

## **C4 | BREAKING FREE FROM GENDER-BASED VIOLENCE**

Gender-based violence (GBV) is understood as violence that is directed against a person on the basis of gender, and is an outcome of gender inequalities and discrimination. It is universal and transcends race, caste, class, culture, ethnicity, identity, disability, religion and regions. However, the forms of violence and their prevalence vary across locations.

The intersections of gender and race, caste, class, religion, sexuality, disability, age, work, etc., create further vulnerabilities to violence (Sama 2013). While women and girls are the primary targets of gender-based violence, boys and men, transgender and queer persons experience violence based on their gender and sexual identities. Gender-based violence is used to assert control and power, to ‘punish’ supposed transgression of gender, sexuality, religion and caste norms (Sama n.d). For example, in war, racial, ethnic, caste-based and communal violence, sexual violence is used as a tool to punish and dishonour the ‘other’.

A range of factors conspire to maintain and perpetuate gender-based violence, considered one of the most severe forms of human rights violations. These include social, economic and political structures, discriminatory legal systems, and cultural systems that legitimize violence. Gender-based violence manifests in various forms – verbal, non-verbal, physical, mental, emotional, social and economic. The forms of gender-based violence include intimate partner violence, non-partner sexual violence (the most prevalent globally), child sexual abuse, trafficking of women and girls, female genital mutilation, sexual harassment at the workplace, forced marriage, forced sterilization, sex selection at birth, etc. (Sama 2013).

### **Recognition of gender-based violence as a human rights and public health issue**

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations General Assembly in 1979. However, international bodies such as the United Nations did not explicitly articulate a strong position on the issue until 1992, when an expert committee monitoring the CEDAW adopted General Recommendation 19,<sup>1</sup> correcting a major flaw in the Convention. In 1993, at the Vienna Conference, Violence against Women was officially recognized as a human rights violation and the General Assembly adopted the Declaration on the Elimination of Violence against Women (DEVAW) in the same year. A Special Rapporteur

on Violence against Women (SRVAW) was established in 1994 as a special mechanism to monitor violence against women, including its causes and consequences worldwide.

In 1995, the Platform for Action of the Fourth World Conference on Women, Beijing, clearly articulated the need to strengthen health systems and to involve healthcare providers in addressing gender-based violence. The core document directed countries to ‘... develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse, or other abuse resulting from armed and non-armed conflict’ (Section 106(q)).

The World Health Organization (WHO) in its 2009 report on *Women and Health* emphasizes that ‘violence is an additional significant risk to women’s sexual and reproductive health and can also result in mental ill-health and other chronic health problems’ (WHO 2009). In 2013, a declaration of commitment to end sexual violence in conflict was signed by 113 member states at the 68th United Nations General Assembly. In the same year, the fifty-seventh session of the Commission on the Status of Women (CSW) resolved to eliminate all forms of violence against women and girls. Further, it recognized the adverse consequences on health, the need to provide support to victims and survivors, along with affordable and accessible healthcare services, and take necessary steps to sensitize and strengthen the capacity of public officials and professionals and hold them accountable, including in the healthcare sector (CSW 2013).

Women’s rights groups, organizations, networks and alliances have been actively involved in country, regional as well as international processes aimed

#### **Box C4.1 UNiTE to End Violence against Women**

The United Nations observes International Day for the Elimination of Violence against Women on 25 November every year. The date marks the brutal assassination, in 1960, of the three Mirabal sisters, political activists in the Dominican Republic.

In 2008, the United Nations secretary-general’s UNiTE to End Violence against Women campaign was initiated to raise public awareness and increase political will and resources for preventing and ending all forms of violence against women and girls in all parts of the world. In July 2012 the UN secretary-general proclaimed the 25th of every month as Orange Day to highlight issues relevant to preventing and ending violence against women and girls.

*Source:* UNiTE (n.d.)

at informing and strongly advocating for recognition of gender-based violence as a human rights and health issue.

### Gender-based violence: how prevalent is it?

Global data indicates that 35.6 per cent of women have reported experiencing physical and/or sexual partner violence, or sexual violence by a non-partner (WHO 2013a). The prevalence in different WHO regions is as follows:

TABLE C4.1 Prevalence of gender-based violence

Region (WHO)	Prevalence %
South-East Asian	37.7
East Mediterranean	37.0
African	36.6
Region of the Americas	29.8
European	25.4
Western Pacific	24.6

Intimate partner violence is the most common type of violence against women, affecting 30 per cent of women worldwide; 7.2 per cent of women have experienced sexual violence by a non-partner (*ibid.*). The gendered nature of violence is evident from the fact that more than 75 per cent of violence against women globally is committed by male intimate partners (Fleming et al. 2013). Existing figures depict a small part of the entire picture, given the



**Image C4.1** Protest against rising sexual violence in New Delhi, India (Sama Resource Group for Women and Health)

silence and stigma surrounding reporting of gender-based violence and the perceived as well as real risks entailed in its disclosure.

### **Consequences for human rights and health**

Gender-based violence violates a range of human rights of women and girls, including their rights to Life, Health, Equality and Non-discrimination, Liberty and Mobility, Free Speech and Expression, Social Security, Education, Work and Livelihood, Shelter and Adequate Standard of Living, Participation in Social and Political Activities (Sama 2013). The Right to Health implies freedom from violence and non-discrimination, and gender equality and access to various other socio-economic determinants.

GBV has extremely serious implications for health, both physical and psychological, and has immediate as well as long-term consequences. Women who have been physically or sexually abused by their partners are 16 per cent more likely to have a low-birth-weight baby; they are more than twice as likely to have an abortion, almost twice as likely to experience depression, and, in some regions, are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence. Women who have experienced non-partner sexual violence are 2.3 times more likely to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety (WHO 2013a). Victims of GBV suffer from a range of conditions that affect their reproductive health. Disability, anxiety and post-traumatic stress disorder (PTSD) are also important consequences of GBV. There is also increasing evidence linking intimate partner violence with the health of children (ibid.).

However, despite such evidence, actions to prevent GBV and to address public health consequences remain limited. A public health approach implies multi-sectoral, coordinated efforts to prevent gender-based violence as well as to address the consequences of violence.

### **Health system response to gender-based violence**

The healthcare system and healthcare providers are often the first point of contact for survivors of violence. Studies have shown that women who have experienced violence are more likely to seek healthcare than those women who have not, even if they do not disclose the violence (ibid.).

However, barriers to accessing healthcare exist in most countries and particularly for survivors of gender-based violence (see Box C4.2). Currently, only a limited number of countries provide comprehensive services to survivors of violence in general and of intimate partner and sexual violence in particular (ibid.). Even when services for dealing with the immediate physical health consequences of GBV are available, mental health services for survivors of violence are widely absent (ibid.). Consequently, not all those experiencing violence directly seek healthcare and yet, when they do, their health problems may not be attributed to violence.

#### **Box C4.2 Access to care for immigrant and racialized women survivors of sexual assault**

The Peel Committee on Sexual Assault (PCSA) was formed in 1989 by a group of service providers concerned about the lack of services in the region of Peel, Ontario, Canada, for survivors of sexual abuse. PCSA conducted a study that examined ‘racial inequities of the Canadian Health Care System and its impact on access to primary health care for immigrant and racialized women survivors of sexual assault’ in the region of Peel.

Some of the significant findings were:

- Only 6 per cent of sexual assault survivors ever approach police. Most never approach or tell anybody. Most survivors have at least two chronic illnesses.
- One service provider, working with survivors of sexual assault, reported that 75–85 per cent of the women accessing services are racialized or immigrant women.
- Factors that place immigrant and racialized women at risk include: systemic racism, language barriers, isolation, lack of status (legal authorization to remain in Canada), fear, lack of knowledge of resources that can help, and different understandings of what constitutes sexual assault. Respondents reported that women do not ask for help because they fear deportation. One respondent reported: ‘For blind women like me, we need to know where to go. When I finally opened my door [to leave my husband], I didn’t know where to turn because there was so much fear.’
- Barriers to accessing primary healthcare that were identified included: lack of access to health practitioners; fragmented health services for survivors of sexual assault; lack of practitioner awareness of the complex experiences of racialized and immigrant survivors; and barriers to disclosure. A respondent said: ‘... you don’t have the opportunity to talk with them [doctors] ... they say they don’t have time for you ... how do we open their minds and our hearts that we need more time?’

Clearly, there needs to be a reorganization of primary healthcare services for immigrant and racialized women. The impact of violence and sexual assault on the health of women should be central to their care, particularly for survivors living with chronic illness. Ultimately, the assessment of how gender and race impact women’s health could result in possible interventions that will improve individual overall health and health equity in the system.

Further, since the healthcare system may often be the first and the only point of contact that survivors of gender-based violence access, it is an important location for provision of a comprehensive response, including provision and facilitation of referrals. Healthcare providers can play a key role in screening for violence as well as in referring victims to appropriate agencies for help. Health facilities can also play an important role in documenting GBV, which is vital for victims who seek justice.

To effectively reach out to victims of GBV, healthcare systems need to inculcate a ‘gendered’ approach and build the capacity of healthcare providers to deal with gender, sexuality and violence. Care providers who have undergone training are more likely to enquire about GBV and to feel competent to address the needs of survivors. Survivors are also likely to be more inclined and encouraged to discuss the violence or abuse if they perceive the provider to be sensitive and skilled, and if follow-up is offered (PAHO 2003). Studies have clearly shown that negative attitudes of healthcare providers are identified by women as the primary obstacle to accessing necessary care.

### The way ahead

Policy, law and guidelines on gender-based violence must incorporate a comprehensive health system response. It is necessary to develop clear guidelines, protocols and curricula that are gender- and rights-based. The healthcare sector’s response to gender-based violence in humanitarian emergency situations (disasters, conflicts, etc.) needs to be strengthened.

Elimination of gender-based violence requires action at various levels, including steps to address societal issues related to power and dominance, access to resources and entitlements, etc. This is an appropriate moment to review progress and the challenges that remain, as well as to inform future development frameworks and strategies towards preventing and ending gender-based violence.

A new development framework (post-2015) that is transformative must address the structural causes of inequality and marginalization. It must address the convergence of the pernicious effects of globalization, militarism, conflict and fundamentalisms that particularly target women’s bodies and livelihoods. Eliminating violence against women must be a target of the post-2015 agenda, along with ensuring decision-making of women in the home, in the community, in development planning and implementation (UN Women 2014).

### Note

<sup>1</sup> The General Recommendation no. 19 focused on Violence against Women. It specifically includes GBV within the definition of discrimination and defines GBV as ‘violence that is directed against a woman because she is a woman or that affects women disproportion-

tionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.’ The GR 19 also appended detailed comments on violence to the different articles of the Convention.

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