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Research Article

Emergency Department Approach to the Growing Global Public Health Problem: Violence Against Women

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Abstract

Violence Against Women (VAW) is a growing problem threatens women's physical, mental and social well-being with a nature differing among cultures worldwide. In this review, we aimed to present prevalance and socio-cultural characteristics of VAW in different countries and make suggestions for Emergency approach.

Keywords: Violence against women; Abuse; Emergency Department

Introduction

Violence Against Women (VAW) is a public health problem, and at the same time, human rights violation all over the world[1-3]. The term 'VAW' involves the infliction or threatened infliction of physical, sexual and psychological/emotional violence, i.e. any type of aggression committed by a person with the intent of inflicting harm or exercising power and control over a woman or girl [4]. Common causes and types of VAW are listed in the table. Violence against women seems to be more often than predicted. According to UN reports, the prevalence of domestic violence in Belgium, the USA, Norway, New Zealand, South Korea, Colombia, and Guinea is 25%, 28%, 17%, 38%, 20%, 58%, and 67%, respectively [5]. In another study by the World Health Organization with 24,000womenin 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania) showed that 15%-71% of the participants were subjected to violence by their husband [6].

In this review, our aim is to identify socio-economical and cultural components of VAW and make suggestions to contribute to appropriate approach in the Emergency Department (ED).

Material and Methods

Scientific databases such as PubMed, Science Direct, Web of Science, and Google Scholar were investigated entering the word "violence against women" and country names from the continents. The search was performed by giving priority to recent (last 3 years) studies in order to compose a review in the light of current literature.Studies regarding domestic violence and violence from a partner were also included into the study. While reviews and researches on VAW were included, case reports were excluded in the review.

Europe

Violence against women in Europe is not only pronounced in low-income European countries such as Lithuania, Estonia and Latvia, also pronounced in economically advanced countries such as Finland, Denmark, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland. This results reveal that low income and the absence of gender equality are clearly not the explanation for the high frequency of victim-blaming attitudes in other European countries [7]. In a study in a gynecological emergency department in Rome, it was determined that there has been little change in the number of cases seen during the 15 year period [8].

In a study, VAW was categorized in to three parts as socio-demographical characteristics, well-being related characteristics and marriage related characteristics, and socio-demographical characteristics were found to be the main cause of VAW [9].

Violence against women is a common public health problem in Turkey, but women were not organized regarding bringing it to the public's attention until the 1980s [10].

As the refugee crisis has arisen in Europe, women forced to migrate from their homelands have become subjects to violence

during their journey and/or on arrival in a destination country [11].

In a study among medical students, it was determined that 11.5% of the women had been sexually assaulted. In the same study, importance of educational programmes was underlined [12].

In a study, women in Spanish universities were investigated in regards to VAW and it was reported that 62% of the students know of or have experienced situations of sexual abuse within the university institutions, but only 13% identify these situations in the first place [13].

In a study, as the most serious consequence of VAW, ratio of death due to violence was found to be 12.9% [14]. A study from Spain revealed characteristics of the intimate related violence victims as minor acts of physical violence towards young adult women, either married or single, with children, unemployed and with a low family income level [15]. This is an important finding since young abused women are known to be three times more likely to suffer psychological distress and have somatic complaints, and use medication [16].

In a study conducted by a questionnaire in Belgium, Iceland, Denmark, Estonia, Norway, and Sweden, it was reported that an overall lifetime prevalence of any abuse was reported by 34.8% of the pregnant women. In the same study, the ratio for physical abuse ranged between 9.7-30.8% [17].

Prostitution in some European countries is also a factor for exposure to violence and consequent elevated mental health concerns [18].

In a study in Romania, controlling behaviour or emotional, physical, or sexual abuse against women by the partner was expressed as having occurred at least once in more than half of the cases [19].

Africa

In Rwanda a study indicated that VAW is increasing by the years [20]. In another study in Kenya, majority of the perpetrators were found to be husbands [21].

According to 2012-2013 Mali Demographic and Health Survey, controlling behavior, childhood exposure to violence, and husband's use of alcohol were reported to be predictors of physical and sexual abuse [22].

In a study, it was reported that most of the HIV-infected, pregnant VAW victims were more likely to be unmarried, substance users, and to score above the threshold for psychological distress and depression in Cape Town, South Africa [23].

In Tanzania the lifetime exposure to violence was found to be 65 % among ever-married or ever–partnered women and the most frequent abuse method was emotional [24]. A study from Ghana revealed that risk of domestic violence was 41% higher for women whose husbands ever experienced their father beating their mother. Other predictors of potential VAW were found to be place of residence and alcohol use [25].

In a study in Nigeria, it was reported that economic reasons were the most common cause of VAW and risk was lower for women with an educated partner [26]. It was reported that VAW during pregnancy is correlated with low birth weight in Southeast Ethiopia [27]. In a study, VAW was found to effect younger women more frequently. The study also revealed the effect of cultural differences on VAW. Moslem women and those who are involved in traditional beliefs were more likely to expose VAW. Additiomally women with low income were more likely to face violence [28]. In their study, Fidan et al. emphasize the importance of gender equality for VAW prevention [29].

America

Prevalence of domestic violence is increasing in the USA [30]. A study in Brazil revealed that most of the VAW were emotional type and VAW resulted in sexual intercourse for fear, depressive-anxious mood and drug use. Additionally, majority of the patients described themselves as black or mixed-race, having less than eight years' schooling, not being in work, having a partner at the time of the study or in the last 12 months, having children,or following a religious practice. In the study, it was reported that 31.3% of the women used of alcohol and one or more unlawful drugs, such as marijuana, crack or cocaine [31]. In a study by Cavanaugh et al., it was reported that VAW was related to sexual violens and high rates of recent sexual violence in this population and foreign-born Latina were more likely to experience violence when compared with those born in the USA [32].

Violence against women is also an important cause of economic burden in the USA [33]. Search for strategic plans emphasizing primary prevention, advancing the science of prevention, translating science into effective programmes stil continue in the US [34].

Australia

In an Australian study, VAW was found to be stronglyrelated to domestic relocation [35]. It was reported that Immigrant and refugee women who have resettled in Australia are known to face barriers accessing services aimed at preventing and responding to family violence [36]. In a study, it was reorted that greater investment in violence reduction strategies is required and economically justified, particularly in young women. While anxiety and depression was reported to represent the greatest proportion of the disease burden attributable to violence, women subjected to violence tended to have other behavioural risk factors for chronic disease and the impacts extend to the whole family, in particular children

who can also suffer health impacts from witnessing violence [37]. In another study, 90% of participants had some education or training about intimate partner violence. Participating midwives generally reported a high level of knowledge about intimate partner violence but held misconceptions about risks and characteristics of perpetrators of violence [38]. Social contact and interaction are particularly appreciated by victims of VAW, as is instrumental support such as financial help, housing, and child care [39]. When speaking of measures in Australia, national bipartisan policies at federal, state and often local levels, an emphasis on prevention and early intervention in health services; innovative interventions to improve the responses of health professionals and the health system responses to violence are required. It continues to be difficult to achieve sustained changes or indeed to support a majority of health care professionals to identify and support women experiencing violence, their children and families [40].

Asia

In Iran psychological, physical, life threatening and sexual violence were found to be 59.7%, 33.2%, 10% and 39.3%, respectively. Significant difference was found between violence and some socio demographic characteristics including: age, years of marriage, occupation, education, smoking, number of children, satisfaction with baby sex and socio economic status [41]. In another study from Iran,the majority of the victims reported experiencing domestic violence and emotional violence was more prevalent than other kinds of violence. Additionally, lower education level, marriage at a younger age, shorter duration of marriage, fewer children, being a housewife, and husband's unemploymenthad a significant relationship with domestic violence against women [42].

Hajnasiri et al. investigatedall the relevant articles on domestic violence in Iran published between the years 2000 and 2015 systematically. Based on the 31 articles, which represent a sample size of 15,514 persons, they estimated the prevalence of domestic violence to be 66% [43].

In Lebanon, Syrian refugee women's health, and specifically their sexual and reproductive health, was found to be severely affected. An increase in gender-based violence and early marriage, a lack of access to emergency obstetric care, limited access to contraception, forced cesarean sections, and high cost of healthcare services, all contribute to poor sexual and reproductive health resulting in violence [44]. The systematic use of sexual violence as a tactic of war is well-documented. Emergent narratives from the Middle East also highlight increasing risk and incidence of violence among displaced populations in refugee camps in countries bordering states affected by conflict [45].

Speaking of violence against women; Female Genital Mutilation/Cutting (FGM/C) may present as cutting, pricking, removing and sometimes sewing up external female genitalia for non-medical reasons. The practice of FGM/C is highly concentrated in a band of African countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen, and in some countries in Asia like Indonesia [46].

In a study in Japan, characteristics of sexual assailants were investigated and common features were found to be Blaming the Victim, Minimization, and Avoidance of Responsibility [47].

In malaysia The prevalence of any form of violence against pregnant women was 35.9%, consisting of: any psychological (29.8%); any physical (12.9%); and any sexual (9.8%) violence. Violence against pregnant women was significantly associated with: women's use of drugs, having had exposure toviolence during childhood, having a violence-supporting attitude, having two or more children; and having partners who were smokers, alcohol drinkers, or had controlling behavior [48]. In Vietnam significant risk was found tobe associated with husbands' behaviour that supports male power (extra-marital relationships; fighting with other men) and alcohol use [49].

In a study in Saudi Arabia, it was reported that there was no significant correlation between socio-demographic characteristics and being abused or not. However, by further analysis we found more sexual abuse among non-working women [50].

A study in China revealed that a husband's gender traditionalism was positively associated with husband-to-wife physical assault only when the husband was coupled with a wife who has non-traditional gender attitudes [51].

In Hong Kong, sexual violence (13.4%) was more frequent than physical violence (11.7%).Women were more likely to be abused by men they knew (13.5%) than by strangers (8%) [52].

A study was conducted to investigate the association between Intimate Partner Violence against women and child morbidity in South Asia. The children of an abused mother were found to be more likely to experienceiseases like fever, diarrhea and acute respiratory infection compared to the children of non-abused mothers [53]. A review of data from 81 countries revealed that South Asia has the second highest prevalence of violence (41.7%) [54].

In Sri Lanka, there appears to be a positive change in the perception of inter-personel violence, which is no longer viewed as an entirely private matter, encouraging more women to seek outside services. However, in moving forward, there is a need to address many of the barriers that prevent women from seeking legal redress and recourse from violence [55].

In Afghanistan, less than half reported abuse to health care providers or were asked by health care providers about the context of their injuries [56].

A study in Saudi Arabia revealed that the overall prevalence of domestic violence was 80.7 and 100.0% for physical and psychological violence, respectively. On studying the reasons for physical violence, half (50%) of the participants reported no clear cause, 19.2% reported failure to adequately care for children (such as cleaning, feeding, and dressing), and 7.8% reported causes related to poor scholastic achievement and couple conflict about appropriate approaches of upbringing of children. Suspicion on wife's fidelity was the most common form of psychological violence (21%) [57].

Emergency Approach and Conclusion

Violence against women is a complex issue involving social, economic and traditional components. Early identification of violence in families andthe application of intervention programs by health and socialservices centers may prevent many of the undesired consequences of this VAW. There is additionallya critical need to determine and deal with the factorscontributing to the emergence of VAW [42]. Etiological factors and characteristics of VAW are summarized in table 1.

Common causes of Violence against women
Lack of adequate legal sanctions
Social status overlooking violence
Inequality among genders
Unprotected human rights
Weak institutional community response
High criminal violence level
High armed conflict
Place of residence
Marriage-related factors
Alcohol/drug use
Childhood exposure to violence
Traditions
Domestic relocation
Lower education level
Marriage in a young age
Unemployment
Supported male power
Common types of Violence against women
Verbal abuse
Physical abuse
Sexual abuse
Emotional abuse
Behavior controlling
Female genital cutting

Table 1: Etiology and types of Violence against women.

In terms of the Middle East, democratization and women's rights can be traced through the recent events. Health service providers, particularly those who work in EDs should be aware of the impact of intimate violence women and be aware of women at risk using the knowledge of maternal characteristics statistically associated with VAW. Detecting violence and screening for post-traumatic stres disorder in clinical settings like EDs may be beneficial for those who suffer from VAW. Assessment by specialists in forensic documentation and interpretation of injuries with the provision of balanced expert opinions for court purposes can result in a number of benefits for the victims and the criminal justice system, including an increase in the rate of successful prosecutions [58,59].

It is also important to improve gender equality through public education on gender relationships, educate women and provide economic opportunities, and eliminate common laws that sustain gender inequality as necessary steps to fight against VAW [29].

The importance of adopting standard violence concepts and promoting the recognition and evaluation of this form of violence amongst health care professionals, criminal investigators and forensic personnel must be emphasized [15,40]. Emergency departments may be the first places where victims contact an official.

Academics and politicians face many challenges in their efforts to reduce VAW. Investing in public education and awareness initiatives and constant monitoring are essential to assess the effectiveness of efforts to change public attitudes for victims VAW [60]. Suggestions to eliminate VAW are listed in Table 2.

To take measures for early detection of VAW
Screening for post-traumatic stres disorder following VAW
Improving gender equality
Increasing economical and educational status of women
Improving laws for VAW
Assessment of the efforts to change public attitude

VAW: Violence against women

Table 2: Suggestions to avoid violence against women.

Most of the women are known to visit EDs several times before the violent episode, often with traumas. Emergency Department medical and nursing staff should be prepared and trained to successfully identify and manage victims of violence.

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