Violence against women IV

Dilemmas and opportunities for an appropriate health-service response to violence against women

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This article is an overview of the role of health services in secondary and tertiary prevention of intimate partner violence. In it, I review the evidence, which comes mostly from developed countries, on the effectiveness and limitations of in-service training programmes to identify and care for women who have experienced intimate partner violence. I also discuss recent initiatives in developing countries to integrate concerns on gender-based violence into health-care services at different levels, some of the dilemmas and challenges posed by the current approaches to intimate partner violence, and recommendations for future interventions.

Violence against women is associated with many negative health consequences for women.[1] The health sector has an important role, as part of a multisector effort, in primary prevention.[2] However, its main role is in secondary and tertiary prevention, especially in intimate partner violence and sexual violence. Early identification of the problem can reduce its consequences and decrease the likelihood of further victimisation. Health professionals are most likely to inquire about intimate partner violence if there is a physical injury, although even then women can receive treatment without being asked about its cause. Although intimate partner violence is a common cause of injury in women, injury that requires treatment is not the most common outcome of such violence,[3] thus increasingly, emphasis has been placed on early identification of women during antenatal care, other obstetric or gynaecological consultation, primary health-care, and mental health-services. As a result, in recent years, many professional associations have issued guidelines for clinicians on how to identify women who are abused (figure 1).[4–7] This process has often been referred to as screening for intimate partner violence. In-service training programmes and service protocols to implement screening have been developed in many settings. Additionally, some medical and nursing schools have introduced the subject of violence into their curricula. However, several problems have been encountered in attempts to implement screening interventions in health services.

The use of the term screening in this context is potentially confusing. Screening in public health implies the ability to identify a condition with good specificity and sensitivity, and to provide an effective response. None of these conditions are met satisfactorily in the case of screening for intimate partner violence. In published work on intimate partner violence, screening, as traditionally understood in medicine—ie, asking questions of all symptom-free women in a given setting, such as antenatal care—is often referred to as universal screening, although occasionally universal is used to refer to including some women in all units of a health facility. Selective screening is used to describe asking questions of women in whom one has reason to suspect abuse as a cause of presenting symptoms—eg, a woman in antenatal care with unexplained bruises on her stomach.

Some practitioners strongly advise health providers to ask all women who come into contact with them about domestic violence,[4–7] but others argue that in certain settings this approach might not be feasible and recommend selective approaches (S Watts, personal communication). Furthermore, others, especially among advocates of women's rights, challenge the assumption that disclosure of intimate partner violence is always beneficial to women and caution about "individual agents of change working within untransformed institutions" and the risks of unforeseen outcomes of well motivated change.[8] Although there might be general agreement that health services have an important role in addressing intimate partner violence, and that asking

DOMESTIC VIOLENCE GUIDE

Domestic Violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, that adults or adolescents use against their intimate partners. Without intervention, the violence usually escalates in both frequency and severity resulting in repeat visits to the healthcare system.

Screen All Patients For Domestic Violence:

- Talk to the patient alone in a safe, private environment
- Ask simple direct questions such as:
  - Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely.
  - Are you in a relationship with a person who physically hurts or threatens you?
  - Did someone cause these injuries? Who?

The best way to find out about domestic violence is to ask directly. However, be aware of:

History suggesting domestic violence; traumatic injury or sexual assault; suicide attempt; overdose; physical symptoms related to stress; vague complaints; problems or injuries during pregnancy; history inconsistent with injury; delay in seeking care or repeat visits.

Behavioral clues: evasive, reluctance to speak in front of partner; overly protective or controlling partner.

Physical clues: any physical injuries; unexplained, multiple or old injuries.

Take a Domestic Violence History:

- Past history of domestic violence, sexual assault.
- History of abuse to any children.

FAMILY VIOLENCE PREVENTION FUND

Family Violence Prevention Fund, San Francisco, CA, USA

Figure 1: **Screening guidelines for health-care providers**

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women about abuse is generally a good thing, there needs to be greater clarity on who should ask the questions, of whom, in which settings, and after what training. Ensuring women's safety during and after disclosure is of paramount importance. Information is also needed on which approaches are most effective, and what needs to be in place to respond appropriately.

Ensuring safety for women

Some argue that asking women about partner violence in a sympathetic and non-judgmental manner can in itself be therapeutic (figure 2). This approach can signal that someone is interested, that the woman is not alone, and that there is a space in which she can talk about the problem if and when she wishes to do so. Many women, regardless of whether they had experienced intimate partner violence, would welcome health providers asking questions on abuse—even if they chose not to disclose experiences of intimate partner violence.[9,10] However, some women in abusive relationships may fear for their safety when asked such questions.[10] Asking for help can be a decisive moment in the life of a woman, and may be a first step in the process towards leaving a violent relationship. However, this period is also known to be a time of risk, which health-care workers should remember and thus make a woman's safety and security paramount in any intervention.

Providing a safe space in which women can, if they wish, disclose abuse is essential. Privacy and confidentiality must be guaranteed when asking questions about intimate partner violence. This precaution is especially important in resource-poor settings where there might be no proper walls or separate facilities, and partners, relatives, or others might be able to hear the questions. An inability to guarantee privacy and confidentiality can put women at risk and will be a barrier to disclosure since fear of retaliation by a partner, lack of a trusting relationship with a health-care provider, and concern about confidentiality are reasons for not wanting to talk about abuse,[11,12] alongside shame and denial of the seriousness of the problem. How questions are asked can reassure the woman or make her feel revictimised.[13] Thus, learning to ask in a non-judgmental and sensitive way is a critical component of any training.

Confidentiality of information provided is also important. In small communities especially, respect for confidentiality by health professionals is essential, as is ensuring that patients' records are seen only by those who need to see them. Some health professionals who have doubted the ability of health services to maintain confidentiality have consequently been reluctant to ask women about abuse. This concern is sometimes related to fears for their own safety if privacy is breached.[14] Even in situations in which sensitive and caring clinicians ask women to disclose information, once this information is entered into a woman's record it might not always be possible to control its use. Information might be used in ways that are harmful to women by the courts, child protection services, insurance companies, and even by the abuser. Therefore, the means to ensure confidentiality and safety of information is essential, and women should be informed if the health-care provider cannot guarantee this standard.

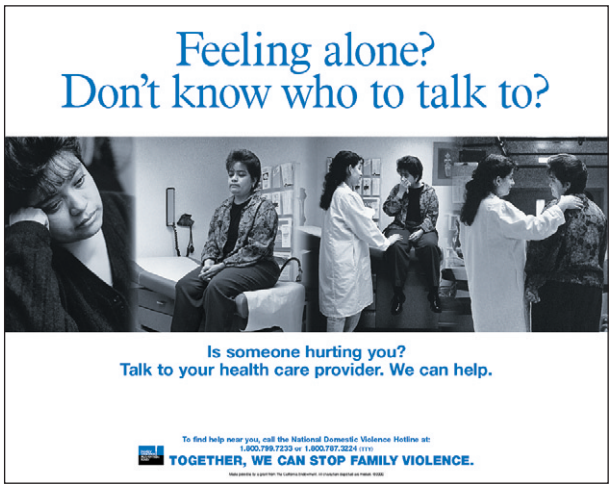

Figure 2: **Poster encouraging people to talk to health-care providers**

Interventions in health-care settings

Reviews of in-service training and screening programmes have shown the lack of formal assessment of such interventions and that there are few data on their effectiveness.[15,16] The few assessments that have been done focus on process measures, such as increases in identification rates, and lack well defined, long-term outcome measures.[17,18] Experiences have been documented almost exclusively in developed countries, particularly the USA. However, initiatives are now also underway in developing countries such as the International Planned Parenthood Federation (IPPF) Western Hemisphere project to integrate gender-based violence into the work of three of their Latin American affiliate countries,[19] a programme to train primary health-care nurses in South Africa,[20] and a UNICEF-supported Woman-Friendly Hospital scheme in Bangladesh.[21]

Evidence from US studies in emergency departments, antenatal, and primary care settings suggests that introduction of protocols or validated screening tools increases identification and documentation rates of domestic violence.[17,22–24] An intervention, which included routine use of questionnaires with questions on domestic violence and placement of posters in clinical areas, designed to improve how questions were asked about domestic violence, case finding, and management in primary care, increased records of health workers asking about violence for up to 9 months and resulted in a small increase in case finding.[25] However, sustaining such gains is difficult. In another study, researchers revisiting an emergency department 8 years after the successful introduction of a screening programme found that identification rates had fallen back almost to their original level.[26] An assessment in 12 midsized hospital emergency departments randomly assigned to intervention and control groups, found significant between-group differences at 18–24 months' follow-up in staff knowledge and attitude, patients' satisfaction, and scores on a system-change indicator, but no significant difference in identification rates of abused women.[27] Even with protocols and training for early identification and referral in place in health-care facilities, this procedure is not done routinely by most practitioners.[28] Physicians cite many barriers to asking women about abuse, including lack of time and support resources, fear of offending the woman, lack of training, fear of opening "Pandora's box", and frustration at the perceived lack of responsiveness of patients to their advice.[28–31] Lack of community resources and referral networks for abused women,[14] and of scientifically assessed and effective interventions, also act as a barrier to physician intervention.[16]

Training in health-care settings

Many problems with implementation of appropriate interventions could arise from inadequate training. Although some efforts[32,33] have begun to integrate violence against women or family violence into undergraduate curricula of doctors and nurses, most health professionals will graduate without having heard about these issues. These issues should be given higher priority since education would provide the basis for later in-service training. A review of primary care, obstetrics and gynaecology, and nursing texts in the USA from 1990–96 found that only nine (38%) of 24 obstetrics and gynaecology, six (35%) of 17 primary care, and two (29%) of seven emergency medicine textbooks included material on domestic violence.[34] Although comprehensive in-service training programmes would still be necessary, such programmes would be improved if these issues were part of undergraduate curricula and basic medical and nursing textbooks included them systematically.

Most in-service training programmes rely on an average of 1–3 h of training,[15] although some curricula being tested in developing countries take 3 days or even longer.[19,20] For many health professionals, these training sessions may be the first time they have heard about the issue, although this may gradually change as the topic becomes incorporated into more undergraduate curricula. Values, attitudes, and prejudices strongly affect perception of the issue, which is often seen by health providers as a non-medical or non-health issue. 1 h of training, although useful to raise awareness of the problem, is clearly inadequate for dealing with such a complex behavioural issue and addressing the values and attitudes of providers—let alone of the health system in which the woman and health provider interact. In communities in which intimate partner violence is the norm, such attitudes might be especially difficult to address. For example, in a study with primary health-care nurses in South Africa, male nurses listed not obeying or respecting husbands and infidelity as reasons that justified beating a woman. The nurses described beating as both a means of discipline and of expressing love or forgiveness for women's transgressions.[35]

Training programmes might also need to address providers' own experiences of violence, which will probably reflect the prevalence of intimate partner violence in the population. For example, in the South African study,[35] more than a third of female nurses had been physically abused and an equal number had been sexually abused.[28] 15% of obstetric nurses in Canada reported experience of physical intimate partner violence and 23% of being afraid of their partner.[36] Similarly, in other studies, a high proportion of physicians, both male and female, reported that they had experienced physical intimate partner violence.[29,37] There is a need to understand better how health providers' attitudes and experiences of intimate partner violence affect their willingness and ability to address violence with their patients, and to address this issue in training.

Classification of domestic violence as a risk factor for various health problems, rather than as a disorder or disease, may make it more acceptable for health practitioners to ask routinely about violence. Clinicians might be more likely to perceive this approach as enabling them to improve their effectiveness, understand better the origins of a health problem, provide better care and treatment, and reduce the costs of inappropriate prescribing, unnecessary tests, and even surgical interventions. However, this approach does not circumvent the need to respond appropriately to the underlying problem if and when it is disclosed by a patient, and this factor remains a major stumbling block in persuading health providers to ask about abuse.

A reason frequently cited by health professionals, particularly doctors, for not asking women about abuse is feeling frustrated and powerless at their inability to "fix" the problem or what they perceive as women's failure to follow their advice or change their situation. An essential part of the training of health professionals, therefore, has to focus on helping them understand the process by which abused women make decisions. As Landenburger[38] points out, abuse is a complex phenomenon, and women do not see their choices as being simply to stay in or leave the relationship. Women may want help to address abuse, but not to end the relationship. Understanding the dynamics of a woman's experience of abuse is helpful in understanding why women leave or stay in relationships.[38] Health providers need to understand the experiences of women and support them in their decisions, while trying to increase their safety. The process of separating from and eventually leaving abusive relationships is a long-term process and asking for help might be one step in this direction.[39] Helping women to regain confidence in their abilities to make decisions can only occur if their decisions are respected.

Gender and power in the health system

The inequalities between women and men that are common in most societies are usually also reflected in the health sector. Warshaw[40] has discussed extensively how the medical model and its institutions restrict the possibilities of responding to women experiencing violence. She emphasises the need for structural transformation as essential for development of an effective health-service response to women in abusive situations. This change is especially important in settings in which violence against patients in health institutions is common.[41]

For training to be effective and enable staff to respond appropriately to the needs of women, it needs to challenge health professionals to address issues of power and abuse in their own lives, at work, and in society. In addition to providing health workers with professional skills, training must help providers to address their values and attitudes towards violence against women and enable them to deal with their own situations of violence. Innovative ways of doing such training should be implemented, carefully recorded, and assessed. Integration of gender concerns into violence curricula is an important element of this process, although studies are needed to show effects on changing attitudes and practices. For example, in Ireland,[42] health providers must complete a 2-day training course on gender issues before being trained on violence against women; in South Africa[20,35] and the IPPF/WHR Latin America programme,[19] addressing providers' values and attitudes towards gender issues forms an integral part of training. This approach to training is essential for long-term change, but has practical implications since training takes longer and therefore is likely to be more costly than standard training. The need for training that can increase effectiveness of health care and have long-term effects has to be carefully balanced with the realities of limited time for participation in training, high staff turnover, affordability, and sustainability.

Context specific models

The level of intervention that is appropriate will vary between settings depending on the availability of human and financial resources and of services to which health workers can refer women. Different levels of response are possible, ranging from posters or other messages

highlighting the problem to more proactive interventions. Even within one health-care setting such as a hospital, there may be great variation between units in what is feasible. Protocols, training, and information should be adapted to the specific needs of each unit (S Watts, personal communication). Models for addressing intimate partner violence developed in the USA, Europe, or other industrialised settings might not be relevant for developing countries or other resource-poor settings and should be carefully assessed for suitability before introduction into a specific context. Experiences of designing interventions in different settings should be shared and reviewed, differences and similarities explored, and assessment methods defined.

Primary health-care and reproductive health-services could potentially be used for early identification of women experiencing abuse. Most women are likely to contact health services for minor illnesses, contraception, or antenatal care. However, in many settings, these health-care providers are already overstretched and have too many responsibilities and too little training or support. Adding one more responsibility or one more subject to their curricula is often ineffectual. Therefore, health-sector responses to intimate partner violence should be adapted to specific situations with allowance for the level of resources and types of external support available in and outside the health sector. Interventions appropriate in a district hospital in an urban area where non-governmental organisations provide support services for women will be very different to those appropriate for a rural community health-centre with no support services. In some settings, rather than starting a screening programme for intimate partner violence, it might be more appropriate for health workers to enlist the support of communities in changing socio-cultural norms condoning violence and developing programmes to empower women and give them information on their rights.

Assessment and outcome measures

Although asking questions about abuse is an intervention in its own right and might be effective, the experience of most clinicians is that an appropriate response is needed when women have been identified as being abused. However, screening might become an end in itself rather than a first step towards making available or providing access to a range of services and responses. In some cases, a list of telephone numbers or possible places for referral can be provided, and in others referral to a shelter or other service may be arranged. However, often there may not be shelters or services to which women can be referred. In these situations, before instituting screening, health-care workers may need to identify individual providers of help, explore the availability of safe spaces in the community, enlist local leaders, and promote development of social sanctions for men who abuse women and of support services for women. Health-care services should have good relations with women's shelters and other non-governmental organisations working on violence, and benefit from these groups' experience. Domestic violence advocates have been brought into health-service sites so that they can respond immediately to the needs of providers and abused women, for example, in the Womankind model,[43] which has helped to ensure an adequate response for abused women and provided support to the provider.

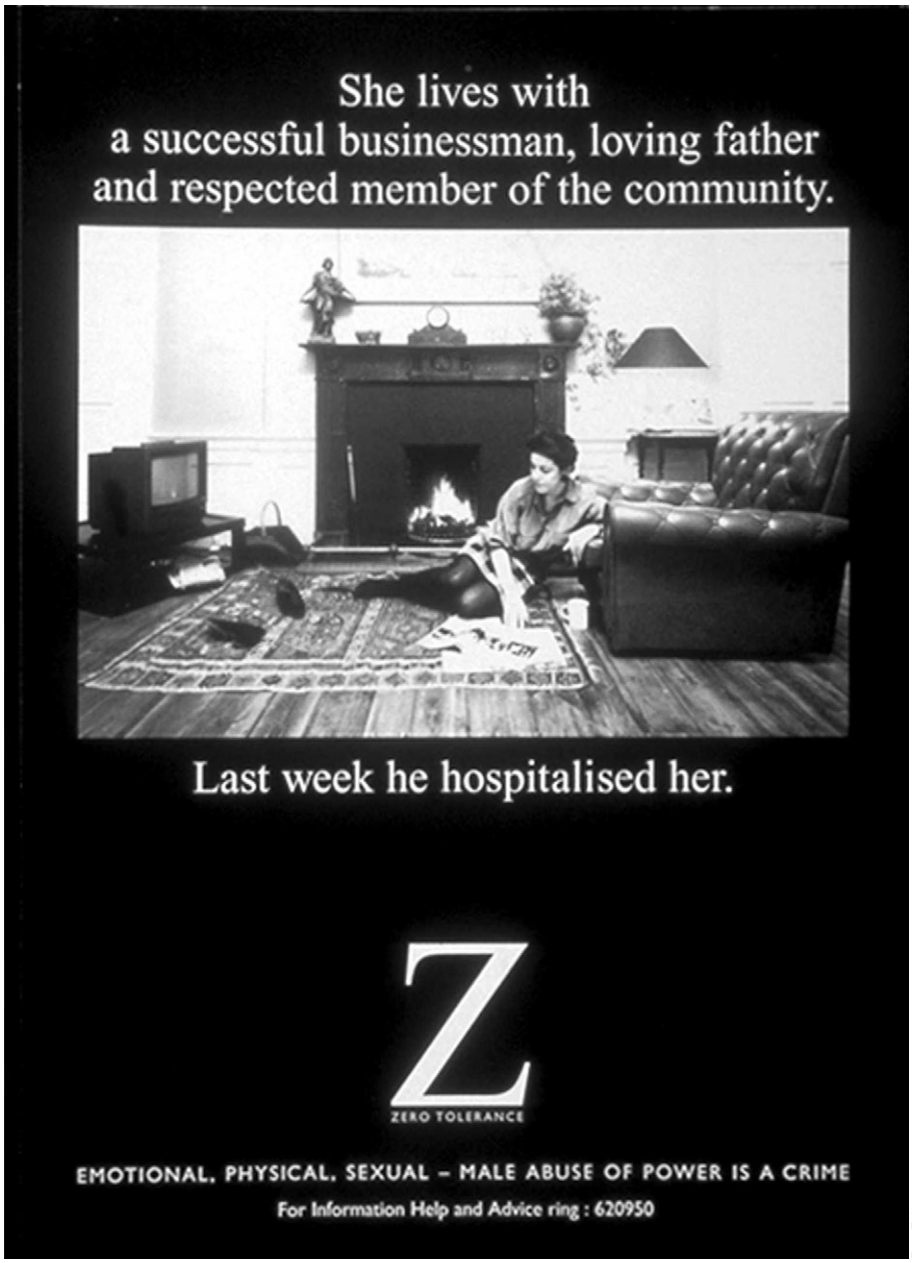

Figure 3: **Poster from the Zero Tolerance Campaign in Scotland, UK, challenging attitudes towards violence against women**

To assess the effectiveness of health-service responses to intimate partner violence, more agreement is needed on what constitutes a good outcome of an intervention. Most assessments of health-service interventions have been restricted to recording changes in knowledge, and at times practice, among health providers.[15,16] Little evidence exists for the effect of asking women about violence on the women themselves, and for how this effect may vary for women in different circumstances. Clearly, the perspectives of abused women need to be studied and taken into account when designing interventions, since they are the ultimate beneficiaries of these actions. Medical outcomes such as reducing death and injury from intimate partner violence need to be balanced with measures of women's wellbeing such as improved self-esteem and quality of life. Long-term outcome measures are also needed, and could include a decrease in use of health services; and improved health, wellbeing, and safety for women and their children. A higher priority should be given to assessment of screening interventions with quantitative and qualitative studies that include in-depth interviews with women to assess which interventions they think work and why.

Conclusions and recommendations

Health services are increasingly recognised as being able to play an important part in addressing the more common forms of violence against women, especially in secondary and tertiary prevention. A consensus is also growing on the need to assess and identify effective health-sector interventions to convince health providers and policy makers of the value of these interventions. Although research on interventions is methodologically difficult and can be expensive, without a concerted effort in this direction we will continue to bemoan the lack of evidence for effective health-sector interventions, without being able to move forward. Actions are needed, such as the establishment of a fund to support intervention research, especially in resource-poor settings where few services exist for abused women. Randomised controlled trials or studies with quasiexperimental designs,[44] which include in-depth analyses of which interventions abused women think are effective and why,[27] are needed to provide an evidence base for interventions.

An effective response from the health sector to women living with violence will include regular training of health workers that addresses their own values and attitudes and provides specific skills, and development of protocols for all relevant clinical settings, not just emergency rooms. Better recording and sharing of experiences across settings is needed, since one model is unlikely to be effective in all settings. Every setting will need specific adaptations of interventions after careful assessment of barriers and opportunities including staffing patterns, and availability of internal and external resources, such as services for referral. The role of the health sector in identifying men who abuse women and in developing interventions for them must be explored. Development of stronger partnerships with non-governmental organisations that have been working with women in abusive situations is likely to enhance the effect and sustainability of interventions. Additionally, integration of violence and abuse issues into undergraduate curricula and basic textbooks for various health providers deserves more attention.

Health-sector response needs to be accompanied with changes in other sectors and other institutions, especially the legal and law-enforcement sectors, and with more concerted efforts to address men who abuse women. Moreover, response must be accompanied by changes in social norms that perpetuate and condone violence against women. The health sector can contribute to public education efforts to address attitudes, behaviours, and cultural norms that perpetuate violence (figure 3). Finally, there is a need to develop and assess further multidisciplinary and community-based responses and models for addressing intimate partner violence in the health sector.

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Uses of error

Individual and evidence-based

Thierry Poynard

I did an uncomplicated, pain-free intercostal liver biopsy on a patient with hepatitis B. The sample showed no necrosis or fibrosis, and the patient was simply followed until 4 years later when the transaminases flared, and I decided to do another intercostal liver biopsy. I went in, using the scar of the previous biopsy as a landmark. This time my needle immediately hit the gallbladder. The patient screamed, the biopsy needle was full of bile and the abdomen became hard. The diagnosis was obvious. We gave the patient morphine and did an immediate laparoscopy, which showed the gallbladder perforation. The surgeon did a peritoneal lavage, and clipped the hole in the gallbladder. The patient was discharged after 48 h in hospital and had no pain during the next 10 years of follow-up.

In clinical research one way to practise auto-critique is to look at the truth survival of original articles. I recently identified 474 original articles about cirrhosis or hepatitis published from 1945 to 1999, and compared the truth survival of my own original articles. Six blind observers classified the main conclusions of the articles as being true, obsolete or false. The truth survival (the percentage of studies not being false or obsolete) was assessed by the Kaplan Meier method. In the year 2000, 285 out of 474 conclusions (60%) were still considered true, 91 were considered obsolete (19%) and 98 (21%) false. At 15 years the survival without false conclusions was 97±3% for my articles versus 94±1% for the other authors; the survival rate without false or obsolete conclusions was lower 81±3% versus 95±1% (logrank=3·99 p=0·08).

The main lesson of these errors is the fragility of our medical certainty. My clinical certainty of a safe biopsy landmark led to a severe complication 5 years later. Nineteen percent of my own evidence-based certainty was obsolete 15 years later and 3% was false. These errors push me to invent non-invasive markers of liver diseases and remind me not to believe in a single scientific truth.

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