- 18 Mostra denutrimto e/o disidratazione
- 19 Mostra sonnolenza durante il giorno
- 20 Ci sono animali domestici in cattivo stato
- 21 Non indossa occhiali o protesi dentarie e acustiche necessarie
- 22 E' rimproverata continuamente
- 23 Ha dipendenza affettiva
- 24 Non viene visitata regolarmente dal medico di famiglia



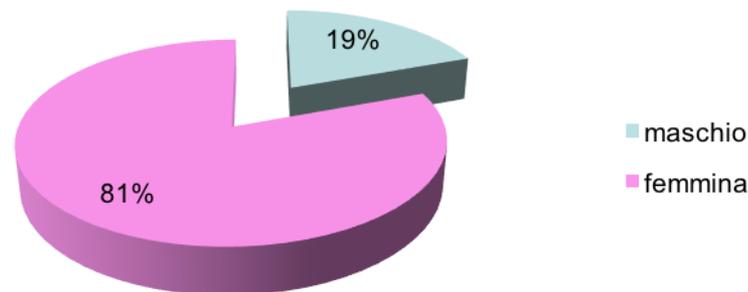


✓ 88 persone con età >65 anni

### Genere caregiver

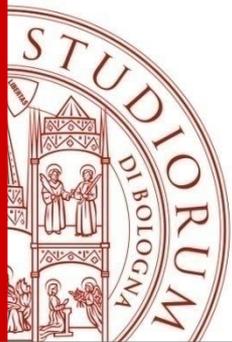


### Genere persona anziana



**Età caregiver: range 20-85**

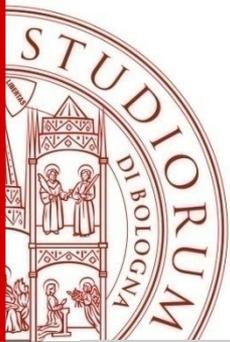
**Età persona anziana: range 65-96**



## PRINCIPALI FATTORI DI RISCHIO

- *Demenza* (70%)
- *Dipendenza finanziaria* (42%)
- *Abuso di alcol* (65%)





HACKARD LAW

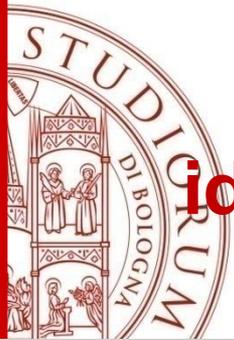


# TEAM UP AGAINST ELDER ABUSE



# Assistenza:

identificazione, presa in carico e denuncia  
all'Autorità Giudiziaria



HACKARD LAW

**TEAM UP AGAINST  
ELDER ABUSE**

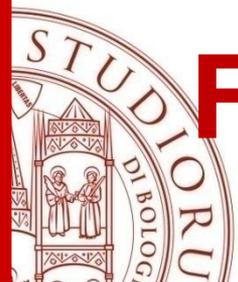


1. Are you afraid of anyone in your family?
2. Has anyone close to you tried to hurt or harm you recently?
3. Has anyone close to you called you names or put you down or made you feel bad recently?
4. Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
5. Has anyone forced you to do things you didn't want to do?
6. Has anyone taken things that belong to you without your OK?



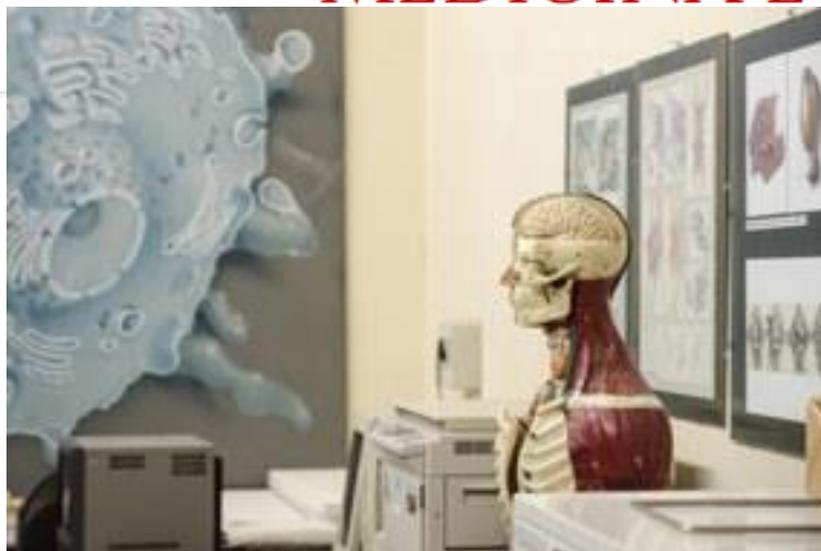
If abuse is suspected, report concerns to the appropriate authorities.  
Document this suspicion and any evidence of abuse.

# Formazione dei sanitari fin dal corso di studi

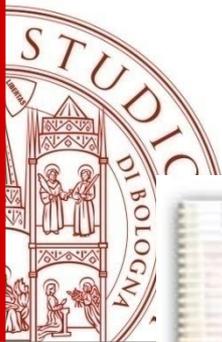


ALMA MATER STUDIORUM  
UNIVERSITÀ DI BOLOGNA

LAUREA MAGISTRALE A CICLO UNICO IN  
**MEDICINA E CHIRURGIA**



Corso elettivo "VIOLENZA SULLE DONNE: VALUTAZIONE DEL TRAUMA PSICHICO E DEGLI ASPETTI MEDICO-LEGALI C.I.



# RICERCA



## I nostri motori di ricerca

Con la testa e con il cuore facciamo grande la ricerca. Ogni giorno.

**5X1000  
DELL'UI**  
Bologn  
Scopri di più





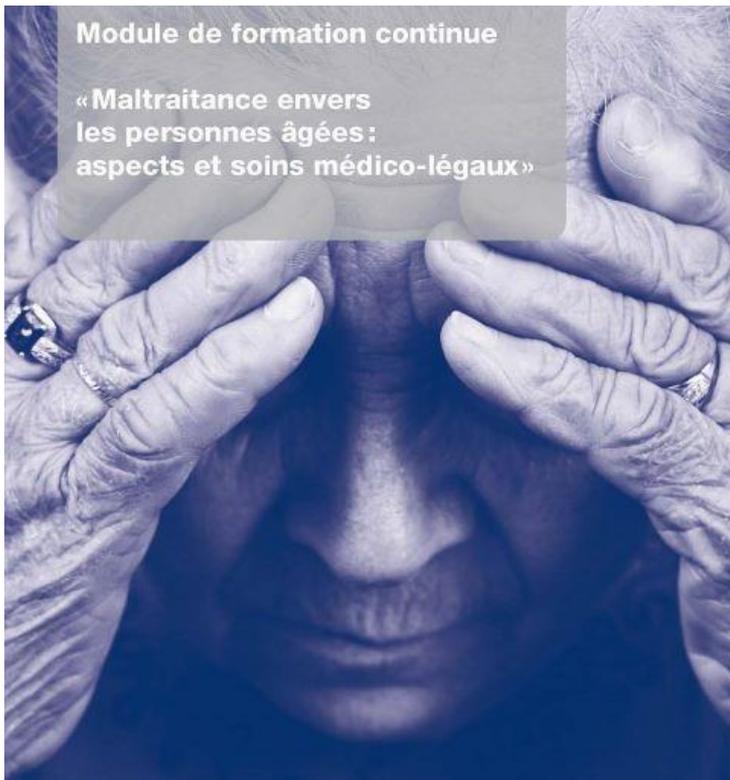
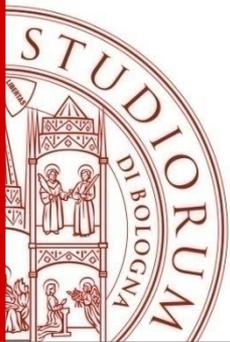
## These are tough issues and we need to be cautious

- Don't want to accuse unfairly
- Don't want to miss an abusive situation and fail to protect a vulnerable person
- We need to ask the right questions and listen with a critical ear to explanations



Center of Excellence  
in Elder Abuse and Neglect

University of California, Irvine • Program in Geriatrics • [www.centeronelderabuse.org](http://www.centeronelderabuse.org)



Module de formation continue  
« Maltraitance envers  
les personnes âgées :  
aspects et soins médico-légaux »

It's Not Right!



Join Northumberland Elder Abuse Resource Network To

## Become A Champion for Social Change

Through "It's Not Right!" – Changing the Conversation to Stop Abuse of Older Adults

Help Northumberland County become a great place to grow up in and to grow old in by educating the community about the **It's Not Right! Campaign** to change the conversation to stop abuse of older adults

Champion training will be taking place on Monday, November 13 from 9am – 4pm at the Columbus Community Centre, 232 Spencer St E, Cobourg



To register for training contact Kelly, It's Not Right! Project Coordinator, 905-372-1545 ext. 249 or [krobinson@cornerstonenorthumberland.ca](mailto:krobinson@cornerstonenorthumberland.ca)





### Box 1.3. Ageism

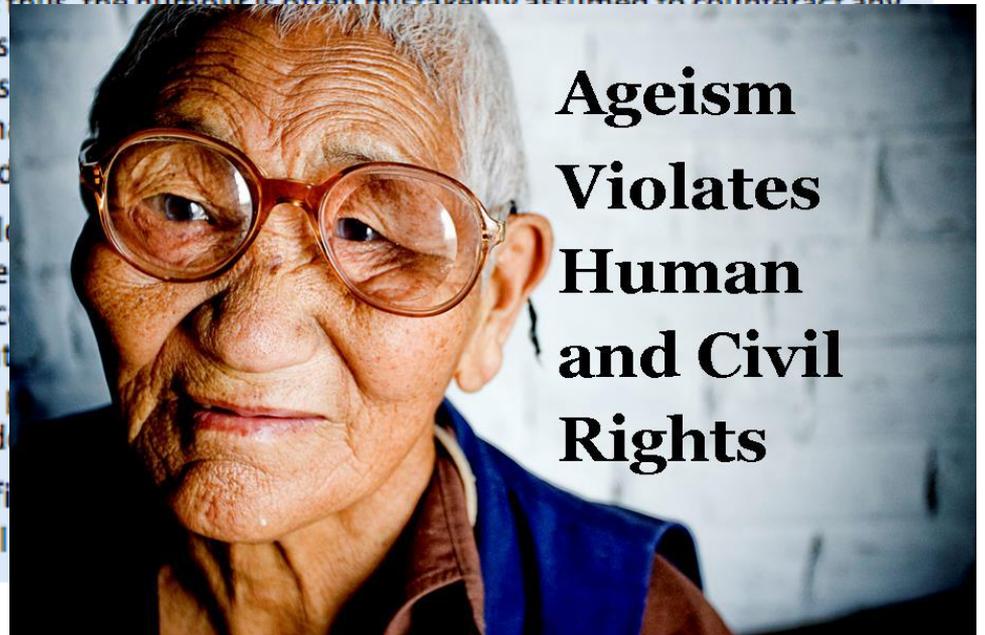
Ageism is the stereotyping of and discrimination against individuals or groups based on their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs (46).

Negative ageist attitudes are widely held across societies and not confined to one social or ethnic group. Research suggests that ageism may now be even more pervasive than sexism and racism (48, 49). This has serious consequences both for older people and society at large. It can be a major barrier to developing good policies because it steers policy options in limited directions. It may also seriously impact the quality of health and social care that older people receive.

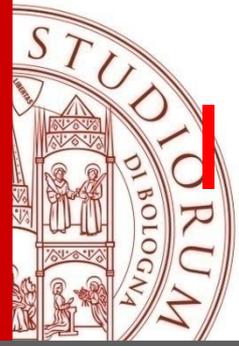
These negative stereotypes are so pervasive that even those who outwardly express the best of intentions may have difficulty avoiding engaging in negative actions and expressions. Furthermore, negative ageist attitudes are often seen as humorous and based in some degree of fact; thus, the humour is often mistakenly assumed to counteract any negative effects on the older person. Yet ageism has productivity, and cardiovascular stress (50). And these are the inaction and deficits that result from their internalized ageism within the health and social-care settings where older people live.

Some of this prejudice arises from observable biological facts. The stereotype of older age may be distorted by awareness of biological and psychological facts, little or no account is taken to minimize the effects of age-related loss, nor the contributions made during this period of life and the contributions made.

This socially ingrained ageism can become self-fulfilling, physical and cognitive decline, lack of physical



**Ageism  
Violates  
Human  
and Civil  
Rights**

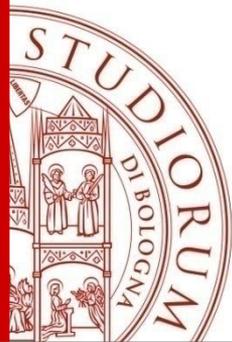


# I costi della violenza



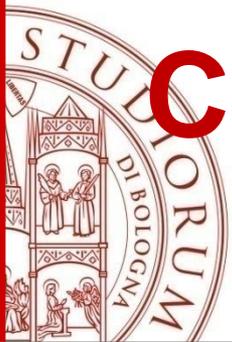
Conoscere i costi della violenza, quale problema di salute pubblica, *permette di gestire le risorse disponibili in modo più efficiente ed efficace.*

***The economic dimensions of interpersonal violence, WHO, 2004.***



**Table 1. A typology for costing violence**

COST CATEGORY	TYPE OF COST	COMPONENTS
Direct	Medical	Hospital inpatient Hospital outpatient Transport/ambulance Physician Drugs/laboratory tests Counselling
	Non-medical	Policing and imprisonment Legal services Foster care Private security
Indirect	Tangible	Loss of productivity (earnings and time) <sup>a</sup>  Lost investments in social capital Life insurance Indirect protection Macroeconomic
	Intangible	Health-related quality of life (pain and suffering, psychological)  Other quality of life (reduced job opportunities, access to schools and public services, participation in community life)



# Codice di deontologia medica 2014



**FNOMCeO**

Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri

## **Art. 32**

### **Doveri del medico nei confronti dei soggetti fragili**

Il medico tutela il minore, la vittima di qualsiasi abuso o violenza e la persona in condizioni di vulnerabilità o fragilità psico-fisica, sociale o civile in particolare quando ritiene che l'ambiente in cui vive non sia idoneo a proteggere la sua salute, la dignità e la qualità di vita.

Il medico segnala all'Autorità competente le condizioni di discriminazione, maltrattamento fisico o psichico, violenza o abuso sessuale.

Il medico, in caso di opposizione del rappresentante legale a interventi ritenuti appropriati e proporzionati, ricorre all'Autorità competente.

Il medico prescrive e attua misure e trattamenti coattivi fisici, farmacologici e ambientali nei soli casi e per la durata connessi a documentate necessità cliniche, nel rispetto della dignità e della sicurezza della persona.

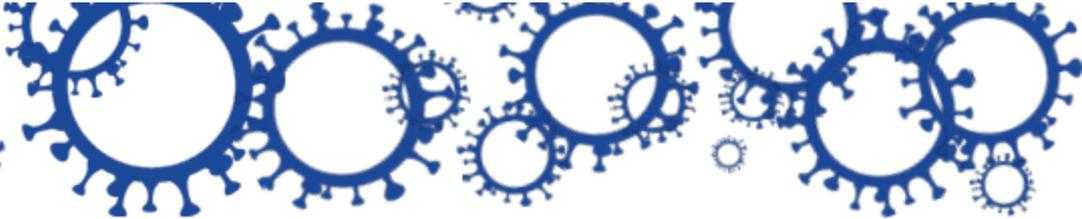
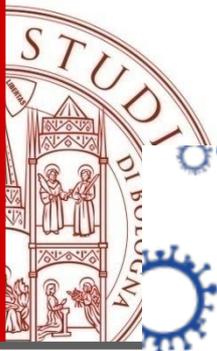


Sanità, Senato approva disegno di legge per la sicurezza delle professioni sanitarie: “Episodi di violenza inaccettabili. È la strada giusta”

**Le violenze denunciate contro gli operatori sanitari nel 2019 sono circa 1200. In Italia si verificano in media 3 aggressioni al giorno, il numero potrebbe essere anche più alto calcolando gli episodi non denunciati.**

**Le donne sono bersaglio di aggressioni nel 68% dei casi.**





# COVID-19 and violence against women

## What the health sector/system can do

26 March 2020

### Violence against women remains a major global public health and women's health threat during emergencies

- Violence against women is highly prevalent. Intimate partner violence is the most common form of violence.
  - Globally, 1 in 3 women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by any perpetrator in their lifetime. Most of this is intimate partner violence.
- Violence against women tends to increase during every type of emergency, including epidemics. Women who are displaced, refugees, and living in conflict-affected areas are particularly vulnerable.
- While data are scarce, reports from China, the United Kingdom, the United States, and other countries suggest an increase in domestic violence cases since the COVID-19 outbreak.<sup>1,2</sup>
  - According to one report, the number of domestic violence cases reported to a police station in Jingzhou, a city in Hubei Province, tripled in February 2020, compared to the same period the previous year.<sup>3</sup>
- The health impacts of violence, particularly intimate partner/domestic violence, on women and their children, are significant. Violence against women can result in injuries and serious physical, mental, sexual and reproductive health problems, including sexually transmitted infections, HIV, and unplanned pregnancies.

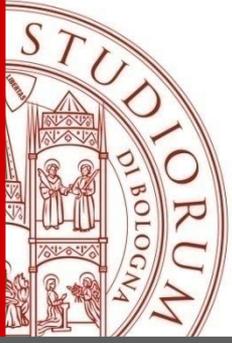


## How COVID-19 can exacerbate risks of violence for women

- Stress, the disruption of social and protective networks, and decreased access to services all can exacerbate the risk of violence for women.
- As distancing measures are put in place and people are encouraged to stay at home, the risk of intimate partner violence is likely to increase. For example:
  - The likelihood that women in an abusive relationship and their children will be exposed to violence is dramatically increased, as family members spend more time in close contact and families cope with additional stress and potential economic or job losses.
  - Women may have less contact with family and friends who may provide support and protection from violence.
  - Women bear the brunt of increased care work during this pandemic. School closures further exacerbate this burden and place more stress on them.
  - The disruption of livelihoods and ability to earn a living, including for women (many of whom are informal wage workers), will decrease access to basic needs and services, increasing stress on families, with the potential to exacerbate conflicts and violence. As resources become more scarce, women may be at greater risk for experiencing economic abuse.<sup>4</sup>
  - Perpetrators of abuse may use restrictions due to COVID-19 to exercise power and control over their partners to further reduce access to services, help and psychosocial support from both formal and informal networks.
  - Perpetrators may also restrict access to necessary items such as soap and hand sanitizer.<sup>5</sup>
  - Perpetrators may exert control by spreading misinformation about the disease and stigmatize partners.<sup>5</sup>
- Access to vital sexual and reproductive health services, including for women subjected to violence, will likely become more limited.
- Other services, such as hotlines, crisis centers, shelters, legal aid, and protection services may also be scaled back, further reducing access to the few sources of help that women in abusive relationships might have.

**The risks of violence that women and their children their face during the current COVID-19 crisis cannot be ignored.**

17 June 2020



# ADDRESSING VIOLENCE AGAINST CHILDREN, WOMEN AND OLDER PEOPLE DURING THE COVID-19 PANDEMIC: **KEY ACTIONS**

Many countries around the world have implemented lockdowns, stay-at-home, and physical distancing measures to contain the spread of COVID-19. The home, however, is not always a safe place for children, adolescents, women and older people who are experiencing or are at risk of abuse. Evidence shows that violence can increase during and in the aftermath of disease outbreaks <sup>(1)</sup>.

In many countries affected by COVID-19, records from helplines, police forces and other service providers indicate an increase in reported cases of domestic violence, in particular child maltreatment and intimate partner violence against women <sup>(2, 3, 4, 5, 6, 7)</sup>. These numbers, however, do not represent the prevalence of the problem, as we know that most cases are not reported to services. In several other countries there appears to be a decline in the reported numbers of child abuse victims and women survivors seeking help in-person or remotely since lockdown measures were implemented. This may be due to the child's or woman's inability to leave the home or access this help privately

whilst confined with a perpetrator, or service reductions or closures. Although less reported, this combination of increased risk of violence and reduced ability to obtain help during the COVID-19 pandemic is likely to be similar for older people experiencing abuse and neglect.

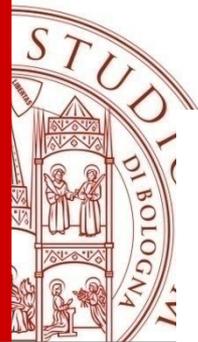
**10-50%** increase in domestic violence helpline calls in some countries

**3x** increase in intimate partner violence reports in Hubei province of China

**92,000** child abuse reports to one helpline in India

**10x** increase in abuse and neglect of older people in some settings

*(Data from media reports)*



## Who will be at higher risk of violence during confinement?

- Children, adolescents, women, men and older people who already live in homes with violence prior to the start of the COVID-19 pandemic will be more exposed to their abuser by stay at home measures.
- Children, adults and older people living with disabilities or mental health issues are at a higher risk of being subjected to violence irrespective of being confined and have fewer opportunities to seek help.
- Children, women and older people from ethnic minority or indigenous populations, LGBTQ persons, migrant and refugee populations and those living in poverty face a cumulative burden of discrimination, stigma and disadvantage and higher rates of violence in general. They may also have more challenges accessing services.



### Children

- Fewer opportunities than adults to leave the house and access help.
- Smaller children are less likely to understand or have access to pathways for seeking help.
- Lack of access to school as a safe space and no school-related support networks due to school closures.
- Heightened risk of online abuse due to increased time online.

2

Addressing violence against children, women and older people during the COVID-19 pandemic: **key actions**

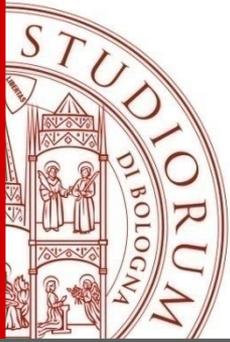


- ## **Women**
- **Disproportionate and high household burden of care due to home schooling and caring for sick and older people can increase stress and conflict with partners.**
  - **Stay-at-home orders may increase the frequency of demands for sex from a partner and thereby, increase risk of sexual coercion or unwanted sex. Furthermore, condoms and contraception may be less accessible.**
  - **Telephone ownership or internet access may be limited or monitored by the partner.**
  - **Financial dependency on their partners, and for older women on other family members (e.g. grown children), can increase economic abuse.**



- ## **Older people**
- **Mobility issues can limit opportunities to seek help.**
  - **Face barriers to accessing trustworthy information using newer technologies, including the internet.**
  - **May be encouraged or forced to stay in quarantine much longer, because of their higher risk of infection, which may prolong social isolation, increase abuse, and reduce opportunities to seek help**
  - **Physical dependence on other household members (e.g. for food, getting dressed, using the bathroom).**
  - **COVID-19 has led to staff reductions in long-term care facilities, due to illness or self-isolation (staff), and the suspension of family visits, increasing the isolation of residents and the already high risk of violence and neglect.**

# Governments and policy makers



## PLAN

- Include violence prevention and response in pandemic preparedness and response plans and in risk mitigation communications. Ensure these activities are adequately resourced.
- Ensure prevention and response programmes and services for those affected by violence are maintained during lockdowns and adapt them as needed.
- Promote paid sick, medical, family leave and affordable child care for all essential workers.

## INFORM

- Inform the public about the availability of services to prevent and respond to violence via multiple channels (e.g. radio, television, notices in grocery shops or pharmacies) and in multiple formats, including Braille.
- Alert essential service providers in the community (mail carriers, meter readers, first responders, food delivery services) about signs that indicate violence, abuse or neglect (including self-neglect in older people), and what to do if help is needed by survivors
- Alert older people and trusted others to the main types of financial scams being perpetrated and provide information on how to avoid them and what to do if targeted.

## PREVENT

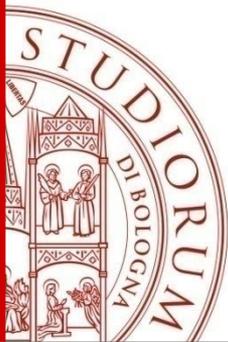
- Enforce rules and regulations to reduce risks associated with violence, for example, harms caused by alcohol, weapons, drug use and/or addictive behaviours.
- Conduct campaigns to advise people to reduce their consumption of alcohol or other substances.

## SUPPORT SURVIVORS

- Make provisions to allow those seeking help for violence to safely leave the home, even during lockdown.
- Keep existing helplines functioning or establish new ones where they don't exist. Ensure that helplines are free and can be reached by all survivors of violence (including older people). Offer multiple means of contact for helplines, including phone and text message or chat, or silent calls.
- Identify ways to make services accessible remotely (e.g. by messenger, m-health, telemedicine), including by removing any user fees.
- Ensure long term-care institutions for older people have policies and procedures on how to respond to violence if it happens<sup>(20)</sup>.

## WORK

- Track and update information about referral services, share it with service providers and make it accessible to the public.



## Programme managers



### PLAN

- Where data are collected on violence, adhere to WHO's ethical and safety recommendations on violence against women to inform prevention and response efforts.

### INFORM

- Inform health workers involved in the COVID-19 response and those who provide essential services to children, women and older people about the signs, symptoms and risk factors of violence in the home and when and how to ask about violence in a safe manner.
- Increase public awareness about violence in the home, how to remain in touch with survivors, and how and where to refer them for help and support without compromising their safety.

### PREVENT

- Provide parenting tips to caregivers in confinement or quarantine
- Encourage self-care and techniques to reduce stress and mental distress<sup>(21, 22)</sup> and positive coping strategies, social support, safety planning and avoidance of unhelpful coping strategies such as the use of tobacco, alcohol or drugs.
- Provide information, support and, if possible, respite care to caregivers, particularly those caring for older people with dementia. Information should include tips about how to manage stress, to reduce the likelihood of perpetration of violence.
- Maintain programmes and services for mental health and the prevention of alcohol and substance use.
- Where there are self-help or peer support groups (e.g. for survivors of violence, alcohol and drug addiction, mental health, older people's associations, peer support groups), facilitate alternative means by which they can continue to operate.
- Where there are existing services for perpetrators of violence, identify ways that they can seek anonymous help and advice online or via telephone.

### WORK ACROSS SECTORS

- Collaborate with non-governmental organizations and other sectors to align messages about violence in the home, existing prevention programmes and services.



EXECUTIVE BOARD

COMMISSION ON THE STATUS OF WOMEN

TRUST FUNDS

GET INVOLVED

ABOUT

WHAT WE DO

WHERE WE ARE

HOW WE WORK

PARTNERSHIPS

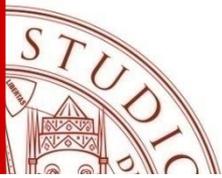
NEWS AND EVENTS

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# The Shadow Pandemic: Violence against women during COVID-19





## The issue

One in three women worldwide experience physical or sexual violence mostly by an intimate partner. Violence against women and girls is a human rights violation.

Since the outbreak of COVID-19, emerging data and reports from those on the front lines, have shown that all types of violence against women and girls, particularly domestic violence, has intensified.

This is the Shadow Pandemic growing amidst the COVID-19 crisis and we need a global collective effort to stop it. As COVID-19 cases continue to strain health services, essential services, such as domestic violence shelters and helplines, have reached capacity. More needs to be done to prioritize addressing violence against women in COVID-19 response and recovery efforts.

Everyone has a role to play.



# Violence Against Women and Girls and COVID-19

Globally,

**243** million



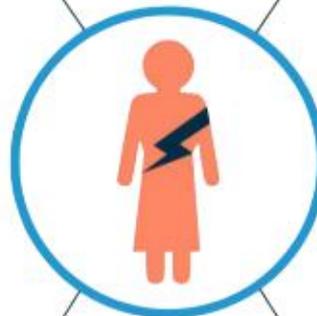
women and girls aged 15-49 have been subjected to sexual and/or physical violence perpetrated by an intimate partner in the previous 12 months.

**The number is likely to INCREASE as security, health, and money worries heighten tensions and strains are accentuated by cramped and confined living conditions.**

**Emerging data shows that since the outbreak of COVID-19, violence against women and girls (VAWG), and particularly domestic violence, has INTENSIFIED.**

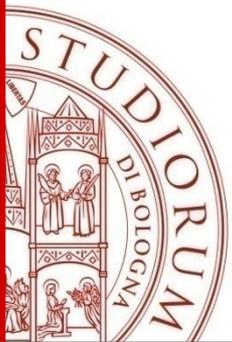
In **France**, reports of domestic violence have increased by **30%** since the lockdown on March 17.

In **Argentina** emergency calls for domestic violence cases have increased by **25%** since the lockdown on March 20.



In **Cyprus** and **Singapore** helplines have registered an increase in calls of **30%** and **33%**, respectively.

Increased cases of domestic violence and demand for emergency shelter have also been reported in **Canada, Germany, Spain, the United Kingdom** and **the United States**.



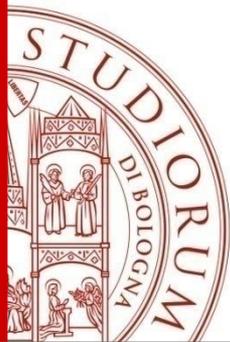
25 NOVEMBRE

# La pandemia della violenza: più donne uccise, meno denunce

**Il Covid non ferma i femminicidi. Boom di chiamate al 1522. Un anno di Codice rosso: 4mila indagini. Conte: «La strada è lunga»**

di Chiara Di Cristofaro e Manuela Perrone





#### TAVOLE DI DATI

### IL NUMERO DI PUBBLICA UTILITÀ 1522 DURANTE LA PANDEMIA (PERIODO MARZO-OTTOBRE 2020)

Il numero delle chiamate valide sia telefoniche sia via chat nel periodo compreso tra marzo e ottobre 2020 è notevolmente cresciuto rispetto allo stesso periodo dell'anno precedente (+71,7%), passando da 13.424 a 23.071. La crescita delle richieste di aiuto tramite chat è triplicata passando da 829 a 3.347 messaggi. Tra i motivi che inducono a contattare il numero verde raddoppiano le chiamate per la "richiesta di aiuto da parte delle vittime di violenza" e le "segnalazioni per casi di violenza" che insieme rappresentano il 45,8% delle chiamate valide (in totale 10.577). Nel periodo considerato, rispetto allo stesso periodo dell'anno precedente, esse sono cresciute del 107%. Crescono anche le chiamate per avere informazioni sui Centri Anti Violenza (+65,7%).

Il numero verde, durante il periodo di lockdown, ha fornito informazioni e consulenze anche ad utenti che erano portatori di necessità diverse da quelle della violenza e dello stalking (3.493 chiamate pari al 15,1% delle chiamate valide); in queste occasioni le operatrici hanno offerto supporto indicando altri numeri utili agli utenti a testimonianza della funzione di "vicinanza" che questo servizio ha erogato in un particolare momento di crisi.

Il servizio 1522 svolge un'importante funzione di snodo a livello territoriale tra i servizi a supporto di coloro che vi si rivolgono: il 76% delle vittime viene indirizzato verso un servizio territoriale e di queste l'87,6% (pari a 7.741 chiamate) viene inviato ad un CAV.