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Review article

EBCOG position statement on violence against women

EBCOG

Violence against women is a major public health problem as well as being a violation of women's human rights [1]. The United Nations defines violence against women as “any act of gender-based violence that results in physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”. In the family, it includes battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation, and violence related to exploitation. Within the community it includes rape, sexual abuse, sexual harassment and intimidation in the workplace, as well as trafficking of women, forced prostitution and violence perpetrated or condoned by the State [2].

In most EU Member States, it is only in the last two to three decades that violence against women has emerged as a major concern that warrants appropriate legal and political recognition. The problem is very prevalent in most societies and is increasingly relevant to clinicians and healthcare systems. As many as one in three women has experienced physical or sexual violence, one in five by a current or previous partner. One in ten women has experienced some form of sexual violence and one in 20 has been raped [3]. However emotional abuse remains the most common type of intimate partner violence [4].

Victims of domestic (or intimate partner) violence (DV) are at increased risk of injury and disability, and may present to clinicians with many symptoms including chronic pain, arthritis, headaches, gastrointestinal signs, vaginal bleeding, social dysfunction, insomnia, post-traumatic stress disorder, anxiety, depression and suicidal thoughts. For many the first incident occurs in pregnancy and DV is associated with a higher incidence of unwanted pregnancy and abortion as well as pregnancy complications and poor outcomes for babies. DV has a deleterious effect on pregnant women's health increasing the risk of delayed entry into care, preterm delivery and IUGR as well as the use of tobacco, alcohol, and illicit drugs. Newborn and children are at increased risk of physical injury and child abuse is more common in families with a history of DV [1,5,6]. Non-partner sexual violence can also lead to serious health consequences, particularly mental health disorders and alcohol abuse. Furthermore, exposure to any form of sexual violence increases the risk of exposure to other forms of violence [7].

The fear of being blamed and a perceived lack of support from families, friends, and services leads to a reluctance to seek help [7]. Furthermore DV is underecognised in women who present to medical services, whether primary or secondary, and physicians frequently fail to make the diagnosis. The injuries resulting from violence are often not well recorded and this has implications for future care and protection [4].

Health care professionals can play a vital role in detecting violence and helping the victims. Comprehensive care will include a supportive and non-judgmental first-line response, a clear agreed care plan and mental health support [7]. Emergency contraception and STI prophylaxis should be considered. No single factor explains why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. A mature cooperation between healthcare professionals, law enforcement officials and NGOs is essential.

EBCOG strongly supports the developing consensus view [8] that all healthcare systems should have programs for the training of professionals as well as clinical protocols to intervene on behalf of patients who experience any type of violence. These protocols should feature prominently in hospital quality improvement programs [9].

Authors contribution

The first draft of this Paper was written by Dr. Kristina Jariene, Lithuanian University of Health Sciences, and peer reviewed by the following: Dr Teresa Bombas University of Coimbra; Dr Rolf Kirschner, Oslo University Hospital; Dr Tahir Mahmood, Victoria Hospital, Kirkcaldy; Prof Jacky Nizard, Université Pierre et Marie Curie, Paris; Dr. Joao Redondo, Coimbra Psychiatric Hospital; Prof Vlad Tica, Constanta County Hospital, Romania.

The final version was approved by the President and Executive of EBCOG.

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