

POLICY BRIEF

Structural violence & its impact on women's health

About this policy brief: Civil society organisations 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. Through the forum, stakeholders come together to discuss, debate, and develop a consensus position or set of positions and recommendations with 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.

The 2017 Commonwealth Civil Society Policy Forum 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.

Three policy briefs have been developed on these issues. The briefs have been shared with civil society across the Commonwealth through an online survey to gain input into and consensus on the proposed recommendations and action to be presented to Commonwealth Health Ministers.

Introduction

Equitable access to health care and other social services is a shared aspiration across Commonwealth and many other countries. For most countries however, the deficits in health policy and practice result in patterns of inequity and exclusion that have contributed to structural violence¹ against socially marginalized citizens, especially women in their diversities. 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 and determine services and opportunities².

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 (especially those living with HIV) of all ages, 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 fulfil human dignity, life and health. Structural violence is an "avoidable impairment of fundamental human needs" and is a major contributing factor for premature death and unnecessary disability³. This violence is often a result of poor health policies and practices that harm or fail to protect citizens from avoidable violations, deaths and injustices; 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 a 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. It will focus on how structural violence impacts on vulnerable⁴ and marginalized women broadly but also place an emphasis on the evidence and experiences of women living with HIV in their diversities.

Health inequities and entrenched social determinants for health

Social determinants of health involve the conditions in which people are born, where they live and work and their 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 communities especially women has been occasioned by deficient health systems, particularly primary health care (PHC) systems, which in turn leads 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 uneven across the Commonwealth regions⁵.

In developing countries, mostly poorer African and Asian Commonwealth countries, PHC is not as accessible or effective as 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 a lack of emergency obstetric care, among others.

Human rights violations and discrimination

All Commonwealth countries are party to at least one human rights treaty that addresses health-

1. Structural violence refers to systematic ways in which social or institutional structures harm or otherwise disadvantage individuals.

2. World Health Organisation (2011). *Women's Health Report*. Available at: <http://www.who.int/> [Accessed 16 May 2017]

3. Galtung, J. (1969). *Violence, Peace and Peace Research*. Available at: https://www.jstor.org/stable/422690?seq=1#page_scan_tab_contents [Accessed 16 May 2017]

4. Women living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, transgender and intersex persons, Sex Workers, Older women, women with mental health challenges, migrant populations to mention but a few.

5. World Health Organisation (2011). *Women's Health Report*.

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 and/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 in terms of poor health and shortened lives. Common cases of human rights violations in the health care setting include;

(a) Forced sterilization

Like any other contraceptive method, sterilization should only be provided with the full, free and informed consent of the individual in question. Without this, there are instances where people belonging to certain population groups, including women 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 African Commonwealth countries supports this contention. The voices of 40 women living with HIV who experienced forced sterilization were documented in Kenya in 2012⁶ and more than 20 cases were documented in Uganda⁷. 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 positive⁸. A similar study in Kenya found 9.6% of respondents reported they had been coerced into considering sterilization⁹. The PLHIV 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 considering sterilization, termination of

pregnancy, and use of Family Planning 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 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 care¹⁰. Sex workers living with HIV, drug users living with HIV, and young women living with HIV face particular forms of violent treatment in health care settings because of, among other reasons, their sexual orientation, occupation, status at birth and their age.

(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 centre staff pose barriers to reproductive health care access¹¹. Studies by the International Community of Women living with HIV and AIDS (ICW) in India found that HIV positive women using 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 is also reported on the labour ward. Women living with HIV were being told to wait until all other women had been delivered. One woman was told by a health care worker: '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'¹². These are just some examples of the many reproductive health violations reported by women living with HIV in both developed and developing countries.

6. Kasiva, F., (2012). *Robbed of choices: forced and coerced sterilization of women living with HIV in Kenya*. Available at: <https://profiles.uonbi.ac.ke/kihara/files/report-on-robbed-of-choice-forced-and-coerced-sterilization-experiences-of-women-living-with-hiv-in-kenya.pdf> [Accessed 16 May 2017]

7. International Community of Women Living with HIV Eastern Africa (2015). *Violation of Sexual and Reproductive Health Rights of Women Living with HIV in Clinical and Community Settings in Uganda*. Available at: <http://www.icwea.org/wp-content/uploads/downloads/2015/11/ICWEA-Sexual-Reproductive-Health-Rights-Report-Uganda.pdf> [Accessed 16 May 2017]

8. Joint United Nations Programme on HIV/AIDS (2013). *The People Living with HIV Stigma Index Uganda Report*. Available at: <http://www.stigmaindex.org/sites/default/files/reports/Uganda%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202013%20-%20Final.pdf> [Accessed 16 May 2017]

9. Joint United Nations Programme on HIV/AIDS (2011). *The People Living with HIV Stigma Index Kenya Report*. Available at: <http://www.stigmaindex.org/sites/default/files/reports/Kenya%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202009.pdf> [Accessed 16 May 2017]

10. Petretti, (2009). Title not available. p.4.

11. Hale, F., Vazquez, M., (2011). *Violence Against Women Living with HIV/AIDS: A Background Paper*. Accessed at: <http://salamandertrust.net/wp-content/uploads/2012/12/VAPositiveWomenBkgrdPaperMarch2011.pdf> [Accessed 16 May 2017]

12. Hale, F., Vazquez, M., (2011). *Violence Against Women Living with HIV/AIDS: A Background Paper*.

High cost and inaccessibility to health care

A report entitled “Health Care Costs Are a Barrier to Care for Many Women”¹³ showed that unmet health care needs due to prohibitive costs 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 out of pocket expenses. Health insurance coverage does not eliminate cost-related barriers to care. Women generally face higher health costs than men 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 offer little or no health care 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 services¹⁴. One of the keys to improving women’s health therefore is the removal of financial barriers to accessing health care, accompanied by efforts to ensure that health services are appropriate, acceptable, of high quality and are 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 violence¹⁵. Thus GBV is a result of social norms, cultures and systems and seriously affects all aspects of women’s health, physical, sexual and reproductive, mental and behavioral. The 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 aged 15 to 44 in developing countries¹⁶. A recent study published by the WHO in 2013 systematically reviewed studies providing data on the health effects of physical and sexual intimate partner violence and non-partner sexual violence against women.

The review identified several 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 have not experienced IPV. While the 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).

13. Shartzter, A., Long, SK., Benatar, S. (2015). *Health Care Costs Are a Barrier to Care for Many Women*. Available at: <http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html> [Accessed 16 May 2017]

14. Shartzter, A., Long, SK., Benatar, S. (2015). *Health Care Costs Are a Barrier to Care for Many Women*.

15. The Council of the European Union, (2014). *Council conclusions on EU Return Policy*. Available at: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/jha/143105.pdf [Accessed

16 May 2017]

17. This methodology estimates the healthy life years of life lost to men and women due to different causes. World Bank (1993). *Costs of Gender-Based Violence*. Available at: <http://siteresources.worldbank.org/INTGENDER/Resources/costsandimpactsofgbv.pdf> [Accessed 16 May 2017]

Policy recommendations

- It is recommended that Commonwealth Ministers of Health declare an end to all forms of violence, both interpersonal and structural, identify and commit to instituting mechanisms to address GBV around a clear and coherent agenda, ensuring social cultural systems, laws and policies are preventing violence and influencing violence free systems and communities.
- It is recommended that Commonwealth Ministers of Health work with their governments to remove all financial barriers that limit women and girls from accessing health care services. Governments should reduce service fees that deter a common person, especially those from poor and war torn countries, to have access to care. Removing financial barriers to care must be accompanied by efforts to ensure that health services are appropriate, acceptable and of high quality to meet the needs of girls and women.
- It is recommended that Commonwealth Ministers of Health ensure that there is substantial investment in PHC that will result in: the continuous availability of essential drugs; prevention services for endemic diseases; immunization services; treatment of communicable and non-communicable diseases; maternal and child health services; nutritional services; health education; and water and sanitation services. Women's health services should be integrated as a mandatory part of UHC and regulations established, monitored and enforced at all levels to increase utilization and accessibility.
- It is recommended that Commonwealth Ministers of Health adopt indicators that demonstrate leadership and the implementation of international aspirations, progressive laws and policies that protect women and girls against violence and enhance equitable health development.
- It is recommended that Ministers commit budget allocations to women's health, women's education and empowerment, the involvement of women in decision making and governance, and an understanding of gender that puts both women and men's unique health needs into consideration.
- It is recommended that Commonwealth countries pass, adhere and strictly implement all the recommendations by the UN, WHO and other international health agencies to promote healthy women's lives and to protect women's health against the ill effects of structural violence in order to achieve the Declaration of Alma-Ata for sound health for all by 2020.

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