

# Violence Against Girls and Women

**A Public Health Priority**



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# Violence Against Girls And Women: A Public Health Priority

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## International Milestones in Addressing Violence Against Women

### **Convention on the Elimination of All Forms of Discrimination Against Women, 1979**

Guarantees women equal rights with men in all spheres of life, including education, employment, health care, the vote, nationality, and marriage. The Committee on the Elimination of Discrimination Against Women was established to review reports which all countries that are signatory to the Convention must submit on women's status.

### **World Conference on Human Rights, Vienna, 1993**

Vienna Declaration and Programme of Action: Affirmed that women's human rights are a fundamental part of all human rights. The Declaration asserted for the first time that women's human rights must be protected, not only in courts, prisons, and other areas of public life, but also in the home. Progress made in implementing the Vienna Declaration was reviewed at the March–April 1998 session of the UN Commission on Human Rights.

The 1993 UN Declaration on the Elimination of Violence Against Women for the first time provided a definition of violence, and included psychological violence in the definition.

### **International Conference on Population and Development (ICPD), Cairo, 1994**

Affirmed that women's rights are an integral part of all human rights. Stressed that "population and development programmes are most effective when steps have simultaneously been taken to improve the status of women". Women's empowerment was a central theme of the conference. Recommended actions for governments included prohibiting the trafficking of women and children, promoting discussion of the need to protect women from violence through education, and establishing

preventative measures and rehabilitation programmes for victims of violence. ICPD was the first international forum to acknowledge that enjoyment of sexual health is an integral part of reproductive rights. Men's rights and responsibilities toward their partners were noted,

*"Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their sexual lives. Equal relationships between men and women in matters of sexual relationships and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour."*

(ICPD Programme of Action, paragraph 7.37)

### **UN Fourth World Conference on Women, Beijing, 1995**

The Conference Platform for Action recognized that "all governments, irrespective of their political, economic, and cultural systems, are responsible for the promotion and protection of women's human rights". This document also specifically declared that violence against women is one of the 12 critical areas of concern and is an obstacle to the achievement of women's human rights. Section 106(q) states that countries should "integrate mental health services into primary health-care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse, or other abuse resulting from armed and non-armed conflict".

Source: Panos. 1998. *The Intimate Enemy: Gender Violence and Reproductive Health*. Panos Briefing No. 27.

# Introduction

Gender-based violence is recognized today as a major issue on the international human rights agenda. This violence includes a wide range of violations of women's human rights, including trafficking in women and girls, rape, wife abuse, sexual abuse of children, and harmful cultural practices and traditions that irreparably damage girls' and women's reproductive and sexual health.

Although reliable data on the incidence of gender-based violence are scarce, especially for developing countries, there is an increasing body of knowledge indicating that it is widespread and common. It occurs in a broad context of gender-based discrimination with regard to access to education, resources, and decision-making power in private and public life.

In 1993, the *World Development Report* of the World Bank estimated that “women ages 15 to

44 lose more Discounted Health Years of Life (DHYLs) to rape and domestic violence than to breast cancer, cervical cancer, obstructed labour, heart disease, AIDS, respiratory infections, motor vehicle accidents or war.”

Since the Convention on the Elimination of All Forms of Discrimination Against Women was adopted by the United Nations General Assembly in 1979, important progress has been made in establishing gender-based violence as a human rights concern. But much less headway has been made in addressing violence against girls and women as a public health issue. Changes in reproductive health policy-making will be critical to recognizing and addressing the consequences of violence for women's health.



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## The ‘Culture of Silence’

Gender-based violence is universal, differing only in scope from one society to the next. Much of this violence is inflicted on girls and women by husbands, fathers, or other male relatives. The home can be one of the most dangerous places for a woman to be.

Domestic violence exists in a “culture of silence” and denial, and of denial of the seriousness of the health consequences of abuse at every level of society. The fact that domestic violence against girls and women has long been considered a “private” affair has contributed to the serious gap in public health policy-making and the lack of appropriate programmes.

*“All her married life, Kanaka Thilaka used to hide the bruises on her body with her sari. Early this year, her husband made sure she could not afford even a strand of camouflage. Traumatized by years of physical abuse, Thilaka confronted her husband, saying that if he didn’t stop, she would commit suicide. But her husband mocked her by throwing kerosene on her [and burning her]. Today, she’s barely alive and the scars all over her body cannot be hidden . . . ‘My future is gone. All that worries me now are my children,’ she whispers.” (Menon, Subhadra, and Stephen David. 7 December 1995. “Brutal Retaliation.” *India Today*.)*

Given that gender-based violence is so widespread, the relative lack of policy debate and decision-making about it is remarkable (although there have been some encouraging recent policy statements in several Latin American countries, for instance). Moreover, the health consequences of both physical and psychological violence against women have hardly been touched by the public health sector.

Few studies have been made of gender-based violence, partly because of the lack of accurate definitions, but also because it is so seldom reported to authorities. Women have many reasons for not

reporting incidents of violence. Legal authorities often do not take appropriate action. Many women do not know their legal rights. Women have good reason to fear that they will be victimized again, either by insensitive, accusatory questions or by actual assault. It is estimated that more than 60 per cent of rape victims know their attackers. And health care facilities and police seldom consistently record data on violence against women, the sex of the perpetrators, or the relationship of the abuser to the victim.

## Defining Gender-based Violence

The issue must be defined before appropriate measures can be taken. The United Nations Declaration on Violence Against Women provides a basis for defining gender-based violence. According to Article 1 of the Declaration, violence against women is to be understood 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 deprivations of liberty, whether occurring in public or private life”.***

Article 2 of the Declaration presents what the international community recognizes as generic forms of violence against women. The definition encompasses (but is not limited to): physical, sexual, and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry-related violence, marital rape; female genital mutilation and other traditional practices harmful to women; nonspousal violence; violence related to exploitation, sexual harassment, and intimidation at work and in educational institutions; forced pregnancy, forced abortion, and forced sterilization; trafficking in women and forced prostitution; and violence perpetrated or condoned by the state.

Girls and women face systematic discrimination from entrenched power relations that perpetuate the almost universal subordination of females. This leaves them highly vulnerable to being harmed physically, sexually or psychologically by the men in their families and communities.

In developing programmes to address this, the following definition may be helpful:

*“Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportio-*

*tionately. It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community). It includes that violence which is perpetrated or condoned by the state”.*

*- (UNFPA Gender Theme Group, 1998)*

This definition clearly states the social dimensions and root causes of violence against women and girls. Without this understanding of the issue, there can be no focused and responsive policy and programming efforts to deal with that violence.



# Forms of Gender-based Violence and Their Consequences

Violence against women and girls has a direct bearing on their reproductive and sexual health and rights, and is recognized by the World Health Organization (WHO) as a priority public health issue. Dealing with this violence as a public health issue is one of the most pragmatic and effective ways to combat it.

A “life-cycle perspective” recognizes the specific kinds of violence suffered by girls and women at each stage of their life cycle, and their immediate and long-term effects. This throws the problem into high relief, presenting a compelling case for urgent public policy initiatives, particularly in the area of reproductive health.

## Bias in Infancy and Early Childhood: The Case of the ‘Missing’ Girls

Even before girls are born, they suffer from the widely prevalent preference for sons. Societies’ strong preference for male children in some countries has led to female infanticide and selective abortion of female foetuses. In China, a 1987 census survey showed half a million fewer female infants than one would expect, given the normal biological ratio of male-to-female births. The ratio of males to females has been rising since 1982.

Other studies reveal that increased availability of reproductive technology such as amniocentesis and ultrasound has enabled this particular form of gender-based violence. Similar patterns of higher than normal male-to-female sex ratios are found in India and the Republic of Korea.

The cumulative impact of the abortion of females was powerfully demonstrated by Nobel prize-winner Amartya Sen’s groundbreaking work on the “missing women”. The results indicated that male-to-female ratios in China, South Asia, and North Africa were higher than normal. Sen concluded that if these regions had normal

sex ratios, there would be more than 60 million more females alive today.

Closely related to gender-based violence is discrimination that can be life threatening. In poor communities, little girls are often neglected and even denied food, education, and medical care. Data from developing countries indicate that the mortality rate among girls age 1 to 4 is higher than that among boys in the same age group.

## Sexual Abuse of Children and Adolescents

Sexual abuse of children is common, but discussion of it is generally taboo, and facts are therefore difficult to come by. However, indirect evidence strongly suggests that child pornography, child molestation, incest and prostitution are all widespread. For example, evidence of sexual abuse may be extracted from patient records at treatment centres for sex-related diseases, crisis centres, or maternity hospitals. A 1988 study in Zaria, Nigeria, found 16 per cent of female patients seeking treatment for sexually transmitted diseases (STDs) were children under age 5, and another 6 per cent were between ages 6 and 15.

A study based on the records of the Maternity Hospital of Lima, Peru, revealed that 90 per cent of young mothers aged 12 to 16 had become pregnant because they had been raped. The vast majority had been victimized by their father, stepfather, or a close relative. In Costa Rica, an organization working with adolescent mothers reported that 95 per cent of its pregnant clients under 15 were victims of incest.

Sadly, children themselves provide some insight into the prevalence of sexual abuse. In 1991, a Nicaraguan health non-governmental organization (NGO) held a national conference for children participating in the CHILD to CHILD programme, which aimed to train youngsters to be

better child-care providers for their siblings. These children declared that physical and sexual abuse were the health concerns they were most worried about.

U.S. studies confirm that child sexual abuse victims suffer from psychological effects that carry over into adulthood. This psychological trauma is often manifested in physical problems such as pelvic pain, headaches, asthma, and gynaecological problems. These girls also endure long-term damage to their self-esteem, serious depression, and are often unable as adults to negotiate safe sex, or enjoy intimacy and relationships.

A significant link has also been established between childhood sexual abuse and teenage pregnancy. According to U.S. research findings, compared to teens who became pregnant but had not been abused, sexually abused girls initiated intercourse a year earlier and were likelier to use drugs and alcohol. The average age of first intercourse for abused girls was 13.8, as contrasted with the national average of 16.2. And only 28 per cent of these abused teens used birth control at first intercourse.

The schooling of girls who suffer violence in the home is often derailed as well, especially for those incest victims who are expelled from school when their pregnancy is detected.

## Female Genital Mutilation

Harmful traditional practices such as female genital mutilation (FGM) and child marriage also injure young girls. Ironically, women are often the enforcers of these customs.

It is estimated that between 85 to 114 million women and girls, most of whom live in Africa, the Middle East, and Asia, have undergone FGM in one form or another. FGM or “female circumcision” refers to the removal of all or part of the clitoris and other genitalia. Those who perform

the extreme form, infibulation, remove the clitoris and both labia and sew together the two sides of the vulva. This leaves only a small opening to allow passage of urine and menstrual blood. Other forms include removing all or part of the clitoris (clitoridectomy), or the clitoris and inner lips (excision). About 85 per cent of women subjected to FGM undergo one or the other of these less radical forms of the practice.

This terrible mutilation of girls is based on a prevailing social consensus that female sexuality must be controlled, and the virginity of young girls preserved until marriage. Men in these cultures will not marry uncircumcised girls or women whom they view as “unclean” and “sexually permissive”.

*“The memory of their screams calling for mercy, gasping for breath, pleading that those parts of their bodies that it pleases God to give them be spared. I remember the fearful look in their eyes when I led them to the toilet, ‘I want to, but I can’t. Why Mum? Why did you let them do this to me?’ Those words continue to haunt me. My blood runs cold whenever the memory comes back.”*

-Gambia. (Center for Reproductive Law and Policy. 1994. *Violations of Women’s Reproductive Rights: A Selection of Testimonials from Around the World.*)

This rite of passage is not only extremely painful but results in serious mutilation of parts of girls’ reproductive system and may cause infection and death. FGM exposes young girls to high health risks and seriously affects the quality of the rest of their lives.

The medical complications arising from FGM can be severe. The most radical form—infibulation—involves more extensive cutting and stitching and poses significantly higher risks of haemorrhage and infection. The immediate risks of FGM include haemorrhage of the clitoral artery, infection, urine retention, and blood poisoning from unsterile, often crude, cutting implements.

Later complications are mainly due to the partial closing of the vaginal and urethral openings, and include chronic urinary tract infections, repeated reproductive tract infections, and back and menstrual pain. The ability to experience sexual pleasure is effectively destroyed. In some cases complications can lead to sterility, a particularly devastating outcome for these women, whose value is perceived largely in terms of their ability to bear children.

*“Reports from Somalia indicate that shiftas [bandits] used knives to rip open the vaginas of women who have undergone female genital mutilation before raping them.”* (Center for Reproductive Law and Policy. 1996. *Rape and Forced Pregnancy in War and Conflict Situations.*)

## Child Marriage

In many regions of the world where virginity is given a high social value, girls are married off at a young age, often to men many years older. A child bride faces greater health risks and experiences real physical violation and trauma as her young body is forced to deal with early sexual activity and the strains and pains of pregnancy and childbirth.

One of the more damaging results of early child-bearing is vesico-vaginal or recto-vaginal fistulae. This complication, due to prolonged obstructed birth, leads to loss of full control of urinary and/or rectal functions. Given their lack of access to health care, most girls with this condition are unlikely to receive proper treatment. In the worst cases, many are divorced or abandoned and become social outcasts.

## Adolescence

In the hierarchy of gender-based power relations, adolescent females occupy the lowest rung. Their opportunities for self-development and

autonomy are limited due to societies' denying them access to education, health care, and gainful employment. On top of this, many are confronted with sexual coercion and abuse, often starting at a very young age.

Adolescent girls are relatively powerless when dealing with older partners, increasing their risk of infection from STDs and/or AIDS. Many older men deliberately seek out young girls in the mistaken belief that their chances of AIDS infection will be reduced. This behaviour is reflected in the faster-rising rate of infection among girls than boys.

Many teenagers are unable to negotiate for protected sex. Further compounding their vulnerable position is their lack of knowledge of contraceptive methods and lack of access to reproductive health information and services.

Illegal abortions due to sexual coercion and assault present many serious gynaecological problems. Despite restrictive laws, pregnant teens who are desperate often risk the dangers of unsafe illegal abortions. There is evidence that many young women are dying because they are unable to receive proper treatment in time to save them from complications of an aborted pregnancy.

*“Veronica was admitted to the... medical ward with a fever and diagnosis of malaria. ...On Day 14 ... a gynaecologist examined Veronica because she was not responding to anti-malarial treatment... and found her to have large amounts of purulent-smelling vaginal discharge, fever and severe pallor. ... She was transferred to the gynaecology ward with a diagnosis of post-abortion septicemia. She deteriorated with insomnia, persistence of fever, and abdominal pain. ...Veronica, age 18, died on [her] eighth day... [in] the gynaecology ward.”* -Zambia. (Center for Reproductive Law and Policy. 1994. *Violations of Women's Reproductive Rights: A Selection of Testimonials from Around the World.*)

The consequences of rape for female adolescents are especially tragic in many countries where the prevailing conservative social attitude puts a premium on a young girl's virginity. The extent of this is measured by the cruel and unusual punishment that is the fate of girls who are raped.

A study of the consequences of rape for young unmarried girls in rural Bangladesh, for example, highlighted numerous cases of victims beaten, murdered, or driven to suicide because

of the "dishonour" that their rape or illegitimate pregnancy brought on the family. The study found that there are 130 per cent more deaths from injury—suicide, homicide, assault, and complications from induced abortions—among single than among married teenage girls. Similarly, in Alexandria, Egypt, a study of female homicides showed nearly half of the women and girls killed had actually been murdered by relatives after they had been raped.

## 'My Face Was On Fire'

At 16, Nurunnahar was a beautiful young woman with a bright future. But "in 1995, a young boy of my village told me he was in love with me. He got angry when I refused him. One night the boy, along with ten of his friends, stormed into our house and threw acid at my face. It was so painful. I felt as if my face was on fire. I underwent treatment for seven months. It shattered my dreams."

But Nurunnahar did not give up. "I resolved to start a new life no matter if I'm beautiful or not." Now a student at Dhaka Commerce College, Nurunnahar thinks of starting a career but, painfully, very rarely of marriage.

"Six of the accused, out of 11, were acquitted by the court. Two were sentenced to death, but they are planning to appeal to the High Court. I don't know what will ultimately happen, but the acquitted persons are now threatening to kill me."

According to the Bangladesh Women's Legal

Committee, the police recorded 174 similar incidents in the country between April and December 1997. Ten of the victims were girls under age 10 and 79 were between 11 and 20.

Beena, another victim, was attacked when she tried to save her younger sisters from the hands of miscreants. She has recovered after seven operations in eight months, but the acid disfigured her face, neck and part of her chest. She now works with Naripokkho, a women's rights organization, helping acid attack victims share their pain, comfort one another and come to terms with their new reality.

A 1997 investigation into 46 such incidents found that 21 had occurred over either a failed offer of love or marriage, four over dowry, three over either land disputes or past familial enmity, five over conjugal feuds and 13 over other disputes. Most attackers were neighbours of the victims.

-Women's Feature Service. From UNFPA. *Populi*. March 1999.

In Latin America, 12 countries still have archaic laws on the books that allow the rapist to avoid imprisonment if he marries the woman he raped. Even in cases of gang rape, as long as one man offers marriage (often accepted and urged on the woman by her family), all the rapists escape punishment.

*"[We] had no source of income and relatives used to give us some food. I came to know of an agent ... who would arrange jobs outside of Bangladesh .... I was sold for Rs. 80,000 (\$2,000) to Osman .... I had a high price because I was a virgin and the most beautiful." -Bangladesh. (Center for Reproductive Law and Policy. 1994. *Violations of Women's Reproductive Rights: A Selection of Testimonials from Around the World.*)*

## Reproductive Years

Domestic violence is the most common form of gender-based violence. In every country where reliable, large-scale studies on gender violence are available, upwards from 20 per cent of women have been abused by the men they live with.

More recent studies based on research in 35 diverse countries confirm the pervasive pattern of abuse by male partners: one fourth to more than one half of women reported being physically abused by a present or former partner. Significantly, an even larger percentage reported suffering ongoing emotional and psychological abuse, a form of violence that many battered women view as worse than physical abuse.

Often research into this issue is hampered because women are taught to accept physical and emotional mistreatment as a "normal" part of marital relations. Women may therefore understate the level of physical and psychological violence in their intimate relationships.

The other decisive factor in women's reluctance to come forward is the imbalance in the power relations between men and women. Besides the social stigma, women fear incriminating family members, particularly husbands, whom they depend on not only financially but also emotionally. Women who do decide to leave abusive relationships have minimal safety nets and limited opportunities for rebuilding their lives.

*A Cambodian mother told this to her abused daughter who had run away from her husband: "Please go back home. Don't be afraid of your husband, he won't beat you until you are dead. At most, he will just hit you until you are unconscious. If he beats you to death I will bury your bones." (Panos. 1998. *The Intimate Enemy: Gender Violence and Reproductive Health.*)*

Abused women face a host of physical injuries that include chronic complaints such as headaches, abdominal pains, muscle aches, sleeping and eating disorders. Battered women are more likely to experience persistent miscarriages and recurrent vaginal infections. Fearful of using birth control, they are more likely to experience unwanted pregnancies and resort to illegal, unsafe abortions.

Pregnant women are particularly vulnerable to gender-based violence. Some husbands become more violent during the wife's pregnancy, even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage and four times the risk of having a low-birth weight baby. Making matters worse is the fact that a high percentage of women in developing countries have poor health to begin with, due to malnutrition, inadequate health care, and the burdens of the gender division of labour. Other pregnancy complications that may be associated with abuse are pre-eclampsia and premature labour.

## Rape and Coerced Pregnancy

Coerced pregnancy, an extreme form of gender-based violence, is usually a result of rape. Rape victims suffer from both the physical consequences of sexual assault and the equally debilitating psychological trauma. The physical injuries can range from cuts and bruises to broken bones and loss of consciousness. A study of rape victims in Bangladesh found that 84 per cent suffered severe injuries resulting in unconsciousness or even death.

Studies show that rape survivors have high rates of persistent post-traumatic stress disorder and make up the largest single group diagnosed with the disorder. And rape victims are nine times likelier than non-victims to attempt suicide and to suffer major depression. Furthermore, 50 to

60 per cent of the victims experience sexual dysfunction, including fear of sex and problems with arousal.

One of the most serious consequences of rape is unwanted pregnancy. Tragically, these women find little support for their condition and face limited options for dealing with the problem in ways that preserve their dignity and provide them with the necessary medical care. Very often, they are presented with torturous choices of having to either complete the pregnancy or resort to illegal, dangerous abortion methods.

Women who have been raped not only endure the physical and emotional horrors of sexual violation, but face exposure to infection from sexually transmitted diseases including HIV/AIDS.

**Table 1: Health consequences of violence against women**

Physical health outcomes:	Mental health outcomes:
Injury (from lacerations to fractures to internal organ injury) Unwanted pregnancy Gynaecological problems STDs, including HIV/AIDS Miscarriage Pelvic inflammatory disease Chronic pelvic pain Headaches Permanent disabilities Asthma Irritable bowel syndrome Self-injurious behaviour (smoking, unprotected sex) Suicide Homicide Maternal mortality	Depression Fear Anxiety Low self-esteem Sexual dysfunction Eating problems Obsessive-compulsive disorder Post-traumatic stress disorder

**Source:** World Health Organization. *Violence and Injury Prevention: Violence and Health: Violence Against Women: A Priority Health Issue*. WHO Information Kit on Violence and Health.

## Rape in Wartime

The scale and premeditated nature of sexual violence against women and girls in several recent wars has resulted in a major shift in the way International Tribunals on War Crimes regard such acts of violence. In two of the latest tribunals, one focusing on Bosnia and the other on Burundi and Rwanda, mass rape has been recognized and prosecuted as a legitimate crime against humanity.

*“They liked to punish us. They would ask women if they had male relatives in the city; I saw them ask this of one woman, and they brought her 14-year-old son and forced him to rape her.... On [another] occasion, I was raped with a gun by one of the three men already in the room.... [O]thers stood watching. Some spat on us. They were raping me, the mother and her daughter at the same time. Sometimes you had to accept ten men, sometimes three.... I felt I wanted to die... the Serbs said to us ‘Why aren’t you pregnant?’ ...I think they wanted to know who was pregnant in case anyone was hiding it. They wanted women to have children to stigmatize us forever. The child is a reminder of what happened.” -Anonymous, Bosnia. (Center for Reproductive Law and Policy. 1996. Rape and Forced Pregnancy in War and Conflict Situations.)*

## Post-menopausal Years

Women tend to live longer than men and generally have a longer period of chronic disabilities. In many cultures older women are completely dependent on other members in the community for support, leaving them vulnerable to abuse. In cultures where women have low socio-economic status and no property rights the problem is further aggravated. The seriousness of reproductive health morbidity among women in the post-menopausal stage of their life cycle is indicated by the prevalence of breast and cervical cancer, as well as osteoporosis. Moreover, older women

usually suffer from extreme poverty, are exposed to physical abuse, and lack any form of support services catering to their special needs.



# Effects on Sexual and Reproductive Health Decision-making

The trauma of sexual coercion and assault at different stages of their life-cycle leaves many women and girls with severe loss of self-esteem and autonomy. This, in turn, means that they do not always make the best sexual and reproductive health decisions for themselves. Many accept victimization as “part of being female”.

Early traumatic sexual experiences can result in (among other things) unprotected sex with multiple partners, prostitution, and teen pregnancy. Findings of a community-based study showed that 49 per cent of childhood sexual abuse victims reported being battered in adult relationships. As many as 68 per cent of incest victims reported being the victims of rape or attempted rape later in their lives.

## A Deterrent to Using Reproductive Health and Family Planning Services

A common misconception in many countries is that contraception, because it provides protection against pregnancy, promotes promiscuity among women. Also, many cultures measure a man's virility by the number of children he is able to father. Consequently, a woman's use of contraceptives may be perceived as a threat to her partner's masculinity. Studies from countries as diverse as Bangladesh, Mexico, and South Africa provide strong evidence that fear of abuse from male partners is a critical factor in women's decisions on contraceptive use.

In many countries, the law requires husbands' permission before contraception is administered to women. These women are at increased risk of violence if they use contraception without the approval of their partners.

*“I am about to have my seventh [child]. I do not know how to explain to my husband that I do not*

*wish to have any more. . . . [M]y mind would go racing as soon as I hear him climb into bed . . . and start having sex with me. . . . I don't know how long I can go on producing children for I feel like a baby machine where you press a button and something pops out.” -Fiji Islands. (Center for Reproductive Law and Policy. 1994. *Violations of Women's Reproductive Rights: A Selection of Testimonials from Around the World*)*

According to the NGO Family Planning International Assistance, women in Kenya often forge their partners' signatures rather than risk violence or abandonment by requesting permission to use family planning services. Similarly, focus group discussions on sexuality in Mexico and Peru confirm that women feared violence, desertion, or accusations of infidelity if they proposed using contraception. When family planning providers in Ethiopia stopped requiring spousal consent, use of the clinics' services increased by 26 per cent in a short period of time.

## Sexually Transmitted Diseases

Women's and girls' ability to protect themselves from STDs and HIV/AIDS is drastically weakened by the threat of male violence. Violence increases the risk factor for women by exposing them to forced and unprotected sex. Their ability to negotiate condom use by their male partners is inversely related to the extent or degree of abuse in their relationship.

Many AIDS-prevention strategies are based on negotiated condom use between partners. This relies on the gravely mistaken assumption that there is equality of power between men and women. Even in consensual unions, women may lack full control over their sexual lives. Available studies from Latin America and Asia confirm that women's bargaining power in married life is weakest when it comes to sex and reproduction.

# Effects on the Economics of Reproductive Health and Family Planning Service Delivery

Violence against women and girls puts a strain on the limited resources of most national public health care systems. The culture of silence about the causes of injury and pain suffered by too many women and girls results in an inefficient use of available services, since treatment will only provide a temporary reprieve if the root causes are not addressed directly.

In structural adjustment programmes, reforms in the health sector have focused on streamlining and cost-recovery of services. But many victims of gender-based violence do not receive adequate health care until they are critically disabled—by which time both human morbidity and medical costs are unnecessarily high. Because of this gap in health care in the public health sector, much of the responsibility for the care of abused women has been delegated by default to small women's organizations which have neither the resources nor the capacity to fully meet their needs.

Yet the health sector is uniquely situated to be an open door to aid for the women who have no other contact with authorities who can help them. Health care providers can refer women to other resources, such as legal services, safe houses for battered women, and counselling by gender-sensitive NGOs.

The World Bank has taken action to determine the precise toll of gender violence in the lives of women. The 1993 issue of the *World Development Report* estimated the healthy years of life lost to men and women due to adverse causes. Every year lost due to premature death is counted as one "disability-adjusted life year" (DALY), and every year spent sick or incapacitated is counted as a fraction of a DALY, with the value determined by the severity of the disability.

This analysis indicates that rape and domestic violence are major causes of disability and death

among women of reproductive age in both developed and developing countries. They are risk factors for a number of disease conditions such as STDs, depression and injuries.

In developing countries, it is estimated that rape and domestic violence account for 5 per cent of the healthy years of life lost to women of reproductive age. The percentage is even higher where the overall burden of disease faced by women has been reduced. For example, in China, where the disease burden is on the decline, the healthy years lost due to rape and domestic violence has increased to 16 per cent of the total burden.

Globally, the health burden from gender violence among women age 15 to 44 is comparable to the burden of other risk factors and diseases such as HIV, tuberculosis, sepsis, childbirth, cancer, and cardiovascular disease (see Table 2).

These percentages are important indicators of the demands on the health care system. The physical and mental consequences of gender violence are usually sustained over an extended period of time and require monitoring and close follow-up if they are to be fully and effectively addressed.

The Fourth World Conference on Women, held in Beijing in 1995, specifically endorsed the concept of integrating relevant services for women into primary health care. This implies that the health sector, particularly the reproductive health and family planning sector, needs to more systematically study and respond to the specific health care requirements of victims of gender violence. The economic arguments for cost-effective health service delivery need to take into account the impact of violence against women on women's health. As the pressure for integrating and decentralizing services grows, it will be crucial to create policy reforms that respond to women's specific needs so that appropriate preventive as well as curative programmes are put in place.

**Table 2: Estimated global health burden of selected conditions for women age 15 to 44**

Condition	Disability-adjusted life years lost (millions)
Maternal conditions	29.0
Sepsis	10.0
Obstructed labour	7.8
STDs (excluding HIV)	15.8
Pelvic inflammatory disease	12.8
Tuberculosis	10.9
HIV/AIDS	10.6
Cardiovascular disease	10.5
Rape and domestic violence	9.5
All cancers	9.0
Breast	1.4
Cervical	1.0
Motor vehicle accidents	4.2
War	2.7
Malaria	2.3

Source: World Bank. 1993. *World Development Report 1993: Investing in Health*.



## Policy Reform Process

From the foregoing review of the scope of gender-based violence, it is clear that addressing the issue of gender-based violence and its reproductive health effects requires the concerted effort of governments and civil society as a whole. Programmes will need to incorporate the concept of human rights, recognition of sexual and reproductive rights as human rights, and commitment to gender equity and gender equality as stated in the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women.

Chapter IV of the ICPD Programme of Action specifically pointed out that “experience shows population and development programmes are most effective when steps have simultaneously been taken to improve the status of women”.

Given the clear policy parameters established by the ICPD, the process of legal and health system reform under way should ensure that the following key policy initiatives are undertaken comprehensively and systematically.

**Linking sexual and reproductive health and rights.** Reproductive health professionals are usually the front-line care providers for women and girls who are victims of violence. The consequences of gender violence, such as miscarriages, pregnancy, induced or illegal abortion, and other gynaecological complications, are very much within the domain of reproductive and sexual health. Health care providers, therefore, need to be conversant with reproductive and sexual rights and their application in practice. They also have a critical role to play in monitoring the adherence to nationally adopted international conventions.

Because of the general lack of awareness and sensitivity of many health workers to the health

risks faced by victims of abuse, service providers generally give only minimal support or care. If, however, reproductive and sexual health policy were to explicitly incorporate a reproductive rights perspective, then the neglect of abused women and girls could begin to be addressed. The International Planned Parenthood Federation’s Charter on Sexual and Reproductive Rights is one instrument that helps guide efforts to link reproductive health information and services to women’s human rights concerns.

**Policy-oriented research.** The paucity of country-specific information about the extent of violence against women has been a major barrier for policy-making and programming on this issue. Policy-oriented research would provide the hard facts to establish that this “private” and family-related issue has very public consequences. Findings of such research must be applied to the development of appropriate social support systems, including health care delivery.

**Interagency collaboration.** Addressing gender inequality and inequity, which is the root cause of gender-based violence, will require cooperation across a broad spectrum of government and civil society, including the education, health, trade and labour, economic and social sectors. Such a span of activity goes beyond the capacity of a single organization. Recommendations from international forums provide a framework for agencies to develop complementary programmes. The United Nations Development Assistance Framework and the World Bank’s Sector-wide Approach could be used to help coordinate agencies’ support for national programmes designed to eradicate gender-based violence. One example of such an effort is the Inter-American Development Bank programme against violence, which supports research and advocacy to mobilize commitment in several countries in Latin America.

## End Violence Campaign in Latin America and the Caribbean

In 1997, a wide range of intergovernmental organizations (including UNFPA, the United Nations Development Fund for Women, UNICEF, the United Nations Development Programme, the Joint UN Programme on HIV/AIDS, the Office of the UN High Commissioner for Human Rights, and the Economic Commission for Latin America and the Caribbean) launched a campaign in every country in Latin America and the Caribbean to demand an end to violence against women and girls, as part of a campaign to commemorate the 50th anniversary of the Universal Declaration of Human Rights.

The campaign is intended to reinforce the ideal that every person has the right to live life free of violence, and that there are no human rights without women's rights. Among its achievements were "*The Man and Woman Story*", a television programme in Jamaica on the relations between the sexes; and the inauguration in Quito, Ecuador, of *Casa de las Tres Manueles*, a women's centre for victims of domestic violence.

## Developing National Policy

While numerous international conventions and declarations recognize gender violence as a human rights issue, that recognition has yet to be fully translated into national policy. A case in point is the Convention on the Elimination of All Forms of Discrimination Against Women, which provides a comprehensive framework for addressing gender violence. Thirty countries have yet to sign it; one third of those which signed have lodged substantive reservations; and 24 countries have specifically lodged reservations against Article 16—a core provision that guarantees equality between men and women in marriage and family life.

In order for policy-makers to address gender violence seriously, they must draw up and monitor a well-defined and substantive national gender policy. Violence against women and girls must be understood as a development issue that requires public policy debate and action. Given a specific policy framework, it normally follows that a national strategy is developed to achieve the stated goals. Such a strategy should include

catalytic interventions on behalf of gender equality.

Gender violence is a bona fide development concern, not just a "women's issue" to be addressed mostly by women's NGOs. Governments and institutions therefore need to commit their own financial resources to combatting the problem, instead of relying solely on external donor sources. Strategies to promote gender equality and women's empowerment will be critical to the success of any national development plans. Government institutions and NGOs must work together to change hearts and minds, reform laws, and build up support services such as shelters, hotlines, and crisis centres.

**Legal reform and legislative initiatives.** One strategy for change is to urge the legislative sector to institute reforms that will underscore the seriousness of acts of violence against women and girls. In particular, it is urgent that nations establish the criminality of such abuse, both to prosecute cases and to convict and punish perpetrators.

Many aspects of the legal system are inimical to the interests of women victims of violence, and advocacy is critical to changing them. Some countries, unfortunately, have still done little or nothing to change. Even where legislation on gender violence is on the books, the actual prosecution of perpetrators is far from straightforward.

There are some areas for legal reform that are worth highlighting. Court systems and procedures can be a major hindrance to prosecution. Often the forms of evidence that are required for submission and the process of testifying make it very difficult for women, particularly when they involve husbands and male family members they depend on. Changes in systems and procedures, less politically sensitive, are one place to start the process of reform.

It is important to recognize the legislative momentum generated on gender-based violence, particularly after ICPD and Beijing. However, the enforcement of laws against gender violence remains very inadequate. The key enforcers of the law, including judges, lawyers and police officers, have yet to fully accept violence against women as a criminal act.

*According to a member of the Kenya chapter of the International Federation of Women Lawyers (FIDA), "Most cases die at the police station, where you are prevailed upon by your family, your community and your social and economic standing to drop it." FIDA is campaigning to criminalize wife beating and make it distinct from the general charge of assault. (Panos. 1998. *The Intimate Enemy: Gender Violence and Reproductive Health.*)*

For gender violence to emerge from its veil of secrecy, law enforcement officials at all levels must assume a more visible and active role by taking the appropriate preventive as well as protective measures.

The following areas for legislative support and

action are suggested:

- ★ Outlaw domestic violence, marital rape, and other forms of gender violence;
- ★ Reform existing laws to promote the active prosecution of gender-based crimes such as rape and domestic assault;
- ★ Develop training programmes on gender violence for police, lawyers, and judges;
- ★ Increase women's presence in law enforcement by recruiting, and promoting to senior levels, women police officers, judges, and prosecutors;
- ★ Promote NGO efforts to provide human rights education and legal literacy training for women and girls;
- ★ Integrate gender-sensitive indicators in all crime statistics to highlight the gendered nature of violent crime.

#### **Participation of women in public life.**

Redressing gender inequality in both public and private power relations is essential if gender violence is to receive the level of policy attention it deserves. This calls for increasing the number of women decision makers, policy makers, and managers.

#### **Building a Knowledge Base**

Existing data, while they show the severity of violence against women, cannot provide an in-depth understanding of gender-based violence. Specifically, more information is needed on the various forms of gender violence, on the physical and mental consequences, and on the effectiveness of support services provided to victims of violence. The public health sector needs to review its health information database in order to incorporate the consequences of

gender-based violence for women's health.

In developing countries in particular, large-scale data must be collected on the prevalence of sexual assault, child sexual abuse, and harmful traditional practices. Qualitative data on women's experiences of violence, their definitions of "violence", and their coping strategies would provide useful insights for designing effective programme responses. The experiences of women's NGOs and women's networks working with abused women can provide important insights on how best to manage the information-gathering process.

To build a knowledge base, one must establish a research agenda to decide the most critical areas for research and, ultimately, policy action. Researchers and those providing support services to victims of abuse can work together to produce relevant, policy-oriented information.

The following areas for research are proposed:

- ★ Improved data on prevalence of gender-based violence at different stages of women's life cycle;
- ★ Analysis of hospital or clinic data to gauge the number of women victims of violence treated at these facilities;
- ★ Studies on the financial cost of gender-based violence on the health care system;
- ★ Studies of the impact of domestic violence and sexual assault on birth outcomes, pregnancy complications, illegal abortions, rates of miscarriage, and low birth weight;
- ★ Investigation of links between gender violence and reproductive health issues such as safe motherhood, AIDS prevention, and family planning;
- ★ Studies that evaluate the effectiveness of

programmes' efforts to eliminate gender-based violence;

- ★ Operational research on model programmes to see what will work;
- ★ Preparation of profiles of the wide spectrum of victims of gender violence.

### Philippines Women's Health Research Project

A three-year project coordinated by the University of the Philippines Center for Women Studies Foundation has conducted research on Philippine women's knowledge of their reproductive rights and the services available to them, as well as understanding the health needs of victims of abuse. The Center has used the research results to develop advocacy materials to distribute to policy makers, media professionals, women's advocates, and health practitioners. These materials support changes in the laws on women's rights and reproductive health, passage of a proposed anti-rape bill and an anti-domestic violence bill, and government subsidy of health care for women victims of abuse.

### Reproductive and Sexual Health

Complementing efforts in the legal and policy arenas, gender violence must be addressed via public health institutions, working in concert with other elements in society. Given women's reluctance to report the abuse they are suffering, it is up to health workers, particularly those in reproductive health services such as antenatal clinics, maternity services, and family planning clinics, to be keenly alert to the possibility that their clients have been abused.

Gender violence has serious sexual and reproductive health consequences which are only now beginning to be dealt with directly by national reproductive health programmes. An effective health-care sector response to domestic violence might include the following:

- ★ Forming intersectoral working groups to share information and coordinate efforts, made up of health professionals and representatives from local organizations that provide services to victims of violence;
- ★ Developing specific protocols on gender violence, highlighting the clinical profile of victims, referral systems, screening questions, and legal information; and ensuring privacy, confidentiality, and sensitive treatment;
- ★ Training staff in counselling, examining victims, and collecting legal evidence for prosecution;
- ★ Incorporating gender-based violence as a topic in public-health-training curricula for care providers;
- ★ Developing referral networks and resource materials;
- ★ Establishing partnerships with community-based experts involved in gender-based violence programmes and services.

**Emergency situations.** Among refugees during wars or civil unrest, a new social dynamic may prevail: rape, forced prostitution, forced marriage, and increased levels of female genital mutilation may be resorted to as a means of cementing cultural identity, even if these practices were not prevalent in the home region.

In 1995, a group of about 25 humanitarian

### Gaza Women's Centre for Health Care, Social Assistance, Legal Counselling, and Community Education

In response to numerous requests for help from Palestinian women refugees, the Italian Association for Women in Development and a local NGO in Gaza, the Culture and Free Thought Association, established a Women's Health Centre in the Bureij Refugee Camp to provide an integrated package of services: pregnancy and post-natal monitoring; screening and prevention of female cancers; counselling teenagers about responsible sexual behaviour; counselling about domestic violence and gender equality; and a popular gymnastics programme.

Fifteen to 20 monthly workshops focus on topics of health, psychology, and legal and social issues. The project relies on community participation and outreach, and conducts training for health professionals as well.

and reproductive health agencies, coordinated by the Office of the United Nations High Commissioner for Refugees and including UNFPA, developed a Minimum Intervention Service Package for use during the emergency phase of civil unrest. The package includes home delivery kits, condoms, emergency contraception, and educational materials. Increasing efforts are needed to address the psycho-social dimensions, both to prevent the escalation of gender-based violence and to treat its victims, particularly adolescent girls. Encouraging the active participation of refugees in health service planning and delivery is key to their effectiveness.

## Information, Education and Communication and Advocacy

Information, education, and communication (IEC) and advocacy have an important role in opening up public debate on the issue of gender violence.

The debate will need to engage all the key opinion-makers such as religious and community leaders, teachers, school administrators, politicians, and entertainers. Such a debate would aim to eventually shift gender-based violence from a taboo issue and a private matter to one that is an issue for public policy.

**Building a constituency.** The peculiar features of gender violence—high social acceptance and therefore low public visibility except for some sensational cases—heighten the need for building a critical mass of support. Such a constituency can keep the pressure on with campaigns to educate the public, and seek changes in policy and institutional culture to redress the serious grievances of abused women and girls.

The catalytic efforts of women’s NGOs to promote recognition of reproductive and sexual health and rights need to be scaled up and their concerns to become of interest to society as a whole. Building up these small and under-funded networks is an important part of advocacy strategy.

**Involving young people.** A special effort should focus on adolescents. Adolescents have very few role models of male-female relations based on equality, mutual respect, and harmony; and they need to develop communication and negotiation skills that will enable them to have intimate relations reflecting these values, particularly in their reproductive and sexual life.

Much of what they see only serves to reinforce gender violence as an acceptable part of their lives. Adolescent boys must be taught that vio-

lence against women or girls is not part of their “birthright”. Adolescent girls need to be taught about the nature of gender violence—particularly the socialization process that leads girls to accept this violence as part of being female. They need to be helped to develop self-confidence, self-esteem, and awareness of their reproductive rights. Population/family life education and sex education programmes need to focus on these concerns. Peers and peer counsellors are an important means of reaching out to youth.

### Gender Violence and the Male Point of View

A regional conference in June 1998, in Santiago, Chile, discussed the other side of the gender equality equation: how men see male sexuality, identity, and power. “Gender Equity in Latin America and the Caribbean: Challenges for Male Identities” had the objective of promoting a regional discussion on male identities, gender equity, power systems, and sexual and reproductive health and rights.

**Involving men.** A large part of the social acceptance of gender-based violence comes from men who essentially see abuse as a male “prerogative”. Therefore, changing the mindset of male partners is an important part of the equation for achieving harmony and mutual respect in gender relations.

**Community-based workers and traditional birth attendants.** Monitors of the effects of the 1995 Beijing Platform for Action report impressive gains in legislation about women’s human rights and gender-based violence. Yet, for these laws to be socially rooted, values at the community level still have to change. In many countries, the practice of customary laws still

supersedes civil law, leaving a legal quandary there is little political will to challenge.

Sensitizing local, community-based workers and social workers to the health costs of gender violence can yield real dividends in eventually changing community values. Traditional birth attendants and traditional healers could well serve as agents of change by informing women about their reproductive and legal rights, and working with health workers to reach out to the community.

**Creating a public will for change.** Real and lasting change in social perceptions of gender-based violence can only come from within. Community-based organizations are already providing medical, legal and counselling services for victims of gender violence and advocating changes in existing laws and customs through education and lobbying. In many countries, these organizations have served to focus political attention on this long-neglected problem.

A number of strategic advocacy and critical-mass-building measures are proposed to counter public tolerance of gender violence:

- ★ At the government policy level, coordinating the efforts of all the players in the legal, health, and education systems in a national strategy;
- ★ Developing alliances with parliamentarians, women's NGOs, religious leaders, teachers, and entertainers;
- ★ Urging the media to promote positive images of gender roles and relations between men and women and to remove existing biases;
- ★ Ensuring that school curricula and teaching materials do not include gender bias and stereotyping;
- ★ Training teachers and educators to be sensitive to signs of gender violence in the school.



## Developing Culturally Appropriate Alternatives to FGM

The innovative Reproductive, Educative, and Community Health (REACH) project focuses on the reduction of female genital mutilation in the Kapchorwa district of Uganda. The overall aim “is to increase people’s awareness of the harmfulness of the practice and to encourage the development of alternative and culturally valid ways of performing rites of passage”. The project takes a multi-pronged approach:

- ★ Information, education and communication programmes targeting women, opinion leaders, policy makers, health providers, religious leaders, husbands, adolescents, and the circumcisers themselves;
- ★ Research on the extent and type of the practice and the reasons behind it;
- ★ Policy and legislative initiatives to urge outlawing the practice;

- ★ Training of health care providers to recognize and treat complications of FGM;
- ★ Psychological counselling for emotionally disturbed circumcised women and girls;
- ★ Alternative income-generation activities for circumcisers;
- ★ Strengthening positive traditional practices regarding rites of passage and celebrations;
- ★ Resource mobilization, in-country and external, to eradicate FGM.

In the first two years, the combined effect of all these activities has been a 36 per cent reduction of FGM in the communities where the project was implemented.



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