DOMESTIC VIOLENCE IN THE REGION:
AN INTRODUCTION

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Intimate partner violence is a global public health crisis because of its high prevalence[1] and its association with deleterious physical, mental, and reproductive health outcomes[2]. Efforts to examine the prevalence, consequences, and causes of intimate partner violence cross-culturally have increased over the past decade. Examples include the World Health Organization (WHO) multi-country study on women's health and domestic violence against women, the World SAFE initiative, and implementation of domestic violence modules in some Demographic and Health Surveys (DHS)[3].

Violence is defined by the World Health Organization (WHO) as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development, or deprivation" (WHO, 2002). WHO further categorizes violence into seven types: child abuse, elder abuse, sexual violence, intimate partner violence, youth violence, collective violence, and self-directed violence.

Over the past 25 years those working in the field of violence prevention have brought about a major paradigm shift from an assumption that violence is inevitable to the recognition that violence is preventable, through the application of evidence-based programs to prevent specific types of violence. How could tools of dissemination be used more effectively? How could newer tools such as the internet and mobile technologies be introduced into this field?

Intimate partner violence includes a range of abusive behaviors perpetrated by someone who is or was involved in an intimate relationship with the victim. Although IPV affects men and women as victims and perpetrators[4], more women experience IPV and most studies about screening and interventions for IPV enroll women. Approximately 1.3 to 5.3 million women in the United States experience IPV each year[5,6]. Lifetime estimates range from 22% to 39%[7,8]. The National Intimate Partner and Sexual Violence Survey indicated that 30% of women experience physical violence, 9% rape, 17% sexual violence other than rape, and 48% psychological aggression from their intimate partners over their lifetimes[9]. Costs related to IPV are estimated to be between $2 and $7 billion each year[10].

Intimate partner violence has immediate health effects, such as injuries[11] and death[12] from physical and sexual assault; sexually transmitted infections, including HIV[13]; pelvic inflammatory disease[14]; unintended pregnancy[15]; and psychological distress. Assaults during pregnancy adversely affect the health of pregnant women and newborns[16,17] and IPV is associated with preterm birth, low birth weight, and decreased mean gestational age[18]. Long-term conditions that are associated with IPV include chronic pain, neurologic disorders, gastrointestinal disorders, migraine headaches, and other physical disabilities[19], as well as posttraumatic stress disorder, depression, anxiety disorders, substance abuse, and suicide[20].

Routine screening for IPV in health care settings could identify women at risk and lead to interventions that reduce violence and improve health outcomes. New recommendations from the Institute of Medicine[21], as well as recommendations from professional organizations[22], support screening. Screening by health care professionals is generally acceptable to women under conditions that are perceived as private and safe and when women are asked questions in a comfortable manner, although there is no consensus about the optimal screening setting or method[23].

Studies from Middle Eastern countries indicate a high prevalence of intimate partner violence in the region. According to a nationally representative sample of Egyptian women, at least 1 in 3 was subjected to physical violence following marriage, and these acts were perpetrated almost exclusively by their husbands[24]. In two nationally representative samples of Palestinian women (West Bank and Gaza), over half the respondents reported experiencing at least 1 act of physical violence from their

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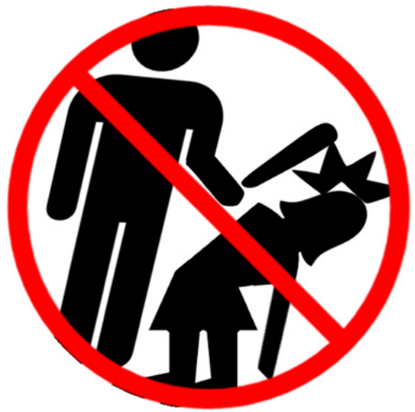
husbands in the 12 months preceding the survey[25]. Among primary health care clinic attendees in Aleppo, Syria, 23.1% of respondents reported experiencing physical violence at least 3 times in the year preceding the survey, most frequently by their husbands[26].
In Jordan, the percentages of women experiencing at least 1 form of control or violence since marriage were: control, 97.2%; psychological violence, 73.4%; physical violence, 31.2%; and sexual violence, 18.8%[27]. These figures demonstrate high prevalence estimates of intimate partner violence in the region.

The prevalence estimate of physical intimate partner violence in these studies is within the range of most sites investigated in the WHO multi-country study (23%–49%), as is the prevalence estimate for sexual violence (10%–50%)[28],[29].
In 2004, the U.S. Preventive Services Task Force (USPSTF) position was that evidence was insufficient to support screening women for intimate partner violence (IPV). Now, an updated USPSTF review[30] shows that screening can accurately identify women who are experiencing IPV. Specific benefits of screening vary by population, but potential adverse effects are minimal for most women. Highlights of the review are as follows:
• **Effectiveness of screening:** One large, randomized controlled trial of screening versus usual care showed that post-traumatic stress disorder symptoms, alcohol-related problems, quality of life, depression, and mental health scores improved in both groups. Screened women were more likely to initiate discussions of IPV with their clinicians.
• **Diagnostic accuracy of screening tools:** Seven instruments (Table below) for detecting past, current, or recent IPV or predicting likelihood of future IPV had high diagnostic accuracy (80% sensitivity and specificity).
• **Effectiveness of interventions to reduce IPV exposure, physical or mental harms, and mortality:** Six trials showed that counseling interventions decreased pregnancy coercion, improved birth outcomes, and reduced IPV in new mothers.



• **Adverse effects of IPV screening and intervention:** Few studies reported adverse effects, which were generally limited to discomfort, loss of privacy, emotional distress, and concern about further abuse.

Table: Intimate partner violence screens with high diagnostic accuracy

1. Humiliation, Afraid, Rape, Kick (HARK)
2. Hurt, Insult, Threaten and Scream (HITS)
3. Ongoing Violence Assessment Tool (OVAT)
4. Slapped, Threatened and Thrown (STaT)
5. Woman Abuse Screening Tool (WAST)
6. Childhood Trauma Questionnaire-Short Form (CTQ-SF)
7. Partner Violence Screen (PVS)

A US government-backed panel on Tuesday recommended doctors ask their female patients about domestic violence they are currently experiencing or may have faced in the past. The U.S. Preventive Services Task Force, an expert group that sets screening guidelines, said there is “adequate” evidence that asking about partner violence - and referring women who need it to counseling services - can reduce their mental and physical harm related to the abuse.

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GBV AND THE CHALLENGE OF HEALTH CARE DELIVERY

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Lebanon has made incremental progress addressing the issue of gender- based violence (GBV) at different levels over the past several years. The tasks and advocacy conducted by the civil society to highlight and deconstruct GBV issues as well as lobby for policy, procedural changes, and services are remarkable in that progress. In 1997, Lebanon has signed the "convention on the elimination of all forms of discrimination against women" but refused some articles (Women's rights monitor, 2000); In 2008, the 40th session of the Committee on Elimination of Discrimination Against Women (CEDAW) noted the achievements of Lebanon which were documented in the 3rd periodic report, namely the implementation of the "WEPASS" project under the Security Council resolution 1325, addressing the issue of integrating GBV services and sensitizing providers to GBV issues in the primary health care centers (PHCs). However, the Committee expressed its concern about the persistence of violence against women (VAW), including domestic violence, and about the absence of a comprehensive approach to VAW. Lebanon was urged by the Committee to exert efforts towards establishing and implementing comprehensive measures to address all forms of VAW, and to enact legislations on it. In addition, special emphasis was put on the need of victims of violence (women and girls) to have access to immediate means of redress and protection, and that perpetrators are prosecuted and punished. This emphasis represents a clear declaration on the need to offer services to victims of VAW. Most recently, a draft of a law on the criminalization of domestic violence was presented by Kafa's and was approved by the Lebanese Cabinet in April 6, 2010. This is expected to fill the gap in the Lebanese code regarding domestic violence by punishing the perpetrator and assuring protection for women and their children. It assures safe housing, enabling environment for reporting and economic security in case of imprisonment of the perpetrator (KAFA, 2010). The draft law is expected to be discussed and passed by the parliament.

In this respect, and in response to global recognition of the seriousness of GBV, and in the context of Lebanon, the interest and need for gender - based violence (GBV) programs and services continue to grow. The diverse and accumulated work around GBV led to the realization that the approach to GBV should be comprehensive and holistic, so that a culture around women's rights and equality is being reared and nurtured in all aspects of governance, civil society, and health services; a fact that was strongly realized by the CEDAW committee. Besides the constitutional, legislative, and social aspects of the GBV, the aspect of service provision to victims of VAW, their follow up, and referral should receive ample attention.

In 2006/2007, and following July 2006 Israeli war on Lebanon, a *"Rapid assessment of women and girls' needs for protection in selected war affected areas"* was conducted by UNFPA in the southern suburb area (*Dahiye*). This study generated sufficient evidence on the need to address protection from and prevention of all kinds of VAW, and the importance of empowering women and strengthening their role in the civil society. This study and many others have been conceptualized within the framework of integrating GBV services within holistic RH services. In specific, many agencies- namely UNFPA- was seeking to link GBV to RH services and to integrate it within PHC services. In 1998, the UNFPA published a Programme Advisory Note, Reproductive Health Effects of GBV, which described the serious long term effects of GBV, including reproductive, mental, psychological, and social consequences. Later on, UNFPA published a guide: "A Practical Approach to Gender-Based Violence" that provided guidance on how to address GBV within RH health services. In 2001, a multi-country pilot project, "Strengthening the Capacity of the Health Sector to Address GBV" was launched. In this project, four health centers were selected in Lebanon for implementation of the programme guide. As part of implementation, health care providers were trained in identifying and referring GBV survivors, as well as screening all women visiting the centers for GBV during a 2 month period. The data revealed the extent to which women visiting the centers are exposed to GBV. Around 35% of those women reported being exposed to at least one form of violence [excluding sexual violence] and 21% knew of a family member being exposed. These women had significantly more health related complaints than non victims. These results parallel other international data in showing the importance of integrating GBV into RH services.

With the presiding situation of crisis and conflict, and the expected waves of displaced subjects, the issue of GBV takes a priority, and namely within clinical setting and management guidelines. Currently there are several ongoing programs and services addressing various aspects of GBV burden, but many of the victims do not know how and where to seek help and treatment, but we still need more readiness and preparation of health care services to deal with GBV issues. In this regard, a pilot project initiated in 2002 by the United Nations Population Fund (UNFPA) aimed at sensitizing health care workers to GBV and assessing the magnitude of this problem in primary care settings (PHC). The study showed that 35% of women presenting to PHC centers were exposed to at least one type of violence. In 2006, UNFPA undertook a Rapid Appraisal of Reproductive Health Services in Lebanon which revealed a significant deficiency in GBV services and lack of awareness of the health care service providers of the resources available to GBV Victims. The attitudes of the providers surveyed in the appraisal towards integrating a service dealing with victims of GBV in PHC centers were conflicting; close to 50% of the providers refused to have this service and to offer it. Providers claimed that such a service is beyond the scope of the PHC services and their own skills and job description.

The existing GBV services cover almost all the geographi-

cal areas in Lebanon (Beirut, Mount Lebanon, North, South, and Bekaa) and are located in central cities and towns, and other accessible locations. It is important to note that this kind of distribution represents sort of a national network trying to attend to all possible victims or potential victims of VAW. At the same time the availability of these services in different geographical areas, allow women and girls accessibility to seek the service they deem suitable and appropriate for the case in question. Being spread out across Lebanon, the services can also collaborate exchange necessary information and on various types and issues from different regions. In these NGOs, health services cover medical consultation that includes assessment, evaluation of general and reproductive health outcomes due to violence. It also includes necessary treatment and referral to assigned centers under the supervision of forensic doctors. As for psychosocial counseling and listening, experienced psychologists and trained counselors provide victims with effective counseling using different techniques, like listening, educating victims, raising awareness on their rights and building capacities and skills on how to manage and avoid situations leading to violence, as well as on how to deal with marital and family conflicts. Drama therapy, recreational activities, and other social events are utilized to serve psychosocial support for victims. The psychosocial counseling service is the most commonly practiced service among all the organization due to the importance that in addressing GBV issues

There are close to ten organizations in the private sector and about 3-4 “functions” in the public sector that are working to provide a kind of comprehensive services for victims of GBV, as well as addressing the Lebanese community at large. Although the early efforts on women’s rights started by the work of female activist and women rights groups in the 70,s and 80,s, the momentum was decelerated by civil unrest (1975- 1990). During the 1990s, and with the beginning of collaboration between the Lebanese government and UN agencies, namely UNFPA through the RH project, the issue of GBV began to surface and was picked up by few organizations. As the international debate began to increase the visibility and importance of GBV, the local civil community was able to echo similar discussions that deconstructed the issue of VAW and facilitated activities addressing issues like: women’s rights, legal and policy status, research and services. The early efforts to include GBV services in the PHC centers (UNFPA, 2004) was not very encouraging as more than 50% of health care providers were not enthusiastic about it. In fact most of them believed that GBV is not their direct concern as a health issue. This “understandable” response can be related to a whole culture around GBV and VAW which is totally lacking in the curricula and training of health care providers, as well as in the society as a whole. This could be one of the reasons that led to the housing of GBV services within several NGOs to be delivered within a package of health/ medical and other services.

Although the role of these service- based NGOs is vital in dealing with the consequences of GBV, it remains unclear to what extent those services are able to screen and prevent GBV incidence; a burden that could have been curbed by health care providers who are expected to screen and investigate about GBV in women presenting to the clinics/ PHC for regular medical consultation or follow up visits. Delivery of GBV services is basically a political and a cultural issue; a laborious transformation is needed at the level of public services (ministries and other institutions) that adopt a gender- based approach within a human right framework. This remains clouded by the controversies of the existing political system in Lebanon, and the attitudes of the health systems and health care providers.