Violence against women and girls 2

The health-systems response to violence against women

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Health systems have a crucial role in a multisector response to violence against women. Some countries have guidelines or protocols articulating this role and health-care workers are trained in some settings, but generally system development and implementation have been slow to progress. Substantial system and behavioural barriers exist, especially in low-income and middle-income countries. Violence against women was identified as a health priority in 2013 guidelines published by WHO and the 67th World Health Assembly resolution on strengthening the role of the health system in addressing violence, particularly against women and girls. In this Series paper, we review the evidence for clinical interventions and discuss components of a comprehensive health-system approach that helps health-care providers to identify and support women subjected to intimate partner or sexual violence. Five country case studies show the diversity of contexts and pathways for development of a health system response to violence against women. Although additional research is needed, strengthening of health systems can enable providers to address violence against women, including protocols, capacity building, effective coordination between agencies, and referral networks.

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This is the second in a Series of five papers about violence against women and girls

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Introduction

Violence against women is a global public health and clinical problem of epidemic proportions.[1] It is also a gross violation of women's human rights. Violence affects the health and wellbeing of women and their children, with vast social and economic costs.[2–4] Its adverse physical, mental, and sexual and reproductive health outcomes[5,6] lead women who are abused to make extensive use of health-care resources.[4,7] Health-care providers frequently, and often unknowingly, encounter women affected by violence.

The health-care system can provide women with a safe environment where they can confidentially disclose experiences of violence and receive a supportive response. Furthermore, women subjected to intimate partner violence identify health-care providers as the professionals that they trust with disclosure of abuse.[8] However, the crucial part that health-care providers and services can play to address violence against women is often not recognised or implemented. Health systems need to strengthen the role of providers as part of a multisectoral response to violence against women.[9]

This Series paper is based on evidence on the health-care response to violence against women, experience of the implementation of services to address violence against women in diverse countries, and consultations with those involved in the planning or delivery of services in resource-poor settings. We describe the challenges involved in engagement of the health sector and make recommendations to integrate effective care for women experiencing violence.

Rationale for a health-care response

As noted in the 2013 WHO report, *Global and regional estimates of violence against women*,[6] one in three women worldwide who have ever had a partner report physical or sexual violence, or both, by an intimate partner. This violence contributes to the burden of women's ill health in many ways.[5,6] Women with a history of intimate partner violence are more likely to seek health care than are non-abused women.[4,10,11] For example, Bonomi and colleagues[4] showed that women who were physically abused used more mental health, emergency department, hospital outpatient, primary care, pharmacy, and specialty services.

Key messages

- The health-care system has a key part to play in a multisectoral response to violence against women; that role, however, remains unfulfilled in many settings.
- Violence against women needs to have higher priority in health policies, budget allocations, and in training and capacity building of health-care providers.
- Although evidence of effective interventions in health-care services remains scarce, especially for resource-poor settings, there is a global consensus that health-care professionals should know how to identify patients experiencing intimate partner violence and provide first-line supportive care that includes empathetic listening, ongoing psychosocial support, and referral to other services, as well as comprehensive post-rape care for sexual assault victims.
- The health system needs to ensure the enabling conditions for providers to address violence against women, including good coordination and referral networks, protocols, and capacity building.
- No model of delivery of health-care response to violence against women is applicable to all settings, and countries should develop services that take into account resources and the availability of specialised violence-support services.
- Violence against women should be integrated into medical, nursing, public health, and other relevant curricula, and in-service training should ensure that health-care providers know how to respond appropriately and effectively; this training needs to be sustained and supported by ongoing supervision and mentorship.
- Health policy makers should show leadership and raise awareness of the health burden of violence against women and girls and the importance of prevention among health-care providers, managers, and the general public.
- More research is needed to be able to quantify the health burden associated with different forms of violence, and to assess and scale up interventions to prevent, and respond to, violence against women.

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Search strategy and selection criteria

We based this Series paper on the systematic review linked to the WHO 2013 guidelines *Responding to intimate partner violence and sexual violence against women*[13] and the systematic reviews[14] informing the UK National Institute for Health and Care Excellence (NICE) Domestic violence and abuse 2014 guidelines, and other relevant systematic reviews.[15–17] To update the evidence base on interventions for violence against women, we searched PubMed and Google Scholar for relevant trials and systematic reviews from May 1, 2012 (NICE reviews), or Dec 1, 2011 (WHO reviews) to June 30, 2014, with the keywords "intimate partner violence" or "domestic violence" or "gender violence" or "violence against women", and "healthcare" without language restrictions. We have prioritised systematic reviews and trials in our citations.

Women also experience other forms of violence, including rape and other sexual violence at the hands of acquaintances, friends, and strangers; physical and sexual violence from relatives; trafficking; female genital mutilation; early and forced marriage; and murders in the name of so-called honour.[12]

All of these forms of violence can bring women into contact with the health-care system, which must be prepared to respond. This Series paper focuses on intimate partner and sexual violence because they are the most common worldwide and have most evidence for effective interventions.

Data sources

In addition to the literature search (search strategy and selection criteria panel),[13–17] this paper is based on consensus in meetings of experts for the development and implementation of the WHO clinical and policy guidelines,[18,19] and included lessons learned from different countries in building a health system response. Five case studies (appendix) show different challenges, policies, and processes, although not based on formal assessment (table).

See **Online** for appendix

	Focus	Issues it illustrates
South Africa	Post-rape care	Collaboration between the Ministry of Health and researchers to develop policy, guidelines, and training on sexual violence
Brazil	From post-rape abortion to sexual violence to intimate partner violence	Role of women's ministries and the process of change over time
Spain	Intimate partner violence and sexual violence	Role of a legal framework and development of a national health-care response
India	Sexual violence	Model led by a non-government organisation in public health hospitals
Lebanon	Intimate partner violence	Challenges of implementation of a health-system response when violence against women is not recognised as a problem

Table: **Summary of country case studies**

What can health systems do?

The main role of health-care systems for women, and their children, facing the health effects of violence is to provide supportive care. This supportive care can contribute to prevention of violence recurrence and mitigation of the consequences, address associated problems, such as substance misuse and depression, and provide immediate and ongoing care. The health system also has a part to play in primary prevention (ie, prevention of violence occurring before it starts), through documenting violence against women, emphasising its health burden, and advocating coordinated action with other sectors (figure 1).

Implementation of health-care policies and training programmes for providers to address violence against women face individual and system barriers.[20–23] Evidence suggests that information dissemination or training in isolation do not create consistent, sustainable change,[23–25] and that a comprehensive systems approach is needed.[23,24–29]

Figure 2[30] provides an overview of the necessary elements at the level of the providers and services, and of the health system more broadly, organised by core components (or building blocks): service delivery, health workforce, health information, infrastructure and access to essential medicines, financing, and leadership and governance.[31]

Many countries have begun to address violence against women in health care with varying success, as shown by the case studies (appendix). The case studies also show that progress in the integration of violence against women into health systems is slow and incremental. In many countries, social and cultural barriers need to be overcome (eg, Lebanon [appendix]), and in most countries, health system barriers such as high staff turnover and limited resources must be addressed (eg, India and South Africa [appendix]). Traditional biomedical approaches are inadequate and inappropriate to address violence against women,[32] so changes will be needed (eg, India [appendix] and Spain [panel]).[33–39]

What can health providers do?

Overview

The appropriate response by health-care providers will vary depending on the women's level of recognition or acknowledgment of the violence, the type of violence, and the entry point or level of care where the survivor is identified. Actions by health-care providers include identification, initial supportive response to disclosure or identification, and provision of clinical care, follow-up, referral, and support for women experiencing intimate partner violence, in addition to comprehensive post-rape care and support for victims of sexual assault.

Different women will have different needs, and the same woman will have different needs over time. She might present with an injury to the accident and emergency department, with depression or functional

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