

Primary prevention of violence against women

Hyman I, Guruge S, Stewart DE & Ahmad F

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ABSTRACT

The best mechanisms to prevent violence against women were reviewed in a critical appraisal conducted by the University Health Network Women's Health Program. Several promising primary interventions were identified. These included: educational and policy-related interventions to change social norms, early identification of abuse by health and other professionals, programs and strategies to empower women, safety and supportive resources for victims of abuse, and improved laws and access to the criminal justice system. The policy recommendations emerging from this analysis are presented.

Violence against women is present in every society and culture. The United Nations Declaration on the Elimination of Violence Against Women defines violence against women as 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 of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life.¹ Encompassed in this definition are a wide range of behaviors including: incest and child abuse, rape, dating violence, wife/partner abuse, and elder abuse.

Different etiologic theories have been proposed to explain the causes of violence against women. According to social scientists, violence is hypothesized to stem from the traditionally devalued and inferior roles accorded to women in the family and society. Psychological theories attribute blame to the victim or the perpetrator. Other theories implicate the role of witnessing violence and substance abuse in the etiology of crime.

Between May and September 1999, the University Health Network Women's Health Program was commissioned by the Ontario Ministry of Health Women's Health Council to conduct a critical appraisal of the published literature to identify best mechanisms to influence health risk behavior. Violence against women (e.g., domestic violence, sexual abuse, sexual assault) was included among these health behaviors. Relevant literature was identified using key informants/experts, health databases (e.g., MEDLINE, CINAHL, HEALTHSTAR, PSYCHINFO, PSYCHLIT, SOCIOFILE) and health Web sites.

This review reflects our position that violence against women is a societal and community issue. As such, strategies targeted at individuals and families

are insufficient to address this problem. Rather, primary prevention is critical. This article summarizes our findings regarding the most effective interventions to prevent violence against women in society today.

FINDINGS

Until recently, most interventions in the area of violence toward women were based at an individual level. They included reactive interventions such as crisis management, emergency care, and criminal justice against perpetrators, rather than societal or proactive interventions. However, it is increasingly being recognized that successful interventions in reducing violence toward women in society need to be focused on primary prevention and to involve multiple levels of service providers and government. Although the development and coordination of appropriate services and supports for children and women who have been abused are also necessary, these are considered to be secondary and tertiary prevention and are beyond the scope of this review.

Primary interventions include: 1) education and public awareness, 2) early identification, 3) empowerment and life skills development for women, 4) safety and support programs, and 5) legal policy. Each of these is discussed in the next few sections.

Education and Public Awareness

Early education and awareness raising is critical to reduce the prevalence of violence toward women in society. Successful educational campaigns have targeted children and youth, women, and society as a whole.

The main aims of school educational programs are to change attitudes toward love, sex, and violence, and to provide students with alternative skills to resolve conflicts. As suggested by the health behavior literature, interventions which were peer-based were most promising.^{2,3} Several programs were identified that informed students from junior kindergarten to Grade 12 about family violence. However, fewer programs existed for college and university students.

A broader awareness of risk factors for abuse and available resources within a community helps to interrupt this cycle of violence. For example, programs that trained community-based facilitators to identify and support women at increased risk of violence were successful.⁴ Because many of the roots of devaluing women are based on religious and cultural beliefs, church and community leaders were considered to be in an ideal position to provide support as well as to change social norms regarding violence.

Early Identification

Early identification is critical to ensure safety of women and children, prevent further victimization, and reduce negative health consequences.⁵ Health professionals, especially primary care physicians in rural communities, are often the first individuals to come into contact with abused children and women.^{6,7} An estimated one-third of all women's visits to emergency departments are for domestic violence.^{8,9} Nurses and outpatient physical therapists are in an ideal position to recognize injuries resulting from battery.¹⁰⁻¹²

Yet, many studies indicated that health professionals frequently failed to recognize and effectively intervene in cases of abuse.^{7,13,14} A substantial proportion (20%) of abused women who presented to physicians had previously sought attention for injuries on multiple occasions¹⁵ and only a small fraction (5%) of women's visits to emergency departments for domestic

violence were correctly documented as abuse-related.⁸ Much of the research in this area has been concerned with the identification of barriers to physicians' diagnoses and intervention in cases of abuse. These include:

- Lack of knowledge and training
- Societal misconceptions about abuse, e.g., "abuse is a rare event," "abuse doesn't occur in normal relationships," "abuse is private," "blaming the victim"
- Physician's attitudes, e.g., abuse is beyond the traditional medical model of treating physical symptoms
- Psychological impact of abuse and abuse intervention on provider
- Structural constraints, e.g., assessment of abuse is not routine, no time
- Lack of supportive institutions, e.g., few professional and hospital abuse protocols
- Lack of awareness of community resources
- Lack of interdisciplinary teams and collaborative partnerships with community, legal, and child protective systems to intervene effectively^{7,13,16}

Educational interventions, screening tools, and policy initiatives are all necessary to improve the ability of health professionals to identify, assess, and intervene in cases of family violence. Mandatory courses on violence toward women need to be included in the curricula of medical, nursing and other health professional training programs. A number of model courses exist—for example, the American College of Obstetricians and Gynecologists developed a course on domestic violence for residency training.⁹ Health professionals, especially those working in rural areas, also need to be informed of the social, legal, financial, and medical resources available to assist women and children who have been abused. Screening tools such as SAFE or ALPHA which ask direct, nonjudgmental questions about abuse have been found to increase detection significantly and should be adopted.¹⁶ Because hospitals with policies are more likely to screen and refer abused women and children than those without,¹⁷ hospital accreditation could be made contingent on the implementation of protocols. For example, the U.S. Comprehensive Accreditation Manual for Hospitals Handbook (Section PE 1.8) includes a section that evaluates whether possible victims of abuse are identified using appropriate criteria.

Empowerment and Life Skills Development for Women

Studies have shown that when women are not provided with concrete tools to modify their social or economic circumstances, the recurrence of violence is more likely.¹⁸ The main aim of these interventions is to enable women to become more independent by building self-esteem and increasing skills and resources. A variety of programs were identified that provide education about the cycle of violence and patterns of abuse, assertiveness training, job counseling, literacy and language training, and women's self-defense. To improve the accessibility of programs for women, it was recommended that child care, transportation, and financial subsidies be made available if necessary. It was further suggested that programs be delivered through multiple channels such as schools, workplaces, women's groups, places of worship, and community organizations.

Initiatives that facilitate the development of supportive networks and empower women should also be developed and supported. Given the fact that ethnocultural communities now represent approximately 26% of the population of Ontario, a proportion which rises to 42% for major urban centers, all programs and materials need to be culturally, linguistically, economically, and legally appropriate.¹⁹

Safety and Support Programs

Initiatives to improve the safety of women and children should be encouraged. These include:

- Telephone hotlines. In its trial period, the National Domestic Violence Hotline received up to 10,000 calls per month for assistance and has been reauthorized for an additional 3 years²⁰
- Transportation policies and procedures, e.g., request stops for women at night, designated waiting areas on subway platforms
- Campus community safety programs, e.g., Walksafer Service, Working Alone Service, emergency phones on campus and in underground parking garages
- Community safety and crime prevention programs

Safety measures for abused women and children, such as shelter services (for either victim or perpetrators), house surveillance, monitoring devices, rape crisis centers, and low-income housing certificates for victims who are trying to escape batterers were also recommended.

Legal Policy

Many new policies have been developed to reduce crime and overcome barriers to the criminal justice system for women. These include an expansion of criminal laws to include crimes based on a victim's gender, and requirements for reporting violent crimes against women on college and university campuses.²⁰ However, women continue to face numerous access barriers to the criminal justice system. Postmodern feminist Linda Mills²¹ advocated for multifaceted and multideliberative legal social work systems which recognize that true empowerment for battered women is achieved through the acknowledgement of the woman's need to reconsider and reevaluate the meaning of the trauma in a flexible time frame and a supportive environment. For example, women should have the opportunity to file complaints in informal but confidential and private settings, e.g., with social workers at hospital emergency rooms, in (women-staffed) police stations, on hotlines, and in legal services offices. Restraining orders and legal remedies should be available if desired. Abused women should have a choice of financial assistance (e.g., welfare, credit, alimony, job assistance) as well as other government programs including housing and childcare where required. Finally, communication channels between health professionals, social workers, and the law enforcement system need to be strengthened.

SUMMARY

Until recently, most interventions in the area of violence toward women were reactive rather than proactive. This critical appraisal identified several promising primary interventions to reduce violence toward women in society. These included: educational and policy-related interventions to change social norms, early identification of abuse by health and other professionals, programs and strategies to empower women, safety and supportive resources for victims of abuse and improved laws, and access to the criminal justice system.

Based on this review, several policy recommendations were made to the Ontario Ministry of Health Women's Health Council. These have been grouped under the following headings: multisectoral policies, education of health professionals, routine screening, safety, and community development.

POLICY RECOMMENDATIONS

1. Multisectoral policies
 - Increase the value and improve the image of women in society
 - Increase women's awareness of available resources
 - Increase government support for health promotion strategies including mass media, school-, and university-based awareness, and response programs
2. Education of health professionals
 - Mandatory training in "violence against women" should be implemented in health care provider curricula
 - Continuing education programs should be developed to assist in the identification of victims and to provide appropriate responses
3. Routine screening by health professionals
 - Routine screening for violence/abuse by physicians and other appropriate health care professionals should become a standard of care
 - Routine screening for abuse and response and referral by appropriate hospital staff should be made a requirement for hospital accreditation
4. Safety
 - Establish hotlines to facilitate reports of violence and information about emergency services, especially in rural or remote areas
5. Community development
 - Increase the involvement of community organizations and religious leaders in the development of awareness of the unacceptability of violence against women and encourage support systems for women
 - Promote public and community-based safety and support measures

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