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# Women, marginalization, and vulnerability: introduction

"*We must unite. Violence against women cannot be tolerated, in any form, in any context, in any circumstance, by any political leader or by any government*" (Ban Ki-moon, International Women's Day, 5 March 2009). The UN Secretary-General Ban Ki-moon opened the International Women's Day in 2009 with this statement. Yet a lot needs to be done to stop women's discrimination, violence, and marginalization. Towards the end of 2012, a series of events have increased the attention and the awareness of the public opinion on gender discrimination and violence. On October 9th, 2012, Malala Yousafzai, a 15 year old human rights activist for women and girls' education, was shot on her way to school as a consequence of her activism. Malala survived the attempted murder, and went on to become the youngest person ever to receive the Nobel-Prize, and is leading one of the most impressive international movements for girls' and women's human rights. However, many others girls and women in the world cannot say the same. While writing this introduction, Reyhaneh Jabbari was executed in Iran for having killed the man who tried to rape her.

Every year, millions of women and girls around the world experience some form of physical or psychological violence and discrimination, with dramatic consequences for their health and human capital.

Gender discrimination starts inside the mother's womb. The biological sex ratio at birth averages 106 boys for every 100 girls. In Eastern, South, and Central Asia, the sex-ratio has reached values up to 130 (WHO, 2011). Such levels can happen only under specific circumstances such as selective abortion or infanticide. Despite the efforts of the countries with such unbalanced sex ratios at birth to put in place policies aimed at avoiding gender selection during pregnancy (e.g. restricting the use of technology to identify the gender of the foetus), the complexity of the problem requires breaking cultural gender attitudes within societies.

Immediately after birth, gender biases against girls show up in a variety of dimensions related to their health. Discriminatory allocation is present in food allocation, vaccinations, access to healthcare, and household healthcare expenditure (Khera *et al.* 2014), with boys more likely to receive better care than girls. Despite the worldwide effort to reach gender parity in school atten-

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dance, the gap is still wide in many low-income countries, especially in rural areas (UNESCO, 2003). The gap is again the product of cultural norms, where families, primarily those with limited resources, tend to perceive boys' education as more economically beneficial than girls'. The limited access to education can be considered the first step against girls' human capital development. Restriction to education has life-long and intergenerational effects, and is the pillar on which girls' and women's vulnerability and marginalization rests and women's empowerment is dismantled. Lack of economic autonomy, fair pay, an imbalance in the number of working (paid and unpaid) hours are all dimensions which affect women's health and wellbeing (UNFPA, 2007) and increase their risk of poverty.

Inequalities in the power distribution between men and women result in a condition of subordination and danger throughout a woman's life. Nowadays almost 700 million women have been married before the age of 18 (30% of which before reaching 15 years of age), with South Asia and Sub-Saharan Africa being the regions with the highest rates of child marriage (UNICEF, 2014). The impact on girls' physical and psychological wellbeing is enormous. Girls are usually married to older men, isolated from their family of origin, forced to skip school, unable to negotiate with their partners about any aspect of their life, including decisions about contraception and their own health.

Within their new households, women face pressure from their partner and, often, extended family, to contribute to household production and reproduction. It is in fact within the household that one of the most common forms of violence occurs: physical and psychological violence inflicted by an intimate partner (IPV). Up to 70% of women worldwide have experienced some form of violence from an intimate partner (WHO, 2013). For high-, middle- and low-income countries, it has been widely demonstrated that IPV is associated with poor health in women (Campbell, 2002; Bonomi et al. 2006; Dillon et al. 2013). This includes both physical health problems (such as chronic disorders, chronic pain, gynaecological problems, and increased risk of STIs) and mental health issues (e.g. depression, self-harm, anxiety). IPV can often result in the woman's death: 38% of the all women's murders reported having been committed by an intimate partner (WHO, 2013).

Women's subordination within society is also reflected in cultural practices such as genital mutilation (FGM), which affects between 100 and 140 million women worldwide. Based on the most recent estimates, in Africa 91.5 million girls and women 9 years of age and over are living with the consequences of FGM (UNICEF, 2013). Moreover, girls and women around the world have to face the daily risk of being raped (WHO, 2007), abused (WHO, 2005) or trafficked (WHO, 2012).

Finally, although women in low-income countries are at a higher risk of victimization than women in high-income countries, it is also true that based

on the last Global Gender Gap report (World Economic Forum, 2014) there is no country in the world in which the gender gap has been closed.

The nine papers included in this Thematic Issue - two of which have been published in Genus, Volume LXX(1) 2014 -, tackle the problem of women's vulnerability from different perspectives, providing valuable insights into the problem, its determinants and possible actions.

Four papers are centered on intimate partner and domestic violence. Raushan and Raushan use a nationally representative survey to investigate the prevalence of forced sex and its associated factors in India. In West Bengal, Bihar, Uttar Pradesh and Rajasthan (almost 30% of the total Indian population), more than 10% of married women have experienced forced sex by their intimate partner. Results suggest that the human capital of the members of the household and the economic wellbeing of the household itself play a protective role. Similarly, the work by Pomper and colleagues in Burkina Faso focuses on two different dimensions of women's sexual autonomy: the legitimacy to refuse sex with the intimate partner, and the degree of agreement with being beaten if the refusal occurs. Again, improving women's education and economic wellbeing are seen as necessary steps to improving women's autonomy and reducing IPV. The paper by Rajan provides an interesting analysis of the association between household arrangements and domestic violence. From the analysis of 52 in-depth interviews, the author provides a clear description of the effects of matri-local (when the couple resides with the wife's family) versus patri-local (when the couple resides with the husband's family) household arrangements on women's vulnerability to intimate partner violence and abuse by inlaws. The results suggest that matri-local residency offers the best protection to women against domestic violence. Patri-local residency is, on the other hand, the most vulnerable situation for the wife; she is not only at risk of IPV but also abuse by inlaws. The unbalanced economic distribution and decision-making process within the couple in patri-local arrangements as well as the social isolation experienced by the wife, are all factors that dramatically increase her vulnerability. These contributions are a clear call for economic and educational programmes that address gender inequalities within the household. However, Rajan's paper suggests that the phenomenon is much more complex, and that women's vulnerability is linked to social norms and cultural dimensions in society, which are harder to change. On this aspect, the paper by Utomo and colleagues, based on understanding domestic violence in Indonesia, reminds us that domestic violence affects all the members of the household and contributes to the intergenerational transmission of social and cultural norms. Children in primary school are less aware of domestic violence than children in secondary school, with only 70% of Grade 6 students being able to describe a father hitting a mother as domestic violence (versus 95% among Grade 12 students). Students with more traditional gender role attitudes are less likely to identify domestic vio-

lence when this occurs. As the author suggests, "the earlier students understand the unacceptability of violent behaviour and abusive language, the greater is the chance that they will not become perpetrators later in life and that they will report domestic violence when it is observed". Similarly, Pomper and colleagues observed young women being more tolerant of wife beating than older women. The transmission of gender roles occurs as soon as children are embedded in the household environment. Changing gender roles requires discussion in school as well as a general effort to have egalitarian gender role attitudes within the school, and a drastic change in the social paradigm. The fact that cultural norms are extremely hard to change is also shown by Dodoo and colleagues (Dodoo *et al.*, 2014). Wife subordination is often the consequence of economic dependence on the husband. The authors analyse women's reproductive obligations caused by bridewealth payment, a diffuse habit in some African countries, through which the husband acquires full authority over the timing and number of children. Results suggest that education, in this case, has limited effects. Bridewealth is an extremely strong cultural norm which requires policies to tackle the normative obligations created by these types of marital contracts.

Female genital mutilation is another example of women's vulnerability linked to cultural, religious and social factors within households and communities. Looking at the practice of FGM in Nigeria, Oyefara provides a picture of the cultural beliefs underlying the practice there. Reducing promiscuity is considered the main justification for performing FGM; however, this work highlights how this perception doesn't correspond to reality. Circumcised women in the study had higher levels of promiscuity than uncircumcised ones. On the other hand, the former experience long lasting negative sexual and mental health consequences, including being deprived of the human right of leading a fulfilling sexual life. Education is a protective factor in these socio-cultural practices, with more educated mothers less likely to circumcise their daughters in the future than uneducated mothers.

Even if FGM is a practice linked to specific subpopulations in specific countries, it is a reality that needs to be addressed in and by Western countries, as migration makes the practice a global phenomenon.

Many EU countries have put in place severe laws to restrict the practice of FGM. The EU Community issued the Communication to the European Parliament and the Council "*Towards the elimination of female genital mutilation*". Alone in the UK there are around 66,000 women with FGM and 30,000 at risk of the practice (European Community, 2013).

The papers by Farina and Ortensi and Leye and colleagues (Leye *et al.*, 2014) highlight the need for gathering information about FGM in Europe.

The former, using data from a survey about the sexual and reproductive health of migrant women, looks at the practice of FGM among second generation migrants. Lower levels of cutting have been observed among second

generation migrants as a consequence of the characteristics of their migrant mothers, who in turn also had lower levels of FGM and a higher propensity to abandon the practice.

Leye and colleagues, through a systematic review of the available statistics on FGM, raise the need for monitoring the prevalence of FGM within the European Union. The widespread lack of *ad-hoc* studies, funding aimed to improve the monitoring process, and networking across countries, result in poor and partial information which is not helpful for policymaking.

Finally, the paper by Acharya and Clark addresses the problem of women's trafficking and vulnerability to sexually transmitted infections. Based on their results, trafficked women in the two Mexican cities analysed are forced into unsafe sex and unable to negotiate condom use, which means that they are at high risk of STIs and HIV. The trafficked women in the study also experienced other health problems, including sleep disorders and pain, which affected their daily lives.

Through these selected papers and diverse viewpoints, we hope to enrich and further motivate the discussion of women's exposure to violence.

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