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Violence against women
A priority health issue

Introduction

The WHO Women's Health and Development Unit (WHD) was established in 1980 to promote and coordinate women's health and development activities in all WHO programmes. The overall aim of the Unit is to contribute to the promotion and improvement of women's health and rights, and to the development of health programmes and policies that promote gender equality and equity for women in health. Its current work is geared towards integrating a gender perspective into health research, policies and programmes, and increasing available knowledge on specific neglected women's health issues.

WHD's work in neglected women's health issues currently focuses on violence against women and female genital mutilation. Among its advocacy and information activities, WHD, in consultation with experts in the field, produced Female genital mutilation, an information package available in French and English. This widely-requested package has since been updated and reprinted and is now being translated into Arabic. With the present information package, on violence against women, WHD continues its information and advocacy role in women's health.

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

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

The recognition of violence as a public health issue requires that WHO develop appropriate public health guidelines and standards. This demands extensive consultation and planning. The current document is intended to be an information tool to further discussions and actions to curb violence against women. It confirms WHO's commitment to addressing this most urgent problem.
Violence against women is present in most societies but it often goes unrecognized, accepted as part of the order of things. Information about the extent of this violence from scientifically sound studies is still relatively scant. However, domestic violence against women has been documented for all countries and socioeconomic environments, and available evidence suggests that it is much more far-reaching than was previously believed. In different parts of the world, between 16% and 52% of women suffer physical violence from their male partners, and at least one in five women suffer rape or attempted rape in their lifetimes. It is also well-known that rape and sexual torture are systematically used as weapons of war. Violence negates women's autonomy and undermines their potential as individuals and members of society.

The need for more research on the connection between human rights, legal and economic issues, and the public health dimensions of violence is clear. A rapidly growing body of evidence shows that women's experience of violence has direct consequences not only for their own well-being, but also for that of their families and communities. In addition to broken bones, third degree burns and other bodily injuries, abuse can have long-term mental health consequences, including depression, suicide attempts and post traumatic stress disorder. Violence involving sexual assault may also cause sexually transmitted diseases, unwanted pregnancies and other sexual and reproductive health problems. For girls, the health consequences can carry on into their adult lives.

Violence against women can also have inter-generational repercussions. For example, boys who witness their mothers being beaten by their partners are more likely than other boys to use violence to solve disagreements in their own adult lives. Girls who witness the same sorts of violence are more likely than other girls to become involved in relationships in which their partners abuse them. Thus, violence tends to be carried over from one generation to the next.

The health care system has an important role to play along with many other sectors, such as the judicial, police and social services. However, those systems are largely ill-prepared to deal with the consequences of violence or even recognize the signs. Health care workers must be trained to recognize both the obvious and the more subtle signs of violence, and to meet women's health needs in this regard. From a public health perspective, it is equally important that strong prevention programmes and well-coordinated legal and social support services are in place.

WHO has a crucial role to play in helping countries foster the health and well-being of all people. Our Member States have a fundamental responsibility to ensure that women's health is protected and promoted. They urgently need to make a commitment to support programmes for the management of the health consequences of violence against women. They must also implement overall strategies that will end such violence. Together, we must work in close collaboration with organizations at local and national levels. Through research, standard-setting, and technical support activities, WHO will help its Member States develop and strengthen integrated and multi-sectoral responses at local and national levels.

World Health Organization July 1997
Violence against women and girls is a major health and human rights issue. At least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life. Many, including pregnant women and young girls, are subject to severe, sustained or repeated attacks.

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

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

United Nations definition

The Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993, defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".² It encompasses, but is not limited to, "physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychologi-

cal violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."

Why are definitions and measurements important?

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

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

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

The severity of violence recorded may also vary between studies. For example, one researcher may record all violence regardless of whether it results in bodily injury, whereas
The most common form of violence against women is domestic violence, or violence against women in families. Research consistently demonstrates that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person.¹

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

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

Physical abuse

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

It is likely that these studies, from both industrialized and developing countries, underestimate the problem for many reasons.

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

Rape in intimate relationships

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

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

Psychological or mental violence

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

Failures of detection

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

Health consequences

The consequences of violence against women may be non-fatal in the form of physical injuries, ranging from minor cuts and bruises to chronic disability, or mental trauma. They may also be fatal, resulting from either intentional homicide or injuries sustained or from AIDS. In the case of mental trauma, women may commit suicide as a last resort to escape violence. In this package, the sheet on Health consequences discusses this issue in more depth.

Initiatives against violence

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

• Support groups where battered women can share experiences have proved, in Argentina, Australia, Costa Rica, India, Japan, Liberia and other countries, to be an effective way of helping women end or cope with their violent relationships.

• Local community involvement in the reporting and rebuking violent husbands is having some success in Belize, India and among Aboriginal people of Canada.

• Women’s police stations have been set up throughout Latin America and in a number of Asian countries to provide a more committed and concerned response to crimes against women.

• Courses in non-violent parenting and conflict resolution, for adults and children, are available in an increasing number of countries, including Jamaica and Canada.

• Legal literacy programmes and free legal advice encouraging battered women to press charges is being tried in Nicaragua, Costa Rica and Uganda.

• Sensitivity training for health professionals and the police, and the adoption of new protocols for dealing with the victims of domestic violence, has been introduced in Zimbabwe, the United States, Brazil and elsewhere.

• Safe-houses and shelters, for women leaving abusive partners, have been set up in Egypt, Paraguay, El Salvador, Malaysia, the United Kingdom, Canada and other countries.


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

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

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

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

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

### Statistics on sex crimes\(^4\)

<table>
<thead>
<tr>
<th>Country</th>
<th>Attackers known to victim (%)</th>
<th>Victims aged 15 or less (%)</th>
<th>Victims aged 10 or less (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peru (Lima)</td>
<td>60</td>
<td>-</td>
<td>18(c)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>68</td>
<td>58</td>
<td>18(c)</td>
</tr>
<tr>
<td>Mexico (City)</td>
<td>67</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>Panama (City)</td>
<td>61</td>
<td>40</td>
<td>-</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>-</td>
<td>47</td>
<td>13(d)</td>
</tr>
<tr>
<td>Chile (Santiago)</td>
<td>72</td>
<td>58</td>
<td>32</td>
</tr>
<tr>
<td>United States</td>
<td>78</td>
<td>62</td>
<td>29</td>
</tr>
</tbody>
</table>


\(^4\)Includes attempted and completed rape and sexual assaults such as molestation, except for the US data which is for completed rape only.

\(a\)Percentage of survivors aged nine or less.
\(b\)Percentage of survivors aged six or less.
\(c\)Percentage of survivors aged seven or less.
Violence against women

In situations of armed conflict and displacement

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

Some forms of violence resulting from conflict/refugee situations

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

Increased violence against women during conflict

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

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

Who is most vulnerable?

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

Health consequences

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

**Impact on health systems**

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

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

**Sources:**


- Working with victims of organized violence from different cultures. The International Federation of Red Cross and Red Crescent Societies, 1995.

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

**Sexual abuse of children**

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

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

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

Research in Kingston, Jamaica, reported that 17% of a random sample of 452 primary school girls, ages 13-14, had experienced attempted or completed rape, half before the age of 12.¹

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

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

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

**Commercial exploitation**

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

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

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

**Female genital mutilation (FGM)**

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

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

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

**Son preference**

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

**Other forms of discrimination**

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

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


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

**Physical consequences**

**Homicide**

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

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

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

**Serious injuries**

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

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

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

**Injuries during pregnancy**

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

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

**Injuries to children**

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

In one study of abused women in Bogotá, Colombia, 49% reported that their children had also been beaten.⁶
Health workers have a crucial role to play in helping women and children who experience violence. Those working in the community, in health centres and clinics, may hear rumours that a woman is being beaten or a child abused, or notice evidence of violence when women seek treatment for other conditions. Those working in hospital emergency departments may be the first to examine women injured by rape or domestic violence. Health workers visiting institutions such as prisons, mental hospitals and retirement homes may be the only source of outside help for victims of abuse.

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

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

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

The role of health workers

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

At a minimum, health workers can:

- First, “do no harm”. Unsympathetic or victim-blaming attitudes can reinforce isolation and self-blame, undermine women’s self-confidence, and make it less likely that women will reach out for help.
- Be attentive to possible symptoms and signs of abuse and follow up on them.
- Where feasible, routinely ask all clients about their experiences of abuse as part of normal history taking.
- Provide appropriate medical care and document in the client’s medical record instances of abuse, including details of the perpetrator.
- Refer patients to available community resources.
- Maintain the privacy and confidentiality of client information and records.

Routine screening and protocols

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

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

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

What WHO is doing

WHO Headquarters
Women’s Health and Development (WHD)

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

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

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

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

Researchers, health care providers, women’s health advocates, and staff from several WHO programmes attended a WHO consultation on violence against women in Geneva in February 1996. They reviewed existing information concerning the scale of violence against women by partners, the health consequences and interventions, and ongoing research initiatives. Recommendations made by consultation participants formed the basis for WHO’s Plan of Action.

Plan of action on violence against women

Multi-country research

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

Documentation and testing of effective interventions

Often the most effective groups in the field are those who lack the time and funding to document their work. WHO plans to invest in systematically recording interventions by such groups in developing countries so that others can benefit as they begin their work. A small-grants fund will support the documentation of ongoing interventions and of lessons learned.
Violence against women

What non-governmental organizations are doing

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

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

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

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

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

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

Health and Development Policy Project (HDPP)
6930 Carroll Ave, Suite 430
Takoma Park
Maryland 20912, USA
Tel: (301) 270 1182
Fax: (301) 270 2052
E-mail: hdpp@igc.apc.org
HDPP works to ensure that the field of international health becomes a constructive force in addressing violence against women. Presently, HDPP is developing a manual on conducting research on gender-based violence and is collaborating with in-country partners to implement pilot prevention projects.

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

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

Latin American and Caribbean Women’s Network against Domestic and Sexual Violence  
Casilla 2067, Correo Central  
Santiago, Chile  
Tel: (562) 633 4582  
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The Network has members in most countries of the region. It has ensured the issue of violence against women is on the public agenda through organizing seminars, coordinating regional campaigns, and raising the issue with governments and international organisations. The Network produces a quarterly newsletter, ‘Boletín’.

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

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

Selected human rights documents, UN declarations and treaties

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

Global documents

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

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

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

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

The Convention on the Elimination of All Forms of Discrimination against Women (1979) is the most extensive international instrument dealing with the rights of women. Although violence against women is not specifically addressed in the Convention, except in relation to trafficking and prostitution (article 6), many of the anti-discrimination clauses protect women from violence. States Parties have agreed to a policy of eliminating discrimination against women, and to adopt legislative and other measures prohibiting all discrimination against women (article 2). In 1992, the Committee on the Elimination of Discrimination Against Women (CEDAW) which monitors the implementation of this Convention, formally included gender-based violence under gender-based discrimination. General Recommendation No. 19, adopted at the 11th session (June 1992), deals entirely with violence against women and the measures taken to eliminate such violence. As for health issues, it recommends that States
II) adopted the Istanbul Agenda which deals with gender-based violence within the context of shelter and the urban environment. Governments committed themselves to promote shelter and support basic education and health services for women and children who are survivors of family violence.

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

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

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

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

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

Special Rapporteur on violence against women, its causes and consequences

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


WHA49.25  Prevention of violence: a public health priority

The Forty-ninth World Health Assembly,

Noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children;

Endorsing the call made in the Declaration of the World Summit for Social Development for the introduction and implementation of specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect;

Endorsing the recommendations made at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) urgently to tackle the problem of violence against women and girls and to understand its health consequences;

Recalling the United Nations Declaration on the elimination of violence against women;

Noting the call made by the scientific community in the Melbourne Declaration adopted at the third international conference on injury prevention and control (1996) for increased international cooperation in ensuring the safety of the citizens of the world;

Recognizing the serious immediate and future long-term implications for health and psychological and social development that violence represents for individuals, families, communities and countries;

Recognizing the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities;

Recognizing that health workers are frequently among the first to see victims of violence, having a unique technical capacity and benefiting from a special position in the community to help those at risk;

Recognizing that WHO, the major agency for coordination of international work in public health, has the responsibility to provide leadership and guidance to Member States in developing public health programmes to prevent self-inflicted violence and violence against others,

1. DECLAR ES that violence is a leading worldwide public health problem;

2. URGES Member States to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it;

3. REQUESTS the Director-General, within available resources, to initiate public health activities to address the problem of violence that will:

   (1) characterize different types of violence, define their magnitude and assess the causes and the public health consequences of violence using also a "gender perspective" in the analysis;

   (2) assess the types and effectiveness of measures and programmes to prevent violence and mitigate its effects, with particular attention to community-based initiatives;

   (3) promote activities to tackle this problem at both international and country level including steps to:

      (a) improve the recognition, reporting and management of the consequences of violence;

      (b) promote greater intersectoral involvement in the prevention and management of violence;

      (c) promote research on violence as a priority for public health research;

      (d) prepare and disseminate recommendations for violence prevention programmes in nations, States and communities all over the world;

   (4) ensure the coordinated and active participation of appropriate WHO technical programmes;
(5) strengthen the Organization's collaboration with governments, local authorities and other organizations of the United Nations system in the planning, implementation and monitoring of programmes of violence prevention and mitigation;

4. FURTHER REQUESTS the Director-General to present a report to the ninety-ninth session of the Executive Board describing the progress made so far and to present a plan of action for progress towards a science-based public health approach to violence prevention.

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(Sixth plenary meeting, 25 May 1996 - Committee B, fourth report)