Physical Education, Health and Social Sciences

https://journal-of-social-education.org E-ISSN: 2958-5996

P-ISSN: 2958-5988

Evaluating WHO Gender Mainstreaming Strategy in Middle East: It's Role in Addressing Physiological and Psychological Violence to Improve Maternal and Child Health Outcomes

Sundas Maqbool[1], Dr Hafiza Rakhshan Urooj[2], Hafiz Ahmad Jamal[3]

[1,3] MPhil (Political Science), School of Integrated and Social Science, University of Lahore, Pakistan. Email: sundas.maqool@gmail.com, hafizahmadjamal9@gmail.com

[2] MBBS, associated with Medical Practice in Defense Forces, Pakistan. Email: drrakhshanurooj@gmail.com

DOI: https://doi.org/10.63163/jpehss.v4i1.1662

Abstract

Domestic violence is a global public health concern that adversely affects the mental well-being of mothers, the dynamics of parent-child relationships, and the behavioral development of children. Attachment theory posits that disruptions in maternal sensitivity and caregiving due to violence might threaten children's emotional stability and development. Gender-based violence is critically analysed using the gender and power theory formulated by Robert W. Connell. A primary objective of the WHO is to enhance maternal health, which is essential for the well-being of newborns. Physiological and psychological aggression is intrinsically connected to the maternal healthcare pathway framework. Pre-conception, prenatal care, professional delivery assistance, postnatal support, and neonatal services are essential for maternal well-being. The mental well-being of both the practitioner and every individual in the delivery room is of paramount significance.

Keywords: *Violence, Maternal Health, WHO, Policy, Legal Frame Work*

Introduction

A worldwide public health issue, domestic violence has a detrimental impact on the mental health of mothers, parent-child interactions, and the behavioral outcomes of children. According to attachment theory, children's emotional stability and development may be jeopardized by disturbances in maternal sensitivity and caregiving brought on by violence. Violence by intimate partners towards women constitutes a significant infringement of human rights and a critical global public health issue. This violence encompasses physically, sexually, and mentally detrimental actions inside marriage, cohabitation, or any other type of partnership, in addition to emotional and financial abuse and manipulative behaviors. Intimate partner violence can result in significant immediate and prolonged physical and psychological health consequences, such as injuries, depression, anxiety, unintended pregnancies, and sexually transmitted infections, among others, and may even culminate in fatality. It is projected that 38–50% of female homicides are perpetrated by intimate partners worldwide. Intimate partner violence incurs significant social and economic burdens for governments, communities, and individuals.

Maternal mental health and children's behavioral results are negatively impacted by exposure to domestic violence, which may jeopardize the mother-child bond. In the South Asia the significance of treatments that strengthen mother caregiving sensitivity, foster secure parent-child attachment,

and lessen the negative impacts of violence on family well-being. Gender-based violence, while prevalent in South Africa, is also observed in various other nations. Reports indicate instances of violence directed at women during concerts in the United Kingdom, assaults on women defecating in public in Bangladesh, attacks on female university students in Norway, and the practice of female genital mutilation in numerous nations. This underscores the necessity of educating and engaging males in all dialogues and educational efforts to mitigate this scourge.

Advocates for women's rights have diligently labored for several years to highlight the issue of gender-based violence on a global scale. This has prompted several nations to implement significant measures at the national level to eliminate violence against women. The issue lies in the fact that these measures have predominantly concentrated on enhancing legislation concerning violence against women, while insufficient attention has been given to the enforcement of these laws and addressing the root cause of the issue, which is the power disparity between genders and the articulation of gender roles throughout society.

Women who have endured violence and abuse face a markedly heightened risk of adverse health outcomes across multiple domains, necessitating specialized and customized primary care. This critique underscores substantial deficiencies in this area of study, especially with cardiovascular ailments, endocrine disorders, and neurological symptoms and illnesses. It illustrates the necessity for more longitudinal research in this domain to enhance the healthcare of women who have undergone IPV and to identify the physiological mediators of these results(Stubbs & Szoeke, 2022).

Violence affects millions of women and girls globally. A variety of negative effects on women, their families, and society at large are linked to violence against women and girls, which can take many different forms, including physical, emotional, and sexual assault. Health care providers who assist women throughout the perinatal period should evaluate the hazards associated with exposure to past or present violence and how this may impact them during pregnancy. Psychiatrists who work with pregnant and postpartum women should take violence into account as a significant risk factor in a woman's mental health presentation since it can raise the likelihood of anxiety, sadness, and post-traumatic stress disorder (PTSD). Domestic abuse and violence may contribute to many perinatal suicides and raise the chance of domestic homicide. Engagement with mental health services and response to treatment can be enhanced by sensitive assessment and efficient management of women who have experienced violence(van Daalen et al., 2022).

Historical Background:

Given its historical roots in the subjugation of girls and women, especially those who are racialized, sexually diverse, Indigenous, or disabled, and the dominance of men, particularly White men, gender-based violence is acknowledged as a separate type of violence. The prevalence rates of violence suffered by women, girls, and those who identify as gender nonconforming both inside and outside of sports show that this domination still exists today on a global scale. This chapter reviews the various types of gender-based violence in sports and discusses how the lack of conceptual clarity is impeding the field's progress(Kerr, 2022).

Because it immediately affects the health of their partners and children, women's physical and mental well-being is vital. Regional differences exist in the prevalence of lifetime intimate partner violence (IPV), which ranges from 20% in the Western Pacific to 22% in Europe and high-income nations, 25% in the Americas, and 33% in Africa(Alaswad et al., 2026).

Although edutainment has the ability to significantly alter behavior, research on how well it addresses violence against women and children is still in its early stages. The results of 21 thorough studies assessing the effects on attitudes, norms, and behaviors connected to violence are compiled in this study. Overall, 64 percent of 11 studies report decreases in violent behaviors, while 71

percent of 21 studies show encouraging decreases in attitudes and conventions that encourage violence. With somewhat moderate results (13 studies, 57–69 percent demonstrate protective impacts), the largest body of evidence relates to violence against women. Though based on fewer studies, the evidence regarding child, early, and forced marriage is stronger (8 studies, 63–75 percent demonstrate protective impacts). Only one study, with negligible results, covers violence against children, and there are promising but few studies that address female genital mutilation. Although negative effects are uncommon, a number of studies indicate different results based on the target group, research arm, and follow-up duration. Information gathering, individual persuasion, norm diffusion, and improved service connections are some of the mechanisms that have an impact on reducing violence. Despite these positive results, more investigation is required to resolve methodological issues and fully realize the promise of edutainment for widespread behavior modification related to violence(Peterman, 2026).

According to the World Bank, one in three women will experience GBV, or violence against women and girls, at some point in their lives. The statistics are startling: 200 million women have undergone female genital mutilation, 35% of women worldwide have experienced physical and/or sexual intimate partner violence or non-partner sexual violence, 7% of women have been sexually assaulted by someone other than a partner, and up to 38% of female murders are committed by intimate partners.

The World Health Organization acknowledges gender-based violence as a serious public health issue. In addition to being a direct cause of harm, illness, and death, it also indirectly affects women's health through unintended pregnancies and related health risks, mental illness, STDs, HIV, and acquired immune deficiency syndrome (AIDS).

Authorities frequently struggle to tackle gender-based violence, despite the existence of legislation and guidelines, mostly due to its association with deeply rooted gender power dynamics in certain societies. The absence of political and institutional resolve to address GBV is perpetuated by societal perceptions. Gender-based violence is perceived as an integral aspect of existence in numerous societies, with minimal or no impetus on governments to tackle the issue. Gender-based violence inflicts profound harm on victims and their families while also imposing considerable social and economic burdens. The World Bank approximates that in certain nations, violence against women incurs costs equivalent to 3.7% of their gross domestic product (GDP), surpassing the educational expenditures of most governments by more than double.

Hypothesis

Gender base violence is a serious issue; it can be of both types physiological and psychological WHO can play a crucial role in addressing the problem of gender-based violence against women because it directly affects maternal health, which in turn affects child.

Research Question

1. Does psychological and physiological violence impact maternal health, and what are its repercussions on offspring?
2. What strategies can the WHO implement to reduce physical and psychological violence against women and improve maternal and child health outcomes in the Middle East?

Research Methodology:

This research generated worldwide, regional, and national estimates utilizing information from the WHO Global Database on the Prevalence of Violence against Women. The data were obtained via a methodical literature research that explored MEDLINE, Global Health, Embassy, Social Policy,

and Web of Science, Google Scholar alongside thorough investigations of national statistics and several websites. A national consultation procedure revealed supplementary research.
This document has been developed by desktop research, which evaluates data disseminated in reputable journals and publications. In order to incorporate varied evidence in fulfilling its objectives, this paper will also reference grey literature, including newspapers, governmental reports, publications from international organizations, research institutions, and both national and international non-governmental organizations. The studies incorporated were carried out, representative at either the national or sub-national scale, involved women aged 15 and above, and employed act-based assessments of physical, sexual, or both forms of intimate relationship abuse. Data not derived from population samples, such as administrative records, studies lacking generalizability to the entire population, studies reporting only the aggregate prevalence of physical or sexual intimate partner violence alongside other violence forms, and studies with inadequate data for extrapolation or imputation were omitted. We constructed a Bayesian multilevel model to concurrently assess lifetime and past year intimate partner violence based on age, year, and country. This methodology was modified to accommodate diverse age demographics and variations in outcome definitions, while also weighting surveys based on their national or sub-national representativeness.

Theoretical Frame Work

Gender and Power Theory

Gender Base Violence and be critically examines through gender and power theory developed by Robert W. Connell. One of the agenda' of WHO is to improve maternal health, which is necessary for a healthy new born child. Theory also examine the gender base violence, emphasizes on medical health facilities given to the mother. Social norms and gender expectations are also main component of the theory.

Maternal Health Care Pathway Model

Physiological and Psychological Violence is directly linked to maternal health care pathway model. Pre-pregnancy, Antenatal care, Skilled birth attendance, Postnatal care, Neonatal care are necessary for maternal health. Mental health of both the practioner and every person in labor room is of utmost important.

Literature Review:

Violence directed at women constitutes a worldwide public health issue, with approximately one in three women encountering either physical or sexual violence from intimate partners at some point in their lives. Worldwide, around 38% of killings perpetrated against women are carried out by a male intimate partner. Aggression towards women can adversely impact their psychological, physical, and reproductive well-being. The transformative implications and repercussions of violence against women globally warrant heightened focus to guarantee the eradication of risk factors, financial backing for investigative study to enhance victim identification, and studies aimed at improving the effectiveness of therapeutic interventions. All medical practitioners, mental health professionals, social service experts, and public health proponents should enhance these initiatives(Lutwak, 2024).
Roughly half of all men and women will encounter emotional intimate partner violence (IPV) during their lives, a type of violence closely linked to other types of IPV, underscoring the necessity for enhanced comprehension for evaluation and therapeutic objectives. The bio-psycho-social framework was employed to direct the research. Employing data from 181 studies, which produced 348 effect sizes, we performed a meta-analysis investigating the associations between

emotional IPV perpetration and victimization and mental and physical health outcomes. We additionally investigated whether the associations between mental and physical health were considerably more pronounced for emotional IPV perpetration or victimization, and whether these associations differed between men and women. Suicidal thoughts, post-traumatic stress disorder, anxiety, depressive manifestations, borderline personality disorder, psychological suffering, physical discomfort, trauma, rage, shame, deteriorating physical health, antisocial personality disorder, and somatic complaints were markedly correlated with emotional intimate partner violence victimization. Anger, emotional dysregulation, and psychopathology exhibited a more robust association with the perpetration of emotional intimate partner violence (IPV) than with victimization, while post-traumatic stress disorder (PTSD) and psychological distress showed a stronger correlation with victimization. Post-traumatic stress disorder and suicidal thoughts exhibited a more robust association with intimate partner violence victimization in women compared to men, while anger was a notably more significant factor in intimate partner violence perpetration among women than men. This research underscores the significance of a comprehensive strategy for addressing the needs of both victims and offenders of IPV, emphasizing the necessity of considering all facets of the bio-psycho-social framework(Spencer et al., 2024).

Our research substantiates that, alarmingly, physical or sexual violence, or a combination of both, perpetrated by male intimate partners against women is widespread worldwide. In summary, our findings indicate that over 25% (27%) of women aged 15–49 who have ever had a partner have encountered physical or sexual violence, or both, from a current or former intimate partner at least once in their lives; additionally, 13% had faced such violence in the previous year. This discovery indicates that in 2018, as many as 492 million women aged 15–49 who have ever been in a partnership experienced this form of violence from an intimate partner at least once since turning 15. This research highlights the significant prevalence of recent intimate partner violence faced by young women, with approximately one in six women (16%) aged 15–24 years reported to have endured physical, sexual, or both forms of intimate partner violence in the year prior to the survey. It is imperative that we persist in fortifying, standardizing, and enhancing the capabilities for the gathering, reporting, and utilization of data concerning violence against women to aid nations' initiatives and to track advancements at national, regional, and global scales. We advise that governments allocate resources for targeted surveys on violence against women or extensive modules employing professionally trained interviewers, ensuring compliance with ethical and safety protocols to more accurately assess the prevalence of violence against women. These enhanced assessments are vital for the formulation of efficient prevention strategies and initiatives. It is essential to create comprehensive survey instruments to gain deeper insights into the violence faced by women who endure various forms of discrimination, such as those with disabilities, indigenous and minority ethnic or migrant women, transgender women, and women in same-sex relationships, for whom data is presently scarce(Sardinha et al., 2022).

Intimate partner violence (IPV) is a troubling phenomenon globally. Individuals affected by intimate partner violence often endure prolonged psychological illnesses and difficulties in their everyday functioning. As many as 164 female victims of intimate partner violence (IPV) were referred by their primary care physicians to the Adult Mental Health Centre of Sant Cugat del Vallès (Barcelona) from 2010 to 2016, where they underwent various assessments including the Index of Spouse Abuse (ISA), Beck Depression Inventory (BDI-II), State-Trait Anxiety Inventory (STAI), Maladjustment Scale (MS), and the Severity Symptom Scale for Post-traumatic Stress Disorder (EG). Out of 164 women referred, 102 (62.2%) consented to partake, with a mean age of 44.98 years (age range 19–71), and 73% exceeded the threshold in the physical IPV dimension (ISA). Additionally, 73% exhibited symptoms of sadness, 77% demonstrated trait anxiety, and

87% showed modified scores for state anxiety. The occurrence of post-traumatic stress disorder was notably elevated at 87%. IPV had a substantial impact on every facet of daily life for 92% of the participants. The study's subjects encountered numerous psychological symptoms and significant disruption in all facets of their everyday existence. The repercussions were of comparable severity among individuals experiencing emotional abuse in relation to those who endured physical violence Cirici Amell, R., Soler, A. R., Cobo, J., & Soldevilla Alberti, J. M. (2023).

The World Health Organization (WHO) possesses a definitive authority to orchestrate and engage in health emergency responses. The absence of guidelines on gender inclusion within the global health security framework is regarded as significantly concerning. During a crisis, such a public health disaster, gendered vulnerabilities can significantly impact society; these calamities may exacerbate unequal gender frameworks or hinder gender advancement. The neoliberal framework characterizes crises as mere anomalies within the functioning of a fundamentally robust market economy. The WHO continues to be the primary technical and normative authority in global health governance. In 2005, nations consented to implement the International Health Regulations (IHR) to collaboratively manage Public Health Emergencies of International Concern. To discern WHO's oversight of gender in health emergency preparedness and response, we examined WHO's initiatives on gender, equality, and human rights, the HEP, and the IHR team. The policies examined in our inquiry encompassed counsel, direction, and support regarding gender and/or women in health crises, enhancement of IHR core capacities, and assessments of national health security action plans. Although gender is contingent upon context, we may discern various gender stereotypes and disparities that are intensified during health crises, particularly impacting women. These encompass the expectation to undertake both formal and informal caregiving responsibilities, the interruption of routine sexual and reproductive health services, heightened risks of gender-based violence, and considerable economic instability(Wenham & Davies, 2022). During the late 1980s, investigations into abortions conducted outside of medical facilities predominantly concentrated on measuring and decreasing 'illegal abortions,' possibly stemming from a noted association between stringent abortion regulations and elevated maternal morbidity and death rates. In 1992, a technical working committee from the WHO deliberated on the necessity of comprehending both the legality and the safety of abortion services. Their 1993 paper introduced the phrase 'unsafe abortion'—determined that the legal status of services might not be the crucial element of abortion safety. The research delineated the attributes of 'unsafe abortion' as an abortion conducted without sufficient provider expertise, employing perilous methods, and/or taking place in unclean environments. Subsequent to the release of this report, the discourse and emphasis in research regarding abortions performed outside clinical environments transitioned notably from legality to the notion of abortion safety. Abortion continues to be a primary contributor to maternal mortality in certain contexts, and substantial efforts are still required to enhance the quality of surgical abortions in low-resource environments when complication rates exceed those in high-resource areas. Furthermore, the self-administration of medical abortion, in numerous contexts, significantly deviates from the established normative benchmarks of self-care as outlined in a recently published WHO consolidated guideline and its corresponding conceptual framework on self-care interventions in sexual and reproductive health(Gerdts et al., 2022).

WHO strategies for gender equality

Gender equality in health signifies that individuals of all genders, including women, men, and those with varied sexual orientations and gender identities, possess equal chances to actualize their rights and health potential, devoid of violence, discrimination, and coercion. Gender-sensitive strategies acknowledge and address gender disparities in health while aiming to tackle the root

causes of health-related gender inequalities. Considering that the WHO functions in 194 Member States, the gender norms influencing the health of women, men, and individuals of varied SOGIE, as well as strategies to advance gender equality, will vary based on the specific setting. Social conventions can diminish the autonomy of women and girls regarding their health decisions, while simultaneously increasing the propensity for men to engage in hazardous activities. Individuals of varied SOGIE, including women and girls, are more prone to experiencing violations of their health rights due to imbalanced power dynamics in patriarchal society. A fundamental approach to guarantee the identification and resolution of pertinent gender concerns in a culturally sensitive way is to promote equal involvement of men, women, and those with varied SOGIE. Furthermore, the inclusion of especially marginalized populations – including impoverished girls and boys, women with impairments, and women from indigenous backgrounds – must be guaranteed throughout all phases(World Health Organization, 2023).

Gender disparity constitutes a significant and enduring societal issue. Public policies can significantly influence gender equality and the achievement of equitable access to opportunities, resources, and rights for women, men, and diverse gender identities. This chapter offers essential insights, guidance, best practices, and approaches derived from the available research regarding the gender ramifications of public policies. It also succinctly examines essential gender-sensitive policy efforts and frameworks, gender mainstreaming, and instruments such as gender impact assessments, gender-sensitive budgeting, or policy evaluations. This chapter additionally examines essential gender-sensitive policies such as family and work-life balance initiatives, equality measures in the labor and political domains, diversity, anti-discrimination and anti-violence regulations, as well as educational and scientific programs aimed at achieving gender equality(Hervías Parejo & Radulović, 2023).

Violence against women in Middle East

Intimate partner violence (IPV) severely impacts the physical, sexual, reproductive, and mental health, along with the social welfare of individuals and families. Elements linked to heightened intimate partner violence against women were identified and classified into four tiers based on the revised integrative ecological framework. At the personal level, risk factors were associated with either victims or offenders of intimate partner violence. Elements associated with marriage and familial discord were examined and categorized at the family level, while aspects pertaining to the extended family and the characteristics of marriage were classified at the community level. Ultimately, risk variables associated with the cultural milieu, shaped by political and religious influences, were incorporated at the society level. The intricate nature of violence against women in the Arab region necessitates culturally attuned responses, which must be paired with organized efforts to enhance the status of Arab women across all spheres(Moshtagh et al., 2023).

Social transformation and community progress mostly arise from technology innovations, class struggles, and political engagement. Every social formation exists within and is influenced by a national class hierarchy, a regional environment, and a worldwide network of governments and markets. The world-system theory perceives nations and their economies as embedded within a global capitalism framework characterized by a labor division that aligns with its integral components—core, periphery, and semi periphery. Consequently, significant social transformation does not transpire independent of the global setting. I’m sorry, but it seems that the text you provided is not sufficient for me to create paraphrases. Could you please provide a more detailed text? Consequently, to comprehend the functions and status of women or alterations in familial structures, it is essential to analyses economic advancement and political transformation, which are influenced by both regional and global dynamics. The examination of women's employment reveals that structural factors such as class positioning, governmental legal frameworks,

developmental strategies, and global market variations collectively influence the speed and pattern of women's incorporation into the workforce and their access to financial resources. The institutions frameworks are influence by social transformations within a Marxist-informed world-system viewpoint. The institutions are situated within a hierarchical class framework (the mechanisms of production, accumulation, and surplus allocation), a configuration of gender roles and standards (designated responsibilities for men and women via tradition or legislation; societal perceptions of femininity and masculinity), a geographical milieu (e.g., the Middle East, Europe, Latin America), and a global system of nations and markets marked by disparities among core, periphery, and semi periphery nations(Moghadam, 2003).

Violence against women (VaW) constitutes a pervasive offence and infringement of women's rights. It exists in every nation without exception and transcends cultural, social, educational, economic, and racial divides. Notwithstanding the extensive research and the plethora of publications addressing this issue, the domain is devoid of a cohesive and uniform methodology to assess and contrast the prevalence of VaW among nations. Accurate measurement of this issue is essential for formulating preventive policies and methods to mitigate it. This article formulates a worldwide and multidimensional index of VaW (VAWI) encompassing 102 nations. It is a unique metric that quantifies the overall degree of Violence against Women (VaW) by aggregating data from the primary categories of VaW (physical, sexual, psychological, and economic violence) into a singular number ranging from 0 to 1, with 0 indicating total nonexistence of violence and 1 representing the furthest amount of violence within a nation. The suggested index is simple to calculate and allows for international comparison. Our primary findings indicate that the countries exhibiting the highest degrees of global VaW are Yemen, Senegal, Oman, Cameroon, and Uganda. The nations exhibiting the least amounts are the Northern European countries, Canada, and Malta. This VAWI offers a unique and significant advancement in the examination of gender-related topics. It serves the dual purpose of tracking VaW data statistics within nations over time and facilitating comparisons between countries. Moreover, it may prove beneficial in formulating novel policy measures aimed at mitigating VaW(Mojahed et al., 2022).

Gender Responsive Governance and WHO

Gender equity and social inclusion are essential, but they remain vulnerable to oversight in the formulation and execution of national One Health action plans. The recommendations issued by the Quadripartite international entities (World Health Organization, Food and Agriculture Organization of the United Nations, United Nations Environment Programmed, and World Organization for Animal Health) acknowledge these principles, yet they do not offer explicit instructions for their effective implementation at the national level. This article presents the Gender-Responsive and Inclusive Implementation Guide for National One Health Action Plans (GeRIGOH), created by the NEOH Gender Working Group, as a pragmatic resource to facilitate the incorporation of gender equity and social inclusion into national One Health action plans. It is designed for One Health professionals aiming to integrate inclusive, equity-focused strategies into One Health planning and execution. Methods: GeRIGOH adheres to the five fundamental stages outlined in the Quadripartite international organizations' Guide for executing the One Health Joint Plan of Action at the national scale: situational assessment, establishing multi-sectoral One Health coordination, strategizing for execution, carrying out the plan, and evaluating, disseminating, and progressively applying insights gained. Findings: GeRIGOH provides 32 essential yes/no enquiries and factors to facilitate equitable decision-making, inclusive stakeholder participation, equitable resource access, and thorough monitoring and evaluation systems. Conclusion: While GeRIGOH emphasises action planning at the national level, it provides ideas and enquiries that

can guide more inclusive methodologies in a broader context and acts as an essential instrument for promoting more inclusivity, sustainability, and resilience. (Garnier et al., 2025)

Infant Morality

The importance of infant mortality as a crucial measure of a country's health condition and welfare has been extensively recorded in both sociological and biological studies. Despite a continuous drop in the infant mortality rate in the United States since 1933, it remains persistently elevated compared to numerous other developed nations. The rate of decrease in the US infant mortality rate has not matched that of other developed nations. In 1988, the United States was positioned 23rd globally in terms of infant mortality, whereas in 1960, it had the 12th rank internationally Forty-five. The United States' comparatively poor international status regarding newborn mortality largely arises from the significant racial (Black/White) gap in infant survival rates and the longstanding socioeconomic disparities present in the nation. Significant disparities in newborn mortality rates among Whites, Blacks, and several other racial/ethnic groupings have been thoroughly recorded. Significant disparities in infant mortality have been observed concerning critical socioeconomic factors such as schooling and household income. Negative eleven Moreover, the prolonged trends in the reduction of newborn mortality in the United States have not been consistent across different socioeconomic and demographic subgroups, nor in the causes of baby fatalities.6A A thorough examination of historical trends, current conditions, and future trajectories of infant mortality is essential for crafting effective maternal and child health initiatives and policies, as well as for shaping complete national health strategies(Newman, 1907).

From 2005 to 2014, the rate of infant mortality decreased for all significant racial and ethnic demographics, with the exception of infants born to AIAN women. Throughout these years, disparities remained across various population segments. Between 2005 and 2014, the most elevated infant death rates were recorded for newborns born to non-Hispanic black women, while the lowest rates were noted for children born to Asian and Pacific Islander women. Infants born to Puerto Rican moms exhibited the greatest rates of infant mortality among Hispanic women. Reductions in infant mortality rates were noted in two-thirds of all U.S. states and Washington, D.C. Between 2005 and 2014, infant mortality rates decreased for four out of the five primary causes of death, although there were no notable alterations in the rates by cause of death over the past year (Mathews, T. J., & Driscoll, A. K. 2017).

Legal Frame Work on Gender Base Violence

The Declaration on the Elimination of Violence Against Women (UN General Assembly, 1993, henceforth DEVAW) characterizes gender-based violence (GBV) as “any act of violence that leads to, or has the potential to lead to, physical, sexual, or psychological injury or distress for women, encompassing threats of such actions, coercion, or unjust restrictions on freedom, regardless of whether they transpire in public or private spheres” (Article 1). This form of violence acknowledges the entrenched social and cultural frameworks, norms, and values that regulate society, frequently sustained by a culture of denial and silence.

The UN Office on Drugs and Crime (UNODC) reported in 2017 that the global female homicide rate was roughly 2.3 per 100,000 women, with 87,000 women intentionally murdered, predominantly by male suspects, and the majority of these killings occurred within intimate or familial contexts, where 58 percent of female victims were killed by a partner or male relative, one-third by a former or current partner, and women constituted 82 percent of all homicides perpetrated by intimate partners (UNODC, 2018, pp. 1-2). The survey additionally emphasized that victims have often endured non-fatal gender-based violence, with most incidents representing

the culmination of interpersonal or domestic abuse. The continual prevalence of GBVF is undoubtedly alarming.

Global Declaration of Human Rights: Although the initial human rights legislation established by the UN did not explicitly address violence against women, it remains pertinent. One of these statutes encompasses the 1948 Universal Declaration of Human Rights (UN General Assembly, 1948, henceforth UDHR), which was initially non-binding for member nations. It has garnered extensive recognition as the framework for essential human rights principles, leading to its current status as a binding manifestation of customary law and a definitive interpretation of the UN's foundational treaty, the United Nations Charter (UN, 1945). At the moment of the UDHR's ratification, there was widespread agreement that the rights enshrined should be codified into legal treaties, so obligating the States that consented to their provisions. This resulted in protracted discussions within the Commission on Human Rights, a political entity made up of State delegates, which convened annually in Geneva until 20065 to address a broad spectrum of human rights matters (UN General Assembly, 2006).

Conclusion:

Universal Declaration of Human Rights while the original human rights framework instituted by the UN did not specifically tackle violence against women, it continues to be relevant. One of these laws includes the 1948 Universal Declaration of Human Rights (UN General Assembly, 1948, hereafter referred to as UDHR), which was originally non-enforceable for member states. It has received widespread acknowledgement as the foundation for fundamental human rights tenets, resulting in its present role as a binding expression of customary law and a conclusive elucidation of the UN's principal treaty, the United Nations Charter (UN, 1945). Upon the ratification of the UDHR, there was a broad consensus that the rights articulated should be formalized into legal treaties, thereby binding the States that agreed to their stipulations. This led to extended deliberations inside the Commission on Human Rights, a political body composed of State representatives, which met annually in Geneva to tackle a wide range of human rights issues

Bibliography

Alaswad, N. K., Hassan, S. M. S., Elhay, H. A. A., Ahmed, M. R., & Ali, A. A. M. (2026). Domestic violence's impact on maternal–child relationship and child behavior: A nursing study from Egypt. *BMC Psychology*, *14*(1), 85.

Garnier, J., Griffith, E. F., Maudling, R., Becerra, N. C., Boriani, E., Berger, C., Bagnol, B., Savic, S., & Charron, D. (2025). Toward more equitable One Health: A Gender Responsive and Inclusive Implementation Guide for National One Health Action Plans (GeRIGOH). *CABI One Health*, *4*(1), 0037.

Gerdts, C., Bell, S. O., Shankar, M., Jayaweera, R. T., & Owolabi, O. (2022). Beyond safety: The 2022 WHO abortion guidelines and the future of abortion safety measurement. *BMJ Global Health*, *7*(6).

Hervías Parejo, V., & Radulović, B. (2023). Public policies on gender equality. In *Gender-competent legal education* (pp. 405–428). Springer.

Kerr, G. (2022). What Is Gender-Based Violence? In *Gender-based violence in children's sport* (pp. 33–45). Routledge.

Lutwak, N. (2024). The psychology of health and illness: The mental health and physiological effects of intimate partner violence on women. In *The Psychology of Health and Illness* (pp. 105–119). Routledge.

Moghadam, V. M. (2003). *Modernizing women: Gender and social change in the Middle East*. Lynne Rienner Publishers.

Mojahed, A., Alaidarous, N., Shabta, H., Hegewald, J., & Garthus-Niegel, S. (2022). Intimate partner violence against women in the Arab countries: A systematic review of risk factors. *Trauma, Violence, & Abuse*, *23*(2), 390–407.

Moshtagh, M., Amiri, R., Sharafi, S., & Arab-Zozani, M. (2023). Intimate partner violence in the Middle East region: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *24*(2), 613–631.

Newman, G. (1907). *Infant mortality: A social problem*. EP Dutton and Company.

Peterman, A. (2026). Edutainment to prevent violence against women and children. *The World Bank Research Observer*, *41*(1), 78–117.

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet*, *399*(10327), 803–813.

Spencer, C. M., Keilholtz, B. M., Palmer, M., & Vail, S. L. (2024). Mental and physical health correlates for emotional intimate partner violence perpetration and victimization: A meta-analysis. *Trauma, Violence, & Abuse*, *25*(1), 41–53.

Stubbs, A., & Szoeke, C. (2022). The effect of intimate partner violence on the physical health and health-related behaviors of women: A systematic review of the literature. *Trauma, Violence, & Abuse*, *23*(4), 1157–1172.

van Daalen, K. R., Kallesøe, S. S., Davey, F., Dada, S., Jung, L., Singh, L., Issa, R., Emilian, C. A., Kuhn, I., & Keygnaert, I. (2022). Extreme events and gender-based violence: A mixed-methods systematic review. *The Lancet Planetary Health*, *6*(6), e504–e523.

Wenham, C., & Davies, S. E. (2022). WHO runs the world–(not) girls: Gender neglect during global health emergencies. *International Feminist Journal of Politics*, *24*(3), 415–438.

World Health Organization. (2023). *Guidance note on integrating health equity, gender equality, disability inclusion and human rights in WHO evaluations*. World Health Organization.

Cirici Amell, R., Soler, A. R., Cobo, J., & Soldevilla Alberti, J. M. (2023). Psychological consequences and daily life adjustment for victims of intimate partner violence. *The International Journal of Psychiatry in Medicine*, *58*(1), 6-19.

Mathews, T. J., & Driscoll, A. K. (2017). *Trends in infant mortality in the United States, 2005-2014.*