Gender-based Violence
Introduction

Gender-based violence (GBV) is violence directed at an individual based on his or her sex, gender identity or expression of socially defined norms of masculinity and femininity. Both men and women can experience GBV, but because rates among women are significantly greater, violence against women is the focus of this review. GBV can take various forms and is experienced differently by women and girls around the world, but all forms have gender inequality at the core.

The global conversation about GBV, and advocacy to prevent it, has increased considerably in recent years, drawing more resources to building an understanding of the problem and ways to address it. Efforts to end GBV normally fall into one of three categories:

1) Primary prevention – preventing GBV from occurring to women and girls who have not previously experienced violence and preventing new occurrences from happening to those who have already experienced it.

2) Secondary prevention (often called “response”) – preventing further violence and/or providing support for survivors of violence. This usually includes service level interventions in health and other social service settings.

3) Tertiary prevention (often part of response) – support with long-term legal, advocacy and psychosocial needs.

In order to be effective at any of these stages of prevention, a comprehensive approach is needed to not only reduce the incidence of violence, but also to change the social norms and gender imbalances that allow it to persist.

PREVALENCE AND FORMS OF VIOLENCE AGAINST WOMEN

Intimate partner violence (IPV) is the perpetration of violence by a current or former partner, and it is the most common form of GBV. The latest estimates from the World Health Organization (WHO) signal that roughly one-third of women worldwide have experienced either physical or sexual IPV.2

The prevalence is lowest (23%) in WHO-defined high-income countries and highest in the African and Southeast Asian regions, at 46% and 40%, respectively. Thirty percent of women in the Americas region and 27% of women in the European and Western Pacific Regions have experienced intimate partner violence.2

Seven percent of women have experienced sexual violence by a non-partner. The highest estimates come from central and southern Africa (21% and 17%, respectively), and the lowest from South Asia (3%). Limited data on non-partner sexual violence are available from North Africa and the Middle East, Eastern Europe, Asia Pacific, and high income countries.3

Other forms of violence against women include child sexual abuse (experienced by 20% of girls worldwide), trafficking, female genital mutilation (most often in countries in Africa and the Middle East), honor killings (most often in the Middle East and South Asia), and forced or early marriage (affecting 60 million girls worldwide, half of whom live in South Asia).4

HEALTH EFFECTS OF GENDER-BASED VIOLENCE

GBV is closely tied to negative health outcomes in women. In addition to injuries, some of which can be near-fatal or fatal, women who experience GBV are at higher risk of negative sexual and reproductive health outcomes. In some regions, they are 50% more likely to acquire HIV or syphilis than other women, and they also face an increased risk of unintended pregnancy, having a low-birthweight baby, having complications during pregnancy and childbirth, or having an induced or unsafe abortion. As a result of prolonged fear and stress, women who experience violence are also more likely to develop somatic disorders, depression, or substance use disorders; and consider or attempt suicide.2

The burden of disability due to GBV leads many women to seek health services more often, putting an added strain on the health system. The social and legal sectors must also use resources to respond to women’s needs for protection, psychosocial support, and legal recourse. Estimates of the social and economic costs of GBV are only available from a few countries, but they generally represent 1-2% of a nation’s annual gross domestic product (GDP).4
Definitions

GENDER
Gender refers to the socially constructed relationship between women and men and the attributes, behavior and activities to which each is expected to adhere. Gender differences are determined and reinforced by cultural, historical, ethnic, religious and economic factors. Gender roles differ over time and between cultures, but may be changed. Gender is often wrongly conflated with “sex”, which refers to the biological differences between women and men.

GENDER-BASED VIOLENCE (GBV)
Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. GBV primarily affects women and girls, although boys and men and sexual and gender minorities also experience it.

INTIMATE PARTNER VIOLENCE (IPV)
Intimate partner violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. It includes a range of sexually, psychologically and physically coercive acts used against adult or adolescent women by a current or former intimate partner, without her consent. Though women can be violent toward men in relationships, and violence exists in same-sex partnerships, the largest burden of intimate partner violence is inflicted by men against their female partners.

SEXUAL VIOLENCE
Sexual violence is defined by WHO as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or acts otherwise directed against a person’s sexuality, using coercion, by any person, regardless of their relationship to the victim. The perpetrator of sexual violence may be a date, an acquaintance, a friend, a family member, a current or former intimate partner, or a complete stranger. Sexually violent men come from all backgrounds, rich and poor, educated and uneducated, religious and non-religious.

SURVIVOR/VICTIM
These terms refer to a person who has experienced any form of GBV. These terms are often used synonymously, but PSI uses the term “survivor” to emphasize that people who experience GBV are not just “passive” victims of these crimes, but are surviving them, actively trying to stop the violence in their lives, and seeking support.

PERPETRATOR
A perpetrator is a person, group, or institution that directly inflicts, supports and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority and can thus exert control over their victims.
What Works to Prevent Gender-based Violence?

Prevention of GBV demands more than simply changing the behavior of perpetrators. The evidence suggests that the most effective approaches are gender transformative, in that they reach beyond the attitudes and behaviors of those directly involved (perpetrators and survivors) to challenge harmful societal norms and promote women’s status more generally.1

A 2015 review of the evidence on GBV interventions suggests that the most effective programs are those that work with entire communities – particularly boys and men – through meaningful dialogue and mobilization efforts that help people identify and deconstruct GBV, challenge harmful gender norms, and develop strategies for increasing gender equality and protecting women and girls.5

The strongest interventions work across all levels of the ecological model – individual, interpersonal, service, community, and policy.6 Evidence suggests that coordinating multiple sectors and combining several intervention components is more effective than using just one approach, but this requires significant and sustained coordination and investment.4,6

An in-depth look at the most effective interventions at each level is provided in the following sections.

Individual and Interpersonal Level

EMPOWERING WOMEN

One component of most prevention programs is direct engagement with women to make them aware of the different forms of GBV and recognize when it is happening to them. It is essential that women know their rights and where to access support if they are experiencing or have questions about GBV. In communities and cultures where violence against women is common, many women will not even know that what is happening to them is wrong or is against the law (if it is indeed against the law). They may themselves accept or condone violence against themselves or other women because that is all they know and have been taught.6

A critical first step, therefore, is raising awareness among women and their communities of what GBV is; its impacts on individuals, families, and communities; and options for support and safety. Equally important is working with women to build their confidence and provide the support needed for them to take action, if they wish to do so.

These messages must be embedded within broader interventions to empower women, which may relate to their rights to choose if, when, and with whom to marry and have children; school enrollment; and economic empowerment.1,5

Since so many women are completely dependent on their male partners, access to education and/or financial support can be transformational in helping a woman leave an abusive relationship, increasing her power to negotiate with her partner, or bringing additional income that could reduce some of the stress and potential triggers for discord and violence in the home.6

The IMAGE intervention in South Africa combined the provision of microfinance loans with training on HIV infection, gender norms, domestic violence, and sexuality for women. After one year, women in the intervention group had experienced half the rate of IPV in the last 12 months compared to women in the comparison group.7 Programs in Kenya and Ecuador have demonstrated the effectiveness of cash transfers for reducing intimate partner violence.1 Cash and material incentives dependent on school enrollment have showed positive effects on delaying child marriage, and because the girl also receives additional years of education, she is more likely to gain knowledge and confidence that could give her more power in later relationships.1

ENGAGING BOYS AND MEN

In recent years, interventions have shifted from targeting men as potential perpetrators of violence to engaging them as partners in GBV prevention. There has been some controversy around this effort, as some groups think that programming for men will divert funds from women’s services.8 Effective programs, however, recognize that preventing future instances of violence requires transforming social constructions of masculinity that have historically nurtured male dominance. Social norms, values, and institutions create a set of acceptable behaviors and roles for men and
women, and violence is often an unacknowledged (and in some cases, accepted) way for men to assert their socially sanctioned power.  

Many men want to prevent GBV. They may have experienced it themselves or witnessed it happening to their family members; they may want to change the norms that pressure them to express masculinity in certain ways, and they may want to alleviate women’s suspicions of them as potential perpetrators. Men may already recognize the importance of gender equality but struggle to express it, especially when societal norms favor male dominance.  

Gender-transformative approaches are needed because they address and seek to change the formations of masculinity that license the use of violence toward women. Popular mechanisms for delivering gender-transformative messages include dramas, workshops, school curricula, and role models and mentors. The content of these programs often centers on exploring the multiple expressions of masculinity and discussing the similarities between men and women.  

Extra care is needed to engage men who have experienced violence themselves and men who abuse alcohol and other substances, a behavior that is associated with both the experience and the use of violence.  

There have not been many rigorous evaluations of the impact of male engagement programs on the incidence of GBV, and the majority are limited to high-income countries; however, results show that men report having a better understanding of and interest in gender and violence issues after participating.  

Facilitating Dialogue Between Men and Women  

Evidence suggests that the most effective interventions find opportunities to engage men and women in activities together.  

Facilitating discussion between women and men can help promote understanding of the others’ experiences and lead to improved interactions. Interventions should seek to challenge men and women’s understanding of their own masculinity or femininity and their roles in relationships and in society. The most effective programs recognize the complexities of behavior and how they are shaped by wider societal norms, and they are aspirational in that they offer a vision of a more equitable society and both men and women to act to achieve it. Changes to individual behavior must complement strategies at the societal level to change norms about violence and gender.  

SERVICE LEVEL  

The healthcare system should play an active role in GBV response and prevention. Women sometimes present with acute injuries as a result of physical or sexual assault, but women who experience GBV are more likely to use the healthcare system even if they do not come specifically for injuries related to the violence. They may be in need of HIV testing services, family planning, safe abortion or post-abortion care, and antenatal care. The same woman may need a combination of services at once, and her needs may change over time.  

In their healthcare settings, providers can offer what is called a “first-line response” for survivors of GBV. This involves clinical care for acute injuries, as well as post-exposure prophylaxis for HIV prevention and emergency contraception for pregnancy prevention; empathetic listening; basic counseling on the survivors’ rights and options; and referrals to social services. A first-line response – also known as supportive care – helps mitigate the consequences of violence that cannot be immediately addressed, such as depression and substance abuse, and connect women to needed legal, social, and psychiatric support. It also provides women with a safe space to discuss their experiences and plan for their safety. Moreover, the health system can contribute to primary prevention by raising awareness about the prevalence and signs of GBV to help women recognize when it is happening to them.  

Some low- and middle-income countries use a model of a one-stop crisis center for cases of GBV, but there is no conclusive evidence of whether offering services through one provider, one facility, or one system is most effective. WHO recommends that services be integrated into primary care facilities where possible. In order for women to access services beyond the primary care facility, a coordinated multi-sectoral response is needed.  

Resources are needed to train providers on how to sensitively ask questions and to listen and respond to women’s
concerns and needs. Providers need ongoing supervision and support, coordinated referral networks, essential clinical supplies, and confidential, private spaces to talk with women. The health system may need to increase the staff and improve capacity at facilities so that providers have the time, skills, and incentives to respond to GBV. Having earmarked funds for GBV response is important in order to track the costs of GBV services, and it also lends extra support for advocacy by acknowledging the necessity of the service.

Variations in funding and buy-in from providers make it difficult to generalize about what approaches work best at the service level, especially where resources are scarce. Facilities that participate in intervention programs should keep complete and careful records to contribute to the evidence base about what works, while also ensuring confidentiality and privacy of this highly sensitive information.

**COMMUNITY LEVEL**

Community mobilization and advocacy initiatives have increased recognition of GBV as a human rights violation and spurred the development of programs that address underlying factors in the community, rather than just focusing on behavior change at the individual level.

Family members, neighbors and peers are often the first people to whom women disclose that they have experienced violence, so it is important that they have supportive attitudes about GBV and know where to help women seek services. In general, there is strong evidence that community-level programs positively change the knowledge and attitudes of members, although their effect on rates of violence is unclear.

Community mobilization activities, such as public awareness days, group training, social and mass media, and edutainment, aim to raise awareness about GBV and spark discussion about societal norms and practices. A community mobilization program in Uganda, SASA!, resulted in significantly lower acceptance of IPV among women and men; greater acceptance that women can refuse sex; and lower rates of experiencing physical or sexual IPV in the past year. These changes occurred at the community level – not just among those who were exposed to the intervention – highlighting the program’s transformative power. Because of its effectiveness, SASA! has been replicated in more than a dozen other countries.

Other community-level approaches include working with institutions (such as schools and workplaces) to reduce systematic violence against women and enable them to access support services. Programs implemented at schools in South Africa, Ghana, and Malawi have demonstrated that training teachers and students increased their knowledge and decreased their acceptance of GBV and strengthened their confidence to discuss the subject matter with each other.

In Latin America and South Asia, the creation of female-only police stations (or female-only areas within police stations) provides a safe space for reporting violence. Reporting has increased in some settings, but there is no evidence yet of the effectiveness of this type of intervention for reducing GBV at a community level.

**POLICY LEVEL**

The number of countries with domestic violence legislation grew from four in 1993 to 76 by 2013. Most have concrete policies that forbid child marriage, prosecute perpetrators of violence, and enable survivors to access clinical services for abuse and sexual assault. National initiatives led by ministries of health have facilitated stronger advocacy, supportive policies and budgets, and coordination; while workplaces increasingly have sexual harassment policies and permit personal leave for employees to seek support services.

When initiatives are found to be effective and innovative, community leadership should support them through policy, advocacy, and investment. Policies are necessary to provide survivors with legal recourse when they have experienced GBV. However, simply having policies does not prevent GBV from happening. In many cases, policies have been weakly enforced due to lack of adequate funding and political will. Furthermore, policies that aim to ensure survivors have access to support services can be undermined by poor implementation. Coordination among the various sectors involved in GBV services is needed to identify and respond to cases of GBV and inform survivors about their rights and options. Actors in the GBV response must also be supported with adequate budgets and capacity-building measures to do their work.
What Does **Not** Work to Prevent GBV?

**Bystander interventions** have not proven to be effective for preventing violence, but there may still be value in educating individuals to recognize violence and decrease acceptance of violence in their communities.\(^5\)

**Interventions with perpetrators** demonstrate little evidence of behavior change, often due to a high dropout rate of program participants and deeply-set structural factors that motivate perpetration of violence.\(^1,11\) Evidence from Asia suggests that the threat of fines and incarceration does not deter perpetrators of rape – countries with high rates of rape conviction also had the highest incidence of rape.\(^12\) On the other hand, mandatory reporting and arrest for domestic violence is not effective either. Experts recognize that this approach may further disempower women by mandating a reaction to experienced violence, and in some cases, mandatory reporting has escalated violence at home.\(^11\)

**Universal screening for GBV** (screening every woman who walks through the door) is not endorsed by WHO as an effective way to identify women who need services, especially where there are limited referral options and human resource constraints.\(^10,11\) Rather, healthcare providers should be trained on how to recognize the physical and emotional symptoms of violence and how to broach the subject with women who present with those symptoms.\(^10\)

Other interventions may be an important part of a comprehensive response to GBV but are not effective as standalone strategies. These include safety improvements in school hygiene facilities for girls and single-component mass media campaigns to raise awareness of violence.\(^13\) In general, single-component programs are far less effective than strategies that work at all levels to prevent GBV.\(^4,6\)
Future Research

Evidence on the prevalence and forms of GBV has expanded rapidly in recent years, although data mostly come from high-income countries and are sparse in several regions. More population-based research is needed in order to create a clearer picture of GBV around the world. Currently there is very little research on the prevalence and complexities of some forms of violence like trafficking, rape, honor killings, child marriage and abuse, and violence in conflict settings. There is also a limited understanding of the various experiences a woman may have with GBV over her lifetime and what services and supports she might need at different points. More can be done to capture the range of experiences and their short-term and long-term health and social consequences for women.

Understanding of the psychological side of violence – what motivates perpetrators, and what causes some survivors to be more resilient than others – is limited. Gaining better insight into the minds of perpetrators and survivors of violence can help design more targeted and relevant programs.

There is much more to learn about the most effective ways to prevent and respond to GBV. Currently, most of the evidence on GBV interventions comes from high-income countries, and it is difficult to conclude how they might work in settings with constrained resources. In particular, more research is needed on school-based, workplace, and community interventions; police and legal interventions; media communications; economic empowerment; crisis interventions, like hotlines and one-stop health centers; counselling, therapy and psychological support; and interventions that engage parents, couples, and peers.

Programs that have shown to work in controlled settings should be further evaluated for their scalability and attribution of effect to their different components. Research should also aim to answer questions about the level of exposure needed for impact, the role of contextual factors, pathways for change, and variations in program effect among people of different ages and experiences.

Finally, more evaluations need to measure changes in GBV rather than just the factors associated with it; and they should evaluate the impact at the community level, not just among participants in the program. Standard indicators and approaches to evaluation would allow for better synthesis of different program outcomes and the tracking of change over time.
Glossary

GENDER
Gender refers to the socially constructed relationship between women and men and the attributes, behavior and activities to which each is expected to adhere. Gender differences are determined and reinforced by cultural, historical, ethnic, religious and economic factors. Gender roles differ over time and between cultures, but may be changed. Gender is often wrongly conflated with “sex”, which refers to the biological differences between women and men.

POWER
Power is understood as the capacity to make decisions. All relationships are affected by the exercise of power. When power is used to dominate, it imposes obligations on, restricts, prohibits and makes decisions about the lives of others.

GENDER-BASED VIOLENCE (GBV)
Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. GBV primarily affects women and girls, although boys and men and sexual and gender minorities also experience it.

VIOLENCE AGAINST WOMEN
Violence against women is defined by the UN Declaration on the Elimination of Violence against Women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”. It is a form of gender-based violence and includes sexual violence. The Declaration states that “[Violence against women] is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.

SURVIVOR/VICTIM
These terms refer to a person who has experienced any form of GBV. These terms are often used synonymously, but PSI uses the term “survivor” to emphasize that people who experience GBV are not just “passive” victims of these crimes, but are surviving them, actively trying to stop the violence in their lives, and seeking support.

PERPETRATOR (ALSO CALLED “BATTERER” OR “ABUSER”)
A perpetrator is a person, group, or institution that directly inflicts, supports and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority and can thus exert control over their victims.

COERCION
Coercion is forcing, or attempting to force, another person to engage in behaviors against her/his will by using threats, verbal insistence, manipulation, deception, cultural expectations or economic power.

CONSENT
A person consents when she/he makes an informed choice to freely and voluntarily do something. There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation. Any agreement obtained from a person who is below the legal (statutory) age of consent, or is defined as a child under applicable laws, is not considered to be consensual.

DOMESTIC VIOLENCE (DV)
Domestic violence includes all acts of physical, sexual, psychological or economic violence within the family or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim. Domestic violence is not an isolated, individual event, but rather a pattern of perpetrator behaviors used against a survivor.

INTIMATE PARTNER VIOLENCE (IPV)
Intimate partner violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. It includes a range of sexually, psychologically and physically coercive acts used against adult or adolescent women by a current or former intimate partner, without her consent. Though women can be violent toward men in relationships, and violence exists in same-sex partnerships, the largest burden of intimate partner violence is inflicted by men against their female partners.

PHYSICAL VIOLENCE
Physical violence is the intentional use of physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence
include: slapping (with open or closed hand), shoving, pushing, punching, hitting, beating, scratching, hair pulling, strangling, biting, spitting, grabbing, shaking, spitting, kicking, burning, throwing, twisting of a body part, forcing the ingestion of an unwanted substance; restraining a woman to prevent her from seeking medical treatment or other help; and using household objects to hit or stab a woman, using weapons like knives or guns.\textsuperscript{10, 11, 12}

**PSYCHOLOGICAL VIOLENCE**

Psychological violence is an action or set of actions that directly impair the woman’s psychological integrity. Acts of psychological violence include: threats of violence and harm against the woman or somebody close to her, through words or actions (e.g., stalking or displaying weapons); harassment at the work place; critical, humiliating and insulting comments meant to undermine the survivor’s sense of self-worth and self-esteem (e.g., repeatedly claiming that survivors are crazy, incompetent, and unable to do anything right; isolation and restrictions on communication (e.g., through locking her up in the house, forcing her to quit her job or prohibiting her from seeing a doctor); and use of children by a violent intimate partner to control or hurt the woman (e.g., through attacking a child, forcing children to watch attacks against their mother, threatening to take children away, or kidnapping the child). These acts constitute both violence against children as well as violence against women.\textsuperscript{13, 14, 15}

**ECONOMIC VIOLENCE**

Perpetrators control survivors by controlling their access to all of the family resources: time, transportation, food, clothing, shelter, property, insurance, and money. He may actively resist the survivor becoming financially self-sufficient as a way to maintain power and control. Conversely, he may refuse to work and insist that she support the family. Survivors are put in the position of having to get “permission” to spend money on basic family needs (such as food, health care, education, housing). When the survivor leaves the violent relationship, the perpetrator may use economics as a way to maintain control or force her to return: refusing to pay bills, instituting legal procedures that are costly to the survivor, or destroying assets in which she has a share. All of these tactics may be used regardless of the economic class of the family.\textsuperscript{16}

**SEXUAL VIOLENCE**

Sexual violence is defined by WHO as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or acts otherwise directed against a person’s sexuality, using coercion, by any person, regardless of their relationship to the victim.\textsuperscript{17}

The perpetrator of sexual violence may be a date, an acquaintance, a friend, a family member, a current or former intimate partner, or a complete stranger. Sexually violent men come from all backgrounds, rich and poor, educated and uneducated, religious and non-religious.

**RAPE**

Rape is defined as penetration of the vulva or anus, using a penis, other body parts or an object without the voluntary consent of the individual.\textsuperscript{18} Marital rape is defined as sexual intercourse forced on a woman by her husband against her will.\textsuperscript{19}

**FORCED MARRIAGE**

A forced marriage is one that is lacking the free and valid consent of at least one of the parties. In its most extreme form, forced marriage can involve threatening behavior, abduction, imprisonment, physical violence rape and, in some cases, murder.\textsuperscript{20}

**PRIMARY PREVENTION**

Any programs, interventions or strategies aimed at stopping violence before it occurs is referred to as primary prevention.\textsuperscript{21}

**SECONDARY PREVENTION**

Strategies aimed at minimizing the harm that occurs once violence is taking place, as well as immediate post-violence intervention aimed at preventing re-victimization are considered secondary prevention.\textsuperscript{22}
References


