MWIA TRAINING MODULE ON VIOLENCE

Domestic Violence and Mortality

Definition of the type of abuse[1]

Homicide is the most severe health outcome of violence against women. Like domestic violence itself, intimate partner homicide is a universal phenomenon, independent of education, socioeconomic factors or culture. However, these factors shape the way domestic violence leads to fatality occurs. Intimate Partner Violence (IPV) related deaths include homicides where the victim was an intimate partner of the assailant (e.g. current or former spouse/ girlfriend. Other IPV associated deaths including victims who were not the intimate partner (i.e., family and friends who intervened in IPV, bystanders, and/or first responders)[1]. Domestic violence often begins insidiously and gradually progresses in its severity, to its fatal and largely preventable endpoint, as seen in Cases 5, 18, and 35.

General facts/Prevalence rates

- Fatality arising from violence against women is almost universally under-reported[1, 2, 3, 4].
- Globally, up to 38-50% of murders of women are committed by a male intimate partner[1].
- Homicide is one of the leading causes of death for women under 44 years[1].
- Globally, interpersonal violence accounts for 1.6% of deaths in women and 5.2% in men[2].
- IPV occurs in both male-female and same-sex relationships; however it is most commonly directed at women by men[2].
- A multi-national study showed 40-70% of female murder victims were killed by a male partner, frequently in the context of an ongoing abusive relationship; this contrasts with only 4% of men murdered by female partners in the U.S[3].

Risk factors

- Many factors place women at increased risk of **violent death in the home**, including:
  - Socially isolation (refer to Case 16), immigrants (Case 3), or those in rural settings[1, 2, 4].
  - Illicit drug and alcohol use, especially in developed countries[4].
  - Access to weapons in the US and petrol used to set women alight in India[2, 4].
- **Cultural factors** placing women at greater risk of fatality include:
  - Societies with patriarchal structures and gender inequality, especially those punishing women who disobey family, do not meet cultural expectations or are independent[1, 2, 4].
  - Fanatical interpretations of religion. In such settings, perpetrators, bystanders and victims may view such action as justified, rather than a human rights violation[1, 2].
  - "Honour killings" are undertaken in societies where killing a woman who has been sexually "defiled" (either through rape or voluntary extramarital sex) is thought to cleanse the male partner's (or family's) honour[1]. Honour killings are distinct from domestic violence because they are planned in advance and can involve multiple family members as perpetrators who often face no negative stigma. Globally, it is estimated that 5000 women per year are killed in this way, although cases are likely to be under-reported, because many communities consider it a private matter or falsely report murder as suicides[2].

Prevention

- Informal networks (such as family, friends and neighbours) are usually the first point of contact for abused women, rather than more formal services[1, 2]. Thus education of the general public, as well as increased accessibility to crisis intervention and counseling, housing, medical and legal advocacy, and access to other community services will be key.
- Integration into health services must be supported by trained staff that can detect abuse, intervene quickly, and suggest follow up services[2]. The applicability of this is outlined in Case 5, where the victim denies physical abuse and insists that the injuries are the products of accidents.
- Approximately one in 10 victims of IPV-related homicide experienced some form of violence in the preceding month[2] (Case 5 and 18), which could have provided opportunities for intervention. This makes **early detection** crucial to prevent IPV related mortality.
- **IPV lethality risk assessments** conducted by first responders, such as paramedics, police, and health professionals, have high sensitivity in identifying victims at risk for future violence and homicide[2]. Such assessments may facilitate immediate intervention.
- Integrating early detection measures into **reproductive health services**[2], may also motivate pregnant women (who are at higher risk of IPV) to act given her changing family circumstances.
- A coordinated multilevel approach tailored to the community is essential to reduce IPV mortality. **Primary prevention strategies** involve challenging social norms that condone and thus perpetuate violence against women, and should also include involving **religious authorities** in programmes and **education** for bystanders to intervene[1].
- Given that arguments and jealousy are common precipitating factors for IPV-related homicides, **teaching safe and healthy relationship skills** can assist young persons to manage emotions and relationship conflicts and improve their problem-solving and communication.
- Preventing IPV also requires broader and long term strategies that address **community factors** such as reducing social disadvantage, poverty, and underlying health inequities caused by barriers in language, geography, and cultural familiarity[1, 2, 3].
- State statutes **limiting access to firearms** for persons under a domestic violence restraining order can serve as another preventive measure.
- Increasingly, criminal justice professionals and others practitioners involved in domestic violence cases are using **fatality reviews** as a tool to help reduce intimate partner homicide by examining the events leading up to the death, identifying gaps in service delivery, and improving preventive interventions[2]. They also contribute to IPV research through identifying relevant social, economic, and policy trends that compromise women's safety. Policy changes, criminal justice intervention strategies and political initiatives can then target these factors, enhancing prevention and intervention programs aimed at reducing fatal outcomes of domestic violence.

References

1. Petrosky, E., Blair, J. M., Betz, C. J., Fowler, K. A., Jack, S. P. & Lyons, B. H. (2017) Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence — United States, 2003–2014. *Morbidity and Mortality Weekly Report, 66*(28), 741-746. doi: http://dx.doi.org/10.15585/mmwr.mm6628a1.
2. WHO. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women.* Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/43310/9241593512_eng.pdf
3. Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B. & Lozano, R. (2002). Violence by intimate partners. In *World report on violence and health* (pp. 87-113). Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf
4. Bailey, J. E., Kellermann, A. L., Somes, G. W., Banton, J. G., Rivara, F. P. & Rushforth, N. P. (1997). Risk Factors for Violent Death of Women in the Home. *Archives of Internal Medicine, 157*(7), 777-782. doi: 10.1001/archnite.1997.00440280101009