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Short Note

Violence against Woman in the Developing World through a Primary Care Lens

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Primary Health Care settings are unique in its nature because it deals with an entire family across the life span. Therefore, the primary care doctors may have also a unique opportunity in identifying and responding to cases of **Violence Against Women (VAW)** The different types of VAW experience have a significant negative impact on health and wellbeing not only on the female victim only but also have its trajectories on their family and community.

VAW usually starts even before the girl is born. In 1964, a questionnaire was administered to 380 Western university students, to determine the respondent's preference for a child of a particular sex. When respondents were asked to cite preference if they could have only one child, 92% of the males and 66% of the females preferred their only child to be a boy [1]. Unfortunately; till date gender preference for male children and the undesirability of female children persists in many parts of the world, including nations in Asia, the Middle East, and Africa [2] **Gender preference** affect the survival, nutritional status of daughters, their physical development, and differential access to education and health facilities [3,4]. It also affect the pregnant women mental health in the pre and postnatal period. In China, before the one child policy in the 1960s, the sex ratio at birth (SRB) was 106 boys for every 100 girls. The SRB peaked above 120 boys for every 100 girls in the 2004 and 2007 cohorts [5]. The risk of postpartum depression is increased in Chinese women who give birth to a female infant compared with those who give birth to a male infant [6] Moreover, in the prenatal period, family preference for a male child was associated with prenatal anxiety [5].

Female Genital Cutting (FGC) is practiced in societies with diversified cultures and religions in Africa and Asia, Its long-term complications include pain, and scarring [7]. Some of the women experienced the negative reproductive health effects of FGC [8]. The practice is deeply rooted and continues among immigrants to industrialized countries. The international community views FGC as a human rights violation [9]. The percentage of women who had FGC performed on at least one daughter was significantly lower in 2011 than in 2006 (71.6% vs 77.8%, P=0.04) after the complete ban on female genital cutting in Egypt by 2006 law. However, Egyptians still need to change the attitude of mothers through community awareness besides the law [10].

Although more boys were physically abused and neglected, but more girls were **sexually abused** during their childhood [11]. Women in their 30s and 40s who were injured by their abusers, or abused by a relative, had a greater number of mental health symptoms in adulthood [12]. Although depression risk increases for all sexually abused females, this increase is less dramatic for mothers. Fortunately it means that having children moderates depression among previously sexually abused woman [13].

It is difficult to obtain accurate data on **forced marriage**. The motivations behind it vary and include what families would see as 'positive' reasons. Women may be subject to repeated sexual assault, domestic violence from their partner or extended family they live with [14]. Rates of mental illness and suicide have been found to be elevated in South East Asian communities within the UK, particularly in adolescent girls [15].

In both forced and normal marriage arrangements, women could be prone to **domestic violence (DV) which Comprised also Intimate Partner Violence (IPV)**. Suicide and self- harm could follow domestic violence and commonly by jumping or hanging [16]. A recent review article highlights the Arab researchers' attempts to investigate the mental health impact of violence in their countries before the Arab Spring. The study found that domestic violence attracted most attention after civil strife in Palestine and Lebanon [17]. Another recent article highlights the role of the primary care physician in addressing the problem of DV. Albeit the victims of DV are frequent primary care users, they are infrequently recognized by the doctors [18].

When the Moslem wife reaches her 40sor becomes near to menopause, she would be prone to another sort of violence due to the attitude of some Moslems to have another wife. **Polygamy** is banned in some Moslem countries, yet its practice persists and could be associated with women's marginalization and mental health sequelae. Polygamy is associated with poor women mental health regardless of their socioeconomic position and education [19].

A recent study compared the number of articles on child abuse to **elderly abuse** and found that the ratio child/elderly is equal to 1/0.04. The authors concluded that there is poor research interest on this phenomenon [20] Besides the insufficient research on elderly abuse screening and prevention, there is a lack of consistency in definitions between researchers

[21]. Elderly women often encounter more challenges compared with men and are more prone to abuse. Predictors of abuse in a Nigerian study were urban residence, financial dependency, and a high level of educational attainment [22].

Besides the physical complications of VAW across her life cycle, the **psychological impact** was summarized in a table by Forsdike et al. [23]. It depends actually on the age of the female victim. During childhood, they encounter insomnia, bed wetting, anxiety and depressive symptoms and suicide ideations. Being adults, they encounter somatoform disorders, post traumatic stress disorders (PTSD), substance abuse, eating disorders besides depression and suicidal ideations. For the elderly victims, depression, anxiety and insomnia are there. The author also summarizes what the general practitioners need to understand naming it the **9 steps for intervention or the 9Rs**. The PHC doctor should be oriented about his **Role** with victimized patients, and express his **Readiness** to listen and manage them. Doctors should be trained to **Recognize** symptoms of violence keeping in their mind its **Risk** factors. Usually the patient need to be **reviewed** several times after his first visit or even being **Referred** to higher levels of care. Doctors should be **Reflective** in their management with a **Respecting** attitude to their patients [23].

The **ecological model for family violence prevention across the life cycle** was displayed in a published paper. All types of violence are interrelated together. Risk assessment and abuse screening is recommended. Collaborative research is also a crucial issue. Interventions should be on many levels of them is the educational, health services, community and society levels [24]. Besides the primary care doctors, **emergency doctors** also have an important role in reducing violence through medical education, research, surveillance, public education, advocacy, and clinical practice [25].

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