

# *Reproductive Health, Gender and Human Rights: A Dialogue*

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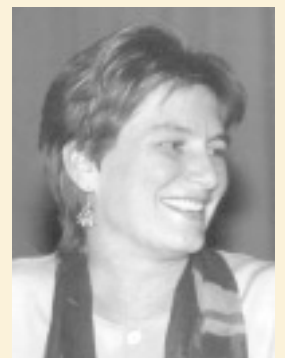
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## 8. Violence Against Women: Impact on Sexual and Reproductive Health

Fifteen years ago, violence against women was not recognized as either a public health *or* a human rights problem. Major public health institutions did not mention it, and the human rights community was primarily focused on violations perpetrated in the public sphere, while violence against women tends to take place in private. We have come very far in the past 15 years.

The conclusions in this paper about violence and reproductive health are based on a global review of the published and unpublished literature available on violence, including methodical searches of MEDLINE, POPLINE, the WHO gender violence database and a variety of specialized violence libraries. Over 1,000 articles were reviewed, indexed and synthesized, including more than 35 population-based surveys of violence and 40 in-depth qualitative studies. The paper also draws upon research conducted by Mary Ellsberg as part of a research collaboration between Umeå University in Sweden and the León Medical School in Nicaragua (Figure 8-1). The Umeå/León research collaboration built upon an existing public health surveillance site that routinely collects vital events and other health data from 10,000 households in the province of León. The researchers conducted a population-based survey on domestic violence among a subset of households and included experiences of physical and sexual abuse as variables in a number of nested case-control studies designed to evaluate risk factors for under-5 mortality, adolescent pregnancy, high-risk sexual behavior and low birth weight.

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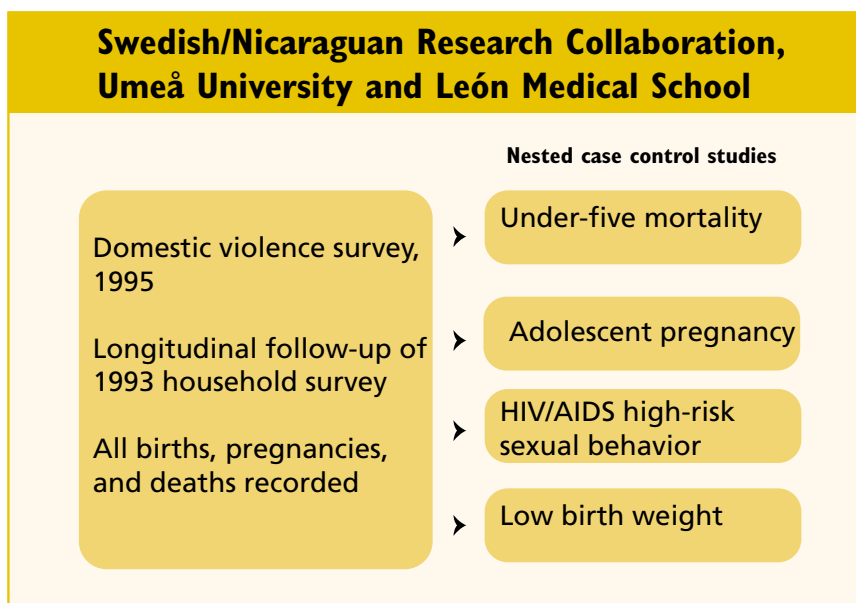


Figure 8-1

<sup>1</sup> At the time this presentation was made, Heise and Ellsberg were affiliated with the Center for Health and Gender Equity (CHANGE); they joined PATH on April 1, 2001.

## **Dimensions of the Problem**

- ◆ A recent review of 50 population-based studies carried out in 36 countries indicates that between 10-60 percent 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 (Heise et al., 1999).
- ◆ 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.
- ◆ Twelve-month rates of partner violence vary widely from fewer than 3 percent of ever-partnered women in the United States, Canada and Australia to 23 percent of women in Santiago, Chile; 33 percent of women in Managua, Nicaragua; and 52 percent of Palestinian women in the West Bank and Gaza strip (Heise et al., 1999).

## **Physical Violence Is Usually Accompanied By Sexual and Emotional Violence**

Violence against women is often categorized as physical, sexual or emotional violence, but in intimate partnerships, these types of violence frequently overlap. For example:

- ◆ Among 613 ever-abused Japanese women, 57 percent experienced all three types of abuse (Yoshihama and Sorenson, 1994).
- ◆ Globally, one-third to one-half of all physically abused women also report forced sex (Koss et al., 1994; Leibrich et al., 1995; Ellsberg et al., 2000).
- ◆ Most physically abused women also experience severe emotional abuse. In the León, Nicaragua study, 97 percent of women who were physically abused by a partner were also emotionally abused (Ellsberg et al., 2000).

Although violence against women is ubiquitous, rates of abuse can vary greatly, even in areas of close proximity. For example, in the state of Uttar Pradesh, India, the percentage of men who admitted hitting their wives in the last year varied from 11 percent in Naintal district to 33 percent in Banda district (Narayana, 1996). This variation raises an interesting question: what combination of factors best accounts for this three-fold difference in rates of violence between neighboring districts? If we can answer this question, we will have gleaned important insights for future prevention efforts.

## **Low Socioeconomic Status Also Increases Risk of Violence**

Although violence cuts across all socioeconomic groups, studies in the United States and numerous other countries indicate that women living in poverty

are at increased risk of physical abuse by an intimate partner (Heise et al., 1999). It is as yet unclear why poverty increases women's risk of violence—whether it is due to low income itself or to other factors that accompany poverty, such as crowding or hopelessness. For some men, living in poverty is likely to generate stress, frustration and a sense of inadequacy for having failed to live up to their culturally defined role of provider. Although low socioeconomic status appears to be a marker for increased risk, the relationship between poverty and risk of abuse deserves far more study.

What we do know is that violence against women is a product of the gender subordination of women. Four factors are consistently associated with violence (Heise, 1998; Levinson, 1989):

- ◆ Norms of male entitlement and ownership of women.
- ◆ Male control of wealth in the family.
- ◆ Notions of masculinity that are tied to dominance and honor.
- ◆ Male control of decision-making in the family.

### **Violence Has Many Culturally Ascribed Meanings**

In many parts of the developing world, wife beating is conceptualized as a form of chastisement—the husband's right to “correct” an erring wife. 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”* (Jejeebhoy, 1998).

In many developing countries women share the notion that men have the right to discipline their wives by using force. Beating is considered acceptable as long as it is for a “just cause.” Indeed, the acceptability of violence generally involves a complex equation of who does what to whom, and for what reason. One of the most commonly accepted justifications for wife beating is refusal of sex or transgression against other gendered norms.

The concept of beating as discipline has been found in qualitative research throughout the world. As an indigenous woman in Mexico said, *“I think that if the wife is guilty, the husband has the right to hit her...If I have done something wrong...nobody should defend me. But if I haven't done something wrong, I have a right to be defended”* (Gonzalez Montes, 1998).

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## The Origins of Violence Are Multi-Causal

Increasingly, experts are using an “ecological model” to understand the interplay of personal, situational and sociocultural factors that combine to cause

abuse (Figure 8-2). An ecological approach to abuse argues that no one factor alone “causes” violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting will react violently. In the ecological framework, social and cultural norms—such as those that assert men’s inherent superiority over women—combine with individual level factors—such as whether a man was abused himself as a child—to determine the likelihood of abuse. The more risk factors present, the greater the likelihood that violence will occur.

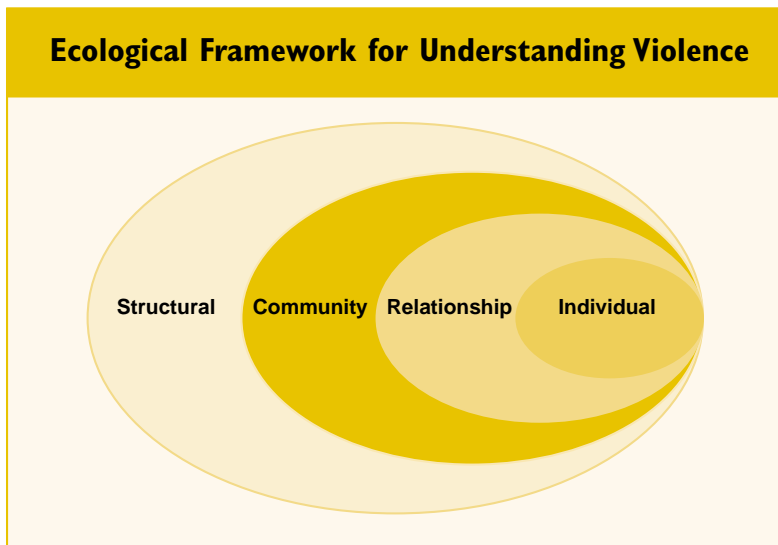


Figure 8-2

## Health Consequences of Abuse

Like smoking, victimization is a risk factor for a variety of unhealthy outcomes. In addition to causing immediate physical injury and mental anguish, violence increases women’s risk of future ill health. A wide range of studies shows that women who have experienced physical or sexual violence, whether in childhood or adulthood, are at greater risk of subsequent health problems. Compared to non-abused women, women who have been victimized have: 1) reduced physical functioning, 2) more physical symptoms, 3) worse subjective health, 4) more life-time diagnoses of health problems and 5) higher health care utilization. The impact of abuse persists long after the abuse has stopped. The more severe the abuse, the greater the number of symptoms and the more severe the effect on women’s physical and mental health (Leserman et al., 1996). The sections below describe the variety of negative health outcomes linked to abuse.

## Violence Increases Risk for Gynecological Problems

Sexual and physical violence appear to increase women’s risk for many common gynecological disorders, including: 1) vaginal bleeding, 2) painful menstruation, 3) vaginal discharge, 4) sexual dysfunction, 5) pelvic inflammatory disease and 6) painful intercourse.

Abuse may also be linked to the etiology of chronic pelvic pain, a debilitating condition that frequently has no identifiable cause. In Europe and the United States, chronic pelvic pain is responsible for ten percent of all gynecological visits and one-quarter of hysterectomies (Walker et al., 1992). Although chronic pelvic pain can be caused by adhesions, endometriosis or infections, in about half the cases there is no identifiable pathology. A number of studies have found that women suffering from chronic pelvic pain are more likely to have a history of childhood sexual abuse (Walker et al., 1992), sexual assault (Chapman, 1989; Rapkin et al., 1990) or physical and sexual abuse by their partners (Schei, 1990).

### Fatal and Non-Fatal Outcomes of Abuse

The following table outlines the fatal and nonfatal outcomes, including physical and mental health problems, and behavioral and reproductive health consequences of three types of abuse.

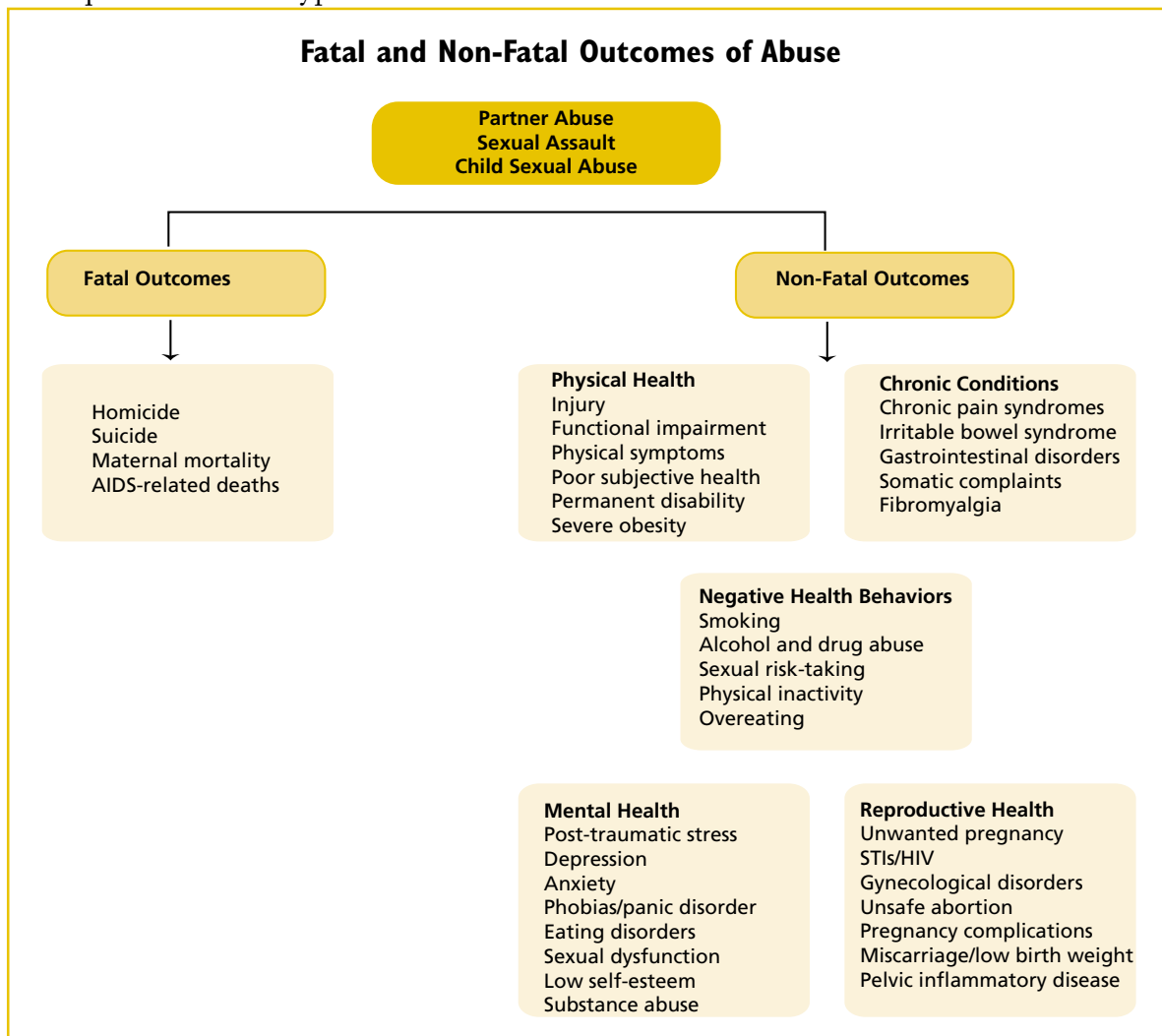


Figure 8-3

## Violence Leads to Unwanted Pregnancies

If women cannot control their sexual encounters, they are at risk of unwanted pregnancy. Studies from Bolivia, Chile, India, the Philippines and the United States have all found that partner violence is more common in families with four or more children (Larrain, 1994; David and Chin, 1998; Jejeebhoy, 1998; Najera et al., 1998; Martin et al., 1999; Rosales et al., 1999; Tjaden and Thoennes, 2000). Researchers have argued for years that perhaps having many children increased the likelihood of abuse, either by increasing stress or provoking marital disagreements. Recent research from León, Nicaragua, however, suggests that the relationship may work the other way, with violence serving as a risk factor for having large families. Through life table analysis, the Nicaraguan study indicated that partner violence generally began early in the marriage, preceding the arrival of many children. In the León study, 80 percent of the women who had ever been abused said that the abuse began in the first four years of marriage (Ellsberg et al., 2000).

## Violence Undermines Women’s Contraceptive Use

Numerous studies indicate that violence reduces women’s sexual autonomy and increases women’s fear that raising the topic of contraception will have violent consequences. The following studies, conducted in 10 countries with a variety of

female subjects, have examined the relationship between contraceptive use and violence.

Sometimes a woman’s fear of violence is warranted and sometimes not, but fear cuts off the discussion of contraceptive use. In Ghana, where 51 percent of women and 43 percent of men agree that a husband is justified in beating his wife if she uses family planning without permission, a woman explains:

Violence Undermines Women's Contraceptive Use	
<b>Bolivia</b>	Aymara market women (Choque et al., 1994)
<b>Brazil</b>	Female factory workers (Goldstein, 1994)
<b>Cambodia</b>	Abused women (Zimmerman, 1995)
<b>Ghana</b>	Married women (Ezeh, 1993)
<b>Guatemala</b>	Pregnant women (Lundgren et al., 1992)
<b>India</b>	Married women (George and Jaswal, 1993)
<b>Jamaica</b>	Low-income workers (Chambers et al., 1992)
<b>Mexico</b>	Family planning clients (Folch-Lyon et al., 1981)
<b>Peru</b>	Community members (Fort, 1989)
<b>Uganda</b>	Married women (Blanc et al., 1996)

Figure 8-4

*“I cannot even speak of family planning in passing to my husband. Every morning, whenever he hears people discussing family planning over the radio, he gets so angry...he fumes and shouts, cursing under his breath. If he can threaten a wireless, an inanimate thing, what would he do to me if I open the topic?” (Bawah et al., 1999).*

## Violence Reduces Women’s Sexual Autonomy

In many parts of the world, marriage is interpreted as granting men unconditional sexual access to their wives, a “right” enforced through force if necessary. Among 98 percent of currently married women in Uttar Pradesh, India, 68 percent report being coerced into sex by their husbands; 31 percent report being forced through beatings (Khan et al., 1996). The high level of nonconsensual sex occurring in marital unions is supported through both qualitative and quantitative data.

In Egypt and Ghana, 70 percent and 33 percent of women respectively agree that a man is justified in beating his wife if she refuses sex, as compared to 7 percent of women in Nicaragua (Rosales et al., 1999). In Papua New Guinea, 63 percent of high school boys agree that men are justified in hitting their wives if they talk back or disobey them (Bradley, 1985). These attitudinal data suggest a strategic point for intervention because the practice of violence against women is belief-driven and beliefs can change.

## Reproductive Health Sequelae of Childhood Sexual Abuse

Violence operates through multiple pathways to affect women’s sexual and reproductive health. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancy if women are forced to have sex, or fear using contraception or condoms because of their partners’ reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs indirectly by increasing sexual risk-taking in adolescence and adulthood.

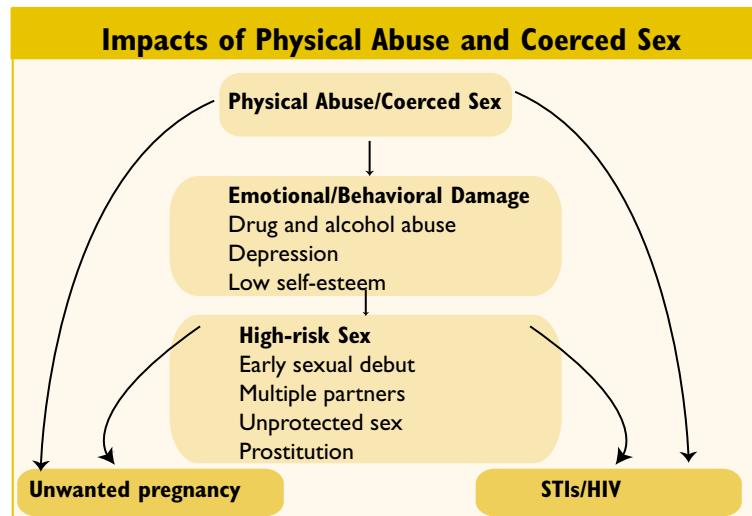


Figure 8-5

## Violence Contributes to Teenage Pregnancy

Studies in the United States have established the link between childhood sexual abuse and increased risk of teen pregnancy (Beitchman et al., 1991; Boyer and Fine, 1992; Butler and Burton, 1990). Childhood sexual abuse is associated with earlier age at first intercourse and an increase in certain risky behaviors, such as having sex with many partners. We now have data from developing countries to substantiate this relationship. Specifically, a case reference study in Nicaragua found that after controlling for education, area of residence and poverty, the risk

of adolescent pregnancy was 2.5 times higher for women who had been abused in childhood. About 15 percent of adolescent pregnancies in this setting could be attributed to sexual abuse in childhood (Elmer Zelaya, unpublished data).

### **Violence Increases STI/HIV Risk and Undermines Prevention Programs**

On average, women who have been sexually abused as children are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs—all risk factors for contracting STIs/HIV. Moreover, women who experience forced sex are at higher risk of contracting HIV. In a recent case control study in rural Uganda, coerced sex in the last year emerged as one of the most potent risk factors for acquiring HIV infection in the past 12 months (Quigley et al. 2000).

Studies from 12 countries identify fear of abandonment and fear of violence as major obstacles to women's willingness and ability to negotiate condom use. At the 12<sup>th</sup> International AIDS Conference held in Geneva in 1998, investigators repeatedly noted that pregnant women cited fear of a violent response by husbands as the reason that they did not want to be tested for HIV or, if tested and found to be HIV+, did not want to take AZT therapy during labor for fear of revealing their HIV status to their husbands (Brown, 1998).

### **Violence Leads to Adverse Pregnancy Outcomes, Including Low Birth Weight**

The literature shows that violence during pregnancy is associated with: 1) late entry into prenatal care, 2) increased smoking and substance abuse during pregnancy, 3) premature labor, 4) bleeding during pregnancy, 5) vaginal and cervical infections, 6) miscarriage and abortions and 7) low birth weight. Links between violence against women and low birth weight have been found in numerous studies in the United States, as well as studies conducted in Norway, Mexico, and Nicaragua. 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 León, 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. Violence in pregnancy accounted for 16 percent of low birth weight among the infants studied and posed a greater risk of low birth weight than such factors as pre-eclampsia, bleeding and smoking (Valladares et al., 2000 forthcoming).

### Violence Has a Significant Impact on Child Mortality

Violence may undermine child survival as well. In León, Nicaragua, women with no history of abuse were matched in a case-control study with women who had experienced physical and/or sexual abuse by an intimate partner. After adjusting for age, parity, education, residence, and poverty status, the researchers found a six-fold greater risk of under-5 mortality and an almost eight-fold risk of infant mortality for women who had experienced physical and sexual abuse by a partner. We need to explore this issue in more depth to begin to understand the reasons for these outcomes. In terms of population-attributable risk, one-third of child deaths in this region can be attributed to physical or sexual abuse of the mother by an intimate partner (Asling-Monemi et al., 2000). Similar findings emerged from studies conducted in India and Zimbabwe.

Nicaragua’s 1999 Demographic and Health Survey, which included a module on violence, also found a link between partner abuse and infant and under-5 mortality (Rosales et al., 1999). The rates of diarrhea and malnutrition are somewhat higher and the rates of immunization somewhat lower among children of women who have experienced partner violence. This suggests that women with violent partners have less access to resources, less mobility, weaker bargaining power, and are thus less able to maintain their children’s health. This finding also warrants further exploration.

Studies on Violence and Low Birth Weight	
<b>United States</b>	
Amaro, 1990	Dye, 1995
Berenson, 1994	McFarlane, 1996
Bullock, 1989	O’Campo et al., 1994
Cokkinides, 1999	Parker, 1994
Curry, 1998	Webster et al., 1994
<b>Norway</b>	
Schlei	Valledares, 1998
<b>Mexico</b>	
Valdez, 1997	

Figure 8-6

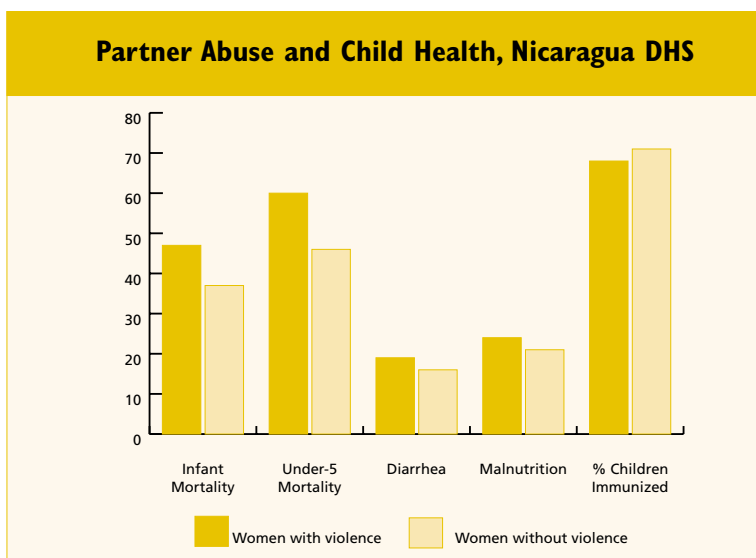


Figure 8-7

## Conclusion

Partner abuse and sexual coercion have a grave impact on the health of women and children, and reproductive health workers need to screen and give appropriate care to women exposed to violence. While the public health approach has given us the data we need to demonstrate the magnitude of the problem, we also need the added value of the human rights perspective to get beyond efficiency arguments. What if we had found low odds ratios for the impact of violence upon health outcomes? Even if the health impacts of violence against women were inconsequential, the human rights approach tells us that we cannot justify ignoring this phenomenon: it is a violation of women's rights regardless of the costs. As a first step, we need to create among women a collective sense of entitlement to a life free of violence. Human rights education—translating the discourse of human rights to make it meaningful to women at the grassroots level—is a critical mechanism in this process to both prevent and combat violence against women. It will be a major contribution.

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