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EDITORIAL

INTIMATE PARTNER VIOLENCE: DOES OUR RESPONSE TALLY WITH THE AVAILABLE EVIDENCE?

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Historically called "domestic violence" the term "intimate partner violence (IPV)" describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner (1). The condition is a serious, but preventable public health problem that affects millions in the westerns world (1,2). A World Health Organization (WHO) multi-country study on women's health and domestic violence undertaken in developing settings, including Ethiopia, confirmed that physical and sexual partner violence against women is widespread, prevalence varying from 15-71% (2). The few reports on population-based surveys in Ethiopia have shown that the prevalence of IPV among married women is high and that, in their lifetime, three out of four women experience at least one incident of IPV(3,4). The available evidence indicates that IPV is often obscured within general life events, but could exert a wide range of consequences, and calls for urgent attention at all levels of societal hierarchy including policymakers, stakeholders and professionals to alleviate the situation (2-4).

In spite of an apparent global increase in the magnitude of the problem, current evidence comes largely from industrialized settings. Methodological differences limit the extent to which comparisons can be made between studies and there is paucity of reports showing the size and health outcomes of IPV in developing settings. While there are many challenges to collecting high quality epidemiological data on IPV and to establishing public health surveillance systems in these settings, the lack of a standard case definition for IPV remains the most outstanding one. First and foremost, this has possibly thwarted efforts to collect relevant information in a systematic fashion. It has also rendered the comparability of IPV and associated health-related outcomes reported from different sources such as comparisons by geographic areas, or the ability to compare data over time difficult (5). Moreover, lack of a consistent and standard definition would pose critical challenges to monitoring trends over time.

A combination of individual, relational, community, and societal factors contribute to the risk of becoming an IPV perpetrator or victim (6). Understanding these multilevel factors can help identify various opportunities for prevention. Data from developed settings emphasize some, but not all, of the consequences of IPV. Besides death, physical violence by an intimate partner can be associated with a number of adverse health outcomes - direct physical injury (7); result of the impact of IPV on organ systems through chronic stress or other mechanisms (8); and associated with a variety of negative health behaviors (7,9).

The report in this issue of the Ethiopia Medical Journal (EMJ) suggests that IPV is associated directly or indirectly with acquisition of human immunodeficiency virus (HIV) infection among women by increasing exposure to risky sexual behaviors (10), It also identified some of the most consistent factors associated with a man's increased likelihood of committing violence against his partner(s). The report, based on similar previous observations in-country and elsewhere in other similar setting, highlights the need to include IPV prevention and control interventions in the national response against the HIV epidemic. The report also alludes to the need for a broader look into IPV prevention and violence against women in general.

Preventing IPV requires reaching a clear understanding of the driving factors, coordinating resources, and fostering and initiating change in individuals, families, and the society at large, and ultimately reducing its occurrence by promoting healthy, respectful, non-violent relationships (11). However, the solutions are just as complex as the problem and there is a lot to learn about the metrics of IPV prevention and delivery of care to the victims. A health-care provider is likely to be the first professional contact for victims of IPV, including sexual assault. Evidence suggests that women who have been subjected to violence seek health care more often than non-abused women, even if they do not disclose the associated violence. They also identify health-care providers as the professionals they would most trust with disclosure of abuse. Guidelines are evolving to equip healthcare providers with evidence-based direction as to how to respond to IPV, including sexual violence against women (12).

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Available evidence suggests that IPV is a major public health problem driven by multiple and complex socio-cultural and economic factors. It appears that much more epidemiological data is required in Ethiopia in order to build a comprehensive understanding about the determinants of the problem and develop acceptable, effective and cost-efficient responses. There is an urgent need for a standardized definition and systematic collation of published information to inform the customization and further development of the evolving international guidelines. This may also help in drawing due attention to IPV, and violence against women in general, at all level and by key stakeholders- policy makers, training programs, care providers, and the public.

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