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The Center for Health and Gender Equity (CHANGE) is a research and advocacy organization that seeks to integrate concern for gender equity and social justice into international health policy and practice. CHANGE staff can be reached by e-mail at change@genderhealth.org or at <http://www.genderhealth.org>.

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Ending Violence Against Women

Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family. Increasingly, gender-based violence is recognized as a major public health concern and a violation of human rights.

The effects of violence can be devastating to a woman's reproductive health as well as to other aspects of her physical and mental well-being. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections, and adverse pregnancy outcomes. Yet victims of violence who seek care from health professionals often have needs that providers do not recognize, do not ask about, and do not know how to address.

What Is Gender-Based Violence?

Violence against women and girls includes physical, sexual, psychological, and economic abuse. It is often known as "gender-based" violence because it evolves in part from women's subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimize and therefore perpetuate violence against women. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

Two of the most common forms of violence against women are abuse by intimate male partners and coerced sex, whether it takes place in childhood, adolescence, or adulthood. Intimate partner abuse—also known as domestic violence, wife-beating, and battering—is almost always accompanied by psychological abuse and in one-quarter to one-half of cases by forced sex as well. The majority of women who are abused by their partners are abused many times. In fact, an atmosphere of terror often permeates abusive relationships.

How Health Care Providers Can Help

Health care providers can do much to help their clients who are victims of gender-based violence. Yet providers often miss opportunities to help by being unaware, indifferent, or judgmental. With training and support from health care systems, providers can do more to respond to the physical, emotional, and security needs of abused women and girls.

First, health care providers can learn how to ask women about violence in ways that their clients find helpful. They can give women empathy and support. They can provide medical treatment, offer counseling, document injuries, and refer their clients to legal assistance and support services.

Family planning and other reproductive health care providers have a particular responsibility to help because:

- Abuse has a major—although little recognized—impact on women's reproductive health and sexual well-being;
- Providers cannot do their jobs well unless they understand how violence and powerlessness affect women's reproductive health and decision-making ability;
- Reproductive health care providers are strategically placed to help identify victims of violence and connect them with other community support services.

Providers can reassure women that violence is unacceptable and that no woman deserves to be beaten, sexually abused, or made to suffer emotionally. As one client said (379), "Compassion is going to open up the door. And when we feel safe and are able to trust, that makes a lot of difference."

Societal Responses

Health workers alone cannot transform the cultural, social, and legal environment that gives rise to and condones widespread violence against women. Ending physical and sexual violence requires long-term commitment and strategies involving all parts of society. Many governments have committed themselves to overcoming violence against women by passing and enforcing laws that ensure women's legal rights and punish abusers. In addition, community-based strategies can focus on empowering women, reaching out to men, and changing the beliefs and attitudes that permit abusive behavior. Only when women gain their place as equal members of society will violence against women no longer be an invisible norm but, instead, a shocking aberration.

This report was prepared by Lori Heise, Mary Ellsberg, Lic. Med. Sci., and Megan Gottmoeller, MPH, of the Center for Health and Gender Equity (CHANGE). Bryant Robey, Editor. Stephen M. Goldstein, Managing Editor. Vera M. Zlidar, Research Analyst. Design by Linda D. Sadler. Production by John R. Fiege, Merridy Gottlieb, Peter Hammerer, and Deborah Maenner.

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The World Takes Notice

Violence against women is the most pervasive yet least recognized human rights abuse in the world. It also is a profound health problem, sapping women's energy, compromising their physical health, and eroding their self-esteem. Despite its high costs, almost every society in the world has social institutions that legitimize, obscure, and deny abuse. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

For over two decades women's advocacy groups around the world have been working to draw more attention to the physical, psychological, and sexual abuse of women and to stress the need for action. They have provided abused women with shelter, lobbied for legal reforms, and challenged the widespread attitudes and beliefs that support violent behavior against women (209).

Increasingly, these efforts are having results. Today, international institutions are speaking out against gender-based violence (see box, p. 5). Surveys and studies are collecting more information about the prevalence and nature of abuse. More organizations, service providers, and policy-makers are recognizing that violence against women has serious adverse consequences for women's health and for society.

A growing number of reproductive health programs and practitioners understand that they have a key role to play in addressing violence, not only in helping individual victims but also in preventing abuse. As more becomes known about the scope of gender-based violence and the reasons behind it, more programs are finding ways to address it.

What Is Violence Against Women?

The term "violence against women" refers to many types of harmful behavior directed at women and girls because of their sex. In 1993 the United Nations offered the first official definition of such violence when the General Assembly adopted the Declaration on the Elimination of Violence Against Women. According to Article 1 of the declaration, violence against women includes:

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 deprivations of liberty, whether occurring in public or private life. (444)

There is increasing consensus, as reflected in this declaration, that abuse of women and girls, regardless of where and how it occurs, is best understood within a "gender" framework because it stems in part from women's and girls' subordinate status in society.

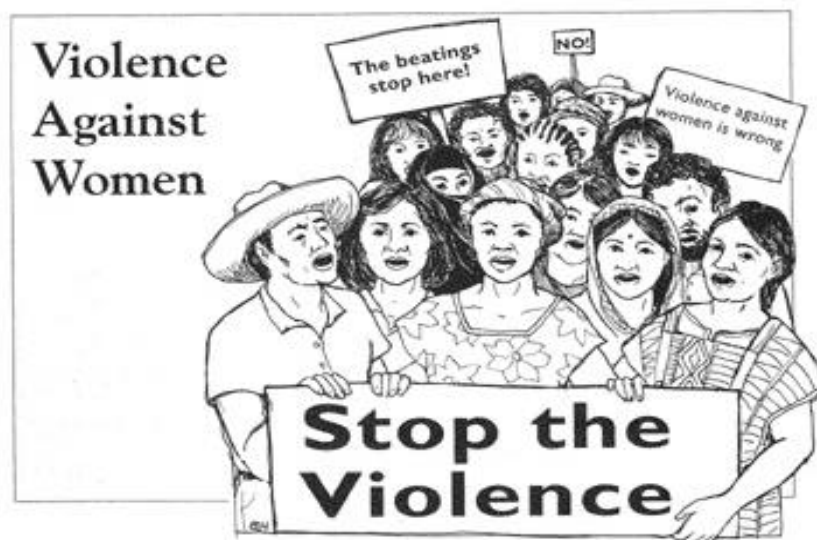
Article 2 of the UN Declaration clarifies that the definition of violence against

women should encompass, but not be limited to, acts of physical, sexual, and psychological violence in the family and the community. These acts include spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, and traditional practices harmful to women, such as female genital mutilation (FGM). They also include nonspousal violence, sexual harassment and intimidation at work and in school, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state, such as rape in war.

This issue of **Population Reports** focuses principally on two types of violence: (1) abuse of women within marriage and other intimate relationships and (2) coerced sex, whether it takes place in childhood, adolescence, or adulthood. This focus reflects the types of abuse most dominant in the lives of women and girls around the world.

Other forms of abuse—such as trafficking in women, rape during war, female infanticide, and FGM—are also important. They are not included in this report, however, because they deserve separate consideration (see, for example, **Population Reports**, *Female Genital Mutilation: A Reproductive Health Concern*, Supplement to Series J, No. 41, October 1995). Limiting the focus of the report to intimate partner violence and sexual coercion makes it possible to discuss these issues and appropriate program responses in more depth.

Violence against women is different from interpersonal violence in general. The nature and patterns of violence against men, for example, typically differ from those against women. Men are more likely than women to be victimized by a stranger or casual acquaintance. Women are more likely than men to be victimized by a family member or intimate partner (55, 96, 212, 258, 436). The fact that women are often emotionally involved with and financially dependent upon those who abuse them has profound implications for how women experience violence and how best to intervene.



Hesperian Foundation (54)

Around the world, a growing number of people are speaking out about the widespread problem of violence against women, including both physical and psychological abuse by intimate partners and sexual abuse. Many health providers are getting the message.

Table 1

Physical Assault on Women by an Intimate Male Partner

Selected Population-Based Studies, 1982–1999

Percentages rounded to whole numbers

"P" after year indicates the year of publication for studies not reporting the field work dates.

*Population of respondents:

1 = all women

2 = currently married/partnered women

3 = ever-married/partnered women

4 = married men reporting on own use of violence against spouse

5 = women with a pregnancy outcome

6 = all men reporting on own use of violence against partners

7 = married women; half with pregnancy outcome, half without

**Nonrandom sampling techniques used.

*Sample group included women who had never been in a relationship and therefore were not in exposed group.

^aRate of partner abuse among ever-married/ partnered women, recalculated from author's data.

^c Although sample includes all women, rate of abuse is shown for ever-married/partnered women (N not given).

^dPerpetrator could be family member or close friend.

^eSevere abuse

^fAny physical abuse/severe physical abuse only

^gPhysical or sexual assault

^hIn past 3 months

Compiled by the Center for Health and Gender Equity (CHANGE) for Population Reports

		Sample			% of Adult Women Physically Assaulted by an Intimate Partner		
Region, Place & Year of Field Work (Ref. No.)	Coverage	Size	Popu- Lation*	Age	In Pre- vious 12 Months	In Cur- rent Re- lationship	Ever (in Any Re- lationship)
AFRICA, SUB-SAHARAN							
Ethiopia 1995 (110)	Meskanena Woreda	673	2	15+	10 ^h		45
Kenya 1984–87 (362)	Kisii District	612	7	15+		42	
Nigeria 1993P (331)	Not stated	1,000	1				31 ^a
South Africa 1998 (235)	Eastern Cape	396	3	18–49	11 ^b		20 ^b
	Mpumalanga	418	3	18–49	12 ^b		29 ^b
	Northern Province	465	3	18–49	5 ^b		20 ^b
South Africa 1998 (281)	National	5,077	2	15–49	6		13
Uganda 1995–96 (33)	Lira & Masaka Districts	1,660	2	20–44		41	
Zimbabwe 1996 (464)	Midlands Province	966	1	18+			17 ^c
ASIA & PACIFIC							
Australia 1996 (490)	National	6,300	1		3 ^c	8 ^c	
Bangladesh 1992 (407)	National (villages)	1,225	2	<50	19		47
Bangladesh 1993–95 (422)	Nasimagar Thana	3,611	2			32	
Bangladesh 1993 (255)	Jessore & Sirajgonj (rural)	10,368	2	15–49		42 ^d	
Cambodia 1996P (325)	Phnom Penh & 6 prov.	1,374	3				16
India 1993–94 (233)	Tamil Nadu	859	2	15–39		37	
	Uttar Pradesh	983	2	15–39		45	
India 1995–96 (288)	Uttar Pradesh, 5 dist.	6,695	4	15–65		30	
India 1999 (496)	6 states	9,938	3	15–49	14 ^e		40/26 ^f
Korea, Rep. of 1989 (253)	National	707	2	20+	38/12 ^f		
New Zealand 1994 (272)	National	2,000	6	17+	21 ^g		35 ^g
Papua N. Guin. 1982 (437)	National, rural (villages)	628	3**				67
Papua N. Guin. 1984 (366)	Port Moresby (low income)	298	3**				56
Philippines 1993 (323)	National	8,481	5	15–49			10 ^d
Philippines 1998 (57)	Cagayan de Oro City & Bukidnon Province	1,660	2	15–49			26
Thailand 1994 (215)	Bangkok	619	4			20	
EUROPE							
Moldova 1997 (410)	National	4,790	3	15–44	7+		14+
Netherlands 1986 (383)	National	989	1	20–60			21/11 ^{a,f}
Norway 1989P (403)	Trondheim	111	3	20–49			18
Switzerland 1994–96 (178)	National	1,500	2	20–60	6 ^g		21 ^g
Turkey 1998 (223)	E and SE Anatolia	599	1	14–75			58 ^a
United Kingdom 1993P (308) ..	North London	430	1	16+	12 ^a		30 ^a
LATIN AMERICA & CARIBBEAN							
Antiquea 1990 (200)	National	97	1	29–45			30 ^c
Barbados 1990 (494)	National	264	1	20–45			30 ^{a,g}
Bolivia 1998 (338)	3 districts	289	1	20+	17 ^a		
Chile 1993P (268)	Metro. Santiago & prov.	1,000	2	22–55		26/11 ^f	
Chile 1997 (312)	Santiago	310	2	15–49	23		
Colombia 1995 (337)	National	6,097	2	15–49		19	
Mexico 1996 (363)	Metro. Guadalajara	650	3		15		27
Mexico 1996P (191)	Monterrey	1,064	3	15+			17 ^g
Nicaragua 1995 (130)	León	360	3	15–49	27/20 ^f		52/37 ^f
Nicaragua 1995 (163, 312)	Managua	378	3	15–49	33/28 ^f		69
Nicaragua 1998 (386)	National	8,507	3	15–49	12/8 ^f		28/21 ^f
Paraguay 1995–96 (105)	Nat'l, except Chaco reg.	5,940	3	15–49			10
Peru 1997 (188)	Metro. Lima (middle and low income)	359	2	17–55	31		
Puerto Rico 1995–96 (105)	National	4,755	3	15–49			13 ^b
Uruguay 1997 (440)	Montevideo & Canelones	545	2**	22–55	10 ^g		
NEAR EAS & NORTH AFIRCA							
Egypt 1995–96 (132)	National	7,121	3	15–49	16 ^d		34 ^b
Israel 1994 (197)	West Bank & Gaza Strip (Palestinians)	2,410	2	17–65	52/37 ^f		
Israel 1997P (196)	Arab, except Bedouin	1,826	2	19–67	32		
NORTH AMERICA							
Canada 1993 (378)	National	12,300	1	18+	3 ^{c,g}		29 ^{c,g}
Canada 1991–92 (367)	Toronto	420	1	18–64			27 ^a
United States 1995–96 (436) ...	National	8,000	1	18+	1.3 ^a		22 ^a

World Organizations Speak Out

In the 1990s violence against women has emerged as a focus of international attention and concern:

- In 1993 the UN General Assembly passed the Declaration on the Elimination of Violence Against Women, UN Resolution 48/104 (444).
- At both the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing, women's organizations from around the world advocated ending gender violence as a high priority (479). The Cairo Programme of Action recognized that gender violence is an obstacle to women's reproductive and sexual health and rights, and the Beijing Declaration and Platform for Action devoted an entire section to the issue of violence against women.
- In March 1994 the Commission on Human Rights appointed the first Special Rapporteur on Violence Against Women and empowered her to investigate abuses of women's human rights (479).
- In 1994 the Organization of American States (OAS) negotiated the Inter-American Convention to Prevent, Punish and Eradicate Violence Against Women. As of 1998, 27 Latin American countries had ratified the convention (82).
- In May 1996 the 49th World Health Assembly adopted a resolution (WHA49.25) declaring violence a public health priority (479). WHO is sponsoring, together with the Center for Health and Gender Equity (CHANGE) and the London School of Hygiene and Tropical Medicine, a multicountry study on women's health and domestic violence.
- In September 1998 the Inter-American Development Bank (IDB) brought together 400 experts from 37 countries to discuss the causes and costs of domestic violence, and policies and programs to address it. The IDB currently funds research and demonstration projects on violence against women in six Latin American countries.
- In 1998 UNIFEM launched regional campaigns in Africa, Asia/Pacific, and Latin America designed to draw attention to the issue of violence against women globally (502). UNIFEM also manages The Trust Fund in Support of Actions to Eliminate Violence Against Women, an initiative that has disbursed US\$3.3 million to 71 projects around the world since 1996 (503).
- In 1999 the United Nations Population Fund declared violence against women "a public health priority" (445).

Intimate Partner Abuse

Worldwide, one of the most common forms of violence against women is abuse by their husbands or other intimate male partners. Partner violence occurs in all countries and transcends social, economic, religious, and cultural groups. Although women can also be violent and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

While research into intimate partner abuse is in its early stages, there is growing agreement about its nature and the various factors that cause it. Often referred to as "wife-beating," "battering," or "domestic violence," intimate partner abuse is generally part of a pattern of abusive behavior and control rather than an isolated act of physical aggression. Partner abuse can take a variety of forms including physical assault such as hits, slaps, kicks, and beatings; psychological abuse, such as constant belittling, intimidation, and humiliation; and coercive sex. It frequently includes controlling behaviors such as isolating a woman from family and friends, monitoring her movements, and restricting her access to resources.

Magnitude of the Problem

In nearly 50 population-based surveys from around the world, 10% to over 50% of women report being hit or otherwise physically harmed by an intimate male partner at some point in their lives (see Table 1). The data in Table 1 refer only to women who have been physically assaulted. Research into partner violence is so new that comparable data on psychological and sexual abuse by intimate partners are few.

Physical violence in intimate relationships almost always is accompanied by psychological abuse and, in one-third to over one-half of cases, by sexual abuse (59, 75, 131, 258, 272). For example, among 613 abused women in Japan, 57% had suffered all three types of abuse—physical, psychological, and sexual. Only 8% had experienced physical abuse alone (485). In Monterrey, Mexico, 52% of physically abused women had also been sexually abused by their partners (191). In León, Nicaragua, among 188 women who were physically abused by their partners, only 5 were not also abused sexually, psychologically, or both (131).

Most women who suffer any physical aggression generally experience multiple acts over time. In the León study, for example, 60% of women abused in the previous year were abused more than once, and 20% experienced severe violence more than six times. Among women reporting any physical aggression, 70% reported severe abuse (130). The average number of physical assaults in the previous year among currently abused women surveyed in London was seven (308); in the US in 1997, three (436).

In surveys of partner violence, women usually are asked whether or not they have experienced any of a list of specific actions, such as being slapped, pushed, punched, beaten, or threatened with a weapon. Asking behavioral questions—for example, "Has your partner ever physically forced you to have sex against your will?"—yields more accurate responses than asking women whether they have been "abused" or "raped" (127). Surveys generally define physical acts more severe than slapping, pushing, shoving, or throwing objects as "severe violence."

Measuring "acts" of violence does not describe the atmosphere of terror that often permeates abusive relationships. For example, in Canada's 1993 national violence survey one-third of women who had been

Table 2. Approval of Wife-Beating
Percentage by Rationale, Selected Studies, 1985–1999

Country & Year (Ref. No.)	Respondents	She	She	He	She
		Neglects Children and/or House	Refuses Him Sex	Suspects Her of Adultery	Answers Back or Disobeys
Brazil (Salvador, Bahia) 1999 (348)	M	—	—	19 ^a	—
	F	—	—	11 ^a	—
Chile (Santiago) 1999 (348)	M	—	—	12 ^a	—
	F	—	—	14 ^a	—
Colombia (Cali) 1999 (348)	M	—	—	14 ^a	—
	F	—	—	13 ^a	—
Egypt 1996 (132)	Urban F	40	57	—	59
	Rural F	61	81	—	78
El Salvador (San Salvador) 1999 (348)	M	—	—	5 ^a	—
	F	—	—	9 ^a	—
Ghana 1999^b (23)	M	—	43	—	—
	F	—	33	—	—
India (Uttar Pradesh) 1996 (319)	M	—	—	—	10–50
Israel (Palestinians) 1996^c (195)	M	—	28	71	57
New Zealand 1995 (272)	M	1	1	5 ^d	1 ^e
Nicaragua 1999^f (386)	Urban F	15	5	22	—
	Rural F	25	10	32	—
Papua New Guinea 1985 (39)	High school F	—	—	—	59 ^g
	High school M	—	—	—	63 ^g
Singapore 1996 (83)	M	—	5	33 ^h	4
Venezuela (Caracas) 1999 (348)	M	—	—	8 ^a	—
	F	—	—	8 ^a	—

F = Female M = Male

Note: — indicates this question not asked

^a"An unfaithful woman deserves to be beaten"

^bAlso, 51% of men and 43% of women agreed: "husband is justified in beating" his wife if she goes out without his permission.

^c"She won't do what she is told."

^dAlso, 11% of urban women and 23% of rural women agreed "husband is justified in beating" his wife if she goes out without his permission.

^e"She speaks disrespectfully to him."

^fAlso, 23% agreed "wife-beating is justified" if not respect her husband's relatives.

^g"She is sexually involved with another man." she does

^h"He catches her in bed with another man."

Compiled by the Center for Health and Gender Equity for **Population Reports**

Physically assaulted by a partner said that they had feared for their lives at some point in the relationship (378). Women often say that the psychological abuse and degradation are even more difficult to bear than the physical abuse (57, 58, 96).

Dynamics of Abuse

Many cultures hold that men have the right to control their wives' behavior and that women who challenge that right—even by asking for household money or by expressing the needs of the children—may be punished. In countries as different as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, Tanzania, and Zimbabwe, studies find that violence is frequently viewed as physical chastisement—the husband's right to "correct" an erring wife (10, 39, 94, 189, 204, 233, 303, 341, 407, 488). As one husband said in a focus-group discussion in Tamil Nadu, India, "If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings" (233).

Justifications for violence frequently evolve from gender norms—that is, social norms about the proper roles and responsibilities of men and women (94). Typically, men are given relatively free reign as long as they provide financially for the family. Women are expected to tend the house and mind the children and to show their husbands obedience and respect. If a man perceives that his wife has somehow failed in her role, stepped beyond her bounds, or challenged his rights, then he may react violently.

Table 3. Help-Seeking by Physically Abused Women

Selected Studies, 1993–1999

Country & Year (Ref. No.)	% of Abused Women Who:			
	Never Told Anyone	Contacted Police	Told Freinds	Told Family
Bangladesh 1993 (255).....	68	—	—	30
Canada 1993 (240).....	22	26	45	44
Cambodia 199P (325).....	34	1	33	22
Chile 1993 (268).....	30	16	14	32 ^a
Egypt 1995–96 (132).....	47	—	3	44
Ireland 1995P (330).....	—	20	50	37
Moldova 1997 (410).....	—	6	30	31
Nicaragua 1998 (386).....	37	17	28	34
United Kingdom 1993P (308).....	38	22	46	31

^a 32% told her family, 21% told his family.

"P" after year indicates year of publication for studies not reporting field work dates.

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Worldwide, studies identify a consistent list of events that are said to "trigger" violence. These include: not obeying her husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, refusing him sex, or expressing suspicions of infidelity (10, 39, 189, 204, 233, 303, 341, 407, 451, 488). All of these constitute transgression of gender norms.

In many developing countries women share the notion that men have the right to discipline their wives by using force (see Table 2). In rural Egypt, for example, at least 80% of women say that beatings are justified under certain circumstances (132). One of the circumstances that women most often cite is refusing a man sex (23, 103, 132, 386). Not surprisingly, refusing sex is also one of the reasons women cite most often as triggering beatings (248, 322, 475, 488).

Societies often distinguish between just and unjust reasons for violence, as well as between acceptable and

unacceptable amounts of aggression. The notion of “just cause” permeates findings on violence in many countries. Certain individuals, usually husbands and elders, may have the right to chastise a woman physically for certain transgressions, but only within limits. If a man oversteps these limits by becoming too violent or for beating a woman without “just cause,” others have cause to intervene (189, 210, 368, 407). As a woman in Mexico put it, “If I have done something wrong..., nobody should defend me. But if I haven’t done something wrong, I have a right to be defended” (189).

Even where culture itself grants men substantial control over female behavior, abusive men generally exceed the norm (240, 382, 386). For example, data from the Nicaragua Demographic and Health Survey (DHS) show that, among women who were abused physically, 32% had husbands who scored high on a scale of marital control compared with only 2% among women who were not abused physically. The scale included such behavior as the husband’s continually accusing his wife of being unfaithful and limiting her access to family and friends (386).

Women's Response to Abuse

Most abused women are not passive victims but use active strategies to maximize their safety and that of their children (62, 119, 202, 258). Some women resist, others flee, and still others attempt to keep the peace by capitulating to their husbands’ demands. What may seem to an observer to be lack of response to living with violence may in fact be strategic assessment of what it takes for the woman to survive in the marriage and to protect herself and her children.

A woman’s response to abuse is often limited by the options available to her (119). Women consistently cite similar reasons that they remain in abusive relationships: fear of retribution, lack of other means of economic support, concern for the children, emotional dependence, lack of support from family and friends, and an abiding hope that “he will change” (10, 131, 330, 413, 488). In developing countries women cite the unacceptability of being single or unmarried as an additional barrier that keeps them in destructive marriages (169, 368, 488).

At the same time, denial and fear of social stigma often prevent women from reaching out for help. In surveys, for example, from 22% to almost 70% of abused women say that they have never told anyone about their abuse before being asked in the interview (see Table 3, p. 6). Those who reach out do so primarily to family members and friends. Few have ever contacted the police.

Despite the obstacles, many women eventually do leave violent partners—even if after many years, once the children are grown (129, 227). In León, Nicaragua, for example, the likelihood that an abused woman will eventually leave her abuser is 70%. The median time that women spend in a violent relationship is five years. Younger women are more likely to leave sooner (131).

Studies suggest a consistent set of factors that propel women to leave an abusive relationship: The violence gets more severe and triggers a realization that “he” is not going to change, or the violence begins to take a toll on the children. Women also cite emotional and logistical support from family or friends as pivotal in their decisions to leave (52, 62, 65, 69, 202, 413).

Leaving an abusive relationship is a process. The process often includes periods of denial, self-blame, and endurance before

women come to recognize the abuse as a pattern and to identify with other women in the same situation. This is the beginning of disengagement and recovery. Most women leave and return several times before they finally leave once and for all (264).

Regrettably, leaving does not necessarily guarantee a woman’s safety. Violence sometimes continues and may even escalate after a woman leaves her partner (227). In fact, a woman’s risk of being murdered is greatest immediately after separation (60).

Explaining Intimate Partner Abuse

While intimate partner abuse is widespread, it is not universal. Anthropologists have documented small-scale societies—such as the Wape of Papua New Guinea—where domestic violence is virtually absent (95, 275). This finding stands as testament to the fact that social relations can be organized in a way that minimizes partner abuse.

In many places the prevalence of such violence varies substantially among neighboring areas (255, 319). These local differences are often greater than the differences among countries. For example, in Uttar Pradesh, India, the percentage of men who said they beat their wives varied from 18% in Naintal District to 45% in Banda (319). The percentage that physically forced their wives to have sex varied from 14% to 36% among districts (see Table 4).



Hesperian Foundation (54)

A woman’s response to abuse is often limited by the options available to her.

Table 4. Variations in Men’s Attitudes and Rates of Abuse
Selected Districts, Uttar Pradesh, India, 1995–1996

District	% Who Admit to Forcing Wife To Have Sex	% Who Agree That If Wife Disobeys, She Should Be Beaten	% Who Admit to Hitting Wife	% Who Hit Wife in Last Year
Aligarh.....	31	15	29	17
Banda.....	17	50	45	33
Gonda.....	36	27	31	20
Kanpur Naqar.....	14	11	22	10
Naintal.....	21	10	18	11

Source: Narayana 1996 (319)

Population

Why is violence more widespread in some places than in others? While studies do not provide clear answers, they do identify some characteristics of societies and of relationships that help explain differences in prevalence of violence against women.

Violence and socioeconomic status. Although domestic violence occurs in all socioeconomic groups, studies find that women who live in poverty are more likely to experience violence than women of higher status (188, 215, 253, 268, 288, 25, 378, 386, 427).

A Framework for Understanding Partner Violence

What causes violence against women? Increasingly, researchers are using an “ecological framework” to understand the interplay of personal, situational, and sociocultural factors that combine to cause abuse (118, 210). In this model, violence against women results from the interaction of factors at different levels of the social environment.

The model can best be visualized as four concentric circles. The innermost circle represents the biological and personal history that each individual brings to his or her behavior in relationships. The second circle represents the immediate context in which abuse takes place—frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded—neighborhood, workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

A wide range of studies agrees on several factors at each of these levels that increase the likelihood that a man will abuse his partner:

- **At the individual level** these include being abused as a child or witnessing marital violence in the home (218, 310), having an absent or rejecting father (118), and frequent use of alcohol (30, 263, 291, 310, 339, 352).

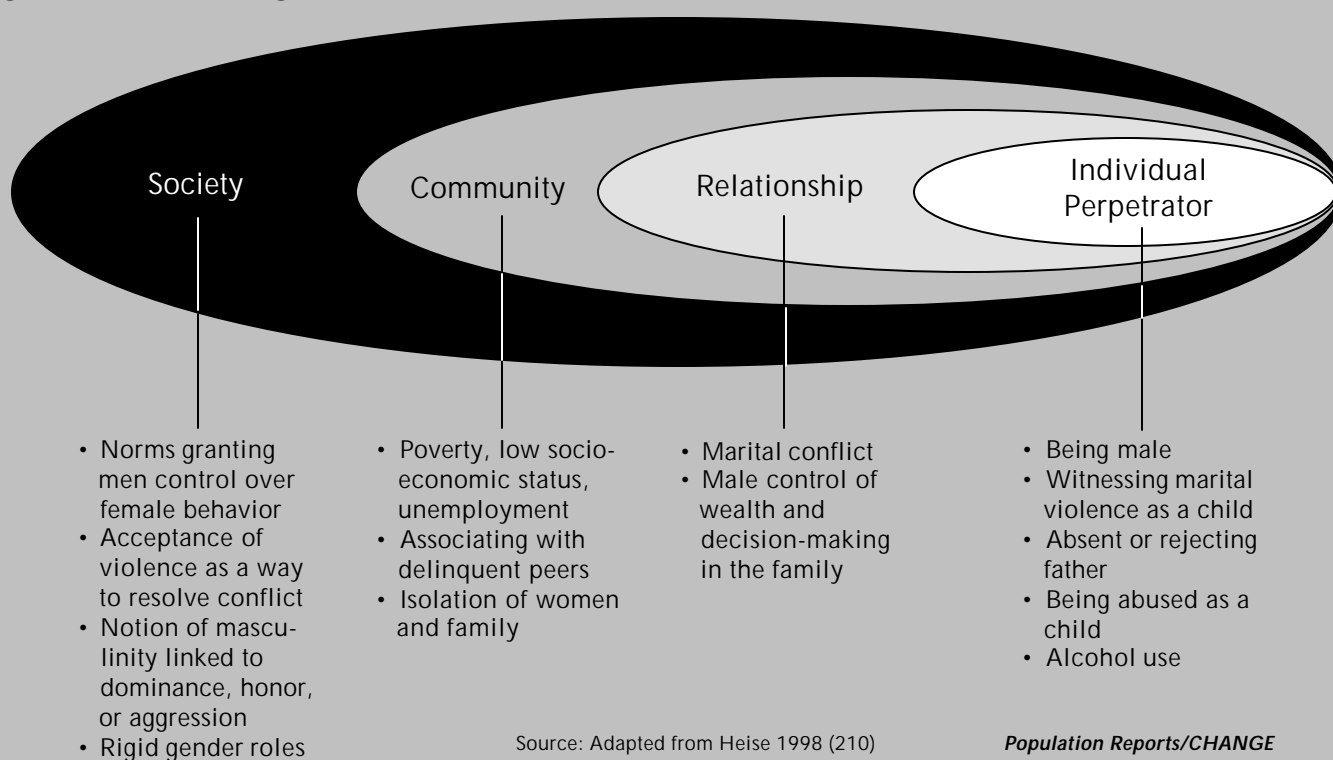
- **At the level of the family and relationship**, cross-cultural studies have cited male control of wealth and decision-making within the family (275, 339) and marital conflict as strong predictors of abuse (215, 219).

- **At the community level** women's isolation and lack of social support, together with male peer groups that condone and legitimize men's violence, predict higher rates of violence (159, 255, 339).

- **At the societal level** studies around the world have found that violence against women is most common where gender roles are rigidly defined and enforced (210) and where the concept of masculinity is linked to toughness, male honor, or dominance (95, 393). Other cultural norms associated with abuse include tolerance of physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes, and the perception that men have “ownership” of women (210, 275, 310, 340).

By combining individual-level risk factors with findings of cross-cultural studies, the ecological model contributes to understanding why some societies and some individuals are more violent than others and why women—especially wives—are so consistently the victims of abuse.

Figure 1. Ecological Model of Factors Associated with Partner Abuse



It is unclear, however, why poverty increases the risks of violence—whether it is due to low income itself or to other factors that accompany poverty, such as crowding or hopelessness. For some men, living in poverty is likely to generate stress, frustration, and a sense of inadequacy for having failed to live up to their culturally defined role of provider. Poverty may also provide cause for marital disagreements and at the same time make it difficult for women to leave violent or otherwise unsatisfactory relationships.

Low socioeconomic status probably reflects a variety of conditions that in combination increase women's risk of victimization (210). Increasingly, experts are using an “ecological model” to understand the interplay of personal, situational, and sociocultural factors that combine to cause abuse (see Figure 1). An ecological approach to abuse argues that that no one factor alone “causes” violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting may act violently toward a woman. In the ecological framework, social and cultural norms—such as those that assert men's inherent superiority over women—combine with individual-level factors—such as whether a man was abused himself as a child—to determine the likelihood of abuse. The more risk factors present, the higher the likelihood of violence.

Other factors of the social environment combine to protect some women. For example, when women have authority and power outside the family, rates of abuse in intimate partnerships appear to be lower (94, 275, 407). Likewise, prompt intervention by family members appears to reduce the likelihood of domestic violence, as does the presence of all-woman collectives (94, 275). By contrast, where the family is considered “private” and outside public scrutiny, rates of wife abuse are higher (275).

Sexual Coercion

Sexual coercion exists along a continuum, from forcible rape to nonphysical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical or social consequences if she resists sexual advances.

Some forms of coercion—such as forced penetration (rape), sexual assault (forced sexual contact), and sexual molestation of children—are recognized as crimes by many legal systems. Other forms—such as intimidation, verbal pressure, or forced marriage—are culturally tolerated and at times even condoned (211, 390). Still others involve collusion by organized crime or the military, such as trafficking in women and children, and rape in war.

Most nonconsensual sex takes place among people who know each other—spouses, family members, courtship partners, or acquaintances (211, 479). Sexual coercion can take place at any point in a woman's life. Children as young as several months old have been raped or otherwise sexually molested. Even in old age women are not immune: Rape crisis centers report victims in their seventies and older (211).

Much sexual coercion takes place against children or adolescents in both industrial and developing countries. Between one-third and two-thirds of known sexual assault victims are



Woman, Law and Development Centre Nigeria

As this poster from Nigeria illustrates, violence against women takes many forms. Often, social and cultural norms condone gender-based violence.

age 15 or younger, according to information from justice systems and rape crisis centers in Chile, Peru, Malaysia, Mexico, Panama, Papua New Guinea, and the US (212). During childhood young girls can become easy targets for older male relatives or friends who obtain sex through force or deception. Later, boyfriends, teachers, relatives, or other men in authority may force young women into unwanted sexual encounters.

Forced Sex in Marriage

Ironically, much nonconsensual sex takes place within consensual unions. Not all women experience sex negatively, of course, and many experience pleasure. For some, however, sex is just another medium for male control.

For example, in a 15-country qualitative study of women's HIV risk, women related profoundly troubling experiences of sex within marriage. Respondents frequently mentioned being physically forced to have sex and/or to engage in types of sexual activity that they found degrading and humiliating (466). Others gave in to sex out of fear of the consequences of refusal, such as physical abuse, loss of economic support, or accusations of infidelity. Many other studies have noted this type of “defensive acquiescence” (103, 136, 248, 365).

In Papua New Guinea, for example, among 95 women interviewed in depth, about half said their husbands had forced them into sex. One-third of those forced said they had been

beaten into sex, and one-fifth had been harangued into it by a drunken husband (322). In Uttar Pradesh, India, about two-thirds of 98 respondents reported being forced into sex by their husbands—about one-third of them by beatings (248).

Forced Sexual Initiation

For a substantial minority of women, sexual initiation is a traumatic occurrence accompanied by force and fear. For others, sexual initiation, although not physically forced, is nonetheless unwanted—an experience they perceive as happening to them rather than as something they choose (see Table 5).

For example, at an antenatal clinic in the outskirts of Cape Town, South Africa, 32% of 191 teenage mothers, whose average age was 16, reported that their first intercourse had been forced. Some 72% reported having had sex against their will at some point, and 11% said they had been raped. Seventy-eight percent said they would be beaten if they refused sex, 39% feared being laughed at, and 6% said they would lose their friends. Some 58% said their sexual partner had beaten them ten or more times (282). Also, in a study in the Eastern Cape of South Africa, the reasons that young girls most often gave for beginning sex was being “forced by partner,” at 28%, followed by “peer pressure,” at 20% (50).

Culture: A Double-Edged Sword

In all societies there are cultural institutions, beliefs, and practices that undermine women's autonomy and contribute to gender-based violence. Certain marriage practices, for example, can disadvantage women and girls, especially where customs, such as dowry and bridewealth, have been corrupted by Western “consumer” culture.

In recent years, for example, dowry has become an expected part of the marriage transaction in some countries, with future husbands demanding ever-increasing dowry both before and after marriage. Dowry demands can escalate into harassment, threats, and abuse; in extreme cases the woman is killed or driven to suicide, freeing the husband to pursue another marriage and dowry (237, 368, 407).

Elsewhere, husbands are expected to pay “bridewealth” to compensate the bride's family for the loss of labor in her natal home. In parts of Africa and Asia this exchange has likewise become commercialized, with inflated bridewealth leaving many men with the impression that they have “purchased” a wife. In a recent survey in the Eastern Cape Province of South Africa, 82% of women said it is culturally accepted that, if a man pays *lobola* (bridewealth) for his wife, it means that he owns her. Some 72% of women themselves agreed with this statement (235).

Both marriage traditions undermine the ability of women to escape abusive relationships. For example, parents on the Indian subcontinent are reluctant to allow their daughters to return home for fear of having to pay a second dowry, whereas in bridewealth cultures, women's parents must repay the man if their daughter leaves the marriage. As an abused woman in India observed, “One often feels like running away from it all. But where does one go? The only place is your parents' house, but they will always try to send you back” (451).

Cultural attitudes toward female chastity and male honor also serve to justify violence against women and to exacerbate its consequences. In parts of Latin American and the Near East, a man's honor is often linked to the sexual “purity” of the women in his family. If a woman is “defiled” sexually—either through rape or by engaging voluntarily in sex outside of marriage—she disgraces the family honor.

For example, in some Arab societies the only way to “cleanse” the family honor is to kill the “offending” woman or girl. A study

of female homicide in Alexandria, Egypt, found that 47% of all women killed were murdered by a relative after they had been raped (190). At a recent conference in Jordan, experts from six Arab countries estimated that at least several hundred Arab women die each year as a result of honor killings (231).

Culture is neither static nor monolithic, however. Women's rights activists argue that communities must dismantle those aspects of culture that oppress women while preserving what is good. In the words of Ghanaian lawyer Rosemary Ofi-Ofi, “A culture that teaches male mastery and domination over women must be altered” (332).

Women at the forefront of the women's human rights movement point out that appeals to culture are often an excuse to justify practices oppressive to women. Sudanese physician Nahid Toubia asks, “Why is it only when women want to bring about change for their own benefit that culture and custom become sacred and unchangeable?” (211)

Although culture can aggravate women's vulnerability, it can also serve as a creative resource for intervention. Many traditional cultures have mechanisms—such as public shaming or community healing—that can be mobilized as resources to confront abuse. Activists from Canada's Yukon Territory, for example, have developed Circle Sentencing, an updated version of the traditional sanctioning and healing practices of the Canadian aboriginal peoples. Within the “circle,” crime victims, offenders, justice and social service personnel, as well as community residents, listen to the victim's story and deliberate about how best to “restore justice” to the victim and the community. Sentencing often includes reparation, community service, jail time, treatment requirements, and community healing rituals (22, 289).

Activists in India and Bangladesh likewise have adapted the *salishe*—a traditional system of local justice—to address domestic violence. For example, when a woman is beaten, the West Bengali NGO Shramajibee Mahila Samity sends a female organizer to the village to consult with the individuals and families involved. The organizer then facilitates a *salishe*, attempting to steer the discussion in a prowoman direction. Collectively, the community arrives at a proposed solution, which is formalized in writing and monitored by a local committee (102).

Adolescent boys admit that coercion of female partners is common. In Kenya, for example, boys ages 12 to 14 and 15 to 19 in focus-group discussions observed, "We seduce them at first, but if they remain adamant we force them," including sometimes drugging them or gagging them to prevent screams (301). During focus-group discussions in South Africa, one teenage girl observed, "I actually think forced sex is the norm. It is the way people interact sexually" (450).

The younger a woman is at first sexual intercourse, the more likely that sex is forced. In New Zealand, for example, one girl in every four who had intercourse before age 14 reported that she was forced to do so, often by a much older man (112). Likewise in the US, 24% of those who had intercourse before age 14 reported having been forced (2).

Even when first intercourse takes place within marriage, it can be traumatic, especially where women and girls are given little information about sex (186). A study among married women in a poor community of India reported that many women found their first sexual experience to be traumatic; only 18% had even a vague idea of what to expect on their wedding night. One woman recalled, "It was a terrifying experience. When I tried to resist, he pinned my arms above my head" (248).

Girls who are married off at a young age are especially vulnerable. Although the practice of child marriage is declining, many young girls still are married off unwillingly, often to men many years their elder (277).

Intercourse at young ages, even when culturally supported, can be traumatic for girls. For example, when anthropologist Mary Hegland interviewed Iranian women living in the US about their sexual initiation in Iran, many recounted graphic stories of forced defloration. Often, relatives held a girl down while the man forced himself on her. The interviewed women used terms like "rape" and "torture" to describe their experience but said that the word "rape" would never be applied to these experiences in Iran because the sex took place within marriage (208).

Sexual Abuse in Childhood

Sexual abuse of children is widespread in virtually all societies. Child sexual abuse refers to any sexual act that occurs between an adult or immediate family member and a child, and any nonconsensual sexual contact between a child and a peer. Laws generally

consider the issue of consent to be irrelevant in cases of sexual contact by an adult with a child, defined variously as someone under 13, 14, 15, or 16 years of age.

Because of the taboo nature of the topic, it is difficult to collect reliable statistics on the prevalence of sexual abuse in childhood. The few representative sample surveys that exist report that such abuse is widespread (see Table 6, p. 12). The studies are not directly comparable because of differences in samples and in definitions of abuse. Most distinguish between abuse that involves physical contact and abuse that does not, such as exhibitionism. They also report on different types of sexual contact—for example, genital touching versus intercourse.

Although both girls and boys can be victims of sexual abuse, most studies report that the prevalence of abuse among girls is at least 1.5 to 3 times that among boys, and sometimes much more (75, 153). In Barbados, for example, 30% of women and



Hesperian Foundation (54)

For Many young women, unmarried or married, sexual initiation is a terrifying experience, accompanied by fear and force—as young men will often admit. The younger a woman is at sexual initiation, the more likely that sex is forced.

Table 5. Prevalence of Forced First Intercourse
Selected Studies, 1989–1999

Country & Year (Ref. No.)	Size	Sample Type	Age	% Whose First Intercourse was Forced
Argentina 1998(186).....	201	Clinic-based	15–18	6 (41 ^a)
Central African Rep 1989 (79)	1,307	National	15–50	21
Jamaica 1997 (226).....	51 ^b	School-based	8th grade	12
Kenya 1994 (334).....	9,997	School-based	12–24	8 forced 6 "tricked"
Mozambique 1993 (17).....	189	School-based	12–23	8
New Zealand 1993–94 (112).....	458	National, longitudinal	18 & 21	7 25 ^c
Sierra Leone 1998P (87).....	144	Convenience	adult	31
South Africa 1999 (453).....	544 ^b	Matched case-control	<19	32 pregnant 18 nonpregnant
United States 1992 (270).....	1,663	National	18–59	4 (25 ^a)

^aUnwanted but not forced

^bSexually active girls only

^cOf those sexually active before age 14

^dOf those sexually active before age 15

^P after year indicates year of publication of studies not reporting the field work dates.

Compiled by the Center for Health and Gender der Equity (CHANGE) for Population Reports.

Table 6. Prevalence of Child Sexual Abuse
Selected Studies, 1990–1998

<i>Country & Year (Ref. No.)</i>	<i>Study Method & Sample</i>	<i>Definition of Child Sexual Abuse</i>	<i>Prevalence</i>
Antigua 1993 (200)	Probability sample of 97 women.	Sexual contact that is unwanted or with a biological relative; or <16 with perpetrator 5+ years older	11% of women report sexual exploitation before age 20
Australia 1997 (156)	Retrospective study of 710 women	Sexual contact <12 with perpetrator 5+ years older; or unwanted sexual activity at ages 12–16	20% of women report abuse
Barbados 1993 (199)	National random sample of 264 women	Sexual contact that is unwanted or with a biological relative; or <16 with perpetrator 5+ years older	30% of women report abuse
Canada 1990 (498)	Population survey of 9,953 men and women age 15+	Unwanted sexual activity, contact and noncontact, while growing up	13% of women, 4% of men report abuse
Costa Rica 1992P (497)	Retrospective survey of university students	Unwanted sexual activity, contact and noncontact; no ages specified	32% of women, 13% of men report abuse
Germany 1992 (405)	Multiple-screen questionnaire answered by 2,151 students in Würzburg and Leipzig	Distressing sexual activity, contact and noncontact, <14; or with perpetrator 5+ years older	In Würzburg 16% of girls, 6% boys; in Leipzig 10% of girls, 6% of boys report abuse
Malaysia 1996 (415)	Retrospective self-administered questionnaire answered by 616 paramedical students	Vaginal or anal penetration, or unsolicited sexual contact, or witnessing exhibitionism <18	8% of women, 2% of men report abuse
New Zealand 1997 (149)	Birth cohort of 520 girls, studied from birth to age 18	Unwanted sexual activity, contact and noncontact, <16	14% of girls report contact abuse; 17% report any abuse
Nicaragua 1997 (336)	Anonymous self-administered questionnaire answered by 134 men and 202 women ages 25–44 drawn from population-based sample	Sexual contact, including attempted penetration, <13 with perpetrator 5+ years older; or nonconsensual activity >12	26% of women, 20% of men report abuse
Norway (Oslo) 1996 (354)	Population-based sample of 465 adolescents, ages 13–19, followed for 6 years	Sexual contact, including “intercourse after pressure,” occurring between a child <13 and an adult >17; or involving force	17% of girls, 1% of boys report abuse
Spain 1995 (279)	Face-to-face interviews and self-administered questionnaires answered by 895 adults ages 18–60	Unwanted sexual activity, contact and noncontact, <17	22% of women and 15% of men report abuse
Switzerland (Geneva) 1996 (198)	Self-administered questionnaire answered by 1,193 ninth grade students	Unwanted sexual activity, contact and noncontact	20% of girls, 3% of boys report contact abuse; 34% of girls, 11% of boys report any abuse
Switzerland (national) 1998 (501)	National survey of 3,993 girls, ages 15–20, enrolled in schools or professional training programs	“Sexual victimization,” defined as “when someone in your family, or someone else, touches you in a place you didn’t want to be touched, or does something to you sexually which they shouldn’t have done.”	19% of girls report abuse
United States 1997 (471)	National 10-year longitudinal study of women’s drinking that included questions about sexual abuse, answered by 1,099 women	Unwanted sexual activity, contact and noncontact, <18; or <13 with perpetrator 5+ years older	21% of women report abuse
United States (Midwest) 1997 (280)	Self-administered questionnaire answered by 42,568 students in grades 7–12	“Sexual abuse,” defined as “when someone in your family or another person does sexual things to you or makes you do sexual things to them that you don’t want to do.”	12% of girls, 4% of boys report abuse
United States (South) 1994 (317)	Anonymous self-report survey of 3,018 adolescents, grades 8 and 10	Forced intercourse only	13% of girls, 7% of boys report abuse
United States (Washington State) 1997 (424)	Multiple-choice survey of 3,128 girls in grades 8, 10, and 12	“Sexual abuse,” defined as “when someone in your family or someone else touches you in a sexual way in a place you didn’t want to be touched, or does something to you sexually which they shouldn’t have done”	23% of all girls; 18% of 8th graders, 24% of 10th graders, 28% of 12th graders report abuse

Compiled by Center for Health and Gender Equity (CHANGE) for Population Reports

2% of men reported behavior constituting sexual abuse in childhood or adolescence (199). Abuse among boys may be underreported compared with abuse among girls, however.

Women tend to report being more profoundly affected by sexual abuse than do men, although some men and boys undoubtedly suffer greatly (336, 373). The experience of being penetrated appears to be especially traumatic for both boys and girls (42, 81, 247, 336).

Studies consistently show that, regardless of the sex of the victim, the vast majority of perpetrators are male and are known to the victim (217, 336, 396, 414). Many perpetrators were themselves sexually abused in childhood, although most boys who are sexually abused do not grow up to abuse others (462).

Sexual abuse can lead to a wide variety of unhealthy consequences, including behavioral and psychological problems, sexual dysfunction, relationship problems, low self-esteem, depression, thoughts of suicide, alcohol and substance abuse, and sexual risk-taking (25, 53, 81, 276, 399). Women who are sexually abused in childhood also are at greater risk of being physically or sexually abused as adults (26, 37, 149).

Although for some children the effects of sexual abuse are severe and long-term, not all will experience consequences that persist into later life (247, 314). Sexual abuse is most likely to cause long-term harm when it extends over a long period, is by a father or father figure, involves penetration, or involves force or violence (26, 247, 373).

A child's resilience and the response a child receives when disclosing the abuse also affect the long-term consequences (85, 247, 396). When children who disclose abuse are believed and supported, the consequences are often less severe than when disclosure is met with disbelief, blame, or rejection (396).

Impact on Women's Reproductive Health

Physical and sexual abuse lie behind some of the most intractable reproductive health issues of our times—unwanted pregnancies, HIV and other sexually transmitted infections, and complications of pregnancy. A growing number of studies document the ways in which violence by intimate partners and sexual coercion undermine women's sexual and reproductive autonomy and jeopardize their health.

Violence operates through multiple pathways to affect women's sexual and reproductive health (see Figure 2, p. 14). Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies *directly*, if women are forced to have sex, for example, or fear using contraception or condoms because of their partners' reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs



Hesperian Foundation (54)

Sexual abuse in childhood and adolescence seems widespread virtually everywhere. Most perpetrators are known to the victim.



Cousins/Women and Law in Southern Africa (500)

In some countries, such as Zimbabwe, women's groups have prepared manuals (500) and other materials to help family, friends, and social services support the victims of sexual abuse and domestic violence.

indirectly by increasing sexual risk-taking in adolescence and adulthood.

Sexual Autonomy and Unwanted Pregnancies

In many parts of the world marriage is interpreted as granting men the right to unconditional sexual access to their wives and the power to enforce this access through force if necessary

(409). Women who lack sexual autonomy often are powerless to refuse unwanted sex or to use contraception and thus are at risk of unwanted pregnancies.

As a 40-year old woman in Uttar Pradesh said, “What can I do to protect myself from these unwanted pregnancies unless he agrees to do something? Once when I gathered the courage and told him I wanted to avoid sex with him, he said, ‘What else have I married you for?’ He beats me for the smallest reasons and has sex whenever he wants” (248).

Not surprisingly, many women acquiesce to having sex even if they do not want it. For example, in the Western Visayas region of the Philippines, 43% of the married women of reproductive age who were surveyed said they were afraid to refuse their husbands’ sexual advances, often because refusal might cause their husbands to beat them (103).

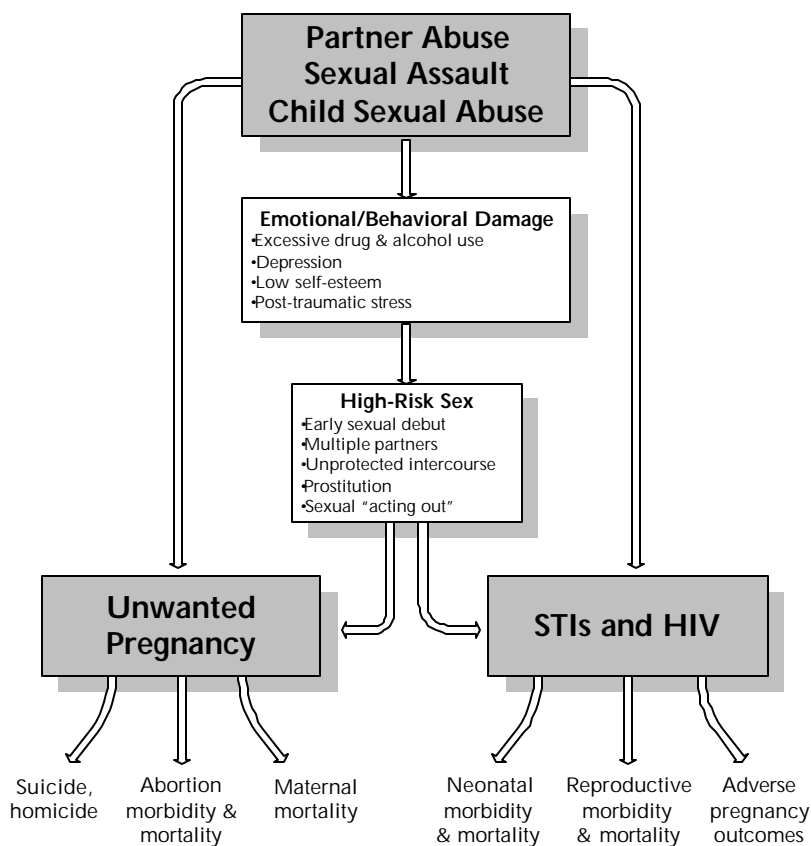
Many studies have found that violence toward women is more common in families with many children (103, 130, 233, 268, 288, 318, 386, 436). Researchers have long assumed that

having many children increases women’s risk of being abused, perhaps by increasing levels of stress within the family or provoking more marital disagreements. Recent research in Nicaragua, however, suggests that the relationship may be the reverse, with domestic violence increasing the likelihood that a woman will have many children. The study found that abused women were twice as likely as other women to have four or more children. But 50% of all physical abuse began within the first two years of the relationship, and 80% began within four years (131). The fact that abuse preceded having many children suggests that violence is a risk factor for having many children, rather than a consequence.

A large-scale survey among married men in Uttar Pradesh, India, demonstrates directly that forced sex can lead to unintended pregnancies. Men who admitted having forced their wives to have sex were 2.6 times more likely than other men to have caused an unplanned pregnancy (288).

Contraceptive use. Many women are afraid to raise the issue of contraception for fear that their partners might respond violently (23, 33, 84, 135, 157, 158, 411). In some cultures husbands may react negatively because they think that protection against pregnancy would encourage their wives to be unfaithful. Where having many children is a sign of virility, a husband may interpret his wife’s desire to use family planning as an affront to his masculinity (411). In Kenya some men say that they oppose the use of contraception because they fear it will weaken their control over their wives (32, 463).

**Figure 2. Violence Against Women:
Direct and Indirect Pathways to Unwanted
Pregnancy and Sexually Transmitted Infections**



STI = sexually transmitted infection
HIV = human immunodeficiency virus (which causes AIDS)
Source: Adapted from Heise et al. 1995

Population Reports/CHANGE

(211)
Violence by intimate partners and sexual coercion harms women’s reproductive health both directly, by causing unwanted pregnancies and STIs including HIV/AIDS, and indirectly, by causing emotional and behavioral damage that leads to a variety of risky se

When asked what happens if a woman practices family planning without her husband's consent, men interviewed in Ghana gave such replies as, "It is fitting enough to beat her for not consulting you earlier before going ahead to practice family planning," and "It is not good for you to keep such a woman since she did so without first consulting with you" (135). In Cape Town, South Africa, young women described how their partners beat them and tore up their clinic contraceptive cards (475).

For women living with men who are violent, the fear of a negative reaction is often enough to cut off discussion of contraception. As one woman said of her husband, "Whenever he hears people discussing family planning over the radio, he fumes and shouts.... If he can threaten a wireless, what would he do to me if I open the topic?" (23).

Fortunately, not all women who fear a negative response are necessarily at risk of abuse. Studies suggest that many husbands are more open to family planning than their wives may think (117). Communication within marriage about sex is often so limited, however, that spouses often do not know their partners' views of family planning. Wives whose husbands actually favor family planning may assume that their husbands' attitudes mirror cultural norms that disapprove of it. In Uganda, for example, 24% of women thought their husbands disapproved of contraception when in fact their husbands approved (33).

Violence Leads to High-Risk Sexual Behavior

Children who have been sexually abused often engage in sexual behavior, as adolescents and as adults, that puts them at risk of unintended pregnancies and sexually transmitted infections. Some researchers view the risky sexual behavior of abuse victims as an effort to gain control or mastery of a childhood experience in which they felt violated and powerless (154). Others note that the experience of incest and sexual abuse can make it difficult for victims to form healthy intimate relationships. One researcher has observed that a victim's "heightened need for intimacy, coupled with the sexualization of affection, may lead her to seek warmth and closeness through repeated sexual encounters" (116).

Adolescent pregnancies. Victims of sexual abuse in childhood appear more likely than other teens to become pregnant in adolescence. In the early 1990s studies in the US began to find a consistent association between sexual abuse in childhood and adolescent pregnancy (25, 37, 56). The studies also found a clear and consistent link between early sexual victimization and a variety of risk-taking behaviors, including early sexual debut, drug and alcohol use, more sexual partners, and less contraceptive use (148, 455).

Noting that programs have had difficulty reducing rates of adolescent pregnancy by providing sex education and access to contraception alone, researchers suggested that sexual victimization in childhood might help explain high-risk sexual activity and pregnancies among adolescents (37). Some have questioned whether it is the sexual victimization itself that contributes to the risk of adolescent pregnancy or whether both are caused by some third factor, such as an unhealthy and disorganized home life. Studies have shown that many of the factors that predispose a young child to sexual abuse, such as absent or dysfunctional parents, are also risk factors for adolescent pregnancy (314, 385).

Although the question is not fully resolved, three recent studies



JHU/CCP

In this scene from the Egyptian television series "And the Nile Flows On," a husband slaps his wife when he discovers that she has been using contraceptive pills without his knowledge and consent. Many women are afraid even to raise the issue of family planning for fear their partners might disapprove and respond angrily and violently.

that examined the independent effects of sexual abuse and other factors suggest that sexual abuse itself has an effect on adult sexual behavior beyond the effect of family background (149, 314, 315). In all three studies victimization in childhood made an independent contribution to problems of mental health, sexuality, and social functioning in adults.

Researchers continue to explore the exact mechanism through which sexual abuse increases the risk of teenage pregnancy. Sexual abuse appears to contribute to teen pregnancy indirectly, by lowering the age at first intercourse and by increasing sexual risk-taking among young people (424). Studies in Barbados, New Zealand, Nicaragua, and the US confirm that, on average, sexual abuse victims start having voluntary sex significantly earlier than nonvictims (37, 149, 155, 199, 241, 336, 385, 424). Such studies also link sexual abuse to a variety of high-risk sexual behaviors in adolescence, including having sex with many partners, using drugs and abusing alcohol, not using contraception, and trading sex for money or drugs.

Childhood abuse has also been linked to unintended pregnancies among adult women. A study of 1,200 women in the US found that women who reported being psychologically, sexually, and/or physically abused, or whose mother was beaten by a partner, had higher rates of unintended first pregnancies than women who did not experience abuse. The likelihood that a woman's first pregnancy was unintended increased with both the number of different types of abuse she experienced and the frequency of abuse (114).

STIs including HIV/AIDS. Sexual abuse in childhood appears to increase the risk of sexually transmitted infections (STIs) among adults, largely through its effect on high-risk sexual behavior (98, 148, 149, 199, 239, 385, 389, 424, 455, 487). Several studies have linked a history of sexual abuse to selling sex for money or drugs (37, 229, 389, 423, 484). For example, researchers in Rhode Island, US, found that men and women who had been raped or forced to have sex in either childhood or adolescence were four times more likely than people who had not been abused to have worked in prostitution. They were also twice as likely to have multiple sexual partners in a single year and to have casual sex (487). Among women, victims of childhood sexual assault were twice as likely to be heavy consumers of alcohol and nearly three times as likely to become pregnant before the age of 18. While the abused

women studied did not have higher rates of HIV, men who had experienced childhood sexual abuse were twice as likely to be HIV positive as men who did not, independent of a history of intravenous drug use or prostitution (487).

In a nationally representative study of men and women in Barbados, anthropologist Penn Handwerker found that sexual abuse was the most important determinant of high-risk sexual activity during adolescence, including both young age at first sexual intercourse and a high number of sexual partners (199). The direct effects of childhood sexual abuse on number of partners remained significant into the respondents' mid-thirties. For men, abuse in childhood also was closely linked to not using condoms in adulthood, even after accounting for other variables affecting condom use.

Abuse in childhood also increases the risk of sexually transmitted infection through its effect on drug use. Sexually abused or assaulted women often turn to drugs as a coping mechanism, in addition to engaging in such unhealthy behavior as unprotected sex and trading sex for money or drugs (21, 43, 162, 254, 349, 372, 412, 426).

In a study at an outpatient methadone maintenance clinic in the South Bronx of New York, early sexual abuse—especially incest—emerged as one of the most formative experiences in the lives of women addicted to such drugs as crack, cocaine, and heroin. A “sense of stigmatization and shame” leaves victims feeling “unloved, unlovable, and unable to say ‘no’ to things they do not want to do such as having sex or using drugs,” researchers concluded (482).

Not surprisingly, victims of other types of violence, most notably partner abuse, are also at increased risk of STIs. In the US state of North Carolina, for example, women who reported physical and sexual abuse by a partner were more than twice as likely to have experienced STIs as were other women, even after accounting for confounding variables. Data from India suggest that abusive men may be more likely to expose their wives to infection. Abusive men were significantly more likely to have engaged in extramarital sex and to have STI symptoms than were nonabusive men (286).

Violence Compromises HIV Protection

In a recent speech Peter Piot, the Executive Director of UNAIDS, noted that violence against women has many links to HIV/AIDS. “Violence against women is not just a cause of the AIDS epidemic,” he pointed out. “It can also be a consequence of it” (357).

Condom negotiation. Violence influences the risk of HIV and other STIs directly when it interferes with women's ability to negotiate condom use. For many women, asking for condoms can be even more difficult than discussing other contraceptives because condoms are often associated with promiscuity, infidelity, and prostitution.

Raising the issue of condom use within marriage or other primary partnerships is especially difficult (107). As a 46-year-old respondent in Brazil said, “If I ask my husband to use a condom now, he is going to ask ‘why?’ He is going to think I am fooling around or that I am accusing him of fooling around, two things that shouldn't be happening” (185).

The summary report of the Women and AIDS Research Program of the International Center for Research on Women (ICRW) concludes that “initiating condom use is simply not practical for many women around the globe” (466). In Guatemala, India, Jamaica, and Papua New Guinea, women reported that

bringing up condom use—with its implication that one partner or the other has been unfaithful—risks a violent response (170, 214, 234, 483).

Women in Brazil, Haiti, Rwanda, South Africa, Uganda, and the US have voiced similar fears (33, 186, 194, 245, 441, 449, 472, 481). In South Africa the notion that violent indignation is an appropriate response to women requesting condoms was so ingrained among a group of migrant workers that an audience of 1,000 men broke into cheers when the male character in an anti-HIV street play hit his wife for suggesting that he use a condom (172).

Voluntary counseling and testing. In some places women's fear of men's reaction has kept them away from voluntary HIV/AIDS counseling and testing (45). This reticence has implications both for controlling sexual transmission of the virus and for efforts to reduce mother-to-child transmission.

Health professionals have only recently begun to consider the implications of encouraging women to reveal HIV infection to their partners. Concerned that many infected women were not sharing their test results with their partners, researchers in Nairobi began to explore why. Among 243 women, only 66 disclosed their status to their partners. Of these 66 women, at least 11 had been chased away from home or replaced by another wife, 7 had been beaten up by their partners, and one had committed suicide, according to spontaneous reports by the women or their relatives (431).

In response, the study team revised its protocol to allow women to decide voluntarily whether to receive their results and to counsel women on the possible risks and benefits of disclosure to an intimate partner. As a result, reports of violence diminished markedly in the next year, with no drop in the percentage of partners counseled.

In the US findings have been mixed on the impact of fear of violence on women's willingness to be tested for HIV. Fear of violence was not a dominant factor in women's decision to decline an HIV test among women attending STD clinics in Miami or Newark. Nearly one woman in every six reported partner violence in the past year, but victims were no more likely than others to decline a test, except among women who had been injured by their partner within the past 12 months (283).

Other studies, however, find that the fear of violence is a serious concern for some women, suggesting that domestic violence should be considered when formulating partner notification policies and in HIV counseling (175, 387). In a US survey of 136 providers of HIV-related care, 24% reported having at least one female patient who experienced physical violence after disclosing her HIV status to her partner, and 45% had patients who feared such a reaction (388).

Reducing perinatal transmission. Fear of violence has also interfered with efforts to reduce mother-to-child transmission of HIV. In a study of perinatal programs in six African nations, for example, fear of ostracism and domestic violence was an important reason that pregnant women refused HIV testing or did not return for test results (45). Elsewhere, fear of violence has interfered with women's willingness and ability to comply fully with a short-course regimen of AZT to reduce perinatal transmission of HIV. In Côte d'Ivoire only 3% of women studied took all of the recommended doses of AZT during labor. Researchers attributed women's reluctance to take AZT to their fear of revealing their HIV infection to friends and family, often

for fear of violence (45).

Similar concerns have been voiced by HIV-infected women who have been advised to bottle-feed their infants to avoid HIV transmission. In areas where breastfeeding is the norm, women fear that using a bottle would brand them as infected with HIV, possibly exposing them to abuse (45).

Violence Leads to High-Risk Pregnancies

Around the world, as many as one woman in every four is physically or sexually abused during pregnancy, usually by her partner (18, 64, 99, 132, 167, 240, 268, 274, 325, 326, 386). Estimates vary widely, however. Within the US, for example, estimates of abuse during pregnancy range from 3% to 11% among adult women and up to 38% among teenage mothers (99). Some of this variation is likely due to differences in how the questions were asked, how often, and by whom (167, 355).

Obstetric risk factors. Violence before and during pregnancy can have serious health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care (99, 113, 296, 351, 430, 447, 448) and to gain insufficient weight (27, 99). They are also more likely to have a history of STIs (6, 287), unwanted or mistimed pregnancies (68, 88, 167, 448), vaginal and cervical infections (99, 296, 351), kidney infections (88), and bleeding during pregnancy (99, 351).

Adverse pregnancy outcomes. Violence may also have a serious impact on pregnancy outcomes. Violence has been linked with increased risk of miscarriages and abortions (6, 232, 386), premature labor (88), and fetal distress (88). Several studies also have focused on the relationship between violence in pregnancy and low birth weight, a leading contributor to infant deaths in the developing world (6, 28, 51, 63, 88, 99, 121, 150, 193, 351, 355, 404, 447, 448). Although the findings are inconclusive, seven studies suggest that violence during pregnancy contributes substantially to low birth weight, at least in some settings (51, 63, 99, 150, 351, 447, 448). In one study at the regional hospital in León, Nicaragua, researchers found that, after controlling for other risk factors, violence against pregnant women was associated with a threefold increase in the incidence of low birth weight. Violence in pregnancy accounted for 16% of low birth weight among the infants studied and posed a greater risk of low birth weight than such factors as pre-eclampsia, bleeding, and smoking (448).

How violence puts pregnancies at above-average risk is unclear, but several explanations have been suggested (326, 355). Blunt abdominal trauma can lead to fetal death or low birth weight by provoking preterm delivery (92, 342, 397). Violence also may affect pregnancy outcome indirectly by increasing women's likelihood of engaging in such harmful health behaviors as smoking and alcohol and drug abuse (see p. 20), all of which have been linked to low birth weight (6, 67, 88, 121, 193, 285, 296, 351). Thus, particularly where smoking and substance abuse in pregnancy are relatively common, these behaviors may be the main ways in which violence in pregnancy reduces birth weight (99, 351).

Extreme stress and anxiety provoked by violence in pregnancy also may lead to preterm delivery or fetal growth retardation by increasing stress hormone levels or immunological changes (179, 225, 454). Stress can reduce women's ability to obtain adequate nutrition, rest, exercise, and medical care (64, 355). Stress resulting from abuse appears to be the most likely explanation for the link between violence and low birth weight found in studies in Nicaragua and Mexico, where smoking and



MEXFAM (299)

As this Mexican guide to coping with domestic violence suggests, physical and sexual abuse during pregnancy is common. Worldwide, as many as one woman in every four is abused during pregnancy.

alcohol use in pregnancy are rare but violence in pregnancy is common (447, 448).

Violence and maternal deaths. On the Indian subcontinent, violence may be responsible for a sizeable but underrecognized proportion of pregnancy-related deaths. In India verbal autopsies from a recent surveillance study of all maternal deaths in over 400 villages and 7 hospitals in three districts of Maharashtra revealed that 16% of all deaths during pregnancy were due to domestic violence (164). In rural Bangladesh homicide and suicide, motivated by dowry-related problems or the stigma of rape and/or pregnancy outside of marriage, accounted for 6% of all maternal deaths between 1976 and 1986 and 31% of maternal deaths among women ages 15 to 19 (141). The risk of injury-related death was nearly three times higher for pregnant teenagers than for nonpregnant teenagers or for older pregnant women (384).

Violence Increases Risks for Other Gynecological Problems

Sexual and physical violence appears to increase women's risk for many common gynecological disorders, some of which can be debilitating. An example is chronic pelvic pain, which in many countries accounts for as many as 10% of all gynecological visits and one-quarter of all hysterectomies (125, 271, 456).

Although chronic pelvic pain is commonly caused by adhesions, endometriosis, or infections, about half the cases of chronic pelvic pain do not have any identifiable pathology. A variety of studies have found that women suffering from chronic pelvic pain are consistently more likely to have a history of childhood sexual abuse (456), sexual assault (80, 90, 125, 230, 369), and/or physical and sexual abuse by their partners (401, 403).

Past trauma may lead to chronic pelvic pain via unidentified injuries, by stress, or by increasing women's susceptibility to somatization, the expression of psychological distress through

physical symptoms (125, 145, 259). Also, sexual abuse in childhood has been linked to increased sexual risk-taking and thus to STIs, which can lead to chronic pelvic pain, often due to pelvic inflammatory disease.

Other gynecological disorders associated with sexual violence include irregular vaginal bleeding (180), vaginal discharge, painful menstruation (184, 230), pelvic inflammatory disease (402), and sexual dysfunction (difficulty in orgasms, lack of desire, and conflicts over frequency of sex) (184, 402, 403). Sexual assault also increases risk for premenstrual distress, a condition that affects 8% to 10% of menstruating women and causes physical, mood, and behavioral disruptions (183). The number of gynecological symptoms appears to be related to the severity of abuse suffered, whether there was both physical and sexual assault, whether the victim knew the offender, and whether there were multiple offenders (181, 182).

Threats to Health and Development

The negative consequences of abuse extend beyond women's sexual and reproductive health to their overall health, the welfare of their children, and even the economic and social fabric of nations. By sapping women's energy, undermining

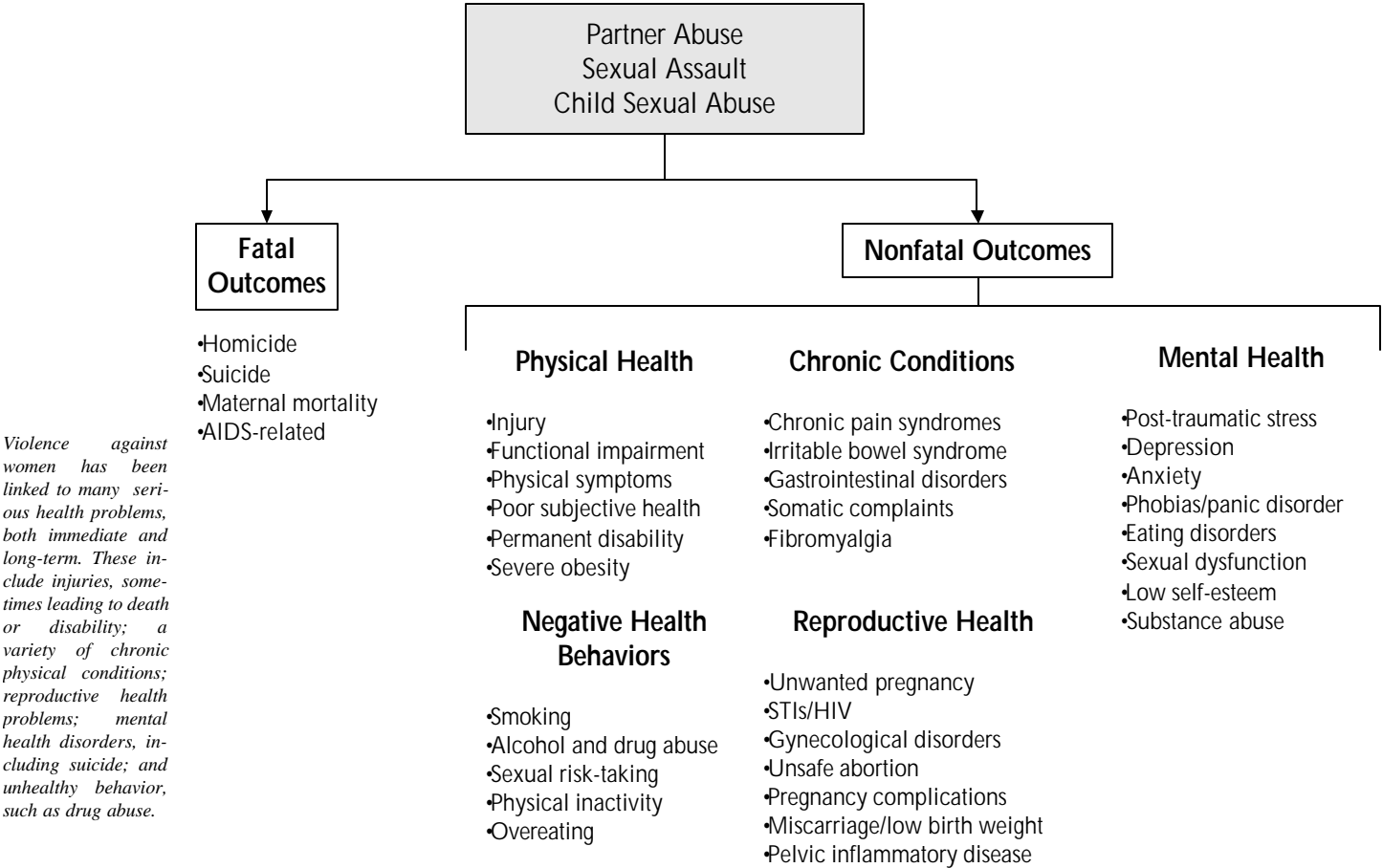
their confidence, and compromising their health, gender violence deprives society of women's full participation. As a UNIFEM report on violence observed, "Women cannot lend their labor or creative ideas fully if they are burdened with the physical and psychological scars of abuse" (73).

Violence as a Risk Factor for Disease

Victimization is a risk factor for a variety of unhealthy outcomes. In addition to causing immediate physical injury and mental anguish, violence also increases women's risk of future ill health. A wide range of studies show that women who have experienced physical or sexual abuse, whether in childhood or adulthood, are at greater risk of subsequent health problems (111, 148, 181, 260, 273, 291, 292, 455).

Violence has been linked to many serious health problems, both immediate and long-term. These include physical health problems, such as injury, chronic pain syndromes, and gastrointestinal disorders, and a range of mental health problems, including anxiety and depression. Violence also undermines health by increasing a variety of negative behaviors, such as smoking and alcohol and drug abuse (see Figure 3).

Figure 3. Health Outcomes of Violence Against Women



Source: Center for Health and Gender Equity (CHANGE)

Population Reports

Because most early studies on abuse and health involved women seeking medical treatment, their findings could have overstated the relationship between violence and poor health. But links between victimization and ill-health have been confirmed in recent studies among more representative groups, including random samples of women in the community and women visiting primary health care facilities.

One such study in a large health maintenance organization (HMO) in Washington state, US, found that women who experienced any type of abuse in childhood—whether physical, sexual, emotional, or neglect—had significantly poorer health than their peers. The study found that women who suffered maltreatment in childhood had more sexual and reproductive health problems, poorer physical functioning, more risky behavior, and more physical symptoms than nonabused women. Moreover, the average woman who had been abused in childhood also had more diagnoses across a wide range of health problems, including infectious diseases, mental health problems, and chronic conditions such as hypertension, diabetes, and asthma (455).

Studies among women at HMOs provide good opportunities for examining the cumulative impact of violence on women's health because HMOs generally provide for all of their members' health care—including drugs, surgeries, doctors' visits, and hospital stays (148, 260). Collectively, these HMO studies suggest three main conclusions about the health consequences of physical and sexual abuse of women:

- The influence of abuse can persist long after the abuse has stopped (148, 261).
- The more severe the abuse, the more severe its impact on women's physical and mental health (273).
- The impact of different types of abuse and multiple episodes over time appears to be cumulative (148, 260, 291, 455).

Physical Consequences of Abuse

Not surprisingly, violence is a major cause of injury to women, ranging from relatively minor cuts and bruises to permanent disability and death. Population-based studies suggest that 40% to 75% of women who are physically abused by a partner are injured by this abuse at some point in life (131, 325, 330, 378, 383, 436). The consequences of such injuries can be severe: In Canada 43% of women injured by their partners had to receive medical care, and 50% of those injured had to take time off from work (378).

In its most extreme form, violence kills women. Worldwide, an estimated 40% to over 70% of homicides of women are committed by intimate partners, often in the context of an abusive relationship (15, 177). By contrast, only a small percentage of men who are murdered are killed by their female partners, and in such cases the women often are defending themselves or retaliating against abusive men (418).

Nevertheless, injury is not the most common physical health outcome of gender-based abuse. Abuse may lead to any number of physical ailments including irritable bowel syndrome, gastrointestinal disorders, and various chronic pain syndromes. Studies consistently link such disorders to a history of physical or sexual abuse (108, 273, 457, 458). Abused women also have reduced physical functioning, more physical symptoms, and spend more days in bed than nonabused women (181, 273, 292, 383, 429, 458).



National Coalition Against Domestic Violence

In the US, as elsewhere, domestic violence is a major cause of injury to women. Over half of women who are abused by a partner are injured by this abuse at some point in their lives, some fatally.

Violence Erodes Women's Mental Health

Many women consider the psychological consequences of abuse to be even more serious than its physical effects. The experience of abuse often erodes women's self-esteem and puts them at greater risk of a variety of mental health problems, including depression, post-traumatic stress disorder, suicide, and alcohol and drug abuse.

Depression. Depression is becoming widely recognized as a major health problem around the world (446). The situation is particularly acute among adult women (477), who in most countries suffer depression at nearly twice the rate seen in men (97, 327, 467). Some researchers have suggested that most of the difference between the incidence of depression in women and men may be due not to biology, but rather to poverty, gender-based discrimination, and gender-based violence (13).

Women who are abused by their partners suffer more depression, anxiety, and phobias than women who have not been abused, according to studies in Australia, Nicaragua, Pakistan, and the US (74, 100, 126, 152, 376). Among women ages 15 to 49 in Nicaragua, for example, battered women were six times more likely to experience emotional distress, as measured on an international mental health scale, than were other women. Physical abuse was the single most important risk factor for emotional distress in this study, accounting for roughly 70% of mental health problems among women (126).

Sexual assault in either childhood or adulthood is also closely associated with depression and anxiety disorders (42, 53, 81, 276, 469). Most likely to lead to psychological disorders are sexual abuse occurring before age seven or eight, abuse by

more than one perpetrator, abuse that includes genital or anal penetration, and abuse that is frequent or continues over a long period of time (42, 81, 320).

Post-traumatic stress disorder. Many abused women experience post-traumatic stress disorder (PTSD), an acute anxiety disorder that can occur when people go through or witness a traumatic event in which they feel overwhelming helplessness or threat of death or injury (8). The symptoms of PTSD include mentally reliving the traumatic event through flashbacks, or “flooding”; trying to avoid anything that would remind one of the trauma; becoming numb emotionally; experiencing difficulties in sleeping and concentrating; and being easily alarmed or startled.

Rape, childhood sexual abuse, and domestic violence are among the most common causes of PTSD in women (36, 42, 44, 101, 380, 400, 433, 452). The chances that a woman will develop PTSD after being raped are between 50% and 95%, according to studies in France, New Zealand, and the US (36, 41, 101). One study in the US found that the psychological effects of being raped were comparable to the effects of being tortured or kidnapped (41).

Suicide. For some women the burden of abuse is so great that they take their own lives or try to do so. Studies from a number of countries, including Nicaragua, Sweden, and the US, have shown that domestic violence is closely associated with depression and subsequent suicide (1, 6, 29, 72, 246, 386). Battered women who develop PTSD appear to be most likely to try suicide (433).

Women who have experienced sexual assault either in childhood or as adults are also more likely to attempt suicide than other women (148, 280, 292, 317, 381, 470). The link is strong even after controlling for such individual risk factors as women's sex, age, and education and for presence of PTSD symptoms and psychiatric disorders (104, 421).

Alcohol and drug use. Victims of partner violence and women sexually abused as children are more likely than other women to abuse alcohol and drugs, even after controlling for such other risk factors as prior use, family environment, or parental alcoholism (133, 250, 265, 291, 304, 306). In a survey among women seeking primary care, those who had been abused by their partners within the previous year were three times more likely than those not recently abused to be drinking large amounts of alcohol and four times more likely to be using drugs (291).

Do abused women try to blunt their reactions to trauma by dulling their senses with alcohol and drugs? Or are women who use alcohol and drugs more likely to live in ways that put them at greater risk of being abused by men? In the US a 2-year longitudinal study sought to answer this question (250).

The study found that women who used illicit drugs, but not those who used alcohol, were at increased risk of being assaulted over the next two years of follow-up. As expected, any past or recent history of assault was associated with increased rates of alcohol and drug use, even after controlling for prior use and other factors. These findings suggest that increased alcohol use is more of an after-the-fact coping response to victimization, whereas drug use increases risk of being victimized at the same time that victimization increases the likelihood of using drugs (250).

Domestic Violence Undermines Children's Well-Being

Conflict between parents frequently affects their young children. Children who witness marital violence face increased risk for such emotional and behavioral problems as anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares, and physical health complaints (124, 244, 294). Such children also are more likely to act aggressively during childhood and adolescence (419, 420).

Children who witness violence between their parents often develop many of the same behavioral and psychological problems as children who are themselves abused (124, 228). In Nicaragua children of battered women

were more than twice as likely as other children to suffer from learning, emotional, and behavioral problems and almost seven times as likely to be abused themselves, physically, sexually, or emotionally (131). Among abused women in Nicaragua, 49% said that their children often witnessed the violence (131), as did 64% of women in Ireland (330) and 50% in Monterrey, Mexico (191).

Studies in the US have found that in 30% to 60% of families where husbands abuse their wives, the children also are abused (9, 123). Clinical experience suggests that this pattern exists in the developing world as well (131). While children's reactions to violence vary according to their age, sex, and the social support that they receive (228), children who both witness and experience abuse have the most severe behavioral problems (124).

Violence may undermine child survival as well (11, 232). In León, Nicaragua, researchers found that the children of women who were physically and sexually abused by their partners were six times more likely than other children to die before the age of five. The study controlled for other factors affecting infant and child survival. One-third of all child deaths in this setting were attributable to partner violence (11). A study in the Indian states of Tamil Nadu and Uttar Pradesh also found that women who had been beaten were significantly more likely than nonabused women to have had an infant death or pregnancy loss from abortion, miscarriage, or stillbirth. The

(Text continues on page 25.)



"No one has the right to abuse you. If you suffer violence in your home, your health is seriously affected. Consult us," a Peruvian placard states. The reverse side reminds providers to take the opportunity to talk about violence.

SPECIAL GUIDE:

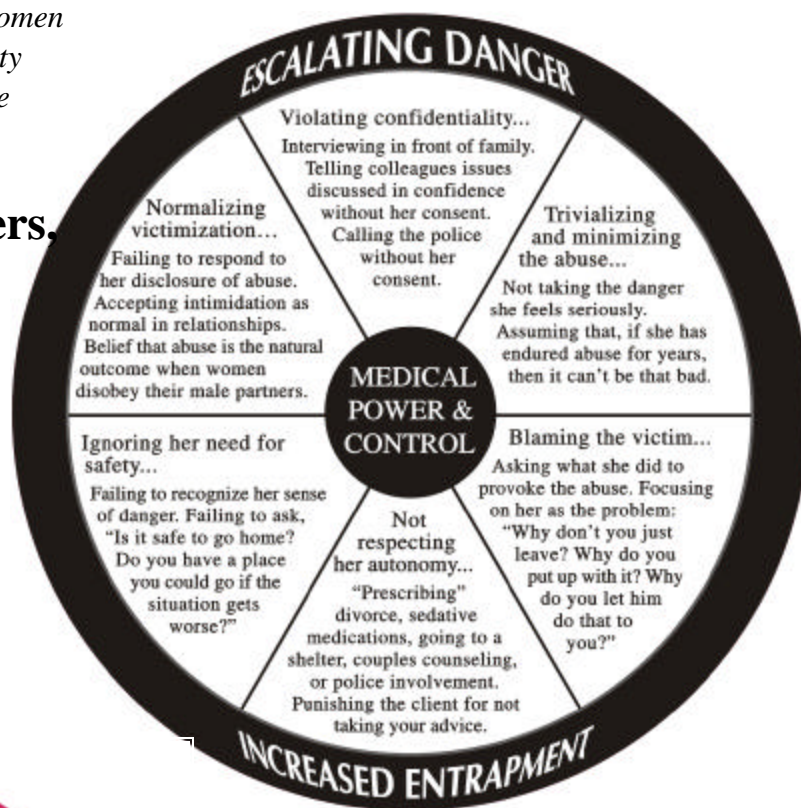
What Health Care Providers Can Do About Domestic Violence

Health care providers can help solve the problem of violence against women if they learn how to ask clients about violence, become better aware of signs that can identify victims of domestic violence or sexual abuse, and help women protect themselves by developing a personal safety plan. Everyone can do something to help promote nonviolent relationships.

Health Care Are We Part of the Problem?

Workers.

Women's advocates in the US have used the "power and control" framework for many years to describe how some men use violence to dominate their partners and maintain control with the relationship. The wheel at right is adapted from that framework to show how the behavior of health care providers often contributes to women's victimization.

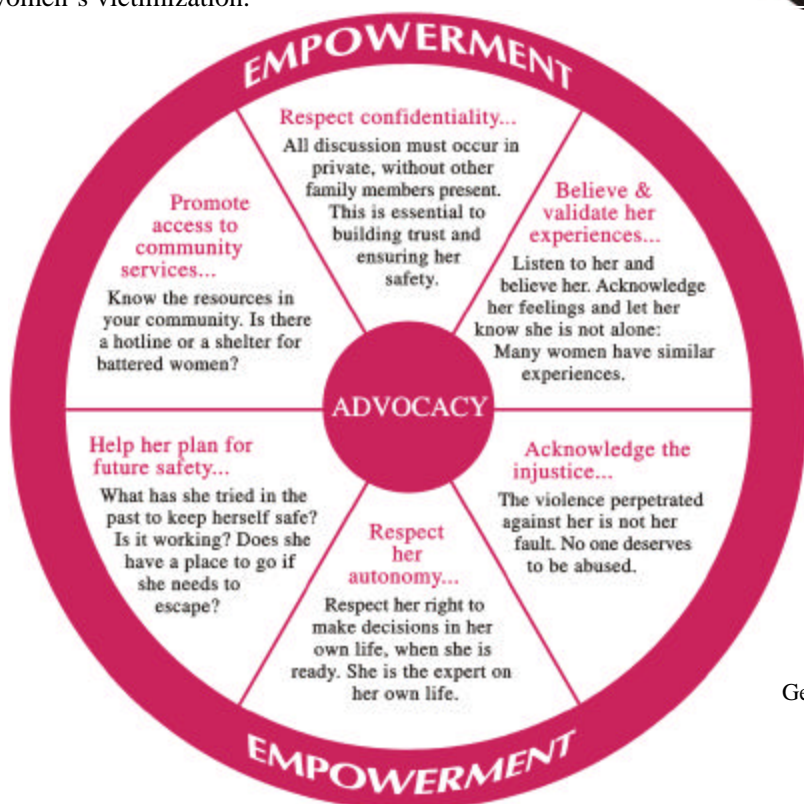


Or Are We Part of the Solution?

An alternative wheel suggests how health workers can help empower women to overcome abuse.*

*Adapted from: *The Medical Power & Control Wheel*. Developed by the Domestic Violence Project, Inc., 6308 Eighth Ave., Kenosha, WI 53143, USA.

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How to Ask About Abuse

One day after reading an educational booklet on domestic violence, Richard Jones, former president of the American College of Gynecologists and Obstetricians, asked a long-time patient whether her husband had ever beaten her. To his amazement, she replied, “Doctor Jones, you can’t imagine how long I’ve been waiting for you to ask me that question” (242).

Any service provider can make a difference by “asking the question.” Jones now asks every patient about abuse and encourages all of his students to do likewise. An important first step is considering how to broach the subject and then developing a standard way to ask the question for all clients. Here are some options:

Introducing the Question

- ▶ “Before we discuss contraceptive choices, it might be good to know a bit more about your relationship with your partner.”
- ▶ “Because violence is common in women’s lives, we have begun asking all clients about abuse.”
- ▶ “I don’t know if this is a problem for you, but many of the women I see as clients are dealing with tensions at home. Some are too afraid or uncomfortable to bring it up themselves, so I’ve started asking about it routinely.”

Asking Indirectly

- ▶ “Your symptoms may be related to stress. Do you and your partner tend to fight a lot? Have you ever gotten hurt?”
- ▶ “Does your husband have any problems with alcohol, drugs, or gambling? How does it affect his behavior with you and the children?”
- ▶ “When considering which method of contraception is best for you, an important factor is whether you can or cannot anticipate when you will have sex. Do you generally feel you can control when you have sex? Are there times when your partner may force you unexpectedly?”
- ▶ “Does your partner ever want sex when you do not? What happens in such situations?”



**Providers:
Be Alert for
"Red Flags"**

The best way to uncover a history of abuse in female clients is to ask about it. Nonetheless, several types of physical injuries, health conditions, and client behavior should raise health care providers’ suspicion of domestic violence or sexual abuse. When these signs, or “red flags,” are present, providers should be sure to ask their clients about possible abuse, remembering to be empathic and respectful of the client’s privacy.



Domestic Violence

- ▶ Chronic, vague complaints that have no obvious physical cause,
- ▶ Injuries that do not match the explanation of how they occurred,
- ▶ A male partner who is overly attentive, controlling, or unwilling to leave the woman’s side,
- ▶ Physical injury during pregnancy,
- ▶ Late entry into prenatal care,
- ▶ A history of attempted suicide or suicidal thoughts,
- ▶ Delays between injuries and seeking treatment,
- ▶ Urinary tract infection,
- ▶ Chronic irritable bowel syndrome,
- ▶ Chronic pelvic pain.

Asking Directly

- ▶ “As you may know, it’s not uncommon these days for a person to have been emotionally, physically, or sexually victimized at some time in their life, and this can affect their health many years later. Has this ever happened to you?”
- ▶ “Sometimes when I see an injury like yours, it’s because somebody hit them. Did that happen to you?”
- ▶ “Has your partner or ex-partner ever hit you or physically hurt you?”
- ▶ “Has your partner ever forced you to have sex when you didn’t want to?”
- ▶ “Did you ever have any upsetting sexual experiences as a child?”

Questions for Use in Clinical Histories or Patient Intake Forms

- ▶ “Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?”
- ▶ “Have you ever been raped or forced to engage in sexual activity against your will?”
- ▶ “Did you ever have any unwanted sexual experiences as a child?”

Sources: Center for Health and Gender Equity and Family Violence Prevention Fund, 1988 (460).

Sexual Abuse

- ▶ Pregnancy of unmarried girls under age 14,
- ▶ Sexually transmitted infections in children or young girls,
- ▶ Vaginal itching or bleeding,
- ▶ Painful defecation or painful urination,
- ▶ Abdominal or pelvic pain,
- ▶ Sexual problems, lack of pleasure,
- ▶ Vaginismus (spasms of the muscles around the opening of the vagina),
- ▶ Anxiety, depression, self-destructive behavior,
- ▶ Sleeping problems,
- ▶ A history of chronic, unexplained physical symptoms,



When providers ask about violence, women will have many things to tell them.


Suggestion: Discuss with colleagues how to respond with empathy and respect

- ▶ Having difficulty with or avoiding pelvic exams,
- ▶ Problems with alcohol and drugs,
- ▶ Sexual “acting out,”
- ▶ Extreme obesity.

Sources: Center for Health and Gender Equity and Family Violence

Developing a Safety Plan

Health care providers can help women protect themselves from domestic violence, even if the women may not be ready to leave home or report abusive partners to authorities. When clients have a personal safety plan, they are better able to deal with violent situations. Providers can review these points and help each woman develop her own personal safety plan:

- ▶ Identify one or more neighbors you can tell about the violence, and ask them to seek help if they hear a disturbance in your home.
 - ▶ If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
 - ▶ Stay away from any room where weapons might be available.
 - ▶ Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best.
 - ▶ Have a packed bag ready, containing spare keys, money, important documents, and clothes. Keep it at the home of a relative or friend, in case you need to leave your own home in a hurry.
 - ▶ Devise a code word to use with your children, family, friends, and neighbors when you need emergency help or want them to call the police.
- 
- ▶ Decide where you will go if you have to leave home and have a plan to get there (even if you do not think you will need to leave).
 - ▶ Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he is demanding to calm him down. You have the right to protect yourself and your children.
 - ▶ Remember: you do not deserve to be hit or threatened.

Source: Adapted from Buel 1995 (49)

How to Promote Nonviolent Relationships Wherever You Are

Everyone can do something to promote nonviolent relationships.

Health workers can:

- ▶ Educate themselves about physical, sexual, and emotional abuse and explore their own biases, fears, and prejudices.
- ▶ Provide supportive, nonjudgmental care to victims of violence.
- ▶ Ask clients about abuse in a friendly, gentle way.

Leaders of reproductive health programs can:

- ▶ Establish policies and procedures to ask women clients about abuse.
- ▶ Establish protocols that clearly indicate appropriate care and referral for victims of abuse.
- ▶ Promote access to emergency contraception.
- ▶ Lend facilities to women's groups seeking to organize support groups and to hold meetings.

Community and religious leaders can:

- ▶ Urge understanding, compassion, and concern for victims of violence.
- ▶ Challenge religious interpretations that justify violence and abuse of women.
- ▶ Make their houses of worship available as temporary sanctuary for women in crisis.
- ▶ Provide emotional and spiritual guidance to victims of abuse.
- ▶ Support the efforts of abused women to leave relationships that put them at risk.
- ▶ Integrate discussions on healthy relationships and alternatives to violence into religious education programs.

The mass media can:

- ▶ Respect the privacy of victims of rape by not printing their names without their permission.
- ▶ Avoid sensationalizing cases of violence against women; place events in their proper context, and use them as an opportunity to inform and educate.
- ▶ Provide free airtime or space for messages about gender violence and announcements of available services.
- ▶ Reduce the amount of violence portrayed on television.
- ▶ Develop socially responsible radio and television programming that depicts equitable and nonviolent relationships between men and women.
- ▶ Develop programming that creates public dialogue about sexual coercion, rape, and abuse.

Parents can:

- ▶ Refrain from arguing in front of their children.
- ▶ Teach their children to respect others and themselves.
- ▶ Encourage the health, safety, and intellectual development of their daughters as well as their sons, and encourage their self-esteem.
- ▶ Avoid hitting their children; use nonviolent forms of discipline instead.
- ▶ Teach children nonviolent ways to resolve conflicts.
- ▶ Talk to their children about sex, love, and interpersonal relationships; emphasize that sex should always be consensual.

study controlled for other influences on infant mortality such as mother's education, age, and parity (232).

While it is unclear exactly how domestic violence affects child survival, one explanation is that the children of mothers who are abused are more likely to be born underweight, a factor that increases risk of dying during infancy or childhood (see p. 17). Another possible explanation is that mothers with violent partners may have lower self-esteem, less mobility, weaker bargaining power, and less access to resources and thus are less able to keep their children healthy.

In rural Karnataka, India, a study found that children of mothers who were beaten received less food than other children did, suggesting that these women could not bargain with their husbands on their children's behalf (165). Similarly, 1998 DHS data from Nicaragua show that children of battered women were more likely than other children to be malnourished. They were more likely to have had a recent bout of diarrhea and less likely to have received oral rehydration therapy. They also were less likely to have been immunized against childhood diseases (386) (see Figure 4).

Gender-Based Abuse Hinders Development

In addition to its human costs, violence against women hinders women's participation in public life and undermines the economic wellbeing of societies. Although techniques of estimating the economic and social costs of violence are imperfect, studies have begun to provide insights into the ways that gender-based violence undermines women's participation, reduces their productivity, and drives up costs to the economy, including medical care costs.

Women's participation. Violence against women hinders their participation in development projects and lessens their contribution to social and economic development. In Mexico

a study that sought to learn why women often stopped participating in development projects found that men's threats were a major reason. Men perceived the growing empowerment of their wives as a threat to their control and beat them to try to stop it (73). In Papua New Guinea some husbands have prevented their wives from attending meetings by locking them in the house, by pulling them off vehicles taking them to the meetings, or by pursuing and dragging them home (38).

Even if men do not prevent women's participation, they may use force to deprive them of its

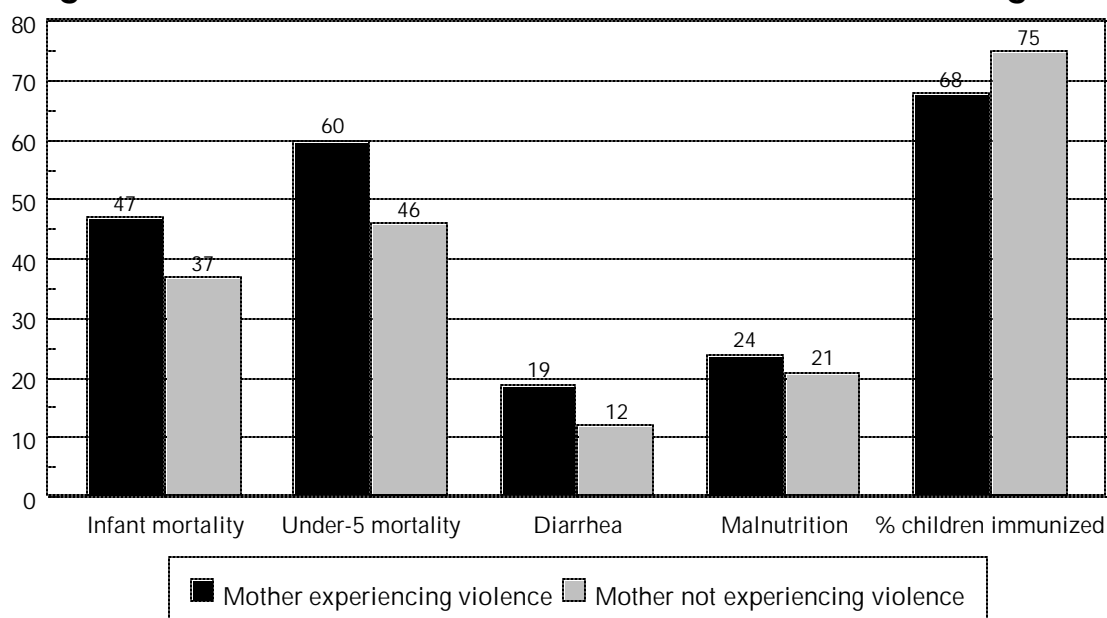
benefits. Women participating in micro-credit schemes in Bangladesh and Peru and garment workers in the Mexican *maquiladoras* report that husbands often beat their wives and take what the women have earned (73, 406, 407).

To avoid violence, many women censor their behavior to suit what they think will be acceptable to their partners, in effect "making women their own jailers" (38). In Papua New Guinea, for example, a study by the Department of Education found that a main reason that female teachers gave for not taking promotions was fear that it would provoke their husbands to more violence (174).

Such fears can lead to adverse effects on the health of women and their families, as well as reducing earnings. Fear of rape, for example, has contributed to undernutrition among Ethiopian refugee families living in Sudanese border camps (266). Ethiopian women refugees surveyed said they cooked fewer meals for their children because they feared being raped while out collecting firewood. In fact, many had been raped during the 2- to 3-hour forays to collect fuel. In Gujarat, India, female rural health promoters discussing obstacles to their work emphasized their reluctance to travel alone between villages for fear of being raped. They asked for self-defense training to continue their work (249).

Women's productivity. Researchers have only begun to explore the possible impact of domestic violence on women's labor force participation and earnings, and studies yield inconsistent conclusions. In studies in Santiago, Chile, Managua, Nicaragua, and Chicago, for example, the impact of domestic violence on women's likelihood of being employed varied greatly (278, 312). Some women worked less in order to protect their children or because their partners would not allow them to work, while other women sought employment to lessen financial dependence on their abuser.

Figure 4. Partner Abuse and Child Health, Nicaragua



All differences significant at the level of $p < .05$

Source: Rosales Ortiz 1999 (386)

Domestic violence damages infants and young children as well as their mothers. As DHS research in Nicaragua shows, children whose mothers have experienced violence are more likely to suffer poor health and die.

Population Reports/CHANGE

Domestic violence does appear to have a consistent impact on women's earnings and their ability to remain in a job, however (47, 278, 312). The study in Chicago found that women with histories of domestic violence were more likely to have experienced spells of unemployment, to have more job turnover, and to suffer more physical and mental health problems that could affect their job performance. They also had lower incomes and were much more likely to receive public assistance (278). Similarly, in Managua abused women earned 46% less than women who did not suffer abuse, even after controlling for other factors affecting earnings (312).

Evidence from the US suggests that victimization in childhood may also reduce a woman's educational attainment and income. Researcher Batya Hyman found that women who were sexually abused in childhood earned 3% to 20% less annually than women who had not been abused, depending on the type of abuse experienced and the number of perpetrators (222). Incestuous abuse affected income indirectly through its impact on educational attainment and mental and physical health status. Women sexually abused by strangers suffered an additional direct effect on income.

Costs to the economy. For countries the costs of gender-based violence are substantial. For example, in Canada a 1995 study estimated that violence against women cost the country 1.5 billion Canadian dollars (US\$1.1 billion) in lost labor productivity and increased use of medical and community support services (106). Another study in Canada put the cost of violence against women much higher, after including costs for social services, criminal justice, labor and employment, and the health care system. The study estimated that physical and sexual abuse of girls and women cost the economy 4.2 billion Canadian dollars each year, nearly 90% of that borne by the government (192).

Not surprisingly, women who have experienced physical or sexual assault in either childhood or adulthood use health services more often than other women, as studies in Nicaragua, the US, and Zimbabwe show (147, 257, 273, 312, 394, 455, 464, 473). Over their lifetimes, victims of abuse average more surgeries, physician and pharmacy visits, hospital stays, and mental health consultations than other women, even after accounting for other factors affecting health care use.

Such increased need for health care adds considerably to health care costs. For example, in the Washington state HMO study (see p. 19), the added cost associated with childhood abuse for this plan alone was estimated at over US\$8 million per year (459). Another US HMO study found that female victims of partner violence cost the health plan 92% more than a random sample of other women who received services from the health plan that year. The extra costs were not due to excess emergency room charges (473).

Health Providers Play a Key Role

Health care providers can play a crucial role in addressing violence against women. In most countries the health care system is the only institution that interacts with almost every woman at some point in her life. Thus health care providers often are well placed to recognize victims of violence and to help them. Moreover, because violence increases the risk of other health problems for women, early help can prevent serious conditions that follow from abuse.

Recently, the health community has begun to mobilize to meet this challenge. In 1993 the Pan American Health Organization (PAHO) became the first international health institution to recognize violence against women as a high-priority concern, when it passed resolution CD39.R8, urging all member governments to establish national policies and plans for the prevention and management of violence against women (344). In 1996 the 49th World Health Assembly followed suit, declaring violence a public health priority (478). Both PAHO and WHO initiated programs on violence against women in the mid-1990s.

Some health care systems have started to address domestic violence as part of clinical practice. In 1992, for example, the American Medical Association published diagnostic and treatment guidelines for domestic violence, and the US Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began including an evaluation of emergency room policies and procedures for dealing with abuse victims in its accreditation reviews (7, 489). More recently, Brazil, Ireland, Malaysia, Mexico, Nicaragua, and the Philippines have developed pilot programs that train health workers to identify and respond to abuse (115, 277, 370). Several Latin American countries also have incorporated guidelines for addressing domestic violence into their national health sector policies (345).

Despite such efforts, progress is slow. In most countries doctors and nurses rarely ask women whether they are being abused, even when there are obvious signs of abuse (71, 161, 347). Facilities that have established guidelines often do not monitor or enforce their implementation (86, 144, 298). US studies have found that few health care facilities have complied with the JCAHO requirements (139).

Barriers to Addressing Violence

Why have health care providers been slow to address violence against women? Doctors often think that their patients, rather than themselves, constitute the main obstacle to better care (139). But health workers themselves often are part of the problem (see p. 21).

A complex interplay of professional, cultural, personal, and institutional concerns shape the ability and willingness of health workers to address domestic violence, according to studies in Africa, Asia, Latin America, and the US (86, 143, 252, 361, 374, 428, 465). Some of the biggest barriers that block effective response are health care providers' lack of technical competence, cultural stereotypes and negative social attitudes, and institutional constraints.

Lack of technical competence and resources. Health workers often do not ask women about their experience with violence because they feel unprepared to respond to the needs of victims. Some view domestic violence as a private issue and

fear that clients would be upset or offended if asked about violence. Others feel that they do not have the time or resources to help (86, 374, 428).

Practitioners who have received special training on violence are more likely to inquire about violence and to feel competent to address the needs of abused women (309, 434). Although some professional schools are making efforts to address domestic violence—for example, nursing schools in the US (476)—most professional schools worldwide do not address violence or do so only minimally (5, 321, 353). For example, a study in the US found that two-thirds of health practitioners had never received training on domestic violence (434). In Mexico and Zimbabwe health care providers said that their medical training was in fact an obstacle to dealing with abuse because it prepared them only to address a patient's physical symptoms rather than the whole person (143, 465).

Cultural stereotypes and negative social attitudes. Health care providers typically share the same cultural values and societal attitudes toward abuse that are dominant in the society at large. Thus they may think that some women deserve abuse or that a wife's obligation is to be sexually available to her husband at all times (252). They also frequently assume that domestic violence and sexual assault occur only among poor women or among women of certain ethnic or religious backgrounds (86, 252). Such attitudes stand in the way of sympathetic and caring response to abused women who seek care.

For example, in South Africa a study found that female nurses generally recognized domestic violence as a serious problem for women but also thought that women themselves held attitudes and acted in ways that could provoke violence, including rape (252). Male nurses reported a long list of reasons that would justify a man in beating his wife, including if she disobeyed him, was disrespectful, or neglected household or childcare duties. They did not think that a man had committed rape if he forced his wife to have sex, and they thought that the practice of wife-beating was both a means of discipline and a way of expressing love or forgiveness (252).

Even in cultures where partner violence is considered unacceptable, negative social attitudes about battered women are often deeply imbedded and difficult to overcome. These beliefs may affect how health workers assess a woman's truthfulness or her responsibility for her situation. In the US, for example, clinicians revealed their biased attitudes by making such statements as "A battered woman tells you what you want to hear" and "Women in violent situations are difficult to deal with. We find it hard to accept women who don't get out of such a situation" (86).

Some male clinicians may hesitate to accept a woman's account of violence because they identify with the offender. As one US doctor said, "Maybe my discomfort with it is that I've experienced that kind of rage myself" (374). Female health workers who have themselves been victims of abuse also may have a hard time discussing violence with their clients. Studies have found that as many as one female health practitioner in every three has experienced violence herself (252, 309, 370, 428).

Institutional constraints. Clinicians working with victims of violence often feel that their institutions and colleagues value their work less than other types of clinical intervention (86). Most programs designed to address abuse in health care settings have been the work of very committed individuals, but their initiatives rarely have become institutional policy. With the



Sando Moore/Women's Rights International

Community leaders' commitment is key. Playing roles in the story of a woman raped in wartime, traditional birth attendants in Liberia learn to lead community response to sexual abuse of women.

departure of these key leaders, many programs lose momentum, and some end (86, 298).

Legal liability or involvement is a major concern that keeps health workers from doing more for victims of abuse. In some countries health workers often refuse to examine raped or otherwise abused women because they want to avoid having to testify in court (221, 347, 465). Other countries have passed laws mandating that health care providers report child abuse and, sometimes, abuse of adult women. With adult victims, however, such laws are generally counterproductive because they take control away from the abused woman, jeopardize her safety, and may make it less likely that she will seek health care for fear that her partner will be arrested as a result (7, 78, 221, 236, 461).

Women's needs are often neglected because of bureaucratic gaps or inadequate coordination between the health and criminal justice systems. In some countries doctors are prohibited from treating women who have been raped or battered without authorization from the courts or police. In others, only court-appointed forensic doctors may examine crime victims (461). In Zimbabwe, for example, a woman who has been raped may have to wait three days or more for an appointment with a government medical officer. These officers are the only physicians authorized to document rape or assault cases. By that time most of the physical evidence may be lost (465). Similar requirements exist elsewhere, including the countries of Central America, India, and Peru (202, 220, 361).

The lack of referral services and insufficient coordination between health workers and referral services often prevent women from receiving necessary medical care, including emergency contraception and STI screening. In Zimbabwe a woman who had been raped reported that, "The police said they could not file my case without a medico-legal exam. I went to the matron (at the health center). I was then advised to come to the (women's center). They sent me to Social Welfare. At Social Welfare I kept on being referred from one person to another the whole day. I went back the next day and was told to go back to the police station" (465).

Women's reluctance to disclose violence. Unless women are asked directly about violence, many do not volunteer information. For example, as noted in Table 3, the 1998 Nicaragua DHS found that over one-third of women who had been abused by their partners had never told anyone. Although

57% of the women had suffered injuries, only 13% had ever received medical attention. Even then, most women did not disclose the cause of their injuries. Only 7% of women reported having ever sought help at a health center or hospital for violence (386).

Shame was one of the main reasons that women in Nicaragua gave for not disclosing violence. As one woman explained, "I thought that there were only a few people who lived like this and that it would be embarrassing for someone to find out that he was hurting me this way" (131). Many women say nothing about violence because they fear that they will be blamed for it. A US woman told researchers that, even though her injuries often brought her to the doctor, she had kept their cause to herself for nine years (379).

Fear of reprisals from their abusers is another reason that many women stay silent. As one woman in the US observed, "I knew that if I was to tell them what actually happened, they would call the police and I would have to file a report, and they couldn't guarantee me that they would be there 24 hours to protect me from this maniac" (379).

In much of the world women are unable to obtain health care without the knowledge or permission of their spouses or other male family members (333, 386). Women living in abusive relationships typically are subject to strict controls over their mobility, and abusive husbands may go to great lengths to keep them from getting help. Often, men will not allow their wives to visit a health center unescorted, especially if they are going to be treated for injuries due to violence (293). Women are especially unlikely to disclose abuse to a health care provider in front of their abuser.

Asking About Abuse

Once a woman decides to seek help from a health care institution, the response she receives is crucial. Many clinicians fear that asking patients about violence and sexual abuse will open a "Pandora's Box," unleashing issues that they have neither the time nor the skills to deal with (428). When health workers fail to ask about violence, however, particularly when there are obvious signs of it, women are likely to assume that they are not interested (465). An indifferent or hostile reaction from health care providers reinforces a woman's feelings of isolation and self-blame and makes it harder for her to mention the topic again.

Lack of confidentiality can be particularly devastating, as well as placing women at risk for further abuse. A woman in Zimbabwe complained, "I went to the hospital because my husband beat me when I got pregnant. What hurt me was that there was no confidentiality by the doctors and nurses treating

me. Everyone in the ward got to know that I had been beaten by my husband" (465).

For many women, facing indifference and hostility from health personnel is like being victimized again by the very system that is supposed to help. One Latin American woman who went to a health center said, "I felt hurt, wounded, because when you go, you hope that someone would at least give you a little help. But when you get there you feel even more dejected.... They don't give you any encouragement.... They treat you like the cashier in the supermarket" (202).

A Panamanian woman who miscarried as a result of her husband's beatings described her experience with the health center in this way:

When the doctor attended me, I explained to him what happened, that I had been beaten, and I said, "I know this isn't your job, but I need a favor. My husband is outside in the hallway, and I need you to call a policeman

to help me stop him before he catches me again." The doctor answered that this wasn't his problem, that I was free to leave however I wanted. He just said, "Take this for the swelling" and left me alone in the room. (347)

"It is my impression that some women have been waiting their whole lives for someone to ask," notes Ana Flavia d'Oliveria, a Brazilian public health physician who began an abuse screening program among her prenatal care patients (213). In fact, most women, regardless of whether they have been abused themselves, feel that physicians should routinely ask their patients about abuse (71, 161). Among South African women attending a community health clinic in Cape Town, for example, 88% said they would welcome routine inquiry about violence during health visits (251).

The way in which a woman is asked about violence makes an enormous difference to whether she will disclose her situation. If asked about violence in a nonjudgmental, empathic way, she is more likely to answer truthfully. Women are more inclined to discuss abuse if they perceive the clinician to be caring and easy to talk to, and if follow-up is offered (293, 379).

Placing brochures or posters about domestic violence in a clinic or office can increase women's comfort in talking about abuse (293). Sometimes, medical staffs have found it helpful to wear buttons with the message "It's OK to talk to me about family violence and abuse." A US medical association produced a poster to place in waiting rooms saying, "We may forget to ask, but we **always** want to know if you are experiencing violence at home" (48).



Domestic Violence Center of Howard County, Maryland

Strategically placing posters or brochures around health clinics can encourage women to feel at ease in bringing up the topic of abuse. This US poster has a pocket to hold brochures.

When a woman discloses abuse, it is important that providers ask questions in ways that are sensitive and supportive, that do not tell women what to do but that help them examine their options. What providers say and counsel often influences their clients' attitudes and actions.



When there are obvious signs of abuse, such as unexplained injuries, health workers should ask, "Who did this to you?" If there are no signs, clinicians have found that the best way to ask about violence is to bring it up routinely as part of taking a clinical history (see pp. 22–23). For example, the provider can say, "Because violence is so common these days, I ask all my patients whether they have ever been hurt by someone close to them." This phrasing can help to keep a woman from feeling that she has been singled out for questions.

Several short screening questionnaires have been developed to help health care providers identify victims of abuse (120, 146, 295). At one prenatal clinic, detection of lifetime violence rose from 14% with routine inquiry during a social service interview to 41% using the 5-question Abuse Assessment Screen (328). Another study found that asking three brief questions correctly identified the majority of abused women:

- (1) "Have you been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?"
- (2) "Do you feel safe in your current relationship?"
- (3) "Is there a partner from a previous relationship who is making you feel unsafe now?"

The questions took an average of just 20 seconds to ask, less time than measuring the client's vital signs (146).

There is no international consensus on whether all women should be routinely screened for violence when they visit a health care facility. Some advocates argue that failure to screen is a serious breach in the quality of health care (49). Others feel that screening all women on every visit may not be feasible, particularly where budgets are low and personnel are overworked. Some express concern that identifying women who are abused may be counterproductive if there are no services or resources to offer them and could lead to greater frustration for both clients and providers (277).

Each health service should decide upon a detection policy that best meets its clients' needs and local resources. Options other than universal screening include:

other key symptoms raise "red flags" about domestic violence and sexual abuse that should arouse providers' suspicions (166, 343, 370) (see pp. 22–23). When one or more of these symptoms are present, health workers should ask directly about abuse.

Strategic screening. Another option is to screen all women for abuse in certain services that are considered strategic because of the number of abused women attending them, because special risks are involved, or because they present good opportunities for discussing abuse. Routine screening might be especially appropriate in the following services:

- **Maternal and child health services.** Because violence is at least as common and often more serious than a variety of other conditions that health workers routinely screen for during pregnancy, most experts contend that all women attending prenatal care should be screened for abuse (64, 295). The prenatal care setting is especially conducive to discussing abuse because trust can develop as women return for repeat visits. Postpartum screening is also important, since violence may become more frequent or more severe after delivery (176). Pediatric and well-baby visits provide another good opportunity to identify and provide support for mothers and children living with violence (20).
- **Reproductive health services.** Discussions about contraception or STI prevention provide a good opportunity for discussing abuse. Women who have been abused in the past or who currently suffer violence may be unable to control the timing of sexual encounters or to negotiate condom use. Therefore routine screening in family planning and STI prevention programs is essential to ensure that counseling messages are tailored to the needs of battered and sexually or emotionally abused women.
- **Mental health services.** Because violence is associated with such mental health disorders as depression and post-traumatic stress disorder (53, 66, 375), women attending mental health services should be considered a particularly high-risk group for violence.
- **Emergency departments.** Partner violence is a cause of many physical injuries among adult women (see p. 19), and women with injuries that warrant emergency medical attention are likely to be among those most severely abused. Therefore, a reasonable policy is to ask all women coming to emergency rooms with traumatic injury whether their injuries are due to intimate partner violence (120, 297).

Supporting Women Who Disclose Abuse

Health workers often feel that there is little they can do when a woman discloses abuse. But what providers say and do can have an important influence on a woman's course of action (171, 293). The act of asking questions about violence can let women know that providers consider violence to be an



Ask when there are signs of abuse. Without asking, it is difficult to identify women suffering abuse. Providers should keep in mind that, contrary to popular belief, physical injury is not the most common symptom of abuse in women. More common are chronic vague complaints with no obvious physical cause. Such complaints and



Hesperian Foundation (54)

Most health care providers can do more to document cases of abuse.

important medical problem and not the client's fault. A Latin American woman said, "The doctor helped me feel better by saying that I didn't deserve this treatment, and he helped me make a plan to leave the house the next time my husband came home drunk" (202).

Women in the US also emphasize the power of validation, noting that it provided "relief," "comfort," "planted a seed," and "started the wheels turning" toward changing their perception of their own situation (171). Some of the ways in which health workers can promote healing for women living with violence are described in the "Empowerment Wheel" used in violence prevention training (see p. 21).

Even if an abused woman does not disclose the violence on a first visit, asking about it shows that the clinician cares, and thus she may decide to talk about it later. While health workers ideally should coordinate their actions with community-based services, such as local women's groups, providers can take several useful actions immediately during the clinic visit (350, 460):

1. Assess for immediate danger. Find out whether the woman feels that she or her children are in immediate danger. If so, help her consider various courses of action. Is there a friend or relative who can help her? If there is a women's shelter or a crisis center in the area, offer to make contact. Some hospitals and clinics have adopted explicit policies allowing abused women to be admitted overnight if it is unsafe for them to return home (243, 277). Leaving a violent partner temporarily does not necessarily end the violence, however. The most dangerous moment for a woman with an abusive partner is often immediately after she leaves or decides to leave a relationship (60).

2. Provide appropriate care. For women who have suffered sexual assault, appropriate care may include providing emergency contraception and presumptive treatment for gonorrhea, syphilis, or other locally prevalent STIs. Unless

clearly necessary, clinicians should avoid prescribing tranquilizers and mood-altering drugs to women who are living with an abusive partner since these may impair their ability to predict and react to their partners' attacks.

3. Document women's condition. Few providers adequately document cases of abuse against women. In Johannesburg, South Africa, a review found that in 78% of cases of abuse providers had not recorded the identity of the perpetrator. Clinical records included such graphic but general descriptions as "chopped with an axe" or "stabbed with a knife" (313).

Careful documentation of a woman's symptoms or injuries, as well as her history of abuse, is helpful for future medical follow-up. Documentation is also important in the event that she decides to press charges against the abuser or to seek custody of children. Documentation should be as thorough as possible and clearly state the identity of the offender and his or her relationship to the victim.

4. Develop a safety plan. Although women cannot prevent violence from recurring, and they may not be ready to report their partner to the police, there are ways that they can protect themselves and their children. These include keeping a bag packed with important documents, keys, and a change of clothes, or developing a signal to let children know they need to seek help from neighbors. Health care providers should review a sample safety plan with the woman and decide together which actions may help in her situation (see p. 24). Sample safety plans can also be taped to clinic bathroom and examining room walls, where women can read them without embarrassment.

5. Inform women of their rights. When a woman takes the step of disclosing her situation, it is crucial that medical practitioners reaffirm that the violence is not her fault and that no one deserves to be beaten or raped. The penal codes of most countries criminalize rape and physical assault, even if specific laws against domestic violence do not exist. Medical staff should find out what legal protections exist for victims of abuse and where women and children can turn for genuine help in enforcing their rights.

6. Refer women to community resources. Health care providers can help victims of abuse by identifying them early and referring them to available local resources. The needs of victims generally extend beyond what the health sector alone can provide. Therefore it is essential that health care providers know in advance what other resources are available to help victims of abuse. It is especially useful for health workers to meet personally with others who provide services for victims of violence because a provider will be more likely to refer a woman to someone whom they know—when there is a face behind the name.

Moving Outside the Clinic

To address violence against women, it is important for health care programs to move outside the clinic. Most health programs engage in community activities. Some of these can be mobilized to address abuse. Especially important is addressing gender inequity and abuse through community health promotion activities and mass-media campaigns.

Community health promotion. For years health projects have used community outreach and peer education techniques to promote family planning, oral rehydration therapy, and other healthy behavior. Such techniques also can address the problem of violence—for example, by challenging harmful

traditional gender norms and promoting new norms.

For example, the Mexican Family Planning Association (MEXFAM) has begun integrating antiviolenence work into all of its programming. With funding from the MacArthur Foundation, MEXFAM has produced posters and workshop materials that encourage rural and indigenous men and women, including young people, to reflect upon domestic violence and its negative impacts. The goal is to help men and women begin to recognize the costs of abusive behavior and thereby become more motivated to change it (299).

In Honduras the Programa Feminina Hondureña de Salud Comunitaria (PROFEHSAC) has added drama, discussion, and role-playing on domestic violence to its training program for health promoters. As a result, PROFESHAC health promoters have become major agents of change in their community, offering support to victims and holding discussion sessions with men, women, and youth (284).

The new popular education manual, *Where Women Have No Doctor*, should greatly facilitate such work because it features entire chapters on sexuality, domestic violence, mental health, and rape (54). Designed for low-literacy populations, this resource manual includes basic information on the dynamics of abuse and suggests how community health workers can assist victims and work to change cultural norms.

Programs also can include gender and violence themes in small-group sessions designed for other purposes. An example is Stepping Stones, a curriculum for sexual health and HIV prevention. Building on the pioneering work of two Brazilians—educator Paolo Freire and theater director and social activist Augusto Boal—the curriculum uses a problem posing approach to encourage reflection on complex issues such as trust, risk, the meaning of love, and learning to say “no” (468). A recent South African adaptation of the Stepping Stones curriculum adds a module specifically to address abuse and coercion in relationships (216).

Communication campaigns. Reproductive health programs also can use the mass media to address violence against women. During the 1990s, for example, a network of over 100 women's organizations in Nicaragua mounted an annual mass-media campaign to raise awareness of the impact of violence on women (128). Using slogans such as “Quiero vivir sin violencia” (I want to live without violence), the campaign mobilized communities against abuse. According to the 1998 DHS, more than half of the Nicaraguan population had heard at least one of the campaign's messages, and one-half of all women who had heard the messages were able to repeat at least one of the slogans (386).

Another Nicaraguan organization, Puntos de Encuentro, recently mounted a campaign specifically to reach men (307) (see photo). The campaign built on the results of an in-depth qualitative study designed to explore what benefits, if any, nonviolent men perceived from their nonviolence.

Another innovative communication program in Western Australia used radio and television spots to encourage abusive men to seek help voluntarily by calling a Men's Domestic Violence Helpline. The Helpline offers phone counseling and refers men to free, government-sponsored treatment programs. After only 7 months, 69% of adult men in the general population were aware of the helpline for abusive men, and 1,385 men had called, including 867 self-admitted batterers, almost half of whom accepted a referral for counseling (493).

Reproductive health programs also can ensure that communication campaigns do not inadvertently reinforce negative gender roles or deliver negative messages about gender-based abuse. The imagery used in campaigns helps shape how people think and behave (16, 358). Campaigns that seek to promote contraceptives or condoms specifically by appealing to macho imagery, for example, run the risk of reinforcing negative male stereotypes that undermine women's power within sexual relationships. The Jamaican marketing campaign for *Slam*

condoms, for example, used explicit references to rough sex and pictures of scantily clad dance hall girls to promote condom use to men (395).

Similarly, evaluation of *Hum Log (We the People)*, India's first television soap opera designed to promote social themes, found that its plot inadvertently reinforced domestic violence. Characters intended to be positive role models did not consistently benefit from treating women better, while the negative role models were not consistently punished for treating women poorly (46). Many viewers of the program praised the long-suffering woman who

accepted abuse from her husband and noted that she kept peace in her family, thus benefiting from her self-effacing behavior (416).

In contrast, the South African television drama “Soul City” successfully used entertainment media to challenge attitudes and norms that perpetuate abuse. This prime-time television drama weaves social responsibility themes concerning sexual coercion, harassment, and domestic violence into its stories. In addition, the program collaborates with the National Network on Violence Against Women to provide a toll-free hotline and free counseling services for victims of violence. “Once people can witness their own situations on television, and watch the characters they relate to solve their problems, they are empowered to take action in their own lives,” said Soul City researcher Thuli Shongwe (34).



Puntos de Encuentro

Unlike the recent disastrous Hurricane Mitch, violence against women is “a disaster that men can prevent,” this Nicaraguan poster points out. It urges men on the verge of violence to control their anger, talk about their feelings, and respect their wives.

Reproductive Health Programs in the Lead

In developing countries a number of reproductive health programs have taken the lead in addressing violence against women. The efforts of these programs are making it easier for other programs to tackle the complex issues of gender-based violence.

South Africa: Addressing violence as part of “life skills” workshops.

The Planned Parenthood Association of South Africa (PPASA), together with AVSC International's Men as Partners Program, has developed a program that integrates participatory activities on gender, sexual power, and intimate relationships into PPASA's “life skills” workshops. The program began after a survey of 2,000 South African men found that 58% believed that the concept of rape did not apply to a husband forcing his wife to have sex, 48% thought the way a woman dressed caused her to be raped, and 22% approved of a man hitting his partner (compared with 5% who approved of a woman hitting her partner) (371).

Latin America: Integrating violence issues into other reproductive health care.

The IPPF Western Hemisphere Region is currently working with affiliates in the Dominican Republic, Peru, and Venezuela to integrate attention to gender-based violence into other sexual and reproductive health programming. For example, in Venezuela PLAFAM has trained service providers, redesigned patient routing forms, and created new case registration forms (12).

Peru: Women listening to women's voices. ReproSalud, an innovative reproductive health program of the Peruvian women's organization Manuela Ramos, helps rural women organize to address reproductive health issues that they identify as most important. Of the 51 communities that had held *diagnosticos* as of March 1998, 12 communities had identified domestic violence as one of their three most important problems (262).

The Philippines: Organizing against violence. The Davao City Coordinating Council on Violence Against Women has carried out activities to reduce violence at all levels of society. These activities range from puppet shows that encourage community dialogue about gender-based violence to city-wide training for police, health workers, and government officials (70). In 1997 the Davao City Council passed the Women's Development Code, a landmark ordinance that promotes

and protects the rights of women and includes extensive provisions on gender-based violence, including comprehensive counseling, medical and legal support for victims, and women's desks in all Davao City police departments (109).

Tanzania: Organizing to protect refugee women. The International Rescue Committee (IRC) has launched a project on sexual abuse and gender-based violence among the Burundian refugee women housed in camps in the Kibondo district of Tanzania. The project has used participatory research and peer outreach workers to organize the camp communities to deal with gender-based violence. The project provides counseling, 24 hour a day medical services, and access to emergency contraception through four drop-in centers (324).

Liberia: Training traditional birth attendants. In 1993 Mother Patern College of Health Sciences in Monrovia, Liberia, joined with Women's Rights International, a US-based NGO, to address the aftermath of rape during Liberia's seven-year civil war. The project's Liberian staff developed a participatory program for traditional birth attendants. The program uses exercises such as “Kaymah's Trouble,” a story of a woman raped during the war, to help traditional birth attendants expand their roles as community leaders to address violence against women (474).

Nicaragua: Researching the reproductive health consequences of violence. Since its 1991 inception, the research collaboration between Ume—University, Sweden, and the Faculty of Medicine in León, Nicaragua, has yielded some of the richest data available anywhere on the reproductive health consequences of violence against women. Working closely with the Nicaraguan Women's Network Against Violence, researchers integrated questions on violence into a series of studies exploring infant mortality, adolescent pregnancy, HIV risk, and low birth weight. As frequent references in this report indicate, these pioneering studies have produced a wealth of information (129).

An Agenda For Change

Ending violence against women requires strategies coordinated among many sectors of society and at community and national levels. In some countries reproductive health programs have taken the lead in addressing violence against women (see box above). But efforts must go far beyond the health sector alone. An agenda for change must include: empowering women and girls; raising the costs to abusers; providing for the needs of victims; coordinating institutional and individual responses; involving youth; reaching out to men; and changing community norms.

Empowering Women and Girls

Empowering women and girls is not only a worthy goal in its own right but also a key strategy for eliminating violence. Women will never escape violence as long as they are financially dependent on men and derive their social value exclusively from their role as wife and mother. Legal codes and customary practices in many parts of the world still treat women as second-class citizens, denying them the right to own property, to travel freely, and to gain access to economic and productive resources. In virtually all countries women are underrepresented in positions of leadership, and their specific concerns are rarely reflected in public policy. As a result, women frequently lack the power necessary to make basic decisions and informed choices about their own health or sexuality (442).

Empowerment is generally viewed as a long-term process, occurring at the international, national, community, and individual level. Its goals are to:

- Eliminate laws that discriminate against women and children,
- Strengthen women in leadership and decision-making,
- Increase access to education for women and girls,
- Increase women's access to and control over economic resources,
- Increase women's access to health information and women's control over their own bodies,
- Improve women's self-esteem and sense of personal power.

Worldwide, networks of women's groups are working to achieve these goals through grassroots activism and lobbying at a political level to change discriminatory policies and practices. Women's organizing has achieved some impressive gains. For example, in the last decade 24 Latin American and Caribbean countries have reformed laws related to domestic violence, largely due to pressure from women's groups (346, 480).

In addition, thousands of NGOs are working to instill a greater sense of entitlement among women via human rights education, legal literacy programs, gender training, and other small-group efforts. In Nepal, for example, the Asia Foundation sponsored human rights workshops in 1998 for 90,000 rural women to educate them about their rights and to encourage collective action. In the Muslim world the Sisterhood Is Global Institute runs similar workshops for women. Their manual, *Safe and Secure: Eliminating Violence Against Women in Muslim Societies*, uses case studies to spark discussion of issues such as child marriage, honor killings, and spousal violence (4). According to the institute, "Women must reclaim and re-interpret their culture in order to reach the goal of self-empowerment" (417).

Raising the Costs to Abusers

Research in the US shows that rates of interpersonal violence decrease in response to policies and laws that make violent behavior more costly to abusers (137). Western countries have relied heavily on the criminal justice system to achieve this goal, and in response to women's activism many developing countries have followed suit. At least 53 countries have passed legislation against domestic violence. More than 27 have enacted laws against sexual harassment, and 41 now regard marital rape as an offense (82, 346, 443, 480).

Although such legislation varies, most laws include some combination of protective or restraining orders and increased penalties for offenders. Protective orders allow judges to remove an abuser temporarily from the home and to order him to seek counseling, to get treatment for substance abuse, to pay maintenance and child support, or some combination of these. If a man violates a protective order, he can be arrested and jailed.

In most countries, however, procedural barriers, gaps, and biases undermine the law's ability to deter violence and to protect women and children (91). Laws are enforced by male judges, prosecutors, and police officers, many of whom share the same victim-blaming attitudes of the society at large. Thus, as well as passing laws, it is crucial to sensitize police officers, lawyers, judges, and other members of the legal system and to help women know enough about the legal system to be able to insist on their rights.

In addition, many communities have explored other means to raise the costs to individual abusers of their violent behavior, such as public shaming, picketing an abuser's home or workplace, and requiring community service for offenders. Such practices presume that community disapproval can help deter domestic violence. As a Cambodian activist notes, "If a man feels that he will be severely 'looked down on' for battering his wife..., it is likely that domestic assault will decrease" (488).

In the US state of Texas, for example, an innovative judge is sentencing batterers to "shame sentences," ordering one abusive man to apologize to his wife publicly on the steps of City Hall, for example, and another to carry a sign around a local shopping mall that read, "I went to jail for assaulting my wife. This could be you" (173). Similarly, Indian activists often stage *dharnas*, a form of public shaming and protest, in front of the house or workplace of abusive men (305).

Providing for the Needs of Victims

The needs of victims are complex. A woman in crisis needs physical safety, emotional support, and assistance in resolving such issues as child support, custody, and employment. If she chooses to press legal charges against her abuser, she also

needs help negotiating police and court procedures. Often, what she needs most is a safe, supportive environment in which to explore her options and decide what to do next.

In many countries advocates have responded by setting up crisis centers or other services to address the many needs of abused women and girls. Such centers generally offer medical, legal, and counseling services, often all in one location. Some services are funded and run by government, and others, by women's organizations or other nonprofit groups.

Services run by women's groups have pioneered the use of support groups and nondirective feminist counseling designed to empower women. Support groups can play an important role in reducing women's sense of isolation, allowing them to develop a common understanding of violence and to share coping strategies (408).

Developed countries often have relied on shelters to protect women in crisis. Shelters are costly to maintain, however, and require women to uproot themselves and their children just when familiar surroundings and continuity in schools and friendships could be a great support. Communities are now experimenting with other low-cost ways to increase women's safety, such as providing safe home networks and sanctuary churches where women can seek safety and support. In industrial countries such as Sweden and the US, municipal governments and private companies have tried providing battered women with cellular phones, alarm devices, and even guard dogs to help protect them from abusive partners (360).

Elsewhere, governments have experimented with police stations staffed only by women—an innovation that began in Brazil and has now spread throughout Latin America and parts of Asia (267, 359). Although good in theory, such efforts to date have faced many problems, evaluations show (134, 205, 302, 305, 359, 432).



Alice Payne Merritt, JHU/CCP

In Bolivia girls march to celebrate the International Day of the Child. Empowering women is not only a worthy goal in its own right but also a key strategy for eliminating gender-based violence.

Table 7. How Health Care Systems Can Respond

<i>Community Level</i>		
Typical Staff Include: Community health workers (CHWs) Trained traditional birth attendants (TBAs) Traditional healers Pharmacists	First-Order Response <ul style="list-style-type: none"> Integrate lessons on abuse, sexuality, and healthy relationships into CHW and TBA training. Goal: To sensitize workers and help them respond sympathetically to victims of abuse.	Additional, More Advanced Response <ul style="list-style-type: none"> Encourage CHWs to become active community change agents by: <ul style="list-style-type: none"> starting public discussion of violence via role-playing, posters, and community events, holding workshops to change community norms and attitudes. Train CHWs to facilitate support groups for abused women. Encourage CHWs to accompany women to the police and the medical examiner's office when they choose to report rape or domestic assault.
<i>Primary Care Level</i>		
Typical Staff Include: Health post: Nurses Auxiliary nurse-midwives Clinic: General practitioner Midwives	First-Order Response <ul style="list-style-type: none"> Sensitize staff to violence by providing experiential training that examines attitudes and beliefs. 	Additional, More Advanced Response All of the above plus: <ul style="list-style-type: none"> Train staff to identify and respond appropriately to victims of abuse. Encourage proper documentation and safety planning. Facilitate linkage with local women's groups, where they exist. Display posters and pamphlets in waiting areas.
<i>Polyclinic or Hospital Level</i>		
Typical Staff Include: Midwives General practitioners Medical specialists Social workers	First-Order Response <ul style="list-style-type: none"> Train staff to identify and respond appropriately to victims of abuse. Encourage proper documentation and safety planning. Facilitate linkage with local women's groups, where they exist. Display posters and pamphlets in waiting areas. 	Additional, More Advanced Response <ul style="list-style-type: none"> Initiate active screening for abuse among selected patient populations, e.g., in prenatal care clinics, casualty departments, mental health clinics. Develop site-specific protocols for responding to victims. Incorporate questions on abuse into intake forms or patient interview schedules; prompts can be rubber-stamped on existing forms. Organize a self-help support group for women or lend facility to groups willing to do so. Coordinate with a local women's group to have an advocate on call to help abused women (or train someone in-house). Establish specialized services for victims of sexual assault, including proper collection of forensic evidence.

Prepared by the Center for Health and Gender Equity (CHANGE) for *Population Reports*

While the presence of a women's police station increases the number of abused women coming forward, frequently the women require services—such as legal advice and emotional counseling—that are not available at the stations. Moreover, the assumption that female officers will be more sympathetic to victims has not always proved true. Female officers assigned to all-women stations frequently have been ridiculed by their peers and have become demoralized. To be viable, this strategy must be accompanied by sensitivity training for officers, mechanisms to reward and legitimate the work, and provision of a wider array of services (205, 305, 359).

Coordinating Institutional and Individual Responses

In most countries women have to overcome many institutional barriers to get the help they need (347). There is little coordination among the many institutions with which abuse victims interact, such as health care, child welfare, and law enforcement agencies (347, 438). Even worse, when victims seek help, some of these agencies tend to be unresponsive or even hostile.

Institutions at all levels of the health care delivery system and in the community can best respond to the needs of abused women if they are trained and organized to do so. The appropriate types of response depend on the level and staffing of the institution (see Tables 7 and 8). People not only in health care but in other areas as well—including community and religious leaders, the mass media, and parents—can promote nonviolent relationships (see p. 24).

Many countries have developed national and local plans to improve coordination between public officials and community advocates and to monitor the quality of services for victims. The Pan American Health Organization has sponsored project in 10 Latin American countries to explore how best to facilitate coordinated community action. The project includes creating community-level coordinating councils, reforming the response of formal institutions such as the police and health system, and creating support groups for victims and treatment programs for perpetrators (201, 486). A similar project is underway in six additional countries with support from the Inter American Development Bank (224, 311).

Table 8. Applying Communication Strategies to Address Violence

Communication Focus for Different Audiences

Strategies for Clients/Community Members	Strategies for Health Care Providers
When Audience Is Adults	
<ul style="list-style-type: none"> Conduct workshops and campaigns to de-legitimize violence as a way to resolve conflict or to “discipline” women or children. Highlight the prevalence of abuse and its costs to families and society (e.g., impact of witnessing violence in childhood). Promote supportive responses (not blaming) to victims of physical or sexual abuse, using street theater, alternative media, and public education campaigns. Integrate plot lines about physical and sexual abuse into TV and radio programming, especially into social dramas produced to promote reproductive health. Ensure that all media projects produced to promote family planning or other health goals promote gender equity by portraying competent women and caring men. Conduct health campaigns to discourage use of alcohol and drugs. Promote human rights education and other ways to empower women. 	<ul style="list-style-type: none"> Stress key role that health care providers can play in early detection, treatment, and referral of victims of violence. Educate providers on the long-term health consequences of physical and sexual abuse. Promote an ethic of care so that providers see themselves as responsible for the whole person, not just the person’s symptoms.
When Audience Is Children	
<ul style="list-style-type: none"> Promote life-skills training in schools and out-of-school settings; include age-appropriate content on sexuality, conflict resolution, building healthy relationships, and personal safety. Initiate specialized campaigns to prevent violence, e.g., “Hands are not for hitting.” 	<ul style="list-style-type: none"> Alert providers to the prevalence and epidemiology of child abuse, including sexual abuse. Educate providers on the long-term consequences of early abuse, both sexual and nonsexual. Encourage providers to promote nonphysical forms of child discipline.
When Audience Is Adolescents	
<ul style="list-style-type: none"> Provide comprehensive sexuality education including exercises that examine gender norms, double standards for male and female sexual behavior; role-playing on resisting pressure to engage in unwanted sexual behavior. Enable boys and girls (first separately, then in mixed groups) to discuss relationships, love, anger, jealousy, and abuse. Educate young women about their rights. 	<ul style="list-style-type: none"> Alert providers to the high possibility of sexual abuse in cases of STI or pregnancy in girls underage 14. Help providers confront their own attitudes toward adolescent sexuality, proper gender roles, and victims of rape or abuse.

Prepared by the Center for Health and Gender Equity (CHANGE) for *Population Reports*

Involving Youth

Social behavior is learned at an early age. Around the world a number of programs are working with young people to encourage nonviolent forms of conflict resolution, to challenge traditional gender norms, and to create new models of healthy relationships—for example:

- In Mexico the Instituto Mexicano de Investigación de Familia y Población A.C. (IMIFAP), a nongovernmental organization, has developed an experiential workshop for adolescents to help prevent violence in dating and friendship relationships. The workshop, called *Rostros y Máscaras de la Violencia* (Faces and Masks of Violence), uses participatory techniques to help young people explore expectations and feelings about love, sex, and romance; to distinguish between romantic and controlling behavior; and to understand how traditional gender roles inhibit both male and female behavior (142).
- The Ugandan magazine for teens, *Straight Talk*, focuses on relationships and stresses gender equity, positive values, and interpersonal skills. A recent edition entitled *A NO Means NO* uses a comic-book style to discuss sexual coercion and abuse. More than 115,000 copies of *Straight Talk* are



Straight Talk

A Ugandan teens' magazine directly addresses sexual coercion.

Strengthening Health Service Responses: Lessons Learned

Globally, health systems and providers have only recently begun to tackle the challenge of responding to physical and sexual abuse. Most violence interventions in health care settings—with the exception of a handful in the US—have not been formally evaluated, and pilot interventions in resource-poor settings are just beginning (78, 277). There is an urgent need for more demonstration projects, with thorough evaluation, to determine what works or does not work in different settings. Nonetheless, some tentative lessons have emerged:

1. Do more than train. While training health care providers is important, training alone is seldom enough to change providers' behavior toward victims of domestic violence (298, 435). Although training can improve providers' knowledge and practice in the short term, the impact of training generally erodes unless a variety of other measures also are taken that support and sustain new approaches (203, 298).

2. Adopt a systems approach. Achieving lasting change requires transforming the health system itself as well as changing the behavior of individual providers (40, 89). When managers, administrators, and the health care system itself encourage and reward new, caring behavior towards victims of abuse, providers will feel better able to recognize and address violence (61, 355, 398, 491).

Adopting a systems approach to addressing violence means developing policies and protocols and ensuring that they become expected practice throughout a health care system, from the top policy makers to the front-line providers. (For a description of systems approaches in reproductive health care, see **Population Reports, Family Planning Programs: Improving Quality**, J-47, November 1998).

3. Make procedural changes in client care. Often, making such procedural changes as adding prompts for providers on medical charts (e.g., stickers asking about abuse, or a stamp that prompts providers to screen) or including appropriate questions on intake forms and interview schedules can encourage attention to domestic violence (329).

For example, in one US study identification rates almost doubled after staff were given a one-hour presentation on domestic violence and a violence screening question was added to the emergency department patient record chart. Evaluation showed that the addition of the chart prompt, rather than the training, made the difference (335). In another US study identification of abused women in a primary care clinic rose from none, with discretionary inquiry, to 12% when a single question on abuse was added to the client health history form (160).

4. Confront underlying attitudes and beliefs. Most training programs for health care workers have focused on the clinical management of victims. This approach yields limited results, however, because providers themselves generally share the same biases, prejudices, and fears regarding abuse as the society at large. As programs have gained experience, it has become clear that providers must examine their own attitudes and beliefs about gender, power, abuse, and sexuality before they can develop new professional knowledge and skills about dealing with victims (252, 277).

In South Africa, for example, the Agisanang Domestic Abuse Prevention and Training Project (ADAPT) and its partner, the Health Systems Development Unit of the University of Witwatersrand,

developed a gender training program to be incorporated into a four-week reproductive health curriculum for nurses. The program focused first on the nurses, not as health care professionals but rather as men and women themselves. It used role-playing, popular sayings, and wedding songs to help participants analyze common notions about violence and about the proper roles of men and women. Only then did the training turn to the nurse's responsibilities as health professionals. A post-training survey found that participants no longer believed that beating a woman was justified and that most accepted the concept of marital rape (252).

5. Redefine success. Health workers often feel reluctant to address cases of domestic violence because it is a problem that cannot easily be cured or even addressed. In response, some training projects have tried to help the provider reframe their role from "fixing" the problem and dispensing advice to providing support. Revising expectations in this way has helped providers overcome feelings of resentment and impotence in addressing domestic violence (374).

Reframing the provider's role also helps promote women's self-determination. Counseling concerning abuse, like contraceptive counseling, should be nondirective and respect women's choices. As one advocate put it, "We are trying to work through the frustration of providers who don't understand that it takes time for a battered woman to take action. When we ask a woman to make a decision within 10 minutes, we are saying, 'We know what's good for you.' This is no different from the batterer who makes all the decisions for her" (452).

6. Provide opportunities to model new behavior. Two major barriers to asking clients about abuse are providers' belief that violence is uncommon among their clients and providers' fear of how the clients will respond (151, 428). Opportunities to practice new behavior can help overcome both barriers. In working with medical students, for example, Pakistani physician Fariyal Fikree often issues a challenge: "Go out and ask your next five clinic patients a simple screening question for abuse. With this direct experience base, you will be in a better position to evaluate the utility of this practice."

This exercise breaks down the student's resistance, replaces assumptions with experience, and stimulates their interest in learning more about family violence. Generally, students come back from the experience amazed at how many women disclosed abuse and how willing women were to discuss such matters (151).

7. Be strategic about where you start. Changing health systems is difficult. Thus the best practice is usually to start where success is most likely. Often this strategy means choosing to undertake pilot interventions first in settings where there is substantial internal and external support for change.

Internally, it is important to gain the commitment and support of top managers early. Efforts to integrate concern for sexuality into family planning programs have shown that institutional support is absolutely essential to program success (24, 398).

Externally, it is best to undertake pilot interventions where support and referral services for abuse victims already exist. This will not be possible in all instances, but, given that there are so few pilot initiatives yet in resource-poor settings, it makes sense to begin where there are community resources to draw upon.

8. Plan for staff turnover. In most health systems, particularly in developing countries, staff members routinely rotate in and out of clinics and other health centers. Thus policies on violence must be institutionalized, and training will be needed for new staff members on a continuing basis (329).

9. Follow up. Programs should provide continuing support to individuals and institutions attempting to reform their response to domestic violence. Projects that have attempted to spark change by using a “train the trainer model”—inviting providers to attend a centralized training and then expecting them to duplicate the training in their home setting—have generally found that such schemes do not work well without substantial continuity and support (61).

High-Priority First Steps

Reproductive health professionals often feel that the issue of violence against women is too complex and too overwhelming to tackle. But fundamental change can—and often must—begin incrementally. A graduated response to violence could begin with the following steps:

Priorities for Donors

Research into vaginal microbicides. Changing the power balance between women and men in sexual relationships will take time—time that women at risk of HIV and other sexually transmitted infections today do not have. Thus a high-priority investment by donors must be research into vaginal microbicides—substances, similar to today's spermicides, that women could use to protect themselves from infection—if necessary, without the knowledge or cooperation of their sex partners. Scientists predict that a first-generation microbicide could be developed within 5 years given sufficient investment. Presently, research in this area is inadequate. Women's and AIDS groups have organized the Global Campaign for HIV/STI Prevention Alternatives for Women to demand more investment in microbicide development (495).

Pilot projects. More must be learned about how to integrate concern for gender-based abuse into other reproductive health programs. Immediate support is needed for pilot projects with strong evaluation components to discover what works best in different settings, particularly where resources are few.

Priorities for Program Planners

Integration into ongoing training. The most effective way to improve training about abuse for reproductive health care providers is to integrate it into current training, especially when training addresses quality of care, counseling, and male involvement. At a minimum all training for providers can add sensitization exercises about gender, sexuality, and abuse.

Make new norms a program objective. Measurable indicators of reproductive health program success can include, for example, changes in the percentage of women and men who agree that a married woman has a right to refuse sex. The DHS now include such questions. With new norms as a program objective, managers will focus attention on how best to encourage changes in public attitudes about women's autonomy and men's behavior.

Priorities for Providers

Discuss with women clients how much they can control sexual encounters. This is a crucial consideration in choice of a family planning method. Providers can point to methods that a woman can use without her partner's knowledge or if she cannot anticipate sex. Also, providers can emphasize that sex—including sex within marriage—should be wanted by both parties, not forced by the man.

distributed monthly throughout Uganda and supplemented with workshops (425) (see photo, p. 35).

- A Canadian group, *Men for Change*, has developed an anti-violence curriculum called “Healthy Relationships.” Designed for middle-school youth, it includes three modules: Dealing with Aggression; Gender Equality and Media Awareness; and Forming Healthy Relationships (391).

Reaching Out to Men

Working with men to change their behavior is an important part of any solution to the problem of violence against women. To date, most programmatic work with men has focused on establishing treatment programs for men who batter. Begun in the US, such programs have since spread to Argentina, Australia, Canada, Mexico, and Sweden, among other countries (14, 77, 93).

In the US the courts generally require men's participation in treatment programs instead of imprisonment for domestic and sexual abuse, although some men participate voluntarily. The content and philosophy of the programs vary, as does their length, which can range from three to nine months. The primary goal is for participants to accept personal responsibility for their violent behavior and to learn nonviolent ways to manage their anger and interpersonal conflict. Some programs attempt explicitly to confront traditional attitudes regarding gender roles and male dominance in relationships (78, 207).

Only a handful of such programs have been rigorously evaluated. Evaluations suggest that the majority of men (53% to 85%) who complete such programs remain physically nonviolent for up to two years after treatment (122, 187). But between one-third and one-half of men who enroll in such programs never complete them. Thus the proportion of all male abusers who benefit from treatment programs is small (122). Moreover, while men may refrain from physical violence after treatment, many continue other types of threatening or coercive behavior toward their partners (122, 439). Nevertheless, a recent evaluation of programs in four US cities found that most abused women felt “better off” and “safer” after their partners entered a treatment program (187).

Other recent programs encourage men to examine their assumptions about gender roles and masculinity and to become agents for change in the community. In the Philippines, for example, the NGO Harnessing Self-Reliant Initiatives and Knowledge (HASIK) uses gender training as a point of entry for organizing against violence in depressed areas of Quezon City.

Men in the Talanay community formed a group named SWAT, for Support for Women Advocates of Talanay, to help men become better aware of gender issues. Members of the group intervene with the abusive husbands of women who have sought help at the local crisis center (364).

In some communities groups of men have come together to challenge male violence and to explore new models of manhood. Hundreds of men from Nairobi recently took part in a march to speak out against gender-based violence. "We are here to assert men's commitment to eradicate the customs, beliefs and attitudes that influence men to violate women and mete out violence against them," said Reverend Timothy Njoya, organizer of the march (138). Men's groups against violence exist in Canada, Nicaragua, Zimbabwe, and elsewhere (206, 300, 307, 465).

Changing Community Norms

Ending violence against women means changing the community norms and cultural attitudes and beliefs that give rise to men's abusive behavior toward women and that permit it to persist. Changing community norms alone will not eliminate violence. Nevertheless, it is difficult to make progress until there is a consensus in society that violent behavior is wrong.

A variety of norms and beliefs are particularly powerful in perpetuating violence against women. These include a belief that men are inherently superior to women, that men have a right to "correct" female behavior, that hitting is an

appropriate way to discipline women, that a man's honor is linked to a woman's sexual behavior, and that family matters are private and it is inappropriate for others to intervene (210).

Programs designed to change these beliefs must draw people into discussion rather than alienate them by appearing to "demonize" men. To encourage people to consider new norms, programs have used such techniques as community theater and small-group work. In Cambodia, for example, the Project Against Domestic Violence sponsored a traveling theater troupe to encourage discussion about domestic violence and to portray models of new behavior. The troupe performed in 35 villages around the country and drew crowds of 5,000 to 30,000 people at each performance (19).

Laws can be changed and programs enacted that better protect victims of abuse, raise the social cost to the abuser, and influence cultural values. Perhaps most important, however, social attitudes must change so that women gain greater control over their own bodies, over economic and family resources, and over their lives in general.

Health programs and other institutions can help change the perception—often so deep-seated that it is unconscious—that women are fundamentally of less value than men. In the words of human rights activist Charlotte Bunch, "Only when women and girls gain their place as strong and equal members of society will violence against women no longer be an invisible norm, but instead a shocking aberration" (443).

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An asterisk (*) denotes an item that was particularly useful in the preparation of this issue of *Population Reports*.

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