OUTLOOK

Violence Against Women: Effects on Reproductive Health

Millions of girls and women suffer from violence and its consequences because of their sex and their unequal status in society. Violence against women (often called gender-based violence) is a serious violation of women's human rights. Yet little attention has been paid to the serious health consequences of abuse and the health needs of abused women and girls. Women who have experienced physical, sexual, or psychological violence suffer a range of health problems, often in silence. They have poorer physical and mental health, suffer more injuries, and use more medical resources than non-abused women.

Females of all ages are victims of violence, in part because of their limited social and economic power compared with men. While men also are victims of violence, violence against women is characterized by its high prevalence within the family; its acceptance by society; and its serious, long-term impact on women's health and well-being. The United Nations has defined violence against women as "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 private life."[1]

Health care workers have the opportunity and the obligation to identify, treat, and educate women who are being abused. Health care institutions can make significant contributions to addressing violence against women by supporting clinicians and clients. Developing and institutionalizing national health-sector policies, protocols, and norms about violence call attention to the problem of gender-based violence, and help ensure quality care for survivors of abuse.

This *Outlook* issue focuses on the reproductive health consequences of violence against women. It provides examples from research and successful programs and explores how the health sector can take an active role in the prevention and treatment of violence against women.

How Common Is Violence Against Women?

Globally, at least one in three women has experienced some form of gender-based abuse during her lifetime.[2] Violence against girls and women can begin before birth and continue throughout their lives into old age (see Figure 1). Women are reluctant to discuss abuse, and may accept it as part of their role. Even assuming that current data

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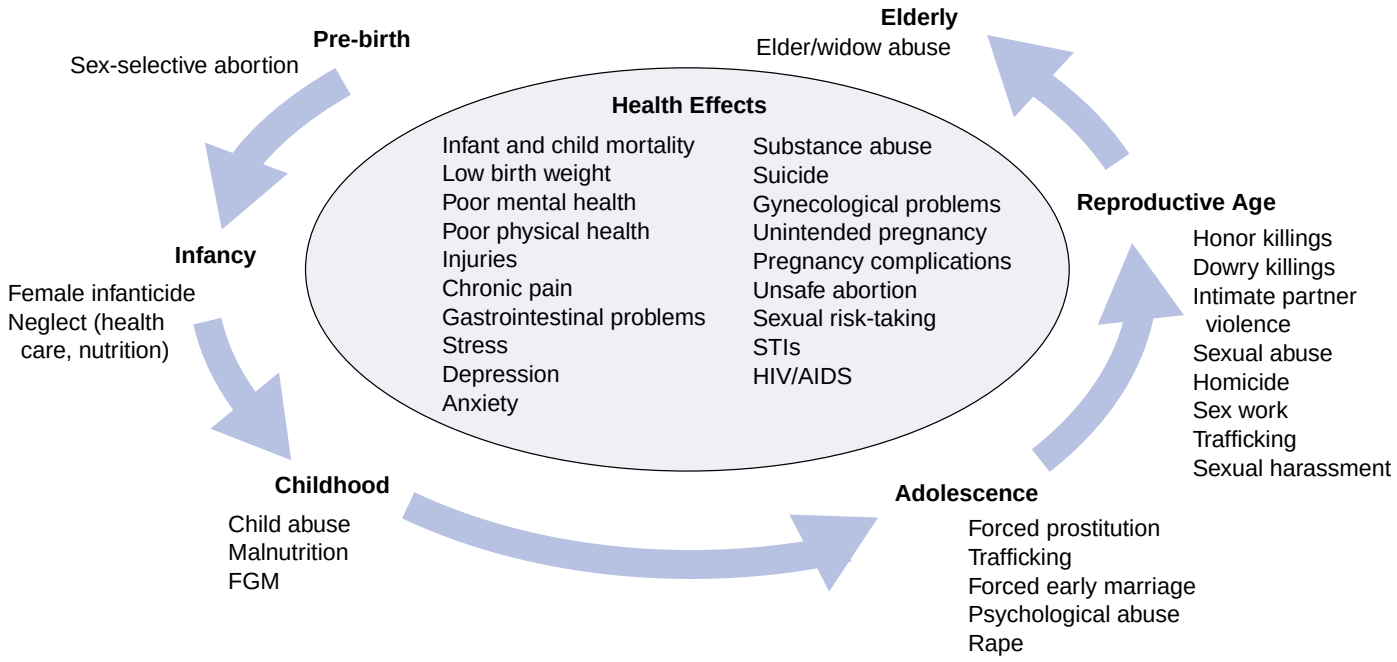
Figure 1. The Life Cycle of Violence Against Women and Its Effects on Health*



*The categories of abuse and resulting health effects listed here are representative, not comprehensive.

Based on information from Watts and Zimmerman, 2002[3] and Campbell, 2002.[4]

underestimate the prevalence of violence against women, millions of girls and women worldwide suffer from gender-based violence and its consequences.

The most common forms of violence against women are physical, sexual, and emotional abuse by a woman's husband or intimate partner. Surveys indicate that 10 to 58 percent of women have experienced physical abuse by an intimate partner in their lifetimes (see Figure 2).[2] Preliminary results from a World Health Organization (WHO) Multi-Country Study on Women's Health and Domestic Violence indicate that in some parts of the world as many as one-half of women have experienced domestic violence.[5]

Various forms of violence against women and their prevalence are described below:

- Between 12 and 25 percent of women have been forced by an intimate partner or ex-partner to have sex at some time in their lives.[6]
- Rape as part of warfare is now used to disrupt communities and perpetuate ethnic cleansing. Similarly, sexual violence against women in refugee camps and centers for displaced women is now recognized as a significant problem.
- Forced sexual initiation and sexual abuse of children are common throughout the world. Cross-sectional studies show that 40 percent of women in South Africa, 28 percent in Tanzania, and 7 percent in New Zealand reported that their first sexual intercourse was forced.[3]
- A review of studies in 20 countries found that prevalence of sexual abuse of girls ranged from 7 to 36 percent.[7] Most abusers are men known to the victim.[3]
- Early marriage of girls is most common in sub-Saharan Africa and South Asia. Official data on very early marriage (under age 15) are limited, but studies indicate that in parts of East and West Africa, for example, marriage at age 7 or 8 is not uncommon; in parts of northern Nigeria, the average age of marriage is 11 years.[8] Early marriage limits educational and other opportunities for girls, and often leads to early childbearing and increased health risks.
- Sex-selective abortion, female infanticide, and the systematic neglect of girls' nutritional and health needs all contribute to higher mortality of girls. These factors have resulted in an estimated 60 to 100 million "missing" women and girls worldwide.[3]
- In some regions, women are harmed by traditional practices such as dowry-related deaths, acid-throwing, and honor killings.
- Health care professionals participate in culturally supported forms of abuse, such as virginity examinations, forced cesarean-section deliveries, and female genital mutilation (see box, page 4).[9,10]
- Trafficking in women and girls for forced labor and sexual exploitation is another type of gender-based abuse that harms women and girls (see box, page 6).

Factors That Contribute to Violence Against Women

Violence against women occurs in every country among all social, cultural, economic, and religious groups. At the societal level, violence against women is most common within cultures where gender roles are strictly defined and enforced; where masculinity is closely associated with toughness, male honor, or dominance; where punishment of women and children is accepted; and where violence is a standard way to resolve conflicts.[2,11] While abuse occurs in all socioeconomic settings, poverty and stress associated with poverty contribute to intimate partner violence.[11]

Within relationships, male control of wealth and decision-making and relationship instability are strongly associated with abuse.[2] It was once thought that women with many children were at increased risk of abuse. Research now indicates, however, that domestic abuse increases women's risk of having many children by limiting their ability to control the timing of sex and the use of contraception.[12]

Violence Against Women and Public Health

Women who are abused have poorer mental and physical health, more injuries, and a greater need for medical resources than non-abused women.[4] The WHO Multi-Country Study on Women's Health and Domestic Violence found that abused women in Brazil, Japan, and Peru are almost twice as likely as non-abused women to report their current health status as poor or very poor.[5]

The impact of gender-based abuse on physical health can be immediate and long-term. Women who are abused rarely seek medical care for acute trauma, however. Less than half of women in the United States who have been abused seek treatment for the resulting injuries.[4] Even when women seek treatment, their health problems may never be attributed to abuse. Survivors of abuse often exhibit negative health behaviors, including alcohol and drug abuse. Chronic health problems stemming from abuse include chronic pain (headaches, back pain); neurological problems and symptoms, including fainting and seizures; gastrointestinal disorders; and cardiac problems.[4]

Abused women often live in fear and suffer from depression, anxiety, and even post-traumatic stress disorder.[4] A study in North America showed that abused women were three times more likely to suffer from post-traumatic stress disorder than non-abused women.[4] The WHO Multi-Country Study found that women in Peru, Brazil, Thailand, and Japan who had been physically and sexually abused by their partners were more than twice as likely as non-abused women to have considered suicide.[5]

According to research in Nicaragua, children of abused mothers also may have higher levels of infant and child mortality.[13] Even if they are not the targets of abuse themselves, children who witness abuse are more likely to suffer from learning, emotional, and behavioral problems.[12] These children also are at increased risk of becoming abusers and of being abused later in life.[2]

Reproductive Health Effects

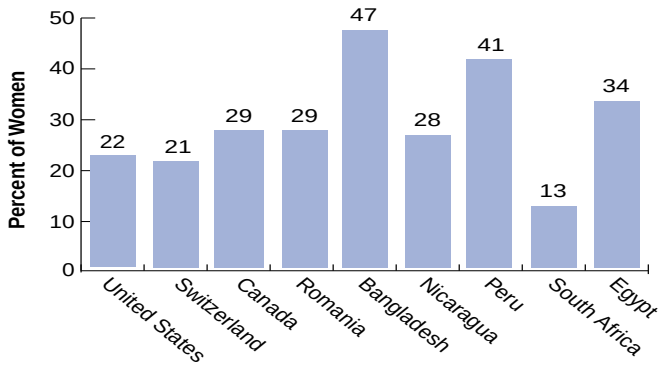
Women's reproductive and sexual health clearly is affected by gender-based violence. A U.S. study found that women who experienced intimate partner abuse were three times more likely to have a gynecological problem than were non-abused women.[4] These problems include chronic pelvic pain, vaginal bleeding or discharge, vaginal infection, painful menstruation, sexual dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infection, and infertility.

Sexual abuse, especially forced sex, can cause physical and mental trauma. In addition to damage to the urethra, vagina, and anus, abuse can result in sexually transmitted infections (STIs), including HIV/AIDS. Women who disclose that they are infected with HIV also may be subjected to violence.[4]

Early childbearing, often a result of early and forced marriage, can result in a range of health problems, including effects of unsafe abortion. Girls under 15 years of age are five times more likely to die in childbirth than women in their twenties.[14] They also are at higher risk for obstetric fistula, which can result from prolonged and obstructed labor.[15]

Abuse limits women's sexual and reproductive autonomy. Women who have been sexually abused are much more likely than non-abused women to use family planning clandestinely, to have had their partner stop them from using family planning, and to have a partner refuse to use a condom to prevent disease.[5] Survivors of abuse

Figure 2. Intimate Partner Violence in Selected Countries*



*Percentage of adult women who have been physically assaulted by an intimate partner according to national surveys. Due to differences in study population and methods, results are not necessarily comparable.

Sources: Heise et al., 1999;[2] Serbanescu et al., 1999;[16] INEI, 2001.[17]

are more likely to practice high-risk sexual behaviors, experience unintended pregnancies, and suffer from sexual dysfunction than non-abused women.[2]

Studies show that physical abuse occurs in approximately 4 to 15 percent of pregnancies in the United States, Canada, Sweden, the United Kingdom, South Africa, and Nicaragua.[4,12,20,21] Intimate partner abuse during pregnancy may be a more significant risk factor for pregnancy complications than other conditions for which pregnant women are routinely screened, such as hypertension and diabetes.[22] 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.[2] Abuse of pregnant women is associated with unsafe abortion, miscarriage, stillbirth, low birth weight, and neonatal mortality. Although it is difficult to determine a causal relationship between abuse and these adverse outcomes, a recent meta-analysis of 14 studies indicates a significant association between low birth weight and abuse during pregnancy.[23] A study in Nicaragua found a four-fold increase in low birth weight among infants born to women who had been physically abused in pregnancy.[24] Abuse may directly influence birth weight through, for example, blows to the abdomen precipitating premature labor. Indirectly, abuse is associated with factors also known to contribute to low birth weight, for example, smoking, alcohol and substance abuse, and STIs.

Female Genital Mutilation

Female genital mutilation (FGM)—also known as "female genital cutting" and "female circumcision"—is a culturally supported form of gender-based violence prevalent in more than 20 countries in Africa, Asia, and the Middle East. The term FGM describes a variety of procedures involving the partial or complete removal of the external female genitalia and/or injury to the female genital organs for cultural, traditional, or other non-therapeutic reasons.[18] More than 130 million girls and women have undergone the procedure, and an estimated two million girls are at risk of FGM every year.[18]

FGM is associated with a range of serious health problems, including infection, chronic pain, sexual dysfunction, and obstetric complications. Less is known about the psychological and emotional consequences of FGM, but stress, anxiety, and depression may be associated with the procedure.

Efforts to eliminate FGM range from high-level government actions to community education; the lessons learned from these projects apply to preventing all forms of gender-based violence. Legal reforms, education, and training are key factors, although these efforts alone are not sufficient to change behavior. For example, some efforts to educate people about the harmful health effects of traditional FGM procedures have resulted in a "medicalization" of FGM; people believe the procedure is safe when done in a medical setting. Health personnel need special training to recognize complications resulting from FGM, and to manage pregnancy, childbirth, and postpartum care for women who have undergone the procedure.

Where FGM is regarded as an important rite of passage into adulthood, elimination efforts need to take into account the positive aspects of the rituals surrounding FGM, and enable communities to preserve these through alternative rites of passage.[19] Programs to eliminate FGM can serve as models for the development of broader interventions aimed at changing traditional practices that harm women. For more information about FGM, please see *Outlook*, Volume 16, Number 4, and the Reproductive Health Outlook (RHO) website, www.rho.org/html/hthps.htm.

Addressing Violence Through Reproductive Health Programs

The health effects of violence against women are serious, far-reaching, and intertwined. Health care providers have the opportunity and the obligation to identify cases of abuse. For many women in developing countries, a visit to a health clinic for reproductive or child health services may be their only contact with the health care system. The health care sector can capitalize on this opportunity by ensuring a supportive and safe environment for clients, helping providers ask about abuse, and helping women receive the care they need. The steps involved in integrating gender-based violence into health programs have been outlined in a guide developed by UNFPA.[25]

Ask about abuse. Training practitioners to ask women about abuse in a direct interview can be an effective way to identify survivors of abuse.[26,27] Nonetheless, few health practitioners routinely ask about abuse, even in resource-rich countries.[27] In some programs, screening of all women may be impractical, and even unethical if not done appropriately and confidentially. Screening of specific groups, such as women seeking prenatal care or other reproductive health services, may be more feasible.

Identify barriers. Screening programs need to overcome barriers at the provider and health care system levels.[2] Providers perceive lack of training, time, and effective interventions to be primary barriers to screening.[28]

Providers also can be reluctant to screen because they:

- feel uncomfortable asking about the topic,
- are fearful of the woman's response,

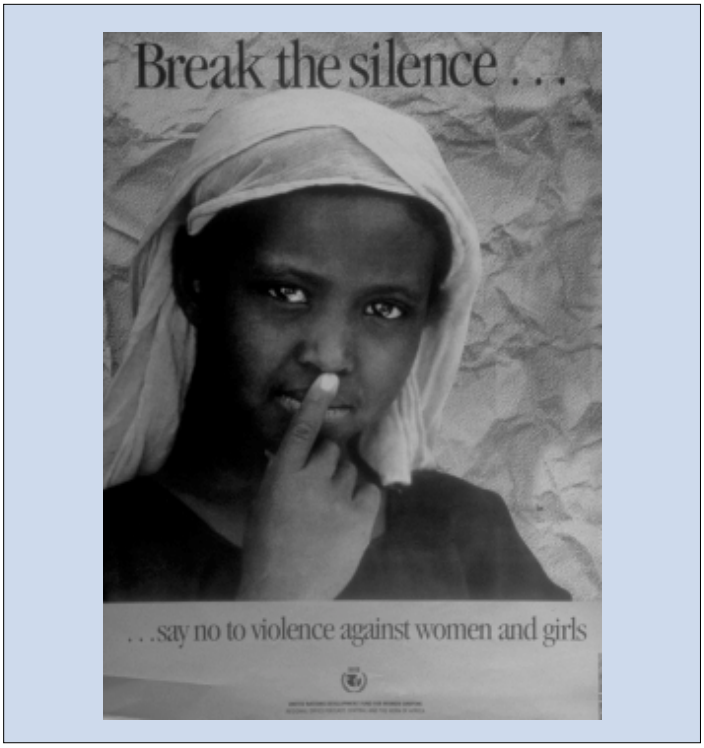
- face cultural and language differences with clients,
- are afraid of offending clients, and
- are frustrated by the perceived lack of response by clients to the advice provided.[26,27]

Many of these barriers relate to providers' attitudes and biases. Because providers often share the same social and cultural environment as their clients, they also may experience or use violence. A qualitative study of 38 primary health care nurses in rural South Africa found that the nurses had experienced similar or higher levels of violence than their clients, for example.[29] Other studies found that high proportions of health care providers in many countries have experienced intimate partner violence.[26] An especially concerning observation is that nurses and other health care providers are sometimes abusive towards patients in their care,[30] and may even be subject to abuse themselves within the health sector.[31]

Many women welcome the chance to discuss their experiences;[2,32] asking about violence and allowing women to talk can be therapeutic. Some clients, however, fear that routine screening and mandatory reporting of abuse to authorities will have negative consequences.[33] In the WHO Multi-Country Study, many women reported that they did not seek help after experiencing abuse because of embarrassment, fear of consequences, or acceptance of intimate partner violence.[5]

Provide training. Providers need training to sensitize them to their own beliefs and feelings about abuse, as well as to help them develop the skills necessary to assist abused women. Training can help reorient providers towards a role of supporting abused women and helping them make changes that will reduce the risk of abuse. At the Asociación Civil de Planificación Familiar (PLAFAM) in Caracas, Venezuela, staff received sensitization and training prior to addressing gender-based abuse in their reproductive health clinics.[34] Staff members were given the chance to role-play during the training, both as practitioners and as clients. By acting as "clients," the staff experienced how helpful it can be to have someone listen empathetically and talk with them about their experiences.

A variety of training strategies have been used in a domestic violence project of the Pan American Health Organization (PAHO), carried out in ten Central American and Andean countries. Some countries have elected to sensitize all clinic personnel to violence, while others train those in a certain sector, such as mental health.[35] Some also include specialized training in forensic medical procedures and in detecting child sexual abuse. Experiential training, as well as internships and exchanges, are effective training strategies. Including violence and abuse in the curricula of medical education could help sensitize health care professionals and better prepare them to address these issues. Providers also need opportunities for ongoing training, especially given high staff turnover. While training increases the likelihood that clients will be asked about abuse, program managers need to reinforce its importance and providers need to be held accountable for identifying abuse among clients.



Efforts such as this poster from the United Nations Development Fund for Women (UNIFEM) can help reduce the stigma associated with gender-based violence. Photo courtesy of UNIFEM, through the Media/Materials Clearinghouse, JHU/CCP.

Facilitate screening. Screening tools can help providers bring up the subject of abuse in a non-judgmental and consistent manner. By following a short list of questions, providers can ask clients about current and past experiences with physical, emotional, and sexual abuse. At PLAFAM, use of a systematic screening tool increased detection of violence among clients from 7 percent to more than 30 percent. The providers found the questionnaire easy to use and more efficient than previous efforts to screen. A stamp on the client's chart helped document abuse and provided a record to use for evaluation.[36]

Providers must ensure a safe, confidential environment and establish a relationship of trust and respect for their clients prior to asking about abuse. Client waiting areas can offer educational materials, including posters on the walls and informational brochures, to let clients know that abuse can be discussed safely at the facility. Providers must be careful not to place clients at increased risk by violating their confidentiality. It is the provider's role to empathize and validate clients' experiences, and to support their autonomy in deciding what to do about their situations.

Offer appropriate services. Knowing that a woman has experienced abuse enables a health care provider to better care for her. Women who suffer intimate partner violence often have specific reproductive health care needs, including STI testing and treatment, and special concerns about keeping their contraceptive use secret. Women who have been raped need counseling, and may need emergency contraception, prophylactic antibiotics, and/or antiretroviral therapy. They also should be offered support and referral for psychological, medical, and legal follow-up. In many countries, police require women to have a medical exam and receive a medical certificate prior to filing an official complaint for domestic violence.[37] The level of care provided to women who have been abused will depend on the resources available on-site and within the community.

> "Women are waiting for someone to ask them about [gender-based violence]...I believe that when we ask, women think: 'Finally someone is giving me the chance to talk about this suffering.' "
> —Staff member at PLAFAM, Venezuela[32]

Empower providers and clients. Providers need to know that their efforts to identify abuse are valued, and they must be empowered to help their clients if screening reveals abuse.[38] New ways of evaluating the effectiveness of provider interventions are needed. In addition to preventing death and disability, it may be equally important to achieve improved self-esteem and reduced anxiety and stress among abused clients.

Some programs have found that being able to refer a client on-site for more in-depth counseling is helpful.[32,35] The designated counselor (not necessarily a mental health professional) can help clients determine their needs and plan of action. This requires good knowledge and coordination between health care services and appropriate legal, social, and community services. PLAFAM researched and developed a directory of psychological, social, and legal organizations in the local area to which abused women can be referred.[32] Keeping the directory up-to-date ensures continuing collaboration and coordination among agencies.

Institutions can establish support groups for survivors of abuse, as well as for the providers themselves, who may need to discuss their experiences and feelings. By offering assistance to many women at one time, support groups are cost-effective, and seeing others who have experienced abuse and exchanging advice can be empowering for participants.[35]

As a recent review of the PAHO domestic violence project showed, institutions also can be instrumental in establishing national norms and protocols for identifying abuse.[35] Wide dissemination of policies and procedures related to abuse can improve the quality of care within the health sector. Documenting and developing information systems to identify cases and track abuse will help define the health burden and impact of abuse, and increase its visibility.

Reach out. Substantial work must be done outside of clinic settings to address violence against women (see box, page 7). Improvements in communication and coordination among referral networks will help abused women negotiate the complex web of services and institutions to get the help they need. In Nicaragua, more than 100 organizations in the National Network of Women Against Violence,

Trafficking in Women

Between 700,000 and 2,000,000 people, most of them women and children, are trafficked across international borders every year for forced labor, including sex work.[39] Most of these victims of trafficking originate in Asia, but substantial numbers come from countries in the former Soviet Union (100,000), Eastern Europe (75,000), Latin America and the Caribbean (100,000), and Africa (50,000).[39]

Trafficking in people is estimated to be the third largest source of profits for organized crime, yielding billions of dollars of profit every year.[39] Ethnic conflicts also contribute to trafficking, especially of women and girls.[40] Many trafficked people are kidnapped or misled, while others turn to trafficking networks for assistance in being smuggled. Low-income families may see no other choice than to sell their daughters for sex work.

Women and girls who are forced into sex work and those who are sexually abused suffer a range of health problems. Furthermore, trafficked women rarely seek health care because they fear being deported, lack the necessary money, or are prevented from seeking care.[41] They have a high risk of complications and infertility due to undiagnosed and untreated STIs, including HIV/AIDS, and risk complications from pregnancy and unsafe abortion.[42]

Health care providers in regions where trafficking is common should be informed about the situation and offer care wherever possible. Overall, efforts to stop trafficking depend on international and national cooperation from the highest levels of government to grassroots social-service agencies, and between social, judicial, law enforcement, and migration authorities. For more information on trafficking, visit Stop-Traffic at www.stop-traffic.org.

Jijenge!: Mobilizing Communities in Tanzania

Jijenge! initiated a pilot project to develop community awareness of violence against women in Igogo, a low-income, semi-urban community of 4,000 families within Mwanza, Tanzania.[43] After gaining the support of community leaders, the project educated community members using a variety of media, including public discussions, theater and radio programs, and print materials. Jijenge! also recruited and trained a "watch group" of community men and women to intervene whenever they witnessed violence.

The project operated a reproductive health clinic that provided services and counseling to help women identify the causes of their reproductive health problems. This approach was revolutionary in Mwanza, and women traveled long distances to receive care from the clinic. Women and men began to seek counseling from staff, and counselors reviewed women's rights and provided referrals to police stations, social welfare agencies, hospitals, and courts.

The Jijenge! program has shown that:

- People are willing to discuss violence against women, and even intervene against violence.
- Anti-violence messages work best when received from a variety of sources over time.
- Discussing violence in terms of promoting "family harmony" is more effective than a rights-based approach.
- Men need to be addressed both separately and in mixed groups.
- Endorsement by influential community members is critical.
- Service providers need to be sensitized to domestic violence and given tools to take action against it.
- Project staff and community volunteers need ongoing support and opportunities for continued skill building.
- Meaningful behavior change takes time.

together with the National Police Force, have been the main forces behind improving institutional coordination.[35]

As influential community leaders, health care professionals—women and men—have important roles to play in promoting violence prevention in the community. They can gain the support of other community leaders (such as religious leaders and politicians) and promote "zero tolerance" of violence in relationships. Talking about the prevalence and health effects of abuse, and educating all community members about their legal, social, and human rights can help change attitudes, behaviors, and cultural norms. Individuals and health care organizations also can work to change national and local policies that restrict women's rights, such as eliminating spousal consent rules for contraception. Involving men in this effort is key.

Conclusion

The health care sector can have a significant impact on publicizing and addressing violence against women, and on reducing the reproductive health problems related to abuse. With training and support from program managers, health care providers can learn to identify and care for women who have experienced violence. For screening to be useful, providers must be well trained in how to ask about and respond to abuse, and be prepared to help survivors of abuse with treatment and referral. They also must learn to work with agencies in other sectors. Coordinated efforts and the development of effective referral networks and information systems can maximize scarce resources.

Changing people's behavior and attitudes towards violence requires long-term commitment. Community health care workers and other influential health providers can take the lead in introducing awareness and behavior change in the community. They can create a community-based response to violence by stimulating discussions, educating community members about the costs and consequences of abuse, and advocating for nonviolent relationships. Exposing violence and enabling vulnerable and marginalized people to receive necessary services will help break the life cycle of violence and promote the rights of women and girls.

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