World Health Organization

SUMMARY

# Responding to intimate partner violence and sexual violence against women: clinical and policy recommendations

## Introduction

Violence against women is a major public health and human rights issue, with intimate partner violence and sexual violence among the most pervasive forms of violence against women. Research, initially from North America and Europe, but increasingly from other regions, has demonstrated the high prevalence of violence against women globally and its adverse physical and mental health outcomes, in both short and long term (Campbell, 2002; Garcia Moreno et al, 2005; Ellsberg et al, 2007; Bott et al, 2012).

Although violence against women has been accepted as a critical public health and clinical care issue, it is still not included in the health-care policies of many countries. The critical role that the health system and health-care providers can play in terms of identification, assessment, treatment, crisis intervention, documentation, referral and follow-up, is poorly understood or accepted within the national health programmes and policies of various countries.

Women who have been subjected to violence often seek health care, including for their injuries, even if they may not disclose the associated abuse or violence, and a health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Women also identify health-care providers as the professionals they would most trust with disclosure of abuse (Feder et al, 2006)

Health professionals can provide assistance to these women by facilitating disclosure, offering support and referral, gathering forensic evidence — particularly in cases of sexual violence — or by providing the appropriate medical services and follow-up care.

Health-care providers who come into contact with women facing violence need to be able to recognize signs of it, and respond appropriately and safely. Individuals exposed to violence require comprehensive, gender- sensitive health-care services that address the physical and mental health consequences of their experience and aid their recovery. Women mayalso require crisis intervention services in order to prevent further harm. In addition to providing immediate medical services, the health sector is potentially a crucial gateway to providing assistance through referral pathways to specific services for violence against women-or to other aid that women may require at a later date, such as social welfare and legal aid. In all circumstances, there is a minimum first-line supportive response required and the first recommendation below outlines this minimum.

Violence against women is also a violation of a woman's human rights. Policies and laws need to be revised to ensure they do not discriminate against women and that they adequately penalize acts of violence, including those that take place within the home. Furthermore, services should aim to be, "delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives".[1]

This document summarizes *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, the World Health Organization (WHO), 2013 publication,[2] developed by an international group of experts following a thorough review of evidence. It contains evidence-based recommendations for the introduction of policies into health services and programmes to improve responses within the health sector to violence against women. Each recommendation is classified as either "strong" or "conditional", on the basis of the generalizability of benefit across different communities and cultures, the needs and preferences of women to access services, as well as taking into consideration the level of human and other resources that would be required. Further clarifications are noted below some recommendations as remarks.

It is understood that these recommendations will need to be adapted to specific local and/or national circumstances, taking into account the availability of resources, as well as national policies and procedures.

## Who are these recommendations for?

The recommendations are aimed at health-care providers because they are in a unique position to address the health and psychosocial needs of women who have experienced violence. They also seek to make health-care providers and policy-makers in charge of planning, funding and implementing health services and professional training more aware of violence against women, to encourage an evidence-informed health-sector response, and improve capacity building of health-care providers and other members of multidisciplinary teams. They should also prove useful to those responsible for developing training curricula in medicine, nursing and public health.

[1] CEDAW General Recommendation 24, para 22
[2] For full document, see http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

# 1. Providing first-line women centred-care

**Recommendation 1**

Women who disclose sexual assault by any perpetrator or violence of any form by an intimate partner or other family member should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence.

This includes:

- being non-judgmental, supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, without pressuring her to talk (care should be taken during sensitive topics when interpreters are involved)
- providing information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

It is important to ensure:

- that the consultation is conducted in private
- confidentiality, while informing women of the limits of confidentiality, for example if there is mandatory reporting.

**Remarks**

(a) Any intervention must be guided by the principal to "do no harm", ensuring the balance between benefits and harms, and prioritizing the safety of women and their children as the uppermost concern.

(b) The privacy and confidentiality of the consultation, including discussing relevant documentation in the medical record and the limits of confidentiality with women, should be a priority. Therefore, good communication skills are essential.

(c) Health-care providers should discuss options and support women in their decision-making. The relationship should be supportive and collaborative, while respecting women's autonomy. Health-care providers should work with the women, presenting options and possibilities, as well as providing information, with the aim to develop an effective plan and set realistic goals, but the woman should always be the one to make the decisions.

(d) In some settings, such as emergency care departments, as much as possible should be done during first contact, in case the woman does not return. Follow-up support, care, and the negotiation of safe and accessible means for follow-up consultation should be offered.

(e) Health-care providers need to have an understanding of the gender-based nature of violence against women, and of the human rights dimension of the problem.

(f) Women who have physical or mental disabilities are at an increased risk of intimate partner and sexual violence. Health-care providers should pay particular attention to their multiple needs. Women who are pregnant may also have special requirements (see recommendation 8).

# 2. Identification and care for survivors of intimate partner violence

## 2.1 Identifying women experiencing intimate partner violence

| Box 1 | Minimum requirements for asking about intimate partner violence against women |
|---|---|

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

The issue of safe and effective identification within health-care settings of women experiencing partner (or domestic) violence is an important one. Studies have shown that while "screening" (i.e., asking all women who come for health care) increases identification of women with intimate partner violence, it does not reduce partner violence and has not been shown to have any notable benefit for women's health. The following recommendations have been identified:

**Recommendation 2**

"Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) should not be implemented.

**Remarks**

(a) There is strong evidence of an association between intimate partner violence and mental health disorders among women. Women with mental health symptoms or disorders could be asked about intimate partner violence as part of good clinical practice, particularly as this may affect their treatment and care.

(b) Intimate partner violence may affect disclosure of HIV status or jeopardize the safety of women who disclose, and affect their ability to implement risk-reduction strategies. Asking women about intimate partner violence could be considered in the context of HIV testing and counseling, although further research to evaluate this is needed.

(c) Antenatal care is an opportunity to enquire routinely about intimate partner violence because of the dual vulnerability of pregnancy. There is some limited evidence from high-income settings to suggest that advocacy and empowerment interventions (e.g., multiple sessions of structured counselling) following identification through routine enquiry in antenatal care, may result in improved health outcomes for women, and there is also the possibility for follow-up during antenatal care. However, certain things need to be in place before this can be done (see Box 1 on minimum requirements).

### Recommendation 3

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence (see Box 2 for examples of associated clinical conditions), in order to improve diagnosis, identification and subsequent care (see recommendation 30).

**Remarks**

(a) A minimum condition for health-care providers to ask women about violence is that it is safe to do so (i.e. the partner is not present); they must be trained on the correct way to ask and on how to respond to women who disclose violence (see Box 1 on minimum requirements). This should at least include first-line support for intimate partner violence (see recommendation 1).

(b) Providers need to be aware of, and knowledgeable about, resources available to refer women to when asking about intimate partner violence.

**Box 2 Examples of clinical conditions associated with intimate partner violence[a]**

- Symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genito-urinary symptoms including frequent bladder or kidney infections
- Adverse reproductive outcomes including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

[a] Adapted from Black MC Intimate partner violence and adverse health consequences; implications for clinicians. American Journal of Lifestyle Medicine, 2011, 5:428-439.

**Recommendation 4**

Written information on partner violence should be available in health-care settings, in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms. This information should be accompanied by appropriate warnings about taking them home if an abusive partner is there.

## 2.2 Providing care to women survivors/living with partner violence

Effective interventions to support women survivors of intimate partner violence were broken into four categories:

- Psychological interventions
- Advocacy/empowerment interventions
- Mother–child interventions
- Other interventions (i.e. expressive writing and yogic breathing).

The following recommendations were made:

*Psychological interventions*

**Recommendation 5**

Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depressive disorder or alcohol use disorder) who are experiencing intimate partner violence, should receive mental health care for the disorder in accordance with the WHO mhGAP Intervention guide 2010a delivered by health-care professionals with a good understanding of violence against women.

**Remarks**

a) Use of psychotropic medications in women who are either pregnant or breastfeeding requires specialist knowledge and is best provided in consultation with a specialist where available. For details on management of mental health issues in these two groups please see the mhGAP guidelines (WHO, 2010a).

**Recommendation 6**

Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) interventions, delivered by health-care professionals with a good understanding of violence against women, are recommended for women who are no longer experiencing violence but are suffering from PTSD.

*Advocacy/empowerment interventions*

**Recommendation 7**

Women who have spent at least one night in a shelter, refuge, or safe house should be offered a structured programme of advocacy, support, and/or empowerment.

**Remarks**

a) The extent to which this may apply to women leaving the household in situations where shelters do not exist is not clear.

(b) This may be considered for women disclosing intimate partner violence to health-care providers, although the extent to which this may apply in circumstances outside of shelters is not clear and should be researched further.

(c) In populations where the prevalence of intimate partner violence is high, priority should be given to women experiencing the most severe abuse. (The guideline development group did not agree whether this should extend to severe psychological abuse.)

(d) Interventions should be delivered by trained health-care or social care providers or trained lay mentors, tailored to the woman's personal circumstances and designed to combine emotional support and empowerment with access to community resources.

**Recommendation 8**

Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.

**Remarks**

(a) Information about exposure to violence should be recorded unless the woman declines, and this should always be conducted in a discreet manner (i.e. not with labels or noticeable markings that can be stigmatizing for women, especially when health-care professionals label them as "battered"). Women may not wish to have information recorded in their clinical history files, in the fear that their partner may find out. Women's preferences need to be balanced against the need to ensure adequate forensic evidence in circumstances where women decide to pursue a legal case, and the reporting policies at each health-care facility.

(b) A woman should be helped to develop a plan to improve her safety and that of her children, when relevant.

(c) Attention should be paid to self-care for providers, including the potential for vicarious trauma (see Glossary).

*Mother –child interventions*

**Recommendation 9**

Where children are exposed to intimate partner violence at home, a psychotherapeutic intervention, including sessions with and without their mother, should be offered, although the extent to which this would apply in low- and middle-income settings is unclear.

**Remarks**

(a) The cost of intensive psychotherapeutic interventions focusing on the mother–child, and lack of providers trained to deliver this type of intervention, makes it challenging to implement them in resource-poor settings.

**violence (IPV = intimate partner violence)**

Provide information on IPV in private areas

NO

Are there clinical symptoms of IPV or concerns about IPV? (See Box A)

YES

- Give information on services if available.
- Do not pressure to disclose.
- Offer information on IPV impact on health and children.
- Offer follow-up appointment.

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**V Advocacy**

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Box A – Clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, PTSD, sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Box B – First-line support

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. This includes:

- ensuring consultation is conducted in private
- ensuring confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)
- being non-judgemental, supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken with the use of interpreters for sensitive topics)
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.