Violence against women: the hidden health burden

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Introduction

The health consequences of violence against women may be a serious problem worldwide, as gender violence is a significant cause of female morbidity and mortality, and represents a hidden obstacle to economic and social development. By sapping women's energy and confidence, gender violence can can deprive society of their full participation. As the United Nations Fund for Women (UNIFEM) recently observed, "women cannot lend their labour or creative ideas fully if they are burdened with the physical and psychological scars of abuse" *(1)*.

In recent years, the world community has taken some tentative, yet important, steps toward urging greater attention to the issue of gender-based abuse. Various United Nations bodies, including the Commission on the Status of Women, the Economic and Social Council, and the Committee on Crime Prevention and Control, have passed resolutions recognizing violence against women as an issue of grave concern. Negotiations are underway through the Organization of American States to draft a Pan American treaty against violence against women.

This international attention comes on the heels of over two decades of organizing by women's groups around the world to combat gender-based abuse. Women have started crisis centres, have had laws passed, and have worked to change the cultural beliefs and attitudes that undergird male violence. A recent directory published by the Santiago-based ISIS International, lists 379 separate organizations working against gender violence in Latin America alone *(2)*.

These grassroots efforts need to be supported and amplified by strong governmental commitments to prevent violence and assist survivors of abuse. Some argue that to date, few governments have taken violence against women seriously, failing to recognize either the extent of the problem or its implications for health and development. In part, this reflects active denial; but it is a denial facilitated by the lack of solid data documenting the pervasiveness and health consequences of abuse. Furthermore, ignorance is often an excuse for inaction.

In order to draw attention to and marshall greater support for violence-related programmes, this article will seek to: *(i)* summarize the existing information on gender-based abuse; *(ii)* identify data gaps and priority areas for research; and *(iii)* discuss methodological issues related to the study of the health consequences of gender violence.

Definition of gender violence

In September 1992, the United Nations Commission on the Status of Women convened a special working group to prepare a draft declaration against violence against women. This declaration — to be voted on by the Commission in the autumn of 1993 — includes for the first time a proposed definition of gender-based abuse. This draft definition of "violence against women" includes "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life *(3)*". Among the specific acts listed in the declaration are:

> Physical, sexual and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence, violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the State.

This article accepts the Commission's definition as a point of departure; for the sake of brevity, it explores only a subset of the above-mentioned abuses.

Wife abuse

The most endemic form of violence against women is abuse of women by intimate male partners. Studies have documented severe and ongoing abuse of women in almost every culture, save for a handful of small-scale societies where wife beating occurs only rarely. Levinson's analysis of ethnographic data from 90 peasant and small-scale societies indicates that in 86% of these, there is violence against wives by husbands. Only 16 of the societies studied "can be described as essentially free or untroubled by family violence" *(4)*. In an analysis of ethnographic research on 14 cultures by female anthro-

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pologists using female informants, Counts et al. identified only one society, the Wape of Papua New Guinea, that have little or no woman abuse *(5)*. In the United States of America, for example, experts estimate that 2-4 million women are battered each year *(6)*. Similarly, between one-third and one-half (or more) of women surveyed in many developing countries report being beaten by their partner *(Box 1)*.

The health consequences of such violence are considerable. In the United States, wife abuse is the leading cause of injury among women of reproductive age (See, for example, *7,8*,[b]); moreover, between 22 and 35% of women who visit emergency rooms are there for symptoms related to abuse *(6)*.

Wife abuse also provides the primary context for many other health problems. Battered women are 4-5 times more likely to require psychiatric treatment and 5 times more likely to attempt suicide than are other women.[c,d] They are also at increased risk of alcohol abuse, drug dependence, chronic pain, and depression *(9,10)*. In one study of health care utilization in the United States, a history of rape and/or assault was a stronger predictor of physician visits and outpatient costs than a woman's age or other health risks, such as smoking *(11)*.

Similar data are beginning to emerge from the developing world. A United Nations case study on wife abuse in China reports that domestic violence causes 6% of serious injuries and death in Shanghai.[d] In Papua New Guinea, 18% of all urban wives surveyed had received hospital treatment for injuries inflicted by their husbands *(12)*.

A matter of life and death

Since it often results in forced suicide and murder, gender violence is an important cause of female mortality. After reviewing evidence from the United States, Stark & Flitcraft conclude that "abuse may be the single most important precipitant for female suicide attempts yet identified" *(10)*. One out of every four suicide attempts by women is preceded by abuse, as are half of all attempts by African American women *(10)*. Stark[b] reports that 26% of all female suicide attempts presenting to Yale University Hospital in 1979 were associated with abuse as were 50% of attempts made by African American women. The battered women also accounted for 42% of all traumatic attempts and were significantly more likely to attempt suicide more than once (20% vs. 8%). A cross-cultural survey of suicide by Counts draws the same conclusion, citing evidence from Africa, Peru, Papua New Guinea and several Melanesian islands *(13)*.

The relationship between domestic violence and homicide may be even stronger. In Canada, 62% of women murdered in 1987 died as a result of domestic violence *(14)*, and in Papua New Guinea, almost three-fourths of women murdered were killed by their husbands *(12)*. In India, increased commercialization of dowry has led to a dramatic rise in dowry-related murders and suicides. Increasingly, dowry is being seen as a "get-rich-quick" scheme by prospective husbands, with young brides suffering severe abuse if ongoing demands for money or goods are not met. A frequent subterfuge is to set the woman alight with kerosene and then claim she died in a kitchen accident — this crime is known as bride-burning.

In 1990, the police officially recorded 4 835 dowry deaths in all of India, but the Ahmedabad Women's Action Group estimates that 1 000 women may be burned alive annually in Gujurat State alone *(15)*. In both urban Maharashtra and greater Bombay, 1 out of every 5 deaths among women aged 15-44 year is due to "accidental burns". For the younger age group, 15-24, the proportion is 1 out of 4 *(16)*. This suggests that a significant number of homicides and suicides are being recorded as "accidents" instead of intentional injuries.

Violence may also be responsible for a sizeable, although yet unrecognized, portion of maternal deaths, especially among young unwed mothers. Fauveau & Blanchet report that in Matlab Thana, Bangladesh, homicide and suicide — motivated by stigma over unwed pregnancy, or resulting from beatings or related to dowry — accounted for 6% of all maternal deaths between 1976 and 1986.[e] The figure rises to 22% if one includes deaths due to botched abortions, many of which are also related to shame over pregnancies out of wedlock.

Rape and sexual abuse

In recent years, it has become increasingly recognized that rape and sexual abuse are far more common than was thought earlier. An island-wide survey of women in Barbados revealed that 1 in 3 women had been sexually abused as children.[f] In

[b] Stark, E. The battering syndrome: social knowledge, social therapy and the abuse of women. Ph.D dissertation, Department of Sociology, Suny-Binghamton, 1984.

[c] Observation about psychiatric treatment from: Koop, C.E. Violence against women: a global problem. Address by Surgeon-General Koop at the Pan American Health Organization, Washington, DC, May 22, 1989.

[d] Wu, H. Proceedings of the Expert Group meeting on violence in the family with a special emphasis on its effects on women. United Nations Case Study of China. Vienna, Austria. UN Doc. BAW/EGM/86/CS.15, 1986.

[e] The World Health Organization (WHO) defines maternal mortality as a death during pregnancy or within 42 days afterward, from causes related to or aggravated by the pregnancy or its management.

[f] Handwerker, W.P. Gender power difference may be STD risk factors for the next generation. Paper presented at the 90th Annual Meeting of the American Anthropological Association, Chicago, Illinois, 1991.

Box 1 Prevalence of wife abuse, studies in selected countries

Country	Sample size	Sample type	Findings	Remarks
Barbados (Handwerker, 1991)	264 women and 243 men aged 20-45 years	Island-wide national probability sample	30% of women battered as adults	50% of women and men report their mother being beaten
Antigua (Handwerker, 1993)	97 women aged 20-45 years	Random subset of national probability sample	30% of women battered as adults	50% of women and men report their mother being beaten
Kenya (Raikes, 1990)	733 women from Kissi District	District-wide cluster sample	40% "beaten regularly"	Taken from contraceptive prevalence survey
Papua New Guinea (Toft, 1987)	Rural: 736 men and 715 women Urban low income: 368 men and 298 women Urban high income: 178 men and 99 women	Rural survey in 19 villages in all regions and provinces Urban survey with oversample of elites	60% rural women "beaten"" 56% urban low-income women "beaten" 62% urban elite women "beaten"	Almost perfect agreement between % of women who claim to have been beaten and % of men who admit to abuse
Sri Lanka (Sonali, 1990)	200 mixed ethnic, low-income women from Colombo	Random sample from low-income neighbourhood	60% had been beaten	51% of women said husbands used weapons
India (Mahajan, 1990	109 men and 109 women from a village in Juliundur District, Punjab	50% sample of all scheduled caste households and 50% of non-scheduled caste households	75% of scheduled caste men admit to beating their wives; 22% of higher caste men admit to beatings	75% of scheduled-caste wives report being beaten "frequently"
Malaysia (Raj-Hashim, 1993)	713 women and 508 men over 15 years of age	National random probability sample of Peninsular Malaysia conducted by a large market research firm in South-East Asia	39% of women reported having been "physically beaten" by a partner in the last year	Annual figure; 15% of adults consider wife beating acceptable (22% among Malays)
Colombia (Profamilia, 1992)	3 272 urban women 2 118 rural women	National probability sample	20% physically abused; 33% psychologically abused; 10% raped by husband	Part of Colombia's DHS survey
Costa Rica (Chacon et al., 1990)	1 388 women	Random sample of women attending child welfare clinics	50% reported being physically abused	Sponsored by UNICEF/PAHO
Costa Rica (1990)	1 312 women aged 15-49 years	Random probability sample of urban women	51% reported being beaten up to several times per year; 35% reported being hit "regularly"	
Guatemala (Coy, 1990)	1 000 women	Random probability sample of women in Sacatepequez	49% abused; 74% by an intimate male partner	Includes physical, emotional and sexual abuse in adulthood; study sponsored by UNICEF/PAHO

Mexico (Jalisco) (Ramirez & Vasquez, 1993)	1 163 rural women and 427 urban women in Jalisco State	Random household survey of women on DIF register	56.7% of urban women and 44.2% of rural women reported physical abuse	Experienced some form of "interpersonal violence"
Mexico (Valdez Santiago & Cox, 1990)	342 women from Nezahualcoyotl	Random, probability sample of women from city adjacent to Mexico City	33% had lived in a "violent relationship"	
Ecuador (CEPLAES, 1992)	200 low-income women	Random convenience sample of Quito barrio	60% had been "beaten" by a partner	37% of those beaten were assaulted every day up to once a month
Chile (Larraín, 1993)	1 000 women in Santiago, aged 22 to 55 years, involved in a relationship of 2 years or more	Stratified random probability sample with a maximum sampling error of 3%	60% have been abused by a male intimate; 26.2% have been physically abused (more severe than pushes, slaps or having object thrown at you)	70% of those abused are abused more than once a year
Norway (Schei & Bakketeig, 1989)	150 women aged 20 to 49 years in Trandheim	Random sample selected from census data	25% had been physically or sexually abused by a male partner	Does not include less severe forms of violence like pushing, slapping or shoving
New Zealand (Mullen et al. 1988)	2 000 women sent questionnaire; stratified random sample of 349 women selected for interview	Random probability sample selected from electoral rolls of five contiguous parliamentary constituencies	20.1% report being "hit and physically abused" by a male partner; 58% of these women (>10% of sample) were battered more than 3 times	
United States of America (Straus & Gelles, 1986)	2 143 married or co-habiting couples	National random probability sample	28% report at least one episode of physical violence	
United States of America (Grant, Preda & Martin, 1991)	6 000 women state-wide from Texas	State-wide random probability sample	39% have been abused by male partner after age 18; 31% have been physically abused	>12% have been sexually abused by male partner after age 18
United States of America (Teske & Parker, 1983)	3 000 rural women in Texas	Random probability sample of communities with 50 000 people or less	40.2% have been abused after age 18; 31% have been physically abused	22% abused within the last 12 months

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Seoul, Republic of Korea, 17% of women surveyed reported being a victim of an attempted or completed rape.[g] In the United States, 78 adult women — and at least as many girls and adolescents — are raped each hour *(17)*.

Contrary to popular perception, the majority of rape survivors know their assailants, a reality confirmed by studies in Malaysia, Mexico, Panama, Peru and the United States *(Table 1)*. A large percentage of rapes (36-58%) is perpetrated against girls 15 years or younger, with a substantial proportion against girls under 9 years. Rape survivors exhibit a variety of trauma-induced symptoms, including sleep and eating disturbances, depression, feelings of humiliation, anger and self blame, nightmares, fear of sex, and inability to concentrate.[h] Survivors also risk becoming pregnant or contracting sexually transmitted diseases (STDs), including HIV/AIDS. A rape crisis centre in Bangkok, Thailand reports that 10% of their clients contract STDs and 15-18% become pregnant as a result of rape, a figure consistent with data from Mexico and

Table 1
Statistics on sexual crimes, selected countries[a]

Tableau 1
Statistiques des agressions sexuelles, échantillons de pays[a]

	Percentage of perpetrators known to victim – Pourcentage d'agresseurs connus de la victime	Percentage of survivors 15 years and under – Pourcentage de survivants de 15 ans et moins	Percentage of survivors 10 years and under Pourcentage de survivants de 10 ans et moins
Lima, Peru – Lima, Pérou	60	–	18[b]
Malaysia – Malaisie	68	58	18[c]
Mexico City – Mexico	67[d]	36	23
Panama City	63	40	–
Papua New Guinea[e] – Papouasie-Nouvelle-Guinée[e]	–	47	13[f]
United States of America – Etats-Unis d'Amérique	78	62[g]	29

[a] Studies include rape and sexual assaults such as attempted rape and molestation except for United States data which includes only completed rapes. – Les études ont porté sur les viols et agressions sexuelles telles que tentative de viol et attentat à la pudeur sauf aux Etats-Unis d'Amérique où seuls ont été pris en compte les viols effectifs.
[b] Percentage of survivors age 9 and younger. – Pourcentage de survivants de 9 ans et moins.
[c] Percentage of survivors age 6 and younger. – Pourcentage de survivants de 6 ans et moins.
[d] Data from *Carpeta basica*. 1991. Mexico City: Procurador de Justicia del Districto Federal de Mexico. – Données fournies par *Carpeta basica*. 1991, Mexico City: Procurador de Justicia del Districto Federal de Mexico.
[e] Bradley, C. *Why male violence against women is a development issue: Reflections from Papua New Guinea*. Paper for United Nations Fund for Women (UNIFEM), 1990.
[f] Percentage of survivors age 7 and younger. – Pourcentage de survivants de 7 ans et moins.
[g] Percentage of survivors age 17 and younger. – Pourcentage de survivants de 17 ans et moins.

Sources: Malaysia – Malaisie *(20)*, Panama City *(21)*, Peru – Pérou *(22)*, Mexico City *(23)*, United States – Etats-Unis *(17)*.

[g] Shim, Y-H. Sexual violence against women in Korea: a victimization survey of Seoul women. Paper presented in St. Petersburg, Russia at the Conference on "International Perspectives: Crime, Justice and Public Order", June 21-27, 1992.

[h] Kilpatrick, D. Testimony before the house select committee on children, youth and families. Washington, DC, March 28, 1990.

Korea.[i,j,k] In countries where abortion is illegal in case of rape, victims often resort to illegal abortions, greatly increasing their chance of future infertility or even risking death.

Response of the health sector

Violence against women has only recently begun to be recognized as a health problem by the medical and public health establishment. In the United States, the American Medical Association (AMA) launched a major campaign in 1991 to educate the public and physicians about family violence *(18)*. Similarly, the Joint Commission on Hospital Accreditation issued new standards requiring all hospitals to develop protocols and provide training to their staff on how to respond to different forms of abuse. After training and protocols were introduced, the percentage of women found to be battered rose from 5.6% to 30% at the emergency department of the Medical College of Pennsylvania *(19)*. Once identified, the women can be referred to shelters, counselling and other potentially life-saving services.

On the international front, violence is slowly becoming recognized as an obstacle to women's health and development. In 1991, the Pan American Health Organization (PAHO) sponsored a conference in Managua, entitled "Violence against women: a problem of public health". The Ministry of Health of Colombia issued an action agenda on women's health which included a programme on the "prevention of abuse and attention to victims of violence." In 1992, the United Nations Fund for Women (UNIFEM) published *Battered dreams: violence against women as an obstacle to development (1)*.

Measurement and research issues

As with any issue similarly underreported and fraught with problems of measurement, deriving accurate statistics on violence against women represents a great challenge. However, to assume that women will not disclose abuse would be a mistake for researchers; it has been observed by most researchers to date that women are remarkably willing, indeed eager, to share their experiences. As was the case with abortion, once researchers have created a safe space for discussion, women have proved willing to discuss abuse. Indeed, it is important for researchers to consider the sensitive nature of violence when designing research strategies. Perhaps most important is ensuring the physical and emotional safety of the women being interviewed. Not only for the woman's safety, but also for the sake of accuracy, it is essential for women to be interviewed away from their partners or other family members who may be perpetrators. Also, prior to initiating research, there is an ethical obligation to investigate the psychological and legal resources available locally to support women who disclose having suffered abuse or violence.

Priority data needs on violence against women

- Better definitions of rape, child sexual buse, wife abuse, and other forms of gender violence to facilitate measurement and comparison across populations.
- Better data on the incidence and prevalence of gender-related violence in representative populations of women.
- Data on the percentage of women presenting in different contexts (e.g. emergency rooms, family planning clinics, etc.) who have been raped and/or abused. (This will help convince health care providers of the prevalence of abuse as well as help define the potential of using different settings as points of identification and referral for victims.)
- Data on health care and social costs of domestic violence and sexual assault/abuse. Estimates of cost of emergency services, indirect costs of productivity losses, costs associated with increased utilization of primary care services, etc.
- Data on the mental health consequences of violence: relative risk among victimized and non-victimized women for suicide attempts, alcohol and drug abuse, depression, somatic health complaints, anxiety, sexual dysfunction, etc.
- Data on the impact of domestic violence and/or sexual assault/abuse on birth outcomes: rates of miscarriage, low birth weight, pregnancy complications, etc.
- Studies that analyse the relationship between gender violence and other development issues such as Safe Motherhood, child survival, prospects for AIDS prevention, family planning etc.
- Descriptive profiles of the typical presenting symptoms of rape and abuse victims (location of injuries, somatic complaints, etc.) so as to facilitate identification by health care providers.

Suggestions for the research community

While existing data are sufficient to capture the severity of the problem, research is still needed to

[i] Thai data from "Ban Thanom Rak", a home for rape survivors run by the Friends of Women, Bangkok, Thailand as quoted in Archavanitkui, K. & Pramualratana, A. Factors affecting women's health in Thailand. Paper presented at the workshop on Women's Health in Southeast Asia. Population Council, Jakarta, October 29-31, 1990.

[j] Mexican data from COVAC, 1990. "Evaluación de proyecto para educación, capacitación y atención a mujeres y menores de edad en materia de violencia sexual, Enero a Diciembre 1990." Mexico City: Asociación mexicana contra la violencia a las mujeres; and CAMVAC, 1985. "Carpeta de información básica para la atención solidaria y feminista a mujeres violadas." Mexico City: Centro de apoyo a mujeres violadas.

[k] Korean data from Shim, Y-H., see footnote 8.

improve our understanding of gender violence and to help design better interventions, using the list of priority issues for research, above. In addition, the following suggestions could greatly facilitate future work on violence:

- WHO and other agencies could sponsor cross-cultural research on violence against women. Donors could convene meetings of researchers and women's advocates working on gender violence to begin exploring methodological issues with respect to studying violence against women and girls. (All research efforts can draw on the experience of NGOs that have worked to combat gender violence and provide services for victims.)
- On-going research efforts, such as focus groups and surveys being conducted on sexuality for the purposes of developing HIV/AIDS prevention programmes, can use these opportunities to explore the role that violence and coercion play in women's sexual and reproductive decision-making.
- All crime statistics should be broken down by gender (for both the perpetrator and the victim). Information should be recorded on the relationship between the perpetrator and the victim, to help identify the gender-specific nature of much of violent crime.

Governments and the international community should recognize that it is important for women to live free from physical and psychological abuse. Gender violence is damaging, both physically and mentally. A health research agenda that values women can no longer ignore this regrettably frequent reality of women's lives.

Summary

Violence against women is a major health problem around the world. It often goes unnoticed and undocumented partly due to its taboo nature. A number of recent studies have explored the extent and patterns as well as the health consequence of violence in different cultures. The studies cited indicate that violence against women is widespread and an important cause of morbidity and mortality among women. Injuries due to violence have only recently been recognized as an important public health problem. More research is needed to improve our understanding of gender violence, and to design better interventions.

Résumé

La violence contre les femmes: un problème de santé caché

La violence contre les femmes est un problème majeur de santé dans le monde entier, mais elle est souvent inaperçue et inobservée, en partie parce qu'elle constitue un tabou. Récemment, un certain nombre d'études ont porté sur l'ampleur et les schémas de la violence dans différentes cultures ainsi sur les conséquences pour la santé. Ces études indiquent que la violence contre les femmes est très répandue et constitue une importante cause de morbidité et mortalité. Ce n'est que récemment que les traumatismes dus à la violence ont été reconnus comme un important problème de santé publique. De nouvelles recherches sont donc nécessaires pour améliorer notre compréhension de cette violence et mettre au point de meilleures interventions.

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