22 Structures of Violence Throughout the Life Course: Cross-Cultural Perspectives of Gender-Based Violence

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Gender-based violence is a significant health, economic, social, and political problem that affects every inhabited corner of the globe. Every single country on the planet confronts the crisis of gender-based violence, and it is widely recognized as one of the most urgent issues to be addressed at the international level.

Although the research community first took note of forms of violence we now group under the umbrella term of gender-based violence 40 years ago, it has only been in the last 20 years that significant policy and legal frameworks have been generated and adopted to ensure countries are working to prevent and end the scale and scope of violence in their communities. This chapter discusses the broad framework of gender-based violence, and focuses most specifically on the two forms of violence most prevalent across the globe: domestic violence and sexual violence. Next this chapter provides an overview of social science research conducted at the local level to make sense of the way forms of violence impact people in their everyday lives. Lastly, the chapter explores how violence impacts particular demographic categories in different ways, and how programs and policy must better attend to the diversity of experiences people have with violence.

22.1 Understanding and Defining Gender-Based Violence

Gender-based violence is a broad term used to describe a range of violence experiences. The United Nations definition explains:

> 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, and including domestic violence, crimes committed in the name of honour, crimes committed in the name of passion, trafficking in women and girls, traditional practices harmful to women, including female genital mutilation, early and forced marriages, female infanticide, dowry-related violence and deaths, acid attacks and violence related to commercial sexual exploitation as well as economic exploitation. (United Nations High Commissioner for Human Rights 1993)

Gender-based violence can happen to any individual regardless of gender, age, race, and other demographic markers. However, the majority of victims of gender-based violence are women, and therefore this chapter is primarily concerned with detailing the experiences of diverse women around the globe.

It is useful to put the acts of gender-based violence abuse into two categories. Interpersonal

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N. E. Riley, J. Brunson (eds.), *International Handbook on Gender and Demographic Processes*, International Handbooks of Population 8, https://doi.org/10.1007/978-94-024-1290-1_22

violence occurs when an individual is specifically targeted by another individual or groups of individuals based on gendered categories or expectations. Structural violence occurs when the act of violence is not specifically targeting a particular individual, but ideas, policy, structures, or laws negatively impact one group of people over others. Structural violence refers to the processes, policies, and polities that systemically produce and/or reproduce "social and economic inequities that determine who will be at risk for assaults and who will be shielded from them" (Farmer 2005:17–18).

Therefore, a woman may experience structural violence and interpersonal violence simultaneously. To narrate an example: a woman learns that her partner believes that women are less valuable than men, that women have a duty to serve men, and therefore he has a right to physically assault his partner because she did not do as he asks. The woman in this example is being physically harmed as an act of interpersonal violence, precipitated by a set of beliefs her partner holds about gender roles and structural violence.

There are many forms of intimate partner violence and structural violence, including genital cutting, forced marriage, plastic surgery, discrimination against LGBTQI (lesbian, gay, bisexual, transgender, queer, and intersex) populations, the absence of laws that ensure equal access to education, jobs, and healthcare, and more obvious forms like domestic violence, sexual assault, and rape. Researchers and advocates who work within the framework of gender-based violence see the expression of violence as directly related to the cultural and social structures that allow the violence to occur. Mainstream populations are becoming much more cognizant of this relationship, and it is increasingly common to see and hear violent acts discussed in terms of "toxic masculinity" or "rape culture."

All forms of gender-based violence are acknowledged as serious problems women face around the world; however, international and national bodies recognize that the most persistent and prevalent forms of abuse are domestic violence and sexual assault. Domestic violence is the use of physical, verbal, sexual, emotional, or financial violence against a current or past partner, either in a marriage contract or *de facto* relationship. Domestic violence can occur in relationships from young teenagers to elderly partners, and is expressed in relationships regardless of whether or not the couple have children. While the broader term of family violence is inclusive of violence enacted by any family member against another (parent to child, sibling to sibling, between in-laws, for example), the most commonly reported form of abuse is between two people in an intimate, sexual relationship (Watts and Zimmerman 2002).

The second most common form of violence categorized as gender-based violence is sexual assault, inclusive of rape. For the purposes of theorizing and responding to gender-based violence, we focus on sexual assault that occurs between known and unknown individuals, as well as rape that happens in marital relationships. While we acknowledge that child sexual abuse is a significant global problem, this form of sexual assault and/or rape requires a unique framework for analysis. Herein, we are primarily concerned with sexual assault and rape as enacted against individuals beginning in the teenage years. There is significant overlap between domestic violence and sexual violence in marriage and cohabitating relationships, and this will be discussed in detail.

22.2 The Scope of Gender-Based Violence

In 2005, the World Health Organization published the most comprehensive study to date of rates of violence from around the world. Over 24,000 women participated in the study, from the countries of Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Tanzania, and Thailand. New Zealand independently adopted the research protocol to add an additional data set. The household surveys and interviews were carried out in the capital cities. In addition, in some countries, rural sites were identified. In the case of Samoa, the entire country was canvased.

The World Health Organization study found that the rates of violence ranged from 13% in some contexts (largely urban areas) to 61% of the study population experiencing some form of domestic violence at the hands of a partner. The rates of sexual abuse reported were between 6 and 59%, depending on country and population density. The overlap of sexual abuse and domestic violence in a relationship was significant, with a range of lowest reported figure at 15–71% having experienced sexual abuse and other forms of abuse at the hands of a partner. From these data we can see that the rates of domestic violence range from one-fifth of a given population to nearly two-third of a population, and sexual abuse impacts one-third to two-thirds of a country's female population. This is not an insignificant problem impacting a minority of the population. The World Health Organization study provided the global evidence that violence against women is the root cause of, and consequence for, serious health, social, and economic problems, and these forces in turn generate and exacerbate the rates of violence found in individual societies, aspects of which we detail in this chapter.

Importantly, the World Health Organization study also documented the beliefs held by women about violence either directed at them or found generally in society. This information is important for considering how individual countries, as well as international bodies, must conceptualize prevention efforts as part of a cultural change process. Not surprising, the acceptance of abuse was higher among women who had experienced it. This is not an insignificant finding, and is a critical point as far as how programs individually intervene with victims of abuse, as well as how prevention efforts must be crafted in ways that do not further blame the victims for their abuse.

Victims of domestic violence and sexual abuse often express these common feelings: (1) They are to blame for the abuse, thus justifying the abuse that is experienced; (2) They are often dependent emotionally and financially on the individual perpetuating the abuse, thereby taking blame as a way to justify staying in a violent situation; (3) They hold hegemonic beliefs that women are less valuable than men, or believe that men have a right to hold power over women, including access to sex regardless of a woman's consent. The World Health Organization study found that women with higher rates of education lived in more urban settings, as opposed to women with lower literacy rates who live in more provincial or rural areas. This finding is also significant for supporting critical attention to political-economic structures and differences cross-culturally.

22.3 Social Science Perspectives and Lessons for Practice

Perhaps the most important finding from this report was, in the words of the World Health Organization study authors, that violence is not "inevitable." This conclusion is reaffirmed when we look cross-culturally to understand gender-based violence.

22.3.1 Culture and Diversity in Gender-Based Violence: Causes and Experiences

Anthropology is broadly defined as the holistic study of humans, both past and present. Anthropologists aim to describe and present an understanding of culture, whether at the individual, group, or societal level. Anthropologists utilize both qualitative and quantitative methodologies to interrogate the concept of culture. A foundational qualitative methodology in anthropology is ethnographic fieldwork, defined as an immersive experience that draws upon intensive interaction with a local community, while participating and observing daily behaviors. Anthropologists participate in the culture's daily activities at both the personal and societal levels while observing everyday occurrences.

The framework and methods of anthropology ground cross-cultural studies of gender-based violence that detail the scope and scale of gender-based violence around the world. In this section, we highlight important work by ethnographers who detail the everyday lives of people

experiencing violence and those working to prevent and end violence in their societies.

The World Health Organization data dovetail with the significant work of anthropologist Peggy Sanday, who in her pioneering study, argues that there are "rape prone" and "rape free" societies (1981). Sanday documented over 130 cultures from around the globe using the Human Relations Area Files, coding for different forms of violence from each ethnographic work. What Sanday found was quite striking, and she divided her results into two categories: rape prone and rape free cultures. What she found in rape prone societies were high rates of gender antagonism, ideologies that were misogynistic, and practices and traditions that were built around the subordination of women. In rape free societies she identified greater rates of egalitarianism, ideologies of respect between male and female roles, and more male involvement in child rearing. This work was critical for challenging the contemporary discourse that violence, including forms of rape and domestic violence, was inevitable and embedded biologically within human DNA. Sanday's work demonstrated that while we find violence across cultures and enacted by young and old, male and female, and among people of different faiths, it was clear that cultural norms and beliefs are the fulcrum of the expression of violence. Her work influenced a number of other scholars who dedicated their research to studying the local expressions of, and impacts from, violence, with domestic violence and sexual assault being the two most persistent forms of violence ethnographers found in these local contexts.

Following from Sanday's work, David Levinson (1989) published *Family Violence in Cross-cultural Perspective,* which, similar to Sanday's work on rape and sexual assault, examined cultural patterns that led to higher or lower rates of family violence across a range of cultural forms. Soon thereafter a group of ethnographers specialized in the cultures of Oceania published their findings of rates of violence in Oceania in Dorothy Counts' special issue of *Pacific Studies* in 1990. Following the publication of the 1990 issue of Pacific Studies, Counts complemented Sanday's pioneering work and helped establish violence against women as a legitimate research domain within the discipline. The legitimacy of this work was cemented by the publication of two major works, *Sanctions and Sanctuary: Cultural Perspectives on the Beating of Wives* (Counts et al. 1992) and the second edition of the book, *To Have and To Hit: Cultural Perspectives on Wife Beating* (Counts et al. 1999).

The first ethnographies appearing in the early 2000s often focused on life history narratives of women's experiences with violence, thus allowing for readers to see how violence is experienced across the life-course (Goldstein 2003; McClusky 2001). As the acceptance of treating violence against women as a legitimate area of study grew, others turned their attention to how various state and non-governmental institutions respond to the violence, and women's experiences with structures of care (Plesset 2006). The area of study that received the greatest attention was the intersection of women's experiences of violence and the legal/criminal systems responsible for redress. These included texts that specifically looked at policing responses to violence (Alcalde 2010; Hautzinger 2007; Santos 2005) or the way court systems managed the process (Lazarus-Black 2007; Macaulay 2005; Mir-Hosseini 2011). Others turned to health responses and issues related to medical professionals and their understanding of violence against women (Wies and Haldane 2011, 2015).

What followed were numerous nuanced and ethnographically rich monographs and edited collections that detailed the quotidian aspects of violence across diverse cultural terrain. Two things stand out about this work: while the forms of violence across cultural groups are varied and locally specific, the most common forms of violence were abuse from a man against his female partner, and sexual assault by a man or group of men against a woman or group of women. Thus, "domestic violence" and "rape" were the most persistent forms of abuse, even though a whole host of other forms were documented: male and female genital cutting, in-law abuse, child abuse, persecution of gender fluid or gender anomalous individuals, rape as a weapon of war, forced eating, and forced seclusion during menstruation

and/or pregnancy. Additionally, there were common forms of structural violence: laws or practices that prohibited women in leadership roles, ownership of land, access to resources, or ability to participate in educational settings.

22.3.2 Radiating Health Impact of Gender-Based Violence: Quantitative and Qualitative Patterns

Gender-based violence is widely recognized as a significant health issue throughout the world. The impact on individuals due to violence against women is manifested in a number of ways. Most visible is physical abuse, in the form of broken bones, black eyes, or homicide. However, the impact of domestic violence on individuals goes beyond physical abuse to include many aspects of health, and patterns emerge according to demographic labels.

Gender-based violence negatively affects women's reproduction outcomes and reproduction experiences. In the United States, prevalence of gender-based violence during pregnancy is estimated to be between 0.9 and 20.1% (Petersen et al. n.d.), data that serve as the impetus for understanding violence patterns among pregnant women. Sharps et al. (2007:105–106) define perinatal intimate partner violence as "violence that occurs before, during, and after pregnancy, up to 1 year postpartum, and is committed by an intimate partner: spouse, ex-spouse, boyfriend and/or girlfriend or ex-boyfriend and/or girlfriend." Perinatal violence is associated with a number of poor health-related outcomes for both the mother and the fetus or infant. Women who experience abuse prior to or during pregnancy are also more likely to enter into prenatal care later in pregnancy, which adds further possibilities for negative health outcomes for both the mother and the fetus. The health effects for the fetus and/or infant are similarly negative. Perinatal violence is associated with low birth weight, preterm birth, fetal fractures, and miscarriage (Hill et al. 2016).

Within the pregnant women demographic is variance based on identity, such race, ethnicity, nationality, and geographic location. Among Latina women in the United States, experiences of gender-based violence is predictive for elevated risk of postpartum depressive symptoms (Jackson et al. 2015). Across cultures, the research demonstrates that a woman's reproductive activities and experiences are used as a justification for violence against women, as well as results in escalated likelihood to experience violence. In this way, violence not only affects reproduction, but reproduction also affects violence.

The mental health consequences of gender-based violence are as great as the physical health consequences, if not greater. Women who experience gender-based violence are consistently found to have more depressive symptoms than women who do not report violence, with the prevalence rates ranging from 10.2 to 31.9% (when including anxiety) (Campbell 1998).

Another way to conceptualize poor mental health is through trauma, including posttraumatic stress disorder (PTSD). Posttraumatic stress theory "suggests that some traumatic like experiences are so overwhelming for certain individuals that they cannot assimilate them and thus are psychologically harmed by them" (Ericksen and Henderson 1998:148). Not surprisingly, higher rates of PTSD are found among battered women living in shelters than women in the general population (Campbell 1998). Oftentimes PTSD is presented as a sleeping disorder or stress, causing some scholars to surmise that PTSD is misdiagnosed and therefore underreported among victims of domestic violence. The effects of trauma include radiating health impacts, such as related and diagnosable mental health problems, biological vulnerability and changes, and physical pain and recurring ailments (physical injury, chronic physical injury, and exacerbation of other health problems) (Logan et al. 2002).

There is a body of literature assessing the correlations between HIV prevalence and the violence one experiences over the lifecourse. Social science scholars, particularly behavioral scientists, have used qualitative and quantitative data instruments to demonstrate a positive relationship between sexual violence and HIV prevalence

(Braitstein et al. 2003; Gielen et al. 2001; Simoni and Ng 2002). This research shows that all forms of violence, but child sexual abuse in particular, is predictive of HIV risk and other health risk behaviors. Research has also associated partner violence and low education levels with HIV prevalence, suggesting that partner violence is more prevalent among poorer women, which in turn is a risk factor for increased HIV transmission (Jewkes et al. 2003). In a non-urban domestic violence shelter in Alabama, researchers found that women who experience both physical and sexual abuse are more likely to have a history of multiple sexually transmitted diseases and be worried about HIV infection (Wingood et al. 2000).

Overall, while relationships exist between violence and increased HIV infection risk, cross cultural studies have yet to present sufficient qualitative, comprehensive data that explains why this relationship exists (Maman et al. 2000). Based on available literature, it is reasonable to surmise that increased HIV risk is related to both (1) engaging in sex work to overcome impoverishment and (2) sexual violence. Gender-based violence poses barriers to antiretroviral treatment, therefore rendering women experiencing violence as additionally vulnerable while living with HIV (Hatcher et al. 2015).

Beyond the specific forms of infection, injury or social vulnerability, more holistically-situated evidence has emerged to demonstrate how gender-based violence generates considerable bodily and mental health consequences over a lifetime. Two relatively new ethnographies explore the consequences of gender-based violence on a woman's health long after any noticeable injuries have healed. In her beautifully crafted book, *Traumatic States: Gendered Violence, Suffering, and Care in Chile* (2013), Nia Parson presents the testimonials of survivors who detail the way violence and trauma experiences impacted their lifelong health. Parson explores the way "healing" is not a short term project, but rather something that unfolds over the life course. Therefore, the narratives suggest that relatively time-limited interventions do not mitigate against lasting mental and bodily health effects. Parson notes how institutional structures, inclusive of non-governmental organizations, state agencies, and security forces, work in concert to unintentionally reinforce the ill-effects of abuse and generate new trauma of their own. While most workers at the women's organizations seek to eliminate the trauma caused by abuse and help women move away from violence and towards healing, their own constraints, in terms of limited financial resources, their own recovery from violence, and general lack of training in some circumstances, ends up operating as a form of structural violence as a consequence.

Sameena Mulla similarly explores the relationship between structural violence, interpersonal violence, and long-term suffering in her book *Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention* (Mulla 2014). Mulla documents the immediate medical intervention that occurs after a sexual assault or rape in the United States, as specially trained sexual assault examiner nurses carefully collective the evidence needed to establish a legal case against the sexual assault perpetrator. Mulla carefully considers the way that the nurses engage in this labor as a form of care for the victims and documents their commitment to helping the victims have the physical evidence needed to make a criminal case- despite the fact that their work with the victim is short-lived and necessarily clinical. Mulla illustrates the way victims feel violated not only by the assault, but also by the interventions after the assault, leading to experiences of depression, anxiety, and even suicidal ideation. Parson and Mulla demonstrate how the health impacts of violence are not immediately evident, nor easily cured.

22.3.3 Gender-Based Violence and Structural Violence: Intersections of Political Economy

What stands out from the locally-focused work is the way interpersonal violence and structural violence intertwine. In all the ethnographies listed above, the woman's experience with violence is

often exacerbated by the very interventions ostensibly designed to assist her, and her reasoning for why the violence occurred in the first place is often situated in cultural narratives of kinship, marriage, child rearing, and gendered expectations. Recent work by Lynn Kwaitkowski demonstrates this beautifully in the narratives she has documented by women in Vietnam (2016). In Kwaitkowski's work she captures the way women who are experiencing violence vacillate between knowing it is wrong, and justifying it at the same time, drawing from different cultural scripts to assert their response to the violence as valid, and to maintain some degree of agency. This is not an unusual response, particularly in circumstances where, similar to their male counterparts, women believe that violence is normal and to be expected (Brunson 2011; Harvey and Gow 1994; Toren 1999). The World Health Organization study also captured this in their report: the women who had experienced abuse were more likely to hold beliefs that the violence is acceptable.

Karin Friederic explores a different problem related to changing beliefs around violence and gender norms in her work addressing the lack of resources and education in a small community in rural Ecuador. Friederic's work examines the way notions of universal human rights are presented to the women and men of *Los Colinas*, and the way her interlocutors make sense of international concepts within local space. This introduction of rights based language is not without consequences, and Friederic states:

> Scholarship and activism that uncritically celebrates the spread of human rights as a positive, civilizing force invariably contribute to binaries that are not only conceptually problematic, but also pragmatically dangerous. At the other extreme, critical development and human rights literature that critiques the underlying Western bias and neocolonialist tendencies behind the language of human rights similarly over-simplifies and demonizes a movement that has provided important openings and opportunities for families, communities and nation-states to reduce violence. (Friederic 2015:180)

Thus the value and importance of the local ethnography is not to challenge wholesale the reality of violence across cultures and societies, or even to nullify the value of rights-based language and approaches to ending the toxic nexus of interpersonal violence and structural violence. Rather, it allows policy and programmatic responses to be better aligned with the realities of people's lives on the ground.

Understanding how anthropologists theorize, investigate, and negotiate political economic structures provides useful frameworks for reducing incidence in our professional communities. Of note, Madelaine Adelman's *Battering States: The Politics of Domestic Violence in Israel* (2017) chronicles the intersection of statecraft and domestic violence, analyzing the mechanisms of state authority and the impact on victims, frontline workers, advocates, and state agents. Her work is prescient for any community in many ways. For example, by engaging holistically the multiple actors involved with domestic violence at different levels, she exposes the often invisible ways that seemingly disparate constituents are affected by, responsible for responding to, and involved in framing domestic violence. Further, her deeply descriptive narratives that explicitly examine the process of statemaking, particularly policy and process procedures, illustrates the ways that people are involved in constructing culture by engaging with systems and structures that are similarly culturally-constructed. What we learn from this provocative research is applicable in any setting. First, we must consider the broad scope of constituents affected by violence, harassment, and discrimination to engage as many people as possible in solution building. Secondly, an anthropological lens compels us to connect violence, discrimination, and harassment within larger political economic arrangements that influence identity and power within our communities.

22.4 Challenges for Prevention and Intervention: Multiplicities of Identity

The impact of gender-based violence is often aggregated according to demographic population categories. This serves to highlight disparities in

incidence and prevalence between various demographic groups, as well as assists with funneling limited resources to populations disproportionately affected by gender-based violence. The value of the social science perspective is attention to disparities and marginalization while balancing the experiences of individuals and the pressures of societal structures. The diversity of the human experience compels us to recognize that not all populations will individually experience gender-based violence in the same way, or delivered by the same category of perpetrator.

Domestic violence in lesbian relationships is often identified by the same patterns that indicate domestic violence in heterosexual relationships. In fact, despite popular belief, research indicates that lesbian battering is just as serious an issue as domestic violence among heterosexual partners (McLaughlin and Rozee 2001). To fully understand the individual impact upon lesbians who experience violence, services and resources must be provided in a way that is differently rooted in power inequalities than models of "male patriarchal violence" or sexism, since those messages are not readily translatable to lesbian victims or perpetrators. Furthermore, intervention structures threats to divulge sexual orientation and internalized homophobia may be used as powerful tools of abuse in same-sex relationships (Mahoney et al. 2001).

Domestic violence is equally as likely to occur in urban and rural areas. However, based on survey research in Kentucky, rural women are more likely to experience violence in the form of being shot at and tortured (Websdale 1998). Furthermore, societal characteristics differ between rural and urban areas, and this affects those who experience domestic violence. In rural areas, people are more likely to experience "limited access to services, lower education and literacy rates, norms and attitudes of tolerance toward domestic violence, isolation, and poverty" (Logan et al. 2001:267).

One significant obstacle to receiving domestic violence shelter services is location. Women living in rural areas often must travel to urban areas to seek shelter, and those shelters that are located in rural areas witness their own obstacles.

> The institutional terrain in the rural communities studies is far less hospitable to innovation than it is in urban areas. There is no network of alternative services providers, since the service-delivery system is composed almost entirely of state and local bureaucratic agencies and no opportunity to build coalitions with other groups that are working for social and economic justice. (Tice 1990:95)

Despite the unique obstacles of rural domestic violence sheltering such as location and a lack of a social service network, rural domestic violence organizations still ascribe to the models of empowerment and advocacy that reinforce feminist philosophies of female independence and equality (Tice 1990).

Women of color, working class women, poor women, and rural women have historically been differently placed within the feminist social movement (Berger Gluck 1998). The feminist social movement in its "collective ideology and construction of the battered woman problem, has indeed failed to represent those women- battered women- most at the margins" (Kanuha 1996:45). The failure of the feminist social movement, and subsequently the domestic violence social movement, to historically account for minority women exacerbates structural racism already pervasive in American society and furthers racial and ethnic barriers to accessing services.

For instance, the legal system does not respond to all people the same way and has a different history with different populations. Therefore, black women may be more hesitant to contact the police or file an Emergency Protection Order due to a history of racism and historic inattention to minority protection (West 2002). Furthermore, racially and ethnically marginalized people are more likely than white women to speak a language other than English as a first language, furthering their exclusion from accessing services in a predominantly English-speaking country.

By recognizing the barriers that minority women face when accessing service for individuals affected by domestic violence, we can begin to overcome them. These barriers may include historic and structural racism, language barriers, and lack of trust between victims and service providers. Therefore, barriers to services rooted in language, race, or ethnic background must be

overcome on the part of the service provider to accommodate the diversity of women affected by domestic violence.

Mandatory legal sanctions have been a blessing and curse for people who experience domestic violence. While the justice system measures success by prosecutions, women may measure success in increased personal control. However, some domestic violence courts have instituted mandatory prosecution policies, where "victims are forced to participate in criminal justice proceedings under threat to criminal sanctions" (Ford 2003:669). Not only does this perpetuate a woman's feelings of not being in control over decisions that directly affect her life, it can also be argued that the policies reinforce a patriarchal power structure since it the justice system that is legitimized and validated in the process.

The healthcare sector is also the target of mandatory reporting policies, which "require doctors to file a domestic violence report with the police when they suspect that the patient's injuries are related to intimate abuse" (Mills 1999:562). Supporters of this policy argue that women are more likely to visit a physician or emergency room after an abuse incident than they are to call the police, and therefore the healthcare sector is a valuable point of intervention. However, if women know that mandatory reporting policies exist and a woman does not wish her partner to be arrested or prosecuted, the policy may deter her from seeking health care. Research is unclear whether mandatory healthcare personnel reporting is effective and the extent to which it may cause more harm than good. One study showed that in a sample of abused women the majority supported a mandatory reporting law and less than half felt they would have been at an increased risk for abuse due to a healthcare provider filing a mandatory report (Malecha et al. 2000).

22.5 Conclusion

Gender-based violence, as we have demonstrated throughout this chapter, is multifaceted, complex, and impacts every segment of society. While the expression and experience of violence vary by culture and by each individual, there are common patterns that emerge and barriers that appear across cultural and social differences. As we made clear in this chapter, the most significant area of concern for wellbeing is the health impact on an individual who has experienced violence. While many responses to gender-based violence are concerned with the immediate health impact of the abuse, often in the form of visible injuries, attention must be paid to the invisible and long-term effects of abuse on an individual and community over time. This includes the emotional and mental health stress caused by living with violence; the epigenetic effects we are only now learning about when gender-based violence is experienced in utero; and the chronic pain one lives with into older adulthood from poorly healed bones or torn muscles. Scars that forever remind the person and others of the pain they endured, and the shame and stigma of being vulnerable to abuse. As we demonstrated in this chapter, the syndemic aspect of gender-based violence is considerable, as witnessed by high rates of co-occurrence of gender-based violence with HIV/AIDS, drug and alcohol misuse, other communicable diseases and sexually transmitted infections, and social impacts such as lower educational attainment, higher rates of joblessness or underemployment, and homelessness.

Additionally, the demographic diversity of experiences, especially for vulnerable populations, and the particular barriers to care are critical issues requiring attention and advocacy for them to be addressed. For example, in the latest version of the national prevention strategy to end gender-based violence in Australia, *Change the Story*, only four mentions of disability are found in the 74 page document (Haldane 2017). This is a significant problem when confronted with the evidence that women with disabilities are at greater risk for harm from violence, and one-fifth of the Australian population has a disability. Therefore, the national prevention strategy failed to account for one of the most vulnerable demographic groups. This is common across prevention and intervention strategies, and is a considerable barrier to care.

While the health impact on individuals and communities is the most consequential, as Shell-Duncan made clear, we cannot solve social problems through medicine alone (Shell-Duncan 2008). One concern with looking at gender-based violence as a health or medical issue is the tendency to individualize the problem, and treat the experiences of abuse on a case-by-case basis. As the above literature review reveals, gender-based violence is a social, economic, cultural, and political problem, one that impacts individuals and leaves them with considerable health consequences.

An inspiring model that bridges the macro-level issues of policy engagement to the micro-level impact of abuse on a woman's health across the life course is provided in Melissa Beske's monograph, *Intimate Partner Violence and Advocate Response: Redefining Love in Western Belize* (2016). In this work, Beske provides us with an intimate and engaged portrayal of a community that establishes a response to violence, including the diversions and challenges that the interventions take over the years. Beske positions herself as an engaged and applied anthropologist, conducting fine-grained ethnographic research while simultaneously working as a service provider in the non-governmental anti-violence organization. Beske captures the myriad ways that abuse impacts health, family, social relationships and its migration into the policy domain. The locally grounded, detail rich, and long-term commitment to the fieldsite provides us with the insights required to consider how to establish responses in remote areas, the barriers to service, and the considerable grassroots organizing required for change to occur. It also offers a refutation to the simplistic assumption that more money and resources delivered by Western agents is the solution. "Development" in this form has unintentionally done more harm than good. When local communities identify the program, mobilize for change, and then demand their wealthy counterparts to fund the grassroots efforts, a better informed and potentially productive intervention can ensue. Beske's work demonstrates the value of holistic responses to violence that attend to all the various social institutions (political, educational, medical, kinship, etc.) and that providing adequate resources during the development of interventions can have enormous benefits over the long term.

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