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Policy suggestions to deal with intimate partner violence in Pakistan

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Injury is one of the leading causes of mortality and disability in the world. It is a significant public health problem that is often over looked in the developing world. The burden of non-communicable diseases (including injuries) is increasing and currently accounts for nearly half of the global burden of disease among all ages [1]. Five million people worldwide lose their lives annually as a result of trauma and injury [2]. Globally, among the age range of 15-44 years, the leading cause of fatal injury are traffic collisions, inter personal violence, self harm, war, drowning and exposure to fire.

Intimate partner violence (IPV) is "a pattern of abusive and coercive behaviors, including physical, sexual, and psychological attacks and economic coercion that adults or adolescents use against their intimate partners" [3]. IPV occurs in all countries, all cultures and at every level of society without exception, although some populations (low income groups) are at a greater risk of IPV as compared with others [4]. Prevalence of life time physical and sexual partner violence or either ranges between 15-71% as reported by World Health Organization multi-country study on women's health and domestic violence [1].

One quarter to almost half of all women in the developing world have reported physical abuse by a present or former male partner [5-7]. Domestic violence has been shown to disproportionately affect women of low socioeconomic status [7-10].

Pakistan is the seventh most populous country in the world with a population of 164 million [11]. Violence is a major public health problem in Pakistan [12]. Violence primarily affects wage earners and can include anything from intimate partner violence (IPV) to war. A study conducted to assess the magnitude of IPV in Pakistan indicated that 44% of women experience life time marital physical abuse [12]. Reported risk factors for domestic violence against women include low educational status, low empowerment, poverty, the dowry system, and an addiction to alcohol in males.

In cultures such as the Pakistani society; women are culturally trained to be subservient. They accept callous behavior from their husbands as a part of the norm and at times physical violence directed towards the women is also disregarded [12]. A study done in post partum women of a large public tertiary hospital in Karachi reported 44% of women had suffered a lifetime marital physical abuse and 23% during the index pregnancy [12]. IPV is not openly discussed in Pakistani society. Patients would seldom seek out the help of a mental health expert to cope with their issue [13].

Stages faced when attempting to deal with IPV: (a) the victim does not recognize IPV as an issue and is not interested in change (b) the woman acknowledges the problem and consider possible change (c) the woman intends to modify and has made a plan (d) the woman follows through the plan (e) the woman keeps the new action as part of her daily activity and is taking steps to prevent relapse.

Prevention of abuse to women is a national precedence, [14] as the number of IPV is escalating including abuse during pregnancy. The increase of IPV in women are due to poverty, least opportunities to participate in political activities, low empowerment and autonomy, dowry system in low income countries and substance abuse and alcohol use by partner. These issues should be addressed appropriately. Primary preventive interventions should focus on improving the status of women and reducing norms of violence, poverty, and alcohol consumption [15]. Women who are empowered educationally, economically and socially are most protected. Secondary prevention is instantaneous response to violence

and also includes care before accessing to hospital and emergency department care. Tertiary prevention deals with long term issues such as rehabilitation and reintegration along with the reduction of the recurrence of such abuse in future [16].

We need to put emphasis on a coordinated community response to domestic violence, in order to get any sustainable results in IPV prevention. When we bring the disciplinary training of public health to a problem,, we implement what we have learnt academically and tend to ignore the local context, the needs expressed by the people and their culture.

Stronger partnerships between private/public settings can take place, for example, legal agencies working with health sectors. It should be possible for one organization to provide one aspect of support with concurrent services being offered by another party, with out having the woman run in several different directions, which is cumbersome in terms of the social freedom given to women in a culture. Also, the onus of providing complete services does not lie on one party-the burden is shared. In a resource scarce setting this is valuable. By including the health, legal and social service sectors, as a comprehensive support program, the State will take a step forward in fulfilling an obligation to curtail domestic violence under international human rights laws. Female police should be trained to deal with IPV related problems, so that a female victim could feel safe and protected. IPV violence should be made a punishable crime and loop holes in the laws should be addressed, so that the impetrators do not go free.

Women are reluctant to report their problem to physicians and they, in turn, do not sufficiently investigate the possibility of exposure to IPV with their patients. Hence, Obs/Gyn physicians could be trained in screening for IPV and form linkages in the reporting system of possible case of violence [16].

Technical training is another aspect that could be stressed upon, such as capacity building for women living in low income settlements or in the rural settings. IPV screening could be started and volunteers could be motivated by incentives. Community health workers, lady health visitors and even traditional birth attendants could be trained for screening and counseling services pertaining to IPV. A three day course for these occupations could ensure a certain level of competency in a cost effective way. This community link can, reach the greater and much ignored rural population.

The media is another useful tool that could be utilized, for example, radio and TV could be used to broadcast campaigns that addresses the issue at hand in a way that is acceptable to the population. Furthermore village schools and other places of social congregation within the villages could be asked to provide positive feedback regarding campaigns that a NGO or the government may want to run. Hence social acceptance is guaranteed.

Another issue is education. With illiteracy prevalent in societies where three meals a day are not a reality, education understandably takes a back seat. Hence, projects that provide occupational training in which women are paid to participate in classes could be a model that could simultaneously be undertaken as a subsidy partner scheme, running parallel to the main program. Providing financial incentives would encourage economic independence for women.

All this requires practical actions, awareness raising, advocating for more resources and channelling those resources, more training and capacity building at the national level and taking these steps within the community. Only by making these changes in a sustainable manner and monitoring the progress, would we then be able to say that we have the capacity to replicate these policy changes and apply them to countries that are culturally and economically similar to Pakistan.

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