PROBLEM OF VIOLENCE AGAINST WOMEN AROUND GLOBE

—Dr Sohan Raj Tater

Physical and sexual violence against women

The severity of physically violent act was ranked according to its likelihood of causing physical injuries. Being slapped, pushed or shoved were defined as moderate physical violence. Being hit with a fist, kicked, choking, burning, dragged, threatened with a weapon or having weapon used against her were defined as severe physical violence. Ranking such acts by severity is controversial. Clearly, under certain circumstances a shove can cause severe injury, even though it is catagorised as "moderate" violence. For the most part, however, this ranking conforms with other measures of severity, such as injury. According to this definition, the percentage of ever partnered women experiencing severe physical violence ranged from 4% of women in Japan to 49% in rural area of Peru, with most countries falling between 13% and 26%. If women have ever experienced partner violence, it is highly likely that at some time an act of severe violence will occur. In only three countries-Bangladesh, Japan and Serbia Montenegro-had a great problem of women experienced only moderate violence that had experienced severe violence.

The proportion of women who had ever suffered physical violence by male partner ranged from 13% in Japan to 61% in rural area of Peru. Japan also had the lowest level of sexual violence at 6% with the highest figure of 59% being reported in Ethopia. Over all the percentage of women who reported sexual abuse by a partner ranged from 6% in Japan, Serbia, and Montenegro to 59 in Ethopia, with the majority of places falling between 10% and 50%. The proportion of women physically forced into intercourse ranged from 4% in Serbia and Montenegro to 46% in rural area of Bangladesh and Ethopia. Nearly one third of Ethopian women reparted being physically forced by a partner to have sex against their will with in the

past one year. The high rate of forced sex is particularly alarming in the light of the AIDS epidemic and the difficultly that many women have in protecting themselves from HIV infection.

Sexual violence was considerably less frequent than physical violence in most places, it was more frequent in rural area of Bangladesh, Ethopia and urban Thailand. In countries where large cities and rural places were both studied, the overall level of partner violence were higher in the rural places. The most common act of violence experienced by women was being slapped by their partners from 9% in Japan to 52% in rural Peru. This was followed by being stuck with a first, for which these two places again represented the extremes. (2% and 42% respectively) In most places, between 11% and 22% of women reported being hit by a partner with his fist.

In most places, about half of sexual violence was a result of physical force rather than fear. In Ethopia and Thailand, however, a large proportion of women reported having sex because they were afraid of something their partners might do. In all places, some women reported being forced by partners in to sexual behaviours that they found humiliating. Less than 2% of women in Ethopia, Japan, Serbia and Montenegro and urban united Republic of Tanzania reported this, compared to 11%, of woman in rural area of Peru.

Emotional Abuses against women

It is found that women frequently consider emotionally abusive acts to be more devastating than physical violence. The specific act of emotional abuse by a partner included the following :

(i) being insulted or made to feel bad about oneself.
(ii) being humiliated or bellittled in front of others.
(iii) being intimidated or scared on purpose (for example by a partner yelling and smashing things)
(iv) being threatened with harm (directly or indirectly in the form of a threat to hurt someone the respondent cared about)

Across all countries around globe between 20% and 75% of women had experienced one or more of these acts, most with in the past one year. Those most frequently mentioned were insults, belittling and intimidation.

Threats of harm were less frequent, although almost one in four women in rural Brazil and rural Peru reported being threatened. Among women reporting each type of act two thirds or more had experienced the behaviour more than one.

Women's attitude towards violence

Physical violence is defined by following behaviour :

(1) slapped her or thrown something at her that could hurt her.
(2) pushed or shoved her.
(3) hit her with a fist or something else that could hurt
(4) kicked, dragged or beaten her up.
(5) chocked or burnt her on purpose.
(6) threatened her with or actually used a gun knife or other weapon against her.

Sexual violence is defined by the following behaviour :

(i) being physically forced to have sexual intercourse against her will.
(ii) having sexual intercourse because she was afraid of what her parent might do.
(iii) being forced to do something sexual she found degrading or humiliating.

In addition to women's experience of violent acts, the WHO study investigated two important aspects of women's attitude to partner violence.

(a) the circumstances under which women believe that a man is justified in beating his wife (wife-beating is probably the most common expression for physical violence by a male partner) and
(b) women's belief about whether and when a woman may refuge to have sex with her husband.

First, women were presented with sex different situations and were asked, for each of these, whether she agreed or not that the specific reason justified wife beating. The reasons most commonly given included not completing housework adequately, refusing to have sex, disobeying her husband and being unfaithful. There was wide variation in women's acceprance of different reasons and indeed with the idea that violence was

ever justified. The most marked variation was between the urban industrialization places and rural and traditional ones.

Second, respondents were also asked whether they believe a woman has a right to refuse sex with her husband in a number of situations, including if she is sick, if she does not want to have sex, if the husband is drunk and if the husband is drunk and if the husband is mistreating her. As with physical violence, women appeared to make distinctions between the acceptability of different reasons to refuse sex. Fewer moment felt sex could be refused based on a woman's preference (she does not want it) than if she was ill or the partner was drunk or abusive. In the rural sites of Bangladesh, Peru and the united Republic of Tanzania and in Ethopia and Samoa between 10% and 20% of woman felt that woman did not have the right to refuse to have sex under any of these circumstances.

(4) Mitigation of violence against women

Violence against women by an intimate partner is a major contributor to the ill health of women. This study analyses data from 10 countries and sheds new light on the prevalence of violence against woman in countries. It also uncovers the forms and patterns of this violence across different countries and cultures, documenting the consequences of violence for women's health. This information has important implications for prevention, care and mitigation.

The health center can play a vital role in preventing violence against women, helping to identify abuse early, providing victims with the necessary treatment and referring women to appropriate care. Health services must be places where women feel safe, are treated with respect, are not stigmatized and where they can receive quality, informed support. A comprehensive health sector response to the problem is needed, in particular addressing the reluctance of abused women to seek help. The high rates documcuted by the study of sexual abuse experienced by girls and women are of great concern, especially in light of the HIV epidemic. Greater public awareness of this problem is needed and a strong public health response that focuses on preventing such violence from occurring in the first place.

We should advocate gender equality in health for women and men around the world, we should bring attention to the ways in which biological and socio-cultural factors affect the health of women and men, boys and girls. We should increase knowledge strengthen the health sector response by gathering evidence, strengthening capacity and engaging in advocacy on how gender and gander inequality affect health. We should focus on the ways that gender, as a social construction, affects the health of both men and women. But we also realise that gender inequality has a higher toll on woman's health due to the discrimination they face in nearly every culture. Gender inequality exacerbates the harmful effects to poverty and lack of education on women's health, hampering the ability of millions of women worldwide to access health care and achieve the best possible level of health.

In 2007, the 60th world health organization-World Health Assembly passed a resolution on Integrating gender analysis and actions into the work of who with following resolution :

(i) Increase knowledge and evidence on the impact of gender inequalities on specific health problems, health services and successful responses.

(ii) Develop tool to promote and expand health sector policies, interventions and programmes at the regional and country level that systematically address gender concerns including gender based violence.

(iii) Develop skills and build capacity, with in and outside WHO, to promote policies and programmes that help women and men to lead healthy lives and benefit from health care services.

(iv) Improve public understanding of gender issues by developing advocy material and activities.

(v) create awareness and provide support to WHO member states to design and promote gender-sensitive health policies and strategies.

The result of the WHO multi country study on women's health and domestic violence against women highlight the need for urgent action by a wide range of actors, from local health authorities and community leaders to national governments and international donors. As the study clearly

demonstrates, violence against women is wide spread and deeply ingrained and has serious impacts on women's health and well-being. It's continued existence is morally indefensible, its cost to individuals, to health systems and to society in general is enormous, Yet no other problem of public health has until relatively recently been so widely ignored and so little understood. The wide variation in prevalence and patterns of violence from country to country and even more important, from place to place with in countries, indicate that there is nothing "natural" or inevitable about it. Attitudes can and must change, the status of women can and must be improved, men and women can and must be invinced that partner violence is not an acceproble part of human relationship.

While life expectancy is higher for women then men in most countries a number of health and social factors combine to create a lower quality of life for women. Unequal access to information, care and basic health practices further increases the health risks of women. Discrimination on the basis of their sex leads to many health hazards for women, including physical and sexual violence, sexually transmitted infections, HIV/AIDS, malaria and chronic obstructive pulmonary disease. Tobacco use is a growing threat among young women, and mortality rates during pregnancy and childbirth remain high in developing countries.

Factors those protect women violence

We are to investigate personal, family and social factors those might protect a woman from violence. A variety of factors or different levels and with in different context of a woman's life.

(1) Individual factors included the woman's level of education, financial autonomy, previous victimization, level of empowerment and social support and whether there was a history of violence in her family as she was growing up.

(2) Partner factors included the male partner's level of communication with her, use of alcohol and drugs, employment status, whether he had witnessed violence between his parents as a child and whether he has physically aggressive towards other men.

(3) Factors related to the immediate social context included the degree of economic inequality between men and women, levels of female mobility and autonomy, attitude towards gender rules and violence against women the extent to which extended family, neighbours and friends intervene in domestic violence incidents, levels of male aggression and crime and some measure of social capital.

It is found that higher education was associated with less violence at many places. At some places (urban Brazil, Namibia, Peru, Thailand and the United Republic of Tanzania) the protective effect of education appears to start only when women's education goes beyond secondary school. Previous research also suggests that education for women has a protective effect, even when controlling for income and age (13,14). It may be that women with higher education have a greater range of choice in partners and more ability to choose to marry or not and are able to negotiate greater autonomy and control of resources with in the marriage.

—Adviser, Jain Vishva Bharati University, Ladnun (Raj.)

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