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OTHER URGENT THREATS TO WOMEN'S HEALTH: THE UNFINISHED AGENDA

VIOLENCE AGAINST WOMEN

Violence against women and the Millennium Development Goals: Facilitating women's access to support

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Abstract Violence against women is a serious health and development concern, as well as a violation of women's human rights. Violence against women has a devastating effect on women's sexual and reproductive health, as well as the health of their children, and is rooted in gender inequality. Reducing violence against women is therefore a key strategy for the achievement of the Millennium Development Goals. Key lessons have emerged from more than two decades of experiences dealing with violence against women within the health sector. Interventions must go beyond training and curricula reform and utilize a system-wide approach, including changes in policies, procedures and attention to privacy and confidentiality. Providers must work together with other sectors, particularly at a community level, to strengthen local networks for support of survivors of violence. Prevention activities are critical, particularly those that seek to change cultural norms and laws that encourage violence and discriminate against women and girls.

"I used to think that death was the only way out... I thought it was my fault that he hit me. Here [at the clinic], I've learned that it's not so... my self-esteem was very low, [but] here they teach us to love ourselves." (survivor of violence interviewed at a clinic in Honduras) [1]

"People tell us that this center is different; it is warmer... they come here because we listen to them...." (Nurse, El Salvador) [1]

These statements illustrate a profound policy shift that has occurred in recent years within the international health community with regard to violence against women. Only 10 years ago, the health needs of abused women were virtually ignored outside of a few industrialized countries. Presently, violence against women is recognized as a grave global public health concern, as well as a

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human rights issue. In 1996 the World Health Assembly declared violence to be a public health priority, and followed this up in 2002 with the publication of the World Report on Violence and Health, with in-depth discussions of intimate partner and sexual violence. The efforts of the international women's movement to effect this change are reflected in the Millennium Declaration, adopted in September, 2000 by the General Assembly of the United Nations which recognized "the promotion of gender equality and empowerment of women" as one of the eight Millennium Development Goals and resolved "to combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women." Because of its grave impact on the health and wellbeing of women and children, strategies to improve maternal and child health must include concerted and comprehensive efforts to address violence against women [2].

1. The scope and magnitude of violence against women

The United Nations provides a broad framework for understanding violence against women, also referred to as gender-based violence (GBV), as any act "that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life." [3] Violence against women includes acts that take place in the home or the community as well as acts that are perpetrated or tolerated by governments. In many parts of the world, violence is expressed in different manners according to cultural and historical circumstances. Examples include: prenatal sex selection and neglect of girls, honor and dowry-related violence, trafficking of women and girls for sexual exploitation, female genital mutilation, and violence against women in situations of armed conflict [4]. What all share is that they are rooted in women's lack of power in relationships and in society relative to men [5].

The most common and well documented forms of violence are intimate partner violence, also known as "domestic violence" and sexual violence by non-partners (i.e., child sexual abuse, rape). A recent review of over 70 population-based studies performed throughout the world found a wide range in the prevalence of physical partner violence, from 10% to 60% of ever-partnered women [6]. A review of 25 studies worldwide indicates that 11% to 32% of women report that they experienced sexual abuse in childhood [6,7].

A major difficulty in comparing these figures is differences in the manner in which violence is defined and measured and the time frame during which the data were collected [8]. To address the need for comparable data on violence, the World Health Organization recently completed a Multi-Country Study on Domestic Violence and Women's Health, performed in 10 countries with more than 24,000 women [9]. This study provides one of the first opportunities to examine GBV across different cultures and socio-economic settings. The findings show that between 13% and 61% of ever-partnered women experienced physical abuse by an intimate partner. The range of reported sexual partner violence was even greater, from 6% to 59%, whereas the range of women reporting either sexual and/or physical violence by a partner was 15% to 71%. These figures are greater than previously reported in many countries, due in part to the special measures used in the study to enhance safety and disclosure of violence.

2. Health effects of violence against women

GBV is associated with serious health problems affecting both women and children, including injuries, gynecological disorders, mental health problems, adverse pregnancy outcomes, and STIs [10]. Violence can have direct consequences for women's health, and it can increase women's risk of future ill health. Therefore, victimization, like tobacco or alcohol use, is increasingly viewed as a risk factor for a variety of diseases and conditions, and not just as a health problem in and of itself [10,11].

Population-based studies indicate that 40% to 75% of women who are physically abused by a partner report injuries due to violence at some point in their life [9,12,13]. Studies have consistently linked a history of physical or sexual abuse with a broad range of symptoms of physical ill health, including irritable bowel syndrome, sexually transmitted diseases, gastrointestinal disorders, gynecological problems, including vaginal bleeding and vaginal infections, urinary tract infections, and various chronic pain syndromes, including chronic pelvic pain. Women who have been abused tend to experience poorer physical functioning, more physical symptoms, and more days in bed than do women who have not been abused [14,15]. A history of violence has also been linked to such serious mental health problems as depression, anxiety, post-traumatic stress disorder, and suicidality [16].

A growing body of research indicates that violence may increase women's susceptibility to

HIV infection [17,18]. Studies carried out in Tanzania, Kenya and South Africa found that seropositive women were more likely than their seronegative peers to report physical partner abuse [19—21]. There is little information as yet to indicate how violence increases women's risk for HIV. However, Dunkle and colleagues suggest that abusive men are more likely to have HIV and impose risky sexual practices on their partners. There are also indications that disclosure of HIV status may put women at risk for violence [19].

In its most extreme form, violence kills women. Worldwide, an estimated 40% to more than 70% of homicides of women are perpetrated by intimate partners, frequently in the context of an abusive relationship [22—24]. A study of female homicide in South Africa estimated that a woman is killed by her intimate partner in South Africa every 6 h [25]. Studies in Bangladesh and Nicaragua indicate that femicide may have an important contribution to maternal mortality [26,27].

3. Violence against women in pregnancy

Violence during pregnancy is as common or more so than many conditions that are commonly screened for in antenatal care. Recent studies from dozens of countries found the prevalence of physical abuse during pregnancy between about 3% to 11% in industrialized countries, and approximately 4% to 32% in developing countries [9,13,28—31].

Although in some cases pregnancy may act as a trigger for violence, the majority of women who are abused during pregnancy were also abused before and after the pregnancy (more than 80% in most studies) [9,28,29,32,33]. However, great differences exist among countries in the proportion of ever abused women who experience violence in pregnancy (from 10% and 15% in Indonesia and Ethiopia, respectively, compared to 44% of ever-abused women in rural Peru) [34—36]. These figures suggest that cultural norms in different societies influence the degree to which pregnancy offers women a period of relative protection from physical violence. Violence during pregnancy has been associated with a variety of obstetrical risks, including late entry into prenatal care, increased smoking and substance abuse, a history of STIs, unintended pregnancy (mistimed or unwanted), vaginal and cervical infections, kidney infections, miscarriages/abortions, premature labor, fetal distress, bleeding in pregnancy, and inadequate weight gain [16,37—40].

Recent research has focused on the relationship between violence in pregnancy and low birth weight, a leading cause of infant deaths in the developing world [41—43]. Findings from studies performed in the United States, Mexico, and Nicaragua suggest that violence during pregnancy contributes to low-birth-weight, preterm delivery, and to fetal growth retardation. According to studies performed in Nicaragua, women who experience physical or sexual violence during pregnancy were three times more likely to deliver a low-birth-weight infant and up to six times more likely to experience an infant death [44,45]. The pathways by which violence impacts pregnancy outcome are not yet clear, although a few alternative explanations have been suggested, including trauma, poor or late care in pregnancy, increased cortisol levels due to stress, and increase high risk behaviors such as smoking and substance abuse related to violence [43,46].

4. The health care response to violence against women

Health services, and particularly reproductive health programs, provide a unique window of opportunity to address the needs of abused women, as most women come into contact with the health system at some point in their lives. The last two decades have been accompanied by considerable progress, albeit not sufficient, in improving women's access to support and services for violence within the health sector. Interventions in industrialized countries have centered primarily on provider training and the development of protocols and tools for identifying and referring survivors of domestic violence or sexual assault. In contrast, efforts in developing countries have aimed more often to strengthen the overall capacity of the health sector to address violence against women [47]. For example, a program implemented by the Pan American Health Organization (PAHO) throughout Central America and the Andean countries aims to improve policy and legislation on GBV, to increase access and quality of health services for survivors, and to forge community-based networks to improve multi-sectoral coordination and to promote violence prevention activities [1].

Unfortunately, few of the initiatives, either in industrialized or developing countries have been rigorously evaluated [48,49]. Having said this, several promising approaches have emerged which provide valuable insights to guide future programming [47,50,51].

5. Breaking the silence

Although battered women tend to use primary and secondary health services more than non-abused women, only a very small percentage of them are identified by health workers, as the latter are typically reluctant to ask women about experiences of violence, for fear of offending women or of opening up "a Pandora's box" of issues that they will not have the time or skills to address. Even when women show clear signs of abuse, providers often do not ask about violence. A Salvadoran doctor explained his reluctance in this way,

"Sometimes when I ask a woman about violence, she dissolves in a sea of tears... and I have to wait. When someone isn't sensitized he can get annoyed and think, 'Why did I even ask? 'Now how am I going to get rid of her?'" [1]

Unfortunately, women who are experiencing violence rarely reveal their situation spontaneously, as they may be ashamed to admit what is happening or fear that the provider will not believe them, or worse, blame them for the violence. In settings where mandatory notification laws are enforced, women fear telling a provider about violence will lead to police involvement, and possible reprisals on the part of the abuser. A multicountry study performed in gynecology clinics in 5 Nordic countries found that, although 38—66% of women had experienced physical partner violence, only 2—8% of these women had ever confided in their gynecologists [52]. Similar results have been found elsewhere [53—55].

"Women do not speak for fear that [the husband] will be put in jail and then no money will come into the household. Also because they are afraid of him. They think, "'if I talk he will kill me, he will choke me....'" (Woman activist from San Cristóbal, Guatemala) [1]

"I thought that there were just a few people living like this and that it was something shameful.... I thought it would be embarrassing for someone to find out that a man was hurting me this way." [56]

Despite the many barriers, most studies indicate that if women are asked about violence in private, in a non-judgmental and empathetic way, they will answer truthfully, and may welcome the opportunity to discuss their situation. In fact, most women, regardless of whether they have been abused themselves, feel that physicians should ask their patients routinely about violence [53].

Because violence presents such a serious threat to women's health, many experts encourage providers to ask women about violence as a routine part of clinical history taking. Routine inquiry or screening for violence among all women who attend health services, regardless of the reason for the visit, is increasingly considered the standard of care in the United States and many other industrialized countries [57]. Many studies in a variety of settings have shown that a combination of training for health providers, establishment of institutional screening policies and the use of a short screening tool or chart prompt can dramatically raise identification rates for violence [58—60].

6. Encourage system-wide changes

Critics of routine screening point to the lack of evidence that training or screening policies contribute to better outcomes for women, such as reduced violence, or improved self-esteem and quality of life [47—49,54,61]. This may be due in part to methodological weaknesses in evaluation designs, but also may reflect the fact that many programs, particularly in industrialized countries, appear to place more emphasis on increasing identification rates than on providing support and appropriate referrals for women who disclose violence. This circumstance had led some international experts to question whether it is even ethical to screen for violence if there is not a program in place and services to refer women to once they disclose violence [62].

Furthermore, abundant evidence exists to show that training alone has no appreciable effect on provider behavior unless it is accompanied by changes in procedures and systems. Even in institutions where successful screening programs have been implemented, gains are quickly lost in the absence of continuous supervision and follow-up [12,63,64]. Institutional change must include implementation of new procedures with regard to patient flow, documentation, measures to ensure privacy and confidentiality, and the creation of referral networks. An example of a system-wide approach to domestic violence in a U.S. hospital included such components as: training for providers, a domestic violence protocol, chart prompts, public health campaigns, provider feedback, quality improvements, and an on-site domestic violence coordinator. An evaluation of the program found that staff considered the chart prompt, the

on-site coordinator, and receiving systematic feedback to be much more useful for institutionalizing the program than the training curriculum and the protocols [58]. A review of the PAHO program in Central America also found that having designated staff to counsel clients, and to provide emotional and technical support to providers, were key elements of a successful approach [1].

7. If she says yes, then what?

Providers are often frustrated in working with survivors of violence, either because they feel powerless to "fix" the problem, or because women are "non-compliant" and do not follow their advice to the letter. Despite this, it is important that providers reframe their notion of a "successful" intervention, as interviews with survivors stress how the right words spoken at the right time can be a powerful catalyst for change. One woman in the U.S. explained it as follows:

"The doctor helped me feel better by saying that I didn't deserve this treatment, it was bad, and he helped me make a plan to leave the house the next time my husband came home drunk". [65]

According to the staff of the Barrios Lourdes Polyclinic in El Salvador,

"Women are waiting for someone to knock on their door; some of them have been waiting for many years... They are grateful for the opportunity to unload their burden". [1] "Sometimes they come to us, not expecting us to solve their problems, but rather to be listened to ...what they hope for is some advice." [1]

Striking evidence in support of this approach was seen in a randomized control study of an empowerment-based intervention for abused Chinese pregnant women in Hong Kong. The intervention consisted simply of a 30-min counseling session, where women were given supportive messages designed to enhance their self-esteem and sense of autonomy. After 6 weeks, the experimental group had significantly higher physical functioning and significantly lower scores for postnatal depression than those who did not receive the intervention. The authors concluded that the opportunity to talk about their problems, to be listened to, and to have their feelings acknowledged had been key to the positive impact of the interventions, as many of the women in the intervention group reported being ignored and even ridiculed when they tried to discuss their problems with others previously [66].

8. Address provider attitudes

Health providers often share the same stigmatizing attitudes as the population at large, and these can be serious barriers towards improving the quality of care for victims of abuse. A study in South Africa found that many nurses believed that, "women enjoy punishment," [67] whereas a Latin American survey found more than half of providers felt that some women's inappropriate behavior provokes their husband's aggression [68]. Similar findings have been reported in United States [69]. In addition, some providers may have their own experiences with violence, as victims or abusers; such experiences and attitudes inevitably influence the way they will respond to clients living with violence. Training programs must give providers an opportunity to talk about their experiences and to challenge prevailing attitudes about gender and power and stigma.

9. Challenge cultural norms that encourage violence against women

In many parts of the world, women are expected to be submissive and sexually available to their husbands at all times, and it is considered both a right and an obligation for men to use violence in order to "correct" or chastise women for perceived transgressions. Violence within the family is considered a private matter in which outsiders, including government authorities, should not intervene. For unmarried women, sexual violence is so stigmatizing that most women prefer to suffer in silence than to risk the shame and discrimination that would result from disclosure.

In order to effectively promote sexual and reproductive health, it is necessary to create awareness at a community level on the health effects of GBV and how GBV itself is rooted in unequal gender relations. Many programs specifically address cultural norms and promote gender equity. These programs, as well as "edutainment" mass media programs, have shown promising results in terms of changing attitudes of men and women around gender norms and violence against women [47].

10. Encourage coordination with other sectors

Health programs must coordinate closely with other social actors at a national and local level to improve the response of governments and communities to violence against women [47,50,51]. The development of community-based networks greatly enhances the quality of care provided to survivors, and helps to ensure that women do not fall through the cracks when they have to interact with several different institutions. Furthermore, community groups working on GBV typically have more experience in dealing with abused women and can provide technical support to health services who are initiating activities. In Nicaragua, for example, nearly every major town has a commission that deals with violence against women. These commissions meet regularly to evaluate the coordination of services, as well as to plan public awareness activities, such as the yearly campaigns around the 16 Days of Activism against Gender Violence, held internationally each year [47].

A randomized control study in the U.S. evaluated a community-based advocacy program for domestic violence and found that women who received the support services, including a night in a shelter, experienced less violence over a 2-year period than women who did not receive the services. Moreover, these women reported a higher quality of life and social support, and had less difficulty obtaining community resources [70].

11. Invest in evaluation

The lack of rigorous evidence to guide programming remains a critical problem for the field. Far too little attention has been paid to evaluating ongoing interventions, particularly in resource-poor settings. As Davidson and colleagues point out, "We need to know what approaches are most effective, whether we do more good than harm, and if women are ultimately benefited." [64] New indicators are needed that move beyond simply measuring identification and referral rates and focus instead on measures of women's wellbeing and satisfaction with services. One promising tool, the Domestic Violence Survivor Assessment, developed jointly by researchers and counselors, uses a "stages of change" model to help counselors understand battered women's views and reactions to violence at different moments in the relationship, while encouraging personal growth. The tool can also be used to measure the outcomes of interventions [71].

12. Promote women's empowerment

"What helped me was to realize that I wasn't alone. There are many of us who feel trapped and silenced inside ourselves. Learning about laws and communicating among ourselves were also very important to help us break our silence." [1]

The words of this survivor of violence from Honduras underscore a key lesson learned from over two decades of experience: any intervention to reduce violence against women must take place within the context of sustained collective efforts to promote gender equality and the empowerment of women and girls. To achieve a lasting impact, it is necessary to dismantle discriminatory laws and policies against women and to challenge deeply embedded social norms that posit men's right to control female behavior. Until women and girls are able to enjoy all the benefits of citizenship on an equal basis with men, including education, justice, political and economic participation, it is difficult to imagine how significant progress might be achieved with regard to the rest of the Millennium Development Goals.

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