STRUCTURAL VIOLENCE AND ITS IMPACT ON WOMEN’S HEALTH
Policy Brief

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Civil Society across the Commonwealth, supported by the Commonwealth Foundation, host an annual policy forum addressing the theme of the annual Commonwealth Health Ministers’ meeting (CHMM) which is held each year in Geneva on the eve of the World Health Assembly. The 2017 Commonwealth Civil Society Policy Forum will be held Saturday 20 May, 3.00 - 6.30 pm, at the Starling Hotel in Geneva, and will address the following issues:

- Funding models to finance universal health coverage;
- The politics of wellbeing;
- Women’s voices on structural violence in health care.

Through the policy forum, Commonwealth civil society comes together to discuss, debate, and develop a consensus position or set of positions and recommendations and/or a declaration for action on the policy issues under discussion. These positions or requests for action are then presented by civil society to Commonwealth Health Ministers at their meeting.

Three policy briefs have been developed on the three issues outlined above. These policy briefs will then be shared with civil society across the Commonwealth through an online survey to gain input into and consensus about proposed recommendations and action to be presented to Commonwealth Health Ministers at their meeting.

INTRODUCTION

Equitable access to health care and other social services is a shared aspiration across Commonwealth countries. For most countries however, the deficits in health policy and practice results in patterns of inequity and exclusion that have contributed to structural violence\(^1\) against its socially marginalized citizens - women in their diversities in particular. Many of the main contributing factors to women’s morbidity and mortality in both rich and poor countries have their origins in societies’ attitudes toward women, which are reflected in the structures and systems that set policies, determine services and create opportunities\(^2\).

Despite considerable progress on health outcome indicators over the past three decades, societies are still failing women at key moments in their lives. Not everyone has benefited equally from recent progress and too many girls and women are still unable to reach their full potential because of persistent health, social and gender inequalities and health system inadequacies. These failures are most acute in poor countries, and among the poorest women in all countries of the world. Women in their diversities (especially those living with HIV) of age, health status, sexual orientation, and disability, have experienced negative health outcomes core to their existence and dignity as human beings.

The notion of structural violence as a form of violence against women arises from the human rights principle by which all governments have the duty to protect, promote and fulfill human dignity, life and health. Structural violence is an “avoidable impairment of fundamental human needs”. Structural violence is a major contributing factor for premature death and unnecessary disability.\(^3\) This violence is often a result of poor Government’s health policies and practices that harm or fail to protect its citizens from avoidable violations, deaths and injustices;

\(^1\) Structural violence refers to systematic ways in which social or institutional structures harm or otherwise disadvantage individuals.
\(^2\) WHO- Women’s Health Report 2011
\(^3\) Johan Galtung, Violence, Peace and Peace Research - 1969
policies and practices which are subsequently institutionalized by health administrators, financial/budget decision makers, medical doctors, and other health workers.

Evidence from several Commonwealth countries confirms that there is gross impact of violence that affects women resulting from unjust social, political, and economic systems. The consequences of these structural inequalities in turn affect health care utilization patterns. This policy brief will limit its position and evidence to four thematic areas of structural violence, focusing on how structural violence impacts on vulnerable and marginalized women broadly but, place an emphasis on the evidence and experiences of women living with HIV.

HEALTH INEQUITIES AND UNRESPONSIVE SOCIAL DETERMINANTS FOR HEALTH

Social determinants of health are the conditions in which people are born, grow, live, work and age, shaped by the distribution of money, power and resources at global, national and local levels. A disproportionate burden of ill health and social suffering amongst vulnerable women has been occasioned by deficient health systems particularly primary health care systems (PHC) in turn leading to structural inequities and violence. Progress in improving enabling environments for health and increasing access to the care and services that could make a difference to women’s health is patchy and uneven across the different regions⁴.

In developing countries, mostly poorer Commonwealth Africa and Asia, PHC is not as accessible or effective; people delay seeking help; rely on emergency care; and lose the benefits of continuity of care. Evidence suggests there is much higher maternal mortality in poorer regions due to a lack of effective PHC: low family planning availability or use; limited access to antenatal care; inadequate HIV services; long distances to facilities; lack of basic information; and lack of emergency obstetric care, among others.

GROSS HUMAN RIGHTS VIOLATIONS AND DISCRIMINATION

All Commonwealth countries are party to at least one human rights treaty that addresses health-related rights. Yet harmful laws, policies and practices routinely interfere with access to health care and increase vulnerability to ill health, particularly for women, poor, marginalized or criminalized populations. Despite some advances in gender equality over the past several decades, women have taken the brunt of human rights violations and endured disproportional suffering as a result. They have paid dearly with their health and their lives.

(a) Forced sterilization: Like any other contraceptive method, sterilization should only be provided with the full, free and informed consent of the individual. However, in some countries of Asia and Africa, people belonging to certain population groups, including people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, transgender and intersex persons, continue to be sterilized without their full, free and informed consent. Data from sub-Saharan Commonwealth Africa supports this contention. The voices of 40 women living with HIV who experienced forced sterilization were documented in Kenya in 2012⁵ and more than 20 cases were documented in Uganda⁶ According to the 2013 PLHIV Stigma Index report in Uganda, at least 11% of respondents claimed a health care professional coerced them into considering sterilization because they were diagnosed HIV positive⁵. A similar study in Kenya found 9.6% of respondents reported they had been coerced into considering sterilization⁶. The PHA stigma indices that were carried out in Uganda, Kenya, Tanzania, South Africa and Nigeria found that women living with HIV were forced and/or coerced into sterilization, termination of pregnancy, and use of FP options, without their consent (ICWEA, 2015).

(b) Stigma discrimination and poor attitudes in health care facilities: Health care is one of the many settings where women living with HIV experience violence, abuse and lack of respect for their rights. A UK study carried out

⁴ WHO- Women’s Health Report 2011
⁵ “Robbed of Choices: forced and coerced sterilization of women living with HIV in Kenya, 2012
⁶ Violation of Sexual and Reproductive Health Rights of Women Living with HIV in Clinical and Community Settings in Uganda, ICWEA June 2015
⁷ The People Living with HIV Stigma Index Uganda Report, 2013
⁸ The People Living with HIV Stigma Index Kenya Report, 2011
by Positively Women found that while 96% of women living with HIV surveyed were registered with a general medical practitioner (GP), 60% would not tell their GP about their HIV status because of the fear of judgmental treatment or breaches of confidentiality, while 33% felt their HIV status prevented them from accessing good GP care. Sex workers living with HIV, drug users living with HIV, and young women living with HIV, may face particular forms of violent treatment in the health care setting.

(c) Other Reproductive health rights violations: Studies by the World Health Organisation (WHO) and UNFPA show that disruption, denial, and/or unavailability of contraceptive supplies; judgmental or biased treatment based on reproductive status or choices; coercive FP counselling; forced sterilization; verbal or physical abuse by providers and health center staff, pose barriers to reproductive health care access. Studies by the International Community of Women living with HIV and AIDS (ICW) in India found that HIV positive women attending reproductive health services were pinched, punched and scolded by health workers during procedures because of their HIV status. Health service violence against women living with HIV also occurs in the labor ward. Women living with HIV were being told to wait until all other women had been delivered: ‘If I touch you and then I deliver other women’s children, the virus will be transmitted to them. I just do not care what you go through’. These are part of the many reproductive health violations that women living with HIV undergo every other day in both developed and developing countries.

HIGH COST AND INACCESSIBILITY TO HEALTH CARE

A report entitled “Health Care Costs Are a Barrier to Care for Many Women” showed that unmet health care needs because of cost are more common among women than men (40.2% of women and 29.5% of men report cost-related unmet needs); women are also more likely than men (20.6% versus 16.6%) to report that they and their families had problems paying or were unable to pay medical bills; and young, low-income and uninsured women are more likely than other women to report unmet needs for health services because of costs. Health insurance coverage does not eliminate cost-related barriers to care. Women face higher health costs than men due to their greater use of health care yet they are more likely than their male counterparts to be poor, unemployed or else engaged in part-time work or work in the informal sector that offers no health benefits. Evidence from several countries shows that removing user fees for maternal health care, especially for deliveries, can both stimulate demand and lead to increased uptake of essential services. One of the keys to improving women’s health therefore, is the removal of financial barriers to accessing health care. Removing financial barriers to care must be accompanied by efforts to ensure that health services are appropriate, acceptable, of high quality and responsive to the needs of girls and women.

GENDER BASED VIOLENCE (GBV)

Direct GBV is mostly interpersonal violence against women that includes physical, sexual, psychological, and economic violence. GBV is a result of social norms, cultures and systems that have embraced it and seriously affects all aspects of women’s health - physical, sexual and reproductive, mental and behavioral health. Health consequences of GBV can be both immediate and acute as well as long lasting and chronic; indeed, negative health consequences may persist long after the violence has stopped. Rape and domestic violence account for 5% of the healthy life years of life lost to women age 15 to 44 in developing countries. A recent study published by the WHO in 2013 systematically reviewed studies providing data on health effects of physical and sexual intimate violence.
partner violence and non-partner sexual violence against women. The review identified, among others, the following consequences of violence against women: Globally, 38% of all murders of women are reportedly committed by intimate partners; out of all women who experienced physical and/or sexual violence by an intimate partner, 42% experienced injuries, as a result; Compared to women who have not experienced partner violence, women survivors of such violence face a 16% higher risk of having a low-birth weight baby, are more than twice as likely to have an induced abortion, and are more than twice as likely to experience depression. In some regions, women who experienced sexual IPV are 1.5 times more likely to acquire HIV and 1.6 times more likely to have syphilis, compared to women who have not experienced IPV. While health consequences of GBV are similar across low, middle- and high-income countries, the nature or severity of the effects of such violence may vary according to context-specific factors, such as poverty; gender inequality; cultural or religious practices; access to health, legal and other support services; conflict or natural disaster; HIV prevalence; and legal and policy environments (WHO PAHO 2012a).

POLICY RECOMMENDATIONS

1. Structural violence, even when it is indirect and invisible, has gross effects on the lives of women, especially vulnerable women. Commonwealth Ministers of Health are called upon to declare an end to all forms of violence, both interpersonal and structural, identify and commit to instituting mechanisms to address gender based violence around a clear and coherent agenda, ensuring social cultural systems, laws and policies are preventing violence and influencing violence free systems and communities.

2. Removal of financial barriers to accessing health care is key to improve women’s health. Removing financial barriers to care must be accompanied by efforts to ensure that health services are appropriate and acceptable of high quality to the need of girls and women. Commonwealth Ministers of Health are therefore called upon to work with their government and remove all financial barriers to health with special focus on women and girls.

3. There is need to focus on the PHC sector, so that systems are better positioned to meet the unique needs of vulnerable women in terms of access, comprehensiveness and responsiveness and building resilient health systems that address all social determinants of women’s health. Commonwealth Ministers of Health are therefore called upon to ensure that there is substantial investment in PHC that will results in: continuous availability of essential drugs; prevention services for endemic diseases; immunisation services; treatment of communicable and non-communicable diseases; maternal and child health services; nutritional services; health education; and water and sanitation services.