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CONFRONTING INTIMATE PARTNER VIOLENCE, A GLOBAL HEALTH CARE PRIOTITY

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Abstract

Intimate partner violence—physical, psychological, or sexual abuse of women perpetrated by intimate partners—is one of the most common forms of violence against women, and is associated with adverse women's reproductive and maternal health outcomes. We review the opportunities for addressing intimate partner violence by the health system, examine promising approaches, and outline future challenges for developing effective health systems responses to violence. Evidence shows that women seldom approach support services in response to violence, but do seek health care at some point in their lives. In fact, women's utilization of reproductive health services in particular has been increasing globally. These services have a broad reach and represent an important opportunity to engage in violence prevention. Although health systems-based responses to intimate partner violence have emerged, rigorous evaluations to guide program planning and policy efforts to reduce violence are limited. US programs have expanded from improving individual provider prevention practices to instituting system-wide changes to ensure sustainability of these practices. Developing country program responses, though limited, have been system-wide and multi-sectoral right from the start. Our review highlights three challenges for developing and expanding health systems responses to violence. First, interventions should focus on creating a supportive environment within the health system and strengthening linkages across health care and allied sectors. Second, rigorous evaluations of health-sector based interventions are needed for a sound evidence-base to guide programmatic and policy decisions. Finally, research is needed to identify the entry points for engaging men on violence prevention, and to examine the feasibility and effectiveness of such interventions.

Keywords

Intimate partner violence; global health; health care interventions

Violence against women is a fundamental violation of women's human rights. It is highly prevalent worldwide, and cuts across socioeconomic, cultural, and religious lines. Intimate partner violence (IPV) – actual or threatened physical, psychological, or sexual abuse of women perpetrated by intimate partners - is one of the most common forms of violence against women. It has been estimated that approximately one in three women has been psychologically, physically or sexually abused by a male partner during their lifetime (1). Rape and domestic violence (a form of IPV that includes violence by other family members)

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figure among the top ten global causes of years of life lost due to premature mortality and disability (2).

IPV is associated with a broad array of adverse reproductive, maternal, and child health outcomes. It includes women's risk for long-term health conditions such as physical disabilities chronic pain, and depression, as well as unwanted and unplanned pregnancies, miscarriages, sexually transmitted diseases, HIV infection, neonatal, infant, and maternal mortality, low birth weight, malnutrition, stunting and wasting, mental health disorders, depression, post-traumatic stress disorder, and suicidality (3–19). In some countries, physical violence has been associated with a lowered likelihood that couples will adopt modern contraception (19,20), while in others, women experiencing IPV though more likely to use modern contraception are at higher risk for unplanned pregnancies, multiple induced abortions, and report a loss of sexual autonomy as compared to women who do not experience IPV (21–23).

The immediate health care costs of IPV to families and communities are also substantial. Moreover, women who experience IPV tend to have poorer health outcomes (1,24) and more frequent health care utilization as compared to nonabused women (25,26). Studies from the US with health care plan users have found average health care costs to be significantly higher among abused as compared to nonabused women (27,28), as well as greater utilization of all hospital services among women currently experiencing abuse (27). These rates remain higher (by approximately 20%) even 5 years after the abuse has ceased (29). Annual health care costs were estimated to be 42% and 33% higher for women experiencing physical and non-physical abuse respectively as compared to nonabused women in one study (27), while a CDC country-wide study estimated the annual costs for medical care and mental health services to be $4.1 billion (30). Health care cost data from developing countries suggests that in some countries out of pocket expenditures on IPV-related services can be as high as 75% of a household's average weekly income (31).

Evidence also shows that while women who experience IPV rarely seek help from the police or support agencies, they will seek health care services at some point in their lives (32–35). This is especially the case in developing countries (31). In fact, women's utilization of reproductive health (including family planning, maternal and child health) services has been increasing globally, particularly in developing countries (36). For example, in 2008, 80% of pregnant women in the developing world received at least one antenatal visit by a skilled healthcare provider, up from 64% in 1990. Taken together, this evidence on the widespread prevalence of IPV, resulting adverse health outcomes and costs, and increasing health care utilization among women, not only underscores the need for health care programs and systems to respond to IPV but also suggests that they represent an important opportunity to engage in IPV prevention and management.

In keeping with the focus of this theme issue on global health delivery and implementation, this article reviews the opportunities for addressing IPV within and by the health care system, focusing particularly on reproductive health programs. Here we describe several promising approaches, and outline challenges that need to be addressed for developing effective health systems responses to IPV. We examine data and experiences from both developed and developing countries. It is important to point out that there are some fundamental differences between these two groups in terms of resource availability, health system infrastructure, and characteristics of the populations being served. For example, marriage tends to take place at a much earlier age in developing countries and reproductive health programs serve young, married adolescents, while teen pregnancies are more common among unmarried adolescents in most parts of the more developed West. Throughout the article, while describing current approaches for IPV prevention and

management within the health system, we compare and contrast evidence from more and less developed countries in order to enable the reader to better understand the spectrum of potential health care responses to this important public health challenge.

METHODS

This paper is based on a review of the peer-reviewed and grey literature on health system responses to IPV. We identified original research papers, reviews, project/program reports, and other material pertinent to the theme of interest using Pubmed, ISI Web of Knowledge, and Popline for the years 2000 through 2011. Search terms used included intimate partner violence and its synonyms (e.g., gender-based violence, domestic violence) in combination with health care interventions, clinic interventions, physicians, health care providers, reproductive health and costs.

OPPORTUNITIES FOR PREVENTION AND MITIGATION OF VIOLENCE

Globally, considerable investments have been made in improving and expanding reproductive health services. Expanding women's access to quality health care services is central to the global efforts to achieve the Millennium Development Goals (MDGs). In fact in September 2010, the United Nations Secretary-General launched the Global Strategy for Women's and Children's Health to accelerate progress towards the MDGs (37). In response, governments, philanthropists, community service organizations, and others have come forward with an estimated $40 billion for initiatives during the next five years (38).

Reproductive health programs represent important opportunities to engage in IPV prevention. The primary focus of most of these programs is young women – a group that is especially vulnerable to IPV. In many developing countries, marriage occurs early and is the norm for women (39). Women who marry young are also more likely to report physical and emotional abuse (40). In fact, women's first experience of IPV often occurs during the early years of marriage, when they are also likely to be seeking reproductive health care. In India, for example, well over two thirds of ever married Indian women who had births in the three years prior to a nationally representative survey had sought antenatal care (41). In the same survey, 87% of women with a history of IPV reported that it was initiated within the first 5 years of marriage (41).

In contrast, in many developed countries a large proportion of young women utilizing reproductive health care tend to be unmarried adolescents, and clinics specifically serving adolescents and catering to their special needs have been widely established. Studies show that women in their mid to late adolescence are at highest risk for violence from an intimate partner (42,43), and female users of adolescent clinics are at high risk for victimization irrespective of their reasons for seeking health care (44). In a cross-sectional survey administered to young women in the 16–29 year age group in Northern California, 53% of the respondents reported experiencing physical or sexual violence from an intimate partner (45). Moreover, studies from the US have revealed that women who experience IPV are more likely to also experience reproductive coercion, that is being forced by a male partner to get pregnant, undergo sterilization, or seek an abortion (22,45–47). Family planning clinics catering to young women thus represent an important opportunity to identify victimization and offer resources and referrals to those in danger of IPV. However, data show that despite the availability of guidelines in many developed countries for health care professionals on how to respond to IPV, there are numerous missed opportunities in reaching and assisting women who experience IPV (26,48–50). For example, in a small study among women presenting to the justice system, 86% of respondents had utilized

healthcare services within the previous year, but less than a quarter had been assessed for IPV (25).

The importance of reproductive health programs in reaching women at risk of IPV is further underscored by the fact that women's utilization of reproductive health services has been increasingly globally, while their use of other institutional services (e.g. police, social services) in response to IPV continues to be limited (32–35).

Between 1991 and 2000, use of antenatal care increased by 31% in Asia and 14% in Latin America and the Caribbean (51). Clinics offering family planning and maternal and child health services may thus not only be the sole source of health care accessible to women, but their only point of contact with formal institutions and structures of support.

Given that IPV is known to heighten the risk of adverse reproductive, maternal, and child health outcomes (52), failure to address this issue threatens the effectiveness of women's health promotion efforts (53,54). For example, although data are limited, IPV is an often unrecognized but significant cause of maternal deaths around the world, leading the World Health Organization to declare it a worldwide epidemic (55). Evidence from the United States suggests that pregnant women with a history of abuse are more likely to be murdered or experience an attempted murder than non-abused pregnant women (56). Indeed, framing violence prevention as an integral part of reproductive health promotion is likely to be a safer and more acceptable strategy than one focused exclusively on violence prevention (57).

PROMISING EVIDENCE-BASED APPROACHES TO VIOLENCE PREVENTION IN HEALTH CARE SETTINGS

The evidence-base on health systems approaches to violence prevention is relatively small compared to that on the prevalence of IPV and its adverse health impacts. Moreover, there is a dearth of rigorous evaluations to guide program planning and policy efforts to reduce IPV. In the US, much of the research on IPV interventions in the health care setting has focused on assessing improvements in individual health care providers' knowledge and practices and identification of IPV rather than better outcomes for women (58). However, a few recent studies – notably in reproductive health and primary care clinics – have reported benefits to women in terms of mitigation of the impact of IPV on health outcomes and reductions in violence. A study with adolescent women attending family planning clinics in Northern California applied a harm-reduction approach to IPV prevention, recognizing that while providers cannot end IPV they can address its health consequences (59). Using this perspective, health care providers in family planning clinics were trained to screen for specific reproductive health risks associated with IPV rather than merely screening for acts of physical, sexual and psychological violence, and to take concrete steps to reduce the health risks, thereby improving women's health outcomes. Screening combined with the offer of more longer-acting contraceptives and resources for domestic and sexual assault assistance was found to be effective in reducing women's risk of being coerced into pregnancy and enabling them to end unhealthy and unsafe relationships.

Another example is a randomized controlled trial among abused women utilizing four urban primary care clinics in the United States (60). The trial examined the impact of nurse case management combined with abuse assessment and provision of referrals compared to abuse assessment and referrals alone on women's safety behaviors, use of community resources, and subsequent experience of violence. Researchers found that simple assessment of abuse followed by referrals resulted in an increase in women's safety behaviors and use of community resources, and a reduction in women's experience of violence. Similarly, in a

study among prenatal care patients, those who received an interactive 15-minute multimedia-based assessment (the Video Doctor) followed by personalized counseling by a health care provider (aided by a printed Cue Sheet alert with suggested counseling messages) were more likely to report having IPV discussions with their provider and finding provider interactions to be helpful, as compared to patients receiving standard care (61).

Most interventions in the US have focused almost exclusively on changing practices of individual health care providers. However, there has been a growing recognition that individual providers' practices are shaped by the organizations in which they work, which, in turn, are influenced by the broader environment in which they are situated. Thus, instituting system-wide changes may be critical to ensuring that provider practices improve and that improvements are sustained. Broad heath system change necessitates a number of actions, including 1) creating a supportive environment within the system for clients to discuss IPV and for physicians to screen patients for IPV, 2) displaying informational material in the clinics, 3) focused training for all health care providers with mechanisms for continuous feedback and evaluation as staff practice their new skills, 4) on-site referral services 5) strong linkages between the health sector and community agencies, 6) commissioning an independent task force within the organization to develop and promote an integrated IPV-response, and 7) ensuring inter-departmental collaboration (62,63).

A recent review of studies that evaluated IPV screening programs within health care settings underscored the importance of a "comprehensive" approach, that is, one that includes institutional support, screening components at multiple levels, and builds provider self-efficacy.

Institutional support, effective screening protocols, thorough initial and ongoing training, and immediate access/referrals to onsite and/or offsite support services were all factors found to promote provider self-efficacy. Comprehensive programs were more effective in terms of higher IPV screening and disclosure/identification rates (64).

These findings are bolstered by other research. In one study following the implementation of an institutional approach, physicians' knowledge, attitudes, and practices towards IPV as well as IPV-inquiry rates increased almost two fold (62). In another study, a multifaceted program resulted in sustained improvement in physicians' recognition of the importance of managing IPV and their self-efficacy in responding to patients (63).

Although not rigorously evaluated, there have been several efforts across the developing world to establish IPV interventions that are multi-level and multi-sectoral right from the start. The Pan American Health Organization (PAHO), for instance, trained and sensitized healthcare personnel across different departments as well as allied service providers in ten Latin American countries to ensure that women experiencing IPV received health care and justice (65). They also worked with governments to develop national policies outlining the role of health care providers in addressing IPV, and widely disseminated these policies. Another unique aspect of this program was ensuring participation by service providers in developing norms, standards, and protocols to ensure their ownership over the program. Finally, building on the strengths of existing community networks in some countries, they also trained and sensitized members of the community (including religious leaders, school teachers, community leaders, and members of women's organizations) and facilitated the formation of community support networks. These networks were considered important in creating awareness about the ills of IPV and women's rights, and holding service providers accountable. Similar efforts to build health-sector capacity to address IPV are underway in Bangladesh, Brazil, and South Africa (66–68).

There also have been several attempts in developing country settings to integrate IPV services at primary and secondary levels of health care. In one model, selected services such as screening, counseling, psychological therapy, health care treatment, and legal aid were integrated at a single facility. For example, in Brazil, a dedicated counseling and support intervention for IPV survivors was established within a primary care center (68). In Honduras, family counseling centers have been established at regional mental health clinics and provide individual and group counseling for abused women (65). Another approach has been to offer a comprehensive range of services at a single site, usually established at secondary or tertiary levels of care. This one-stop crisis center model initially developed in Malaysia is now being implemented in Thailand, Namibia, and Bangladesh. Typically these centers are located in emergency departments of large public hospitals, and provide a wide range of services to IPV survivors, including health care, legal, welfare and counseling services (69,70). The centers are also well connected to women's groups in the community and other specialized services that women may need, and offer a 24-hour hotline service. A third approach to integrate IPV care has been to establish linkages across multiple service providers, wherein basic services (health care treatment and IPV screening) are available at one facility, with referrals to other facilities for specialized services. For example, at three regional clinics of the International Planned Parenthood Federation (IPPF), which offer primary-health care, IPV screening and counseling were integrated into existing sexual and reproductive health services (71). This involved training all health care professionals to screen, treat, and refer IPV survivors using a standardized screening tool. Each IPPF clinic established partnerships with local non-governmental organizations (NGOs) that offered specialized services for abused women.

In summary, health sector-led IPV prevention efforts in low and middle-income countries appear to be different from those in industrialized countries in that the majority go beyond implementing basic training and guidelines for health care providers. Rather, they emphasize integration and collaboration among service providers within a health facility as well as with providers in other allied sectors (65–68). Further, efforts in the former have recognized the importance of introducing legislation to improve women's access to justice; national policies that outline specific roles for service providers; and training for service providers at all levels and across all sectors, including health and law enforcement (65–68). Finally, they give importance to developing and strengthening linkages with community agencies, building on their strengths and networks, in order to create rights consciousness among women and the desire to hold service providers accountable.

The reasons underlying the development of multi-level and multi-sectoral approaches to IPV prevention in developing countries are unclear. It may be in part a result of the kinds of leadership behind these programs, which have included multilateral agencies like PAHO and organizations with strong roots in advocacy (and hence, partnership-building skills) such as IPPF that tend to be institution/systems-oriented. Moreover, interventions in developing countries have had to raise the profile of IPV as a health and rights issue not only in the health sector but also in the broader community. For example, many developing countries lacked legislation addressing IPV and referral linkages between various service providers. In contrast, US health systems responses to IPV have developed within the health system, been driven by a recognition of its adverse health impacts, and parallel responses to other health conditions in terms of provider initiated screening, counseling and referrals. Lastly, differences in national health policies and the organization and financing of health systems may also account for some of the variation seen in responses to IPV in the US compared to the developing world. Nonetheless, emerging evidence from the US and developing country settings indicates that comprehensive health system interventions with multi-sectoral and multi-level linkages are potentially the most effective.

CHALLENGES IN CONFRONTING INTIMATE PARTNER VIOLENCE GLOBALLY

Our review highlights three key challenges that need to be addressed for developing and expanding health systems responses to IPV. First and foremost is a need to expand the focus of health systems-based IPV prevention interventions beyond changing individual provider practices, and which, although essential, are likely to have limited impact. It is critical to build a supportive environment for health care providers and women seeking care, including physical spaces that facilitate sensitive conversations, informational materials to promote awareness, and on-site and referral support services. The creation of a supportive environment will necessitate a coordinated response across health care and allied sectors. Initiatives such as those that have been undertaken in Latin America suggest that such coordinated efforts are feasible in low- and middle-income countries.

Second, there is a need for a sound evidence-base to guide programmatic and policy decisions. Most IPV interventions in low- and middle-income countries are in the early stages of conceptualization or implementation, and few have been rigorously evaluated. Planning rigorous evaluations, that is, prospective randomized evaluations, should be considered an integral part of the development and implementation of health-sector based IPV interventions (72). Prospective studies are critical in order to assess changes in IPV-related attitudes, behaviors, and health outcomes, and to determine whether changes are sustained over time. However, even when prospective designs are used, challenges remain in evaluating multi-sectoral and multi-level interventions. For example, teasing out the relative contributions of different program may necessitate relatively complex study designs. That said, recent advances in the planning and implementation of combination HIV prevention interventions has led to the development of strategic guidance on program evaluation that may be applied to work on IPV (73).

Third, there is no doubt that IPV prevention efforts must engage with men, families and communities. IPV is a multifaceted phenomenon, influenced not just by individual-level factors, but by a whole host of interpersonal, societal, situational, and socio-cultural factors and processes. Thus, prevention efforts will need to reach out to men, families and communities (74). While reproductive health and other programs offer multiple opportunities to engage with women, the entry points for engaging men on violence prevention need to be identified. Programs that focus on promoting parenting and strengthening intimate relationships offer a promising avenue of research (75), and may be adapted to antenatal care settings. Research is needed to examine the feasibility and effectiveness of such an approach, especially in low- and middle-income countries.

After decades of research documenting the high prevalence of IPV worldwide, the time has come to make a concerted push forward on expanding our understanding of how to prevent violence and its adverse impacts on women and their families. Indeed, many prevention efforts are underway, but need to be systematically documented and rigorously evaluated. Taking advantage of these windows of opportunity is an urgent global health priority.

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