



# Briefing

## **Violence against women, health & the women's voluntary & community sector**

September 2008

Understanding and supporting women and their organisations

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## Introduction

"Your health is bound to be affected if, day after day, you say the opposite of what you feel, if you grovel before what you dislike and rejoice at what brings you nothing but misfortune. Our nervous system isn't just a fiction, it's a part of our physical body, and our soul exists in space and is inside us, like the teeth in our mouth. It can't be forever violated with impunity."

Boris Pasternak, *Doctor Zhivago*; Quoted in *Strong at the Broken Places* by Linda Sanford<sup>1</sup>

The purpose of this briefing is to make the links between violence against women (VAW) and health explicit. Currently, VAW is largely confined to the area of criminal justice, which ignores the significant impact that it has on many other areas of society. The health effects of violence against women are long-standing and far-reaching.

This briefing also examines the significant but under-valued role of women's voluntary and community organisations (VCOs) in supporting and meeting the complex needs of marginalised and vulnerable women who experience violence. Their role within the health agenda is therefore vital.

Failure to effectively address the health impacts of VAW is costly to the public, private and third sectors, as well as the individuals directly affected (including family and friends). It also shows an appalling disregard for the many women and girls experiencing violence.

It also breaches domestic, European and international obligations to address violence against women, including the Public Sector Equality Duties, the European Convention on Human Rights, the Human Rights Act 1998, the Beijing Platform for Action, United Nations (UN) Convention on the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination Against Women.<sup>2</sup>

The Gender Equality Duty, which came into force in April 2007, places a legal obligation on public authorities, (including central government department's such as the Department of Health and statutory health bodies such as the National Health Service) to have 'due regard' to the need to promote equality of opportunity between women and men and to eliminate unlawful harassment and discrimination. 'Due regard' requires public bodies to take action on the most important gender equality issues. The prevalence of VAW in the UK should therefore ensure it is a gender equality priority for all public bodies.

The endemic levels of violence against women are a major public health issue and one the Government has been slow to act upon cross-departmentally. It is a health issue because of the physical and psychological injuries that are sustained

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<sup>1</sup> Quote taken from:

[http://www.mind.org.uk/Information/Factsheets/Sexual+abuse/#Health\\_problems\\_that\\_may\\_be\\_suffered\\_by\\_survivors\\_of\\_sexual\\_abuse](http://www.mind.org.uk/Information/Factsheets/Sexual+abuse/#Health_problems_that_may_be_suffered_by_survivors_of_sexual_abuse)

<sup>2</sup> Coy, M., Lovett, J. & Kelly, L. (2008) *Realising Rights, Fulfilling Obligations: A Template for an Integrated Strategy on Violence Against Women for the UK*. End Violence Against Women. London.

which lead to a plethora of other problems such as mental health problems, lost income, costs to health services and the criminal justice system, child protection cases and so on.

Acknowledging and addressing VAW as a health issue would contribute to the overall reduction of VAW as well as ensuring that appropriate and accessible support is available for the many women and girls who are experiencing violence and abuse. This also has wider societal benefits in terms of helping women to engage with and participate in society.

## **Why violence against women is a gender equality issue**

*"Violence against women is an issue that cannot wait. A brief look at the statistics makes it clear. At least one out of every three women is likely to be beaten, coerced into sex or otherwise abused in her lifetime...No country, no culture, no woman young or old is immune to this scourge. Far too often, the crimes go unpunished, the perpetrators walk free."<sup>3</sup>*

Remarks by Secretary General Ban Ki-moon to the Commission on the Status of Women  
New York, 25 February 2008

Violence against women is acknowledged by the United Nations as one of the key causes and consequences of women's inequality. It also represents a violation of women's and girl's fundamental human rights. VAW manifests in a number of ways including: **rape and sexual abuse, female genital mutilation, forced and early marriage, stalking, crimes in the name of 'honour', trafficking and sexual exploitation, sexual harassment and domestic violence.**

Studies have illustrated that VAW is widespread in our society. For example:

- 45% of women have experienced some form of domestic violence, sexual assault or stalking.<sup>4</sup>
- It is conservatively estimated that 80,000 women suffer rape every year.<sup>5</sup>
- At least 32% of children, mostly girls, experience some form of child sexual abuse.<sup>6</sup>
- An estimated 66,000 women living in the UK have undergone female genital mutilation (FGM) and 21,000 girls under 16 are currently at risk.<sup>7</sup>
- In 2004, the Metropolitan Police decided to re-open 114 murder cases from the previous decade, which they now think may be so-called 'honour' killings.<sup>8</sup>

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<sup>3</sup> <http://endviolence.un.org/>

<sup>4</sup> Walby, S. & Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office. London.

<sup>5</sup> Ibid.

<sup>6</sup> HM Government (2007) *Cross-government Action Plan on Sexual Violence and Abuse*. Home Office. London.

<sup>7</sup> Forward (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*. Forward. London.

<sup>8</sup> <http://news.bbc.co.uk/1/hi/uk/3828255.stm>

- The Forced Marriage Unit in the Foreign and Commonwealth Office deals with approximately 250 forced marriage cases each year. Approximately 85% of these are female.<sup>9</sup>

Violence against women reinforces patriarchy, in which power imbalances between men and women are legitimised through key institutions. Overwhelmingly, the perpetrators of violence are men (and often known to the women) and victims are women. The very fact that they are *women* makes them more vulnerable to experiencing violence as the United Nations statement on VAW clearly illustrates:

***“Violence that is directed at a woman because she is a woman or that affects women disproportionately.”***

VAW is highly effective because although not all women experience violence (although most women will experience low level harassment from men in public spaces - which is part of the spectrum of violence) they are aware that they *could* be potential victims and this restricts women’s ability to fully participate in society.

For example, at certain times areas become ‘no-go’ for women and if they do use these spaces at the ‘wrong time’ are often blamed if anything happens to them.

***“A woman is more likely to be sexually assaulted than she is to get breast cancer. But, unlike cancer, sexual violence is rarely discussed. There is a stigma attached to sexual crime, the result of attitudes that lay the blame on the woman for the rape, not the perpetrator. Women may also blame themselves, and can be reluctant to ask for help for fear of not being believed.”<sup>10</sup>***

Research by Amnesty clearly illustrated that it is widely believed that women are responsible for what happens to them. More than a quarter (26%) of those surveyed said that they thought a woman was partially or totally responsible for being raped if she was wearing sexy or revealing clothing, and more than one in five (22%) held the same view if a woman had had many sexual partners. Similarly, more than a quarter of people (30%) said that a woman was partially or totally responsible for being raped if she was drunk.<sup>11</sup>

These attitudes contribute to a culture of ‘virtual impunity’ in which not only are conviction rates are appallingly low but access to support for survivors of sexual assault is extremely limited.<sup>12</sup>

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<sup>9</sup> Statistics from End Violence Against Women:

[www.endviolenceagainstwomen.org.uk/pages/honour\\_crimes\\_forced\\_marriage.html](http://www.endviolenceagainstwomen.org.uk/pages/honour_crimes_forced_marriage.html)

<sup>10</sup> new philanthropy capital (2008) *Hard knock life – Violence against women: A guide for donors and funders*. npc. London.

<sup>11</sup> Amnesty UK (2005) *Sexual Assault Research*. Amnesty. London.

<sup>12</sup> Kelly, L. (2005) *How violence is constitutive of women’s inequality and the implications for equalities work*. Child and Woman Abuse Studies Unit. London Metropolitan University. London.

## Why violence against women is a health issue

**The World Bank has estimated that violence against women is just as serious a cause of death and incapacity among women of reproductive age as cancer and a greater cause of ill health than traffic accidents and malaria combined.**<sup>13</sup>

VAW has both immediate and long-term effects and can result in minor to serious physical injuries and even death. It can have significant impacts on women's reproductive and sexual health and their mental health. It has major consequences in terms of depression, anxiety, post-traumatic stress disorder and suicide and self-harm amongst women.

N.B. Where the data is not referenced, it relates to the next instance where data is referenced.

### Physical impacts of VAW

- On average, two women a week are killed by a violent partner or ex-partner. This constitutes nearly 40% of all female homicide victims.<sup>14</sup>
- During the worst incident of domestic violence experienced, 46 per cent of women sustained a minor physical injury, 20 per cent a moderate physical injury, and six per cent severe injuries.<sup>15</sup>
- 70% of incidents of domestic violence result in injury, (compared with 50% of incidents of acquaintance violence, 48% of stranger violence and 29% of mugging).<sup>16</sup>
- Chronic physical health problems e.g. irritable bowel syndrome, backache and headaches are associated with VAW.<sup>17</sup> (Campbell 2002).

### VAW and reproductive and sexual health

- 30% of domestic violence starts in pregnancy (based on reported cases and therefore likely to be an underestimate).<sup>18</sup>

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<sup>13</sup> Unifem (2003) *Not a minute more: Ending Violence Against Women*. United Nations Development Fund for Women. New York.

<sup>14</sup> Povey, D. (2005) *Crime in England and Wales 2003/2004: Supplementary Volume 1: Homicide and Gun Crime*. Home Office Statistical Bulletin No. 02/05. Home Office. London; Department of Health (2005) *Responding to Domestic Abuse*. DH. London. (from 'Statistics on Domestic Violence': [www.womensaid.org.uk](http://www.womensaid.org.uk))

<sup>15</sup> Walby, S. & Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office. London.

<sup>16</sup> Dodd, T. et al (2004) *Crime in England and Wales 2003-2004*. Home Office. London (from 'Statistics on Domestic Violence': [www.womensaid.org.uk](http://www.womensaid.org.uk))

<sup>17</sup> Campell, J.C. (2002) *Health consequences of intimate partner violence*. 359(9314):1331-6. Lancet.

<sup>18</sup> Department of Health (2005) *Responding to Domestic Abuse*. DH. London.

- Domestic violence has been identified as a prime cause of miscarriage or still-birth, and of maternal deaths during childbirth.
- Between 4 and 9 women in every 100 are abused during their pregnancies and/or after the birth.
- 12% of the 378 women whose death was reported to the Confidential Enquiry on Maternal Deaths had voluntarily reported domestic violence to a healthcare professional during their pregnancy. None had routinely been asked about domestic violence so this is almost certainly an under-estimate.
- A U.S. study found that women who experienced intimate partner abuse were more likely to have a gynecological problem than were non-abused women. These problems include chronic pelvic pain, vaginal bleeding or discharge, vaginal infection, painful menstruation, sexual dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infection and infertility.
- Sexual abuse, especially rape, can cause physical and mental trauma. In addition to damage to the urethra, vagina and anus, abuse can result in sexually transmitted infections, including HIV/AIDS.
- Women who have been sexually abused are much more likely than non-abused women to have had their partner stop them from using family planning and have a partner refuse to use a condom to prevent disease.
- Studies show that physical abuse occurs in approximately 4 to 15 percent of pregnancies in the United States, Canada, Sweden, United Kingdom, South Africa and Nicaragua.
- Abuse during pregnancy has been linked with delays in obtaining prenatal care, increased smoking and drug/alcohol abuse during pregnancy, poor maternal weight gain and depression.<sup>19</sup>
- Violence against women in the form of childhood sexual abuse has been shown to increase the probability of risky sexual behaviour later in life. Such behaviours include consensual sex at an earlier age, multiple partners, transactional sex, and heavy use of alcohol or drugs. These behaviours also increase the risk for HIV, other Sexually Transmitted Infections and unintended pregnancies.<sup>20</sup>
- Female Genital Mutilation (FGM) is defined by the World Health Organisation as the range of procedures which involve "the partial or complete removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reason". It has numerous short-term health implications which include: severe pain and shock, infection, urine retention, injury to adjacent tissues, immediate fatal haemorrhaging.<sup>21</sup>

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<sup>19</sup> Data from Programme for Appropriate Technology in Health (PATH): [http://www.path.org/files/EOL20\\_1.pdf](http://www.path.org/files/EOL20_1.pdf):

<sup>20</sup> Data from the World Health Organisation: <http://www.who.int/gender/documents/MDGs&VAWSept05.pdf>

<sup>21</sup> Data from FORWARD: <http://www.forwarduk.org.uk/>

- Long-term complications of FGM include: extensive damage of the external reproductive system, uterus, vaginal and pelvic infections, cysts and neuromas, increased risk of Vesico Vaginal Fistula, complications in pregnancy and child birth, psychological damage, sexual dysfunction, difficulties in menstruation.<sup>22</sup>

## VAW and mental health

- The World Health Organisation estimate that up to 60% of women in the UK mental health service population have been sexually abused in their lifetimes and 20% of victims of sexual violence will use health services in the first year, but by the second year, 50% are 'heavily embedded' in the health system.<sup>23</sup>
- Childhood experiences of abuse and of witnessing family violence increase women's risk for intimate partner violence, poor physical health and frequent mental distress.<sup>24</sup>
- Women's experience of child sexual abuse and domestic violence are linked to long term mental illness and also with physical and sexual health problems.<sup>25</sup>
- Rape victims are far more likely than victims of other violent crime to experience long-term mental health problems.
- Long-term effects of recent and historic sexual abuse include:
  - post-traumatic stress disorder
  - anxiety and panic attacks
  - depression
  - social phobia
  - substance misuse
  - obesity
  - eating disorders
  - self harm and suicide.<sup>26</sup>
- A study of the impact of child sexual abuse on mental health found a clear association with child sexual abuse and increased rates of a range of mental disorders in child and adulthood. These included: major affective disorders, anxiety disorders, personality disorders and disorders of childhood.<sup>27</sup>

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<sup>22</sup> Ibid.

<sup>23</sup> Taken from presentation by Dr Maureen Dalton a consultant in obstetrics and gynaecology at the Royal Devon and Exeter Hospital

<sup>24</sup> Bensley, L., Van Eenwyk, J. & Wynkoop Simmons K. (2003) *Childhood family violence history and women's risk for intimate partner violence and poor health*. *Am J Prev Med*. 2003 Jul;25(1):38-44.

<sup>25</sup> Department of Health (2003) *Women's Mental Health: Into the Mainstream, Strategic Development of Mental Health Care for Women*. DH. London.

<sup>26</sup> HM Government (2007) *Cross-government Action Plan on Sexual Violence and Abuse*. Home Office. London; Department of Health (2006) *Tackling the health and mental health effects of domestic violence and sexual abuse*. DH. London.

<sup>27</sup> Spataro, J., Mullen, P.E. et al (2004) *Impact of child sexual abuse on mental health*. *The British Journal of Psychiatry*; 184: 416-412.

- Disclosure to medical professionals was 6 per cent for adult abuse and 4 per cent for child abuse while disclosure to counsellors/therapists was 12 per cent with 14 per cent of women and 8 per cent of men disclosing to counsellors/therapists.<sup>28</sup>
- 40% of adults who are raped tell no one about it. 31% of children who are abused reach adulthood without having disclosed their abuse. This means that victims don't get the support they need to deal with the sexual violence they have experienced.
- Of women who had been subject to serious sexual assault (including rape), since the age of 16:
  - 52% had suffered depression
  - 5% had attempted suicide
  - 4% had become pregnant as a result of the rape
  - 38% had stopped trusting people and 15% go out less often.<sup>29</sup>
- Women who have suffered domestic violence have approximately twice the level of usage of general medical services and between 3 and 8 times the level of usage of mental health services.<sup>30</sup>
- 70% of women psychiatric inpatients and 80% of those in secure settings have histories of physical or sexual abuse.<sup>31</sup>

### **Depression**

- One study showed that the average rate of depression amongst battered women was 48%, the rate of suicidality was 18% and post traumatic stress disorder (PTSD) was 64%.<sup>32</sup>
- Another study found that among women who were depressed, 67% had experienced domestic violence.<sup>33</sup>
- Abused women are at least three times more likely to experience depression or anxiety disorders than other women.<sup>34</sup>

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<sup>28</sup> McGee, H. (2002) *The SAVI Report: Sexual violence and abuse in Ireland*. The Liffey Press. Dublin

<sup>29</sup> Walby, S. & Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office. London.

<sup>30</sup> Walby, S. (2004) *The Cost of Domestic Violence*. Women and Equality Unit. London.

<sup>31</sup> Data from Women's Aid: [www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=000100010008000100360002](http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=000100010008000100360002)

<sup>32</sup> Golding, Jacqueline M. (1999) *Intimate partner violence as a risk factor for mental disorders: A meta-analysis*. Journal of Family Violence, 14, 2, 99-132. (from Walby, S. (2004) *The Cost of Domestic Violence*)

<sup>33</sup> Bradley, Fiona, Mary Smith, Jean Long and Tom O'Dowd (2002) *Reported frequency of domestic violence: cross sectional survey of women attending general practice*. British Medical Journal, 324, 1-6. (from Walby, S. (2004) *The Cost of Domestic Violence*)

<sup>34</sup> Data from Women's Aid: [www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=000100010008000100360002](http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=000100010008000100360002)

### ***Post-traumatic stress disorder***

- The existence of PTSD is high and lasts a long time among women who have been raped according to many studies with research reporting rates of between 50% and 95%.<sup>35</sup>
- Studies have estimated that 40% of rape victims suffer traumatic neurosis and 10% from more severe psychological injuries. By comparison, it is estimated that robbery victims have a 2% rate of severe psychological injury.<sup>36</sup>
- 49% of rape victims, 24% of victims of non-rape sexual assault and 32% of those who had been badly beaten up suffered PTSD, which lasted more than 10 years in more than half the cases of PTSD.<sup>37</sup>

### ***Suicide and self-harm***

- Nearly 13% of suicides and suicide attempts may be attributed to domestic violence.<sup>38</sup>
- One third of all suicide attempts and half of those by black and minority ethnic women can be attributed to past or current experiences of domestic violence.<sup>39</sup>
- Domestic violence commonly results in self-harm and attempted suicide: one-third of women attending emergency departments for self-harm were domestic violence survivors; abused women are five times more likely to attempt suicide; and one third of all female suicide attempts can be attributed to current or past experience of domestic violence.<sup>40</sup>

### ***Eating disorders***

- Research indicates that physically abused girls are more likely to develop eating disorders.<sup>41</sup>
- 61% of girls with eating disorders have reported sexual abuse; 85% have reported physical abuse.<sup>42</sup>

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<sup>35</sup> Sadler, A. G. et al (2000) *Health related consequences of physical and sexual violence: Women in the military*, *Obstetrics and Gynecology*, 96, 3, 473-480; Population Reports (1999) *Ending Violence Against Women*. Issues in World Health, Series L, Number 11. Population Information programme, John Hopkins University School of Public Health, Baltimore / Center for Health and Gender Equity, Maryland. (in Walby, S. (2004) *The Cost of Domestic Violence*).

<sup>36</sup> Cohen, Mark A. (1988) *Pain, suffering, and jury awards: A study of the cost of crime to victims*, *Law & Society Review*, 22, 3, 537-555. (in Walby, S. (2004) *The Cost of Domestic Violence*).

<sup>37</sup> Ibid.

<sup>38</sup> Walby, S. (2004) *The Cost of Domestic Violence*. Women and Equality Unit. London.

<sup>39</sup> Data from Women's Aid website: [www.womensaid.org.uk](http://www.womensaid.org.uk)

<sup>40</sup> Stark, E. and Flitcraft, A. (1996) *Women at risk* London: Sage; Mullender, Audrey (1996) *Rethinking domestic violence: The Social Work and Probation response*. Routledge .London. (In 'Statistics: Domestic violence [www.womensaid.org.uk](http://www.womensaid.org.uk))

<sup>41</sup> Hernandez, J. (1995) *The Concurrence of Eating Disorders with Histories of Child Abuse among Adolescents*. *Journal of Child Sexual Abuse*, 4, 3: 73-85.

<sup>42</sup> Miller, Katherine J. (1996) *Prevalence and Process of Disclosure of Childhood Sexual Abuse among Eating-Disordered Women*. In *Sexual Abuse and Eating Disorders*, ed. Mark F. Schwartz & Leigh Cohn, 36-51.:Brunner/Mazel.New York.

## VAW and substance misuse

- Many women use substances as a response to and a way of dealing with abuse. Many women who access drug and alcohol services will have current or past experience of domestic violence.
- Women experiencing domestic violence are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.
- 40% of Asian women who seek treatment for alcohol misuse are experiencing domestic violence.
- When a woman seeks support, information or treatment for her substance misuse, her partner may become even more abusive, or may actively prevent or discourage her attendance at a substance misuse service.<sup>43</sup>

## Costs to the health service of VAW

Violence against women has significant financial costs to the NHS. The Cross-government Action Plan on Sexual Violence and Abuse reported that the cost of sexual violence to society was £8.5 billion in 2003-04 *alone*. They stated that **“much of this cost is made up of lost output and costs to the health service resulting from long term health issues faced by victims. Addressing problems early should help prevent these long-term costs.”**<sup>44</sup>

Investment in health services (both statutory and voluntary) which identify and address VAW would result in significant cost savings to the NHS.

- It costs the NHS £1.2 billion a year for purely physical injuries with an added £176 million for mental health care.<sup>45</sup>
- Each rape costs over £76,000.
- The estimated cost of domestic violence to hospital, ambulance, GP and prescription health care services is £1,220,247,000:
  - Hospital and ambulance services - £1,158,053,000
  - GP services (GP visits, prescriptions, travel and associated costs) - £62,194,000
  - Of these: £1,208,405,000 is cost to the state/society and £11,743,000 is cost to the patients.<sup>46</sup>

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<sup>43</sup> Data from:

[www.womensaid.org.uk/landing\\_page.asp?section=000100010009000500200003](http://www.womensaid.org.uk/landing_page.asp?section=000100010009000500200003)

<sup>44</sup> HM Government (2007) *Cross-government Action Plan on Sexual Violence and Abuse*. Home Office. London.

<sup>45</sup> Walby, S. (2004) *The Cost of Domestic Violence*, London. Women and Equality Unit. London.

- It is estimated that the cost of treating depression in women who have experienced domestic violence is £105,252,000. Given that this figure is based on data from the early 1990s, it is likely that the actual figure would be much higher.<sup>47</sup>

## **Women's voluntary and community organisations**

Women's voluntary and community organisations (VCOs) emerged out of the women's liberation movement of the 1970s and 80s. Many were set up by women out of sheer necessity, to provide a means of escape for women in violent situations (up until then no provision existed). Issues affecting women, such as domestic violence, were considered to be a private matter and beyond the realms of Government policy. It is testament to the tenacity and struggle of women's VCOs and women's campaigning that this now seems unbelievable.

The underpinning philosophy of women's VCOs was significantly influenced by feminist theory which links women's experiences of violence with patriarchy. This exposes the unequal power relations between men and women and the systematic and structural discrimination that women face as a result. It identifies men's violence against women as a key mechanism for maintaining authority and control over women.

Women's VCOs continue to form a distinct and unique part of the wider voluntary and community sector. Over the past forty years, they have amassed a wealth of expertise and experience in meeting the complex needs of the most marginalised and vulnerable women in our society.

They have developed a theoretical model which acknowledges the links between violence against women and power and control. This has led to specific ways of working with women, which is acknowledged by VAW experts as best practice. Furthermore, they plug the gap in mainstream services which cannot or will not address women's complex needs which often arise as a result of violence and abuse.

Research has found that women's VCOs share a number of characteristics which make them a distinct and innovative part of service provision. These include:

- Provision of women-only space.
- Focus on empowerment and independence.
- Service user involvement and high level of peer support.
- Integrated 'one-stop-shop' service.
- Needs-based approach.
- Reaching 'hard to reach' women.<sup>48</sup>

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<sup>46</sup> Walby, S. (2004) *The Cost of Domestic Violence*. Women and Equality Unit. London.

<sup>47</sup> Ibid.

<sup>48</sup> Women's Resource Centre (2006) *Why women? The women's voluntary and community sector: changing lives, changing communities, changing society*. WRC. London.

These characteristics are part of what makes women's VCOs unique (and difficult to replicate), as well as in demand. Women-only space is highly valued; our recent research found that many women would not attend a mixed gender service.<sup>49</sup> Women's VCOs have the added advantage of being independent from the state which is why they are better able to support vulnerable groups who are usually considered to be 'hard to reach'. Without women's VCOs these particularly marginalised groups would have nowhere to turn.

Unfortunately, commissioners' lack of knowledge about women's organisations and the emphasis on 'efficiency savings' means that these valuable services, particularly women's health organisations, are struggling to survive.

There is a very real danger of losing the knowledge and skills of women's VCOs as they are further marginalised within these policy agendas. This is ironic considering that women's VCOs offer the needs-led, empowering and accessible services to which the Department of Health (DH) aspires in its vision for modern and responsive health services.<sup>50</sup>

However, the DHs approach to gender inequality and VAW has been fragmented and inconsistent.<sup>51</sup> At the strategic level, policies and guidance have been produced which evidence the impact of gender inequality and VAW on health and make recommendations for gender-specific approaches to be implemented.<sup>52</sup> However, this has not yet translated in to practice or better outcomes for women service users.

Furthermore, Section 64 funding (which has now been replaced by the Innovation, Excellence and Service Development Fund) has consistently marginalised women's VCOs. Since 2002, women's VCOs have seen a decrease in their funding from 2.94% in 2002/3 to 1.43% in 2007/8.<sup>53</sup> This has corresponded with an increase in funding to generic health and social care providers.

At the local level, End Violence Against Women (EVAW) has found that "Across the nations and regions stakeholders report extreme difficulty in engaging local Primary Care Trusts (PCTs) with the VAW agenda."<sup>54</sup>

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<sup>49</sup> Women's Resource Centre (2007) *Why women-only? The value and benefit of by women, for women services*. WRC. London.

<sup>50</sup> Department of Health (2006) *Our Health, our care, our say: a new direction for community services*. DH. London; Department of Health (2005) *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England*. DH. London; Department of Health (1999) *National service framework for mental health: Modern standards and service models*. DH. London.

<sup>51</sup> End Violence Against Women (2007) *Making the Grade? 2007. The third independent analysis of UK Government initiatives on violence against women*. End Violence Against Women. London.

<sup>52</sup> e.g. Department of Health (2003) *Mainstreaming gender and women's mental health: implementation guidance*. DH. London.

<sup>53</sup> Based on Women's Resource Centre audit of DH funding to women's VCOs (Unpublished).

<sup>54</sup> Coy, M., Lovett, J. & Kelly, L. (2008) *Realising Rights, Fulfilling Obligations: A Template for an Integrated Strategy on Violence Against Women for the UK*. End Violence Against Women. London.

## **Crisis in funding for the UK women's voluntary and community sector**

### **Example - Rape Crisis centres<sup>55</sup>**

Rape Crisis centres are a key example of a sector facing a severe funding crisis. Centres are closing at an alarming rate (nine in the last five years) and there is a major risk that without urgent attention the sector could be significantly diminished, leaving many of their service users with nowhere to turn.

#### **Services provided by Rape Crisis centres**

Member groups of Rape Crisis (England and Wales) provide specialist, dedicated services to (primarily) women and girls who have experienced rape, childhood sexual abuse and/or other forms of sexual violence. They offer a wide range of support and information for survivors, families, friends and professionals including: telephone helplines, face-to-face counselling and support, group work, advocacy (such as supporting women to access the criminal justice system or housing), practical support and supervision for other agencies.

Since the late 1970s, Rape Crisis centres have provided services to women and girls in a women-centred and often women-only environment, where survivors can talk to specialist staff and volunteers about their experiences of sexual violence. They encourage self-referrals and have a long history of working from a feminist perspective and within a framework of empowerment. The Rape Crisis sector campaigns and raises awareness of the impact of sexual violence and the needs of those affected by sexual violence, including the hidden needs of adult survivors of childhood sexual abuse.

**Rape Crisis centres work with women and girls of all ages, from three to 84 years old. Women from a wide diversity of backgrounds are supported by Rape Crisis.**

Rape Crisis centres have a pivotal role to play in supporting women to deal with the emotional and mental health repercussions of violence and abuse, providing:

- **Long term support** regardless of when the violence/abuse was experienced (research found that 78% of service users were presenting as a result of abuse that had occurred some time ago).
- **Holistic services** which address cross cutting issues such as mental and emotional health problems, substance misuse, eating disorders, self-harm as well as providing advocacy and referral support etc.
- **Independent support** which women (particularly those from marginalised communities such as black and minority ethnic, refugee, lesbian and bisexual women) may find less stigmatising and more approachable than statutory services. It also may be the *only* place in which they disclose their experiences of abuse.

<sup>55</sup> Women's Resource Centre and Rape Crisis (England & Wales) (2008) *The Crisis in Rape Crisis*. WRC. London.

- **Unconditional support** for those women who do not want to report to the police (which comprise approximately 90% of Rape Crisis centre service users).

These characteristics are distinct from Sexual Assault and Referral Centres (SARCs), which are usually joint funded by the Police and health services. SARCs offer support to women and men survivors, usually of recent sexual assault, provide health and medical checks and crisis intervention, short term counselling and aim to improve the forensic response to survivors of abuse. SARCs are an important element in the (limited) range of service provision available but should be viewed as complementary to Rape Crisis centres as opposed to an alternative.<sup>56</sup>

There is a huge demand for these Rape Crisis centres. A recent survey of 35 of the 38 remaining Rape Crisis (England & Wales) affiliated centres reported that they support a significant number of service users each year. There are also significant waiting lists for Rape Crisis centres. Twenty-five centres had a combined total of 510 women on their waiting lists. **The average length of time women spent on the waiting list was 84 days or approximately three months, although as this quote, from a Rape Crisis centre worker illustrates, this could be much longer:**

*Living 'hand to mouth' for funding has led to less frequent recruitment of new volunteers since April 2005. At the same time, demand for our services has increased. The gap has meant that our waiting list (by February 2007) had shot up to 6-9 months, with women who needed evening appointments waiting over a year for ongoing counselling. Women often feel very distressed at the point they access counselling; having to wait so long further compounds their distress and adds to their feelings of being let down and not cared for by society.*

The Cross-government Action Plan on Sexual Violence and Abuse has acknowledged "the vital and significant contribution that the sexual violence and childhood sexual abuse voluntary sector makes" and states that "it is important to acknowledge that these organisations are delivering crucial mental health services."<sup>57</sup> It also acknowledges that many of these organisations in this area are having difficulty accessing funding and that sustainability is a key concern.

<sup>56</sup> End Violence Against Women, Rape Crisis (England & Wales), the Child and Woman Abuse Studies Unit & the Fawcett Society (2008) *Not either/or but both/and: Why we need Rape Crisis Centres and Sexual Assault Referral Centres*. Fawcett. London.

<sup>57</sup> HM Government (2007) *Cross-government Action Plan on Sexual Violence and Abuse*. Home Office. London.

## **Outcomes for service users of Rape Crisis centres**

Rape Crisis centres provided service user evaluations as part of WRCs and Rape Crisis (England & Wales) research ' *The Crisis in Rape Crisis* ', to illustrate outcomes of the services provided.

Centres reported that the positive impacts of their services had reverberated across families, communities and society as a whole:

*"We are providing a much needed and valued service. Many of the women using the service have approached health services and been unhappy about what is available for them. Using our counselling service has enabled them to regain control of their lives. This has a much wider impact than for just the individuals receiving counselling – it also has a huge impact on their families, friends and communities."*

*"I had severe depression, problems with sex and flashbacks before I had counselling at (the Rape Crisis centre)."* (Service user quote)

In spite of the clear demand for and positive outcomes of these services, recent research showed Rape Crisis centres to be 'spectacularly under-funded'.<sup>58</sup> Audited accounts revealed that the combined annual incomes of the 35 Rape Crisis centres for the fiscal year 2006-07 were £3,570,912.29. It starkly illustrates the low priority which sexual violence is afforded when compared to local authority spending on domestic violence through their Supporting People grants in 2005-06 of £59m and Victim Support (a generic service provider), which received £30m from the Home Office.

At the local level, sexual violence services for women are unlikely to be funded by statutory health services. Out of the 35 Rape Crisis affiliated centres surveyed, 46% had applied to Primary Care Trusts (PCTs) for funding. However, PCT funding represented only 6.5% of all funding to Rape Crisis centres in 2006/07, arguably a disproportionate figure, given the well-evidenced impact of rape and sexual abuse on the physical and mental health of women.<sup>59</sup>

In the long-term, the closure of women's health and social care VCOs increases the use of statutory health and social care services, as service-users often have nowhere else to go or are forced to seek the services of hospitals because their (preventable) problems have escalated or become acute, undermining the Government's wider health reform strategy to invest in preventative care, make health services more responsive to local need, and provide tailored care closer to home.

Furthermore, the focus on (short-term) 'efficiency savings' in commissioning, at the expense of broader social and environmental outcomes will have detrimental consequences to service users, particularly the most vulnerable and marginalised.

<sup>58</sup> Women's Resource Centre and Rape Crisis (England & Wales) *The Crisis in Rape Crisis*. WRC. London.

<sup>59</sup> Data from WRC and Rape Crisis (England & Wales) survey of 35 remaining centres affiliated to Rape Crisis (England & Wales).

**Already, commissioning and procurement practices are squeezing out preventative or specialist service providers due to the economies of scale that larger, generic organisations can provide. However, this does not necessarily translate in to better outcomes for service users.<sup>60</sup>**

**The DH is in a unique position to make a significant contribution to reducing VAW.** Extending screening for domestic violence to all forms of VAW and in all areas of health care; implementing gender sensitive approaches – particularly where it is well known that violence and abuse are underlying other problems (e.g. mental health, self-harm and suicide) and championing the work of women’s VCOs by acknowledging their role as health service providers and raising awareness amongst commissioners will lead to better health outcomes for women (and wider society) in the short and long-term and will result in significant cost savings to the health service.

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<sup>60</sup> new economics foundation (2007) *Unintended Consequences: How the efficiency agenda erodes local public services and a new public benefit model to restore them*. nef. London.

## Summary of key issues

- Violence against women is both a cause and consequence of women's inequality and affects women's ability to fully participate in society.
- Violence against women has significant and long term physical and mental health effects.
- Violence against women costs the NHS £1.2 billion a year for purely physical injuries with an added £176 million for mental health care.
- Addressing the health impacts of violence against women has broader social impacts, helping women regain control of their lives and participate in society.
- Women's VCOs provide added-value in terms of offering women-only, women-centred, holistic, long-term and independent services.
- Women's VCOs (such as Rape Crisis centres) are delivering crucial mental health services but are chronically under funded.
- Women's VCOs are value for money and make costs savings to the state, especially preventative services which aren't captured in current commissioning practices.
- Failure to support women's VCOs will result in a loss of expertise and experience in meeting the specific needs of women who have experienced violence and will result in increased burden on statutory services.
- **The DH is in a unique position to make a significant contribution to reducing VAW.**

## Recommendations for the Department of Health

Violence against women is acknowledged by the United Nations as one of the key causes and consequences of women's inequality. It also represents a violation of women's and girl's fundamental human rights. VAW manifests in a number of ways including: **rape and sexual abuse, female genital mutilation, forced and early marriage, stalking, crimes in the name of 'honour', trafficking and sexual exploitation, sexual harassment and domestic violence.**

- Violence against women needs to be a Department of Health (DH) strategic priority **within their plans to cut health inequalities.**
- The DH needs to produce specific guidelines for health commissioners on equality in commissioning to ensure that women's organisations and other marginalised groups are not excluded or disadvantaged.
- Commissioning guidance should stress the value and legality of women-only services and those targeting minority women.<sup>61</sup>
- The DH should promote a 'public benefit' commissioning model which takes account of social equalities, environmental and economic outcomes.<sup>62</sup>
- The DH needs to engage and support the women's sector to fulfil its obligations to women under the Gender Equality Duty. They need to fund women's VCOs appropriately through the Innovation, Excellence and Service Development Fund and ensure their engagement in the commissioning process.
- To ensure that effective services are provided to all parts of the local, diverse community, commissioners need to actively engage the women's sector (especially in joint strategic needs assessments). This is in keeping with the tenets of active promotion of anti-discriminatory policies laid out in the Public Sector Equality Duties. They should be remunerated in full for their time.
- The history of poor engagement between the DH and the women's sector needs to be addressed by having a specific strategy to address VAW and a mechanism whereby women's organisations can have a constructive conversation with key DH decision-makers about their needs and to discuss how to encourage a better relationship for future shared objectives and priorities.
- The DH should engage with the women's sector in a review of how it is ensuring compliance with the Convention on the Elimination of All Forms of Discrimination Against Women.<sup>63</sup>

<sup>61</sup> Coy, M., Lovett, J. & Kelly, L. (2008) *Realising Rights, Fulfilling Obligations: A Template for an Integrated Strategy on Violence Against Women for the UK*. End Violence Against Women. London.

<sup>62</sup> new economics foundation (2007) *Unintended Consequences: How the efficiency agenda erodes local public services and a new public benefit model to restore them*. nef. London.

## Recommendations for PCTs and other NHS organisation

- Statutory health services such as PCTs must acknowledge the role of women's VCOs in supporting the mental health needs of women who have experienced violence and ensure they are sustainably and adequately funded.
- PCTs should engage local women's VCOs in service planning and designing commissioning processes that will encourage diverse providers and improve how they measure value for money in public services.
- We would advocate that PCTs work along the lines of the Audit Commission's 'intelligent commissioning' model or the new economics foundations 'public benefit model'.<sup>64</sup>

For example, the intelligent commissioning model proposes that commissioners:

- Maintain a detailed understanding of what services their users need and involve local voluntary organisations in identifying them.
- Develop a good understanding of the market, knowing who can supply particular services at an affordable price.
- Run an effective procurement process, balancing the need for short-term efficiency gains with longer-term market development objectives. This includes providing a choice of grants or contracts, developing a sound basis for determining price, having a transparent and efficient process prior to awarding the contract or grant and an effective management of the working relationship after the grant or contract has been awarded.

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<sup>63</sup> Convention on the Elimination of All Forms of Discrimination Against Women (2008) Advanced Unedited Version. *Concluding observations of the Committee on the Elimination of Discrimination against Women: United Kingdom of Great Britain and Northern Ireland*. United Nations. New York.

<sup>64</sup> Audit Commission (2007) *Hearts and minds: commissioning from the voluntary sector*. Audit Commission. London.

## **About the Women's Resource Centre**

WRC is a charity which supports women's organisations to be more effective and sustainable. We provide training, information, resources and one-to-one support on a range of organisational development issues. We also lobby decision makers on behalf of the women's not-for-profit sector for improved representation and funding.

Our members work in a wide range of fields including violence against women, health, employment, education, rights and equality, the criminal justice system and the environment. They deliver services to and campaign on behalf of some of the most marginalised communities of women.

There are over ten thousand people working or volunteering for our members who support almost half a million individuals each year.

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