Sweden
Sverige

UNDP

CENTRUL DE DREPT
AL FEMEILOR
Promovând împreună drepturile femeilor
Advancing women's rights together

ANDREI PĂDURE, ARINA ȚURCAN-DONȚU

DOMESTIC AND GENDER-BASED VIOLENCE

TRAINING MANUAL

[343.55+305]:614.253(075.8)
P 12

Approved by the Quality Management Council, 'Nicolae Testemitanu' SUMPh
Protocol No. 3 of 21.12.2021

Authors:

Andrei Pădure, PhD, Dr. med. habil., Associate Professor, Department of Forensic Medicine at 'Nicolae Testemitanu' SUMPh;

Arina Ţurcan-Donţu, PhD student, Institute of Legal, Political and Sociological Research, lawyer, Women's Law Center

With the contribution of **Sergiu Toma**, PhD in Psychology, Director of the Institute for Family and Social Initiatives

Reviewers:

Eduard Lungu, associate professor, PhD, Department of forensic medicine, 'Nicolae Testemitanu' SUMPh

Rodica Gramma, associate professor, PhD, master in law and health management, Department of forensic medicine, 'Nicolae Testemitanu' SUMPh

Vladimir Vataman, associate professor, PhD, Department of morphopathology, 'Nicolae Testemitanu' SUMPh

Valeriu Cobeţ, professor, Dr. med. habil., Department of physiopathology and clinical physiopathology, 'Nicolae Testemitanu' SUMPh

Coordinated by the Women's Law Center

Nowadays, domestic and gender-based violence is considered one of the most frequent crimes committed in any society and country in the world, reaching epidemic proportions. The Republic of Moldova has carried out several actions in the recent years intended to ensure gender equality and to prevent and combat domestic violence. However, actions can be implemented successfully only by engaging trained professionals, who are not affected by stereotypes and social norms, including healthcare professionals.

The paper includes theoretical aspects of the 'Domestic and gender-based violence' course and is intended for medical students, residents, clinicians and teaching staff of the Department of Forensic Medicine at 'Nicolae Testemitanu' SUMPh as a training material for the teaching process.

DESCRIEREA CIP A CAMEREI NAŢIONALE A CĂRŢII

Pădure, Andrei.

Domestic and gender-based violence : (Training manual) / Andrei Pădure, Arina Ţurcan-Donţu; with the contribution of Sergiu Toma ; Women's Law Center, UNDP Moldova. – Chişinău : S. n., 2022 (Bons Offices). – 176 p. : fig., fot., tab.

Referinţe bibliogr.: p. 172-176 (99 tit.). – With the financial support of Sweden. – 51 ex.

ISBN 978-9975-87-922-4.

TABLE OF CONTENTS

FOREWORD

Domestic and gender-based violence is a public health problem and doctors need specific knowledge and skills to ensure an appropriate response. In order to achieve this goal, doctors should understand what domestic and gender-based violence means, know the causes and consequences of this phenomenon for victims, their descendants and for the society as well, their important role in the identification of victims and potential victims, recognition and documentation of injuries, reporting and referring the victim to other professionals, specialized services for the subjects of domestic violence and authorities. Regretfully, the extent of domestic and gender-based violence in the Republic of Moldova is high, certain stereotypes regarding the role of men and women persist within the society, but doctors do not have appropriate knowledge and practical skills in identifying and managing cases of domestic and gender-based violence. As a result, victims of domestic and gender-based violence do not seek medical help, or even if they do, they do not receive information and appropriate treatment, being unable to fulfil their constitutional rights to health, bodily integrity, life and fair justice.

In recent years, the Republic of Moldova has carried out several actions focused on reducing the incidence of domestic violence and violence against women, some of the most important being the adoption of Law No 45/2007 on preventing and combating domestic violence and signing, in February 2017, and ratification on 14 October 2021 of the Council of Europe Convention on preventing and combating violence against women and domestic violence (2011), known as the Istanbul Convention. At the same time, in 2018, the Government of the Republic of Moldova approved the 2018-2023 National Strategy on preventing and combating violence against women and domestic violence and the Action Plan for 2018-2020 on its implementation. Based on these regulatory acts, the Ministry of Health, Labour and Social Protection and the 'Nicolae Testemitanu' State University of Medicine and Pharmacy have been entrusted to mainstream the topics of violence against women and domestic violence in the curriculum of the initial and ongoing training for doctors and medical practitioners. In order to achieve this goal, the training curriculum entitled 'domestic and gender-based violence' has been developed and approved during 2018.

The paper includes theoretical aspects of the 'Domestic and gender-based violence' course and it is designed for trainers and trainees as a training material for the teaching process. The training material will increase the understanding among doctors and future doctors regarding all aspects of the domestic and gender-based violence phenomenon in order to improve their professional interventions towards these cases and to ensure the rights of victims. The work was developed under the project 'Strengthening efficiency and access to justice in Moldova', implemented by UNDP Moldova with the financial support of Sweden.

Authors

TOPIC 1

The concept of domestic and gender-based violence

Domestic and gender-based violence is one of the most common human rights violations affecting the relationships between family members and it has a significant impact on their health (physical, psychological, sexual and reproductive) and the entire society. The health sector plays a crucial role in identifying cases of domestic and gender-based violence and providing a comprehensive professional response, as victims require medical care, and for many of them, a visit to the doctor becomes the first, and often the only, step in accessing the necessary services. Due to these reasons, doctors need to know how to identify this category of victims and offer healthcare based on their needs, as these actions are decisive in preventing and combating domestic and gender-based violence.

The extent of domestic and gender-based violence

Violence against women and domestic violence are among the most severe and widespread offences modern societies deal with, infringing the rights and dignity of their members. These phenomena persist in all countries of the world, regardless of political or economic structure, population wealth, race, culture. Although domestic violence was recognized as a social phenomenon, all countries in the world encounter this issue, but each country has its own approach based on culture, traditions, perceptions etc.

Globally, statistical data on the prevalence of domestic and gender-based violence are provided by the World Health Organization (WHO), the Council of Europe, the United Nations agencies (UN Women, UNFPA, UNODC).

The United Nations Office on Drugs and Crime (UNODC) Global Study on Homicide (2019) estimates that about 137 women across the world are killed by their intimate partner or by a member of the family every day, and the home is the most likely place for a woman to be killed. From the same source we note that 50,000 women (58%) were killed by a close person in 2017: 30,000 were killed by intimate partners, 20,000 – by relatives; 8 out of 10 victims resulting

from intimate partner homicide are women. The study shows that the global female intimate partner or family-related homicide rate is 1.3 per 100,000 female population (Figure 1), with the lowest rate in Europe (0.7) and the highest – in Africa (3.1).

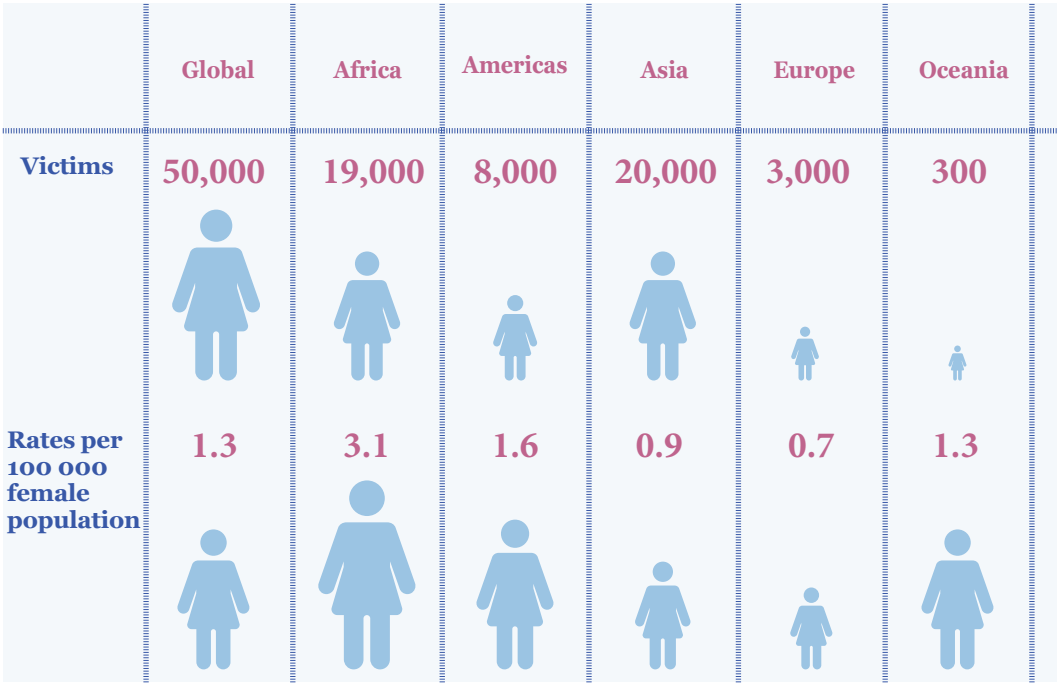


FIGURE 1. The rate of women killed by intimate partners or other family members per 100,000 female population worldwide
(www.unodc.org/documents/data-and-analysis/gsh/Booklet_5.pdf)

A survey published by WHO in 2013 on the global and regional prevalence of gender-based violence shows that 35% of women who are in a relationship or used to be, have been subjected to physical or sexual violence perpetrated by their intimate partner during their lifetime, and 7.2% of women have experienced sexual violence perpetrated by a non-partner.

Council of Europe statistics reflect that one in four women has suffered from domestic violence during her lifetime, and one in ten women has experienced sexual violence. According to the same source, about 45% of women have experienced some form of violence during their lifetime, and between 12% and 15% of women from Europe, over the age of 16, are victims of domestic violence. The survey *'Violence against women: an EU-wide survey'* (2014) estimates that 13 million women in the EU have experienced physical violence in the course of 12 months before the survey interviews, 3.7 million women have experienced sexual violence, 5% of women admitted being raped since the age of 15. According to the survey *'Violence against women in the European Union'*, there are about 3,500 deaths related to domestic violence in the European Union every year and 9 victims are recorded daily, 7 of them being women.

The survey *'Violence and health in Sweden'* (2015) reports that 46% of women and 38% of men have experienced some form of violence in their lifetime. The same survey highlights that women have been subjected to physical violence perpetrated more frequently by their intimate partner (14%) and less frequently by someone else (3%), while men have been subjected to physical violence perpetrated less frequently by their intimate partner (5%) and more frequently by other persons (16%).

Although the female rate of intimate partner or family-related homicide at the global level is the lowest in Europe, this indicator is decreasing continuously every year, reaching 0.47 in 2016 (Figure 2).

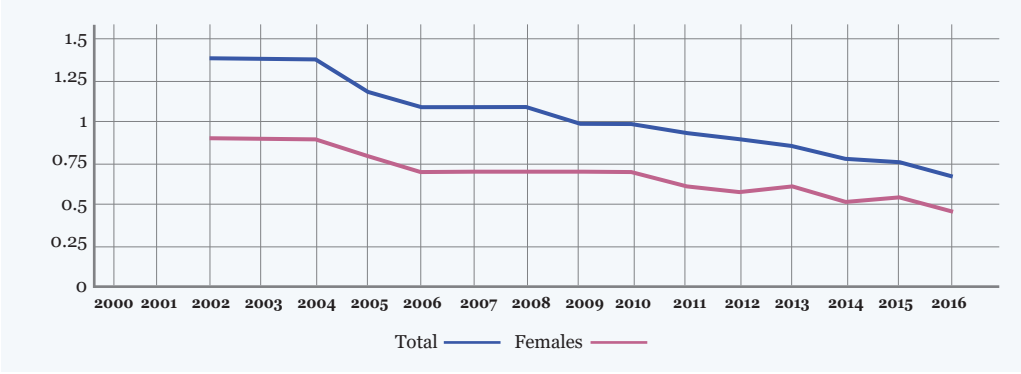


FIGURE 2. Dynamics of homicide (above) and femicide (below) rates in the EU per 100,000 population
(https://ec.europa.eu/eurostat/databrowser/view/sdg_16_10/default/line?lang=en)

According to the data provided by the Ministry of Internal Affairs, the homicide and femicide rates per 100,000 population in the Republic of Moldova (by total population – 3.5 million, as well as by the number of permanent residents – 2.6 million) are much higher than the average rate in the European Union countries (Figure 3).

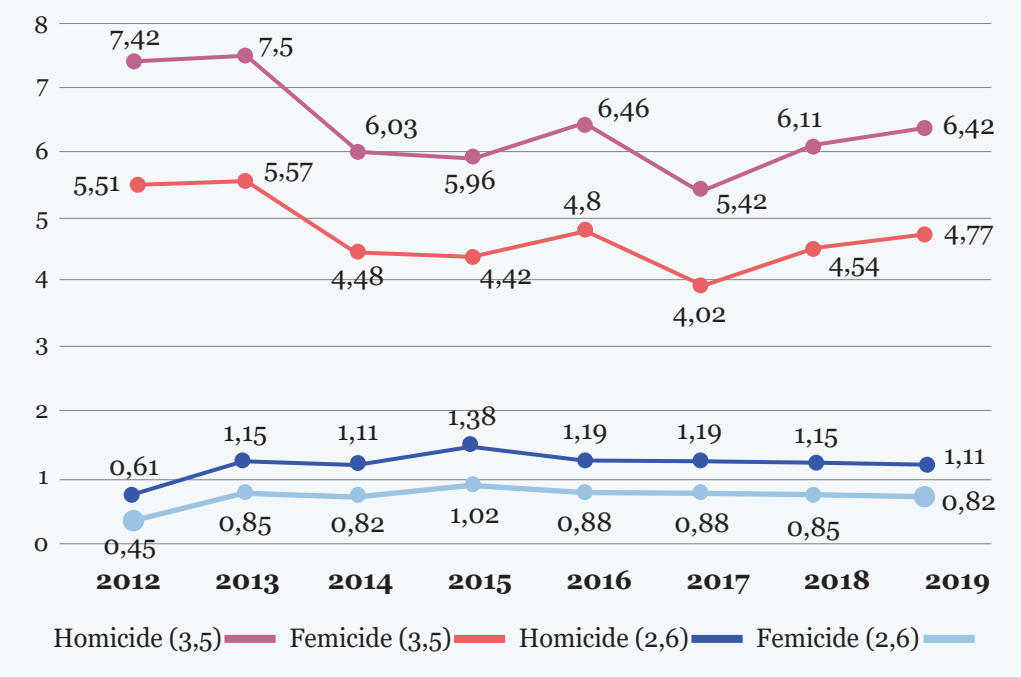


FIGURE 3. Dynamics of homicide (above) and femicide (below) rates in the RM per 100,000 population

(http://politia.md/sites/default/files/ni_violenta_in_familie_3_luni_2020_pentru_pagina_web-konvertirovan.pdf)

A recent survey (2019) conducted by the Organization for Security and and Co-operation in Europe (OSCE)[1] shows that 73% of women in the Republic of Moldova have experienced at least one form of violence perpetrated by intimate partners at some point in their life, the most common form of violence being psychological violence – 71%, followed by physical violence – 33%, that is much higher than the EU average.

The scale of domestic violence can be reflected through the dynamics of victims' reporting to the police. Based on the data provided by the Ministry of Internal Affairs, there is a steady increase in case reporting from 6,569 cases in 2012 to 12,970 reported cases in 2020[2] (Figure 4).

[1] The survey 'Well-being and Safety of Women', OSCE, 2019, pag. 6.
[2] politia.md/sites/default/files/ni_privind_infractiunile_ce_atenteaza_la_viata_persoanei_si_cele_de_violenta_in_familie_pentru_2020_pagina_web_a_igp.pdf

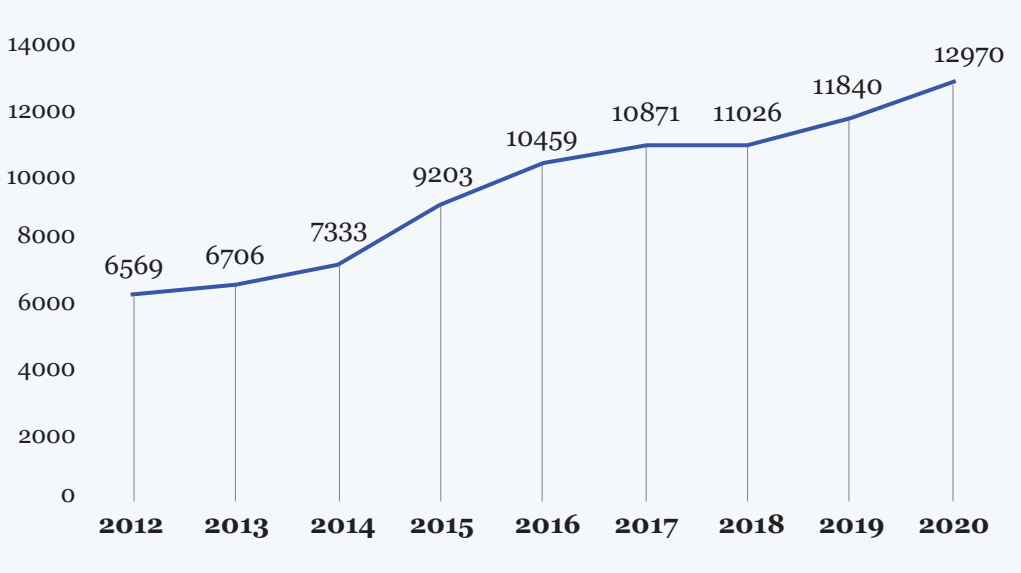


FIGURA 4. Dynamics of domestic violence reported cases (2012-2020)

Defining domestic and gender-based violence

Violence and violent behaviors are significant issues of modern society that affect all population categories regardless of age, sex or social status. Several definitions are used for interpersonal violence between family members, between men and women, but most of them emphasize violence perpetrated by men against women as a form of unequal power relations.

World Health Organization defines **violence** as *the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation*[3].

Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011) considers domestic violence as *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.*

[3] https://www.who.int/violenceprevention/approach/definition/en/

In compliance with Law No 45/2007 of the Republic of Moldova on preventing and combating domestic violence, **domestic violence** is defined as acts of physical, sexual, psychological, spiritual or economic violence *except for actions taken in self-defense or of another individual, committed by a family member against another family member, inflicting material or moral damage upon the victim*.

In fact, domestic violence is a form of aggressive, repetitive and coercive behaviors that men use most frequently to control their partners. Regardless of how resilient and resistant as women and children who have been directly affected by violence within the family may be, they are in a vulnerable situation both in terms of what may happen whether they continue to experience violence and whether they decide to report the abusive actions of the intimate partner they live with.

Domestic violence is a form of aggressive and coercive behaviors that adults and adolescents use against their actual or former partners or some family members.

In order to outline the gender inequality, the international law operates with definitions such as gender-based violence, violence against women and violence against intimate partner.

Thus, the UN Declaration on the elimination of violence against women (1993) defines **violence against women** as *any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*[4]. The declaration emphasizes that violence against women is a manifestation of historically unequal power relations between men and women, that resulted in men's domination and discrimination against women, and the violence is one of the crucial social mechanisms that puts women into a subordinate position compared to men.

Violence against women is also defined in the Istanbul Convention (2011) 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*. The convention is based

[4] https://www.ohchr.org/EN/ProfessionalInterest/Pages/ViolenceAgainstWomen.aspx

on a strong belief that domestic violence affects women disproportionately (women and girls are at a greater risk of gender-based violence than men), men can also become victims of domestic violence, children are victims of domestic violence, including as witnesses. In this respect, the Convention on the Elimination of Discrimination against Women (CEDAW) outlines that violence against women is 'violence which is directed against a woman because she is a woman'.

The Istanbul Convention (2011) also includes the term **gender-based violence against women** that is understood as *violence that is directed against a woman because she is a woman or that affects women disproportionately*.

In the context of domestic violence, World Health Organization (2013) provides the term of **intimate partner violence** that refers to behavior by an intimate partner that causes physical, sexual and psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors. This comprises violence caused by both current and former spouse, or any other intimate partner (for instance: cohabiting partner).

Therefore, the defining element of domestic and gender-based violence, highlighted in almost all definitions, is the control or coercion that can occur through the exercise of power, influence and domination of a family member or an intimate partner on other family members.

Forms of domestic and gender-based violence

Domestic and gender-based violence comprises a wide variety of harmful, damaging actions. Law No 45/2007 on preventing and combating domestic violence acknowledges the following forms of domestic violence: physical, sexual, psychological, spiritual, economic.

- ***Physical violence*** means intentional harm to physical integrity or health by hitting, pushing, slamming, pulling hair, stabbing, cutting, burning, strangling, biting, in any form and of any intensity, by poisoning, intoxication, other actions with similar effect.
- ***Sexual violence*** is understood as any violence of a sexual nature or any illegal sexual conduct within the family or within other interpersonal relationships, such as marital rape, prohibiting the use of contraception, sexual harassment; any unwanted imposed sexual conduct; forced prostitution; any illegal sexual conduct with a minor family member, including fondling, kissing, photographing the child or other unwanted touching with sexual connotations; or other actions with a similar effect.

- ***Psychological violence*** includes enforce of will or personal control; provocation of tension and mental suffering through offenses, ridicule, swearing, insulting, nicknames, blackmail, demonstrative destruction of objects, verbal threats, ostentatious display of weapons or hitting domestic animals, neglect; involvement in personal life; acts of jealousy; imposing solitary confinement through detention, including at home; isolation from family, community, friends; prohibition and/or creation of impediments to professional achievement, or prohibition and/or creation of impediments to completion of educational program at the educational institution; persecution by contacting or attempting to contact, by any other means or through any other person, the victim who has been caused a state of anxiety, fear for personal safety or for the safety of close relatives, being forced to change the lifestyle; dispossession of identity documents; intentional deprivation of access to information; other actions with similar effect.
- ***Spiritual violence*** is expressed by underestimating or diminishing the importance of meeting the moral-spiritual needs by prohibiting, limiting, ridiculing, penalizing the aspirations of family members, by prohibiting, limiting, ridiculing or punishing access to cultural, ethnic, linguistic or religious values; imposing a system of unacceptable personal values; other actions with similar effect or similar repercussions.
- ***Economic violence*** is defined as deprivation of economic means, including lack of primary livelihoods, such as food, medicine, basic necessities; abuse of various situations of superiority to steal the person's property; prohibition of the right to own, use and dispose of the joint assets; unfair control over joint assets and resources; refusal to support the family; coerce into doing hard and harmful work to the detriment of health, including of a minor family member; other actions with similar effect.

A form of domestic violence that is not included in the legislation of the Republic of Moldova is ***honor-related violence***. This term is used to designate a wide variety of violent actions against a victim, usually (but not always) a woman, the most serious of which is honor killing. Although there is no unanimously accepted definition of honor-related violence, it means any form of violence committed against women within patriarchal families where the primary violence justification is the protection of 'honor' which exists as a social system of values, norms and traditions. Therefore, acts of violence are the consequences of actions that have brought dishonor upon the entire family. A man is considered a defender of his personal and family's honor within a family based

on 'honor', his responsibility is to protect the family from any denigrating or humiliating behavior that might be seen by the community that the family belongs to. The perpetrator's actions are motivated by 'regaining the honor' lost due to the victim's behavior, the actions which are accepted by the community as a social norm that promotes discrimination against women and gender-based violence. The purpose of honor-related violence is to control de behavior and sexuality of girls and women, which are strongly connected to family honor, while chastity (virginity) is considered a family's 'property'. The life of girls and women who live in families based on 'honor' is limited in terms of various daily choices: social company, clothing, freedom of action, education, job, marriage, divorce etc. The freedom of action of children living in 'honor'-based families is decreasing as they age, while the freedom of action of children living in families that do not share these social norms is increasing with age. Although honor-related violence is perpetrated more frequently by men, women become perpetrators as well. Honor-related violence can take several forms, such as kidnapping, physical violence, acid attacks, but specific examples of such violence include forced marriage, female genital mutilation (Topic 4) and honor killing. The violence can be caused by any woman's attempt to express her decision-making independence, as well as by any deviations from imposed sexual behavior that claimed to have brought dishonor, such as clothing considered inappropriate by the family/community, refusal of an arranged marriage, seeking a divorce, a victim of a sexual assault, losing virginity before marriage, committing adultery, homosexual relations.

Violence against girls and women occurs at different stages of their life cycle (childhood, adulthood, advanced age) and it takes different forms depending on age:

TABLE 1 Types of violence depending on women's and girls' stages of life

Stages of life	Type of violence
Prenatal	prenatal sex selection, physical abuse perpetrated against a pregnant woman, forced pregnancy
Infancy	infanticide; physical, emotional and sexual abuse, violent living environment, differentiated access to nutrition and medical services, genital mutilation
Childhood	violent living environment; physical, emotional and sexual abuse; child prostitution; early marriage; genital mutilation; differentiated access to nutrition, medical services and education
Adolescence	prostitution and pornography; sexual harassment at school, in the street and in other public places; early marriage; honor-related violence; intimate partner violence; rape and sexual violence; genital mutilation
Adulthood	sexual harassment at work and in other public places; intimate partner violence; rape and sexual violence; sexual exploitation and human trafficking; forced pregnancy; economic abuse; honor-related violence; femicide
Older women	physical abuse; intimate partner violence; rape and sexual harassment

Understanding the dynamics of domestic and gender-based violence

While communicating with victims of domestic violence, medical staff may encounter inexplicable situations when victims diminish the severity of their problem or sustained injuries, continue the relationship with a violent partner, blame themselves for the intimate partner's aggression etc. The knowledge of the dynamics of domestic and gender-based violence helps medical staff understand certain victim's behaviors and provide an appropriate professional response, without any prejudices, but based on primary support (listening, clarifying the needs and concerns, validating feelings and providing safety and support needed). Not knowing the dynamics of violence in a relationship can further harm women who experience violence and can hinder medical staff from providing necessary care.

There are several theories that prove how cohabitation with a violent partner changes the perception of victims towards violence and explains why the victim continues to cohabit with the partner and tolerate violence.

The cycle of violence

In 1979, American psychologist Lenore E. Walker introduced the concept of 'cycle of violence' to describe the cyclical nature of the intimate relationships marked by violence and to explain why some women maintain these relationships with their abusive partners. According to this concept, an abusive relationship follows 3 consecutive phases:

- **I phase:** It is characterized by a gradual increase in tension. A woman tries to calm down her partner, changes her behavior according to her partner's whims creating a false impression that she can control aggression and prevent violence. During this phase, the perpetrator observes the victim's behavior, tries to blame the victim for everything, creates situations to justify the abuse against the victim, some unjustified grievances and threats occur. The victim changes the behavior as well, she is very careful and tries to avoid abuse by any means, meets any whims of the perpetrator and feels constant tension.
- **II phase:** It implies an uncontrolled release of tension, expressed as an acute bout of physical, sexual or psychological violence lasting from a few minutes to several hours, which ends when the perpetrator temporarily stops abusing the victim. The perpetrator cannot control the behavior and any resistance makes him even more violent. During this phase, the perpetrator intensifies the control over the victim who becomes scared and helpless. It is a kind of 'a game of power' used to show the victim who is 'the boss' in the relationship. Note that the intensity and the duration of violence is increasing proportionally to the number of relapses.
- **III phase:** ('honeymoon') the perpetrator feels guilty, finds the justifications for violence, apologizes and promises to change his violent behavior. He can display an affectionate and caring behavior; this behavior makes the woman believe that her violent partner has a good side as well, the one that she will be able to maintain adjusting to her partner's behavior by changing her behavior. The 'honeymoon' phase can give the victim hope that the perpetrator has indeed changed this time.

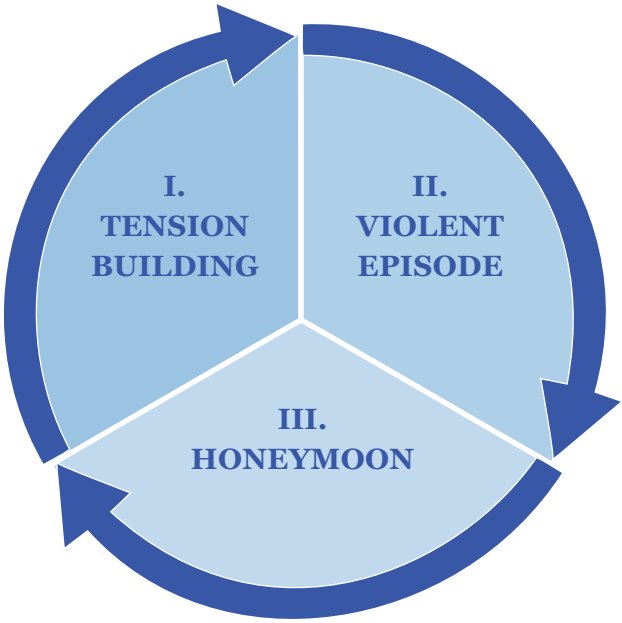


FIGURE 5. The cycle of violence

The cycle of violence can only be broken if the victim does not immediately forgive the cases of violence, resists or seeks help. Relatives, friends and some professionals (police officer, social worker, doctor, mayor) can be support persons in case of violence. In time, the victim loses the ability to perceive the violent nature of the relationship and cannot break up without specialized assistance.

The cycle of violence is repetitive, and in time the interval between phases shortens, violent actions intensify and become severer, and the 'honeymoon' phase decreases and disappears. Women become isolated, develop an emotional relationship with the perpetrator and a surviving strategy that can include extreme and dangerous passivity like denying abuse, refusing the offered help and even protecting the perpetrator. All these changes in behavior are determined by a number of causes and factors related to keeping the person safe, including the Stockholm syndrome.

Stockholm Syndrome

Stockholm syndrome is one of the (surviving) phenomena that provides partial insight into the tendency of some domestic violence victims to maintain their safety and security by justifying violent actions.

This syndrome, in fact, is a phenomenon in psychiatry, characterized by the victim's sympathy towards their perpetrator, invader or abductor and it has been recorded among hostages, prisoners of war, child victims, members of religious sects. The phenomenon was first noticed in 1973, when the offenders who robbed a bank in Stockholm, abducted four persons and held them hostage for 6 days. During this time, the hostages bonded spiritually with the offenders, perceived the police as enemies, resisted attempts to be rescued and refused to testify against the abductors. Women who have experienced domestic violence frequently bond with the perpetrator and even identify themselves with him. This is one of the surviving strategies of the victim. If an abusive partner is sometimes ready to do even the smallest concessions or shows a warm attitude, the woman hopes and is ready to give him a second chance.

The syndrome can be developed if 4 conditions are met:

- the victim's life is in danger (or the victim thinks so);
- the victim cannot escape or thinks that is not able to;
- the perpetrator is sometimes friendly;
- the victim is isolated from the outside world.

As a result of the syndrome, assaulted women are grateful for any act of kindness shown by the perpetrator, they deny abuse, are extremely vigilant towards the perpetrator's needs and are suspicious about those who try to help them.

Nevertheless, according to certain scientific opinions the Stockholm syndrome has to be used with care when explaining the victim's attachment and behavior, as there is a difference between victims of domestic violence and the persons abducted by bank robbers in Stockholm!

In the context of family life, there is an inherent tendency to be emotionally bonded, it is a biological mechanism for adaptation and maintaining psychological safety, as well as social safety (trusting partner's actions, expecting their care and protection, being available for this). Thus, the syndrome can be considered an adaptive reaction that leads to maintaining the victim's personal safety. At the same time, the effects and consequences of reporting violence can be analyzed via the Table ***'Victim's dilemmas in making the decision to leave the partner or to report domestic violence'.***

TABLE 2 Victim's dilemmas in making the decision to leave the partner or to report domestic violence

Categories of dilemmas	Risks if the victim stays in a relationship with the abusing partner	Risks if the victim leaves/ reports violence
Physical safety	**Physical injuries.** He might continue hitting or hurting her. **Death.** He might kill her or the children. **Sexual abuse.** He might sexually assault her.	**Physical injuries.** He might continue hurting, stalking her. **Death.** Leaving does not ensure that he will not find her, and it might increase the chance she or the children will be killed.
Children's upbringing	**Child abuse.** Children will become the target of abuse (especially if they interfere and defend) and will adopt the behavior **Loss of children.** The abuser could make false allegations of child neglect or abuse. Failure-to-protect arguments could be used to remove children or terminate parental rights.	**Child abuse.** Children are at risks of repeating violence when they meet after separation. **Loss of children.** They might be manipulated by the abuser or taken by force and convinced that if they return to the victim, they will lose their other parent forever.
Financial/ Economic	**Living standard.** The abuser might control the money and the victim might not have everything needed for living. The abuser could lose or quit his job. The abuser might make the victim lose or quit her job. **Loss of income/job.** The abuser might keep her from working or limit how much she works. He might sabotage her efforts to find a job or her success in a job or training program. **Loss of or damage to possessions.** He might destroy things of importance or of value to her.	**Living standard.** The victim might have to support her children and herself entirely, thus having less than she has. She might have to look for a rent or to stay together with the abuser until the division of property (if there is any). **Loss of income.** The victim will have to continue to communicate in order to receive alimony and thus to be the target of accusations and reproaches. **Loss of or damage to possessions.** The abuser might destroy things of importance or of value to her that belong or would belong to her.

Family and friends	**Physical injuries.** The abuser might threaten or attack family members if they get involved or interfere in their family relationship. **Loss of support.** The victim might lose connection with friends if they find out what is happening or if she refuses their help.	**Physical injuries.** The abuser might threaten or attack family members if they get involved or interfere in their family relationship. **Loss of support.** The victim might lose connection with friends if they do not support her decision to leave the relationship.
Psychological	**Continuous threats and stress.** The suffering will continue. The victim might start using alcohol/ drugs to cope with suffering. **Suicide.** She might threaten to end her life or even do it.	**Continuous threats and stress.** The suffering will continue. The victim might start using alcohol/drugs to cope with suffering. **Suicide.** She might threaten to end her life or even do it.

'Normalization' of domestic violence

Another strategy to adapt to a violent environment in which a victim of domestic violence lives is normalization, which explains why women who live with a violent partner experience difficulties in identifying the relationship as marked by violence, it is the normalization of violence. In general, persons who witness acts of domestic violence are prone to become either more tolerant to it or – sometimes victims or perpetrators. Cohabitation with a violent partner or being in an environment like this changes people's perceptions of violence. As a result, women who live with a violent partner can perceive an act of violence as a consequence of their own failure. Moreover, assaulted women do not want to be perceived as 'battered women' and their partners as 'perpetrators' because they have to admit the fact that their relationship is different from that of other members of society. As a result, both partners minimize the severity of violence. Only after leaving the violent partner, after the end of his control and isolation, as well as psychological rehabilitation, a woman can assess the relationship as a violent one.

The effects of the 'normalisation' of domestic violence might be also observed through distorted perceptions of society. Thus, the survey *'Men and gender equality in the Republic of Moldova'* (2015) showed that 27.7% of men and 17.5% of women believe that a woman should tolerate violence in order to keep her family, but 41.1% of men and 19.1% of women think that there are situations when a woman should be beaten!

At the same time, the tendency to normalise acts of violence is strongly influenced by the tendency of people who use violence in relationships to apply manipulation, control and isolation techniques.

Partner's isolation:

- At the beginning of the relationship the partner might express disagreement that it should maintain supportive relations providing the reason that 'I love you so much, who else do you need?' and 'I want you to be with me all the time'.
- The intention is to control the time and isolate her from family and friends support system that might address questions.
- For instance, he might monitor her email, frequently ask for explanations of places where she spends time.
- He might constantly criticise her family and friends or harass her so much that it is easier for her to stop contacting them. He might make it impossible for her to be in contact with others by using coercion, threats or force.

Using children:

- At the same time, he might punish the children as a way to hurt/intimidate the victim.
- He might abuse the children or force them to watch the abuse of the victim.
- He might use the children to spy on the victim or report on her activities.
- He might threaten to kidnap or kill the children if she leaves.
- He could gain legal custody just to take the children or use custody and visitation arrangements to harass or harm the victim.

Discredit the victims's reputation and social status:

- The perpetrator might discredit the victim's relationships with members of the community (neighbours, friends, relatives), such as employers, by spreading rumours or distorted information. For example, he might tell others she is crazy or a liar, or he might send messages from her email address to alienate her from friends and family.

Direct threats through destroying property and harming pets:

- The perpetrator might hit the wall next to where the victim is standing or throw objects at her. He might pound the table next to the victim or break her favourite possessions. He might say: 'Look what you made me do' or 'You'll be next'.
- The abuser might harm pets to hurt and intimidate the victim.
- The perpetrator might follow, threaten, harass and terrify the victim's current or ex-partner, especially after she has left or they were separated.
- The perpetrator might monitor the victim's whereabouts, daily activities, phone conversations or email to prove to her that she cannot conceal anything from him.

All these examples are difficult to prove and often induce a state of hopelessness and despair to the victim, and as a result there is a strong fear to report the phenomenon to the competent bodies.

Power and Control Wheel

Domestic violence has a cyclical nature and does not limit just to a single bout of physical, psychological or sexual abuse, but includes a number of systematic violations of human rights, perpetrated by a family member or an intimate partner aiming at imposing power and control over the victim. Domestic violence might occur at any time in a couple's life. Perpetrators sometimes manifest their behaviour at the beginning of the relationship, sometimes it takes years for the first signs of abuse to appear.

The exercise of power and control is a mechanism that ensures the perpetuation of violence and keeps women in a subordinate position. The Power and Control Wheel was developed by the Domestic Abuse Intervention Programs in Minnesota, USA and it is a model that provides an understanding of the manifestation and mechanisms of power and control within intimate partner relationships (Figure 6). 'The Wheel' consists of eight parts specifying behaviours that are more difficult to be identified by the victim, but which firmly establish a pattern of coercion and control in a relationship in order to deliberately dominate the intimate partner: intimidation; emotional abuse; isolation; minimizing, denying and blaming; using children; male privilege; economic abuse; coercion and threats. These actions are taken to exercise 'the power and control'. Thus, any form of domestic violence is used by a perpetrator to exercise power over the victim and to control her actions and deeds.

FIGURE 6. Power and Control Wheel

Perpetrator's regular usage of different behaviours, reinforced by one or several acts of physical violence, form a wider system of abuse. Perpetrators who use coercive controlling violence believe they are entitled to control the actions, thinking, and behaviours of their partner and other family members. The victim has little or no autonomy in this type of relationship and often feels trapped. Implicitly or explicitly, perpetrators might resort to extortion, to manipulations such as 'you can't leave me without being punished'. Although physical assaults may occur only once or occasionally, these are threats of future violent attacks and they allow a perpetrator to take control over a woman's life and situation.

These tactics develop big vulnerabilities for victims that 'paralyse' them and decrease their capacity to take action. Only one incident of physical violence or threat of physical violence followed by non-physical abuse and coercion is enough to establish power and control. For example, an attempt to strangle the victim might establish the control of the perpetrator and the submission of the victim. The perpetrator's anger, vandalising the property, destroying furniture, throwing objects from the house, are just some examples of intimidation that might frighten all family members, without any need for the perpetrator to use physical violence.

In fact, relationships between intimate partners and other family members should be based on equality (Figure 7).

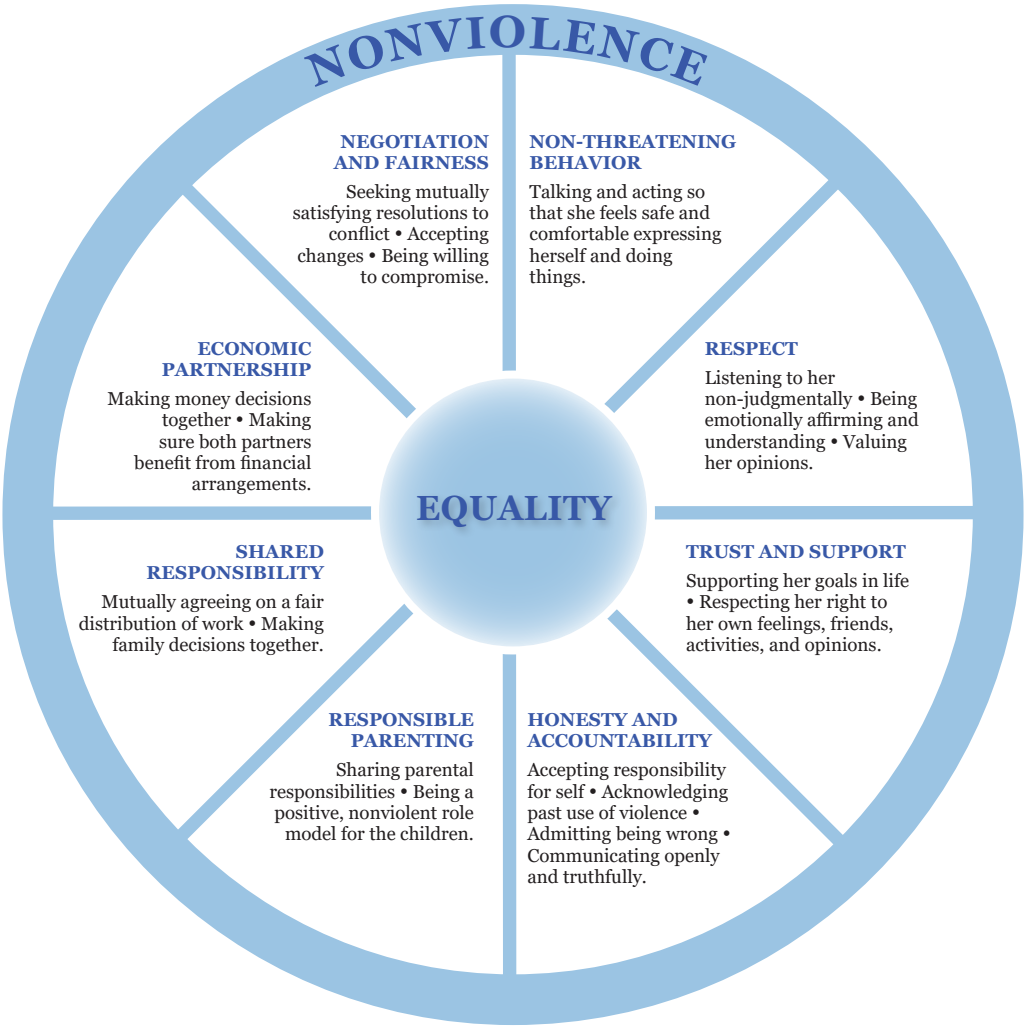


FIGURE 7. Equality Wheel

Causes of domestic and gender-based violence

Domestic and gender-based violence is not driven by a single cause, rather by a complex of factors. In 1998, L. Heise introduced 'the ecological framework', which outlines a range of factors that make a person become a victim or a domestic perpetrator. The framework distinguishes 4 levels of risk factors: individual, interpersonal, community, societal (Figure 8).

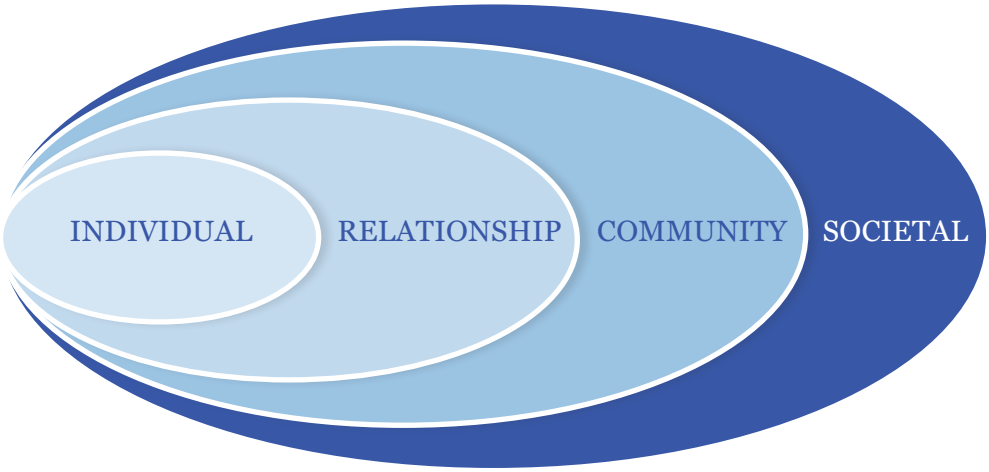


FIGURE 8. Ecological framework for understanding violence against women (by Heise L. (1998))

The model explores the link between individual and contextual factors and considers violence as a product of several causal factors that influences human behaviour.

TABLE 3 Ecological framework of domestic and gender-based violence

INDIVIDUAL LEVEL	biological factors and personal biography that influence the behaviour and increase the risk of perpetration or exposure to acts of violence
low income, low educational level, impulsiveness, depression, substance abuse, past experience of violence (childhood, previous relationships), inability to express feelings of anger properly (aggressive behaviour), unwanted pregnancy, perception of violence as acceptable behaviour	
RELATIONSHIP LEVEL	social connections and relations (with colleagues, partners or family members)
men with multiple partners/infidelity, marital relationships with a low level of satisfaction towards partners, constant arguments, differences between partners' education levels, the family blames the victim rather than the perpetrator for violence	

COMMUNITY LEVEL	the environment where the person develops social relations (school, workplace and residence)
reduced interventions on the community level (drug trafficking communities, high unemployment rate, high social isolation (people do not know their neighbours or do not participate in the community life), they live in an environment of violence; the risk of violence is higher in some poor communities, with a few or poorly performing institutions.	
SOCIETAL LEVEL	cultural and social norms that shape gender roles
traditional gender, societal and cultural norms that support violence, considering domestic violence as a private problem of a family, not as an act of violence that can be prevented, lack of community intervention in cases of domestic violence, norms that prioritise parents' rights over children's well-being, norms that support men's superiority over women and children, promoting financial inequality of partners	

Myths concerning domestic and gender-based violence

Myths are some ideas and beliefs that have no objective foundation, are not based on facts and respectively, are false. Myths regarding domestic violence provide misinformation about the phenomenon and its causes, shape its perception and society's response to cases of violence. They are harmful as they distort the actual situation on domestic and gender-based violence and due to this fact, they can discourage the intervention of various professionals, including healthcare professionals.

Society is affected by many myths concerning domestic violence, but we will focus on just a few of these below.

TABLE 4 Myths regarding domestic and gender-based violence

Domestic violence is not so widespread or serious
In fact, every second woman has experienced some form of violence throughout life, but about 137 women across the world are killed in the family every day (see topic *The extent of domestic and gender-based violence*)

Domestic violence occurs only in poor families or among persons with no education

In fact, domestic violence occurs in all socio-cultural environments, with no exceptions; many cases of domestic violence have been recorded also among people with higher education and social status; the victims from these environments are more reluctant to report assaults due to shame, social pressure or fear to affect their reputation in their social and professional circles

Domestic violence should be solved within the family, because it is a private issue

In fact, domestic violence is not a private issue, but a social problem, it cannot be solved with any specialised assistance; the attempt to address it alone reinforces the position of the perpetrator and intensifies the vulnerability of the victim

Victims accept the aggression

In fact, victims do not retaliate because of fear; they perceive that the risk is higher if they leave the family and end up to fear for the safety of their children; some perpetrators kill their victims when they have the courage to leave them

If the violence were so severe, the women would break up with her partner

In fact, many times, a female victim does not end up a violent relationship, the reasons are emotional and financial dependence on the perpetrator, the children and limited resources to raise them, mistrust and low self-esteem or lack of social and family support, social blame

The beating begins when losing temper

In fact, physical assault occurs in a relationship where the perpetrator has already controlled the partner through fear; physical assault is just a form of violence and is generally associated with other violent behaviours; domestic violence is intentional behaviour and the perpetrators are not out of control

Alcohol consumption is the cause of domestic violence

In fact, the surveys show that only 10% of family perpetrators have mental disorders, the rest are not affected in terms of their judgment and control over their reactions and behaviour; most abusive men do not behave violently except for their relationship

Perpetrators often suffer from mental disorders

In fact, the surveys show that only 10% of family perpetrators have mental disorders, the rest are not affected in terms of their judgment and control over their reactions and behaviour; most abusive men do not behave violently except for their relationship

Only women are victims of domestic violence
In fact, everyone can be a victim of domestic violence; although statistics show that most victims are women, men make up a certain percentage (see topic *Domestic violence subjects*)
Men are victims of domestic violence as often as women are
In fact, the surveys highlight that women are victims in most cases of domestic violence; men experiencing domestic violence have better access to resources in order to leave a violent situation (see topic *Domestic violence subjects*)
There is no rape between husband and wife
In fact, rape is defined by action, not by the identity of the perpetrator or the victim; any coercive sexual intercourse is rape, regardless of whether the victim is or is not in a marital relationship with the perpetrator

Healthcare professionals should distinguish myths from truth because:

- myths and stereotypes about domestic violence shape professionals' perceptions of the phenomenon and their response to the problem;
- myths might prevent doctors from identifying a case of domestic violence and providing needed help;
- myths are harmful because victims are usually blamed for domestic violence;
- healthcare professionals should distinguish myths from reality to understand the situation and the victim's needs while maintaining a professional and impartial attitude.

Domestic violence subjects

The domestic and gender-based violence surveys have shown that women (including girls) and children are at a greater risk of violence than men. The *'Domestic violence against women survey'*, conducted in 2011 by the National Bureau of Statistics of the Republic of Moldova, has highlighted that the most affected victims of violence are women from rural areas, those with a low level of education, unemployed or self-employed seasonal agricultural workers. Children are victims of domestic violence both directly and indirectly as witnesses.

Nevertheless, there is also a category of people vulnerable to domestic and gender-based violence:

- women; especially with no vocational education;
- pregnant women;
- people with children;
- children and adolescents;
- older people;
- people with physical and mental disabilities;
- people of different cultures and languages (mixed families);
- people living in rural and remote communities;
- people suffering from psychoactive substance abuse;
- people with low level of literacy;
- LGBT people (homosexual, lesbian etc.)

Istanbul Convention (2011) recognises that women and girls are at a greater risk of gender-based violence than men. According to the data of the Ministry of Internal Affairs of the Republic of Moldova, more than 84% of victims of domestic and gender-based violence are women and girls[5] (Figure 9). Beijing Declaration and Platform for Action (1995) recognised that adolescent girls are more likely to become victims of violence, including sexual violence, than adolescent boys. From the same source, we note that the majority of domestic homicide victims are women (81.11%); the statistic data correlate with international data that show the share of female victims murdered by an intimate partner or a family member worldwide (82%)[6].

In terms of the perpetrator's profile, the statistic data of MIA (Figure 10) show a significant predominance of men (92.61%) in this regard.

[5] Briefing Note of MIA. https://politia.md/sites/default/files/ni_violenta_in_familie_3_luni_2020_pentru_pagina_web-konvertirovan.pdf

[6] UNODC. Global Study on Homicide 2019. https://www.unodc.org/documents/data-and-analysis/gsh/Booklet_5.pdf

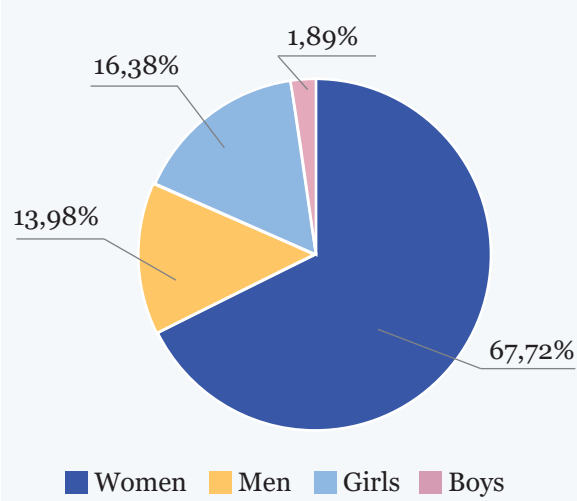


FIGURE 9. Profile of domestic violence victims

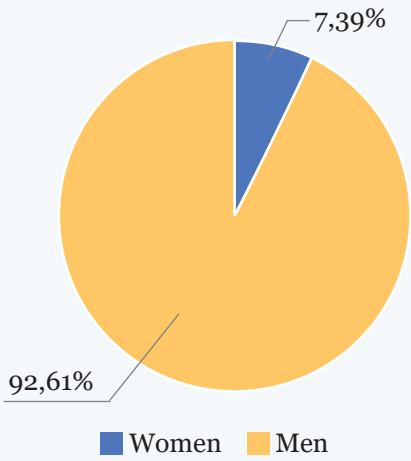


FIGURE 10. Profile of domestic violence perpetrators

Consequences of domestic and gender-based violence

Consequences of domestic and gender-based violence are broad and various, affecting victims, children and society in general, including physical, psychological, financial and social aspects.

As any social negative phenomenon, domestic and gender-based violence has social-economic consequences, such as:

- an increasing number of sick leave;
- increased insurance expenses;
- low work productivity, wasted working time;
- high mortality;
- unnecessary expenses in various areas (maintaining public order, justice, medicine etc.);
- support for children left without parental care;
- violence perpetration from generation to generation;
- the deep-rooted idea of so-called male superiority.

The economic consequences affect both victims and countries' economies overall. Thus, the European Institute for Gender Equality estimates the costs of gender-based violence in the European Union at EUR 366 billion annually,

79% of these costs incurred due to violence against women[7]. EIGE found that the highest cost is generated by the physical and emotional impact (56%), followed by criminal justice services (21%) and loss of economic production (14%). Other costs can include civil justice services (e.g.: for divorce and child custody procedures), aid for housing and child protection. A study conducted by the United Kingdom in 2019 estimated that the overall cost of domestic violence in 2016-2017 amounted to over GBP 66 billion and included costs for physical and emotional damages incurred by victims as a result of the abuse, loss of productivity etc.[8] Gender-based violence generates costs for taxpayers in countries from other continents, as well. A study in Australia estimated expenses related to violence against women and children in 2015-2016 at AUD 22 billion[9]. Canada spends CAD 7.4 billion to address the consequences of violence by intimate partner[10]. A study conducted by the United States in 2018 estimated annual costs of USD 55 billion only to address the effects of exposing children to domestic violence[11].

The study '*Cost estimate report on domestic violence and violence against women*' (2016) conducted in the Republic of Moldova, assessed expenses in the areas of social protection, medicine and justice of about MDL 36 million in 2014. Since the response mechanism of state authorities is focused on the alleviation of consequences rather than prevention, most expenses were in the health sector and amounted to MDL 15,845,000, mostly borne by the victims and not by the state. Judicial expenses, estimated at about MDL 14,990,000, are the costs of assistance for victims of violence during court hearings and were also covered mostly by victims. Social sector expenses amounted to about MDL 5,195,000 and 60% were provided by non-profit organisations. According to the report, compensations of about MDL 1,550,970 have been paid on the decisions of the European Court for Human Rights (ECtHR) only for 4 years.

---

[7] https://eige.europa.eu/news/gender-based-violence-costs-eu-eu366-billion-year

[8] The economic and social costs of domestic abuse (2019). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918897/horr107.pdf

[9] The cost of violence against women and their children in Australia (2016). https://www.dss.gov.au/sites/default/files/documents/08_2016/the_cost_of_violence_against_women_and_their_children_in_australia_-_summary_report_may_2016.pdf

[10] https://canadianwomen.org/the-facts/gender-based-violence/

[11] Exposure to domestic violence costs US government $55 billion each year (2018). https://www.sciencedaily.com/releases/2018/04/180425093846.htm

Apart from economic costs and social impact, domestic and gender-based violence has also moral consequences. The list can be exemplified by the following:

- impact on relationships between partners,
- marriage breakdown,
- disruption of parent-child relationships,
- increased criminality in the society,
- decline in general human values.

Domestic violence has a serious impact on all victims, but particularly affects women and children.

The consequences of gender-based violence seriously harm all aspects of women's health: physical, sexual and reproductive, mental and behavioural health. The consequences might be immediate and severe, as well as long-term and chronic. The stronger the act of violence is, the greater is the impact on women's health. Moreover, experiencing more forms of violence (for ex. physical and sexual) and/or incidents of violence might lead to serious health problems over time, including the battered woman syndrome (described by Lenore E. Walker (1984)), a subcategory of posttraumatic stress disorder. Gender-based violence might result in women's death, either as a consequence of acts of violence or in the long term – due to other adverse health effects. Death can be caused by both femicide and suicide due to the consequences of psychological trauma. According to the data of MIA, 30-35 family homicides occur annually in the Republic of Moldova, and about 5 deaths are caused by suicide associated with acts of domestic violence.

The consequences and effects of domestic violence can be seen in the following areas of the victim's life:

- ***Health status*** – the victim might suffer from a range of bodily injuries, with different degrees of severity, that might require more or less medical care, including disability, total or partial loss of working capacity, or the victim's death.
- ***Victim's personal accomplishment*** might be affected by restrictions on education, job deprivation or loss, as a result of the perpetrator's interdictions to get employed or his jealousy scenes. Due to physical violence, the victim may often be absent from work and this might be a reason for losing her job. The lack of a job makes the victim financially dependent on the perpetrator and more vulnerable.

- ***Social life*** – victims are isolated from family, group of friends, work colleagues or social care services. The victim's social isolation is one of the most severe failure factors for the victim's attempt to break the addiction.

The full range of domestic violence consequences on women's health are illustrated in Figure 11.

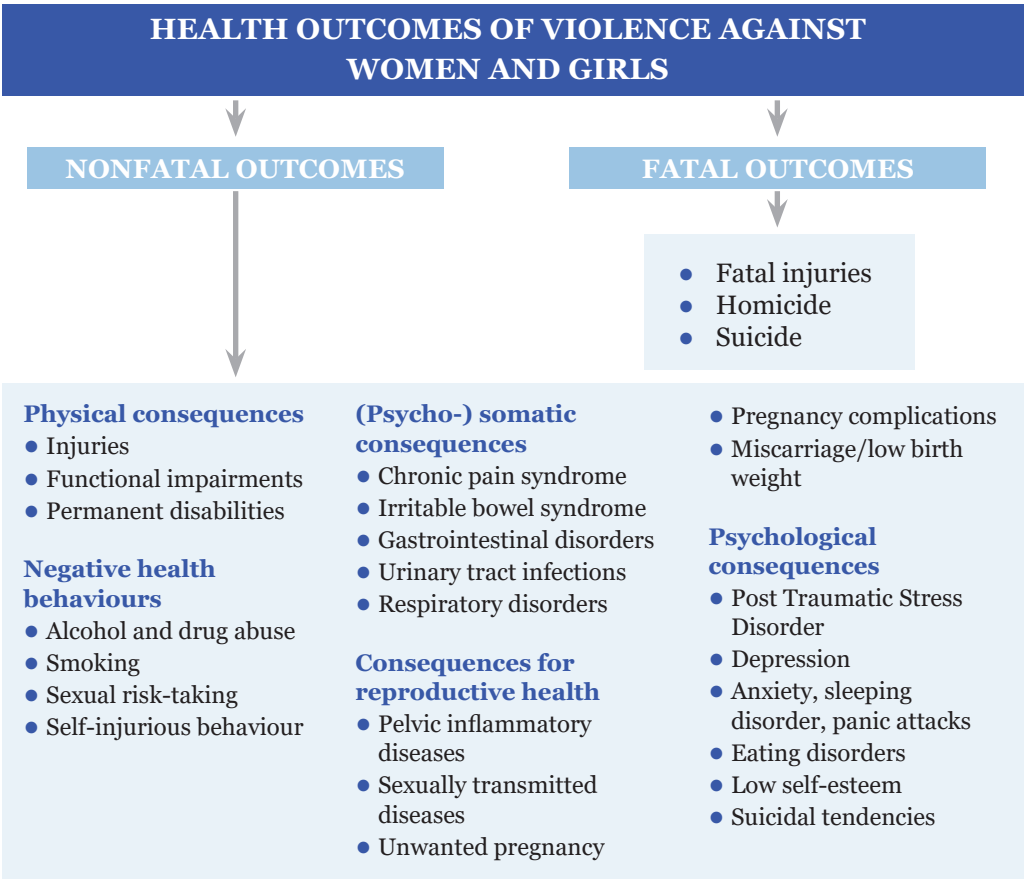


FIGURE 11. Domestic violence consequences on women's health (by Heise L. et. al. (1999), CHANGE (1999))

- **Mental health issues.** Although psychological violence and emotional negligence might be difficult to identify compared to physical violence, their effects might also be subtle. A survey found that 80% of children whose childhood was marred by violence suffered from at least one type of psychiatric

disorder by the age of 21. The categories of problems vary and might be diverse, such as depression, anxiety disorders, food disorders and suicide that are associated with psychological violence.

- **Posttraumatic stress disorder** – this consequence often limits person's capacity to feel safe and even in the absence of real danger, the person experiences strong feelings of emotional imbalance and has difficulty with organising the daily activities independently. The person often requires psychological and medical support (as appropriate) to manage fear and anxiety. This consequence can also lead to a number of other psycho-emotional disorders: sleep, food disorders, alcohol abuse, phobia etc.
- **Cognitive ability disorders (frequently among children).** Cognitive development of abused and neglected children may be seriously affected. Linguistic incompetence of abused children is more obvious from early age. A further 'recovery' is a significant challenge for many children as in certain extreme cases, the brain development is hindered by the lack of positive stimuli. Hindering their development impedes children access and enjoy many of their rights, and, also, put them at risk to have their rights violated.

Children are often subjected to different forms of violence in their family, including as a disciplinary and 'educational' method. Domestic violence against children is associated to a high risk of developing somatic, psychological, behavioural and cognitive problems, such as:

- Battered child syndrome (1962);
- retardation (intellectual development delays);
- emotional and mental disorders: anxiety, depression, low self-confidence, increased aggressiveness, including self-aggressiveness, insecurity, angst, blame against oneself;
- frustration;
- post-traumatic stress disorders;
- learning/ sleeping disabilities;
- behavioural and relationship problems with the peers;
- high level of tolerance for violence developed.

Even if parents, who should protect and care for their child, are violent towards him/her, they still remain an authority for the child. **A child assaulted by his/her parents does not cease to love them, he/she ceases to love himself/herself**. Parents' violence reduces child's self-esteem, leading to different kind of frustrations and inferiority complex. The child becomes aggressive, and aggressiveness becomes a rule in relationships with his peers.

The survey *'Men and gender equality in the Republic of Moldova'* revealed that physical violence has been present in 50 per cent of families of 1500 men who have participated in the survey. The domestic violence is perpetuated by children who become victims or witnesses of violence. Parents who have been witnesses or victims of an abusive behaviour in their childhood tend to apply such behavioural model in relation to their own children in their families. Thus, the survey data reveal that male respondents who were victims of violence in their early age (in family or outside it) stated that they would keep using this behaviour in relation to their wives and children in their own families. On the other hand, children's victimisation increases the risk to become victims in adulthood. Thus, the *'Violence against women: an EU-wide survey'* indicates that 30% of women who were victims of a sexual abuse committed by a foster or current partner had been victims of sexual abuse in their childhood. In comparison, only 10% of women who were not subjected to sexual victimisation in their current or previous relationship reported a sexual violence experience in their early age.

Although domestic violence against children has severe consequences, the cases of children's victimisation are rarely reported.

Reporting cases of domestic and gender-based violence

Domestic violence is a latent crime. Most cases are not reported to the authorities. Social and cultural context in the Republic of Moldova includes many barriers and challenges for ensuring the safety of victims and accountability of perpetrators. Even though MIA official statistics show an increased reporting of cases of domestic violence (see Figure 4), the studies indicate that this phenomenon is still underreported. According to the sociological survey *'Opinions, perceptions and experiences of young people about domestic violence/violence against a partner'* conducted in 2014, nine in ten people believe that domestic violence is not reported by victims. The low rate of reported cases of domestic violence is confirmed by the survey *'Men and gender equality in the Republic*

of Moldova' (2015), according to which, only 8.4% of women assaulted in their families reported the case to the police. The following reasons were identified:

- the fear of the perpetrator;
- tendency to keep the family;
- lack of awareness of mechanisms for settling cases of violence;
- mistrust in institutions empowered to intervene in domestic violence;
- perpetrator's control and isolation of victims;
- strong pressure from the perpetrator, his family or other people to convince the victim to waive of the complaint;
- low level of satisfaction of the police's intervention.

The EU countries register better results in reporting cases of domestic violence than the Republic of Moldova. Thus, according to *'Violence against women: an EU-wide survey'* (2014), the victims reported the most severe incident of violence committed by their partner in 14% of the cases. The *'Violence and health in Sweden Survey'* (2015) showed that 20% of victims reported cases of domestic violence to the police.

There are still many factors that impede victims to report domestic and gender-based violence, like:

- ***Victims lacking sufficient information*** on how to properly report an act of violence and the services available. According to the *'Men and Gender Equality'* Study, 62.4% of women are aware of the existence of laws on violence against women, 9.1% denied their existence and 28.4% are not aware of their existence[12]. Victims living in urban areas, having a high level of education, and higher family income are more aware of protection mechanisms against domestic violence and of the existence of support services. In rural areas, victims of domestic violence have limited knowledge of the laws, which is usually provided by media. The victims who have a TV, radio or Internet connection have easier access to information. If victims come from socially disadvantaged families and do not have electronic means of information their access to information is limited, and many of them are not even aware that there are laws protecting them or how to access services for victims of domestic violence.

[12] 'Men and Gender Equality', Women's Law Centre, Sociopolis, Chisinau, 2015.

- ***The incorrect information on the sanctions that can be imposed on the perpetrator*** is an impediment to reporting/notification of cases of domestic violence. The myth about perpetrators being penalized with a fine is a barrier to reporting domestic violence. Even though the existing laws no longer provide for a fine for domestic violence, few victims know about these legislative changes. The myth that domestic violence perpetrators are sanctioned with a fine only is still part of the general perception of the population, and the thought that the fine will be paid from the family budget, which is often modest, is an obstacle to reporting domestic violence to the authorities.
- ***Tradition, cultural specificity and gender bias force women to tolerate domestic violence and to hesitate to report it to authorities.*** The situation described is much more pronounced in communities with strong patriarchal values. Social rules and attitudes lead to gender inequality and violence prevalence. Domestic violence creates a violent society and vice-versa, a society tolerating violence in public life highlights the violent trends within the family, transmitting them through generations[13]. The number of women reporting cases of violence from the current partner is very small in the Republic of Moldova – 8.4%[14]. Most of the time, women do not believe that reporting violence experiences will provide them protection. This is a potential explanation for the fact that seven in ten women who have identified the most severe incident of physical and/or sexual violence from their current partner have not notified the police or any other service or organisation (70%). This is also true for the most serious incidents of violence from the previous partner (58% of women have not reported) and to most serious incidents of violence from a non-partner (51%)[15].
- ***The myths about domestic violence make victims hesitate in reporting cases to authorities.*** Very few women reported the most serious instances of violence, this being the case for half of women who believe domestic violence to be a 'private matter' that should be dealt with within the family[16]. Thus, more than half (55%) of women in the Republic of Moldova, four times more than in the EU (14%), consider domestic violence as a private matter that should be dealt with within the family. These stereotypes and prejudices enhanced by friends, relatives, representatives of different

[13] 'Wellbeing and Safety of Women', OSCE, 2019, p. 19.
[14] 'Men and Gender Equality', Women's Law Centre, Sociopolis, Chisinau, 2015, p. 16.
[15] 'Well-being and Safety of Women', OSCE, 2019, p. 50-51, 63.
[16] 'Well-being and Safety of Women', OSCE, Chisinau, 2019 https://www.osce.org/files/f/documents/e/f/425867_0.pdf

authorities, and perpetuated by religious institutions, make women suffer silently.

- ***Financial dependence on the perpetrator*** and insufficient financial sources to travel to the district center for accessing the services available to victims, as well as to initiate procedural and legal actions, etc.
- ***Insufficient number of services provided free of charge to victims of domestic violence.*** The interview participants noted that people seek legal advice only when they have a problem.
- ***Lack of trust in the institutions that should provide support and free services to domestic and gender-based violence victims.*** Violence against women is rarely reported to the police and other organisations, as there is a lack of trust in the institutions that should provide support and services to victims. Shame, fear of the perpetrator, and the lack of long-term and practical support, such as housing and financial aid, are the barriers that prevent women from reporting cases of domestic violence. Although many women stated having suffered bodily harm and psychological consequences as a result of the most serious of physical and/or sexual violence they experienced, very few reported these cases to the police or other institutions. In the perception of the victims of domestic violence, even if violence is reported, the chances of justice being served are questionable[17].

[17] 'Well-being and Safety of Women', OSCE, Chisinau, 2019 https://www.osce.org/files/f/documents/e/f/425867_0.pdf

TEMA 2

International and national legislation on domestic and gender-based violence

International legal framework on combating domestic and gender-based violence

Domestic violence is a serious infringement of human rights. The human fundamental rights and freedoms are premises provided by the national law and recognised by the international law for every individual in his relations with the community and the state, expressing certain fundamental social values.

The constitution and consolidation of the Republic of Moldova as an independent and democratic state, with the status of subject of international law (1991), lead to the internationalisation of national law, especially in the *field of protection of human rights and fundamental freedoms* by ratifying a large number of documents with universal jurisdiction in the human rights domain, paving the way towards a system of international protection.

According to Article 4(2) of Constitution in case of disparities between national and international law on the human fundamental rights, international provisions prevail[18]. This constitutional requirement expresses the attachment to the international regulations, and, at the same time, shows the receptivity of our country in applying the treaties to which it is party.

Below are several international acts to which Republic of Moldova is part of, related to preventing and combating domestic and gender-based violence.

Convention on the Elimination of All Forms of Discrimination against Women[19] is the most comprehensive treaty on the rights of women. The Convention ensures the equality between women and men in civil, political, economic and cultural rights. The Convention establishes that the states are not only obliged to avoid infringements, but are also responsible for the actions of private actors if they fail to prevent and punish such actions.

[18] Report of the Constitutional Court of the Republic of Moldova in the 16th Conference of European Constitutional Courts.

[19] English abbreviation CEDAW

Though the indicated international act does not expressly prohibit domestic violence, the Recommendation 19 of CEDAW Committee establishes that ***'gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men'***.

Council of Europe Convention on preventing and combating violence against women and domestic violence[20] (known as *Istanbul Convention*) was opened for signature on 11 May 2011 in Istanbul. It is the first European legally mandatory document for preventing, investigating and punishing instances of violence against women and domestic violence, protection of victims, criminal prosecution of the perpetrators and adoption of a wide range of measures to stop this disaster. At the same time, this is the most comprehensive instrument of legal cooperation.

The goal of Istanbul Convention is zero-tolerance for any form of violence against women, which is an important step in the efforts of European institutions and national authorities to ensure security and safety in Europe, as well as worldwide.

The Istanbul Convention defines different forms of violence against women: physical, sexual and psychological and establishes the connection between achieving gender equality and eradication of violence against women. Thus, the structural nature of violence against women is an emergence of historical positions of inequality between women and men.

On 6 February 2017, the Republic of Moldova signed the Istanbul Convention. Therefore, the consent of the Republic of Moldova to be bound by this treaty was expressed. This way, the Republic of Moldova has become the 44th state to sign the Treaty. The ratification of the Convention on preventing and combating violence against women and domestic violence was set as national priority, including in many national policy documents, as well as in the National Human Rights Action Plan for 2018-2022, approved by the Parliament Decision No. 89 of 24.05.2018 and the 2018-2023 National Strategy to Prevent and Combat Violence against Women and Domestic Violence and the 2018-2020 Action Plan implementing it, approved by the Government Decision No. 281 of 03.04.2018. The Republic of Moldova ratified the Istanbul Convention on 14 October 2021.

[20] English abbreviation CAHVIO

UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[21] defines the term 'torture' as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. Domestic violence is, the same as torture, about 'injury, pain and death'[22], while it is perceived in many parts of the world as a 'daily, normal problem, not a serious infringement of human rights'. In its case-law, the European Court of Human Rights[23] stated that torture or bad treatments are committed, in the case of domestic violence, by individuals, which is a form of gender-based violence. Therefore, domestic violence is a form of torture, inhuman and degrading treatment and punishment.

European Convention on Human Rights[24] is the main instrument developed within the Council of Europe for ensuring human fundamental rights. The States Signatories to the Convention are obliged not to infringe the guaranteed rights and freedoms and to ensure a proper legal protection. The Republic of Moldova is part of the European Convention on Human Rights since 12 September 1997. European Court of Human Rights has the mission to verify the actions of Member states related to the provisions of the Convention. Though domestic violence is not a new phenomenon, the ECtHR case-law on domestic violence has been issued recently, with the first case of Kontrova against Slovakia examined in 2007[25]. Given that ECHR does not include express provisions on domestic violence, the following provisions of the European Convention on Human Rights are applicable in the cases of violence:

---

[21] Adopted by the United Nations General Assembly on 10 December 1984

[22] Sally Engle Merry, 'Human rights and transnational culture: Regulating gender violence through global law' (2006) 44 Osgoode Hall LJ, pag. 53, 56

[23] Abbreviation ECtHR

[24] Abbreviation ECHR

[25] Aalbers C., Vîlcu N., Obligaţiile pozitive ale statului în jurisprudenţa Curţii Europene a Drepturilor Omului în materie de violenţă în familie, Chişinău, 2019 [State's positive obligations in the European Court of Human Rights case-law regarding domestic violence, Chișinău, 2019]

- *Article 3 of Convention* prohibits torture, inhuman and degrading treatment and punishment
- *Article 8* – ensures the right to respect for private and family life
- *Article 13* – ensures the right to an effective remedy at national level
- *Article 14* – prohibits discrimination, including on grounds of sex.

United Nations Convention on the Rights of the Child[26] promotes the rights of children in family and society, the principles for ensuring the protection and assistance a child needs to fully play his role within the society, with the following guarantees provided:

- the right to a standard of living adequate for the child's development;
- elimination of violence and economic and sexual exploitation of children;
- the right to special protection and care, especially appropriate legal protection, before and after birth.

Regarding the state's obligation to protect children against violence, the Convention on the Rights of the Child provides that: *'States Parties shall ensure that: (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment'*[27]. Article 19 of the Convention provides that states are obliged to undertake all appropriate legal, administrative, social and educational measures to protect the child against any form of violence, injury or physical or mental abuse, abandonment or neglect, ill treatment or exploitation, including sexual abuse, while being in care to one or both parents, or of one or more legal representatives, or any person having rights of custody.

Convention on the Rights of People with Disabilities[28] is an international treaty on the rights of people with disabilities. The Republic of Moldova ratified the CRPD on 21 September 2010. The Convention aims to promote, protect and ensure full and equal exercise of all human fundamental rights and freedoms by all people with disabilities and to promote respect for their intrinsic dignity. CRPD addresses the following concepts:

[26] The United Nations Convention on the Rights of the Child of 20.11.89 was adopted at the UN General Assembly on 20 November 1989, entered in force for the Republic of Moldova since 23.02.1993, International Treaties 1/51, 1998. The Republic of Moldova adhered to the Convention by the Parliament Decision No. 408-XII of 12.12.90, News No. 12/303, 1990.

[27] Article 37, Convention on the Rights of the Child; adopted in New York, 20 November 1989, published in the Official edition „International Treaties', 1998, vol. 1, p. 51, ratified by the Republic of Moldova by Parliament Decision No. 408-XII of 12.12.1990, published in News No. 12, 1990;

[28] English abbreviation CRPD

- concept of equality and non-discrimination in the exercise of all fundamental rights and freedoms;
- equal legal capacity and supported decision making;
- reasonable accommodation and free access to justice for people with disabilities.

Convention on the Rights of People with Disabilities acknowledges that people with disabilities keep facing barriers in their participation as equal members of the society, as well as infringements of human rights, like:

- people with disabilities are subjected to various or serious forms of discrimination;
- people with disabilities shall have the possibility to actively engage in decision making, development of policies and programs, including those concerning them directly.

The establishment of national protection mechanisms against domestic and gender-based violence was an important step related to the observance of international instruments in the field and marked the beginning of the harmonization of national legislation with the international and European standards on human rights. Therefore, in the next section, we will refer to the national framework on the protection of victim of domestic and gender-based violence.

National regulatory acts on preventing and combating domestic and gender-based violence

The ***Constitution of the Republic of Moldova*** adopted on 29.07.1994 is the supreme law of the country. The laws or other legal acts and regulations that contradict the provisions of the Constitution do not have any legal power (Article 7 – Constitution, Supreme Law). The right to life, as well as the right to physical and mental integrity are natural inherent rights of the human being, as part of inviolabilities.

The Constitution of the Republic of Moldova regulates the following aspects applicable to instances of domestic and gender-based violence:

a) *Article 16(2)* indicates that: 'all citizens of the Republic of Moldova are equal before law and the public authorities, regardless of ...sex', and *Article 28* states that 'the State respects and protects the private and family life'. It also guarantees the inviolability of personal liberty and safety and provides that the state will respect and protect the right to intimate, private and family life.

b) Any person has the right to effective satisfaction from authorized courts against acts that violate their legal rights, freedoms and interests. No law can restrict access to justice (Article 20 of the Constitution).

c) The right to defence is ensured. Every human is entitled to react independently, by legal means, to the infringements of his rights and freedoms. During the whole process, the parties are free to be assisted by a lawyer, who is elected or appointed from office (art. 26 of the Constitution).

d) Article 24 of the Constitution states that 'No one shall be subjected to torture or to any cruel, inhuman or degrading punishment or treatment'. Involvement in the activity of people who defend themselves within the established limits is punishable by law.

e) Article 29 regulates the inviolability of domicile and provides an exception for the cases requiring 'to eliminate an imminent danger threatening the life, physical integrity or belongings of an individual'. This constitutional provision allows police, in case of reporting instances of domestic violence, to intervene and isolate the perpetrator.

f) The State shall respect and protect the private and family life (Article 28 of Constitution).

g) The family shall constitute the natural and fundamental element of the society and shall enjoy protection from the State and the society. The family shall be founded on a freely consented marriage between man and woman, on their equality of rights and on the right and obligation of parents to ensure upbringing and education of their children (Article 48(1) and (2) of Constitution).

h) Any persons shall exercise his/her constitutional rights and freedoms in good faith, without any infringement of the rights and liberties of the others (Article 55 of Constitution).

Taking into account the above-mentioned principles, we have to outline that public authorities are obliged to respect and protect human dignity.

Law No 121 of 25.05.2012 on Ensuring Equality[29]. Violence against women transcends the victim's personality, regardless of who she is and represents, in fact, a serious form of **gender-based violence** and a serious **discrimination** of women. Therefore, domestic violence is an infringement of the right to non-discrimination – right recognised by international instruments and the national legislative framework, which, first of all, violates the human dignity and value.

To this end, the Law on Ensuring Equality prohibits discrimination, including based on sex and establishes in *Article 1(1) 'The aim of this law is to prevent and combat discrimination, as well as to ensure equality of all persons in the Republic of Moldova in the political, economic, social, cultural and other spheres of life, regardless of race, colour, nationality, ethnic origin, language, religion or beliefs,* ***sex****, age, disability, opinion, political affiliation or any other similar criterion'*. Based on this law, the Council for Preventing and Eliminating Discrimination and Ensuring Equality (hereinafter – *Council for Equality*) – collegial body established to ensure protection against discrimination and equality of all people considered victims of discrimination. Any person considered to be victim of discrimination is entitled to take legal action and to require further infringement of his/her rights with restoration of the existing situation previously to the violation of his/her rights, as well as compensation for the material and non-material damage suffered[30]. Instances of discrimination are liable to disciplinary, civil, administrative or criminal procedures, according to the law in force[31].

Law on Health Care No. 411 of 28.03.1995 provides in Article 46 that family has the right to protection for its members and to social protection. Parents must take care of the child's health, ante-natal and postnatal development, his physical, spiritual and moral education and cultivate a healthy lifestyle[32].

Law on Child Rights No. 338 of 15.12.1994 sprovides for the legal status of the child as individual, for ensuring physical and spiritual health of the child, developing his civic awareness based on national and general human

[29] Law No 121 of 25.05.2012 on Ensuring Equality // OG Nr. 103 of 29.05.2012, Article 355.
[30] Article 18(1) of Law No 121 of 25.05.2012 on Ensuring Equality // OG Nr. 103 of 29.05.2012, Article 355.
[31] Article 17 of Law No 121 of 25.05.2012 on Ensuring Equality // OG Nr. 103 of 29.05.2012, Article 355.
[32] Article 47 – Parents duties towards their children

values, offering special care and social protection to children with no family on a temporary or permanent basis, or who face other adverse or extreme conditions. Under this law, a person is considered a child since birth and until 18 years old.

Article 4 of the Law on the Child Rights ensures the right of child to life and physical and mental inviolability, and the protection of the child rights is ensured by the respective competent bodies by law enforcement bodies (Article 2 – Bodies of protection bodies of the child's rights and interests). The state protects the personal inviolability of the child of any form of exploitation, discrimination, physical and mental violence, rejecting any cruel, rude, insulting derogatory behaviour, insults, ill-treatments, engagement in criminal actions, starting to drink alcohol, illegal use of psychotropic and narcotic substances, gambling, begging, inciting or forcing to illegal sexual activities, exploitation for prostitution or any other illegal sexual practices, pornography and pornographic materials, including from parents or statutory subrogatory persons, relatives (Article 6 – Right to protection against physical and mental violence).

Family Code No 1316 of 26.10.2000. Article 2 of Family Code establishes that family and family relationships in the Republic of Moldova are protected by the state. Family relationships are regulated in accordance with the following principles:

- monogamy
- marriage based on free consent between men and women
- equal rights of spouses in the family
- mutual moral and material support
- marital fidelity
- priority of child's education in the family
- care to provide support
- education and safeguarding of the rights and interests of minors and other family members who are unable to work
- amicable settlement of all family life issues
- inadmissibility of deliberate interference in family relationships
- free access to legal protection of legitimate rights and interests of family members.

The Family Code sets up certain warranties in family relationships, like:

a) All married persons have equal rights and obligations in family relationships, regardless of sex, race, nationality, ethnic origin, language, religion, opinion, political affiliation, wealth and social origin (Article 5(1) of FC).

b) All family problems are jointly settled by spouses, according to the principle of equality in family relationships. Each of the spouses is entitled to continue or independently choose his/her occupation or profession. The spouses choose their residence freely and independently. The relationships between spouses are based on mutual respect and help, joint obligations for supporting family, taking care and educating children (Article 16 of FC).

c) If during the examination of the divorce application, one spouse does not consent to the divorce, the court shall defer the examination of the case, setting a deadline for reconciliation of one to six months, except for divorce cases started on the ground confirmed by evidence of domestic violence (Article 37(4) of FC).

d) The child education methods chosen by parents shall exclude abusive behaviour, insults and all forms of ill-treatment, discrimination, mental and physical violence, corporal punishments, etc. (Article 62(2) of FC).

e) Parents may be deprived of parental rights if they apply cruel behaviour against the child via physical or mental violence, attempt to the sexual inviolability of the child (Article 67, d) of FC).

Law No. 140 of 14.06.2013 on Special Protection of Children at Risk and of Children Separated from their Parents[33] regulates the risk situations for children, as well as the algorithm for identification, assessment, assistance, referral, monitoring and record keeping of children at risk and of those separated from parents, as well as the authorities and structures responsible for the implementation of the respective procedures. In the context of this law, the children shall enjoy protection without any discrimination, irrespective of race, colour, sex, language, religion, political or other opinions, nationality, ethnicity or social origin, birth status, financial situation, degree and type of disability, specific aspects of upbringing and education of children, their parents or other legal representatives, their location (family, educational institution, social service, healthcare facility, community, etc.).

[33] Law 140 on the Special Protection of Children at Risk and Children Separated from Parents was adopted on 14 June 2013 by the Parliament of the Republic of Moldova and entered in force on 01 January 2014.

By ***Law No 112 of 09.07.2020, entered in force on 14.08.2020***, the Law No 140/2013 on the Special Protection of Children at Risk and Children Separated from Parents was amended and supplemented regarding:

a) the amendment of the notion child separated by parents, legal representative of the child, imminent danger and specialist in the child rights protection;
b) definition of the notion legally responsible for the child;
c) supplementing of duties of territorial supervisory authorities concerning: legal representation of children victims or witnesses of the crime; performance of duties related to the establishment and payment of daily allowances to children who are temporary or totally without parental care;
d) exposure of the duties of central authorities for the protection of the child;
e) planned placement within the guardianship/trusteeship service, placement of the child of a minor parent, as well as mandatory measures undertaken for preparing the children within placement services for the independent life after leaving these services;
f) delimitation of functions of representation and legal responsibility for children separated from parents between the supervisory authorities and children's caregivers;
g) establishment of the procedure of custody for children with parents/only parent being temporary in another region in the country or abroad, as well as monitoring their situation.

Meanwhile, this regulatory act mentioned in the Law No. 140/2013 introduced the notion **'legal guardian of the child** – *the person or the authority legally appointed to exercise the rights and obligations related to the proper upbringing and care of the child, by providing physical, emotional and developmental support according to the child's rights and interests'*. Meanwhile, the notions 'child separated by parents', 'legal representative of the child', 'imminent danger' and 'child rights protection specialist' were reviewed.

By the amendments and addenda to the ***Law No. 112 of 09.07.2020***[34] the custody was introduced for the first time. This is a temporary form of protection that may be instituted to the child separated from parents given that parents/ the only parent is left for more than two months in another region within the country or abroad. The custody is established by the local guardianship authori-

[34] MO No. 205-211/14.08.20, Article 454; in force 14.08.20

ties' decision[35]. Article 13-13[1] of Law 140/2013 describes the procedure of establishing the custody for a child with parents/the only parent or guardian/tutor left to another region within the country or abroad. In order to protect the child against any possible abuse or violence, Article 13[2] of Law 140/2013 provides that the custodian/legal guardian cannot be a person deprived of parental rights, as well as the person convicted for premeditated crimes against a person's life and health, crimes against the person's liberty, honour and dignity, crimes concerning sexual life, crimes against family and minors.

Law on Preventing and Combating Domestic Violence No. 45 of 01.03.2007 sets up the legal and organisational basis of the activities for preventing and combating domestic violence, authorities and institutions authorized with powers to prevent and combat domestic violence, the mechanism for notifying and settling cases of violence. At the same time, the abovementioned law establishes the liability of the perpetrator in the Contravention Code and Criminal Code according to the law in force, for committing acts of domestic violence, as well as violating the requirements of the protection order.

Domestic violence is a serious infringement of human rights. Adoption of Law No. 45 of 01.03.2007 on Preventing and Combating Domestic Violence marked the acknowledgment and the beginning of implementing international commitments assumed by the Republic of Moldova for eradicating and interfering in the settlement of acts of violence by means of concrete mechanisms, setting up authorities and institutions authorized with powers to prevent and combat domestic violence.

Though the Law No. 45/2007 provided an excellent basis for enlarging access to justice and the security of victims of domestic violence, and important measures for the development of a comprehensive response were realised, we are still far from eliminating domestic violence. ECtHR reminds regularly the states that they are obliged not only to adopt laws, but also to apply them effectively.

Law No. 45/2007 establishes the typology of centres/services available for the victims of domestic violence and for their children. At the same time, the law provides for the possibility to create centres/services of assistance and counselling for family perpetrators, which offer special information and counselling services for individuals/couples, legal counselling, referral and facilitation of access for the perpetrator to medical, employment and professionalisation services.

In order to ensure the protection and security of the victim, the Law No. 45/2007 sets up that the police must immediately respond to communications

[35] Article 13(1) Law No. 140/2013

about domestic violence cases and not to underestimate the importance of the actions aimed to tackle any forms of domestic violence[36]. Following the assessment of risks, in case of establishment of circumstances generating a reasonable suspicion that acts of domestic violence have been committed and/or an imminent danger of repeating or committing violent actions persists, the police is obliged to dispose for the immediate issuance of the emergency restraining order against the perpetrator for the settlement of the crisis and, at the same time, they undertake necessary actions for the identification of the domestic violence crime. During the action period of the emergency restraining order, the victim is entitled to require, under the law, the issuance of a protection order[37].

In accordance with the law, the healthcare bodies are authorised with functions of preventing and combating domestic violence. The role of health facilities of all types and levels is oriented towards the following actions:

a) organise information campaigns;
b) report to the police the cases of domestic violence;
c) ensure counselling and health care for victims;
d) settle, within the limits of their power, the victim's request for forensic examination of the seriousness of bodily or health injury;
e) initiate and implement programs and services for perpetrators;
f) ensure the implementation of rehabilitation, detox and psychotherapeutic programs;
g) initiate sustainable partnerships with all programs that target the health of mothers and children;
h) conclude service provision contracts with the rehabilitation centres/services for victims and perpetrators.

Law No 45/2007 establishes also the subjects of domestic violence, where the perpetrator and the victim are members of the same family. As family members may be considered the following subjects:

a) in joint habitation: persons in marriage relationship, divorced spouses, persons under guardianship and trusteeship in respect of whom a measure of legal protection has been instituted, their relatives and in-laws, relatives of the spouses, persons who are in relations similar to those between spouses (domestic partners) or between parents and children;

[36] Article 12(5) of Law No. 45 of 01.03.2007 on Preventing and Combatting Domestic Violence // O.G. No. 55-56 of 18.03.2008, Article 178.
[37] Article 12[1] of Law No. 45 of 01.03.2007 on Preventing and Combating Domestic Violence // O.G. No. 55-56 of 18.03.2008, Article 178.

b) in separate habitation: persons in marriage relationships, divorced spouses, their relatives and in-laws, adopted children, persons under trusteeship in respect of whom a measure of legal protection has been instituted, persons who are or have been in relationships similar to those between spouses (cohabitation).

The rights of victims of domestic and gender-based violence

According to Articles 11-12 of Law No 45/2007, the victim is granted the protection of legal rights and interests, being entitled to notify any case of domestic violence. The victim has the right to assistance for physical, psychological and social recovery via special medical, psychological, legal and social actions. The provision of protection and assistance services is not determined by the victim's will to report and participate in legal prosecutions of the perpetrator. The victim's right to private life and confidentiality of information is granted.

The Law No 45/2007 sets up that the authorities with powers to prevent and combat domestic violence have to interfere actively in the response mechanism both at the prevention, and at the assistance and protection stages. The authorities are obliged to react promptly to any notification and inform the victims about:

- their rights;
- authorities and institutions entitled to prevent and combat domestic violence
- type of services and organisations that can help them;
- assistance available for them;
- where and how they can submit a complaint;
- the procedure following the submission of the complaint and their role in this procedure;
- the way they can be protected;
- to what extent and under what conditions they can access legal advice or assistance;
- a possible danger for their life or health if a detained or convicted person is liberated;
- the annulment of the protection order.

Specialized assistance is provided to victims of domestic violence only by centres of assistance and protection for victims of domestic violence. To this end, Article 10 of Law No 45/2007 establishes the conditions and the procedure of constitution of rehabilitation centres for victims. The centres/services of assistance and protection for victims of domestic violence and for their children provide special services like: accommodation (placement), legal, psychological, social and emergency medical assistance, as well as other types of assistance.

The centre provides free special social services and responds to the specific and actual needs of every assistance beneficiary, like:

a) ensuring reception, protection and placement of victims of domestic violence;

b) ensuring services of personal hygiene;

c) providing legal, social, psychological and emergency medical assistance;

d) providing information for seeking accommodation, preschool or secondary institutions;

e) providing non-formal education for achieving knowledge and developing necessary skills for social integration;

f) promoting socialisation and development of relations with the community and/or family;

g) facilitating access and informing the beneficiary about the social protection system;

h) drawing up, together with the beneficiary, the Individual Care Plan against any forms of intimidation, discrimination, abuse and exploitation;

i) supporting the couple parent-child/children in the development of the autonomy that may encourage his reintegration into family and/or community;

j) monitoring the post-integration situation of beneficiaries into family and community.

Health care facilities have an important role in the response to cases of domestic violence and ensuring that victims are treated in a way promoting their health and safety. Health care providers are the first to contact with victims and have a major role in identifying and referring them. Thus, besides the provided services, health care providers have an important role in identifying cases of violence, facilitating the referral of victims within the health system and to other service providers. To this end, we mention that health professionals providing **primary support** to victims need to inform them about their rights, including

to social, psychological and legal assistance and guide them towards support, forensic and other services important for the victims. This aims to guarantee the observance of rights and safety of the victim. If the victim is in ***crisis***, the social worker and/or the police are recommended to refer her and her children to specialised services providing help to victims of domestic violence within their region. If there are no placement services or places available within their region, the community social worker sends a request via e-mail to the Ministry of Health, Labour and Social Protection (Division for Gender Equality Policies/ Center for Assistance and Protection of Victims). Health professionals need to cooperate with the social worker who is responsible at the community level for the management of case of the victim, which involves opening a file on the case of domestic violence, including:

1. concluded agreement;
2. initial assessment;
3. individual care plan and referral form, etc.

At the same time, if the victim has been referred to placement, the community social worker stays in touch with the case manager of the centre where the victim has been placed to coordinate the help provided by the end of the placement period and the return of the victim in the community. After leaving the placement, the community social worker continues to ensure the implementation of the Individual Care Plan and the monitoring of the case.

As regarding the confidentiality, we mention that while interacting with victims, health professionals have to inform the victim about his/her right to offer ***informed consent*** and to choose information that is to be devolved and that is to be confidential, including about the possibility to share information about the case with other institutions/services.

According to Law on Personal Data Protection[38], personal data processing is performed with the personal data subject's consent. The personal data subject's consent is not required if the processing is needed for an operator's duty performed in line with the law, for protecting the life, physical integrity or health of the personal data subject, etc.

[38] Law No 133 of 08.07.2011 on Personal Data Protection // O.G. No 170-175 of 14.10.2011, Article 492.

In this respect, Article 11 (2[1]) of Law No 45/2007 guarantees the right to private life and confidentiality of information regarding the victim. Similar provisions are included in Law on Patient's Rights and Responsibilitie[39]. All data concerning the identity and condition, diagnosis and treatment of the patient are confidential and are to be protected after he is dead as well. The confidentiality of information concerning the demand for health care, examination and treatment is ensured by the attending physician and by the professionals providing health services, as well as other people who are aware of this information because of their professional and job duties. Confidential information may be provided only if the patient explicitly agrees whit that or if the law expressly requires it. Disclosure of confidential information without the consent of the patient or his legal representative shall be allowed at the reasonable request of the criminal prosecution body or the court related to the conduct of the criminal prosecution or the judicial process, according to the legislation; on grounds supposing that the damage caused to the person's health results from illegal or criminal actions, the information shall be submitted to authorised law enforcement bodies.

Right to legal aid. Taking into account the issues of the experienced psychological trauma, domestic violence victims can hardly defend their rights in courts, and, most of times, do not have financial means to pay a lawyer by contract. This is why the state guarantees free legal aid to victims of domestic violence. **Legal aid is freely provided to the victim.**

The lawyer can present the legal means available to the victim and encourage them to end the violent couple relationship and use the instruments of legal protection. The lawyer shall help the victim of domestic violence to become aware of and understand their rights, shall explain correctly the way that every decision affects them and its the legal effects.

While providing aid to the victim, health professionals have to explain the what rights they have, including the right to free state-guaranteed legal aid, as well as services available and special organisations providing such services.

[39] Law No 263 of 27.10.2005 on Patient's Rights and Responsibilities // O.G. No 176-181 of 30.12.2005, Article 867.

Legal aid may be required by the victims of domestic violence regardless of their income, at any stage of the criminal or administrative proceeding, and until the initiation of the proceeding in civil cases.

In order to obtain the assistance of a lawyer providing state-guaranteed legal aid, the victim of domestic violence has to fill in an application for qualified legal aid and submit it in person or by fax/email to the Territorial Office of the National Legal Aid Council (NLAC). The contact details of the NLAC's Territorial Offices and the application forms for obtaining state-guaranteed legal aid can be found on the website[40].

The mechanism for addressing domestic violence cases

Law No 45/2007 sets up that the victim has the right to report any case of domestic violence and require protection. The representatives of authorities entitled to prevent and combat domestic violence are prohibited to undertake actions aiming to deter the victim from reporting the acts of violence experienced.

Article 12(4) of Law No 45/2007 sets up the liability of professionals responsible for ensuring the confidentiality to report the instances of domestic violence endangering the victim's life or health or the imminent danger of such act to occur to the competent authorities. In other cases, the reporting shall be done only with the victim's consent. Reporting cases of violence against children, including reasonable suspicion of such cases, is mandatory and does not require the victim's consent.

Regarding the committing of acts of domestic violence, Article 11 of Law No 45/2007 sets up that people in positions of accountability that are aware of an existing danger for the life and health of a potential victim must report it to the authorities entitled to prevent and combat domestic violence. The authorities entitled to prevent and combat domestic violence are obliged to react promptly to any notification and inform the victims about their rights, where and how they can submit a complaint and get protection, etc. According to Article 12 of Law No 45/2007, requests concerning committing acts of domestic violence may be submitted by people in functions of accountability and by professionals interacting with the family, by the guardianship authority, other people with information about an imminent danger of committing or already committed acts of violence.

[40] https://cnajgs.md/ro/bmn/page/contacte ;https://formulare.cnajgs.md/

Police may be notified on the acts of domestic violence by:

a) complaint;
b) denunciation;
c) self-incrimination
d) materials of the fact-finding body;
e) identification by the criminal prosecution body or the prosecutor of the reasonable suspicion concerning the acts of domestic violence;
f) any other information concerning domestic violence reported by phone, fax, media sources, Internet.
g) verbal and/or written signs about domestic violence acts.

The procedure of identification, recording and initial assessment, documentation and record-keeping of suspected cases of violence, neglect, exploitation and trafficking of children is regulated by the Government Decision No 270 of 08.04.2014 on Approving the instructions on the inter-sectoral cooperation mechanism for the identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation and trafficking. Indicated instructions target the employees of central and local public authorities, institutions and services within and subordinated thereof, who work in the field of social assistance, education, health care, law enforcement bodies, which have to cooperate to prevent violence, neglect, exploitation, trafficking of children, as well as combating them via social assistance, educational, public order and health care services.

This instruction provides that the representatives of education, health care and social assistance facilities, regardless of their legal type of organisation, cultural, public order, State Labour Inspectorate, other authorities and public institutions with powers in the field of child protection, are obliged to:

1) to record the notifications of people concerning the suspected cases of violence, neglect, exploitation, trafficking of children and/or to take action on its own motion when identifying suspected cases of violence, neglect, exploitation, trafficking of children (hereinafter – suspected case), applying sectoral procedures;
2) to immediately inform by phone the local guardianship authority, and within 24 hours to submit the notification form of the suspected case of violence, neglect, exploitation, trafficking of children (hereinafter – notification form). The notification form shall be filled in with the data owned at the moment of the identification of the suspected case, particularly

based on information collected from the source reporting the suspected case. Missing information shall be collected by the case manager during initial case assessment;

3) to immediately provide additional information to: a) the territorial police inspectorate / prosecutor's office – if they know or suspect a child to be a victim of a criminal or administrative offence; b) emergency health care service – if the notification includes information on the existence of an imminent danger for the child's life or health, of suicide attempts of children; c) state labour inspectorate – if the suspect case includes information that child's labour is used in works involving difficult, damaging and/or dangerous conditions, as well as in works that might cause damages to children's health or moral integrity.

Along with people in positions of accountability and professionals, Law No 45/2007 sets up the obligation to report domestic violence acts for every person who is witness to acts of domestic violence or reasonably suspects that such acts have been or may be committed.

Protective measures: The instruments for prompt response for protecting the victims of violence are ***1) the protective order*** and ***2) the emergency restraining order***.

The definition of the emergency restraining order was included in Article 2 of Law No 45/2007: the **emergency restraining order** is an administrative document issued by the police applying protective measures meant to ensure immediate removal of the perpetrator from the residence of the family subjected to violence and establishment of certain prohibitions provided by law in order to prevent the recurrence/committing of instances of violence, thus guaranteeing the safety of the victim and of other members of their family inside and outside their house.

Article 12^1 of Law No 45/2007 provides that, following the assessment of risks, in case of establishment of circumstances generating a reasonable suspicion that acts of domestic violence have been committed and/or an imminent danger of repeating or committing violent actions persists, the police is obliged to dispose for the immediate issuance of the emergency restraining order against the perpetrator within 10 days for the settlement of the crisis. At the same time, they undertake necessary actions for the identification of the domestic violence crime. The emergency restraining order is immediately applied, the perpetra-

tor and the victim (as for children – the legal representative of the victim) are informed about the restrictions applied, the rights and obligations they have to assume and about the liability for non-enforcement of the restriction order. The perpetrator is entitled to appeal against the emergency restraining order in court, but the submitted request does not suspend the action of the restraining order.

The implementation of the measures in the emergency restraining order is monitored by the police. During the action period of the emergency restraining order, the victim is entitled to require the issuance of the protective order, under the law. In this case, the action of the emergency restraining order is legally extended and ends up with the implementation of protective measures set up by the court[41].

Once the emergency restraining order is issued, the perpetrator and the victim (as for children – the legal representative of the victim) shall be informed about the restrictions applied, the rights and obligations they have to assume and about the liability for non-enforcement of the restriction order[42].

In order to ensure the safety and protection of the victim, the police officer who has issued the emergency restraining order requires the perpetrator to give all the keys from the house when leaving the residence. These ones are further given to the victim or submitted to the police unit for provisional storage. When leaving the residence, the perpetrator can only take necessary personal articles (clothes, documents, hygienic articles) under the police supervision.

The **protection order** is a legal act, by which the court applies protection measures to the victim for a certain period of time. When responding to cases of domestic violence, we recommend that health workers inform the victim about the possibility to obtain a protection order.

To request a protection order, the victim may apply to the court in person or through a representative, to whom powers have been delegated (for example via a lawyer). If victims cannot to submit the application due to reasons of health, age, other justified reasons, at his/her request, the application for a protection order may be submitted, in the interests of the victim, by the police, the social assistance body or by the prosecutor. Health workers are not entitled to submit an application for protection order, but taking into account the obligation to report cases, as per principles described above, when identifying a case that requires protection measures it is recommended to notify immediately the police, social workers or the prosecutor.

[41] Law No 45/2007, Article 121.
[42] Law No 45/2007, Article 121(2).

The victim's inability to submit an application for protection order may refer to the situation in which the victim is in a state of helplessness:

a) fizică (a) physical (the victim is hospitalized, is in a placement center, is traumatized, has found refuge in another shelter, is elderly, takes care of children, other cases with similar effect);

b) psychological (the victim is in depression, is emotional, isolated, scared, has mental distress, other cases with similar effect).

In all cases mentioned above, the application shall be accompanied by the victim's request, stating the reasons or the situation resulting in victim's inability to address personally.

If the employee of the police, of the social assistance body or the prosecutor receives the victim's application for protection order, and the victim is unable to submit the application personally, in the shortest time, but not later than 24 hours, this application shall be forwarded in the court along with all evidence materials for review.

In order to avoid an imminent danger, prevent a severe crime against life, health and integrity, the protection order can impose one or more protection measures to the perpetrator.

Depending on each case, the court will apply the most adequate measures to offer maximum protection to the victim and to children, as appropriate. The protection measures are exhaustively listed in Law No 45/2007 and the Code of Civil Procedure (CCP), as follows:

a) obligation to temporarily leave the common house or to stay away from the victim's house, without deciding on the mode of ownership over the goods;
b) obligation to stay away from the victim's location, at a distance that would assure his/her security, excluding any visual contact with the victim or with his/her children, with other people dependent on him/her;
c) prohibition of any contact, including by telephone, by mail or in any other way, with the victim or his/her children, with other people dependent on him/her;
d) prohibition of approaching certain places: the victim's workplace, the children's study place, other stated places that the protected victim attends;
e) obligation, until the cease of the protection measures, to contribute to the maintenance of their common children with the victim;

g) limitation of the rights over the goods that are in the victim's possession and use;
h) obligation to participate in a special treatment or counselling program to reduce the violence or stop it;
j) prohibition of keeping and carrying a gun.

Obligation of the perpetrator to temporarily leave the common home, without deciding on the administration method and the right of disposal over the goods. When the circumstances of the case form the definite persuasion in the court that the perpetrator's behaviour aims to inflict a real, accentuated state of fear to the victim and that his presence near the victim puts his/her life, health and his/her integrity in danger, it will be enforced the measure provided in Article 278[7] (2)(a) CCP. Though the ownership right of the perpetrator can be violated by this measure, in cases of domestic violence, according to the ECtHR law, the victim's life and health have priority. In cases of domestic violence, the perpetrator's priority rights cannot replace the victim's rights to life and physical and mental integrity *(Opuz cause vs. Turkey judgement of 09.06.2009, application No 33401/02, pt. 147)*. Respectively, this measure can be enforced even if the perpetrator is the sole holder of the ownership right over the house in which he lives together with the victim.

The prohibition of any contact, including by telephone, by mail or in any other way, with the victim or his/her children, with other people dependent on him/her:

If such a measure is ordered, the court may not allow the (minor) victims to choose the possibility to contact with the perpetrator father during the enforcement of this measure, compiling ambiguous forms, contrary to the purpose of the law *(for example, to allow the perpetrator to communicate with the children throughout the protection measures only at his wish)*.

The prohibition of approaching certain places: the victim's workplace, the children's study place, other stated places that the protected victim attends. When ordering the protection measure provided in Article 278[7] (2)(d) CCP the court will determine during the hearing the places attended by the victim and her children in order to list them accurately in the protection order. This information is necessary for protection order supervision. Since 3 January 2021, if the perpetrator is prohibited to approach certain places: the victim's workplace, the children's' study place, other stated places that the protected victim attends, the court will compulsorily order, ***the electronic monitoring of the domestic perpetrator***, as it is provided by law.

Prohibition of keeping and carrying a gun. When ordering the protection measure provided in Article 278[7] (2)(j) the keeping and carrying of guns are regulated by Law No 130/ 2012 on the regime of guns and ammunition for civilian use. In case of violence the law expressly provides for limiting the right to possession and carrying a gun of people who put in danger the public order, life and bodily integrity of people and are registered with the police. The people who, in their working activity, are equipped with guns, can use these guns during the working hours only, if they cannot harm the victim. The people equipped with guns at work are prohibited to carry guns out of working hours.

Obligation to participate in a special treatment or counselling program to reduce or eliminate the violence. If such an action is determined by the court as being necessary to reduce or eliminate violence, the court will take into account the framework Regulation on the Organisation and Operation of Assistance and Counselling Center for Domestic Perpetrators and of the Minimum Quality Standards, approved by Government Decision No 496 of 30.06.2014. Note that according to point 25 of the above Regulation, in order to admit at the Center for Family Aggressors it is necessary the perpetrator's written consent, but when relating to minors- their legal representative's consent.

Also, the court will analyse, on the basis of the submitted evidence and own judgement, if the perpetrator does not have the contraindications, provided in pt. 2 of Annex 1 of the Regulation, preventing his admission to the Assistance and Counselling Center for Domestic Perpetrators, such as:

1) presence of communicable diseases in active state;
2) certification of behaviour disorder which are real danger for the Center and counselling group members;
3) addiction to alcohol and psychoactive substances;
4) presence of mental disorder (mental illnesses or mental deficiency).

When enforcing this measure, note that for each perpetrator, the case manager develops an individualised planning of services and implementation of support plan, which is reviewed once in two months. According to pt. 29 of Annex 2 at the above-mentioned Government Decision, the duration of the group counselling program is 24-26 weeks, i.e. 6-6,5 months. Respectively, when enforcing this measure, the court will not indicate its term, which will be determined by the Assistance and Counselling Center for Domestic Perpetrators for each individual case.

The measure of obliging to take a medical examination of the mental state and drug/alcohol addiction and, if there is a medical opinion confirming drug/alcohol addiction, **to undergo a forced medical treatment of alcoholism/drug addiction, is inserted in Article 215[1] Code of Criminal Procedure. Respectively, this measure can be requested and enforced only as part of criminal proceedings.**

- ***Term of protection measures:*** The protection measures are temporary, the duration of the measures is expressly determined by the court, depending on the case circumstances. According to Article 15 of Law No 45/2007, the provided protection measures are enforced for up to 3 months, to immediately remove the imminent danger of exposing the victim and children to violent acts.
- ***Extension of the protection measures:*** When the danger maintains and there is a need for protection, the person, that submitted the application for protection measures for the victim of domestic violence, can afterwards submit an application to extend the term of the measure enforcement. The application for extension of the protection measures term must be submitted and reviewed before the expiry of the first term. After the term expiration, the submitted application will be considered as a new application and will be randomly examined by a judicial panel in a separate proceeding.
- ***Application cancellation:*** At the victim's justified request, the court may revoke the applied protection measures, assuring itself that the victim's wish is freely stated and was not subjected to the perpetrator's pressures. The revocation may be ordered if the following requirements are cumulatively met: the perpetrator complied with the determined prohibitions and obligations; the perpetrator followed/is following the counselling or the treatment determined for him/her.

Liability for violation of the emergency restriction order

When issuing an emergency restriction order, the employee of the fact-finding body or of the criminal investigation body issuing it will compile the minutes upon handing over the emergency restriction order by the countersignature which, the perpetrator will confirm: that he has been informed of the measures laid down in the emergency restriction order, of the rights and obligations relating to the issuance of the order about the sanctions to be imposed in the event of failure to adhere to the measures established by the emergency restriction order.

In case of deliberate non-execution or avoiding the execution of the emergency restriction order by the domestic perpetrator, a contraventional procedure shall be started based on essential elements of the contravention component provided in Article 318[1] of the Contraventional Code.

According to Article 318[1] Contraventional Code, the non-execution or avoiding the execution of the requirements stated in the emergency restriction order is sanctioned with a fine from 60 to 90 contraventional units or with an arrest from 3 to 10 days.

In case of emergency restriction order violation, the official examiner is entitled to enforce constraining procedural-criminal measures, in compliance with Article 435 of the Contraventional Code, which establishes the possibility to detain the offender.

Liability when the protection order is violated

The non-execution of the measures in the protection order, issued by the court, is subjected to prosecution and criminal punishment as per Article 320[1] of the Criminal Code – *deliberate non-execution or avoiding the execution of the court determined measures in the protection order of the victim of domestic violence*.

The non-execution of the protection order measures consists in the perpetrator's disagreement to execute the restriction measures indicated in the protection order, such as:

- to approach of victim's home, of whereabouts the victim is, at a distance that would not ensure the victim's security;
- to contact the victim, his/her children, other people dependent on him/her;
- to come to the victim's workplace or home;
- to not undertake the necessary actions for protection order execution (unwillingness to leave the common home, to contribute to the child support that he/she has with the victim etc.).

In case of protection order violation, the police is entitled to enforce constraining criminal procedural measures, in accordance with Article 165(2)(2) Code of Criminal Procedure (CCP), which determines the possibility to detain the accused, the defendant that violates the protection order in the event of domestic violence, as well as Article 185(2)(3) CCP, according to which the suspect, the accused, the defendant, that violated the protection order in the case of domestic violence can be placed in pre-trial detention.

Deliberate non-execution or avoiding the execution of the measures established by the court in the protection order for a victim of domestic violence is be punished by unpaid community service from 160 to 200 hours or by detention up to 3 years.

Liability for domestic violence acts

Criminal liability for domestic violence

The Criminal Code (CC), Article 201[1] punishes physical, psychological and economic violence against a family member.

For purposes of Article 201[1] CC, any perpetrator's family member can be a victim of domestic violence. The notion of family member is stipulated in Article 133[1] CC, which asserts as true two different acceptances, depending on the absence or presence of the perpetrator's cohabitation with the victim:

a) in the cohabitation state: persons in marriage relationship, divorced spouses, persons under guardianship and trusteeship, their relatives and in-laws, relatives' spouses, persons who are in relations similar to those between spouses (cohabitation) or between parents and children;

b) in separate habitation: persons in marriage relationships, divorced spouses, their relatives and in-laws, adopted children, persons under trusteeship, persons who are or have been in relationships similar to those between spouses (cohabitation).

For purposes of Article 133[1] (a) CC, the term 'cohabitation' is a coexistence action, i.e. the fact of inhabiting, living, cohabiting (in the same house, dwelling, space, courtyard...) along with the persons in marriage, divorced, under guardianship and trusteeship, their relatives and in-laws, persons in relationships similar to those between spouses (cohabitation) and between parents and children.

The legal rights and obligations of the married persons, i.e. of the spouses, come into force on the day of marriage registration at the civil status bodies. For people in divorce is notable that in case of marriage dissolution by the civil status body, this finishes on the day of divorce registration, including on the basis of marriage dissolution notice, issued by the notary, and in case of marriage dissolution by the court – from the day when the court judgement became final.

The expression 'persons under guardianship and trusteeship' stipulates that the guardianship and trusteeship is established on children that are separated from their parents for the purpose of education and schooling, as well as of protection of their legitimate rights and interests. The guardianship is established on children under the age of 14. When reaching the age of 14, the guardianship

becomes trusteeship, without issuing an additional ordinance by the guardianship authority. The trusteeship is established over minors aged between 14 and 18 years old. The guardianship and trusteeship on children left temporarily without parental care, for the children left without parental care is established by territorial guardianship ordinance, in compliance with the Law No 140/2013 on Special Protection of Children at Risk and Children Separated from their Parents.

According to Article 134 CC, kinship means the bond based on a person's descent from other one or on the fact that more persons have one common ascendant. In the first case, the kinship is in a straight line, and in the second one – in a collateral line. The degree of kinship is set up by number of births. The relatives of one of the spouses are in-laws of the other one. The line and degree of affinity are similar to the line and degree of kinship. Close relatives are the parents, children, adoptive parents, adopted children, sisters and brothers, grandparents and their grandchildren.

The statement 'persons that are in relationships similar to those between spouses (cohabitation)' covers the persons that are in an emotional, physical and intellectual relationship, which implies that the partners live together, but without legal benefits, i.e. without performing legal forms.

Article 201[1] CC criminalizes the following forms of domestic violence:

1. Physical violence. In compliance with Article 2 of the Law on Preventing and Combating Domestic Violence, physical violence means intentional harm to bodily integrity or health by hitting, pushing, slamming, pulling hair, stabbing, cutting, burning, strangling, biting, in any form and of any intensity, by poisoning, intoxication, other actions with similar effect.

The mistreatment implies the act of beating, hitting, treating someone abusively, other violent acts can be those described in the notion of exposed physical violence, as well as other acts with similar effects.

2. Psychological violence. Article 201[1] (1)(b) CC presents the offence of psychological violence as being committed by containment, intimidation, aiming to impose the will or the personal control over the victim. The forms of psychological violence are provided in Article 201[1] (1)(b) CC – 'containment, intimidation, aiming to impose the will or personal control over the victim'.

The purpose of imposing the will or personal control over the victim is characteristic of domestic violence. Violence is always a manifestation of abuse of power and control, for the purpose of imposing will or control over the family members who have less power or own fewer resources.

Containment is a form of psychological violence, which consists in isolation from the family, community, friends, prohibition of professional development, prohibition to attend an educational institution, deprivation of access to information, etc.

Intimidation implies an action/inaction that violates the victim's psychological integrity. The methods of intimidation are mentioned in the psychological violence definition in Article 2 of Law No 47/2007, implying verbal threats, cursing, insulting, demonstrative destruction of objects, showing off the gun, hitting the domestic animals. The consequence of intimidation actions can be tested by examination or psychological evaluation reports which find and appreciate the severity of the consequences and mental suffering of the victim.

3. Economic violence provided in Article 201^1 (1)(c) consists in deprivation of economic means, including the lack of primary livelihoods (such as: food, medicines, basic necessities, as per Article 2 of Law No 45/2007); the neglect resulted in slight harm to bodily integrity or to health.

Child neglect, according to Article 3 of Law No 140 of 14.06.2013 on the Special Protection of Children at Risk and Children Separated from their Parents, implies the voluntary or involuntary omission or ignorance of the accountability on the child raising and educating, which endangers their physical development, bodily integrity, physical or mental health and may take forms of:

- food neglect - depriving the child of food or his/her malnutrition;
- neglect in providing clothes - lack of clothes and/or shoes, in particular, those necessary for the cold period of the year;
- neglect of hygiene - failure to comply with the general rules of personal hygiene, unsanitary housing conditions that threaten the child's life or health;
- healthcare neglect - lack or refusal of healthcare necessary for child's life protection, bodily integrity and health, failure to go to the doctors in emergency cases.

4. The **sexual violence** committed over one of the family member comprises constitutive elements of the offence component provided in Article 171(2) (b^2), Article 172(2)(b^2), Article 173, Article 174 and Article 175 of CC and it will be classified in the proper way based on the stated articles. Article 201^1 (2) CC lists the following aggravating factors:

a) actions committed on two or more family members;

b) actions committed in connection to the request for or enforcement of the protection measures;

c) actions that inflicted medium harm to bodily integrity or to health.

At the same time, Article (3) 201[1] CC lists actions that:

a) inflicted the severe harm to bodily integrity or to health;

b) provoked suicide or attempted suicide.

Besides, Article 201[1] (4) CC lists actions that caused the severe harm to bodily integrity or to health resulting in victim's death.

In Article 201[1] CC, paragraphs (2)(c), (3)(a) and (b), (4) provide four distinctive offences depending on the harmful consequences:

1. medium harm to bodily integrity or to health;
2. severe harm to bodily integrity or to health;
3. suicide or attempted suicide;
4. victim's death.

Each of these harmful consequences must have a causal relation with the deliberate action or inaction committed by a family member against another family member.

The severity of bodily harm is established only under Ministry of Health Regulation on Forensic Assessment of the Bodily Harm Severity No 199 of 27.06.2003.

Contraventional liability for domestic violence

Contraventional Code was supplemented with Article 78[1] – domestic violence – mistreatment or other violent actions, committed by a family member against another family member, which have caused slight harm to bodily integrity.

According to Ministry of Health Regulation No 199/2003 'slight harms' are injuries that do not generate a health disorder for more than 6 days or a permanent work inability[43].

The mistreatment term was examined above, the explanation being valid in the context of achieving the objective side of the domestic violence contravention as well.

In the context of Article 78[1] CC, the action is a perpetrator's active behaviour and may be manifested through beatings, which is characterized by applying multiple and repeated hits. If the beatings result in bodily and health harm, their severity is assessed in compliance with Ministry of Health Regulation No 199/2003. Finding of actions such as beatings, mortification or torture are within the competence of the fact-finding bodies, prosecution and court. The medical examiner is responsible for only finding the presence, character and age of the bodily harm

[43] Pt. 74, Part V of the Regulation on Forensic Assessment of the Bodily Harm Severity of 27.06.2003, approved by Order of the Minister of Health No 199 of 27 July 2003.

or of the health generated by certain mentioned actions, traumatic agent and way of causing of the injuries based on medical data[44].

Subsequently, whether, in the outcome of the illegal actions over the organism/body, which is included in the notion of beatings, mortifications, tortures, no bodily harm was established by the medical examiner, then their finding is within the competence of the facts-finding bodies or prosecution on the basis of other evidence and should be classified as slight injuries.

In case of finding slight injuries only, characteristic of the contravention stated in Article 78[1] CC, but which have a systematic nature, these show an abusive and aggressive behaviour, of imposing the will and control over the victim. Respectively, the material of the contraventional process will be forwarded to the prosecution, and the deed will be classified as psychological violence, as per Article 201[1] (1)(b) Criminal Code[45].

[44] Pt. 79, Ibid.

[45] Notification of the General Prosecutor's Office No 25-2d/18 – 183 of 27 April 2018

TOPIC 3

Gender norms, masculinity and violence

Istanbul Convention (2011) emphasizes that gender-based violence against women is a structural phenomenon, deeply rooted in the unequal power relations between men and women. Violence against women is based on their discrimination and the violence can be eradicated only by removing all forms of discrimination against women and promoting substantial gender equality, including by empowering women. Thus, the solution in the fight with violence against women consists in insurance of a real partnership between women and men, based on equality, implementation of their rights and insurance of the same possibilities and contributions in the society.

The study *'Men and Gender Equality in the Republic of Moldova'* (2015) found the existence of deeply rooted patriarchal attitudes and stereotypes regarding the roles and responsibilities of women and men in the family and society. These stereotypes and preconceived ideas support gender inequality in the private and public life, sex-based discrimination and idea of man's superiority over woman, approaches related to patriarchal societies, and are the reason of the genuine causes of domestic violence and gender. Therefore, the gender-based violence continues because of social expectations relating to the gender roles associated with a man or a woman.

Sex vs. Gender

Sex. Law No 5/2006 on Equal Opportunities between Women and Men defines sex as *all anatomic and physiological characteristics that distinguish the humans in males and females*. So, the sex is innate and reflects the anatomic and physiological characteristics that make the distinction between males and females. The sex of an individual and his/her biological functions are genetically arranged and comprise the following six component parts: (i) chromosomes, (ii) gonads, (iii) internal genitals, (iv) external genitalia, (v) sex hormones and (vi) secondary sexual characteristics. It is considered that exactly these biological characteristics and differences (including reproductive) were essential in delimitating the social roles (of gender) of the men and women as an innate process. For example, if a woman gave birth to a baby, it is natural for her to take

care of him/her, or if a man is physically stronger, it is natural for him to make important decisions for family and society, including to be better remunerated.

Gender. Istanbul Convention (2011) explains the gender as *socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men*. Law No 5/2006 on Equal Opportunities between Women and Men considers the gender as *a social aspect of the relations between women and men manifested in all spheres of life*. Therefore, gender represents the mental, cultural and social differences between women and men and can be regarded as a set of qualities assigned 'to a real man' or 'to a real woman'. So, the society assigns to men and women certain roles and has certain expectations from them regarding their observance. These social roles are acquired and learned in the family, at school, in cultural and religious institutions. Since gender is the output of the society and customs, gender perceptions differ from one society to another, being connected to the cultural and religious customs, as well.

Due to its anatomic and physiological peculiarities, the sex does not change, whereas the gender can change throughout time and space.

TABLE 5 Sex vs. Gender

SEX	GENDER
• biological identity • anatomic and physiological (biological) differences between women and men • innate and genetically arranged characteristics • unchangeable	• social identity • mental, cultural and social differences between women and men • characteristics and roles assigned by the society • changeable throughout time and space

The gender is strongly tied to the **social norms**, being determined and perpetuated by these. The explanatory dictionary of the Romanian language defines the norm as a rule determined by law or usage, order recognised as compulsory or recommendable. The social norms are a set of rules that regulate the social relationships, behaviour and, thus, the human society's actions. A social norm is a rule that determines the individual's behaviour in a specific situation. Being a complex set of structures, the society imposes a developed and dynamic system of social norms. Therefore, the social norm is a behaviour rule adopted by certain communities of people as positive valuables and imposed to its members. By means of these norms, the society shapes its members' behaviour.

The social norms are built by society's expectations, founded on the beliefs of some representatives about what others should do or what they accept. The social norms are imposed and kept by the society's influence via some distinctive mechanisms, such as approval (acceptance) or disapproval (non-acceptance). Those individual behaviours that preserve the social order are accepted by the others members of the group, whereas the behaviours that differ from the imposed rules and others' expectations are rejected. It is stressed that the social norms have a dynamic character and change throughout the time.

The social norms can be both beneficial and harmful. Examples of beneficial norms include people's mutual greeting and the way of greeting, 'the dress code' for certain events, the respect of the young people towards the elderly ones etc. The harmful norms result in prejudice and, examples related to domestic and gender-based violence include the use of the violence to educate children, subordination of the intimate partner, female genital mutilation.

Gender roles

The social norms determine gender roles, which are assigned by society to men and women, based on the biological differences between them. The society associates certain roles with their members' sex and instils them since childhood by educating a certain behaviour inherent to a gender. These social characteristics, roles and responsibilities are based on certain stereotypes and differ in various cultures, societies and historical periods. The gender roles express the gender identity and embrace those behaviours, life style and individual characteristics that are deemed to be proper to a man and to a woman by a certain group of people or a society, based on society's expectations, including the occupation. In this way, the men are supported to adopt the norms related to and associated with masculinity, and women - with femininity. For example, it is considered normal for a man to mow the lawn, whereas a woman is expected to stay in the house and take care of children. In the patriarchal cultures and societies, the men are regarded as the total holders of power in the private and public space and are thus leaders in these domains. In those societies, the political, leadership activities and other domains believed to be more significant from social and financial points of view are dominated by men. At the same time, the women are accepted as subdue persons, mainly focused on home, household and children. These roles are specifically connected to the reproductive function, a function that does not substantially generate an economic, familial and national impact, that is why the woman's traditional social roles are regarded by the society as more inferior compared to those of man.

Persons (either women or men) who do not observe the gender roles assigned by the community in which they live are regarded as nonconformists and are rejected by the society. This disapproval mechanism perpetuates the gender roles. Another important mechanism of strictly maintained gender roles are the stereotypes based on gender, which represent a way by which the society transmits their expectations to women and men. The stereotypes are some beliefs regarding the features and activities considered to be suitable for women and men and can be noticed in various domains such as family, politics, economy, society. Certain gender roles and stereotypes contribute to the acceptance of domestic violence and against women which is why all the professionals who support the domestic violence combating and prevention, especially the health staff must be aware of this. The stereotypes related to gender roles can be dangerous so that these are able to impede health staff to understand the particular needs of the domestic violence victims and to reply properly to the violence cases.

The gender role impacts can be seen in every society. According to the survey *'Men and Gender Equality in the Republic of Moldova'* (2015) there are feminized domains – education and masculinised – business and politics *('women are not regarded as worthy and strong candidates, as good as men')*. The same survey emphasizes that 90.5% of interviewed men and 81.5% of women believe that the most primordial thing for a woman is taking care of house and cooking for family, and 85.6% of men state that they have to make the last decision in the family.

Gender roles change over time. In this way, over the last period more and more assigned jobs and activities for men are performed by women, and others meant for women (ex: cooking, children care – paternal leave) are taken on by men. Currently, in more developed countries there is a trend of decreasing the number of jobs traditionally assigned only to women or only to men. Overall, any person is entitled to decide if to follow the gender roles or not.

Gender equality, gender inequality and gender-based discrimination

Gender roles and stereotypical approaches can lead to gender inequality and, in this way, to gender-based discrimination.

Gender equality assumes that both men and women enjoy the equal conditions in the achievement of their rights. The statement and Beijing Platform for Action (1995) underlines that gender equality is the only efficient way to build a developed, resistant and proper society. In this sense, Law No 5/2006 on Equal Opportunities between Women and Men explains the equality between women

and men (gender equality) as equality in rights, equal opportunities in exercising one's rights, equal involvement in all areas of life and equal treatment of women and men. Gender equality is essential to ensure equal development opportunities for both men and women and by no means goes against men. Both men and women have the potential to contribute to developing the society in which they live under all aspects (social, cultural, political, economic), that is why they should have the equal conditions to make the most out of this possibility. Istanbul Convention (2011) stresses that the achievement of equality between women and men, de jure and de facto, is a key element in preventing violence against women.

Gender inequality manifests itself via determined differences between women and men, that tend to assign a bigger importance and value to the characteristics and activities related to what is masculine, causing this way unequal power relationships. Most patriarchal societies promote the idea that the female gender has less power, privileges and rights, which is in opposition to values based on observance of humans' rights. The truth is that the unequal conditions are not defined by biological peculiarities, but rather by social norms and values. Taking into account that these are taken over through observation and learning and referring to the constant evolution of society and destruction of traditional model, the key to eradicate violence is to ensure that women and men are equal partners, have the same rights and responsibilities, the same opportunities and that their contribution is equally appreciated and respected.

Gender stereotypes represent a set of social or cultural prescriptions of the gender roles, preconceived ideas that assign qualities, characteristics, activities and roles randomly to women and men. Thus, it is prescribed to the women and girls to be obedient, passive, compliant, focused on caring for others. On the other hand, the expectations towards men/boys are to hold power, to strengthen their social and professional performance. For example, a lasting stereotype is that men are the head of households and they should be the main providers of income, whereas women should give priority to the family life and the children raising and caring. In reality, both women and men can actually accomplish these roles. Certain roles or stereotypes create vicious practices and support violence against women.

The patriarchal social patterns and gender-based stereotypes promote the traditional roles, influence the social and professional choices of men and women and, in this way, limit their development opportunities. This also limits women's participation in society development and makes it impossible to fully use their social and professional potential. This results in gender inequality, leading to gender discrimination. The stereotyped social norms are materialised

in the people's perception of gender equality. In this sense, the survey *'Men and Gender Equality in the Republic of Moldova'* (2015) finds that 46.5% of interviewed men and 37% of women believe that women acquire rights by stepping over men's rights. The perception of gender equality on the labour market worsens. Even though the Labour Code provides for guarantees of equal conditions for women and men, that would allow professional and family life reconciliation, a considerable number of women continue to be economically passive due to family responsibilities, including those tied to children caring. In the recent years this category of women's share has remained stable at around 11% of all inactive women in the Republic of Moldova, which is around 130 - 140 thousand persons[46]. The childbirth makes women to withdraw from the labour market. This is caused by gender stereotypes and prejudices, lack of policies focused on family life harmonization with job responsibilities, but also by lack of childcare services which would let the young women to reconcile the family responsibilities, childcare and professional life (e.g. insufficiency of nurseries) particularly in the rural area. Though men and women enjoy the same rights, they cannot accomplish them properly in the daily life and frequently turn into victims of different forms of gender-based discrimination. This form of discrimination has many sides and can take place in any area, such as social, cultural, political, economic, manifested by such differences as pay gaps, unequal involvement in the political life, unfair separation of jobs and activities in the private life etc. Discrimination is a social pathology. Law No 121/2012 on Equality defines discrimination as any distinction, exclusion, restriction or preference in equal rights and freedoms of a person or a group of persons, as well supporting the discriminatory behaviour based on real or supposed criteria. The Law No 5/2006 on Equal Opportunities between Women and Men explains sex discrimination as any distinction, exclusion, restriction or preference, aiming at or resulting in limitation or intimidation of the recognition, performance and implementation based on equality between women and men of fundamental human rights and freedoms and recognizes two forms of discrimination based on this criterion: direct and indirect discrimination. According to the mentioned law, direct sex discrimination implies any action that, in similar situations, discriminates a person in comparison to another person of the other gender, also by reason of pregnancy, maternity or paternity. The indirect sex discrimination is any action, rule, criterion or practice identical for women and men, but with unequal effect or result for one of the genders. The indirect discrimination manifests itself more frequently via removal from certain social spheres.

[46] The economic costs of gender inequality in the Republic of Moldova, WLC, 2020, p. 14 http://cdf.md/files/resources/148/Raport_Inegalitati_Gen_Final.pdf

According to the law, the following are not regarded as discriminatory:

a) provision of special conditions to woman during pregnancy, post-partum and breastfeeding;
b) qualification requirements for activities in which the sex peculiarities are a crucial factor due to the specific conditions and how the respective activities take place;
c) special advertisements for employment of persons of a certain sex in the work place where, given the nature or special conditions of performing the job, as provided by law, special characteristics based on sex are decisive;
d) affirmative actions, i.e. special temporary actions to speed up the attainment of real gender equality, intended to eliminate and prevent discrimination or disadvantages that result from the existing attitudes, behaviours and structures.

UN Convention on the Elimination of All Forms of Discrimination against Women (1979) defines the discrimination towards women as any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. The same convention underlines that discrimination against women violates the principles of equality of rights and respect for human dignity, that it is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity. The General Recommendation No. 19 of Committee of this UN Convention established that 'gender-based violence, including domestic violence, is a form of discrimination that 'seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men'.

The pyramid of violence

Understanding the roots of domestic and gender-based violence is a significant precondition for ensuring an adequate response by health professionals. Any type of violence, including rape and murder, are neither accepted nor tolerated by society. Only few know, however, that certain phenomena accepted and promoted among the society's members are the reason for these extreme

forms of violence. The way in which the society takes part in spreading the severe forms of violence is exemplified by the pyramid of violence. This is a diagram which shows how the language and things perceived by us as natural cause stereotypes that lead to violence.

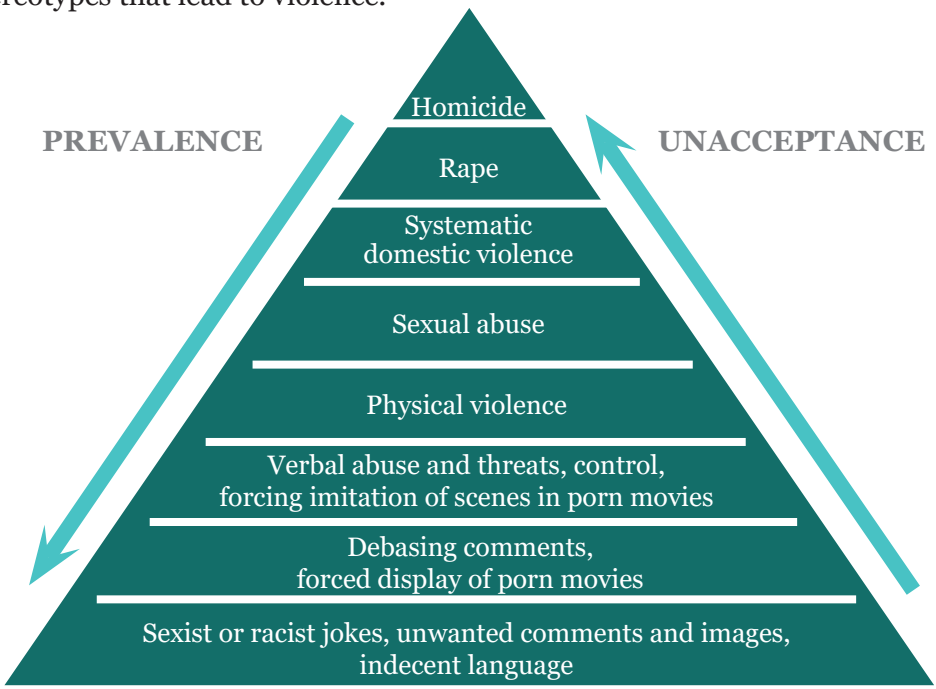


FIGURE 12. Pyramid of violence

At the bottom of pyramid are the phenomena seen as innocent, but at its top - socially deviant phenomena. When increasing the severity of the phenomena, their prevalence reduces and the society's intolerance towards it increases. Thus, this pyramid is a pattern of violence perpetuation - higher levels display less socially accepted behaviours.

Violence begins with established attitudes and prejudices about other people, no matter if these are justified or not. Gender-based violence is caused by sexist attitudes and stereotypes, including about gender roles, and these, at their turn, are the outcome of sexist language, comments and jokes. Unfortunately, the society accepts them without being aware that these attitudes shape the gender stereotypes and lead to control, abuse and violence. As abusers express these attitudes and enjoy the support of others, they reinforce their persuasion that certain kinds of people are not equal with them and move to higher levels of the pyramid. Soon, the people who share biases and stereotypes begin to verbally express their superiority, discriminate and harass others both verbally

and physically. As abusers go up the pyramid, they feed themselves with the acquired power and deem that they have the right to use their power for controlling the people that are not equal to them. For the same reason, they think that the victim did something to deserve the attack and do not have the capacity to recognize their actions as deviant.

The pattern of the pyramid of violence shows where and how the violence begins; hence we can use it to see how to stop the violence. Many of the phenomena which the society considers unavoidable are, actually, the expression of some values and attitudes able to evolve in time and space.

Sexism and sexist language

Sexism is a form of sex discrimination manifested through behaviour, attitude or conditions about a gender or sex as inferior, or less competent, less valuable than the other gender or sex, or which makes use of prejudices and stereotypes in the misrepresentation of the woman and man image, or of the social aspect of relationships between women and men, or of the masculinity and femininity. The explanatory dictionary of the Romanian Language defines sexism as sexual discrimination which works, as a rule, to the detriment of women and in favour of men. The sexism is consolidated via gender stereotypes, affecting both women and men and making it impossible to express gender equality.

Admitting the value of sexist language as a cause of promoting inequality between women and men and gender-based violence, Law No 5/2006 on Equal Opportunities between Women and Men forbids such a language. The law defines sexist language as expressions and addresses that present a woman and a man in a humiliating, degrading and violent manner, offending their dignity.

Unfortunately, the sexist language is still widespread in the society and can be noticed in various social areas, including in the media that also participates in shaping the society's perception of women and men, promoting inequality through this language. For example, the news from on-line media with the title *'NAC takes out its heavy artillery! Starting with today a young lady will fight corruption'* (published in 2018) rendered a sexist message, arousing a wave of criticism. In this regard, the media education portal *Mediacritica* commented that the news author kept the expression 'young lady', which has a minor informational value, but conveys a sign that the journalist prefers to emphasize the woman's age and marital status, to the detriment of her professional qualities. Besides this, the expressions 'NAC takes out its heavy artillery' and 'a young lady will fight corruption' is based on undue contrast between the stereotype of

female fragility and tough working conditions in the law enforcement bodies. Both the ostentatious highlighting of woman's stereotyped features and emphasizing the contrasts imply that this comes as an exception, which only feeds the gender stereotypes[47]. According to Law No 1227/1997 on Advertising, the sexist advertising is regarded as an amoral advertising and is prohibited. For the purpose of this law, an advertising is sexist if it portrays a woman or a man as a sexual object, in humiliating or degrading, violent situations that offend the human dignity or promote sexist stereotypes for discriminatory purposes, maintaining a traditional perception of the woman as a weak, vulnerable, and dependant, being of an inferior social position.

The Contraventional Code penalises sexist advertising with a fine of 18 to 90 c.u. applied to the individual, a fine of 120 to 240 c.u. applied to the individual in position of accountability, with a fine of 240 to 300 contraventional units applied to the legal entity.

The use of sexist language is fought not only by punishing legal entities, but also through various campaigns, also those promoting gender equality and non-discrimination.

The Republic of Moldova also has a Council for Preventing and Eliminating Discrimination and Ensuring Equality (http://egalitate.md/), which is a public authority with the mission of preventing and protecting against discrimination, ensuring equality, promoting equal opportunities and diversity.

Toxic masculinity and violence

Masculinity is a social construct that embraces a set of expectations or social standards related to how men should think and act. Though many men often cannot achieve or observe the respective standards, they feel the society's pressure and tend to obey. Masculinity comprises the autonomy, dominance and control, aggressiveness and toughness, risk taking, suppression of emotions, hypersexuality and heterosexuality. The extreme forms of masculinity represent a toxic masculinity that boosts the inequality and gender violence. The toxic masculinity can create and justify the men's perception of having privilege and power over women. The toxic masculinity promotes a pattern of behaviour strongly tied to the traditional stereotypes that portray men as socially dominant and 'normalises' the violence as a way of social communication. The rigid ideas of masculinity do not allow men much space for being who they really are or how they truly feel.

[47] http://mediacritica.md/ro/domnisoara-si-artileria-grea-cum-alimenteaza-presa-stereotipuri-de-gen/

Men that develop a rigorous attachment towards 'toxic masculinity norms' are more prone to prove sexist attitudes and behaviours, to apply violence and sexual harassment against women, especially when their masculinity is defied or when they meet difficulties in aligning to these norms. Because of the social expectations these men adapt only to masculinity values and norms and avoid other behaviours considered feminine. These damaging norms limit men's potential to have a caring attitude towards other family members as affectionate fathers, husbands, sons or brothers. At the same time, these can influence the way in which men behave among themselves, the sexist, homophobic, aggressive behaviours being used to assert their masculinity.

Aggressiveness and violence are strongly associated with toxic masculinity. This link is often supported and justified by the society, glorified in the popular culture, celebrated in some sports or spread by the belief that men's aggression is just the way they are.

Men that resort to the toxic masculinity patterns are subjected to some bigger risks of health, being pressured to conform to them. There is a high rate of depressions and suicide among these men, they are more prone to engage themselves in risky behaviours, such as dangerous driving, consumption of toxic substances. Also, these men rarely tend to ask for help, and when it is given to them, they are more likely to reject it.

Therefore, the toxic masculinity can make men to commit violence acts against women, other men and themselves.

The toxic masculinity can be fought by breaking its patterns and promoting positive masculinity. In this sense, it is important to understand that the men and women cannot be restricted to certain rigid gender boxes and the gender roles can change.

TOPIC 4

Sexual violence. Consent for sexual intercourse

Sexual violence implies any sexual contact without the partner's consent or with regards to which the partner cannot express a valid consent. Thus, sexual violence is an abuse in which the sexual intercourse is unwanted, accomplished by force, threat, constraint and/or taking advantage of victim's inability to protect him/herself or express his/her will and is based on the lack of consent or vitiated consent. So, the key element that differentiates a lawful sexual intercourse from an abuse (illegal act) is the mutual and valid agreement of both partners involved in the respective sexual intercourse.

Consent for sexual intercourse

A consent assumes that both partners are entirely aware of what is happening or what is about to happen and mutually want the intercourse, any of them may refuse and none of them is forced to do anything against his/her will. The abusive behaviour violates the sexual freedom and inviolability of the individual and implies forcing the partner to have sex, which can be accomplished in multiple ways, as well as through taking advantage of the state of impossibility to defend or express the will. The physical constraint manifests itself through the hitting the victim, tying, fixing to certain immovable objects by handcuffing, violent undressing of the genitals and putting the victim's body in a certain position, twisting the hands, forced holding in a locked room, etc. The psychological constraint has more forms: threatening of victim with physical violence or his/her death or that of his/her relatives, taking advantage of position or authority (employer, professor, trainer). It is essential when the victim perceives the threat as real, implying, in fact, psychological pressure over the victim for suppression of his/her will. The threat can be expressed verbally, through special gestures, showing off a gun, handcuffs, rope or other objects that would scare the victim. The impossibility of defending implies physical incapacity to withstand against perpetrator because of the physical disabilities, fatigue, an uncomfortable position in which the victim was caught, etc. The impossibility to express his/her will implies a psychophysiological condition that deprives the victim of the ability to be aware of what is happening with him/her or to express

the will due to the young age, mental disorders, excessive drunkenness, coma etc. The impossibility of defending or expressing his/her will can be temporary or permanent.

The Universal Declaration of Fundamental Human Rights and Freedoms accords to all people the right to life, freedom and security, right inherent to the sexual domain, as well. The personal freedom also refers to the right of each individual to decisional autonomy, which is manifested either by consent or by rejection. Consent means offering permission and accepting something, being aware of the decision's impact. Any sexual intercourse can be accomplished only if both partners want it, the consent being a expression of a conscious and positive decision to engage in sexual activity. This statement is valid for married couples or couples living in similar arrangements, so that there is no obligation to do something against the will in a relationship, and the fact that the partners have an intercourse does not represent an obligation for victim. At the same time, sexual violence is determined by the perpetrator's acts, but not by his/her and the victim's status. In this regard, the Criminal Code of the Republic of Moldova incriminates marital rape, i.e. the sexual violence committed over a family member (Article171(2)(b^2)).

For offering a valid consent, the partner must have the possibility to make a conscious and freewill decision. Istanbul Convention (2011) underlines that a consent has to be offered willingly, as an outcome of the individual's free will, assessed in the context of the surrounding circumstances. The alcoholic or narcotic intoxication, as well as any situation that leads to dizziness or loss of consciousness (coma, narcosis) can affect a person's capacity to make decisions and, thus, to give consent for engaging in a sexual activity. Due to the age peculiarities, minors do not have the capacity to give a valid consent for a sexual intercourse. For this reason, any sexual intercourse with a minor will be considered an offence even though there is consent. The age at which the minor is allowed to give a consent for a sexual intercourse may vary from country to country. For example, in the Republic of Moldova the age for consent is 16 years old, in the most European countries it varies between 14 and 16 years old (ex.: Romania, France – 15 years old), though in some of them it goes up to 17-18 years old (Cyprus, Ireland). People with mental disorders are also vulnerable due to their mental health condition, they cannot give a valid consent. Hence, a person's consent can be vitiated by age under 16 years old, by mental disorders with decreasing or losing the ability to think, and by states that affect the consciousness, and any sex act related to such a consent is a sexual abuse and an offence on sexual life.

The consent is a precondition for every sexual intercourse. Even if the partners agreed in the past to have an intercourse, it does not mean at all that they have automatically accepted to do it again. Furthermore, each partner is free to withdraw his/her consent any time and this decision must be respected by the other partner.

SILENCE DOES NOT REPLACE CONSENT AND DOES NOT MEAN OFFERING CONSENT!

Thus, a valid consent for a sexual intercourse must meet the following dimensions: voluntary (freely expressed), conscious, revocable.

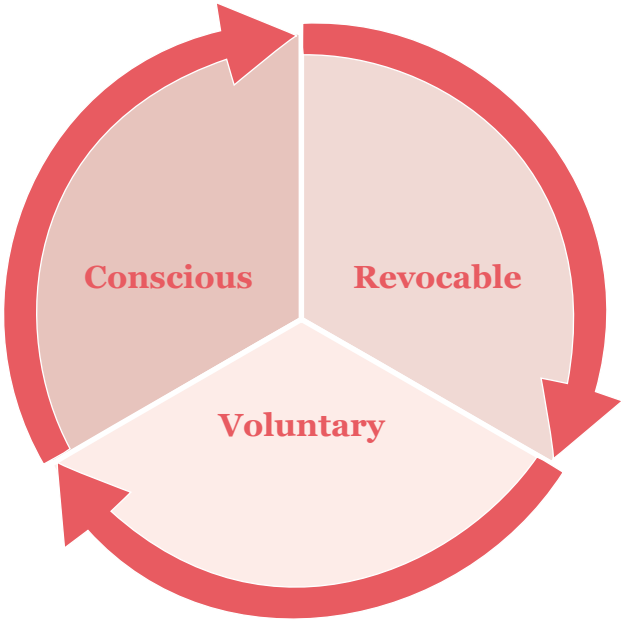
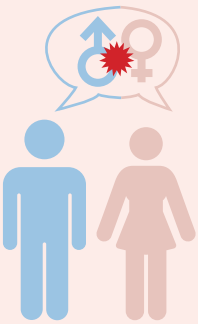


FIGURE 13. Dimensions of the consent for a sexual intercourse

Consent is a manifestation of mutual respect between partners and has to become a necessary part of the communication culture (***the culture of consent***) between partners that engage in a sexual intercourse. Any intercourse that does not observe this desideratum is an illegal act and part of the culture of rape. The effects of the ***culture of rape*** are ravaging for society, justifying the sexual violence and perpetuating it. The consequences of the culture of rape

are experienced by the victims of sexual abuse as well, being considered by the society and untrained professionals as responsible for the abuse. So, the liability for sexual abuse is thrown on victims instead of abusers. The impact of the culture of rape on the society's believes is clearly depicted in the survey *'Men and Gender Equality in the Republic of Moldova'* (2015).



Attitude towards rape

42,2%	**26,1%**	If a woman is raped, it means she did something to get into this situation.
45,8%	**27,7%**	In some cases of rape, woman also wanted to be raped.
58,0%	**44,6%**	If a woman does not put any physical resistance when raped, then we cannot say that this action was a rape.
34,4%	**31,8%**	When a victim of rape has a bad reputation, then it is considered that she was not raped.

FIGURE 14. 'Men and Gender Equality in the Republic of Moldova' survey

The issue of freely expressed sexual consent becomes a more actual topic in the European countries. So, more countries like United Kingdom, Ireland, Luxembourg, Germany, Sweden, Cyprus, Spain and Ukraine adopted the so-called *Law of consent*, which emphasizes that a sexual intercourse must be voluntary, and any intercourse without consent is, in fact, a rape. The law is meant to establish the consent and provides that, if an individual is willing to have sex with someone who is inactive or gives ambiguous signs, it will be needed to ask the other individual if he/she wants it. Now, in the Republic of Moldova, the legal liability for a sexual abuse occurs when the abuser physically or psychologically constrained the victim, or took advantage of his/her state of helplessness. But, if the victim did not physically withstand or did not say 'no', the sexual abuse is excluded.

Signs of free expression of consent, hesitation and refusal

As giving consent to an act of sexual nature is the condition that separates a consensual intercourse from an abuse, it is important to know the way the partners could express it. While communicating partners send various ***verbal*** and ***non-verbal signals***, which are hints expressing ***consent***, ***refusal*** or ***hesitation***. Verbal communication and reading the partner's body language makes it possible to have consensual sex and avoid a non-consensual intercourse, i.e. an abuse.

Verbal communication is an important way of expressing partners' feelings and willingness. This does not have to be necessarily embarrassing, but rather the other way around – it could be part of foreplay. Obviously verbal communication takes mainly the form of questions, such as: *What would you like us to do now? Would you like us to continue in the bedroom? Would you like to show me your bedroom? Would you like to help me take my clothes off? Would you like me to take your top off? Where would you like me to touch you? Do you like it? Do you feel good? Do you think we could continue? Do you think we're rushing things?*

Non-verbal communication can also express the wishes of a person and can show if a person wants to engage in a sexual relationship, if he/she looks happy, responds to partner's actions or the opposite – he/she feels uncomfortable, looks scared and petrified. Every partner must be aware of the way the other partner feels and, in turn, send him/her signals of how they feel.

Thus, ***the consent is about visual observation, listening and verbal communication!***

Although a valid consent can be expressed verbally or non-verbally, the body language is not enough for an agreement, because the non-verbal behaviour can be misinterpreted, which in an intercourse represents the risk of deviation into abuse and illegality. The best approach implies clear verbal communication (for ensuring consent), supplemented with non-verbal behaviour.

In the communication process the partners could answer through confirmation signs, refusal or hesitation for sexual intercourse and these signs must be recognised to insure a fully agreed act. The confirmation signs are a consent expression and allow the further involvement in sexual intercourse. But, offering the consent for a sexual act does not automatically assume its offering for any sexual activity. For this reason, it is important for partners to mutually express the consent for all sexual activities they engage. The consent must be expressed including for the use of means to prevent the sexually transmitted infections and unwanted pregnancies. The hesitation signs show a confusion state and the

indecision of the partner, which has to be respected by the other partner. The refusal signs signify the rejection by a partner to initiate a sexual intercourse, a choice which, as well, has to be respected as a part of decisional autonomy. The refusal can be determined by different factors and can be temporary or permanent. The hesitation and refusal refer to advancement in the sexual intercourse, certain sexual practices or even the entire sexual act. So, ***the sexual intercourse can take place only if both partners exchange consent signs and cannot be accomplished if at least a partner expresses hesitation signs or especially refusal***.

TABLE 6 Actions of sexual partners depending on transmitted signals

Valid consent – act	**Continue and communicate**
• partners have expressed their consent for the sexual intercourse • the consent is not affected by age, mental abilities and consciousness	• you and your partner have reached a mutual decision about how far you want to go • both you and your partner are comfortable about the situation you are in • both you and your partner are sure you can stop any time
Take a break and discuss	**You have to stop**
• you are not sure about the partner's wishes • you get ambiguous signals from your partner • the partner does not know or understand your intentions • the partner stops or is not responsive	• the partner hesitates or refuses the sexual intercourse • the partner's consciousness is affected by states of intoxication or other states • the partner is asleep or passed out • you and your partner are younger than the age of consent

According to the 2018-2023 National Strategy on Preventing and Combating Violence Against Women and Domestic Violence, out of spectrum of crimes related to violence against women, which are found in the Istanbul Convention, the Republic of Moldova has included only rape. Statistics show an increase in the number of rapes among sexual crimes – from 215 cases in 2000 to 352 cases in 2014. The number of cases of rape reported per 100 000 people reveals the same increasing trend from 6 cases in 2000 to 10 cases in 2014. According to the National Bureau of Statistics, this incidence is maintained in the following

years, even with a slow increasing trend, especially of the total number of sexual offences. At the same time, the statistical data from the Ministry of Internal Affairs are alarming, with a constant increase of sexual offences in family environment in the last years.

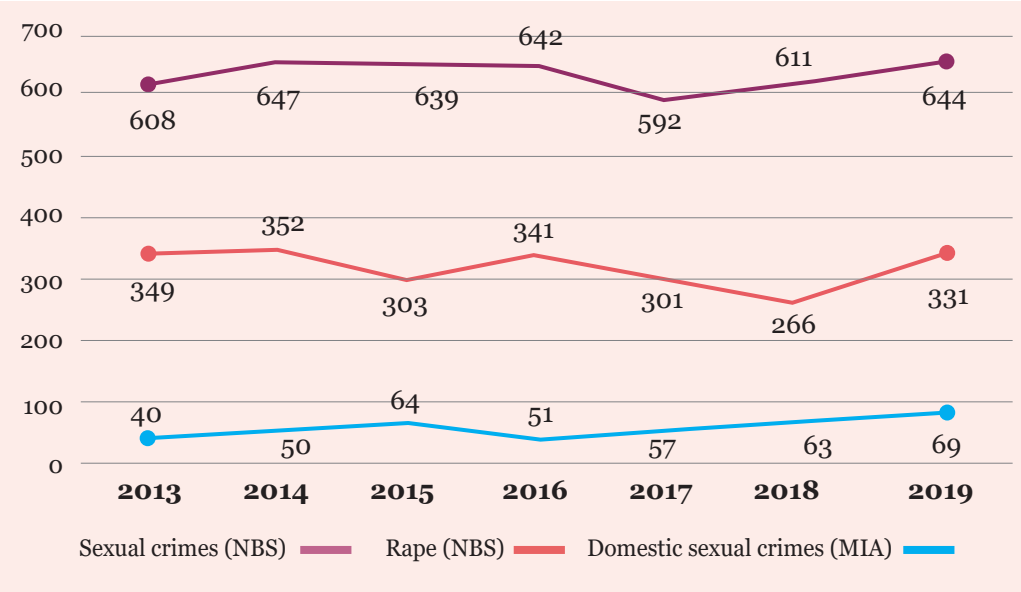


FIGURE 15. Dynamics of sexual crimes, including in family (absolute figures)

Forensic medical examination of sexual offences

Forensic medical examination is one of the important evidence recognised by the Criminal Procedure Code (Article 93) in investigating different offences regarding the citizen's health, bodily integrity and life, including those concerning sexual life. According to the same Code (Article 143), forensic medical examination is mandatory in cases of sexual violence. Meanwhile, forensic medical examination is also an important instrument in cases of disputable sexual states, like: sex of the person, sexual maturity, virginity, reproductive ability, conception date, pregnancy, abortion, birth, infection with sexually transmitted diseases. The need for the resolution of disputable sexual states is required by the investigation of different offences like sexual-related ones, abortion, infanticide, bodily injury and other conditions (intersex, infertility, etc.).

Nonetheless, forensic medical examination in sexually-related cases, is required more often for sexual offences, the victim and the perpetrator being subjected to the investigation. The objectives of the forensic medical examination

in sexual offences are related to the identification of physical signs of the sexual intercourse (vaginal, oral or anal penetration), identification of injuries on the victim's body viewed as signs of physical or mental constraint, and on the perpetrator's body as signs of self-defence of the victim. Assessment of evidence, proving an act of sexual violence and legal classification of the perpetrator's actions under the provisions of the Criminal Code falls within the competence of criminal prosecution bodies and court.

Forensic medical examination in cases of sexual violence shall be performed according to certain principles deriving from the specific of this form of violence. One of these is the principle of promptness, presuming that any unjustified delay of the forensic medical examination compromises the obtaining of medical evidence and biological samples. In cases of sexual violence, it is important to examine both partners so that the signs of penetration and other evidence may be found to both of them. Moreover, biological samples found on the victim's and perpetrator's bodies allow to establish the connection between them, which serves as important legal evidence. All sexual violence cases have to be comprehensively addressed, taking into account the victim's needs, particularly those related to health. Besides, the World Health Organization underlines in the *'Guidelines for medico-legal care for victims of sexual violence'* (2003) that the victim's medical needs (treatment of injuries, emergency contraception, management of STIs) prevail on other needs (forensic, legal). For this reason, forensic medical examination is less important (than the medical needs) and can be performed only if there is no medical emergency and the victim does not need immediate medical care. Therefore, if during the forensic examination a situation arises that requires the provision of medical assistance (including emergency), the forensic staff must request emergency medical assistance (112) and provide medical assistance until the arrival of the ambulance. The forensic examination of the victim of sexual violence must be carried out simultaneously with the medical examination performed by the gynaecologist and other specialists, depending on the health needs of the victim, in a manner that minimizes the number of examinations and interviews.

Given that sexual abuses do not allow delays, these are viewed as forensic emergencies, and, according to the Regulation of Forensic Medicine Center, shall be examined 24 hours/7 days a week.

Forensic examination of the victim of sexual violence shall be carried out within health care facilities, in warm premises with sufficient combined lightening (natural and artificial), by the gynaecologist together with the forensic examiner. The health staff shall be rather of the same sex as the victim.

The forensic medical examination of the victim shall be carried out in compliance with medical ethics, on the basis of consent and by applying lawful methods of examination. During the examination it is not allowed to apply research methods accompanied by strong sensations of pain, which may have negative effects on health, as well as those prohibited in the medical practice. It is prohibited to use violence, threatening, deceit or other illegal methods aiming to obtain information from an examined person.

Examination of a living person shall be conducted only with his/her free consent, except for cases where examination is mandatory under procedural legislation. Within the judicial proceedings, the person to be examined shall provide a written consent to the person requesting the examination. Apart from court proceedings, the person's consent is expressed once the extrajudicial examination request has been completed and submitted in the format approved by the Center of Forensic Medicine. If the person to be examined is under 16 years of age or he/she is subject to a legal protection measure, his/her consent shall be drawn up by his/her legal representative. The suspect, accused, defendant, person towards whom medical coercive measures are applied may be subjected to examination in a coercive manner, according to the provisions of the Criminal Procedure Code.

During the forensic examination it is allowed to take samples needed for conducting the investigation, from the person examined. Samples may be taken by the medical examiner or another professional in the presence of the medical examiner. Sampling is documented in the forensic examination report. It is prohibited to take samples forcibly from people subjected to volunteer examination. Examination of the genital and perianal region, collection of biological samples and photographic documentation of lesions and other changes can occur only when the medical examiner has obtained informed consent from the person examined or his/her legal representative and form approved by Center of Forensic Medicine has been completed.

The forensic examination may be assisted by people entitled by the procedure laws. Presence of other people is allowed only with the consent of the person examined and with the written consent of the person who requested the examination. The examination of the minor is assisted by his/her legal representative and/or defender. The person who is subjected to a legal protective measure may independently give consent for his/her examination. In this case, there is no need for the consent of provisional guardian or tutor or his/her representation by the tutor. The consent of the person to be examined may, also, be given on behalf of this person by the authorised representative via a further protective

measure, if the mandate allows it. It is prohibited to examine a person subjected to a legal protective measure if the examination is contrary to his/her will. The identification of the protected person's desires must be assisted by a trustee who shall facilitate the establishment of these desires. The trustee may be any person voluntarily elected by the person suffering of mental disorders. Failing to choose, the trustee shall be appointed by the local guardianship authority. If the person's examination implies undressing, only people of the same sex may be present during the forensic examination (this restriction does not apply to medical staff).

The forensic medical examination of the victim is carried out on the basis of the algorithm stipulated by the Standard Methodology for Forensic Medical Examination of Persons:

1. Establish the identity of the victim and explaining the examination procedure;
2. Review the submitted documents:
   - *the order requesting forensic examination or the request for extra-judicial examination;*
   - *medical documents in original (in case of requesting health care assistance before the forensic medical examination).*
3. Develop the action plan
4. Conduct forensic medical examination of the victim:
   - *collect the medical history (including the special one);*
   - *collect the charges;*
   - *perform the examination itself;*
   - *take photographs for legal purposes;*
   - *take samples and request complementary forensic investigations.*
5. Interpret the complementary investigation results and correlating them with the changes identified during the victim's examination;
6. Draft the research results (Judicial Examination Report/Extra-judicial Examination Report).

Forensic medical examination starts with the ***identification of the victim*** based on the identity card or birth certificate, or any other valid official document (e.g.: passport). Following the person's identification, the medical examiner has to be present and inform about his role in the forensic examination, the importance, objectives and the (step-by-step) procedure for its performance.

Instruments or equipment used during the forensic examination have to be shown to the person examined, while explaining the purpose and the way they have to be used. If the victim has questions about the following procedures, these one shall be explained to him/her. The victim shall be informed that he/she is controlling the rhythm, length and components of the examination and that he/she can refuse any stage of the examination at any moment of it. The medical examiner shall inform the person examined about medical examiner's duty to report the case to the police.

The forensic examination itself starts with ***collecting the medical history*** (circumstances of the case) that has to be detailed and consecutive. During discussions, visual contact has to be maintained, if appropriate from cultural point of view. The interview shall not be hurried, the victim dictates its rhythm. The victims may encounter difficulties in describing certain more painful or traumatic details (e.g.: oral or anal penetration) and avoid to mention them. Nonetheless, the medical history is important for identifying potential injuries, and in the cases of sexual violence and for evaluating the risk of pregnancy, STIs or HIV and victim's referral. Medical tools used in the forensic examination shall be prepared prior to the victim's arrival, and covered during the interview. Discussion during examination shall be relevant to the case of abuse. The victim shall be allowed to independently narrate the events and only after that may open-ended specifying questions be addressed. Listening is the key element for an effective communication and it is important for psychological recovery.

During the interview, the medical examiner has to show respect and empathy, observing all ethical principles in all cases. Neglecting, rude or blaming attitude while communicating with the victim may re-traumatise him/her, especially victims of sexual violence and torture. Collecting medical history shall not be similar to an interrogation. Narration of facts shall be free, avoiding any leading questions, expressing doubts concerning the circumstances described, criticism, and particularly, disputes with the person examined based on the circumstances of the case or on contradictory information. On the contrary, it is critical to validate the victim's emotions for his/her psychological recovery.

Collecting the medical history of children has certain specificities related to age peculiarities.

BOX 1 Collecting the medical history of children

- all children have to be addressed in a sensitive manner given their vulnerability
- the level of development has to be established in order to understand the age restrictions – young children do not have the sense of time and can use certain terms differently than adults, which makes it difficult to interpret the narration.
- the medical examiner shall appear to the child as a person aiming to help
- the first name shall be used as the child prefers (e.g.: Ionuț, Geta)
- first, they have to ask children if they know that they are at the doctor
- in order to establish contact, the interview should started with general questions (in what grade they study, how many brothers/sisters they have)
- children should to narrate the incident using their own words
- children, particularly, teenagers may feel embarrassed by the discussions on sexual topics
- encouraging the child to ask questions facilitates the communication
- young children may answer to questions in written, by drawings or pictures
- circumstances related by minors shall be appreciated critically

The medical history guides the medical examiner towards obtaining certain incontestable evidence and identifying the traumas. This is why it has to reflect all circumstances of the abuse:

- time, place (including the nature of the surface on which the abuse was committed;
- the number of perpetrators and data on their identity (including last and first name, if known);
- people present at the moment of the incident;
- in case of recurrent abuse, when it has started, when it has happened before, under what conditions, how often;
- the way of inflicting traumas (traumatic objects used and their features, the way of applying the trauma, injured regions of the body);

- the victim's sensations (what he/she has heard, seen or smelled) in some situations (e.g.: blindfolded/ with a hood on his head) may be the only information;
- the symptoms occurred and their development (loss of consciousness and its duration, their own sensations, sensual disorders, limited movements, appearance of haemorrhages, etc.);
- provided health care (when, in what health care facility), consultations (doctor's specialty, date of the request, measures undertaken and volume of health care), as well as performed medical investigations (clinical consultations and complementary investigations (instrumental/laboratory).

The medical history of sexual violence has to include additional information determined by the specific of the abuse:

- how the victim was undressed (who and how);
- nature and description of the sexual abuse;
- type of penetration (vaginal, oral, anal) and means used (penis, fingers, objects);
- the fact and place of ejaculation (cavity of the victim's body, the victim's body, objects on the site);
- what happened with the condom after the incident, if it was used when committing the abuse;
- contact of the perpetrator's mouth with certain parts of the victim's body;
- forced contact of the victim's mouth with certain parts of the perpetrator's body;
- is the victim has bathed, urinated, defecated, vomited, used a vaginal douche or changed her clothes after the incident;
- type of toxic substances used and their quantity if the sexual abuse was committed by taking advantage of the victim's impossibility to express his/her will, determined by the alcoholic or narcotic intoxication.

Additional information indicated in the general medical history of the sexual abuse are useful for orienting the medical examiner, explaining certain findings and orienting the performance of biological sampling needed for substantiating the circumstances.

Note that victims of sexual violence may encounter difficulties in the chronological reproduction of events, which shall not be regarded as a lie. This situation is a neurophysiologic reaction to the trauma experienced – the victim can

describe the event better if he/she has slept, and most of details he/she can communicate 72 hours after the traumatic event.

Symptoms are a part of the forensic examination and are registered from the words of the victim without interpreting or commenting on them. Symptoms have to be precise and detailed, mentioning for each of them the moment and the consecutiveness of their occurrence, frequency, duration, intensity of expression, etc. In the case of older traumas, chronic symptoms and their development have to be mentioned. No abstract symptoms, like 'pain in the area of the injuries', are allowed.

Cases of sexual violence require, along with the overall medical history of the abuse, to collect the ***special medical (sexual) history***.

In the case of female victims, the following information shall be collected:

- the age when the first menstruation occurred;
- the nature of the period: abundance, pains, duration of the menstrual cycle in days, duration of the period in days, the first day of the period;
- previous sexual experience and the age when it has begun, date of the last consensual sexual intercourse, with or without condom, with ejaculation in cavities or without it;
- occurrence and number of pregnancies, abortions, births, evolution of pregnancies;
- existence and nature of vaginal discharge;
- use of contraceptives and their type;
- existence of sexually transmitted infections (Gonorrhoea, Syphilis, Chlamydia, Genital Herpes, Trichomoniasis, Mycoplasmosis, genital warts, HIV, etc.);
- viral hepatitis experienced.

In the case of male victims and perpetrators, the following information shall be collected:

- previous sexual experience and the age when it has begun, date of the last consensual sexual intercourse;
- existence and nature of the urethral discharge;
- existence of sexually transmitted infections (Gonorrhoea, Syphilis, Chlamydia, Genital Herpes, Trichomoniasis, Mycoplasmosis, genital warts, HIV, etc.);
- viral hepatitis experienced.

The forensic medical examination of the victim is performed to detect lesions and other evidence in order to confirm/deny the victim's allegations and solve the objectives of the examination. For these reasons, the forensic examination should be complete (all anatomical regions of the body), detailed, consecutive and systematic, in craniocaudal direction, anteroposterior and from right to left. If it is necessary to undress for the examination, the victim must not be undressed completely, clothes must be removed gradually (upper body apart from lower body) to avoid the feeling of exposure. To ensure victim's dignity, he/she must be allowed to undress alone and without hurrying, and can be helped only at her/his request or in the case of young children. It is advisable to provide a robe during the examination. The forensic medical examination is performed according to the clinical examination methods of the patient: inspection, palpation, percussion, morphometry, anthropometry and can take place both macroscopically and with the use of a magnifying glass to identify details. The examination begins with general information about the examined person (general health, position (active, passive, forced), body type, nutritional status, skin and mucous membranes colour and condition) and continues with the detailed examination of the head, neck, chest, abdomen, back, upper and lower limbs, genitals and perianal region.

The general information about the examined person is supplemented with anthropometric data: weight, waist, chest expansion measurement, pelvic measurements.

After general data, ***secondary sexual characteristics*** are examined and recorded, adipose tissue deposition, the characteristics and degree of axillary/pubic hair, and in females – mammary glands development (shape, size, consistency, colour of the mammary areolas, shape of nipples, nipple discharge).

A particular attention is drawn to the examination of concealed anatomical regions (armpits) and skin folds. In sexual violence cases, the lesions can be found on the face, neck, mammary glands, genitals, inner surface of the thighs and legs.

The bodily injuries are examined in the same time with the anatomical regions and are described according to the scheme:

- ***location of the injury*** (the anatomical region and its surface, distance from the landmarks in centimetres);
- ***height of injury*** (from the floor to the lower part of the injury caused by firearms);
- ***type of injury*** (bruise, excoriation (abrasion), wound, fracture, etc.);

- ***shape of injury*** (will be compared with geometric figures, if the shape cannot be compared, irregular shape is indicated);
- ***position of the injury towards the midline of the body*** (organ, bone);
- ***injury dimensions*** (length, width and depth) in centimetres
- ***colour of the injury and adjacent areas;***
- ***characteristics of the injury surface*** (relief, colour);
- ***the characteristics of the margins, ends, walls and bottom of the wounds;***
- ***the presence of heterogeneous deposits or impurities*** (inside or around it);
- ***the condition of adjacent tissues;***
- ***the presence or absence of haemorrhage*** in the damaged tissues and other signs that reflect the vitality of the injury;
- ***the signs of injury regeneration.***

In order to identify the object which caused trauma, will be indicated the lesional characteristics that reflect the shape, nature and other construction specifications of the object.

Genital-anal examination consists of the examination of the external genitalia and the anus with the perianal region and has certain characteristics depending on the age and sex of the victim. In young children, both genital and anal examination should be performed in any case of sexual abuse, and in minors and adults, the need for genital and/or anal examination is determined by the circumstances of the individual case (e.g. if the victim describes only oral penetration, there is usually no indication for genital-anal examination) provided there is a clear history of sexual violence, penetration and the type of penetration is defined. This examination in female victims usually takes place in supine position on the gynaecological chair, but can also be performed in children regardless of their gender and in the elbow-knee position on a bench. However, in case of children, this can be a traumatic position if the sexual abuse took place in the same way. That is why, it is important to clarify the position in which sexual abuse took place, while taking the medical history, to avoid it during the genital-anal examination. As an alternative, the child may be examined in supine position with the legs bent and flopped apart or with the knees pulled towards the chest or in the lateral position.

The condition of the external genitalia in girls and women focuses on the correct development of the genital labia (majora and minora) and clitoris (shapes, sizes, anatomical position, closure of the vaginal opening by the labia majora), the condition and colour of the vulval vestibular mucosa, the presence of infection signs, vaginal discharge (colour, density, quantity). In order to examine the external genitalia and the hymen, the medical examiner will grab between the thumb and forefinger the both labia majora and minora and will pull gently towards himself/herself, up and sideways. If any bright blood or traces of bleeding is present, its origin should be established. The lesions are found more frequently in the region of vestibular fossa.

The condition of the hymen involves the examination and recording of its anatomical features: hymen shape (annular, crescentic, labial, septate, lobed, etc.), height in the anterior/posterior/lateral parts, hymen thickness and consistency, hymen elasticity, shape and diameter (including extension) of the hymenal opening, the presence of the contraction ring, the characteristics of the rim (thin, thickened, fringed, etc.), the presence, location and the characteristics (colour and density of the rims, depth, bottom shape) of natural notches, arrangement symmetry and their correlation with longitudinal vaginal folds. In case of raptured hymen, will be examined and described the number of ruptures, location, shape of the rupture and its bottom, the characteristics of the rims (presence/absence of haemorrhage, edema, tenderness, granulation, scarring; colour of the rims in relation to the intact surface of the hymen, density), depth. Other hymenal lesions (bruises, excoriations) are recorded according to the general description of bodily injuries. The location of the lesions, ruptures and natural notches of the hymen are specified clockwise. If no lesions are detected, attention is drawn to the morphological features of the hymen, which would allow or exclude a complete sexual intercourse without damaging it.

Attention, digital or bimanual examination, vaginal speculum are not used in the examination of children of prepubertal age unless there are medical indications (vaginal lesions, internal bleeding)! Vaginal speculum can be used in minors and adult women, and it should be moistened only with saline or distilled water. Speculum can be used only after the vaginal specimens have been collected.

The condition of the external genitalia in boys and men cincludes the examination of penis and scrotum. The condition of the penis includes the correct anatomical development, the presence or absence of abnormalities, the colour and condition of the skin and mucous membranes, the consistency and

size of the penis (length along the dorsal surface from the root of the penis (pubic symphysis) to the tip of the glans and the widest part of the glans) in a relaxed state, the presence and mobility of the foreskin (covering the penis glans and exposing it), the condition of the frenulum of penis, the location of the urethral meatus (external orifice) on the glans penis and the presence or absence of discharge, or of the foreign bodies. The condition of the scrotum provides for the recording of its symmetry and dimensions (ordinary, reduced, enlarged), the condition (folded, extended), the consistency and colour of the skin of the scrotum; the presence and location of the testicles, the dimensions (length, width, thickness), elasticity (soft, soft-elastic, elastic), the characteristics of the surface (smooth, irregular), the presence or absence of the algic syndrome on palpation and bilateral cremasteric reflex. Note that testicular torsion is an emergency and requires immediate surgical intervention.

The condition of the anus and perianal region sfocuses on the shape, tone and dilation of the anus, the colour of the mucosa, the condition of rectal folds (not noticible, pronounced), the presence of anal and rectal mucosa lesions (bruises, excoriations, fissures, wounds), the presence of bleeding or its traces. The morphological characteristics of the identified lesions are described according to the general examination and description of the lesions. The location of the anus lesions is reflected clockwise. In case of children, the digital rectal examination is recommended only if the presence of foreign bodies in the rectum is suspected because it can imitate the abuse itself and re-traumatize the child. This examination can be performed when the sphincter is relaxed, which is achieved by placing the examining finger on the perianal tissues. In cases of severe anal and rectal pain, bleeding or inserted foreign bodies, it is necessary to perform a proctoscopy.

If during the examination of the genital-anal region are detected impurities (grass blades, textile threads, etc.) or loose hairs (especially in children without pubic hair or in minors with shaved hair) they should be described, and the hairs are collected for biological analysis to identify their source. In case of pubic hair, it can be combed to remove all loose hairs.

The main objective in cases of sexual violence is to identify the signs of sexual abuse, especially the evidence of sexual contact and intercourse. By sexual intercourse, in forensic medicine is meant the introduction of the penis into the vagina or vaginal vestibule, even if the introduction was not associated with defloration or ejaculation. Therefore, the sexual intercourse does not mean the contact of the genitals, but a vaginal penetration must take place. In case of a perverse sexual intercourse, an oral or anal penetration takes place. Signs of

sexual intercourse can be identified immediately after the act (recent signs), as well as after a certain time after the act (late signs).

Vaginal penetration can be proven at early stages by hymen ruptures in virgin women, hymen or vaginal mucosa/wall lesions (bruises, excoriations, lacerations), the presence of seminal fluid in the genitals and indirectly by the presence of perpetrator's pubic hair. At late stages, sexually transmitted infections and pregnancy can advocate for vaginal penetration. These signs are important both to prove the intercourse and to indicate the approximate time when it occurred. It is worth mentioning that recent signs of the intercourse can be seen a limited time. Thus, hymenal ruptures heal by scarring within 10-14 days, a process that may be extended up to 20 days due to acute inflammation or infectious complications. Note that the hymen may remain intact even after sexual intercourse in cases of incomplete penetration (vaginal vestibule) and the complacent hymen, characterized by high dilatability due to low height (distance between insertion base and free rim), large hymenal orifice (over 2.5 cm) and high elasticity. Superficial lesions of the hymenal membrane and vaginal mucosa have a similar term of healing and of disappearance. In minors as well as in adult women in cases of forceful penetration and use of various objects, more severe lesions may occur, such as fourchette and navicular fossa lesions, those that involve the vagina walls (especially the rectovaginal fascia), including the adjacent perineum. These lesions require longer time for healing and health care, including primary surgical treatment. In case of ejaculation inside vagina and if special measures were not taken that would lead to destruction, sperm can be detected morphologically in the vagina for 3-5 days after the intercourse and the genetic material can be identified up to 7 days. The perpetrator's hairs detected in victim's genitals area do not confirm the occurrence of a sexual intercourse, but only the contact between the genitals. However, the detection of perpetrator's hairs inside victim's vagina would argue in favour of a vaginal penetration. As well, vaginal penetration can be proved by textile fibres detection from perpetrator's underwear or clothes in the victim's vaginal content. Sexually transmitted infections acquire probative value of sexual intercourse when the victim did not suffer from these diseases until the intercourse, and the examination of the perpetrator established that he had been already infected at the time of intercourse.

In case of perverse sexual intercourses, can be detected as well recent and late signs of oral and anal penetration.

Anal penetration can be revealed by the ruptures of the mucosa and perineum, traces of semen, hairs from the perpetrator and sexually transmitted infections. Anus lesions occur especially in people who did not experience such type of sexual intercourse, violent sexual intercourse and in children. The healing of these lesions and, therefore, their disappearance, respects the general terms of healing of the lesions depending on their severity. Scars may indicate anal penetration at later stages. Traces of perpetrator's semen can be found in the anal content only if the intercourse took place without a condom and the perpetrator ejaculated into the rectum. Note that these traces can be detected only until the first defecation.

Buccal penetration pmay be confirmed by lesions of the buccal cavity mucosa, traces of perpetrator's semen, perpetrator's hair and sexually-transmitted infections. Buccal mucosa lesions usually take the form of ecchymoses, which can be found at the level of cheeks, hard and soft palate and they disappear within around 14 days. Rarely there could be other lesions, such as mucosa excoriation. Traces of perpetrator's semen can be found in the buccal content only if the intercourse took place without a condom and the perpetrator ejaculated into the buccal cavity. Remember that such traces can be found only within a few hours from the coitus, as they are mechanically removed by the saliva that washes the buccal cavity and they are destroyed under the action of amylase. That's why traces of semen can only be found in the channel formed between the cheek and the gums and under the tongue. The evidential value of perpetrator's hairs and sexually-transmitted infections in case of buccal and anal penetration is similar to the case of vaginal penetration.

Signs of the sexual intercourse may be also found on perpetrator's body, in the genital area. Thus there will be recent and later signs that a man has had sex. Victim's biological traces may be found on glans penis and neck, such as vaginal, rectal or buccal epithelium, depending on the type of penetration. Similarly, traces of faeces may be found in case of anal penetration. In case if the victim has some bleeding injuries, traces of victim's blood may be found on perpetrator's glans penis and its neck. In case of violent sexual intercourse, as well as when abusing minors and small children, there might be injury of the frenulum and even gland penis mucosa denudation. An indicator of contact between victim's and perpetrator's genitalia may be hairs of the victim that could be found around perpetrator's genitalia, his/her pubic hair or underwear. A later sign would be a sexually-transmitted infection, which would have evidential value only if the perpetrator suffered of no sexually-transmitted infection before the

intercourse and during victim's examination it was found that she was already infected at the time of the intercourse.

If sexual abuse took place by penetration using a condom, the latter becomes important judicial evidence as it can show the connection between the victim and the perpetrator. Thus, perpetrator's semen traces can be found inside the condom (if there was an ejaculation), while on its outside traces of victim's epithelium may be found. The source of biological material can be identified by means of serological and genetical tests. Other objects found at the abuse scene also have importance for judicial reasons (underwear, towels, tissues, tampons, etc.), as they may bear biological traces. Presence of biological traces coming from the perpetrator and the victim will establish the connection between these people, as well as the connection between them and the scene. Moreover, the presence of semen and vaginal, buccal or rectal epithelium traces will confirm that some sexual activity took place there.

Subsequent to the forensic medical examination of the victim and perpetrator, there can be demanded additional **forensic-medical biological tests** (identify the biological source) and, more seldom, toxicological tests (state of helplessness caused by alcoholic or narcotic inebriation). Samples are needed in order to help prove the physical connection between the people and/or people and objects and places. Type and volume of taken samples are decided by the medical examiner depending on case circumstances, goals of the forensic medical examination and what was found during the forensic medical exam. The medical examiner shall submit the collected samples to the laboratory, using the approved *Referral Form* for each additional test. Samples taken by the clinician (e.g. gynaecologist), in the absence of the medical examiner (in case of sexual abuse that lead to medical emergencies) shall be submitted to the representative of the criminal prosecution body as provided for by the Criminal Procedure Code. Clothing and other objects (paper tissues, towels, sheets, fingernail bits, etc.) with possible biological traces shall be picked by the representative of the criminal prosecution body to order biological tests; if some of the things are wet – they will be left to dry first. The act and purpose of the sampling, as well as the specific collected samples (type of specimen, number of objects, place of sampling) shall be written in the forensic medical examination report.

In case of recent sexual violence, in order to gather evidence of the sexual intercourse and to identify the perpetrator, it is essential to sample specimens for biological tests, and in case of abuse committed by taking advantage of the victim's helplessness caused by his/her alcoholic or narcotic inebriation it is necessary to

take blood and urine samples for a toxicology screening. Samples shall be taken as soon as possible after the abuse – ideally within 24 hours for biological tests and within 12 hours for toxicology screening.

The following types of samples may be collected from sexual assault victims and perpetrators for biological tests (serological, cytological, genetic):

BOX 2 Specimens for biological tests

- ***vaginal content*** is sampled, using a sterile DNA-free swab and making circular movements, from the cervix, endocervical canal (only in adult females and minors on Tanner 4-5 stage), and posterior vaginal fornix; the swab shall be smeared immediately on two slides; vaginal content can be samples up to the seventh day from the intercourse if no genital hygiene was carried out;
- ***anal content*** is sampled until the 3rd day or the first defecation and only after the skin around the anus is wiped with a sterile DNA-free swab in order to prevent vaginal content leaking in there; the swab is inserted into the rectum, 4-6 cm deep, and then it is used to wipe the mucosa by rotating; the swab shall be immediately smeared on two slides;
- ***buccal content*** is sampled using a sterile DNA-free swab from the inner cheek mucosa where it meets the gums of teeth the inner side of the lips and under the tongue; the swab shall be smeared immediately on two slides; buccal content may be sampled in the first 12 hours, until oral hygiene and first meal (in some situations – coma, for instance – it is allowed up to 48 hours);
- ***content of the glans penis*** is sampled as print-smears by pushing microscope slides against various areas of the glans, but it is also mandatory to thoroughly wipe the glans and neck with a sterile DNA-free swab slightly moistened in sterile distilled water;
- ***suspected traces of semen and saliva on the body*** (places where the perpetrator ejaculated or where perpetrator's mouth touched the victim's body) are sampled by scrubbing with a sterile DNA-free swab (wet traces), if needed (try traces) the swab is moistened with saline or sterile distilled water; the traces from the *vulva* are sampled from the inner surface of labia majora, from labia minora and from the vulvar vestibule, while the perianal swab is taken from within 3 cm radius from the anus; *perianal* samples are taken first, then – vulval, and ultimately – vaginal samples; samples from the *genital-anal area* must be taken before the manual examination or examination using the vaginal speculum;

- if the victim defended and injured the perpetrator with his/her fingernails, it is necessary to sample the ***subungual content*** together with distal edge of the fingernails from both hands using the scissor down to the soft tissue, without damaging it; in case of shortly cut fingernails, the subungual content is sampled using a sterile DNA-free swab; fingernails or swabs of each hand are packed separately in paper envelopes, mentioning which hand they belong to, then they are put together into one envelope, which is sealed and labelled appropriately; pieces of broken fingernails can be picked on site;
- ***hairs*** loosely hanging on the body (pubis, vaginal cavity, anal cavity) or clothes shall be picked by the examiner by hand, wearing gloves, or using a pair of forceps with smooth and soft tips or hairs can be combed during the genital-anal examination onto an A4 sheet of paper and packed separately.

Besides biological evidence taken from victim's and perpetrator's cavities and body, in case of sexual abuse it is necessary to take reference samples (blood, saliva, buccal epithelium, hair), which is ordered and organised by the criminal prosecution body in line with the Criminal Procedure Code:

BOX 3 Reference biological samples

- ***a blood sample*** is drawn under sterile circumstances from a fingertip or vein into a sterile tube, vial or syringe – at least 2 ml with no added preservatives; if the blood cannot be sent in liquid form, then it shall be collected on a piece of gauze (5x5 cm) folded into 4-5 layers and then dried;
- ***buccal epithelium*** is collected by brushing a sterile DNA-free swab against the inner cheek mucosa in a twirling back-to-front and front-to-back motion; buccal epithelium is collected from each cheek using a separate swab, which are packed individually after drying; in case of babies, buccal epithelium shall be sampled at least one hour after they are fed;
- in order to establish the secretion category, the ***saliva sample*** is to be collected after rinsing the buccal cavity using a sterile gauze DNA-free swab (5.0x.5.0 cm), folded into several layers, by putting it into the buccal cavity, under the tongue, until it soaks with saliva;
- ***hair samples*** from the scalp and/or pubic area are collected by cutting 15-20 hairs with sharp scissors as close as possible to the skin; the hair samples must be packaged separately from other samples in a paper envelope and be labelled with content and area of collection.

Traces of semen and saliva on the person's body or clothes can be detected easier in UV light. In case if the sample is taken using a swab, the latter should be twirled in order to increase its area of contact with the biological trace and to collect as much material as possible. Minimum pressure should be applied on the swab during the sampling, which should be just enough to collect the biological trace and avoid exfoliation of person's epithelial cells. During the collection of biological specimens from the victim, it is necessary to prevent their contamination with biological material coming from the health professionals and the suspect.

The smears and swabs with sampled biological material must be dried at room temperature, in a clean, ventilated room, protected from direct sunlight and away from artificial heating sources; then they shall be packaged separately in paper containers (envelopes, bags, etc.) without a transport medium. It is mandatory to submit the control material used to collect the biological specimen (cotton swab or gauze), including vials with leftover distilled water or saline solution, which shall be packaged in a separate envelope.

Microscope slides with dried biological material shall be arranged with the smear surfaces facing each other, the swab dried beforehand shall be placed between them and then all of this is packaged in a paper container.

Blood and urine samples for a toxicology screen shall be collected by the doctor under hospital conditions, in line with MHLSP Order No 30/2019 on collection and analysis of biological specimens to determine blood alcohol, consumption of narcotics and other psychotropic substances or other medicines with similar effects.

It is mandatory to package the specimens, as this aims at ensuring the sample safety and preventing its contamination, that is why every sample has to be packaged separately. Dried samples are packaged in containers made of paper or another porous substance that prevents condensation and, respectively, alteration of the biological specimen because of bacteria. It is compulsory to seal the samples and this shall be done in such a way that opening them would lead to an obvious damage of the package or the seal, so that any unauthorised intervention would be prevented. Every packaged sample (container) shall be labelled with the following data: case number; container content; name and surname of the examined person; name and surname of the professional who collected the sample; date and time when the sample was taken; number of the container out of the total number of containers (e.g. 1/3, 2/4). If two or more samples were taken from a certain area, it is necessary to specify the order of sampling on the packaging. Biological specimens shall be sent to the laboratory as a priority (cyto!) following the *sample chain of custody* (controlled management).

In order to ensure the possibility of maximum sampling of specimens, to avoid their destruction and to prove a sexual abuse, it is essential that some actions and procedures are undertaken and others are avoided.

BOX 4 Actions to be taken by sexual violence victims to preserve evidence

Actions to carry out
• the victim and the perpetrator should undergo a forensic examination as soon as possible • the victim should be open to communicate all details of the abuse • the victim should accept the medical and forensic examination • the victim should submit all objects (including clothes) that might bear biological traces
Actions to be avoided
• intimate hygiene or shower • washing hands and subungual space • defecation, oral hygiene (in case of anal or oral penetration), urination • undressing and washing the clothes or other objects that bear biological traces • changing the ambiance of the place where the sexual abuse happened • disposal of garbage bin content or destruction of the used condoms.

Having completed the forensic examination of the victim, the medical examiner must ensure that the case is reported to the Police under extra-judicial examinations and that the victim is referred to other professionals.

Reporting the case to the Police

In case of an extra-judicial examination regarding victims of sexual violence, the medical examiner shall inform the appropriate Police precinct and, in case of alleged torture, shall inform the Prosecutor's Office. They shall use the Single National Service for Emergency Calls, 112, to report such cases.

Referring the victim to other professionals

Most often, in case of soft tissue (tegument, mucosa) injury, the examination of the person's body is enough to achieve the goals of the examination. However, if there's a suspicion of deep injury in soft tissues, bones, joints or internal organs, then it is necessary to carry out additional tests in order to confirm or rule

them out, which will allow ascertaining the full amount and nature of all injuries (external and internal). The need to carry out additional tests must result from the changes found out during the forensic medical examination. For instance, if there is a suspected head injury, it is necessary to consult the neurosurgeon. In case of suspected osteoarticular injury, the victim must be referred to the trauma doctor, as well as to run X-ray and imaging tests. If there are suspicions for internal organ trauma, the victim must be referred to various clinicians, who would decide on their own on the type and extent of clinical and para-clinical examinations needed to confirm or deny the existence of trauma or pathological process. Sexual violence victims need to be monitored by means of follow-up visits that would cover their mental health status, prevention of STIs, HIV, viral hepatitis, prevention of unwanted pregnancy.

Besides medical and forensic-medical support the victim also needs psychological, social and legal support. After the forensic medical examination is over, the victim must be referred to professionals that can provide her the appropriate support or to specialised centres that support victims of sexual violence.

In case if sexual violence victims go to the healthcare facilities and need an emergency intervention that cannot be postponed, then the forensic medical tasks shall be fulfilled by the health professionals. Medical support after rape and other sexual abuse consists of the following stages:

1. Initial assessment, including obtaining the informed consent
2. Obtaining the medical history, including the special one
3. Physical and pelvic examination
4. Documentation of findings and traumas
5. Collection of medical and forensic-medical evidence
6. Prescription of treatment
7. Counselling the victim
8. Referring the victim to other specialised services (other doctors, social assistance, psychological support, NGO)
9. Reporting the case to law enforcement bodies
10. Follow-up.

Consequently, the health professionals will have to carry out both clinical and forensic-medical tasks.

Sexual offences and the role of forensic medical examination

Sexual offences are deeds that harm the sexual freedom and inviolability of a person and are criminalised by the Criminal Code of the Republic of Moldova. In Criminal Law, sexual freedom means the freedom of a person from sexual aggression and abuse of a criminal nature, conditioned by the person's self-determination to decide on his/her own with whom and in what form to meet his/her sexual needs. By comparison, sexual inviolability is perceived as the lack or irrelevance of such a desire. Sexual offences have a deeply antisocial significance and generate consequences both at social and, particularly, individual level. They include offences against the sexual inviolability and sexual freedom of a person (Articles 171, 172, 173) and offences against the sexual inviolability of minors (Articles 174, 175, 175[1]).

Rape (Article 171 of the CC) is a sexual intercourse committed by a person's physical or mental coercion or taking advantage of their inability to defend themselves or to express their will. According to the Criminal Code, both women and men can be rape victims. A rape victim may be either adult or minor, either unmarried or married/divorced (marital rape), either with no sexual life before the rape or having sexual experience, including people that offer sexual services against payment. It is important that in all these situations the victim is of a different gender than the perpetrator. A common feature of physical and mental coercion is that the victim's resistance against the sexual intercourse is broken by causing a harm, and its amplification may be avoided only if the victim accepts the sexual intercourse. It does not matter if the victim's resistance was broken easily or not. If the coercion was committed by one person and the rape – by another, then, from the perspective of Criminal Law, the two of them are co-perpetrators in case of the rape. The phrase 'taking advantage of victim's status' means, in Criminal Law, that the perpetrator was aware of the difficult situation of the victim and used it to have a sexual intercourse with him/her. The rape offence is deemed to be committed since the beginning of the complete or incomplete sexual intercourse. The punishment that the Criminal Code stipulates for committing a rape is perpetrator's imprisonment for 3 to 5 years.

The criminal legislation provides for a series of circumstances of the rape that aggravate the legal liability to which the perpetrator may be held. Therefore, the rape committed by a person who had committed a rape before, committed knowingly against a minor (14-18 years of age), committed knowingly against a pregnant woman, committed against a family member, committed by

two or more people, accompanied by a deliberate infection with an STI, committed with particular cruelty, as well as rape committed for sadistic reasons shall be punished by 5 to 12 years of imprisonment. The perpetrator's situation is aggravated if the rape is committed against a person who they certainly knew was under 14 years of age, against a person that is under perpetrator's care, safeguarding, protection, education or treatment; if the rape caused deliberate infection with AIDS, caused by imprudence a severe injury of the bodily integrity or health, led by imprudence to the victim's death or ended up with other severe consequences. In such circumstances the punishment is harsher and provides for imprisonment for 10 to 20 years or even life imprisonment.

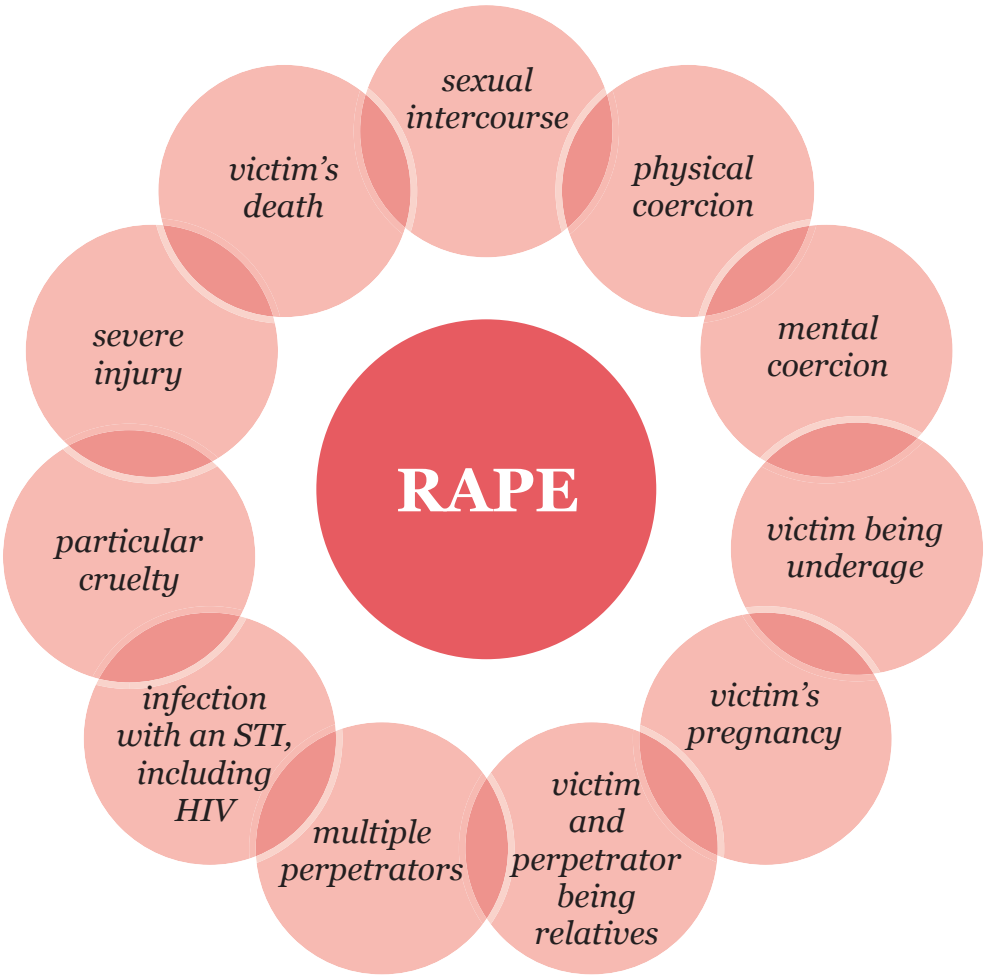


FIGURE 16. Regulatory elements of rape and aggravating factors that can be proved by means of health system's response

When gathering evidence of the rape offence, the forensic medical examination, particularly, and the health system altogether play an essential role, as the medical and forensic knowledge allows proving almost all regulatory elements that represent the rape and its aggravating factors (Figure 16). Thus, without an appropriate response of the health system, it is difficult or virtually impossible to prove the rape offence.

Violent actions of sexual nature (Article 172 of the CC) include homosexuality or fulfilling sexual desire in perverted ways, committed by a person's physical or mental coercion or taking advantage of their inability to defend themselves or to express their will. Under violent actions of sexual nature, the sexual instinct is fulfilled either by means of homosexual activities, which means that perpetrator and victim are of the same sex or by oral or anal penetration, which the criminal legislation treats as perversions. From the perspective of criminal law, this offence may take multiple forms and consists of genital-anal, digital-anal, oral-genital, oral-anal intercourse and contacts, dildos, etc. The defining element of this offence is, similarly to rape, the lack of consent or vitiated consent of the victim, committed by physical or mental coercion of the person or taking advantage of their inability to defend themselves or to express their will. These notions have the same significance as the similar notions defining the rape offence. Violent actions of sexual nature are deemed to be committed since the moment they start. The aggravating factors related to violent actions of sexual nature, as well as the criminal liability are similar to the rape offence. The similarity of violent actions of sexual nature and the rape lead to the fact that forensic medical examination and response of the health system have the same importance for evidence gathering.

Sexual harassment (Article 173 of the CC) is another sexual offence and is a show of a physical behaviour, verbal or non-verbal, that harms the dignity of the individual or creates an unpleasant, hostile, degrading, humiliating or offensive feeling in order to coerce individuals into sex or other unwanted sexual actions perpetrated though threat, constraint, blackmail. Taking into account the specific nature of this offence, the forensic medical examination and the response of the health system may prove only the physical behaviour, given that it had physical consequences, such as body injuries. Sexual harassment shall be punished by a fine in the amount of 650 to 850 conventional units or by unpaid community service for 140 to 240 hours or by imprisonment for up to 3 years.

Sexual relationship with a person under the age of 16 years (Article 174 of the CC) relates to a sexual contact different from rape, vaginal, anal, oral or other penetration committed against a person about whom the perpetrator certainly knew that he/she was under 16 years of age. Normal sexual development of minors is closely related to their sexual inviolability, both of them being protected by the criminal legislation, by holding the perpetrator accountable – the punishment is 3 to 7 years of imprisonment. Criminal liability arises when the perpetrator knows certainly, does not presume, that at the moment of the offence the victim had not reached the age of 16 years. The person that has a sexual contact with a minor aged under 16 years shall not be subject to criminal liability if he/she is at a similar physical and mental development level with the victim. The liability for a sexual contact with a minor is valid even if the minor consented, because, given the age particularities, the minor's consent is considered to be vitiated. The punishment that the Criminal Code stipulates for this offence is perpetrator's imprisonment for 3 to 7 years. When it comes to this offence, the forensic medical examination has a high evidential value as it allows proving the sexual contact, vaginal, anal or oral penetration acts, as well as the minor's age (if his/her identity is not known).

Perverted actions (Article 175 of the CC) relate to the sexual inviolability of minors and cover acts committed against a person about whom the perpetrator certainly knew that he/she was under 16 years of age, which consist of exhibition, indecent touches, talking to the victim about sexual acts in an obscene or cynical manner, determining the victim to take part in or attend pornographic performances, providing the victim with pornographic materials, as well as other actions of sexual nature. The victim of perverted actions can be a minor boy or girls, while the abuser can be either male or female. Perverted actions can be committed against the victim or in his/her presence. With respect to this offence, the forensic medical examination can prove the age of the minor (when his/her identity is unknown), indecent touches and making the victim do something, if such deeds led to certain physical consequences, such as an STI in case of contact between genitals or body injury, as a consequence of determining the victim to do so. The punishment that the Criminal Code stipulates for committing perverted actions is perpetrator's imprisonment for 3 to 7 years.

Grooming a minor for sexual purposes (Article 175[1]) includes proposing, convincing, manipulating, threatening, promising to offer various benefits, which can be also done via information technology or digital communications, in order to set a meeting with a minor with the purpose to commit any sexual offence against him/her, if such actions were followed by material deeds leading to such a meeting. This offence is punished by imprisonment for 2 to 6 years. The aggravating factors related to the offence of grooming a minor for sexual purposes include the actions carried out: towards a minor in a helpless situation caused by illness or disability; by a member of minor's family, by a person who lived with the minor or by the person in whose care, under whose protection, education or treatment the minor is; and by a person that has been previously convicted for a sexual offence or for other actions that are relevant for the case. Given that all actions that are part of grooming a minor for sexual purposes have no consequences of physical nature, both the forensic medical examination and the health system cannot contribute to proving this offence. Nevertheless, the forensic medical examination can shed light on a number of circumstances that could be treated as aggravating factors of the offence, such as the minor being helpless because of an illness or disability and the kinship with the perpetrator.

Sexual violence in armed conflicts

Sexual violence has been part of the wars since the dawn of time. Sexual violence has been and keeps being used as a weapon in most armed conflicts all over the world. During an armed conflict, women and girls are most vulnerable to sexual violence. For instance, during the World War II, the Russian, German and Japanese soldiers had been abusing women in a systematic manner; in the '70s Pakistani soldiers abused sexually women from Bangladesh, while Turkish soldiers abused women from Cyprus during the occupation. In the '60s and '70s American soldiers abused Vietnamese women, while in the '90s rape was used in the conflicts that took place in (former) Yugoslavia, Sierra Leone, Rwanda and Chechnya. Similarly, girls and women are kept as sexual slaves and/or combatants' 'wives'. The Istanbul Convention (2011) acknowledges that the current violation of human rights in time of armed conflicts – which affects the civilians, especially women, under the form of rape and sexual violence – is widespread. Nonetheless, men and boys are also subjected to sexual violence, especially when imprisoned or forcibly recruited into the armed forces. Certain people, such as single women, homosexuals, housewives, are more vulnerable to sexual violence in time of armed conflicts. Victims, especially men, often do not report the crimes committed against them as they are afraid to be stigmatised.

The perpetrators that commit sexual violence during armed conflicts are the members of official military and security forces, of unofficial military and paramilitary groups, humanitarian and peacekeeping personnel, civilians, including refugees.

Sexual violence is applied as a strategic weapon at war, and the woman's body becomes a 'battlefield'. There is a dangerous tactic behind sexual violence – it aims to punish, scare, stigmatise, and apply psychological pressure on the adversary. The purpose of sexual violence in armed conflicts is to humiliate the adversaries (mostly men) who fail in their traditional role of a protector, especially when sexual abuse takes place in public or in presence of relatives and friends. However, women, who are often associated with the nation, are subjected to humiliation, torture and degradation. In this respect, Ruth Seifert's opinion on rape (1992) is representative: 'Rape is not an aggressive expression of sexuality, but a sexual expression of aggression. In the perpetrator's psyche, it does not fulfil sexual functions, but is a manifestation of anger, violence and domination of a woman. The purpose is to degrade, humiliate and subjugate her[48]. At the same time, this form of violence becomes an efficient strategy of ethnic cleansing, as a component of conquering territories and peoples.

Sexual violence in armed conflicts has devastating consequences for women and their children, as well as negative effects on the entire family, community or ethnic group the abused women are part of. Generally, sexual violence in armed conflicts has consequences similar to the rape committed under different circumstances (beyond armed conflicts). Sexual violence leads to unwanted pregnancies and giving birth to adversaries' children. Women can either try an abortion in circumstances that put their life at risk or commit infanticide after birth. Victims of sexual abuse might be infected with HIV. As a result, rape victims are often stigmatised and banished from their communities or even killed (for honour), as they are deemed to be dishonoured and responsible for the abuse. Victims' children have a similar fate, as they are viewed as 'enemy's children'. At the same time, the fear of sexual abuse increases the number of refugees, especially women and girls, who try to leave the territories that are under occupation or in process of becoming occupied.

Sexual violence has high-impact social consequences even after the armed conflict, as follows: undermining social stability by destroying families and communities; the fear of sexual violence limits women's mobility, thus making them give up on various activities in favour of housework; sexual offenders are often left unpunished and this undermines the trust in state's ability to protect its citizens.

[48] Seifert R. War and Rape. Analytical Approaches (1992)

Sexual violence in armed conflicts is considered to be a ***war crime,*** an ***act of terrorism,*** and ***trafficking in human beings.***

In order to protect the rights of women and girls during armed conflict, the United Nations Security Council adopted the Resolution 1820 (2008) on women, peace and security, whereby it qualified sexual violence in armed conflicts as an instrument of war and declared that rape and other forms of sexual violence may be war crimes, crimes against humanity or acts of genocide. Resolution 1820 calls the parties to armed conflict to protect civilians against sexual violence, to enforce military disciplinary measures, to train the troops, to uphold the principle of command responsibility, and to hold the perpetrators liable. Another important international instrument to help combat sexual violence in armed conflict is the United Nations Security Council Resolution 1888 (2009) on acts of sexual violence against civilians in armed conflicts, which demands that holding sexual abuse perpetrators to justice becomes a priority in order to prevent impunity and reinstate women subjected to sexual abuse. Together, Resolutions 1820 and 1888 must ensure that peacekeeping personnel is properly trained and equipped to prevent sexual violence in armed conflict. To this end, the Istanbul Convention (2011) stipulates that its provisions are valid for times of peace, as well as for armed conflict situations.

Female genital mutilation

According to the World Health Organization (2020), female genital mutilation comprises *all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons*[49]. Female genital mutilation is recognized internationally as a violation of the human rights of girls and women, being an extreme form of their discrimination. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

UNICEF (2016) stated that even though the precise number of women that have undergone genital mutilation is not known, it is estimated that at least 200 million women and girls all over the world have been subjected to this practice; more than half of them live in just three countries: Indonesia, Egypt, and Ethiopia. Out of the total number of women estimated to have undergone this harmful practice, 44 million were girls below age 15[50]. The same source reveals that in most of the countries, the majority of girls were cut before age 5. In Yemen, 85

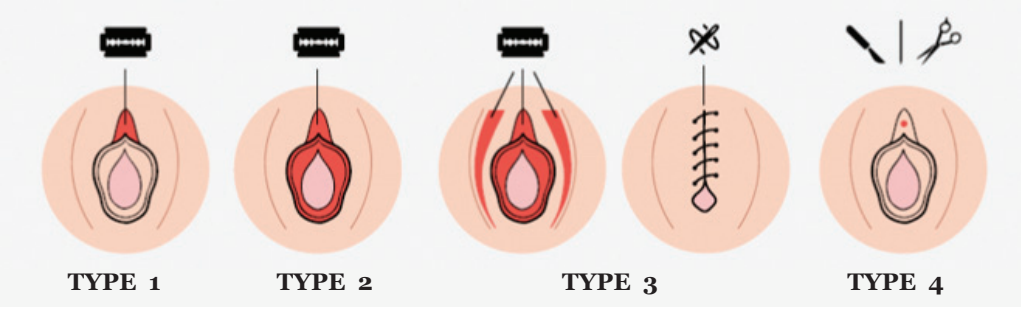
[49] https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
[50] https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

per cent of girls experienced the practice within their first week of life. Annually, around 3 million girls are at risk of genital mutilation.

A global prevalence study carried out by WHO (2016) showed that female genital mutilation is much more widespread in North Africa (Sub-Saharan Africa) and in some regions of the Middle East, particularly Iraq and Yemen. This practice has also been reported in India, Indonesia, Israel, Malaysia, Thailand, and United Arab Emirates. As population migration grew bigger, this phenomenon began to be recorded among migrants and asylum-seekers in Europe and North America (the USA and Canada), becoming a public health issue. Studies regarding the prevalence of female genital mutilation show high indicators in such countries as Sudan (82.83%), Egypt (95.10%), Guinea (98.34%). UNICEF (2016) highlights that prevalence of female genital mutilation has generally decreased over the last three decades, but not all countries advanced on this path.

BOX 5 Types of female genital mutilation

TYPE 1	partial or total removal of the clitoral glans
TYPE 2	partial or total removal of the clitoral glans and the labia minora, with or without removal of the labia majora
TYPE 3	'sealing' (infibulation), that is cutting the labia minora or labia majora, and stitching labia majora (leaving just some opening for urination, intercourse) – then reopening for childbirth, followed by re-sealing.
TYPE 4	other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.



Female genital mutilation is usually performed in unsafe hygienic conditions, using habitual tools, such as blades, knives or even glass shards.

In most countries the procedure is performed by traditional practitioners, who are often close female relatives, such as grandmothers, aunts, etc. Nevertheless, UNICEF (2016) found that more than a half of the girls in Indonesia had this procedure performed by a trained health professional, which means that health professionals are involved in a severe violation of human rights and are carrying out harmful practices that contradict medical ethics.

When it comes to female genital mutilation, **THERE ARE NO BENEFITS, JUST HARM!**

Female genital mutilation harms girls and women, and consequences are severe, including medical, physiological and psychological issues, which can be either short or long term. The most frequently reported consequences of mutilation are the following:

BOX 6 Consequences of female genital mutilation

Immediate consequences	Subsequent consequences
• intense pain • haemorrhage • urinary and genital infections • sepsis • death	• several *complications* – urinary (infections, pain), vaginal (painful menstruation, difficult discharge of blood), *sexual* (painful intercourse, low level of satisfaction) • pregnancy and childbirth complications • psychological, social consequences

Female genital mutilation is not just a matter of human rights, but it is also a public health issue. Thus, WHO (2020) estimates that the treatment of health complications caused by female genital mutilation in 27 countries with high prevalence amounts to USD 1.4 billion per year.

It is believed that female genital mutilation is a complex issue with many underlying causes:

- **psycho-social reasons** – to control woman's sexuality
- **social and cultural reasons** – transition from girl to woman age
- **myths about female genitalia** – the uncut clitoris could grow to the size of a penis, mutilation increases woman's fertility or baby survival
- **hygienic and aesthetic reasons** – in some communities female genitalia are believed to be ugly and dirty

- **socio-economic reasons** – in some countries mutilation is a precondition for marriage (as the woman depends on the man, she accepts mutilation for economic reasons) or for inheritance.

As female genital mutilation is qualified as a violation of human rights, in most countries people that practice it are brought to justice, and genital mutilation is included in the list of offences provided for by the Criminal Code. To this end, the Istanbul Convention (2011) demands the mandatory criminalisation of the female genital mutilation practice. In countries where this practice is widespread, the liability for it differs and in some cases it is missing. Namely, the sanctioning legislation is missing in some countries (Ethiopia, Madagascar, Sierra Leone, Sudan), while in other countries (e.g. Guinea) the sanctioning is very mild and consists of some hours of unpaid community work. At the same time, the Egyptian legislation allows genital mutilation just in hospitals and people are held liable only if this rule is violated. Obviously, the lack of punishment contributes to the perpetuation of female genital mutilation. At international level, the position on female genital mutilation is unequivocal and the response comes from several organisations such as WHO, UNICEF, UNFPA, UN in the form of various declarations, resolutions, programs, strategies and policies aimed at fighting this harmful practice by strengthening the response of the health system; training on causes, forms and consequences; developing publications and advocacy tools at international, regional and local level.

Some sources perceive circumcision as an expression of male genital mutilation. This practice is spread as a religious tradition among Jews and Muslims, but it is also found in some Christian communities in the USA and Australia. Circumcision is done for hygienic reasons and to reduce infections. Even though circumcision does not have the severe consequences of female genital mutilation, it is still a surgical intervention with no medical indication to do so, which could lead to various complications, including death.

TOPIC 5

Preventing and Combating Domestic and Gender-Based Violence

The prevention process has a key-role in reducing/combating any negative social phenomenon, as well as in reducing the post-factum costs of its consequences. The prevention should be complex and include interventions at the individual risk factors level, as well as actions at community and social level. The prevention process should be focused on combating the root causes of domestic and gender-based violence. According to the literature, violence against women and domestic violence are deeply rooted in inequality between women and men. The understanding of this phenomenon should start from the fact that violence is a scourge that not only affects women, but affects the whole society by determining the subordination of women in all areas. The essential components of the prevention process of violence against women and domestic violence consist of the multitude of measures aimed at combating stereotypes, patriarchal attitudes, prejudices regarding the roles of women and men, reinforcing professionals in the field, but also awareness-raising activities and promoting the 'zero tolerance' message towards this phenomenon for the general public, but also for certain social categories.

The National Strategy on Preventing and Combating Violence Against Women and Domestic Violence for 2018-2023 highlights the following sectoral and systemic gaps in handling the phenomenon, which compromise the prevention and combating efforts:

- the persistence of a high level of tolerance in society towards the phenomenon of DV and GBV (patriarchal attitudes and deeply rooted stereotypes regarding the roles and responsibilities of women and men in the family and society);
- the partially used potential of educational system;
- insufficient information campaigns;
- the stereotyped perceptions of the professionals of the responsible authorities for preventing and combating domestic violence (DV) and gender-based violence (GBV);
- tendentious presentation by the media (women portrayed as helpless victims, marginalized and trapped in a vicious circle);

- the absence of uniform working practices, as well as the low capacity of LPA authorities to intervene in preventing and combating the phenomenon;
- shortage of early intervention actions;
- limited access of the victims of domestic violence to specialized services;
- the fragmented response of the health system;
- the economic dependency of the victims on the domestic perpetrators;
- fragmentary and delaying police intervention;
- persistence of stereotypes and prejudices in justice;
- the lack of firm actions to ensure the execution of protection orders and the lack of effective sanctioning of perpetrators;
- ineffective sanctioning of perpetrators;
- prohibiting access to justice of victims of domestic violence (private lawyers);
- deficient handling of sexual violence cases;
- deficient mechanism of budgetary financing of services dedicated to the subjects of domestic violence;
- fragmentary and uneven statistical data collection.

Authorities and professionals entitled to prevent and combat domestic and gender-based violence

In order to ensure the prevention process and effective protection, the involvement of several responsible institutions and organizations is needed, which should send clear and consistent messages of zero tolerance towards domestic and gender-based violence. The experience of other countries proves that an effective response to domestic violence depends on the proper functioning of the system and the ability to provide victims of violence with immediate protection and support services.

At the same time, by ensuring the functioning of an effective support system, placing the rights and needs of the victim at the heart of all measures taken through the effective cooperation of all agencies, relevant institutions and organizations, the state sends the message that domestic violence is a serious crime, severely taken in consideration, ensuring the effective prevention of the phenomenon, the protection of victims of domestic violence and the accountability of domestic perpetrators[51].

[51] Article 7 – Comprehensive and coordinated policies of the Council of Europe Convention on preventing and combating violence against women and domestic violence.

Also, it is necessary to train all involved professionals and to implant knowledge about violence and its consequences for effective prevention and combating of domestic and gender-based violence, providing adequate professional support to victims, changing attitudes, perceptions and stereotypes. This desideratum can be found and in the National Strategy on Preventing and Combating Violence Against Women and Domestic Violence for 2018-2023 and in the Action Plan for its implementation.

The Law No 45/2007 establishes the legal and organisational bases for activities on prevention and combating domestic violence, as well as the authorities and institutions entitled to prevent and combat domestic violence, as reflected in the table below.

TABLE 7 Authorities and institutions entitled to prevent and combat domestic violence

Central specialized state bodies	LPA specialized authorities and decentralised structures	Support centers and services
• Ministry of Health, Labour and Social Protection • Ministry of Education, Culture and Research • Ministry of Internal Affairs • Ministry of Justice	• Social assistance and family protection directorates/sections • General divisions for education, youth and sports • Healthcare bodies • Police territorial units	• Support and protection centers/services for domestic violence victims and their children • Assistance and counselling centers/ services for domestic perpetrators • Other organizations with specialized activities in the field

In accordance with the Law No 45/2007, the attributions of developing and promoting of policies on preventing and combating domestic violence and the social assistance of victims and perpetrators are assigned to Ministry of Health, Labour and Social Protection.

At the same time, the Inter-ministerial Coordination Council on prevention and combating domestic violence was created to the Ministry of Health, Labour and Social Protection, which includes a representative of the central authorities, the Ministry of Health, Labour and Social Protection, the Ministry of Education,

Culture and Research, the Ministry of Internal Affairs, the Ministry of Justice, civil society representatives and other stakeholders. The Inter-ministerial Coordination Council is responsible for ensuring coordination and collaboration between ministries and other central administrative authorities with competences in the field of preventing and combating domestic violence.

The health care institutions have a major role in preventing and combating domestic and gender-based violence, because health care providers are the first who contact with the victims. Thus, besides the provided services, health care providers have an important role in identifying cases of violence, facilitating the referral of victims within the health system and to other service providers.

The police represent a very important link in a much larger system of authorities entitled to prevent and combat domestic and gender-based violence. During the intervention, the police officers have to assess the risk and take the necessary measures to ensure the immediate safety of the victim, by:

a) issue of the emergency restraining order, ensuring the safety of the victim and other family members inside and outside their home;
b) placement of victims in specialized rehabilitation or placement centers (with victim's consent);
c) informing and assisting the victim in obtaining the protection order, issued by the court. In case of victim's inability (physical or mental), the police officers have to submit a request to the court, demanding the issue of protection restraining order against the perpetrator.

Within the actions of prevention and combating domestic and gender-based violence, the police also intervene by applying coercive measures against the perpetrator, which can be achieved by:

1) contraventional or criminal sanctions
2) bringing the domestic perpetrator who committed or may commit domestic violence acts to police stations, in order to document the committed cases or to initiate contravention or criminal proceedings, as well as to initiate the restriction procedure, by the protection order of victims of domestic violence, issued by the court;
3) application of coercion contraventional or criminal measures against the perpetrator;
4) assisting in the application of medical coercion measure by the court against persons addicted to alcohol or suffering from chronic alcoholism or drug addiction;

5) supervision of established restrictions observance by protection order of victims of domestic violence, issued by the court, both in civil and criminal proceedings.

The multidisciplinary teams include a police officer, a community social worker, a family doctor, the guardianship authority, the mayor, the employees of the educational institutions. The duties of these teams are regulated by Law No 45/2007 and Law No 436/2006 on local public administration governing the duties of the local public authority.

BOX 7 The notion of multidisciplinary team

The multidisciplinary team: a group of people in positions of responsibility, entitled to prevent and combat domestic violence, consisting of: community social worker, family doctor, representatives of educational institutions, police officer, representatives of the local public administration authority, other bodies and competent non-governmental organizations, meant to intervene in solving cases of domestic violence and providing the necessary services and assistance in accordance with the provisions of the legislation in force.

The Methodical Instruction on Police Intervention provides that the police officer, when responding to a case of domestic violence, has to inform through a referral form the social worker, within a maximum of 72 hours,[52] about the registered case of violence. Referral forms are recorded in the Register of referral forms on domestic violence cases[53].

The role of professionals within the territorial social assistance structures in solving cases of violence. The intervention of territorial social assistance structures follows several objectives:

1. ensure the identification of the victims of domestic and gender-based violence;
2. contribute to ensuring and/or increasing the safety of victims at all stages of intervention;

[52] The Order of the Ministry of Internal Affairs No 360 of 08.08.2018 on the approval of the Methodical Instruction on Police Intervention in Preventing and Combating Domestic Violence, Annex 2.

[53] The Order of the Ministry of Internal Affairs No 360 of 08.08.2018 on the approval of the Methodical Instruction on Police Intervention in Preventing and Combating Domestic Violence, Annex 10.

3. observe the basic principles in social assistance field;
4. ensure the registration, documentation of domestic violence cases and report the statistical date on this phenomenon;
5. facilitate the referral of domestic violence victims to service providers.

The social worker is obliged to inform and guide the victim to access the specialized services provided on daily basis, such as: psychological assistance, health care services, forensic examination, legal aid. According to the Instruction on the intervention of territorial social assistance structures in cases of domestic violence[54], any identified, notified, referred or reported case of domestic violence is recorded by the professionals within territorial social assistance structures in the *Register of domestic violence cases*. At the request of the court, the territorial structure of social assistance presents a report of the family concerned, including the perpetrator.

Both in families where conflicts occur and in families affected by domestic violence, the main working method of the social worker is the case management[55] through which are identified the problems encountered by the family members and are established the needs to overcome difficult situations. The social worker, in agreement with the beneficiaries and their families, develops and implements the Individual Care Plan for each case, provides primary social services, at the same time, mobilizes the community in order to solve the domestic violence cases.

Prevention of domestic and gender-based violence is based on the interaction between subjects from all sectors – public, private and associative, a distinct actor being also the civil society organizations.

The partnerships, between civil society and public authorities in the field of prevention and combating the domestic and gender-based violence, have proved over time the efficiency in solving the problems and have contributed to the development of several protection mechanisms in this area. In order to remedy the situation, civil society and development partners have implemented and supported multiple initiatives and projects to eliminate and prevent violence against women and domestic and gender-based violence. For the most part, the activity of non-profit organizations, which advocate and promote a world without violence, is focused on providing legal aid and psychological assistance to victims of domestic violence, and even providing shelter.

[54] Order of the Ministry of Health, Labour and Social Protection No 903 of 29.07.2019 approving the Instruction on the Intervention of Territorial Social Assistance Structures in Cases of Domestic Violence

[55] Case Management, approved by MLSPF Order No 71 of 03.10.2008.

The role of society in preventing and combating domestic and gender-based violence

Domestic violence is a latent crime. Domestic violence creates a violent society and vice-versa, a society tolerating violence in public life highlights the violent trends within the family, transmitting them through generations[56].

Domestic and gender-based violence is a serious social problem. Therefore, the prevention of domestic and gender-based violence should not be aimed exclusively at professionals entitled with responsibilities in this field, but it is necessary a real involvement of the community in these combating violence programs. Violence occurs as a result of the interaction of several factors in society, the immediate environment, relationships and individual factors. Domestic and gender-based violence is not an isolated event that exists in a social vacuum. Even if no witnesses are present when it occurs, the violence takes place in a specific socio-cultural context in which family and friends form a social network. Therefore, we expect the social network to respond to violence in a certain way, members of society having a moral obligation to report the acts of violence.

The strategies for prevention and combating domestic and gender-based violence must target several directions:

- improve the awareness and knowledge about violence;
- promote gender equality and decrease social stereotypes;
- promote among the population the spirit of becoming active witnesses, i.e. to report cases to the police and other authorities.

The studies in the field show that very few women reported the most serious cases of violence, this being the case for half of women who believe domestic violence to be a 'private matter' that should be dealt with within the family[57]. Thus, more than half (55%) of women in the Republic of Moldova, four times more than in the EU (14%), consider domestic violence as a private matter that should be dealt with within the family.

These stereotypes and prejudices enhanced by friends, relatives, representatives of different authorities, and perpetuated by religious institutions, make women suffer silently.

The myths about domestic violence make the members of the community who witness the acts of violence hesitate in reporting cases to authorities. The role of society members as active witnesses and case reporters to the police and

[56] 'Wellbeing and Safety of Women', OSCE, 2019, p. 19.
[57] 'Wellbeing and Safety of Women', OSCE, Chisinau, 2019 https://www.osce.org/files/f/documents/e/f/425867_0.pdf

other authorities is important, as it is well known that any crime occurs only in the presence of a few elements: the offender, the victim and the lack of supervision.

Thus, the traditional attitudes and norms contribute to a high prevalence, most of witnesses of acts of gender-based violence believing that domestic violence is a private matter or believing that the victims are to blame. The situation described is much more pronounced in communities with strong patriarchal values.

In order to increase the reporting of cases of domestic and gender-based violence, including by members of the community witnessing acts of violence, it is recommended the following activities to be implemented:

1) increase the information and awareness of the population against various manifestations of all forms of violence against women and domestic violence, as well as their social, economic and legal consequences and methods to solve cases of violence;
2) inform the population about the victims and witnesses' rights, the procedures and services through which they can benefit from protection and support;
3) include in school subjects on equality between women and men, human rights and the prevention of violence in educational programs, as well as in teacher training programs;
4) implement programs for the early prevention of violent behaviour in interpersonal relationships, especially among young people;
5) develop family psychological support programs for couples.

World Health Organization pays a special attention to violence in general and to interpersonal violence in particular. According to WHO Resolution No 56.24 of 28.05.2003, Member States are encouraged to monitor and report the magnitude of the problem, risk factors, current efforts to prevent violence and future actions to encourage multisectoral responsibilities[58].

On 15 September 2005, the WHO Regional Committee for Europe issued the resolution RC55/R9/, aimed at preventing physical aggression, urging the health sector to take the lead in the multisectoral intervention to prevent and combat violence.

[58] Krug, E., Dahberg, I., Mercy J., Zwi, A. & Rafael, L. (eds.) (2002). World Report on Violence and Health. Online version, http://whqlibdoc.who.int/hq/200279241545615.pdf -12/08/2007)

Similar recommendations are included in the WHO Europe Strategy *'Investing in children: the European child and adolescent health strategy 2015-2020'* which focuses on interventions to prevent violence and emotional abuse against children and adolescents as one of the priorities for intervention, defined by thematic area, dedicated specifically to this field. In this respect, WHO recommends member states to assess the extent of violence as the public health problem of students and the risk factors associated with it, according to the ecological model.

The strategies for prevention and combating domestic and gender-based violence must focus on several stages:

1. ***universal stage*** – early interventions – dedicated to general public, a certain group (age, job);
2. ***selective stage*** – risk management – dedicated to groups with high risk for domestic and gender-based violence;
3. ***indicated stage*** – consequence management – dedicated to perpetrators and victims.

The ecological model is a concept that targets the understanding of interpersonal violence as a public health problem and associated risk factors, proposes intervention methods and assessment of prevention programs.

From the perspective of the ecological model, prevention programs addressing the multitude of risk factors, must operate at multiple levels:

1. ***individual level*** – support for completion of secondary education;
2. ***relational level*** – effort to prevent child abuse and partner violence;
3. ***community level*** – education and intervention programs to reduce alcohol consumption and
4. ***societal level*** – to reduce unemployment and socio-economic inequities.

Community risk factors for violence include situational factors (use of unsafe routes to school, slums), high residential mobility, high unemployment, lack of community agents' protection in schools, clubs, bars, lack of jobs and presence of drugs in different locations.

TABLE 8 Risk factors of violence persistence

Individual level	Relational level	Community level	Societal level
• unstable personality • early trauma • emotions • alcohol/drugs • poverty	• stereotypes • family patterns • obedience code • power relations • mutual approvals	• failed sanctions • codes of honour • hated groups • discrimination • limited state allowances	• devaluation of women • children status • impunity • masculinity • violence and the media

In the context of the multiple forms of violence and the diversity of risk factors, the preventive activity requires a constant 're-development' in relation to current realities. WHO[59] recommends focusing strategies on preventing and combating domestic and gender-based violence on the following dimensions:

1. Develop secure and stable relationships between children and their parents/caregiver;
2. Develop life skills among children and adolescents;
3. Reduce the availability and abusive alcohol consumption;
4. Reduce access to weapons, knives and toxic substances;
5. Promote gender equality to prevent violence against women;
6. Change cultural and social norms that support violence;
7. Victim identification, development of care and support programs.

To be effective, all strategies for prevention and combating domestic and gender-based violence have to be applied until the acts of violence are committed, during them and after they have been concluded.

[59] Violence prevention: the evidence (2010)

TOPIC 6

Healthcare system response to domestic and gender-based violence

The role of the healthcare system in preventing and combating domestic and gender-based violence

The health sector is an important (and often the only) point of entry for victims of domestic and gender-based violence, which allows cases to be identified and managed appropriately, providing victims with the necessary spectrum of medical and non-medical services by referral. Domestic and gender-based violence is a public health problem and, therefore, it is crucial that doctors have specific knowledge and skills in order to ensure an appropriate response and prevent this phenomenon. However, to achieve this objective, doctors must understand what this distinct form of violence involves and know the components of a professional correct response. Otherwise, victims of domestic and gender-based violence lose confidence in the health system, do not seek medical help, or even if they do, they do not receive information and appropriate treatment, being unable to fulfil their constitutional rights to health, bodily integrity, life and fair justice.

The abused women often seek medical care without telling that they have been subjected to aggression or acts of violence. Surveys[60] show that most of the women have significant confidence in health care providers and find acceptable to be inquired by doctors about acts of violence if they are suspicious and detect injuries on patients' bodies. Therefore, health professionals are in an exclusive position to intervene, to provide health care, vital information and appropriate support in critical situations to women and children subjected to chronic violence. Even if the victims have not disclosed the act of violence, they know that they could return anytime to talk to the health care staff, which does not exclude the essential role of these professionals in providing health care to victims of violence.

[60] 'Violence against women: an EU-wide survey. Main results', p.65

BOX 8 Why should the health sector address domestic and gender-based violence?

DOMESTIC AND GENDER-BASED VIOLENCE IS A HEALTH PROBLEM!

- Doctors are often the first and sometimes the only professionals who contact with the victims of violence
- Medical staff is strategically positioned to identify situations in which people are subjected or/and are at risk of being subjected to acts of violence
- Doctors have knowledge and skills to react to violence by helping to improve health, patient safety, referral to other services
- The health sector is an important point of entry for victims of domestic and gender-based violence
- It is highly likely that assaulted women would seek health care in comparison with other services
- Violence is a determining cause for injuries and illness
- Sooner or later, most women come to attention of health services, especially in relation to sexual and reproductive health
- When informed about violence in the clinical history, health professionals are able to provide better services to women by:
  - *identifying women at risk before violence escalates*
  - *diagnosing the consequences and ensuring appropriate care*
  - *reducing the negative consequences of violence on victims' health*
  - *helping victims to receive help/services/protection*
  - *improving sexual, reproductive and HIV-related health*
  - *understanding the origin of chronic diseases (e.g. irritable bowel syndrome)*
- Forensic medicine has an important role in collecting evidence for prosecuting perpetrators

Health professionals have knowledge and skills to react to violence by helping to identify victims, improve health, patient safety, referral to other services!

To ensure an effective response to cases of domestic and gender-based violence, health care staff need to understand the violence dynamics, as many doctors (from the same community as victims and perpetrators) share the norms, stereotypes and attitudes of the society in which they live, and negative attitudes can cause additional damage to victims, including through retraumatization. On the other hand, the misunderstanding of violence dynamics can lead to a situation when health care providers start wondering why the woman does not break off with her abusive partner or they may think that the woman does not need help or even deserves such help.

The ignorance of violence can cause additional damage to victims of domestic and gender-based violence.

TABLE 9 Behaviour of health care providers and consequences for the victims

Provider behaviour	Possible consequences
Accuses or shows lack of respect for women or girls	Inflicts trauma or additional emotional distress
Does not recognize domestic violence as the basis of chronic or recurrent pathology	Women receive inappropriate or inadequate health care
Fails to provide adequate care to victims of rape	Unwanted pregnancy, untreated STIs, unsafe abortions
Violates privacy and/or confidentiality	The partner or family member becomes violent after learning the information
Domestic violence is not addressed within family planning or STI/HIV counselling	Unwanted pregnancy, STIs/HIV/AIDS, unsafe abortion, additional violence
Ignores signs of fear or emotional distress	The woman is later traumatized, killed or commits suicide

Healthcare system response to domestic and gender-based violence cases should be provided at different levels:

- Medical staff level
- Health care facilities management level
- Political-administrative level.

Medical staff level. The role of medical staff is very important in providing an appropriate response and submits several requirements, according to which staff must:

- understand the core, dynamics, manifestation and consequences of domestic and gender-based violence;
- inform patients about domestic violence and its health consequences;
- ask questions about domestic violence if there are specific clinical symptoms;
- create an empathetic and confidential environment;
- provide supportive health care (medical/psychological);
- document health consequences of domestic violence;
- provide assistance to the victim in drawing up the safety plan;
- refer the victims to other services
- provide follow-up and further care.

Health care facilities management level. The role of management is also important and consists in providing an organizational structure that would allow health care providers to fulfil their role through the following mechanisms:

- provide administrative support, including financial support;
- develop and implement internal operational procedures;
- ensure that provided services promote the human rights and non-discrimination principles, focusing on the needs of women and girls (as predominant victims of domestic and gender-based violence);
- provide adequate infrastructure to ensure patient confidentiality and safety (e.g. private room for consultations without the partner);
- raise awareness of the whole staff and strengthen their skills on how to recognize and respond to domestic violence;
- provide informational materials to the patients and staff on the intervention algorithm and available resources (e.g., posters, leaflets, flyers, booklets);
- build partnerships with other organizations (medical and non-medical), which activate in the field of domestic violence;
- implement a monitoring and evaluation system to assess the impact of undertaken interventions in order to improve medical staff response to domestic violence cases.

Political-administrative level is national and consists in development of the conceptual framework on the public institutions' response to domestic violence, ensuring the dissemination of information and training of professionals with responsibilities in the field of preventing and combating this social phenomenon. In the absence of national policies and strategies, the previous levels efforts will have a limited impact. As an example of a national conceptual framework can serve the 2018-2023 National Strategy on Preventing and Combating Violence against Women and Domestic Violence and its 2018-2020 Implementing Action Plan, approved by the Decision of the Government of the Republic of Moldova No 281/2018. At the same time, the political-administrative level is responsible for dissemination of policy and staff training on policy implementation.

Integrating the response of healthcare system to domestic and gender-based violence in existing health services is important while planning health care services. This approach means that health services for domestic violence victims should be provided within the existing health care services and not separately, as services integrated in the general health system framework may facilitate women's access to all the necessary services provided in a single institution. On the contrary, the provision of health services to domestic violence victims separately from other categories of patients may encounter certain difficulties and lead to discrimination.

Medical staff intervention in domestic violence cases

The health care provided to victims of domestic and gender-based violence is based on several ***guiding principles***, which have to be followed:

- *gender-sensitive approach:* in the process of assisting the victim, the health professional will demonstrate an approach that recognizes gender dynamics, the impact and consequences of domestic violence; will also take into account their specific needs, especially those belonging to marginalized groups, applying a non-discriminatory approach, ensuring full and equal access to quality healthcare;
- *victim-centred approach:* in the process of providing care to the victim, the health professional will respect victim's wishes, rights and dignity, as well as to assist her/him in decision-making;
- *safety and security approach:* the safety of the victim and of the health professional should be a priority in the process of organizing and providing care to the victim. The assessment of victim's safety has to be performed when the victim is identified or when it is assumed she was

subjected to domestic violence. During the consultation of the victim, the possible threats (aggressive husband/live-in partner/family members) must be taken into account, in order to ensure that the consultation of the victim excludes any possible damages, including to the victim or other peers;

- *approach based on confidentiality and protection of privacy:* it is important to respect the confidentiality, in order to ensure the safety of both the victim and the health professional. The confidentiality of the victim must be respected al all stages of care provision. It implies the revealing only the necessary information, only in situations where it is necessary or requested and only with the victim's consent, with the exceptions provided by law. The protection of privacy during victim's consultation (identification and clinical management) and the confidentiality of data collection, keeping records and sharing information, will reduce the exposure to risk of both the victim and the health professionals. The respect of confidentiality ensures that the victim will not be subjected to further threats and/or violence, as a result of addressing for care, thus protecting health professionals from the threats of perpetrators or aggressive family members. Shared confidentiality in the health system implies that certain information about the victim could be shared with other healthcare professionals only on the basis of the 'need to know'. Medical information can be shared with colleagues if there is a medical reason and the healthcare provider refers the victim to another stage/other care provider. This fact must be explained to the victim in advance, so that he/she understands what information and to whom it will be shared, thus obtaining his/her consent. If confidentiality is limited by mandatory reporting regulations, the victim must be informed immediately;
- *informed choice:* unless the child and the adult with disabilities in respect of whom a measure of legal protection has been instituted, the actions of the health professional must be carried out only with victim's permission, after obtaining informed, written consent, signed by the victim;
- *non-discriminatory approach:* regardless of age, race, nationality, religion, sexual orientation, gender identity, disability, marital status, educational and socio-economic status, all victims have equal rights and will be treated in the same way, ensuring equal access to quality health services. Regarding victims who are in situations significantly different (victims with disabilities, multiple vulnerabilities or who have other protected criteria (ethnicity, race, religion)) the principle of positive measures or

reasonable accommodation will apply, which implies, for example, the examination of the victim where he/she is located if the victim's access to the premises of the health care facilities is not adapted for people with physical disabilities; involvement of a sign language interpreter in the case of victims with sensory disabilities;

- *professional approach:* the health professional who provides care to victim, argues for the applied care measures and is responsible for the taken actions.

To ensure an effective response of the medical staff, the care provided to victims should include the following ***basic elements***:

1) victim identification;
2) first aid provision;
3) lesion care and urgent medical treatment;
4) examination of sexual abuse signs and provision of medical assistance;
5) mental health assessment and provision of the necessary support;
6) documentation of the medical act and referral.

Identification of the victim of domestic violence

The assistance provided to the victim will start with victim's identification, which is the first stage of any intervention performed by health workers at the level of pre-hospital emergency health care, primary health care, specialized outpatient health care and hospital care.

The victim can be identified during the preventive medical examination, through active home visits of the family doctor/nurse, through victim's addressing to health care institution for primary or specialized health services, as well as by requesting pre-hospital emergency care in cases of medical-surgical emergencies.

The identification of the victim by the health professional can also be performed based on additional information provided by extended family members (who include all relatives up to the fourth degree of kinship), neighbours and other people in the community or based on references or recommendations from various institutions, including healthcare, as well as by anonymous notifications.

While identifying suspicious cases, the health professional may rely on direct and indirect observation of specific signs (physical injuries/traumas that

can be examined, as well as behavioural that can be observed) pointing at possible domestic violence.

Victims are not always ready to talk about the violence they have been subjected. Behavioural indicators and/or signs and symptoms that indicate possible domestic violence, can be detected by:

1) observations of the victim's behaviour;
2) observations of the perpetrator's behaviour;
3) medical consequences of domestic violence.

Observing the victim's behaviour can identify the frequently encountered psychological violence, manifested by various signs and symptoms, such as:

1) ***instinctive-subjective disorders:*** feelings of restlessness, helplessness, irascibility, discouragement, lack of calm and joy of life, headache, overwork, insomnia, fear, frustration;
2) ***symptoms of inhibition and sadness:*** anxiety, heaviness, elements of self-aggression with suicidal thoughts, marked depression, emotional disorders in the form of laughter and crying, slow thinking, tense facial expressions, wrinkled forehead;
3) ***protection symptoms:*** the victim feels the need for protection, support, understanding; seeks support from relatives, medical help; cannot control alone his/her suffering, needs to be active, strong.

In addition to the symptoms of psychological violence, certain behaviours of the victim may also betray the patient as a victim of domestic and gender-based violence. These include:

- frequent appointments with the doctor for vague symptoms;
- attempt to hide or minimize the injuries;
- avoidance of communication with the doctor in the presence of the partner or the adult accompanying the victim;
- the victim's fear of the accompanying partner or adult;
- non-compliance with the prescribed treatment;
- frequent no show appointments with the doctor.

The behaviour of the partner or perpetrator may also indicate that the victim is being abused by him/her. The possible behavioural manifestations of the partner/perpetrator are:

1) the partner/perpetrator escorts the victim and insists on being present and answering questions in his/her place;
2) the partner/perpetrator denies or minimizes the caused injuries;
3) exaggerated jealousy or passivity manifested by the partner/perpetrator.

Along with the signs of psychological violence, the identification of a possible victim of domestic violence can take place based on trauma and clinical conditions such as:

1) the medical consequences specific to each type of violence;
2) symptoms of chronic gastrointestinal disorders (irritable bowel syndrome), urogenital (frequent urination, chronic kidney infections);
3) reproductive system disorders (frequent unwanted pregnancies, late addressing, postpartum complications, vaginal bleeding, STIs, unexplained pelvic pain, sexual dysfunction);
4) central nervous system problems (persistent headaches, cognitive problems, hearing loss)
5) divergences between the origin of the injuries and the victim's explanations or inconsistent explanations.

BOX 9 Specific features of domestic violence lesions

- Multiple lesions, at various stages of healing, in several areas of the body (especially on the face and arms), which may not be the result of falling;
- Unexplained lesions, confusingly explained or inconsistent with the explained cause
- Symmetrical lesions
- Lesions in places hidden by clothing

If there is evidence or suspicion that a person is a victim of domestic violence, the health professional should make every effort to ensure that he or she receives the full available support. Identification of the victims of domestic and gender-based violence has a number of benefits. Thus, the identification of the victim is inevitably followed by the provision of medical assistance and other care that the victim needs. If the health system is unable to identify victims of domestic violence, they will receive only those healthcare services that will be

necessary depending on their clinical condition, without benefits from the specific services these categories of victims may need. Identification of the patient as the victim of domestic violence helps the medical staff explain the symptoms of uncertain origin. All this would help to improve the quality of victims' life and reduce the irrational and inefficient use of human, material and financial resources of the health system.

Communication with victims of domestic violence

Asking questions about domestic violence can be a challenge for any health care provider. For this reason, a number of conditions must be met in order to increase the victim's level of trust in the health professional:

- the discussions should take place in a private and confidential space involving only strictly necessary medical staff;
- should be avoided the interviews about violence in the presence of a family member, a friend or a child over the age of 2;
- it is necessary to provide an interpreter for immigrant women, refugees or if they belong to an ethnic group who do not speak the local language;
- the involvement of family members as interpreters should be avoided.

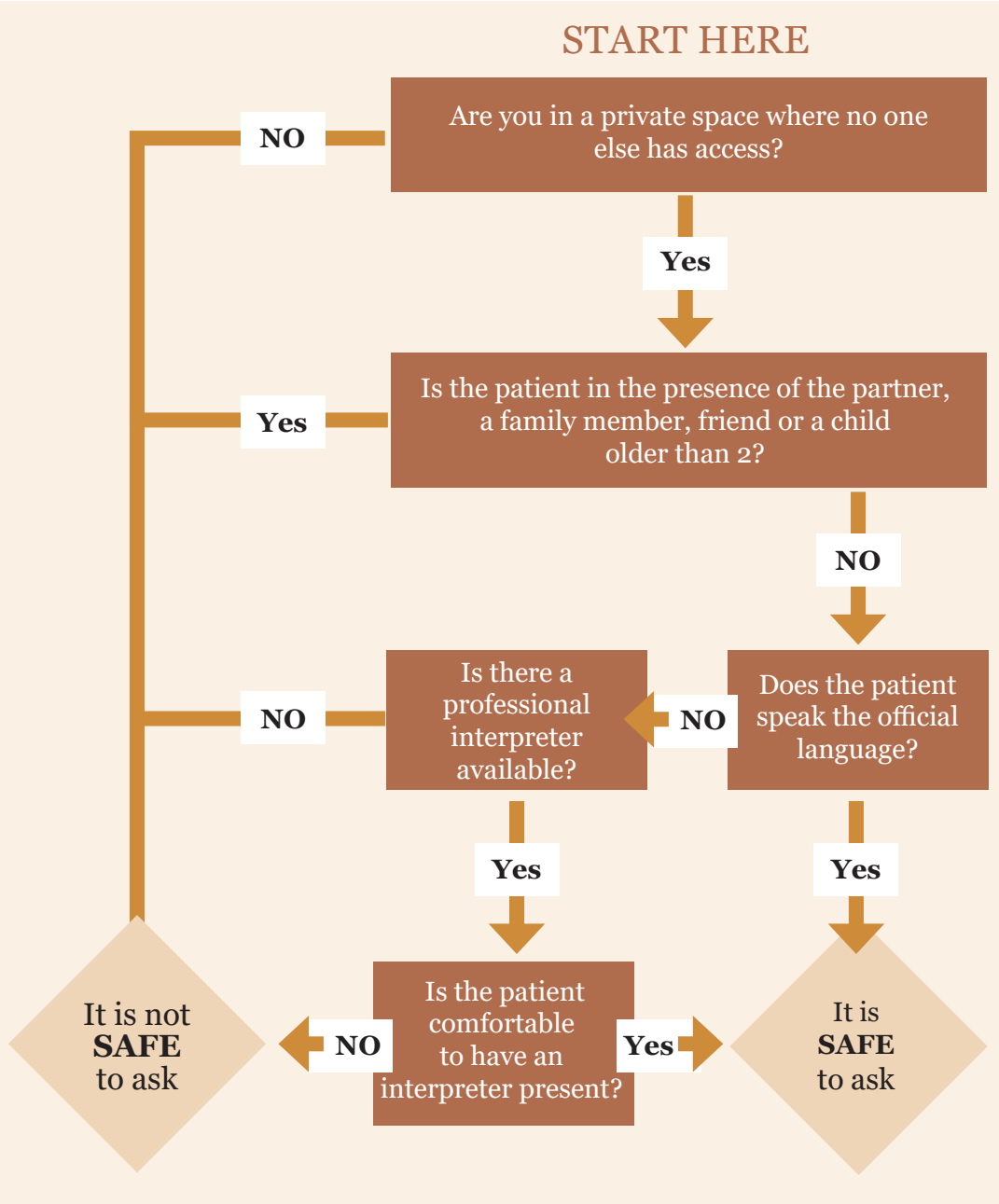


FIGURE 17. Communication safety algorithm with victims of domestic and gender-based violence

(source: Handbook for training medical staff in addressing gender violence, 2015)

BOX 10 Tips for communication with victims of domestic violence

- Take the initiative and ask about violence – do not wait for the woman to initiate this discussion; it demonstrates the professional's responsibility for the victim's situation and helps to increase her/his trust;
- Avoid asking the victim about domestic violence in the presence of a family member, friend or child/children over the age of 2;
- Explain that the information will remain confidential and inform the victim about any confidentiality restrictions;
- Use eye contact as culturally appropriate, and focus all attention on the victim; avoid doing paper work at the same time;
- Be aware of victim's body language; how you stand and hold your arms and head, the nature of your facial expression and tone of voice – all convey a clear message to the victim about how you perceive the situation; show a supportive attitude; avoid body language conveying the message of irritation, disbelief, dislike or anger toward the victim;
- Demonstrate an uncritical and supportive attitude, do not judge a victim's behaviour based on culture or religion or any other aspects;
- Use an understanding voice to encourage the victim;
- Formulate questions and phrases in a supportive and non-judgmental manner, using an empathetic voice;
- Listen carefully to her experience, avoid unnecessary interruptions and ask questions for clarification only after she has completed her account;
- Be patient with the victim, as she/he is in a state of crisis and may have conflicting emotions (Stockholm Syndrome), and if it does not help revealing details, tell her/him what made you think about the violence;
- Avoid passive listening and non-commenting, as this may make her think that you do not believe her and that she is wrong, and the perpetrator may be right; carefully listen to her experience and assure her that her feelings are justified;
- Use the same language as the victim; if the victim speaks other language, ask for the help of a colleague who speaks the same language or for an interpreter to assist her/him;
- Adapt language and words at the understanding level of the victim; do not use professional jargon and expression that might confuse the victim;
- Do not blame the victim, avoid questions such as 'Why do you stay with him/her?', 'Did you have an argument before violence happened?';

- Underline that domestic violence cannot be tolerated and it is not the victim's fault but the perpetrator's responsibility for his behaviour;
- Use supportive statements, such as: 'I am sorry that this happened to you' or 'You really have been through a lot', which may encourage the victim of domestic violence to disclose more information;
- Underline the existence of available options and resources.

After the victim of domestic violence is identified, the health professional has to assess victim's needs and decide about the next steps of care, reporting and referral of the case.

Medical intervention

After the patient has reported an act of domestic violence, the medical staff must perform a medical examination and provide the necessary health care. The process of healthcare provision begins with the obtaining of a prior mandatory ***informed consent*** in accordance with the Law No 411/1995 on health care (Article 23) and Law No 263/2005 regarding patient rights and responsibilities (Article 13). Giving consent initially involves informing the patient about all stages and components of the medical act, the associated benefits and risks, existing alternatives and prognosis in a way accessible to the victim, so that she understands all the options she has and makes informed conscious decisions about the following actions. At the same time, the health professional has to explain to the victim the limits of confidentiality and the obligation to share information with other institutions or services under the Law No 45/2007 on Prevention and Combating of Domestic Violence. The medical intervention regarding the child-victim must be made mandatorily in the presence of his/her legal representatives (parents, adoptive parents, guardians/curators), with the participation of the psychologist or the teacher, where appropriate. If the child-victim does not have a legal representative from those indicated or in case of a conflict of interest between the legal representative and the child, the criminal prosecution body or the court shall designate as legal representative the territorial guardianship authority. The person who is responsible for causing the damage is not admitted as the victim's legal representative. If the child holds the status of a child temporarily left without parental care or child without parental care, his/her legal representative is the territorial guardianship authority, unless he/she has a guardian/curator. In the case of extrajudicial examination, if

the child victim does not have a legal representative from those indicated or in case of a conflict of interests between the legal representative, the request and examination of the child are performed with the participation of the representative of the territorial guardianship authority, appointed by the head of the institution concerned, whose rights of the authority are defined in the power of attorney. When submitting the request regarding the extrajudicial examination under the conditions described above, the representative of the territorial guardianship authority acting in the interest of the child will obligatorily attach the power of attorney confirming his/her rights of authority, and, where appropriate, the copy of the employee identification and the employment order. The curator, caregivers (foster parent, parent educator) or representatives of residential institutions where children are placed have the status of the legal guardian, who assists and accompanies the child to the medical examination, but has no right to legal representation of the child's interests. The children in custody or who are placed in foster families, family-type home, will be represented by the representative of the territorial guardianship authority. Adolescents, including minors with full legal rights may be able to give consent themselves. If the patient is under 16 years of age, the consent shall be given by the legal representative. In case of a risk of imminent death or serious health threat, the health care services may be provided without the consents of the legal representative. The child should never be examined against his or her will, whatever the age, unless the examination is necessary for medical care.

Medical intervention for victims of domestic and gender-based violence includes medical examination of the victim in private and safe conditions, immediate solution of urgent medical problems, provision of necessary health care, including urgent contraception, STI prevention, viral hepatitis, HIV in case of sexual abuse.

It is important that response of any medical staff (including forensic) to cases of domestic violence should provide the victim with the ***primary support*** which implies ensuring practical and emotional needs through listening, clarifying the needs and concerns, validating feelings and providing safety and support needed. The domestic and gender-based violence victims have distinct needs in comparison with the victims of other traumatic events, determined by the dynamics of this form of violence. For these reasons, healthcare should be focused on the needs of victims of domestic violence and include a number of elements.

BOX 11 Elements of health care focused on the needs of domestic violence victims (primary support)

- adopt a supportive, free of prejudice attitude and validate women's statements
- provide practical support and care that meet the needs of the victim
- questions about the history of violence, careful listening but without putting pressure on the victim to speak, assisting the woman to access information about resources, including legal or other services, that might be helpful
- help victim to access information on services he/she needs, including legal, social and other services victim finds useful
- ensure confidentiality by informing the victim about the limits of confidentiality (for instance, about the mandatory reporting)
- examine the victim in the absence of the perpetrator and only if the conditions are safe for the medical staff and the victim
- ensure and mobilize the social assistance service

Validation of women's statements and feelings, along with the provided minimal support (especially psychological) are part of first-line support. All women who reveal that they have been subjected to acts of domestic and gender-based violence should benefit from this type of support, as it represents a psychological first aid.

Medical history collection represents the next stage and is necessary to record the traumatic event circumstances, in order to guide the medical examinations and to assess the type and volume of the needed intervention. The history should include a detailed and chronological description of the attack; the date, time and duration; perpetrator's data and the people present; use of weapons.

Formulating questions in a professional way helps the victim to avoid feelings of isolation, blame and shame. Even if the patient does not reveal her situation at that time, she will know that the doctor is aware of her situation and will be able to return in the future to talk about it. The victim may be helped to talk about the event, especially when she avoids answering the introductory and direct questions.

CASETA 12 Example of questions for the discussion with the victim

Introductive questions	Direct questions
• 'I know from personal experience that many people suffer from domestic violence. Do you have a similar problem?'	• 'I am concerned that your symptoms may be caused by violence. Were you hit by someone, your husband/partner?'
• 'Many of my patients are abused by their aggressive partners. Some of them are afraid to talk about it. Have you ever been abused by your partner?'	• 'Have you ever been hit by your husband/partner?'
	• 'Have you ever been abused by your partner?'

While collecting the history, the victim must not be listened passively, be blamed for what happened, be asked provocative questions ('Why are you staying with him?', 'Had you argued before he became violent?', 'Why did you criticise him?'), non-verbal messages of irritation, distrust, antipathy or even anger mast not be sent towards the victim.

After the history is collected, the health professional performs the full physical examination (including genitals in case of sexual violence), following general principles of examination:

- the victim will be explained the medical examination procedure, what it includes, why and how it is performed, with the opportunity to ask questions, in order to avoid the examination becoming another traumatic experience;
- the victim will be asked if she wishes to be examined by a female doctor, especially in cases of sexual violence;
- the victim will not be left alone while waiting for the medical examination;
- the victim will be asked to undress completely and put on a medical robe so as to allow the examination of hidden lesions;
- during the physical examination, to detect signs of violence, uncovered parts of victims' body will be examined first, then the rest of the body; particularly, areas covered by clothing and hair will be examined;

- in case of sexual violence the whole body will be examined, not only genitals or abdominal area;
- both severe and minor lesions will be examined;
- victims' emotional and psychological state will be taken into account;
- throughout the physical examination the victim will be informed about what the medical staff plans to do, his/her permission being required;
- if the victim refuses a part or the entire physical examination, he or she will be allowed a degree of control over his or her examination, an approach that is important for his or her recovery.

If a victim is identified in a serious, life-threatening condition, he or she will be referred immediately to inpatient treatment. If the victim does not have serious lesions, she/he will be treated on-site. If the identified victims exhibit signs/symptoms characteristic to psychological violence, the health professional will provide counselling (within the limits of professional competence), will inform the victim about specialised services available in the area (psychologist/psychiatrist) and only with victim's consent, will refer him/her for specialised assistance available in the administrative territory, or, as appropriate, to other facility.

Barriers that obstruct health care

Healthcare professionals should be aware of certain barriers that could prevent women who have experienced domestic violence from accessing health services and disclosing to doctors the acts of violence they were subjected. Recognizing these barriers would help healthcare professionals avoid them and thus provide an effective response.

BOX 13 Barriers impeding victims to access health care services

Barriers faced by women	Barriers faced by medical staff
• shame, feelings of guilt • fear of being blamed and negative reactions from professionals • ignorance of existing protection mechanisms • lack of trust in medical staff • fear of violence escalation • fear of stigmatization and social exclusion • social isolation • lack of safe options for the woman and her children • lack of access to service providers (e.g.: disabilities, long distances to healthcare units) • language and cultural barriers	• lack of knowledge about domestic violence and how to provide a proper response • ignorance of available services • a large amount of work (overload) • lack of institutional support in the form of operational procedures • personal attitudes and misconceptions about domestic violence • personal abuse experience • the doctor's indifference (it is not his/her problem) • lack of operational procedures and intervention protocols • uncertainty about legal obligations (e.g. confidentiality rules or reporting obligation)

Documentation of medical acts and bodily injuries

One of the mandatory elements of the medical act is its documentation. The results of the victim's examination are recorded in a medical document (Outpatient medical record (Form No 025/e), Inpatient's medical record (Form No 003/e), EHC request form (Form No 110/e) etc.) depending on the stage and type of medical assistance provided. The medical record is filled in accordance with the provisions of the Instruction on completion of inpatient medical record (F 003/e), approved by the order of the Ministry of Health No 265 of 03.08.2009. The medical staff has the professional obligation to record all the components of the medical intervention. All medical information about the victim is recorded in the medical documentation, including demographic information (e.g. name, surname, age, sex), the obtained informed consent, life history, trauma conditions, complaints, physical examination results, bodily injuries, the performed investigations and their outcome, the diagnosis of the

disease/trauma, being also specified the *Consequences of domestic violence*, the evolution of the pathological process, the treatment tactics, the medicines provided or prescribed, the information offered to the victim and her referral to other services. Medical documentation should be kept in a safe and confidential place. For the patient, the medical documents contain data on the consequences of violence and value as forensic evidence, which will serve to incriminate the perpetrator's actions. Note that coordination between medical staff and the police is necessary for the preservation of evidence and its use in litigation. However, documents are important sources for other health professionals involved in providing a complex and appropriate health care.

It is important to describe the act of violence in the medical documents, using the correct terminology, while collecting history and recording the case circumstances. The term violence must not be replaced by general notions, such as conflict or dispute. The way of describing the act of violence determines the way of perceiving the violence in the family. Through the description, the act of violence can be distorted and concealed. It is mandatory to use the active form of the event reporting. For instance, John hit Helen. In this case, in description, the perpetrator is the central figure. If the passive form is used for reporting (e.g. Helen was hit by John), the victim appears as the central figure, and the perpetrator is somewhat 'in the shadow' of the victim. In this way, the focus is shifted from the perpetrator to the victim. The use of the passive form depersonalizes the story (Helen was hit) will generally lead to the 'disappearance' of the perpetrator, and the veiled form of the reporting (There was a dispute/family conflict) will completely disguise the act of violence. For instance, in an order for forensic examination on the victim of domestic violence, was used the following description: Helen was assaulted by her partner following a conflict. In this way, the perpetrator 'disappeared' from the story, and with it, his role in causing violence has toned down. In this way, the responsibility for the act of violence is shifted from the perpetrator to the victim. Moreover, the notion of domestic violence has disappeared from the description, which has diminished the individual and social importance of this phenomenon and thwarted all efforts to take appropriate measures to combat it. Such a situation affects the victim as she no longer benefits from the inter-disciplinary professional support that is necessary for the victim of domestic violence.

For the full documentation of bodily injuries, establishing the mechanisms and conditions of their formation (vitality and injury age, type of traumatic agent, etc.), legal qualification of the perpetrator, including the severity of their consequences, the injuries must be fixed in the medical documentation respecting mandatorily the standard scheme for their description.

External lesion description provides the obligatory indication of the following characteristics: *the exact location of the lesion* (are recorded the anatomical area, its surface, the correlation with the anatomical points); *type of lesion* (bruising, excoriation, laceration, etc.); *the shape of the lesion* (will be compared with geometric figures, if the shape cannot be compared, irregular shape is indicated); *position of the lesion towards the midline of the body* (organ, bone); *lesion dimensions* (length, width and, separately, depth) in centimetres; *the colour of the lesion and adjacent areas; the characteristics of the lesion surface* (relief, colour, presence and level of excoriation crust in relation to intact skin); *the characteristics of the edges, ends, walls and bottom of the wounds; the presence or absence of haemorrhage* and its degree, *the signs of lesion regeneration; the presence of heterogeneous deposits or impurities* (soot, lubricants, rust, cloth fragments, shards of glass, etc.) on the surface of the lesion or in its depth; *the condition of adjacent tissues* (edematous, hyperemic, impure, etc.). At the same time, in order to identify the traumatic agent, those signs and morphological features that reflect the shape, characteristics of the surface and other important properties of the traumatic object will be indicated.

When describing lesions, it is not allowed to replace their morphological characteristics by general or diagnostic expressions (e.g.: soft tissue contusion, cut wound/contusion, etc.). The general requirements for the description of local changes are common to all medical specialties, with some description features in some specialties, such as ophthalmology, otolaryngology, etc.

Risk Assessment

The safety of patients exposed to domestic violence must be the focus of any intervention of health professionals. That is why, during intervention, the health professional should assess the risk by questioning the victim about the risk factors that trigger the domestic violence and/or may favour the escalation of acts of violence. The questionnaire is a set of questions that the victim has to answer during the examination of the domestic violence case.

The initial risk assessment by the healthcare professional, in all identified/reported cases of domestic violence, aims to identify the people at risk, the risk factors, which may be identified, and the risk degree to which the victim or his or her family members are subjected, as well as establishing the type of required intervention (hospitalization/referral to a specialized center/etc.).

The following circumstances may be risk factors:

- previous acts of violence against the victim and the history of abuse;
- types of violence;
- previous convictions or reports to police;
- legal or unlawful possession and/or use of weapons or threats of use weapons;
- victim's suffocation;
- violent behaviour outside the family;
- separation and divorce;
- alcohol and/or drug use by the perpetrator;
- threats, especially death threats;
- extreme jealousy and possessiveness;
- extreme patriarchal concepts and attitudes;
- non-compliance with orders imposed by the court or police.

To identify the risk to the life or bodily integrity of the victim, the medical staff should assess the risks using the Questionnaire and the Professional's Guide on risk assessment from the Instructions on the healthcare institution intervention in cases of domestic violence, approved by the order of the Ministry of Health, Labour and Social Protection No 1167 of 15 October 2019:

No	Question	Response	
1.	Does the perpetrator often use violence?	Yes	No
2.	Has the violence recently gotten worse?	Yes	No
3.	Does the perpetrator try to control who you talk to, where you go, what clothing you wear or what you do?	Yes	No
4.	Do you think the perpetrator will seriously injure or kill you, your children, or someone close to you?	Yes	No
5.	Does the perpetrator frequently monitor your whereabouts, show up to your home or work uninvited, or initiate unwanted contact in person, by phone, text message or other electronic communication?	Yes	No
6.	Has the perpetrator intimidated or threatened you if you tried to end the relationship, leave, get help, or talk to someone close to you about the abuse?	Yes	No
7.	Has the perpetrator ever strangled or choked you? Or has the perpetrator ever used physical force in a way that interfered with your ability to breathe or cause you to faint?	Yes	No
8.	Did you experience physical violence or abuse during pregnancy?	Yes	No
9.	Has the perpetrator ever threatened or prevented you from seeking help, particularly from the police, courts, or an advocate?	Yes	No
10.	Has the perpetrator ever used weapons/objects?	Yes	No
11.	Has the perpetrator ever pressured or forced you to do things sexually you didn't want to?	Yes	No
12.	Has (offender's name) ever threatened or attempted suicide?	Yes	No

The more risk factors are identified in a certain case, the greater the risk that the violence acts will recur or that violence will escalate. Risk assessment allows healthcare professionals to support patients in identifying measures needed to increase their safety and those close to them, but also to alert victims about the existing risks.

Supporting the patient in developing a safety plan

Safety planning is a part of the overall risk management process and can help the woman prepare to leave the relationship safely if the violence escalates.

While developing the safety plan, the medical staff and the victim should be guided by the following suggestions:

- Identify one or more neighbours you can tell about the violence and ask them to help you if they hear something disturbing coming from your home.
- Do you have friends or relatives you trust who could shelter you for a few days with your children?
- Think in advance about where you will go if necessary and work out a plan to get there even if you do not think you will have to leave.
- If you feel that you cannot avoid an argument, try to have it in a room where you can leave easily.
- Stay away from any room where may be weapons.
- Rehearse the way to get out safely of the house. Identify the most suitable doors, windows, elevators or stairs.
- Get a bag ready containing spare keys, money, important documents and clothes. Keep this bag at a friend or relative's home, in case you need to leave in a hurry.
- Set a warning code/word to use with your children, family, friends, and neighbours when you need emergency help, or if you want them to call the police.
- Use your instincts and judgment. If the situation is dangerous, think about giving the perpetrator what he wants, to calm him down. You have the right to protect yourself and your children.
- Remember, you do not deserve to be battered or threatened.

Reporting the case to the police

After the intervention, the medical staff must report mandatorily the case to the territorial police bodies in the following situations:

1) child victims of any form of violence, without their consent;
2) domestic violence acts that endanger the victim's life or health or the existence of an imminent danger that such violence may occur, without the victim's consent;

3) people with moderate or serious bodily injuries, committed as a result of an offense against them;

4) at the victim's explicit request.

In other cases, the case will be reported to the police bodies only with the victim's consent.

The following provisions of national law serve as a basis for the mandatory reporting of the case to the territorial police bodies:

- ***Article 12 (4) and (4¹) of Law No 45/2007 on Preventing and Combating Domestic Violence:***

People with responsibilities and professionals required to ensure confidentiality are obliged to report to the competent authorities on acts of domestic violence, which endanger the life or health of the victim or there is an imminent danger that such acts of violence may occur. In other cases, the reporting will be done only with the victim's consent. Reporting cases of violence against children, including reasonable suspicion of such cases, is mandatory and does not require the victim's consent.

- ***Article 12 (4) (e) of Law No 263/2005 on the Rights and Responsibilities of the Patient:***

Prezentarea informaţiei confidenţiale fără consimţământul pacientului sau al reprezentantului său legal (al rudei apropiate) se admite la existenţa temeiului de a crede că prejudiciul adus sănătăţii persoanei este rezultatul unor acţiuni ilegale sau criminale informaţia urmând a fi prezentată, în acest caz, organelor de drept competente.

- ***Article 13 (4) (e) of Law No 264/2005 on the Exercise of the Profession of Doctor:***

Disclosure of information to other people, which constitutes professional secret without the consent of the patients or of their legal representative, shall be allowed if it is supposed that the damage caused to the person's health is the consequence of an illicit act.

- ***Joint Order of the Ministry of Health and Ministry of Internal Affairs No 369/145 of 20.05.2016 regarding the measures for improving the cooperation between the Ministry of Health and Ministry of Internal Affairs:***

The health care institutions staff, regardless of the affiliation and the legal form of organization, is obliged to immediately inform the territorial subdivisions of the police about provision of the medical assistance to people with moderate or serious bodily injuries, committed as a result of an offense against them.

- ***Instructions on the cross-sectors cooperation mechanism for the identification, assessment, referral, assistance and monitoring of children who are victims and potential victims of child violence, neglect, exploitation and trafficking (Government Decision No 270/2014:***

The representatives of the health care institutions, regardless of their legal form of organization, are obliged to immediately inform by phone the local guardianship authority, and to send the notification form within 24 hours of the suspected case of violence, neglect, exploitation, trafficking and in addition, to inform the territorial police inspectorate/prosecutor's office – if they know or suspect that a child is a victim of a crime/contravention and the emergency medical service – if the notification contains information on the existence of imminent danger to the life or health of the child, suicide attempts of children. Village mayors (communities) and town mayors are considered as local guardianship authorities, and in Chisinau and Balti Municipalities – divisions/sections for Social Assistance and Family Protection/Municipal Division for Child Protection.

The reporting of the case to the police bodies is carried out by completing and sending the notification/reporting form of domestic violence case from the Instructions on the healthcare institution intervention in cases of domestic violence, approved by the order of the Ministry of Health, Labour and Social Protection No 1167 of 15 October 2019.

If reporting to the police is not mandatory and the victim does not give his/her consent for the reporting, the healthcare professional should inform the victim about the existing risks to reduce their level.

Failure to report violence cases against children to the relevant guardianship authorities will result in contraventional liability of the person responsible for reporting. Thus, according to Article 65 of the Contravention Code of the Republic of Moldova (violation of the legislation on special protection of children

at risk and children separated from parents), failure to ensure compliance by employees of health care institutions with the terms and procedures provided by the cross-sectoral cooperation mechanism regarding the transmission of notifications to relevant guardianship authority regarding the children at risk and regarding the cases of violence, neglect is sanctioned with a fine from 15 to 60 CU for individuals, with a fine from 30 to 150 conventional units applied to people in charge with or without the deprivation of the right to hold certain positions or to practice certain activities for a period of 3 months to 1 year; failure to notify the guardianship authority by the person in charge and by other persons obliged to do so about a danger to the life or health of the child or about the violation of his/her legitimate rights and interests is sanctioned with a fine from 15 to 30 conventional units.

Referring cases of domestic violence

Victims who were subjected to domestic and gender-based violence have multiple and complex needs, such as health care, psychological counselling, social assistance, police protection, legal aid and safe accommodation. Medical staff often represents the point of entry for victims in the field of social services as these professionals have a strategic position to identify cases. However, it is impossible for the victim to benefit from the full range of services he/she needs in a health care institution. Therefore, cross-sectoral cooperation and development of a referral system for victims to various institutions and authorities are needed to ensure an effective professional response and all domestic violence victims' needs. Referrals represent an important stage in domestic violence case management.

The referral system eis a comprehensive institutional framework, which connects different entities with different specializations, responsibilities and powers in a cooperation network. This system aims to protect and support victims, provide support for their recovery, prevent violence and prosecute perpetrators. The system describes a process where medical staff communicates with the patient and other professionals specialized in preventing and combating domestic and gender-based violence. The referral mechanism can work at different national, regional, municipal, community levels.

However, within healthcare institutions there must be an institutionalized system for referral which will cooperate with other institutions and organizations specializing in the protection of victims' gender rights in the family. At the same time, the existence of the system and its principles of operation must

be known to the medical staff involved in providing health care to victims of domestic violence.

So, for an efficient referral it is necessary that the medical staff:

- be able to recognize and facilitate the disclosure of a case of domestic violence;
- be able to assess the situation and the individual needs of the patient;
- to inform the victim on the possibility to be referred to other service providers and obtain victim's consent;
- to know and provide data on organizations that provide services to victims of domestic violence (name of the institution, address, contact telephone number, contact person; type of support that could be provided by a particular service provider, information on the costs related to the services provided, etc.);
- to inform the victim about the information which will be shared with other service providers.

Victim's referral to other partners may take place only with victim's consent. The referral to health care professionals' consultation is made on the basis of the referral form (Form No 027/e), which includes the information collected during the primary medical examination (complaints, medical diagnosis highlighting the potential causal link with the form of violence; specification of clinical investigation results and paraclinical services performed and the care services provided, in accordance with the symptoms and pathology identified under the National Clinical Protocols and the medical diagnosis and treatment standards in force). If the victim needs other support services (social assistance, psychological support, legal aid, etc.) the health professional must inform her/him about them (at local/regional/national level) and, based on her/his needs, refer her/him to another institution, according to the domestic violence referral form included in the Instructions on the healthcare institution intervention in cases of domestic violence, approved by the order of the Ministry of Health, Labour and Social Protection No 1167 of 15 October 2019.

The referral system of the victims of domestic violence should include a wide range of different governmental and non-governmental authorities, institutions and services with responsibilities fin preventing and combating domestic violence, such as general assistance services (health care and social), women centers and shelters, sexual assault centers, women's help lines, the police and the judicial system. The available resources for victims of domestic violence and perpetrators are listed in the annex.

In cases of domestic violence when the perpetrator manifests mental and behavioural disorders, including due to psychoactive substances abuse, and refuses specialized treatment, the victim must be informed about the family's right to request the support of the relevant bodies: Social Affairs Commission at the level of the local public authority (empowered to refer the person to medical examination within the Expert Commission on Drugs, to obtain an opinion on the degree of alcohol, drugs abuse and to determine the necessary support, which will be provided by the specialized healthcare institution), police, prosecutor's office, court which, in accordance with the legal provisions, are entitled to intervene to reduce domestic violence committed by people with mental disorders or diseases.

Forensic medical examination

Forensic services are provided by the Center of Forensic Medicine within its territorial subdivisions located in the district centers and municipalities. Each subdivision provides services to the police inspectorates, prosecutor's offices, courts and the population of the respective territorial-administrative unit.

The purpose of forensic investigations is to document the violence consequences and collect biological materials that will be used as evidence to prove or disprove a connection between people and/or between people and places or objects and, thus, will allow the incrimination of the perpetrator's actions. The competence of forensic investigation is limited to the explaining the phenomena of medical and biological nature for judicial purposes.

A forensic examination is ordered by the criminal investigation bodies (criminal investigation officer, prosecutor) or the courts in a judicial process (criminal, contraventional, civil). At the same time, any individual can request, based on his/her application and an official identity document (birth certificate (for children), identity card, passport, driving license), an extrajudicial forensic examination.

A forensic examination is carried out based on the examination of the person, as well as of the medical documentation. In the cases of forensic examinations performed on the basis of medical documents, it is important to describe correctly and completely the morphological characteristics of the lesions and to justify the diagnosis through conclusive, objective clinical and paraclinical data, tasks which are performed by medical staff. The incomplete description of the morphological characteristics of the lesions will not allow the medical examiner to solve the objectives of the forensic examination regarding the circumstances of trauma occurrence (time, mechanism, traumatic object, etc.), which makes

impossible to confirm by objective evidence and sufficient scientific material of the circumstances invoked by the victim. Note that clinical diagnoses aiming unconfirmed lesions by objective data are not subject to forensic qualification as lesions, therefore the perpetrators cannot be held legally liable for the caused damages. In both cases, the law enforcement body and the court find it impossible to take measures against the perpetrators and to fulfil the victim's right to fair justice.

The forensic examination is usually performed in the territorial forensic medical departments during their work hours and must be carried out as soon as possible after the trauma to avoid losing evidence, especially in cases of sexual violence. For this reason, at the written request of the applicant, the forensic examination of the person may also be performed at his/her location (health care institution, detention institutions, the court, person's domicile (as an exception)). The forensic examination of people can be performed outside working time of the forensic department in cases of sexual assault (within 5 days from the incident), as well as in other cases when there is a risk of tampering with evidence or changing the factual situations.

Forensic intervention in cases of domestic violence is based on the same guiding principles as the response of the health system and includes the same basic elements:

1) identification of the victim of domestic violence;
2) providing first aid (if necessary);
3) conducting forensic examination, including documentation;
4) risk assessment;
5) reporting the case to the police and the referral of the victim.

Resources available to victims of domestic violence and perpetrators

Learn about the local and national resources to which you can refer the victim, including specialist services. The following websites and contact details may be helpful:

1. *Local/territorial guardianship authorities*

- ***local guardianship authority*** – village (commune) and town mayors;
- ***territorial guardianship authority*** – divisions/sections for social assistance and family protection/Chisinau municipal division for child protection. In Balti and Chisinau the territorial guardianship authorities shall perform the duties of local guardianship authority, except for the autonomous administrative and territorial units being part of them, where the duties of local guardianship authority shall be performed by the mayors of these administrative and territorial units.

2. *Services for victims:*

- ***Center for assistance and protection of victims and potential victims of human trafficking in Chisinau***
  tel.: 0(22)92-71-94, 0(22)92-71-74, 079 336 663,
  e-mail: shelter_team@cap.md, site: www.cap.md

- ***International Center for Women's Rights Protection and Promotion 'La Strada'***
  Trust Line: 080 088 008
  tel.: 0 (22) 23-49-06, fax: 0 (22) 23-49-07, e-mail: office@lastrada.md,
  site: www.lastrada.md

- ***Women's Law Centre (WLC)***
  tel./fax: 0 (22) 81-19-99, GSM.: 068 855 050, 080 080 000 (free call);
  e-mail: office@cdf.md, site: www.cdf.md

- ***National Center for Child Abuse Prevention (NCAPC)***
  tel.: 078 000 480; 0 (22) 75-88-06, 75-67-78, fax: 0 (22) 74-83-78,
  e-mail: office@cnpac. md, site: www.cnpac. md

- ***Promo-LEX Association***
  tel./fax: 0 (22) 45-00-24, e-mail: info@promolex.md,
  site: www.promolex.md

- ***'Casa Marioarei' Shelter***
  tel.: 0 (22) 72-58-61, e-mail: cmarioarei@gmail.com;
  site: www.antiviolenta.md

- ***Rehabilitation Center for Victims of Torture 'Memoria'***
  tel/fax: 0 (22) 27-32-22,0 (22) 27-06-19, 079 704 809,
  e-mail: rctv@memoria.md, site: www.memoria.md

- ***Emergency Shelter for domestic violence victims (Telenești)***
  Tel: 079 588 052

- ***'Contemporary Women's Dignity and Rights' Center (Balti)***
  tel.: 0 (231) 70-778, 0 (231) 77-794, 0 (231) 70-149, 079 055 616,
  e-mail: olgapatlati@mail.ru

- ***Family Crisis Center 'Sotis' (Balti)***
  tel.: 0 (231) 92-541, fax: 0 (231) 33-475, e-mail: ccf.sotis@gmail.com

- ***Maternal Center 'Pro Familia' (Causeni)***
  tel.: 0 (243) 26-721, 0 (243) 26-975, 0 (243) 26-835,
  e-mail: profamilia2006@gmail.com

- ***Maternal Center 'Pro-Femina' (Hancesti)***
  tel.: 0 (269) 23-364, e-mail: profemina.2009@mail.ru

- ***Maternal Center (Cahul)***
  tel.: 0 (299) 44-080, e-mail: centru-maternal.cahul@mail.ru

- ***Center for Assistance and Counselling for Victims of Domestic Violence 'Ariadna' (Drochia)***
  tel.: 0 (252) 20–308, 079 000 118; e-mail: cm_ariadna@yahoo.com

- ***'Stimul' NGO (Ocnita)***
  tel.: 060 165 416, fax: +373 (271) 2 33 51;
  e-mail: moldovastimul@inbox.ru

- ***'Vesta' NGO (Comrat)***

tel.: +373 (298) 840 63, +373 (298) 840 62

- ***Youth Resource Center 'Dacia' (Soroca)***

tel.: 0 (230) 23-619, 0 (230) 92 964; e-mail: crt.dacia@gmail.com;
site: www.youthsoroca.md

3. Services for perpetrators:

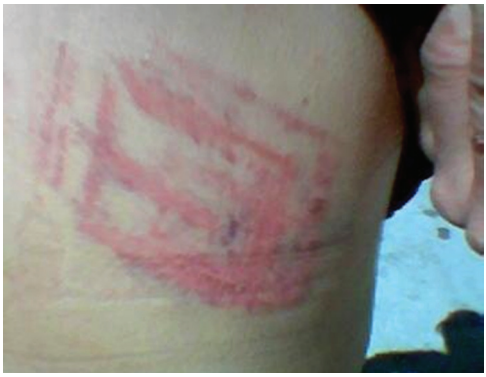
- ***Behavioural change program for men who use violence (Chisinau)***
  tel.: 060 474 277; e-mail: cnfacem@gmail.com

- ***Center for Assistance and Counselling for Domestic Violence Perpetrators (Drochia)***
  tel.: 079 000 115

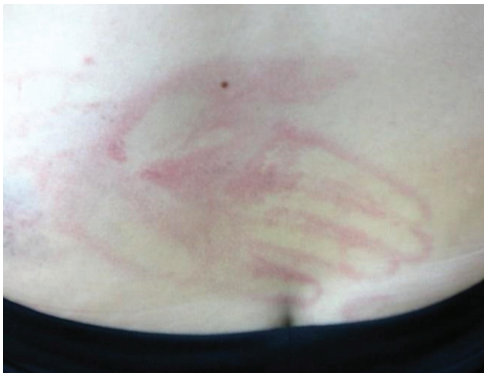
- ***Center for Assistance and Counselling for Domestic Violence Perpetrators (Causeni)***
  tel.: 079 998 755; e-mail nonviolenta.causeni@yahoo.com

- ***Center for Assistance and Counselling for Domestic Violence Perpetrators (Ocnita)***
  tel.: 079 782 093; 027 164 832

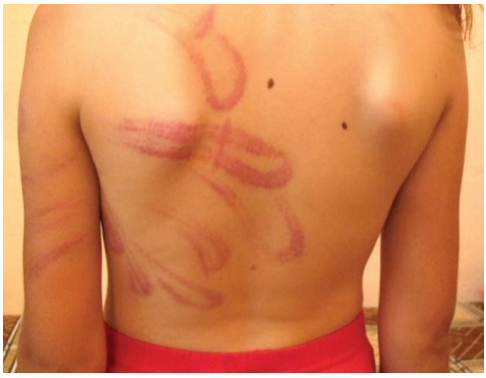
Bodily injuries related to domestic and gender-based violence



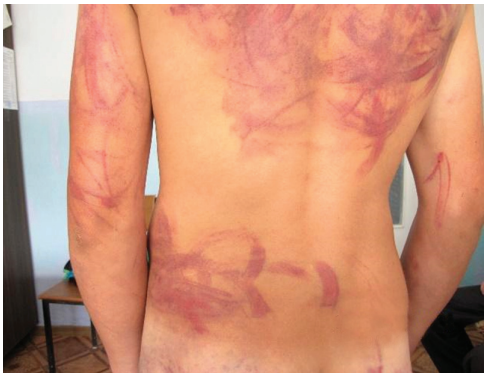
Bruises left by the buckle



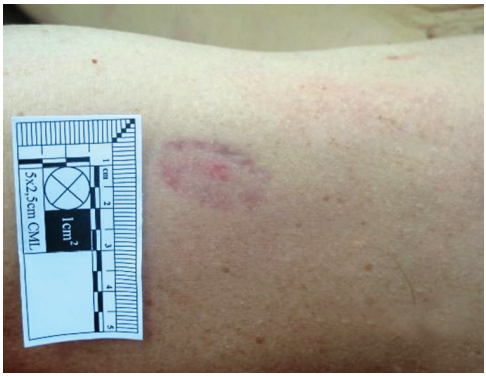
Bruises by slapping



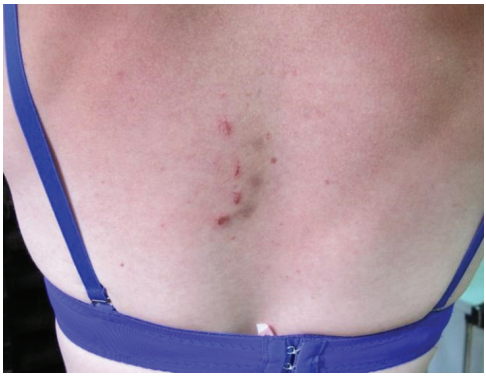
Bruises caused by a bent cable



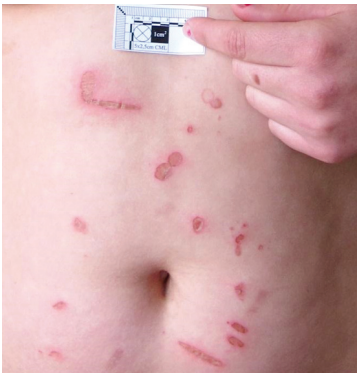
Bruises left by the carpet threshing tool



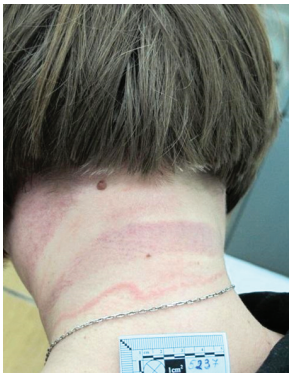
Bite mark



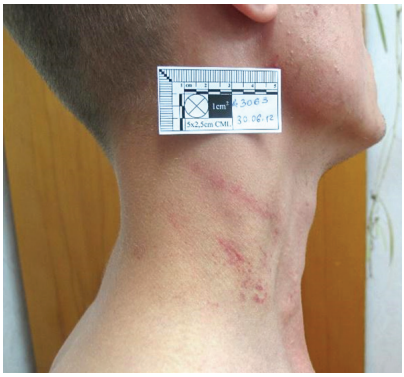
Excoriations and bruises inflicted by fingers – forced pulling of the body



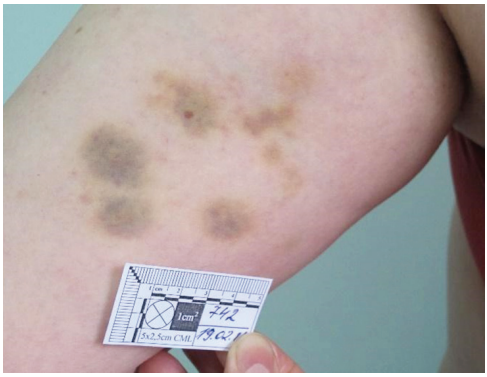
Cigarette burns



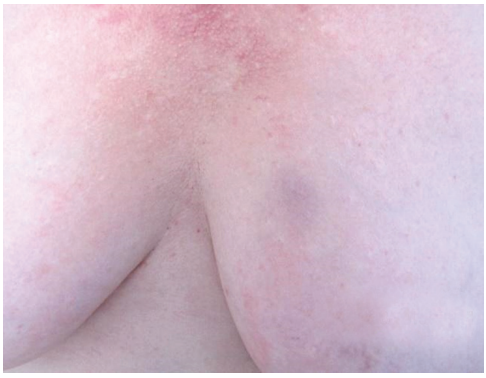
Strangulation with a towel – mechanical asphyxia



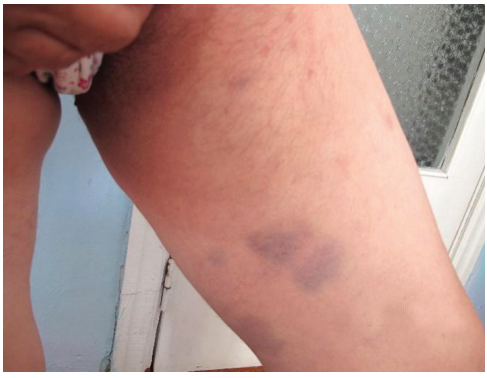
Manual strangulation – mechanical asphyxia



Bruising on the inner surface of the arm – restraining the victim by hands



Breast bruises – sexual assault



Bruising on the inner surface of the thigh – sexual assault

Bibliography

1. 1. Aalbers C., Vîlcu N. Obligaţiile pozitive ale statului în jurisprudenţa Curţii Europene a Drepturilor Omului în materie de violenţă în familie. Manual destinat practicienilor din sectorul justiţiei pentru a asigura accesul la justiţie a victimelor violenţei în familie, 2019, http://cdf.md/files/resources/145/Handbook_RO.pdf
2. Aggrawal A. Forensic and medico-legal aspects of sexual crimes and unusual sexual practices. Boca Raton: CRC Press, 2009. 410 p.
3. Albu N. Dimensiunea de gen în sectorul de securitate şi apărare. Manual. Modulul IV: violenţa sexuală şi în bază de gen în condiţii de pace şi conflict. Chişinău: Tipogr. „Elan Poligraf", 2017. 140 p.
4. Andersson T., Heimer G., Lucas S. Violence and health in Sweden: a national prevalence study on exposure to violence among women and men and its association to health. Uppsala, 2014, 94 p.
5. Bastick M., Grimm K., Kunz R. Sexual violence in armed conflict. Global Overview and Implications for the Security Sector. Geneva: SRO Kundig, 2007. 214 p.
6. Beijing Declaration and Platform for Action. United Nations, 1995. https://www2.unwomen.org/~/media/headquarters/attachments/sections/csw/pfa_e_final_web.pdf?v=1&d=20150303T234153
7. Blank K., Rösslhumer M. Manual de instruire a cadrelor medicale în adresarea violenţei de gen. Vienna, 2015. 96 p.
8. Brânză S. ş.a. Drept penal. Ediţia a II-a. Chişinău: „Cartier", 2005, vol. 2. p.159-179
9. Bunăstarea şi siguranţa femeilor, OSCE, 2019. https://www.osce.org/files/f/documents/e/f/425867_0.pdf
10. Căprioară F. M., Căprioară A. C. Ce este şi ce nu este violenţa? Acta Universitatis George Bacovia. Juridica - Volume 2. Issue 2/2013, http://juridica.ugb.ro/
11. Cheianu-Andrei D., Perevoznic Iu., Zaporojan-Pîrgari A. et al. Bărbaţii şi egalitatea de gen în Republica Moldova: În baza metodologiei IMAGES. Chişinău: „Bons Offices", 2015. 128 p.
12. Codul Contravenţional al Republicii Moldova, nr. 218/2008. În: Monitorul Oficial nr.78-84 din 17.03.2017
13. Codul Civil al Republicii Moldova, nr.1107/2002. În: Monitorul Oficial nr.82-86/661 din 22.06.2002
14. Codul de Procedură Civilă al Republicii Moldova, nr. 225/30.05.2003. Republicat în: Monitorul Oficial nr.130-134/415 din 21.06.2013
15. Codul de Procedură Penală al Republicii Moldova nr.122/2003. În: Monitorul Oficial nr. 248-251 din 05.11.2013
16. Codul Familiei al Republicii Moldova, nr.1316/26.10.2000. În: Monitorul Oficial nr. 47-48/210 din 26.04.2001
17. Codul Penal al Republicii Moldova nr. 985/2002. Monitorul Oficial nr.72-74 din 14.04.2009
18. Codul Penal al României nr. 286/2009. În: Monitorul Oficial nr. 510 din 24.07.2009, http://legislatie.just.ro/Public/DetaliiDocumentAfis/223635
19. Comitetul CEDAW. 2015. Recomandarea generală nr. 33 privind accesul femeilor la justiţie, alin. 26
20. Concluziile comune pentru „Eliminarea şi prevenirea tuturor formelor de violenţă împotriva femeilor şi fetelor" Secţiunea C 57 sesiune 2013
21. Constituţia Republicii Moldova adoptată la 29.07.1994

22. Convenţia asupra eliminării tuturor formelor de discriminare faţă de femei adoptată de Adunarea Generală a Naţiunilor Unite prin Rezoluţia 34/180 din 18.12.1979. Ratificată de către Parlamentul Republicii Moldova conform Hotărârii nr. 87-XII din 28.04.1994, https://old.msmps.gov.md/sites/default/files/document/attachments/cedaw_text_20rom.pdf
23. Convenţia Consiliului Europei privind prevenirea şi combaterea violenţei împotriva femeilor şi a violenţei domestice, 2011, https://rm.coe.int/168046253e
24. Fisher B. S., Lab S. P. Encyclopedia of Victimology and Crime Prevention. SAGE Publications, 2010. p. 257
25. Ghervas M., Gornea M., Maxim I. et. al. Implementarea legislaţiei cu privire la prevenirea şi combaterea violenţei în familie. Suport de curs. Chişinău: „Bons Offices", 2015. 144 p.
26. Gill A. Honour killings and the quest for justice in black and minority ethnic communities in the UK. Crim Justice Policy Rev., 2009, 20(4), p. 475-494
27. Global and regional estimates of violence against women: prevanlence and health effects of intimate partner violence and non-partner sexual violence. WHO, 2013. https://www.who.int/publications/i/item/9789241564625
28. Guidelines for medico-legal care for victims of sexual violence. World Health Organization, 2003, 144 p.
29. Heise L. Violence against women: An integrated, ecological framework. Violence against Women. 1998, vol. 4, nr. 3, p. 262-290
30. Heise L. What Works to Prevent Partner Violence? An Evidence Overview. https://www.oecd.org/derec/49872444.pdf
31. Heise L., Ellsberg M., Gottemoeller M. Ending Violence Against Women. Baltimore: John's Hopkins University School of Public Health, 1999. Report No.: Series L, No. 11. 44 p.
32. Horga I., Nicoară B. Prestarea serviciilor de către poliţie, parte a răspunsului multisectorial în cazurile de violenţă în bază de gen. Proceduri Standard de Operare, 2015. http://antiviolenta.gov.md/wp-content/uploads/2019/08/Prestarea-serviciilor-de-asistenta-medicala.pdf
33. Hotărârea Guvernului Republicii Moldova nr.129/2010 cu privire la aprobarea Regulamentului-cadru de organizare şi funcţionare a centrelor de reabilitare a victimelor violenţei în familie. În: Monitorul Oficial nr .30-31/176 din 26.02.2010
34. Hotărârea Guvernului Republicii Moldova nr. 270/2014 cu privire la aprobarea Instrucţiunilor privind mecanismul intersectorial de cooperare pentru identificarea, evaluarea, referirea, asistenţa şi monitorizarea copiilor victime şi potenţiale victime ale violenţei, neglijării, exploatării şi traficului. În: Monitorul Oficial nr. 92-98 din 18.04.2014
35. Hotărârea Guvernului Republicii Moldova nr. 281/2018 cu privire la aprobarea Strategiei naţionale de prevenire şi combatere a violenţei faţă de femei şi a violenţei în familie pe anii 2018-2023 şi a Planului de acţiuni pentru anii 2018-2020 privind implementarea acesteia. În: Monitorul Oficial nr.121-125 din 13.04.2018
36. How Do I Know If I Have Consent? https://www.dartmouth.edu/consent/communication/whendo.html
37. Integrating poverty and gender into health programmes. A sourcebook for health professionals: module on sexual and reproductive health. WHO, 2008 https://apps.who.int/iris/bitstream/handle/10665/206996/9789290613893_eng.pdf?sequence=1&isAllowed=y
38. Investing in children: the European child and adolescent health strategy 2015–2020. WHO, 2014. https://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf
39. Kandala N.-B., Komba P. N. Female genital mutilation around the world: analysis of medical aspects, law and practice. Springer International Publishing AG, 2018. 226 p.
40. Legea Republicii Moldova nr.121/2012 cu privire la asigurarea egalităţii. În: Monitorul Oficial nr.103 din 29.05.2012

41. Legea Republicii Moldova nr.1227/1997 cu privire la publicitate. În: Monitorul Oficial nr. 67-68 din 16.10.1997
42. Legea Republicii Moldova nr.137/2016 cu privire la reabilitarea victimelor infracţiunilor. În: Monitorul Oficial nr. 293-305 din 09.03.2017
43. Legea Republicii Moldova nr.140/2013 privind protecţia specială a copiilor aflaţi în situaţie de risc şi a copiilor separaţi de părinţi. În: Monitorul Oficial nr.167-172/534 din 02.08.2013
44. Legea Republicii Moldova nr. 198/2007 cu privire la asistenţa juridică garantată de stat. În: Monitorul Oficial nr. 157-160/614 din 05.10.2007
45. Legea Republicii Moldova nr. 263/2005 cu privire la drepturile şi responsabilităţile pacientului. În: Monitorul Oficial nr.176-181 din 30.12.2005
46. Legea Republicii Moldova nr. 320/27.12.2012 cu privire la activitatea poliţiei şi statutul poliţistului. În: Monitorul Oficial nr. 42-47/145 din 01.03.2013
47. Legea Republicii Moldova nr. 338/1994 privind drepturile copilului. În: Monitorul Oficial nr.13/127 din 02.03.1995
48. Legea Republicii Moldova nr. 411/1995 a ocrotirii sănătăţii. În: Monitorul Oficial nr. 34 din 22.06.1995
49. Legea Republicii Moldova nr. 436/2006 privind administraţia publică locală. În: Monitorul Oficial nr. 32-35 din 09.03.2007
50. Legea Republicii Moldova nr. 45 din 01.03.2007 cu privire la prevenirea şi combaterea violenţei în familie. În: Monitorul Oficial nr. 55-56 din 18.03.2008
51. Legea Republicii Moldova nr. 5 din 09.02.2006 cu privire la asigurarea egalităţii de şanse între femei şi bărbaţi. În: Monitorul Oficial nr. 47-50 din 24.03.2006
52. Legea Republicii Moldova nr. 547/25.12.2003 a asistenţei sociale. În: Monitorul Oficial nr. 42-44/249 din 12.03.2004
53. Legea Republicii Moldova nr. 68 din 14.04.2016 cu privire la expertiza judiciară şi statutul expertului judiciar. În: Monitorul Oficial nr.157-162 din 10.06.2016
54. Legea Republicii Moldova nr.713/2001 privind controlul şi prevenirea consumului abuziv de alcool, consumului ilicit de droguri şi de alte substanţe psihotrope. În: Monitorul Oficial nr. 36-38/208 din 14.03.2002
55. Men in focus. Unpacking masculinities and engaging men in the prevention of violence against women. https://media-cdn.ourwatch.org.au/wp-content/uploads/sites/2/2019/11/06231948/Men-in-focus-Summary.pdf
56. Metodica-tip de efectuare a expertizei judiciare medico-legale – Expertiza medico-legală a persoanelor. Ordinul CML nr. 40 din 28.12.2017 cu privire la aprobarea şi implementarea în practica medico-legală a metodicilor-tip de efectuare a expertizei judiciare
57. Milošević G. B. Gender equality and gender-based violence: handbook. Belgrade: Scanner studio, 2013. 178 p.
58. Morari G., Pădure A., Zarbailov N. Ghid pentru specialiştii din sistemul de sănătate privind intervenţia eficientă în cazurile de violenţă împotriva femeilor. Chişinău: Ed. Cartea Juridică, 2016, 160 p.
59. Nivelul infracţionalităţii în Republica Moldova în anul 2020, https://statistica.gov.md/newsview.php?l=ro&idc=168&id=6929
60. Notă informativă a MAI al Republicii Moldova privind starea infracţionalităţii în domeniul infracţiunilor ce atentează la viaţa şi sănătatea persoanei, precum şi celor comise în sfera relaţiilor familiale pe parcursul a 3 luni ale anului 2020, https://politia.md/sites/default/files/ni_violenta_in_familie_3_luni_2020_pentru_pagina_web-konvertirovan.pdf
61. Notă informativă privind practica judiciară ce vizează aplicarea măsurilor de protecţie în cazurile de violenţă în familie (Capitolul XXII2 CPC) CSJ, 2020
62. Observaţii finale ale CEDAW privitor la Moldova, CEDAW /C/MDA/ CO/6 10 martie 2020

63. Ordinul Ministerului Afacerilor Interne nr. 360 din 08.08.2018 cu privire la aprobarea Instrucţiunii metodice privind intervenţia Poliţiei în prevenirea şi combaterea cazurilor de violenţă în familie
64. Ordinul Ministerului Sănătăţii nr. 265/2009 privind Instrucţiunea cu privire la completarea Fişei medicale a bolnavului de staţionar (F003/e)
65. Ordinul Ministerului Sănătăţii, Muncii şi Protecţiei Sociale nr.1167/2019 cu privire la aprobarea Instrucţiunii privind intervenţia instituţiilor medico-sanitare în cazurile de violenţă în familie
66. Ordinul Ministerului Sănătăţii, Muncii şi Protecţiei Sociale nr.1167 din 15.10.2019 cu privire la aprobarea Instrucţiunii privind intervenţia structurilor teritoriale de asistenţă socială în cazurile de violenţă în familie
67. Ordinul Ministerului Sănătăţii, Muncii şi Protecţiei Sociale nr. 30/2019 cu privire la recoltarea şi analiza probelor biologice pentru stabilirea alcoolemiei, consumului de droguri şi de alte substanţe psihotrope, de medicamente cu efecte similare acestora
68. Pachetul serviciilor esenţiale pentru femei şi fete supuse violenţei. Elemente de bază şi instrucţiuni privind calitatea https://www.md.undp.org/content/moldova/en/home/library/effective_governance/serviciile-esen_iale-pentru-femeile-i-fetele-supuse-violenei-.html
69. Perevoznic I. Monitorizarea proceselor de judecată pe cauze de violenţă în familie, violenţă sexuală şi trafic de fiinţe umane, 2018. http://cdf.md/files/resources/135/CDF_Monitorizare_web_RO.pdf
70. Perevoznic I., Rusu L., Ţurcan A. Raport de analiză a compatibilităţii legislaţiei Republicii Moldova cu prevederile Convenţiei Consiliului Europei privind prevenirea şi combaterea violenţei împotriva femeilor şi a violenţei domestice, 2019. http://cdf.md/files/resources/141/CDF%20Raport%20compatibilitate.pdf
71. Popovici L., Vişanu S., Sincovschi T. et.al. Documentarea violenţei în bază de gen: Ghid practic. Chişinău, Tipogr. „Depol Promo", 2019. 92 p.
72. Prestarea serviciilor de aistenţă medicală, parte a răspunsului multisectoriale în cazurile de violenţă în bază de gen. Proceduri Standard de Operare. UNFPA, 2015, 31 p.
73. Preventing and combating sexism. Recommendation CM/Rec(2019)1 adopted by the Committee of Ministers of the Council of Europe, 2019 https://rm.coe.int/cm-rec-2019-1-on-preventing-and-combating-sexism/168094d894
74. Prpic M. Combating ‹honour› crimes in the EU. https://www.europarl.europa.eu/RegData/etudes/BRIE/2015/573877/EPRS_BRI(2015)573877_EN.pdf
75. Raport al Curţii Constituţionale a Republicii Moldova la cel de al XVI-lea Congres al Conferinţei Curţilor Constituţionale Europene
76. Raport de estimare a costurilor violenţei în familie şi a violenţei împotriva femeilor în Moldova. Chişinău: Nova Imprim. 88 p.
77. Raport din perspectiva respectării drepturilor omului. Implementarea legislaţiei Republicii Moldova cu privire la violenţa în familie, 2012, http://cdf.md/files/resources/122/Raport%20Violenta%20complet%20RO.pdf
78. Regulamentul Centrului de Medicină Legală. Hotărârea Guvernului Republicii Moldova nr. 58 din 04.02.2010. În: Monitorul Oficial nr.20-22 din 09.02.2010
79. Regulamentul-cadru de organizare şi funcţionare a Centrului de Asistenţă şi Consiliere pentru Agresorii Familiali şi standardele minime de calitate. În: Monitorul Oficial nr.174-177/535 din 04.07.2014
80. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO Press, 2013, 56 p.

81. Rezoluţia Consiliului de Securitate al ONU nr.1820 din 2008 privind femeile, pacea şi securitatea, http://undocs.org/en/S/RES/1820 (2008)
82. Rezoluţia Consiliului de Securitate al ONU nr.1888 din 2009 privind violenţa sexuală împotriva civililor în conflictele armate, https://www.un.org/ruleoflaw/files/N0953446.pdf
83. Schornstein Sh. L. Violenţa domestică şi asistenţa medicală. Chişinău: Epigraf SRL, 2003. 204 p.
84. Seifert R. War and Rape. Analytical Approaches (1992), https://wilpf.org/wp-content/uploads/2014/08/1992_War_and_Rape.pdf
85. Standardele CEDAW pentru consolidarea răspunsului de sănătate la violenţa în bază de gen (Recomandarea Generală nr. 24)
86. Standardele CEDAW pentru soluţionarea eficientă a cazurilor de violenţă în bază de gen (Recomandarea Generală nr.19)
87. Strengthening health system responses to genderbased violence in Eastern Europe and Central Asia. A resource package. UNFPA and WAVE 2014. 346 p.
88. Tulbure I. Sistemul normelor sociale. Revista naţională de drept. Chişinău, 2016. nr. 7, p.19-24
89. Turliuc M. N., Huţuleac A. K., Dănilă O. Violenţa în familie. Teorii, particularităţi şi intervenţii specifice. Iaşi: Editura Universităţii „Alexandru Ioan Cuza", 2009, https://www.researchgate.net/profile/Maria-Turliuc/publication/273454357_Violenta_in_familie_Teorii_particularitati_si_interventii_specifice/links/554ba3ef0cf29f836c979407/Violenta-in-familie-Teorii-particularitati-si-interventii-specifice.pdf
90. Tyyskä V., Saran S. Family Violence. Ryerson University, 2013, p .2
91. Universal Declaration of Human Rights, https://www.ohchr.org/en/udhr/documents/udhr_translations/eng.pdf
92. UNODC. Global Study on Homicide 2019. Vienna, 2019, 38p.
93. Violence against women: an EU-wide survey Main results. Luxembourg: Publications Office of the European Union, 2015. 193 p.
94. Violence prevention: the evidence. WHO, 2010, https://apps.who.int/iris/bitstream/handle/10665/77936/9789241500845_eng.pdf?sequence=1&isAllowed=y
95. Violenţa faţă de femei în familie în Republica Moldova. Chişinău: Nova Imprim SRL, 2011, 148p.
96. Violenţa împotriva femeilor: o anchetă la nivelul UE. Rezultatele pe scurt. Luxemburg: Oficiul pentru Publicaţii al Uniunii Europene, 2014, 44 p.
97. Violenţa sexuală şi de gen împotriva refugiaţilor, returnaţilor şi persoanelor deplasate intern. Ghidul UNHCR de prevenire şi răspuns. Bucureşti: Pass International Com-Prod, 2003. 35 p.
98. Walker L.E. Battered Woman. New York: Harper & Row, 1979. 288 p.
99. Welchman L., Hossain S. 'Honour' Crimes, Paradigms, and Violence against Women. New-Delhi: Zubaan, 2006, 384 p.

ECtHR Case-law

1. Cauza Mudric contra Republicii Moldova, nr.74839/10, Hotărârea din 16.07.2013. Definitivă la 16 octombrie 2013
2. Cauza B. contra Republicii Moldova, Hotărârea din 16.07.2013.
3. Cauza Eremia contra Republicii Moldova, Hotărârea din 28.05.2013
4. Cauza T. M. şi C. M. contra Republicii Moldova, Hotărârea din 28.01.2014

This Training Manual was developed with the support of Women's Law Center within the framework of the 'Strengthening efficiency and access to justice in Moldova' Project implemented by UNDP Moldova, with the financial support of Sweden. The content of this publication is the sole responsibility of the authors and does not necessarily represent the views of UNDP and Sweden.