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# Effects of Societal/Domestic Violence on Health of Women

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## Abstract

**Introduction:** Violence is widespread, affects women of all cultures globally, breeds in silence, and finds legitimacy through cultural norms. Perpretors are partners, husbands, family, and friends. It may be domestic violence (DV), sexual (SV) or other type of violence at home or work or public place, serious violation of women's rights as human beings. It is important cause of physical, psychological health problems.

**Objectives:** Objectives were to get information about burden of intimate partner/ domestic/societal violence, effects on women's health.

**Material and Methods:** Information as per objectives was collected by various search engines by simple review and local research, experience of managing cases was added.

**Results:** Violence is personal, sensitive matter so there are limited planned studies. However, it is being increasingly discussed as global public health issue, human rights violation. Physical injury is most visible form of DV. Between 1-20% of women have been victims of DV during pregnancy too. Early marriage, alcohol, employment, unemployment, abuse as child, poverty, rapid socio economic changes, justification of wife beating are known causes. Studies regarding SV in India revealed cultures that approved violence, harmful gender norms, traditions, violence as accepted means of conflict resolution. Besides DV/SV, mental, financial violence also continue as decisions about financial spending, health care are made by men. Physical violence may cause fracture, other injuries abdominal, on private parts or pregnant uterus. Pregnancy outcome depends on duration of pregnancy, victimizing events. Many psychological consequences, suicides have been reported. Cost of violence in terms of health care is tremendous.

**Conclusion:** Violence has varieties which affect, women's health in many ways globally. For prevention, awakening of society, tackling inequalities, empowerment, integration of post violence care into reproductive health services are needed. Health providers need to be trained to support sufferers. Women need to be aware of services.

**Keywords:** Women's health; Violence; Pregnancy outcome

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## Introduction

Violence against women is widespread, occurs in nearly every country and every culture. In many parts of the world, the marital relationship has the dominance of husband, dependence and obedience of wife who submits/surrenders at the cost of own advancement, self-esteem, and even health. Gender inequalities in everyday life, work, responsibilities, a form of violence remain invisible. Violence means 'Act that causes or has the potential to cause physical, mental harm and is rooted in gender inequality Heise et al [1] described violence against women as the most pervasive yet least recognised human rights abuse cutting across geographical, racial, social and economic boundaries in the world WHO [2] defined violence as "The behaviour by an intimate partner or ex-partner that caused physical, sexual or psychological harm and included physical aggression, sexual coercion, psychological abuse and controlling behaviours".

However culprits are not only partners but family, friends and alleys too. Domestic violence (DV) includes any form of violence suffered from biological relative, usually women by men of family or relatives. The problem breeds in silence and finds legitimacy through cultural norms. Violence represents a serious violation of women's rights, an important cause of injury, and is a risk factor for many physical and psychological health problems. Violence is also believed to be as common as many diseases for which routine screening are offered during pregnancy. Violence during pregnancy is being increasingly recognized as a clinical as well as a public health problem because effects of violence during pregnancy could be devastating, immediate and long lasting, for the woman as well as her baby.

## Objective

Were to get information related burden of intimate partner, domestic, societal violence and its effects on health of women.

## Material and Methods

Information as per the objectives was collected by various search engines by simple review. Information of Local research and experience of managing cases were added. Historically, proper studies are limited as violence is a personal and sensitive matter. However, it has been recognized as a global public health issue, as well as a human rights violation and is being increasingly discussed in recent times. So whatever studies, opinions were available were looked into for the article without going into type of review, weakness of the article but all available relevant information was added, strength of the article.

### Types of violence

Women are commonly pushed, slapped, hit with hands or feet or even stick or threatened with a weapon. Physical injury has been reported to be the most visible form of Domestic/Intimate partner violence (PV) [3]. Emotional and mental abuse are equally troubling but sometimes communities do not see them as problems. Women also suffer sexual violence (SV) from intimate partner globally. Forced sexual initiation, both within and outside marriage are known to cause injury, sometimes with dangerous immediate effects like shock due to bleeding or chronic pain. Well designed cross sectional studies of forced first sex revealed, 28%, 40% and 7% of women respectively in Tanzania [4], South Africa [5] and NewZealand [6] had reported first sexual intercourse forced. Research also suggested that the younger a woman was at first intercourse, the more likelihood was that force was used with more chances of injury. In the New Zealand study, 25% girls who had first sex before age 14 years reported forced sex [7]. SV, the manifestation of social, psychological, and economic subordination of women, has existed since ancient times, but has remained largely hidden. In countries such as China, India, Pakistan, and some other countries, sex selective abortions, foeticide, infanticides, which lead to prevention of birth of a girl are extreme forms of violence which change the ratio of men to women. Female foeticide can lead to health hazards in the mother too. Unfortunately sometimes the health sector also victimises women. Besides physical and sexual violence, other forms of abuse, mental and financial also continue because of various reasons, including decisions about the household regarding, money, health care and child care being made by husbands, sometimes mother in laws, women against women too.

### Magnitude of violence

In a recent analysis, the London School of Hygiene and Tropical Medicine and The Medical Research Council found that globally approximately 30% of women in a relationship have been the victim of DV **(Table 1)** [2]. The magnitude of some of the most common and most severe forms of violence against women, PV at home, work places, IPV; sexual abuse by intimate or non-intimate partners; trafficking, forced prostitution, exploitation of labour, and debt bondage of women and girls; PV and SV against prostitutes; sex selective abortions, female infanticide, and the deliberate neglect of girls; and rape in war is really not known. There are so many aspects with so many perpetrators, spouses/partners, families, neighbours, employers, men in position of power, and strangers too. Violence is almost universally under-reported. The prevalence of violence suggests that globally, millions of women are experiencing violence or living with its consequences. DV is difficult to measure, because of lack of reporting, stigmatization, even no standard methodology to define. Latest estimates have revealed that one in three women experienced PV or SV, or both in their lifetime by a partner or a non partner [8]. A review of nearly 50 population based surveys from around the world found that between 10-50% of women reported being hit or physically abused by an intimate male partner at some point in their lives [9]. A study revealed that the reported SV rate in India was among the lowest in the world and the instances of violence were reported lowest among Buddhist and Jain women, and highest among Muslim women [3]. However it is a subject of research, whether it is under reporting or there is comparatively less violence. According to United Nations Population Fund Report, around two-thirds of married Indian women were victims of DV and as many as 70 per cent of married women in India between the age of 15 and 49 were victims of beating, rape or forced sex. The National Crime Records Bureau (NCRB) records in India, which was used in the Court, revealed that in 2011, a total of 1, 14, 372 cases were registered under crimes against women in matrimonial homes [10]. According to NCRB [11] in India, the number of reported rapes increased 700% since 1971 when it started to be recorded. It is essential that meaningful, sustained, and widespread actions are taken for recognition of the global prevalence of violence.

### Causes and frequency of violence

Early marriage, alcohol, women's employment, unemployment, experience of abuse as a child, poverty, rapid socio economic changes, and justification of wife beating are known causes. Studies conducted regarding underlying factors for SV in India reported even a culture that approved violence, harmful gender norms and traditions, and social acceptance of violence as an accepted means of conflict resolution [12-14]. Mostly it is husband who has control of finances and husbands believe that they have a right to abuse women if they do something which makes them angry. Some women suffer violence because they work outside home and others because they do not work.

**Table 1** Health consequences of violence [2].

| Population group exposed to and type of violence | Health and socioeconomic consequences |
|---|---|
| **1. All groups subjected to violence** | Physical injuries Mental health problems (e.g. depression, anxiety, post-traumatic stress disorders)<br>• Suicide<br>• Risk of no communicable diseases.<br>• Health-harming behaviors (e.g. alcohol and drug use, smoking, self-harm and risky sexual behavior)<br>• Productivity<br>• Human and economic costs for survivors, families and society |
| **2. Women and Girls**<br>*a. Intimate partner violence* | Sexual and reproductive health problems, including unwanted pregnancies, STI and HIV, pregnancy loss, including miscarriages and induced abortions, low birth-weight babies, pre-term births, traumatic gynecological fistula, chronic pain syndrome<br>• Induced abortion<br>• sexually transmitted infection (STI) and HIV<br>• 41% pre-term birth<br>• 16% low birth-weight babies<br>• Infant mortality<br>• Children with developmental and behavioral problems |
| *b. Female genital mutilation (FGM)* | • Obstructed labor and perinatal mortality<br>• Infections<br>• Cysts and abscesses<br>• Fistula<br>• Psychological and mental health problems<br>• Sexual dysfunction |
| *c. Early marriage* | • Early pregnancy and risk of perinatal and maternal mortality and morbidity<br>• Girls' access to education, livelihood skills<br>• Social isolation |
| **3. Children, including adolescents** | • Health-harming behaviors<br>• Mental and other health problems<br>• Educational attainment and future employment prospects<br>• Intergenerational perpetuation of cycle of violence, i.e.<br>• likelihood of girls later being subjected to intimate partner violence or sexual exploitation and trafficking<br>• Likelihood of boys becoming perpetrators or being subjected to violence later in life<br>• Youth violence involvement over time in other forms of violence as victims and perpetrators |

The major cause of DV has been attributed to an unequal balance of power in the relationship of man and woman. There is no conclusive evidence in relation to education of men and women [15]. Even educated women suffer violence. Dowry, desire for a male child and alcoholism of the spouse have been reported to be major factors of DV against women. In a study by Chhabra et al., women when asked why they were violated, 11% said it was poverty, 19% dowry; 24% dislike of husbands and/or family members, infertility 19%, husband's extra-marital relations 3% and some others said alcoholism. Ten percent women said they were assaulted because they had no male child. Suspicion of infidelity was the reason in 14%. Reasons given were almost similar in all economic classes, irrespective of educational level [16]. Adolescent girls were uniquely vulnerable during pregnancy. In a study of the 2,000 pregnant women interviewed, around 48% reported that they were physically hit or slapped or kicked during pregnancy, many repeatedly. Though more teenagers (66%) and illiterate women (70%) were assaulted, those with a postgraduate degree (41%) had also suffered and 30% of them had suffered violence before pregnancy also [17]. Between 1 and 20% of women have been reported to be victims of domestic violence during pregnancy [18]. Women's employment has been found to be a risk factor for intimate partner violence in both slums and non-slum settings in India. In another study of PV, when 2000 women were interviewed, 67% reported assault by their husbands, 4% by the mother-in-law, 18% by the father-in-law, 9% by sister-in-law, 3% by others, and 68% had multiple perpetrators. After assault, 43% had to be taken to a health facility, for bruises, cuts, burns or fractures. In another study about SV during pregnancy, 31% of 2000 pregnant women reported that they did not wish to have sex during pregnancy but were forced to have which affected their physical and mental health. In the study of SV of 2000 women interviewed, 35% had suffered SV. Seven percent of interviewed and 20% of all sufferers of violence reported that they were forced to have sex with other person, 1.5% reported sexual advances made towards them at work places and 5% had been forced by their own husbands and/or family members to have sex with other persons. Of all the sufferers only 5% had reported to police and 62% did not speak to anyone. Most women had not sought medical services. All household chores were reported to be performed only by women even during pregnancy. In a study some pregnant women were not allowed to work outside, but those who worked outside did all the household work also during pregnancy. Perception that men did outside jobs, women only household, was not true. Some pregnant women (32%) did

report differences in their everyday chores during pregnancy. But 68% had to do everything which they did in nonpregnant state during pregnancy also, which affected their health in general [19].

## Effects of violence on health

In the past decade, increasing attention has been focused on the effects of male partner violence on women's physical and mental health. A study has shown significant association between lifetime experiences of PV or SV or both, by a male intimate partner, and a wide range of self reported physical and mental health problems in women [20]. Epidemiological and clinical studies have revealed that physically and sexually violent acts by IP were consistently associated with gynaecological disorders, adverse pregnancy outcomes, irritable bowel syndrome, other gastrointestinal disorders, and chronic-pain [21-23]. Many reported that abused women have more physical symptoms of poor health, and more days in bed than do women who were not abused [24-29]. PV and SV have also been associated with psychiatric problems, depression, anxiety, phobias, post-traumatic stress disorder, suicidality, alcohol and drug abuse [30-35]. Sometimes women are even murdered by husbands/family for dowry, no male child or infertility. Although there may be distinctions among victimizing events, the mental health impact of violence is remarkably similar globally. Most victims experienced an immediate post victimization distress response. In some cases mental distress failed to resolve and developed into a chronic, though heterogeneous symptom pattern. Unfortunately violence histories go undetected among psychiatric patients due to obvious reasons in healthcare systems [36,37]. A study conducted in India revealed that women with a lifetime history of IPV were more likely to have reported poorer physical and mental health compared to those without a lifetime history of IPV 6% to 59% [3]. Numerous studies revealed that most women who died of homicide were killed by their partners or ex-partners [38]. The injuries sustained by women because of physical and sexual abuse may be extremely serious. In Papua New Guinea, 18% of all urban married women had to seek hospital treatment following domestic violence [39]. Research in Cambodia revealed that 50% of women reporting abuse had sustained injuries [40]. Canada's national survey on violence against women revealed that 45% of wife assault incidents resulted in injuries, and of the injured women, 40% subsequently visited a doctor or a nurse [41]. In a three-year study of 1203 pregnant women in the hospitals in Houston and Boston, United States it was revealed that abuse during pregnancy was a significant risk factor for low birth weight (LBW), low maternal weight gain, infections and anaemia [42]. Violence against women, either through rape or by affecting a woman's ability to negotiate contraceptive use may result in unwanted pregnancy. The resultant pregnancy specially during early or middle adolescence, before girls are biologically and psychologically mature, is associated with adverse health outcomes for both the mother and child. Infants may be premature, of LBW, or be small for gestational age with more mortality. DV is also associated with LBW infants, may be premature, or be small for gestational age with more fetal/neonatal/mortality [43,44]. PV during pregnancy can cause abortion, placental abruption, rupture of uterus and intra uterine death of the baby. In countries where abortion was illegal, expensive or difficult to obtain, women resorted to illegal abortion, with fatal consequences [38]. They usually developed a sense of low self-esteem than those who had not experienced abuse. They were more likely to neglect themselves and engage in risky behaviours such as early or unprotected sexual intercourse. Many psychological consequences, even suicide have been reported for women who were beaten or sexually assaulted [38]. Across countries, women's experience of IPV is associated with a reduction in time between pregnancies and an increase in the risk of unintended pregnancy; the magnitude of this effect varied by country and over time [45]. Research in the United States has shown that battered women, compared to women not living with violent men, were five times more likely to commit suicide [46]. Many were severely depressed or anxious, while others displayed symptoms of post-traumatic stress disorder. In one study in León, Nicaragua, after controlling for other factors, researchers found that abused women were six times more likely to report experiencing mental distress than non-abused women [47]. Researchers later reported women who experience violence in the home are significantly more likely to have poor self-reported health, suicidal thoughts and experience other health problems. The health effects appear to be long lasting [20]. In the United States, women battered by their partners have been found to be between four and five times more likely to require psychiatric treatment than non-abused women [46]. Sexual abuse lies behind some of the most intractable reproductive health issues, sexually transmitted diseases (STDs) including HIV, unwanted pregnancies and their complications. In Thailand, researchers found that one in ten victims of rape had contracted a STD because of the attack [48]. A major study in the United States found that having been the victim of childhood abuse or violent crime doubled a woman's likelihood of suffering from severe menstrual problems, STDs, or urinary tract infection. DV tripled her likelihood [49]. A growing number of studies document the ways in which sexual coercion and violence by intimate partner undermined a woman's sexual and reproductive autonomy and jeopardizes her health [50]. Research in Norway revealed that chronic pelvic pain was significantly associated with a history of DV [51]. Other research from the United States revealed that patients with irritable bowel syndrome, compared with those with the less serious inflammatory bowel disease, were more likely to have suffered severe sexual trauma, severe childhood sexual abuse or some form of sexual victimization [52]. Abused women were more likely to smoke than women without a history of violence [53].

# Results

## Added health care cost

Studies revealed that the cost of violence against women to society were tremendous, in terms of health care alone. A proportion of the cost was for treating serious physical injuries. A substantial amount was also spent on psychological problems including managing anxieties and symptoms which happier, more confident, women may be able to tolerate, ignore or shrug off [38]. One study in the United States revealed that outpatient care for women with a history of sexual or physical assault costed two and

a half times as much, as care for other women, after controlling for other variables [53]. Direct cost included, the one incurred by the police, courts and legal services to prosecute perpetrators of abuse; the cost of treatment programmes for men who battered, and other offenders; the medical care cost of treating the direct medical consequences of sexual and physical abuse; and social service cost, including child protection services [38].

## Discussion

In the past some years, WHO, the American Medical Association, International Federation of Obstetricians and Gynecologists, Royal College of Nursing, and other professional medical organizations have made statements about the public health dangers of violence against women [54]. Health sector also needed to work on the causes and primary, secondary and tertiary prevention by doing research about women living with violent partners without endangering these women. Understanding gender based violence and the appropriate case management of women with a current or previous history of violence are now recognized as core competencies required by health workers. Although persistent and new challenges to addressing violence against women remained, there have been important improvements in global policy action against violence. "The elimination of all forms of violence against women" is a target of the Sustainable Development Goal 5, to increase women's empowerment and gender equality, global recognition of elimination of violence against women as fundamental to sustainable human development and health for all [55,56]. The public health implications of violence against women and the importance of the health sector's role have also gained policy-level traction. At the World Health Assembly, a Global Plan of Action was approved to strengthen the health system's response to interpersonal violence [2]. This plan laid out concrete actions for states, WHO, and other key actors, including building the skills of health-care providers so that they responded effectively to women who experienced violence, and strengthened the capacity and linkages between services, including mental health. In low-income and middle-income countries, such services are extremely limited. Action is needed on all forms of violence against women, including SV by strangers or acquaintances, sexual harassment, child sexual abuse, and trafficking, including that suffered by refugee women and girls fleeing war or in conflict settings [57-58]. Mothers played an important role in educating adolescent girls regarding sexual health. In India the Protection of Women from Domestic Violence Act 2005, an Act of the Parliament of India was enacted to protect women from DV. It was brought into force by the Indian government from 26 October 2006. The Act provided for the first time in Indian law a definition of "domestic violence", this definition being broad, included not only PV, but also other forms of violence such as emotional, sexual, and economic abuse. It was a civil law meant primarily for protection and not meant to penalize criminally [3]. However as with other laws everyday irregularities are visible. WHO developed guidelines and tools on the healthcare response to IPV and SV also [59-61].

## Conclusion

For prevention of violence of all types awakening of society, broader coalition between communities, health services are needed. There is need of integration of such services into reproductive health services. Providers need to be trained to support sufferers and women need to be aware of services. While attempts are needed to prevent, it is essential that the healthcare providers who manage such women are aware of the possibilities.

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