The **Women's** Health Council
*Comhairle Shláinte na mBan*

# Violence Against Women **& Health**

2007

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The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. Following a recommendation in the Report of the Second Commission on the Status of Women (1993), the national *Plan for Women's Health 1997-1999* was published in 1997. One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland.
Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:

- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women
- Quality in the provision and delivery of health services to all women throughout their lives
- Relevance to women's health needs

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's 'Quality and Fairness' document (2001). This definition states that

*'Health is a state of complete physical, mental and social well being'.*

# Violence Against Women & Health 2007

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*"Violence against women is widespread and deeply ingrained, and has serious impacts on women's health and wellbeing. Its continued existence is morally indefensible; its costs to individuals, to health systems, and to society in general is enormous. Yet no other major problem of public health has – until relatively recently – been so widely ignored and so little understood"*

(García-Moreno et al., 2005 )

## Introduction

The problem of Violence Against Women (VAW) continues to plague our society causing appalling damage to the lives of thousands of women and children. The immense negative repercussions of being exposed to physical, sexual, or psychological abuse have been well documented worldwide, and are well accepted by both professionals working in this field and society at large. Significant government funding has been directed to this area in order to provide support to women who experience abuse. However, rates of violence remain unacceptably high and services are still inadequate given the magnitude and the complexity of the problem.

While VAW represents first and foremost a crime and as such must be dealt with by the law enforcement and justice system, many women do not present to law enforcement authorities. On the other hand, most women do, at some point during their abuse, come into contact with the health services. Therefore, health services have a responsibility of care not only to address the immediate health concerns of abused women but also to provide information and referral to other relevant support organisations.

In Ireland, very welcome steps are being taken towards the adoption of a 'whole government' approach to this issue (Department of Justice Equality & Law Reform, 2007) through the establishment of COSC – the new executive office to combat domestic violence and related issues[1]. The problem of VAW is extremely complex and requires a multi-layered analysis and approach that goes beyond the scope of this report. The aim of this document is to examine two major issues:

1. the impact of VAW on the health of women, and
2. the health sector response to it.

VAW can only truly be addressed by the removal of the violence from women's lives, rather than by treating the consequences of it. However, keeping in mind the danger of medicalising the problem, it has become accepted internationally that the health sector has a key role to play in combating this terrible infringement of women's human rights. A public health approach, now included in the more inclusive 'population health' framework, is advocated in order to maximise the impact that the health sector can have on tackling this problem and, therefore, improving women's health and lives. To quote Gro Harlem Brundtland: "While public health does not offer all of the answers to this complex problem, we are determined to play our role in the prevention of violence worldwide" (WHO, 2002: preface).

The review of literature presented in this report does not attempt to be exhaustive, but focuses specifically on health-based research with a view to provide specific recommendations on how to strengthen the health sector response to this complex social problem.

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[1] This new executive office was established under the aegis of the Department of Justice, Equality and Law Reform as part of the National Women's Strategy 2007-2016.

## What do we mean by VAW?

In 1993 the United Nations provided the first internationally agreed definition of Violence Against Women in its Declaration on the Elimination of Violence Against Women: *"any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats such as acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life".*

This declaration recognises that:
*"violence against women is a manifestation of historically unequal power relations between men and women, which has led to domination over and discrimination against women, and to the prevention of their full advancement and that violence against women is one of the crucial mechanisms by which women are forced into subordinate position compare to men".*

Because of its historical link with gender discrimination, VAW has in recent times been often referred to as 'Gender-Based Violence' (GBV). This term highlights the need to understand violence within the context of women's and girls' subordinate status in society. In fact, gender inequality is now deemed one of the principle causes of violence. In exposing women, by virtue of their gender, to physical, sexual and/or psychological abuse, VAW represents a serious obstacle to equality between men and women (Council of Europe, 2006). VAW is thus both a manifestation of gender inequality and a means to the maintenance of such power imbalance (Watts and Zimmerman, 2002). It serves to perpetuate male power and control. It is sustained by a culture of silence and denial of the seriousness of the health consequences of abuse. In addition to the harm caused to individual women, VAW also exacts a significant social toll in terms of services and reduced morbidity and mortality for women and their children (UNFPA, 2007). Such violence, therefore, cannot be understood or combated while ignoring the social norms and unequal gender roles existing in any society (WHO, 2005).

Throughout this report the two terms of VAW and GBV will be used interchangeably and other terms, such as intimate partner violence, will also be used reflecting their use in the literature. Although women can be violent towards their male partners and violence also occurs between partners of the same sex, internationally the overwhelming burden of partner violence is borne by women at the hands of men (WHO, 2002). This has also been found to be the case in Ireland (McGee et al., 2002; Watson and Parsons, 2005). Moreover, Irish studies also show that women are more affected by violence than men at comparable levels of abuse.

There are many forms of violence against women, and they are often divided into four categories:

- physical violence
- sexual violence
- psychological/emotional violence (including coercive acts)
- threat of physical or sexual violence (WHO, 2005).

The most common form of violence experienced by women globally is intimate partner violence, also often referred to as domestic violence, sometimes leading to death (WHO, 2005; United Nations, 2006). The second most common form of abuse is sexual violence. Emotional abuse has also been found to be common in Ireland (Watson and Parsons, 2005) and is significantly associated with physical or sexual violence, or both, worldwide (UNFPA, 1999). Other types of violence seem to be more directly linked to localised social norms with specific types of violence being particularly prevalent in some countries but not others. The

table below illustrates this cultural variation. This paper will focus on the three types of violence mentioned above, which are also most common in Ireland, whilst also being conscious that other forms, such as sexual harassment and forced prostitution are also present in this society.

Many women experience multiple episodes of violence that may start in the prenatal period and continue through childhood to adulthood and old age. For this reason, a lifecourse approach to the problem is considered to be a useful analytical tool (Heise et al., 1994; Itzin, 2006). This approach highlights the cumulative impact of violence experienced by girls and women, especially in terms of its physical and mental health consequences. While many of the forms of violence listed below are not common to the Irish setting, its underlying framework remains valid in terms of the development of interventions.

| Phase | Type of Violence |
|---|---|
| Prebirth | Sex-selective abortion (e.g. China, India);<br>Battering during pregnancy;<br>Coerced pregnancy (e.g. mass rape in war) |
| Infancy | Female infanticide;<br>Emotional and physical abuse;<br>Differential access to food and medical care for girl infants |
| Girlhood | Child marriage;<br>Genital mutilation;<br>Sexual abuse by family members and strangers;<br>Differential access to food and medical care;<br>Child prostitution |
| Adolescence | Dating and courtship violence (e.g. date rape, acid throwing in Bangladesh);<br>Economically coerced sex (e.g. African secondary school girls dating 'sugar daddies' to afford school fees);<br>Sexual abuse in the workplace;<br>Rape;<br>Sexual harassment;<br>Forced prostitution;<br>Trafficking in women. |
| Reproductive Age | Abuse of women by intimate male partners;<br>Marital rape;<br>Dowry abuse and murders (e.g. India)<br>Partner homicide;<br>Psychological abuse;<br>Sexual abuse in the workplace;<br>Rape;<br>Sexual harassment;<br>Abuse of women with disabilities. |
| Elderly | Abuse of widows;<br>Elder abuse. |

**Table 1.** Lifecourse approach to VAW. Source: (Heise et al., 1994)

## Causes of Violence

Around the world, the events that trigger violence in abusive relationships have been found to be remarkably consistent. They include: disobeying or arguing with the man, questioning him about money or girlfriends, not having food ready on time, not caring adequately for the children or the home, refusing to have sex and the man suspecting the woman of infidelity (WHO, 2002). However, identifying the deeper causes of violence is a more complex issue.

The most comprehensive explanation for the problem of violence against women comes from what has been called the 'ecological model' (Heise et al., 1999). This model helps us to understand the complex interaction of risk factors at individual, family, community and societal levels. As such it provides a clarification of all the numerous variables that influence the extent and manifestations of gender-based violence cross-culturally and over time.

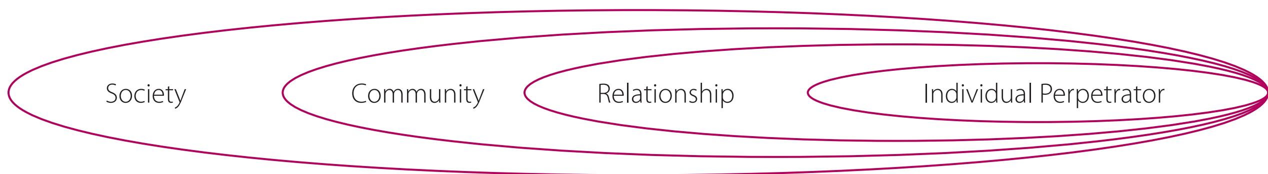


**Figure 1.** Ecological Model of VAW

| | |
|---|---|
| Personal | Being male<br>Witnessing marital violence as a child<br>Absent or rejecting father<br>Being abused as a child<br>Alcohol abuse |
| Relationship | Marital conflict<br>Male control of wealth and decision-making in the family |
| Community | Poverty, low socio-economic status, unemployment<br>Women's isolation and lack of social support<br>Male peer groups that condone and legitimise men's violence |
| Society | Norms granting men control over female behaviour<br>Acceptance of violence as a way to resolve conflict<br>Notion of masculinity linked to dominance, honour or aggression<br>Rigidly defined and enforced gender roles |

**Table 2.** Ecological Model of VAW collated from Heise et al., 1999.

Violence against intimate partners occurs in all countries, all cultures and at every level of society without exception, although some populations, such as low-income groups, have been found to be at greater risk than others. While there are no clear-cut explanations for the increased risk of low-income women, evidence points to the strain on relationships that financial hardship can cause as well as the greater practical difficulties for women wishing to leave violent relationships because of their reduced mobility, opportunities for work outside the home, and access to information (Campbell, 2002; García-Moreno, 2002; Moracco et al., 2007). This has also been found to be the case in Ireland (Kelleher et al., 1995). Ultimately, low socio-economic status probably reflects a variety of conditions that in combination increase women's risk of victimisation (Heise et al., 1999).

In a nationally representative survey of domestic violence in Ireland, it was found that a number of factors were associated with an increased risk of having experienced domestic abuse, including:

- Being female;
- Being a young adult;
- Having parents who were abusive to each other;
- One partner controlling decisions about money;
- Ever having had children; and
- Being isolated from close family and neighbourhood supports (Watson and Parsons, 2005).

In an Irish setting, it is also particularly relevant to point to the role of alcohol in abuse. Alcohol was found to be involved in a significant number of cases of sexual assault on women (McGee et al., 2002), and one third of domestic abuse cases (Watson and Parsons, 2005). It is important to point out that alcohol exacerbates but does not cause violence against women, however public health policies for reducing harm from alcohol misuse would have an impact in the incidence of VAW.

Finally, as mentioned earlier, the underlying gender inequality and unequal power relations in society underpin all causes of gender-based violence.

## The extent of the problem

Research has shown that violence against women is endemic in many countries. While various statistics are now available it is important to remember that any of them are bound to be under-estimates of the scale of the problem due to the hidden nature of this crime and women's reluctance to report it. However, in every country where reliable, large-scale studies on gender violence are available, upwards from 20% of women have been abused by men they live with (UNFPA, 1999). A recent international comparative study of violence against women found that between 13% and 61% of women who had ever been in a relationship had suffered physical violence, with most research sites identifying rates between 23% and 49% (García-Moreno et al., 2005). One third to one half of all cases of physical abuse have been found to involve sexual abuse (UNFPA, 2000), and Garcia-Moreno *et al.* (2005) found the lifetime prevalence of sexual abuse to be between 6% and 59%, with most sites falling between 10% and 50%. Emotional violence is also very prevalent in abusive relationships. Across all countries studied, between 20% and 75% of women had experienced one or more emotionally abusive acts in the previous 12 months. This form of abuse is identified as being even worse than physical abuse by many women both worldwide (UNFPA, 1999; Velzeboer et al., 2003; WHO, 2005), and in Ireland (Watson and Parsons, 2005).

Internationally the general characteristics of violence against women are:

- the great majority of perpetrators of violence are men;
- women are at the greatest risk from men they know;
- physical violence is almost always accompanied by psychological abuse and in many cases by sexual abuse;
- most women who suffer any physical aggression by a partner generally experience multiple acts over time;
- VAW cuts across all socioeconomic class, religious and ethnic lines;
- men who batter their partners exhibit profound controlling behaviour. (Velzeboer et al., 2003)

In Ireland, the most recent survey on domestic abuse found that 15% of women (or about 1 in 7) have experienced severely abusive behaviour of a physical, sexual or emotional nature from

a partner at some time in their lives (Watson and Parsons, 2005). One woman in 11 had experienced severe physical abuse in a relationship, one in 12 sexual abuse and one in 13 severe emotional abuse. Women's Aid reported that in 2006, 24,146 calls were made to its Helpline and support workers responded to 11,994 calls (Women's Aid, 2007)[2]. The breakdown of the type of abuse reported is illustrated below (Figure 1). However, many callers disclose experiences of multiple forms of abuse in line with international research.

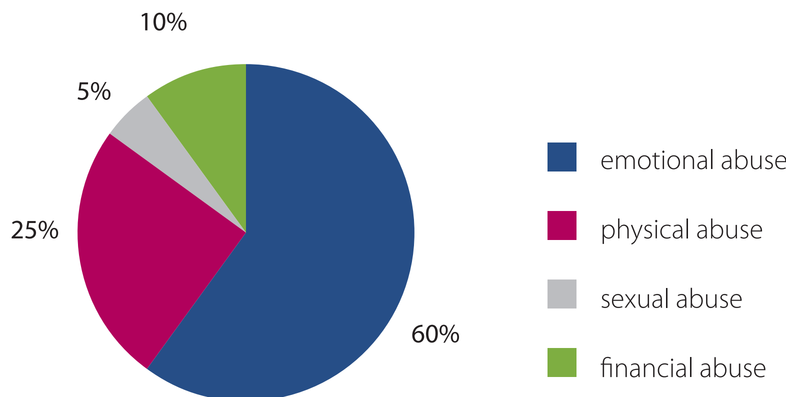


**Figure 2.** Types of Abuse recorded by Women's Aid Helpline in 2006.

In the *Sexual Abuse and Violence in Ireland (SAVI)* study, one in five women (20.4%) reported experiencing contact sexual assault as adults with a further one in twenty (5.1%) reporting unwanted non-contact sexual experiences (McGee et al., 2002). More than four in ten women (42%) reported some form of sexual abuse or assault in their lifetime. The most serious form of abuse, penetrative abuse, was experienced by 10% of women. The Dublin Rape Crisis Centre reported receiving 12,244 genuine[3] counselling calls in 2006 (Dublin Rape Crisis Centre, 2007). The calls were almost evenly split between adult rape (48.4%) and child sexual abuse (42.3%) (see Figure 3 below). Again, many callers disclosed that they have experienced more than one type of abuse in their lives.

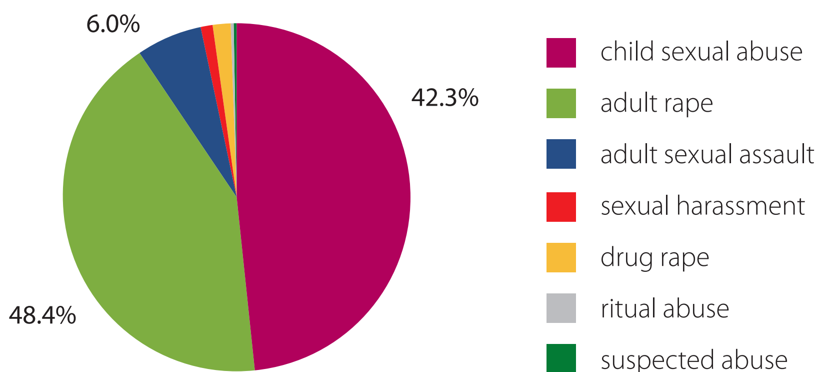


**Figure 3.** Dublin Rape Crisis Centre Breakdown by Type of Abuse in 2005.

[2] 12,152 calls were recorded as missed. These are calls that could not be answered as the service was working to capacity/all support workers were engaged on the line.

[3] Genuine calls refer to the number of calls after hoax, hang-up, silent and obscene calls are subtracted from the total number of calls.

While these services continue to strive to expand their services in order to cater for the needs of women, it is also believed that as a result of awareness raising campaigns more women are now willing to come forward to seek support in dealing with the abuse than in the past.

Looking at the criminal reporting of VAW, Garda statistics indicate a total of 1,188 instances of breach of domestic violence orders in 2005 (An Garda Síochána, 2006). They also showed that 80% of sexual offences victims in 2005 were female (an increase from 77% from 2004) with more than 800 instances of sexual assault, almost 350 cases of rape and 7 cases of incest were reported to them in 2005 (An Garda Síochána, 2006).

## Intersectoral approach

Given the multi-faceted causes of VAW and its widespread and complex nature, an intersectoral approach is required to address this issue. The WHO recommends the following whole system approach to the problem of gender-based violence:

1. create, implement and monitor a national action plan for VAW prevention, supported by multisectoral action plans;
2. enhance capacity for collecting data to monitor VAW, and the attitudes and beliefs that perpetuate it;
3. define priorities for, and support research on, the causes, consequences, costs and prevention of VAW;
4. promote primary prevention responses;
5. strengthen responses for victims of violence, including the health sector response and sensitising the criminal justice system;
6. integrate violence prevention into social and educational policies, and thereby promote gender and social equality;
7. increase collaboration and exchange of information on violence prevention; and
8. promote gender equality and women's human rights and compliance with international agreements (WHO, 2002; García-Moreno et al., 2005).

### *Prevention*

If primary prevention is a cornerstone of a public health approach, reducing the acceptability of all forms of VAW becomes one of its fundamental goals. As illustrated earlier, GBV cannot be understood or combated while ignoring the social norms and unequal gender roles existing in any society (WHO, 2005). Hence, a key step in tackling this problem is the promotion of gender equality. In Ireland, it is hoped that the *National Women's Strategy 2007-2016* (Department of Justice Equality & Law Reform, 2007) will aid in this objective. Improved socio-economic and legal status for all women as well enhanced engagement in employment, education and political participation have all been found to act in a protective manner in relation to violence (García-Moreno *et al.*, 2005).

Continued and increased efforts are also required in order to challenge the widespread tolerance and acceptance of many forms of violence against women. Victim blaming still persists across the EU (Gracia and Herrero, 2006). When victims are believed to cause their own troubles or to get what they deserve the chances of them receiving help or moving away from violence are significantly reduced. Therefore, considerable effort must be put into changing these attitudes and preventing violence happening in the first place. For this purpose, work

at community level, through general information and awareness raising campaigns, as well as in schools, is particularly important (Reid, 2003). Small and large scale media campaigns play a vital role in the prevention of VAW. Education has been identified as a key element in the prevention of GBV. Hence, all health sector educators, such as medical and nursing schools, should adopt an approach that promotes gender equality and challenges the attitudes that support VAW. All organisations involved in education should be encouraged to adopt a similar approach.

A review of prevention programmes carried out by the WHO in 2002 indicated that worldwide there are insufficient programs aimed at primary prevention – measures to stop violence before it happens – compared with secondary (more immediate responses to violence, such as emergency services and Sexual Assault Treatment Units) or tertiary prevention (long term care in the wake of violence, such as physical rehabilitation and mental health recovery for victims). There was also an imbalance in the focus of programmes – community and societal strategies were often under-emphasised compared with programmes addressing individual and relationship factors (WHO, 2002). The WHO emphasised that it is crucial that VAW prevention programmes are established at all levels of intervention, including community and societal strategies, and that they integrate with other sectors such as education, employment, housing, justice, safety and security, social action, sports and recreation, and welfare. Table 3 outlines possible elements of a primary prevention strategy and highlights in particular the role that can be played by the health sector and other sectors.

| Prevention Strategy | Intervention by the health sector | Intervention by other sectors which the health sector should advocate for |
|---|---|---|
| Creating a climate of non-tolerance of VAW | – Health information campaigns<br>– Training health sector staff about VAW | – Comprehensive legislation<br>– Training and monitoring the justice system<br>– Public information campaigns<br>– Support for community action and ngos |
| Empowering women | – Promoting gender equality in service provision and in health service employment<br>– Promoting gender equality in clinical practice and training | – Working towards gender equality in employment<br>– Improving levels of female involvement in decision-making<br>– Positive role modelling of women through the media<br>– Promotion of sexual equality in schools |
| Changing community norms | – Addressing issues of gender and violence in community-based health and training programmes | – Addressing gender inequality and GBV in school life-skills programmes<br>– Supporting community initiatives on VAW<br>– Promoting men's groups addressing masculinity and VAW |
| Research and monitoring | – Collection of data on VAW and support for research | – Allocation of funds to support research into VAW in all sectors |

**Table 3.** Primary Prevention of VAW adapted from Jewkes, 2002.

### *The Role of Men*

Finally, in terms of primary prevention, addressing gender socialisation and use of aggression and violence early on, before behaviour patterns are set, is critically important. While men's attitudes and behaviours obviously play a part in gender-based violence, the impact of gender socialisation on men has largely been ignored in the study of violence (García-Moreno, 2002; Krantz, 2002).

The most common interventions dealing specifically with men are batterer intervention programs that aim to change male behaviour. Overall, batterer intervention programmes appear to contribute to cessation of physical domestic violence in around 53% to 85% of men who complete them. However, most studies show a dropout or non-engagement rate of about two-thirds of the rate of completers, and most men do not come back after the first session (García-Moreno, 2002).

A recent evaluation of gender-based programmes seeking to engage boys and men in achieving gender equality and equity in health found that well designed programmes were effective in changing men's and boys' attitudes and behaviours in relation to a variety of topics influenced by gender, including violence against women (Baker *et al.*, 2007). Moreover, those programmes that promoted more gender-equitable relationships were the most successful.

As Velzeboer *et al.* state: "It is impossible to eliminate VAW if the attitudes and behaviour of violent men are not changed as a central part of this process" (2003). Given that the consequences of their actions have a negative impact on women's health, changing these attitudes must in part be placed within the remit of public health promotion bodies.

## Violence and Health

While initiatives in other areas are vital, as seen, in the prevention and the implementation of a coordinated response to VAW, the remainder of this report will focus on health repercussions of this problem and how the health sector can be best equipped to address them. A health-focused analysis of VAW is crucial not only because the consequences of VAW require a significant amount of health care system resources, but most importantly because the health care system is often the route through which victims seek to access supports. Therefore, the health sector response is key and needs to be advocated and supported. At the same time it is crucial to emphasise that a balance needs to be struck to avoid falling into the trap of medicalising the problem. We must ensure that we do not transform the woman into the patient, and the problem, which is a complex social one, into a medical problem (García-Moreno, 2002)

In the past two decades research has begun to document the grave repercussions of violence on the health of abused women, and that of their children. Many studies conducted worldwide now show that abused women have significantly worse physical and mental health than non abused women (Heise *et al.*, 1994; Heise *et al.*, 1999; UNFPA, 1999; García-Moreno *et al.*, 2005; WHO, 2005; Rivara *et al.*, 2007). Because of the health burden of VAW, these findings have expanded the focus on VAW beyond a human rights' perspective to include a public health approach. Both the Cairo Programme of Action in 1994 and the Beijing Declaration and Platform for Action in 1995 devoted an entire section to the issue of VAW. In May 1996, the World Health Assembly adopted the United Nations' definition, quoted earlier, and a resolution

(WHA49.25) declaring violence a public health priority and urging the adoption of a 'gender perspective' in its analysis. In 1999 the United Nations Population Fund declared violence against girls and women specifically a "public health priority". Since then VAW has been recognised as a key determinant of health (WHO, 2002; García-Moreno *et al.*, 2005) and efforts have intensified by international human rights and health organisations to raise awareness about the traumatic health consequences of violence and provide guidance in how to address them. However, the problem is far from being resolved and health services still often fail to respond to this issue in an appropriate manner.

Below is a summary diagram of the many negative health consequences of violence.

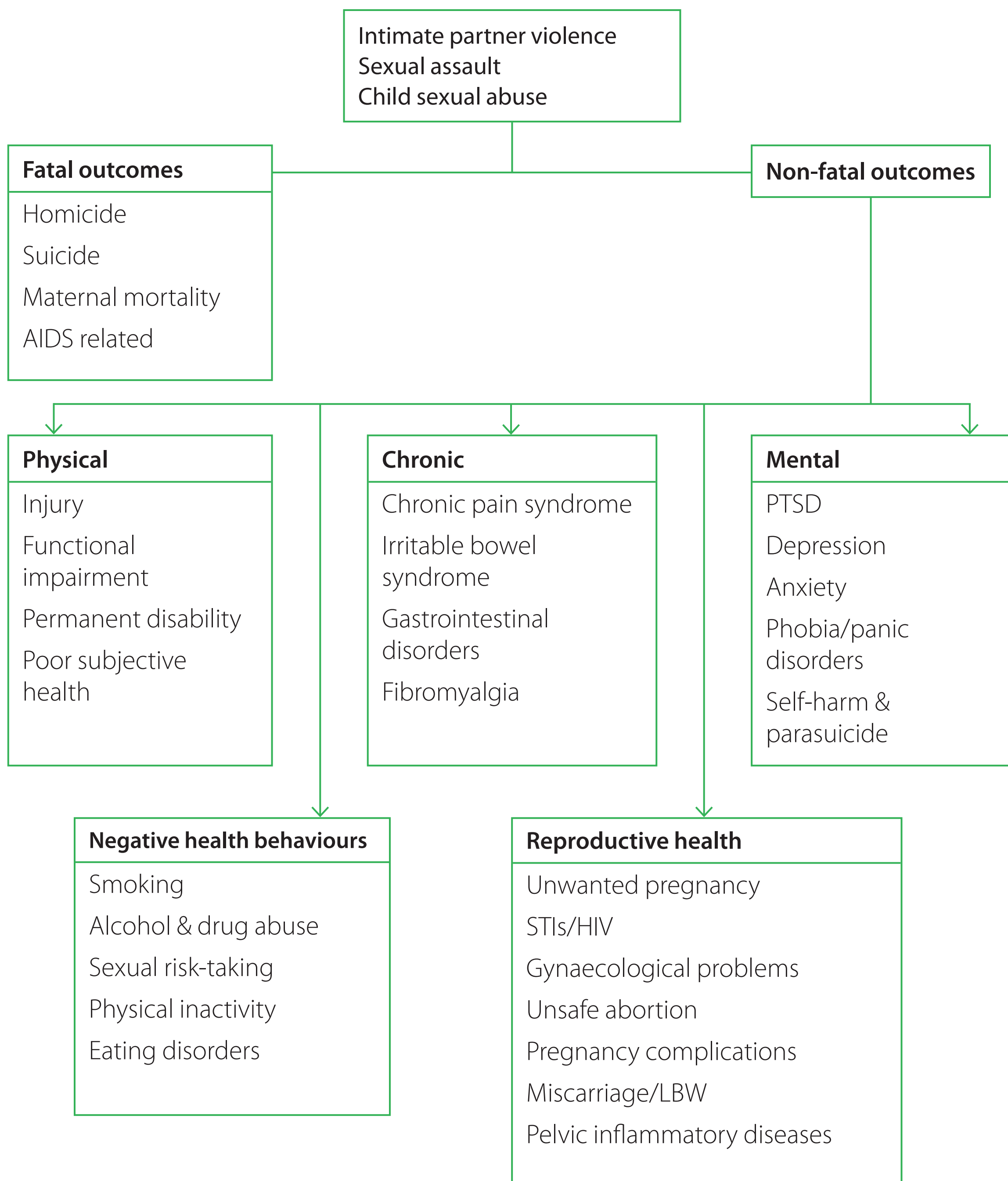


**Figure 4.** Health repercussions of VAW adapted from WHO, 2005.

### *Burden of Disease*

The first major report to highlight the harmful link between violence and health was published by the World Bank in 1994 (Heise *et al.*, 1994). The authors stated that in established market economies gender-based victimisation was responsible for 1 out of 5 healthy years of life lost to women of reproductive age. Moreover, at a global level, they considered the health burden from violence against women aged 15 to 44 to be comparable to that posed by other risk factors and diseases high on the world agenda, such as HIV, tuberculosis, sepsis during childbirth, cancer and cardiovascular disease. In 2006, it was estimated that domestic violence and rape accounted for 19% of the total burden of disease for women aged 15 and 44 in developed countries (United Nations, 2006). In Europe, the Council of Europe estimated that more women die or are seriously injured every year through domestic violence than through cancer or road accidents (Reid, 2003).

In the state of Victoria, Australia, intimate partner violence (IPV) was associated with 2.9% of the overall burden of disease for all women, and 7.9% for women aged 18 to 44 (Vos *et al.*, 2006). Moreover, IPV represented a greater risk to health than risk factors traditionally included in burden of disease studies, such as raised blood pressure, tobacco misuse and increased body weight. Poor mental health contributed to 73% and substance abuse 22% to the disease burden attributed to IPV. For all ages combined, IPV caused more disease among women than alcohol and illicit drugs.

Irish research on domestic violence has also shown that domestic abuse is associated with poor health and disability. Women describing their health as 'fair' to 'poor' were twice as likely as women in 'very good health' to have experienced severe abuse in the previous 5 years (Watson and Parsons, 2005). This study also found that severe abuse is associated with poor health and is an ongoing limiting condition for women but not for men.

It has been established that for over 50% of all women murdered internationally, the perpetrator was a male intimate partner (WHO, 2005). This statistic also holds true in Ireland (Women's Aid, 2007). While the incidence of femicide might be limited, each death associated with gender violence is a preventable death, usually of a woman with many years of life ahead of her and therefore contributes significantly to premature mortality.

### *Physical Health Repercussions*

Population-based studies suggest that 40% to 75% of women who are physically abused by a partner are injured by this abuse at some point in their life (Heise *et al.*, 1999). The consequences of these injuries can be severe requiring emergency medicalisation. Apart from injuries, abused women experience various physical health problems such as: headaches, abdominal pains, muscle aches, bleeding, irritable bowel syndrome and increased gynaecological problems (UNFPA, 1999). Research also suggests that abuse can also be associated with delayed physical effects, particularly arthritis, hypertension and heart disease (Heise *et al.*, 1994).

Very little data exists in Ireland in relation to the physical health repercussions of violence against women. However, between 1992 and 1993 Women's Aid and St James' hospital carried out a joint research project on domestic violence in the Accident & Emergency Department (Cronin and O'Connor, 1993). The research found that during a one-year period there were 119 female admissions as a direct result of an assault by an intimate partner. The types of injuries sustained included bruising, lacerations, fractures, loss of consciousness, attempted strangulation, broken teeth and sexual assault.

### *Sexual and Reproductive Health*

Sexual abuse, including forced intercourse within marriage and refusal by men to use condoms, puts women at risk of unwanted pregnancy, HIV/AIDS and other sexually transmitted infections (STIs). American research has shown that up to 30% of women raped there every year develop an STI as a result (UNFPA, 2000). Fear of male reprisal is also a deterrent to the use of contraceptive methods by women (WHO, 2005). The impact of gender on sexual health in general and STIs in particular in Ireland has been extensively documented (Women's Health Council, 2006). Fifty to 60% of victims of sexual abuse have also been found to experience sexual dysfunction, including fear of sex and problems with arousal (UNFPA, 1999).

Around the world, as many as one woman in four is physically or sexually abused during pregnancy, usually by a partner (Heise *et al.*, 1999). Violence before and during pregnancy has been found to have serious health consequences for both mother and child. Violence leads to high-risk pregnancies and pregnancy related problems, including miscarriage, pre-term labour and low birth weight. Research among pregnant women attending the Rotunda Hospital in 1995 revealed that 1 in 8 women had personal experience of abuse during pregnancy (O'Donnell *et al.*, 2000). Seventy four per cent of affected women reported mental abuse and 69% had suffered physical abuse.

### *Mental Health Repercussions*

Psychological consequences of VAW can include: depression, anxiety, post-traumatic stress disorder, psychosis, phobias, substance abuse, sleep and psychosomatic disorders, eating disorders, self-harm and suicide (WHO, 2005). Depression and anxiety are particularly common consequences of abuse. The set of psychological and behavioural symptoms displayed by women in violent relationship have been described as 'battered woman's syndrome'. These symptoms, which include depression, low self-esteem and isolation, are now recognised as an implied category of Post-Traumatic Stress Disorder (PSTD) (WHO, 2005). Rape survivors have been found to have high rates of PSTD and make up the largest single group diagnosed with this difficulty (UNFPA, 1999).

Women who have ever experienced physical or sexual violence, or both, by an intimate partner have been found to have significantly higher levels of emotional distress and are more likely to have thought of suicide or to have attempted suicide, than women who have never experienced partner violence (García-Moreno *et al.*, 2005). Rape victims are 9 times likelier than non-victims to attempt suicide and to suffer major depression (UNFPA, 1999). A meta-analysis of 18 studies found an average rate of PTSD among abused women of 64%, a rate of depression of 48% and a suicide rate of 18% (Golding, 1999). Reflecting the very serious nature of the consequences of VAW, in 2006 the World Psychiatric Association issued a consensus statement for the prioritisation of women's mental health recognising VAW as a major determinant of mental distress and psychiatric illness in women (Stewart, 2006).

The greater prevalence of depression and anxiety in women worldwide as well as in Ireland points directly to the extent of violence being experienced by women (Women's Health Council, 2005). For instance, in a study of Irish general practices, it was found that among women who were depressed, 67% had experience domestic violence as compared to 33% who had not. This finding means that two-thirds of women with depression have experienced abuse in their home (Bradley *et al.*, 2002). Similarly, in a national survey carried out in 1995 by Women's Aid, 65% of women who experienced violence in the home reported that they had also suffered from depression (Kelleher *et al.*, 1995). A localised study in the HSE Mid West Area also found that up to 20% of female patients using their Adult Mental Health Services had or were experiencing domestic violence at the time of the study (HSE Mid West, 2005).

The *SAVI* report (2002) also documented the impact of sexual violence on the Irish population. A quarter of women reported having symptoms consistent with a diagnosis of PTSD at some time in their lives following, and as a consequence of, their experiences of sexual violence. Those who had experienced sexual violence were also significantly more likely to have used medication for anxiety and depression or to have been a psychiatric hospital inpatient than those without such experiences. For instance, those who had experienced attempted or actual penetrative sexual abuse were 8 times more likely to have been an inpatient in a psychiatric hospital than those who had not been abused.

### *Other Health Related Repercussions*

Women who have experienced or are experiencing violence and abuse also often engage in health damaging behaviours such as unsafe sex, alcohol and drug misuse, and smoking and eating disorders, which in turn contribute to their already high level of physical and psychological morbidity (WHO, 2005). Victims of partner violence and women sexually abused as children have been found to be more likely than other women to misuse alcohol and drugs, even after controlling for other risk factors such as prior use, family environment, or parental alcoholism (Heise *et al.*, 1999). A recent American study found that, compared to women with no experience of intimate partner violence, women who reported IPV in their adult lifetime were more likely to be current or former smokers, to engage in risky sexual behaviours and to heavy or binge drinking in the past year (Bonomi *et al.*, 2006).

Early traumatic experiences have also been found to be a factor in later unprotected sex with multiple partners, prostitution and teen pregnancy. In a community-based study, 49% of childhood sexual abuse victims reported being battered in adult relationships and as many as 68% of incest victims reported being the victims of rape or attempted rape later in their lives (UNFPA, 1999). These statistics clearly point to the significant risk of revictimisation for many women who experience abuse.

### *Health Service Utilisation*

A recent US study found that healthcare utilisation was higher for all categories of service during intimate-partner violence compared to women without IPV, and decreased over time after cessation of IPV (Rivara *et al.*, 2007). However, healthcare utilisation was still 20% higher 5 years after women's abuse had ceased compared to women without IPV. Adjusted annual total healthcare costs were 19% higher in women with a history of IPV (amounting to $439 per annum) compared to women without IPV. After adjusting for calendar year, age, education and the presence of major unrelated illness, the odds ratio of use for women with IPV ever was approximately 50% higher for emergency visits, twofold higher for mental health visits, and six-fold higher for use of alcohol or drug services. The number of visits for primary and specialty care and pharmacy use was 14% to 21% higher in women with IPV ever compared to those with no history of IPV. Rates were highest during the period of IPV and decreased after cessation of IPV. Nevertheless, even after 5 years after cessation significantly higher use of all types of services except inpatient hospital care remained.

One of the few Irish studies on this topic found that 39% of women in a relationship attending a sample of 22 Irish general practices had experienced domestic violence (Bradley *et al.*, 2002). The study considered this prevalence to be double that in Irish community based random surveys suggesting that women who experience domestic violence are over-represented in general practice.

### An Irish Case Study

No comprehensive analysis of the health implications of VAW has been carried out in Ireland to date[4]. However, data are available from a localised case study conducted by the Letterkenny Women's Centre Counselling Service in relation to domestic violence. Since 2003 the counsellors of this centre have been collating data on the health repercussions experienced by their clients (Hudis and Britton, 2007)[5]. The table below indicates the percentage of their clients who have been affected by different health difficulties. While the study is small and localised in nature, involving only between 35 and 49 women each year, and does not provide any information on the health status of women prior to their contact with the service, it nevertheless provides an insight into the devastating effect of violence in women's lives and on their health in an Irish setting.

| | 2003 | 2004 | 2005 |
|---|---|---|---|
| Physical Illness as direct result of physical violence | 47% | 51% | 47% |
| Stress related physical illness | 57% | 60% | 75% |
| Drug prescription for depression and/or anxiety | 64% | 57% | 75% |
| Previous admissions to a psychiatric hospital / ward | 23% | 20% | 16% |
| Suicidal attempts, ideation or feelings | 55% | 46% | 49% |
| Drug, alcohol and non-prescription drugs misuse | 32% | 26% | 20% |

**Table 4.** Health repercussions of domestic violence documented by the Letterkenny Women's Centre.

The centre's counsellors also highlighted the impact of trauma on the victims of domestic violence, and its effects on their clients. Over the past few years, they have been able to document the physical as well as psychological signs of stress they encounter in their work.

### Physical signs of stress

- More than half of clients have digestive problems, particularly irritable bowel syndrome, and fewer, but still a significant number, have duodenal or stomach ulcers.
- Other types of stress related illness include fibromyalgia, neck, shoulders and back problems.
- Chronic ailments aggravated by stress have included asthma and eczema.
- Due to stress many clients have a depleted immune system and frequently catch colds, 'flu, chest and throat infections and stomach bugs which they find difficult to shake off.

### Psychological signs of stress

- Significant numbers of clients come to counselling suffering from insomnia.
- The majority of clients present with anxiety or panic disorders and some are prescribed medication for this from their GP.
- A smaller number of clients, connected to anxiety and panic attacks, have agoraphobia and occasionally obsessive compulsive disorder. A few clients self-harm by cutting.
- Some clients have what is commonly described as PTSD and experience flash backs.

[4] The Regional Planning Committee on VAW in the HSE West area also collects data through the services which it funds and from these data health impacts could also be identified. However, analysis of this data collection exercise has not been published to date. Personal communication with Kate Walshe, Chairperson, RPC on VAW, HSE West, 29th June 2007.

[5] The Women's Health Council wishes to express its gratitude to the Letterkenny Women's Centre Counselling Services for allowing us access to this unpublished research.

***Other psychological effects of domestic violence:***

- All clients have low self-esteem generally ingrained through years of being criticised, put down, verbally abused and controlled. Low self-esteem prevents women from gaining education, work, friends, social life and can have a significant effect on how they parent their children.
- The majority of clients experience depression with half to three quarters taking medication for this, prescribed by their GP. Around a quarter are availing of psychiatric services.
- The majority of women have attempted suicide or had suicidal ideation or feelings.
- Most women seen for counselling have an eating disorder or eating issues. Most commonly women suffer from compulsive or comfort eating and are struggling with weight gain. Some other clients struggle with inability to eat resulting from fear, anxiety and stress.

## The Cost of VAW

All the data presented so far point to a huge cost to the health services in terms of caring for women who have experienced violence. A number of studies have attempted to quantify this cost. An analysis based on costs for one year in England and Wales in 2001 calculated that the cost to the NHS for physical injuries is around £1.2 (€1.8[6]) billion a year (Walby, 2004). This included GPs and hospitals. Physical injuries accounted for most of the NHS costs, but there was an important element of mental health care, estimated at £176 (€259) million. These estimates implied that around 3% of the NHS expenditure was due to the physical injuries associated with domestic violence (DV). Moreover, the total cost of domestic violence to services amounted to £3.1 (€4.6) billion, while the loss of the economy was £2.7 (€4.0) billion. This amounted to over £5.7 (€8.4) billion a year. This included not only physical domestic violence, but also rape, sexual assault and stalking by intimates. An additional element was the human and emotional cost. The study acknowledged that violence leads to pain and suffering that is not counted in the cost of services. This amounted to over £17 (€25) billion a year. Including all costs, the total for domestic violence for the state, employers and victims was estimated at around £23 (€33.9) billion.

As similar study in the US found the costs of intimate partner rape, physical assault and stalking to exceed $5.8 (€4.3) billion each year, nearly $4.1 (€3.0) billion of which was for direct medical and mental health care services (NCIPC, 2003). The total costs of IPV also included nearly $0.9 (€0.7) billion in lost productivity from paid work and household chores for victims of nonfatal IPV and $0.9 (€0.7) billion in lifetime earnings lost by victims of IPV homicide. The largest component of IPV-related costs, however, was health care, which accounted for more than two-thirds of the total costs.

In Canada, the net lost earnings of battered women unable to work because of assault were estimated at more than CAN$7 (€4.9) million per year, according to an estimate in 1995. Cost to the welfare system to support women who had left a violent relationship were an estimated CAN$1.8 (€1.2) billion a year. Costs to the health care system were deemed to be comparable or even higher (WHO, 2005). Further, it has been found that women who have been abused earn 3% to 20% less each year than women who have not been abused (Heise *et al.*, 1994).

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[6] Currency exchange rates accurate as of 4th June 2007 and accessed through www.xe.com

Irish estimates in relation to sick pay, lost productivity and wages point to a cost of €573m each year[7]. Even from a purely economic perspective, because of the huge cost to the health sector it has been argued that cost-effective health service delivery needs to take into account the impact of violence against women on women's health (UNFPA, 1999; WHO, 2002; Butchart *et al.*, 2004).

### *Children and the cycle of violence*

Taking an even longer-term view of this problem in terms of future costs to society, it is important to recognise that the negative consequences of VAW do not affect just the women concerned but also their children, whether they witness abuse or are themselves abused. Child abuse and partner violence are estimated to overlap in 40% to 60% of cases (García-Moreno, 2002). However, even children who witness abuse suffer from this experience and have been found to be significantly more at risk of health problems, poor school performance and behaviour problems (Heise *et al.*, 1999). Moreover, witnessing acts of abuse as a child has also been identified as one of the risk factors for perpetrating abuse as an adult, thus instigating a self-perpetuating cycle of violence (WHO, 2002; Velzeboer *et al.*, 2003). Therefore reducing the societal and individual costs of VAW requires breaking the cycle of violence.

## A health sector response to VAW

The statistics presented above make for very grim reading and provide an indisputable case for the fact that gender-based violence causes immense negative health repercussions both in the short and in the long term for women, their children and society in general. Gender-based violence has therefore been recognised as a key determinant of health. As mentioned at the beginning of this report, The Women's Health Council acknowledges that this problem needs to be tackled in a multi-sectoral way, never forgetting that it is a crime and as such it unquestionably demands the involvement of the justice system. Nevertheless, the Council wishes to advocate the adoption of an integrated and coordinated health sector response to VAW to promote and strengthen the role of the health sector in this historically neglected area.

In 2005 the WHO published a report highlighting domestic violence against women as a 'major contributor to the ill-health of women' and encouraging the health sector to take a proactive role in responding to the needs of the many women living in violent relationships. Moreover, it stated that looking at violence against women from a public health perspective offered a way to capture the many dimensions of the phenomenon (García-Moreno *et al.*, 2005).

Based on international epidemiological evidence, it is also now argued that violence should be conceptualised as a risk factor for health problems, increasing the risk of a variety of diseases and conditions, rather than as a health condition in itself (Brundtland, 2002; García-Moreno *et al.*, 2005). This enables better understanding of the many health consequences, interactions and synergies among them, and potential benefit of different forms of prevention and response. It also points to various possible channels in the health system through

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[7] Personal communication with Christina Sherlock, Women's Aid, on 12th June 2007. This figure was reached by extrapolating from the England and Wales study referred to above.

which to identify women in need of help; not only in A&E departments, but, for example, in psychiatric services, antenatal care services and clinics for STIs (García-Moreno, 2002). As Vos *et al.* (2006) showed in their analysis, IPV is an even greater ill-health risk than many other major risk factors traditionally included in burden of disease studies, such as raised blood pressure, tobacco use and increased body weight. As such, greater and commensurate emphasis should be placed on violence in health promotion campaigns, and service resources allocation. Moreover, as violence leads to many other negative health behaviours, such as smoking, poor nutrition, substance abuse and stress, interventions aimed at these problems will also not succeed without addressing this underlying problem (Campbell, 2002; Victorian Health Promotion Foundation, 2004).

García-Moreno sums up the reasons why we should be looking at violence against women as a health problem thus:

- There is more and more evidence that gender-based abuse is a major cause of disability and ill health for women.
- Health providers are uniquely placed to assist and provide support to victims.
- Violence has a significant impact on health services and on costs which are often unidentified.

The field of public health and health promotion offer useful skills and learning from tackling other health problems that would also helpful in the context of a multi-sector response (2002).

Looking at policy recommendations stemming from national research, the *SAVI* report recommended the adoption of a 'health promotion' perspective on disclosure meaning that people need to see others 'going public' about their experiences and being treated in a fair and reasonable manner as a consequence (McGee *et al.*, 2002). The national study on domestic violence also included detailed recommendations for the Department of Health and Children and the Health Service Executive highlighting the crucial role that health services play in this area (Watson and Parsons, 2005).

### *Health Services*

Despite the importance of the health sector in addressing violence against women, and the key role that it can play in this area, national research to date indicates that the experiences of women who do seek help and support from health professionals is not always positive. Women's Aid has highlighted concerns about the many obstacles within the health system which still exist in relation to women's safety, such as institutional barriers; issues of confidentiality; documentation; appropriate referral; lack of policies and procedures, and a lack of connection to the legal system (Martin, 2002). And they have found that in too many instances women regret that they ever broke the silence surrounding their abuse due to the negative consequences and escalated violence they experienced following disclosure (O'Connor, 2002).

Many reports have now been produced in the international arena on how to maximise the impact of the health sector in relation to combating and addressing gender-based violence (Heise *et al.*, 1999; UNFPA, 1999; WHO, 2002; Velzeboer *et al.*, 2003; WHO, 2005; United Nations, 2006). The list of recommendations overleaf is taken from the most comprehensive analysis of Women's Health and VAW (García-Moreno *et al.*, 2005) and provides a synthesis of general guidelines on how to ensure that the response of the sector is adequate and represents a real support for women in need. This report also includes broader recommendations on how to deliver a national multi-sectoral plan to combat gender-based violence, which are explored at the beginning of this document.

| |
|---|
| 1. Develop a comprehensive health sector response to the various impacts of VAW |
| 2. Address the reluctance of women to seek help |
| 3. Identify the sector's particular strengths in prevention and service delivery |
| 4. Response to VAW to be integrated in all areas of care |
| 5. Avoid over-medicalisation of the problem, especially in relation to mental health |
| 6. Create formal referral procedures and protocols to liaise with other relevant sectors |
| 7. Raise awareness of VAW throughout the sector |

**Table 5.** Comprehensive health sector response to VAW adapted from García-Moreno et al., 2005.

The study also recommended exploiting the potential of reproductive health services as entry points for identifying women in abuse relationships, and for delivering referral and support services. This is because, as noted above, severe physical violence during pregnancy is not uncommon, threatening both mother and unborn child. Furthermore, significant associations exist between physical and sexual violence by partners and miscarriage, abortion, as well as high parity and STIs. In Ireland reproductive health services are mainly delivered through primary health and maternity care, thus these two sectors should be particularly targeted for training and service improvements.

Other areas not directly related but which have been identified as playing a significant role in shaping the range and quality of services available to victims of violence include: abortion, HIV/AIDS prevention; access to HIV/AIDS counselling testing and treatment; treatment for drug and alcohol misuse; working conditions of service providers; general structure of service in terms of their public or private provision, available aid, or fees required (Butchart et al., 2004). All of these areas would need to be incorporated into a comprehensive sector response in order for it to be successful.

## Strengthening the Health Sector Response

As mentioned above, the key to a successful response to gender-based violence within the health sector is to develop and implement an integrated strategy for all areas from policy making to service delivery. Any more detailed and specific recommendations in relation to this integrated approach would require a detailed analysis of the Irish health system, which is beyond the scope of this document. However, after reviewing the literature available, a number of areas can be identified which present particular challenges but which, if addressed properly, could lead to significant improvements in abused women's experience of the health services.

### *Health Professionals' Response*

National and international studies show that while women are often extremely reluctant to contact the police when they experience violence, they often do make contact with health services, either to address their injuries or seeking routine care for themselves or their children. This might be because of their less stigmatising nature, giving health professionals a unique opportunity to respond to violence (Henwook, 2001).

In an Irish survey on domestic violence, it was found that 29% of respondents were likely to report the abuse to general practitioners, the third most frequent choice after family and friends (Kelleher et al., 1995). In a more recent study, over 1 in 6 of those affected had confided in a GP, with about 1 in 20 confiding in a nurse or a hospital doctor (Watson and Parsons, 2005). In relation to sexual violence, disclosure to health professionals was found to be strikingly low with only 6% of respondents having disclosed adult abuse (McGee et al., 2002). Responding to a question on whether they would disclose if something happened to them in the future: 85% of respondents felt they would disclose to a doctor.

These statistics clearly point to the role that health professionals in Ireland could play as the first point of contact for many victims of abuse and how, with appropriate training and an integrated sector response, they could provide ongoing support and an invaluable stepping-stone to empower women to remove violence from their lives. Unfortunately, it has been found internationally that many health workers are reluctant to bring up the issue even when there are clear signs of abuse (Velzeboer et al., 2003). Irish research on sexual violence pointed to a resistance among many health professionals to discuss this problem and that patients were not routinely asked about histories of sexual violence (McGee et al., 2002).

Researchers have suggested a number of explanations for this reluctance. Some have argued that many health providers may feel they lack the time, support from their superiors, or even facilities such as a private space for interviews to deal with violence, even when they have the information and interest to do so (García-Moreno, 2002). Others list the following reasons:

- fears or experiences of exploring the issues of domestic violence;
- lack of knowledge of community resources;
- fear of offending the woman and jeopardising the doctor-patient relationship;
- lack of time;
- lack of training;
- lack of control;
- infrequent patient visits;
- unresponsiveness of patients to questions;
- feeling powerless; and
- not being able to fix the situation (British Medical Association, 1998).

Hence, in order to facilitate health professionals to deal with the situation properly the above concerns need to be addressed. In particular, training, as well as cooperation from all levels of the system, would be essential in order to ensure that all service providers feel confident and follow best practice when dealing with women who experience violence.

It is clear that the role of the health professional is crucial, and the lack of appropriate training could have serious repercussions for tackling VAW. International research highlights the extent to which attitudes of health staff are likely to influence whether women feel comfortable about disclosing violence or not (García-Moreno et al., 2005). A recent study into attitudes towards domestic violence in the European Union show a high prevalence of victim-blaming (Gracia and Herrero, 2006). Health providers often share the same stigmatising attitudes as the population at large. These attitudes can be a serious barrier to improving the quality of care for victims of abuse (Brundtland, 2002). Findings from Irish research on sexual violence also show that those who received help from medical professionals provided mixed ratings. Medical personnel were seen as needing to provide more information regarding other available services and options (McGee et al., 2002). Furthermore, a significant minority (13% of those

who reported adult sexual assault) felt that medical professionals made them feel responsible for their experience of sexual violence, while 20% of them felt that their case was not taken seriously.

Deeply ingrained attitudes toward gender roles have also been found to play a part in health professionals' assessment and treatment of abused women. A recent Dutch study analysed general practitioners' attitudes towards partner abuse and found that there were differences between male and female groups in discussing this topic (Lo Fo Wong et al., 2006). Major contrasts in opinions were seen in:

- the role of sexuality: some of the male GPs stated that denial of sexual relationships by a spouse was a contributing and eliciting factor to male aggression, whereas female doctors emphasised unanimously the humiliation of sexual coercion and the danger of opposing it.
- Children as witnesses: this issue was discussed in female groups only.
- Female doctors talked about emotional involvement with patients and male doctors about keeping distance.
- Female doctors viewed leaving an abusive partner as a process whilst male doctors often experienced frustration at the abused woman's unwillingness to leave the abuser.
- Experiences with abused patients: female doctors remembered more actual cases.
- Practices in managing partner abuse differed between male and female GPs.

As a result of their findings, the authors recommended that male doctors should reflect on the effects of masculine views on sexuality and their reluctance to address the problem whilst female doctors should learn in particular to balance more their emotional involvement and professional attitude.

Moreover, health professionals must ensure that: women are not stigmatised or blamed when they seek help, that they receive appropriate medical attention and other assistance, confidentiality, and that their security is protected (García-Moreno et al., 2005). International studies have found that victims of rape and domestic assault frequently report being humiliated and degraded by the very providers who are supposed to help them. For example, health professionals might not document and collect evidence properly, hence reducing the chances of successful prosecution. They might treat women as hypocondriacs or for nonexistent mental illness. Research in the US found that emergency room doctors are more likely to prescribe tranquillizers and pain medication to battered women than to trauma victims who are battered. This has serious consequences since, by deadening the pain and clouding judgement, tranquillizers can prolong the battering relationship and make it more difficult for women to assess their options or take action to protect themselves (Heise et al., 1994).

### *Training*

Through training and implementing some specific actions in consultations, health professionals can significantly support women who experience violence. Indeed, training on the issue of gender-based violence as well as gender in general has been recommended by the World Health Organisation (Sundari Ravindran, 2006) and should commence as early as possible in undergraduate and postgraduate education as well as through continuing education modules throughout one's career. This training must include not only the clinical guidelines for the treatment of the health repercussions of violence, and the use of appropriate referral paths, but also provide an in-depth analysis of the underlying societal and cultural factors underpinning gender-based violence, and how these variables greatly impinge on women's ability to respond to it and remove it from their lives.

The effectiveness of training was investigated by a survey of 1,000 nurses and 1,000 physicians in 2004 regarding attitudes and behaviours with respect of IPV in Ontario, Canada (Gutmanis et al., 2007). Preparedness emerged as a key construct related to whether respondents routinely initiated the topic of IPV. Inadequate preparation, both educational and experiential, emerged as a key barrier to routine inquiry, as did the importance of the real world pressures associated with the daily context of primary care practice.

The British Medical Association compiled an action list for healthcare professionals in order to ensure that they follow best practice guidelines when treating domestic violence. These are also relevant for other types of abuse; and include:

- privacy and confidentiality;
- questioning;
- respect and validation;
- assessment and treatment;
- record keeping and concise documentation;
- information giving; and
- support and follow up (British Medical Association, 1998)

In 2003, following their Pan-American study on how health care workers can best support women living with abuse, the WHO recommended the following actions:

| | |
|---|---|
| Assess immediate danger | Find out whether the woman feels that she or her children are in immediate danger and consider various courses of action |
| Provide appropriate care | For women who have suffered sexual assault, appropriate care may include providing emergency contraception and treatment for STIs.<br>Unless necessary, clinicians should avoid prescribing tranquillisers and mood-altering drugs since these may impair their ability to predict and react to their partners' attacks. |
| Document the woman's condition | Careful documentation of a woman's symptoms or injuries, as well as her history of abuse, are helpful for future medical follow-up.<br>Documentation is also important in the event that she decides to press charges. |
| Develop a safety plan | Health care providers should review a sample safety plan with the woman and decide together which actions may help in her situation. |
| Inform the woman of her rights | Medical staff should find out what legal protections exist and where women and children can turn to for genuine help in enforcing her rights. |
| Refer the woman to other community resources | The needs of victims generally extend beyond what the health sector alone is able to provide.<br>It is especially useful for health workers to meet personally with others who provide services because providers will be more likely to refer a woman to someone whom they know. |

**Table 6.** How health professionals can support women adapted from Velzeboer et at., 2003.

### *Screening*

As well as increasing the awareness and training of health professionals, another strategy that has been found to be effective is the introduction of routine questioning (Brundtland, 2002). Many studies indicate that women living in violent situations rarely reveal their situation spontaneously to medical personnel, even when seeking help for violence-related problems, such as physical injuries (Velzeboer et al., 2003). Hence, it is not enough to simply wait for women to disclose violence on their own. Experience has shown that many women are willing to talk about violence, but it is usually necessary for health personnel to take the initiative and open the discussion. Survivors of domestic violence who took part in a consultation in the UK stated that they desperately wanted their GP to ask them if they were being abused in the home (Women's National Commission, 2003). Irish research has also shown that women would find it acceptable for their usual GP to ask about violence during a consultation about unrelated matters (Bradley et al., 2002; Paul et al., 2006). A recent study of routine questioning during antenatal care found that women attending a Dublin maternity hospital not only found it acceptable to be asked questions regarding partner abuse in the hospital setting, but also considered that such questions should indeed be asked (McDonnell et al., 2006).

Providers have found that, contrary to their expectations, women are willing to admit abuse when questioned directly and non-judgementally (Heise et al., 1994). Researchers have found that 3 to 4 simple questions are generally enough to screen for physical and sexual abuse. Questions should be asked in person and in private, and the questioner should make sure that the potential abuser is not present to avoid putting the woman at additional risk. Providers can emphasise to a woman that no one deserves to be beaten or raped, and help her think through options for protecting herself. Asking about IPV serves many purposes: it is a powerful statement to the victim. It also removes the veil of secrecy and supports disclosure. Finally, asking also changes social norms and norms in healthcare settings (Coker, 2006).

Even if a woman says 'no', routine questioning underlines the fact that violence is a concern for health (Stark, 2002). Routine enquiry should never be treated as a one-off activity and some studies have found that it may be necessary to ask women about violence on more than one occasion before they feel comfortable discussing the issue (Velzeboer et al., 2003). Enquiry at specified intervals increases the likelihood of a woman feeling safe enough to talk about her abuse. For example, women who develop a relationship with health professionals during a pregnancy might be more open to choosing to disclose abuse once the relationship is well established (Department of Health, 2005).

Screening for violence may be performed in any area of health services. The most important requisites for an effective screening program are privacy, trained and empathetic staff, and the ability to listen and offer some basic counselling (Velzeboer et al., 2003). Because of the emotional demands of dealing with this issue, a support system should also be available for health professionals (Department of Health, 2005).

However, the introduction and practice of routine screening within healthcare settings, and especially primary care, has also been criticised as not being sufficiently evidence-based (Ramsay et al., 2002; Goodyear-Smith and Arroll, 2003; MacMillan and Wathen, 2003). What is recommended is 'diagnostic assessment' or 'selective screening' which involves asking patients presenting with specific signs and symptoms about abuse (MacMillan and Wathen, 2003). The ability of health care providers in all settings to detect signs and symptoms of abuse would thus become even more crucial, and specific training would therefore become even more necessary in order to ensure that questions are indeed asked.

### *Role of Advocacy*

In terms of specific interventions, survivors of violence often mention the need for someone to give them support in dealing with the experience of abuse as well as during their attempt to free their lives of it (Women's National Commission, 2003; Department of Health, 2005). Research shows that the majority of women experiencing IPV are not able to identify themselves and their children as needing treatment and care for the effects of domestic abuse on their physical and mental health, nor to secure access to information and support (Itzin, 2006). Moreover, studies also indicate that on average, a woman will make between 5 and 12 contacts with her local community before getting the help that she requires. Often this is because either she receives no help at all from the agencies/people she approaches, or the information or services they give are contradictory or unhelpful (NDVIA, 2003).
A comprehensive review of interventions aimed at reducing violence and promoting the well-being of women experiencing partner violence carried out on behalf of the Department of Health in England focused many of its recommendations on the need to strengthen advocacy services within health settings (Ramsay et al., 2005). Firstly, the authors stressed the need to improve links between community-based advocacy programmes for women who experience violence and local health services. Secondly, they emphasised the need to improve the availability of advocacy within health services to women disclosing abuse within the setting.

Following on from their study of gender-based violence in an Irish Accident & Emergency Department, Cronin and O'Connor (1993) described the introduction of a 24 hour, 7 day service from a medical social worker designated to A&E Department as essential if women who have disclosed violence are to be given the help they need. They explained that medical social workers can facilitate women by:

- arranging safe accommodation (refuges) for women and their children;
- providing on going support and counselling to the women;
- liaising with community care, in the protection of children directly at risk, and children witnessing abuse;
- linking women into community and support services;
- informing women of their legal options and arranging legal aid; and
- accompanying women and giving evidence in court.

While the role that medical social workers could play in providing immediate support as well as a direct link with community-based support services should not be undervalued, it is important that the wellbeing of women who have experienced or are experiencing abuse should be at the forefront of their remit. A consultation among women in the North East of Dublin showed that women felt that when services did respond to their needs it was more as a result of the fact that the children were perceived to be at risk rather than because of a genuine concern for the women's health (Kelleher et al., 1995).

### *Data Collection*

In order to ensure that the problem of violence against women is properly reflected in health utilisation statistics and therefore in the funds allocated to tackle this significant health issue, it is crucial that accurate statistics are compiled in all relevant health settings. The public health sector worldwide needs to review its health information database in order to incorporate the consequences of gender-based violence for women's health (UNFPA, 1999).

The WHO recommends that surveillance systems for violence should consider collecting, as a minimum, information identifying the type of violence, the sex and age of the victim, as well as the age and relationship of the perpetrator to the victim (Velzeboer et al., 2003). However, it is also important to remember that information systems are only valid if the data are used to improve services. Not only is it a waste of resources, but also it is unethical to collect information or carry out active screening for violence with the sole purpose of information-gathering, if no services are offered in return.

As highlighted throughout the document, Irish data on the interaction of gender-based violence and the health of women in Ireland is extremely scarce and a considerable investment in appropriate data collection mechanisms is required in order to ensure that the response is adequate and commensurate with the problem at hand.

### *Good Practice model to sum up?*

As mentioned earlier, the Pan-American Health Organisation has carried out the most comprehensive case study of strategy implementation within the health sector against violence against women. They also carried out an evaluation of their strategy which was aimed at building an integrated approach to VAW. Their conclusions were the following:

- a systems approach may increase impact.
- Universal screening is not always the golden standard. It may be the long-term aim but other steps may be necessary before it.
- Mere identification is not enough.
- Horizontal integration works best. Integrating violence across different health programmes appears to be more useful than addressing violence as a separate program.
- Caregivers need emotional support.
- The approach to GBV should be holistic.
- Documentation and follow up are central elements to the health sector response (Velzeboer et al., 2003).

These findings provide further evidence that the health sector offers great potential in supporting women who are affected by violence as well as their families. While all solutions need to fit within a local cultural and structural framework, it is now well demonstrated that an integrated approach within the health sector, linking in with other relevant statutory and non-statutory programmes and supports, can be an invaluable asset in improving the well-being of women experiencing abuse. In the evaluation of their project, Velzeboer et al. found that women provided the most positive responses when they felt that the institutions, whether public or private, were genuinely concerned about their welfare, provided emotional support and information, respected and supported them, and showed a willingness to defend their rights and safety (2003). This is the kind of service that the health sector should aim to provide in all its encounters with women who have suffered violence.

## National Policy

While women's organisations and other non-governmental organisations started highlighting the problem of VAW in Ireland in the 1960s and 1970s, the first key policy step into bringing this issue onto the public agenda was the establishment in 1996 of a Task Force on Violence Against Women. In 1997, it published its *Report* identifying specific recommendations for Health and Social Services:

- In a hospital setting, places should be available in an observation ward where women suspected of being victims of violence can be accommodated overnight. Such a procedure would give women time and space to consider their options, rather than immediately returning to a violent environment following medical treatment;
- Health Service providers should adopt written protocols and procedures in relation to domestic violence and rape. These policies should be backed up by appropriate training for front-line staff;
- Posts of Medical Social Worker should be an accepted part of the cadre of staff in the Accident & Emergency Departments of all large hospitals;
- Access to accredited counselling services should be provided for women and children who have experienced domestic violence. The funding and provision of this service should form part of the development of regional service plans;
- Community based health services should have sufficient information available to them to act as a gateway for specialist services on violence against women.

These recommendations remain relevant today and work is ongoing towards their implementation.

Following on from the report, in 1997 a Minister of State was appointed at the Department of Justice, Equality and Law Reform with special responsibility for equality issues, including violence against women measures. The same year, the Minister established a National Steering Committee on Violence Against Women (NSConVAW). A representative from the Department of Health and Children was included in the membership of this Committee[8]. Eight Regional Planning Committees were also established (see below).

In terms of specific health policies, VAW featured in the *Discussion Document* leading up to the *Plan for Women's Health 1997-99* (Department of Health, 1995). The key recommendations in this area focused on liaison between health boards and voluntary organisations providing support and accommodation for women victims of violence, and on the expansion and coordination of other relevant health services. The final document published in 1997 included many other recommendations (Department of Health, 1997), showing that this issue had received significant attention from the public during the intervening consultation. Actions listed for the responsibility of the Department of Health included:

- Playing a full role in relation to the coordination of Government policy by the Office of the Tánaiste and encouraging a coordinated response within the health and personal social services to women who are victims of violence;
- Ensuring the implementation of new powers for the health boards to intervene to protect women against violence spouses;

[8] Currently this representative is sourced from the Health Promotion Policy Unit of the Department.

[9] These were regional health authorities which have now been incorporated into the national Health Service Executive.

- Working closely with health boards, voluntary hospitals and the Irish College of General Practitioners to develop protocols in relation to the recognition of violence against women and good practice in relation of referral of such women;
- Working closely with the training and education bodies in health and personal social services to increase the awareness of professionals of violence against women.

In relation to the then health boards[9], the document recommended that they:

- Develop support services for women and children who are victims of violence; and
- Provide counselling and specialist investigation and treatment services for victims of rape and sexual abuse.

Again, work to implement these recommendations is ongoing and has been taken over by the Health Service Executive (HSE), and the National Steering Committee on VAW operating through national and regional bodies.

Looking at more general policies and strategies, the problem of violence against women did not feature in the *National Health Promotion Strategy 2000-2005* (Department of Health and Children, 2000). However, it was included in the National Health Strategy a year later under "Actions for Women's Health" (Department of Health and Children, 2001), indicating a continued support for measures to prevent domestic violence and to support victims. However, it was again omitted from the new Primary Care Strategy (Department of Health and Children, 2001) despite the key role that GPs play as first points of contact, and from the new Mental Health Strategy (Department of Health & Children, 2006) despite the well-documented serious mental health repercussion of violence on its victims.

Looking at the most recently published government strategy for women, the *National Women's Strategy 2007-2016* (Department of Justice Equality & Law Reform, 2007), the newly established Health Service Executive was identified as the key source of funding for support services in the field of violence against women. A total of €12m was allocated to VAW by the Department of Health and Children between 2003 and 2006 inclusive. Starting in 2005, this allocation was administered by the HSE. In 2007 a total of €18m was allocated to this area, including additional funding for overall service provision, and the implementation of the Review of Sexual Assault Treatment Services[10]. However, despite this significant funding, many services struggle to cope with demand, pointing to the widespread nature of the problem and its historic neglect.

The main initiative in relation to VAW in the *National Women Strategy* was the establishment of COSC, the new executive office to combat violence against women. It is expected that representatives of the HSE and the Department of Health and Children will also be part of this office (Government Information Services, 2007). Apart from some other recommendations reiterating previous and ongoing awareness raising and funding initiatives, a new particularly welcome recommendation was that personnel of all health services be trained to fully understand the impact of sexual, emotional and physical abuse.

Housing is another area that, while not strictly related to health, plays a very significant part in the wellbeing of women affected by violence. VAW has been identified as one of the principal causes of homelessness among women and children in Ireland (National

[10] Personal communication with Paula Mullin, Health Promotion Policy Unit, Department of Health & Children, 25th October 2007

Women's Council of Ireland, 2000; Smith et al., 2001). Hence, housing policy and funding for emergency accommodation, including refuges, play a key role in helping women access safe accommodation. In Ireland, local authorities have the responsibility for the provision of housing from their own resources, including for victims of domestic violence. This area was identified as one requiring further development by the NSConVAW. However, a recent review of housing policy and practice for women experiencing domestic violence found that there is currently no integrated framework by local authorities and the health services encompassing crisis refuge, supported housing and long terms housing needs (O'Connor, 2006). In the review, O'Connor recommends that a centrally devised and agreed set of guidelines should be compiled to ensure that Local Authorities and health services in any part of the country provide women who are or have experienced violence with a consistent and coherent approach to their short term and long term housing needs. For example, greater communication and collaboration is required to assist women who have multiple needs. As mentioned earlier, many women affected by abuse will also experience drug misuse, often used as a coping mechanism against the violence. However, emergency accommodation is often denied to these women. What is required instead is the establishment of collaborative forms of support to meet all the various needs of women who are trying to remove themselves from a violent situation.

Despite all the activity in this area during the last decade, a recent evaluation of the Irish government's record by the UN Committee on the Elimination of Discrimination against Women raised a number of concerns in relation to the prevalence of VAW, low prosecution and conviction rates, high withdrawal rates of complaints and inadequate funding to organisations that provide support services to victims (CEDAW Committee, 2005). Reviews of the sector by NGOs have also expressed anxiety at the lack of progress in the implementation of various recommendations and the lack of a coordinated approach to the problem (O'Connor, 2004; Amnesty International, 2005). It is hoped that the new executive office COSC will bring significant improvements in these areas as well as harbinger the development of an integrated response to include a health sector plan.

### *Local Responses to Date*[11]

Under the NSConVAW, 8 Regional Planning Committees (RPCs) were given responsibility for regional measures. Responsibility for establishing and supporting the RPCs rested with the then health boards, and their work still falls within the remit of the Health Service Executive. The work of the RPCs seems to vary locally and it is unclear how the health sector reform and the establishment of COSC might affect their future. However, some excellent initiatives in the realm of health have originated in the work of all the RPCs.

Over the years the Eastern Regional Planning Committee has produced a number of publications providing information and guidance in terms of referrals, housing policy, refuges and effective responses across other sectors (Breslin, 2000; Kelleher Associates, 2001; Northern Area Health Board, 2004; O'Connor, 2006), reflecting the concentration of both services and

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[11] The information is based on the responses received from key personnel within the HSE. A number of attempts were made to ensure that the most up-to-date and accurate information was obtained. However, in spite of these attempts there may be additional activities which have not been captured.

[12] Personal communication with Kate Walshe, Chairperson, RCP on VAW, HSE West, 10th May 2007.

[13] Personal communication with Dr. Jackie Benbow, Finglas Mental Health Services, 1st August 2007.

population in this geographical area. The Mid West, Western, North Western and Southern RPCs also produced a number of publications both independently and in conjunction with other providers in the health, housing and justice sector among others[12]. A very useful document produced by the Western RCP has been the *Guidelines for Professionals providing services to women and children who are experiencing violence* (2002).

Specifically in relation to mental health issues, the HSE Mid-West Area Adult Mental Services also collated and published a document to assist health professionals screening and dealing with VAW in mental health settings in conjunction with the local RCP (2005). This project also included the development of a screening tool and training module. Following on from the experience in this area, the HSE Dublin-North East is hoping to pilot this approach in their mental health services[13].

The North Eastern Regional Planning Committee has also been particularly active in evaluating its local services and supporting new initiatives in this field (Timoney et al., 2004). In its evaluation of services, the RPC highlighted the need for medical services, and especially GPs, to engage with screening, identification and referral of women who may be experiencing violence (Timoney et al., 2004). As a result of this study, this RPC in conjunction with the newly established Dublin/North East Health Service Executive is now collaborating with the Irish College of General Practitioners to develop GP training in this area in a project also partly funded by Department of Justice, Equality and Law Reform. This is a two-year project with three components:

1. the development of guidelines for the management of domestic violence for primary healthcare professionals and a suite of supportive educational resources;
2. dissemination of the educational materials to GPs and practice nurses and relevant GP and nurse trainers and tutors; and
3. embedding the topic of training and continuing professional development for GPs and practice nurses[14].

The review also recommended that guidelines be produced for local hospitals to identify and respond to violence against women. These were published and launched earlier this year (Health Service Executive, 2007). The work of all these RPCs is ongoing and it is expected to feed into any future work of the NSConVAW and COSC.

With regard to acute services in other parts of the country, due to effectiveness of the St James' Hospital project mentioned earlier in this report, similar projects have been introduced in the A&E Departments of Beaumount Hospital, the Adelaide and Meath Hospital, the National Maternity Hospital, and the Rotunda Hospital. Aims of the programme have been to:

- provide training for the medical and nursing staff and increase awareness and understanding of the different level of abuse;
- develop procedure and protocol for the handling of cases;
- record the number of women who are admitted with suspected or disclosed abuse by their husband, partner or male family member. The name, age, marital status of patient is to be recorded (Kelleher et al., 1995).

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[14] It is expected that this project will be completed by the end of 2008 with the launch of an impact document and a teaching pack. Personal communication with Dr. Naoimh Kenny, Assistant Director, Women's Health Programme, ICGP, 10th July 2007.

The North Eastern RCP's evaluation of service came to the conclusion that most organisations who come into contact with women who experience domestic or sexual violence do not have policies or procedures in place to guide staff in this area of their work (Timoney et al., 2004). This acts as a barrier to women being successful in seeking support and assistance as staff may not know how to react to a woman who discloses abuse and consequently may miss an opportunity to refer her or treat her appropriately.

While it is evident that many worthwhile programmes have been developed locally in particular areas of the country, what is lacking is a national systematic approach by the health sector in providing its own services, as well as linking with other statutory and non-statutory service providers. Again, it is hoped that the newly established executive agency, COSC, will provide the necessary leadership in this development. However, the Department of Health and Children and the HSE will need to spearhead action specifically linked to their sector and develop a nationwide strategy so that women throughout the country can receive the same high quality response when disclosing abuse.

## Conclusion

While the problem of gender-based violence is extremely complex, this review set out to illustrate two key issues specifically linked to health:

- The impact of VAW on the health of women; and
- The health sector response required to address this.

International and Irish research clearly points to the extensive damaging effects that violence has on the physical, mental and emotional health of women, as well as that of their children. These repercussions are not only due to the extent of VAW, which is likely to be much greater than available reports indicate because of its hidden nature, but also because of its significant long-terms effects, which continue long after the violence has stopped. In light of its huge health damaging potential, many international health organisations have declared VAW a 'public health concern' and recognise it as a key determinant of health.

There is also growing evidence that health providers are uniquely placed to assist and provide support to victims of violence, who often access health services but rarely contact the justice system in relation to the abuse they experience. While any response to VAW undoubtedly needs to be inter-sectoral and multi-faceted, strengthening the health sector response to VAW will provide one significant way to improve the situation of women. An integrated sector response is required which addresses violence within all its aspects of policy and service provision, and the World Health Organisation in particular has now developed very strong recommendations for an integrated sector response that could be adapted to the Irish setting. Additionally, some specific interventions, such as improved training for health professionals, screening and access to advocacy services have also been seen to provide some benefits to victims.

However, unless data collection and research in this area in Ireland is strengthened, it will be difficult to implement evidence-based initiatives. Studies conducted in Ireland are still few and do not provide extensive information on the health aspects of VAW. A significant programme of research in this area is required in order to expose the extent of violence, its impact on its victims, how the health sector is currently responding to their needs and what improvements are required in order to improve the situation.

Many developments have taken place at the national and local level since the first Task Force on Violence Against Women was established in 1996. However, the health sector response to women experiencing violence and abuse in Ireland still lacks a consistent nationwide approach. The Women's Health Council believes that within the Health Service Executive, with its strong Population Health approach, and the recently established agency to address domestic violence and related issues, COSC, there is the opportunity to ensure that Ireland, too, adopts a comprehensive health response to this devastating social problem.

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