

## Violence against Women: Health Sector Responses

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*National health policies, institutions and programs must pay greater attention to gender-based violence (GBV) not only as a public health problem, but a key component of the HIV/AIDS pandemic. We have some of the tools and knowledge to make a difference – the same tools that have successfully been used to tackle other health problems. Violence is often predictable and preventable.*

**Gro Harlem Brundtland, Director General, WHO, 2002**

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### Violence against Women: The Hidden Health Burden

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Violence against women exists to some degree in virtually all societies and all socio-economic and cultural groups. Estimations on the prevalence of violence against women vary depending on the type of violence in question. A study of 10 countries found that between 13 and 62 percent of women have experienced physical violence by a partner over the course of their lifetime and between 3 and 29 percent of women reported violence within the past year (Bott, Morrison and Ellsberg, 2005).

A growing body of evidence documents the consequences of VAW for women’s health and well-being, ranging from fatal outcomes such as homicide, suicide, and AIDS-related deaths to non-fatal outcomes such as physical injuries, chronic pain syndrome, gastrointestinal disorders, unintended pregnancies, pregnancy complications, and sexually-transmitted infections (STIs) (Heise, Ellsberg, Gottemoeller, 1999).

Physical and sexual violence has consequences for women’s mental health, such as post-traumatic stress syndrome, depression, anxiety, and low self-esteem, as well as behavioral outcomes such as alcohol and drug abuse, sexual risk-taking, and a higher risk of subsequent victimization. It has become increasingly clear that injuries represent only the tip of the iceberg in terms of negative health effects, and that violence is more appropriately conceptualized as a risk factor for health problems than as a health condition in itself. (See Box 1 for a summary of the health consequences of intimate partner violence and sexual violence.)

**Box 1. Health consequences of intimate partner violence and sexual violence by any perpetrator**

Fatal outcomes	Nonfatal outcomes		
	Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioral outcomes
Femicide	Fractures	Gynecological disorders	Depression and anxiety
Suicide	Abdominal/thoracic injuries	Pelvic Inflammatory disease	Eating and sleep disorders
AIDS-related mortality	Chronic pain syndromes	Sexually-transmitted infections, including HIV	Drug and alcohol abuse
Maternal mortality	Fibromyalgia	Unwanted pregnancy	Phobias and panic disorder
	Permanent disability	Pregnancy complications	Poor self-esteem
	Gastrointestinal disorders	Miscarriage / low birth weight	Post-traumatic stress disorder
	Irritable bowel syndrome	Sexual dysfunction	Psychosomatic disorders
	Lacerations and abrasions	Unsafe abortion	Self harm
	Ocular damage		Unsafe sexual behavior
	Burns		
	Ear Injuries		

**Sources:** Adapted from Heise and Garcia Moreno, 2002 (pg 101); and Heise, Ellsberg and Gottemoeller, 1999 (pg 18).

## Health Services as an Opportunity

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*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.*

Nurse, El Salvador

*I used to treat women with muscle spasms all the time, and I never asked them any questions. Then I started to realize that many of these cases were due to violence.*

Doctor, Nicaragua

Health services, and in particular, reproductive health programs provide a unique window of opportunity to address the needs of abused women, since most women come into contact with the health system at some point in their lives. Despite the compelling evidence that VAW is a serious health risk for women, the health sector has lagged far behind other public sectors (for example, criminal justice) in tackling the issue. Research indicates that although battered women used primary and secondary health services more than non-abused women, a very small percentage of them are identified as battered by health workers. Health providers are typically reluctant to ask women about experiences of violence - either from fear of offending women or reluctance to open a “Pandora’s box” of issues to which they will not know how to respond. Providers often feel that they do not have the knowledge or skills to address VAW. They lack knowledge both about national legislation on domestic violence and about local services to which women might be referred. They often do not recognize VAW as a public health problem and do not see it as part of their role to ask clients about violence or provide any kind of support for victims.

Overlooking the health implications of violence against women is not just a missed opportunity. Women sometimes disclose intimate partner violence, rape or sexual abuse to health care providers, and providers who respond by blaming the victim may inflict severe emotional trauma. Providers who view violence as a social rather than a health issue may fail to provide holistic care, to recognize women in danger, or to provide necessary, even life-saving care, such as STI prophylaxis. Moreover, health systems that do not protect patient confidentiality may put women at risk of additional violence from partners or other family members. Growing evidence suggests that public health policies, institutions, and programs must pay more attention to violence against women not only as a public health problem in and of itself, but also as a key component of the HIV/AIDS pandemic.

## Promising Practices

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***Use a systems approach to promote institutional change.*** Evidence suggests that without system-wide reforms and support, single training sessions or even routine screening policies rarely produce long-term changes in the quality of care for survivors of violence (Heise, Ellsberg, and Gottemoeller, 1999). Instead, Heise et. al. suggest reforms throughout the organization, including changes in procedures and systems, norms, policies and protocols, infrastructure upgrades to ensure private consultations, creation of referral networks, and strengthening the ability of staff to provide emergency assistance such as danger assessment, safety planning, emotional support, STI prophylaxis, and emergency contraception.

The International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) carried out an initiative illustrating the “systems approach” in four member associations in Latin America, namely: Profamilia (the Dominican Republic), INPPARES (Peru), and PLAFAM (Venezuela), with some participation from BEMFAM (Brazil). Evaluations showed that the initiative improved provider attitudes and practices; strengthened patient privacy and confidentiality; increased detection of women who experienced physical and sexual abuse; improved the overall quality of women’s health care; and benefited survivors through the provision of specialized services such as legal aid, counseling and support groups (Guedes, Bott, and Cuca, 2002).

***Address provider attitudes.*** Health providers often share the same stigmatizing attitudes as the population at large. These attitudes can be a serious barrier to improving the quality of care for victims of abuse.

***Address the underlying gender norms that support violence in the community.*** In order to effectively promote sexual and reproductive health, it is necessary to create awareness at a community level on the health effects of VAW and how VAW itself is rooted in unequal gender relations.

Some of the specific practices that are being used with success include:

- ***Routine screening for violence by trained health care providers (also called routine enquiry)*** – intake interviews of women attending clinics for regular check-ups enable providers to better identify cases of physical and sexual abuse. This practice of routine screening for victims of violence is increasingly considered the standard of care in industrialized countries and is supported by researchers and advocates. However, providers must be trained to respond to disclosures of violence appropriately, ensuring privacy, confidentiality and support for the victims;
- ***Multi-sectoral collaboration*** – in which health care organizations join community-based networks with other governmental and non-governmental institutions, such as legal aid, criminal justice institutions, the police, women’s groups, social welfare education, and social services. Evidence suggests that these networks enhance the range and quality of services accessible to survivors, and help to ensure that women do not fall through the cracks when they have to interact with several different institutions. For example, PAHO has worked with 10 countries in Central America and the Andes to promote an integrated health sector approach to violence against women through policies and legislation related to violence, increasing access to services, and forging multi-sectoral networks at a community level for violence prevention (Velzeboer et al., 2003).
- ***Coalitions for public health research and advocacy*** – which conduct research, build research capacity, disseminate research findings and use research to advocate for policy reforms. The South African Violence against women and Health Initiative convinced two medical schools to include VAW in their curriculum, helped develop a one-week

module on rape for medical students, and contributed to new national policies on the issue;

- **Community-level initiatives to reduce VAW** – often components of HIV/AIDS prevention or reproductive health programs – are well exemplified by the *Stepping Stones* community “training packages” used in seven sub-Saharan countries, as well as the Philippines. These programs aim at encouraging communities to question and rectify the gender inequalities that lead to HIV/AIDS, VAW, and other health problems with workshops, community-wide meetings, drama, and peer group discussions that include changing male roles and conceptions of masculinity. Other programs, such as *Men as Partners*, in South Africa (led by *EngenderHealth*), and *Program H* in Latin America (led by Instituto Promundo), target specific groups such as men or young people; and
- **Mass media “entertainment-education” (“edutainment”)** - involves the use of radio and television (including soap operas, audience participation programs and school-based activities linked to the radio and television programs) to prevent VAW. The best known is *Sexto Sentido* (*The Sixth Sense*), a weekly radio and TV series in which young people grapple with sexuality, family violence, rape, and HIV/AIDS; *Sexto Sentido* is produced in Nicaragua by the NGO Puntos de Encuentro. Another example is *Soul City*, conducted by South Africa’s Institute for Health and Development Community. Evaluations of both programs indicate that they have had a positive impact on knowledge and attitudes regarding VAW.

## Further Reading

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Bott, Sarah, Andrew Morrison and Mary Ellsberg, Preventing and Responding to Violence against women in Middle-and Low-Income Countries: A Global Review and Analysis, World Bank Policy Research Working Paper 3618, the World Bank, Washington, DC, June, 2005

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Heise, Lori, Mary Ellsberg, and Megan Gottemoeller. 1999. “Ending Violence Against Women,” *Population Reports*, Volume XXVII, Number 4, Series L, Number 11. Available at: <http://www.inforhealth.org/pr/111/violence.pdf>

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Velzeboer, Marijke, Mary Ellsberg, Carmen Clavel Arcas and Claudia Garcia-Moreno, *Violence against Women: The Health Sector Responds*, Pan American Health Organization and World Health Organization, Washington, D.C., 2003

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