

Gender-specific medicine watch

Observatory on the Italian scenarios, congress reports, news from the literature, tools and resources

The social and health costs of gender-based violence on women's health in Italy

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Introduction

In 2004, the Victorian Health Promotion Foundation published a research report – *The Health Costs of Violence* – which showed that 9% of all health problems affecting women under 45 were caused by domestic violence.

In 2009 the Australian government published *Time for Action*, stating that the government's position on violence against women is *zero tolerance*. A research commissioned by the National Council found that violence against women allegedly cost the Australian economy about A\$ 13.6 billion for the current year, and will reach A\$ 15.6 billion in 2021-22, if no appropriate actions are undertaken.

The WHO reiterated that such a widespread phenomenon is a public health problem of epidemic proportions, representing the leading cause of death among women worldwide. In the first Report on *Violence and health in the world*, written in 2002, the multifaceted nature of the problem and the need to use multiple data sources – also related to the costs of health and social interventions – clearly emerge, linking them to possible savings related to prevention programs. Evidence shows that women who have been subjected to violence episodes suffer from a greater number of health problems and, consequently, require more frequent admissions, visits and tests, while also consuming a higher amount of drugs.

In this context, the approval of the decree implementing the *Plan for the application and dissemination of gender medicine*, provided for by Art. 3 of Law 3/2018, can be a useful point of reference and an even more effective response to the issue.

Statistics

The latest ISTAT data on the violence suffered in Italy by women aged 16 to 70 during their life show that 31.5% of them (equal to 6 million 788 thousand women) experienced some form of physical or sexual violence; 4 million 400 thousand endured psychological violence from their current partner; and 3 million 466 thousand were victims of stalking.¹

Among the subjective indicators of health inequalities – which are the subject of the reports on health equity – gender appears among the determinants;² but still violence against women is not taken into adequate consideration as a risk factor. An absent “nosological item”, which highlights the distortions of a lack of interconnection between the causes of the diseases and the issues concerning the traditional and consolidated asymmetries in the private sphere; disparities that an unconditioned scrutiny should instead consider as relevant analytical categories. Therefore, the division that still characterizes the subject – and confines it in a social rather than healthcare-related literature, albeit broad, and certainly specialized – appears perfectly clear. It is therefore necessary to lay the foundations for the overcoming of a boundary that remains within the limits of a “neutral” and sectorial observation, when instead, in order to act, the capacity to see beyond words is required, since we are dealing with the suffering of people. It is

not enough to *medicalize* the disorder, says Good;³ it is also important to analyze the temporal order of a life story, since the disease is not only rooted in the body.

The Italian response and the integrated Tuscan model

In Italy – due to robust regional differences and a decrease in resources – a delay in the policies and the difficulty of dealing with the multiple aspects of the problem are widely reported. In particular, if the issue has been included into welfare intervention strategies with personal protection measures, the integration with the health aspect still risks to be affected/afflicted by further difficulties, despite the obvious consequences. The problem becomes even more relevant when the physical and psychic consequences of the abuses, which impact the onset of diseases and their chronicization, are added to the plurality of needs and the definition of an urgent intervention. Consequently, uncoordinated interventions, and closure in competence areas, must be overcome in order to operate in multidimensional contexts, where all aspects are adequately considered and implemented. The underlying theme of reflection will have to be increasingly related to health and the possible health responses, keeping in mind the gender category and trying to connect elements that, so far, have had a parallel but not convergent arrangement, also within the sociology of health and medicine.

In this perspective, *WeWorld Intervita* promoted a research entitled *How does silence cost?*; and starting precisely from this question we must ask ourselves what to do in order to support a different and

long-term vision, which offers a perspective, rather than the sum of the investment costs. Hence, the need to adopt strategies based more on prevention than on reparatory interventions, to undertake synergistic and coordinated actions, thus overcoming the currently episodic and time-limited measures.

Here, we suggest a different model of institutional response – the innovative experience of the *Codice Rosa* (“Pink Code”), recently introduced in Tuscany – underlining the positive effects that can be achieved with an effective social and health integration and a multidisciplinary approach.⁴

In fact, among the social factors that most affect health on a broad spectrum, the different forms of violence – from psychological to physical – definitively occupy a relevant space in the reflection on the effects of gender inequalities in the prevention, diagnosis and treatment of diseases. Discriminations that, precisely in these acutely conflicting dynamics, highlight the evident measure of a persistent power imbalance, of a wide asymmetry in access to resources and services, of a right of citizenship still weak for women and characterized on the basis of not entirely residual male privileges.

In this field, as is well known, still persist theoretical knots deriving from the correct use of the term “gender” in medicine and from the consequences of this reductive interpretation,⁵ which also refer to a renewed dialectic on the epistemological level between the disciplines. In particular, both a shared reconsideration of the categories and languages, which can open up to a possible osmosis between medical science and human sciences, and a heuristic exchange of the methods and tools used in research, precisely built within a multidisciplinary perspective, are needed, in order to improve the understanding of the health processes.

Furthermore, particular attention should be paid to the difficulties of creating an integrated social and health system⁶ which can operate synergistically, which comes on top of the lack of an evaluation of the practices implemented in order to counter the multiple forms of women abuse in all environments, in the workplace as well as at home.

A different perspective, that implies the overcoming of clinical investigation – based essentially on biological, genetic and hormonal factors – to broaden our vision to the cultural and social determinants, to that complex interaction (referred to in directives, action plans, national and international policies and strategies) which finds however an obstacle in the passage from the principles to their application in daily experience. Resistances attributable to the ontology of scientific knowledge itself, that much literature, starting from feminist criticism, has brought to light.⁷

The Codice Rosa

With the *Codice Rosa* model, which intends to operate within a health concept closer to listening and to the humanization of care, the anatomical and physiological differences between the sexes – associated with a *modus operandi* that has certainly had its diagnostic and therapeutic efficacy – can be overcome, while remaining within a strictly biomedical context, and opening instead to the social aspects and the different readings arising from them.

The Health and Social Plan of the Tuscany Region has been including the *Codice Rosa* since 2013 and provides for its dissemination to the Emergency Rooms of all the Local Health Authorities and Hospitals of the Region. Thanks to a “domino effect”, this tool is spreading also to other Regions, following the criticalities detected by several parties in the responses to gender violence.

With this pathway, which links the various Institutions to act on

the same problem and with different competences and skills, we aim at giving an effective response to the victims of violence as soon as they arrive at the Emergency Room, also by means of a greater diagnostic and therapeutic efficacy, while allowing maximum privacy and protection.^{8,9}

As is known, this is the most delicate phase, since those who visit the Emergency Room have not yet decided whether to report their attacker; these are different users than those of the anti-violence centers, therefore a circular exchange between the different nodes of the network, diversified by function and content, is important.

It’s a teamwork between the various operators, which is defined as “syncretism and contamination”, and which produces a continuous theoretical (through training) and practical exchange of views on the cases to be solved.

Considering once more the problem from the perspective of the victims of abuse and violence, what we tried to bring out leads us to reflect once again on how a broken silence and the explicit request for help represent a crucial issue.

An issue which, in fact, is affected by psychological components, personal cultural and socio-economic conditions, as well as social elements and characteristics of the local context. Being able to count on an institutional network of integrated support and protections can offer an important window of opportunity and facilitate, if not the elimination, certainly the substantial containment of the phenomenon.

The propensity to report to the police is the result of a path of awareness, and requires the intervention of multiple actors and mutually interacting and cooperating institutions: from the Emergency Departments to the safe houses, from the police to the social workers, from the volunteers to the HCPs. A support that is stronger if gender violence is included as

a relevant element in the analysis of health inequalities as a cross-sectional category, and as a determinant – and not only a social one – that women pay. And, to finish, in the words of the dissertation of Dr. Maria Fischmann, who graduated in medicine in Pisa in 1893: *“the depressed state in which the woman lies in today's society (...), being married and under her husband's dominion, she is always in a state of inferiority that oppresses her, she cannot defend herself, she cannot struggle (...). Laws such as social uses prescribe her to suffer and to be silent (...). The influence of the state of mind on the functioning of the intestine is not a utopia”*.⁹

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Gender medicine: the knowledge of the staff of the Local Health Authority of Bologna

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The Emilia-Romagna 2017-2019 Social and Health Plan recognizes the importance of gender as a health determinant, as well as that of gender medicine as *“an innovative approach to health inequalities, starting from the onset and evolution of the disease – from symptoms, diagnosis and prognosis to treatments – related not only to a different diagnostic-prescriptive appropriateness, but also subject to social, cultural, psychological, economic and political inequalities”* (sheet no. 9) (<https://sociale.regione.emilia-romagna.it/piano-sociale-e-sanitario-2017-2019>).

With the aim of promoting actions to fight against inequalities and devise innovative projects for the personalization of care as part of modern welfare models, the Local Health Authority of Bologna established the working group on gender medicine, extending participation therein to representatives of the University Hospital of Bologna, of the Order of Physicians and the Order of Nursing Professions in the Metropolitan Area of Bologna. The group, consisting of 21 professionals from both the health and the administrative areas, also includes a general practitioner and the President of the association for social development and support *Medicina europea di genere* (MEG, “European Gender Medicine”) which, since 2015, has been involved in local activities, including the organization of seminars and congresses on the subject and popularization and awareness-raising activities for citizens, healthcare professionals and social workers.

The main objective of the group is to investigate the health inequalities related to gender differences and, based on the results, to plan,

develop and implement actions and tools aimed at ensuring the best therapeutic appropriateness. The first specific actions to raise awareness on this issue and to ensure the professional updating are planned for 2019 and 2020.

Based on the proposal of the MEG association, the group promoted a fact-finding inquiry, to be implemented through the administration of an online questionnaire among all the operators of the three Health Authorities of the metropolitan city of Bologna, as well as among general practitioners. The action aimed to arouse curiosity on the subject of gender medicine within the Authority, since both at the national and regional levels this field is considered strategic for the scientific research. It was also considered important to act by progressive steps, stimulating the interest in the study of the topic not only according to a didactic-educational, seminar approach, addressed exclusively to health personnel, but also starting from the analysis of the data concerning the provision of prescriptions, the access to services and hospitalization and home care, since the statistical analysis as a function of the “gender” variable is not yet an established approach. At the base of the questionnaire was the will to organize a public event for the restitution of the results and a first professional updating training initiative on some conditions selected as “meta-trackers”. The pathological conditions identified by the group in the questions of the questionnaire can in fact explain the pathological aspects that vary according to the patient's gender, and can be useful in highlighting the complexity of the approach through gender. The strategy implemented is able to provide, for these conditions, additional information, emphasized to the citizen and to the healthcare professional in the formative moments which follow the questionnaire.

The prefix “meta” – when used in Italian in compound words – has the