



Invited Commentary

Invited Commentary: Disclosure of Gender-Based Violence in Developing Countries

Hind A. Beydoun* and May A. Beydoun

* Correspondence to Dr. Hind A. Beydoun, Graduate Program in Public Health, Eastern Virginia Medical School, 651 Colley Avenue, Room 401, Norfolk, Virginia 23501-1980 (e-mail: baydouha@evms.edu).

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The evolving concept of gender-based violence (GBV) is a multifaceted issue of public health significance. Until recently, most studies examining GBV have been conducted in North America. In this issue of the *Journal*, Palermo et al. (*Am J Epidemiol.* 2014;179(5):602–612) report their secondary analyses involving approximately 300,000 women from 24 developing countries who participated in Demographic and Health Surveys between 2004 and 2011. The focus of their article is on the prevalence and determinants of disclosure of GBV to formal authorities, including health care or legal professionals, police, and nongovernmental organizations. Their results indicate a wide gap between prevalence of GBV (40%) and GBV disclosure (7%), implying an underestimation of GBV that ranges from 11- to 128-fold, depending on the region and type of reporting. The extent of underreporting of GBV also varied according to personal characteristics such as age, marital status and urban or rural residence. GBV has been linked to a myriad of health problems, and it has been shown that health care utilization is considerably higher among women who have experienced GBV. Primary and secondary prevention efforts should continue to target GBV, and creative ways of addressing GBV nondisclosure should take into account regional variations and personal characteristics of affected women.

disclosure; gender; public health; survey; violence

Abbreviation: GBV, gender-based violence.

The concept of gender-based violence (GBV) has been evolving over the years, and it is a multifaceted issue of great public health significance. GBV has been linked to a myriad of physical and mental health problems. It has also been shown that health care utilization is considerably higher among women who have experienced GBV. Until recently, GBV has been studied mostly in North American societies. In this issue of the *Journal*, Palermo et al. (1) carried out secondary analyses of approximately 300,000 women from 24 developing countries by using data from Demographic and Health Surveys from 2004 through 2011. Their article focuses on estimating the prevalence of GBV and exploring determinants of disclosure of GBV to formal authorities, including health care or legal professionals, police, and nongovernmental organizations. Their key findings reflect a wide gap between prevalence rates of GBV (40%) and GBV disclosure (7%). This implies an underestimation of GBV

prevalence that ranges from 11- to 128-fold, depending on the region and type of reporting. Underreporting of GBV was also associated with personal characteristics such as age, marital status and urban or rural residence.

EVOLUTION OF THE CONCEPT OF GBV

General knowledge, attitudes, and beliefs concerning GBV as a phenomenon have evolved over time. In particular, the “feminist movement” of the 1970s was instrumental in raising awareness and gradually shifting the issue of GBV from the private to the public domain (2). Subsequently, a wide spectrum of legal, social, and medical services was created, securing help for victims of GBV, and thus reducing GBV’s societal burden (3, 4). Published research tackling the issue of GBV has dramatically increased over the past 20 years (2, 5). Specifically, observational studies have

been concerned with determining the problem's extent and identifying types, risk factors, and health correlates of GBV. Most of these studies used developed countries as their contextual setting, particularly urban regions of North America (3, 6–22). Although many were national surveys, special studies also evaluated GBV among women in prenatal care (13–19) and among those seeking help for injuries by using data obtained from medical records, shelters, and crime reports (8, 9, 23–28). Recently, experimental studies were designed to assess the effectiveness of new and existing interventions in various settings (29).

A perpetrator often relies on GBV as a strategy to gain or maintain power and control over the victim. A common stereotype is that perpetrators are typically male and victims are typically female (2, 5, 30). However, current evidence suggests that, although women are in fact more prone to be injured or murdered by their partners, men and women tend to be equally aggressive in an intimate relationship, supporting the idea of “gender symmetry” (30, 31). Although violence can be bidirectional, with the same individual alternatively acting as victim or perpetrator, researchers exploring GBV within the reproductive health context have traditionally adopted the “feminist” framework by focusing on women as “victims” and men as “perpetrators” (32, 33).

MULTIFACETED NATURE OF GBV

GBV can take many forms, including physical, sexual, and emotional/psychological violence. Although conceptually distinct, these subtypes are rarely mutually exclusive. Indeed, the term “battering” was used in the past to designate not only emotional or psychological abuse, but also repeated physical or sexual assaults (34–49). Whereas physical and sexual assaults are incidental, emotional and psychological abuse is normally chronic in nature (50–60). Physical violence or abuse involves contact that is intended to cause pain, injury, or other physical suffering. This includes but is not limited to violent activities such as striking, punching, pushing, pulling, slapping, kicking, strangling, drowning, and exposure to noxious substances (50, 61–68). Sexual violence or abuse refers to forced sexual acts (e.g., nonconsensual sexual behaviors, rape, or sexual assault), both in the context of dating and marital relationships (14, 52, 55, 59, 69). By contrast, emotional or psychological types of abuse frequently involve a situation in which a power imbalance exists between the perpetrator and the victim of abuse, leading to acts of humiliation and intimidation and other controlling behaviors (50–60, 70).

BURDEN OF GBV IN THE UNITED STATES AND WORLDWIDE

Studies have been conducted to estimate the burden of GBV in the general population of the United States. Previous population-based studies include the 1975 National Family Violence Survey, the 1985 National Family Violence Resurvey, the 1995 National Longitudinal Couples Survey, the National Crime Victimization Survey, and the National Violence Against Women Survey (71, 72). Estimates from the 1993–1998 National Crime Victimization Survey conducted

by the Bureau of Justice Statistics (Washington, DC) among 293,400 households and 574,000 individuals aged 12 years and older suggest that, each year, 1 million violent crimes are committed against individuals by current or former spouses, boyfriends, or girlfriends. These violent acts include murder, rape, sexual assault, robbery, aggravated assault, and simple assault. Based on National Crime Victimization Survey data, almost half of the victims report the violence to law enforcement authorities, and many incidents result in minor injuries not requiring medical attention. Intimate partner homicides comprise approximately 33% of murders in women and approximately 4% of murders in men. Similarly, approximately 85% of incidents over the course of a year are committed against women. Overall, the annual prevalence rates of GBV are estimated to be 7.7 per 1,000 women compared with 1.5 per 1,000 men (73). The National Violence Against Women Survey was conducted through telephone interviews of 8,000 women and 8,000 men by the National Institute of Justice (Washington, DC) and the Centers for Disease Control and Prevention (Atlanta, Georgia). Nearly 25% of surveyed women and 7.6% of surveyed men disclosed rape and/or physical assault by a current or former spouse, cohabiting partner, or dating partner at least once during their lifetimes. In addition, 1.5% of women ($n = 1.5$ million) and 0.9% of men ($n = 834,732$) said they had been raped and/or physically assaulted by a partner in the previous 12 months. Nearly 5% of women and 0.6% of men reported having been stalked by an intimate partner during their lifetimes. Moreover, 0.5% of women ($n = 503,485$) and 0.2% of men ($n = 185,496$) reported having been stalked by an intimate partner in the past year (74, 75). In 2005, the Behavioral Risk Factor Surveillance System introduced for the first time a GBV module to collect data on a nationally representative sample of 70,000 respondents from 16 states and 2 territories (76, 77). The Behavioral Risk Factor Surveillance System's definition of GBV included violence perpetrated by current and former intimate partners and encompassed physical and/or sexual assaults without encompassing psychological abuse or battering during the respondents' lifetimes and during the previous 12 months. Among women, the estimated lifetime prevalence of GBV—including threatened physical violence, attempted physical violence, completed physical violence, and unwanted sex—was 26.4% (95% confidence interval: 25.7%, 27.2%). By contrast, the 12-month prevalence of completed physical and/or sexual violence was only 1.4% (95% confidence interval: 1.2%, 1.7%) (77).

The World Health Organization's Multi-Country Study on Women's Health and Domestic Violence was conducted between 2000 and 2003, shedding light on the global burden of GBV (78). Using standardized household surveys, the investigators estimated prevalence rates of physical and sexual forms of violence among a sample of approximately 24,000 women aged 15–49 years from 15 sites in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania. Lifetime prevalence of physical or sexual violence, or both, varied from 15% to 71%, with 2 sites having a prevalence of less than 25%, 7 sites having a prevalence of 25%–50%, and 6 sites having a prevalence of 50%–75%. Between 4% and 54% of

respondents reported physical or sexual violence, or both, in the past year (78).

PHYSICAL AND MENTAL HEALTH CORRELATES OF GBV

Victims of GBV were shown to be at increased risk for detrimental physical health outcomes such as injury (20, 79), disability (80, 81), chronic pain (20, 79, 81–83), arthritis (81), headaches or migraine (81, 83), gastrointestinal symptoms (20, 79, 81), and vaginal bleeding and sexually transmitted infections (20, 32, 79, 83). In addition, the prevalence of mental health problems was exceptionally high in victims of GBV. These included substance use and abuse (20, 84), social dysfunction (20, 79), insomnia (20, 79), posttraumatic stress disorder (82, 85–88), anxiety (20, 79), depression (82, 89–95), and suicidal thoughts (83, 96, 97).

GBV AND DEPRESSION: SYSTEMATIC REVIEW AND META-ANALYSIS

A recent systematic review and meta-analysis quantified the association between GBV among adult women and major depressive disorder, as well as elevated depressive symptoms and postpartum depression (98). The review involved a PubMed search from 1980 to 2010 of English-language observational studies, resulting in 37 eligible studies. The meta-analysis estimated a 2- to 3-fold increased risk of major depressive disorder and a 1.5- to 2-fold increased risk of elevated depressive symptoms and postpartum depression among women who were exposed to violence compared with those who were unexposed. Moreover, the study suggested that 9%–28% of these outcomes can be attributed to lifetime exposure to GBV.

HEALTH CARE UTILIZATION BY GBV VICTIMS

Because of GBV's association with a myriad of health conditions, its impact on health care utilization is likely sizeable. In a recent cohort study (47), health care utilization and costs for women with and without a history of GBV were compared. Among 3,333 women aged 18–64 years, GBV experience since age 18 years was determined from responses to telephone interviews using questions from the Behavioral Risk Factor Surveillance System and the Women's Experience with Battering Scale. A total of 1,546 women reported having experienced GBV in their lifetimes, of which, 87% reported that the GBV had ceased. Health care utilization was higher for all categories of service for victimized women compared with women who had not experienced GBV and decreased over time after cessation of GBV. However, health care utilization was still 20% higher among women 5 years after the abuse stopped compared with that of women who had not experienced GBV. Adjusted annual total health care costs were 19% higher in women with a history of GBV compared with women without such a history. Based on GBV prevalence of 44%, the excess costs due to victimization were approximately \$19.3 million per year for every 100,000 women (47). Coker et al. (99) estimated direct medical expenditure for physician, drug, and

hospital utilization among Medicaid-eligible women who were currently experiencing GBV compared with those not currently experiencing GBV. In a family practice-based cross-sectional study, women were screened for current GBV by using a 15-item index of spouse abuse (physical) between 1997 and 1998. Larger physician, hospital, and total expenditures were found in women with higher victimization scores compared with those reporting no current GBV after adjustment for potential confounders. The mean annual total expenditure difference between the highly abused and nonabused groups was \$1,064 (95% confidence interval: \$623, \$1,506) (99). In another study (100), computerized cost data were analyzed for 126 identified victims of GBV in a large health plan and were compared with data from a random sample of 1,007 female enrollees (aged 18–64 years) who used health care services in the same year. The authors found that an annual difference of \$1,775 or more was spent for victims versus the comparison group. Regression analyses found that victims were significantly younger and had more hospitalizations, general clinic use, mental health services use, and out-of-plan referrals. Use of emergency department services was the same across groups (100).

DISCLOSURE OF GBV IN HEALTH CARE SETTINGS

Health care settings may provide a key opportunity for confidential disclosure of GBV by patients to their providers who could subsequently intervene by connecting them to the appropriate resources (40). However, multiple barriers may impede screening and identification of victims in a clinical setting and their referral to onsite or offsite services (40, 101–103). Random reviews of 746 medical charts were conducted at 1 primary care center, and the following results were obtained: 36.6% of patients were tagged for screening and, of those tagged, 86.1% had documentation of screening. Moreover, 5% screened positive for GBV, with 50% of those documenting clinician follow-up and referral to onsite services (101).

In a review article (104), potential barriers to GBV screening and identification in health care settings were summarized. Provider barriers included lack of knowledge, fear of offending patients, perceived time pressures, perceived irrelevance of GBV to health care practice, fear of loss of control of the provider-patient relationship, personal attitudes and accountability, past experience with abuse, and perceived danger. Patient barriers included lack of trust, fear of retribution, fear of loss of control, sense of futility, the nature of the intimate relationship, lack of knowledge of helping resources, embarrassment, and humiliation (104).

IMPLICATIONS AND NEXT STEPS

Disclosure of GBV is a necessary first step toward reducing health risks associated with this phenomenon. Primary and secondary prevention efforts should continue to target GBV, and creative ways of addressing GBV nondisclosure should take into account regional variations and personal characteristics of affected women.

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