SYSTEMATIC REVIEW

Socio-cultural aspects of gender-based violence and its impacts on women's health in South Asia [version 1; peer review: 1 approved with reservations]

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Abstract

This review attempts to shed light on the socio-cultural roots of gender-based violence (GBV) and its impact on women's health with a special reference to reproductive health in the context of South Asia. It also identifies the policy and capacity gaps that impede the implementation of gender-related development goals and makes recommendations in light of the ongoing situation.

Led by the growing recognition of the pivotal importance of women's and child's health in national development processes, the issues surrounding gender-based violence (GBV) are being given increasing prominence in the global public health agenda. However, developing regions such as South Asia and Sub Saharan Africa are lagging far behind in this respect and failing to prioritize and implement gender-related development strategies. South Asian nations in their pursuance of gender-related goals are faced with host of infrastructure issues in financing, policy guidance, implementation and legislation terms. This study highlights the fact that GBV is essentially a socio-cultural issue which calls for developing gender-sensitive social policies and making strategic investment to promote social capital tailored especially to promote a more nuanced view of women's health and human rights.

Method: Cochrane Database of Systematic Reviews, Embase, Ovid MEDLINE, PsycINFO, and Web of Science were searched for original and review articles published between January of 2000 to July of 2015. Boolean search was performed to identify suitable articles relating to GBV conducted on South Asia (Bangladesh, India, Nepal, Pakistan, Sri Lanka) by using the following search terms: South Asia, GBV, IPV (intimate partner violence), domestic violence, women's health, reproductive health, risk factors, perpetrator, sexual abuse. Reference lists were searched manually for articles relevant to this study

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Any reports and responses or comments on the article can be found at the end of the article.

(snowballing). One volunteer from each country included in the study helped in reviewing renowned local media reports and constitutions to gather policy information germane to GBV issues.

Keywords

GBV , IPV , Human right , South Asia , Healthcare , Women's health

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Introduction

Despite the widespread recognition of the critical importance of women's health in the process of socio-economic progress, a confluence of socio-political factors continue to thwart the efforts to advance women's health status and human rights. Globally, gender-based violence (GBV) remain the largest single cause of morbidity and mortality among women aged between 15–49 years, claiming more lives than cancer, malaria, traffic accident and war combined (Murthy, 2009). Women's health issues began to attract special focus in the arena of global public health since the 1990s with GBV coming into spotlight with the publication of the United Nations Declaration on the Elimination of Violence against Women (DEVAW) in 1993.

GBV is regarded as a significant public health issue and is a major risk factor of women's health related vulnerabilities (mainly reproductive and psychological health), especially in the underdeveloped regions like South Asia. This study explores the socio-cultural roots of gender gradient and the impact of GBV on women's reproductive health in this region. Violence against women (VAW) is observed in all societies both industrialized and developing. In South Asia, however, the violence statistics depicts a heart-rending scenario (described in the third section). Prevalence of IPV (Intimate partner violence) is strikingly high in South Asia, particularly with regard to spousal violence, early marriages, honor-killing (HK), forced sex and sex trafficking (WHO, 2005). In Bangladesh, a country of around 160 million people where the incidence of VAW is deplorably high (Johnston & Naved, 2008), the first country representative survey on gender violence was conducted only once in 2011.

A recent World Bank report titled '*Violence against Women and Girls Violence against Women and Girls: Lessons from South Asia Lessons from South Asia*' presents the most comprehensive GBV issues in south Asia. The report highlights that: 1) South Asia has the highest female to male child mortality rate than anywhere else in the world and 2) has the highest rate of child marriage with remarkably high incidence of intimate partner violence (IPV) (Solotaroff & Prabha, 2014). Child marriage together with dowry, and illiteracy constitute the most common set of risk factors of domestic violence in South Asia. Data from a nationally representative study in Pakistan showed that in about half of the marriages, the women were less than 18 years of age. In Nepal, 40% of girls get married by the age of 15 with 7% before reaching 10 (Nasrullah et al., 2009). In India, where 68% of the female population is illiterate, 47.4% of girls aged between 20–24 years got married before 18, and 42% become mother before reaching 20 (NFHS-3, 2005–06). Governments' commitment to address gender-related crimes are reflected through various policies: *The Dowry Prohibition Act (1980; 1986)* and *The Prevention of Women and Child Repression Act (2000)* in Bangladesh; *The Dowry Prohibition Act (1961, Amended in 1986)* and *Protection of Women from Domestic Violence Act (2005)* in India; *Domestic Violence Act (2009)* in Nepal, *Women Protection Act (2006)* in Pakistan, *The Prevention of Domestic Violence Act (PDVA, 2005)* in Sri Lanka. Although governments and civil society organizations (CSOs) are constantly striving to curb gender related crimes (Naved & Akhtar, 2008), lack of comprehensive data and failure to detect and address

the underlying causes stemming from various socio-cultural complexities are hampering progress. As described in the following section, GBV is fundamentally a by-product of the complex interplay of religious, ideological, socio-cultural factors. Entanglement of GBV with traditional socio-cultural dimensions is the main reason legislative interventions alone have had little impact. This culturally intricate nature of the problem calls for developing socially innovative programs tailored to encourage ideological changes and embracing more ethically acceptable norms. As a potential solution to this intricate problem, previous studies have recognized the need for developing a more gender-sensitive policy framework by aligning the various socio-political, cultural and economic factors that underpin health and human rights of women (Johnston & Naved, 2008). This means there is a strong need for policy makers to adopt more timely decisions and innovative strategies by increasing cooperation with representatives of civil societies and private sectors, local and international human rights non-governmental organizations (NGOs) and donor agencies (Actually I meant organization which operate in a political context and have commitments to donate. Charities act occasionally, but donor agencies act more routinely when needs arise) in the effort to effectively address gender-related issues.

Women's attitude to domestic violence: the south Asian context

Though globalization has brought about certain changes in social values and attitudes towards gender issues in South Asia, traditional patriarchal values still persist in many societies and contribute to the erosion of women's human rights. Stringent socio-cultural practices and patriarchal attitudes are reported to give rise to devaluation of the role of women and increase the likelihood VAW (Niaz, 2003). In certain communities or social segments, arranged marriage, dowry, and restriction of female socialization to some degree are considered supportive of preserving the familial norms and values that has been passed down through generations. Paradoxically, though this segment is getting increasingly smaller in number and has been practicing the traditional way without experiencing any noticeably adverse impacts in the personal and/or social sphere, it silently imparts the dominant patriarchal social system, which renders the complete abolition or prevention of the traditional gender-biased practices an extremely complex task for legal system. A qualitative study conducted on 22 South Asian adolescent girls in Canada showed that their parents and communities have more stringent rules for female socialization than any other community in the country (Talbani & Hasanali, 2000).

Interpersonal and socio-cultural norms are the ultimate determinants of the nature of GBV. For instance, in typical South Asian culture, male figures are traditionally seen as an embodiment of inheritance, entitlement, and power where domestic violence (in some form or other) is justified (to a great extent) by long-standing cultural and societal values and is seen as an inevitable part of conjugal life resulting from time to time as a natural process in a rather happily living couple. Thus, the depth of the problem is subject to being over- and/or underestimated or completely neglected depending on the depth of individual's perception of and willingness to acknowledging it as a problem. According to a study conducted

on a slum population in Mumbai, the 35% of women indicated that wife-beating is justifiable if they disrespected their in-laws or argued with their husband, or failed to provide good food, housework and childcare, or went out without permission (Das *et al.*, 2013). It is not unusual for South Asian women to prefer suffering spousal violence than going to court fearing that this may incur in social stigma, which is more excruciating and would worsen their family problem. Researchers noted that South Asian women are exceptionally inclined to maintaining cultural values of family structure, marriage, and religious practice even when trying to adjust to different gender role expectations, language, and cultural values in a foreign country (Inman *et al.*, 2001). A similar tendency is observed among immigrant South Asian women of silently accepting abusive behavior inside family and avoiding to seek consultation and legal services.

Nature, prevalence and risk factors of GBV in South Asia

In general terms, GBV encompasses following categories: IPV (denotes relationship to perpetrator), domestic violence (denotes location of the abuse) and violence against women (denotes the sex of the survivor) (WHO, 2005), each of which can take various forms of physical and mental torture e.g. physical manhandling, financial threats, sexual abuse, emotional blackmailing. The World Health Organization (WHO) defines violence as “the result of the complex interplay of individual, relationship, social, cultural and environmental factors” (Krug *et al.*, 2002). The categorization of GBV provided by Article-2 of (Declaration on the Elimination of Violence against Women) (United Nations, 1993) is as follows:

Violence against women shall be understood to encompass, but not be limited to, the following:

1. *Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.*
2. *Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.*
3. *Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.*

Obtaining accurate data on GBV has several inherent challenges that lie in the variations in definitions and methodology and especially in underreporting by the victims as the topic is usually associated with element of shame and embarrassment. In a population-based comparative study conducted in India, men were found to report higher prevalence of all forms of violence compared to women (Babu & Kar, 2009). According to the WHO multi-country study, women in Japan were the least likely to suffer domestic violence while the greatest prevalence of violence was reported in Bangladesh, Ethiopia, Peru and the United Republic of Tanzania (WHO, 2005).

Apart from violence incidences in domestic setting, girls and women trafficking is another serious gender and human right issue which is highly prevalent across South Asia. Shockingly, families and friends/acquaintances constitute the majority of perpetrators behind women trafficking, with Nepal claimed to face one of the worst trafficking scenario in the world (Silverman *et al.*, 2007). According to a study based in Nepal, in about 80% of the cases, the perpetrator used to be a member of the victim's own family (Dhakal, 2008). Women and girls (South Asian) rescued from brothels in Mumbai reported that over half of the victims were trafficked by individuals previously known to them (Silverman *et al.*, 2007). Study conducted on a South Asian brothel population found that one fourth of the subjects were trafficked through someone they knew and suffered more frequent violent incidents (Sarkar, 2008).

Prevalence. Violence against women, in any form, is highly prevalent across South Asia (Table 1) (Hadi, 2000 and Naved & Akhtar, 2008). In Northern India, 25% of husbands reported having perpetrated physical violence against their wives during the preceding year and 30% reported having committed sexual violence (Ahmad *et al.*, 2015). In a Bangladesh study, more than one in three men reported physical violence, sexual violence, or both against their wives in the past 12 months (Fulu *et al.*, 2013), one of the worst result for any South Asian Nation. According to the Violence against Women Survey in Bangladesh (VAW 2011), the first nationwide survey in the country conducted by the Bangladesh Bureau of Statistics (BBS) in collaboration with the United Nations Population Fund (UNDP), nearly 77% of the study subjects were abused in last 12 months and only 8% of women said they had never been abused by a man other than their husbands. In Pakistan, the Human Rights Commission (HRCP) estimated the prevalence of domestic violence as 65%, one-third (30.4%) of which was reported to be sexual violence (HRCP, 2004). Honor killing

Table 1. Intimate Partner Violence (%) in selected South Asian countries.

Country	Survey (Year)	Coverage	Physical		Sexual	
			Last year	Life time	Last year	Life time
Bangladesh	DHS 2007	Nationwide	18.4	48.7	11	17.8
India	DHS 2005–06	Nationwide	21.4	35.1	7.2	10
Nepal	DHS 2011	Nationwide	10.4	23.1	7.7	14.3

Source: UN Women. Violence against Women Prevalence Data: Surveys by Country (As of December 2012). DHS: Demographic and Health Survey

(HK) is another serious public health concern in the country with an estimated 1957 HK events taking place from 2004 to 2007, according to a study based on newspaper reports (Nasrullah *et al.*, 2009). Sri Lanka, despite having the highest literacy rate (both sexes) and the best gender parity situation (Global gender index 2014) in South Asia, the prevalence of IPV remains shockingly high (40%, as of 2010) (Jayatilleke *et al.*, 2010). In Nepal, one-third (35%) of all married women are reported to experience domestic violence.

Risk factors of domestic violence in South Asia

The causes of GBV are social, economic, cultural, political and religious (Sanjel, 2013). According to locally available reports (reports not circulated internationally), the causes of domestic violence vary greatly from simple matters as failing to finish cooking on time to more important matters such as inability to produce male offspring or infertility. Reviews on GBV in South Asian countries summarized that GBV results most commonly from illiteracy to low education; economic, educational and cultural inferiority of women, family size, number of male children, women's acceptance of violence, and marital discord (Babu & Kar, 2009). Women belonging to lower castes, who are illiterate, and come from poor economic backgrounds are also more at risk of experiencing violence than others (Babu & Kar, 2009). India alone saw almost 7,000 dowry related deaths in 2005 (Garcia-Moreno, 2009). In Nepal, among the various causes of domestic violence, dowry-related hostilities, second marriages by husbands, assaults on women accused of being witches, and disputes involving properties are the main reasons (Gao *et al.*, 2012, and Dhakal, 2008). A study in Bangladesh found that young age (20–29 years) illiteracy and poverty increased a married women's risk of being sexually abused and the risk is less among women who participate in credit programs and financially contribute to their families (Hadi, 2000). Educated and working women suffer less violence due to their greater economic independence and better understanding of rights and higher access to resources. A study conducted in Urban Slums in Lahore, showed that family affairs particularly issues with in-laws, poor house management, lack of proper care of children, bringing insufficient dowry, financial problems, an act against the will of husband, and inability to give birth to a male child were associated to domestic violence against women (Nasrullah *et al.*, 2009).

GBV and women's health in South Asia

GBV is a major threat to global public health and poses significant barriers to the advancement to women's health. GBV can cause a host of acute to long-term health effects with serious and aggravating consequences on reproductive, sexual and psychological status: physical injuries and disabilities, spread of sexually transmitted diseases (STDs), unintended pregnancies, gynecological problems, mild to severe mood disorder and suicide (Kaur & Garg, 2008). In a study encompassing all the six zones of India, 37% of the women reported a high prevalence of psychological violence (Kaur & Garg, 2008).

Globally, GBV places women in significantly susceptible to human immunodeficiency virus (HIV) infection. In sub-Saharan Africa for instance women aged 15–24 are about eight times more likely to be HIV positive compared to their male counterparts. In Asia, women account for a growing proportion of HIV infections: from

21% in 1990 to 35% in 2009 (UNAIDS, 2010). Though the rate of HIV in South Asia is comparatively lower than in other developing countries, future risk of spread remains high given the rising incidence of GBV in this region. Researchers at Harvard University found that in India the risk of HIV infection among married women who experienced domestic violence were about four times higher in comparison to those who did not face any violence (Silverman *et al.*, 2008).

Impact of GBV on reproductive health

In recent years there has been a rising interest in women's reproductive health development related researches and programs to enhance reproductive health across the globe (Kaddour *et al.*, 2005). Universal access to quality sexual and reproductive health (SRH) services is regarded as a key component to fulfilling many (if not all) of the MDGs (Millennium Development Goals), especially the ones relating to maternal and child health, HIV and gender equity. Researches demonstrated that SRH is of fundamental importance to national health and to the economic development at large (Mishra & Lohiya, 2016). Despite the governments solid endeavor to meeting the health related MDGs, those concerning reproductive health remain largely unmet.

Literature review on reproductive health indicates an escalating concern on domestic violence and its repercussion on health and overall being of women and children. Researchers across various global regions have identified GBV as a major contributor to poor reproductive outcomes for women, with abused women twice as likely to report unintended pregnancy and three times more likely to give birth as an adolescent compared to those not experiencing any violence (Silverman & Raj, 2014). A similar scenario exists across South Asia where GBV constitutes a significant share of all SRH related burden. A study based on NFHS in India (National Family Health Survey- 1998–99) revealed that women who were physically mistreated by their husbands were almost twice as likely to experience unintended pregnancies (Begum *et al.*, 2010). Another NFHS (2005–06) based study including 65610 married women in reproductive age (15–49 years) reported that 23.9% of women experienced at least one form of IPV and had pregnancy related complications (Winter & Stephenson, 2013). Apart from direct impact on health status, GBV tends to undermine women's reproductive control, inadequate communication and cooperation regarding family planning, sexual and reproductive health issues, poor delivery preparedness and pre- and postnatal care. Almost all IPV perpetration in South Asia occurs within marriage (Fulu *et al.*, 2013). Results from a cross-sectional study conducted in Lahore (Pakistan) showed that women who experienced domestic violence were more likely to suffer from poor prenatal care, unplanned pregnancies and poor self-reported reproductive health and lack of cooperation in contraceptive use from husbands as compared with non-abused women (Zakar *et al.*, 2012). A growing evidence supports the fact that state of maternity does not have any significant protective effect on women from violent spousal behavior. The incidence of domestic violence during maternity in India was reported to be 21–28% (Das *et al.*, 2013). A more recent evidence from Uttar Pradesh shows that ~ 47% of the women had experienced some form of violence during their last pregnancy (Ahmad *et al.*, 2015). Obstetricians in Pakistan reported

that more than 30% of Pakistani women suffer from some form of domestic violence. This situation is especially vulnerable for women who become mother at a premature age. The average median age at first birth in South Asia is far lower than observed in other parts of Asia (17.9 in Bangladesh, 19.9 years in Nepal, 21.8 years in Pakistan) (NFHS-3, 2005–06). Moreover, premature marriage and childbearing cut short young women's educational and employment opportunities and increase the likelihood of lifelong subordination to their husbands.

In addition to GBV, more abhorrent forms of violence are female feticide and sex-selective abortion, which are becoming increasingly popular in South Asia and represent emerging challenges for achieving gender equity and enhancing women's health and human rights. In addition to compromising the efforts to promote women's health, feticide itself is a precarious process and increases the risk of maternal morbidity and mortality. South Asian societies exhibit an explicit leaning for male children usually to secure family wealth, preserving family line and avoiding the expenses of dowry. Gender imbalance (skewed sex ratio) has already began to take shape in India (Notably in Punjab, Rajasthan and Haryana) and to cause adverse social impacts in terms of age, caste, religion. Young male citizens are predicted to exceed their female counter parts by a staggering 10–20% by next 20 years.

Role of healthcare system in tackling GBV

The World Health Assembly recognizes GBV as a major public health issue that warrants immediate attention from governments and healthcare organizations. A literature review study by USAID suggested that GBV has implications for almost every aspects of health policy and programming ranging from primary care to reproductive health programs (Guedes, 2004). Studies have also shown that gender-sensitive healthcare policies can make a difference in the lives of those who experience abuse (Garg & Singh, 2013). Though the problem is essentially social, the healthcare system holds a crucial role in the prevention and intervention of GBV starting from ensuring effective screening of victims, informing people about the health impacts to meeting their physical and psychological health needs. Compared to communicating with surveyors and administration, people naturally have more confidence and are less introvert and withdrawn with caregivers because of the characteristic psychological support and reliance that people tend to attach on caregivers which can be leveraged to improve the screening, treatment, rehabilitation procedure and disseminating violence related advices. Incorporating social media tools in public health service programs could serve an equally vital part in abating the complexities of stigma and culture of silence associated with GBV which is also fundamental to promote care-seeking behavior. Interdisciplinary team health specialists including PHWs (Public health workers), clinicians and medical anthropologists can mutually cooperate in classifying and categorizing the health consequences of GBV understanding the urgency of the situation, making critical referrals accordingly and designing easily accessible and effective caregiving models especially for those living in remote areas.

Enabling healthcare to GBV prevention however doesn't guarantee the end of abusive behavior. A qualitative study conducted in Brazil showed that the physicians were unable to handle the

situation as patients suffered repeated torturing with worsening health conditions despite regular treatment, and complained about society's indifference regarding the matter (Elisabeth *et al.*, 2013). To break recurring abuse among the victims, community clinics working in collaboration with NGOs offer the potential to reduce the physical and communication distance between victims and the legal service systems, NGOs might be better equipped to interact with the administrative bodies. On the policy front, the addition of a gender dimension in a broader public health policy framework and strategic resource allocation to promote gender-sensitive social and healthcare policies should target the advancement of women's psychological and reproductive health.

Conclusion and policy recommendations

This review provides an update on GBV in south Asia and reveals that GBV in all its forms and the contextual determinants are highly prevalent across this region. GBV is a ubiquitous public health issue around the globe, however bears special significance in the context of South Asia owing to its deep-rooted socio-cultural barriers compounded by poor healthcare and social infrastructure and lack of institutional accountability. GBV, as a multidimensional problem, calls for a multidimensional solution. The study also highlights that GBV preventive measure must focus on strategic areas of women empowerment such as leveraging gender and sex education, job creation, designing gender-sensitive public policy, law enforcement and strengthening administrative transparency. By drawing evidence from locally available resources and published research articles, this study concludes by making the following policy recommendations that:

1. A growing evidence suggests that poverty and lack of access to productive resources among women significantly increase the risk of domestic violence (DV) and sex trafficking (Babu & Kar, 2009; Fulu *et al.*, 2013). Microcredit programs positively correlate with decreased violent events (Hadi, 2000) and minimize gender disparity in funding. Studies have shown that in South Africa, Intervention with Microfinance for AIDS and Gender Equity (IMAGE) has reduced the incidence of IPV by half (Kim *et al.*, 2007). As the birthplace of microfinance, gender based microfinance programs can do wonders for south Asian women in helping to improve economic autonomy, decision-making power, right to health, freedom from discrimination. However, special monitoring systems must be in place to ensure that women have full control over the economic opportunity they are receiving, have equal access to inputs and face no wage discrimination.
2. Evidently, people (most) are not aware of the various health and socio-economic impacts of GBV and its negative repercussions on children, other family members and overall wellbeing of the family. Nationwide anti-violence campaign and behavior change intervention programs should target awareness creation to reduce gender biases and encourage gender-sensitive behavior, eradication of health and gender-related illiteracy and ensure men's participation at levels of such programs.
3. The impact of skewed sex ratio is already noticeable in term of demographic imbalance and has the potential to cause

huge social externalities if unchecked for long. In some areas, the sex ratio of females to males has dropped to less than 8:1 (Ahmad, 2010). Controlling prenatal sex screening and sex-selective abortion technologies therefore presents an urgent imperative. Female feticide embodies a flagrant violation of human rights and decline of moral values and ethics on which rests the very foundation of civilization. This odious act must be prevented with urgency through introducing rigorous policy instruments.

4. Frail law enforcement and prosecution systems is a significant challenge to confronting GBV. According a nine-country study in the Asia Pacific region (Including Bangladesh and Sri Lanka) conducted jointly by UNDP, UNFPA (United Nations Population Fund), UN Women and UN in 2013, 72–97% of men who had committed rape were never punished which confirms a serious unaccountability of the human rights law. To overcome the lack of policy and managerial transparencies, it is imperative to establish a robust domestic legal system and independent human right institution at local and national level.
5. Globally, resources allocated by the government to health-promoting activities are very limited compared to investments in medical care (Piroska *et al.*, 2006). The operational financing and the integration of healthcare system with GBV agenda depend greatly on political commitment for adequate resource allocation, especially when developing a new branch in public health with sufficient human resources trained in understanding the context, meeting the unique needs of GBV patients and building physical infrastructures such as transportation, community service centers, special examination and counseling rooms. The healthcare expenditure among abused women is significantly higher compared to non-abused women. Special attention must be paid so that financial barrier doesn't compromise the healthcare service of the marginalized population.
6. Progress can be thwarted by inadequate information and underreporting the prevalence of GBV. Conducting national survey on regular basis by developing an effective screening strategy to identify GBV cases is crucial to making culturally tailored GBV prevention and intervention strategies which will assist greatly in assessing and monitoring progress towards gender equity.

7. Long-term success against GBV will require the adoption an interdisciplinary operational framework by incorporating a wide spectrum of crosscutting strategies and enhancing multi-stakeholder engagement in the overall development process. Political commitment are vital to minimize policy related barriers and developing a gender-friendly political environment. Creating a greater synergy between government and civil society organizations (CSOs) is equally essential to understanding the barriers to implementation of policies and how they can be overcome.

Strengths and limitations of the study

This study has drawn evidence from locally available gray literature which portray the facts better but are not usually considered for academic researches. Current state of GBV in five South Asian countries were reviewed: Bangladesh, India, Nepal, Pakistan, and Sri Lanka. Clinical studies and any studies before 2000 were not included. The most recent studies and studies by native authors were given priority. Only population-based studies conducted on native South Asian women were considered for this review, studies on migrant South Asians were not included. Health effects GBV was limited to reproductive health.

Author contributions

GB conceptualized the study. GB and SS were responsible for literature search and selection of suitable research materials. All authors contributed to drafting the manuscript. GB and SY contributed to critical reviewing and modifications. All authors read the final version of the manuscript and approved it for publication.

Competing interests

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The article is on an important subject for reviews and studies, however it needs major revision.

As one looks at the title and tries to understand what the authors wish to share, the expectations given by the title are different than what the article provides. The review methodology mentions the Cochrane Database of Systematic Reviews – the expectation was that they would be ordered in relation to title, socio-cultural aspects of gender based violence and relevant information, the introduction of the subject as per the title, the frequency of GBV, which socio-cultural aspects affect GBV in the proper order, what are the effects on women's health, and to what extent.

However, as one goes through the article (if one overlooks issues related to grammar, language, and the repetition of sentences) it seems a lot was needed, and that the study format as it was designed executed and discussed is different to the design as per the title. The current structure of Introduction, Incidence, Risk Factors, Attitude aspects (with studies based on interviews, about GBV, visible, invisible), the Impact of GBV on non-pregnant and pregnant women's health, means that some paragraphs are not really relevant to the title.

In addition, there are also references included in the Conclusion section.

Overall, in my opinion both the design and execution could have been much better, and the discussion should be more orderly also. The grammar and language should have been looked over, for example avoiding repeated sentences.

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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