



A global overview of gender-based violence

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Abstract

This paper provides an overview of the extent and nature of gender-based violence and its health consequences, particularly on sexual and reproductive health.

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Violence against women is the most pervasive yet least recognized human rights violation in the world. It also is a profound health problem, sapping women's energy, compromising their physical health, and eroding their self-esteem. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections (STIs), and adverse pregnancy outcomes.

Despite its high costs, almost every society in the world has social institutions that legitimize,

obscure and deny abuse. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

For over two decades women's advocacy groups around the world have been working to draw more attention to the physical, psychological, and sexual abuse of women and to stress the need for action. They have provided abused women with shelter, lobbied for legal reforms, and challenged the widespread attitudes and beliefs that support violent behavior against women [1].

Increasingly, these efforts are having results. Today, international institutions are speaking out against gender-based violence. Surveys and studies are collecting more information about the prevalence and nature of abuse. More organizations, service providers, and policy-makers are recognizing that violence against women has serious

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adverse consequences for women's health and for society.

1. Extent and nature of the problem

Gender-based violence includes a host of harmful behaviors that are directed at women and girls because of their sex, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation, and sexual abuse of female children. Specifically, violence against women includes any act of verbal or physical force, coercion or life-threatening deprivation, directed at an individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination (2).

2. Intimate partner violence

The most pervasive form of gender violence is abuse of women by intimate male partners. A recent review of 50 population-based studies carried out in 36 countries indicates that between 10 and 60% of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner [2]. Although women can also be violent and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

Representative sample surveys indicate that physical violence in intimate relationships is almost always accompanied by psychological abuse and, in one-third to over one-half of cases, by sexual abuse [3–5]. Most women who suffer any physical aggression generally experience multiple acts over time. However, measuring 'acts' of violence does not describe the atmosphere of terror that often permeates abusive relationships. For example, in Canada's 1993 national violence survey one-third of women who were abused physically in a relationship said they had feared for their lives at some time [6]. Women often say that the psychological abuse and degradation are even more difficult to endure than the physical abuse itself.

3. Sexual coercion and abuse

Sexual coercion and abuse also emerge as defining features of the female experience for many women and girls. Forced sexual contact can take place at any time in a woman's life and includes a range of behaviors, from forcible rape to non-physical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical or social consequences if she resists sexual advances.

Studies indicate that the majority of nonconsensual sex takes place among individuals known to each other—spouses, family members, courtship partners, or acquaintances [7,8]. Ironically, much nonconsensual sex takes place within consensual unions. For example, in a 15-country qualitative study of women's HIV risk, women related profoundly troubling experiences of forced sex within marriage. Respondents frequently mentioned being physically forced to have sex and/or to engage in types of sexual activity that they found degrading and humiliating [9].

Regrettably, much sexual coercion takes place against children or adolescents in both industrial and developing countries. Between one-third and two-thirds of known sexual assault victims are age 15 or younger, according to information from justice systems statistics and rape crisis centers in Chile, Peru, Malaysia, Mexico, Panama, Papua New Guinea and the United States [10].

Sexual exploitation of children is widespread in virtually all societies. Child sexual abuse refers to any sexual act that occurs between an adult or immediate family member and a child, and any nonconsensual sexual contact between a child and a peer. Laws generally consider the issue of consent to be irrelevant in cases of sexual contact by an adult with a child, defined variously as someone under 13, 14, 15, or 16 years of age.

Because of the taboo nature of the topic, it is difficult to collect reliable figures on the prevalence of sexual abuse in childhood. Nonetheless, the few representative sample surveys provide cause for concern. A recent review of 17 studies worldwide indicate that anywhere from 11 to 32% of women report behavior constituting sexual

abuse in childhood. Although both girls and boys can be victims of sexual abuse, most studies report that the prevalence of abuse among girls is at least 1.5 to 3 times that among boys [11]. Abuse among boys may be underreported compared with abuse among girls, however.

Studies consistently show that, regardless of the sex of the victim, the vast majority of perpetrators are male and are known to the victim [12–14]. Many perpetrators were themselves sexually abused in childhood, although most boys who are sexually abused do not grow up to abuse others [15].

Although for some children the effects of sexual abuse are severe and long-term, not all will experience consequences that persist into later life [16,17]. Sexual abuse is most likely to cause long-term harm when it extends over a long period, is by a father or father figure, involves penetration, or uses force or violence [16,18,19].

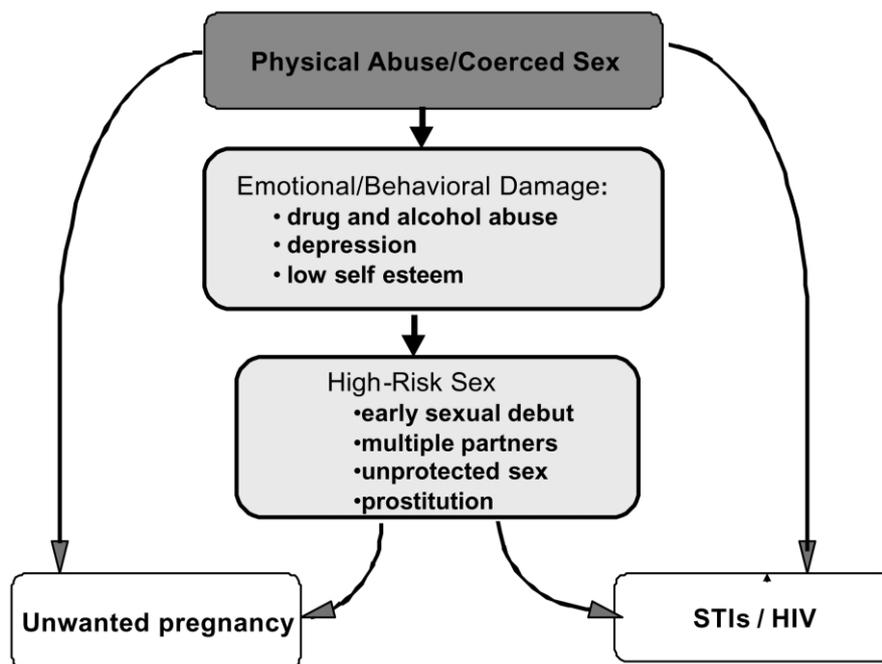
4. Explaining gender-based violence

While violence against women is widespread, it is not universal. Anthropologists have documented small-scale societies—such as the Wape of Papua

New Guinea—where domestic violence is virtually absent [20,21]. This reality stands as testament to the fact that social relations can be organized in such a way to minimize abuse.

Why is violence more widespread in some places than in others? Increasingly, researchers are using an ‘ecological framework’ to understand the interplay of personal, situational, and sociocultural factors that combine to cause abuse [22]. In this model, violence against women results from the interaction of factors at different levels of the social environment.

The model can best be visualized as four concentric circles. The innermost circle represents the biological and personal history that each individual brings to his or her behavior in relationships. The second circle represents the immediate context in which abuse takes place: frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded in neighborhoods, the workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.



A wide range of studies agree on several factors at each of these levels that increase the likelihood that a man will abuse his partner:

(1) At the individual level these include being abused as a child or witnessing marital violence in the home [23], having an absent or rejecting father [24], and frequent use of alcohol [25].

(2) At the level of the family and relationship, cross-cultural studies have cited male control of wealth and decision-making within the family [21] and marital conflict as strong predictors of abuse [23].

(3) At the community level women's isolation and lack of social support, together with male peer groups that condone and legitimize men's violence, predict higher rates of violence [26,27].

(4) At the societal level studies around the world have found that violence against women is most common where gender roles are rigidly defined and enforced and where the concept of masculinity is linked to toughness, male honor, or dominance [22]. Other cultural norms associated with abuse include tolerance of physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes, and the perception that men have 'ownership' of women [21,22].

By combining individual-level risk factors with findings of cross-cultural studies, the ecological model contributes to understanding why some societies and some individuals are more violent than others and why women, especially wives, are so consistently the victims of abuse.

Other factors combine to protect some women. For example, when women have authority and power outside the family, rates of abuse in intimate partnerships are lower [21]. Likewise, prompt intervention by family members and friends appears to reduce the likelihood of domestic violence. By contrast, where the family is considered 'private' and outside public scrutiny, rates of wife abuse are higher [21].

Justifications for violence frequently evolve from gender norms—that is, social norms about the proper roles and responsibilities of men and women. Many cultures hold that men have the right to control their wives' behavior and that

women who challenge that right—even by asking for household money or by expressing the needs of the children—may be punished. In countries as different as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, Nicaragua, Tanzania, and Zimbabwe, studies find that violence is frequently viewed as physical chastisement—the husband's right to 'correct' an erring wife [2]. As one husband said in a focus-group discussion in Tamil Nadu, India, 'If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings' [28].

Worldwide, studies identify a consistent list of events that are said to 'trigger' violence. These include: not obeying her husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, refusing him sex, or expressing suspicions of infidelity. All of these represent transgression of dominant gender norms.

5. The impact of violence on women's reproductive health

A growing number of studies document the ways in which coercion and violence undermine women's sexual and reproductive autonomy and jeopardize their physical and mental health (see Table 1). Although violence can have direct health consequences, it also increases women's risk of future ill health. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies *directly*, if women are forced to have sex, for example, or fear using contraception or condoms because of their partners' potentially violent reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STDs *indirectly* by increasing sexual risk-taking in adolescence and adulthood. Therefore, like tobacco or alcohol use, victimization can best be conceptualized as a risk factor for a variety of diseases and conditions [2].

5.1. Reduced sexual autonomy leads to unwanted pregnancies and STIs/HIV

In many parts of the world marriage is interpreted as granting men the right to unconditional

Table 1
Health outcome of violence against women

| Partner abuse, sexual assault, child sexual abuse | |
|---|------------------------------|
| <i>Fatal outcomes</i> | |
| | Homicide |
| | Suicide |
| | Maternal mortality |
| | AIDS-related |
| <i>Nonfatal outcomes</i> | |
| <i>Physical health</i> | |
| | Injury |
| | Functional impairment |
| | Physical symptoms |
| | Poor subjective health |
| | Permanent disability |
| | Severe obesity |
| <i>Chronic conditions</i> | |
| | Chronic pain syndromes |
| | Irritable bowel syndrome |
| | Gastrointestinal disorders |
| | Somatic complaints |
| | Fibromyalgia |
| <i>Mental health</i> | |
| | Post-traumatic stress |
| | Depression |
| | Anxiety |
| | Phobias/panic disorder |
| | Eating disorders |
| | Sexual dysfunction |
| | Low self-esteem |
| | Substance abuse |
| <i>Negative health behaviors</i> | |
| | Smoking |
| | Alcohol and drug abuse |
| | Sexual risk-taking |
| | Physical inactivity |
| | Overeating |
| <i>Reproductive health</i> | |
| | Unwanted pregnancy |
| | STIs/HIV |
| | Gynecological disorders |
| | Unsafe abortion |
| | Pregnancy complications |
| | Miscarriage/low birth weight |
| | Pelvic inflammatory disease |

sexual access to their wives and the power to enforce this access through force if necessary. Women who lack sexual autonomy often are powerless to refuse unwanted sex or to use contraception and thus are at risk of unwanted pregnancies.

As a 40-year-old woman in Uttar Pradesh said, ‘What can I do to protect myself from these

unwanted pregnancies unless he agrees to do something? Once when I gathered the courage and told him I wanted to avoid sex with him, he said what else have I married you for? He beats me for the smallest reasons and has sex whenever he wants’ [29].

Many women are afraid to raise the issue of contraception for fear that their partners might respond violently [30–36]. In some cultures husbands may react negatively because they think that protection against pregnancy would encourage their wives to be unfaithful. Where having many children is a sign of male virility, a wife’s desire to use family planning may be interpreted as an affront to her husband’s masculinity [30].

For women living with men who are violent, the fear of a negative reaction is often enough to cut off discussion of contraception. As one woman said of her husband, ‘Whenever he hears people discussing family planning over the radio, he fumes and shouts... If he can threaten a wireless, what would he do to me if I open the topic?’ [33].

Violence influences the risk of HIV and other STIs directly when it interferes with women’s ability to negotiate condom use. For many women, asking for condoms can be even more difficult than discussing other contraceptives because condoms are often associated with promiscuity, infidelity, and prostitution.

Raising the issue of condom use within marriage or other primary partnerships is especially difficult [37]. As a 46-year respondent in Brazil said, ‘If I ask my husband to use a condom now, he is going to ask ‘why?’ He is going to think I am fooling around or that I am accusing him of fooling around, two things that shouldn’t be happening’ [38].

Sexual victimization in childhood appears to place young women at increased risk of pregnancy during their teenage years. In the early 1990s studies began to find a consistent association between sexual abuse in childhood and adolescent pregnancy [39–41]. The studies also found a clear and consistent link between early sexual victimization and a variety of risk-taking behaviors, including early sexual debut, drug and alcohol use, more sexual partners, and less contraceptive use.

Childhood abuse has also been linked to unintended pregnancies among adult women. A study of 1200 women in the US found that women who reported being psychologically, sexually and/or physically abused, or whose mother was beaten by a partner, had higher rates of unintended first pregnancies than women who did not experience abuse. The likelihood of an unintended first pregnancy increased with both the number of different types of abuse women experienced, and its frequency [42].

In a 1999 speech, Peter Piot, the Executive Director of UNAIDS, noted that violence against women has many links to HIV/AIDS. ‘Violence against women is not just a cause of the AIDS epidemic,’ he noted, ‘it can also be a consequence of it.’ Sexual abuse in childhood appears to increase the incidence of STIs among adults, largely through its effect on high-risk sexual behavior ([43–50]). Several studies have linked a history of sexual abuse to higher risk of selling sex for money or drugs [39,50–53]. Abuse in childhood also increases the risk of HIV/AIDS through its effect on drug use. Sexually abused or assaulted women often turn to drugs as a coping mechanism, in addition to such unhealthy behavior as having unprotected sex and trading sex for money or drugs [54–61].

In some places, fear of men’s reaction has also hindered efforts to encourage voluntary HIV/AIDS counseling and testing among women [62]. This has implications both for controlling sexual transmission of the virus and for efforts to reduce mother to child transmission.

5.2. Violence increases risks for other gynecological problems

Sexual and physical violence appears to increase women’s risk for many common gynecological disorders, some of which can be debilitating. An example is chronic pelvic pain (CPP), which in many countries accounts for as many as 10% of all gynecological visits and one-quarter of all hysterectomies [63–65].

Although CPP is commonly caused by adhesions, endometriosis, or infections, about half the cases of CPP do not have any identifiable pathol-

ogy. A variety of studies have found that women suffering from CPP are consistently more likely to have a history of childhood sexual abuse [64], sexual assault [63,66–69], or physical and sexual abuse by their partners [70,71].

Past trauma may lead to CPP via unidentified injuries, by stress, or by somatization—the expression of psychological distress through physical symptoms [63]. Also, sexual abuse in childhood has been linked to increased sexual risk-taking, and thus to STIs, which can lead to CPP, often due to pelvic inflammatory disease.

Other gynecological disorders associated with sexual violence include irregular vaginal bleeding [72], vaginal discharge, painful menstruation [68,73], pelvic inflammatory disease [74], and sexual dysfunction (difficulty in orgasms, lack of desire and conflicts over frequency of sex) [71,73,74]. Sexual assault also increases risk for premenstrual distress, a condition that affects 8 to 10% of menstruating women and causes physical, mood, and behavioral symptoms [75]. The number of gynecological symptoms appears to be related to the severity of abuse suffered, whether there was both physical and sexual assault, whether the victim knew the offender, and whether there were multiple offenders [76,77].

5.3. Violence leads to adverse pregnancy outcomes

Around the world, as many as one woman in every four is physically or sexually abused during pregnancy, usually by her partner [78–87]. Estimates vary widely, however. Within the US, for example, estimates of abuse during pregnancy range from 3 to 11% among adult women and up to 38% among teenage mothers [80]. Some of this variation is likely due to differences in how the questions were asked, how often, and by whom [81,88].

Violence before and during pregnancy can have serious health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care [80,89–94] and to gain insufficient weight [80,95]. They are also more likely to have a history of STIs [96], unwanted or mistimed pregnancies [81,94,97], vaginal and cervical infections

[80,90,91], kidney infections [97], and bleeding in pregnancy [80,90].

Violence may also have a serious impact on pregnancy outcomes. Violence has been linked with increased risk of miscarriages and abortions [83,98], premature labor [97], and fetal distress [97]. Several studies also have focused on the relationship between violence in pregnancy and low birth weight, a leading contributor to infant deaths in the developing world [80,90,93,94,97–103]. Although the findings are inconclusive, several studies suggest that violence during pregnancy contributes substantially to low birth weight, at least in some settings. In one study at the regional hospital in Leon, Nicaragua, for example, researchers found that after controlling for other risk factors, violence against pregnant women was associated with a threefold increase in the incidence of low birth weight [94].

How violence puts pregnancies at above-average risk is unclear, but several explanations have been suggested [82,88]. Blunt abdominal trauma can lead to fetal death or low birth weight by provoking preterm delivery. Extreme stress and anxiety provoked by violence may also lead to preterm delivery or fetal growth retardation by increasing stress hormone levels or immunological changes. Finally, violence may affect pregnancy outcome indirectly by increasing women's likelihood of engaging in such harmful health behaviors as smoking and alcohol and drug abuse, all of which have been linked to low birth weight.

6. The role of reproductive health professionals

Health professionals can do much to help their clients who are victims of gender-based violence. Yet providers often miss opportunities to help by being unaware, indifferent or judgmental. With training and support from health care systems, providers can do more to respond to the physical, emotional and security needs of abused women and girls. First, health care providers can learn how to ask women about violence in ways that their clients find helpful. They can give women empathy and support. They can provide medical treatment, offer counseling, document injuries and

refer their clients to legal assistance and support services.

Reproductive health professionals have a particular responsibility to help because:

- Abuse has a major—although little recognized—impact on women's reproductive health and sexual well-being;
- Providers cannot do their jobs well unless they understand how violence and powerlessness affect women's reproductive health and decision-making ability;
- Reproductive health care providers are strategically placed to help identify victims of violence and connect them with other community support services.

Providers can reassure women that violence is unacceptable and that no woman deserves to be beaten, sexually abused, or made to suffer emotionally. As one client said, 'Compassion is going to open up the door. And when we feel safe and are able to trust, that makes a lot of difference' [104].

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