MINIMUM STANDARDS FOR SERVICE DELIVERY OF DOMESTIC VIOLENCE IN MALDIVES

Developed by Family Protection Authority, 2024

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Family Protection Authority

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INTRODUCTION

With 1 in 3 women worldwide have experienced some form of physical and sexual violence in their lifetime[1], the prevalence rate of Southern Asia for lifetime intimate partner violence of women aged 15-49 years is 35%[2]. Consistent with these findings, The Maldives Study on Women's Health and Life Experiences showed that 1 in 3 women aged 15-49 have experienced physical and/or sexual violence at some point in their lives, and that the levels of intimate partner violence were higher in the atolls than in Male'[3] with the perpetrators being intimate partners, other family members, colleagues and strangers.

Looking at domestic violence in Maldives, statistics shows that the number of repeated cases has been increasing over the past few years. With the high prevalence rates, meeting the needs of survivors in a standardized and survivor-centric approach is important. A survivor-centered approach creates a supportive environment in which survivor's rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. As such, Family Protection Authority has developed the Minimum Standards for Service Delivery of Domestic Violence in Maldives. These standards aim to create a common understanding of the services that need to be provided to survivors at a minimum by different sectors that respond to such cases. Considering the geographical landscape of Maldives, the resources available for survivors throughout the atolls are significantly limited compared to the Greater Male' Region and has been taken into consideration during the development of the standards. The minimum standards will also follow the international best practices and guiding principles of GBV[4] as elaborated below:

GBV Guiding Principles of a survivor-centered approach.

- Safety: The safety and security of survivors and their children are the primary considerations.
- Confidentiality: Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
- Respect: All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
- Non-discrimination: Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.

[1]UN WOMEN, 'COVID-19 and Essential Services Provision for Survivors of Violence Against Women and Girls', 2020, 11 <https://www.unwomen.org/en/digital-library/publications/2020/04/brief-covid-19-and-essential-services-provision-for-survivors-of-violence-against-women-and-girls>.

[2]World Health Organization, 'Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence', 2013, 1–17 <http://www.who.int/reproductivehealth/publications/%0Aviolence/9789241564625/en/>.

[3]Emma Fulu, The Maldives Study on Women's Health and Life Experiences Initial Results on Prevalence, Health Outcomes and Women's Responses to Violence [Online], 2009.

[4]UNFPA, 'The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming | UNFPA - United Nations Population Fund', Gender-Based Violence Area of Responsibility, 2019, 159 <https://www.unfpa.org/minimum-standards>.

MINIMUM STANDARDS: SOCIAL SERVICES

Accessibility and reporting mechanisms	Under the Domestic Violence Prevention Act (3/2012), a case of domestic violence can be reported by 1. a victim; 2. a witness to the act of domestic violence; 3. a family member of the victim; 4. an acquaintance of the victim; 5. Authority or Ministry; 6. employee of a health or social service provider; 7. a responsible officer of a Government institution working against domestic violence; 8. an employee or member of a association or organization registered to work against domestic violence; 9. the parent, guardian, relative or caretaker of a victim that is a child; and 10. any other person who has information of occurrence of domestic violence. As such, reporting mechanisms must be established in such a way that it is accessible to everyone. <u>Cases reported to the Ministry responsible for state provided social services</u> • As the Ministry responsible for state provided social services (hereby referred to as the Ministry), they must be accessible at all times for case reporting. - The currently existing hotlines for case reporting (1421 for adult-related cases and 1412 for child-related cases) must be accessible 24/7. - Cases reported to the Ministry via email must be attended to within 24-48 hours depending on severity and urgency (cases of high severity must be attended to as soon as possible). <u>Cases reported to other service providers in the social sector</u> • Civil Society Organizations (CSOs) or any other organization involved in service provision in communities should have a safe reporting mechanism in place for survivors to contact them if they want. Under DVPA, service providers are mandated to report any GBV/DV cases to the relevant authorities. While mandatory reporting is intended to protect survivors, in some cases it may conflict with the GBV guiding principles. Therefore, it is necessary for service providers to understand any legal obligations on their part and professional codes of practice to ensure that survivors are fully informed about their choices and limitations of confidentiality due to mandatory reporting. Informing survivors regarding mandatory reporting ensures that service providers can help them make informed decisions about what to disclose during consultations[5]. However, all forms of suspected and confirmed cases of child abuse require mandatory reporting to the relevant authorities.

Inclusivity	• If the survivor has a disability that hinders communication (for example: deaf or mute) or is a foreigner with language barrier, and they have difficulty in written communication for any reason, utilize an interpreter if a trusted family/friend cannot play that role. • The organization can arrange for an interpreter themselves (can be a staff or external interpreter) or coordinate with other stakeholders to arrange an interpreter. • Ensure that external interpreters sign a non-disclosure agreement (or any other similar confidentiality agreement) in order to prevent confidentiality breaches.
Referrals	<u>Referrals from Ministry</u> • There must be a reporting mechanism in place for Ministry to coordinate with the Maldives Police Service (MPS) and the health sector. Even if the Ministry reports a case via phone call due to the urgency, it must be followed up by a written referral within 24-48 hours. • A case referral must be shared with FPA as well. • Service referrals (such as counselling, legal aid, etc..) must be sent in written form. <u>Referrals from other service providers</u> • CSO's or any other service provider can send case referrals and service referrals (such as counselling, legal aid, etc..), and they must be sent in written form. Even if a case is reported via phone due to urgency, it must be followed up by a written referral within 24-48 hours. • Case referrals must be shared with relevant authorities, including FPA.
Psychosocial Support	The term 'Psychosocial' is used to focus on the interaction between the psychological aspects of human beings and their environment or social surroundings . Psychological aspects are related to our functioning, such as our thoughts, emotions and behavior. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work. Psychosocial support is provision of care and support which impacts both the individual and the social environment they live in, and ranges from care and support offered by caregivers, family members, friends, neighbors, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialized psychological and social services[7]. Psychosocial support services can be provided without specialized mental health-care services[8]. • Survivors of DV/GBV experience various psychological and social effects due to stigma, lack of support from family and community and lack of resources to leave the abusive environment. Therefore, psychosocial support is a fundamental element of service provision. • Psychosocial support services are[9]: - survivor centered - age appropriate - build individual and community resilience - support positive coping mechanism

The IASC Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies[10]

Layer 4 Specialized services	Clinical mental health care (by primary health-care staff or mental health professional.
Layer 3 Focused, non-specialized services	Structured emotional and practical support to individuals or families by trained GBV staff.
Layer 2 Community and family supports	Encouraging and strengthening community and family supports; women's and girls' safe spaces reintegeration and empowerment activities
Layer 1 Basic services and security	Advocacy for good humanitarian practice: basic services that are safe, and socially and culturally appropriate; that protect dignity, e.g., quality and compassionate health-care services; and that include responsive security services and GBV risk mitigation across all sectors.

As the effects of DV/GBV depend on individual, family, economic, socio-cultural and environmental factors, the level of psychosocial support needed for the survivor may differ.

- Service providers should be able to provide basic psychological first aid to survivors. The organization is responsible for ensuring that the service providers receive the proper training to be able to provide PFA.
- Service providers can work with the survivor to determine whether they need further/specialized support.
- Service providers need to be able to identify whether the survivor needs more specialized support and help them receive such services.
- Service providers must be familiar with the resources and services that are available and be able to make safe and confidential referrals with informed consent of survivor.

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[5]UNFPA, 'The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming | UNFPA - United Nations Population Fund'.
[6]Vivi Stavrou, UNICEF, and Terre des Hommes, 'ARC Resource Pack Study Material- Foundation Module 7: Psychosocial Support', Foundation Module 7 Psychosocial Support, 2009, 1–47 <https://resourcecentre.savethechildren.net/keyword/arc-action-rights-children-resource-pack>.
[7]Stavrou, UNICEF, and Hommes.
[8]UNFPA, 'The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming | UNFPA - United Nations Population Fund'.
[9]UNFPA, 'The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming | UNFPA - United Nations Population Fund'.
[10]Inter-Agency Standing Committee., 'IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.', Inter-Agency Standing Commitee (IASC), 2007, 186.

Case Management Services	1. Introduction and Engagement with the survivor • Greet and comfort survivor • Build trust and rapport • Assess immediate safety (it is important to use standardized tools for risk assessment). • Explain confidentiality and its limits • Obtain informed consent to engage the survivor in services 2. Assessment • Understand the survivor's situation, identify immediate needs (safety, health, legal/justice and any other needs). • Provide immediate emotional support (psychosocial support, psychological first aid). • Provide information regarding the available services and resources to the survivor. • Determine whether survivor wants further case management services. 3. Case Action Planning • Based on the assessment, develop a case action plan. • Develop a safety plan with the survivor. • Obtain informed consent for making referrals. 4. Implementation • Share any required referrals with the relevant authorities in written form. • Coordinate with other relevant stakeholders when necessary. • Provide ongoing support and direct support to survivor. 5. Case Closure • Close the case when the survivor is ready • Monitor the quality of the services provided. Service providers can also follow any internal procedures set in place by their organization(s). It is important for service providers to maintain documentation of the actions taken and services provided to address accountability and safety of service providers. In cases where the survivor does not want to work with service providers, make a basic safety plan with them, provide them with information of available services and resources and close the case. It can always be reopened if the survivor wishes to. It is of utmost importance that the decisions of the survivor and their right to autonomy be respected, as long as they are adults without any mental incapacity. However, with regard to child survivors it may be necessary to continue monitoring their safety even if they do not wish to. Additionally, if the parent/guardian of the child is unwilling to cooperate with the service providers in ensuring their safety, there are steps that the state can take to address this; • The Ministry can file for a supervision order or a temporary assessment order at court. • Maldives Police Service can also apply for these court orders when necessary.

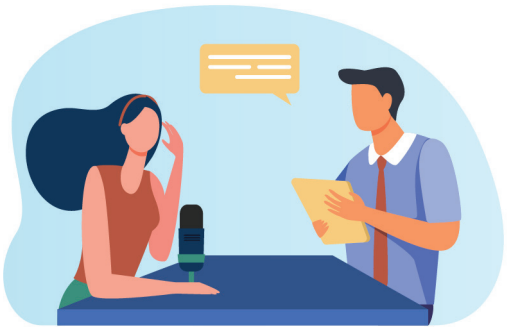
Helplines	• Ensure that these helplines are free of charge. • The organization is responsible for training staff to ensure that staff answering the helplines have the appropriate knowledge, skills and are adequately trained. This includes but is not limited to: - Aware of the services and resources available for survivors. - Basic knowledge of DV/GBV - Survivor-centric communication skills - Psychological First Aid (PFA) - Confidentiality and its limitations - Be able to link to immediate and appropriate police and justice responses when requested or when necessary (if a survivor calls the hotline while the abuse is actively ongoing, contact the police emergency hotline 119 for immediate assistance). • Ensure that information of the helplines and operating hours are clearly and accurately communicated in appropriate channels.
Safe Accommodation	• In cases of emergencies, service providers must arrange safe accommodation for the survivor. Inter-agency coordination can be utilized if necessary. It is important to maintain confidentiality where possible.
Material and Financial Aid, Assistance Towards Economic Independence	• Provide support to access basic needs of the survivor(s) including emergency transport, safe accommodation free of charge where needed. • Provision of immediate basic personal and healthcare items including sanitary products, food and clothing where needed either directly or by coordinating with other institutions. • Coordinate with other agencies like NSPA for financial aid where needed. • Assist survivor(s) in recovery or replacement of important documents such as ID cards, passports, birth certificates, etc. Service providers can coordinate with the relevant authorities. • Help the survivor utilize any financial aid programs if available. • Facilitate access to financial assistance and social protection if required (inter-agency coordination can be utilized if needed). • Facilitate access to vocational trainings, income generating opportunities (inter-agency coordination can be utilized if needed). • Maintain documentation of all services provided, referrals, inter-agency coordination, and any other relevant document related to the case. Ensure the documentations have restricted access to prevent confidentiality breach.
Information	• Written information on DV and GBV, available resources and services, and reporting numbers should be available in the organizations. The information can be in the form of posters, pamphlets or leaflets, available in waiting areas and private areas (such as washrooms), with necessary warnings about taking them home if living with the perpetrator(s). • Ensure that information clear, concise and accurate. • Ensure that information is accessible, taking into account language barriers or any disabilities. • Utilize social media or any other platforms in information dissemination.

MINIMUM STANDARDS: HEALTH CARE FOR DV/GBV SURVIVORS

Identifying abuse	• If a health practitioner suspects abuse during consultation (in a safe space), doctors can ask prompting questions. It is important to ask the appropriate questions in a non-judgmental way in order to be survivor-centric. • If a bystander is accompanying the survivor, try to safely separate the bystander without arousing suspicions to ask the survivor in private. • If unable to separate survivor from bystander, do not ask any questions regarding suspected abuse in the presence of the bystander if you suspect that bystander may be involved in the abuse. Ensure that any questions are asked privately in a safe space. • If it is a female survivor, ensure that a female staff is present during consultation. • A pediatrician should be present or consulted if the survivor is a child. In health centers where a pediatrician is unavailable, consult with a pediatrician at the regional/atoll hospital. • If the survivor shares any incidents of abuse, complete a Medico-Legal Report (MLR) after informing the survivor. - During completion of MLR, explain to the survivor what it is, what it is used for and its importance. • Provide First-Line Support (For more details, refer to Health Sector Response to Gender-Based Violence: National Guidelines for Healthcare Providers on provision of care and prevention of GBV, 2024).

First-Line Support

First-line support involves five simple elements, as summarized below. The letters in the word “LIVES”13 can help you to remember them .
With first-line support, you do NOT need to:
- solve the survivor’s problems;
- convince her to leave a violent relationship;
- convince her to go to any other services, such as the police or the courts; or
- ask detailed questions that force her to relive painful events.



LISTENING

Listen to the survivor closely, with empathy, and without judging

INQUIRING ABOUT NEEDS AND CONCERNS

Assess and respond to the survivor’s needs and concerns – emotional, physical, social, and practical (e.g. childcare)

VALIDATING

Show the survivor that you understand and believe them. Assure them that they are not to be blamed for what has happened

ENHANCING SAFETY

Discuss a plan to protect the survivor from further harm and to prevent violence from occurring again

SUPPORTING

Support the survivor by helping him/ her to access information, services, and social support

• Ensure that the survivor is informed and provided with an adequate explanation and sensitization on the medical issues relating to care provision, as well as any procedures or examinations that may follow. Verbal consent must be obtained prior to any procedures and examinations.
• Conduct a thorough physical examination if the survivor shares any history of physical abuse. Conduct the examination in a private space. Complete an MLR even if there are no outward signs or symptoms of abuse.
• Conduct any necessary tests (example: X-Ray, CT, MRI, USG, etc...).
• Health-care providers must demonstrate survivor-centered attitudes[13] when engaging with survivors at all times.
• Provide psychological first-aid (PFA) for basic psychological support.

Additional factors to consider if survivor is brought by a social worker or police:
• Ensure that consultations are done in private.
• Do not bring the survivor through the normal OPD or waiting areas (if survivor has to go through normal waiting areas with police/case workers, there is a higher chance of confidentiality breach especially in small communities).
- Due to lack of infrastructure, this may be challenging for health centers and regional/atoll hospitals. In order to navigate this, focal points of health facilities, police/case workers can coordinate and bring the survivor through an entrance not used by people other than staff. If this is also not possible due to gaps in the infrastructure, the survivor can be brought in after the out-patient service delivery has stopped for the day or at a time where there are no other out-patients.
- However, if the survivor has serious injuries that require immediate intervention, there may be no other

choice. In such a situation, take utmost care to protect the survivor's identity.

Note: Under DVPA, health-care providers are mandated to report any GBV/DV cases to the relevant authorities. While mandatory reporting is intended to protect survivors, in some cases it may conflict with the GBV guiding principles. Therefore, it is necessary for health practitioners to understand any legal obligations on their part and professional codes of practice to ensure that survivors are fully informed about their choices and limitations of confidentiality due to mandatory reporting. Informing survivors regarding mandatory reporting ensures that health-care providers can help them make informed decisions about what to disclose during consultations. [14]However, all forms of suspected and confirmed cases of child abuse require mandatory reporting to the relevant authorities.

Inclusivity	• If the survivor has a disability that hinders communication (for example: deaf or mute) or is a foreigner with language barrier, and they have difficulty in written communication for any reason, utilize an interpreter if a trusted family/friend cannot play that role. • The health facility can arrange for an interpreter themselves (can be a staff or external interpreter) or coordinate with other stakeholders to arrange an interpreter. • Ensure that external interpreters sign a non-disclosure agreement (or any other similar confidentiality agreement) in order to prevent confidentiality breaches.

[13]Sphere Sphere, The Sphere Handbook Arabic, The Sphere Handbook Arabic, 2018 <https://doi.org/10.3362/9781908176738>.
[14]UNFPA, 'The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming | UNFPA - United Nations Population Fund'.
[15]WHO.
[16]Ministry of Health, Maldives, Supported by UNFPA.

Sexual Violence	• Health facility should be able to provide clinical management of rape or sexual assault. • Steps for the clinical management of rape[15].

Step 1	First-line support (LIVES, Part 2): listening, inquiring about needs and concerns, and validating the survivor
Step 2	Obtaining informed consent and preparing the survivor
Step 3	Taking the history
Step 4	Performing the physical and genital examinations
Step 5	Providing treatment
Step 6	Enhancing safety and referring for additional support (LIVES, Part 2)
Step 7	Assessing mental health and providing psychosocial
Step 8	Providing follow-up care

• Refer to the Health Sector Response to Gender-Based Violence: National Guidelines for Healthcare Providers on provision of care and prevention of GBV, 2024 for detailed explanations of the above steps.
• The above-mentioned guideline also details preventive/prescribing treatments of HIV, STD/STI and pregnancies. These treatments must be informed, offered and provided to the survivor. If these treatments are not available at the health facility, coordinate with the nearest health facility where they are available to provide them to the survivor.
• During the physical and genital examinations, ensure that voluntary consent of the survivor has been obtained for the examination and collection of any samples for forensic evidence.
• Samples for forensic evidence must be collected by using Rape Evidence Kits, as mandated by Act number 25/2021, the First Amendment of the Sexual Offences Act 17/2014. As mandated by the same Act (25/2021), these samples must be taken by a healthcare practitioner with training on how to use a rape evidence kit as well as training on victim-centered and trauma informed approach.

<u>Male Survivors of Sexual violence:</u>

• Male survivors must be offered the same services as a female survivor as mentioned above.
• Sometimes, when a man is anally raped, due to pressure on the prostate, he may have an erection and even ejaculate. Reassure the survivor that it is a physiological reaction beyond his control and should not be considered as giving consent.[17]
• Following the Health Sector Response to Gender-Based Violence: National Guidelines for Healthcare Providers on provision of care and prevention of GBV, 2024[18], preventive/prescribing treatments of HIV, STD/STI must be offered.

Child survivors of DV/GBV	• It is important to understand and recognize that service provision for child survivors is different than that of adult survivors. It is necessary to focus on eliminating barriers and facilitating child survivors' access to services. For example, parents should be informed of the potential long-term sexual and reproductive health implications of denying contraception and medical treatment to adolescent girl survivors of gender-based violence, and should be aware of the life-threatening health consequences of child marriage and early pregnancy. It is important to ensure that female health service providers are available to provide counselling and treatment to adolescent girl survivors that is age-appropriate, accessible, non-judgmental and nondiscriminatory[19]. • All forms of suspected and confirmed cases of child abuse require mandatory reporting to the relevant authorities. • Similar to adult survivors, ensure that the survivor is informed and provided with an adequate explanation and sensitization on the medical issues relating to care provision, as well as any procedures or examinations that may follow. Verbal consent must be obtained prior to any procedures and examinations. • Follow the detailed guidelines with regard to child and adolescent survivors in the Health Sector Response to Gender-Based Violence: National Guidelines for Healthcare Providers on provision of care and prevention of GBV, 2024[20]
Referral, Documentation and Data maintenance	• Health practitioners should be aware of all the services and service delivery institutions. Health facilities must ensure that each health practitioner is aware of all the services and service delivery institutions. • Health practitioner should: - Provide information to the survivor. - Send referrals for services if the survivor consents or wishes to receive services. Referrals include mental health care and other additional available services. - Send DV report via referral form to Police, social workers and FPA. Ensure written referrals are shared within 24-48 hours if a phone call is made at the initial reporting stage. To reduce administrative burden, the referral form can be sent to Police, social workers at the Ministry and FPA in one email. Ensure that it is not sent to the general email of the organization(s); use the reporting emails provided by the organization(s) • Maintain all documentation in a safe and secure location with restricted access. Digital copies of all documentation must also have restricted access (if the original document is a digital version, it not strictly necessary to store a hard copy as long as it is protected and safe). • Documentation can include but is not limited to: - Prescriptions - MLR - DV referral/Service referrals - Any other relevant document with sensitive information • In the event of forensic evidence collection, chain of custody evidence must be documented and maintained, and clearly labeled. • Health facilities should update and maintain data of cases of DV and GBV attended by the health facility. This data must be stored in a safe and secure location with restricted access to prevent any breaches in confidentiality.

Healthcare provider and the justice system	In addition to the completion of MLR, the attending health practitioner must be able to provide statements in a court setting if required.
Information dissemination	• Written information on DV and GBV, available resources and services, and reporting numbers should be available in the healthcare facility. The information can be in the form of posters, pamphlets or leaflets, available in waiting areas and private areas (such as washrooms), with necessary warnings about taking them home if living with the perpetrator(s). • Ensure that information clear, concise and accurate. • Ensure that information is accessible, taking into account language barriers or any disabilities. • Utilize social media or any other platforms in information dissemination.

MINIMUM STANDARDS FOR LAW ENFORCEMENT

Investigation of the domestic violence case	• A positive first respond experience with the police is essential for victims of violence. These services must be readily available to all individuals in the nation. • The first initial contact must give confidence to the victim that the law enforcement service is committed to health and safety and that the complaint is taken seriously. It must also ensure the victim that he/she is supported throughout the process. • Police officers must also follow human rights principles such as maintaining privacy and confidentiality, ensuring freedom for the victim to choose from the remedies available. • All reported incidents of domestic violence must be treated by the police as if they were based on facts. In addition to this, the management of police operations in the event of domestic violence must be carried out on a case-by-case basis. • Assigning female officers to female survivors of domestic violence upon request can be a vital consideration in responding to such cases, as it fosters comfort, trust, and empathy. Female officers can also help break down gender-based barriers and biases, making it easier for survivors to engage with legal and support systems.
Key responsibilities when conducting investigations	Law enforcement officers have several key responsibilities when conducting investigations: • Upholding the law and protecting individual rights • Ensuring confidentiality • Safety, security and respect for service users and staff, within a culture of 'belief' 'taking the side of' the victim • Accessibility – ensuring all women can access support wherever they live and whatever their circumstances. Included here would be the needs of specific groups, such as migrant, young, disabled women and women living in rural areas or those who have been displaced • Availability – this can be met in a variety of ways, including 'on call' systems • Support should be available free of charge • Non-discrimination • Ensuring that frontline officers are non-judgmental, empathetic and supportive in their listening and reporting techniques • Ensuring that there is no forced mediation or alternative dispute resolution[21] • Conducting investigations impartially and objectively • Respecting the dignity and rights of all individuals • Preserving the integrity of evidence • Being transparent and accountable • Refraining from misconduct& • Collaborating ethically with other agencies

[17]Ministry of Health, Maldives, Supported by UNFPA.
[18]Ministry of Health, Maldives, Supported by UNFPA.
[19]UNFPA, 'Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.', Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies, 2015, xiv-pp <http://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf>.
[20]Ministry of Health, Maldives, Supported by UNFPA.

Cases involving women and children	• In domestic violence cases where a child is either a victim or a perpetrator, ensuring the involvement of a caseworker before the police attend the premises can be crucial, depending on the scenario and severity of the situation. • In domestic violence cases involving children, police should be mindful of the needs of children and their specific responsibilities with respect to girls and young women[22] • In domestic violence cases where children are involved, police can file an interim assessment order. An assessment order can be granted where the child is believed to be at risk.
Ethical responsibilities	Upholding these ethical responsibilities is crucial for law enforcement to effectively fulfil its duty to protect public safety while respecting individual rights and liberties. • Standardizing tool – min. one police for each island – specific trainings for these officers • First response police officers should be appropriately qualified and trained: - Minimum initial training and a minimum ongoing training should be part of employment contracts - Initial training should include understanding of the gendered dynamics of violence, awareness of the different forms of violence against women, anti-discrimination and diversity, legal and welfare rights[23] - Police personnel should be trained to facilitate survivor's access to medical assistance and medico-legal examination to ensure that the victims receive immediate medical care and a medico-legal examination is conducted immediately[24].
Provision of protection to the victims of domestic violence	• Finding out whether a protection order has been issued • Providing information to the victims about the court orders that they can request for - Protection order & emergency protection orders - Custody order - Residence order - Compensation order • Providing information to the victims about access to free legal aid through Family Protection Authority

Taking adequate measures against the perpetrators of domestic violence. In cases where the perpetrator can be charged criminally, sending it to the prosecutor general's office.	• Police have the responsibility to advise victims of domestic violence of their rights and available remedies under this Act including the right to lodge a criminal complaint, if applicable. • Ensure that regular monitoring of perpetrators is carried out in compliance with protection orders, whenever it is the responsibility of the police to perform such monitoring. • Arresting perpetrators where necessary – this is a critical component of responding to and preventing further violence. • Drug rehabilitation – waitlisted perpetrators
Early intervention to prevent domestic violence	• Early intervention involves identifying and supporting people at a higher risk of either perpetrating or experiencing violence – as well as working with perpetrators to assist them to change their behaviors and end their use of violence • Creating awareness and sensitizing police personnel on various issues regarding violence against men/women such as existing policies, laws and human rights • Encouraging reporting of violence through provision of information to the community on police commitment[25] • Recognizing the emerging issues in domestic violence from an awareness and advocacy perspective and informing the appropriate authorities

[21]("Police as an Entry Point to End Violence Against Women and Girls," 2020)
[22](Kelly & Dubois, 2008)
[23](Kelly & Dubois, 2008)
[24]("Police as an Entry Point to End Violence Against Women and Girls," 2020)
[25](Police as an Entry Point to End Violence Against Women and Girls, 2020)

MINIMUM STANDARDS: ADVOCACY

Awareness	• Awareness can be directed to the general public as well as specific audiences. • Custom tailoring awareness efforts to specific audiences can help better understand the populations' vulnerabilities and deliver more inclusive and accurate information. • These audiences can include but are not limited to women, men, children, persons with disabilities, older persons, and migrant workers.
Content delivered	Any information on DV prevention delivered to audiences should include the following content. (a) Domestic violence as per DV Prevention Act (3/2012) (b) Domestic relationships as per DV Prevention Act (3/2012) (c) DV acts as per DV Prevention Act (3/2012) (d) Protection Order including Emergency Protection Order (e) Ways to report DV cases including mediums, names of institutions, and contact numbers (f) Additional avenues that offer assistance to victims of DV (psychological, social, legal and any other required support)
Dissemination	Dissemination of information should consider the type of audience and the type of materials/mediums used to convey the information.
Type of audience	• The audience can be a mass audience that consists of the general public with varying demographics or a mass audience of a specific population. • Generally, audiences that involve the public are large but targeted audiences can tend to be large or small

Types of Audience

General Public
• Audience size is usually large

General Public

Dissemination that takes place with mass audiences consists of people of different demographics which in turn results in a difference in their vulnerability status. Such instances arise when activities are targeted to the general public and in open public spaces. The following should be practiced when informing such an audience on DV prevention.

(a) Clarity in language: Avoid using jargon and opt for simpler language to ensure clarity in the information being delivered
(b) Cautious of sensitive content: Refrain from using graphic details in explanations as this may easily trigger person(s)
(c) Inclusivity: Depending on the nature of the dissemination work and the setting at which it takes place, attention should be given to include all possible types of groups that may come to seek information, and this should be considered when developing content.
(d) Confidentiality: Ensure strict confidentiality is maintained at all times by refraining from using personal details of victims and use of documentation that may directly or indirectly affect victims' wellbeing and safety.

Targeted Audience
• Audience size can be small or large

<u>Targeted audiences</u>

Mass audiences can also present themselves in the form of target audiences but in larger numbers. When the number of participants is significantly high, considerations need to be put in place to ensure maximum engagement and interaction as this can be challenging compared to a smaller audience. However, ways to mitigate any conflicts or disruptions that may arise will need to be strategically planned regardless of the size of the audience.
The following should be practiced when informing a target audience on DV prevention.

(a) Clarity and in-depth elaboration: Given the timing, important components can be delivered in detail with clear terminologies to avoid ambiguities and misinterpretations.
(b) Cautious of sensitive content: Being cautious of disclaimers and trigger warnings when giving out graphic or sensitive information.
(c) Inclusivity: When a specific audience is involved, the content developed, and the information delivered should cater to the needs and preferences of the audience.
(d) Sessions targeted for children: When children are the target audience of a session, ensure the information delivered is age-appropriate, in terms of the content delivered, graphics used, and any other methods used during the session.

Type of materials/ mediums	Materials come in physical and digital materials, and the medium in which information is conveyed varies based on the type of material. <u>Physical materials</u> Physical materials can include but are not limited to banners, posters, flyers, flashcards, booklets, and newsletters. Materials should be developed in Dhivehi, English, or the native language of the intended audience. Additionally, the language used must be simple enough to be understood by lay people as any material can be seen and read by secondary audiences as well. In instances where translation of materials is unavailable for languages other than Dhivehi and English but is required for a specific audience, arrangements must be made to at least convey the information verbally. Like the migrant population, the needs and preferences of persons with disabilities will also need to be catered to in terms of accessibility. <u>Digital materials</u> Digital materials can include but are not limited to presentations, video spots, songs, films, and social media posts. As with physical materials, inclusivity and accessibility must be ensured with digital materials as well. For mediums with visual images, including subtitles and sign language interpretation is instrumental in ensuring the message is properly and accurately delivered. Especially when all digital materials are also shared on multiple social media platforms, it is important to use technology to enhance accessibility features. As such, captions can be generated in both Dhivehi and English, include alternative text for describing images, and utilize screen reader software.

Capacity building	Advocates and trainers play an important role as agents to DV victims in understanding and exercising their rights. As such, the capacity building of these advocates is a vital route to empowerment of DV victims and victims. Capacity building ensures all service providers have the capacity and capability to deliver quality services and that service providers have the competency required to fulfill their roles and responsibilities. Capacity building focuses on the following as demonstrated below:

Capacity Building

Trainings - Sensitization Trainings - Refresher Trainings	**Minimum Requirements of advocates**

Trainings	<u>Sensitization trainings</u> Advocates should complete an initial sensitization training with components that cover: • DV Prevention Act (3/2012) • Gendered dynamics of violence from a gender sensitization point of view • Prevalence of DV in the Maldives • Reporting mechanism, referral pathways, and the available resources and services for victims (legal, psychological, social, and any other support services) • Helpline numbers • Communicating with victims • Implementing a victim-centric approach with components that cover (i) confidentiality and safety; (ii) non-discrimination and diversity; (iii) revictimization of victims • Assisting victims with information on trauma, coping and survival <u>Refresher/orientation trainings</u> Service providers should ensure that their staff are up to date with the DVPA and contents mentioned above. In addition to this, they must be oriented and up-to-date with sector relevant regulations/guidelines/procedures. They must undergo refresher/orientation training once every 3 years.
Minimum requirements of advocates	<u>Minimum requirements of advocates</u> (a) Advocates should be professionals who work in the health sector, law enforcement, legal and social services field in state and non-state agencies. (b) Advocates should complete an initial sensitization training with components that encompass DV Prevention Act (3/2012), the gendered dynamics of violence and the context of Maldives (c) Advocates should undergo ongoing refresher training as deemed necessary.

ANNEX

Key Actions – Health Care for GBV Survivors

The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming developed by UNFPA outlines the key actions with regard to Health Care for GBV Survivors.

	PREPAREDNESS	RESPONSE	RECOVERY
Preposition supplies to ensure women and girls receive PEP within 72 hours of potential exposure.			
Work with health-care staff to ensure women and adolescent girls have immediate access to reproductive health services at the onset of an emergency (no needs assessment is necessary) as outlined in the MISP.	✓		
Work with health-care staff to ensure GBV survivors have access to high-quality, lifesaving health care based on World Health Organization (WHO) standardized protocols.		✓	✓
Work with health-care actors to assess health facility readiness and health service provision, and advocate to address gaps to ensure an adequate health response is in place and accessible to survivors.	✓	✓	✓
Enhance the capacity of health-care providers, including midwives and nurses, to deliver quality care to survivors through training, support and supervision, including on GBV prevention and response, clinical management of rape and intimate partner violence.	✓	✓	✓
Establish and maintain safe referral systems among health and other services and among different levels of health care, particularly where life-threatening injuries or injuries necessitating surgical intervention require referral to a facility providing more complex care.	✓	✓	✓
Work with communities to develop safe access, including transportation options, for GBV survivors to obtain health services.	✓	✓	✓
Ensure that a consistent GBV focal point is present in health sector meetings and activities, and that a health sector focal point participates in GBV meetings.		✓	✓
Provide support to health-care actors to train and support medical and non-medical personnel on the needs of GBV survivors and the importance of promoting survivor centered, compassionate care that is appropriate to the survivor's age, gender and developmental stage.	✓	✓	✓
Strengthen the capacity of community health providers, traditional birth attendants and other community-based health actors who are important entry points for referrals and basic support.	✓	✓	✓

	PREPAREDNESS	RESPONSE	RECOVERY
Work with health actors to ensure follow-up and referral of cases.	✓	✓	✓
Work with health providers and community leaders to inform the community about the urgency of, and the procedures for, referring survivors of sexual violence if safe to do so.	✓	✓	✓
Disseminate information and engage communities on the health consequences of intimate partner violence and child marriage, which often increase in emergencies, if safe to do so.	✓	✓	✓
Re-establish comprehensive reproductive health-care services and strengthen national health systems after the immediate emergency onset and during transition phases.		✓	✓

Key Actions – Psychosocial Support

The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming developed by UNFPA outlines the key actions with regard to psychosocial support.

	PREPAREDNESS	RESPONSE	RECOVERY
Assess and strengthen existing psychosocial services, mechanisms and capacities where possible.	✓	✓	
Provide individual and group psychosocial support services that are safe and accessible for women and adolescent girls, welcome and integrate women and girls who experience discrimination, and address barriers to access while not exclusively targeting GBV survivors.	✓	✓	✓
Ensure GBV programming provides women and girl survivors with access to context appropriate individual and/or group psychosocial support services adapted to their ages and needs.	✓	✓	✓
Recruit and train GBV response workers with strong interpersonal skills, belief in gender equality, empathy, and knowledge of the local language(s) and culture(s).	✓	✓	✓
Ensure that all psychosocial support services focused on women and girls promote a sense of safety, calm, self-efficacy, community solidarity and support, connectedness and hope	✓	✓	✓
Establish or strengthen existing safe spaces for women and girls to provide psychosocial support activities (see Standard 8: Women's and Girls' Safe Spaces).	✓	✓	✓
Link with child protection actors to understand available psychosocial support activities for young and adolescent girl and boy survivors of sexual abuse, offer child survivors and caregivers information on services, and refer as appropriate.	✓	✓	✓

	PREPAREDNESS	RESPONSE	RECOVERY
Ensure information about psychosocial support services is shared with and reaches diverse women and girls through targeted outreach.	✓	✓	✓
Train GBV response workers on the root causes, consequences and impacts of GBV, survivor-centred principles and skills, and the capacity to support survivors (whether or not survivors disclose).	✓	✓	✓
Ensure GBV programming provides women and girl survivors with access to context appropriate individual and/or group psychosocial support services adapted to their ages and needs.	✓	✓	✓
Consider and address obstacles to women's and girls' access to psychosocial support services, including emotional distress and fear, documentation, discrimination, safety and security issues, proximity, cost, privacy, language and cultural issues.	✓	✓	✓
Identify and promote community-based support, self-help and resilience strategies, including working with women and girls to establish support groups and networks that promote healing and recovery.	✓	✓	✓
Provide skills and knowledge-building opportunities for women and girls to improve their psychosocial well-being, e.g., social and emotional learning, financial skills, numeracy and literacy, etc. (see Standard 8: Women's and Girls' Safe Spaces), including by linking survivors to livelihood activities and additional services156 (see Standard 12: Economic Empowerment and Livelihoods).	✓	✓	✓
Train GBV response workers to recognize signs that women and girls may benefit from GBV case management or specialized mental health care (see Standard 4: Health Care for GBV Survivors).	✓	✓	✓
Ensure that the minority of GBV survivors who require specialized mental health support are referred to mental health services where available.	✓	✓	✓
Integrate psychosocial support services in the referral pathway, including confidential referrals and links with health-care providers for clinical services/mental health care and other services as needed.	✓	✓	✓
Advocate for all front-line workers (including, for example, registration, health posts, community outreach teams, etc.) to be trained in psychological first aid.	✓	✓	✓

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