Integrating Poverty and Gender into Health Programmes

A Sourcebook for Health Professionals

Module on Gender-Based Violence

World Health Organization
Regional Office for the Western Pacific

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This module is one of a complete set entitled Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals. It was prepared by a team comprising T. K. Sundari Ravindran (consultant and principal writer), Anjana Bhushan, Technical Officer, Poverty and Gender, and Kathleen Fritsch, Regional Adviser in Nursing, World Health Organization Regional Office for the Western Pacific. Breeda Hickey provided critical supplementary inputs and also edited the module. Design and layout were done by Zando Escultura.

ABBREVIATIONS

ADB    Asian Development Bank
AIDS   Acquired immunodeficiency syndrome
DALY   Disability-adjusted life year
DHS    Demographic and Health Survey
GBV    Gender-based violence
GDP    Gross domestic product
GHI    Global health initiative
HIV    Human immunodeficiency virus
HMO    Health maintenance organization
IMF    International Monetary Fund
IMR    Infant mortality rate
IPPF   International Planned Parenthood Federation
LBW    Low birth weight
MDG    Millennium Development Goal
MMR    Maternal mortality rate
NGO    Nongovernmental organization
OECD   Organization for Economic Cooperation and Development
PAHO   Pan American Health Organization
PHC    Primary health care
PRSP   Poverty Reduction Strategy Paper
PTSD   Post traumatic stress disorder
SAGBVHI South African Gender-based Violence and Health Initiative
STI    Sexually transmitted infection
UN     United Nations
UNAIDS Joint United Nations Programme on AIDS
UNICEF United Nations Children’s Fund
UNDP   United Nations Development Programme
VAW    Violence against women
WB     World Bank
WHA    World Health Assembly
WHO    World Health Organization
WPR    Western Pacific Region
Over the past two to three decades, our understanding of poverty has broadened from a narrow focus on income and consumption to a multidimensional notion of education, health, social and political participation, personal security and freedom and environmental quality. Thus, it encompasses not just low income, but lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Multidimensional poverty is a determinant of health risks, health seeking behaviour, health care access and health outcomes.

As analysis of health outcomes becomes more refined, it is increasingly apparent that the impressive gains in health experienced over recent decades are unevenly distributed. Aggregate indicators, whether at the global, regional or national level, often tend to mask striking variations in health outcomes between men and women, rich and poor, both across and within countries.

At the same time, the understanding of poverty has broadened from a narrow focus on income and consumption to a multidimensional notion of education, health, social and political participation, personal security and freedom, and environmental quality. Thus, it encompasses not just low income, but lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Multidimensional poverty is a determinant of health risks, health seeking behaviour, health care access and health outcomes.

It is estimated that about 70% of the world’s poor are women. Similarly, in the Western Pacific Region, poverty often wears a woman’s face. Indicators of human poverty, including health indicators, often reflect severe gender-based disparities. In this way, gender inequality is a significant determinant of health outcomes in the Region, with women and girls often at a severe societal disadvantage.

Although poverty and gender significantly influence health and socioeconomic development, health professionals are not always adequately prepared to address such issues in their work. This publication aims to improve the awareness, knowledge and skills of health professionals in the Region on poverty and gender concerns.

The set of modules that comprise this Sourcebook are intended for use in pre-service and in-service training of health professionals. It is expected that this publication will also be of use to health policymakers and programme managers, either as a reference document or in conjunction with in-service training.

All modules in the series are linked, but each one can be used on a stand-alone basis if required. There are two foundational modules that set out the conceptual framework for the analysis of poverty and gender issues in health. Each of the other modules is intended for use in conjunction with these two foundational modules. The Sourcebook also contains a module on curricular integration to support health professional educational institutions in the process of integration of poverty and gender concerns into existing curricula.

The modules in the Sourcebook are designed for use through participatory learning methods that involve the learner, taking advantage of his or her experience and knowledge. Each module contains facilitators’ notes and suggested exercises to assist in this process.

It is hoped that the Sourcebook will prove useful in bringing greater attention to poverty and gender concerns in the design, implementation and monitoring and evaluation of health policies, programmes and interventions.
Introduction
Introduction

This module is designed to improve the awareness, knowledge and skills of health professionals on gender-based violence (GBV). Health professionals are in a unique position to identify the problem, contribute to its prevention and assist victims. This is because health facilities are probably one of the few public institutions that most women interact with at some point in their lives for pregnancy and delivery-care, for contraception, for health-care for their children or for their general health needs.

Gender-based violence has long remained a feature of family and social life, about which society has preferred to remain silent. GBV takes many forms and affects a large number of women from all parts of the world at different points in their life cycle, from infancy and childhood to adulthood and old age. In recent decades, much has been done to gather evidence on the dimensions of the problem and promote awareness on the seriousness of the issue. National and international organizations have dedicated resources not only for research and advocacy but also for the development of strategies and policies to prevent and address gender-based violence at the local, national and international level.

The module examines the topic of gender-based violence as a health issue through a gender and poverty lens. It is divided into six sections.

- **Section 1** defines gender-based violence, its extent, its consequences on health and on the health care system, and its contribution to inequities in health and the further subordination of women in an already gender-unequal world.
- **Section 2** examines WHAT the links are between poverty, gender and gender-based violence. It examines the unequal gender relations and power imbalances underlying GBV and discusses GBV as a cause and consequence of poverty and economic hardship.
- **Section 3** discusses WHY it is important for health professionals to address gender-based violence, from efficiency, equity and human rights perspectives.
- **Section 4** discusses HOW health professionals and the health care system as a whole can prevent and address gender-based violence, with a special focus on low-income women and those from other marginalized or vulnerable groups. Examples of good practice at the health facility, community and policy levels are presented to illustrate potential interventions.
- **Section 5** provides notes for facilitators.
- **Section 6** is a collection of tools, resources, and references to support health professionals in their work in this field.
1. What is gender-based violence?
1. What is gender-based violence?

Concepts and definitions

The term violence against women has been used to describe many different acts, ranging from murder and rape to sexual harassment and emotional abuse. Clarity on the terms used is important to properly understand the magnitude and dimensions of the problem and to assess its health consequences (see Box 1).

Gender-based violence

The UN Declaration on the Elimination of Violence Against Women (Article 1) defines violence against women as:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

Article 2 of the Declaration further specifies that violence against women should include, but not be limited to:

Acts of physical, sexual and psychological violence whether they be in the family or the community. The acts of violence specified in this article include: spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, traditional practices harmful to women such as female genital mutilation, non-spousal violence, sexual harassment and intimidation, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state such as rape in war.

Forms of gender-based violence

Violence can be divided into four categories:

- Physical violence
- Sexual violence
- Psychological/emotional violence (including coercive tactics)
- Threat of physical or sexual violence

Physical violence is defined as the intentional use of physical force with the potential to cause death, disability, injury or harm. However, violence takes many forms besides physical assault. Many women and girls experience some form of sexual violence during their lifetime, ranging from sexual harassment in public spaces to abusive sexual contact, coercive sex by an intimate partner, and rape.

While acts of physical and sexual violence may be dramatic events readily acknowledged as

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**Box 1. Terms used to describe gender-based violence**

**Gender-based violence** includes all forms of violence involving women and men in which the female is usually the victim. The term 'gender-based' is used to highlight the need to understand violence within the context of women's and girl's subordinate status in society. Such violence cannot be understood, therefore, in isolation from the norms, social structure, and gender roles within the community, which greatly influence women's vulnerability to violence.

**Violence against women** is a term often used synonymously with gender-based violence. However, the term does not make it clear whether or not the violence is derived from unequal power relationships between women and men in society.

**Domestic violence** is a term used with many meanings. The most common usage is with reference to violence by the spouse or intimate partner. However, the term is also used sometimes to describe violence within the family, where the perpetrators are usually male members, for example, violence by the father against the daughter, son against mother and so on.

**Wife-battering** is physical violence by a husband against his wife.

**Spousal abuse/Intimate partner violence** refer to physical, sexual or psychological violence or abuse by one partner against another, in an intimate relationship. The partners could either be male or female. Wife battering is a subset of spousal abuse or intimate partner violence.
Box 2. Forms of gender-based violence

Physical violence is defined as the intentional use of physical force with the potential to cause death, disability, injury or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife or other object), and use of restraints or one’s body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

Sexual violence is divided into three categories:
- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed
- An attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g. because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).
- Abusive sexual contact, including intentionally touching directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g. because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).

Threat of physical or sexual violence: The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. Also the use of words gestures or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent.

Psychological/emotional violence: Trauma to the victim caused by acts, threats of acts, coercive tactics when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence.

Psychological/emotional abuse can include but is not limited to: humiliating a person; controlling what the person can and cannot do; withholding information from the person; getting annoyed if the person disagrees; deliberately doing something to make the person feel diminished (e.g. less smart, less attractive); deliberately doing something to make the person feel embarrassed; isolating the person from friends and family; prohibiting access to transportation or telephone; denying access to money and other resources; threatening loss of custody of children; and, smashing objects or destroying property.

Psychological/emotional abuse as described above may be considered as acts of violence only when there has also been prior physical or sexual violence, or the prior threat of physical or sexual violence.


unacceptable, psychological or emotional violence is more insidious and pervasive. Psychological or emotional violence is defined as trauma to the victim caused by acts, threats of acts and coercive tactics when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence. In addition to actual acts of violence, any act that communicates the threat of physical and sexual violence (as defined above) is in itself classified as a form of violence. Box 2 gives detailed definitions of different forms of violence, while Box 3 describes sexual harassment in the workplace.

Gender-based violence through the lifecycle

Violence against girls and women occurs at different points in their lifecycle. Many women experience multiple episodes of violence that may start in the prenatal period and continue through childhood to adulthood and old age. Box 4 describes violence that may be experienced at different points in a girl’s/woman’s lifecycle. The lifecycle approach to gender-based violence helps one understand the cumulative impact of violence experienced by girls and women, especially in...
Box 3. Sexual harassment in the workplace

**Sexual harassment** is “any unwelcome sexual advance, requests for sexual favours or other verbal or physical conduct of a sexual nature, when it interferes with work, is made a condition of employment, or creates an intimidating, hostile, or offensive work environment.”

**Unwelcome physical conduct of a sexual nature** involves unnecessary, non-accidental physical contact that is unwanted by the recipient. Such contact ranges from unnecessary touching, patting, pinching or brushing against another employee's body, to sexual assault and coercing sexual intercourse.

**Unwelcome verbal conduct of a sexual nature** includes unwelcome spoken sexual advances, propositions or pressure for sexual activity; pressure for unwelcome social activity outside the workplace; unwelcome sexually suggestive remarks, innuendos or lewd remarks.

**Other unwelcome conduct of a sexual nature** include the display of pornography or other materials of a sexually suggestive nature; offensive flirtatious conduct or the making of sexually suggestive gestures; the sending of written communications or objects of an offensive nature.

There are only a small number of empirical studies on the extent of this problem. A recent Australian national household telephone survey reported that 18% of interviewees had personally experienced sexual harassment in the workplace at some time in their lives: 28% of women and 7% of men. In Nepal, a rapid survey conducted by the Forum for Women, Law and Development, covering 62 respondents found that 54% of female workers had experienced sexual harassment in the workplace at some time in their working life.

There is no international labour convention explicitly addressing sexual harassment. However, ILO’s Convention on Discrimination (Employment and Occupation) covers sexual harassment, and this convention has been ratified by 152 countries. Only a few countries have passed laws that deal specifically with sexual harassment, including Australia, Argentina, Belgium, Belize, Canada, Costa Rica, New Zealand, Philippines and Portugal. In other countries, there are laws that include references to sexual harassment or that have been interpreted by courts as covering sexual harassment. For example, the Indian Supreme Court has ruled that public and private employers must take steps to prevent sexual harassment and provide appropriate penalties against offenders.

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**Intimate partner violence or domestic violence**

The most common and endemic form of violence experienced by women all over the world is violence by the spouse or intimate partner. This is often referred to as 'domestic violence'.

Intimate partner violence takes many forms, including physical, sexual and psychological violence over a prolonged period of time. Studies on the nature of intimate partner violence and its manifestations find that there is a 'cycle of violence' that becomes difficult to break. In the first phase of this cycle, there is a gradual increase in tension and conflicts between the couple. The woman tries to appease her partner, generating a false sense of being able to control his aggression. The second phase is one of open, 'explosive' aggression, characterized by physical, sexual and psychological abuse. This phase ends when the aggressor stops the abuse temporarily. A period of reconciliation, or the 'honeymoon' phase, follows. The abuser shows remorse and promises to rectify his behaviour. He may be especially loving and kind, which assures the woman that there is a 'good' side to her partner, which she can retain by adopting appropriate behaviour. This third phase makes her feel that it is not necessary to leave the relationship.

The 'cycle of violence' explains why many women stay in abusive relationships. Over time, they begin to adjust to their partner's violent behaviour by modifying their own. They develop a strategy for survival that may include extreme passivity, even defending the aggressor. Violence in the relationship becomes entrenched and the affected
Box 4. Gender-based violence through the lifecycle

<table>
<thead>
<tr>
<th>Phase</th>
<th>Type of violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prebirth</td>
<td>Sex-selective abortion (as prevalent, for example, in China, India, Republic of Korea); Battering during pregnancy (which can have serious emotional and physical effects on the woman; and effects on birth outcomes); coerced pregnancy (for example, mass rape in war)</td>
</tr>
<tr>
<td>Infancy</td>
<td>Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants</td>
</tr>
<tr>
<td>Girlhood</td>
<td>Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Dating and courtship violence (for example, acid throwing in Bangladesh, date rape in the USA); economically coerced sex (for example, African secondary school girls having to date “sugar daddies” to afford school fees); sexual abuse in the workplace; rape; sexual harassment; forced prostitution; trafficking in women</td>
</tr>
<tr>
<td>Reproductive Age</td>
<td>Abuse of women by intimate male partners; marital rape; dowry abuse and murders; partner homicide; psychological abuse; sexual abuse in the workplace; rape; sexual harassment; abuse of women with disabilities</td>
</tr>
<tr>
<td>Elderly</td>
<td>Abuse of widows; elder abuse</td>
</tr>
</tbody>
</table>


women appear to make no moves to change the situation. Over time, the 'aggression' phase may become more frequent and intense, and could even end in death unless the cycle is broken through sustained external interventions to help the woman.

The extent of the problem

Documenting the incidence of gender-based violence is a difficult and sensitive task fraught with methodological difficulties as well as ethical dilemmas. To begin with, there is a need to define different categories of violence precisely.

A more complex issue relates to recruitment and retention of interviewees. Approaches that do not involve face-to-face interaction, such as telephone interviews and postal surveys, have the benefit of ensuring confidentiality and privacy for the respondent. However, these may not be the best methodologies when studying lower-income groups, and in many developing country settings.

Health center-based recruitment may be useful in getting a larger number of respondents but will not be a representative population, making it unsuitable for estimation of incidence and prevalence.

Community-based surveys involving face-to-face interviews are increasingly being used to get information on population prevalence rates of different forms of gender-based violence and especially intimate-partner violence. This poses a number of ethical dilemmas. The major concern in such surveys is the safety of the respondent. Asking women about their experiences of violence may place them at a high risk of being victimized again by the perpetrator. In having to think about and report on the violence they have experienced, women may experience stress and trauma all over again. The World Health Organization has formulated ethical and safety recommendations for conducting community-based surveys on gender-based violence, stressing...
that nothing is more important than the respondent’s safety.\footnote{The State of World Population Report 2000. Chapter 3.}

Another difficult methodological issue relates to the reliability of self-reported rates of violence. It is acknowledged that women may be reluctant to report violence, especially intimate partner violence, for reasons such as fear of reprisal or, more often, because they have not defined their experience as ‘violence’ or ‘abuse’, even to themselves. The consequence is under-reporting of the prevalence of violence. When studies document lower levels of violence than is actually the case, they may be doing more harm than good because such research may be used to question the importance of gender-based violence as a legitimate area of concern.\footnote{World report on violence and health. World Health Organization, 2002. Chapter 6.} Questions need to be carefully formulated and sequenced, and interviewers trained meticulously in order to minimize under-reporting as well as to uphold ethical and safety standards when conducting the survey.

Despite these numerous difficulties in documenting the extent and nature of gender-based violence, some...
progress has been made in recent years. The *State of world population report 2000* and the *World report on violence and health* present information on physical assault by intimate partners and on sexual violence from several countries (see Figure 1 and Table 1).

In Figure 1, data from selected studies from around the world show that between 16% and 67% of the women surveyed had been physically assaulted by an intimate partner at some point in their lives. The highest rates (67%) have been reported from Papua New Guinea. Figure 1 presents only the proportions suffering physical violence. However, many women suffer multiple forms of violence within the same relationship. Studies suggest that almost all instances of physical assault by an intimate partner are accompanied by psychological abuse and, in one-third to one-half of cases, by sexual abuse. In a study of 360 women in Nicaragua who had ever had an intimate partner, one-fifth had experienced physical, psychological as well as sexual violence from their partners at some point.

The most common sources of information on sexual violence, especially rape and assault by a stranger, are crime statistics. These may be seen to represent only the tip of the iceberg, as only a very small percentage of sexual violence is reported, and sexual violence by an intimate partner may never get reported at all. Table 1 presents data from population-based surveys on the prevalence of sexual assault over the preceding five years. These range from less than 2% to 8%, the highest rates being reported from Rio de Janeiro in Brazil. These figures do not distinguish between sexual assault by a stranger and sexual violence by an intimate partner. Despite their limitations, the data indicate the widespread prevalence of violence in women’s lives in many parts of the world. What the figures cannot portray adequately is the fear and terror that many women live in, and the physical and mental health impact of each act of violence on individual women.
2. What are the links between poverty, gender and gender-based violence?
Factors underlying gender-based violence

Gender-based violence is perpetrated on girls and women primarily because of their gender identity. What makes it different from other forms of violence is that gender-based violence is often socially sanctioned.

Gender roles and norms prevalent in society

Gender-based violence emerges in part from a system of gender relations that assumes male superiority, domination and control over women as the normal order of things, a matter of 'culture'. Socially constructed gender roles and norms vest men with greater access to and control over power and resources, and these are usually reinforced by social institutions, such as the family, school, the workplace and religious institutions. Male authority and control over resources is often sanctioned by law, as in the case of marriage, divorce, and inheritance laws in many countries.

Multiple expressions of violence such as lower investment in girls’ education and health relative to that for boys, forced marriages, feet binding, female genital mutilation and honour killings have for centuries been considered normal and validated by custom. Further, violence and the threat of violence have been used as instruments

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to 'keep women in their place' and punish women who step 'out of line' or do not adhere to societal norms regarding 'appropriate' female behaviour. Thus, in many societies, failure to cook a meal on time or wash a partner's clothes could provoke violence within the household, while venturing out in the community without a male escort could result in a severe reprimand from members of the neighbourhood and community.

The environment in which men are socialized is seen as an important contributor to gender-based violence. The ideas, images and norms that they grow up with, and glorification of the aggressive "macho" man in television, movies and advertising systematically develop values in boys that define being male as synonymous with being aggressive and controlling women. It is also known from research that men who grow up witnessing abuse of women are more likely to themselves become abusers.

In studies on masculinity and gender violence carried out in four sites in India in 2001-2002, a consistent association was found between men's rigid adherence to gender roles and expectations and their reporting of violent behaviour with their wives. There was a difference between men who reported only physical violence and those who reported sexual violence. The former resorted to physical abuse to ensure that their wives conformed to expected female roles. However, those who engaged in sexual violence were less concerned with gender roles and more concerned about power and control over all aspects of their wives' lives.

The power and control wheel

Power and control over women's lives have been acknowledged as the basis of gender violence by the intimate partner and in society at large. The 'Power and Control' wheel (Figure 2) offers a framework for understanding manifestations and mechanisms of power and control in an intimate relationship. These mechanisms include for example, intimidation, cutting off a person's access to cash, restricting her employment opportunities, isolation and emotional abuse. The power and control wheel may be adapted to also understand societal expressions of power and control over women. For example, laws that restrict women's property rights may be seen as the societal equivalent of economic abuse.

While unequal gender relations and men's control over all aspects of women's lives lie at the core of gender-based violence, a number of individual factors are associated with an elevated risk of experiencing such violence. These include, for example, a history of violence in the family, alcohol abuse by men, and personality disorders. However, no single factor can be identified as the principal 'cause' of gender violence. Further, factors underlying gender violence operate at various levels, and not just at the personal level.

The 'ecological model'

The 'ecological' model proposed by Heise consists of four levels of causative factors visualized as four embedded concentric circles (Figure 3). The innermost circle represents the personal history of the woman and man in a relationship. It includes factors such as childhood experiences of witnessing marital violence or themselves having been abused. The second circle represents the immediate context within which violence takes place and may include factors such as male dominance and marital tensions and conflict. The third circle represents the 'ecosystem' factors: the institutions and structures that influence the immediate context. Ecosystem
factors include women's autonomy and access to resources and their social support network. The fourth circle represents the macro context within which the other three circles are imbedded, and consists of factors such as gender roles, acceptance of power hierarchies in general, and acceptance of interpersonal violence. This framework helps understand variations in the prevalence of violence within a given society and also across time. It helps us understand the complex interaction of factors at various levels which increase the probability of a man being abusive within a given setting in a given relationship at a particular point in time.

Gender-based violence and poverty

Poverty as an underlying factor in gender-based violence

Although women from all socioeconomic groups experience gender violence, an increasing number of studies from different parts of the world show that low-income women experience a greater incidence of violence, especially intimate partner violence. Many of these studies have related to welfare recipients in industrialized countries. For example, a study of a representative sample of women welfare recipients in Massachusetts found that 64% had experienced violence by a current or former partner and almost 20% had experienced intimate partner violence in the preceding 12 months. In a 1997 study of intimate partner violence and black women's health, low-income black women had much higher rates of severe intimate partner violence as compared to higher-income black women. The reasons for this association are not clearly understood and need further analysis. Factors associated with poverty, such as living in unsafe neighbourhoods and lack of secure housing, may explain the risk of violence outside the home. Within intimate relationships, arguments over money, hopelessness, crowding and the stress of finding a means of living may be factors that precipitate violence.

The Voices of the poor report of the World Bank suggests that, in some settings, gender violence may be increasing in low-income households because of rapidly changing gender roles. There is increasing economic pressure on poor households, with men in many parts of the world having lost their traditional occupations and jobs. Women have been forced to take on or increase their income-earning activities in addition to their domestic tasks. The relative increase in women's economic power, combined with men's unemployment and limited access to resources, has created feelings of humiliation and emasculation among men and a sense of loss of control within their households. Men's frustration and anger at not being able to fulfil their traditional roles as breadwinners often leads to increasing levels of tension and violence.

Gender-based violence as a cause of poverty and economic hardship

Irrespective of their original socioeconomic status, many women experience financial risks or are impoverished as a consequence of gender violence. After experiencing sexual assault or sexual harassment at work or in a public place, they may be unable to continue in their jobs or perform their jobs efficiently and may frequently have to take time-off from work. They may lose opportunities for further training or promotion because of their unwillingness to risk their safety. Young women fleeing situations of sexual abuse in their immediate setting may drop out of school with limited job skills, restricting their future income-earning opportunities.

Men who batter their intimate partners usually control them through restricted access to cash and credit, isolation from others, and sabotage of educational and job training and employment opportunities. Women choosing to walk away from such relationships may have to leave their jobs and their homes. Safety considerations may mean not receiving any financial support from the partner, since he is also the perpetrator of violence, and having to bear the entire responsibility for the support of any children. This may drive such women survivors of violence deeper into poverty and also create an inter-generational cycle of poverty. Research from the United States shows that children who grow up in women-headed households experience lower
educational and occupational attainment, and girls experience higher risks of teenage pregnancy. Similar results have also been found for women-headed households in Latin America.33,34,35

Well-paying employment opportunities (whether for the first time or through reemployment) may be limited for women leaving abusive relationships, because such women have often had their training and educational opportunities restricted by their partners. In addition, battered women may lack the confidence to seek employment or be unable to do so because of their poor health. They may be burdened with medical expenses and legal fees. All of these can contribute to increased financial vulnerability.

Where poverty and gender violence co-exist, the burden on women is immense. For low-income women, limited financial resources affect every aspect of life. Where and how they live, what they do, who they interact with—all these may be severely restricted because of lack of money. They may suffer from poor physical and mental health. In addition, the complex responsibilities of earning a living, maintaining a household and raising children drains them of physical and emotional energy and self-confidence. When gender violence is superimposed on this reality, women may feel trapped and unable to take on the challenge of changing this situation. Many low-income women stay in abusive relationships because they are economically dependent on their abusers; do not have an alternative place to live; do not have the education or skills to find a job that can support them and their children; often suffer from poor health; and because their self-esteem has been eroded by prolonged abuse or poverty.

The consequences of gender-based violence

GBV affects many women in many parts of the world throughout their life cycles. It gives rise to a wide range of physical and mental health problems including death and disability, making it a major public health concern. Gender-based violence thus perpetuates women’s poverty and powerlessness. In this way, gender-based violence is costly not only to its victims, but to society as a whole.

Health consequences of gender-based violence

There is increasing evidence of many negative health consequences of gender-based violence. According to World Bank estimates, rape and intimate partner violence accounted for 5% of the healthy years of life lost to women aged 15-44 years in developing countries.36 Globally, about 9.5 million disability-adjusted life years (DALYs)37 were estimated to be lost by women in the reproductive age group, comparable to DALYs lost from tuberculosis, HIV and sepsis during childbirth38 (see Table 2).

Figure 4 outlines some of the health consequences of gender-based violence. It illustrates how gender-based violence can have fatal outcomes, including suicides and homicides. Studies from the early 1990s in the United States of America showed that battered women are five times more likely than non-battered women to attempt suicide.39 Early studies from India, based on crime statistics, also suggest a link between marital violence and suicides by young women.40 A more direct association appears to exist between homicide and gender violence. Studies from countries as different as Brazil, Canada, Israel,

Table 2. Estimated global health burden of selected conditions for women aged 15 to 44

<table>
<thead>
<tr>
<th>Condition</th>
<th>DALYs lost (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All maternal conditions</td>
<td>29.0</td>
</tr>
<tr>
<td>Sepsis</td>
<td>10.0</td>
</tr>
<tr>
<td>Obstructed labour</td>
<td>7.8</td>
</tr>
<tr>
<td>STI (excluding HIV)</td>
<td>15.8</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td>12.8</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>10.9</td>
</tr>
<tr>
<td>HIV</td>
<td>10.6</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>10.5</td>
</tr>
<tr>
<td>Rape and domestic violence*</td>
<td>9.5</td>
</tr>
<tr>
<td>All cancers</td>
<td>9.0</td>
</tr>
<tr>
<td>Breast</td>
<td>1.4</td>
</tr>
<tr>
<td>Cervical</td>
<td>1.0</td>
</tr>
<tr>
<td>Motor vehicle accidents</td>
<td>4.2</td>
</tr>
<tr>
<td>War</td>
<td>2.7</td>
</tr>
<tr>
<td>Malaria</td>
<td>2.3</td>
</tr>
</tbody>
</table>

* Rape and domestic violence are included here for illustrative purposes. They are risk factors for disease conditions, such as STIs, depression and injuries, and not diseases in and of themselves.

Papua New Guinea and the United States, have shown that, for over 50% of all women murdered, the perpetrator was a male intimate partner.  

The incidence of extreme violence may be limited, but each death associated with gender violence is an avoidable death, usually of a woman who has several years of active life ahead of her.

**Physical consequences**

Women who have been physically assaulted by their intimate partners often present themselves at hospital emergency rooms or casualty departments, reluctant to admit the true cause of their injury, often reporting it as being an accident. Many others may not be injured seriously enough to need emergency attention, but they receive physical as well as mental scars.

**Mental health consequences**

The mental health consequences of experiencing gender-based violence, physical, sexual or psychological can be far-reaching. Depression, anxiety and sleeping and eating disorders are common long-term consequences of protracted and long-term violence, as is usual in the case of violence by an intimate partner. Suicidal ideation and suicidal behaviour may also be induced. Episodes of physical and sexual violence may give rise to symptoms typical of post-traumatic stress disorder (PTSD).

Based on her path-breaking research with 435 women who had been in violent intimate relationships, Walker coined the term *battered woman’s syndrome* to describe a set of distinct psychological and behavioural symptoms resulting from prolonged exposure to intimate-partner violence. In diagnostic terms, battered woman’s syndrome is the development of characteristic physical, psychological and social abnormalities and symptoms such as depression, low self esteem and isolation which ensue from the direct personal experience of a series of violent acts by an intimate partner. Battered woman’s syndrome is now recognized as an implied category of PTSD.
Sexual abuse and rape are physical and psychological violations of an entirely different genre from other kinds of violence. They cause physical injury as well as profound emotional trauma. Survivors of sexual assault often suffer from a variety of trauma-induced symptoms as well as sexual problems. According to one study from the United States of America, women who had been sexually assaulted (including victims of child sexual abuse) were about two times more likely than women who had not experienced sexual assault to qualify for 10 different psychiatric diagnoses, including depression, alcohol and drug abuse, PTSD, obsessive compulsive disorder, generalized anxiety, eating disorders, multiple personality disorder and borderline personality syndrome.

**Reproductive health consequences**

GBV may also result in fatal and serious non-fatal consequences to women’s reproductive health. For example, maternal deaths attributable to gender violence have been reported from studies in South Asia. In a community and hospital based prospective survey of maternal deaths in Western India, almost 16% of maternal deaths were associated with intimate partner violence or violence by a family member. An earlier study carried out in Matlab, Bangladesh had also found that nine per cent of maternal deaths were caused by injuries and violence. A third of these deaths were suicides and 25% were homicides. Violence against pregnant women may also lead to miscarriage and stillbirth.

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**Box 5. Health consequences of domestic violence: Evidence from a multi-country study**

**Findings for women who have experienced domestic violence when compared with women who have never experienced domestic violence**

**Reproductive health**
- A higher mean number of births in most age groups and countries.
- Less likely to say that their birth was wanted when child was conceived, in all but one of the countries.
- Consistently higher likelihood of having a birth that is not wanted at all, in all but one of the countries.

**Contraceptive use and contraceptive need**
- More likely to have tried contraception, but also more likely to have discontinued it.
- Tend to have a higher total need for family planning.
- Higher total unmet need, in seven countries in the study.
- Higher unmet need for limiting births, in all countries.

**Non-live births**
- More likely to have a non-live birth (due to miscarriage, abortion, or stillbirth).

**Sexually transmitted infections (STIs)**
- Self-reported prevalence of STIs is at least twice that among women who have never experienced violence.

**Antenatal care (ANC)**
- Experience of violence is associated with a delay in accessing ANC.

**Infant and child mortality**
- Evidence of higher rates of infant and child mortality among women who have ever experienced violence. The differentials are not necessarily large but the consistency across countries suggests that the experience of violence could be putting the survival of their young children at risk.
- In six of the nine countries, children are less likely to be fully immunized.
- In five of the countries, children are more likely to have received none of the required vaccinations.

Note: Research conducted in Cambodia, Colombia, Dominican Republic, Egypt, Haiti, India, Nicaragua, Peru, and Zambia.

Sexual abuse, including forced intercourse within marriage and refusal by men to use condoms, puts women at risk of unwanted pregnancy, HIV/AIDS and other STIs. Fear of male reprisal is also a deterrent to use of contraceptive methods by women. Unsafe abortions may result, with potentially serious health consequences.

**Negative health behaviours**

Victims of sexual violence and abuse may also exhibit a higher prevalence of risk behaviours such as unsafe sex, alcohol and drug abuse, and smoking and eating disorders, which in turn contribute to the already high level of physical and psychological morbidity in women experiencing gender violence. Research has found a higher prevalence of risky sexual behaviours and drug use among adolescents and adults who were abused as children.⁴⁹

Box 5 presents findings from a multi-country study using household and individual-level data from Demographic and Health Surveys (DHS) to examine the prevalence and correlates of domestic violence and its health consequences for women and their children.
3. Why is it important for health professionals to address poverty and gender concerns in gender-based violence?
Gender-based violence has serious consequences for women's health and well-being, and for the health of their children. In addition, GBV poses significant costs for the economies of developing countries, including lower worker productivity and incomes, lower rates of accumulation of human and social capital, and the generation of other forms of violence both now and in the future. It is essential, therefore, that every health professional address poverty and gender issues in their work, and also the issue of GBV for reasons of efficiency, equity and human rights.

Efficiency

Efficiency means producing the desired result with the minimum wasted effort. In health, this term refers to better outcomes for health programmes or interventions or a higher probability that desired outcomes will be achieved.

Violence, and women's fear of it, limits women's choices in virtually all spheres of their lives. It detrimentally affects women's self-esteem, their ability to gain an education, earn a livelihood, develop human relationships, and participate in development programmes and in political life. It thus keeps women entrenched in their subordinate position vis-à-vis men, and makes it impossible to escape from poverty.

Gender-based violence may thus be an important barrier to economic and social development. The World Bank's policy research report, Engendering development found strong evidence that gender inequality undermines economic growth and constitutes an obstacle to poverty reduction. Supporting evidence from another World Bank study shows that if the countries of the Middle East, North Africa, South Asia and Sub-Saharan Africa had achieved gender equality in education between the 1960s and 1990s, the income per capita of these countries would have grown by an additional 0.5% to 0.9% per year during that period. For many countries, this would have meant a doubling of their per capita incomes.

Due to its many long- and short-term consequences for women's physical and emotional well-being, the stability of families and the growth and development of children, gender-based violence represents a huge cost to the health care system and to other welfare services. A study at a major United States Health Maintenance Organization (HMO) carried out in 1991 showed that women who had been raped or beaten had medical costs in a given year that were two and a half times higher than those of women who had not experienced such violence. In another study, 22% of women who had a history of childhood molestation or rape had visited a physician ten or more times a year, compared with only 6 per cent of non-victimized women. Thus, large sums of money are spent on an avoidable and preventable cause of physical and mental ill health.

In Canada, the net lost earnings of battered women unable to work because of assault were estimated at more than seven million Canadian dollars (equivalent to more than five million US dollars) per year, according to an estimate made in 1995. Costs to the welfare system to support women who had left a violent relationship were an estimated 1.8 billion Canadian dollars a year (US$1.3 billion). Costs to the health care system could be comparable or even higher.

In view of the large public health burden represented by gender-based violence, improved population health, improved health program objectives and improved health outcomes could be achieved more efficiently by addressing gender-based violence as an important public health issue.

Equity

Equity in health may be defined as the “absence of systematic disparities in health (or major social determinants) between groups with different levels of underlying social advantage or disadvantage, such as different positions in the social hierarchy.” Inequity refers to an inequality that is avoidable and unfair. In effect, this covers most inequalities and thus the terms are often used interchangeably.

Gender-based violence is a manifestation of gender-power inequalities and perpetuates gender-
based discrimination. Achieving gender equity will remain a distant goal as long as gender violence remains unchallenged by public policy, legislation and action. Moreover, evidence suggests that health inequalities (including gender-based ones) are widening. Women, particularly those from low-income or otherwise marginalized or vulnerable populations are more likely to suffer ill-health than men. This is unfair and avoidable. Ensuring health for all is a matter of social justice or equity. To the extent that these inequalities result from GBV, this problem must be addressed for reasons of health equity.

**Human rights**

Gender-based violence represents a violation of women's human rights. This has been pointed out in a number of Declarations from United Nations Conferences.

Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms.

A number of international human rights instruments require States to take effective measures to prevent and eradicate gender-based violence. Several international agreements provide protection to women and girls from violence. These include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention against Torture and the Declaration on the Elimination of Violence Against Women. In addition, WHO's constitution lays down the ideal of "attaining the highest achievable standard of health for all". Ensuring women's right to health will therefore mean implementing programmes and policies for the prevention of gender-based violence and care and treatment for its numerous health consequences.
4. How can health professionals address poverty and gender concerns in gender-based violence?
The role of health care providers

Health providers are in a unique position to intervene in preventing and managing the health consequences of gender-based violence. This is because health facilities are one of the few public institutions that almost all women will come in contact with at some point in their lives, for pregnancy and delivery-related care and contraception, or in the process of seeking health care for their children. In addition, women who are victims of sexual assault are often required by law to be brought to health facilities by the police and those who have been seriously physically injured often come to the emergency department of hospitals for immediate care. A health provider who is well informed and trained to manage victims sensitively could make a significant difference to the woman traumatized by assault.

However, in many settings, health providers may not recognize the problem and thus may be unresponsive to women experiencing violence, choosing to treat them symptomatically rather than probing beneath the surface. In a 1996 WHO consultation on violence against women, a number of provider-related factors were identified as potential barriers to an effective response to gender-based violence. One factor is providers' lack of technical knowledge and skills in gender-based violence, which may render them reluctant to deal with the issue, especially where there are no victim support services to which women may be referred. In this situation, many providers feel inadequate and powerless. Another factor is providers' belief that intimate partner violence is a private matter between the woman and her husband and that it is inappropriate for the health provider to get involved, beyond treating the injuries and health problems. A negative attitude towards women experiencing violence, including the belief that they may have provoked the violence, or that women who continue to stay in violent relationships have only themselves to blame, may prevent the provider from responding sympathetically.

Other barriers to responsiveness include a fear of legal liability, as for example when dealing with cases of sexual assault, rape and serious physical injury. The lack of institutional support and the absence of clear institutional policy and guidelines may be other reasons that come in the way of a sympathetic and proactive role by health providers when dealing with women experiencing gender violence. Some of these policy issues are discussed in his section.
Figures 5 and 6 are adapted versions of the 'power and control' wheel that illustrate how the behaviour of health care providers can contribute to women’s victimization and how health providers can adopt alternative behaviours that empower women to overcome abuse.

The two most important things a health care provider can do about gender-based violence are asking about abuse and supporting women who disclose violence or abuse.66

**Asking about abuse**

A number of studies now indicate that routinely asking about violence and abuse within a health care setting helps identify and provide help and support to a much larger proportion of women than would be the case if the provider waited for the woman to disclose the violence of her own accord.64, 65 Some studies also indicate that women themselves may welcome routine enquiry. For example, among women attending a community health clinic in Cape Town, South Africa, more than 88% of the women welcomed the idea of routine enquiry.66

The routine enquiry need not be elaborate. Three to five screening questions – posed directly or indirectly as appropriate in a given situation – have been found to be adequate in many settings. Sets of routine guiding questions are listed in Box 6.

**Figure 5. Health care workers: are we part of the problem?**

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*Source: Developed by the Domestic Abuse Intervention Project, 202 East Superior Street Duluth, Minnesota 55802 USA.*

**How can health professionals address poverty and gender concerns in gender-based violence?**
A study using the three brief questions listed in section B of Box 6 found that these questions correctly identified a majority of abused women. Only about 20 seconds were required to ask these questions.\(^7\)

Asking about abuse has to be done with great sensitivity. The screening questions may be introduced directly to the patient, or indirectly, depending on the circumstances. Box 7 presents some examples of how the screening questions may be introduced to women directly or indirectly.\(^8\)

Screening women for gender-based violence may be undertaken on a priority basis at least within Maternal and Child Health and Family Planning services, gynaecological services and emergency services. Not only do these settings provide key opportunities for introducing questions related to violence, but they may also be one of the most likely health services that women experiencing gender-based violence will approach.

Health professionals need to be mindful of the victim’s safety when asking her about abuse. As presented in the medical power and control wheels in Figures 5 and 6, privacy, confidentiality and safety are of the utmost importance. Care should be taken to ensure that the abuser is nowhere in the vicinity and will not come to know of the disclosure. The health provider has to provide...
Box 7. Introducing the screening questions

A. Asking directly

- Before we discuss contraceptive choices, it might be good to know a little 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.

B. 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 behaviour 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?


counselling and advice without being prescriptive and taking decisions on behalf of the woman. The provider also needs to understand that not all advice will be followed and to respect the woman’s autonomy to make her own decisions when she is ready to make them.

Asking about abuse may not always lead to disclosure. The woman may be ashamed, viewing the violence as an indication of personal failure and may not be sure of the health care provider’s responses. Prominently placing posters about gender-based violence and making information pamphlets available in waiting rooms and consulting rooms of health facilities may help women experiencing violence feel more comfortable about disclosing it.

Identifying “high risk” women

Box 8 indicates how to identify and screen “high risk” women even when a health facility is busy. While the generic signs and symptoms have been identified, they need to be adapted to suit the specific local setting. For example, CEPAM, an Ecuadorian women’s organization developed its own set of indicators of violence based on their interactions with victims of intimate partner violence. Included in their guidelines as symptoms
Box 8. Identifying “high risk” women

The best way to uncover a history of abuse is for the health care provider to ask about it. If health care providers can recognize signs and symptoms of abuse, they can help identify and screen at least ‘high risk’ women even when the health facility is busy and providers have very limited time. The following have been identified as ‘red flags’ that should alert a health care provider to the possibility that the patient is a victim of violence or sexual abuse:

- 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; and
- chronic pelvic pain.


Supporting women who disclose violence or abuse

The very act of asking a woman about abuse and listening to her disclosure without judgment and with empathy and sensitivity is an act of support. It helps the woman feel that the violence is not her fault and can be the beginning of a process of changing her situation. The 'Empowerment wheel' in Figure 6 outlines how health care providers can help women feel supported and empowered to make a change in their lives. The types of support sought by women who disclose violence to health care providers are presented in Box 9.

Assessing for immediate danger

These actions on the part of health care providers would be appropriate for all women disclosing intimate partner violence. However, some women may be in immediate danger of serious violence and the health care provider has to be able to assess the extent of danger the woman is in. Box 10 lists a number of questions

Box 9. What do women disclosing violence want of health care providers?

A study from Wisconsin, USA of 115 women who had been battered by their male partners offers some insights. According to them, supportive behaviour would include the following:

Medical support
- taking a complete history;
- detailed assessment of current and past violence;
- gentle physical examination; and
- treatment of all injuries.

Emotional support
- confidentiality;
- directing the partner to leave the room;
- listening carefully; and
- reassuring the woman that the abuse is not her fault and validating her feelings of shame, anger, fear and depression.

Practical support
- telling the patient that spouse abuse is illegal;
- providing information and telephone numbers for local resources such as shelters, support groups and legal services;
- asking about the children's safety; and
- helping the patient begin safety planning.

that would help assess whether there is immediate danger to the woman’s life and liberty. If the woman is in immediate danger, she needs to be helped. If such facilities exist, she may be referred to a crisis center or shelter; alternately, the health care provider could offer to call a friend or relative that the woman could stay with till the moment of danger passes. Temporarily staying away from the abusive partner may not make the violence stop, but could help prevent serious injury or death to the woman and/or her children.

Box 10. Danger assessment instrument

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain.
2. Punching, kicking; bruises, cuts, and/or continuing pain.
3. "Beating up"; severe contusions, burns, broken bones.
4. Threat to use weapon; head injury, internal injury, permanent injury.
5. Use of weapon; wounds from weapon.
   (If any of the descriptions for the higher number apply, use the higher number.)

Mark yes or no for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

1. Has the physical violence increased in frequency over the past year?
2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
3. Does he ever try to choke you?
4. Is there a gun in the house?
5. Has he ever forced you to have sex when you did not wish to do so?
6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
7. Does he threaten to kill you and/or do you believe he is capable of killing you?
8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
9. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: ___)
10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ___)
11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can").
12. Have you ever threatened or tried to commit suicide?
13. Has he ever threatened or tried to commit suicide?
14. Is he violent toward your children?
15. Is he violent outside of the home?

Total "yes" answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Source: Website of the National Violence against Women Prevention Research Center of the US Centers for Disease Control and Prevention.
**Detailed documentation**

Careful documentation of the injuries and symptoms with which a woman presents, as well as of the history of abuse, is another way in which health providers can help. Documentation should include not only the nature of injuries and symptoms but also the identity of the abuser as reported by the woman and the nature of his relationship to the woman. This will help future medical follow-up. In case the woman takes legal action, such documentation of a history of abuse by a health provider could prove to be powerful supporting evidence.  

**Safety plan**

Another action that health care providers can take to help women experiencing intimate partner violence is to review a 'safety plan' with them. Box 11 provides a list of issues to discuss with the women, whether or not they are thinking of leaving the abusive relationship. They can then draw on these issues to develop their own specific safety plan as appropriate. Developing a safety plan may help the woman prepare to leave the relationship safely in case the violence escalates.

Developing such a safety plan could prove much more difficult in the case of low-income women, especially those from rural or ethnic minority communities, who may not have the resources to leave the abuser and may not have access to or even be able to afford temporary stays in hotels or guest houses. The health provider may have to find out if there are affordable safe places that the woman can go to, such as homes of friends or relatives. They may be directed to women's shelters or women's organizations that can help them, in places where such facilities exist. Community-based women's groups, such as self-help and microcredit groups, have the potential to provide both financial and psychological support to a woman who wishes to leave a violent relationship. Health facilities could take the initiative to network with such groups and harness their support to help women experiencing intimate partner violence. In the absence of shelters or women's groups and organisations, the health provider may be in a difficult situation, wanting to help but having limited possibilities to do so.

Lessons to date however indicate that, in all circumstances, it is worthwhile to at least talk to the woman, acknowledge and document her situation of abuse and provide whatever help is within the provider's means.

**Providing emotional support to health providers**

An initiative by the Pan American Health Organization (PAHO) to review the experience of health sector responses to gender-based violence showed that caring for survivors of violence was a deeply emotional experience for the health providers concerned. Experiences ranged from feeling emotionally drained to frustration and
anger because the women kept returning to abusive relationships. Coming to terms with the role of a counselor, who merely discusses various options but leaves the final decision to the patient, may be especially difficult for physicians, who are used to giving advice which is often complied with. Emotional support for providers is recommended as an essential component of any gender-based violence intervention programme. PAHO has developed a guide for such support.73

Supportive institutional environment

The support available to health providers within their health facilities could make an important difference to how effectively they can undertake the task of screening for and providing support to women experiencing violence. For example, if the top management of a hospital considers gender-based violence interventions an important priority, then a number of initiatives can be undertaken within that hospital that would strengthen the efforts of individual providers. These may include:

- Training all staff members who interact with patients, from the security guard at the gate to the receptionist and the pharmacist.
- Making available health education materials and information on gender-based violence and on organizations that provide support at strategic points in several departments of the hospital.
- Providing adequate physical space for departments which screen women experiencing violence, to ensure privacy, confidentiality and safety.
- Prominently displaying posters which mention that patients are encouraged to talk to health care providers about their experiences of violence.
- Developing an integrated institutional protocol that clearly states what different levels of staff are expected to do when they encounter a woman who has experienced gender-based violence.

Health sector responses

Health policy

Individual health care providers and health facilities may take the initiative to address gender-based violence. However, such efforts will have limited impact unless there is a specific health sector policy on the issue. The adoption of a specific health sector policy on the role of health care providers in addressing gender violence is important if such care is to be institutionalized within the health sector and not remain an ad hoc initiative of individuals or particular health facilities.

National policies have been adopted by the health sector in many countries of Latin America and the Caribbean as a result of a regional effort by PAHO during the last decade. These policies simply state that sexual and physical violence against women are a serious public health problem and that health services should provide basic services for victims of violence. Many of these policies also specifically call for health services to coordinate with other sectors, as well as with non-health sector responses.

Box 12. Policy recommendations to strengthen the capacity of health providers to address GBV

- Integrate violence issues horizontally into health care services, especially sexual and reproductive health services.
- Use a systems approach for institutional change. Institutional change must include implementation of new procedures with regard to patient flow, documentation, measures to ensure privacy and confidentiality, and the creation of referral networks.
- Address provider attitudes. Provider training must deal with gender and power relations and allow providers an opportunity to challenge their own beliefs and prejudices.
- Encourage coordination with other sectors e.g. justice and social welfare sectors.
- Address the underlying gender norms that support violence in the community. Create awareness at community level of the health effects of GBV and how GBV is rooted in unequal gender relations.

Box 13. Principles of caring for survivors of family violence

- Family violence is a serious problem that affects the physical, emotional, and sexual health of the person that lives with it and her family and can even lead to death.
- Family violence is a criminal offense with legal repercussions; therefore it should be addressed in a timely and effective manner.
- Family violence is the responsibility of all society, as well as a public health and human rights problem.
- Violence is caused by the perpetrator, not the victim.
- Violence is a learned behaviour, and therefore, it can be unlearned.
- Nothing justifies family violence.
- People have the right to live in conditions that allow for their integrated development and respect for their rights.
- All individuals, regardless of sex, age, religion, economic level, sexual orientation, nationality, and political beliefs, should be cared for when requesting services for family violence.
- All individuals who have suffered family violence have the right to services and resources that guarantee personal safety and confidentiality.
- All interventions should be carried out in a manner that respects individuals' rights and empowers them to make their own decisions.


Some policies in the Latin American and Caribbean region also outline basic principles and guidelines for caring for victims of violence from a gender and human rights framework. Box 13 presents the approach of Costa Rica. Such guiding principles are an attempt to ensure that the rights of victims of violence are recognized and that health providers do not inadvertently contribute to accentuating the victim's trauma, as described in the Power and control wheel in Figure 2.

In addition to a health sector policy on the issue, specific government orders may be required to alter institutional procedures that might compromise the safety of the victim of violence. For example, institutions may require women admitted with serious injuries to furnish details about their husbands as next of kin or routinely inform the husbands or fathers/guardians. An altered procedure would take women's consent before informing the next of kin, to protect their safety.

Adopting a health sector policy on gender-based violence is only a starting point. These policies need to be widely disseminated among health care providers as well as the public, in order for them to be implemented effectively.

Location of gender-based violence services within the health sector

PAHO's experience indicates that services for gender-based violence are most effective when located within women's health or reproductive health services. Reproductive health care services are available at all levels of the health sector, from the community and primary care level to tertiary care level. Placing gender-based violence services within this branch enables much wider coverage than when placed within mental health services, which was the other option tried under the PAHO initiative. From the point of view of low-income women, this appears to be the best location, making GBV services physically and financially accessible to them.

Equally, services for gender-based violence should become an integral part of emergency and mental health services at the tertiary care level, the two locations to which women who are seriously affected may come for medical help, or be referred to, from other levels within the health sector.

Table 3 presents objectives and strategies used within the last decade to address GBV at different levels of the health sector in Latin America and the Caribbean. Table 4 presents some ideas on how the health sector can respond at the community, primary care and hospital level.

Developing norms and protocols for addressing gender-based violence

Once a policy has been put in place and the location of services within the health sector...
Box 14. Potentially promising approaches to, and typical problems encountered in, GBV prevention

<table>
<thead>
<tr>
<th>Potentially promising approaches</th>
<th>Typical problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies clarifying providers' role and responsibilities in cases of GBV</td>
<td>Mandatory reporting requirements for cases of GBV</td>
</tr>
<tr>
<td>Broad institutional reforms to improve the health care response to GBV</td>
<td>Routine screening for GBV without broader institutional reforms</td>
</tr>
<tr>
<td>Network and coalitions for referrals, advocacy and education</td>
<td>Failure of health sector to coordinate with other community services</td>
</tr>
<tr>
<td>Community education to change awareness, knowledge, attitudes, behaviours and access to services of GBV as a public health problem</td>
<td>Health education programs that lack a human rights framework</td>
</tr>
<tr>
<td>Reproductive/HIV education for youth that addresses gender and GBV</td>
<td>Reproductive health programs that fail to address gender or sexual coercion</td>
</tr>
<tr>
<td>Policies facilitating access to emergency contraception, prophylaxis for sexually transmitted infections and safe abortion for survivors of violence</td>
<td>Campaigns that use &quot;macho&quot;imagery (e.g. for condom promotion)</td>
</tr>
</tbody>
</table>


decided, standard norms and protocols for various levels of the health sector need to be developed. These should be multidisciplinary and incorporate the roles and responsibilities of all staff likely to interact with women experiencing gender-based violence. Adoption of and adherence to uniform norms and protocols across the health sector are important to ensure good quality services and are also necessary for monitoring and evaluation.

New charts for patient history-taking and clinical tools may have to be developed which incorporate the basic questions for screening and assessment of danger. Tools for detailed documentation of the incident, which records the nature of the injury, the age and sex of the victim and the perpetrator, and details of the relationship of the perpetrator to the victim, will also need to be developed. Making procedural changes, such as a stamp on the patient chart reminding the provider to ask screening questions about violence, or questions in standard intake forms are reported to be more effective than staff training only, in identifying victims of GBV.77,78

Basic packages of services for victims of different forms of GBV also need to be developed and their effectiveness tested for different settings. For example, victims of sexual assault are routinely provided prophylactic anti-retrovirals against HIV infection in some settings. Such a package might include prophylactic drugs for sexually transmitted diseases, emergency contraception, psychological counselling and referral to a rape crisis centre for all victims of rape.

Box 15. 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. 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 stations.

### Table 3. Objectives and strategies used to address GBV in the health sector

<table>
<thead>
<tr>
<th>Level</th>
<th>Objectives:</th>
<th>Examples of Specific Initiatives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laws and Policies</td>
<td>To improve laws and policies</td>
<td>• Reforms of laws and policies regulating the medico-legal system (e.g. introduction of forensic nurses)</td>
</tr>
<tr>
<td></td>
<td>• Clarify providers’ legal responsibilities</td>
<td>• Reform of laws and policies regulating health care providers’ obligations vis-à-vis victims of GBV</td>
</tr>
<tr>
<td></td>
<td>• Encourage a better health sector response to GBV through national, regional, and municipal policies regarding screening, referral, documentation and counseling for victims of violence</td>
<td>• National health policies and protocols</td>
</tr>
<tr>
<td></td>
<td>• Ensure survivors’ rights to services (e.g. emergency contraception, STI prophylaxis, etc.)</td>
<td>• Laws/policies governing forensic medicine; provider obligations, abortion, EC and patient confidentiality</td>
</tr>
<tr>
<td>Institutional reform</td>
<td>To strengthen the response of health care and public health institutions to gender based violence</td>
<td>• Policies, procedures and protocols to improve the health care response</td>
</tr>
<tr>
<td></td>
<td>• Raise awareness of the links between violence and health among service providers, managers, and public health policy makers.</td>
<td>• Sensitization and training of health professionals</td>
</tr>
<tr>
<td></td>
<td>• Improve the quality of care for survivors of violence, including identification, treatment, documentation, information, referrals and follow-up.</td>
<td>• Routine screening and referral systems</td>
</tr>
<tr>
<td></td>
<td>• Increase coordination with other sectors that provide services or work on violence prevention.</td>
<td>• Development of information systems such as epidemiological surveillance and morbidity statistics on violence</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>To increase community mobilization to address GBV as a public health problem</td>
<td>• Specialized survivor services (counseling, support groups)</td>
</tr>
<tr>
<td></td>
<td>• Strengthen community support for survivor services</td>
<td>• Improved coordination and referrals to NGOs and other sectors</td>
</tr>
<tr>
<td></td>
<td>• Strengthen coalitions and networks</td>
<td>• Curricular changes in training of nurses and medical personnel</td>
</tr>
<tr>
<td></td>
<td>• Improve attitudes, norms, practices and resources at the community level</td>
<td></td>
</tr>
<tr>
<td>Individual behavior change</td>
<td>To improve knowledge, attitudes and practices of key groups and the broader population</td>
<td>• Coalitions for public health research and advocacy</td>
</tr>
<tr>
<td></td>
<td>• Promote gender-equitable, nonviolent sexual partnerships</td>
<td>• Community level prevention and mobilization initiatives</td>
</tr>
<tr>
<td></td>
<td>• Increase women’s ability to make decisions about the timing and nature of sexual relationships</td>
<td>• Community-based awareness campaigns aimed at mobilizing journalists, policy makers and opinion leaders</td>
</tr>
<tr>
<td></td>
<td>• Decrease tolerance for GBV by raising awareness of GBV as a public health problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Encourage victims of abuse to seek health and to disclose violence to service providers</td>
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**Developing a training plan for personnel at different levels of the health sector**

Allocation of adequate resources to provide practical training on how to implement the norms and protocols is important. Health care providers at different levels, from primary care to tertiary, especially those working in reproductive and mental health and emergency care services, need to receive such training. A growing number of countries—Brazil, India, Ireland, Malaysia, Mexico, and the Philippines—have begun pilot projects for training health providers.
Table 4. How health care systems can respond

Typical staff include

<table>
<thead>
<tr>
<th>Community level</th>
<th>First-order response</th>
<th>Additional, more advanced response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers (CHWs)</td>
<td>- Integrate lessons on abuse, sexuality, and healthy relationships into CHW and TBA training.</td>
<td>- Encourage CHWs to become active community change agents by: starting public discussions of violence via role playing, posters, and community events; holding workshops to change community norms and attitudes.</td>
</tr>
<tr>
<td>Trained traditional birth attendants (TBAs)</td>
<td>- Goal: To sensitize workers and help them respond sympathetically to victims of abuse.</td>
<td>- Train CHWs to facilitate support groups for abused women</td>
</tr>
<tr>
<td>Traditional healers Pharmacists</td>
<td></td>
<td>- Encourage CHWs to accompany women to the police and the medical examiner’s office when they choose to report rape or domestic assault.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary care level</th>
<th>First-order response</th>
<th>Additional, more advanced response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health post: Nurses</td>
<td>- Sensitize staff to violence by providing experiential training that examines attitudes and beliefs.</td>
<td>All of the above plus:</td>
</tr>
<tr>
<td>Auxiliary nurse-midwives</td>
<td></td>
<td>- Train staff to identify and respond appropriately to victims of abuse.</td>
</tr>
<tr>
<td>Clinic: General practitioners Midwives</td>
<td></td>
<td>- Encourage proper documentation and safety planning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Facilitate linkage with local women's groups, where they exist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Display posters and pamphlets in waiting areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Polyclinic or hospital level</th>
<th>First-order response</th>
<th>Additional, more advanced response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>- Train staff to identify and respond appropriately to victims of abuse.</td>
<td>- Initiate active screening for abuse among selected patient populations, e.g., in prenatal care clinics, casualty departments, mental health clinics.</td>
</tr>
<tr>
<td>General practitioners</td>
<td>- Encourage proper documentation and safety planning.</td>
<td>- Develop site-specific protocols for responding to victims.</td>
</tr>
<tr>
<td>Medical specialists</td>
<td>- Facilitate linkage with local women's groups, where they exist.</td>
<td>- Incorporate questions on abuse into intake forms or patient interview schedules; prompts can be rubber-stamped on existing forms.</td>
</tr>
<tr>
<td>Social workers</td>
<td>- Display posters and pamphlets in waiting areas.</td>
<td>- Organize a self-help support group for women or lend facility to groups willing to do so.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coordinate with a local women's group to have an advocate on call to help abused women (or train someone in-house).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Establish specialized services for victims of sexual assault, including proper collection of forensic evidence.</td>
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</tbody>
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Experiences in several countries show that it is important to train all staff within a health facility or a particular department to create a supportive environment and ensure that all staff respond in an informed and supportive manner to victims of violence.

Concomitant with in-service training, plans need to be made to incorporate gender-based violence as a topic in pre-service training of nurses, midwives, physicians and other health care providers. There are several examples of incorporating GBV in the pre-service training of medical and nursing professionals, including in developing countries, such as the Philippines and South Africa.

Training to address gender-based violence needs to go beyond clinical and psychological management. It needs to present the gender and rights dimensions of gender-based violence and to inform health care providers of the laws of the country regarding different forms of gender-based violence. International recognition of gender-based violence as a public health and human rights issue and the UN Declaration on the Elimination of Gender-based Violence against Women are important elements to include in training, driving home the international commitment to address and eventually prevent GBV.
Making services affordable for low-income women

As discussed earlier, GBV can have serious health consequences for women. Women may need hospitalization for serious injuries or seek health services frequently for minor injuries or psychological distress. For low-income women, this may mean a huge drain on resources and may result in women not being able to receive medical care or psychological support when they most need it. Health sector policies need to address this issue. In countries where many women are covered by social insurance, the health consequences of GBV should be covered by this insurance. Other pre-payment schemes currently being introduced in many countries as part of health sector reforms and targeting of low-income and marginalized groups, should also include health consequences of GBV as eligible for coverage. Perhaps this very step would set in motion a series of initiatives such as better documentation and recording within the health sector, development of standard protocols and norms, and basic packages of services.

Setting up national violence surveillance systems

Currently, the absence of information on the dimensions of the problem and the difficulty in monitoring the effectiveness of interventions are important deterrents to adequately addressing GBV within the health sector. National violence surveillance systems have been set up in Belize and Panama as part of the PAHO initiative. This system ensures the collection of uniform information on GBV no matter what the first point of contact of the woman, be it the police station, women’s shelter or health services. The information collected includes, at a minimum:

- type of violence;
- sex and age of the victim; and
- sex, age and relationship of the perpetrator.

Adoption of ICD-10 for classification of diseases by a country’s health sector would make it easier to record and report on incidence of gender-based violence against women. The ICD-10 allows for additional codes to be added to the 'injuries' category and to various disease categories that make it possible to indicate violence as a contributing cause. To actively record information on gender-based violence as a correlate of other causes of morbidity or mortality, it will be necessary to train concerned staff and regularly monitor adherence to the new system of recording.

<table>
<thead>
<tr>
<th>Box 16. Experiences from the Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A training programme for health professionals forms part of a comprehensive project by the Philippine General Hospital to address gender-based violence, providing training, services, research, information dissemination and advocacy. Initiated in 1998, the programme, aimed at medical and allied health professionals and others interested in diagnosing and treating women victims of violence, aims to:</td>
</tr>
<tr>
<td>- increase health professionals’ sensitivity, compassion, empathy and respect for confidentiality;</td>
</tr>
<tr>
<td>- strengthen skills in early detection, screening, interviewing, physical examination, treatment, acute crisis intervention and debriefing, and counselling and referral; and</td>
</tr>
<tr>
<td>- increase knowledge of the conditions leading to violence and abuse, and skills in recognising early or subtle signs of violence and abuse.</td>
</tr>
<tr>
<td>2. In addition, violence against women (VAW) issues have been incorporated into existing courses in a nursing college from Silliman University in Dumaguete City and Cebu Doctors’ College of Cebu City. This innovative project was initiated by the Task Force on Social Science and Reproductive Health of the Social Development Research Center of De La Salle University in Manila, a small group comprised of health social scientists, health professionals, biomedical scientists, and health activists that advocate for improved reproductive health for Filipino women and men.</td>
</tr>
</tbody>
</table>
Box 17. Other examples of health sector responses to gender-based violence

- Health sector policies in several Latin American countries have incorporated guidelines for addressing gender-based violence.\(^{82,83}\)
  - In one health center in El Salvador, four nurses were trained to provide crisis intervention and basic counseling. At least one of them is available in each shift to provide backup to doctors who identify a woman in need of help. Also, the center has established a policy that no woman seeking help for violence has to wait in the queue, but can see the health provider right away. The clinic has a separate room, which may be used for counseling.\(^{84}\)
  - In Venezuela, the organization PLAFAM, an affiliate of IPPF Western Hemisphere Region, has trained service providers, redesigned patient routing forms, and created new case registration forms.\(^{85}\)

- In Mumbai, a one-stop crisis center called 'Dilaasa' has been set up within a government hospital to provide integrated services to women presenting with gender-based violence. Trained social workers and counselors staff the center. All staff in the hospital have undergone GBV training, and refer patients to this center. Appropriate clinical care and psychological support are provided, as well as help to find other support services outside the hospital.\(^{86}\)

- In Malaysia, a one-stop crisis centre has been set up in almost all hospitals to provide treatment for victims of violence. Another innovation is a standardized special rape investigation kit used in gathering medical and legal evidence throughout the country.\(^{87}\)

- Since 1995, the Department of Health in the Philippines and the Women's Crisis Center have been jointly piloting a government hospital-based crisis and healing centre for victims of violence against women. The initiative, Project HAVEN, attempts to provide holistic health care within a gender-sensitive and women-friendly environment in a hospital setting. The Project HAVEN Center was established at the East Avenue Medical Center (EAMC) in Quezon City, which serves the "poor and deprived". Located in a separate wing, this hospital-based crisis intervention centre provides medical, psycho-social, legal, material and financial assistance to victims of gender-based violence.\(^{88}\)

- In Liberia, traditional birth attendants were trained to address the aftermath of rape during the country’s seven-year civil war. The training was intended to expand their role as community leaders in addressing sexual violence.\(^{89}\)

- In South Africa, the Agisanang Domestic Abuse Prevention and Training Project and its partner, the Health Systems Development Unit of the University of Witwatersrand, have developed gender and reproductive health courses for nurses with a strong gender component.\(^{90}\)

Monitoring and evaluation of poverty/equity and gender through health information systems

Despite the growing recognition of ongoing and often increasing health inequities both in developing and developed countries, health information systems (HIS) have, to date, been weak in yielding information needed to assess and address health inequities. The challenge is to determine the information needs for addressing health inequities; to shape health information systems to meet those needs; to promote sensitization to equity issues; and to develop the skills required to use information for effective planning and policy-making.\(^{91}\)

In addition to increasing the availability of various data sources, improvements need to be made in the equity-relevant information included. To assess health equity adequately, equity indicators must be constructed. This requires a health measure (or measure of determinant of health) and an equity stratifier (such as a measure of socioeconomic position, sex, age, ethnicity/race, and/or geographical position), as well as the ability to disaggregate information according to these stratifiers.

This can be accomplished either by ensuring that appropriate equity stratifiers and health measures are available in each data source, or by creating mechanisms to link records between data sources. For example, effective linkages can be created by including a unique identifier or geographical code in a variety of data sources. The Health Metrics Network has begun work on constructing equity indicators and creating mechanisms to link records between data sources.\(^{92}\)
Investing in research on gender-based violence

In addition to routine surveillance, a concerted effort is urgently needed in the area of public health research on gender-based violence. As observed earlier, there are very limited data on the incidence and prevalence of different forms of gender-based violence, and especially on sexual violence. The complexity of GBV and its context-specific nature calls for country-specific research.

Box 18. Some guidelines on conducting interviews with women in community-based surveys on intimate partner violence

1. Introducing the study:
   When introducing the study in the community, it is important to:
   - Dress appropriately
   - Make a good first impression
   - Have a positive approach
   - Stress that information gathered will be kept confidential
   - Answer questions frankly
   Introduce the study as “A survey on women’s health and life experiences”. Do not mention domestic violence at initial contact.

2. Conducting the interview:
   - Interview the respondent only
   - Be neutral
   - Never suggest answers
   - Use tact with hesitant respondents
   - Do not judge the woman
   - Do not hurry the interview
   - Do not show questionnaire to anyone!

3. Content of the consent form:
   - Confidentiality of study
   - General purpose of study
   - Some topics may be difficult to discuss
   - Respondent may skip any question or stop the interview at any point
   - Signature of interviewer

4. Asking questions:
   - Read exactly as written
   - Do not suggest one response over another
   - Read questions in the order indicated
   - Don’t skip questions
   - Follow instructions on how to read questions
   - Do not emphasize one response choice over another.

5. Handling Interruptions
   - Explore ways to obtain privacy
   - Re-schedule remaining section of interview
   - Turn to “dummy” questions

6. Safety and ethical issues
   - Sensitivity of research topic
   - Consent of the woman concerned (and not her husband or others) and voluntary participation
   - Confidentiality
   - Physical safety of the respondent
   - Respecting women’s decisions

7. Supporting women reporting violence
   - Your role as an interviewer is to record women’s responses to questions, not to provide counseling or advice.
   When a woman becomes distressed:
   - Take time to talk with kindness and sensitivity
   - Be patient and composed
   - Sympathetic comments, such as “I know this is difficult”
   - Offer to take a break or finish interview later.

8. Supporting women reporting violence
   Only terminate the interview
   - If woman states she does not want to continue
   - If you feel it would be highly detrimental to continue.

9. Support & safety for interviewers
   - Debriefing sessions with supervisors
   - Talk to supervisors or other members of team
   - Ask for counseling
   - Take precautions to ensure safety, e.g., if interview has to be scheduled in the evenings, make sure not to go alone.

Source: Training workshop for field staff. WHO Multi-Country Study on Women’s Health and Domestic Violence. Department of Gender and Women’s Health, Geneva, WHO.
across population groups on the extent and nature of the problem and underlying factors.

An example of a national level initiative that addresses GBV research needs is the South African Gender-based Violence and Health Initiative (SAGBVHI) set up in December 2000. Through partnership with individuals, organizations and institutions across sectors, SAGBVHI aims to build the health sector's capacity to respond sensitively, appropriately and effectively to gender-based violence. One of its main objectives is to strengthen the national research agenda on gender-based violence.

The WHO Multi-Country Study on Women's Health and Domestic Violence Against Women is another such effort. Countries covered by the study include, Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Tanzania and Thailand. The objectives of this study, the full results of which will soon become available, are to:

- obtain reliable estimates of the prevalence of violence against women in different countries throughout the world, in a consistent, standardized manner which will allow for inter-country comparisons;
- document the association between domestic violence against women and a range of health outcomes;
- identify risk and protective factors for domestic violence against women, and compare them between settings; and
- explore and compare the coping strategies used by women experiencing domestic violence.

Guidelines on interviewing techniques in community-based surveys of gender-based violence have been evolved as part of the study and are used in training programmes conducted for field investigators under the study. These guidelines address methodological issues related to data collection through community surveys (see Box 18).

Other responses

Legal and judicial remedies

Legal reforms

During the 1980s and 1990s, legal reforms relating to sexual assault and physical and sexual abuse by an intimate partner were undertaken in several countries. These reforms include:

- changing laws that keep women trapped in abusive relationships, for example, laws related to divorce and inheritance;
- removing barriers to prosecution, for example, the burden of proof in rape resting on the woman and not on the man;
- eliminating aspects of laws that are prejudicial to women, for example, laws that do not recognize as rape sexual assault that is not penile penetration of the vagina, or rape by a husband; and
- enacting gender-sensitive legislation, for example, criminalizing domestic violence, enacting sexual harassment laws and laws recognizing child sexual abuse and incest as sexual assault.

The constitution of Brazil, enacted in 1988, contains a provision that the state should assist the family, in the person of each of its members, and create mechanisms to impede violence in the sphere of its relationships. In 1991, the Canadian government announced a four-year Family Violence Initiative to mobilize community action, strengthen the country's legal framework and establish services within indigenous communities. In Australia, a Commonwealth/State Committee on Violence Against Women (NCVAW) was set up by the prime minister to initiate research, coordinate the development of policy, programmes, legislation and law enforcement and conduct and coordinate community education on violence against women.

In Malaysia, the 1994 Domestic Violence Act (Act 521) recognized domestic violence as an issue of public concern. Now, domestic violence is dealt with as a criminal offence. The main purpose of the Act is to ensure the safety of victims of violence. It provides for interim protection orders and penalties for breach of those orders. It is administered by the Ministry of National Unity and Social Development and enforced by social welfare officers and the police. The Act does not protect individuals who live together but are not married according to civil or customary law.
The Special Act for the Punishment of Domestic Violence and the Prevention of Domestic Violence and Protection of the Victim Acts in South Korea deals with the punishment and rehabilitation of the perpetrator and reporting by medical institutions and counselling centres.  

Collecting forensic evidence

A key component of the justice system is the medico-legal system of collecting forensic evidence in cases of sexual violence. In many countries, this evidence is admissible in court only when collected by specially certified forensic health providers. Typically employed by the public sector, these professionals have in many instances become synonymous with poor access, poor treatment of survivors, and unwillingness or inability to provide urgent medical care. The World Health Organization and PAHO have recently developed a series of guidelines to improve the medico-legal response to sexual and domestic violence. In Latin America, several promising measures have been initiated, such as appointing forensic health providers nominated and trained by women's organizations and allowing general physicians and, in some cases, nurses to collect forensic specimens in Nicaragua.

Civil law

An alternative to criminalizing domestic violence is to use a civil law approach, whereby court orders are issued to prohibit the abuser from contacting or abusing his partner, require him to leave the home, order him to pay maintenance or child support or require him to seek counseling or treatment of substance abuse. However, the evidence on the effectiveness of this approach shows that it may not always be as successful as an arrest in preventing violence.

It is not adequate to just enact laws. Mechanisms need to be put in place to ensure that women who seek legal recourse are not jeopardizing their safety or their jobs/education. For example, laws on sexual harassment in the workplace should have in-built guarantees to prevent women losing their jobs as a consequence.

Mandatory reporting

In some countries, domestic violence laws or laws on sexual assault require mandatory reporting of the crime by health care providers who treat the victims. Such provisions however, while they may increase reporting, could be counter-productive and create formidable barriers for women trying to access health care services. The trade-offs should thus be carefully weighed before implementation.

Free legal aid

Legal counsel and legal aid at no cost or subsidized costs are important prerequisites for low-income women. Information on the availability of affordable legal counsel and legal aid should be disseminated widely, so that women are well-informed and therefore not hesitant to turn to the law due to lack of adequate funds.

Other judicial remedies

A variety of other judicial and legal remedies have been attempted in various settings. These include women-only police stations; mediation centers which attempt to resolve the issue outside the formal legal system; family courts and special domestic violence courts; training of police personnel, lawyers, public prosecutors and magistrates/judges; and providing women with special advisers to deal with the criminal justice system.

Pro-poor and gender responsive policies

International initiatives

There is increasing international commitment to reducing poverty and inequality and promoting human rights. Poverty Reduction Strategy Papers (PRSPs) chart out a country's plan for socioeconomic development and poverty reduction. The Millennium Declaration, signed in 2000, committed United Nations Member States to a series of time-bound and measurable targets, known as the Millennium Development Goals (MDGs), which contain a number of goals and targets pertinent to the issue of gender-based violence. In particular, the first three goals are relevant, namely:
Goal 1: eradicate extreme poverty and hunger.
Goal 2: achieve universal primary education.
Goal 3: promote gender equality and empower women.

National initiatives

Irrespective of their original socioeconomic status, many women experience financial risks or are impoverished as a consequence of gender violence. The situation is much worse for low-income women. Few policies or interventions have however focused on preventing and eliminating economic consequences following the experience of GBV.

Some measures that may be considered include:
- Programmes that provide for transitional as well as long-term, low-cost housing on a priority basis to women leaving abusive relationships.
- Workplace policies that make it possible for women living in abusive relationships to avail of additional medical leave and to be able to organize their workday flexibly.
- At the very least, policies should be in place that prevent women being terminated from their jobs because of problems at work related to domestic violence. There should also be no discrimination in hiring women who are victims of sexual assault or rape.
- Low-interest loans for women who relocate after leaving an abusive relationship.
- Credit policies that give preferential treatment to women in abusive relationships who wish to gain financial independence, in the same way as affirmative action programmes do for other marginalized groups.
- Special programmes for job training, placement in employment or help with earning a livelihood through other means, to help women avoid being trapped in an abusive relationship.

Government funds may be earmarked to encourage community-based and other non-governmental organizations to implement such programmes. Ideally, an intersectoral approach should be taken in designing and implementing the policies and interventions suggested above.

Box 19. Community-level initiatives to reduce GBV

In Latin America and the Caribbean, many NGOs have launched programmes to promote community-wide changes in attitudes and practices related to gender norms and violence against women—often as a component of HIV/AIDS prevention or reproductive health programmes. The few that have been well evaluated suggest that community-level approaches can be effective in changing violence-related attitudes and behaviours. One example of this is Program H carried out by four NGOs, that aims to change gender norms and sexual behaviours in Bolivia, Brazil, Colombia, Jamaica, Mexico and Peru. The initiative has four components:

a) training professionals to work with young men in the area of health and gender-equity using a set of manuals and videos;

b) social marketing and condoms;

c) promoting health services; and

d) evaluating changes in gender norms.

In 2002, PROMUNDO and Horizons began a two-year evaluation to measure the effectiveness of two different approaches compared to a control site. Researchers have developed a “Gender-Equitable Men” (Leichert) scale with 24 items for measuring attitudes. Methods include pre- and post-tests as well as a six-month follow-up community-based survey. In addition, they are gathering qualitative information among men and their female partners. Preliminary results suggest that the programme has been successful at increasing gender equitable norms and reducing behaviours that put men at increased risk of HIV/AIDS.

Community-based initiatives

**Crisis centres and shelters**

Since the 1960s, women's organizations have campaigned against gender-based violence and developed various measures to provide support to survivors. Crisis centers, women's shelters and short-stay homes have been the most common responses. Crisis centers with trained social workers and counselors are an important component of an integrated response to sexual and domestic violence. Such shelters should be affordable, but alternatives need to be found in resource-poor settings. These could include another safe place of stay as in friend or relative's residence. However, the public welfare system may need to support those providing shelter to women victims of violence in the form of payments.

**Support groups for survivors**

Support groups for survivors of violence are a low-cost and effective way of reaching out to a larger number of women than would be possible if specialized crisis centers were to be set up. Women feel empowered by the realization that their experience of violence is not unique, and is not their failing or fault, when they interact with others in a similar situation. There is much scope for mutual learning on how best to cope with difficult situations, as well as on how to deal with the legal system and the bureaucracy during the changes in life that come with leaving an abusive relationship.

Survivor groups need to be facilitated by a trained facilitator who need not be a professional psychologist or counsellor. What is important is their motivation and training in gender and rights, as well as in ethical norms pertaining to working with women survivors of violence.

**Involving men**

Some initiatives involve men in working against gender-violence against women. There are two different types of men's groups: groups that work directly with men who are perpetrators of violence; and groups that mobilize men, especially youth, to promote non-violent relationships and seek to involve men in preventing and containing gender-based violence.

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**Box 20. Principles of good practice in addressing gender-based violence**

Recent decades of experience in addressing gender-based violence have yielded a number of lessons and good practices. These may be summarized as follows:

- Both national and local level actions are needed to address gender-based violence. National policies play an important role in creating formal mechanisms and in adopting standard norms. For abused women to have access to the services they need, these national actions have to be backed by coordinated community-level initiatives.
- Action is needed across sectors in order to provide an adequate and timely response, especially to low-income women.
- The safety of women should guide all decisions relating to interventions. No intervention should be developed that could potentially jeopardize their safety.
- Training alone does not help. It has to be accompanied by changes in the institutional culture in a direction that supports the involvement of staff in GBV issues, and provides adequate recognition and resources.
- Special policies and interventions are needed to address the specific needs of low-income women, including comprehensive interventions to provide immediate medical care and psychological support, transitional housing and access to training and means of earning a livelihood. Without such comprehensive support, low-income women may be unable to break-free from the dual trap of poverty and gender-based violence.

Treatment programmes for men who batter originally began in the United States. They now exist in Argentina, Australia, Canada, Mexico and Sweden, among other countries. These programmes often aim to bring about a change from a belief system that justifies abusive behaviour to a more respectful belief system that promotes mutuality and equality.

Mobilizing men to become agents of change in gender power inequalities has been adopted in many settings. In the Philippines, the NGO Harnessing Self-Reliant Initiatives and Knowledge (HASIK) uses gender training as an entry point for organizing against gender violence in low-income neighbourhoods of Quezon City. A similar approach has been adopted by the Rural Women’s Social Education Centre (RUWSEC), which works with young men and adolescent boys in the villages of Northern Tamil Nadu in India.

In some countries, men have come together on their own to speak out against gender-based violence and to experiment with new models of masculinity. Men’s groups against violence exist for example, in Canada, India, Nicaragua, and Zimbabwe.

Coordinated community interventions

In many industrialized countries, coordinated community interventions have been put in place to provide integrated services to women experiencing gender-based violence. These usually consist of representatives of women’s groups, health services, law enforcement agencies, the justice system, housing and welfare agencies and batterer treatment programmes. In the United States, for example, about 100 communities have adopted this model. Key elements of the model include:

- written policies or a Memorandum of Understanding indicating how each agency should respond and clarifying coordination and data sharing issues;
- a paid coordinator to manage the task force and oversee the processing of cases;
- training of victims’ advocates to help victims of violence negotiate the court system and social service agencies;
- training for all relevant staff on the dynamics of abuse;
- survivors’ support groups;
- perpetrators’ treatment programmes; and
- monitoring of the functioning of the Task Force by an autonomous body, usually a woman’s organization.

PAHO’s initiative in ten Latin American countries has created community-level coordinating councils that have adopted most of the elements of the above model.

Other community initiatives

Other initiatives at the community level have included training community-based volunteers to provide basic support and referral services and sometimes to act as advocates for women experiencing GBV; public education campaigns and sensitization workshops for community leaders, often with the health sector taking the lead; school-based programmes; and programmes for youth that integrate GBV as a topic within life skills education programmes.
5. Facilitator's notes

These notes are provided to support facilitators in the process of integrating poverty and gender issues into specific health topics. Facilitators are recommended to refer to Section 5 of the foundational modules of this Sourcebook, dealing respectively with poverty and gender, which contain additional notes on the target audience, role of the facilitator and suggested methodologies for learning sessions and for evaluation.

Expected learning outcomes

Upon completion of the module, participants will be able to:

1. Demonstrate an understanding of gender-based violence, including its definitions, various dimensions, extent and health consequences.
2. Demonstrate an understanding of the links between poverty, gender and GBV.
3. Be able to explain why it is important to address GBV from efficiency, equity and human rights perspectives.
4. Indicate how health professionals and the health system can prevent and address GBV, especially with respect to low-income women and those from other marginalized and vulnerable groups.
5. Demonstrate familiarity with some tools, resources and references available to support health professionals in dealing with GBV.

Suggestions for workshop sessions on gender-based violence, poverty and health

Session 1: Understanding gender-based violence

Exercise 1: Defining violence against women

Ahead of time, put up on the wall accounts of gender-based violence from newspapers, magazines and other sources.

Divide participants into small groups and ask them to list, on newsprint or flipcharts, different types of gender-based violence. Ask each group to present their work and define gender-based violence.

Now distribute the United Nations or Center for Disease Control's definitions of gender-based violence. Check if the groups' definitions include:
- physical harm or suffering;
- sexual harm or suffering;
- psychological harm or suffering;
- threats of physical, sexual, psychological harm or suffering;
- coercion;
- arbitrary deprivation of liberty;
- acts in public as well as in private life; and
- violence perpetuated or condoned by the state.

Discuss whether they would like to add other forms of violence to their original list.

Ask participants to walk around and read the accounts of GBV on the wall and discuss the extent to which the United Nations definition includes all these types of instances. Ask participants if they would want to change the United Nations definition? If so, in what ways?

Exercise 2: Myths about violence

Distribute the 'Myths and facts about woman abuse' questionnaire (Teaching aid 1). Ask participants to complete it individually or in pairs. After 10 minutes, go over the correct responses with them. Discuss their responses.

Brainstorm on why people use violence. Summarize the discussion with the following definition:

Violence is any attempt to control or dominate another person.

Distribute the Power and control wheel (Figure 2) and discuss the various forms of gender-based violence.

Session 2: Exploring the underlying causes

In this session, a case study is used to introduce Lori Heise's ecological model on factors underlying GBV.

Distribute to participants 'Miriam's story' (Teaching aid 2). Go over the case study in steps and ask participants to identify the factors that contributed to Miriam's experience of GBV. Then distribute Heise's model (Figure 3) and classify the...
factors identified by participants into the various levels of causes.

Session 3: Extent of the problem and its health consequences

This is an input session based on Sections 1 and 2 of this module, specifically the sections entitled “The extent of the problem” and “Health consequences of gender-based violence.” Facilitate a brainstorming session by asking participants to state their ideas about the extent and consequences of GBV. Record their responses on newsprint or flipcharts.

Session 4: Health provider responses

In this session, role plays are used to acquaint participants with how to ask women about violence and how to provide support.

Divide participants into three groups. Each group is further divided into A and B. Groups 1A, 2A and 3A are given three specific situations for the role play: for example, a young woman rape victim brought in by the police to a health facility; a woman seeking antenatal care who has a past history of violence by her husband; and, a mother bringing in a girl of ten suffering from genital sores.

Distribute to groups 1B, 2B and 3B the section from this module on health provider responses which describe how to ask about violence and how to provide support.

Members of group 1B are health providers who are approached by 1A, the rape victim. The health providers have to take a history and provide care and support to the rape victim. Members of 2B are the health care providers approached by 2A, the pregnant woman with a past history of abuse by husband, and so on.

After each role play, debrief those who participated in the role plays and then have a discussion with the larger group on the challenges involved in the care of women experiencing GBV and how they might overcome these challenges.

Session 5: Health sector responses and responses from other sectors for addressing gender-based violence

The relevant sections may be distributed to participants as reading material before hand, and they can be asked to prepare presentations based on these readings as well as on further references from the web/library on health sector responses.

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Teaching aid 1. Myths and facts about woman abuse

Read the following statements and mark A, B, C, D or E in accordance with the following scale:

A - Strongly agree    B - Agree    C - Undecided    D - Disagree    E - Strongly disagree

1. Assaulted women could just leave their partners if they really wanted to.
2. Some women deserve the violence they experience.
3. Poverty causes family violence.
4. Alcohol causes family violence.
5. As long as children are not abused, they are not affected by witnessing violence in the home.
6. Violence is a private family matter.
7. The community has no right to intervene in family violence.
8. If someone is abusive in a dating relationship, he or she will stop when married.
9. A violent fight can “clear the air”, it probably will not happen again.
10. When a man abuses a woman, he tries to control her.
11. When a man and woman share equal power in a marriage, it is bound to cause some violent fights.
12. If someone swears at or intimidates another person, this is abuse.
13. Schools should have a role in increasing awareness of the effects of violence and how to prevent it.

Visits to projects, government departments or health facilities may be arranged and participants asked to prepare a case report on the interventions from a critical perspective.

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**Teaching aid 2. Miriam's story**

Miriam is 36 years old and the mother of six children. She grew up in a village 400 kilometres away from the capital city of her country. She stopped schooling after her second grade. Her parents were poor, and the school was three kilometres away from the village. Her father believed that educating a girl was like 'watering the neighbour's garden'.

When she was 12, Miriam was circumcised, as was the custom in her tribe. At 16, she was married to a man three times her age. Her father received a substantial lobola. The very next year, she gave birth at home to a baby boy. The baby was stillborn. The health centre was 10 kilometres away, and anyway, did not attend deliveries. Miriam believed that the baby was born dead because of the repeated beatings and kicks she had received all through her pregnancy. Instead, she was blamed for not being able to bear a healthy baby.

Miriam's husband considered it his right to have sex with her, and regularly forced himself on her. Miriam did not want to get pregnant again and again, but had little choice in the matter. She had no time to go to the health clinic, and when she went sometimes because her children were sick, she was hesitant to broach the subject of contraception with the nurses.

Her life with her husband was a long saga of violence. Miriam struggled to keep body and soul together through her several pregnancies and raising her children. She had to farm her small plot of land to feed the children, because her husband never gave her enough money. She approached the parish priest several times for help. He always advised her to have faith in God and keep her sacraments.

One day her husband accused Miriam of 'carrying on' with a man in the village. He had seen Miriam laughing and chatting with the man, he claimed. When she answered back, he hit her with firewood repeatedly on her knees saying 'you whore! I will break your legs'. Miriam was badly injured; she thought she had a fracture. For weeks she could not move out of the house. But she did not have any money to hire transport to go to the health centre. Unable to go to the market to trade, she had no income and literally starved.

Miriam was terrified of further violence. She had had enough. As soon as she could walk, she took her two youngest and left the village. She now lives in a strange village, a refugee in her own country, living in fear of being found by her husband and brought back home.

6. Tools, resources and references
6. Tools, resources and references

Tools and further resources

Tools used in this module

Screening tools for gender-based violence

A. IPPF’s screening tool for gender-based violence
   - Have you ever felt hurt emotionally or psychologically by your partner or another person important to you?
   - Has your partner or another person important to you ever caused you physical harm?
   - Were you ever forced to have sexual contact or intercourse?
   - When you were a child, were you ever touched in a way that made you feel uncomfortable?
   - Do you feel safe returning to your home tonight?

B. Three brief questions to screen for gender-based violence
   - Have you ever been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?
   - Do you feel safe in your current relationship?
   - Is there a partner from a previous relationship who is making you feel unsafe now?


Introducing the screening questions

A. Asking directly
   - Before we discuss contraceptive choices, it might be good to know a little 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.

B. 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 behaviour 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?

Developing a safety plan

- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- 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 may 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 home in a hurry.
- Devise a code word to use with your children, family, friends and neighbours 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 go 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 wants to calm him down. You have the right to protect yourself and your children.
- Remember, you do not deserve to be hit or threatened.


Danger assessment instrument

Contributed by
Jacquelyn C. Campbell,
Ph.D., RN, FAAN

Dear Colleague:

Here is a copy of the Danger assessment instrument which you may duplicate in any quantity desired for use with battered women. In exchange, I would appreciate your sharing with me the results of any research (raw or coded data) which is done with the instrument and/or an approximate number of women with whom the instrument was used, a description of their demographics, their mean score, and the setting in which the data was collected. Please send this information within the next year. I would also be grateful for comments (positive and negative), and suggestions for improvement from battered women themselves, advocates, and professionals who are involved in its use. Finally, I ask that you please correspond with me prior to altering the instrument in any way.

Sincerely,
Jacquelyn C. Campbell,
Ph.D., RN, FAAN

Anna D. Wolf
Endowed Professor
Associate Dean for Doctoral Education Programs and Research,
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Continued on next page
Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain.
2. Punching, kicking; bruises, cuts, and/or continuing pain.
3. "Beating up"; severe contusions, burns, broken bones.
4. Threat to use weapon; head injury, internal injury, permanent injury.
5. Use of weapon; wounds from weapon.

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

____ 1. Has the physical violence increased in frequency over the past year?
____ 2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
____ 3. Does he ever try to choke you?
____ 4. Is there a gun in the house?
____ 5. Has he ever forced you to have sex when you did not wish to do so?
____ 6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____ 7. Does he threaten to kill you and/or do you believe he is capable of killing you?
____ 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
____ 9. Does he control most or all of the your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: _____)
____ 10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: _____)

Continued on next page
Danger Assessment (continued)

11. Is he violently and constantly jealous of you? (For instance, does he say "If I can’t have you, no one can.")

12. Have you ever threatened or tried to commit suicide?

13. Has he ever threatened or tried to commit suicide?

14. Is he violent toward your children?

15. Is he violent outside of the home?

Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Source: website of the National Violence against Women Prevention Research Center of the US Centers for Disease Control and Prevention: [http://www.musc.edu/vawprevention/](http://www.musc.edu/vawprevention/). Go to “Research,” then “Tools and Instruments,” then “Danger Assessment Tool.”

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What do women disclosing violence want of health care providers?

A study from Wisconsin, USA of 115 women who had been battered by their male partners offers some insights. According to them, supportive behaviour would include the following:

Medical support
- taking a complete history;
- detailed assessment of current and past violence;
- gentle physical examination; and
- treatment of all injuries.

Emotional support
- confidentiality;
- directing the partner to leave the room;
- listening carefully; and
- reassuring the woman that the abuse is not her fault and validating her feelings of shame, anger, fear and depression.

Practical support
- telling the patient that spouse abuse is illegal;
- providing information and telephone numbers for local resources such as shelters, support groups and legal services;
- asking about the children’s safety;
- helping the patient begin safety planning.

Some guidelines on conducting interviews with women in community-based surveys on intimate partner violence

Introducing the study:
When introducing the study in the community, it is important to:

- Dress appropriately
- Make a good first impression
- Have a positive approach
- Stress that information gathered will be kept confidential
- Answer questions frankly

Introduce the study as “A survey on women’s health and life experiences”. Do not mention domestic violence at initial contact.

2. Conducting the interview:
- Interview the respondent only
- Be neutral
- Never suggest answers
- Use tact with hesitant respondents
- Do not judge the woman
- Do not hurry the interview
- Do not show questionnaire to anyone!

3. Content of the consent form:
- Confidentiality of study
- General purpose of study
- Some topics may be difficult to discuss
- Respondent may skip any question or stop the interview at any point
- Signature of interviewer

4. Asking questions:
- Read exactly as written
- Do not suggest one response over another
- Read questions in the order indicated
- Don't skip questions
- Follow instructions on how to read questions
- Do not emphasize one response choice over another.

5. Handling interruptions
- Explore ways to obtain privacy
- Re-schedule remaining section of interview
- Turn to “dummy” questions

6. Safety and ethical issues
- Sensitivity of research topic
- Consent of the woman concerned (and not her husband or others) and voluntary participation
- Confidentiality
- Physical safety of the respondent
- Respecting women's decisions

7. Supporting women reporting violence
- Your role as an interviewer is to record women's responses to questions, not to provide counseling or advice.

When a woman becomes distressed:
- Take time to talk with kindness and sensitivity
- Be patient and composed
- Sympathetic comments, such as “I know this is difficult”
- Offer to take a break or finish interview later.

8. Supporting women reporting violence
- Only terminate the interview
  - If woman states she does not want to continue
  - If you feel it would be highly detrimental to continue.

9. Support & safety for interviewers
- Debriefing sessions with supervisors
- Talk to supervisors or other members of team
- Ask for counseling
- Take precautions to ensure safety, for e.g if interview has to be scheduled in the evenings, make sure not to go alone.

Source: Training workshop for field staff. WHO Multi-Country Study on Women’s Health and Domestic Violence. Department of Gender and Women’s Health, Geneva, WHO.
Principles of caring for survivors of family violence

- Family violence is a serious problem that affects the physical, emotional, and sexual health of the person that lives with it and her family and can even lead to death.
- Family violence is a criminal offense with legal repercussions, therefore it should be addressed in a timely and effective manner.
- Family violence is the responsibility of all society, as well as a public health and human rights problem.
- Violence is caused by the perpetrators, not the victim.
- Violence is a learned behaviour, and therefore, it can be unlearned.
- Nothing justifies family violence.
- People have the right to live in conditions that allow for their integrated development and respect for their rights.
- All individuals, regardless of sex, age, religion, economic level, sexual orientation, nationality, and political beliefs, should be cared for when requesting services for family violence.
- All individuals who have suffered family violence have the right to services and resources that guarantee personal safety and confidentiality.
- All interventions should be carried out in a manner that respects individuals’ rights and empowers them to make their own decisions.


Ten guiding principles for the ethical and safe conduct of interviews with women who have been trafficked

1. **Do no harm**
   Treat each woman and the situation as if the potential for harm is extreme until there is evidence to the contrary. Do not undertake any interview that will make a woman's situation worse in the short term or longer term.

2. **Know your subject and assess the risks**
   Learn the risks associated with trafficking and each woman’s case before undertaking an interview.

3. **Prepare referral information. Do not make promises that you cannot fulfill**
   Be prepared to provide information in a woman’s native language and the local language (if different) about appropriate legal, health, shelter, social support and security services, and to help with referral, if requested.

4. **Adequately select and prepare interpreters, and co-workers**
   Weigh the risks and benefits associated with employing interpreters, co-workers or others, and develop adequate methods for screening and training.

5. **Ensure anonymity and confidentiality**
   Protect a respondent’s identity and confidentiality throughout the entire interview process from the moment she is contacted through the time that details of her case are made public.

6. **Get informed consent**
   Make certain that each respondent clearly understands the content and purpose of the interview, the intended use of the information, her right not to answer questions, her right to terminate the interview at any time, and her right to put restrictions on how the information is used.

7. **Listen to and respect each woman’s assessment of her situation and risks to her safety**

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Ten guiding principles (continued)

- Recognize that each woman will have different concerns, and that the way she views her concerns may be different from how others might assess them.

8. **Do not re-traumatize a woman**

   Do not ask questions intended to provoke an emotionally charged response. Be prepared to respond to a woman's distress and highlight her strengths.

9. **Be prepared for emergency intervention**

   Be prepared to respond if a woman says she is in imminent danger.

10. **Put information collected to good use**

   Use information in a way that benefits an individual woman or that advances the development of good policies and interventions for trafficked women generally.


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UN Declaration on the Elimination of Violence against Women

**General Assembly Resolution 48/104 of 20 December 1993**

The General Assembly,

**Recognizing** the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings,

**Noting** that those rights and principles are enshrined in international instruments, including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

**Recognizing** that effective implementation of the Convention on the Elimination of All Forms of Discrimination against Women would contribute to the elimination of violence against women and that the Declaration on the Elimination of Violence against Women, set forth in the present resolution, will strengthen and complement that process,

**Concerned** that violence against women is an obstacle to the achievement of equality, development and peace, as recognized in the Nairobi Forward-looking Strategies for the Advancement of Women, in which a set of measures to combat violence against women was recommended, and to the full implementation of the Convention on the Elimination of All Forms of Discrimination against Women,

**Affirming** that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms, and concerned about the long-standing failure to protect and promote those rights and freedoms in the case of violence against women,

**Recognizing** that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence

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against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men,

Concerned that some groups of women, such as women belonging to minority groups, indigenous women, refugee women, migrant women, women living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women and women in situations of armed conflict, are especially vulnerable to violence,

Recalling the conclusion in paragraph 23 of the annex to Economic and Social Council resolution 1990/15 of 24 May 1990 that the recognition that violence against women in the family and society was pervasive and cut across lines of income, class and culture had to be matched by urgent and effective steps to eliminate its incidence,

Recalling also Economic and Social Council resolution 1991/18 of 30 May 1991, in which the Council recommended the development of a framework for an international instrument that would address explicitly the issue of violence against women,

Welcoming the role that women's movements are playing in drawing increasing attention to the nature, severity and magnitude of the problem of violence against women,

Alarmed that opportunities for women to achieve legal, social, political and economic equality in society are limited, inter alia, by continuing and endemic violence,

Convinced that in the light of the above there is a need for a clear and comprehensive definition of violence against women, a clear statement of the rights to be applied to ensure the elimination of violence against women in all its forms, a commitment by States in respect of their responsibilities, and a commitment by the international community at large to the elimination of violence against women,

Solemnly proclaims the following Declaration on the Elimination of Violence against Women and urges that every effort be made so that it becomes generally known and respected:

Article 1

For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 2

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

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including

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Article 3

Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, **inter alia:**

(a) The right to life;**i**
(b) The right to equality;**ii**
(c) The right to liberty and security of person;**iii**
(d) The right to equal protection under the law;
(e) The right to be free from all forms of discrimination;
(f) The right to the highest standard attainable of physical and mental health;**iv**
(g) The right to just and favourable conditions of work;**v**
(h) The right not to be subjected to torture, or other cruel, inhuman or degrading treatment or punishment.**vi**

Article 4

States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women and, to this end, should:

(a) Consider, where they have not yet done so, ratifying or acceding to the Convention on the Elimination of All Forms of Discrimination against Women or withdrawing reservations to that Convention;
(b) Refrain from engaging in violence against women;
(c) Exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by
(d) Develop penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs caused to women who are subjected to violence; women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered; States should also inform women of their rights in seeking redress through such mechanisms;
(e) Consider the possibility of developing national plans of action to promote the protection of women against any form of violence, or to include provisions for that purpose in plans already existing, taking into account, as appropriate, such cooperation as can be provided by non-governmental organizations, particularly those concerned with the issue of violence against women;
(f) Develop, in a comprehensive way, preventive approaches and all those measures of a legal, political, administrative and cultural nature that promote the protection of women against any form of violence, and ensure that the re-victimization of women does not occur because of laws insensitive to gender considerations, enforcement practices or other interventions;
(g) Work to ensure, to the maximum extent feasible in the light of their available resources and, where needed, within the framework of international cooperation, that women subjected to

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violence and, where appropriate, their children have specialized assistance, such as rehabilitation, assistance in child care and maintenance, treatment, counselling, and health and social services, facilities and programmes, as well as support structures, and should take all other appropriate measures to promote their safety and physical and psychological rehabilitation;

(h) Include in government budgets adequate resources for their activities related to the elimination of violence against women;

(i) Take measures to ensure that law enforcement officers and public officials responsible for implementing policies to prevent, investigate and punish violence against women receive training to sensitize them to the needs of women;

(j) Adopt all appropriate measures, especially in the field of education, to modify the social and cultural patterns of conduct of men and women and to eliminate prejudices, customary practices and all other practices based on the idea of the inferiority or superiority of either of the sexes and on stereotyped roles for men and women;

(k) Promote research, collect data and compile statistics, especially concerning domestic violence, relating to the prevalence of different forms of violence against women and encourage research on the causes, nature, seriousness and consequences of violence against women and on the effectiveness of measures implemented to prevent and redress violence against women; those statistics and findings of the research will be made public;

(l) Adopt measures directed towards the elimination of violence against women who are especially vulnerable to violence;

(m) Include, in submitting reports as required under relevant human rights instruments of the United Nations, information pertaining to violence against women and measures taken to implement the present Declaration;

(n) Encourage the development of appropriate guidelines to assist in the implementation of the principles set forth in the present Declaration;

(o) Recognize the important role of the women's movement and non-governmental organizations world wide in raising awareness and alleviating the problem of violence against women;

(p) Facilitate and enhance the work of the women's movement and non-governmental organizations and cooperate with them at local, national and regional levels;

(q) Encourage intergovernmental regional organizations of which they are members to include the elimination of violence against women in their programmes, as appropriate.

Article 5

The organs and specialized agencies of the United Nations system should, within their respective fields of competence, contribute to the recognition and realization of the rights and the principles set forth in the present Declaration and, to this end, should, inter alia:

(a) Foster international and regional cooperation with a view to defining regional strategies for combating violence, exchanging experiences and financing programmes relating to the elimination of violence against women;

(b) Promote meetings and seminars with the aim of creating and raising awareness among all persons of the issue of the elimination of violence against women;

(c) Foster coordination and exchange within the United Nations system between human rights treaty bodies to address the issue of violence against women effectively;

(d) Include in analyses prepared by organizations and bodies of the United Nations system of social trends and problems, such as the periodic reports on the world social situation,
examination of trends in violence against women;

(e) Encourage coordination between organizations and bodies of the United Nations system to incorporate the issue of violence against women into ongoing programmes, especially with reference to groups of women particularly vulnerable to violence;

(f) Promote the formulation of guidelines or manuals relating to violence against women, taking into account the measures referred to in the present Declaration;

(g) Consider the issue of the elimination of violence against women, as appropriate, in fulfilling their mandates with respect to the implementation of human rights instruments;

(h) Cooperate with non-governmental organizations in addressing the issue of violence against women.

Article 6

Nothing in the present Declaration shall affect any provision that is more conducive to the elimination of violence against women that may be contained in the legislation of a State or in any international convention, treaty or other instrument in force in a State.

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1 Resolution 217 A (III).
2 See resolution 2200 A (XXI), annex.
3 Resolution 34/180, annex.
4 Resolution 39/46, annex.
6 Universal Declaration of Human Rights, article 3; and International Covenant on Civil and Political Rights, article 6.
7 International Covenant on Civil and Political Rights, article 26.
8 Universal Declaration of Human Rights, article 3; and International Covenant on Civil and Political Rights, article 9.
9 International Covenant on Economic, Social and Cultural Rights, article 12.
10 Universal Declaration of Human Rights, article 23; and International Covenant on Economic, Social and Cultural Rights, articles 6 and 7.
11 Universal Declaration of Human Rights, article 5; International Covenant on Civil and Political Rights, article 7; and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
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12. Ibid.
15. Ibid.
21. Ibid.
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93 South African Gender-based Violence and Health Initiative.  
97 Ibid.  
99 Ibid.  
102 Ibid.  
103 Millenium Development Goals.  
105 Axelson B.L. 1997.  
106 Cervantes Islas F. 1999.  
109 Based on this author's first-person experience.  
113 Mertus J., Flowers N. and Dutt M. 1999.  
114 Wolfe et al. 1996.  