



## Relevance and feasibility of WHO recommendations for intimate partner violence care in South African primary health settings

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### ABSTRACT

*The World Health Organization's (WHO) clinical and policy guidelines for responding to intimate partner violence (IPV) against women focus on improving health service delivery of women-centred care. This publication is a watershed. It sounds a call to innovate and implement creative new directions for effective health service-driven, intersectoral responses to IPV. The commentary draws on experience derived from intermittent IPV research in the Western Cape primary health sector. It outlines the eight WHO guidelines which specifically address the health care needs of women experiencing IPV and reflects on their feasibility within the South African context. While these policy recommendations are undoubtedly welcome, the barriers to implementation are acknowledged and discussed. Where possible, innovative ways to move forward are suggested. If taken up, these could aid the alignment of South Africa's standard of IPV care with that of the WHO recommendations. Now is the time for all sectors to mobilise and work together to improve IPV services in South Africa.*

**Keywords:** *women-centred care, intimate partner violence, health service delivery, health systems, Western Cape*

In June 2013, the World Health Organization (WHO) published its first ever clinical and policy guidelines for responding to intimate partner violence (IPV) against women (see Table 1). Women-centred care and the improvement of health systems for IPV care globally are imperative if these standards are to be achieved. This marks a significant turning point in the field, sounding a call to invent and implement creative new directions for effective health service-driven, intersectoral responses to IPV.

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South Africa's extremely high rates of gender-based violence (World Health Organization, 2009), marked by the highest global intimate femicide rate (Abrahams et al., 2009), are indisputable. This commentary draws on experience derived from intermittent IPV intervention research in the primary health sector of the Western Cape (Joyner & Mash, 2011, 2012a, 2012b, in press) to reflect on this policy framework. The valuable idealism of the World Health Organization (WHO) will be counterpointed with a realistic appraisal of some barriers encountered when providing IPV care in a scarcely resourced environment. To date, internationally, there has been marked resistance to engaging effectively and comprehensively with IPV. Yet for practical, ethical and evidence-based reasons, providers should enable survivors to get the help they need. The provider-patient relationship offers a unique opportunity to case find, diagnose and treat abuse and neglect (Cohn, Salmon & Stobo, 2003). Despite health's crucial role, current curricula of most health professionals lack emphasis on appropriate knowledge, skills and confidence building to attend to IPV competently. Most practice settings provide only clinical care at best. Moreover, providers voice feeling unsupported and poorly equipped to handle the frustrations of working with family violence (Joyner & Mash, 2012a, 2012b).

This short communication reflects on the WHO recommendations in the light of the challenges in the South African context, commenting on the value of these policy guidelines but also asking questions about their feasibility given the challenges briefly elaborated on above.

1	Women disclosing any violence by an intimate partner should be offered immediate support. Health-care providers should, as a minimum, offer first-line support. This comprises privacy; confidentiality within limits; non-judgmental, empathic, responsive rather than intrusive support; a careful history of violence; helping access information and resources; assisting with safety for her and children; and providing or mobilising social support. If providers are unable to provide first-line support, they should ensure that someone else is available to do so.
2	Universal screening or routine enquiry is not recommended. Health-care providers should case find opportunistically by asking about IPV when assessing conditions that may be caused or complicated by IPV.
3	Posters and pamphlets on IPV should be available in female-only areas of health facilities.

4	Women with a previously diagnosed, or partner violence-related mental disorder, and who are experiencing IPV, should receive mental health care for the disorder in accordance with WHO mhGAP intervention guidelines (WHO, 2010). <sup>2</sup> Providers should have a good understanding of violence against women.
5	Cognitive behavioural therapy and eye movement desensitization and reprocessing interventions are recommended for women who no longer experience violence but still suffer post-traumatic stress disorder.
6	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.
7	Where children are exposed to IPV, a psychotherapeutic intervention should be provided that includes sessions with and without their mother.
8	Pregnant women who disclose IPV should be offered up to 12 sessions of empowerment counselling and advocacy/support, including a safety component, offered by trained service providers where health systems can support this.

In reflecting on these guidelines given the lack of capacity and skills of current healthcare providers, there are some concerns related to the first and central recommendation. The skill set described here appears straightforward but may pose a risk of secondary traumatisation if appropriate knowledge and skills are not widely disseminated. In practice, IPV skills are highly specialised and complex to master, requiring empathy and understanding which many providers lack. For effective uptake of training, IPV requires dedicated providers who are sufficiently committed to prioritise it. The resistance or challenges to providing appropriate IPV care are compounded by the 2010 Western Cape Health Care Plan which specifies that providers should spend seven minutes per patient (PGWC, 2006).

Another bedevilling factor in the successful implementation of this policy recommendation within the South African context, and perhaps more widely, is that health professional training is functionally biomedical. Health providers often struggle to provide a holistic and patient-centred approach – with significant implications for the provision of IPV care. A recent morbidity survey of South African primary care demonstrated that psychological and social problems are rarely diagnosed or recognised (Mash, Govender, Isaacs, De Sa, & Schlemmer, 2013). Health practitioner training should focus on developing a biopsychosocial approach that can recognise the presence and impact of psychological and social problems on the presenting problem and inform appropriate responses.

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2 Reviews on mental health interventions in populations experiencing intimate partner or sexual violence were complemented by the more general evidence in these WHO mental health guidelines.

Our work has reported on the development and implementation of an IPV intervention model which was specifically formulated for the primary health setting and has been acknowledged as an important contribution (Bateman, 2012). This model starts with a case finding mechanism for IPV developed for this context, thereby aligning with the second recommendation which calls for opportunistic case finding. Yet despite being easier than universal screening, in both rural and urban IPV pilots, most providers fail to implement it in their practice. Referrals to the IPV champion<sup>3</sup> by health providers are rare, despite the presence of a comprehensive service on site which could benefit such patients and their families. Perhaps this can be explained by their reluctance to provide the requisite reproductive healthcare and correct documentation of IPV before referring to the IPV champion for comprehensive, ongoing care (Joyner & Mash, 2012b).

The fourth (mental health) and eighth recommendations (pregnancy) coalesce in important ways and are of particular relevance in the South African context. This discussion links with the first recommendation. In South Africa, abuse and violence escalate during pregnancy, with increasing severity as the pregnancy progresses (Dunkle et al., 2004). Over the past 11 years, the Perinatal Mental Health Project (PMHP) has provided an “integrated maternal mental health intervention in the context of low resourced, high HIV prevalence and overstretched clinical settings” (Meintjies, Field, Sanders, Van Heyningen, & Honikman, 2010, p. 76). PMHP’s partnership with Psychiatry and Mental Health at the University of Cape Town and public health services has enhanced its capacity to demonstrate and provide insight into what is possible to implement in this context.

PMHP data reveals women experiencing domestic violence to be 24 times more likely to qualify on mental health screening for referral to a counsellor ( $n = 1\ 008$ , OR 24, CI 8.86-67.17,  $p < 0.001$ ) (Meintjies et al., 2010, p. 78). It is evident that in this context IPV is usually only one aspect of their counselling, as these women may also experience mental health challenges, may be living with HIV, poverty and unemployment and generally face a lack of support in terms of medical and other care. Attending to women’s mental health issues enables retention in care long enough to improve health and safety, including for their children. Anxiety, depressive and substance abuse disorders are frequently intertwined with IPV. Restoration of self-esteem, planning and problem-solving skills is facilitated by a skilled individual who functions as a case manager and liaison officer. In Joyner’s IPV model, the IPV champion fills this role (Joyner & Mash, 2012a). Diverse clients present with complex needs spanning the mental, physical, courts, social workers and beyond. Each requires

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3 In Joyner’s model, the IPV champion takes over from the referring provider once identification and appropriate clinical care is complete. She assesses the psychological, social and legal needs of each woman, formulates a care plan with relevant referrals with her and provides ongoing support by including her in therapeutic group processes which she facilitates.

individualised care integrated into an ongoing service. The liaison role with psychiatry and trauma services, shelters, non-profit organisations (NPOs), social development and legal services safeguards these marginalised women from disappearing through the cracks.

The WHO specifies that mental healthcare should be provided by those demonstrating a good understanding of violence against women, which is often precisely what health providers lack. The fact that IPV against women is deeply rooted in the gendered nature of human relationships and social structures remains unrecognised. By contrast, the PMHP's superior service is evidenced by its admission that considerable time is spent tracking and following up to facilitate access to services. Its interventions include a focus on de-escalating violence for the individual woman since pregnancy is a highly vulnerable and dependent time. Many stay in relationships while working on safety plans, understanding abuse and the cycle of violence, building social support and planning for leaving an abusive relationship.

Turning to recommendation six, which speaks to the need for a coordinated advocacy response for women who seek refuge in a shelter, it is evident that challenges with implementation would relate to the lack of a clear strategy and network. Turan et al. (2013) report use of "supported referrals" in their programme for prevention of violence against pregnant women in rural Kenya, which provides a good model of the implementation of this policy recommendation. Here community volunteers provide concrete assistance for reaching referral services, "including provision of transport costs, personally escorting women to services, telephoning ahead and offering emotional support" (Hatcher et al., 2013, p. 3). Their preliminary research to develop this intervention found that factors beyond the individual – gender roles in intimate partnerships, family dynamics and community norms – shape high rates of IPV (Hatcher et al., 2013). This valuable research from a contemporary rural African context arguably offers a model for improving IPV services in South Africa. Active engagement of community cooperation and goodwill could hold the keys to enabling implementation of the sixth recommendation.

Recommendation three requires public dissemination of information about IPV. Clearly this is a crucial component of a comprehensive response to IPV, but it begs the question of who will take this initiative. In the Western Cape context, MOSAIC, the Training, Service and Healing Centre for Women, is one example of an organisation that has produced informative pamphlets and posters about IPV which would be ideally suited to women's restrooms. It is important that such initiatives be taken up at national level with the Department of Health collaborating with community and non-governmental organisations to extend such initiatives. This could aid the promotion of community awareness and activism described by Hatcher et al. (2013) as a necessary component to upscale IPV services.

Lastly, the impact of IPV on children is undoubtedly profound, and invites research which will innovate context-specific interventions for families living in low- and middle-income settings. While the state psychotherapeutic resources available are hopelessly inadequate to meet the extent of the need, perhaps cognitive-behavioural therapy and/or eye movement desensitisation reprocessing offer alternatives worth exploring as in recommendation five, which is, however, only directed towards women. Both techniques may be taught to community health workers and implemented under supervision of a psychologist. Such a response to recommendations five and seven may address our paucity of skilled mental health providers and the imperative to capacitate communities to take more ownership in responding to IPV.

In conclusion, while these policy recommendations are certainly welcomed, the barriers to implementation alluded to above need to be acknowledged and addressed. The time is ripe, indeed long overdue, for all sectors to mobilise and work together to prevent transgenerational damage by improving IPV services in South Africa.

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