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An Overview of Health Care Support of Intimate Partner Violence Survivors

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ABSTRACT

Intimate Partner Violence (IPV) has severe physical and psychological effects on survivors. Despite growing awareness, accessing comprehensive health care remains a challenge for many survivors. This review aims to assess the impact of IPV on the survivors, health care needs, and interventions for IPV survivors, evaluate their effectiveness, and identify areas for improvement. This paper reviewed literature and guidelines from reputable journals with a focus on studies about health care support, including interventions and outcomes for IPV survivors. The paper found there is a need for routine IPV screening in health settings, effective multidisciplinary care, and better training for healthcare providers. Barriers such as stigma, resource limitations, and inadequate referral systems were common. Survivors also face difficulties accessing the healthcare system due to fear and confidentiality issues. Quality and effective support requires universal screening, trauma-informed care, and accessible services. While some practices are beneficial, there is a need for standard and improved provider training. Policymakers should focus on overcoming systemic barriers and enhancing support services. The support system for IPV survivors is improving but still faces significant challenges. Addressing these issues through better policies, resources, and training is crucial for providing effective care and reducing the long-term impact of IPV.

Keywords: Intimate Partner Violence, Health Care Support, Survivor support, Multidisciplinary Approaches, Trauma-Informed Care

IINTRODUCTION

IPV has a huge impact on the health of the survivors. While some health implications are limited to a particular type of IPV, some are general. However, since most survivors also suffer multiple types of abuse it makes it worthwhile to discuss these health implications and the resultant healthcare needs of the IPV survivors[1]. These health impacts lead to the health needs of the survivors and it is at this point that the healthcare system is expected to support the survivors. Having established that when these survivors present themselves with their health care needs at the health care facilities, the HCPs are expected to not just attend to their clinical needs but also provide adequate support to the IPV survivors to identify at-risk individuals, reduce and prevent as the case may be, their risk of being subjected to violence through counselling and referral to appropriate resources. This chapter aims to identify the health implications and healthcare needs of IPV survivors, and the roles the healthcare system is to play in their support of IPV survivors.

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HEALTH IMPLICATION OF IPV ON THE SURVIVORS

Figure 1: Image Showing the Health Impacts of IPV on Women

According to WHO, violence has several implications on the health of the survivors especially the women, in some cases, it may be physical, mental, behavioural, or sexual and reproductive health. These implications can linger long after the violence has stopped[2]. Studies of IPV survivors indicate that their experience leaves them unsettled, often distracted at work, and therefore unproductive. It brings associated costs to healthcare systems worldwide[3]. According to research, women who are abused by their partners face major physical and mental health issues that last their entire lives[4]. According to research, violence against women is a more common cause of ill health among women than traffic accidents and malaria combined and is as serious a cause of mortality as cancer[5]. As a result, its public health impact is immense, necessitating a comprehensive response from all sides, including law and policy[6].

Physical Health Implication

In situations where a survivor suffers physical abuse, that is, they are being hit, it results in certain physical health challenges and when visiting the health care facility, they may exhibit one or more physical symptoms such as bruises, abrasions, lacerations, punctures, burns, and bites, as well as fractures and broken bones or teeth, or more serious injuries that can lead to disabilities, such as injuries to the head, eyes, ears, chest, and abdomen, gastrointestinal conditions, long-term health problems, and poor health status, including chronic pain syndromes, death, including femicide and AIDS-related death[7], cardiovascular problems (for example., hypertension), gastrointestinal diseases (for example., stomach ulcers, appetite loss, abdominal discomfort, digestive problems); and neurological problems (for example., fibromyalgia, joint disorders, facial and back pain) (for example., severe headaches, vision, and hearing problems, memory loss, traumatic brain injury). These could potentially result in a temporary or long-term disability[8].

These survivors/patients most times only present the physical ailments without mentioning the abuse at home, however, the non-disclosure may not be intentional as some of them may be ignorant of the connection between the abuse and their ailment while those who know may not disclose for reasons of shame, fear or presence of the perpetrator, etc. This is where the HCP must be experienced and capable enough to screen for IPV in all patients and not just treat the ailment and then risk their lives by sending them back to the abuse, every HCP is expected according to the WHO standard to be able to screen for IPV signs and give necessary support to the survivor.

Mental and Behavioural Impacts

Apart from the physical impacts of IPV on the health of the survivor, there may also be some nonphysical health consequences which though may not be directly obvious can manifest in certain behavioural traits due to the negative impact of the abuse on the mental health of the survivor. In most cases, nonphysical abuse (without being hit) causes more of these mental health and behavioral defects[9]. The impact of non-physical abuse has been

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held to be more grievous than physical abuse because of the impact on the mental health of the survivor[10], although physical abuse may also lead to death, it is easier to identify and help a survivor of physical abuse than a survivor of non-physical abuse. Some other health impacts of non-physical abuse are post-traumatic stress disorder (PTSD), suicide attempts, panic attacks, borderline personality disorder, emotionally unstable, agoraphobia, and personality disorder[11].' It can also manifest in physical ailments like unexplained headaches, stomach aches, extreme tiredness, and substance misuse which usually starts as a coping mechanism.

A broader impact is that the survivors suffer low self-esteem, and self-doubt and most times are unable to identify their experience as abuse[12]. This usually leads to mental torture as they struggle to understand what they are going through and to change or please the perpetrator. It is very easy to miss the IPV survivors in this category. This is because in most cases the survivors are seen through the eyes of the manifested behaviours, they will hold them responsible for their actions and judge them accordingly without considering the root cause of their actions. Unfortunately, the survivors go through this judgmental treatment in the hands of inexperienced HCPs, this worsens their health status and makes them more withdrawn until it becomes too late to help them and they may get to the point where they either kill the abuser, the abuser kills them or they commit suicide[13].

Sexual and Reproductive Health

IPV also has grievous effects on the reproductive health of the survivors. According to a study conducted in the United States, women who have experienced domestic violence are three times more likely to have gynecological issues than those who have not[3]. Chronic pelvic discomfort, vaginal haemorrhage or discharge, vaginal infection, painful menstruation, sexual dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infection, and infertility" were also among the medical issues mentioned[14]. Also included are abortion and unsafe abortion, unexpected and undesired pregnancy because it is often more difficult for women to negotiate the usage of contraception or condoms with their abusive partners. Miscarriage, preterm delivery, and low birth weight are all linked to violence during pregnancy and maternal mortality[15]. Financial abuse in the case where the perpetrator refuses to give the survivor money for antenatal. If the abuser accuses the survivor of infidelity each time she goes for antenatal, such may make the survivor stop attending antenatal and thereby not have adequate medical attention during pregnancy while other health conditions like high blood pressure, depression, etc. can be a big maternal and neonatal risk.

All these above-discussed factors give rise to the healthcare needs of the survivors and thereby establish the strong connection between IPV survivors and the primary, reproductive, child, mental, and dental healthcare providers who are responsible for meeting the healthcare needs of patients.

HEALTHCARE PROVIDERS AND IPV

Healthcare providers in this context include every personnel in a hospital setting who would one way or the other have contact with the IPV survivors and these include but are not limited to the nurses, doctors, pharmacists, healthcare equipment operators, laboratory attendants, record section staff not leaving out the gateman, cleaners, etc. It is important to capture all these people because, at the point of contact with any of these persons, the IPV survivors may perceive an attack, condemnation/judgmental behaviour, or the documents that may support the case of the survivor against the abuser may be carelessly handled leading to non-recording or loss of vital information. Medical doctors/dentists, nurses, pharmacists, laboratory scientists, and other health-related professionals, often known as health professionals also include midwives and allied professionals, especially those who have supervisory, mentoring, and coordination roles[16]. All these healthcare providers have contact with the survivors of IPV at one time or the other and have the opportunity of helping them either stop the abuse or heal from the abuse. Women most especially during pregnancy are susceptible to abuse, hence they see their healthcare providers more often with different complaints that originate from the abuse thereby adding gynaecologists and obstetrics to the list of healthcare providers in this study. However, for this study, HCP shall consist of any health care personnel such as doctors, nurses, laboratory scientists, pharmacists, physiotherapists, any government or private health care facility, hospital, maternity centre, community pharmacies, and all other service providers registered by the government for the provision of prescribed health services for insured persons and their dependants because they are the accredited and licensed authorities to provide health care in Nigeria.

HEALTHCARE SUPPORT OF IPV SURVIVORS

As stated earlier, IPV has a physical and mental impact on the survivors which makes them visit the healthcare system more than those who do not have a history of IPV. Therefore, when a survivor visits a healthcare system, they may present different medical needs ranging from treatment of wounds and injuries, surgeries, long-term

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medical attention and medication, therapy, etc. The healthcare system is to provide on-site IPV services to respond to victims' immediate needs, in an environment that encourages safe disclosure, and community connections with strong leadership who are intentional in providing healthcare support[17]. However, Heise and colleagues noted that women who experience IPV have intricate needs and may need multifaceted services from several sectors, such sectors may include health care, social services, legal entities, and law enforcement, and therefore, multi-sectoral collaboration is essential for ensuring survivors' access to comprehensive services. To achieve this, there were international reviews and one of the recommendations was to transform the whole institutions in every sector, using a gender perspective; in particular, integrate attention to violence against women into sexual and reproductive health services[18]. However, to enable the health sector to accomplish this purpose, there is a need for healthcare providers to have guidelines on the steps, procedures, roles, and obligations involved.

This is per the global action plan to increase the health system's contribution to a multisectoral national response to combat interpersonal violence, particularly violence against women, girls, and children. To improve information and evidence, strengthen healthcare service delivery and healthcare providers' capacity to respond, strengthen programming to prevent violence, and strengthen leadership and governance of the health system, this plan of action urged governments and other national and international partners to act in the foregoing strategic directions[19]. Thus, responding to intimate partner violence and sexual violence against women which was published in 2013 (The Guideline)[20], a list of roles to be carried out by the healthcare provider while providing support for the IPV survivors was stated. These roles were succinctly described in a diagram and tagged "pathway for care for violence by intimate partners"

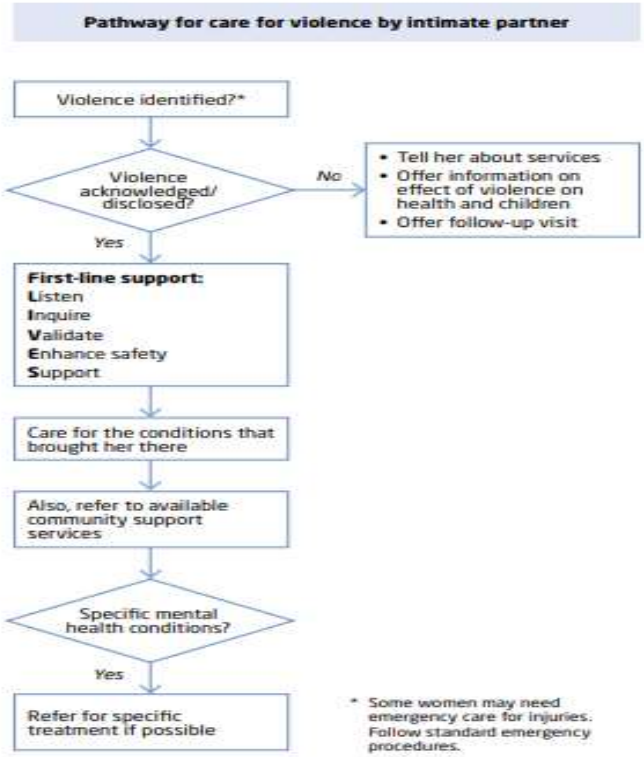

Figure 2: Pathway for care for violence by intimate partner

The roles as stated in the diagram are identification of violence, first-line support, clinical care for the IPV survivor, referral to available community support services, specific mental health conditions, and referral for specific treatment if possible. However, in the *Strengthening Health Systems to Respond to Women Subjected to Intimate*

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Partner Violence or sexual violence: A Manual for Health Managers by WHO, two more roles were added which are integrating into health education and health promotion activities with clients and communities' messages about the human rights violations and harmful health and other consequences associated with violence against women which are the need to seek appropriate and timely care, and prevention and documenting the magnitude of the problem, its causes and consequences, and advocating for coordinated multisectoral prevention and provision of effective responses[21]. These roles will now be discussed in detail.

Identification of Violence

This is done by screening the patients for abuse by asking the patients questions that may lead to answers to confirm violence. The questions can take different forms but one of the recommended ones is the HITS screening tool[22]. This tool consists of short questions on whether the spouse has ever or how often physically hurt, insulted, threatened, or screamed at the patient. A yes to any of these questions confirms violence in the relationship. The healthcare provider must know that some medical conditions may be an outcome of abuse. When and in most cases these medical conditions push the survivors to the healthcare facilities, they only present the ailment that brought them to the healthcare facility. They intentionally or ignorantly leave out the abuse which most time may be the root cause of the ailment, those who do not disclose intentionally avoid the topic for several reasons which include but are not limited to shame, fear of rejection, fear of the abuser, lack of information on available help, etc although in some cases some will admit to violence while others may not. For men especially in a patriarchal society, a male disclosing violence by the wife is seen as a sign of weakness and the male ego would therefore not allow them to disclose violence. Another factor that may affect disclosure is where there was disapproval of the relationship etc. For whatever reason that the patient may not disclose violence, the healthcare provider has a role in identifying when a patient is likely to be a victim of violence.

Primary- and emergency-care facilities, according to research, are excellent places to identify and assist IPV survivors[23]. While IPV has been linked to younger age, female gender, poorer socioeconomic status, family history, and personal history of violence, it has been suggested that IPV should be evaluated in all patients who have a history or evidence consistent with concealed violence[24]. The implication of this is that some IPV survivors may not present any of the risk factors and such will be missed if screening is limited to certain people based on the assumption of those who fall within the risk factor category. The WHO has suggested that universal screening should not be encouraged but that only the patients who exhibit signs of violence should be screened[25]. Some countries support this view because according to them, testing those who might end up free from violence results is wasting of money and resources since there is no evidential support for the benefits, potential harm, and cost of universal screening of IPV[26].

The United States of America, Canada, and other countries support universal screening for the benefit of identifying and helping those survivors. Generally speaking, and in the opinion of this researcher, it appears to be a reasonable suggestion that everyone is screened for IPV in both the primary and emergency settings. These settings are very important because they mostly serve as the first point of call/ entrance in accessing healthcare facilities and some of the patients may not present any sign of violence. Also, the outcome of the screening will determine the applicable intervention to be recommended for the particular patient[26], this will in the long run save costs that otherwise would be spent where identification and intervention are delayed due to the selected screening mode.

A study has shown that during clinical presentations, certain traits might suggest a possible IPV experience and these should arouse the HCP's suspicion of a possible IPV experience of the patient. Some of the traits include the following:

- An inconsistency in injury explanations.
- Delay in obtaining medical help or regular visits to the emergency room or urgent care centre as abusers typically do not want their victims to build a long-term bond with a single doctor. They may believe that in an emergency department, where care may be more fragmented, the victim will be less likely to find an ally[27].
- Appointments that were not kept because the abuser will not allow medical attention, and the patient may be unable to keep appointments. In one study, 17% of IPV victims said their partner made it difficult for them to see a doctor, compared to only 2% of those who were not abused[28].
- Prenatal treatment is started late in pregnancy, regular abortions, sexual assault, and/or the inability to utilise birth control can lead to unintended pregnancies (reproductive coercion).

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- Noncompliance with medication. Survivors may be unable to take medications because the batterer has taken them away or has refused to enable the victim's partner to fill prescriptions.
- When victims appear jittery, scared, or prone to crying. They may appear evasive or angry by avoiding eye contact. A disconnected appearance or a flat emotion could indicate posttraumatic stress disorder.
- Late prenatal care initiation during pregnancy. Abortions, sexual assault, and/or the inability to utilise birth control that can lead to unintended pregnancies (reproductive coercion)
- A companion who is overly attentive or verbally aggressive. If the companion is unduly solicitous or answers questions for the patient, the clinician should be sceptical. If the patient's companion refuses to leave the examination room, the doctor should try to persuade him or her to leave before interviewing the patient. The unwillingness of the patient's partner to leave the patient alone is a crucial symptom.
- Appearance of social isolation, unwillingness to undress or undergo a genital or rectal examination, or trouble with these procedures.

Where the HCP perceives any of the above-listed signs, such HCP should screen for violence. However, despite these signs, a patient may refuse to admit violence and, in such cases, depending on the law of the particular healthcare jurisdiction, the HCPs do not have to mount pressure on the patient to force admission to violence but instead, the HCP should give them time to decide if and to what extent they wish to talk about the violence. The HCP can however offer information on available services should they decide to use them, educate them on the effects of violence on both the women's and children's health, and gently request her consent for a follow-up visit[29]. However, there is an ongoing argument on the issue of mandatory reporting. For example, 45 states and the District of Columbia as of August 1996 have laws requiring health practitioners to report certain injuries suspected of being caused by domestic violence, usually to law enforcement organisations[30]. When a patient presents with an injury that looks to have been caused by a gun, knife, firearm, or other lethal weapons, 41 states require that this be reported[30]. California enacted the first state legislation requiring healthcare practitioners to report domestic violence to legal practitioners in 1994. This legislation makes it mandatory for healthcare providers to report suspected cases of IPV, whether the patient wants it reported or not and any healthcare provider who defaults in this obligation commits a misdemeanour crime. This legislation makes it a duty for every healthcare provider to be on the lookout and report suspected IPV-related injuries while doing this, he is expected to explain the help available and where the patient opposes the report, he finds out the reason for the unwillingness to report, advice the patient and still make the report anyway.

Some of these arguments against mandatory reporting are premised on the opinion that such a position is tantamount to an infringement on the right of the patient. This research however submits that mandatory reporting should be encouraged considering that the state is responsible for all lives, this responsibility should not be limited to where a third party is involved but also self-care should be considered just like in the case of suicide where attempted suicide is a crime, mandatory reporting should be encouraged and applicable on the premise that such reporting is done in the interest of the patient. Time constraints, a lack of screening policies and procedures, discomfort with the topic, fear of offending the patient or partner, privacy concerns, a perceived lack of power to change the problem, and misconceptions about the patient population's risk of exposure to IPV have all been identified as barriers to IPV screening in health care settings[31]. Another known element in determining the rate and efficiency of IPV screening in healthcare settings is provider readiness. However, a qualitative interview with patients and physicians from the Veterans Health Administration (VHA) in the United States (US) found that clear policies, logistics, and processes supporting IPV screening exist and providers' belief that their clinic and supervisor supported IPV screening will enable IPV screening[31].

This explains the need for a law for the healthcare support of IPV survivors which would make it an obligation for the HCP to screen and also provide all the relevant information as to the procedures and forms. Good clinical legislation will address most if not all these barriers and enhance the healthcare support of IPV survivors.

First-line Support

This is the next step that the HCP takes when the patient discloses violence. First-line support provides practical care and responds to a woman's emotional, physical, safety, and support needs, without intruding on her privacy: This stage is very crucial to the survivor. Whatever the survivor experience meted to them at this point determines whether they will follow through with the support or not. Also, this stage may be the only opportunity to save the life of the survivor, therefore it must be handled very carefully. To make the best of this stage, the

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WHO has provided a guideline for the simple tasks for the HCP to follow, known as LIVES which is an acronym for listening, inquiring, validating, enhancing safety, and supporting[32].

- **Listen**: the HCP is to listen to the woman closely, with empathy, and without judging, the discussion should be borne out of empathy and not just an obligation[31]. This is to enable the survivor to feel safe and then open up to discuss the violence with the HCP. To encourage the survivor to open up, the discussion should take place in a private place, although care must be taken in selecting a venue, private should not be misconceived as secluded, where the discussion is with the opposite gender, the survivor may naturally feel unsafe in a secluded place. The office of the HCP with closed but not locked doors should be private enough for such a discussion. Also, the discussion should not take place in the presence of the accompanying children of the survivor, this applies mostly to women and this might cause distraction as they juggle the discussion with attending to the child. The discussion may also send a wrong message to the child who, depending on the age, may not fully understand and therefore resent the mother for reporting or talking badly of the father. The HCP while interacting with the survivors must be sensitive to their feelings while also empathetic. It is not for him to mount pressure on them just to make them speak rather survivors appreciate being given time to process and make their decisions and that is when the HCP can get the best of them.
- **Inquire**: The focus of the HCP at this point should be to assess and respond to the various needs and concerns—emotional, physical, social, and practical (for example., childcare) of the survivor. The goal is to identify their needs and concerns, from the discussion, the HCP should be sensitive to what the concerns are, some may disclose the financial dependence on the abuser as the reason for their unwillingness to leave, for others, it may be due to fear of being harmed by the abuser, others may be lack of shelter while others may not know their experience is abuse. Once the HCP assesses these needs, the HCP is to validate the survivors' concerns and experiences. It is not the time to tell the woman not to die while staying in an abusive marriage because of the children or say, how can you not know you were being abused? These insensitive comments and the like may make the survivor lose confidence and stop opening up. Encouraging and validating words like oh it is very possible to be in an abusive relationship and not know, it is normal to want a home with dad and mum for the children as against single parenting, etc will help make the survivor feel accepted and safe to continue with the story. Give the assurance that there is hope and that it is perfectly okay and normal to seek help. Discuss the available options with her and respect her wishes and connect her with resources for social, physical, and emotional support. Where the discussion gives a possible threat to the life of the survivor, the HCP should discuss safety measures with them. If they choose not to leave, hints on safety measures should be discussed, for example, maintaining a safe distance from the abuser, always making sure to have a calling card on your mobile phone, keeping the doors unlocked, and fleeing at any sign of danger, etc.
- **Validate**: Generally, IPV survivors exhibit different kinds of emotions. While some may feel hopelessness, despair, powerlessness, loss of control, flashbacks guilt, self-blame, shame, or numbness, others might combine two or more of these emotions. This is a very critical moment for both the survivor and the HCP. The HCP at this point is to identify, acknowledge, and validate those emotions and gently redirect the focus of the survivor to the positive emotions or ability of the survivor. Validation with empathy will make the healing process faster and encourage more disclosure. The HCP must carefully choose words that will show empathy and encourage the survivor.
- **Enhance safety**: Most times fear of safety is a key reason for non-disclosure of violence, safety for the survivor or the dependents in the form of children or close relatives. There are instances where the abuser would out of vengeance against the abuser attack the children or relatives of the survivor. In Kano, Hauwa stabbed her two children to death because her husband Ibrahim married a second wife[33]. In a related story, a woman in Benue, who had been having issues of abuse with her marriage, sometimes in 2018, killed her husband, her three children, and herself. In a very recent case, a man killed his wife in Abuja after having a series of abuse in their marriage[29]. If this applies to the survivor, the HCP at this point discusses the gravity of the possibility of danger and goes through the safety options available with the survivor who can then decide on the one that is most suitable for them. The discussion could be around whether they have a safe place to go that can also accommodate children if applicable, the financial capability of the survivor, and whether there are people around as neighbours who can call the police in

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case of an emergency. Safety tips if leaving immediately is not possible for example, staying close to the entrance once violence is imminent, keeping the doors unlocked, keeping the phone handy, and ensuring that there is sufficient airtime for a case of emergency. The HCP must be careful not to put the survivor at any risk while trying to help, calling while at home, unscheduled visits, or unguided text messages should be strictly avoided.

- **Support**: The survivor may need support as it relates to access to a helpline, shelter, support groups in a suitable and appropriate location, crisis centre, legal support, mental health counsellor, social worker, or psychologist. The HCP can take a step further by linking the survivor with a contact at the target support centre. This will enable the continuation of the support of the HCP otherwise if a neutral and untrained staff picks up the survivor's case at random, the survivor may lose hope and withdraw outrightly. It is therefore very essential that there is a synergy between the hospital and the support centres to allow for a flow of services and easy follow-up.

Care for the IPV Survivor

The healthcare needs of IPV survivors are significant and include physical and mental concerns which can be in the form of chronic pain, chronic diseases, and mental illness. As discussed earlier, intimate partner violence has health implications for the survivors, and these health consequences require appropriate medical attention to the specific ailment. There are usually cases of different grades of injuries that may need from drug prescription to major operation. Some with permanent disabilities may require long-term medical attention, while others may require emergency attention. Others may need aids like artificial limbs, eyeglasses, etc. However, some of these survivors may find it difficult to present their health needs in the hospital for reasons of cost, fear of the abuser, low self-esteem, and efficacy[34]. There are instances where these wounded survivors flee the abuser and have to access healthcare without funds, in some instances, it may be a neighbour that would take them to the emergency unit of the hospital, at these points questions are raised as to who pays the bill, who gives consent in cases of emergency operation, etc This is where the healthcare support comes in to ensure the survivors can access quality care even in their crucial helpless condition.

In Nairobi Kenya, Mary M. in early 2020 was living as a single mum away from her estranged husband because of issues of abuse, the estranged husband moved to an accommodation close to hers and mounted pressure on her to return to their matrimonial home but she declined since he was not taking care of the children. On a particular day in the middle of the night, she woke up to see him standing over her with a matchet and to tell her what the problem was, he attacked her with the cutlass which resulted in wounds on her hands and legs, the daughter heard the noise, raised her head but the father slashed her head with the cutlass and she died instantly[35]. This story is only one of many instances of survivors who suffered injuries due to intimate partner violence. At this point in this deadly confused state, Mary M requires unhindered access to emergency medical care, and her location and cost of the health care should not be a barrier. There is a need for a healthcare system that ensures treatment is commenced with or without payment. She was at this point devastated by the death of her child right in her presence and then her wounds need medical attention. She would also need psychological care given the trauma of seeing one of her two children slashed to death by her husband and father of the child, that trauma can lead to a mental crisis which may be permanent if not handled well. The HCP needs to understand that Mary M. in this instance needs more than just treatment of the matchet wounds but also psychological care to address the trauma.

Referral to Available Community Services.

Just like the case of Mary M. mentioned earlier, apart from the HCP attending to the matchet wounds, she would most likely need other supports like legal assistance to prosecute the husband before he commits more harm to her and the remaining child, she would need to see a therapist on how to be able to handle the memory and the trauma of seeing her daughter being killed. While Mary M. may be oblivious to all these other needs at this point, the HCP can support her by referring her to the appropriate service with proper follow-up. Generally speaking, some of these community support services may include shelter, legal assistance, police assistance, psychosocial counselling, rehabilitation activities, reintegration programmes, etc. There are two major models of providing these community support services and they are One-Stop Centers (OSC) and arranged partnerships with community support outside the hospital, and the selected model for each jurisdiction is dependent on the model approved and provided for by the law and policy of each jurisdiction. The one-Stop-Centre (OSC) model provides multi-sectoral case management for survivors, including health, welfare, counselling, and legal services in one

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location. This model helps to minimize referrals and makes it easier for survivors as they will not have to repeat their accounts at every support centre.

Some low- and middle-income countries (LMICs) like Bangladesh, Nepal, Sri Lanka, and Rwanda in supporting IPV survivors use the OSC model while some advanced countries like the United Kingdom also use the OSC model which they call Independent Domestic Violence Advocates (IDVA) centres. In Brazil, however, what they have is a team approach response to VAW where hospitals around the country respond to sexual violence including medical services and psychosocial counselling. Lagos State in Nigeria do not have an OSC model but they have an arrangement with selected support centres that work with the health care facilities.

Specific Mental Health Conditions

Some of the impacts of violence on an IPV survivor may include a variety of psychological and mental health impacts for which survivors may seek psychotherapy or other mental health services. Individuals experiencing IPV may have specific needs and preferences related to mental health care, such experiences could lead to PTSD, depression, drug and substance abuse, suicidal thoughts, a strong urge for revenge, mental instability, etc. The HCP can diagnose such IPV-related mental conditions and then refer to appropriate mental health support facilities where the professional will be flexible and responsive around the discussion of IPV, respect the complexity of clients' lives and support for self-determination, and promote safety and access to internal and external resources for healthy coping. Medical attention is to be patient-centered, and flexible while dealing with each patient, each patient is unique in their experiences, opinions, and expectations. Moving on may mean "a return to normal or a regaining of what has been lost while others may see otherwise. Services should be flexible and adapted to each patient's terms, this is because an attempt to force the usage of terms when the patient is not receptive may lead to re-traumatization[24]. This explains the peculiar role of an HCP in providing support for an IPV survivor with a special mental health condition. There is a high probability that every survivor of IPV needs mental health attention, the only difference is that the extent of the impact on each survivor's mental health may differ from one another.

Special Needs

Survivors may also need special support. There may be cases of survivors who are pregnant, with young children, and those who are HIV-positive. Each of these survivors would require peculiar support in tandem with their individual needs.

Pregnant Women

Women have highlighted the relevant role of HCPs especially midwives in the identification of IPVAW and the wellbeing of their children as one of their main concerns. They, therefore, saw video counselling sessions and safety planning apps as potentially useful tools to counsel and empower women who experience IPVAW during pregnancy. This gives an insight that the model of healthcare support can be extended from physical to virtual and still achieve the desired support. The video packages will be a very good initiative for pregnant women whose husbands prevent them from going for antenatal, however, if not well managed, it may increase the risk of violence against such women if the husband finds out about the video, especially if the video contains anything about IPV and unfortunately violence has to be part of the content of the video. It will, however, be a good step if safety instructions against violence are included in the introduction of the video, this will prepare the mind of the viewer as to when, where, and how to watch the video without incurring the wrath of the abuser[36].

Pregnant women experiencing IPV also appreciate healthcare that is supportive of them provides tailored information, involves their partner as well, and a healthcare system that is efficient, open to the public, and offers continuity of care. To satisfy the complicated health requirements of pregnant women who are experiencing IPV, it is crucial to link maternal health services with the qualities of care that women value[37].

HIV Positive Survivors

The HCP in dealing with a survivor in an HIV setting must understand GBV and its health consequences and inform patients through counseling and/or information, Education, and Communication (IEC) materials (posters, brochures, etc.) about GBV and its health consequences. They are to

"Create a friendly, empathetic, private, and confidential environment, ask about GBV if a client discloses violence or shows common signs and symptoms (clinical inquiry); or ask about GBV among populations at higher risk of GBV if appropriate and only if minimum criteria are met (routine inquiry), provide survivor-centered, empathetic counselling through first-line support to any client disclosing violence. If the survivor has experienced sexual

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assault within 72 hours, offer HIV postexposure prophylaxis, and within 120 hours, emergency contraception, treat as a medical emergency, document key information, refer as needed, and ensure follow-up care[38]."

CONCLUSION

There have been concerted efforts by different states in Nigeria to enhance the healthcare support of IPV survivors in Nigeria, however, there is a need for Nigeria to address the issue as a nation, to enhance the efforts of the different state governments. Also, there is a need to encourage more survivors to access healthcare support and this can be accomplished when survivors know that healthcare support is their right which can be enforced. The various reasons that hinder survivors from receiving support i.e. fear of stigmatization, financial challenges to pay for medical services, ignorance of available support, etc need to be addressed while all the barriers hindering the HCPs from giving support are to be addressed, increased training and encouraged workforce with good working conditions and environment which will reduce brain drain in the health sector and also a legal framework to make the support an obligation for the HCP and all the three tiers of the government to provide all the needed facilities for the support. This is in line with the call by the World Health Assembly, in May 2016 194 Member States (Nigeria inclusive) representatives of the ministries of health endorsed a global plan of action to strengthen the role of the health system, within a national multisectoral response, to address interpersonal violence, most especially against women, girls, and children (global plan of action on violence). This plan of action urged governments and other national and international partners to take action in four strategic directions: 1) strengthening health system leadership and governance 2) strengthening health service delivery and healthcare providers' capacity to respond 3) strengthening programming to prevent violence, and 4) improving information and evidence.

RECOMMENDATIONS

- **Implement Universal Screening Protocols:** by adopting routine IPV screening procedures in all healthcare settings, including primary care, emergency departments, and specialized clinics; Early identification of IPV can facilitate timely intervention and referral to appropriate support services.
- **Enhance Provider Training:** there is a need to develop and mandate comprehensive training programs for healthcare professionals on recognizing signs of IPV, responding effectively, and providing trauma-informed care. Well-trained providers are better equipped to handle IPV cases sensitively and effectively, improving patient outcomes and safety.
- **Develop Multidisciplinary Care Models:** Establishment of integrated care teams comprising medical professionals, mental health specialists, social workers, and legal advisors to provide holistic support to IPV survivors. A coordinated approach ensures that all aspects of a survivor's needs are addressed, from medical care to psychological support and legal assistance.
- **Strengthen Confidentiality and Safety Measures:** Implementation and enforcement of strict confidentiality policies and safety protocols to protect survivors from retaliation and ensure their privacy. Ensuring confidentiality and safety helps build trust and encourages survivors to seek and adhere to necessary care.
- **Expand Access to Resources and Services:** Increase funding and resources for IPV support services, including emergency shelters, counseling, and legal aid. Adequate resources are essential in providing comprehensive support and ensuring that survivors have access to necessary services.
- **Improve Referral and Follow-Up Systems:** It is necessary to develop and maintain effective referral networks and follow-up systems to ensure continuity of care and support for survivors, this will ensure that survivors receive ongoing support and resources tailored to their needs.
- **Promote Public Awareness and Education:** Continuous public awareness campaigns and educational programs to inform the public and healthcare providers about IPV and available support services. This will help to reduce stigma, encourage early intervention, and ensure that survivors and healthcare providers are aware of where to seek help.
- **Monitor and Evaluate Interventions:** A regular assessment of the effectiveness of IPV support interventions and programs through systematic evaluation and research to aid identification of successful practices and areas needing improvement, leading to more effective support strategies.

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- **Advocacy for Policy Changes:** There should be **s**upport and advocacy for policy reforms that strengthen legal protections for IPV survivors and improve access to healthcare and support services to address systemic barriers, enhance resource allocation, and improve overall support for IPV survivors.
- **Foster Collaboration with Community Organizations:** Partnership with local community organizations, including non-profits and advocacy groups, to enhance support networks and outreach efforts. Community organizations often have valuable insights and resources that can complement healthcare efforts and provide additional support to survivors.

Implementing these recommendations can significantly improve the health care support system for intimate partner violence survivors, addressing current gaps and enhancing overall care and outcomes.

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