# Economic Impact of Domestic Violence on Health and the Health Care System

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profem




This project has been supported by *The Open Society Fund Prague* from the programme entitled Let's Give Women a Chance which is financed through the Norway Grants.

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Ekonomické dopady domácího násilí v oblasti zdraví
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# Foreword

It seems that quite a lot of attention has been given to the issue of domestic violence (also, "DV") over the past two years. We have specialised services, intervention centres, the institute of expulsion; we work with children who have been exposed to DV, with the perpetrator, but still, we have been witnessing many problems that we are unable to resolve. It is in particular the state administration that has not been very successful in this area.

Although there are many surveys in the Czech Republic regarding the prevalence of domestic and gender based violence that are as a rule carried out by scientific institutions and non-state non-profit organisations, any additional and comprehensive knowledge of these forms of violence is desperately insufficient. Unlike many other countries, the Czech Republic, however, does not perform any systematic and regular collection of data related to the occurrence of domestic and gender based violence at the level of state administration. Since the state administration lacks sufficient and relevant information, it cannot adopt effective and relevant measures at the nationwide level.

A non-uniform definition remains a problem, too. Each of the existing research studies works with a different definition; i.e. the individual data is hard to compare. Let us hope that the Istanbul Convention signed by the Czech Republic on 2 May 2016 will help unify this definition. This Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence is the most extensive international convention dealing with this serious aspect of human rights violations. It is a tool of the in-

ternational law that is binding for its signatories. The Convention is based on the assumption that violence against women is a form of "gender based" violence. The Convention seeks to change society; to shift the public thinking towards zero tolerance to violence.

The Istanbul Convention requires its parties to collect, at regular intervals, categorised and relevant statistical data on all forms of violence against women, including rape; to carry out population surveys based on the assessment of occurrence of various forms of violence against women, including rape; and it also supports research aimed at identifying the causes, impacts, prevalence and convictions. It also contains a definition of domestic violence on which our research was based as well. We hope the Convention will be ratified soon and the Czech Republic will take assistance to the victims of gender based violence seriously thanks to this Convention.

This document maps out one of the areas of gender based violence, i.e. domestic violence, in the context of its health consequences, and brings strong arguments in favour of system-based changes in the health care system. The Action Plan for the Prevention of Domestic and Gender Based Violence for the Years 2015–2018 has identified a wide range of problems. They include insufficient and unsystematic solutions for assistance to the persons who face gender based violence that should be provided by medical facilities. Another problem is the absence of a system for data collection in health care services. This document reacts to the Action Plan and brings the most recent data.

Using its outcomes, it is possible to set priorities and plan specific steps to improve this situation as well as to evaluate their efficiency.

*Jitka Poláková*
Director of proFem, o. p. s.

# 1. Introduction

Domestic violence (also, "DV") is a complex problem that may be viewed from many aspects. We can say it is a criminal activity, but there is also an important risk factor of poverty of the persons who are or were exposed to domestic violence. Nonetheless, there is always a cause and a consequence in the context of gender based inequality in society.

The main focus of the presented study is on domestic violence from a different perspective than we usually encounter. Here we view domestic violence as a health problem. Domestic violence has not yet been sufficiently examined and analysed from this perspective in the Czech Republic, i.e. it enables us to submit additional important arguments that would point to the magnitude of this issue. Health consequences of domestic violence often complicate life of victims and deteriorate its quality. It is not only about injuries caused by physical assaults, but mainly about health complications resulting from the long-term exposure to psychological abuse, i.e. psychological and mental problems and psychosomatic diseases. Chronic diseases represent a very serious consequence. In the most extreme cases, domestic violence can result in the victim's death.

Our study has primarily focused on one aspect of this issue, i.e. the cost of health care in connection with DV. We do not want to reduce the issue of DV solely to the calculation of economic costs. The price paid by the victims of DV cannot be expressed in money. Actual human costs are not measurable. However, health care costs represent a very significant part of the costs incurred in connection with DV. Therefore, this issue requires special attention.

Timely support of victims and the development of preventive measures are not only a matter of human and social responsibility but also have an economic dimension.

The study entitled "Economic Impacts of Domestic Violence in the Czech Republic" prepared by proFem in 2012 has shown that the largest part of the cost related to the solution of impacts of DV is connected namely with the health care system. The study has estimated the cost to the health care system at CZK 545.9 million a year. This is only an estimate; this sum did not include a host of factors. Therefore, we have decided to examine the health care system in more detail in our next research. As you can read in Chapter 4, the more detailed research has shown that the identified cost is many times higher than our 2012 estimates.

The study focuses on DV against women in partner relationships. However, domestic violence does not regard partners only; it may also be found in relationships between parents or grandparents and children, between siblings or in other close relationships. Men, of course, are also among the victims of DV. However, both surveys and our practice and data from other non-profit organisations and institutions[1] have shown that women make up more than 90% of victims of DV and that DV is a phenomenon that may be mainly found in partner relationships. "With serious forms of domestic violence such as gross forms of physical and sexual violence or dangerous pursuits, we can identify clear gender asymmetry (women account for up to 97% of victims). Gender asymmetry may also be identified in cases of sexual violence and it is also true that women are a majority of persons murdered by their partners."[2] Since our research could not embrace all categories of persons jeopardised by DV, we focused only on DV against women in partner relationships.

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1 Czech Statistical Office. 2016. *Gender: základní pojmy.* [online]. [accessed 2 May 2016]. Available at: https://www.czso.cz/csu/gender/gender_pojmy. In 2015, proFem had 331 clients, of which women made up 90% and men represented 10%.

2 *Akční plán prevence domácího a genderově podmíněného násilí na léta 2015–2018 (Action plan for the prevention of domestic violence and violence against women for the years 2015–2018)*. Praha: Úřad vlády ČR, 2015, p. 10.

We hope this study will be an interesting source of information not only for those who professionally deal with DV but also for the Ministry of Health of the Czech Republic, health insurance companies and other professionals and specialists working in the health sector as well as for the medical staff who encounter victims of domestic violence at their work, whether knowingly or unknowingly. We also hope that the study will give an idea of how significant a problem domestic violence is, also in relation to expenses connected with medical care and treatment of its health consequences.

# 2. Connection between Domestic Violence and Health Consequences

Domestic violence often has a significant impact on health of the persons who experience or have experienced it. These may often be very serious consequences. They largely concern physical and mental health, but they also affect behaviour of victims. Health consequences of DV include not only acute **physical injuries** requiring immediate health care, but long-term psychological and physical health consequences are much more serious. According to the World Health Organisation (WHO),[3] health consequences of violence against women may be acute, long-term, chronic and/or lethal. Health consequences also often persist long after termination of the violent relationship.

Typical **physical injuries** resulting from violence against women include: bruises, burns, bone fractures, dental injuries, injuries of head, ears, eyes, chest and abdomen, impairment of functional abilities and permanent physical consequences. Frequent **psychological consequences** include the post-traumatic stress disorder, depression, anxiety, insomnia, panic attacks, self-harm, suicidal tendencies, eating disorders, loss of self-esteem and self-confidence. DV also results in **psychosomatic health consequences** such as the chronic pain syndrome, irritable colon syndrome, gastrointestinal problems, respiratory difficulties, urinary tract infections. DV may also have a negative impact on **behaviour** resulting in abuse of alcohol, tobacco products and other addictive substances as well as in risky sexual behaviour.

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3 Garcia-Moreno, C., Guedes, A., Knerr, W. *Health consequences. Understanding and addressing violence against women.* [online]. WHO, 2012, p. 1. [Accessed 29 April 2016]. Available at: http://apps. who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf?ua=1.

Last, but not least, they include **consequences related to reproductive health** (ovarian inflammation, sexually transmitted diseases, vaginal infections, chronic pelvic inflammations, unwanted pregnancy, complications in pregnancy, miscarriages).[4]

## 2.1 Foreign Studies on Health Consequences of DV

A survey about prevalence of violence against women carried out in Germany revealed that one fifth of women aged 16–85 years suffered from a physical injury as a result of violence at least once in their lifetime. One third of these women said their injuries had been so severe that they had to seek medical attention. According to the survey, the injuries were repeated in cases where the perpetrator had been their ex- or current partner.[5]

A study about prevalence of violence against women shows that the majority of women who were injured as a result of physical and/or sexual violence by their current or former partner suffered from bruises (89%), physical pain (26%), open wounds (20%), abdominal pain (18%), muscular and ligament injuries (18%), head injuries (18%), vaginal injuries (10%), concussion (10%), physical fractures (5%), miscarriage (4%) and internal injuries (3%).[6]

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4 Garcia-Moreno, C., Guedes, A., Knerr, W. *Health consequences. Understanding and addressing violence against women*. [online]. WHO, 2012, p. 2. [Accessed 29 April 2016]. Available at: http://apps. who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf?ua=1. a Hornberg, C., ed. *Health Consequences of Violence with Special Consideration of Domestic Violence against Women.* [online]. Berlin: Robert Koch Institute, 2008, p. 11. [Accessed 2 May 2016]. Available at: http:// www.rki.de/EN/Content/Health_Monitoring/Health_Reporting/GBEDownloadsT/gewalt.pdf?_ blob=publicationFile.

5 Hornberg, C., ed. *Health Consequences of Violence with Special Consideration of Domestic Violence against Women*. [online]. Berlin: Robert Koch Institute, 2008, p. 12. [Accessed 2 May 2016]. Available at: http://www.rki.de/EN/Content/Health_Monitoring/Health_Reporting/GBEDownloadsT/gewalt.pdf?_blob=publicationFile.

6 Schröttle, M., Müller, U. *Life situation, safety and health of women in Germany. A representative study on violence against women in Germany*. Federal Ministry for Family Affairs, Senior Citizens, Women and Youth 2004. [Accessed 3 May 2016]. Available at: www.bmfsfj.de/Kategorien/Forschungsnetz/forschungsberichte,did=20560.html.

Health consequences include gynaecological problems that more frequently concern women who experienced DV. According to a representative survey in the United States of America, the likeliness of gynaecological problems is much higher in case of abused women than in women who have not experienced violence.[7] Gynaecological problems therefore represent the most significant difference in the health condition of women who have encountered DV and those who have not experienced it.[8] The evaluation of the representative German survey of violence against women[9] has also proved a strong link between violence experienced and the health condition during life. Women who had been exposed to physical attacks, sexual or psychological violence during their life see their health condition much more negatively than women who had not been victims of violence. In addition, women who had suffered from DV show more frequent symptoms of physical and mental health problems (abdominal pain, headache, gastrointestinal problems, tremor, nervousness, dizziness, breathing problems, blood pressure volatility, and other gynaecological problems). There is apparently a strong increase in health difficulties in case of long-lasting violence. Surveys have also proved a relation between physical violence and functional heart problems and asthma.[10] According to a WHO report[11], women who have experienced violence in their partner re-

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7 McCauley, J., Kern, D. E., Kolodner, K., et al. *The battering syndrome: prevalence and clinical characteristics of domestic violence in primary care Internal Medicine Practices*. 1995, Annals of Internal Medicine, 123 (10), pp. 737–746.

8 Campbell, J. *Health consequences of intimate partner violence*. [online]. Lancet 359 (9314), 2002, ppp. 1331–1336. [Accessed 19 April 2016]. Available at: http://www.thelancet.com/pdfs/journals/lancet/ PIIS0140-6736%2802%2908336-8.pdf.

9 Schrottle, M., Khelaifat, N. *Health – Violence – migration: a comparative secondary analysis of the violence-related health situation of women with and without a migration background*. [online]. A research project of the Interdisciplinary Centre for Research into Women and Gender at the University of Bielefeld, 2008. [Accessed 3 May 2016]. Available at: http://www.bmfsfj.de/bmfsfj/generator/Kategorien/Forschungsnetzforschungsberichte,did=108722.html.

10 Mark, H., Bitzker, K., Rauchfuss, M. *Health consequences of experiences of physical and sexual violence in adult women*, 2005. In: Mathias, D., Siedentopf, F., Siedentopf, J. P., et al., ed. *Welcome and departure – psychosomatics between preimplantation diagnostics and paliative carzinoma treatment*, pp. 213–221.

11 Garcia-Moreno, C., Guedes, A., Knerr, W. *Health consequences. Understanding and addressing violence against women*. [online]. WHO, 2012, p. 2. [Accessed 29 April 2016]. Available at: http://apps. who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf?ua=1.

lationship tend to have various chronic health problems such as headache, chronic pelvic pain, spinal pain, abdominal pain, irritable colon syndrome and other digestive disorders. Note also that any failure to recognise violence as the originating factor of health problems and incorrect (or no) treatment may lead to chronic or permanent consequences[12]. For instance, gynaecologists sometimes do not see any direct connection between abdominal pain and possibly experienced violence, and a patient may receive inadequate treatment.

## 2.2 Economic Impact of DV on the Health Sector Abroad

The cost of DV stated in foreign studies mostly concerns the so-called socioeconomic costs including the loss of economic output, the cost of public services including the health sector, the justice system, social services (housing and protection of children), specialised services for victims of violence as well as the additional element of the physical and emotional impact of domestic violence on victims. There are only very few foreign studies or materials focused purely on the calculation of the economic impact of DV on the health sector. It should, however, be added that different countries have different health insurance systems, i.e. no single calculation of the economic impact may be applied.

### United States of America

Women who have experienced violence in a partner relationship need more medical care and are forced to seek medical attention more often than the remaining population. The use of medical services increases along with the

12 Hornberg, C., ed. *Health Consequences of Violence with Special Consideration of Domestic Violence against Women*. [online]. Berlin: Robert Koch Institute, 2008, p. 25. [Accessed 2 May 2016]. Available at: http://www.rki.de/EN/Content/Health_Monitoring/Health_Reporting/GBEDownloadsT/gewalt.pdf?_blob=publicationFile.

severity of violence[13]. A study focused on 3,000 women has shown that annual health care costs were by 42% higher in case of women who had been exposed to physical violence at the time and by 19–24% higher in case of women who had experienced violence over the past five years.[14]

## United Kingdom

A recent study[15] on the cost of gender based violence (GBV) and violence in an intimate partner relationship (IPR) carried out in **the United Kingdom** has calculated the health care **costs** in 2012 related to this type of violence at **EUR 1,942,807,516** (GBV) **and EUR 1,166,765,238** (IPR)[16]. **Violence against women** represents **83%** of the total cost in health care in case of gender based violence (**EUR 1,613,448,832**) and **87%** of health care costs in case of violence in a partner relationship (**EUR 1,012,196,229**). The results of this study have also calculated that the costs of the justice system, health care and social services make up the largest portion of the total costs. Special services aimed at mitigating the consequences and preventing this type of violence account for less than 3%; the proportional part of the costs allocated to prevention may therefore be regarded as very low.

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13 Black, M. C. Intimate partner violence and adverse health consequences: implications for clinicians. [online]. *American Journal of Lifestyle Medicine*, 2011 [Accessed 3 May 2016], 5, pp. 428–439. Available at: http://ajl.sagepub.com/content/5/5/428.full.pdf+html.

14 Bonomi, A. E., et al. *Health care utilization and costs associated with physical and nonphysical-only intimate partner violence*. Health Services Research, 2009, 44, pp. 1052–1067.

15 This case study is part of the report prepared by the European Institute for Gender Equality (2014). Using the results of the UK case study, this report determines, on the basis of extrapolation, estimates of costs of gender based violence and violence in a partner relationship in all EU countries.

16 Walby, S., Olive, P. European Institute for Gender Equality (2014). *Estimating the costs of gender-based violence in the European Union*. Report. Luxembourg.

# 3. Research Methodology

Since there is no official data and statistics in the Czech Republic as regards DV-related health care expenditure, we needed to gather the relevant selective data that could be used to make qualified estimates of this expenditure. A **representative questionnaire-based survey among the Czech female population** was used as a key input for our analysis. It enabled us to map out the prevalence of domestic violence and its specific individual forms among women over 18 years of age and to find out which specific health care forms the women exposed to DV used in 2014. Using these figures, we have made estimates of the financial costs of DV against women with regard to the health care system in the Czech Republic in 2014. Below you will find a more detailed description of individual steps forming our study.

## 3.1 Method of Sample Selection and Data Collection in Questionnaire-based Survey

The survey focused on estimating the financial costs of DV-related medical care was carried out using a questionnaire-based survey. The target group involved women over 18 years of age living in the Czech Republic. The sample was chosen on the basis of a random selection (random route) and the data was collected through personal interviews. We wanted to cover as large a representative sample of the female population as possible, including groups that cannot be reached through internet questioning (people with-

out internet access, senior citizens, and higher income groups not interested in registration in the internet panel, etc.). Advantages of personal interviews also include an option to secure privacy of the respondents during the interviews, i.e. especially the absence of their partner or other persons (potential aggressors) during the actual interview.

The random route method as such almost never provides a sample that would absolutely exactly correspond to the characteristics of the population (here the population of all women in the Czech Republic aged 18 years and more). Therefore, the data set obtained was reweighed in order to fully correspond to the key characteristics of the population according to the age structure and region of residence. The reweighed representative sample was used as an initial source for all calculations made.

Table 1: **Sample and Population Structure**[17]

| | Not weighed | Weighed | Czech Republic – Women as on 01/07/2014 |
|---|---|---|---|
| **Age** | | | |
| 18–24 years | 7.6 % | 9.2 % | 9.2 % |
| 25–34 years | 16.0 % | 16.0 % | 16.0 % |
| 35–44 years | 21.5 % | 19.0 % | 19.0 % |
| 45–54 years | 19.1 % | 14.9 % | 14.9 % |
| 55–64 years | 17.1 % | 16.5 % | 16.5 % |
| 65+ years | 18.7 % | 24.5 % | 24.5 % |

17 All tables and graphs were prepared by MindBridge as part of this survey in 2016.

| | Not weighed | Weighed | Czech Republic – Women as on 01/07/2014 |
|---|---|---|---|
| **Region** | | | |
| Prague | 12.8 % | 12.3 % | 12.3 % |
| Central Bohemia Region | 12.5 % | 12.2 % | 12.2 % |
| South Bohemia Region | 5.8 % | 6.0 % | 6.0 % |
| Plzeň Region | 5.0 % | 5.4 % | 5.4 % |
| Karlovy Vary Region | 2.0 % | 2.8 % | 2.8 % |
| Ústí Region | 8.0 % | 7.7 % | 7.7 % |
| Liberec Region | 4.0 % | 4.1 % | 4.1 % |
| Hradec Králové Region | 5.7 % | 5.2 % | 5.2 % |
| Pardubice Region | 4.7 % | 4.9 % | 4.9 % |
| Vysočina Region | 4.3 % | 4.8 % | 4.8 % |
| South Moravia Region | 11.2 % | 11.2 % | 11.2 % |
| Olomouc Region | 6.2 % | 6.1 % | 6.1 % |
| Zlín Region | 5.3 % | 5.6 % | 5.6 % |
| Moravia-Silesia Region | 12.5 % | 11.7 % | 11.7 % |

**The questionnaire was completed by 3,058 respondents.** Only women were included in the interviews with regard to the sensitive nature of the surveyed issue. We considered the fact that DV against women had been mostly perpetrated by men.[18] We wanted to provide the respondents, including those who had experienced or had been experiencing DV, with as strong feeling of security, comfort and trust as possible.

18 For instance, the German representative study entitled *Health, Well-being and Personal Safety of Women in German. A Representative Study on Violence against Women in Germany*, from 2004, states on p. 14 that only 1% of women in a partner relationship have experienced violence by a woman; the remaining 99% have experienced violence by their partner, a man.

## 3.2 Questionnaires and Operationalisation of DV

For the purpose of our study, we prepared **two questionnaires** (the main questionnaire and medical sheets). The main questionnaire was presented to all **women addressed in the survey (i.e. 3,058 women)**. The second questionnaire (medical sheets) was completed **only by those who had encountered DV and who had been treated for its consequences in 2014 (115 women)**.

**The aim of the first (general) questionnaire** intended for all women over 18 years of age was to evaluate whether the given woman had ever experienced DV in the past and whether she had been treated for consequences of DV in 2014. This questionnaire also mapped out the presence of children during DV and was capturing the basic sociodemographic characteristics.

In order to determine whether or not a respondent was a victim of DV, we had to choose a definition of domestic violence that would be used as a fundamental basis in the survey.

There is no single **global definition of DV**, not even in the Czech Republic, because it is a comprehensive and complex issue that may be viewed from many perspectives. For our survey, we chose the following two definitions of DV as essential elements:

> *Domestic violence shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.*[19]

The second definition focuses merely on domestic violence between partners.

> *Domestic violence occurs on the basis of abuse of power and control by one person (most frequently a man) over another person (usually a woman) in the context of an intimate relationship. Vio-*

19 Definition contained in Article 3 of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention).

*lence can take many forms, including physical violence, psychological violence and emotional blackmail, economic controlling and isolation of the victim, or limitation of his/her moves.*[20]

During preparation of the main questionnaire, considerable attention was given to operationalisation of DV. As the background, we used both our previous research projects, in particular as part of the study of the "Economic Impacts of Domestic Violence in the Czech Republic", and we were also inspired by many international research studies dealing with domestic violence[21]. We were considering how these studies defined the situations in which victims of DV experienced actual violence, whether psychological, physical or economic.

In order to prepare the main questionnaire, we set up a **working group** consisting of the proFem team and the MindBridge team, and we also invited experts from non-profit organisations and state administration who had been dedicated to the issue of DV on a long-term basis. These experts brought their practice-based knowledge and experience to the process of the questionnaire preparation, and we considered it when drafting the main questionnaire. The working group came with a list of situations describing DV. After the pilot study with victims of DV, the final list included a total of forty situations (see Table 2).

In order to be able to determine whether or not a respondent has experienced DV, we developed an operationalised definition of DV based on the fulfilment of at least one of the four conditions based on the experience of

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20 Vargová, B., Vavroňová, M. *Od dobrého úmyslu k dobré spolupráci.* Praha: ROSA, 2008, p. 5.

21 E.g. Hornberg, C., ed. *Health Consequences of Violence with Special Consideration of Domestic Violence against Women*. [online]. Berlin: Robert Koch Institute, 2008. Available at: http://www.rki.de/EN/Content/Health_Monitoring/Health_Reporting/GBEDownloadsT/gewalt.pdf?_blob=publicationFile, Isaac, E. N., Enos, V. P. *Documenting Domestic Violence: How Health Care Providers Can Help Victims.* [online]. National Institute of Justice. Washington, DC., 2001. Available at: <https://www.ncjrs.gov/pdffiles1/nij/188564.pdf>, Müller, U., Schröttle, M., Glammeier, S. *Health, Well-being and Personal Safety of Women in German. A Representative Study on Violence against Women in Germany*. [online]. Federal Ministry for Family Affairs, Senior Citizens, Women and Youth. Berlin. 2004. Available at: <http://www.cahrv.uni-osnabrueck.de/conference/SummaryGermanVAWstudy.pdf>.

any of the 40 situations constituting the elements of DV. The definition of the conditions was based on the principle that to evaluate less serious situations as manifestations of DV, they need to occur repeatedly in combination with other (one or two situations) while in case of the most serious situations (physical assaults with a potential to cause a serious injury or death), their unique occurrence was sufficient.

1) The woman has at least once experienced situations 6, 24, 29, 30 and 34–40 or repeatedly experienced situations 2–4, 8, 12–19, 21, 23, 25–28, 32 or 33;
2) The woman has at least experienced a combination of two situations where unique occurrence of situations 2, 4–6, 13, 15–17, 23–30, 32–40 was sufficient while repeated occurrence was necessary in case of situations 3, 8, 12, 14, 18, 19 and 21;
3) If the woman has experienced situations 10, 11, 20, 22 and 31, it was necessary, for her to be included among the women exposed to DV, that she experienced at least one of these situations repeatedly and repeatedly encountered any other situation except for situation 9;
4) If the woman repeatedly experienced situation 9, she must have experienced at least two other situations in order to be included among victims of DV.

Table 2: **List of Situations Constituting Elements of DV**

| List of Situations Constituting Elements of Domestic Violence |
|---|
| 1) He insisted that he should always know where you were, with whom, and what you were doing |
| 2) He was pursuing you; harassing you with phone calls, text messages, emails (stalking) during or after your relationship |
| 3) He sought to limit/prevent your contacts with friends or family |
| 4) He did not let you in the flat |
| 5) He filed deliberately untrue denunciations or accusations against you |

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|---|
| 6) He psychologically humiliated you on a long-term basis (saying you are worth nothing, ...) |
| 7) He deliberately did things to scare or intimidate you (by shouting, breaking things, ...) |
| 8) He did things with the objective of raising doubts in you with regard to your mental health (deliberately confusing you, hiding things, incapacitating you, ...) |
| 9) He made you sign contracts, invoices or other documents against your will |
| 10) He put you into debt by deliberately failing to pay agreed expenses |
| 11) He limited your access to family funds and shopping without his knowing it |
| 12) He took your income or property |
| 13) He restricted your whereabouts (banning you to leave the house, locking you in, closing you in, tying you, ...) |
| 14) He denied you food or sleep |
| 15) He threatened you to harm or kill you |
| 16) He threatened you to harm your children, relatives or pet or has done so |
| 17) He threatened you to drop you off while driving or dropped you off in an unknown place in the middle of the trip |
| 18) He deliberately destroyed things to which you had an emotional relationship |
| 19) He deliberately destroyed your or your children's medical equipment |
| 20) He threatened you to shave your head or has done so |
| 21) He incited you (physically or verbally) to commit suicide |
| 22) He threatened you to prevent your contact with children or has done so on a long-term basis |
| 23) He made you consume drugs |
| 24) He tried to poison you/He poisoned you with medicines, chemicals or food |
| 25) He prevented you from seeking medical attention |
| 26) He was pawing you, touching your intimate parts or was kissing you against your will |
| 27) He forced you to sex or sexual practices against your will |
| 28) He forced you to sex in front of your children or other people |

| |
|---|
| 29) He published your intimate photos or contacts and/or photos in erotic adverts against your will |
| 30) He tried to induce abortion during your pregnancy or made you have an abortion |
| 31) He made you do physical work lasting several hours |
| 32) He pushed you or slapped you in your face |
| 33) He was tugging your hair, he plucked out your hair |
| 34) He harmed you by deliberately causing you injury (pushing you down the stairs; tripping you up; throwing you out of a driving car, ...) |
| 35) He beat you with his fist or kicked you |
| 36) He pushed your head against an object or a wall |
| 37) He threw a hard object against you or used a hard object to beat you |
| 38) He used a knife, a gun, a paralyser, electric current or another weapon against you |
| 39) He burnt you, scalded you |
| 40) He was smothering you, strangling you |

The answers of the women whether or not they have encountered individual violent situations in their lifetime and if they did, whether such situations occurred only once or repeatedly, were crucial to assess whether or not the given woman was a victim of domestic violence. With each situation experienced (whether once or repeatedly), we also identified whether it had been experienced in 2014 as well.

Another series of questions should determine whether or not the woman had to seek medical attention as a direct or indirect consequence of DV (i.e. a doctor, psychologist, psychiatrist, rehabilitation specialist; whether she had to take medicine, use medical aids, etc.) and whether she had to seek medical attention also in 2014. This information was essential to determine whether the woman should be questioned in the second questionnaire (medical sheet).

**The medical sheets,** i.e. the second questionnaire, were used to provide a detailed description of injuries and consequences of DV treated in 2014. The medical sheets were completed only by those respondents who said in

the main questionnaire that they had been treated as a consequence of DV in 2014 as well. A total of **115 respondents completed the medical sheets**. Domestic violence whose consequences were treated in 2014 could also have occurred prior to 1 January 2014; but it was crucial that the women were treated for the consequences of this assault in 2014.

The primary objective of our survey was to identify and calculate the costs to the health care system as a result of domestic violence. Therefore, we consulted the main questionnaire and especially the medical sheets with a medical officer who subsequently calculated the actual cost of health care. The aim was to ensure that the questionnaire were prepared in a manner that it really could be used to obtain the relevant information necessary to estimate the cost of health care. We also invited a researcher from the Sociologic Institute of the Academy of Sciences of the Czech Republic to consult the actual form of the questionnaire.

## 3.3 Data Collection

The actual field collection of data was preceded by a **pilot study related to both questionnaires** involving 100 women for the main questionnaire and 30 women for the medical sheets. The pilot study was primarily used to verify the accuracy of the questionnaire structure and articulation of individual questions. It took place in June and July 2015 and was used to prepare the final wordings of both questionnaires.

Once the questionnaires were finalised, the process continued with **training of questioners**. A total of four group training sessions were held as well as almost twenty individual sessions with the questioners between the end of August and the beginning of October 2015. During these sessions, the questioners were informed about the topic of the survey and the relating specifics as well as about the questionnaires and methods of their completion. Great emphasis was put on maintaining privacy during the questioning. The questioners were instructed that questions must be given to women alone

(whether at home or in another place), i.e. without her partner or other family members (only the presence of small children under 3 years of age was tolerated). If it was impossible to secure this environment, the questioners had an obligation to try to agree on another date in order to meet these requirements.

The first training was attended by two social workers of proFem who presented the **"Ten Rules"** to the questioners, i.e. instructions on how to communicate with women who have experienced or are experiencing DV. Our intention was that the questioners should realize the specifics of communication with victims of DV and acquire certain perceptiveness and view of this issue. The "Ten Rules" were further distributed to the questioners at the next training sessions by MindBridge, a company organising the training.

Last, but not least, the questioners were advised on security principles during the interviews, especially in case of any unexpected return of a partner. If any such situation occurred, the questioners were instructed to immediately interrupt the interview, leave the place and complete the questioning only when the principles of privacy during questioning were met. The security measures proved right during the interviews because the partner – aggressor returned unexpectedly home in two cases. In both cases, the aggressor was threatening to the questioners. Luckily enough, the questioners left the place of the meeting without any harm.

The actual **field data collection** was conducted in accordance with the principles of random (probability) selection (random route)[22] between Sep-

22 Each questioner received a list of starting points to be used to begin their random route according to specific rules (no questions to be asked at the starting point). First, the questioners should have stood in a place where they would have the starting point at their right hand, then find the fifth house, the fifth floor from above, and then to conduct an interview with the woman – the target person – in this flat. If there lived more women over 18 years of age in the given flat, the questioners asked about the month of birth of all women living in that flat, and the target person was the woman having the nearest birthday after the date of questioning. If the target person was not at home during the first visit of the questioner, the questioner sought to find a date when the woman could be interviewed. The questioner made up to three attempts to contact the selected woman. A similar procedure was applied in a situation when no one was present in the flat during the first visit of the questioner. In such case, the questioner made up to two other attempts to contact persons living in the given flat.

tember 2015 and March 2016. The selection process guaranteed a really random selection of the respondents and made it possible to carry out projections of the findings in the entire population (i.e. all women in the Czech Republic over 18 years of age).

## 3.4 Methodology of Calculating the Cost of DV in Health Care

To calculate the cost of medical care of women who had been treated for consequences of DV in 2014, we primarily used the medical sheets (i.e. the questionnaire completed only by the respondents who had experienced DV, i.e. 115 women). The actual processing was subjected to the idea that it should help women who had been treated for consequences of DV in 2014 (i.e. the actual acts of DV could have occurred before 2014, but the woman affected was also treated in 2014) and that it should describe the undergone treatment in as many details as possible. That means that the questionnaire also asked if the respondents had reported any deterioration of their health condition as a result of DV (i.e. an increased number of medical check-ups, increased doses of medicinal products, changed medication, etc.) and for what psychological and mental problems/injuries caused as a result of DV the women had been treated in 2014. The aim of this very detailed questionnaire was to obtain as much information as possible regarding the undergone treatment, i.e. a detailed description of the injuries, medication used and its dosage, whether the woman had been transported by an ambulance, whether she was hospitalised and how long, whether she attended rehabilitation, etc.

Such information obtained about the treatment of all injuries related to DV undergone in 2014 was subsequently delivered to the medical officer. According to all available data, the medical officer valued the records about individual patients and calculated both the cost to the public health care budget (i.e. the cost paid by health insurance companies) and the cost paid

by the woman alone, in particular in additional fees for prescribed medications and separately in other direct payments. The other direct payments include, but are not limited to, the cost of OTC medications bought by the women, payments and additional payments for medical equipment (lighter plaster cast, orthoses, etc.) or psychotherapy paid from own sources.

The valuation was based on the following sources:

- Regulation of the Ministry of Health of the Czech Republic No. 134/1998 Sb., Sb., as amended, issuing a list of medical interventions with point value
- Regulation of the Ministry of Health of the Czech Republic No. 428/2013, determining the point value, reimbursement of paid services and regulatory restrictions for 2014
- Index of Pharmaceuticals valid for 2014 – https://www.vzp.cz/poskytovatele
- Index of Interventions valid for 2014 – https://www.vzp.cz/poskytovatele

The calculation was made on the basis of the data that the respondent was able and willing to provide. Therefore, at certain moments, the missing data had to be modelled on the basis of long-term experience of the medical examiner and in accordance with the *lege artis* principle.

The cost stated represents the minimum costs we are able to prove within our survey, i.e. our estimates are therefore undervalued. It should be noted that the cost does not include certain specific situations. For instance, considering the method of data collection, women in shelters who had to leave their household and who often face very serious impacts of DV were not included in the survey. This is also the case of deaths as a result of DV and we believe that the questioners had not made it to the respondents with very serious forms of DV at all because they had simply never opened the door.

In case that a woman's health condition had been impaired as a consequence of DV, which was reflected in a higher number of check-ups, a higher number of doses of medications, etc., only the increase was included in the calculation.

The second part of the survey focused on mental and psychological problems. We assessed the cases where the respondents had to seek medical attention or had to receive long-term out-patient treatment due to a worsened mental condition or who were admitted to hospital. In addition to psychiatric care, the out-patient care also usually required long-term psychotherapeutic interventions. Acute hospitalisation subsequent to an ambulance transport was assessed separately. There were also cases of hospital admissions in the follow-up care commitment at psychiatric hospitals. Payments for these hospitalisations were directly proportional to the length of the hospital stay.

If the woman experienced repeated impairment of her psychological condition in 2014, each case was assessed separately from the financial perspective. Costs of pharmaceuticals made up a fairly large part of these costs, but it must be also noted that medicines taken for insomnia are not covered from public health insurance.

The third part assessed cases of physical assaults and physical injuries. With repeated physical assaults, each case was again assessed separately.

In call cases (whether in case of out-patient injury treatment or in case of acute hospital admissions), the calculation included both clinical examinations and complementary examinations, e.g. X-ray, CT or ultrasound examinations, depending on the character of the injury. The calculation of payments also included the cost of any ambulance transport, operations, hospitalisation, as well as the cost of any follow-up rehabilitation care adequate to the type of the injury, depending on the data provided by the respondent.

## 3.5 Methodology of Calculating the Cost of Treatment of Chronic Diseases

To calculate the cost of the treatment of chronic diseases affected by occurrence of DV and paid from public health insurance, we used both the data from the main questionnaire and the figures provided by health insurance company VZP (in Czech: *Všeobecná zdravotní pojišťovna*). Specifically, this

included the data about the number of insured persons having a concrete diagnosis and the total cost of the treatment of all VZP patients with this diagnosis. Using these two figures, the average amount of treatment costs per one insured person was calculated.

That means that the costs were not calculated using the second questionnaire (medical sheets), but were modelled in a way to include all women assumed to suffer from the given chronic diseases as a result of DV.

The costs of the treatment of chronic diseases affected by DV were calculated only for the chronic diseases where our questionnaire survey recorded a statistically significantly higher prevalence in women who had experienced DV compared to the population of women with no experience with DV (of the 16 examined chronic diseases, the statistically significantly higher prevalence of chronic diseases in women who had experienced DV was recorded only in case of two diagnoses: diabetes, high blood pressure). The calculation also omitted gynaecological problems because the questionnaire survey showed lower prevalence within the population compared to the data calculated using the VZP figures. Therefore, it was impossible to determine the share of women who were treated for the given chronic disease and who were not (the calculated number of women who stated in the questionnaire that they had these chronic problems was lower than the calculated number of women who had been actually treated for these problems in 2014 according to the VZP data). This may be explained by the fact that the women questioned did not regard these problems as chronic.

When valuing the costs of the treatment of chronic diseases, we also considered the share of persons in the population suffering from the given chronic disease and seeing a doctor in this respect and of those who are not treated for the given chronic disease (or who do not draw funds from public health insurance for this treatment). This share was calculated using the data from the questionnaire survey and the background documents provided by VZP.

# 4. Survey Outcomes

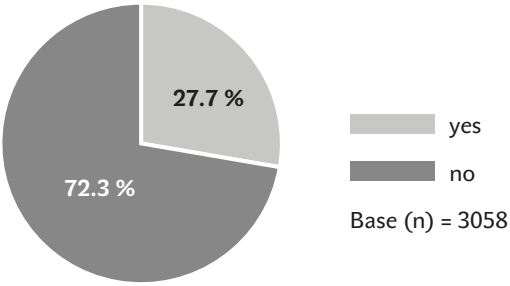
## 4.1 Main Survey Findings

- 27.7% of the respondents in the Czech Republic over 18 years of age have experienced DV in an intimate partner relationship during their lifetime.
- Almost one third of these women had to seek medical attention as a result of DV in an intimate partner relationship.
- Almost one fourth of women (24%) who had experienced DV in their relationship did not seek medical attention even though they needed it due to DV.
- Children were witnesses to DV among partners in 45.2% of cases. A child was physically injured during DV among partners in 2.9% of cases.
- Women who have experienced DV suffer from chronic health problems more frequently than women who have not experienced DV.
- The cost to the public health insurance system related to the treatment of women who experienced DV in 2014 is estimated at CZK 1.85 billion. Of this amount, the highest portion was paid by VZP (approx. CZK 1.241 billion). Victims of DV also paid an additional CZK 215 million.
- The cost of public health insurance incurred in relation to the treatment of chronic diseases affected by DV is estimated at CZK 1.088 billion in 2014.

## 4.2 Occurrence of DV

As shown by the findings of our questionnaire survey, **27.7% of respondents over 18 years of age in the Czech Republic have been subjected to DV during the course of their lifetime**. Should this figure be generally applied to the entire female population in the Czech Republic, **this share corresponds to approx. 1.232 million women** out of 4.449 million women over 18 years of age.

Graph 1: **Occurrence of DV among the respondents in the Czech Republic over 18 years of age**




It must, however, be remembered that this figure includes only DV in an intimate **partner relationship**, with a woman being a victim, and that it does not include other groups of persons who have experienced or are experiencing DV (men, parents and grandparents, etc.). Should we consider other victims of DV, it may be presumed that the prevalence of DV would be even higher.

## 4.3 Cost of Public Health Insurance

The valued data on treatment obtained from 115 respondents out of the total number of 3,058 respondents has been recalculated on the basis of age groups to the entire female population of the Czech Republic aged over 18 years in 2014. According to these calculations, **a total of 3.65% of women over 18 years of age sought medical attention in 2014 as a result of DV,** which corresponds to **162,000 women** if related to the entire population.

The estimated **cost of public health insurance** related to the treatment of victims of DV among women over 18 years of age amounted to approximately CZK **1.850 billion in 2014**. According to our calculations, an additional CZK **215 million was paid directly by the victims in additional fees and charges for the medications prescribed** (CZK 127 million) and in other direct payments (CZK 89 million). The estimated cost to the public health insurance system resulting from DV in 2014 is calculated below as per individual health insurance companies and according to the number of clients of individual insurers.

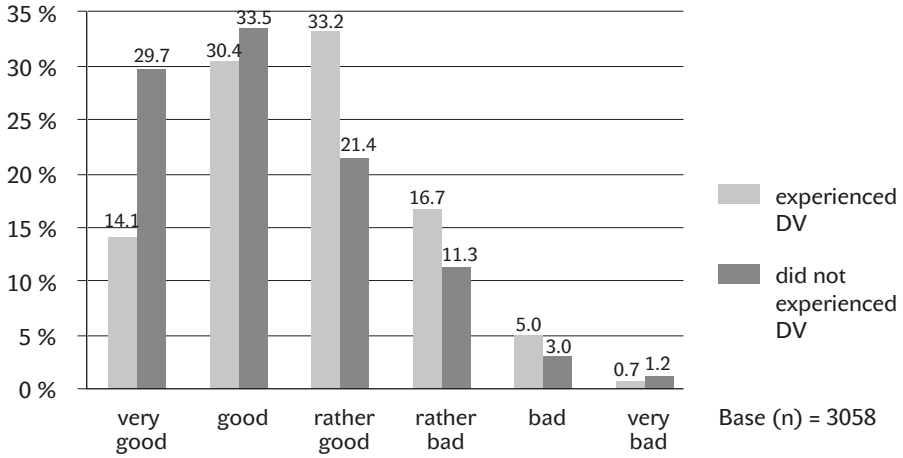
Table 3: **Estimated Cost of Treatment of Victims of DV in 2014**

| Health insurance company | Cost related to DV 2014 (CZK) |
|---|---|
| VZP | 1,240,695,968 |
| ČPZP | 159,388,995 |
| ZPMV | 160,421,230 |
| VojZP | 128,746,363 |
| OZP | 89,186,392 |
| RBPZP | 43,602,804 |
| ZPŠ | 24,277,207 |
| not identified | 4,133,474 |
| **total** | **1,850,452,433** |

## 4.4 Health Condition

**The women who have become victims of DV during their lifetime assessed their health condition as being worse** compared to those who have not experienced DV. For instance, 29.7% of women who have not experienced DV assessed their health condition as very good as compared to 14.1% of those subjected to DV.

Graph 2: **Health condition of female population over 18 years of age (%)**




## 4.5 Chronická onemocnění

V rámci výzkumu bylo taktéž ověřováno, zdali se liší míra výskytu vybraných chronických onemocnění u žen, které byly oběťmi DN, a žen, které jej nezažily.

Tab. 4: **Výskyt chronických onemocnění**

| Chronic disease | Experienced DV | Not experienced DV |
|---|---|---|
| **total** | **847** | **2,211** |
| arthritis | 17.5 % | 12.2 % |
| asthma | 9.3 % | 5.5 % |
| headache, migraines | 42.3 % | 21.0 % |
| backache | 52.0 % | 35.3 % |
| depressions | 19.0 % | 4.0 % |
| diabetes | 11.8 % | 11.2 % |
| gynaecological problems | 16.4 % | 7.8 % |

| Chronic disease | Experienced DV | Not experienced DV |
|---|---|---|
| chronic pain | 14.5 % | 7.5 % |
| insomnia (sleep disorders) | 27.8 % | 13.2 % |
| immunity disorders | 6.4 % | 2.4 % |
| eating disorders | 3.0 % | 1.2 % |
| post-traumatic stress disorder | 2.6 % | 0.6 % |
| anxiety | 17.0 % | 3.7 % |
| blackouts | 6.4 % | 3.7 % |
| high blood pressure | 26.8 % | 23.9 % |
| digestive problems | 15.1 % | 8.2 % |
| none of the stated | 14.2 % | 37.1 % |

**The data obtained shows that statistically significantly higher occurrence of 14 out of 16 examined chronic diseases may be seen in women who have experienced DV**. The survey also found that only 14.2% of women who had experienced DV said that they did not suffer from any of the stated chronic diseases as compared to 37.1% of those who had not been subjected to DV. Women who have experienced DV suffer from, e.g. headache and migraines, backache, chronic pain, anxiety, insomnia, gynaecological problems, and immunity disorders, to a much larger extent, sometimes even twice as much, as compared to women who have not experienced DV. Women with experienced DV reported up to five times higher occurrence of depressions than other women.

However, it is impossible to state on the basis of solely these figures that experience with DV results in higher occurrence of the given chronic disease. To state this, we lack a clearly documented causal relationship, which was not the objective of our research project.

In the following questions, the respondents were asked whether they had suffered from the given chronic disease since their childhood, or if it had emerged during the course of their lifetime. If the occurrence of the given 14 chronic diseases in women with experienced DV were statistically significantly higher dur-

ing the course of their lifetime, it would strongly support the hypothesis about the connection between DV and occurrence of chronic diseases.

In this case, we can see significant differences in the responses given by women having experience with DV and by those with no experience with DV only in two cases. These are chronic pain and immunity disorders where there is statistically higher occurrence of these diseases in women who have experienced DV since their birth while the statistically higher occurrence of these diseases in women who have not been victims of DV was recorded during the course of their lifetime.

Table 5: **Occurrence of Chronic Diseases by the Time of their Origin**

| | DN yes | | DN no | |
|---|---|---|---|---|
| Chronická onemocnění | since birth | during life | since birth | during life |
| arthritis | 3.3 % | 96.7 % | 1.8 % | 98.2 % |
| asthma | 39.8 % | 60.2 % | 35.0 % | 65.0 % |
| headache, migraines | 12.0 % | 88.0 % | 10.9 % | 89.1 % |
| backache | 6.1 % | 93.9 % | 4.3 % | 95.7 % |
| depressions | 4.9 % | 95.1 % | 5.7 % | 94.3 % |
| diabetes | 4.3 % | 95.7 % | 5.1 % | 94.9 % |
| gynaecological problems | 4.8 % | 95.2 % | 5.3 % | 94.7 % |
| chronic pain | 11.0 % | 89.0 % | 3.5 % | 96.3 % |
| insomnia (sleep disorders) | 2.8 % | 97.2 % | 4.5 % | 95.5 % |
| immunity disorders | 33.7 % | 66.3 % | 11.9 % | 88.1 % |
| eating disorders | 13.4 % | 86.6 % | 19.4 % | 80.6 % |
| post-traumatic stress disorder | 6.1 % | 93.9 % | 11.1 % | 88.9 % |
| anxiety | 5.4 % | 94.6 % | 12.8 % | 87.2 % |
| blackouts | 3.3 % | 96.7 % | 3.1 % | 96.9 % |

| | | | | |
|---|---|---|---|---|
| high blood pressure | 2.0 % | 98.0 % | 0.4 % | 99.6 % |
| digestive problems | 8.5 % | 91.5 % | 8.5 % | 91.5 % |

Although in some other cases, we have not seen any statistically significant differences between the group of women with experienced DV and without it, the differences between occurrence of a given chronic disease since birth or later during lifetime may still indicate a certain trend, i.e. that occurrence of certain chronic diseases acquired during lifetime is more frequent in women with experienced DV. The inconclusiveness of the statistically significant differences between both groups of women may be justified by the size of individual subsets of women suffering from the given chronic disease in both groups.

Therefore, let us have a look at the occurrence of chronic diseases in women subjected to DV and without experienced DV in an aggregated form, i.e. let us observe the occurrence of chronic diseases without any differentiation. Although by using this method, we will not be able to determine which specific chronic diseases occur more frequently in individual female groups since birth and which during the course of their lifetime; we will increase the compared number of cases in both groups of women. Using this analysis, we will see that **women who have not been victims of DV show an aggregate of 1.52 chronic diseases, including 0.10 since childhood and 1.42 acquired during their lifetime.** In case of **women with experienced DV, these values are statistically significantly higher because there are on average 2.81 chronic diseases per one woman, including 0.23 since childhood and 2.58 acquired during the course of their lifetime.**

If, with this in mind, we still make an attempt to indicate which chronic diseases occur more frequently in women with experienced DV during the course of their lifetime as compared to the women without experienced DV, we will find out that these might include depressions, insomnia, eating disorders, post-traumatic stress disorder and anxiety. Even though it is impossible to make statistically significant conclusions with regard to these diseases, we may, using these data, trace certain links between experienced DV and a higher frequency of occurrence of these diseases. In such event, we may

draw a logical hypothesis that experienced DV is a cause of occurrence of the given chronic diseases for some of these women. For this hypothesis to be confirmed, it would be necessary to conduct a study specifically focused on examining the impact of experienced DV on the long-term health condition of the population/women.

In our study, we also estimated the cost of these chronic diseases. However, the cost of chronic diseases was not established from the second questionnaire (medical sheets), but it was calculated using a combination of the statistical data provided by VZP and the data from the main questionnaire (see Chapter 3.5).

**The total annual cost of public health insurance incurred in relation to the treatment of chronic diseases affected by DV in the model year 2014 was estimated at CZK 1.088 billion.**

This sum covers only the eleven chronic diseases described below and an absolutely expressed difference between the occurrence of individual chronic diseases in the population of women over 18 years of age with experienced DV and without it, and this amount does not include the assumed share of women who suffer from the given chronic disease but do not draw funds from public health insurance for its treatment.

Tab. 6: **Vyčíslení odhadu nákladů na léčbu chronických onemocnění**

| Chronic disease | Share in women with DV | Share in women without DV | Difference | Absolute difference | Abs. difference-treated | Average treatment costs per insured | Average annual costs (CZK) |
|---|---|---|---|---|---|---|---|
| **arthritis** | 17.5% | 12.2% | 5.3% | 65,345 | 6,760 | 8,707 | 58,864,207 |
| **asthma** | 9.3% | 5.5% | 3.8% | 46,851 | 35,085 | 3,458 | 121,338,018 |
| **headache, migraines** | 42.3% | 21.0% | 21.4% | 263,847 | 12,870 | 2,351 | 30,258,865 |
| **backache** | 52.0% | 35.3% | 16.7% | 205,899 | 78,670 | 3,847 | 302,678,313 |

| Chronic disease | Share in women with DV | Share in women without DV | Difference | Absolute difference | Abs. difference-treated | Average treatment costs per insured | Average annual costs (CZK) |
|---|---|---|---|---|---|---|---|
| **depressions** | 19.0 % | 4.0 % | 15.0 % | 184,940 | 31,360 | 4.255 | 133,432,739 |
| **diabetes** | 11.8 % | 11.2 % | – | – | – | – | – |
| **gynaecological problems** | 16.4 % | 7.8 % | 8.6 % | 106,032 | – | – | – |
| **chronic pain** | 14.5 % | 7.5 % | 7.0 % | 86,305 | – | – | – |
| **insomnia (sleep disorders)** | 27.8 % | 13.2 % | 14.6 % | 180,008 | 871 | 1,504 | 1,309,579 |
| **immunity disorders** | 6.4 % | 2.4 % | 4.0 % | 49,317 | – | – | – |
| **eating disorders** | 3.0 % | 1.2 % | 1.8 % | 22,193 | 10,320 | 12,928 | 133,422,411 |
| **PSD** | 2.6 % | 0.6 % | 2.0 % | 24,659 | 4,330 | 2,875 | 12,450,986 |
| **anxiety** | 17.0 % | 3.7 % | 13.4 % | 165,213 | 37,794 | 3,482 | 131,614,009 |
| **blackouts** | 6.4 % | 3.7 % | 2.7 % | 33,289 | 2,428 | 11,254 | 27,321,710 |
| **high blood pressure** | 26.8 % | 23.9 % | – | – | – | – | – |
| **digestive problems** | 15.1 % | 8.2 % | 6.9 % | 85,072 | 47,441 | 2,858 | 135,595,048 |
| **total** | | | | | | | **1,088,285,884** |

## 4.6 Experience with Different Forms of DV

The most frequent situations encountered by women who have experienced DV include controlling of their whereabouts (68.6% of victims of DV) and long-term psychological humiliation (45.9% of victims of DV). A total of 44.6% of victims of DV experienced a situation where their partner pushed them or slapped them in their face. One third of victims of DV stated their

partner had tried to limit or absolutely restrict their contact with friends or family. Women subjected to DV have also experienced economic forms of DV quite frequently. A total of 18% of women stated their partner had limited their access to family funds; 16% stated the partner had taken their income or property, and 14% had been deliberately put into debt by their partner.

Table 7: **Experienced Situations of DV – Categorised by Frequency of Occurrence**

| Experienced situations | Total | Women with exp. DV | No DV experience |
|---|---|---|---|
| **total** | **3 058** | **847** | **2,211** |
| He insisted that he should always know where you were, with whom, and what you were doing | 19.6 % | 68.6 % | 0.8 % |
| He humiliated you psychologically on a long-term basis | 12.7 % | 45.9 % | 0.0 % |
| He pushed you or slapped you in your face | 12.4 % | 44.6 % | 0.0 % |
| He sought to limit/prevent your contacts with friends or family | 9.2 % | 33.3 % | 0.0 % |
| He was pursuing you; harassing you with phone calls, text messages, emails (stalking) during or after your relationship | 7.1 % | 25.6 % | 0.0 % |
| He deliberately did things to scare/intimidate you | 6.2 % | 22.2 % | 0.0 % |
| He deliberately destroyed things to which you had an emotional relationship | 5.8 % | 21.0 % | 0.0 % |
| He limited your access to family funds and shopping without his knowing it | 5.4 % | 17.9 % | 0.6 % |
| He threatened you to harm or kill you | 5.1 % | 18.4 % | 0.0 % |
| He took your income or property | 4.4 % | 16.0 % | 0.0 % |
| He put you into debt by deliberately failing to pay agreed expenses | 4.2 % | 14.1 % | 0.4 % |

| Experienced situations | Total | Women with exp. DV | No DV experience |
|---|---|---|---|
| He beat you with his fist or kicked you | 3.9 % | 14.1 % | 0.0 % |
| He did not let you in the flat | 3.6 % | 12.9 % | 0.0 % |
| He forced you to sex or sexual practices against your will | 3.6 % | 12.9 % | 0.0 % |
| He threw a hard object against you or used a hard object to beat you | 3.5 % | 12.6 % | 0.0 % |
| He was pawing you, touching your intimate parts or was kissing you against your will | 2.8 % | 10.2 % | 0.0 % |
| He pushed your head against an object or a wall | 2.8 % | 10.2 % | 0.0 % |
| He threatened you to harm your children, relatives or pet or has done so | 2.8 % | 10.0 % | 0.0 % |
| He was tugging your hair/plucked out your hair | 2.7 % | 9.7 % | 0.0 % |
| He did things with the aim of raising doubt about your mental health | 2.3 % | 8.2 % | 0.0 % |
| He threatened to drop you off while driving or dropped you off in an unknown place in the middle of the trip | 2.2 % | 8.0 % | 0.0 % |
| He filed deliberately untrue denunciations or accusations against you | 2.2 % | 8.0 % | 0.0 % |
| He restricted your whereabouts | 1.8 % | 6.4 % | 0.0 % |
| He made you do physical work lasting several hours | 1.6 % | 5.5 % | 0.1 % |
| He caused you harm by deliberately injuring you | 1.5 % | 5.4 % | 0.0 % |
| He threatened you to prevent your contact with children or has done so on a long-term basis | 1.3 % | 4.6 % | 0.0 % |
| He prevented you from seeking medical attention | 1.2 % | 4.2 % | 0.0 % |
| He was smothering you, strangling you | 1.0 % | 3.5 % | 0.0 % |
| He denied you food or sleep | 0.7 % | 2.7 % | 0.0 % |

| Experienced situations | Total | Women with exp. DV | No DV experience |
|---|---|---|---|
| He made you sign contracts, invoices or other documents against your will | 0.7 % | 2.4 % | 0.0 % |
| He tried to induce abortion during your pregnancy or made you have an abortion | 0.6 % | 2.1 % | 0.0 % |
| He made you consume drugs | 0.5 % | 1.7 % | 0.0 % |
| He used a knife, a gun, a paralyser, electric current or another weapon against you | 0.4 % | 1.5 % | 0.0 % |
| He threatened you to shave your head or has done so | 0.3 % | 1.1 % | 0.0 % |
| He incited you (physically or verbally) to commit suicide | 0.3 % | 1.0 % | 0.0 % |
| He deliberately destroyed your or your children's medical equipment | 0.3 % | 1.0 % | 0.0 % |
| He forced you to sex in front of your children or other people | 0.2 % | 0.8 % | 0.0 % |
| He burnt you, scalded you | 0.2 % | 0.7 % | 0.0 % |
| He published your intimate photos or contacts or your contacts and/or photos in erotic adverts against your will | 0.2 % | 0.7 % | 0.0 % |
| He tried to poison you/He poisoned you with medicines, chemicals or food | 0.1 % | 0.4 % | 0.0 % |
| **Nothing of the stated** | 67.5 % | 0.0 % | 93.4 % |

As we can see from the table below, victims of DV in most cases encounter a given situation repeatedly. The highest form of repetitions may be found in the psychological form of abuse. Economic violence also has a frequent rate of occurrence.

Table 8: **Frequency of Experiencing Individual DV Situations – Categorised According to the Frequency of Occurrence**

| Experienced situations | Occurrence in case of women who have experienced DV | | |
|---|---|---|---|
| | total | of which | |
| | | once | repeatedly |
| **total** | **847** | | |
| He insisted he should always know where and with whom you were and what you were doing | 68.6 % | 6.4 % | 93.6 % |
| He humiliated you psychologically on a long-term basis | 45.9 % | 4.6 % | 95.4 % |
| He pushed you or slapped you in your face | 44.6 % | 37.3 % | 62.7 % |
| He sought to limit/prevent your contacts with friends or family | 33.3 % | 8.6 % | 91.4 % |
| He was pursuing you, harassing you with phone calls, text messages, emails (stalking) during or after your relationship | 25.6 % | 7.4 % | 92.6 % |
| He deliberately did things to scare/intimidate you | 22.2 % | 11.4 % | 88.6 % |
| He deliberately destroyed things to which you had an emotional relationship | 21.0 % | 37.6 % | 62.4 % |
| He limited your access to family finances and shopping without him knowing it | 17.9 % | 5.3 % | 94.7 % |
| He threatened you to harm or kill you | 18.4 % | 13.9 % | 86.1 % |
| He took your income or property | 16.0 % | 15.2 % | 84.8 % |
| He put you into debt by deliberately not paying the agreed expenses | 14.1 % | 35.8 % | 64.2 % |
| He beat you with his fist or kicked you | 14.1 % | 23.3 % | 76.7 % |
| He did not let you in the flat | 12.9 % | 39.5 % | 60.5 % |
| He forced you to sex or sexual practices against your will | 12.9 % | 22.2 % | 77.8 % |
| He threw a hard object against you or used a hard object to beat you | 12.6 % | 37.8 % | 62.2 % |

| Experienced situations | Occurrence in case of women who have experienced DV | | |
|---|---|---|---|
| | total | of which | |
| | | once | repeatedly |
| He was pawing you and touching your intimate parts or kissing you against your will | 10.2 % | 25.8 % | 74.2 % |
| He was tugging your hair, he plucked out your hair | 9.7 % | 16.6 % | 83.4 % |
| He did things with the aim of raising doubt about your mental health | 8.2 % | 8.2 % | 91.8 % |
| He threatened you while driving to drop you off or has dropped you off in the middle of the trip in an unknown place | 8.0 % | 51.1 % | 48.9 % |
| He filed deliberately untrue denunciations or accusations against you | 8.0 % | 17.1 % | 82.9 % |
| He restricted your whereabouts | 6.4 % | 15.9 % | 84.1 % |
| He made you do physical work lasting several hours | 5.5 % | 9.8 % | 90.2 % |
| He caused you harm by deliberately injuring you | 5.4 % | 25.8 % | 74.2 % |
| He threatened that he would prevent you or has prevented your contact with children on a long-term basis | 4.6 % | 12.0 % | 88.0 % |
| He prevented you from seeking medical attention | 4.2 % | 32.8 % | 67.2 % |
| He was smothering you, strangling you | 3.5 % | 38.5 % | 61.5 % |
| He denied you food or sleep | 2.7 % | 14.4 % | 85.6 % |
| He made you sign contracts, invoices or other documents against your will | 2.4 % | 44.8 % | 55.2 % |
| He tried to provoke abortion during pregnancy or made you have an abortion | 2.1 % | 72.2 % | 27.8 % |
| He made you consume drugs | 1.7 % | 29.0 % | 71.0 % |
| He used a knife, a gun, a paralyser, electric current or another weapon against you | 1.5 % | 40.5 % | 59.5 % |

| Experienced situations | Occurrence in case of women who have experienced DV | | |
|---|---|---|---|
| | total | of which | |
| | | once | repeatedly |
| He threatened you to shave your head or has done so | 1.1 % | 17.2 % | 82.8 % |
| He incited you (physically or verbally) to commit a suicide | 1.0 % | 16.7 % | 83.3 % |
| He burnt you, scalded you | 0.7 % | 22.8 % | 77.2 % |
| He published your intimate photographs, against your will, or published your contacts and/ or photographs in erotic advertisements | 0.7 % | 63.3 % | 36.7 % |
| He tried to poison you/He poisoned you with medicines, chemicals or food | 0.4 % | 24.2 % | 75.8 % |

## 4.7 Experienced Situations of DV in 2014

In 2014 alone, a total of 37.6% of women who have become victims of DV in their lifetime were subjected to any of the examined situations. In 2014, victims of DV were most frequently exposed to controlling by their partner (23.5% of victims of DV), long-term psychological humiliation (13.5% of victims of DV) or to situations where they had been pushed or slapped by their partner (10.2% of victims of DV).

Table 9: **Frequency of Experiencing Individual Situations of DV in 2014 – Categorised by the Frequency of Occurrence**

| Experienced situations | Occurrence among women who were exposed to DV in 2014 |
|---|---|
| **total** | **847** |
| He insisted that he should always know where you are, with whom, and what you are doing | 23.5 % |
| He humiliated you psychologically on a long-term basis | 13.1 % |
| He pushed you or slapped you in your face | 10.2 % |
| He was pursuing you, harassing you with phone calls, text messages, emails (stalking) during or after your relationship | 8.8 % |
| He sought to limit/prevent your contacts with friends or family | 8.8 % |
| He deliberately did things to scare or intimidate you | 6.6 % |
| He threatened you to harm or kill you | 5.7 % |
| He deliberately destroyed things to which you had an emotional relationship | 5.1 % |
| He limited your access to family finances and shopping without him knowing it | 5.0 % |
| He took your income or property | 4.4 % |
| He beat you with his fist or kicked you | 4.4 % |
| He threatened to harm or caused harm to your children, relatives or a pet | 4.1 % |
| He pushed your head against an object or a wall | 3.4 % |
| He was tugging your hair/plucked out your hair | 3.3 % |
| He threw a hard object against you or used a hard object to beat you | 3.3 % |
| He did not let you in the flat | 2.8 % |

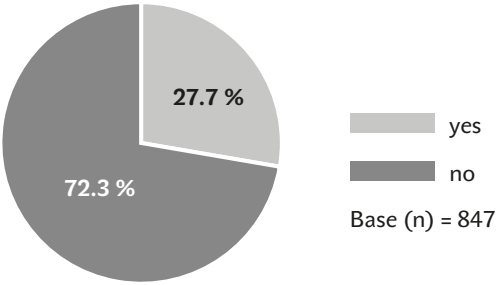
| Experienced situations | Occurrence among women who were exposed to DV in 2014 |
|---|---|
| He put you into debt by deliberately not paying the agreed expenses | 2.7 % |
| He filed deliberately untrue denunciations or accusations against you | 2.6 % |
| He was pawing you and touching your intimate parts or kissing you against your will | 2.3 % |
| He forced you to sex or sexual practices against your will | 2.1 % |
| He prevented you from seeking medical attention | 1.9 % |
| He did things with the aim of raising doubt about your mental health | 1.8 % |
| He restricted your whereabouts | 1.8 % |
| He threatened to drop you off while driving or dropped you off in an unknown place in the middle of the trip | 1.6 % |
| He threatened you to prevent your contact with children or has done so on a long-term basis | 1.6 % |
| He made you do physical work lasting several hours | 1.6 % |
| He caused you harm by deliberately injuring you | 1.4 % |
| He denied you food or sleep | 1.0 % |
| He was smothering you, strangling you | 1.0 % |
| He made you consume drugs | 0.6 % |
| He made you sign contracts, invoices or other documents against your will | 0.4 % |
| He forced you to sex in front of your children or other people | 0.4 % |
| He used a knife, a gun, a paralyser, electric current or another weapon against you | 0.4 % |

| Experienced situations | Occurrence among women who were exposed to DV in 2014 |
|---|---|
| He incited you (physically or verbally) to commit a suicide | 0.3 % |
| He published your intimate photos or contacts or your contacts and/or photos in erotic adverts against your will | 0.2 % |
| He tried to poison you/He poisoned you with medicines, chemicals or food | 0.1 % |
| He tried to induce abortion during your pregnancy or made you have an abortion | 0.1 % |
| He burnt you, scalded you | 0.1 % |
| He deliberately destroyed your or your children's medical accessories and aids | 0.0 % |
| He threatened you to shave your head or has done so | 0.0 % |

## 4.8 Seeking Medical Attention as a Result of DV

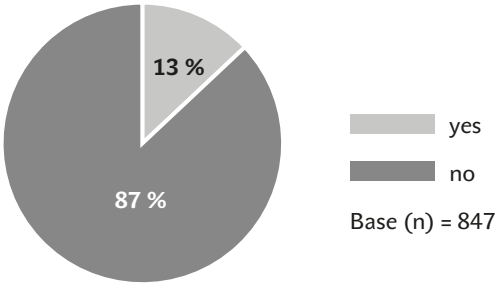
A total of 27.7% of women who were victims of DV had to seek medical attention as a direct or indirect consequence of DV. Should this figure be calculated for the entire population, some 341,000 women are estimated to have sought medical attention at least once in the past, whether as a direct or indirect consequence of DV.

Graph 3: **A woman had to seek medical attention as a result of DV**




**In 2014**, 13% of women who had experienced DV in their lifetime had to seek medical attention, whether as a direct or indirect consequence of DV. Should this result be applied to the entire female population in the Czech Republic over 18 years of age, this share corresponds to about 162,000 women who were made to seek medical attention in 2014 as a result of DV.

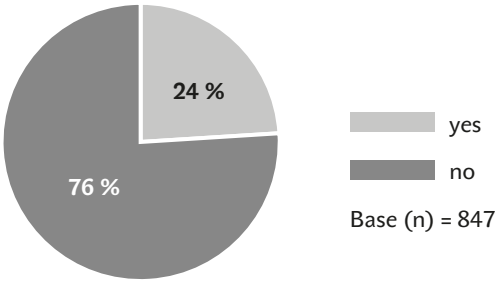
Graph 4: **A woman had to seek medical attention as a result of DV in 2014**



## 4.9 Respondent Did Not Seek Medical Attention Despite Needing It

Almost one quarter of women who had become victims of DV sometime during their lifetime said **that they had not sought medical attention for various reasons even though they had needed it as a consequence of DV**. In absolute figures within the entire population, this number is estimated at about 300,000 women. Women who need medical attention but do not seek it may have various reasons for that. For instance, they may be ashamed for DV they have experienced and do not want anyone else to know about it. Or, the aggressive partner prevents them from visiting a medical facility, or they care for small children who cannot be left alone, etc.

Graph 5: **A woman did not see medical attention even though she needed it as a consequence of DV**



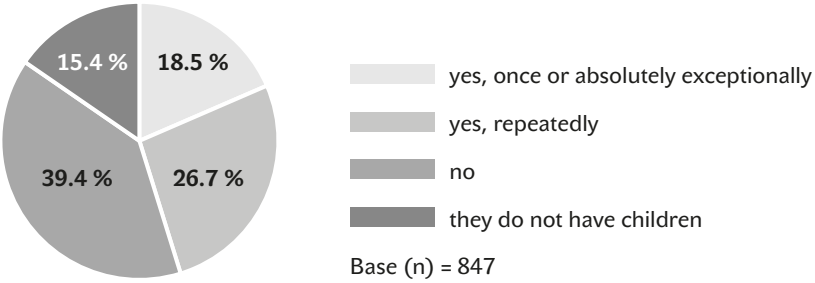

## 4.10 Presence of a Child during DV

Of the total number of women who have experienced DV in their lifetime, 15.4% do not have children. An additional 39.4% of women said their children had not been witnesses to DV. **In 45.2% of cases, children were present during DV**, including in absolutely unique cases (18.5%) (i.e. if this number is applied to the entire population, it is 228,000 cases) and repeatedly

(26.7%) (i.e. 329,000 cases if applied to the entire population). If these findings are generalised to the entire population, we can estimate that children were witnesses to domestic violence at least once in 557,000 cases. If children are subjected to DV among partners, it has a negative impact on them that may be manifested through psychological and psychosomatic problems they have to struggle with all the rest of their life.

> *"Also the 2010 resolution of the Council of Europe points to the danger of the situation when a child is witness to violence. Whenever the mother is a victim, it is highly probable that a child will be a witness. Exposition of a child to violence against the mother (or other family members) is today qualified as a form of the child's psychological abuse with possible serious consequences."*[23]

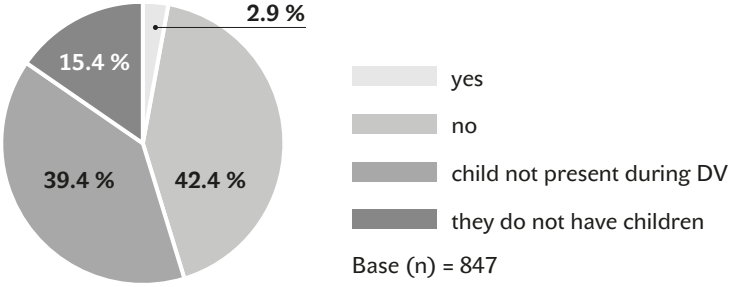
Graph 6: **A child present to DV between partners**




The fact that **the child was physically injured** during DV was stated by **2.9%** of the women who had experienced DV.

23 Ševčík, D., Špatenková N. 2011. *Domácí násilí: kontext, dynamika a intervence*. Praha: Portál, pp. 18–19.

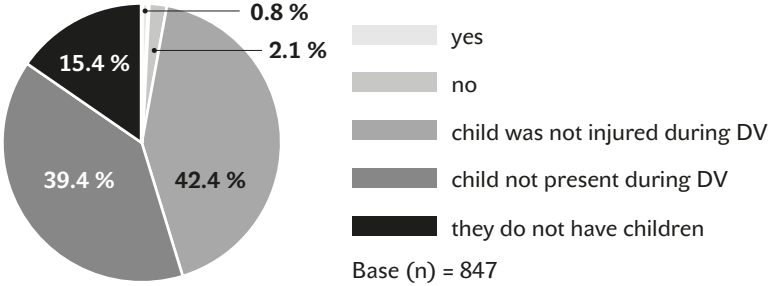
Graph 7: **Injury of a child during DV between partners**




At the very first sight, the share of 2.9% may seem as low occurrence of child injuries during DV. If recalculated to the population of women over 18 years of age, we can, however, estimate that this relates to some 35,700 cases of DV during which a child had been physically hurt. This figure indicates that this is really a serious problem.

A total of 0.8% of women who had experienced DV sought **medical attention for a child** who had been injured during DV. If recalculated to the population of women over 18 years of age, medical attention for an injured child had to be sought in about 10,000 cases of DV.

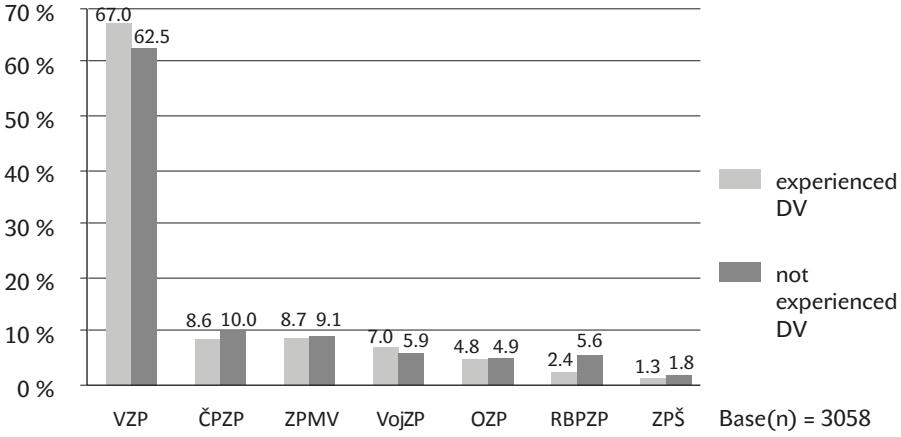
Graph 8: **Medical attention of a child after an injured resulting from DV between partners**



## 4.11 Health Insurance Companies

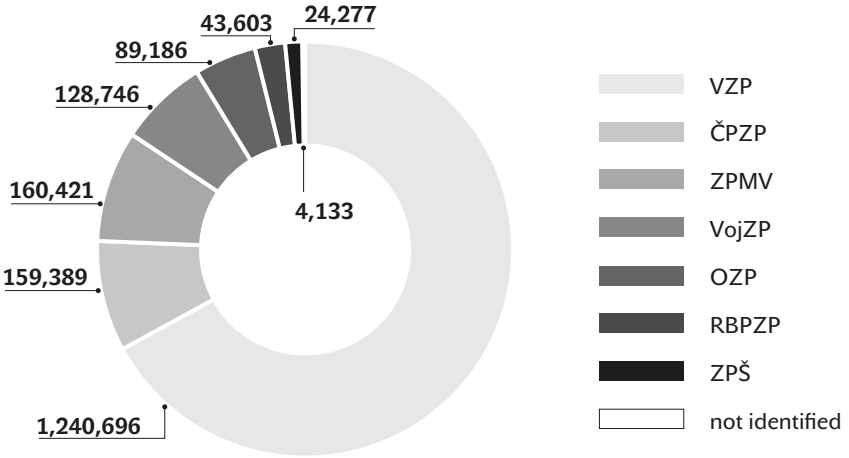
The share of the women who have experienced DV and who have not is statistically significantly different only in case of two health insurance companies, i.e. VZP (In Czech: *Všeobecná zdravotní pojišťovna*) and RBPZP (In Czech: *Revírní bratrská pojišťovna, zdravotní pokladna*). While there are significantly more women – victims of DV who are clients of VZP, it is the opposite in case of RBPZP.

Graph 9: **Health insurance company registration of respondents (%)**




In 2014, medical expenses of the women injured as a result of DV may be divided among the health insurance companies in the proportion stated above (only the expenses paid from public health insurance were included). VZP, the largest health insurance company in the Czech Republic, spent the highest sum on the treatment of consequences of DV in 2014. It was a total of CZK 1.24 billion.

Graph 10: **Estimated cost of insurers related to treatment of consequences of DV in 2014**



# 5. Conclusion and Recommendations

We have looked into the issue of DV in partner relationships from the perspective of health problems of women who have experienced domestic violence and we have described the serious health consequences it may cause. Domestic violence cannot, however, be perceived solely as a private matter of those who were directly exposed to it but it is a society-wide problem actually concerning all of us. DV also has an economic impact that may most significantly be seen in the health sector.

In our study, we used detailed calculations to estimate that the cost of medical care as a result of DV in partner relationships consumes about CZK 1.85 billion a year from the public budget of the Czech Republic. In addition, we have also estimated that women actually pay a not inconsiderable sum of money for prescribed medication and in other direct payments. Chronic diseases are also a serious consequence of DV and our focus was also to estimate the cost of treating chronic diseases. A certain link may be traced between DV and occurrence of certain chronic diseases, but a specific survey of the impact of experienced DV on the long-term health condition of the population would be necessary to prove the causality between DV and chronic diseases, which was neither our objective nor possible for us.

In the Czech Republic, there is no statistical data available as to how many victims of domestic violence receive medical attention. Our survey and research are the first step towards pointing to the need to collect such data. The keeping of statistics and monitoring of gender based violence in the Czech Republic may help to develop and set effective measures that will lead

to the timely recording of cases of DV and that may, ultimately, help reduce the financial costs in health care.

Health insurance companies may recover the cost incurred in relation to medical care and treatment of victims of DV additionally in the form of recourses. However, this does not happen a lot. The reasons include the fact that victims of DV often do not confide in the medical staff that they had to seek medical care or treatment as a result of experienced DV, or they even deny it.

Healthcare professionals may play a significant role in cases of DV. Doctors or nurses may be among the first persons to talk to the victims about their situation and they may guide and support them in addressing their situation. In addition, a failure to recognise the causes of a patient's problems may lead to the need to use medical services more often.

We believe that implementation of the following measures could contribute to increasing the level of care for victims of DV and to better identification of DV in patients:

Recommendations for the health care sector:

- Systematic education of healthcare professionals about issues related to DV. Education in this area ought to focus on increasing the awareness and knowledge of the medical staff about issues related to DV. Also, focus should be put on specific communication with those who have experienced DV as well as on the recognition of specific and frequent injuries that may point to the likeliness of DV. Trained healthcare professionals can better identify health problems that originated as a result of DV, including severe acute and long-term consequences, and they may have a positive impact on providing help to victims and preventing additional violence.
- The following rules ought to be observed when providing medical care to victims of DV:
- Standard medical needs are handy and in place.
- The consultation takes place in a private environment (privacy and anonymity is guaranteed).
- Aid is provided in a place with guaranteed follow-up services.

- Medical care must be able to provide comprehensive aid to the victim of DV who needs to deal with physical and psychological health consequences.
- Organisation of regular interdisciplinary meetings in the health sector with the social and non-profit sector dealing with DV.
- Thorough documentation of injuries where there is suspicion or certainty that they were caused by DV.
- Provision of available psychotherapy and expert psychological and psychiatric assistance paid from health insurance for persons experiencing or having experienced DV.
- An important recommended measure includes **the keeping of statistics** by health insurance companies that would show the share of patients where health problems have been caused by DV, what health consequences they have had and what treatment has been provided to them.

For more consistent prevention and more effective help to victims of DV, we need to set effective and strictly observed mechanisms also in the health care system. Observation of these mechanisms depends on support of the management of hospitals and health care institutions. The management personnel ought to support the set mechanisms and supervise the observation of the commitments arising from the given measures. For a desirable future outcome, regular interdisciplinary co-operation of the health sector with other professional organisations and institutions is a must. Therefore, our study primarily targets those who have competences to propose changes and help with their enforcement. Co-operation of medical institutions with the non-profit sector and mutual sharing of experience and information are key aspects of any success in the prevention of DV. Designation of special departments in medical facilities where the trained personnel would provide the necessary services (in particular social and psychological counselling) to those who have experienced sexual and/or domestic violence could mean a significant progress in the prevention and effective assistance to those who need it.

# 6. Expert Commentary on the Study

**RNDr. Luděk Niedermayer,**
Economist, Member of the European Parliament

Domestic violence ("DV") is one of the very serious social problems of our times in our society that society has not long paid sufficient attention to. It is good that this has changed lately and that there has been increased interest in the problems going on there "behind the closed door". In my opinion, this interest is highly supported by the activities of the non-profit sector and many campaigns seeking to spread not only the awareness about this issue but also to encourage the victims not to resign and not to let their situation lead to serious, even tragic consequences.

Calculations of the economic impact of these acts also serve to encourage interest in this problem, and the study submitted is one of the contributions to this issue.

While, in my opinion, the issues related to DV are very serious from the social perspective (in my view, they are among the worst and most serious social transgressions together with violence against children or racial crimes), the "dry language" of numbers in these studies is in sharp contrast with this highly emotional and fully understandable approach. This is why these studies have a potential to also address other audiences that would otherwise not be so much interested in this problem. Which is highly beneficial.

At the same time, a closely focused approach on the direct economic cost does not cover the wider effects that cannot be measured on a short-term basis and that fall within the health care costs.

They include:

- long-term health consequences (and the related cost) of persons who have experienced DV
- impacts (health impacts) on children, in particular with regard to the fact that a part of DV takes place in the presence of children, which undoubtedly leaves its consequences.

## Specific Notes on the Study

The sample is fairly wide and the questionnaire, in my opinion, very well covers the area observed. The second part (women who faced DV in 2014 and were treated consequences) includes quite a small sample. It would be interesting to compare the basic data with fairly detailed data from Germany, as specified in Chapter 2.1. It is because there is a risk that some victims of DV are still unwilling to acknowledge this fact despite the growing awareness of the issue of DV.

Considering the detailed data provided, it would surely make sense to repeat such inquiries because it may be assumed that especially long-term chronic diseases (Chapter 4.5) (where the different results in both samples for various diseases indicate, in my opinion, a causal link between the given disease and DV) will continue to be manifested or even deepened, which will result in increased social and economic costs.

From the legal perspective, I would be interested in whether and in what cases and with what success the cost may be recovered from the perpetrators and in whether there is any practical experience (whether in favour or against, or the willingness of women experiencing DV) to report these acts.

I would highly recommend that, after our country joins the Istanbul Convention, similar studies use, if possible, the standard methodology that will enable to compare the data in the international perspective. Repeated research that is important for the monitoring of the development should also apply the same methodology.

In conclusion, I think that society ought to do much more to reduce the risks and to limit the number of cases of DV. This applies both to state authorities (social, security bodies) and the activities of the non-profit sector. DV causes suffering of people; it impacts not only on those experiencing it but also on the entire family, and it encroaches upon the life of children who are direct or indirect participants in DV.

Tolerance for DV may result in further expansion of this phenomenon. Taken this view, it would be necessary to understand the further development of persons who are victims of DV as much as possible and what can effectively be done to prevent the risk of repeated DV. And also, we should understand the risk factors further impairing their situation (which is apparently the subject of other studies).

Likewise, it is also important to understand what steps may effectively change the behaviour of those committing DV and what can be done to put an end to such behaviour

# 7. Summary

## Objectives and benefits of the study

The study is the first survey aimed at estimating the costs of domestic violence ("DV") in the health sector of the Czech Republic. Viewing domestic violence as a health problem and its economic impact on the health sector gives the opportunity to see this problem and its devastating consequences in a much broader and other than in so far known perspective. The study is based on the fact that people at risk of domestic violence are mostly women and therefore, it defines domestic violence as violence against women.

This study is also an important contribution to the implementation of the Action Plan for the Prevention of Domestic and Gender Based Violence for the Years 2015–2018 where the collection of statistics and studies is one of the priorities in the area of domestic and gender based violence in the Czech Republic.

## Survey on occurrence and health impacts of domestic violence

In order to calculate the costs of health consequences of DV, it was necessary to obtain relevant and new data which would make it possible to define the rate of occurrence of DV and its health consequences. The survey for the study was carried out between September 2015 and March 2016 on

a representative sample of 3,058 women over 18 years of age living all over the Czech Republic. Among other things, it was established that **27.7%** of women had experienced domestic violence during their lives and one third of them had to seek medical treatment as a consequence of intimate partner violence. One quarter of those women claimed they needed medical care, but they did not visit any healthcare professional.

## Main findings

### Economic impact of domestic violence on the health sector of the Czech Republic

The total amount of the economic impact of DV on the health sector of the Czech Republic during **2014 alone** was estimated at CZK **1.85 billion**. This estimate covers only the costs of providing health care and treatment to women who needed medical attention during 2014 as a consequence of domestic violence between intimate partners.

Most of the costs, approximately CZK **1.241 billion,** have been covered by the General Health Insurance Company (In Czech: *VZP – Všeobecná zdravotní pojišťovna*). An additional CZK **215 million** was paid by the victims of domestic violence in additional fees for prescribed medications and in other necessary direct payments.

In 2014 alone, the costs of public health insurance related to the treatment of chronic diseases in the context of domestic violence have been estimated at approximately CZK **1.088 billion**.

## Sources and methodology

The initial step of our cost analysis study was a representative survey among women in the Czech Republic. This survey enabled us to measure the prevalence of domestic violence (and its various forms) against women over

18 years of age and to find out what kind of medical care and treatment they had received in 2014.The estimates of costs of DV in the Czech health sector in 2014 were consequently based on those findings.

In order to prepare the main survey, we set up a working group consisting of the proFem team, the team of MindBridge research company and other professionals from non-profit and public institutions who specialize in domestic violence. The survey describes 40 situations defining various acts of domestic violence. Those women who appeared to be exposed to domestic violence were asked about their injuries and health consequences and whether they sought medical attention. In addition, those women who claimed that they have sought medical care or treatment during 2014 as a consequence of DV completed a special second survey – detailed medical sheets describing any injuries and treatment received. A total of 115 women completed the medical sheets.

The medical sheets were created in order to describe the course of medical treatment in as many details as possible as well as to describe the deterioration of the women's health (number of medical check-ups, increase of doses of medicine, change of prescribed medication, etc.). Moreover, the sheets were to provide information on physical and mental health problems and other specific information about the treatment those women encountered during 2014.

On the basis of the medical sheets data, the medical officer of the General Health Insurance Company (In Czech: *VZP – Všeobecná zdravotní pojišťovna*) estimated the costs of provided health care. The medical officer estimated the costs of the public health sector budget as well as additional costs paid by the injured women. The estimates were based on the following sources:

- Regulation of the Ministry of Health of the Czech Republic No. 134/1998 Sb., as amended, issuing a list of medical interventions with point values;
- Regulation of the Ministry of Health of the Czech Republic No. 428/2013, determining the point value, reimbursement of paid services and regulatory restrictions for 2014

- Index of Pharmaceuticals valid for 2014 – https://www.vzp.cz/poskytovatele
- Index of Interventions valid for 2014 – https://www.vzp.cz/poskytovatele

It is important to note that those estimates are based on the data that women were able or willing to give and share. The introduced costs that can be proved based on our survey can therefore be considered as underestimated. We should bear in mind that women who live in asylum centres usually face the most serious health consequences, but given the used data collection techniques, these women were not included in our survey. Not to mention, the fatal consequences of domestic violence, e.g. murders.

The costs of public health insurance related to the treatment of chronic diseases in the context of domestic violence were not estimated on the basis of medical sheets data, but were estimated on the basis of the statistical data of the General Health Insurance Company (In Czech: *VZP – Všeobecná zdravotní pojišťovna*) together with the available survey data information.

# 8. Case Histories of DV Impact on Health Condition of Victims

To give some idea of the impact of DV on the health condition of the persons at risk, let us provide specific examples. The case histories were provided by ProFem and by the colleagues co-operating with us on the development of the questionnaire within our working group.

## Marie, a client of the shelter operated by non-profit organisation ACORUS

Marie was 35 years old when she came to the shelter. She had a difficult childhood; her father abused alcohol. He was violent both against the client and her mother. When drunk, he was mostly aggressive, used abusive language, offended people around and made physical assaults. When she was a little girl, Marie **was sexually abused** by her drunken father; he probably confused her with her mother. Marie underwent a gynaecological examination, but her mother did not want her to talk about it. After her mother died when Marie was 12, she grew up only with her father and had to keep the house. When she was 17, she was **raped** in a park when she was going to her train to a boarding school. She was all blood but said at the boarding school that she had fallen on her way.

Marie was married twice and has four minor children. Her first husband abused alcohol and sometimes used physical violence against the client. A son was born of this marriage. Three children were born of the second marriage. Her second husband was unemployed; he used methamphetamine, and had been brutally abusing both Marie and her minor children since 2008. The violent partner was compelled to leave their flat in 2011.

During the expulsion, he was hiding in their common household and violently made Marie cover up for him. According to a police report, the man abused both the client and the oldest son and he was prosecuted for abusing a person living in a common dwelling and abusing an entrusted person. However, by beating her, the man forced Marie to change her testimony and the prosecution was terminated. Marie repeatedly left their household for her father's, but was always forced to come back.

As part of **psychological violence**, Marie's husband used vulgar insults against her and her children, humiliated them, threatened with killing them, setting the flat on fire, etc. **He also emotionally** mistreated the client by throwing her little dog out of the window after which the dog died. She had another dog afterwards, but he slashed his head with an iron fork and made Marie strangle him.

The man also committed **social violence** when he repeatedly did not let Marie out of their home. He locked her in and she could not go to work. As a result of that, she was frequently absent or late at work, for which she received a warning, but then definitely lost her job.

There were also cases of **economic violence**. The man did not have his own income and took her parental allowance and other money she had; he made her seek money at their friends, look for things suitable for a scrapyard and go with scrap. She had to walk 7 km on a busy road three times a day with her children in a pram to get water from her father.

**Physical abuse** took the form of slaps in the face, punching and beating with other objects, kicking, throwing of objects. When she was pregnant, Marie was forced to sit in cold water; she was beaten continuously throughout the whole week; she was made to sleep naked on tiles in the kitchen (while he was sleeping in bed with his dog); he put an activated paralyser to her body; he locked her in the bed; he kept waking her up during the night and did not let her sleep; he made her jump out of the window to commit suicide; he trod on her head; he was burning her with a lighter; he trod on her ribs; he was drowning her in cold water; he attacked her with a chainsaw in a locked flat; he pulled out her teeth with pliers, and did many other things.

The **children** were physically and psychologically abused as well. They were slapped in the face, beaten with fist and other objects (with a wooden rod, a dog lead, a twig, a plastic lath, a metal shaft to the vacuum cleaner, etc.); he gave them a cold shower when they cried. He was kicking the kids, beating them with the back of his hand over their bellies; he threw a three-month-old baby from above on the bed; he incited one of the sons not to obey his mother and give her a hard time like waking up his little sister. The violent husband was also holding a little baby's leg and beat it, telling the baby it was a "wimp"; he threatened to kill the baby. Marie often had to stay outside with her children all day long because they were thrown out of the house. One day, they had to remain outside because the husband was in the flat, having sex with a girl who was reportedly under 15. Suspicions of sexual abuse of one of the daughters were not confirmed; the law case of suspected sexual abuse and endangering a child's upbringing was adjourned.

**Health consequences:**

The client did not seek medical treatment because she did not have any visible consequences; just pain. She later **sought medical attention twice**. The children were examined once in the presence of a social worker and municipal police; the medical report speaks about hematomas and grazes, and the youngest son was hospitalised to complete the examination.

For the second time, Marie sought medical care on her own; the medical report describes consequences of her assault. She was not admitted to hospital, but received painkillers and was recommended to see an ENT specialist in case of problems.

In 2011, Marie was in work incapacity due to problems in kidneys caused by punching in her back, but she told the doctor she had fallen.

During her stay at ACORUS, the client manifested the following **health problems**:

- repeated **flashbacks**, with one of them accompanied by **loss of consciousness** and re-living of the acute assault; negative experiences often come back; she has problems with breathing (saying it feels as

if he were strangling her again); she has an urge to vomit, sweats; she is unable to move from a place; the flashbacks are sometimes accompanied with a stereotype seesaw motion of her body
- **anxiety and fear of seeing a dentist**; flashbacks during dental interventions
- **undue body** tension
- **sleeping difficulties** (difficulties to fall asleep, wakefulness, nightmares)
- **shock reactions** to unexpected motions or sounds
- **fear of speaking with men**
- **anxiety, depression**
- **memory problems**; she says she feels like in the "fog"; she does not remember anything; she needs to write down everything

She was treated by a psychiatrist during the entire stay at ACORUS; she received medication; she was diagnosed with **post-traumatic stress disorder** and depression.

During her stay at ACORUS, the client started seeing a dentist. Through donations, ACORUS managed to procure funds for the basic teeth reconstruction **of** Marie and paid CZK 40,975 for dental interventions.

**The oldest son** was repeatedly seeing **a psychiatrist**. After an attack, he **was injured around his ear** and is manifesting hearing problems. **The other son** is treated at **psychiatry for post-traumatic stress disorder and receives medication**. He is also seeing a child clinical **psychologist**. He manifests **strong tremor** in tense situations where he fears being punished or in situations that reminded him of violent attacks at home or during emotional excitement of certain intensity, e.g. when swinging on a swing. He often manifests strong **outbursts of aggressiveness, anxiety, excessive need of control**. He sometimes exposes himself in socially unsuitable situations.

**The premature birth of the youngest son** may be a consequence of his mother's increased stress and physical suffering. He is **increasingly ill** and some diseases are likely to be **psychosomatic** (asthma, atopic eczema, allergy); he is **less susceptible to** stimuli.

During the next criminal proceeding, the violent husband was finally sentenced to seven years in prison especially guarded, and a duty was imposed on him to pay damages to Marie in the amount of CZK 180,000.

## Simona, a client of the Intervention Centre in Ústí nad Labem

Simona had a violent partner relationship. The client and her six-year-old son from her previous relationship were living with her partner in the common household for about a year.

The first gross and vulgar verbal attack came as early as after three months; the first physical assault took place after six months of their cohabitation. Other attacks came at 4–6 week intervals. Her partner called it "educational, preventive beating, slapping around". Violence became more intense over time; it was more brutal, and intervals between attacks shortened.

The partner manifested various forms of violence during the relationship. **Psychological violence** – frequent curses, strong and vulgar insults, also in the presence of Simona's son, who then kept asking what these words had meant. He later directed his insults also against the son. **Social violence** – Simona was subjected to permanent monitoring; she had to tell him where she went and when she would come back. Her partner often pursued her when she went shopping or visit her mother; he was pursuing her when she was going out and whom she talked to on her way. When she went to see her mother, he was waiting in front of the house to see whether she really was at her mother's. He kept accusing her of infidelity. He checked her telephone – text messages, phone calls. He sometimes watched her with binoculars from an opposite house whether she was at home and what she was doing. This is also what he told her in a text message. **Economic violence** – the partner did not have a job and did not contribute to household expenses. Therefore, the client was put into debt due to unpaid rent. Sometimes at night, he sneaked out of the flat, saying he was going to work. Simona thinks he went out to burgle flats. He also went gambling at night. The client did not know where he got hold of the money for that.

**Physical violence** – slapping and repeated beating; punching in the face or other parts of the body; the client sometimes fell on the floor and curled into a ball with pain, but he did not stop kicking her even afterwards. When she was beaten, she was repeatedly injured, e.g. she cut her forehead by a kitchen table; she had head injuries (broken head from a bathtub – it was stitched up in hospital). The partner tore the medical report apart to get rid of any evidence. He threatened her to kill her if she reported anything to the police.

During the most recent attack, she was punched in her face first and when she fell on the floor, he was kicking her in her back and bottom. All of this lasted about 30 minutes. When she was all blood and cried, her partner shouted at her to stop simulating. Then he sprayed tear gas, which he took out of her handbag, in her face. Then he made her go to the bathroom and undress because he should "scrub her because she is a carrion". He washed all of her body and hair. Then, beaten, she went to sleep. Her partner lay down next to her and tried to have sex with her, which he failed. She was asking him to stop because everything hurt her, but he did not stop and took hot balm and put it on her genitalia. Then he had intercourse with her and did not stop even when she asked him to. She could not sleep at night **due to pain** and had **breathing problems**, which is why she sought medical attention the next day. The doctor found her **rib had been broken, which pierced her lung**. Simona had to **be hospitalised at the ICU**.

Health consequences:

- **Hospitalisation** at **the ICU** (**broken rib and lung perforation**).
- The client was **hospitalised for about five days** and then was released into home care in order to care for her child. Doctors made preliminary estimates regarding her treatment: at least **45 days**.
- During hospitalisation, she was also examined by a psychologist who found that she suffered from **post-traumatic syndrome**.
- Due to previous assaults, the client was **repeatedly treated**; she once had an **X-ray of her head** (broken head from the table) and **was treated at surgery**.

- When she broke her head at the bathtub, the wound was stitched up and she underwent another **X-ray of her head**. In both cases, she did not tell her doctor that she had been assaulted by her partner (due to threats from her partner).
- **Other minor injuries** were treated by the client herself. These were mostly **bruises, slashes, scratches** and **bruises from blows**.

During Simona's hospitalisation, her violent partner was expelled from their flat, and the Police of the Czech Republic later proposed to accuse him of abusing a person living in a common dwelling.

The initial contact with the Intervention Centre (IC) was established during Simona's hospitalisation. Right after her release from the hospital, the IC went to the place of her residence and assisted in the drafting of an application for a preliminary measure for one month, which was subsequently approved by the court. The application was delivered to the local police station. It was not necessary to extend the preliminary measure because the violent partner was taken into custody.

## Martina, a client of proFem

Martina had lived with her husband for five years. They have a four-year-old son. During their relationship, Martina's husband gradually started checking up on her, wanting to know whom she saw, what she did when she was not with him, whom she called, etc. After their wedding, they moved outside Prague. When her son was born, the client started feeling socially isolated because she did not have many opportunities to see other people. Her husband did not wish it; he wanted Martina to stay at home and care for the family. She was the only one to care for the household and their son; he was not involved in the upbringing, referring to his workload. The client was all alone to handle all that. The checking by her husband intensified. For instance, when the client was delayed at the doctor's, he suspected her of "having fooled around with someone else", giving her filthy names. He called her from his work to hear whether she was at home. He was forcing her to sexual intercourse and when she refused, he suspected her of infidelity and was vulgar to her. In the

end, he started abusing her physically. During one of the attacks, he pushed her down so she fell and broke her wrist. He took her to be treated and she was afraid of saying that she had been injured by her husband. After this incident, she wanted to leave him, but he apologized, he was crying, telling Martina she should not take a father from her son and agreeing to visit a marriage counselling centre. The situation improved for several months. They went to the marriage counselling centre only once, then he refused to come and everything started slowly getting back to the groove. The client worked as an architect and went back to work after her maternity leave was over but she had to leave the job after several months. Her husband came to her work to check her several times; he was shouting at her in front of everybody, and he even dragged her once to the toilet to check her underwear. Martina was pregnant with her second baby, but aborted the child. She believes it was the fault of her husband when he once pushed her during a row and she hit an open wardrobe with her belly. She lost the baby a few days afterwards. She told her husband she wanted a divorce, but he threatened he would "show her", that she would not "get away with this". The client was afraid because her husband was influential, but she decided to contact a proFem counsellor.

The client was subjected to **psychological violence** – vulgar insults and humiliation, sometimes in the presence of their son. She had to be constantly on her toes, she could not draw breath; he kept checking her up. As for **physical violence**, she experienced shoving, slaps, punches, strong squeezes of the hand and of her arms. Martina's husband tried to **isolate her socially**; he restricted her contact with her family and friends, he harassed her at her work.

Health consequences:

- **a wrist fracture** – surgical treatment; **miscarriage** – gynaecology examination; the client also had bruises and grazes
- the client is seeing a **therapist**; taking **antidepressants**
- she suffers from **anxiety and feelings of danger**; she has **sleeping problems**.

Martina is now divorced and the son was entrusted into her care.

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# Economic Impact of Domestic Violence on Health and the Health Care System

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Violence against women is a topic that has until recently been a taboo even in the WHO agenda. It is good that this is no longer true and that the international environment and numbers we have available make us look into this issue. However, it is not easy to have available the information that would document the extent of this problem with valid data. The information provided by healthcare professionals who encounter the health consequences of domestic violence may definitely be one of the sources. However, not even such information is easily available. A report taking into account the financial impact of these acts on the health sector is truly a unique source of information. However, such information should not be an end in itself. The main objective of the presented study is to set preventive measures that would prevent domestic violence or at least mitigate its impact on health of the women affected. Big thanks should therefore go to the authors of this report.

*Alena Šteflová*, Director of WHO Office in the Czech Republic

This study is an important contribution to research related to the socioeconomic impacts of domestic violence on Czech society and provides additional arguments why prevention of domestic violence should be given appropriate attention. Support of a functional infrastructure helping victims of violence and prevention of violence are clearly shown, in the light of this study, as the only right steps from the view of enforcement of human rights and the right of all people to dignified life, as well as a clearly economic strategy. And this is an argument carrying even greater weight in contemporary society. Therefore, I believe that this brochure will make its way to the relevant decision-makers and will persuade them that it is really high time to start acting.

*Marta Vohlídalová*, Sociologický ústav AV ČR, v. v. i.

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