Background Over the last three years, the MoHP has established sixteen OCMCs in sixteen districts cross Nepal. Each OCMC aims to provide an integrated package of services for survivors of violence through a 'one-door' system. OCMCs are designed to follow a multi-sectoral and locally coordinated approach to provide survivors with a comprehensive range of services including health care, psycho-social counselling, access to safe homes, legal protection, personal security and vocational skills training.
Methods Reports, monitoring visits, national level annual review with stakeholders inclusive of hospitals, Police, Attorney, Ministry of Women, MoHP, Chief District Officers, Representatives from Prime Ministers and Counsel of Ministers, I/NGOs and survivors.
Results The district report showed that from October 2013 – October 2014, OCMCs have provided essential services required by survivors with 2,273 individuals (2,133 (94%) women and 140 (6%) men) accessing services. A high percentage of women receiving services (53.6%) were victims of intimate partner violence, while 26% had experienced sexual violence. 16% had suffered extreme mental abuse and 4.8% 'other types of violence (trafficking, child marriages). The breakdown of data by age-group shows that violence is common among women between the ages of 15 and 49 years with 1645 women in this category, suggesting married women as the prime targets.
Conclusions OCMCs are a new and challenging initiative. The challenges can be overcome through improved awareness raising activities; capacity building; survivor follow-up; improved screening and coordinating strategies; and more social protection activities. Supporting the establishment of OCMCs in all 75 districts is essential.

570 HEALTH PROFESSIONALS' ROLE IN THE HUMANITARIAN DISARMAMENT MOVEMENT AND PREVENTING ARMED VIOLENCE

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Background Disarmament and war prevention are now widely perceived as humanitarian goals by governments and non-governmental organisations alike. In recent years, "humanitarian disarmament" campaigns have taken on some of the world's worst weapons, including landmines, cluster munitions, small arms, drones, and nuclear weapons.
Description of the problem An evidence-based awareness of the impact of war and all forms of armed violence on public health, documented by health professionals in hospitals and emergency rooms and conveyed through the stories of the victims and their ravaged communities, has catalysed successful campaigns to prohibit the most inhumane weapons and to impose strict new limits on trafficking in others. While the term is relatively new, humanitarian disarmament has been at the heart of health-based organisations' efforts such as the International Committee of the Red Cross and International Physicians for the Prevention of Nuclear War's work for decades. For example, the medical evidence that nuclear war would be a humanitarian catastrophe to which physicians could organise no meaningful response helped mobilise the international community towards a nuclear test ban and non-proliferation.
Results The health facts about nuclear weapons and the devastation they cause have become the foundation of a Humanitarian Pledge to "stigmatise, prohibit and eliminate nuclear weapons" that, at this writing, has been joined by 117 countries. The human consequences of armed violence has been a central concept in achieving landmark treaties and agreements on conventional weapons including the Mine Ban Treaty, the United Nations Programme of Action on Small Arms and Light Weapons, the Convention on Cluster Munitions and the Arms Trade Treaty.
Conclusions Health organisations and agencies have a key role to play in bringing the humanitarian perspective to the development and implementation of policy instruments and agreements designed to prevent armed violence.

571 ANALYSIS ON THE VIOLENCE PREVALENCE AND PREVENTION STATUS IN CHINA

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Background Violence prevention is the priority of public health; and to master the prevalence state and risk factors of violence is the base to develop the prevention strategies. This study aimed to evaluate the violence prevalence and prevention status in China, and to provide reference for the prevention and control of violence.
Methods Violence data were obtained from the National death surveillance data set and National Injury surveillance system. The laws policies, capacity for data collection, programmes and services for violence prevention were described.
Results The trend of violence mortality has declined during 2006–2013. The mortality has decreased from 1.21/100000 in 2006 to 0.65/100000 in 2013. decreased by 46.3%. The violence mortality was high in young adult men, while it was high in female infants and old women who were over 85 years. Chinese laws and policies included the strategies on violence prevention, but not integrated. There were lack of the nonfatal violence data. Most of the prevention programmes were limit and transient.
Conclusions The different violence prevention strategies could be implemented according to gender differences. China could carry out more work in the aspects of legislation, data collection and service routinization.

572 VIOLENCE IN THE HEALTH WORK PLACE SURVEY ABOUT 521 CASES AMONG HEALTH STAFF IN TUNISIA

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Background Violence in the health work place is actually a serious problem in Tunisia. This phenomenon can be explained by the weakness of the security measures in the health facilities, but also by other causes such as lack of health staff or equipment which make timeouts very long and create a kind of pressure in the health care settings.

In Tunisia, the overall situation has changed since January 2011 when the revolution occurred; the general situation in the country became characterised of violence and insecurity. Some national actions have been taken by Ministry of Health in late 2011 in order to eliminate this phenomenon in the health care settings.