Intimate Partner Violence: A Public Health Problem

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Afrimedic Journal 2011;2(1):34-35

INTRODUCTION

Over the past 15 years, Intimate Partner Violence (IPV) has been increasingly seen as an important public health problem.[1] One of the most common forms of violence against women is that performed by a husband or intimate male partner. Although women can be violent in relationships with men, and violence is also found in same-sex partnerships, the overwhelming health burden of partner violence is borne by women at the hands of men.[2]

Intimate partner violence may be defined as a maladaptive behavioural pattern whereby an individual willfully harms their intimate as a means of gaining or preserving power and control within the relationship.[3] It includes acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion and various controlling behaviours such as isolating a person from family and friends or restricting access to information and assistance. Most victims of physical aggression are subjected to multiple acts of violence over extended periods of time.[1] Physical violence in intimate relationships is often accompanied by psychological abuse and in a third to half of cases, by sexual violence.[1,2]

PREVALENCE OF IPV

While studies in Nigeria are inconclusive, the W.H.O multi-national study on women's health and domestic violence showed that the lifetime prevalence of physical or sexual partner violence, or both varied between 15% and 71% in 10 countries.[4] Partner violence also accounts for a significant number of deaths among women.[1] Studies from a range of countries show that 40%-70% of female murder victims were killed by their husbands or boyfriends, often during an on-going abusive relationship[2].

RISK FACTORS

Certain risk factors have been linked to a man's risk of physically assaulting an intimate partner. These include young age, low income, low academic achievement, involvement in aggressive or delinquent behaviour as an adolescent. Others include a family history of violence, excessive alcohol use, certain personality factors such as insecurity, low self-esteem, marital discord, cultures promoting gender inequality and rigid gender roles.[2]

CONSEQUENCES OF IPV

The consequences of IPV range from immediate and long term health outcomes to economic effects. These include physical injuries leading to contusions, abrasions, trauma-related joint disorders, acute sprains and strains, low back pain, cervical pain and degenerative joint disease. Others are psychosocial / mental disorders - substance abuse, family and social problems, depression, anxiety/neuroses and tobacco use. Some other sequelae are female reproductive disorders including menstrual disorders, antepartum hemorrhage, vaginitis, vulvitis, cervicitis and HIV infection. Urinary tract infections, gastro-esophageal reflux disease, headaches, chest pain, abdominal pains and acute respiratory infections are also consequences of IPV.[5] Economic effects could result from reduced productivity due to lost work days and inability to keep up with job demands.

PREVENTION OF IPV

Efforts to combat IPV have largely focused on support for victims; legal reform and police training; treatment programmes for perpetrators. Other efforts focus on specific settings such as hospitals and other health care settings; schools and communities.[2]

Women crisis centers and battered women's shelters have been the cornerstone of programmes for victims of partner abuse in developed countries.[2] These offer individual counseling, job training and assistance in dealing with social services and legal matters as well as referrals for drug and alcohol treatment. Legal reforms-particularly criminalizing domestic violence, and efforts to reform police practice are also common approaches when effected with significant changes in institutional culture and practices.[2]

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Treatment programmes for abusers typically use a group format to discuss gender roles and teach problem-solving skills. Schools seek to address primary prevention by way of addressing youth violence and bullying as well as promoting healthy relationships. Coordinating councils or inter-agency forums are an increasingly popular means of monitoring and improving responses towards IPV at the community level.

CONCLUSION

The health care setting is very important as many victims may not seek help only from a legal or stand-alone services but seek health services through various entry points depending on the associated health challenges. Such entry points include the primary care clinics, accident and emergency departments and family planning clinics. Health care providers should maintain a high index of suspicion as victims are not likely to volunteer that they are in an abusive relationship. Victims having been identified, should be given support, appropriately counseled and proper guidelines for management drawn up including referral to the appropriate quarters to address the various health challenges and social issues.

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