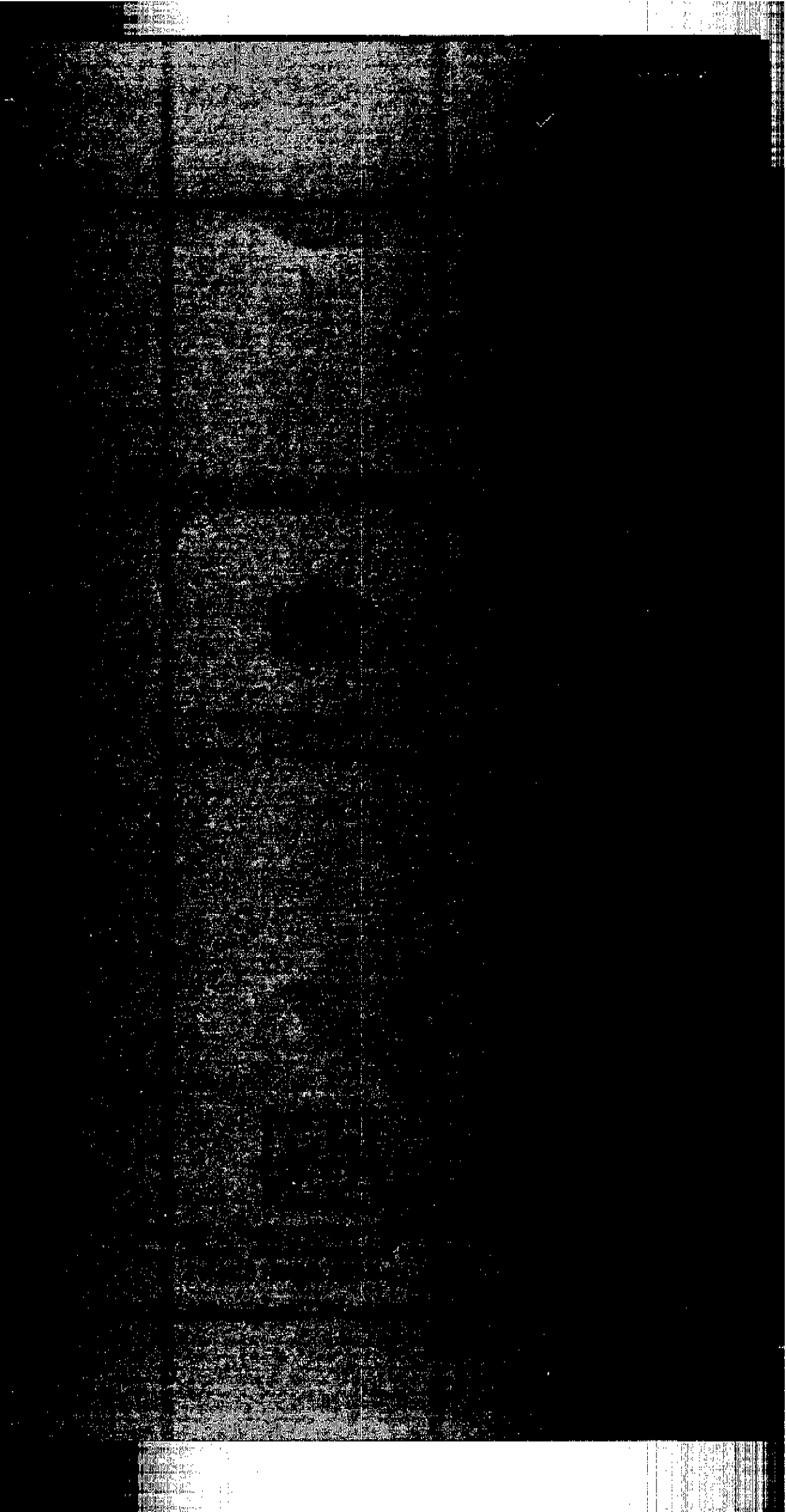

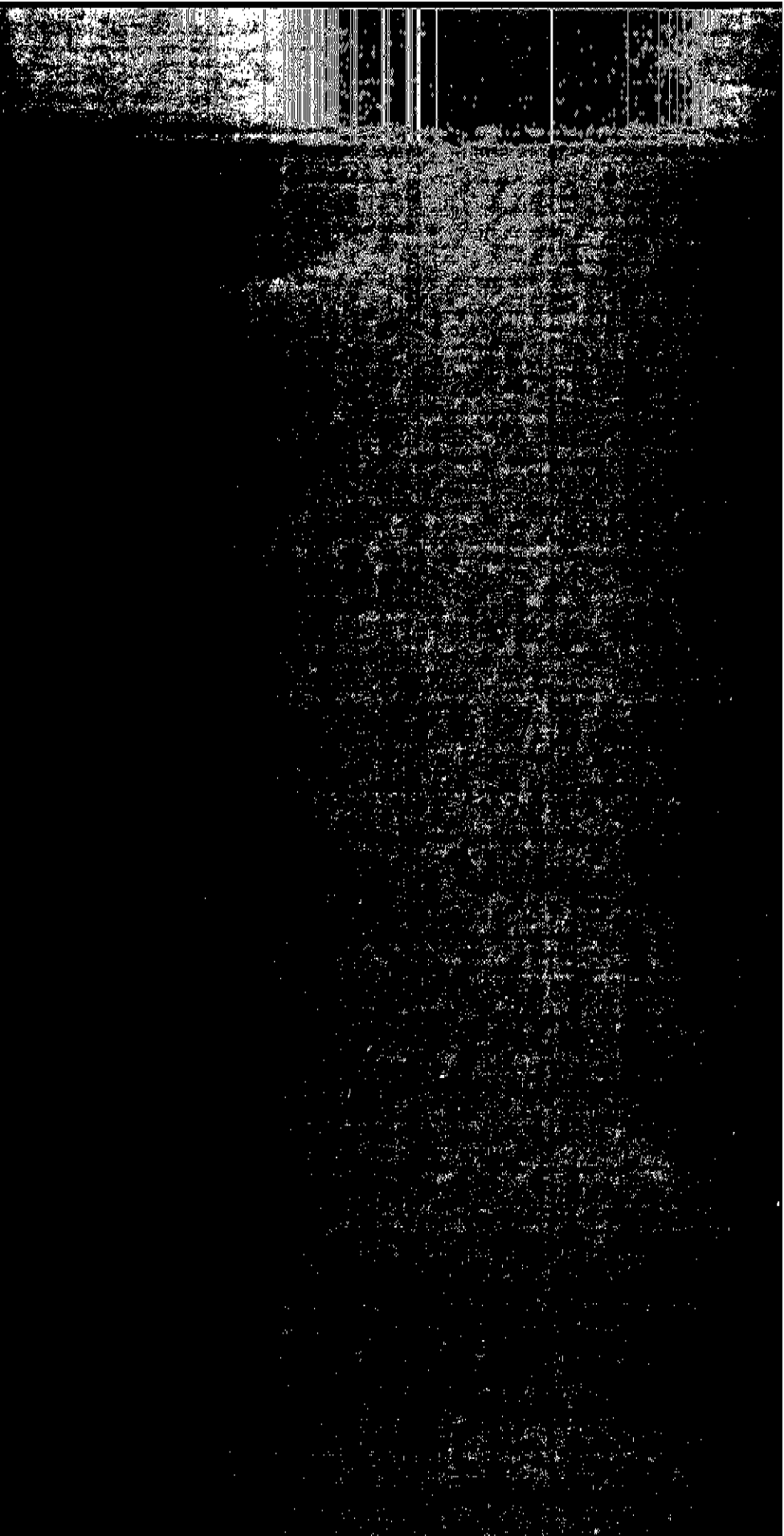

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EXECUTIVE SUMMARY

Violence against women has long been a major concern for women's health and women's human rights advocates. In the last five years it has begun to receive increased attention in the international arena, as a human rights issue and more recently as a public health concern. The Platform for Action of the Fourth World Conference on Women dedicates one chapter to violence against women and makes extensive recommendations for action to governments, NGOs, international agencies and others. WHO recognizes that violence against women constitutes a serious health risk to women, their families and their communities and is committed to defining and taking up its responsibilities in the prevention of violence against women and management of its health consequences. A Consultation on Violence against Women held in Geneva from 5 to 7 February 1996 was the first step in this process. Consultation participants included researchers, health care providers and women's health advocates active in the field of violence against women from several countries, as well as representatives from several WHO programmes.

The Consultation was organized by the Women's Health and Development programme of WHO. It focused on violence against women by partners/ex partners which is one of the most pervasive forms of violence against women. Its objectives were: 1) To review existing information concerning definitional issues, the magnitude of the problem, the health consequences of violence against women and the role of the health sector; 2) to identify gaps in current information and establish priorities for WHO research and action; 3) to determine the most appropriate strategies for research and action to address these issues.

The main recommendations are summarized below:

Recommendations

1. Research

Multi-country study of dimensions, health consequences and risk factors: WHO should undertake a multi-country study on the dimensions and health consequences of and risk factors for violence against women in families. The protocols for this study should be developed by a team of researchers experienced on the subject and involve researchers from those countries where the study will take place. Women's organizations working on violence should be included from the initial stages of the project. WHO should develop and test methodologies for measuring psychological and mental injury from violence in the family.

Review and studies of interventions: WHO should support documentation of effective interventions for prevention and for management of the consequences of violence against women in resource-poor settings.

Research methodologies: WHO should support and collaborate with the International Researcher Network on Violence Against Women in the development of a manual on research and research methodologies for the study of violence against women.

2. Data collection

WHO should set up a data base on the prevalence/incidence and health consequences of violence against women. Researchers, health care providers, advocates and others working in the field should be informed and encouraged to share materials. WHO should commission in-country collaborators to search local university libraries, schools of public health and other centres for unpublished dissertations and other studies to be included in the database.

3. Definitions and classifications

WHD should dialogue with WHO Working Groups for the International Classification of Diseases to re-examine definitions and formulate more precise definitions and classifications for violence against women.

4. Advocacy

WHO should advocate with professional bodies to include violence against women in nursing, medical and other health care curricula. WHO should advocate for appropriate policies and programmes at national level, based on evidence of what works. Public education to promote a change in cultural norms and attitudes that sanction violence against women should be advocated with all other sectors. Internally, WHD should identify other WHO programmes in which violence against women should be integrated. It should promote the full integration of violence against women in the Global Consultation on Violence and Health and any WHO work on issues of violence.

5. Training for health professionals

WHO, along with other international organizations, should support local efforts to develop training manuals that deal with violence against women in families. At a minimum, WHO should (1) compile a list of available training materials and (2) collect and make available free of charge a selection of key resources on violence against women such as training manuals for health care providers and courses on counselling.

6. Collaboration

WHO should collaborate with local women's organizations from the planning stage onwards. It should also establish closer ties with the United Nations Commission of Human Rights' Special Rapporteur on Violence Against Women and with the Committee for the Elimination of Discrimination Against Women.

1 INTRODUCTION

Violence against women has increasingly been recognized in the international arena as a major issue for women's human rights, most recently at the Fourth World Conference on Women held in Beijing in 1995. In 1993 the General Assembly endorsed the UN Declaration on Violence Against Women. More recently there has been a growing awareness of the impact of violence on women's mental and physical health and of the contributions that public health can make to addressing violence. Among the most prevalent forms of violence against women are those perpetrated by intimate partners including the physical, mental and sexual abuse of women and the sexual abuse of children and adolescents.

WHO recognizes the important health consequences resulting from all forms of violence against women. The Women's Health and Development programme (WHD) has ongoing activities addressing some of these issues such as its work on prevention and elimination of female genital mutilation and on women's health in conflict and refugee situations. It seeks to expand its response to include activities addressing the consequences of violence against women, particularly by partners, and rape and sexual violence against adult women and adolescents. This work is coordinated by the Women's Health and Development programme in Family and Reproductive Health but is undertaken in collaboration with other programmes in WHO. This consultation is the first step in the development of WHD's work on violence against women in families/by their partners.

Consultation participants included researchers, health care providers and women's health advocates active in the field of violence against women, from the Netherlands, Norway, the Philippines, South Africa and the United States. Within WHO, the divisions of Emergency and Humanitarian Action; Family and Reproductive Health; and Mental Health and Prevention of Substance Abuse were represented.

Participants discussed definitional issues, the magnitude of the problem and research. They reported on the current knowledge base and identified areas for further action.

They also discussed health care interventions that address violence against women. Participants from South Africa and the Philippines discussed their work in the community and health sector, and in a women's crisis centre, respectively. Other experiences shared were of participatory research and action in collaboration with local women in Liberia and of the Pan American Health Organization's (PAHO) multi-country effort on violence against women in Latin America.

The final day was dedicated to formulating and refining recommendations for WHO action.

This report brings together information from the consultation presentations and discussions and draws upon the materials that participants contributed to the meeting. Recommendations for WHO are presented in Section 8.

2 AIM AND OBJECTIVES OF WHO'S VIOLENCE AGAINST WOMEN INITIATIVE

WHO's aim in the area of violence against women is to work with others to identify effective strategies to prevent violence and to decrease morbidity and mortality among women victims of violence. The specific focus of this initiative is to define the role of the health sector in prevention efforts and in the management of the health consequences of violence against women by their partners. This consultation was the first step in advancing the following objectives:

- Increase the level of knowledge of the magnitude of the problem and its health consequences;
- Identify appropriate prevention and intervention strategies that can reduce the prevalence/incidence of violence against women by their partners;
- Improve the capacity of health care providers at all levels to identify and care for victims of violence against women;
- Support the formulation by governments of adequate policies and protocols to address this issue;
- To serve as an advocate within WHO, other organizations and health professional associations for greater recognition of violence against women and its implications for health policies and programs including reproductive health, injury prevention, mental health, substance abuse and HIV/AIDS prevention.

2.1 Objectives of the consultation

The objectives of the consultation were to:

1. review existing information concerning:
   - definitional issues,
   - the magnitude of the problem,
   - the health consequences of violence against women in families/by their partners, and
   - the role of the health care sector in addressing violence against women;
2. identify gaps in current information and establish priorities for WHO research and action;
3. determine the most appropriate strategies for research and action to address these priorities.

2.2 Scope of the initiative

The group agreed that a focused effort, concentrating mainly on a particular facet of violence against women, could best be concretized into actions. To this end, participants made the following recommendations:

1. WHD's current initiative should emphasise "adult women" with the knowledge that this term has culturally specific meanings and is tied, not to a particular age group, but rather to conditions wherein women are expected to take on the sexual, physical or emotional characteristics of adults, i.e. conjugal relationships.

2. Violence towards adolescent girls should also be addressed and adolescents of both sexes need to be involved in prevention activities. WHD should encourage and seek collaboration with the Adolescent Health and Development programme in this area.

3. Children of victims of violence are also at risk and are a critical group for primary prevention. This area might best be addressed through other divisions of WHO that could work in collaboration with WHD.

4. Physical, sexual and emotional violence by male partners and ex-partners should be central to this initiative. In addition, other intra-familial violence such as physical assaults by parents-in-law and sexually coercive relationships within the family (e.g., abuse of women domestic servants, some of whom are migrants, by their employers) and rape and sexually coercive relationships outside the family (e.g. "sugar daddies") are pertinent, particularly for their reproductive health consequences.

5. Violence against women that is perpetrated or condoned by the State and violence occurring in the community* will be analyzed and work in this area developed within other consultations and fora as feasible and appropriate.

3 DEFINITIONS AND CLASSIFICATIONS

There is no universally accepted definition of violence against women. Some definitions argue for a broad delineation that includes any act or omission that causes harm to women or keeps them in a subordinate position. This would include what is sometimes referred to as "structural violence", for example, poverty and unequal access to health services and education.

The benefit of a broad definition is that it places gender-based violence in the broader social context (Richters, 1994) and allows interested parties to bring attention to many breaches of women's human rights under the rubric of violence against women. The drawback may be that by creating far-reaching meanings, a definition's descriptive powers are lost. "Structural violence" might, therefore, be better dealt with as an issue of discrimination (Heise et al, 1994).

The group agreed that a definition such as the one already adopted by the General Assembly in 1993 in the United Nations *Declaration on the Elimination of Violence against Women* provides a useful framework, but more specific operational definitions will be needed for the activities of WHO. The declaration defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual

* The UN Special Rapporteur on Violence Against Women, in her preliminary report dated 22 November 1994, identified three areas of violence against women: in the family, in the community and that perpetrated or condoned by the State.

or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Violence against women encompasses, inter alia, "physical, sexual and psychological violence occurring in the family and in the general community including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment, and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state."

The need for operational definitions for research and monitoring was identified by the participants, who also recognised that the task of formulating such definitions lay outside their mandate. Rather, the group identified developing operational definitions and international classifications as two distinct areas of work for WHO.

3.1 Operational definitions

Cross-cultural applicability

In the context of international studies, it is important to devise operational definitions that encompass the cultural diversity of violence against women in families. All societies have forms of violence that are socially proscribed and others that are tolerated, or at times encouraged, by social customs and norms. Whether socially condoned or not, these acts and their effects on women's health, need to be recorded. Furthermore, basic differences such as language and legal diversity should also be accounted for in operational definitions and those proposed for international accreditation.

Anthropologists contend that violence against women might best be defined by those who are the victims or observers, not by the perpetrators, as for example, with the Yanomanï people of Brazil. In this culture wife beating has defined meanings that seldom reflect negatively on the men. Nonetheless, women consistently demand an explanation for intended beatings and insist that the explanations given are unfounded and the beatings undeserved. If asked in advance about a beating, women will invariably wish to avoid it (Richter, 1994). Accordingly, addressing only culturally unacceptable forms of violence fails to meet the full spectrum of women's needs. Definitions should register the effects of violence on women's physical, sexual and emotional well-being, as well as the acts themselves.

Terminology

Many terms and phrases have been used to refer to violence against women within the context of family, home or intimate relationship. Neutral terms such as domestic assault, family violence and spouse abuse obscure the gendered reality of abuse. Terms like wife assault, wife battering and woman abuse either exclude the experiences of many women who are not legally married, or as in the case of woman abuse, do not differentiate between violence from known and unknown perpetrators.

Violence against women by their partners articulates the gendered nature of violence and is not limited by legal sanction. It includes psychological and sexual violence, as well

as physical assault. Participants cautioned that this term should be clarified as to whether same-sex partners are included.

Violence against women in the family, a more encompassing term, includes, in some cultures, women who are employed as domestic workers, either as migrant workers or within their own country, and are considered a part of the family that employ them. Many of these women are violated by their employers.

The UN Special Rapporteur on Violence Against Women uses the terms "domestic violence" and "violence against women in the family". Pointing out the exclusionary nature of the term "family", she insists that family be conceptualized broadly as "any unit where the individuals concerned feel they are a family." She also points out that although domestic violence is a neutral term, in the vast majority of cases it is a gender-specific situation of men violating women. When women do strike out against men within families, it is usually in self-defence (UN/ECOSOC, E/CN.4/1996/53).

Defining acute and chronic acts

Researchers and health care providers need an objective scale to measure incidents of violence against women in families. Measures should assess physical, sexual and psychological violence. They should include, inter alia, relationship between victim and perpetrator, weapons used, location of the incident, frequency of the abuse and coercive tactics involved. Some health care providers and researchers express concern about including emotional violence within this context because it is difficult to quantify reliably or even to define. Others question the validity of a psychological component in the belief that it minimizes the "real" violence of physical acts. Participants agreed that despite any measurement difficulties, psychological/mental violence should be included in work on violence against women as it is integral to women's health and quality of life.

Recommendations:

- *WHO should develop gender and culturally sensitive operational definitions for violence against women in families/by their partners that are relevant to the specific tasks undertaken by the Organization (e.g. advocacy, research).*

- *WHO should recognize psychological/mental abuse as integral to violence against women in families and develop and test a methodology for measuring it.*

3.2 International reporting standards

Reporting standards influence work on many levels. Individual women victims of violence are more likely to receive appropriate services if providers accurately identify them and record information in a systematic manner. At community and national levels, data can be used to stimulate changes in health care, legal and social service systems. At an international level, consistent and accurate reporting is needed to strengthen advocacy work.

WHO classification texts* are used globally to classify deaths, diseases and disabilities, particularly in hospitals and out-patient clinics. The US Centers for Disease Control and Prevention (CDC) are currently developing standardized definitions to be used for surveillance of violence against women in the United States.

Anthropologists and women's health advocates have identified an inherent difficulty with attempts to create international classifications: concepts of violence against women vary profoundly across cultures. Diversity exists in peoples' experiences of their own bodies, in the self, in relation to the community, and in the meanings placed on experiences and emotions. Because universal classification systems cannot fully account for the variance that exists between cultures the group suggested they should be used with caution.

Recommendations:

- *WHO should advocate for and guide gender and culturally sensitive changes to international definitions and standards.*
- *WHO should revise the ICD series to better acknowledge the diversity of violence against women and the ensuing health problems. Classifications should reflect this diversity to the extent possible.*
- *WHO should strive to ensure classification compatibility between future revisions of the CDC system, the DSM-IV and ICD classifications.*

4 SCOPE OF THE PROBLEM

4.1 Magnitude

Although reliable population-based data on violence against women by their partners are scant, particularly for developing countries, a growing body of of research confirms its pervasiveness. Approximately 40 valid, population-based quantitative studies indicate that 20-50% of women are victims of physical violence by their partners/ex-partners. On average, 50-60% of women who experience physical violence from their partners are sexually abused by them as well (Heise et al, 1994). Table 1 summarizes some of this data.

From population based studies plus other research based on convenience samples we do know that:

- the perpetrators of violence are almost exclusively men;
- women are at the greatest risk of violence from men they know;

* International Statistical Classification of Diseases and Related Health Problems (ICD-10), the International Classification of Impairments, Disabilities and Handicaps and the International Classification of Mental and Behavioural Disorders. (Another classification system, the Diagnostics and Statistics Manual (DSM-4), originally designed for use in the United States but now intended for international use, roughly parallels the ICD-10.)

- women and girls are the most frequent victims of violence within the family and between intimate partners;
- physical violence in intimate relationships is almost always accompanied by severe psychological violence and verbal abuse;
- violence against women by their partners cuts across socio-economic class (SES), religious and ethnic lines;
- men who batter also exhibit profound controlling behaviour, sexual jealousy and possessiveness;
- almost universally, the response of professionals and social institutions has been to blame the victim;
- violence against women can result in long-term mental, physical and sexual health problems (Heise et al, 1995).

Table 1 Percentage of women who report being hit by an intimate partner

Industrialized regions		**Asia and the Pacific**	
Belgium	25	India	22-75*
Canada	25	Korea	38[a]
Japan	59*	Malaysia	39[a]
Netherlands	21	Sri Lanka (urban)	60*
Norway	25	Papua New Guinea	
New Zealand	17	urban	58
United States	28	rural	60
Latin America and the Caribbean		**Africa**	
Antigua	30	Kenya (Kissi District)	42
Barbados	30	Zambia	40*
Chile (Santiago)	26	Uganda	46*
Costa Rica	54*	Tanzania	60*
Colombia	20		
Guatemala	36*		
Ecuador	60*		
Mexico	34*		

* Study was based on a non-representative sample and cannot be generalized to the country as a whole.

[a] Percent beaten within 12 months prior to interview date.

Source: Survey data compiled by the United Nations Statistical Office, as cited by L. Heise in her presentation.

Inconsistency in definitions contributes to the scarcity of comparable studies. Some studies examine only physical abuse, while others consider physical, sexual and mental abuse. Severity of violence recorded also varies between studies. For example, one researcher may record violence more damaging than slaps or shoves, while another may define physical abuse as any force great enough to cause bodily injury.

Another difficulty in assessing the full magnitude of violence is under-reporting. Women have many reasons for not reporting incidents of violence including, for example, because:

- legal authorities often do not take appropriate action;
- women do not know their legal rights;
- women may be revictimized, either by insensitive, accusatory questions or by actual assault, including within health sectors.

There was general agreement among participants that given a safe environment, most women are willing, and often eager, to disclose and discuss their experiences of violence.

Finally, health care facilities and police that do record data on violence against women often do so inconsistently or do not track the sex of perpetrators or their relationships to victims. Although the exact extent is impossible to determine, estimates suggest that there is consistent under-reporting of violence against women within legal systems. Health care facilities are also likely to under-recognize the extent of violence against women.

4.2 Health consequences

Violence against women in families dramatically increases their risk of poor health. Studies exploring violence and health consistently report negative and far-reaching effects, the true extent of which is difficult to ascertain because of the largely invisible nature of the crimes. An analysis in the World Bank's *World Development Report* (1993), estimating the healthy years of life lost* due to different causes, concludes that between 5% and 16% (depending on the region) of the healthy years of life lost to women of reproductive age can be linked to gender-based victimization, rape and domestic violence.

Participants agreed that conceptualizing violence against women, not as a health problem, but as a risk factor for ill health would discourage the tendency by many health providers to use a disease model and treat symptoms only. When addressed as a risk factor, the focus of treatment shifts to address the underlying violence. Table 2 outlines some of the health consequences of violence against women in families.

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* For the World Bank analysis every year due to premature death was counted as one disability-adjusted life year (DALY) and every year spent sick or incapacitated as a fraction of a DALY, with the value depending on the severity of the disability (World Development Report, 1993).

Table 2 Health consequences of violence against women

Nonfatal outcomes

Physical health outcomes:

- Injury (from lacerations to fractures and internal organs injury)
- Unwanted pregnancy
- Gynaecological problems
- STDs including HIV
- Miscarriage
- Pelvic inflammatory disease
- Chronic pelvic pain
- Headaches
- Permanent disabilities
- Asthma
- Irritable bowel syndrome
- Self-injurious behaviours (smoking, unprotected sex)

Mental health outcomes:

- Depression
- Fear
- Anxiety
- Low self-esteem
- Sexual disfunction
- Eating problems
- Obsessive-compulsive disorder
- Post traumatic stress disorder

Fatal outcomes

- Suicide
- Homicide
- Maternal mortality
- HIV/AIDS

Flavia from the Bombay Women's Centre illustrates the effects of violence on one woman's mental health:

> *"...In fact the body mends soon enough. Only the scars remain... But the wounds inflicted upon the soul take much longer to heal. And each time I re-live these moments, they start bleeding all over again. The broken spirit has taken the longest to mend; the damage to the personality the most difficult to overcome", (Asian and Pacific Women's Network:176, as cited in Richters, 1994).*

Participants warned that the limitations of certain mental health diagnoses such as post traumatic stress disorder (PTSD) need to be recognized. They should be used with caution in situations where critical social and political dimensions may vary from the originating culture. They also expressed concern that PTSD places emphasis on women's disordered responses to violence and diverts attention away from the problem source - men's disordered behaviours. Their conclusion was that men's violent behaviours should be categorized and documented as an abnormal behaviour in international classification texts. Another participant agreed that this problem existed but could be eased if the

medical profession used PTSD in a responsible manner, as a tool to help women understand their behaviours and feelings. Only when such terms are used to pathologize women and, at the same time, neglect underlying violence do problems arise.

Sexual and reproductive health

Dr Berit Schei in her presentation addressed the consequences of violence against women on their sexual and reproductive health.

Existing research draws consistent correlations between violence and women's decreased sexual and reproductive health and well being. Gynaecological problems, pregnancy complications, HIV, STDs, unwanted pregnancy and sexual dysfunction have all been associated with violence against women.

Gynaecological problems and sexual dysfunction

Medically treated pelvic inflammatory disease (PID) has been correlated with living with an abusive partner. Researchers conclude that further investigation is required to confirm the validity of these findings (Schei, 1991).

Strong associations have been found between pelvic pain in women and violence by their partners. Repeated physical violence by a partner is likely to cause organic changes that create pain, both from traumatic and infectious origins. Violence may also cause tissue damage and facilitate infections with endogenous flora. Stress that accompanies living with a violent partner may cause pelvic congestion, a further contributor to pelvic pain (Schei & Bakketeig, 1990).

During her presentation, Dr Schei also referred to women's difficulties in maintaining their reproductive health. Some women report experiencing flashbacks, acute pain and other negative responses during pelvic examinations which may be the consequence of prior experiences of sexual or physical abuse. This area requires further research.

Other problems include lack of libido and difficulties with achieving orgasm (Schei & Bakketeig, 1990). The emotional repercussions of rape and other forms of violence can interfere in women's abilities to have fulfilling sexual lives for years after even a single incident.

Pregnancy complications

Violence against women in families does not abate during pregnancy. One woman describes her situation:

> *"I used to be raped many times a day, also during pregnancy. But what I found most disturbing was being raped after the onset of contractions just before I had to go to the clinic to deliver the baby" (Schei & Bakketeig, 1990).*

Violence against pregnant women may result in miscarriage or perinatal death, as these studies indicate:

- women who are battered during pregnancy, as compared to those who are not, run twice the risk of miscarriage and four times the risk of having a low-birth-weight baby;
- in one inner city county in the U.S., over a 4-year period, trauma was the leading cause of maternal deaths, accounting for 46% of the total;
- women who are victims of violence are three times as likely as non-victimized women to begin prenatal care in the third trimester;
- research in Santiago, Chile revealed that socio-political violence correlated with a 500% increase in risk of pregnancy complications, e.g. premature labour, hypertension. It is reasonable to conjecture that living in a home where violence is a constant threat would produce a similar or more drastic aftermath (Heise, 1994).

HIV, STDs and unwanted pregnancy

The violent behaviours of rape, forced prostitution, and refusal to use condoms, interfere with women's abilities to control their sexual and reproductive lives (Campbell et al, 1995). This puts women at increased risk of contracting HIV/AIDS and other STDs and of unwanted pregnancy.

Rape that occurs prior to marriage carries an additional liability in some cultures where virginity is essential to maintaining the honour of young women and their families. A young woman's loss of virginity, for any reason, can be as devastating a trauma as that suffered from the actual violation. To save their daughter's and their own honour, families are known to seek surgical repair for a damaged hymen, creating further health risks, and at times even to kill the woman.

Recommendations:

- *WHO should investigate culturally sensitive ways to manage the health consequences of violence against women in families/by their partners.*

- *WHO should investigate ways to quantify aspects of mental health as they relate to violence against women in families/by their partners.*

- *WHO should document the consequences of violence against women on women's physical/mental and sexual and reproductive health.*

4.3 Impact on health care systems

Studies consistently report that violence against women in families is a substantial burden on health care systems globally. A few examples were offered:

- Domestic violence is the leading cause of injury to women in Alexandria, Egypt, accounting for 28% of all visits to area trauma units;
- In Papua New Guinea, 18% of all urban wives surveyed had received hospital treatment for injuries inflicted by husbands;

- One major U.S. study found that:

  - a history of rape and/or domestic violence was a stronger predictor of physician visits and outpatient costs than was any other variable, including age and cigarette smoking;
  - victimized women sought medical attention twice as often as non-victimized women in the study year;
  - medical care costs of women who were raped or assaulted were 2.5 times higher than the costs of non-victims (L. Heise, presentation).

Violence against women contributes to an escalating drain of health system resources that might otherwise be utilized for the community as a whole. Often victims present with vague somatic complaints that are difficult to diagnose and treat. Unidentified victims may become over-medicated, repeat users of health services. Furthermore, some research suggests that violence against women by their partners tends to escalate in frequency and severity over time and may lead to homicide. These increased levels of violence will further burden the health care sector.

4.4 Data collection

A systematic collection of global statistics and information on violence against women and its consequences to their health would be beneficial for, inter alia, researchers planning future studies, health care providers planning training programmes and designing protocols, and advocates lobbying government for progressive change.

Clearinghouse

There are a small number of national clearinghouses on violence against women, mostly in industrialized countries. However, the group was unaware of any systematic attempt to form a global clearinghouse. Participants acknowledged that a global clearinghouse on violence against women would be helpful for anti-violence work. Nonetheless, it requires substantial space, human and financial resources and would not be an appropriate priority for WHO at this time.

Many organizations that engage in anti-violence work operate under extreme financial constraints. Any organisation taking on the clearinghouse function should make accessibility a priority issue and ensure that their information is available to these groups.

Central database

At the moment, there is no comprehensive collection of data that is readily accessible to the public. The Health and Development Policy Project (HDPP) in Washington D.C., USA, has, perhaps, the most extensive collection of existing data from developing countries, but the data are not computerized or easily accessible to others.

WHO has already begun to investigate setting up a database on the incidence, prevalence and health consequences of violence against women. Participants agreed that this would provide a source of statistical information and a resource on the health aspects of violence against women. The HDPP register could serve as a basis for a more systematic efforts in this area.

A comprehensive collection should include references to published journal and magazine articles, text books and grey literature (i.e. unpublished works) from university libraries, psychology departments, schools of public health, WHO collaborating centres and Ministries of Health.

Recommendations:

- *WHO should investigate the establishment of a global data base on violence against women at WHO, coordinating with the Gender Statistics Programme of the UN Statistical Office.*

- *WHO should commission in-country collaborators to search local university libraries, psychology departments, schools of public health, collaborating centres and Ministries of Health for unpublished dissertations and other studies for inclusion in the database.*

- *WHO should inform researchers, health care providers, advocates and others working in the field of the database project so that current and future materials will flow into WHO.*

- *WHO should produce occasional publications summarizing current data and ensure they are available free of charge.*

- *WHO should ensure that its materials on violence against women are also available through the International Women's Tribune Centre which distributes a variety of materials free of charge to women's NGOs.*

5 RESEARCH AND RESEARCH METHODS

Much of current research on intra-family violence against women emanates from sociology and criminology perspectives (e.g. who is victimized, what acts are committed). Multi-disciplinary research in the field would provide health care providers and policy makers with a better grasp of the scope and depth of the issue.

One of WHO's comparative advantages is its epidemiological research expertise and its experience and competence in executing multi-country studies. Participants agreed that WHO should employ its expertise to build a firm base of knowledge on violence against women to develop guidelines for progressive change in legal, health care, educational and police systems. The group identified an extensive set of research criteria, including ethical and safety issues, as critical to WHO activities. These are presented below.

Participants emphasized the need to combine quantitative research with qualitative methods, recognising that qualitative research provides a rich data source upon which to build an understanding of women's experiences of violence in their families. Focusing on a small number of people, researchers gather extensive information pertaining to women's lives and the meanings they give to events.

Participants also examined the need to adopt a cross-cultural perspective and a participatory approach in research on violence against women. In her presentation on methodological issues for cross-cultural research, Dr Annemick Richters explained that anthropology takes as its point of departure that "the purposes and meanings of acts of gender violence vary and are largely a function of the culture in which they occur. Anthropological case studies elucidate the cultural, political and economic dynamics of gender relations and sexual behaviour. Studies are also used to document interventions and indigenous protective and preventative strategies that may then be used as prototypes for intervention planning."

Participatory research is designed to enable people to actively participate from the earliest design stages, all the way through to controlling resulting data and governing its uses. It can, in and of itself, generate social and political change. By involving those people who are the focus of the research, it provides maximum benefit for communities, both from the process and the outcome. While the process is lengthy and possibly resource consuming, participatory research is likely to lead to sustainable changes in values, attitudes and behaviours. Such research also increases the pool of experts within local populations and discourages dependence on industrialized countries that hold the majority of research resources.

Participants cautioned against focusing solely on women as victims. Women are also survivors of violence and, as such, have positive attributes. Women and women's communities have strengths that need to be recognized. Research on violence against women that also inquires about women's strengths may double as intervention. Women's articulation of their positive attributes may help to counter some of the negative psychological effects of violence.

Participants recommended that in their work on violence against women, WHO should ensure that:

- research is directed by people who have extensive experience in the field of research on violence against women;
- grant review boards include people who have extensive experience in the field of violence against women;
- extensive and explicit efforts are made to seek out such people.

WHO research on violence against women should:

- be coordinated in WHD and should be gender and culturally sensitive;
- ensure that ethical, safety and legal issues are adequately addressed (Section 7.1, 7.2, 7.3);
- be interdisciplinary, combining quantitative and qualitative methods and different epidemiological designs;
- as much as possible, use an action/participatory research model for interventions and involve women at local levels, both as learners and teachers in the process;
- take place in a variety of settings, particularly on interventions, e.g. urban/rural, with/without services and be designed with consideration for its varying impact depending on the setting;
- feed results back to local sources.

Recommendations:

- *WHO should compile current research and assess its validity as well as develop new research in order to form a sound technical and empirical base for action on violence against women.*

- *Because of WHO's comparative advantage in research, the organization should mobilize external resources to mount a cross-cultural, epidemiological study on the dimensions and health consequences of violence against women. The protocols for this study should be developed jointly by investigators experienced in research in this field and those who would then have primary responsibility for implementing the study in their country of origin. Women's organizations working on violence should be included from the initial stages.*

- *WHO should fully exploit its research capacity by incorporating qualitative and quantitative methods where possible.*

- *WHO should investigate the meanings that women place on violence and develop guidelines for culturally appropriate services and measures to alleviate violence against women.*

- *WHO should consider PAHO's work in the area of intervention based studies as a possible prototype for further work in this area.*

- *WHO should support NGOs already working in the area.*

5.1 Methodological issues

There was consensus among the group that careful attention to methodological issues is critical to work on violence against women. Because both research and interventions in violence against women contain an information gathering component, methodological issues in the two spheres often overlap, for example, the issue of how to ask women about their experiences of violence (see Section 6.2, Service Provision: Identification, follow-up and referrals by health services).*

Response rates to questions on violence against women appear to be heavily influenced by the approach used, by who is doing the asking, and how the questions are framed (see Annex I).

Guidelines for researchers

Discussions on research guidelines and protocols brought attention to the needs of the many researchers globally who are beginning to investigate violence against women. Often they must develop their own answers to exacting methodological questions, sometimes resulting in data that are unreliable or invalid or that are not comparable across cultures.

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* The report "Research Methods and Violence Against Women: Notes from a Meeting", produced by the Health and Development Policy Project, was identified as one reference for those interested in methodological issues.

As well as making costly mistakes, researchers may also put women at an increased risk of violence, for example, by not ensuring that a woman is alone during a phone interview.

Participants were in general agreement that the need for research guidelines to attenuate unnecessary and costly mistakes should not over-shadow cross-cultural issues.

Recommendation:

- *Guidelines for valid research should be developed. WHO should investigate collaboration with the International Research Network on Violence Against Women (IRNVAW)* on the development and testing of research guidelines. The guidelines should fully integrate a cross-cultural perspective.*

Several issues in need of further research were identified by the group during the discussions, but there was no systematic attempt to identify research priorities. These included, for example: traditional preventative and protective strategies and their impact over time; risk factors for women returning to abusive partners; long-term follow-up of victims of violence against women; longitudinal studies on the frequency and severity of violence; the differences between short- and long-term violent relationships; risks to health providers who deal with violence against women.

6 INTERVENTIONS

Health care interventions can occur at many levels. Primary prevention is designed to stop violence against women before it begins, thus averting health problems. Secondary prevention is aimed at ending existing violence early in the process and preventing further damage. Tertiary interventions are designed to end chronic violence, ameliorate the damaging effects and rehabilitate survivors. Interventions are required at all levels simultaneously. Governments and Ministries of Health should strengthen and coordinate systems for delivering prevention programmes as well as ensuring that relevant resources, such as educational materials, are consistently available at local and national levels.

The discussion focused on interventions in four areas:

- policy making, norm setting and training;
- service provision;
- public education;
- evaluation and research.

* The Health and Development Policy Project, based in Maryland, USA convened a meeting in June, 1995 of researchers, the majority of whom had experience studying rape or domestic violence in particular cultural settings. The group agreed to formalize the collaboration and "develop and field test model instruments for measuring violence in different cultural settings" and to consolidate their collective knowledge into a research manual.

6.1 Policy making, norm setting and training

The issue of **definitions and classification,** discussed in Section 3, is a norm setting function in as much as standardized definitions and classifications form the bases of international norms in reporting and record keeping.

The **legislative framework** is also important and may have a profound effect on attempts to lessen violence against women. Legislative reform must be in keeping with available information and international human rights standards.

International organizations dealing with health may use their expertise and credibility to garner support for anti-violence work. This can be done by advocating with national governments and by providing technical support and policy advice to enable national indigenous organizations to articulate their positions and efforts.

Within **health care facilities** there needs to be an administrative commitment to implement and maintain policies that address violence against women. Administrators and directors must develop protocols and monitor their use, update lists of referral services lists, ensure that employees and volunteers are sensitive to gender-based violence issues and provide training and retraining as necessary.

Standardized training for health care providers and administrators is essential to guide them in their work with victims of violence against women. As far as possible, this should be integrated into existing training programmes rather than creating separate programmes.

Addressing values, attitudes and beliefs, both of providers and of target communities, form the backbone of any effective training programme. Issues to address include:

- providers' negative feelings (inadequacy, powerlessness and isolation which may be more acute in areas with few referral services);
- cultural beliefs: violence by partners is a private or family matter;
- beliefs about victims: women provoke violence, women are able to stop the violence by changing their behaviours, most women who stay with violent partners have masochistic tendencies.

Training manuals are necessary to guide health workers, many of whom are unfamiliar with violence against women issues. Because the diverse manifestations of violence against women are often reflections of cultural values, training manuals need to be tailored to particular environments. It may be useful to compile a list and gather samples of available manuals that may be used as a blueprints for others.

Training should be supplemented with protocols to guide providers to effectively implement what they have learned. These should include: proper procedures for documentation for legal purposes, for future medical consultations, and for statistical purposes; legal, ethical and privacy issues; and up to date information on local referral services. Protocols also need to be culture specific with special attention paid to respecting the rights of women.

Recommendation:

- *WHO, along with other international organizations, should support local efforts to create training manuals for health providers, policy makers and administrators that deal with violence against women. At a minimum, WHO should (1) compile a list of available training materials and (2) collect and make available free of charge a selection of key resources on violence against women such as training manuals for health care providers and manuals on counselling.*

6.2 Service provision

Intersectoral collaboration

Effective health care interventions for violence against women are situated within the community and are culturally appropriate. The health sector, along with other formal sectors (e.g. the police and social services) work in concert with community responses. Health care facilities that first gain an understanding of local beliefs and traditional values from the women in the communities they serve are better able to provide appropriate support.

Consultation participants expressed concern about overreliance on methods imported from industrialized countries (e.g. shelters), in intervention strategies for low-income populations. High cost interventions that are set up in areas that lack the resources to maintain them may be ineffective, or counterproductive.

Examples of approaches that use local culture and traditional customs to end violence against women are:

- In Pakistan, women are using texts from the Koran to support their position that women should not be victimized;
- In some communities in South Africa, men were tacitly permitted to discipline their wives. Local women learned that their traditional cultural values condemn men who beat their wives. They are now promoting these values as a way of working towards ending violence.

Recommendations:

- *WHO should support the development and assessment of health sector interventions for prevention and care that are appropriate and sustainable in resource-poor settings.*

- *WHO should support the necessary research and establish recommendations for minimum standards of health care for victims of violence against women in families.*

- *WHO should assess the effectiveness of community-based and indigenous responses to violence and support those that are beneficial, while at the same time, exposing harmful traditions.*

Identification, follow-up and referrals by health services

Health care facilities are often the only point of contact that women have with state agencies. As such, they are ideally located to provide a crucial link between victimized women and suitable referral services, as well as to provide appropriate health care.

Provisions for **minimum standards of health care** improve services in all areas of health care, and no less so when dealing with the health consequences of violence against women in families.

Health care providers and administrators need training to sensitize them to the issue and protocols for effective implementation of standards. To be most effective, health care providers need to work within a network of services designed to meet the needs of victimized women and their families.

Identification is the first step in providing adequate services to women victims of violence. This may be accomplished by self-identification or detection by health care providers.

Efforts to locate victims of violence by **asking selected women** specific leading questions entails a judgement on the part of the health care provider. Various victim profiles are used to guide the selection. Participants considered that profiles which use factors such as poverty, level of education, socioeconomic status, age and other such categories reinforce the statistics that they are based on because they only look for victims within a certain group of women. This serves to strengthen cultural stereotypes, while at the same time causing victims who lie outside the profile to be neglected.

Participants agreed that a more accurate profile would contain items such as: stories that are inconsistent with injuries; recurrent injuries or ongoing depression; repeated presentation with unexplained somatic complaints; injuries to stomach, abdominal area or breasts in pregnant women. There is evidence that the presence of many physical symptoms, depression, anxiety, and previous suicide attempts are strong indicators of domestic violence (McCauley et al, 1995).

Universal screening, that is including questions on violence as a component of routine medical enquiry, has the potential to identify victims of violence for the purpose of providing appropriate health care and referral and maintaining accurate statistical records on the prevalence and health consequences of violence. Questions may be as simple as: "Is there anything you are not happy about?", "Do you have any problems in your relationship?", "Have you been hit or threatened since the last time I saw you?" Or they may be a series of three, four or more questions that enquire about a partner's behaviours, as well as the woman's own emotional state, e.g. "Are you afraid of your partner?"

Despite the obvious benefits, participants expressed concerns about the widespread implementation of universal screening, particularly where no back-up services exist. They emphasised that only with adequate training and protocols can universal screening be safely implemented. Careless implementation may lead to client abuses ranging from victim-blaming, to breaches of confidentiality, to rape. The group also noted that accessible and appropriate services for victims enable health care providers to make more effective interventions.

In terms of **follow-up and referral**, adequate responses to disclosures of violence can include:

- assuring victims that they are not responsible for the violence;
- counselling women on their available options;
- referring women to appropriate services and helping with initial connections;
- documenting injuries for follow-up visits and statistical purposes, collecting evidence for legal purposes;
- helping women assess their safety, i.e. risks of homicide/suicide;
- supporting women in mapping out safety plans, including gathering essential documents and items, if they want to leave their partners;
- counselling women that violence may escalate and that their children may be in danger of attack.

Several **barriers** may interfere with maintaining standards of care for health services in resource poor areas. First, the volume of clients may be so great, and their needs so urgent, that effective care beyond a basic level becomes difficult. Already over-burdened administrators and providers may see taking on another issues, i.e. violence against women, as beyond their capability.

A second barrier is lack of support services. Sensitive health care responses can have a positive effect on women by reducing their feelings of isolation and self-blame. However, additional services such as counselling, legal assistance and self-help groups provide the kinds of on-going services that victims need. Shortcomings in support services may have a negative effect on providers who begin to feel isolated and helpless because their ability to assist their clients is limited.

Recommendations:

- *WHO should investigate the merits and weaknesses of various methods of identifying women who are victims of violence in families and develop guidelines for their use in a variety of settings.*

- *WHO should develop guidelines on minimum standards that can be adapted to different settings.*

6.3 Public health education

Education is a key tool for public health efforts to end violence against women. Health education is used in many fields such as discouraging the use of alcohol and tobacco and encouraging healthy practices such as breast-feeding and exercise. Public education should be coupled with service provision for women victims of violence.

Public education should be in a form that is accessible to its target group, in the local dialect and in clear and simple language so that it is understandable, even for people with low literacy. Examples given were poster campaigns in Alexandra Township in South Africa that use "in" designs and local celebrities to promote anti-violence.

There may be specific public education programmes tailored to particular groups, such as young children where boys learn non-violent ways to deal with disagreements and girls learn about self-esteem. They may be focused on high risk groups such as children who witness their mothers being beaten or who are beaten themselves. These programmes allow children to talk with peers about the trauma they have experienced as well as to learn about respect for themselves and others.

When public education is geared specifically toward women who are currently with abusive partners, it must be in a way that provides information about available support services. For example notices, possibly with referral numbers or addresses, may be posted in toilets or in women's health clinics.

6.4 Evaluation and research

To date there are few published evaluations on the effectiveness of health care interventions, especially in developing countries. Many facilities do evaluate their own work through user surveys and other methods. Intervention evaluations would be helpful for others who plan to establish new interventions or modify other services in order to accommodate victims of violence against women.

The United States National Research Council will publish a review of all intervention studies done in that country in June 1996. Although this is an American text it may be of some help to those planning interventions in developing countries.

Recommendations:

- *WHO should support the documentation and evaluation of current efforts to improve the health system's responses to violence, particularly in developing countries.*
- *WHO should strengthen current successful violence and health initiatives at the country level.*
- *WHO should promote links between health care professionals and grassroots women's groups dealing with violence against women.*

6.5 Women in their communities

Recognition of the work of women's organizations

In all activities it is imperative to recognize, acknowledge and support the contributions and work of local women's NGOs and grass roots organizations. These women form the backbone of anti-violence movements and have taken the lead in the field despite adverse conditions. It is these women who have pushed the violence-against-women agenda forward to its current levels of importance as a human rights and health issue.

Three participants gave presentations on community based initiatives that address violence against women in Liberia, the Philippines and South Africa. A fourth presentation was on PAHO's multi-country action-research programme in Latin America.

Participatory research and action on violence in Liberia

The community based programme on violence against women in displaced persons camps in Liberia is based on *Training for Transformation*, a popular education model.* The initiating survey, designed and conducted by Women's Rights International and local nurse-midwives, addressed a multitude of issues, only one of which was violence against women. The survey identified violence against women as a major issue for the women questioned and traditional midwives were recognised as the most likely candidates to organize women in their communities.

The *Training for Transformation* problem-solving model was used as a basic tool for change as midwives asked themselves and others questions about their lives and experiences of violence. These discussions provided the basis for the design of a quantitative survey. The research, therefore, became an intervention in and of itself as the midwives developed skills to look at public health problems.

In their communities, interventions of individual women matured to a point where women began to work together to intercede on behalf of women who were violated. Women conceived of a number of strategies, ranging from taking complaints of rape to the village chief to women banding together to confront abusers. Women found that working together for economic reasons, such as tending a communal garden, provided them with a safe place to talk about issues such as violence. They developed a training package based on case studies, poems and other local materials.

In the next stage of development traditional birth attendants will continue the "training for transformation" and pass the model on to other communities. Their ultimate target is to have several TBAs in each village who will take on the role of community organizers.

Another pilot training study is currently under way in several hospitals in Monrovia. Nurses are receiving in-service training on violence against women using the problem-solving training modules. The goal of the training is to implement the same methods of violence intervention in institutional settings as was used within communities.

The Women's Crisis Centre in Quezon City, The Philippines

The Women's Crisis Centre in Quezon City has been providing services to women victims of violence for the past seven years. It grew out of several urgent needs: women were victims of military rape; the U.S. military presence had created large numbers of prostituted women; women were being abused by their partners; women domestic workers were being abused by their employers.

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* *Training for Transformation* is a problem-solving methodology for community development that uses Paulo Friere's popular education model based on "conscientization" of people about oppression and liberation. Popular education encourages people to ask questions first about their own lives and their communities and then find solutions. It promotes collective action as a means for progressive social change.

The core programme of the centre is its Crisis Intervention Program which maintains a variety of services for women. Counselling services include feminist counselling, stress management programmes and support groups and a shelter for assaulted women and their children (the only one in the Philippines that accepts children). The centre incorporates positive traditional practices into their services.

Health services are provided in the form of check-ups and accompaniment to clinics, hospitals and forensic doctors. Legal services include access to a network of lawyers and para-legal workers and staff accompaniment to courts, hearings and other government offices. The Centre works with the Alliance for Women's Health and a network of women's organizations to promote progressive legislative changes, such as anti-rape and anti-domestic violence bills.

The Centre is active in training and education. It has set up programmes on training health care providers on feminist counselling, on how to set up a crisis centre, and on how to form support groups and assertiveness training classes.

Information gained from action research is used to shape the services. The Centre supports the notion that women are not subjects or even participants in research, but are the resources. The guiding principles are: research and interventions should be undertaken together; interventions must begin when a woman reveals abuse in any research activity; and research must be undertaken only when it is beneficial to women's lives and health.

A major issue for the Centre is the need for genuinely collaborative work. Ms Raquel Edralin-Tiglao recounted how members of the Women's Crisis Centre staff were called upon as resources to guide a local hospital's efforts to open a crisis centre. When the work was completed, the government shifted its support from the women-run centre to the hospital-run centre. Ms Tiglao noted that collaboration is necessary to avoid situations where one service competes against another for resources. The expertise at the crises centre could be augmented and reinforced by the hospital, so that each group's strengths are maximized.

Agisanang domestic abuse prevention and training in South Africa

Ms Mmatshilo Motsei, while working as a nurse in a township health centre, realized that women were being hurt by abusive partners and, among those who were employed as domestic workers, by their employers. She wanted to talk to women about their situations but realized that there were no services for them in Alexandra Township (pop. 300,000 in an area of 5 sq km). After conducting a survey to identify the needs of abused women in a health care setting, she set up Agisanang Domestic Abuse Prevention and Training (ADAPT) based at the Alexandra Health Clinic.

Counselling and support systems were developed so that victims of abuse would receive non-judgmental care from well informed providers. The centre is community-based and relies on both indigenous and mainstream healing methods. There is a strong emphasis on traditional women-positive ways of healing and problem solving.

Men also receive counselling at the centre. The centre is planning a volunteer-run men's programme which will offer services for men who wish to better understand their abusive behaviours and work towards ending them.

The establishment of the support centre was necessary to deal with referrals from health care providers. Once it was established, the organizers began a training programme for nurses and other providers. The programme was designed so that participants first dealt with violence that they had experienced in their personal lives. The programme believes this is an essential step in the process, as without it workers' own unresolved issues would interfere in their work with others.

Community-based education aims to address values and attitudes and develop non-violent forms of conflict resolution. The programme uses theatre, education programmes for youth, and dance therapy groups designed to draw out women who are hesitant to participate.

The centre works with public allies, such as the police department and the mayor, to create awareness in the community. It promotes well known South African figures as positive local role models. They speak out against violence against women and help to counter the effects of drug-pushers and other negative influences in the community. It holds radio, television, newspaper and poster campaigns as well as public gatherings and marches. The campaigns use slogans such as "Beating your wife does not build a home" and "Real love knows no violence".

In the area of research and documentation, the centre is involved in studies on violence against pregnant women and dating violence in high schools. It is also conducting a situation analysis of community leaders' attitudes towards violence against women and girls.

The centre is linked to regional and national level activities. A national plan to develop a policy on women's empowerment is under way as is a national strategy on violence against women. A manual, being developed to address the health consequences of physical abuse of women, includes basic guidelines for nurses and general practitioners. It's major focus is on counselling for victims of abuse. There is also a pilot project under way to test the feasibility and usefulness of One-Stop Centres that provide justice, police, health and welfare services under one roof.

PAHO/WHO initiative on violence against women

PAHO's Regional Programme on Women, Health and Development has secured extra-budgetary funds to support a four year initiative in 10 countries to address violence against women as a public health problem.* The project will be executed in close coordination with women's groups that have been at the forefront of the effort to combat intra-family violence against women in the countries of Latin America and the Caribbean. Sites in each country have been selected according to specific criteria, including the presence of at least one community-based organization that has been addressing this issue, the existence of a health service, and a population of no more than 50,000 people.

The purpose of the project is to create coordinated community networks where organized groups, both governmental and non-governmental, come together to design and

* The Swedish and Norwegian governments are supporting the project in the seven Central American countries, the Dutch government is supporting the project in Bolivia, Ecuador and Peru. The Inter-American Development Bank has approved the project for an additional 5 countries beginning in 1997: Mexico, Argentina, Brazil, Dominican Republic and Venezuela.

implement approaches to address the multifaceted aspects of this problem. In particular, the project will seek to strengthen the capacity of the health service: a) to assist battered women who come into contact with the service, and b) to develop ways to identify and monitor women who seek care but do not spontaneously disclose their involvement in a violent relationship.

The project also will review the legal modifications needed to confront intra-family violence against women effectively. In particular, it will review the role of the medical forensic doctor as gatekeeper to the legal system and make recommendations as to how to facilitate women's access to assistance from the judicial sector.

At each site selected for project execution, the first step has included a qualitative research effort designed to identify the process followed by women, ages 15 and over, who are affected by intra-family violence, and the factors that influenced their pursuit or cessation of that process. The study includes in-depth interviews with service providers from the health sector, the judicial, legal and law enforcement sectors, the education sector and community organizations. Most importantly, battered women who have sought a solution to their situation have been interviewed.

The purpose of this study are four-fold: i) to gain insights into the types of actions taken by battered women and the strategies they pursue to find solutions to a problem of intra-family violence; ii) to gain insights into the factors that propel battered women to undertake a search for help or that dissuade them from so doing; iii) to shed light on how battered women perceive the responses encountered in their search for help and solutions; and, iv) to gain insights into service providers' preconceptions and responses to intra-family violence against women.

The findings of this study will provide a springboard for discussing, together with all local social actors, the areas of prevention and treatment which must be targeted to improve the response given to battered women, as well as the best mechanisms for stopping intra-family violence against women in the particular project site.

Ultimately, the project as a whole seeks to stimulate the creation of success stories, based on a process of continuous engagement with specific communities, thus exemplifying ways local social organizations can respond, as individual groups and as a network, to violence as a social and public health problem.

7 CRITERIA FOR RESEARCH AND ACTION

7.1 Ethical issues

Participants agreed that in addition to the usual ethical considerations, the following concerns need to be carefully integrated into all research on violence against women. The issues were raised by the group for WHO's later consideration, but not dealt with in detail:

- privacy and confidentiality are a priority;
- studies need to be presented to participants in such a way as to be honest about the study content, while at the same time, not discourage their participation or increase their risks;

- consideration needs to be given to the impact of research on the use of local resources (e.g. health services, shelters, etc.);
- researchers need to be sensitive to women who experience interviews as distressful, whether or not they have disclosed violence.

7.2 Safety issues

Safety was identified as an essential consideration when gathering information concerning violence against women in families/by their partners. Participant and interviewer/provider safety, as well as the security of data need to be addressed during the planning stages of research and intervention activity.

Participant safety

When women disclose information about violent experiences within their families they may be at an increased risk of violence. Perpetrators of violence may be threatened by a woman's breach of confidence about "family matters" and retaliate with increased levels of violence. Longitudinal study methods pose a particular problem as researchers must deal with the problem of maintaining women's safety throughout two or more interviews.

Strict adherence to stringent standards of privacy and confidentiality can enhance women's safety and increase their rates of disclosure of violence. Researchers and health care providers should ensure that all data are collected in private, that files are never left unattended where they may be read by others and that interviews are conducted in private. Breaches of these standards may occur when health care facilities lack the resources, the knowledge or the will to provide necessary security for their files.

Safety of researchers and health care providers

Dr Shana Swiss, in her discussions of participatory research in Liberia, explained that women researchers and health providers are also at risk, particularly in situations of armed conflict. When interviews are conducted in women's homes, interviewers may be at risk either because of their presence in the private sphere or because of the subject matter of their research. In terms of the public sphere, some communities may not want research results on violence to be made public and may make threats or take actions against health care providers or researchers in an attempt to impede the process. This may be particularly so in rural or isolated areas where staff may have little support. The threat of retaliation may also come from those perpetrators who are being studied. In a study of gang rape on campuses in Canada investigators reported receiving anonymous death threats during their inquires (Heise et al, 1995).

Security of data

Ensuring the safe storage of research data and health files helps to ensure that the data are not destroyed or misused. As well as promoting the safety of the women involved, a security system also secures the information itself. This is particularly so in areas where no prior research exists and people may want to obstruct the release of findings. Careful consideration must be given to when, how and to whom data are released. Women, especially in remote areas, may not want information to be made public, even when names

are not used, because it may cause more violence in their own lives or because they feel shame that their experiences of violation will become public knowledge. These feelings may be exacerbated if there are no referral services to support them.

7.3 Legal issues

Many countries have laws that permit medical and counselling records to be subpoenaed to courts of law. Reports detailing, inter alia, illegal substance use or poor mental health could be used to support, for example, the removal into protective custody of a woman's children.

Mandatory reporting laws requiring that disclosures of child abuse be reported to child protection authorities are also common in many countries. The use of illegal substances or poor mental health, which is often present in women who are victims of violence in their families, may also require reporting to authorities. Subsequent to reporting, a child may be taken into protective custody. In some countries, mandatory reporting laws require health professionals to report if the life of an unborn child is in danger (as may be the case where there is violence against pregnant women).

8 RECOMMENDATIONS AND CONCLUSIONS

Consultation participants made the following recommendations:

8.1 Scope of the initiative on violence against women

- WHO should recognize violence against women by partners/in families as a grave risk to the health of women, their families and their communities and take action.

- Recognizing that WHO cannot meet all of the outstanding needs in the field of violence against women in families, WHD should concentrate its efforts on those areas where it has a comparative advantage and responsibility: research, health policy and setting norms and standards in the health arena.

8.2 Research and research methods

Multi-country study on the dimensions, health consequences and risk factors

The group agreed that because one of WHO's comparative advantages is in research, the Organization should mobilize external resources to undertake a multi-country study on the dimensions and health consequences of and risk factors for violence against women in families. The protocols for this study should be developed by investigators already experienced in research on violence against women and involve researchers from the countries under study. Women's organizations working on violence should be included from the initial stages.

Research on violence against women should be coordinated in WHD and should be gender and culturally sensitive.

WHO should recognize psychological/mental abuse as integral to violence against women in families and develop and test a methodology for measuring it.

Review and studies of interventions

WHO should support documentation of effective interventions for prevention and for management of the consequences of violence against women, including support to local NGOs to work on descriptive studies of interventions.

WHO should support the documentation of experiences of health sector/NGO collaboration to address violence against women.

WHO should consider PAHO's work in the area of intervention-based studies as a possible prototype for further work in this area.

Research methodologies

WHO should support and collaborate on the development of a manual on research and research methodologies for the study of violence against women that has been initiated by The International Researcher Network on Violence against Women.

WHO should provide technical assistance for women's organizations so that they may carry out valid and reliable research at the local level.

WHO should conduct a further meeting focused on research to establish an in depth analysis of methodological issues.

WHO should ensure that research and intervention work accommodates the special conditions relevant to work on violence against women. In particular, WHO should adhere to the criteria presented in Section 7.

8.3 Data collection and dissemination

Data base

WHD should develop an international data base on the prevalence/incidence and health consequences of violence against women, coordinating with the Gender Statistics Programme of the UN Statistical Office. It should inform researchers, health care providers, advocates and others working in the field of the database project so that current and future materials will flow into WHO.

WHO should commission in-country collaborators to search local university libraries, psychology departments, schools of public health, collaborating centres and Ministries of Health for unpublished dissertations and other studies for inclusion in the database.

WHO should produce occasional publications summarizing current data and ensure they are available free of charge.

WHO should ensure that its materials on violence against women are also available at the International Women's Tribune Centre which distributes a variety of materials free of charge.

WHO should support others who undertake clearinghouse activities, at a minimum, by channelling all WHO materials on violence against women into those endeavours.

8.4 Definitions and international reporting standards

WHO should develop gender and culturally sensitive operational definitions for aspects of violence against women in families/by their partners that are relevant to the specific tasks undertaken by the organization (e.g. advocacy, and setting norms and standards).

WHD should dialogue with WHO Working Groups dealing with revisions to the International Classification of Diseases publications. The WHO working groups should analyze the ICD series for negative implications and discriminatory phrasing against women that may be in these texts. They should re-examine definitions and formulate more precise classifications for violence against women in families.

8.5 Advocacy

Internal advocacy

WHD should undertake a systematic review of all WHO programmes and activities in order to identify areas where the issue of violence against women by their partners should be integrated. It should evaluate the efficacy of implementing changes to those programmes identified as in need of such a component and ensure effective integration of the recommended actions.

WHD should promote the full integration of violence against women into the mandate of the Global Consultation on Violence and Health and any WHO work on issues of violence.

WHO's Safety Promotion and Injury Control unit should expand its existing position paper, entitled "Violence and Health" to include adequate reference to violence against women in families. Changes should be coordinated by WHD and include the specific concerns raised in this consultation.

External advocacy

WHO should advocate with professional bodies to have violence against women included in nursing, medical and all health care curricula. National and international health care professional organizations should advocate for the addition of culturally sensitive programmes on violence against women into all their professional training and retraining.

WHO should advocate with national and local governments to promote and support collaboration with local non-governmental and grass-roots women's organizations active in the field.

WHO should advocate for training on violence against women for all professionals, including forensic doctors and others who collect forensic evidence in cases of violence against women, as this is often done in an insensitive manner.

WHO should work to ensure that the WHO/Harvard Collaboration on World Mental Health* adequately integrates concern for violence against women into their activities and that the grant review board includes people with extensive experience in the field of violence against women, recognizing that the report upon which the work is based does not deal with the issue in a comprehensive manner.

8.6 Training and training materials

WHO should identify and define the skills and knowledge that are required for policy-makers, health providers and administrators. Training should be mandatory for those professionals, e.g. forensic doctors, to whom women are likely to self-identify as having experienced violence by their partners.

WHO should advocate with professional bodies to include violence againt women into nursing, medical and all health care curricula. National and international health care professional organizations should advocate for the addition of culturally sensitive programmes on violence against women into all their professional training and retraining.

WHO should develop guidelines for use in the health sector which can be adapted to specific needs, and methods to assess effectiveness of health care provider training.

WHO should identify internal training programmes and modules and analyze their need for a violence against women component. As a minimum start these should integrate information on sensitivity to the issue.

8.7 Public health education

WHO should support the popularization of materials to promote an end to violence against women.

8.8 Collaboration

WHO should position itself within the broadening array of local, national and international entities dealing with violence against women.

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* An influential report on mental health (Desjarlai, R. et al., 1995. World mental health: Problems and priorities in low-income countries. New York: Oxford University Press.) brought the issue of the mental health needs of low-income populations to the attention of the UN Secretary-General who called for appropriate actions within the UN system. The report devotes a short piece to the issue of domestic violence in the chapter on "Women". As a result of the UN call for action, WHO, in collaboration with the Department of Social Medicine at Harvard, is preparing a special programme aimed at the mental health needs of low income populations. This programme, complements the existing WHO Mental Health Programme. The WHO/ Harvard programme intends to fund pilot projects, provide seed money, and support and run operational research.

WHD's activities on violence against women should complement its existing programmes on female genital mutilation, violence in situations of conflict and health consequences of discrimination in childhood.

WHO, in its programmatic work, should collaborate with women's grassroots organizations and local NGOs from the planning stage onwards. The Organization should also establish closer ties with the United Nations Commission on Human Rights' Special Rapporteur on Violence Against Women and with the Committee for the Elimination of Discrimination Against Women.

ANNEX I

SOME METHODOLOGICAL ISSUES IN RESEARCH

Framing the research

The question of how to explain to women the nature of the research in which they are participating, is an ethical issue in as much as researchers must not mislead women as to the nature of a study. With this in mind, investigators must nonetheless be aware that certain words may have a negative impact on participation and disclosure rates. Framing research with terms such as violence and assault could discourage some women from participating, whereas framing the work in the context of women's health or safety issues for women may have less negative connotations and encourage more accurate response rates.

Measurement instruments

Information may be elicited either through written self-reports or personal interviews. The former ask women to read questionnaires and write down their answers. The latter use interviews which are conducted in person or by telephone (where available). Women are asked a set of standardized questions by an interviewer who then writes down the answers that are given. As with other areas of study, researchers investigating violence against women in families must guard against under- and over-reporting. It was the general opinion of the researchers present that personal interviews elicit higher and more accurate rates of disclosure than pen and pencil surveys.

Interviewer selection

In her presentation on research methodology, Dr Jacquelyn Campbell explained that disclosure rates for violence against women by their partners are strongly influenced by who is asking the questions. Campbell reported that some research from the United States suggests that women are less likely to disclose violence when the enquirer is a local lay health provider, whom they fear may breach their confidentiality through "gossip". Professional nurses may obtain higher response rates, possibly because they are already trusted on other personal issues such as pregnancy and childbirth. Nurses who integrate violence questions into regular health inquiries may elicit a higher still disclosure rate possibly because they normalize the topic and because women perceive regular inquiries as a sign of genuine caring on the part of the nurse.

Format of questions

How questions are asked is crucial in any research and particularly so in research on violence against women. Studies that progress from less to more personal questions report higher rates of abuse than those that take a less sensitive approach.

The Conflict Tactics Scale, or a modified version of it, is the most extensively used measure to assess levels of violence. The Scale is based on the assumption that people have difficulties revealing information on violent activities. It is introduced with reassuring statements formulated to normalize the topic (e.g. "all couples have disagreements and this study is designed to discover patterns of conflict resolution"). The introduction is followed

by a series of questions which explore the physical context of violence in families. Inquirers begin by asking about milder tactics and build slowly to investigate severe and ongoing abuse.

This scale is valuable in that it has a proven track record in allowing people to disclose information which they might otherwise be unwilling to reveal, thus giving a more accurate picture of the magnitude of violence against women in families, but it has two disadvantages. First, it does not distinguish between offensive and defensive violence. Because the scale does not reflect the context of women's violence to men, resulting data has been used to support the notion that men and women are equally abused, and that men and women are equally responsible for violence in families. A second weakness of the scale is that it does not reveal the extent of the resulting injuries. As such, the impact of men's violence to women, as compared to women's violence to men, is not revealed.

Questions concerning violence against women may also be imbedded in **women's health surveys** which present violence in the context of health. As in the Conflict Tactics Scale, enquiries begin with benign questions, this time concerning other health matters, and lead into more difficult or trauma related questions about women's experiences of violence.

ANNEX II

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ANNEX III

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