Why we need an SIG on Family Violence

Preamble

The World Organization of Family Doctors (WONCA) gathers a very high number of professionals and organizations, and represents them. The creation of a group of experts on specific care issues with a world-wide scope and under the prestige that comes from WONCA can have a great influence on healthcare organizations, healthcare systems and education systems.

The endorsement by WONCA World to this proposed Special Interest Group will enable the future work of the group to be more organized, systematic and widespread. This endorsement could help ensure more effective implementation than the work of individual expert professionals.

For these reasons the steering group composed of delegates of several networks of WONCA request the WONCA World Executive Committee to approve the creation of a WONCA Special Interest Group on Family Violence.

Background

Since 2004, the issue of family violence has been raised by numerous researchers and practitioners from different backgrounds during WONCA conferences. At the WONCA World meeting in Prague in 2013 representatives of Europrev, the WONCA Working Party on Women and Family Medicine, the Vasco da Gamma Movement, researchers from an informal interest group on Family Violence and the European Union General practitioners (UEMO) met and developed a proposal for the formal establishment of a WONCA Special Interest Group on Family Violence.

Definition of Family Violence

For the purposes of this proposal, family violence includes several forms such as intimate partner violence, violence on children, elder abuse (see below). There are four main kinds of violence: physical, sexual, psychological and negligence (deprivation or neglect).

• Intimate partner violence or abuse (often known as domestic violence) – The World Health Organization defines this as any behavior within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship[i]. An intimate relationship may refer to a survivor's current or previous partner or living companion. It includes both survivors who experience abuse and perpetrators of intimate partner violence – a person who commits, or knowingly allows, acts of abuse, neglect or exploitation to occur.

- Children in violent families – children who are members of a family in which abuse and violence occurs, whether or not they themselves are abused
- Child abuse – any type of abuse that involves physical, emotional, sexual, or economic abuse or neglect of a child under 18 years of age (or according to regional definitions[1]) Adult survivors of child abuse – adults who experienced physical, sexual, or emotional abuse or neglect during their childhood or adolescence
- Elder abuse – any type of abuse (physical, emotional, sexual, economic) or neglect of people 65 years of age or over (or according to regional definitions[2]), either in a residential aged care facility, in private care, or living independently.

Importance to Primary health care

The global lifetime prevalence of physical or sexual intimate partner violence (IPV) among ever-partnered women is estimated by the World Health Organization to be 30.0%, ranging from 37% in Africa and South East Asia to around 24% in Europe and Australia. These figures do not include psychological violence as its measurement is too heterogeneously performed according to available literature. Intimate partner violence occurs at all ages being highest in 35-44 years of age (37%) to still 22% between 65-69 years[ii].

Approximately 13% of all murders are related to physical or sexual intimate partner violence(38% of all female murders and 6% of all male murders) ; suicide increases more than 4 fold (OR = 4.54 (1.78 to 11.61).

IPV has been associated with major adverse health conditions and health risk behaviors. Abused women

use medical services more frequently because of increased rates of emotional health issues (depression, anxiety, suicide, somatization, post-traumatic stress disorder, substance abuse) and physical health issues (chronic somatic complaints, reproductive problems and injuries). Estimates are that up to five abused women per week per doctor attend general practices with multiple symptoms.

General practitioners / (family physicians) need to define their approach to family violence globally since the general practice/family medicine is generally the first point of patient contact with the health care system. General practice/family medicine is oriented to individual patients, their family and the community in which they live. Primary health care provides continuity of care (longitudinal or episodic) and simultaneously manages both acute and chronic health problems, which are commonly associated with family violence. In general practice Family Medicine, common health problems and illnesses are presented in an undifferentiated way, often at their early stage, influenced by cultural, social, psychological, existential and physical dimensions. There is an opportunity for early intervention in the cycle of violence in this setting.

Barriers prevent early detection and disclosure of family violence: on the patients' side (feeling of shame, guilt, fear of consequences, fear of mockery, unresponsiveness, etc.); on the physician's part (lack of knowledge and skills, lack of time, personal attitude, fear of opening Pandora's box, lack of control, infrequent visits, fear of jeopardizing the doctor-patient relationship, feeling powerless, and cultural differences).

These are major reasons for doctors to become sensitive to family violence and to search actively for the symptoms and signs of family violence in their population and define their role with victims and their families.

Complexity and need for broad involvement of WONCA members

Dealing with family violence is a complex task in the current society, with specific characteristics and dimensions regarding medical, psychological, social, moral, geopolitical or historical, economical and juridical aspects. Violence within the domestic environment can break the family structure, which is the reference for personal and in particular children's affective, psychological and social development. A strong role in early intervention, identification, encouraging disclosure of family violence and sensitive response to all family members needs to be played by general practitioners/family physicians, academic institutions, non-governmental organizations and international networks.

Systematic reviews have shown the potentials[iii] and limitations of care[iv]. Recent international guidance is provided by WHO[v].

However many issues remain unsolved: how to best respond to women, men and children in the context of family violence; practice implementation needs further development and monitoring of outcomes in different cultural contexts and for specific risk groups; complex ethical and moral issues are also involved related in particular to confidentiality of disclosure, documenting risks and care, sharing information and reporting to public authorities or law enforcement.

There is a need to further clearly define the general practitioner's / family physician's role about how to deal with family violence. Further there is a need to integrate this topic into training in medical and family practice training of many countries.

Therefore there is a strong need for a Special Interest Group within WONCA to further define and study the primary health care response to family violence, improve the quality of care and training on how to deal with patients and their families suffering from family violence and its consequences.

References and footnotes

1. e.g. 16 years of age in New South Wales, 17 years of age in Victoria (Australia)
2. e.g. in Flanders 55 years of age (Belgium)

i. Krug et al.*World Report on Violence and Health*. Geneva: World Health Organization, 2002.

ii. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non partner sexual violence*. World Health Organization. ISBN 978 92 4 156462 5 (NLM classification: HV 6625) , 2013

iii. Ramsay J,Carter Y, Davidson L, Dunne D, Eldridge S, Hegarty K, Rivas C, Taft A, Warburton A, Feder G. *Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse.* 2009; Cochrane review, 2009, CD005043, DOI: 10.1002/14651858.

iv. Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. *Screening women for intimate partner violence in health care settings*. Cochrane review , issue 4, ,2013; Art N° CD007007; DOI 10.1002/14651858

v. *Responding to intimate partner violence and sexual violence against women*. WHO clinical and policy guidelines, 2013, ISBN: 978 92 4 154859 5