Groups of women and girls at risk of violence in the health sector

Harri Lee 9 August 2019

Query: What is the evidence on **which groups of women and girls are most at risk** from VAWG in the health sector? (e.g. women of different ages with emphasis on adolescent girls, pregnant/non-pregnant women, women from minorities, poor women, LGBT, women and girls with disabilities.)

Contents

1. Overview

Violence against women and girls in the health sector is a broad area in which the literature is severely limited and fragmented. Evidence syntheses on violence against women in the health sector as a broad issue does not appear to exist. The emphasis in the literature is in two areas, firstly, the response of the health sector to gender-based violence, usually intimate partner violence (IPV), in homes and communities, and secondly, violence by service users against healthcare workers, which is not necessarily disaggregated by sex. Where evidence on violence in the health sector exists, this is mainly around obstetric violence, particularly mistreatment and abuse against women and girls during childbirth. Data is often concealed within broader studies on the quality of healthcare; focused studies are therefore rare (d'Oliveira et al., 2002). Some of the literature is based on types of violence (eg. obstetric violence, verbal, physical and sexual abuse), whilst other studies focus on at risk groups (e.g.

Box 1: defining violence in the health sector

There is no widely-recognised definition of violence in the health sector. Violence in the health sector is multifaceted, including violence perpetrated by service providers and service users and which includes neglect, physical and sexual violence, verbal abuse, coercion, discrimination, medicalisation of female genital cutting/mutilation (FGC/M), sex selection, virginity testing, denial and/or promotion of services based on HIV status, disability, socio-economic status and involvement in transactional sex and drug/alcohol use, breaches of confidentiality and negative attitudes around (post) abortion care. Violence in primary, secondary and tertiary sectors are included across physical and mental healthcare provision, including in institutional settings.

women with disabilities or older women), or on a particular setting (e.g. institutional). Studies focusing on types of violence or specific settings do not always disaggregate by sex or compare across different groups, making it difficult to assess whether women from specific groups are at a greater risk than others.

The limited evidence suggests that some groups of women are at high risk of violence. Violence against health workers and service users is experienced differently depending on age and reproductive status, sexual orientation and gender identity, disability, socioeconomic and minority status. There is documented evidence particularly in relation to pregnant women and female healthcare workers, with some available studies focusing on women and girls with disabilities, and on lesbian and trans women. Evidence on other groups, in particular poor women and those from minority groups, is sometimes considered within a broader context (particularly in relation to obstetric violence), however focused research appears not to be available. It is important to highlight that women from at risk groups may face violence whether they are seeking treatment for themselves or family members or friends, with trans women in several countries in Latin America and the Caribbean reporting this (Lanham et al., 2019). The literature also suggests violence in the health sector can lead to low uptake of services and adverse health outcomes for marginalised groups, including mental health outcomes and outcomes for new mothers and babies.

Standout statistics from the available literature include:

- A 2018 systematic review of **elder abuse in institutional settings** found that 64.2% staff admitted to elder abuse in the past year (please note data was not sex-disaggregated) (Yon et al., 2018).
- Recent studies on **obstetric violence** show:
    - Prevalence of disrespectful or abusive care of pregnant women in Ethiopia at 49.4% and 13.6% for physical violence (Kassa and Husen, 2019).
    - 20% women in a study in Kenya experienced disrespect and abuse during childbirth, including 18% reporting verbal abuse and 4% reporting physical abuse (Abuya et al., 2015).
    - 97.4% women in a study in nine cities in Peru had experienced at least one of seven categories of disrespect and abuse (Montesinos-Segura et al., 2018).
- A small number of quantitative studies on **forced sterilisation of women with disabilities** indicate:
    - 42% women in psychiatric institutions in Mexico (sample of 51) reported having been sterilised, including those who underwent surgery without being told what it was for and acute pressure from family members (Disability Rights International, 2015).
    - A study in Orissa, India found 6% women with physical disabilities and 8% with mental disabilities had been forcibly sterilised (Mohapatra and Mohanty, 2004).
- Statistics on **violence against women health workers** include:
    - Ethiopia: 100% women healthcare workers reported witnessing sexual harassment in the workplace in the past 12 months (57.1% had witnessed verbal abuse and 59% physical – sample of 553 including men and women) (Yenealem et al., 2018).
    - Nigeria: 40% of 380 health workers in tertiary care settings reported workplace violence in the last month, though data was not sex-disaggregated (Seun-Fadipe et al., 2019).

- Botswana: In 2018, a survey of 201 mental health staff in a psychiatric hospital in Botswana found that 69.8% had experienced physical violence at one time or more in their lives, with 44.1% reporting it in the last 12 months (there was no statistical difference between women and men) (Olashore et al., 2018).

This query has identified several key evidence gaps, which are:

- Conceptual studies exploring definitional and measurement challenges and working towards a global consensus.
- Studies comparing at risk groups to the general population to assess prevalence and heightened risks.
- Studies taking an intersectional approach examining healthcare-related violence and systematically examining how age, gender, disability, race, ethnicity and religion and socioeconomic status overlap.
- Studies taking a life cycle approach, particularly considering adolescent girls and older people.
- Research on obstetric violence measuring a full range of the different types of violence, particularly sexual violence.
- Studies examining elder abuse in institutions disaggregating data by sex.
- Evidence is particularly lacking in relation to some groups, including poor women or women with low levels of education, ethnic, racial and religious minorities and migrant and refugee women.
- Quantitative studies on LGBT women's experience of violence in the health sector.
- Studies examining violence for women and girls with disabilities in institutional settings in low- and middle-income countries (LMICs), in particular for those with psychosocial disabilities.

This query is part of a package of queries on violence against women and girls (VAWG) in the health sector, including on the prevalence and characteristics of VAWG perpetrated within the health sector (Q251), reproductive coercion (Q253), risk factors and opportunities (forthcoming) and approaches that have been taken to address VAWG in the health sector (forthcoming).

2. Methodology

This methodology is described below.

Search strategy: Studies were identified through searches using Google and relevant electronic databases (PubMed, Science Direct, and Google Scholar) for priority sources. Key search terms included: obstetric violence, violence OR abuse OR mistreatment AND women AND health, safeguarding AND health, workplace violence AND health sector, care quality AND women AND health, violence AND health AND adolescent OR disability OR refugee OR socioeconomic OR older etc.

Criteria for inclusion: To be eligible for inclusion in this rapid mapping, evidence had to fulfil the following criteria:

- **Focus**: Research, studies and grey literature on violence against women in the health sector.
- **Time period**: 2000 – July 2019.
- **Language**: English.
- **Publication status**: Publicly available – in almost all cases published online.
- **Geographical focus**: Low and middle-income countries (LMICs).

3. Overview of the evidence

With the exception of studies on obstetric violence, research on violence against women and girls in the health sector does not tend to disaggregate data considering particular at risk groups. Obstetric violence as an emerging field of research tends to disaggregate usually by age, socioeconomic status and race, ethnicity or religion (none of the studies identified used the Washington Group Questions on disability or disaggregated by disability). Other studies tended to focus on a particular group of women but may not disaggregate further. For example:

- Studies on LGBT women talk about lesbian and trans women but do not tend to talk about bisexual or intersex women.
- Studies on women and girls with disabilities sometimes distinguish between those with physical, intellectual and psychosocial disabilities, with those in the latter two categories identified as being at particular risk.
- Studies on female healthcare workers may discuss age and the different types of work and roles women do, eg. doctors, nurses, night shifts etc. but do not tend to consider other groups, such as women with disabilities.
- There is very limited reference in all studies to age, with a particular lack of focus on adolescent girls.

In addition to women and girls, this query identified several studies examining violence and abusive behaviour towards other groups such as ethnic minorities, refugees and people with disabilities where data was not disaggregated by sex. This literature is again fragmented and often included in bodies of literature discussing access to healthcare for these groups in general, rather than focusing only on violence and abuse. Several identified studies did not disaggregate data by sex and therefore highlight the vulnerability of men and boys to some types of violence in health settings, in particular in relation to elder abuse in care homes and violence against healthcare workers. In terms of disability, it is often specific impairment types which are missing from the existing research. For example, a 2012 systematic review of violence against disabled people identified no studies of people with intellectual disabilities in institutional settings, which they highlighted as surprising given this group is thought to be particularly at risk (Jones et al., 2012).

The table below outlines the availability of evidence for each identified at risk group. Please note that this table is based on three days research time and focuses on the availability of evidence in LMICs

– it is not a comprehensive overview of the literature, particularly given the fragmented nature of the evidence. The information in the table should also be interpreted in a relational manner, as there is as yet no strong body of evidence in this field.

Table 1: overview of availability of evidence per at risk group

At risk group	Availability of evidence		
	Non-existent	**Limited**	**Some**
Pregnant women			Obstetric violence a growing area of research, with studies from multiple LMICs, including both quant and qual. These studies more likely than others to disaggregate data including by age, socioeconomic status, race, ethnicity and religion.
Adolescent girls	One variable considered in two or three studies, no focused research identified		
Older women	Some research available from HICs, studies don't always present sex-disaggregated data		
LGBT women		A handful of qualitative studies focusing on LGBT women and access to healthcare	
Poor women	Considered as one variable within larger studies on obstetric violence, no focused studies identified		
Women with limited education	Considered as one variable within larger studies on obstetric violence, no focused studies identified		
Migrant and refugee women	No available studies from LMICs identified		
Ethnic, racial and religious minorities	Emerging data on obstetric violence against racial minorities in Europe and North America and considered as one variable in LMIC studies on obstetric violence, however no focused studies available		
Women and girls with disabilities		Though mostly from HICs, there is some research, mostly on reproductive coercion	
Female healthcare workers			Several studies from LMICs, don't tend to disaggregate further than age, sex, type of role, eg. doctor, nurse

4. Age and reproductive status

The available evidence on violence against women in the health sector in relation to age and reproductive status focuses predominantly on obstetric violence, in the most part violence experienced during and straight after childbirth.[1] The evidence tends to focus on a broad definition of violence including neglect and other mistreatment of women during childbirth, for example through discrimination or denial of services. Whilst verbal and physical violence is often measured, this query found only one or two references to sexual violence against pregnant women and new mothers. It is also important to note that generally, studies on obstetric violence do tend to disaggregate data by sub-group, meaning it is easier to assess heightened risk for particular women than for other types of health sector violence. Given the emphasis on obstetric violence in the literature, much of this section relates to violence against pregnant women.

There is less evidence on violence against adolescent girls and older women in the health sector. It is well-documented that adolescence is a time of heightened vulnerability to violence and abuse for girls, however the existing literature on adolescence and health focuses on healthcare response to intimate partner violence (IPV) and its health impacts such as HIV/AIDS and pregnancy, rather than violence perpetrated by healthcare providers. Whilst there is a body of literature on elder abuse in institutions (mainly from high income contexts), evidence syntheses do not tend to disaggregate data by sex. For example, a 2018 systematic review of elder abuse in institutional settings found that 64.2% staff admitted to elder abuse in the past year (Yon et al., 2018). The included studies were too few to develop pooled prevalence rates (nine), however the study estimates that psychological abuse was most prevalent (33.4%), followed by physical (14.1%).[2] Gender-disaggregated analysis was not included in the report, although it is worth noting that several of the studies included relied on reports by staff who were overwhelmingly women. A 2012 systematic review on prevalence and risk of violence against adults with disabilities by the World Health Organisation found two UK studies on prevalence of violence against older people, both of which focused on people with dementia, although it is not clear if they included sex-disaggregated data[3] (Compton et al., 1997 and Cooper et al., 2009 in Hughes et al., 2012).

Studies of violence in the health sector do not tend to take a life cycle approach. This query did not identify any study which examined women's experience of violence in the health sector over time, although there are one or two pieces of research which highlighted that younger and older women may be at particular risk.

Pregnant women:

The study of obstetric violence is a growing field[4], with high prevalence rates found in several LMIC settings. In a 2002 review of existing studies on violence in obstetric and abortion services, researchers identified neglect, verbal, physical and sexual violence as distinct types of violence experienced by women in several countries, including Brazil, Peru, Nigeria, South Africa and Tanzania (d'Oliveira et al., 2002). Studies in the last ten years include:

[1] See query 253 for more details on obstetric violence and reproductive coercion.
[2] Please note these studies were mostly from high income settings.
[3] Neither of these studies are publicly accessible but are available on academic databases.
[4] The UN Special Rapporteur on Violence Against Women has announced the publication of a thematic report on mistreatment and violence against women during reproductive healthcare and childbirth will be presented at the 74th session of the UN General Assembly in September 2019. See for more details: https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx

- **Ethiopia**: A 2019 systematic review of disrespectful and abusive behaviour in maternity care found a pooled prevalence rate of disrespectful or abusive care of 49.4% and 13.6% for physical violence from seven available studies (Kassa and Husen, 2019).
- **Kenya**: A study of 1,369 women found 20% prevalence of disrespect and abuse during childbirth, including 18% reporting verbal abuse and 4% reporting physical abuse (Abuya et al., 2015).
- **Peru**: A 2016 observational cross-sectional study with 1,528 participants in nine cities found 97.4% had experienced at least one of seven categories of disrespect and abuse (Montesinos-Segura et al., 2018).
- **Tanzania**: A 2014 qualitative study in Morogoro Region found women reported feeling ignored and neglected, being discriminated against, experiencing verbal abuse and physical abuse during childbirth (McMahon et al., 2014). A 2018 survey of 1,779 women in eight health centres in rural northeastern Tanzania found 19.48% women reported experiencing any abusive or disrespectful treatment during childbirth (Kruk et al., 2018). The most common events reported were being ignored (*N* = 84, 14.24%), being shouted at (*N* = 78, 13.18%) and receiving negative or threatening comments (*N* = 68, 11.54%). Thirty women (5.1%) were slapped or pinched and 31 women (5.31%) delivered alone.

Recent evidence underlines the intersectional nature of violence against women, with women from marginalised social groups at greater risk of obstetric violence.[5] The VAWG Helpdesk query 253 on reproductive coercion found limited studies on obstetric violence, specifically non-consented care, against women living with disabilities, young women, transgender women, ethnic minority and indigenous women and women who are sexual minorities (Bell, 2019). Existing studies that highlight the intersectional nature of obstetric violence in LMICs include:

A 2015 mixed methods systematic review on neglectful, abuse and disrespectful treatment of women in childbirth health facilities notes the lack of a global consensus on how to define and measure mistreatment (Bohren et al., 2015). The study, which included 65 studies from 34 countries, was therefore not able to conduct meta-analysis of prevalence rates, however, the report presents a typology of the mistreatment of women during childbirth which includes discrimination based on various characteristics. Qualitative analysis shows:

- **13 studies showed women often reported feeling discriminated against on the basis of ethnicity, race or religion**, leading to low quality of care and demands for bribes, including Somali women with female genital cutting in Canada, Roma women in the Balkans, and refugee women in South Africa.
- **7 studies highlighted age discrimination, particularly for adolescent girls** (particularly when unmarried) or older women of high parity. Studies found that adolescents were humiliated for having sex before marriage.
- **12 studies examined discrimination based on socioeconomic status**. Women in multiple settings, including Ghana and Sierra Leone, reported feeling neglected, humiliated or receiving poor quality treatment because they were poor, illiterate or lived in remote rural or slum dwellings.

[5] Defined in the Organic Law on Women's Right to a Violence-Free Life "the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization and pathologization of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life."

- **3 studies in South Africa, Kenya and Tanzania noted findings of discriminatory behaviour based on HIV status.** This reportedly led to sub-standard care.

Other studies include:

- **Zimbabwe**: a 2019 qualitative study with 20 purposively sampled women in three rural health centres in eastern Zimbabwe shows a combination of factors influence the treatment of women during childbirth, including midwives' subjective perceptions, women's social status and constraints in the healthcare system such as availability of trained midwives. These factors often combine to result in poor service provision including abusive treatment and can have a direct effect on health outcomes and women's satisfaction (Kanengoni et al., 2019).
- **Kenya**: Qualitative research using random sampling of pregnant women found reported incidents of verbal and physical abuse, stigma and discrimination. Women also reported neglect, poor rapport, failure to meet professional standards and health system constraints such as lack of trained staff. No cases of sexual abuse were reported, however the study notes this may be due to the high levels of stigma around sexual violence in this context. The study highlighted that midwives felt a culture of blame was pervasive, with individuals being blamed for adverse outcomes for mother and/or child, including being blamed by senior medical staff and in cases of non-compliance by mothers. Some commented that fear of this blame contributed to their mistreatment of women (Oluoch-Aridi et al., 2018).
- **Nigeria**: Qualitative research with healthcare providers in Abuja, Nigeria, reported that adolescent girls, women giving birth for the first time and women of lower socioeconomic status may be at higher risk of mistreatment during labour, as well as women who had not registered for services prior to the birth as they are blamed for not being prepared (Bohren et al., 2017).

5. Sexual orientation and gender identity

Emerging evidence demonstrates high prevalence of violence against LGBT women in LMICs. A 2017 systematic review included 76 studies and found prevalence rates of lifetime physical violence for lesbians and bisexual women of between 4.6% and 25.1%, whilst lifetime sexual violence for bisexual women was between 1% and 13.2% (Blondeel et al., 2017). However, there is very limited, overwhelmingly qualitative research on violence against LGBT women in healthcare settings at the global level. The existing literature includes some research and guidance on LGBT access to healthcare, including how discrimination affects this, and is predominantly from North America (Smith, 2015). Recent research from LMICs and grey literature at the global level highlights the pervasive nature of discrimination and mistreatment against LGBT women in healthcare settings and fear of this violence:

- A literature review of studies on sexual minority women's health in Latin America and the Caribbean shows that many women are reluctant to go for sexual health screening due to concern they will be mistreated by health workers (Caceres et al., 2019).
- A qualitative study of trans women in El Salvador, Trinidad and Tobago, Barbados, and Haiti in 2016. Quantitative analysis showed that 82.9% of the 74 women interviewed had experienced some form of gender-based violence in the health sector, including physical, sexual, emotional and economic, with emotional violence being the most common (Lanham et al., 2019). The study, titled "We're going to leave you until last, because of who you are", found participants reported being given lower priority, receiving substandard care, being blamed for their health problems and denied care (ibid;).

- Human Rights Watch research in Malawi (2018) found that many transgender women reported that stigma and discrimination in healthcare settings was "routine" which inhibited them from seeking HIV services (HRW, 2018).
- A 2015 World Bank blog on gender-based violence against lesbian and transgender women noted that: "Transgender people are also more likely to experience violence from law enforcement, in homeless shelters, and in healthcare settings."[6]
- Intersex persons may be involuntarily subjected to "sex-normalizing" procedures as infants or children. According to the WHO, children who are born with atypical sex characteristics are often subjected to cosmetic and other non-medically indicated surgeries on their reproductive organs, without their informed consent or that of their parents (WHO, 2014).
- A World Health Organisation Concept Paper from 2013 notes a number of barriers to healthcare access for LGBT groups which include verbal abuse, disrespectful behaviour and denial of care but does not refer to physical or sexual violence (WHO, 2013).

6. Disability and health status

Women and girls with disabilities face a high risk of violence in homes and communities, with a recent study suggesting they are 2-4 times more likely to experience (all forms of) intimate partner violence (Dunkle et al., 2018). Over the last 20 years, research from high-income countries (HICs) has shown people with disabilities are at high risk of violence by healthcare providers, particularly individuals with intellectual or psychosocial disabilities in institutional settings, however this data is often not sex disaggregated. There are a small number of recent studies from LMICs, however violence against people with psychosocial disabilities and in institutions is particularly under-researched (Jones et al., 2012). The intersection with age should also be noted here, as disability prevalence increases with age (WHO, 2011). The studies examined through this query did not identify any which took both age and disability into account, including the temporal onset of the disability and the two-way relationship between disability and violence. For example, it is not clear whether the link between adverse mental health effects of birth-related trauma and the impacts of obstetric violence are being made in recent research.[7][8]

However, there continues to be a lack of robust studies related to violence against people with disabilities in general, not only in healthcare settings. Methodological and conceptual challenges related to measuring violence against people with disabilities include: "a lack of well-designed research studies, poor standards of measurement of disability and violence, and insufficient assessment of whether violence precedes the development of disability, leaves gaps in knowledge that need to be addressed" (Jones et al., 2012, p.899).

Forms of violence highlighted in the available literature include discrimination and denial of services, verbal, physical and sexual abuse, forced contraceptive use and sterilisation, and forced psychiatric care. Several studies highlight the pervasive nature of disrespectful and discriminatory behaviour towards women and girls with disabilities in healthcare, including through

[6] See here for the full text: https://blogs.worldbank.org/voices/gender-based-violence-lesbian-and-transgender-women-face-highest-risk-get-least-attention

[7] For example, in a 2018 systematic review on preventing birth trauma (de Graff et al.,), mistreatment and abuse of women during childbirth is not mentioned. See here for the full text: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/aogs.13291

[8] Please see the Disability Inclusion Helpdesk's query report on mental health, maternal health and SRHR here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818128/query-11-mental-health-maternal-health.pdf

infantilising, disempowering and failing to recognise their decision-making power over their own bodies and sexualities (Plan, 2017; Jones et al., 2018 cited in Fraser & Corby, 2019). According to Human Rights Watch, the practice of sterilisation of women and girls with disabilities is condoned by governments, health professionals and caregivers in order to avoid inconvenience for caregivers, protect against sexual abuse and exploitation, and mitigate against the lack of available inclusive services for these women and girls (Human Rights Watch, 2011).

The specific risk factors making disabled women vulnerable to violence by healthcare providers in LMICs are multiple. A 2012 literature review notes that although the most common perpetrators of violence against women and girls with disabilities are intimate partners and family members, women and girls with disabilities are at risk of violence from personal assistance providers (Plummer and Findlay). Identified risk factors include the isolation of women and girls with disabilities, dependency on caregivers, and the specific nature of some abuse which may not be covered by national legal frameworks, such as removing a scooter battery or moving furniture to place obstacles in the way of people with visual impairments. Women and girls with disabilities may have daily or weekly contact with multiple professional caregivers, particularly in settings such as hospitals and institutional care homes. Issues that may increase their risk include the ongoing and intimate nature of the support, and the targeting of women and girls with disabilities because of perceptions about their vulnerability, both in terms of being physically overpowered and emotionally manipulated (ibid; Women Enabled, 2012). In addition, myths around asexuality and the belief that women and girls with disabilities will be unable to report the violence they experience can lead to heightened risk, including in health settings (Fraser & Corby, 2019).

The grey literature notes how discrimination against women and girls with disabilities impacts on access to healthcare. For example, a 2012 OHCHR thematic study on violence against women and girls with disabilities noted that healthcare provider perceptions can mean women with disabilities are not seen as requiring healthcare services, for example sexual and reproductive health services (OHCHR, 2012). A study of refugees with disabilities in Uganda identified negative attitudes of healthcare providers as the most influential barrier preventing refugees with disabilities from accessing family planning (Tanabe et al, 2015, cited in Fraser & Corby, 2019).

Studies published in the last ten years highlight abuse in a range of contexts:

Abuse against people with disabilities in Uganda: in a qualitative study with people with disabilities and older people in two districts in Uganda, researchers heard multiple reports of abuse in public health services, including denial of care and sexual abuse. The study noted the impact of abusive behaviour on access to treatment (Mulumba et al., 2014).

Women with psychosocial disabilities in Mexico: A 2015 survey of 51 women in psychiatric institutions in Mexico found that 42% had been sterilised and sterilisation had been recommended to half of the women surveyed. These cases included women who underwent surgery without being told what it was for and acute pressure from family members, reportedly to prevent passing on the disability to children (Disability Rights International, 2015).

Country case studies on SRHR violations from Kiribati, the Solomon Islands and Tonga: this report bringing together situational analyses in each country found that women with disabilities underwent involuntary contraceptive use and sterilisation, often to protect against pregnancy in cases of repeated sexual abuse (Spratt, 2012).

Kenya public inquiry into violations of SRHR**:** found that some of the women living with a disability (number not given) claimed that they were forcibly sterilised by healthcare providers, in collusion with family members. Some women with disabilities said they were subjected to forced abortions by care

givers or relatives who are responsible for the pregnancy to avoid embarrassment at home (Kenya National Commission on Human Rights, 2012).

Forced sterilisation in Orissa, India: A study of 12 districts[9] documented the prevalence of abuse of women with physical disabilities compared to women with mental challenges. It found that 6% of women with physical disabilities and 8% with mental disabilities had been forcibly sterilised (Mohapatra and Mohanty, 2004).

Though still small-scale in nature, the following studies outline violence experienced by women living with HIV/AIDS in the health sector. Recent studies include:

- A 2015 survey with 945 women living with HIV/AIDS in 94 countries found that 53% had experienced some form of violence in healthcare settings, with a sharp increase after diagnosis (Orza et al., 2015).
- Findings from a 2019 study with women living with HIV in the Middle East and North Africa found that 41% had experienced violence in healthcare settings (International HIV/AIDS Alliance, 2019).[10] The report highlighted: "Women living with, and at risk of, HIV spoke repeatedly of how they are denied access to treatment and care, including maternity services. Their confidentiality is not protected, they are shouted at, treated inhumanely and humiliated. One woman described how she was slapped by other patients when seeking emergency medical treatment for her son, who died the next day."
- UNAIDS published a background note on discrimination against those living with HIV/AIDS in health settings in 2017. The note recognises the multiple forms of discrimination faced by women living with HIV/AIDS, with discrimination against sexual minorities, sex workers and people with disabilities adding additional layers (UNAIDS, 2017).
- Women living with HIV/AIDS in South Africa reported being verbally abused in healthcare settings in a mixed methods study including 41 interviews and six focus groups (AIDS Legal Network, 2012).

7. Other groups – socioeconomic groups and ethnic, racial and religious minorities

There is a paucity of research which considers the different experiences of some groups of women in particular. These are poor women, women with low levels of education, ethnic, racial and religious minorities, refugee and migrant women, sex workers and drug users. Some data exists on some of these groups as one variable in available studies, particularly women of low social status and ethnic minorities in relation to obstetric violence and reproductive coercion. A wider literature is available on women and marginalised groups, healthcare access and outcomes, including three recent systematic reviews in relation to Roma, Gypsy and Traveller groups, migrants, asylum seekers and refugees, and racial and ethnic minorities (see details below). Disparities in healthcare due to discrimination based on race and ethnicity is an emerging field of research in HICs, including the US and UK, with studies showing a higher risk of adverse maternal health outcomes for black and ethnic minority women published over the last ten years. Studies focusing on health-related violence from LMICs in its broader sense (ie. including physical, sexual violence in addition to verbal abuse and discrimination) appears to be almost non-existent.

[9] The research design was a case-comparison study using written questionnaires. A sample of 729 women, 595 with physical disabilities and 134 with mental challenges was compiled from women responding to a state level survey.
[10] Please note sample size is unclear.

The existing evidence from LMICs includes:

- A 2018 systematic review on Roma, Gypsy and Traveller access to and engagement with health services found discrimination to be one of the key barriers from amongst 99 studies in 32 countries (50 of the 99 available studies cited this as a major barrier) (McFadden et al., 2018). Other factors such as low literacy levels also played a part in limited access in the reviewed studies. Discrimination in healthcare settings for Roma, Gypsy and Traveller groups included "reports of hostile, patronising, judgemental, unsympathetic and even abusive attitudes of healthcare staff, including health professionals and receptionists. These were said to be based on negative stereotypes" (ibid; p. 78). One study even pointed to segregation of Roma people in health settings, with separate showers, eating rooms and facilities (ibid).
- A systematic review of systematic reviews on perinatal outcomes for asylum seekers and refugees included 29 systematic reviews. The review found the available literature highlights negative communication, discrimination, poor relationships with health professionals, as well as racism, prejudice and stereotyping by healthcare professionals (Heslehurst et al., 2018). The review found that discrimination was more likely for refugees and asylum seekers than for the general migrant population (ibid).
- A 2017 systematic review on racism and healthcare which only included studies from HICs and mostly from the United States showed a strong association between the experience of racism, lack of trust, lower satisfaction and lower quality of care, as well as poor communication and relationships with healthcare providers (Ben et al., 2017).
- Forced and coerced sterilisation has been documented against ethnic and indigenous women in several contexts including India, Uzbekistan and Peru,[11] and often involve women waking from caesarean sections to learn they have been sterilised without their consent (Open Society Foundation, 2011; Bell, 2019).
- A 2017 literature review on Syrian refugee women's health in neighbouring countries found that in Turkey, fear of discrimination and mistreatment means Syrian refugee women with disabilities do not access reproductive healthcare (Samari, 2017; cited in Rowherder, 2018).
- Reference to harassment, denial of services, forced HIV testing and exposure of HIV status of sex workers in the health sector (American University College of Law, 2014).
- Reference to denial of care, provision of substandard care, forced treatment, subjection to unknown or experimental medication, for people who use drugs (ibid).

8. Workplace violence against female health workers

There is clear evidence showing female health workers are at risk of workplace violence in LMICs. The evidence is mixed on whether female healthcare providers are at greater risk of all types of violence than male providers, as some studies show increased risk for men, for women or no statistically significant difference. However, as health systems are often women-dominated sectors research suggests the majority of violent incidents are perpetrated against women (including in Brazil, South Africa and Thailand) (WHO, 2002).

The available studies are predominantly mixed methods and show female health workers experience different types of violence, including physical, sexual and psychological by both patients and other staff. A recent UNAIDS background note highlights that female healthcare workers

[11] For information on Peru, see: https://www.amnesty.org/en/latest/news/2018/04/peru-order-to-indict-fujimori-is-a-milestone-in-search-for-justice-for-victims-of-forced-sterilization/

are at risk of entrenched gender-based discrimination particularly in areas of healthcare which are predominantly female-staffed, including through physical and sexual violence and exclusion from participation in leadership and decision making (UNAIDS, 2017). A set of country case studies published by the WHO in 2002 show that risk tends to depend on the type of violence, with female health workers being at particular risk of verbal abuse (WHO, 2002). A set of country case studies published by the WHO in 2002 find that patients tend to be the most common perpetrators in general, and particularly in relation to physical abuse, however other healthcare staff tend to be the most common perpetrators of psychological violence (di Martino, 2002).

Recent studies examine this phenomenon in a range of contexts:

- **Ethiopia:** a 2016 survey of 553 healthcare workers in Gondar, northwest Ethiopia, found that 58.2% healthcare workers had witnessed at least one instance of workplace violence in the past 12 months (verbal abuse: 53.1% and physical violence 22%). The study reports that women healthcare workers are more likely to experience workplace violence, with 57.1% reporting witnessing verbal abuse, 59% reporting witnessing physical abuse, and 100% reporting witnessing sexual harassment. Risk factors included working shifts and being a nurse or a midwife (Yenealem et al., 2018).
- **Nigeria:** 380 health workers in tertiary care settings were recently surveyed in a cross-sectional study using a stratified random sampling technique (Seun-Fadipe et al., 2019). Prevalence of workplace violence in the last month was 40%, with the most common type of violence being verbal abuse, whilst the least commonly-reported type was sexual harassment. The findings showed that factors correlated with experience of workplace violence were being young, with those aged in their 20s most likely to have experienced workplace violence, and being female, with female health workers 1.7 times more likely to have experienced workplace violence in the last year. Other related factors included whether a participant had received training on workplace violence or not, and whether the participant was worried about workplace violence or not, with trained and worried health workers more likely to report violence. Experience of workplace violence was also associated with psychiatric issues (ibid).
- **Brazil:** A 2017 study of 163 healthcare workers in Pouso Alegre municipality in the Brazilian state of Minas Gerais found high rates of gender stereotyping and sexism, with 53.8% displaying gender stereotyping, 64.1% demonstrating benevolent sexism and 58.2% demonstrating hostile sexism[12] (Filho et al., 2017). It should be noted that 89% of this sample were women, and that scores were higher for men, those who had only completed primary education, and those who identified as evangelical Christians (ibid;).
- **Saudi Arabia:** A 2018 survey of healthcare workers in Abha city, Saudi Arabia, with a sample of 738, found that 57.2% female healthcare workers had experienced some type of violence or abuse[13] at one point in their career (Alsaleem et al., 2018). Despite there being no statistical difference between rates of violence experienced by female and male healthcare workers, factors that led to a higher risk of violence included being non-Saudi nationals, a nurse rather than a doctor, working night shifts and working predominantly with male patients (ibid;).

[12] The study used the Gender Stereotyping and Ambivalent Sexism Inventory questionnaires. The study describes the difference as: benevolent sexism is the display of attitudes that appear not to be prejudiced, ie. expressed in a positive way, eg. describing women as fragile, dependent and sensitive. Hostile sexism is the explicit manifestation of prejudice against women. is the manifestation of prejudice against women in an explicit fashion, eg. considering women to be inferior to men, intolerance of women's role in decision making etc.

[13] Types of violence included different forms of physical violence and verbal abuse.

- **Botswana:** In 2018, a survey of 201 mental health staff in a psychiatric hospital in Botswana found that 69.8% had experienced physical violence at one time or more in their lives, with 44.1% reporting it in the last 12 months (there was no statistical difference between women and men) (Olashore et al., 2018).

Experts consulted

Emma Bell, VAWG and health consultant

Erika Fraser, VAWG Helpdesk Lead and Senior Technical Expert, SDDirect

Lorraine Wapling, disability inclusion consultant

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About Helpdesk reports: The VAWG Helpdesk is funded by the UK Department for International Development, contracted through the Inclusive Societies Department (ISD). Helpdesk reports are based on 3 days of desk-based research per query and are designed to provide a brief overview of the key issues and expert thinking on VAWG issues.

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Suggested citation:

Lee, H (2019) *VAWG in the Health Sector: women and girls at risk,* VAWG Helpdesk Research Report No. 252. London, UK: VAWG Helpdesk.