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John Devaney, Caroline Bradbury-Jones, Rebecca J. Macy, Carolina Øverlien, Stephanie Holt

Healthcare-based violence against women strategies to address the problem in Argentina

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Lorena Saletti-Cuesta
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Introduction

Violence against women (VAW) is an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in society. According to United Nations (1993), VAW, a broad umbrella term, is any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. One of the most common forms of VAW is intimate partner violence (IPV) which includes physical, sexual and emotional abuse by an intimate partner.

VAW is an important public health problem and human right concern rooted in gender inequalities. Therefore, there are a number of reasons to focus on healthcare systems for addressing VAW. It is well known that healthcare providers (physicians, nurses, psychologists, etc.) are often women’s first point of professional contact. Moreover, all women are likely to seek health services at some point in their lives, and women and girls experiencing violence are more likely to use health services (World Health Organization (WHO), 2016).

According to the WHO (2016) the roles of the health system within a national multisectoral response to address VAW are to advocate for a public health perspective; identify those who are experiencing VAW and provide them with comprehensive health services at all levels of health service delivery; develop, implement and evaluate VAW prevention programmes as part of its population-level prevention and health promotion activities; and document the magnitude of the problem, its causes and its health and other consequences, as well as effective interventions.

Health-sector responses to VAW

Providing supportive care for women and children facing the consequences of VAW is also an essential role for healthcare providers. The evidence suggests that women-centred health interventions, such as first-line responses, risk assessment, safety planning, counselling and support, all provide some health benefits to women (Ramsay, Rivas & Feder, 2005; Rivas et al., 2015;
Spangaro, 2017; Trbold, McMahon, Alsobrooks, Whitney, & Mittal, 2018; Rivas et al., 2019), even in low- and low-middle-income countries (Kirk, Terry, Lokuge, & Watterson, 2017). However, the evidence for the effectiveness of such health interventions to reduce women’s re-victimisation is weak (Ellsberg et al., 2015).

Globally, there are growing calls among VAW prevention advocates, healthcare providers and policymakers for universal, IPV screening by healthcare providers for all women. Accordingly, IPV screenings during women’s routine healthcare visits are likely the most widespread VAW intervention across all health systems globally. Nonetheless, to date the overall evidence suggests that while universal IPV screening or routine enquiry increases the identification of such violence, it may be ineffective in reducing VAW and/or improving women’s health outcomes (World Health Organization, 2013b; Ellsberg et al., 2015; O’Doherty et al., 2015; Spangaro, 2017). However, more research needs to be conducted to study the complex relationship between screening and improvement in quality of life and/or a reduction in the recurrence of IPV.

Specifically, one area for further research is in the education and training of healthcare staff to improve their identification and responses for VAW, which has been found to be a promising practice (World Health Organization, 2013b). Relatedly, several studies showed improvements in knowledge of providers following a VAW training intervention. Interventions involving interactive techniques (i.e., role playing, discussions simulations) and training in VAW identification, care and referral appear to improve detection and changes in providers’ attitudes. However, evidence also suggest that training programmes in isolation are ineffective to create sustainable change. Instead, personnel training in conjunction with system changes (i.e., standardised documentation), may be the most valuable approaches for bringing about beneficial changes for identification (Ellsberg et al., 2015; García Moreno et al., 2015; Ansari & Boyle, 2017; Spangaro, 2017).

Notably, mother–child interventions, that is, those that strengthen the mother–child relationship in the aftermath of violence, offered in the context of healthcare systems may improve children’s behaviours, self-esteem and anxiety, as well as reduce traumatic stress levels in both children and their mothers. Although such interventions are resource intensive, the severe long-term effects on children from exposure to violence and associated health costs suggest this is likely to be a cost-effective endeavour (World Health Organization, 2013b; Spangaro, 2017).

Furthermore, some healthcare systems offer treatment programmes for those who perpetrate violence that aim to reduce or stop abusive behaviour. However, and again, there is little evidence of the effectiveness of healthcare-based programmes for perpetrators of violence (Ellsberg et al., 2015; Spangaro, 2017).

Prevention of violence is another important role of the healthcare system. Several studies show that it is possible to prevent VAW and that the healthcare sector may be helpful in this regard. Specifically, multisectoral programmes that engage with multiple stakeholders seem to be the most successful to change attitudes and behaviours that support and enable VAW (Ellsberg et al., 2015).

**Elements needed for a robust health-sector response to VAW**

After an expert meeting to develop guidelines for strengthening the health-sector response, the WHO (2010) identified 13 key elements of a health-sector response to VAW, focusing on resource-poor settings (Table 34.1). The first element is an enabling environment of national policies and guidelines to recognise and underscore VAW as a pressing healthcare problem. Moreover, according to García Moreno and collaborators (2015) the necessary core elements in
the delivery of effective women-centred responses come not only from the healthcare system itself but also from a societal level that supports health systems through child protection, laws and criminal justice, social services and community-based services.

Training providers is another recommendation that should include these minimum components: raise clinicians’ awareness to sensitise to them to VAW; build clinicians’ capacities to ask about VAW and listen to women; build clinicians’ skills to support and validate women’s disclosures; enhance clinicians’ attention to ethical issues (i.e., safety and confidentiality); build clinicians’ awareness of legal issues (i.e., women’s rights); build clinicians’ awareness to child protection in the context of VAW; and provide guidance to clinicians concerning documentation and record keeping. In addition, health-sector organisations should strive to build and enhance their VAW care pathways within and external to their systems.

Other elements of a robust health-sector response to VAW include organisation of the systems and services to provide response and support, accountability and monitoring to demonstrate that the problem exists and provide data on the number of cases, as well as additional VAW research and surveillance (WHO, 2010). To distinguish the different approaches to psychosocial and emotional support that victims will need at different points in time (e.g., psychosocial support given by a healthcare professional that has first contact with the woman relative to longer-term support that comes later from other professionals) along with non-negotiable issues and principles (i.e., ethical issues, safety concerns, documentation) are also crucial recommendations.

In addition, the WHO (2010) recommended: asking women about violence if they present with certain health conditions (e.g., injuries); the development of network and multi-agency collaboration, since the healthcare facility will not be able to meet women’s multiple and complex needs; linking VAW with child protection including in mandatory reporting if there is a real risk to the woman’s life, a child is being abused or a person discloses that they intend to harm or kill someone else, while also taking into account local legislation; responding to men as both victims and perpetrators; and primary prevention and health promotion (i.e., integrated messages about VAW as part of routine health-promotion activities).

**Identified barriers**

Although VAW has been accepted as a critical public health problem, it is still not included in the public health policies of many countries. The crucial role that the healthcare systems
play, in a multisector response, is poorly understood and/or not well accepted within many of the national health programmes and policies of various countries and territories (World Health Organization, 2013b). Unfortunately, health systems’ integration of policy and practical attention to VAW is slow and incremental (García Moreno et al., 2015). Although some countries have guidelines to address VAW, generally they are only gradually adopted and then in often haphazard ways due to cultural barriers and limited resources for implementation (García-Moreno et al., 2015).

Despite the fact that healthcare systems have a crucial role in detecting, referring and caring for women affected by violence, there are significant barriers experienced by primary care providers in addressing VAW (Saletti-Cuesta, Aizenberg, & Ricci-Cabello, 2018). At an organisational level, barriers include (1) little or no training for healthcare staff in providing comprehensive care, empathic communication skills, as well as helping staff better understand the social and gendered roots of VAW; (2) high workloads, which in turn, means limited consultation time, competing priorities, limited resources and high staff turnover; (3) healthcare staff’s limited understanding of their legal responsibilities regarding VAW; (4) absence of guidelines to address VAW within the healthcare system; (5) limited supervision or debriefing facilities for healthcare staff and (6) insufficient resources and a fragmented network of community-based VAW services outside of healthcare systems (Saletti-Cuesta et al., 2018).

Furthermore, traditional biomedical approaches, which are often used in healthcare, constitute an important barrier in understanding, identifying and offering compassionate care in VAW situations because biomedical approaches reinforce the division of biological and biopsychosocial needs. Moreover, this approach values technical, clinical skills and laboratory investigations, while also regarding communication skills and emotional/subjective information as less important (García Moreno et al., 2015; Briones-Vozmediano et al., 2015; Saletti-Cuesta et al., 2018).

The importance of the context

As discussed earlier in the chapter, there is insufficient evidence that particular policies, protocols or models of care are more effective than others in responding to VAW. Accordingly, countries should develop responses and services that take into account country-specific resources that are available, as well as the availability of specialised violence-support services (World Health Organization, 2013b; García-Moreno et al., 2015). Health intervention efforts typically used in high- and/or middle-income countries may not translate to low-resource areas effectively due to social, cultural and economic differences. Moreover, when research on healthcare interventions has been limited to high-income countries, little is known about the evidence base of intervention efforts in other countries and contexts (Schwab-Reese & Renner, 2018). For example, women-centred counselling as well as community-based advocacy and support have shown to be helpful for VAW in high-income countries. However, a recent review shows that psychotherapeutic counselling, other forms of counselling and/or support for accessing services (e.g., through crisis centres) may not be helpful in preventing future IPV in low- and low-middle-income countries (Kirk et al., 2017). Because no one model works in all contexts, national leaders who are working to prevent and address VAW in the context of healthcare should develop country-specific policies and programmes, while keeping in mind the availability of resources, current national policies and procedures, as well as other available support services.

In addition, low- and middle-income countries often face the challenge of a growing burden of VAW, while not having sufficient resources and/or healthcare personnel who are skilled in addressing VAW (World Health Organization, 2013b). For example, while research shows
that the global prevalence of IPV among all ever-partnered women is 30.0%, the prevalence was higher in low- and middle-income countries than in high income ones, with women in the Americas reporting the second highest prevalence globally (World Health Organization, 2013a). A recent review and reanalysis of national, population-based VAW estimates from 1998 to 2017 confirms that violence in the Americas remains a crucial problem, which in turn calls for additional prevention, response and research in these parts of the world (Bott, Guedes, Ruiz-Celis, & Mendoza, 2019).

In addition to VAW being a significant problem in this part of the globe, Latin America is one of the world’s most unequal regions. Although health and disease indicators have improved in the past decade, significant and relative inequalities and gaps continue to exist between classes, ethnic groups and geographic areas. While there have been increases in public and private health spending, equitable access to health services for the poorest sectors has yet to be achieved. Public health spending remains insufficient and varies greatly between countries. For example, in 2014, Uruguay assigned more than 6% of their Gross Domestic Product to public health spending while Argentina spent only 2.7% (Benza & Kessler, 2020).

Taking into account the high prevalence of VAW of the region, the inequitable access to healthcare, which is exacerbated by the weak and fragmented Latin America health systems, research on the implementation of VAW health-based strategies are timely and important. For all these reasons, this chapter next presents research that aims to add evidence concerning health-care intervention efforts that address VAW in a middle-income country, specifically Argentina.

**Argentinian context**

The Argentine Republic covers an area of 3,761,274 km² and consists of 23 provinces. Nearly 65% of the population is concentrated in the Centro region, particularly in the province of Buenos Aires. In 2010, the country’s population was 40,117,096, of which 91% lived in urban areas (Pan American Health Organization, 2017).

The proportion of women who reported physical and/or sexual violence ever in the majority of Latin American countries, including Argentina, ranged from one-fourth to one-third (Bott et al., 2019). In 2015 Argentina carried out a telephone survey to estimate VAW using the International Violence Against Women Survey. The percentage of women, aged 18 to 69, who reported physical and/or sexual violence ever was 41.6% (Ministerio de Justicia y Derechos Humanos, 2017).

Since the 1990s, Argentina, similar to other Latin American countries, has passed laws to protect and promote women’s rights mainly in the private sphere. The Inter-American Convention on the Prevention, Punishment and Eradication of VAW (Convention of Belém do Pará) adopted in 1994, represents an important milestone in the area of state responsibility to address this problem. By 2016, the Convention of Belém do Pará had been adopted and ratified by the majority of states, including Argentina. Thanks to the adherence to Belém do Pará, as well as the political efforts and advocacy of civil society organisations – especially feminists – as in other countries, Argentina have made progress in legislation to address VAW (Essayag, 2017). For example, the law N°26.485 titled, “Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women in Areas Where They Develop Their Interpersonal Relations” (Senate and Chamber of Deputies of the Argentine Nation, 2009). The policy included forms of VAW that are not only perpetrated in private and domestic ways but also in the public sphere, including domestic violence, institutional violence, obstetric violence, mediatic violence, violence at the workplace and violence against the reproductive rights. Furthermore, this law emphasises the comprehensive care of the victims through the implementation of prevention,
service and response, as well as in punishment and reparation measures, in coordination with various actors including the education and health governmental sector. Although Argentina is one of the few countries of Latin America that mentioned the health sector in VAW legislation (Ortiz-Barreda & Vives-Cases, 2013), its integration, within the multisectoral commitment to response to VAW, is still a challenge.

A series of violent attacks against women and girls in 2015 generated massive protests nationwide called Ni una Menos (Not One Less; The Guardian, 2016; Terzian, 2017). After a violent murder against a teenager activist from the Not One Less movement (El Pais, 2017), a recently approved national law required mandatory training in gender and VAW for all state officials and workers.

Moreover, in 2018 the legislative debate towards legal abortion reform caused the “green wave”, which in turn, strengthened the feminist movement and situated women’ rights onto the public agenda (Booth, 2018). However, the debate has also impacted on the growing role of anti-rights sectors, who are strongly advocating against a sexual and reproductive rights agenda for Argentina (Vaggione, 2018).

### Argentinian healthcare system

According to the Pan American Health Organization (2017), Argentina’s health system, which includes public, private and social security sectors, is one of the most fragmented and segmented in Latin America. Such fragmentation is largely due to the country’s federal structure, in that each of the 23 provinces functions independently and has constitutional responsibility for the leadership, financing and delivery of health services. The public sector comprises the national and provincial Health Ministries, hospitals and primary healthcare centres. This sector is decentralised from the federal level to provincial or local administrations. Therefore, differences in infrastructure, budget and administration, as well as uneven and unclear distribution of their legally assigned part of the federal budget, result in important regional inequalities (Novick, 2017).

The Pan American Health Organization (2017) concluded that the Argentinian health system’s fragmentation falls into: coverage problems, since not all the population has access to the same health benefits and services; geographic disparities, given the extreme economic-development differences; and differing regulatory functions, since leadership and regulatory authority are diffuse.

In addition, in 2018, the National Ministry of Health lost a level of authority in the institutional hierarchy and was downgraded to a Secretariat. Furthermore, health and educational programmes have been cut, closed and/or emptied due to deepening budget cuts, which in turn, create even more health inequities across regions.

Taking into account the Argentine context, this chapter next presents a study that investigated healthcare-based services and responses for VAW within the public health sector. In the first study phase, the national and provincial Health Ministries’ websites and policies were reviewed between August and September 2019. For each website and set of policy documents, a search of terms and phrases related to VAW was conducted. Once relevant documents were identified, specific content was analysed and classified with focus on the content’s main aim, objectives and target audience and/or participants. In a second study phase, semi-structured interviews were conducted by phone with key informants from provincial Health Ministries in seven provinces of different regions. Snowball techniques were used to recruit participants. Informed consent was given. All the interviews were digitally audio-recorded and transcribed. The main focus of the interviews concerned the response for VAW within the healthcare
sector, experiences in local communities, as well as response barriers and facilitators. A thematic analysis was used to identify, analyse and report patterns (i.e., qualitative themes) within data (Braun & Clarke, 2006). The analysis of both data sources were the basic inputs for the preparation of the Argentinian mapping of health-based VAW strategies.

Discussion and analysis

The presentation of the findings is linked to the study’s phases. In the first phase, the national and provincial Health Ministries’ websites and policies were reviewed. According to the national Health Ministry website a health-based strategy to address VAW, specifically, a protocol to assist victims of sexual violence (Chejter, 2011, 2015), has been developed. The document focused both on emergency assistance after sexual violence, as well as provided a legal framework underscoring the crucial role that healthcare providers should play in addressing VAW. In its second edition of the document, medical, legal and bioethics information was elucidated. Another identified practice carried out by the national Health Ministry was in the training of primary healthcare providers (Pierina Juarez et al., 2012). However, no information concerning its implementation was offered on the website. Only a few informative resources were available on the national Health Secretariat’s website, which were part of the promotion and prevention actions.

As a result of fragmentation, the national Health authority and leadership are limited. Therefore, each of the provinces developed their own approach to respond to VAW, though there were some national standards and resources that all provinces used. Taking into account the number of health-based strategies implemented in each province, Figure 34.1 shows the disparities across the country.

As described earlier, the Argentinian healthcare system is highly decentralised and each of the governments of the 23 provinces are in charge of managing health services, which are offered through a network of hospitals, primary healthcare centres and specialised services (i.e., mental health). Table 34.2 presents the healthcare-based VAW strategies developed in each province according to the website review. The identified strategies across the provinces included having protocols or standard procedures to address VAW; training of providers to understand VAW and provide a comprehensive response (e.g., health workforce development and capacity building); having a health information system for documenting and monitoring VAW; developing primary prevention activities; providing supportive care to survivors of VAW; and creating VAW-focused units or networks within the healthcare management organisation to advocate for transforming institutional cultures to prioritise the tackling of VAW (i.e., by a training plan for providers).

According to the websites, 11 provinces from different regions (47.8%) had offered training to their providers. However, there was no training plan published. Only eight provinces had enacted healthcare protocols to address VAW. However, the majority of the protocols were not available online and information about their contents was difficult to find. Prevention programmes were carried out in only seven provinces (30.4%). According to the websites reviewed, the majority of actions were short term, focused mainly on women, and were offered on key women’ rights dates (i.e., 25th of November and/or 8th of March). Examples of such interventions included mass, public awareness-raising campaigns, recreational actions and/or VAW awareness talks in public spaces or within healthcare institutions. Information regarding the available resources to assist women with violence had been published in the websites of only four provinces (17.4%) (i.e., national or provincial hotlines). Such findings suggest the need to reinforce collaborative intersectoral efforts.
Although Argentinian policy also underscores the importance of developing information systems to document and research VAW, only two provinces mentioned this strategy on their websites. In this regard, only one province had online guidelines available, which focused on improving healthcare providers’ abilities to document, register and record accurately practices related to VAW within their health information system.

By law, all Regional Ministries must include service provision for women who are experiencing violence victimisation, as well as their children. However, only five province websites provided information about the availability of specialised care or programmes within their healthcare services.

The website review also showed, from five provinces, that a potentially promising practice was the creation of units, commissions and/or professionals’ networks to address VAW. These units or networks provided support, coordinated actions, developed trainings and/or assessed healthcare practices.

With the “big picture” of the healthcare-based strategies from the first study phase as a foundation, a second phase was carried out to investigate specific, local healthcare-based services and responses for VAW within the public health sector. Via in-depth interviews, key informants highlighted a growing engagement of some providers from different regions, who despite the lack of political will, supported women who experienced IPV victimisation. Many of these key informants reported relying on informal or personal networks and relationships for advice or

Figure 34.1  Number of healthcare-based VAW strategies by province
referral women. One key informant mentioned that despite the political will to introduce VAW into the health agenda, the financial resources allocated to the creation of units, commissions and/or professionals’ networks to address VAW were scarce (i.e., only one professional assigned to the unit). In another province, an additional key informant reported the same limitation: specifically, a providers’ network was implemented in a hospital without any financial support. Likewise, other key informants described how, in some provinces, primary, violence prevention activities were organised mainly by motivated healthcare providers without any institutionalisation of these programmes.

Some key informants mentioned that, compared to physicians, providers from social and mental health areas of professional practice were the most interested in attending the few VAW courses offered. Likewise, one key informant described how VAW information is under-recorded within existing health information systems conceived mainly for mortality and morbidity information.

Notably, the study results suggest that, in Argentina, there is a growing commitment among healthcare providers to address VAW, which could be related to feminist movement-based activism, especially after the Not One Less movement as well as the country’s 2018 abortion legislative

### Table 34.2 Healthcare-based violence against women strategies in Argentina

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Protocol or standard procedures to address VAW</th>
<th>Training of providers</th>
<th>Health information system</th>
<th>Primary prevention activities</th>
<th>Information on available resources for VAW</th>
<th>Provision of supportive care to survivors of VAW</th>
<th>Violence units/networks within the healthcare system</th>
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debate. Such developments are encouraging and suggest that anti-VAW activism has the potential to improve healthcare prevention and care, as well as challenge unequal gender norms, shape policy agendas and inform interventions (Michau, Horn, Bank, Dutt, & Zimmerman, 2015; Shiffman & Smith, 2007).

This study findings also suggest that women-centred interventions should be strengthened since their effectiveness has been demonstrated in low- and low-middle-income countries (Kirk et al., 2017). In addition, according to the law, prevention and awareness-raising activities should be prioritised, in order to change the gender status quo. Moreover, rather than limit such activities to certain times of the year and/or audiences, VAW prevention and awareness-raising programmes should be delivered throughout the year, as well as to diverse audiences and targets. Notably research from other countries, specifically Spain, has described similar challenges in which prevention and awareness-raising – supposedly a priority within healthcare services – has not been prioritised in practice (Goicolea et al., 2013).

Training for healthcare staff is strongly recommended as an important strategy to ensure that the healthcare sector can address VAW effectively and meaningfully (World Health Organization, 2013b). As first steps, trainings could aim to strengthen healthcare staff members’ understanding of VAW, as well as to address the prejudices and hostile attitudes of some healthcare providers (Saletti-Cuesta, 2018). Therefore, training actions should include all the healthcare professions, not only those related to mental health and social work, and should be developed in all the provinces throughout Argentina.

According to this study’s findings, accurate records were not a priority within the health services, despite the well-known fact that properly collected, managed and analysed data from records can both improve the services provided to women and help inform primary prevention (World Health Organization, 2013b; García Moreno et al., 2015). However, as the World Health Organization (2013b) underscored, such data collection is easier to implement in high-income countries with well-functioning electronic health information systems, compared to the paper-based systems that are currently used in most low- and middle-income countries.

Conclusions

Healthcare systems have a crucial role in preventing, detecting, referring, caring for women affected by VAW, and leading efforts to address this problem. This work provides an overview of the health-based interventions being implemented within the Argentinian public sector.

Despite the positive legislative advances made in the country, the highlighted role of the healthcare systems within a multisector response to VAW, as well as the highlighted role of healthcare in the existing legislation, the study findings revealed important differences in how different Argentine regions both developed and implemented VAW prevention and response strategies. Only a few provinces were actively seeking to respond to the problem. Among those provinces offering VAW strategies, training and healthcare protocols were the most implemented. Thus, there is a clear need to strengthen prevention actions, as well as specialised care services to assist VAW throughout Argentina. In addition, local data from the key informants showed the extent of the problems and challenges. For example, accurate data collection to monitor and assess VAW, which should be prioritised in Argentina, could help strengthen the health system’s response to VAW considerably.

Encouragingly, a promising practice was the creation of VAW units in some provinces. This strategy allowed the coordination of VAW actions within the healthcare system, as well as across the sectors in order to improve VAW prevention and response. In light of this strategy’s promise,
the creation of VAW units could be interesting to implement in other communities and contexts. Moreover, other important study findings highlighted how some healthcare providers’ commitment to addressing VAW, as well how the inclusion of VAW in a broader social agenda point to potential strengths within the health sector that could be fruitfully developed and reinforced throughout Argentina and beyond. The study findings also underscore how healthcare providers should be supported in providing appropriate and comprehensive care through political commitment and institutionalisation of their actions.

Despite the effort made in Argentina to address VAW in the healthcare context, there are some points that are interesting to discuss in order to inform the broader context. The consequences of the decentralisation and fragmentation of the healthcare system are crucial. For example, there is no VAW national health protocol that includes the various forms of VAW incorporated in the Argentinian legislation, and the only existing national protocol is focused only on sexual violence. At the same time, some provinces have designed protocols focused on some types of violence (i.e., sexual violence or IPV).

Therefore, each of the provinces have implemented their own approach and strategies to respond VAW, with great disparities across the region that need to be addressed. Undoubtedly, Argentina is not the only country challenged with a fragmented healthcare system. Accordingly, future research could help address how VAW prevention and response might be implemented and sustained in such complex and dynamic systems.

In addition, the study findings highlighted how the Argentine VAW policies and laws, which are quite meaningful and robust, could be better implemented in the health sector throughout Argentina. Health-sector leadership and political commitment need to be strengthened in order to effectively involve health sectors within a multisectoral response to VAW and to provide a platform for effective and collaborative interventions across the region. Further research should include contextual factors and processes that influence services’ integration of VAW interventions in order to better understand the disparities across the region.

**Critical findings**

- Despite a strong legal framework, which includes the healthcare system as a central element, the Argentinian health sector has not been actively involved in comprehensive responses to VAW.
- There are important differences of the implemented strategies between regions. Only a few Argentinian provinces are actively seeking to respond to the problem. Training and protocols are the most implemented strategies. There is a need of strength prevention actions and specialised care services. Also, local data collection shows the extent of the VAW problem remains a challenge throughout Argentina.
- The commitment of some healthcare providers and the inclusion of VAW on the social agenda are encouraging and suggest potential strategies to improve, not only healthcare prevention and response, but also to challenge unequal gender norms more broadly throughout Argentina.

**Implications for policy, practice and research**

- There is sufficient evidence that VAW is a public health problem and that addressing it in healthcare services is important.
- Health-sector leadership and commitment needs to be increased in order to effectively engage this sector within a multisectoral response to VAW according to the legislation.
• Primary, secondary and tertiary prevention are essential public health interventions and should be developed.
• The importance of the strength of the providers involved with this problem should be supported by political commitment, actions and resources.
• Further research should include contextual factors and processes that influence services’ integration of VAW interventions in order to understand the inequalities across the region.

References


