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Sexual Violence Against Women: A Sinister Public Health Problem

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The recent brutal gang rape and subsequent death of a young woman in New Delhi, India, captured the attention of people worldwide. As we heard, read, and watched in growing horror, the vicious attack in the heart of the capital city brought to the forefront a problem that has escalated in the last few decades to become a shocking depiction of the current state of women in India and other developing nations across the world.

The event led to much soul-searching and an increase in social consciousness that is unusual for a country of immense contradictions. While the political power of New Delhi rests predominantly with women leaders of different electoral groups, the middle and lower socioeconomic classes exist in a primarily patriarchal society. This contrast in culture is prevalent in other regions of the subcontinent, Asia, and Africa. Sexual violence against women (VAW) in these societies continues to be a serious human rights and public health problem; its effects transcend all humanity and result in long-lasting negative physical, mental, and psychosocial impacts. Legal procedures, including the collection of forensic evidence, and irregularities in the conduct of routine investigations can affect the administration of justice. Even as the travesty of the unfortunate Indian girl unraveled, we witnessed an atrocity in our own country as Ariel Castro—a 53-year-old man from Cleveland—was discovered to have held three women captive for more than a decade as his sex slaves. His story is another gruesome and sickening account of VAW.

The United Nations defines VAW as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[1] In an in-depth review of global VAW, *Lancet* published an article that describes the complex nature of the problem, which includes intimate partner violence (IPV); sexual abuse by non-intimate partners; trafficking, forced prostitution, exploitation of labor, and debt bondage of women and girls; physical and sexual violence against prostitutes; sex-selective abortion, female infanticide, and the deliberate neglect of girls; and rape in war.[2] Of late, the term VAW has been broadened to encompass other types of attacks on women including acid attacks, harassment, stalking, and eve-teasing.

The past two decades have seen an increase in the reporting of such acts and constant media coverage but not necessarily an appropriate increase in prosecution and conviction.[3] In a recent study from Bangladesh, the authors opined that sexual harassment results in negative psychological impacts on adolescent girls, including loss of self-esteem and persistent feelings of insecurity.[4] It is also well established that violent exposures are associated with depressive symptoms in women, including post-partum depression and increased under-five child mortality.[5-7] In another recently published study, gender equity policies in select South Asian countries were described.[8] Five countries (Bangladesh, India, Nepal, Pakistan, and Sri Lanka) were found to have several gender-sensitive policies that were measurable by indicators that contribute to health. However, the study concluded that the mere presence of such policies was inadequate to realize true gender equity or empowerment of women and that large inequities in women's health outcomes persist as a result.

In a not-so-surprising analysis from South Sudan, the world's newest nation, 82% women and 81% men agreed that women should tolerate violence to keep the family together.[9] Even more worrisome was the finding that more women than men (47% vs. 37%) agreed that it was acceptable for men to beat their wives for sex. The authors used a Gender-Equitable Men (GEM) scale to capture the perceptions of men in regard to the roles of both genders in family, domestic, and sexual life and defined a gender-equitable man as one "who is respectful to women, who believes that men and women should have equal rights, and who shares responsibility in the household" and is thus opposed to VAW. This acquiescence of gender-biased practices is pervasive in many other countries. The literature is replete with case reports, narrative reviews, and cohort and longitudinal studies that chronicle the existence of these practices in all parts of the world, including the so-called developed nations where women are presumed to be more emancipated and independent.

Apart from the physical, mental, and psychosocial impacts, the economic toll of IPV against women was documented in 2003 to cost the United States approximately $8.3 billion.[10] It is well established that sexual

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assault victims have a higher prevalence of hypertension, obesity, dyslipidemia, and negative lifestyle choices, like smoking, which may be adaptive responses to violence.[11] The global economic burden can only be presumed to be higher and that any report would underestimate the true prevalence of IPV. Additionally, there is substantial evidence of violence outside the home, as in the case of juvenile sexual offenders and those who attack women veterans. In fact, military sexual trauma (MST) is a well-recognized psychiatric disorder that is known to cause depression, post-traumatic stress disorder, and alcohol abuse.[12]

Why does VAW continue to happen even after being widely recognized as a serious public health problem? Why do we, as health care providers and human beings, let this happen? And more importantly, what can we do to stop it?

Screening for sexual violence is still not a routine practice in primary care, and no guidelines by peer institutions like the United States Preventive Services Task Force have emerged to establish such a practice. Health care providers and practices are ill equipped to help victims. Apart from non-governmental organizations who may be able to help on a short-term basis, there remains a dearth of programs that address the proper rehabilitation of victims of VAW. Over the past two years, I have seen a young patient covered in new bruises every time she sees a provider in my clinic. She attributes the bruises to various accidents, but no one—including me—has documented any concern for domestic violence or abuse. I realize that her history does not make sense but did not act earlier due to a lack of training emphasizing early recognition of symptoms and signs of abuse.

The problem has to be addressed on many different levels: political, legislative, judicial, social, medical, and personal. Emancipation of women remains critical, but a more crucial factor is a change in social attitudes toward women. India has seen tremendous financial independence of women based on its commitment to the education of girls. By itself, this has not led to safety and in fact may have contributed to the problem, as women travel alone between school, college, and work at all hours of the day, thus exposing themselves to risks of attacks in a culture holding on fiercely to its patriarchal underpinnings. After the gang rape incident, India saw changes made to its laws based on the recommendations of the Justice Verma committee. Laws related to sexual crimes were reassessed, and the very definition of rape was extended. However, marital rape was not recognized, and army personnel remain immune to prosecution for sex crimes. It remains to be seen if stricter laws result in a reduction of crimes against women.

So what has changed since the Delhi gangrape? I would say nothing if I was a cynical person. But I am not, and thus I prefer to acknowledge what indeed has changed: a) Sexual violence incidents are reported more frequently in India; b) the very powerful Indian media has taken upon itself to fight for victims, discuss related issues freely, and create awareness; c) the immense stigma associated with rape is eroding (and I would consider this a sign of progress); and d) prosecution and punishment of culprits is on the rise. Having said that, the sum total of all changes is only slightly above zero, and we still have a long way to go improve the safety of women in our society. I, a citizen of the United States of Indian origin, feel anxious about traveling to the country where I was born and where the rest of my family still resides. I look for flights that arrive during the day, and I don't think I will ever get into a cab alone in New Delhi. Here in the United States I have started to feel anxious about being alone after dark, even as I recently sat in my car in front of Best Buy while my son went in to buy a video game at 8 pm.

Is it unreasonable that my anxiety extends to the wellbeing and safety of my young niece in India who has all the support needed to have a wonderful education, career, and life there? Is it absurd and irrational that I fervently hope on a daily basis that she will one day come to live in the United States, just so that she doesn't get raped or murdered?

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