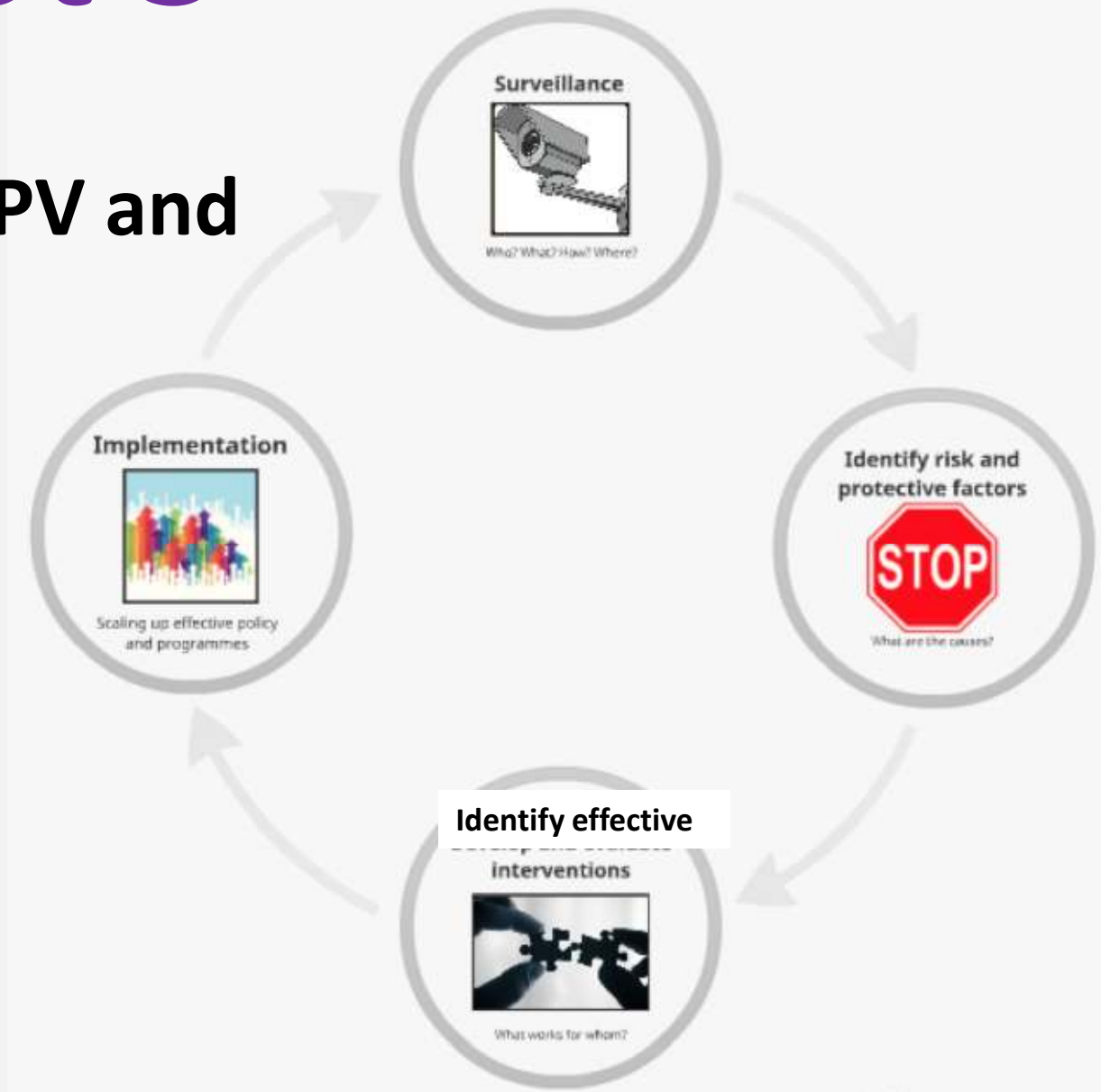
Snapshot 5

Pan American Health Organization

World Health Organization

Responding to IPV and SV:

WHO clinical & policy guidelines



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Identify effective interventions

What works? And for whom?

Overview

- Discuss why health sector needs to respond to violence against women
- Present the WHO recommendations for the health sector to respond to intimate partner violence and sexual violence

WHY should the health sector address VAW?

1. Abused women more likely to seek health services

2. Violence is an underlying cause of injury and ill health

3. Health care providers are often women's first point of professional contact

4. Most women attend health services at some point, especially sexual and reproductive health

5. If health workers know about a history of violence they can give better services for women

- ❖ Identify women in danger before violence escalates
- ❖ Provide appropriate clinical care
- ❖ Reduce negative health outcomes of VAW
- ❖ Assist survivors to access help / services/ protections
- ❖ Improve sexual, reproductive health and HIV outcomes

6. Human rights obligations to the highest standard of health care

Role of the health sector in a multi-sectoral response

Sometimes when I ask a woman about violence, she dissolves in a sea of tears… then I think now how am I going to get rid of her?

Doctor in El Salvador

Ignoring violence can do harm

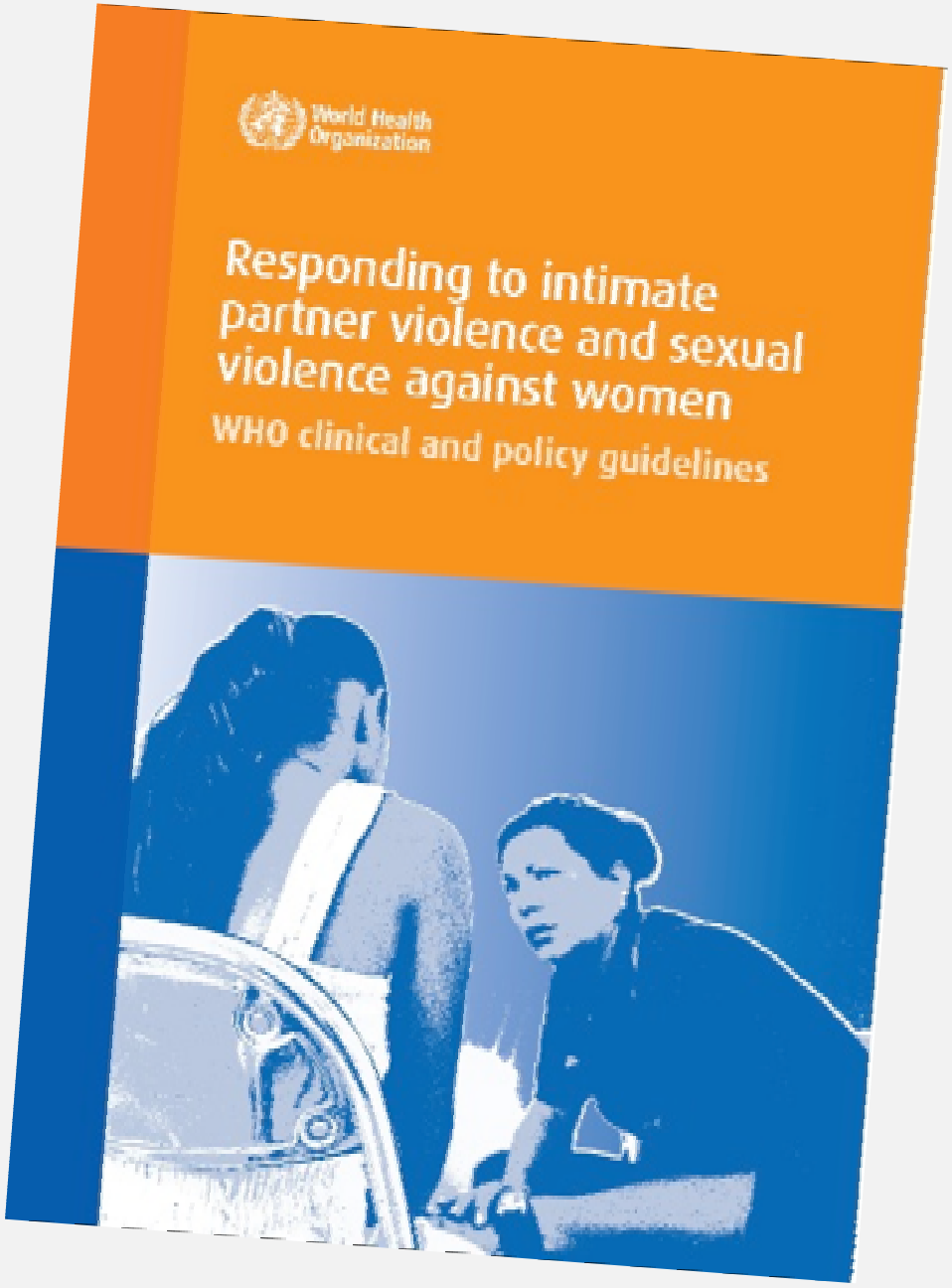
Provider behaviour		Possible consequences
Blames or disrespects women or girls	→	Inflicts additional emotional distress or trauma
Doesn't recognize VAW behind chronic or re-occuring conditions	→	Woman receives inappropriate or inadequate medical care
Fails to provide adequate care to rape victims	→	Unwanted pregnancy, untreated STI, unsafe abortion

Ignoring violence can do harm

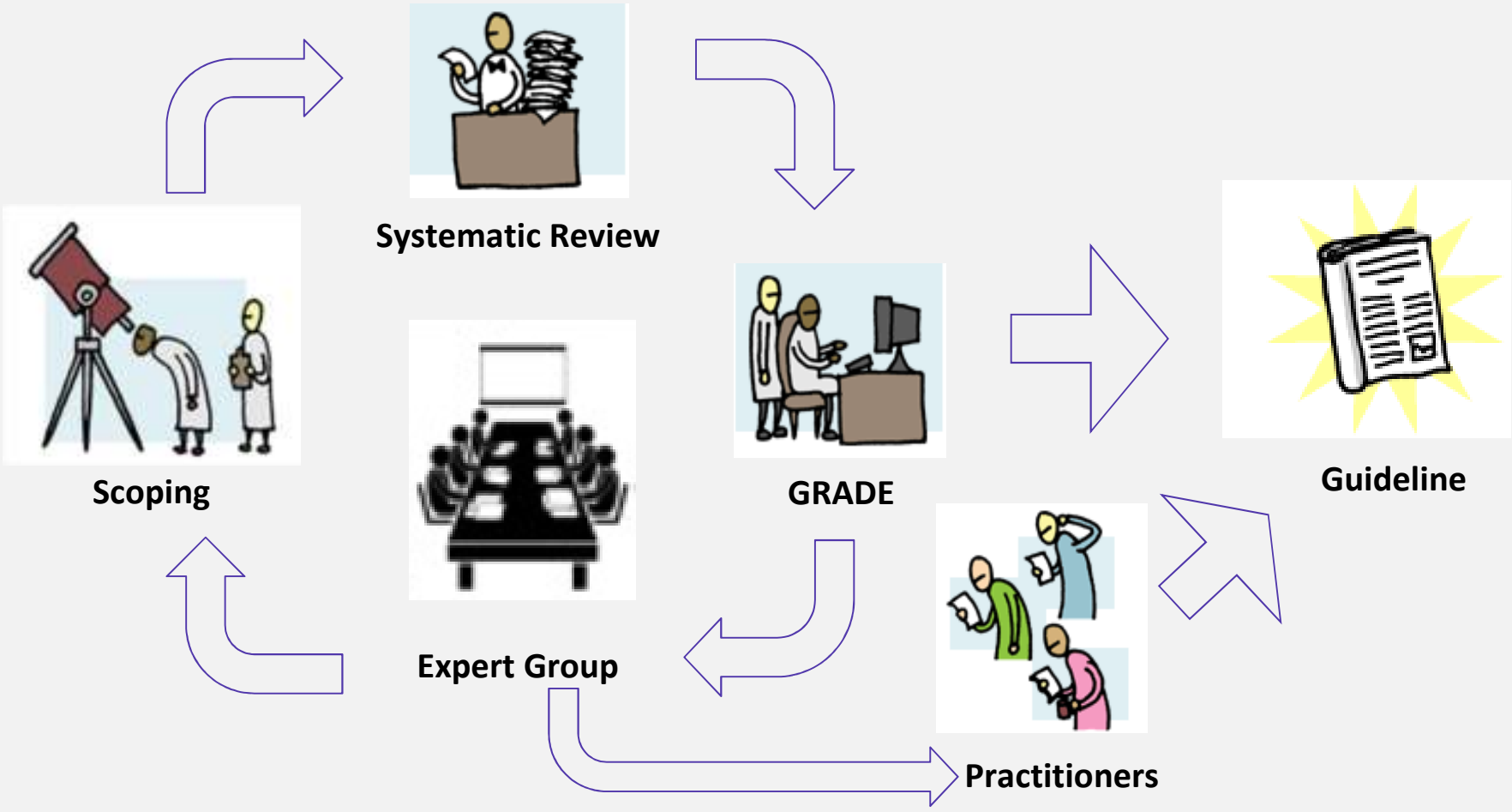
Provider behaviour		Possible consequences
Breaches privacy or confidentiality	→	Partner or family member becomes violent after overhearing information
Doesn't address VAW in family planning or STI/HIV counselling	→	Unwanted pregnancy; STIs/HIV/AIDS; unsafe abortion; additional violence
Ignores signs of fear or emotional distress	→	Woman is later injurerd, killed or commits suicide

The Guidelines: Purpose

- Provide evidence-based guidance for clinicians on how to respond to intimate partner and sexual violence
- Guidance to policy makers on how to deliver training and on what models of health care provision may be useful
- Inform educators designing medical, nursing and public health curricula regarding the integration of training on intimate partner and sexual violence



How were guidelines created?



GUIDELINES FOR HEALTH SECTOR RESPONSE

WHO's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:

Women-centred care:

Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).

Identification and care for survivors of intimate partner violence:

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.

Clinical care for survivors of sexual violence:

Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.

Training of health-care providers on intimate partner violence and sexual violence:

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.

Health-care policy and provision:

Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.

Mandatory reporting of intimate partner violence:

Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.

Woman-Centred Care: It is …

- Being non-judgemental, supportive and validating
- Providing practical care that responds to her concerns, but does not intrude
- Asking about her history of violence, listening carefully, but not pressuring
- Helping her access information about resources, including legal and other services
- Assisting her to increase safety for herself and her children
- Must ensure that:
  - consultation is done in private
  - confidentiality is maintained

Identifying women with IPV

Universal screening is not recommended but…

- Certain sites may want to consider it provided certain requirements are met, including mental health, HIV testing and counselling, antenatal care
- Clinical enquiry is recommended – especially where can improve diagnosis and treatment
- Written information on IPV should be available in health care settings - posters, pamphlets, leaflets made available in private areas such as women's washrooms (with appropriate warnings about taking them home)

Asking about IPV:
Minimum requirements

- A protocol/standard operating procedure
- Training on how to ask, minimum response or beyond
- Private setting
- Confidentiality ensured
- System for referral in place

Care: Survivors of IPV

Primarily focused on mental health

- Mental health care for pre existing or IPV-related conditions
- Cognitive behavioural therapy (CBT) or eye movement desensitization & reprocessing (EMDR) for those suffering PTSD (& no longer in abusive relationship)
- Brief to medium duration empowerment counselling (up to 12 sessions) & advocacy/support, including a safety component, where health systems can support this intensive care.**
- Children exposed to IPV: offer psychotherapeutic intervention, including sessions with & without mother

**Caveat: The extent to which this may apply to settings outside of antenatal care or its feasibility in low- or middle-income countries is uncertain.

Clinical care: Survivors of sexual violence

- First line support (woman-centred care)
- Take a complete history - recording event, any injuries, mental health status, etc.
- If within 72 hours provide:
  - Emergency contraception (up to five days)
  - HIV PEP as appropriate
  - STI prophylaxis/treatment
- Safe abortion as per national law
- Written information for coping strategies for dealing with anxiety/stress

Mental Health: Survivors of sexual violence

- First-line support (woman-centred care)
- Watchful waiting for up to three months (unless there are mental health concerns)
- Treat other mental health conditions, in accordance with WHO guidelines
- If person incapacitated by post-rape symptoms or has post-traumatic stress disorder, arrange for cognitive behaviour therapy (CBT) or eye movement desensitization & reprocessing (EMDR) by a health-care provider with a good understanding of sexual violence.

“There are certain behaviours that are expected of a married woman, and if you don't and your husband beats you up, then it's ok. It's like a parent disciplines a child. Health worker interviewed in Samoa

Training health providers

- All health care providers should be trained in first-line response and acute post-rape care.
- Health-care providers should receive in-service skills-based training, including:
  - when and how to enquire
  - the best way to respond to women
  - when & how is forensic evidence collection appropriate.
- Training should be integrated into undergraduate curricula for health care providers; must address attitudes of health care workers.
- Trainings should be accompanied by reinforcement and provision of continual support

Health care Policy & Provision

- Integrate care into existing health care, rather than as stand-alone service
- Consider different models – no one size fits all, but support provision of care at primary health care level.

Mandatory Reporting

- Mandatory reporting of intimate partner violence to the police by the health care provider is NOT recommended
- But, health care providers should offer to report to appropriate authorities if the woman wants to do so
- Child maltreatment and life-threatening incidents must be reported where there is a legal requirement to do so

System-wide changes necessary

- Emphasis in many countries is on training or routine screening
- Training or screening alone not lead to sustained changes in health worker behavior or improved outcomes for women, unless accompanied by institutional changes
- Institutional changes include: procedures around patient flow, documentation, privacy and confidentiality, feedback to health workers, referral networks