



## **The Project «Domestic Violence – *perception* – *intervention*» in the Maternité Women’s Clinic, City Hospital, Triemli, Zurich**

### **Summary**

«Domestic Violence – *perception* – *intervention*» was a joint project of the City of Zurich Gender Equality Office and the Maternité Women’s Clinic, a clinic for obstetrics and gynaecology in the city of Zurich. The goal of the project was to work out fundamental information on the topic of domestic violence and health, and to develop and test a strategic concept for the clinic.

The whole project «Domestic Violence – *perception* – *intervention*» was divided up into various sub-projects:

- There was an investigation into the current state of the perception and the handling of the problem of domestic violence in the Maternité Women’s Clinic (a survey of employees)
- There was a representative survey of patients of the Maternité Clinic on the topic of ‘health and safety’
- Training of employees
- Institutional measures (guidelines for how to proceed in matters of domestic violence)

The sociologists Daniela Gloor and Hanna Meier of Social Insight Zurich were given the task of carrying out the two surveys.

The project began in the summer of 2002. The first step was to carry out a survey of employees, which demonstrated that the topic of domestic violence is relevant to everyday issues in the hospital and that the employees have a need for both information, and guidelines as to how to deal with it. The written questionnaire for patients that was carried out subsequently (with 1772 replies) pointed to a high degree of involvement in domestic violence. One in ten patients stated that she had experienced physical assault, or the threat thereof, from a person close to her in the twelve months before the survey.

In the practically oriented part of the project, employees were given training and guidelines were worked out. These describe how to act in a concrete case, and contain important documents and fundamental information. An integral part of the guidelines and thus of the procedures of the Maternité Clinic is a screening process regarding domestic violence. In other words, patients are questioned about violent experiences as a routine part of establishing their medical history. The first experiences with the guidelines have been positive – both on the part of the employees as well as on the part of the patients.

After concluding the project in the summer of 2006, the guidelines were introduced definitively in the Maternité Women’s Clinic. This project was the first time in Switzerland that

a comprehensive plan on the topic of domestic violence was developed and introduced in the health sector.

## **1. The Genesis of the Project**

The project was initiated by the City of Zurich Office for Gender Equality. In the late 1990s, the Office played a decisive role in the «Zurich Intervention Project against Violence by Men» («Zürcher Interventionsprojekt gegen Männergewalt», hereafter «ZIP»). That project had as its aim primarily an optimisation of the interventions of the police, the judiciary and counselling services. After ZIP was completed, the Office decided to focus on the health sector for its next project. Experts in the health sector are often the first to come into contact with those affected by violence, or are the only people in whom those affected have enough trust to be able to speak of their experiences. Institutions and experts from the health sector are thus highly suited to recognizing domestic violence and to supporting victims of violence.

The initial exploratory conversations with the Maternité Women's Clinic showed that the topic of domestic violence is rarely discussed explicitly in the everyday life of the hospital. However, this awakened the Clinic's interest in finding out more precisely how often the problem really occurs, how one can recognize it and what might have to be improved in the Clinic itself. It was agreed to carry out this project on the condition that the Women's Clinic would not bear any of the costs, and that the time that the Clinic would have to invest would be kept within reasonable boundaries.

## **2. A Definition of Domestic Violence**

For the two surveys and the training sessions in the Maternité Women's Clinic, the concept of domestic violence was defined as follows:

«Domestic violence» is the term we give to violence among adults who stand, or have stood, in a close social relationship to each other. This means in most cases a partnership or a familial relationship. The concept of violence in one's social vicinity is used synonymously.

Domestic violence comprises the following behavioural characteristics:

- Physical violence such as: hitting, kicking, choking, injury with an object, etc.
- Psychological violence such as: verbal abuse, humiliation, threats, saying someone is mad, using children as a means of applying pressure, damaging things on purpose, etc.
- Sexual violence such as: forcing one to commit sexual acts, rape etc.
- Social violence such as: forbidding someone to have contact with others, isolating someone socially, locking one in, etc.
- Economic violence such as: depriving of money, forbidding or forcing someone to work, etc.

Social and economic violence are to be understood as forms of psychological violence.

### **3. Project Sponsors**

The sponsors of the project «Domestic Violence – *perception – intervention*» were the City of Zurich Office for Gender Equality and the Inselhof Association Triemli, which until the end of 2004 ran the Maternité Clinic for Obstetrics and Gynaecology. At the beginning of 2005, the Maternité was taken over by the Triemli City Hospital.

The Office for Gender Equality belongs to the City Administration of Zurich and has been in existence since the end of 1990 (and at the time was called the Office for Equality between Women and Men). Its task is «to promote the legal and actual equality of women and men in all fields of life and in the city government of Zurich». Working against domestic violence is one of the focal areas of the Office's activities.

The Maternité Women's Clinic has departments for obstetrics and gynaecology, with some 50 beds. There are more than 1400 births there every year and some 2500 gynaecological operations, which makes it one of the biggest clinics for obstetrics and gynaecology in the Canton of Zurich. Besides treating in-patients, it also deals with a large number of outpatients at various special consulting hours. The Women's Clinic has more than 18 full-time positions for doctors and 80 posts for nursing staff. Of the patients that come to the Clinic, half of them have a Swiss passport.

### **4. Goals of the Project**

The most important goal was to gain well-founded knowledge on the topic of domestic violence and health, knowledge that could also be applied outside the Maternité Women's Clinic. Based on this, an intervention plan was to be worked out for the Clinic and training sessions carried out with the personnel. This had the aim of making the doctors, nursing staff and midwives of the Clinic into competent contact people for all patients affected by violence, so that they would be able to offer suitable assistance.

It was also hoped that, over and above the Maternité Women's Clinic itself, the project would lead to a sensitisation to the topic of domestic violence in the health sector.

### **5. Sub-Projects**

The project was divided into the following sub-projects:

- There was an investigation into the current state of the perception and the handling of the problem of domestic violence in the Maternité Women's Clinic (a survey of employees)
- There was a representative survey of patients of the Maternité Clinic on the topic of «health and safety»
- Training of employees
- Institutional measures (guidelines for how to proceed in matters of domestic violence)

A project group was appointed to plan and carry out the sub-projects. This group was comprised of two female employees of the Maternité Women's Clinic and a female employee of the Office for Gender Equality; the latter was assigned to head the project. The sociologists Daniela Gloor and Hanna Meier of Social Insight Zurich were given the task of carrying out the two surveys.

## 6. The Survey of Employees

At the beginning of 2003, all the employees of the Maternité Women's Clinic who as part of their work were in direct contact with patients, were given a written questionnaire. In addition to this, oral interviews were carried out with seven employees (two doctors, two midwives, two members of the nursing staff and the social worker). The following questions were at the core of it all: what significance is accorded the topic of domestic violence in the everyday practical work of the hospital? What are their experiences of domestic violence among patients, and how do the employees deal with this? How is the degree of necessary action judged, and what changes are regarded as important? Do the employees know the problem of 'domestic violence' from their own experience?

The results show that the employees are confronted with domestic violence on a relatively regular basis and that they are open to the idea of the Clinic engaging with the topic:

- Two of those questioned stated that in the three months before the survey, they had had contact with at least one patient of whom they were sure, or of whom they suspected, to have had experienced violence from a person close to them.
- 71% of those questioned are of the opinion that their background knowledge of the topic tends to be insufficient.
- Some three out of four of those questioned stated that they did not feel secure enough and were not able to fall back upon sufficient experience when dealing with this problem.
- One in four of those questioned stated that, as an adult, they had had experience themselves of violence from a person close to them (either physical or sexual violence).
- 82% of those questioned were positive or somewhat positive about the idea of further training on the topic of domestic violence; this was the case across all the professions.
- Most employees (79%) assume that domestic violence is one of the topics for which hospitals should be responsible.

When asked about the difficulties of dealing with domestic violence, the following points were mentioned most often:

- Language problems (90%)
- Problems of time (85%)
- The difficulty of recognizing that a woman had been affected by violence (73%)

## 7. The Survey of Patients

The written survey of the patients was carried out with the goal of acquiring significant data on the degree to which they were affected by violence, and on their health situation. The 15-page questionnaire «Health and the safety of women» was given in German, English, Spanish and Serbo-Croat, and was sent to the patients at their homes together with an accompanying letter from the Chief Physician. The questionnaire was also accompanied by a card with the addresses of advisory services that are specialized in the topic of domestic violence. Participation in the survey was surprisingly high. In total, 1886 women sent back the questionnaire. This corresponds to a total response of 50%. 114 questionnaires could not be evaluated, which meant that the number of usable questionnaires stood at 1772 (47%).

### 7.1. The Degree to which Patients are affected by Violence

The survey asked about violence between adults (from their 16<sup>th</sup> year) that was carried out by (marital) partners, ex-partners or family members. On the basis of numerous concrete examples, three forms of violence were covered: psychological violence and controlling behaviour, physical violence and threats, and sexual violence.

The evaluation demonstrated that one in ten patients experienced physical assault or threats from a person close to them in the twelve months before the survey. In the course of their adult lives, some 28% of the women in the survey had experienced more extreme violence, i.e. several forms of psychological *and* physical or sexual violence, mostly over a longer period of time. Expressed in figures, this is 498 out of 1772 women. Pregnant women are affected by violence close to them in a manner very similar to women who are in contact with the Clinic for reasons other than pregnancy.

<b>Currently affected (i.e. in the 12 months before the survey)</b>	
Physical violence and/or threats by the current partner	7.9 %
Physical violence and/or threats by a former partner	4.2 %
Physical violence and/or threats by family members	1.9 %
Sexual violence	2.0 %
Physical violence and/or sexual violence in total (multiple answers permitted)	10.0 %
<b>Affected in their whole adult life (from their 16<sup>th</sup> year)</b>	
Psychological violence and/or controlling behaviour	76.8 %
Physical violence and/or threats	43.6 %
Sexual violence	12,9 %
More extreme violence	28.1%

## 7.2 Affects on Health as a Result of Violence

The results of the survey show how often domestic violence leads to adverse effects in health. One in two women who have experienced physical violence tell of injuries and further physical effects.

The following injuries and physical effects were mentioned (in descending order of mention)

- Bruises, swellings, contusions
- Hair torn out
- Facial injury (nose, teeth, lips)
- Nausea, vomiting
- Grazes
- Abdominal pain
- Sprains, pulled muscles
- Open wounds, cuts, burn wounds
- Fainting, unconsciousness
- Genital injury
- Complications in pregnancy
- Broken bones, fractures
- Internal injury
- Miscarriage

Women who have experienced domestic violence also tell of emotional and psychosomatic problems that they regard as being a result of that violence. Emotional and psychosomatic effects are observed more often than physical injuries and problems. Only one in four women who have experienced violence have felt no such effects.

Among those women who have suffered a greater degree of violence, 65% report injuries and psychological/psychosomatic problems as a result of it.

<b>Direct affects among those having suffered a greater degree of violence</b>	
Problems sleeping or nightmares	47.0 %
Difficulties in relationships with men	46.5 %
Problems with sexuality	31.5 %
Thoughts of suicide	30.0 %
Eating disorders	29.4 %
Problems at work or in training	27.3 %

These figures allow a comparison between the health situation of women who have experienced no domestic violence, and women who have experienced domestic violence to varying degrees. In the latter case, we distinguish between minor, middling and serious degrees of the violence in question.

When we analyse the results on **physical complaints** as to whether a woman has experienced violence in her immediate circle and, if so, to what degree, then we observe significant differences. The connection is linear, in other words, the greater the degree of violence experienced, the greater the problems. Thus, in the group of women without experience of violence, only one in twenty reports obvious or frequent problems, while among those women affected by a greater degree of violence, one in four women (24.4%) has obvious or frequent physical complaints.

<b>Frequency of physical complaints (in the 12 months before the survey)</b>	<b>Unaffected women</b>	<b>Women affected by greater violence</b>
No complaints, or very few	48.6 %	17.0 %
Some complaints	46.4 %	58,6 %
Clear/frequent complaints	5.0 %	24,4 %
Total	100 %	100 %

As regards the **current state of health** of those questioned, we see the following overall results: one in four women give their health the best mark of 10 (on a scale of one to ten). Six out of ten women regard their health as good or middling (7-9 on the scale). One in seven women chooses a lower mark (1-6 on the scale).

Once more, an analysis produces considerable differences according to different degrees of violence experienced. One in three women without experience of violence regards her current state of health as very good (35.6%). Among the women who have experienced a greater degree of violence, the proportion is much smaller: only one in seven women of this group (14.9%) gives her health situation the top mark of 10.

<b>Current state of health</b>	<b>Unaffected women</b>	<b>Women affected by greater violence</b>
Very good	35,6 %	14,9 %
Good/middling	54,7 %	61,6 %
(Tending to) bad	9,7 %	23,4 %
Total	100 %	100 %

The results of the survey clearly show that experience of violence – even if it lies in part further back in the past – has a lasting negative impact on the health and psychosocial situation of the women concerned. The impact on health is all the greater according to how much greater were the experiences of violence, and how much longer they lasted.

### **7.3 Making Use of Opportunities for Help**

The patients who told of domestic violence were asked what institutional help they had utilized. 336 of the 1772 women questioned have sought help once. 128 women have contacted an institution, 125 women have contacted two or three places, while 83 women have contacted four to eleven.

The institutions or experts most often mentioned were:

<b>Instances contacted (multiple answers possible)</b>	
Psychologists and psychiatrists	26.0 %
Doctors	13.3 %
Police	11.5 %
Lawyer	8.4 %
Marriage guidance counsellor	8.0 %
Another advisory service	7.8 %
Courts (civil/criminal)	7.6 %
Emergency services/hospital	6.6 %
Church or pastoral services	5.3 %
Women's shelter	3.4 %
Victim assistance (Opferhilfestelle)	2.8 %
Emergency helpline (Women's Advisory Centre)	3.0 %
Dargebotene Hand (the Swiss 'Samaritans'), Tel. 143	2,6 %
Number of women	N=845

Calculated as a number of all those questioned, 135 of 1772 women have at least once contacted a doctor, an emergency service or a hospital on account of domestic violence.

Among those questioned who have experienced a greater degree of violence, it was observed that half of these women had made use of institutional help; one in two of those affected by greater violence had not made use of any professional help (46.5%). Those women who despite considerable experience of violence had never sought help, or had done so only after a prolonged period, were asked for the main reasons for this. The reason given most often by far was that they did not regard professional help as necessary (43.4%). Moral qualms and shame were second on the list of the most frequent reasons. Further reasons were a lack of knowledge of the services available, concern about their families and fear of their partner.

#### **7.4 Degree of Contentedness with the Help Given**

Women who had made use of professional help in connection with violent experiences were then asked as to their degree of satisfaction. Top of the list regarding satisfaction were the victim assistance centres, the distress phone service and the women's shelters. Then came: other advisory services, lawyers, emergency services/hospitals, psychologists and psychiatrists, doctors and the courts. There was particular criticism of four institutions: More than a third of the women – almost half – were unhappy with the help given by the police, the church and pastoral care services, the Samaritans and marriage guidance counsellors. Here, however, it must be stated that the negative experiences could also be with regard to events in the more distant past.

Somewhat less than half of those questioned were very content with the **medical care** given. Just half found it 'completely true' that the doctor had regarded them and their situation seriously. With regard to nursing staff, the proportion was lower; only one in four women gave a positive opinion. Only one in three women were very satisfied with the information received from the further instances offering help and assistance.

### **7.5 Attitudes towards Screening (routine questions regarding experience of violence)**

This study also recorded the attitude of the women questioned with regard to screening for experiences of violence. The concrete question was: 'How would you react, if you were visiting a doctor or a hospital and were asked if you were experiencing physical or sexual assault from a husband, partner or another person close to you?' The results show that the majority of the patients have a positive attitude to screening. Almost nine out of ten women find such a question in order, and have no problem with it.

### **7.6 Differences between Migrants and Swiss Citizens**

The survey was directed equally at women with and without a Swiss passport. 27.2% of the questionnaires that were able to be evaluated were from foreigners. This proportion is significantly lower than the proportion of foreign women among the patients at the Maternité (47.2%). Less women with a foreign passport thus completed the questionnaire than did those with a Swiss passport – presumably because of language problems above all. It is difficult to judge whether or not there were other reasons (e.g. less familiarity with surveys, hesitation regarding this survey, a greater degree of taboo surrounding the topic). In total, women from 70 countries took part in the survey.

With regard to the degree of violence experienced, there were no significant differences among different nationalities. Among the women questioned, Swiss citizens and foreigners were affected to a similar degree by violence in their immediate circle.

In part, there are differences in the attitudes towards routine screening questions. Patients who come from eastern European countries, from Africa, Asia or America, expressed scepticism more often about screening (a proportion of between 18.3% and 23.6%) than did Swiss citizens (10.3%) or those from western Europe (9%). The greatest degree of hesitance is found among those foreigners who are most affected by violence. But even women from those same countries who were themselves less affected by violence, are noticeably more critical with regard to such questions than are Swiss and other western European women. This rather sceptical attitude regarding questions about violent experiences could (besides the language barrier) have also led to the lower level of response from foreign women. Precisely such women, who have already been confronted by prejudice and discrimination, presumably fear that such questions are posed only to them, and not to all women irrespective of their land of origin. The manner in which questions about violent experiences are posed is therefore important, as is the general information that accompanies the questions (e.g. the statement that all women are being questioned).

## **7.7 Conclusions Regarding the Results of the Surveys**

The results of the two surveys have shown that:

- The topic of domestic violence is very relevant for the Maternité Women's Clinic
- There is a need on the part of the employees for knowledge and clear guidelines for action
- The project «Domestic Violence – *perception* – *intervention*» corresponds to a need, and that
- the practically oriented sub-projects (training and institutional measures) are very important.

Subsequent to the surveys, the project group was tasked with developing a procedure for dealing with women at the Clinic who have experienced violence, and to formulate this in the form of specific guidelines. On the basis of the positive response from the patients questioned, the Clinic management decided to make screening a part of the new procedures and to introduce it on a trial basis (i.e. routine questions about violent experiences). The project group furthermore was given the task of working out a training plan.

## **8. Guidelines for Dealing with Domestic Violence**

The guidelines were developed by the project group in close collaboration with experts from both inside and outside the Clinic. The guidelines have the goal of placing practicable information, instructions for action and further instruments at the disposal of the employees, and of making it possible to carry out the screening in a competent manner. The employees should know what their task is, what and who can support them in it, and to which instances they can refer those women who have experienced violence.

### **8.1 Contents of the Guidelines**

The guidelines deal with the following topics:

- The definition of domestic violence
- Indicators (what symptoms can suggest the existence of domestic violence?)
- Explanations of screening
- Carrying out the conversation
- The procedural order of the screening and conversation
- Documentation sheets
- Doctor's report
- Offers of help
- Internal flow of information and professional duty of silence
- Setting boundaries and protecting oneself
- Dealing with relatives who practise violence or threaten to do so

The most comprehensive section of the guidelines deals with the screening and carrying out the conversation: when is the screening question asked, and by whom? How should it be introduced, how can it be formulated? What should one take note of, and what happens if a patient answers the question with 'yes'? In what situations should the screening question not be asked (e.g. in the presence of the partner/of relatives)? What should one avoid when in contact with a woman who has experienced violence? Sample sentences are given, and one's attention is drawn to the various possibilities for further conversation. A documentation sheet that is deposited with the social worker, away from the patient's medical history, serves to record the conversation, its findings and measures to be taken. It can be useful to the patient if legal steps become necessary. One important chapter deals with possible reactions of the employees to the reports of women who have experienced violence, and the question as to how they can protect themselves from strain and how they can acknowledge and accept their own boundaries. Reference is also made to the possibility of the employee being affected herself, and to offers of support.

In the course of training sessions, these guidelines sanctioned by the Clinic management were presented to all women on the nursing staff, all midwives and all doctors, and given to them in written form. Furthermore, small brochures were produced in 7 languages that offer the most important counselling addresses, and which can be given as part of the screening process and can be placed in batches in the waiting rooms.

## **8.2 The Trial Phase**

Before the guidelines were applied definitively, it was agreed to have a six-month-long trial phase, during which supporting measures and an evaluation of the first experiences were planned. The employees were given support at selected moments during the trial phase. The social worker and the gynaecologist active in psychosomatic illness paid regular visits to the teams, enquired as to the state of the process, and offered advice when difficulties arose. The employees thus had the opportunity to talk about concrete experiences, to clarify issues on applying the guidelines where clarity was lacking, and to pose questions.

In order to evaluate the trial phase, all the employees who carried out the screening were given a questionnaire to fill out. Furthermore, the documentation sheets had names removed from them and were then evaluated; a random sample of medical histories was sifted, and it was recorded how often the screening had been carried out. Minutes were taken of the meetings between the social worker/gynaecologist and the teams.

The evaluation of the questionnaires, which were filled out by just two-thirds of all the employees surveyed, produced the following results:

- There is a good level of acceptance of the guidelines. 95% regard them as a good means of assistance in getting to know how to deal with cases of domestic violence. Just as many regard screening as a good means of becoming aware of domestic violence and of doing something against it.

- A majority of the employees had hardly any difficulty in asking the screening question. More than 50% have no problem with it. 13% feel that the question could be unpleasant for the patient. Some feel themselves not competent enough. Often, the problem of lack of time was mentioned.
- The reactions of the patients to the screening were predominantly positive. More than 50% of the employees report a positive reaction to the screening question on the part of the patients. 33% felt that the screening question surprised the patient, but only a few experienced a negative reaction from the patient.

In the trial phase, the screening was carried out among more than half of all the in-patients. Outpatients, however, were asked the screening question only rather rarely. One common reason as to why the screening could not be carried out was the patient's insufficient knowledge of German. The reference in the guidelines as to how to carry out the conversation was expanded by the introduction of sample sentences in different languages. But the questioner can only employ the sample sentence if he or she has sufficient knowledge of the language. The possibilities for solving this problem are thus limited. It is not possible to work with translators for the screening process. However, if there is a reasonable suspicion of domestic violence, a translator can be brought in.

Carrying out the screening in the outpatient sector showed up special difficulties. A lack of time, compounded by insecurity or hesitation regarding the topic, all too often conspired to prevent the screening from happening.

During the six-month trial phase, 47 documentation sheets were filled out and passed on to the social worker for her to archive. 14 women told of current experiences of violence; in the other cases, it was a matter of violence in an earlier relationship or during childhood. This result, however, is only reliable to a certain degree. It could not be checked if the employees always remembered to fill out the documentation sheet, nor how many women refused to have one filled out.

The Clinic management decided to introduce both the guidelines and the screening on a definitive basis on 1 January 2006.

## **9. Sensitising and Training the Employees**

The training was divided up into two modules, namely in a basic seminar and an intervention seminar. Both seminars took place during work time.

### **The Basic Seminar**

The goal of the basic seminar was to impart basic knowledge on the topic of domestic violence. After attending the seminar, the employees who are in contact with the patients should know the most important facts on the topic of domestic violence; they should have knowledge of the dynamics of domestic violence, the strategies of violent men and the definitions and symptoms of trauma and post-traumatic stress disorder. The basic seminar

was obligatory for all employees who have contact with patients (doctors, nursing staff, nursing assistants, midwives, social workers, psychologists, staff at the in-patient desk and in the outpatient clinic). It lasted for half a day and was carried out three times with groups of 30-40 participants each.

### **The Intervention Seminar**

The goal of the intervention seminar was for the participants to get to know the guidelines, to practise the screening question and to present the instruments available inside the Clinic. Asking the screening question was practised with role-play, in order to give the participants a greater sense of security. At the end of the intervention seminar, all employees should feel empowered to be able to ask patients about domestic violence as part of the screening process and to initiate further steps if the patient wishes it. The intervention seminar had to be attended by all employees who carry out the screening (doctors, nursing staff, midwives). It also lasted for half a day and was carried out four times with interdisciplinary groups of 20 participants.

### **9.1 Recommendations for the Training of Employees**

The interdisciplinary nature of the training team has proved itself (a doctor, a social worker, and an external woman expert on the topic of domestic violence). In order for the process to be anchored solidly in the Clinic, internal employees take part in the training too. These employees will be the patient's contact people on an everyday basis, since the first concrete contact with the patient shows up the difficulties that arise when dealing with the topic of domestic violence.

The topic of domestic violence prompts feelings of discomfort among most employees. It is feared that the hectic everyday life of a hospital will not allow enough time to do real justice to a woman who is ready to talk. Others are concerned that the screening question can intrude upon the private life of the patient. An employee's own, unresolved experiences as a victim of violence can also be a reason to avoid the topic. Sufficient space must be given to the concerns and uncertainties among the employees. Discussions allow them to see that they are not alone with their problems. Role-play allows difficult situations to be practised and tried out without any pressure being exerted.

In the everyday situation of a clinic, it is necessary to repeat the individual modules in order to make it possible for all the employees to participate. In order to integrate the doctors, it makes sense to pay attention to the existing structures for further training.

The training is a first step towards introducing the topic of domestic violence and how to deal with it in the Clinic. It is very important for continuity that further training follows thereafter and that the process is observed and supported continually.

## 10. Information from the Patients

As part of the project, a brochure was developed in seven languages: German, French, English, Spanish, Tamil, Albanian and Croatian. The brochure lists the different forms of violence. It also encourages the patients to talk in the Maternité about the violence that they have suffered, and to make use of the help offered. The brochure contains the addresses of all the instances dealing with domestic violence in the Zurich area. There is a detachable «emergency card» in credit-card format with the most important telephone numbers, which is ideal for keeping in one's purse. The brochure lies in the waiting rooms and is offered to the patients in the course of the conversation with them.

Besides the brochure, there is a poster in A3 format that is hanging in the foyer and in the wards of the Women's Clinic. The poster makes it clear that domestic violence is a topic that can be talked of at the Women's Clinic.

## 11. Conclusion of the Project and Consolidation

After the definitive introduction of the guidelines, the project was closed in early 2006. In order to ensure that the measures introduced are lasting, it was decided what further action was to be taken, as well as the tasks to be done and who is responsible for them. The training and the support of the employees who use the guidelines allows for the measures worked out in the project to be further implemented and consolidated in the everyday life of the Clinic.

At the end of 2006, the sponsors published a handbook entitled «Recognize domestic violence and react the right way. A handbook for the medical, nursing and counselling professions». The project «Domestic Violence – *perception – intervention*» is described extensively in it. On the basis of the handbook, the Office for Gender Equality regularly puts on training courses for experts in the health sector.

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