World Health Organization

Violence and Injury Prevention

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Violence against women: a priority health issue

Introduction

Violence against women presents a global overview of violence against women, particularly as it pertains to the health of women and girls. The package focuses on violence in families, rape and sexual assault, violence against women in situations of conflict and displacement, as well as violence against the girl child. The consequences of violence on women's health and the role that public health workers can play in multi-sectoral efforts to end the violence are explored. A sample of governmental and non-governmental activities taking place worldwide to end violence against women and alleviate its consequences are also highlighted.

World Health Assembly Resolution 49.25, which proclaims violence to be a public health issue, is found in the package. Information on other international conventions, covenants, and declarations that recognize violence against women as a health and human rights issue and call for concerted action by governments are also included.

The recognition of violence as a public health issue requires that WHO develop appropriate public health guidelines and standards. This demands extensive consultation and planning. The current document is intended to be an information tool to further discussions and actions to curb violence against women. It confirms WHO's commitment to addressing this most urgent problem.

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Definition and scope of the problem

Violence against women and girls is a major health and human rights issue. At least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life. Many, including pregnant women and young girls, are subject to severe, sustained or repeated attacks.

Worldwide, it has been estimated that violence against women is as serious a cause of death and incapacity among women of reproductive age as cancer, and a greater cause of ill-health than traffic accidents and malaria combined.[1]

The abuse of women is effectively condoned in almost every society of the world. Prosecution and conviction of men who beat or rape women or girls is rare when compared to numbers of assaults. Violence therefore operates as a means to maintain and reinforce women's subordination.

United Nations definition

The Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993, defines

violence against women as "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 private life".2 It encompasses, but is not limited to, "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; 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; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."

Why are definitions and measurements important?

Accurate and comparable data on violence are needed at the community, national and international levels to strengthen advocacy efforts, help policy makers understand the problem and guide the design of interventions.

Measuring the true prevalence of violence, however, is a complex task. Statistics available through the police, women's centres, and other formal institutions often underestimate levels of violence because of under-reporting.

Population-based research is more accurate, but the lack of consistent methods and definitions makes comparisons across studies difficult. Because definitions are subjective, survey questions often ask whether women experience specific acts of violence, during a fixed period of time. While some studies examine only physical abuse, others may consider physical, sexual and psychological abuse. In family violence research, some may include only those women currently in a relationship, while others report on women who have ever been married.

The severity of violence recorded may also vary between studies. For example, one researcher may record all violence regardless of whether it results in bodily injury, whereas another researcher may record only incidents in which a physical injury occurred.

Violence across the life span

Violence has a profound effect on women. Beginning before birth, in some countries, with sex-selective abortions, or at birth when female babies may be killed by parents who are desperate for a son, it continues to affect women throughout their lives. Each year, millions of girls undergo female genital mutilation. Female children are more likely than their brothers to be raped or sexually assaulted by family members, by those in positions of trust or power, or by strangers. In some countries, when an unmarried woman or adolescent is raped, she may be forced to marry her attacker, or she may be imprisoned for committing a "criminal" act. Those women who become pregnant before marriage may be beaten, ostracized or murdered by family members, even if the pregnancy is the result of a rape.

After marriage, the greatest risk of violence for women continues to be in their own homes where husbands and, at times, in-laws, may assault, rape or kill them. When women become pregnant, grow old, or suffer from mental or physical disability, they are more vulnerable to attack. Women who are away from home, imprisoned or isolated in any way are also subject to violent assaults. During armed conflict, assaults against women escalate, including those committed by both hostile and "friendly" forces.

Violence against women throughout the life cycle

Phase	*Type of violence*
Pre-birth	Sex-selective abortion; effects of battering during pregnancy on birth outcomes
Infancy	Female infanticide; physical , sexual and psychological abuse
Girlhood	Child marriage; female genital mutilation; physical, sexual and psychological abuse; incest; child prostitution and pornography
Adolescence and adulthood	Dating and courtship violence (e.g. acid throwing and date rape); economically coerced sex (e.G. school girls having sex with "sugar daddies" in return for school fees); incest; sexual abuse in the workplace; rape; sexual harassment; forced prostitution and pornography; trafficking in women; partner violence; marital rape; dowry abuse and murders; partner homicide; psychological abuse; abuse of women with disabilities; forced pregnancy
Elderly	Forced "suicide" or homicide of widows for economic reasons; sexual, physical and psychological abuse

Prevention of violence: a public health priority

During the Forty-ninth World Health Assembly in 1996, Member States agreed that violence is a public health priority. Resolution WHA 49.25 endorses recommendations made at prior international conferences to tackle the problem of violence against women and girls, and to address its health consequences.

An issue for health workers

- Three reasons why violence against women should be a priority issue for health workers are:
- violence causes extensive suffering and negative health consequences for a significant proportion of the female population (more than 20% in most countries); it has a direct negative impact on several important health issues, including safe motherhood, family planning, and the prevention of sexually transmitted diseases and HIV/AIDS;
- for many women who have been abused, health workers are the main, and often the only, point of contact with public services which may be able to offer support and information.

In this package, What health workers can do explores the role of the health worker in a multi-sectoral response.

1. World Bank. World Development Report 1993: investing in health. New York, Oxford University Press, 1993.
2. Declaration on the elimination of violence against women. New York, United Nations, 23 February 1994 (Resolution No. A/RES/48/104).

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Violence against women in families

The most common form of violence against women is domestic violence, or violence against women in families. Research consistently demonstrates that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person.[1]

Men may kick, bite, slap, punch or try to strangle their wives or partners; they may burn them or throw acid in their faces; they may beat or rape them, with body parts or sharp objects; and they may use deadly weapons to stab or shoot them. At times, women are seriously injured, and in some cases they are killed or die as a result of their injuries.

The nature of violence against women in families has prompted comparisons to torture.[2] The assaults are intended to injure women's psychological health as well as their bodies, and often involve humiliation as well as physical violence. Also like torture, the assaults are unpredictable and bear little relation to women's own behaviour. Finally, the assaults may continue week after week, for many years.

Physical abuse

In every country where reliable, large-scale studies have been conducted, results indicate that between 16 and 52 percent of women have been assaulted by an intimate partner (see table). Although national data are scarce, there are a growing number of community-based and small-scale studies which indicate widespread violence against women is an important cause of morbidity and mortality.

It is likely that these studies, from both industrialized and developing countries, underestimate the problem for many reasons. Some women may believe that they deserve the beatings because of some wrong action on their part. Other women refrain from speaking about the abuse because they fear that their partner will further harm them in reprisal for revealing "family secrets", or they may be ashamed of their situation. Furthermore, in many countries there are no legal or social sanctions against violence by an intimate partner. Considering these factors, estimates of the prevalence of physical abuse by a partner are probably conservative.

Rape in intimate relationships

Physical attacks by a partner may include rape and sexual violence. Women in many societies, however, do not define forced sex as rape if they are married to, or living with, the attacker. Although some countries have now recognized marital rape as a criminal offence, others still argue that husbands have a legal right to unlimited sexual access to their wives.

Surveys in a number of countries show that from 10 to 15 percent of women report being forced to have sex by their intimate partner. Among women who are physically assaulted in their relationship, the figures are higher.

Psychological or mental violence

Psychological violence includes repeated verbal abuse, harassment, confinement, and deprivation of physical, financial and personal resources. For some women, the incessant insults and tyrannies which constitute emotional abuse may be more painful than the physical attacks because they effectively undermine women's security and self-confidence. A single occurrence of physical violence may greatly intensify the meaning and impact of emotional abuse. Women have been reported as saying that the worst aspect of battery was not the violence itself but the "mental torture" and "living in fear and terror".

Failures of detection

There has been a failure in most countries to identify and provide support to women suffering from domestic violence. This is due, in part, to the fact that if women do seek help it is from neighbours or family members, not the police or health services. A number of studies have shown that shame or fear of reprisal often prevents women from reporting an attack to authorities, or even speaking to friends about it. Some fear that if their injuries are reported, their children will be taken away by child protection services. Those services which could provide support, such as the police or health care, often do not identify women suffering from violence, or they are unable to respond adequately. They may not be trained to deal with the problem or know where to refer women seeking help. They may be afraid of confronting the problem, or be ill-equipped to deal with the complex situation surrounding the woman who has suffered violence.

Health consequences

The consequences of violence against women may be non-fatal in the form of physical injuries, ranging from minor cuts and bruises to chronic disability, or mental health problems. They may also be fatal; either by intentional homicide, by death as a result of injuries sustained or AIDS, or by suicide, used as a last resort to escape violence. In this package, Health consequences of violence against women and girls explores the issue in more depth.

Initiatives against violence

A growing awareness of the issue of violence against women in families, spearheaded by the efforts of hundreds of women's organizations from around the world, has resulted in a range of initiatives dealing with the problem at almost every level of society. Many of these are under-funded endeavors which are able to help a fraction of the women who need them. Despite this, they do indicate what can be achieved on a wide scale, given the political will.

- *Support groups* where battered women can share experiences have proved, in Argentina, Australia, Costa Rica, India, Japan, Liberia and other countries, to be an effective way of helping women end or cope with their violent relationships.
- *Local community involvement* in the reporting and rebuking violent husbands is having some success in Belize, India and among Aboriginal people of Canada.
- *Women's police stations* have been set up throughout Latin America and in a number of Asian countries to provide a more committed and concerned response to crimes against women.
- *Courses in non-violent parenting* and conflict resolution, for adults and children, are available in an increasing number of countries, including Jamaica and Canada.
- *Legal literacy programmes* and free legal advice encouraging battered women to press charges is being tried in Nicaragua, Costa Rica and Uganda.
- *Sensitivity training* for health professionals and the police, and the adoption of new protocols for dealing with the victims of domestic violence, has been introduced in Zimbabwe, the United States, Brazil and elsewhere.
- *Safe-houses and shelter*s, for women leaving abusive partners, have been set up in Egypt, Paraguay, El Salvador, Malaysia, the United Kingdom, Canada and other countries.

1. Council on Scientific Affairs, American Medical Association, Violence against women: relevance for medical practitioners, Journal of the American Medical Association, 1992, 267(23).
2. United Nations Economic and Social Council, Report of the Special Rapporteur on violence against women, E/CN.4/1996/53, February 1996.
3.PROFAMILIA, Encuesta de Prevalencia, Demografía y Salud, Demographic and Health Survey, Bogotá, Colombia, 1990.
4. Mooney J, The hidden figure: domestic violence North London. School of Sociology and Social Policy, Middlesex University, London, England, 1995.
5. Randall M, Haskell L. Sexual violence in women's lives: findings from The Women's Safety Project, a community-based survey. Violence against women, March 1995, 6-31.

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Violence Against Women Table

Domestic violence against women

Industrialized Countries		
Canada Statistics Canada (1993)	Nationally representative sample of 12,300 women, aged 18 years and older.	29% of ever-married/common law-partnered women report being physically assaulted by a current or former partner since the age of 16.
New Zealand Mullen et al (1988)	Random sample of 314 women selected from five districts.	20% report being hit or physically abused by a male partner.
Switzerland Gillioz et al (1997)	Sample of 1,500 women, aged 20- 60, in a relationship.	20% report being physically assaulted.
United Kingdom Mooney (1995)	Random sample of women in the London Borough of Islington.	25% of women had been punched or slapped by a partner or ex-partner in their lifetime.
United States Straus and Gelles (1986)	Nationally representative sample of married or cohabiting couples.	28% of women report at least one episode of physical violence from their partner.
Asia and the Pacific		
Cambodia Nelson and Zimmerman (1996)	Nationally representative sample of women and men, aged 15-49.	16% of women report being physically abused by a spouse; 8% report being injured.
India Narayana (1996)	Systematic, multi-stage sample of 6,902 married men, aged 15-65, in five districts of Uttar Pradesh.	18-45% percent of currently married men acknowledge physically abusing their wives, depending on the district studied.
Korea Kim and Cho (1992)	Stratified random sample of entire country.	38% of wives report being physically abused by their spouse in the last year.

Thailand Hoffman et al (1994)	Representative sample of 619 husbands with at least one child residing in Bangkok.	20% of husbands acknowledge physically abusing their wives at least once in their marriage.
Middle East		
Egypt El-Zanaty et al (1995)	Nationally representative sample of ever married women, aged 15-49.	35% of women report being beaten by their husband at some point in their marriage.
Israel Haj-Yahia (1997)	Systematic random sample of 1,826 married Arab women (excluding Bedouin) in Israel.	32% of women report at least one episode of physical abuse by their partner during the last 12 months; 30% report sexual coercion by their husbands in the last year.
Africa		
Kenya Raikes (1990)	Representative sample of 612 married women in Kissi District.	42% of women report ever being beaten by a partner, of those, 58% report that they were beaten often or sometimes.
Uganda Blanc et al (1997)	Representative sample of women, aged 20-44, and their partners in two districts, Masaka and Lira.	41% of women report being beaten or physically harmed by a partner; 41% of men report beating their partner.
Zimbabwe Watts (1996)	Representative sample of 966 women over 18 years in Midlands province.	32% report physical abuse by a family or household member since the age of 16.
Latin America and the Caribbean		
Chile Larrain (1993)	Representative sample of women, aged 22-55, from Santiago, in a relationship for more than two years.	26% report at least one episode of violence by a partner, 11% report at least one episode of severe violence and 15% of women report at least one episode of less severe violence.
Colombia DHS III Survey (1995)	Nationally representative sample of 6,097 women in a relationship, aged 15- 49.	19% of women have been physically assaulted by their partner in their lifetime.
Mexico Rodriguez and Becerra (1997)	Representative sample of 650 ever married/partnered women from Metropolitan Guadalajara.	30% report at least one episode of physical violence by a partner; 13% report physical violence within the last year.
Mexico Shiroma (1996)	Representative sample of ever-married/partnered women, 15 years or older, from Monterrey.	16% of women ever married or partnered report physical abuse since the age of 15.
Nicaragua Ellsberg et al (1996)	Representative sample of ever-married women, aged 15- 49, from Nicaragua's second largest city, León.	52% report being physically abused by a partner at least once; 27% report physical abuse in the last year.

1. Blanc A, et al. *Negotiating reproductive outcomes in Uganda*. Kampala, Uganda, Institute of Statistics and Applied Economics, and Calverton, MD, Macro International, 1996.
2. *Colombia Demographic Health Surveys (DHS) III*. Colombia, Profamilia and Calverton MD, Macro International, 1995.
3. Ellsberg M, et al. *Confites en el infierno: prevalencia y caracteristícas de la violencia conyugal hacia las mujeres en Nicaragua*. Managua, Asociación de Mujeres Profesionales por la Democracia en el Desarrollo, 1996.
4. El-Zanaty F, et al. *Egypt Demographic and Health Surveys III*. Cairo, National Population Council and Calverton MD, Macro International, 1996.
5. Gillioz L, et al. *Domination et violences envers les femmes dans la couple*. Lausanne: Editions Payot, 1997.
6. Haj-Yahia M. *The first national survey of abuse and battering against Arab women from Israel: preliminary results*. Unpublished, 1997.
7. Hoffman K, et al. Physical wife abuse in a non-Western society: an integrated theoretical approach. *Journal of marriage and the family*, 1994, 56:131-146.
8. Kim K, Cho Y. Epidemiological survey of spousal abuse in Korea. In: Viano C, ed. *Intimate violence: interdisciplinary perspectives*. Washington DC, Hemisphere Publishing Corporation, 1992.
9. Larrain S. *Estudio de frecuencia de la violencia intrafamiliar y la condición de la mujer en Chile*. Santiago, Pan American Health Organisation, 1993.
10. Mooney J. *The hidden figure: domestic violence in North London*. Middlesex University, School of Sociology and Social Policy, London, 1993.
11. Mullen P, et al. Impact of sexual and physical abuse on women's mental health. *Lancet*, 1988, 1:841-845.
12. Narayana G. *Family violence, sex and reproductive health behaviour among men in Uttar Pradesh, India*. Paper presented at the Annual Meeting of the National Council on International Health, June 1996, Arlington, VA, USA.
13. Nelson E, Zimmerman C. *Household survey on domestic violence in Cambodia*. Cambodia Ministry of Women's Affairs, Project Against Domestic Violence, 1996.
14. Raikes A. *Pregnancy, birthing and family planning in Kenya: changing patterns of behaviour. A health utilisation study in Kissi District*. Copenhagen, Centre for Development Research, 1990.
15. Rodgers K. Wife assault: the findings of a national survey. *Juristat service bulletin*, Statistics Canada, 1994, 14(9):8-9.
16. Rodriguez J, Becerra P. *Que tan serio en el problema de la violencia domestica contra la mujer? Algunos datos para la discusión*. VII Congreso Naciónal de Investigación en Salud Publica, 2-5 de Marzo 1997.
17. Shiroma M. *Salud reproductiva y violencia contra la mujer: un análisis desde la perspectiva de género*. Asociación Mexicana de Población, Consejo Estatal de

Población, Nuevo León, El Colegio de México, 1996.

18. Straus M, Gelles R. Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of marriage and the family*, 1986, 48:465-479.
19. Watts C, Ndlovu M, Keogh E. *The magnitude and health consequences of violence against women in Zimbabwe*. Musasa Project Report, 1997.

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Rape and sexual assault

Large-scale studies of rape and sexual assault are scarce. Those that do exist, however, consistently report high prevalence rates. Research conducted in industrialized countries has shown that the likelihood of a woman being raped or having to fight off an attempted rape is high. In developing countries, research suggests that rape is an ever-present threat and reality for millions of women.

Six separate investigations suggest that between 14% and 20% of women in the United States will experience a completed rape at least once in her lifetime.[1,2]

In a random sample of 420 women in Toronto, Canada, 40% reported at least one episode of forced sexual intercourse since the age of 16.[3]

Although rape and sexual assault may be perpetrated by strangers, evidence from many sources indicates that a high percentage of rapists are acquaintances, "friends", relatives, and those in positions of trust or power. Another consistent finding is the high percentage of young, and often very young, rape victim (see table). Many sexual assaults are perpetrated by more than one attacker. "Gang rape", where two or more men subdue and penetrate their victims, is not uncommon.

Women are also subject to what has been termed "non-contact" sexual abuse in which, for example, men expose their penises or make obscene telephone calls. Where non-contact abuse has been studied, it has been discovered that a high percentage of women have experienced this type of abuse; in some cases up to 50% of all women questioned.

Statistics on sex crimes [a]

Country	*Attackers known to victim (%)*	*Victims aged 15 or less (%)*	*Victims aged 10 or less (%)*
Peru (Lima)	60	-	18b
Malaysia	68	58	18c
Mexico (City)	67	36	23
Guatemala (City)	61	40	-
Papua New Guinea	-	47	13d
Chile (Santiago)	72	58	32
United States	78	62	29

Adapted from: Heise, L. Violence against women: The hidden health burden. World health statistics quarterly, 1993, **46**(1): 78-85.
a Includes attempted and completed rape and sexual assaults such as molestation, except for the US data which is for completed rape only.
b Percentage of survivors aged nine or less.
c Percentage of survivors aged six or less.
d Percentage of survivors aged seven or less.

Women in custody

Often, women who enter prisons are already victims of violence.

In a study of more than 300 women in federal prisons in Canada, 68% of all women, and 90% of Aboriginal women reported physical abuse at some time in their lives.[4]

Violence against women who are in custody in institutions and prisons may be widespread. The nature of abuse ranges from physical or verbal harassment to sexual and physical torture. Various reports on women in custody have shown that women are stripped, shackled and their body cavities searched by male guards. Women from many countries report being raped while in detention centres.[5] Incarceration, intended as a time for reform from criminal activities, then becomes one more episode of victimization. The psychological and physical sequelae of this violence are further compounded by feelings of helplessness, and a general unavailability of medical care and support services.

Trafficking in women, forced prostitution

Each year, thousands of women throughout the world are tricked, coerced, abducted or sold into slavery-like conditions and forced to work as prostitutes, domestic workers, sweatshop labourers or wives. Reports of involvement in international trafficking by state officials and police were routinely received by the United Nations Special Rapporteur on violence against women during her

investigation into this issue.[6]

Violence against women domestic workers

Domestic workers are vulnerable to violent assaults, including physical abuse and rape, by their employers. Migrant women are especially at risk as employers may withhold salaries, passports and personal documents. This limits workers' movement in those countries where aliens are required to carry proof of their legal status, thus impeding any attempts to claim protection at their embassies.

In some countries, domestic workers are not covered by labour laws. Where laws are in place, workers may not be informed of their rights, especially in countries where the host language is unknown to them or they are separated from their social group.[7]

Many women keep the violence a secret

Women who are the victims of sexual violence are often reluctant to report the crime to police, family or others. In countries where a woman's virginity is associated with family honour, unmarried women who report a rape may be forced to marry their attacker. Some may be murdered by their shamed fathers or brothers, as a way of restoring family honour. In some countries, a woman who has been raped may be prosecuted and imprisoned for committing the "crime" of sex outside of marriage, if she cannot prove that the incident was in fact rape.

Some responses to the problem

Women who do disclose abuses are often advised to restrict their movements or adapt their clothing so as to avoid "tempting" men to attack them. This approach is inadequate because it wrongly assumes that men are unable to control their sexual impulses. It also ignores the fact that many rapes are committed in women's own homes, frequently by men whom they know.

A review of Commonwealth government initiatives to combat violence against women has pointed to the relative paucity of campaigns dealing with rape and sexual assault, as compared, for example with wife-battering and sexual harassment.[8] However, women's groups in many countries are offering support across a range of women's issues, including rape and sexual assault, along with domestic violence and child sexual abuse.

- *Survivor groups and rape crisis centres* have been set up in some countries where women can work together to try and overcome their trauma
- *Special rape crisis rooms* have been set up in hospitals in El Salvador and police stations in the United Kingdom for victims to be examined and questioned in privacy
- *Woman police officers* have been recruited and trained specifically to deal with victims of rape and sexual abuse in Bangladesh and Malaysia
- *Theatrical performances* followed by discussions in school and community settings are exploring issues relating to rape in Jamaica
- *Rape crisis telephone lines* have been established in many countries, providing anonymous counselling and support for victims
- *Complaints about violent sexual themes* on television and radio, and in the press are fuelling public debate on these issues in Jamaica.

(See What health workers can do for ways in which health workers can help women and girls who are victims of violence.)

1. Koss M, Gidyez C A, Wisniewski N, The scope of rape: incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. Journal of consulting and clinical psychology, 1987, 55.
2. Kilpatrick DG, Edmunds CN, Seymour AK, Rape in America: a report to the nation. Arlington, VA, The National Victim Center,1992
3. Randall M, Haskell L. Sexual violence in women's lives: findings from The Women's Safety Project, a community-based survey. Violence against women, March 1995, 6-31.
4. Shaw M. The survey of federally sentenced women, as cited in The Arbour Report, Correctional Services of Canada, 1996.
5. United Nations, Economic and Social Council, Report of the Special Rapporteur on violence against women, its causes and consequences, 22 November 1994, E/CN.4/1995/42.
6. United Nations, Economic and Social Council, Report of the Special Rapporteur on violence against women, its causes and consequences, 12 February 1997, E/CN.4/1997/47.
7. Punishing the victim, rape and mistreatment of Asian maids in Kuwait. Middle East Watch, Women's Rights Project, August, 1992, 4(8).
8. Commonwealth Secretariat, Confronting Violence: A Manual for Commonwealth Action, Women and Development Programme, Commonwealth Secretariat, London, UK, 1992.

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Situations of armed conflict and displacement

Armed conflict and uprootedness bring their own distinct forms of violence against women with them. These can include random acts of sexual assault by both enemy and "friendly" forces, or mass rape as a deliberate strategy of genocide.

Some forms of violence resulting from conflict/refugee situations

- Mass rape, military sexual slavery, forced prostitution, forced "marriages" and forced pregnancies
- Multiple rapes and gang rape (with multiple perpetrators) and the rape of young girls
- Sexual assault associated with violent physical assault
- Resurgence of female genital mutilation, within the community under attack, as a way to reinforce cultural identity
- Women forced to offer sex for survival, or in exchange for food, shelter, or "protection"

Increased violence against women during conflict

The general breakdown in law and order which occurs during conflict and displacement leads to an increase in all forms of violence. The tensions of conflict, and the frustration, powerlessness and loss of traditional male roles associated with displacement may be manifested in an increased incidence of domestic violence against women. Alcohol abuse may also become more common and exacerbate the situation.

The underlying acceptance of violence against women which exists within many societies becomes more outwardly acceptable in conflict situations. It can, therefore, be seen as a continuum of the violence that women are subjected to in peacetime. The situation is compounded by the polarization of gender roles which frequently occurs during armed conflict. An image of masculinity is sometimes formed which encourages aggressive and misogynist behaviour. On the other hand, women may be idealized as the bearers of a cultural identity and their bodies perceived as 'territory' to be conquered. Troops may also use rape and other forms of violence against women to increase men's subjugation and humiliation.

Who is most vulnerable?

Some groups of women and girls are particularly vulnerable in conflict and displacement situations. These include targeted ethnic groups, where there is an official or unofficial policy of using rape as a weapon of genocide. Unaccompanied women or children, children in foster care arrangements, and lone female heads of households are all frequent targets. Elderly women and those with physical or mental disabilities are also vulnerable, as are those women who are held in detention and in detention-like situations including concentration camps.

Health consequences

Besides the many physical and psychological consequences of violence against women (see sheet on Health consequences), the impact on the "social health" of a community is both negative and widespread. Social bonds may be broken as women isolate themselves or are isolated by their families and communities. A legacy of bitterness towards the perpetrators may make reconciliation and community reconstruction particularly difficult.

Impact on health systems

In situations of war, the existing health services are usually over stretched and at best functioning at reduced levels. In addition, they are expected to cope with a greatly increased number of injuries because of widespread violence.

Health systems need training support to enable them to deal with such situations. Two useful documents on how to support and help victims of violence in conflict and displacement situations have been produced by the International Federation of Red Cross and Red Crescent Societies and the United Nations High Commission for Refugees (see below).

Sources:
Sexual violence against refugees, Guidelines on prevention and response. Geneva, United Nations High Commission for Refugees, 1995.
Swiss S, Giller J. Rape as a crime of war: a medical perspective. Journal of the American Medical Association, 1993, 270:612-615.
Working with victims of organized violence from different cultures. The International Federation of Red Cross and Red Crescent Societies,1995.
Zwi A, Ugalde A. Towards an epidemiology of political violence in the Third World. Social science and medicine, 1989, 28(7):649-657.

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The girl child

The earliest years of a person's life are supposed to be a time of carefree exploration, growth and support. For millions of girls around the world the reality is quite different. Violence against the girl child includes physical, psychological and sexual abuse, commercial sexual exploitation in pornography and prostitution, and harmful practices such as son preference and female genital mutilation.

Sexual abuse of children

Child sexual abuse is an abuse of power that encompasses many forms of sexual activity between a child or adolescent (most often a girl) and an older person, most often a man or older boy known to the victim. The activity may be physically forced, or accomplished though coercive tactics such as offers of money for school fees or threats of exposure. At times, it may take the form of breach of trust in which an individual, such as a religious leader, teacher or doctor, who has the confidence of the child, uses that trust to secure sexual favours.

Studies have shown that between 36% and 62% of all sexual assault victims are aged 15 or less (see table in Rape and sexual assault information sheet). Research suggests that the sexual abuse of children is commonplace.

Incest, sexual abuse occurring within the family, although most often perpetrated by a father, stepfather, grandfather, uncle, brother or other male in a position of family trust, may also come from a female relative. As with sexual abuse, incest is accomplished by physical force or by coercion. Incest takes on the added psychological dimension of betrayal by a family member who is supposed to care for and protect the child.

Research in Kinston, Jamaica, reported that 17% of a random sample of 452 primary school girls, ages 13-14, had experienced attempted or completed rape, half before the age of 12. 1

In a study of 1193 randomly selected ninth grade students in Geneva, Switzerland, 20% of the girls and 3% of the boys reported at least one incident of sexual abuse involving physical contact. 2

A general unwillingness to acknowledge the extent of child sexual abuse exists in many societies. Attempts to downplay the prevalence and nature of child abuse often blame the victim or the victims' mother for the violence. Accusations against the child include the idea that the child invites the abuse or that she imagines it. The mother may be blamed for "causing" the abuse by refusing to have sex with the abuser, or for "colluding" by not realising or reporting what was going on.

Attention is often focused on commercialized paedophilia, which while important, distracts attention from the more widespread problem of incest and sexual abuse.

Commercial exploitation

The commercial exploitation of children occurs in many settings. The problem includes child prostitution and pornography, the trafficking of children for sexual purposes, and bonded labour.

Many factors can conspire to push children into exploitative and abusive situations. Well documented cases show that families are often deceived by the promise of job opportunities for their children. Sometimes, girls are sent away from home to work and become subject to physical and sexual abuse.

Street children may be at particular risk. With no means of economic or social support, they may be forced to rely on prostitution for survival. They also lack the basic protection that a home and family can offer, thus making them more vulnerable to violent attack on the street.3

Female genital mutilation (FGM)

Today, the number of girls and women who have been subjected to FGM is estimated at more than 130 million individuals worldwide, and a further two million girls are at risk of this practice.4

FGM, a form of violence against the girl child that affects her life as an adult woman, is a traditional cultural practice. In those societies where it is practiced, it is believed that FGM is necessary to ensure the self-respect of the girl and her family and increases her marriage opportunities.

FGM constitutes all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons. FGM is discussed extensively in the WHO document, Female Genital Mutilation (see sheet on Selected readings).

Son preference

In most societies, a higher value is placed on sons. In extreme cases, the reduced status of daughters may result in violence. Prenatal sex selection can result in a disproportionate number of abortions of female, as compared with male, foetuses. After birth, in families where the demand for sons is highest, infanticide of female infants may be practiced.5

Other forms of discrimination

Son preference may manifest in other practices which are discriminatory against girls. These practices include:

- neglect of girls, more so than boys, when they are sick;
- differential feeding of girls and boys;
- a disproportionate burden of housework for girls, from a very young age;
- less access to education for girls than their brothers.6

1. Walker S et al. National and heath determinants of school failure and dropout adolescent girls in Kingston, Jamaica. Washington, DC: International Center for Research on Women. Nutrition of Adolescent Girls Research Program, No. 1, 1994.
2. Halpérin D et al. Prevalence of child sexual abuse among adolescents in Geneva: results of a cross sectional survey. British Medical Journal, 1996, 312: 1326-9.
3. World Health Organization. Commercial sexual exploitation of children: the health and psychosocial dimensions. Paper presented at the World Congress Against Sexual Exploitation of Children, Stockholm, Sweden, 27-31 August, 1996.
4. World Health Organization. Female genital mutilation: report of a WHO technical working group, Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996, WHO/FRH/WHD/ 96.10.
5. Ravindran S. Health implications of sex discrimination in childhood, World Health Organization, UNICEF, 1986.
6. Ravindran S. Health implications of sex discrimination in childhood, World Health Organization, UNICEF, 1986.

Health consequences

Violence against women and girls increases their risk of poor health. A growing number of studies exploring violence and health consistently report negative effects. The true extent of the consequences is difficult to ascertain, however, because medical records usually lack vital details concerning any violent causes of injury or poor health.

Physical consequences

Homicide

Numerous studies report that most women who die of homicide are killed by their partner or ex-partner.

A study of 249 court records in Zimbabwe revealed that 59% of homicides of women were committed by the intimate partner of the victim.[1]

In cultures where the giving of a dowry is practiced, the custom can be fatal for the woman whose parents are unable to meet demands for gifts or money. Violence that begins with threats may end in forced "suicide", death from injuries, or homicide.

Serious injuries

The injuries sustained by women because of physical and sexual abuse may be extremely serious. Many assault incidents result in injuries, ranging from bruises and fractures to chronic disabilities. A high percentage of these require medical treatment. For example, in Papua New Guinea, 18% of all urban married women had to seek hospital treatment following domestic violence.[2]

Research in Cambodia found that 50% of all women reporting abuse had sustained injuries.[3]

Canada's national survey on violence against women revealed that 45% of wife-assault incidents resulted in injuries, and of the injured women, 40% subsequently visited a doctor or a nurse.[4]

Injuries during pregnancy

Recent research has identified violence during pregnancy as a risk to the health of both mothers and their unborn foetus. Research in this area has shown increased levels of a variety of conditions.

In a three-year study of 1203 pregnant women in hospitals in Houston and Boston, United States, abuse during pregnancy was a significant risk factor for low birth weight, low maternal weight gain, infections and anemia.[5]

Injuries to children

Children in violent families may also be victims of abuse. Frequently, children are injured while trying to defend their mothers.

In one study of abused women in Bogotá, Colombia, 49% reported that their children had also been beaten.[6]

Unwanted and early pregnancy

Violence against women may result in unwanted pregnancy, either through rape or by affecting a woman's ability to negotiate contraceptive use. For example, some women may be afraid to raise the issue of contraceptive use with their sexual partners for fear of being beaten or abandoned.

Adolescents who are abused, or who have been abused as children, are much less likely to develop a sense of self-esteem and belonging than those who have not experienced abuse. They are more likely to neglect themselves and engage in risky behaviours such as early or unprotected sexual intercourse. A growing number of studies suggests that girls who are sexually abused during childhood are at much greater risk of unwanted pregnancy during adolescence.

A United States study found that women who experienced childhood sexual abuse are nearly three times more likely than non-victimized youth to become pregnant before the age of 18.[7]

This greater risk of unwanted pregnancy brings with it many additional problems. For instance, it is well documented that childbearing during early or middle adolescence, before girls are biologically and psychologically mature, is associated with adverse health outcomes for both the mother and child. Infants may be premature, of low birth weight, or be small for gestational age.

When an unwanted pregnancy occurs, many women try to resolve their dilemma through abortion. In countries where abortion is illegal, expensive or difficult to obtain, women may resort to illegal abortions, at times with fatal consequences.

In a study in Bombay, India, 20% of all pregnancies of adolescent abortion seekers occurred because of forced sex, 10% from rape by a male domestic servant, 6% from incest, and 4% from other rapes.[8]

STDs including HIV/AIDS

As with unwanted pregnancy, women are vulnerable to contracting sexually transmitted diseases (STDs) because they are unable to negotiate protection.

In Thailand, researchers found that one in ten victims of rape had contracted a STD because of the attack.[9]

Women with STDs have a higher risk of complications during pregnancy, including sepsis, spontaneous abortion and premature birth. Some STDs increase a woman's vulnerability to the HIV virus, as well. Violent sexual assault may also increase their risks because resulting tears to delicate vaginal tissue allow the virus easier entry into the bloodstream. With HIV/AIDS, the consequences are usually fatal for the woman, and possibly for her children as well.

Vulnerability to disease

Compared with non-abused women, women who have suffered any kind of violence are more likely to experience a number of serious health problems.

Research in Norway revealed that chronic pelvic pain is significantly associated with a history of domestic violence.[10]

A major study in the United States found that having been the victim of childhood abuse or violent crime doubled a woman's likelihood of suffering from severe menstrual problems, a sexually transmitted disease, or a urinary tract infection; domestic violence tripled her likelihood.[11]

Other research from the United States has shown that patients with irritable bowel syndrome, compared with those with the less serious inflammatory bowel disease, were more likely to have suffered severe sexual trauma, severe childhood sexual abuse or some form of sexual victimization.[12]

It has been suggested that abused women's increased vulnerability to illness may be due partly to lowered immunity because of stress resulting from the abuse. In addition, self-neglect and increased risk taking have also been implicated. It has been found, for instance, that abused women are more likely to smoke than women without a history of violence.[13]

Psychological consequences

Suicide

For women who are beaten or sexually assaulted, the emotional and physical strain can lead to suicide. These deaths are dramatic testimony to the paucity of options for women to escape from violent relationships.

Research in the United States has shown that battered women, as compared to women not living with violent men, are five times more likely to commit suicide.[14]

Mental health problems

Research suggests that abused women endure enormous psychological suffering because of violence. Many are severely depressed or anxious, while others display symptoms of post-traumatic stress disorder. They may be chronically fatigued, but unable to sleep; they may have nightmares or eating disorders; turn to alcohol and drugs to numb their pain; or become isolated and withdrawn.

In one study in León, Nicaragua, after controlling for other factors, researchers found that abused women were six times more likely to report experiencing mental distress than non-abused women. [15]

Likewise in the United States, women battered by their partners have been found to be between four and five times more likely to require psychiatric treatment than non-abused women. [16]

Rape and childhood sexual abuse can cause similar psychological damage. One occurrence of sexual aggression may be sufficient to create long-lasting negative effects, especially if the child-victim does not subsequently receive appropriate support. Like violence against women in the family, child abuse often continues for many years and its disabling effects can carry over into adult life. For example, the reduced self-esteem of women who have been abused in childhood may result in their making little effort to avoid situations where their health or safety are in jeopardy.

A study carried out in Boston, Los Angeles and San Diego in the United States, Juarez, Mexico, and San Juan, Puerto Rico, showed a strong link between sexual abuse victimization in early life, and involvement later in life in sexual behaviours that place women at risk of contracting HIV.[17]

Effects of witnessing violence on children

Research has shown that children who witness domestic violence often suffer many of the same symptoms as children who have been physically or sexually abused themselves. Girls who witness their father's or step-father's violent treatment of their mother are also more likely to accept violence as a normal part of marriage than girls from non-violent homes. Boys who have witnessed the same violence, on the other hand, are more likely to be violent to their partners as adults.

The León, Nicaragua, study reported that children who had regularly witnessed their mothers being hit or humiliated, compared to other children, were at least five times more likely to experience serious emotional and behavioural difficulties. [18]

Impact on society

Added health care costs

The costs to society of violence against women are tremendous, in terms of health care alone. A proportion of these costs are for treating serious physical injury. A substantial amount is also spent on psychological problems including managing anxieties and symptoms which happier, more confident, women may be able to tolerate, ignore or shrug off.

> One study in the United States showed that outpatient care for women with a history of sexual or physical assault cost two and a half times as much as care for other women, after controlling for other variables.19

Direct costs include those incurred by the police, courts and legal services to prosecute perpetrators of abuse; the costs of treatment programmes for men who batter, and other offenders; the medical care costs of treating the direct medical consequences of sexual and physical abuse; and social service costs, including child protection services.

Effects on productivity and employment

Women experiencing violence may have a reduced contribution to society as well as to their own potential self-realization.

> In Canada's national survey on violence against women, 30% of reported wife assault incidents led to time off from regular activities, and 50% of women who were injured took sick leave from work. 20

Women may be equally intimidated by their husband's violence, which prevents them from advancing at work.

> One development strategy in Madras, India, nearly collapsed when women began dropping out because of the increased incidents of beatings from their husbands, after the women had joined the project.21

The economic impact of abuse may extend to losses in women's earning potential. This may be partly because girls who are victims of violence are likely to be anxious or depressed, and unable to perform to the best of their ability at school. Because of their experience of having no control over their own bodies, the world may become a threatening place where they avoid challenges of any kind.

In areas where sexual abuse of female students by male teachers is prevalent, girls may stay away from school to escape unwanted attention. Elsewhere, parents, who fear that their daughters will be sexually assaulted, may keep them at home until they are "safely married". In many countries, a girl who becomes pregnant is expelled from school, regardless of whether or not the pregnancy was the result of a rape. The consequence, in every case, is a curtailed education, a decreased chance of securing gainful employment, and a reduced contribution to the quality of life for her community.

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What health workers can do

Health workers have a crucial role to play in helping women and children who experience violence. Those working in the community, in health centres and clinics, may hear rumours that a woman is being beaten or a child abused, or notice evidence of violence when women seek treatment for other conditions. Those working in hospital emergency departments may be the first to examine women injured by rape or domestic violence. Health workers visiting institutions such as prisons, mental hospitals and retirement homes may be the only source of outside help for victims of abuse.

Health administrators may also be able to give visibility to the issue of violence against women, bearing in mind that it is a major cause of ill health and incapacity in almost every country. They can ensure that resources are allocated for gathering data, developing guidelines to improve the identification and management of abuse, and training and sensitization of staff. They can foster inter-agency contacts to develop a range of responses to the needs of abused women and girls.

The problem of violence against women is enormous and troubling. There are no easy answers. The health sector cannot solve it alone. Still, with sensitivity and commitment, it can begin to make a difference.

One objective of WHO's work on violence against women is to explore these issues and develop guidelines for health workers to identify and respond appropriately to women and girls who have been abused.

The role of health workers

Most health workers have neither the time nor the training to assume the full responsibility of meeting the needs of women who have been abused. They can, however, identify and refer victims of abuse and where feasible provide care.

At a minimum, health workers can:

- First, "do no harm". Unsympathetic or victim-blaming attitudes can reinforce isolation and self-blame, undermine women's self-confidence, and make it less likely that women will reach out for help.

- Be attentive to possible symptoms and signs of abuse and follow up on them.
- Where feasible, routinely ask all clients about their experiences of abuse as part of normal history taking.
- Provide appropriate medical care and document in the client's medical records instances of abuse, including details of the perpetrator.
- Refer patients to available community resources.
- Maintain the privacy and confidentiality of client information and records.

Routine screening and protocols

Those working to improve the response of the health sector to women who have been abused emphasize the importance of universal screening of women and girls and the development of action protocols.

Screening is the practice of routinely asking all clients/patients if they have experienced sexual or physical abuse.

Protocols are written plans that define, for a particular setting, the procedures that should be followed to identify and respond appropriately to victims of abuse.

Studies show that with proper training and protocols, health care workers can become more sensitive to issues of violence against women. One example is the emergency department of the Medical College of Pennsylvania, Philadelphia, PA, United States. After introducing training and protocols on violence, the proportion of female trauma patients found to be battered increased fivefold, from 6% to 30%.[1]

Experience has shown that probing about abuse only when there are obvious signs of injury is generally not sufficient; more battered women present with vague medical complaints, such as chronic pain, head aches, sleep disturbances and depression, than with physical trauma. Nor are there "profiles" that can reliably predict who is a likely victim of abuse. Instead, some professionals advocate screening of all patients.

Sample screening questions[2]

Because violence is so common in women's lives, I now ask every woman I see about domestic violence. Have you ever been hit or abused by your partner?

Sometimes when I see a woman with an injury like yours it is because somebody hit her. Did this happen to you?

Sometimes when people come to the clinic with symptoms like yours we find that there may be trouble at home. Has someone been hurting you?

You mentioned that your partner drinks alcohol. Does he ever become violent?

Universal screening, however, must be introduced with caution. With adequate training of health workers and establishment of protocols screening can be effective in detecting cases of abuse. Careless implementation of screening may lead to client abuses, ranging from victim-blaming, to breaches of confidentiality, to rape.

Other barriers may interfere with maintaining standards of care for health services in resource poor areas. Sensitive health care responses can affect women by reducing their feelings of isolation and self-blame. However, additional services such as counseling, legal assistance and self-help groups provide other kinds of ongoing services that victims need. Shortcomings in support services may make providers feel isolated and helpless because their ability to help their clients is limited. Furthermore, the volume of clients may be so great, and their needs so urgent, that effective care beyond a basic level becomes difficult. Already over burdened administrators and providers may see taking on another issue, i.e. the health consequences of violence against women, as beyond their capability.

Guidance for health workers

The following is a list of possible recommendations tailored specifically to the challenge of dealing with domestic violence in a clinical setting. Modifications should be explored for other types of abuse and for other settings.

1. Do not be afraid to ask. Contrary to popular belief, most women are willing to disclose abuse when asked in a direct and non-judgmental way, indeed, many are silently hoping someone will ask.
2. Create a supportive non-judgmental environment. Let her tell her story. State clearly that no one deserves to be beaten or raped under any circumstance.
3. Be alert for "red flags". While the best way to uncover domestic violence is to ask directly, several injuries or conditions should raise suspicion for abuse:
    - chronic, vague complaints that have no obvious physical cause;
    - injuries that do not match the explanation of how they were sustained;
    - a partner who is overly attentive, controlling, or unwilling to leave the woman's side;
    - physical injury during pregnancy;
    - a history of attempted suicide or suicidal thoughts; and
    - delay between injury and the seeking of treatment.

4. Assess her situation for immediate danger. Establish whether the woman feels that either she or her children are in immediate danger. If so, help her consider alternative courses of action. Is there a friend or relative she can call? If there is a woman's shelter or a crisis center in the area, offer to contact them.
5. Explain that she has medical and legal rights. The penal codes of most countries criminalize rape and physical assault, even if no specific laws against domestic violence exist. Try to find out what legal protections exist in your locale for victims of abuse and where women and children can turn for help in enforcing their rights.
6. Be prepared to offer a follow-up appointment.
7. Consider providing space in the clinic for self-help support groups.
8. Display posters and leaflets on domestic violence, rape and sexual abuse, where these are available, to raise awareness of the issues and encourage patients to report any abuse they may be experiencing.
9. When possible, avoid prescribing mood altering drugs to women who are living with an abusive partner, since these may endanger their ability to predict and react to their partner's attacks.
10. Develop and maintain contacts with women's groups and other governmental and non-governmental agencies, who offer support to women experiencing violence. Ensure that up to date information on their services is prominently displayed, in the appropriate languages.

Community health promotion

The issue of violence can and should be incorporated into health promotion activities at the community level as well. Increasingly, non-governmental organization-sponsored projects are incorporating themes on violence against women and women's status into training materials for community health promoters.

The Women's Program of Uraco Pueblo in Honduras, for example, includes drama, discussion, and role playing on domestic violence and sexual harassment as part of its overall training program for health promoters.3

The Hesperian Foundation, sponsor of the popular book "Where there is no Doctor", has produced a new popular education manual on women's health that features chapters on domestic violence, mental health, rape, and sexuality.4

1. McLeer SV, Anwar R. A study of women presenting in an emergency department, American journal of public health, 1989, 79:65-67.
2. Adapted from Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers, produced by the Family Violence Prevention Fund, San Francisco in collaboration with the Pennsylvania Coalition Against Domestic Violence, 1995.
3. Heise L, Pitanguy J, Germain A. Violence against women: the hidden health burden, World Bank Discussion Paper No. 255, Washington, DC: The World Bank, 1994.
4. Burns A, et al. Where women have no doctor: a health guide for women, Berkeley: The Hesperian Foundation, 1997.

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What WHO is doing

WHO Headquarters, Women's Health and Development (WHD)

WHO's activities in the area of violence against women were initiated by WHD in 1995. The initiative focuses on the role of the health sector in preventing violence against women and managing its consequences. Current priority areas are violence against women in families and sexual violence.

In mid 1996 a WHO Task Force on Violence and Health was set up to coordinate all work on violence being carried out by various WHO programmes, including WHD.

The long-term aim of WHO activities concerning violence against women is to identify effective strategies to prevent violence and to decrease morbidity and mortality among women victims of abuse. The specific objectives are to:

- increase knowledge on the magnitude of the problem and its health consequences and make this information available to policy-makers, health providers and programme planners;
- identify appropriate prevention and intervention strategies that can reduce the prevalence/incidence of violence against women by partners;
- improve the capacity of health workers at all levels to identify and respond appropriately to victims of mental, physical and sexual abuse;
- support the formulation, by national governments, of adequate anti-violence policies and protocols;
- serve as an advocate within WHO and with professional health associations, concerning the implications of physical, mental and sexual violence for health policies, programmes and training.

Researchers, health care providers, women's health advocates, and staff from several WHO programmes attended a WHO consultation on violence against women in Geneva in February 1996.1 They reviewed existing information concerning the scale of violence against women by partners, the health consequences and interventions, and ongoing research initiatives. Recommendations made by consultation participants formed the basis for WHO's Plan of Action.

Plan of action on violence against women

Multi-country research

The ultimate goal of this research is to generate new data on prevalence, determinants and related risk and protective factors, and health consequences of violence against women. WHO also seeks to: strengthen local research capacity; develop and test new instruments for measuring violence and its consequences, including mental/emotional trauma across cultures; and promote a form of research that serves the needs of women and values the experience of women's groups working on the issue.

Documentation and testing of effective interventions

Often the most effective groups in the field are those who lack the time and funding to document their work. WHO plans to invest in systematically recording interventions by such groups in developing countries so that others can benefit as they begin their work. A small-grants fund will support the documentation of ongoing interventions and of lessons learned. A second fund will seed several research and demonstration projects. In addition, a meeting will be convened to review experiences by the health sector in countries, with particular attention to their appropriateness for resource poor settings.

Development of a research manual

WHO is collaborating on the development and testing of a manual for researchers who undertake community surveys in resource-poor settings. The manual will respond to the need for practical and ethical guidance for research in this area.

Development of a database

WHO has set up a database on violence against women in families, rape and sexual assault, female genital mutilation, and the health consequences of violence against women. Research findings are being collected from around the globe, including hard-to-access unpublished data such as theses, dissertations and the work of local non-governmental organizations (NGOs). The database will be used to discover if sufficient information exists to develop policies and programmes in these areas, where further research is most needed, and the magnitude and severity of related health risks.

Advocacy and information

WHO seeks to ensure greater recognition, with health providers and planners, and within health professional organizations, of violence against women and its implications for health policies and programmes. Advocacy is needed both within and outside WHO; for example, many WHO training programmes could integrate basic information on violence against women. This information package is one tool for such advocacy.

The Rwanda Project

In Rwanda, sexual violence against women and girls were used as weapons of war and genocide.

WHO, with the assistance of the Italian Government, is supporting a project to help women affected by violence through:

- training of health workers;
- establishment of a national network for health and psychosocial assistance.

WHD convened a workshop in February 1997 in Kigali, Rwanda, for health workers and administrators. The workshop was designed to identify problems linked to violence and improve relevant technical skills.

Using the knowledge gained from the workshop, training modules for health workers are being developed. These are expected to enhance the ability of health workers to provide care for women affected by violence.

Pan American Health Organization: working with communities to end violence against women

The Pan American Health Organization (PAHO) is working with 16 Member Countries to address domestic violence against women. PAHO uses a two-pronged approach to increase the capacity of institutions, both governmental and non-governmental, to design prevention and support strategies that can effectively deal with this complex social problem. At the local level, it seeks to create coordinated community networks where the health system, the legal system, police, churches, NGOs and other community-based groups meet regularly to design and carry out a coordinated response to domestic violence. At the national level, it seeks to promote the adoption of laws and policies designed to strengthen the institutional capacity to respond effectively to domestic violence. Additionally, the project fosters linkages with mass media to communicate that violence against women is unacceptable, and to challenge the social attitudes and beliefs which posit the basic superiority of men, granting them the right to control female behaviour.

A convincing proof that domestic violence can be eradicated is the existence of success stories at the community level. PAHO's project seeks to seed those success stories by piloting models of intervention and prevention of violence against women on a small scale. Subsequently, these can be scaled up to achieve broad-based reforms. This project has been designed and is being executed in close collaboration with women's organizations and other NGOs, which have worked extensively on gender-based violence in their respective countries.

A central component of the project is the strengthening of the health sector's ability to identify and respond to battered women. PAHO is piloting models of interventions and prevention of intra family violence against women, including the sensitization and training of health professionals.

Other components of the project include the improvement of information systems for the surveillance of domestic violence; the establishment of self-help groups for women and for offenders; advocacy for necessary legal reforms to protect women and girls; and advocacy for enforcement of laws against domestic violence.

The first step in fashioning the community-based response has been the implementation of a qualitative study at each site which provides not only a baseline measure but also an instrument around which solutions can be collectively designed and pursued. The sobering results of this effort suggest the complex nature of this problem by showing that the institutions which were set up to protect citizens may be part of the victimization.

Undertaking this diagnosis has had the added advantage of serving as an instrument by which those interviewed, specifically key community people and groups, became interested in the problem of domestic violence. Thus, what was conceived initially as an instrument that would reflect community institutions' responses to battered women, became the vehicle for raising awareness of the problem. When results were shared with the community, the commitment to the issue usually had already been nurtured.

Within this context, in the past year, significant advances have been made at the community level in all 25 participating communities. In many countries, the project has been included as part of the "Healthy Municipalities" efforts, and town mayors, state governors, and local authorities are heavily involved. In rural areas with few institutions, the project is seeking to explore, with the community, creative ways to prevent and address violence. This is the case in six sites, many of which are populated primarily by indigenous peoples. Work in these areas has been supported heavily by local parish priests who, with the staff of primary health care centres, are becoming key participants in these efforts in rural areas.

At the national level, the project is working with a variety of participants, mainly ministries of health and justice, women's and human rights groups, and relevant international organizations. In some countries, PAHO has mobilized significant additional local resources to support the project's efforts.

1. A report of the consultation is available from Women's Health and Development, World Health Organization, 1211, Geneva 27, Switzerland.

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What non-governmental organizations are doing

Over the last decade, in all parts of the world, movements to end violence against women have emerged at local and national levels. Countless organizations, collectives and ad-hoc groups are working for change in many sectors. WHO recognises the effort of these organizations, not only in advocacy but also in developing strategies, services and counselling to respond to the needs of women. The commitment of these non-governmental organizations (NGOs) and many individuals has put the issue on the international agenda and promoted discussion of strategies, at national and international levels, to deal with violence against women. Examples of their work can be found in the information sheets, Violence against women in families and Rape and sexual assault.

Growing awareness of violence against women, spearheaded by the efforts of hundreds of women's organizations, has resulted in a range of initiatives that deal with the problem at almost every level of society. Most of the NGOs working in the field of reproductive rights, reproductive health, and women's health, women refugees, include violence against women in their mandate. We provide here a profile of several regional organizations working on violence against women and involved in networking. The reader may also look to their local or national organizations for further information.

Asian Pacific Resource & Research Centre for Women (Arrow)
2nd Floor, Block F, Anjung Felda
Jalan Maktab
54000 Kuala Lumpur, Malaysia
Tel: (603) 2929913
Fax: (603) 2929958
E-mail arrow@po.jaring.my
Homepage: http://www.asiaconnect.com.my/arrow/

ARROW produces bibliographies, annotated resource materials and a bulletin. A recent issue of the bulletin was entitled Violence against women: a silent pandemic. The organization advocates for more extensive national data collection and research, gender sensitive health interventions and swift implementation of the Beijing Platform for Action.

Coordination of Women's Advocacy
CH-1271 Givrins, Switzerland
Tel: (22) 369 4090
Fax: (22) 369 4070
E-mail: cwa@iprolink.ch

Coordination of Women's Advocacy is a network which consists of women in twelve countries specialized in legal, psychosocial and medical, developmental and emergency aspects of women's human rights abuses in times of war and conflict.

Health and Development Policy Project (HDPP)
6930 Carroll Ave, Suite 430

Takoma Park
Maryland 20912, USA
Tel: (301) 270 1182
Fax: (301) 270 2052
E-mail: hdpp@igc.apc.org

HDPP works to ensure that the field of international health becomes a constructive force in addressing violence against women. Presently, HDPP is developing a manual on conducting research on gender-based violence and is collaborating with in-country partners to implement pilot prevention projects.

Isis-Women's International Cross-Cultural Exchange (Isis-WICCE)
P.O. Box 4934
Kampala, Uganda
Tel: (256 41) 244007/8
Fax: (256 41) 268676
E-mail: isis@starcom.co.ug

Isis-WICCE works to change the social, economic, political and cultural institutions that perpetuate or reinforce gender violence. It carries out advocacy work through the provision and exchange of information with women, using an international cross-cultural exchange programme. Isis-WICCE also provides information to influential actors and policy-makers.

Latin American and Caribbean Women's Network against Domestic and Sexual Violence
Casilla 2067, Correo Central
Santiago, Chile
Tel: (562) 633 4582
Fax: (562) 638 3142
E-mail: isis@reuna.cl

The Network has members in most countries of the region. It has ensured the issue of violence against women is on the public agenda through organizing seminars, coordinating regional campaigns, and raising the issue with governments and international organisations. The Network produces a quarterly newsletter, 'Boletín'.

Match International Centre
200 Elgin Street, Suite 1102
Ottawa, Ontario
Canada K2P 1L5
Tel: (613) 238 1312
Fax: (613) 238 6867
E-mail: matchint@web.apc.org

Match International is a development agency which works collaborates with women's groups in Africa, Asia, the Caribbean and South America. In partnership with Match, women around the world are setting up sensitization campaigns, awareness raising activities, assertiveness and para-legal training, popular theatre, and action research to tackle the issue of violence against women.

Women in Law and Development, Africa (WiLDAF)
PO Box 4622
Harare, Zimbabwe
Tel: (263-4) 752105
Fax: (263-4) 733670

WiLDAF, a Pan-African Women's Human Rights Network with membership in more than 22 countries, works for the promotion and protection of women's human rights. They lobby governments for policy and law reform, advocacy, and public education on violence against women. Each year, from 25 November to 10 December, WiLDAF organizes the campaign, 16 Days of Activism on Gender Violence

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Selected human rights documents, UN declarations and treaties

International human rights documents encompass formal written documents, such as conventions, declarations, conference statements, guidelines, resolutions and recommendations. Treaties are legally binding to those States which have ratified or acceded to them, and their implementation is observed by monitoring bodies, such as the Committee on the Elimination of Discrimination Against Women (CEDAW). Declarations reflect the progressive standard of international law. Documents adopted by World Conferences (Conference statements) reflect an international consensus.

Global documents

The Universal Declaration of Human Rights (1948) has formed the basis for the development of international human rights conventions. Article 3 states that everyone has the right to life, liberty and security of the person. According to article 5, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Therefore, any form of violence against women which is a threat to her life, liberty or security of person or which can be interpreted as torture or cruel, inhuman or degrading treatment violates the principles of this Declaration.

The International Covenant on Economic, Social and Cultural Rights (1966) together with the International Covenant on Civil and Political Rights, prohibits discrimination on the basis of sex. Violence detrimentally affects women's health, therefore, it violates the right to the enjoyment of the highest attainable standard of physical and mental health (article 12). In addition, article 7 provides the right to the enjoyment of just and favourable conditions of work which ensure safe and healthy working conditions. This provision encompasses the prohibition of violence and harassment of women in the workplace.

The International Covenant on Civil and Political Rights (1966) prohibits all forms of violence. Article 6.1 protects the right to life. Article 7 prohibits torture and inhuman or degrading treatment or punishment. Article 9 guarantees the right to liberty and security of person.

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) provides protection for all persons, regardless of their sex, in a more detailed manner than the International Covenant on Civil and Political Rights. States should take effective measures to prevent acts of torture (article 2).

The Convention on the Elimination of All Forms of Discrimination against Women (1979) is the most extensive international instrument dealing with the rights of women. Although violence against women is not specifically addressed in the Convention, except in relation to trafficking and prostitution (article 6), many of the anti-discrimination clauses protect women from violence. States Parties have agreed to a policy of eliminating discrimination against women, and to adopt legislative and other measures prohibiting all discrimination against women (article 2). In 1992, the Committee on the Elimination of Discrimination Against Women (CEDAW) which monitors the implementation of this Convention, formally included gender-based violence under gender-based discrimination. General Recommendation No. 19, adopted at the 11th session (June 1992), deals entirely with violence against women and the measures taken to eliminate such violence. As for health issues, it recommends that States should provide support services for all victims of gender-based violence, including refuges, specially trained health workers, and rehabilitation and counselling services.

The International Convention on the Elimination of All Forms of Racial Discrimination (1965) declares that States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the enjoyment of the right to security of the person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution (article 5).

The four 1949 *Geneva Conventions* and two additional Protocols form the cornerstone of international humanitarian law. The Geneva Conventions require that all persons taking no active part in hostilities shall be treated humanely, without adverse distinction on any of the usual grounds, including sex (article 3). They offer protection to all civilians against sexual violence, forced prostitution, sexual abuse and rape.

Regarding international armed conflict, *Additional Protocol I* to the 1949 Geneva Conventions creates obligations for parties to a conflict to treat humanely persons under their control. It requires that women shall be protected against rape, forced prostitution and indecent assault. Additional Protocol II, applicable during internal conflicts, also prohibits rape, enforced prostitution and indecent assault.

The Convention on the Rights of the Child (1989) declares that States Parties take appropriate legislative, administrative, social and educational measures to protect the child from physical or mental violence, abuse, maltreatment or exploitation (article 19). States shall act accordingly to prevent the exploitative use of children in prostitution or other unlawful sexual practices, and the exploitative use of children in pornographic performances and materials (article 34).

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted by the General Assembly in 1990, not yet in force) contains the right of migrant workers and their family members to liberty and security of person as proclaimed in other international instruments. They shall be entitled to effective protection by the State against violence, physical injury, threats and intimidation, whether by public officials or by private individuals, groups or institutions (article 16).

Regional treaties

The European Convention on Human Rights (adopted in 1950 by the Council of Europe) protects the right to life (article 2), the right to liberty and security of person (article 5) and freedom from torture and inhuman or degrading treatment or punishment (article 3). States should secure to everyone, within their jurisdiction, without discrimination, the rights and freedoms defined in this Convention (article 1, 14).

The American Convention on Human Rights (adopted in 1969 by the Organization of American States) also provides the right to life (article 4), the right to humane treatment (article 5), including the prohibition of torture and cruel, inhuman or degrading treatment or punishment, the right to personal liberty and security (article 7), which are all relevant provisions in protecting women from violence in all its forms. In addition, every child has the right to the measures of protection of his or her family, society, and the state (article 19). Discrimination on the basis of sex is prohibited (article 1).

The African Charter on Human and Peoples' Rights (adopted in 1981 by the Organization of African Unity) ensures for all individuals the right to life (article 4) and the right to liberty and security of the person (article 6). Torture and cruel, inhuman or degrading treatment and punishment are prohibited (article 5). Every individual has the right to enjoy the best attainable state of

physical and mental health (article 16). In addition, the Charter proclaims that the State shall ensure the elimination of every discrimination against women and ensure the protection of the rights of the woman and the child as stipulated in international conventions and declarations (article 18).

The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para, 1994) is the only international instrument specifically designed to eradicate violence against women. It provides a detailed list of duties of the States with respect to prevention and punishment of acts of such violence. States Parties condemn all forms of violence against women and agree to pursue, by all appropriate means and without delay, policies to prevent, punish and eradicate such violence (article 7). For example, States Parties should provide specialized services for women who have been subjected to violence, including shelters, counselling services, and care for the affected children (article 8). Individuals and groups can submit complaints regarding State inaction to protect women from violence to the Inter-American Commission on Human Rights.

Conference declarations and resolutions

The issue of violence against women has recently gained more explicit attention in many international meetings. The following list is a selection of statements and decisions on the eradication of all forms of violence against women. Through these Declarations and Statements, Governments have committed themselves to preventing such violence, punishing perpetrators and assisting victims.

In December 1993, the United Nations General Assembly adopted the *Declaration on the Elimination of Violence Against Women*, the first international human rights instrument to deal exclusively with violence against women. It affirms that violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms and is concerned about the longstanding failure to protect and promote those rights and freedoms in relation to violence against women. Furthermore, it provides a clear and comprehensive definition of violence against women. See Definition and scope of the problem, in this package, for the definition, as shown in article 1.

World Conference on Human Rights (1993) adopted the Vienna Declaration and Programme of Action. It states that gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support.

The International Conference on Population and Development, held in 1994 in Cairo, adopted a Programme of Action which emphasizes that advancing gender equality and the empowerment of women and the elimination of all forms of violence against women are cornerstones of population and development-related programmes (principle 4). Governments were called upon to take full measures, including preventive action and rehabilitation of victims, to eliminate all forms of exploitation, abuse, harassment, and violence against women, adolescents and children.

The World Summit for Social Development was held in Copenhagen in 1995. Its Programme of Action strongly condemns violence against women, and repeats the concerns expressed in the Cairo Programme of Action, focusing on violence against children, domestic violence, and rape.

In September 1995, the *Fourth World Conference on Women* adopted the Beijing Declaration and Platform for Action which devotes an entire section to the issue of violence against women. It recognizes that the elimination of violence against women is essential to equality, development and peace. The Platform refers directly to Declaration on the Elimination of Violence Against Women. Furthermore, the Conference called on States to recognize the vulnerability to violence of women belonging to groups such as refugees, displaced persons, migrants and persons with disabilities.

In June 1996, the *Second United Nations Conference on Human Settlements* (Habitat II) adopted the Istanbul Agenda which deals with gender-based violence within the context of shelter and the urban environment. Governments committed themselves to promote shelter and support basic education and health services for women and children who are survivors of family violence.

In August 1996, the *World Congress against Commercial Sexual Exploitation of Children*, in Stockholm, adopted a Declaration and Agenda for Action calling upon States to give high priority to action against the commercial sexual exploitation of children and allocate resources for this purpose. It calls on governments to provide social, medical, psychological counselling and other support to child victims of commercial sexual exploitation, and their families.

The issue of violence against women was taken up by the Economic and Social Council in 1990. Resolution 1990/15 calls upon Governments to take immediate measures to establish appropriate penalties for and reduce the impact of violence against women in the family, workplace and society.

In 1991, the Economic and Social Council adopted resolution 1991/18, in which it urged Member States to adopt, strengthen and enforce legislation prohibiting violence against women and to act accordingly to protect women from all forms of physical and mental violence.

In May 1996, the 49th World Health Assembly adopted a resolution (WHA 49.25) declaring violence a public health priority. It noted the dramatic increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children.

In April 1997, the Commission on Human Rights again condemned, in its resolution 1997/44, all acts of violence against women and emphasized that Governments have the duty to refrain from engaging in violence against women and to prevent, investigate and punish acts of violence against women, whether those acts are perpetrated by the State or by private persons. In its resolution 1997/13 on violence against women migrant workers, it expressed concern about the continuing reports of grave abuses and acts of violence

committed against women migrant workers by some employers in some host countries.

Special Rapporteur on violence against women, its causes and consequences

In March 1994, the Commission on Human Rights appointed a Special Rapporteur on violence against women, its causes and consequences. In 1997, at its 53rd session, the Commission on Human Rights decided that the mandate of the Special Rapporteur should be renewed for three years. The Special Rapporteur may receive and request information from Governments, organizations and individuals on violence against women which is gender-specific, and can initiate relevant investigations.

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Selected readings

Agger I. The blue room. Trauma and testimony among refugee women: a psycho-social exploration. London, Zed Books, 1994.

Carrillo R. Battered dreams: violence against women as an obstacle to development. New York, United Nations Fund for Women, 1992.

Clinkin C. Rape and sexual abuse of women in international law. European journal of international law, 1994, 326:23-28.

Commonwealth Secretariat. Confronting violence: a manual for commonwealth action. London, Women and Development Programme, Commonwealth Secretariat, 1992.

Cook R, ed. Human rights of women: national and international perspectives. Philadelphia, PA, University of Pennsylvania Press, 1994.

Dan A, ed. Reframing women's health: multi-disciplinary research and practice. Thousand Oaks, CA, Sage Publishers, 1994.

Davies M, ed. Women and violence: realities and responses worldwide. London, Zed Books, 1994.

DeKeseredy WS. Enhancing the quality of survey data on woman abuse. Violence against women, 1995, 1(2):158-173.

Heise LL, Pitanguy J, Germain A. Violence against women: the hidden health burden. Washington, DC, World Bank, 1994 (World Bank Discussion Paper No. 255).

Heise L et al. Violence against women: a neglected public health issue in less developed countries. Social science and medicine, 1994, 39(4):1165-1179.

Kerr J, ed. Calling for change: international strategies to end violence against women. The Hague, Development Cooperation Information Department, Ministry of Foreign Affairs, 1994.

Koss MP et al. Deleterious effects of criminal victimisation on women's health and medical utilisation. Archives of internal medicine, 1991, 151:342-347.

The right to live without violence: The Women's Health Collection. Santiago, Chile, Latin American and Caribbean Women's Health Network, 1996.

Peters JL, Wolper A, eds. Women's rights, human rights: international feminist perspectives. New York, Routledge, 1995.

Plichta SB et al. The effects of woman abuse on health care utilisation and health status: a literature review. Women's health issues, 1992, 2(3):154-161.

Plichta SB et al. Violence and gynaecologic health in women <50 years old. American journal of obstetrics and gynaecology, 1996, 174:903-907.

Rothenberg KH et al. Domestic violence and partner notification: implications for treatment and counselling of women with HIV. Journal of the American medical women's association, 1995, 50(3):87-93.

Spijkerboer T. Women and refugee status: beyond the public/private distinction. The Hague, Emancipation Council, September 1994:19-32.

Swiss S, Giller J. Rape as a crime of war: a medical perspective. Journal of the American Medical Association, 1993, 270:612-615.

Strategies for confronting domestic violence: a resource manual. New York, United Nations, 1994.

Violence against women in the family. New York, United Nations, 1989.

Preliminary report of the special rapporteur on violence against women, its causes and consequences in accordance with Commission on Human Rights resolution 1994/45. New York, United Nations, Economic and Social Council, Commission on Human Rights, 1994 (unpublished document, No. E/CN.4/1995/42).

Report of the special rapporteur on violence against women, its causes and consequences in accordance with Commission on Human Rights resolution 1995/85. New York, United Nations, Economic and Social Council, Commission on Human Rights, 1996 (unpublished document, No. E/CN.4/1996/53).

Report of the special rapporteur on violence against women, its causes and its consequences. New York, United Nations, Economic and Social Council, Commission on Human Rights, 1997 (unpublished document, number E/CN.4/1997/47).

Female genital mutilation. Geneva, World Health Organization, 1996 (unpublished document No. WHO/FRH/WHD/ 96.26).

Wulf D. Refugee women and reproductive health: reassessing priorities. New York, Women's Commission for Refugee Women and Children, 1994.

Zapata BC et al. The influence of social and political violence on the risk of pregnancy complications. American journal of public health, 1992, 82(5):685-690.

Zwi A, Ugalde A. Towards an epidemiology of political violence in the third world. Social science and medicine, 1989, 28(7):649-657.

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