

**Programme
Advisory Note**

*Reproductive Health Effects of
Gender-Based Violence:
Policy and Programme
Implications*

Number 6



UNFPA

United Nations
Population Fund

PROGRAMME ADVISORY NOTE

REPRODUCTIVE HEALTH EFFECTS OF GENDER-BASED VIOLENCE: POLICY AND PROGRAMME IMPLICATIONS

The **Programme Advisory Note** (PAN) is intended as a source of practical information, based on evaluation and research activities, to guide UNFPA and other interested parties in the implementation of population and reproductive health programmes.

This Programme Advisory Note was prepared by Ms. Delawit Aklilu, Consultant, in collaboration with the UNFPA Gender Theme Group.

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FOREWORD

The Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo in 1994, notes that “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 reproductive lives” (paragraph 7.34). The Programme of Action goes on to say: “Violence against women, particularly domestic violence and rape, is widespread, and rising numbers of women are at risk from AIDS and other sexually transmitted diseases as a result of high-risk sexual behaviour on the part of their partners” (paragraph 7.35).

Similarly, the Beijing Platform for Action of the Fourth World Conference on Women, held in Beijing in 1995, identifies violence against women as one of its 12 critical areas of concern and outlines measures, including policies and programmes, to address the issue.

This publication has been designed to raise awareness and understanding of the pervasiveness and the nature of gender-based violence as well as the specific effects it has on reproductive health all over the world. It also points to directions that programmes need to take to enable women and girls to live free of violence.

M. Nizamuddin, Director
Technical and Policy Division

TABLE OF CONTENTS

FOREWORD	i
LIST OF TABLES	iv
LIST OF BOXES	iv
LIST OF ABBREVIATIONS AND ACRONYMS	vi
I. SCOPE OF THE PROBLEM	1
A. Background	1
B. The “Culture of Silence”	3
C. Sexual Coercion and Abuse: A Common Denominator in the Lives of Girls and Women	3
D. Gender-based Violence Defined	4
II. FORMS OF GENDER-BASED VIOLENCE	6
A. Life-Cycle Perspective: A Full View	6
B. Gender Bias in the Prenatal Period, Infancy and Early Childhood: The Case of “Missing” Females	6
C. A False Start: Child and Adolescent Sexual Abuse	8
D. Domestic Violence: An Abuse Without a Diagnosis	10
E. Harmful Traditional Practices: Part of a Continuum of Gender-Based Abuse ..	10
III. CONSEQUENCES OF GENDER-BASED VIOLENCE	12
A. Reproductive and Sexual Health Consequences at Various Stages of the Life Cycle	12
B. Effects of Gender-based Violence on Reproductive Health Decision-making and Choices	18
C. Effects of Gender-based Violence on the Economics of Reproductive Health/Family Planning Service Delivery	19
IV. POLICY REFORM PROCESS	22
A. Integration of Gender Planning and Analysis in Population Policies: The Real End-Game	22
B. Creation of New Synergy: Linkage to Reproductive and Sexual Health Rights	23
C. Policy-oriented Research: Filling the Knowledge Gap	24
D. Inter-Agency Collaboration	24

V.	STRATEGIC ENTRY POINTS WITHIN UNFPA CORE PROGRAMMES	25
A.	Reproductive and Sexual Health	26
B.	Population and Development Strategies	34
C.	Advocacy	38
D.	Programmatic Responses Based on Life-Cycle Stages	40
VI.	PATHWAYS FOR CHANGE	43
A.	Building a Knowledge Base	43
B.	Developing National Policy	44
C.	Undertaking Legislative Initiatives	45
D.	Establishing Institutional Responses to Gender-based Violence in the Reproductive Health Sector	45
E.	Creating a Public Will for Change	46
F.	Conclusions	46
	REFERENCES	48

LIST OF TABLES

Table 1.	Percentage of Women Who Report Being Hit by an Intimate Partner	4
Table 2.	Statistics on Sex Crimes	9
Table 3.	Health Consequences of Violence Against Women	12
Table 4.	Estimated Global Health Burden of Selected Conditions for Women Aged 15 to 44	21
Table 5.	Programmatic Responses and UNFPA Core Programming Areas	25
Table 6.	Reproductive Health Effects and Programmatic Responses to Gender-based Violence: The Life Cycle Approach	41

LIST OF BOXES

Box 1.	International Milestones Addressing Violence Against Women	2
Box 2.	Gender-based Violence Throughout the Life Cycle	7

Box 3.	Palestine: Establishment of a Women's Centre for Health Care, Social Assistance, Legal Counselling and Community Education in Gaza	27
Box 4.	Philippines: "Women: Vanguarders of Health" Project	30
Box 5.	Uganda: The Reproductive, Educative and Community Health Programme	31
Box 6.	Gender-based Violence and the Male Point of View	32
Box 7.	Caribbean Initiative	33
Box 8.	Philippines: Women's Health Research Project	35
Box 9.	Gender Bias in China, Republic of Korea and India: Causes and Policy Implications	36
Box 10.	Algeria: Integration of Gender Equality in National Development	37
Box 11.	Regional Collaborative Advocacy Campaign on Gender-based Violence: Latin America and the Caribbean	39

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
CRC	Committee on the Rights of the Child
DALY	Disability-Adjusted Life Year
FGM	Female genital mutilation
FP	Family planning
HIV	Human immunodeficiency virus
IEC	Information, education and communication
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MCH	Maternal and child health
MISP	Minimum Intervention Service Package
NGO	Non-governmental organization
PDS	Population and Development Strategies
PTSD	Post-traumatic stress disorder
RH	Reproductive health
RTI	Reproductive tract infection
STD	Sexually transmitted disease
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

I. SCOPE OF THE PROBLEM

A. Background

Gender-based violence has emerged as a major issue on the international human rights agenda. This recognition has been achieved largely through the persistent advocacy efforts of women's organizations around the world. Such violence includes a wide range of violations of women's human rights, including pornography, trafficking in women, rape and wife abuse, and issues of "structural violence" such as lack of access to schooling, education and resources.

The United Nations Decade for Women provided the needed impetus for focusing on gender-based violence as a priority issue for action by the world community. The United Nations General Assembly passed its first resolution on violence against women in November 1985. The next major turning-point in the development of an international consensus on the issue occurred when the United Nations Commission on the Status of Women convened a special working group to draft a declaration on violence against women. Adopted by the General Assembly in 1993, the declaration provided, for the first time, an official United Nations definition of what constituted gender-based violence. Subsequently, the United Nations International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, and the Fourth World Conference on Women: Action for Development, Equality and Peace, held in Beijing, China, in 1995, are two milestones that have sustained the international community's focus and moved the agenda forward on women's rights issues, including gender-based violence (see Box 1).

The level of gender-based violence that women and girls are encountering has recently increased to alarming proportions. This is especially true for young girls and women caught in the crossfire of war or other emergencies. Rape is now being recognized as a calculated weapon of war against the enemy. In Bosnia-Herzegovina, aside from unreported cases, the number of raped women was estimated (1993) at 20,000 to 50,000.¹ Media coverage of girls and women in conflict situations has portrayed the deliberate use of rape as a means of repression. The scale and premeditated nature of sexual violence against women and girls have resulted in a major shift in the way International Tribunals on War Crimes have come to regard such acts of violence. In two of the latest Tribunals, one focusing on Bosnia and the other on Burundi and Rwanda, a significant change in the proceedings has been introduced with the recognition and prosecution of acts of mass rape as a legitimate crime against humanity.

Although important progress has been made in establishing gender-based violence as a human rights concern, little headway has been made in addressing violence against girls and women as a public health issue. There is a notable absence of attention to this issue in reproductive health (RH) policy-making, a critical and strategic entry point if the consequences of violence against women are recognized as an important and integral part of women's health concerns.

¹World Health Organization, *Gender-Based and Sexual Violence During Armed Conflict and Displacement*, WHO Briefing Package on Violence Against Women (Geneva).

Box 1. International Milestones Addressing Violence against Women

United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1981

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 All Forms 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: Affirms that women's human rights are a fundamental part of all human rights. The Declaration refutes the distinction, sometimes made in human rights discourse, between public and private spheres, declaring 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 privacy of the home. Progress made in implementing the Vienna Declaration was reviewed at the 1998 March-April session of the United Nations Commission on Human Rights. The 1993 United Nations Declaration on the Elimination of Violence against Women for the first time provides a definition of violence in Article 1 and includes psychological violence in the definition.

United Nations International Conference on Population and Development (ICPD), Cairo, Egypt, 1994

Programme of Action: Affirms that women's rights are an integral part of all human rights. Emphasizes 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, not only in politics, government and other professions but also in personal relationships. 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. The 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 reproductive 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, para. 7.34).

United Nations Fourth World Conference on Women, Beijing, China, 1995

Platform for Action: Recognizes 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 specifically states that violence against women is one of 12 critical areas of concern and an obstacle to the achievement of women's human rights.

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

B. The “Culture of Silence”

Much of the available information and documentation on gender-based violence establishes a universal pattern of abuse of women and girls which is differentiated in form and scope only by the specific cultural and social contexts within which it occurs. One of the striking truths about the nature of the violence experienced by girls and women is that, in the great majority of the cases, it is perpetrated by male partners with whom they have an intimate or interdependent relationship. This means that, contrary to the conventional wisdom that the family or extended family is a safe haven of love and support, girls and women are at greatest risk of violence from the very members of their households who are socially responsible for their protection and welfare.

The violence experienced by women takes place mostly within the “privacy” of their homes and, to a large extent, has contributed to a “culture of silence” as regards the health consequences and, in particular, the reproductive and sexual health ramifications of gender-based violence in the lives of girls and women across all social strata. The perception of violence against women as being essentially a domestic and family-related issue has contributed, in large measure, to the serious gap in public health policy-making and the resulting lack of appropriate programmatic responses.

Ascertaining the extent of gender-based violence is difficult. Inconsistencies in definitions of gender-based violence are a major underlying reason for a scarcity of comparable studies. Another major difficulty is the extent of underreporting. Women, the main victims of gender-based violence, have many reasons for not reporting incidences of violence: legal authorities seldom take appropriate action; many women are unaware of their legal rights; and women may be victimized, either by insensitive, accusatory questions or by actual assault. Another major obstacle to ascertaining the extent of gender-based violence lies in the failure of health-care facilities and police consistently to record data on violence against women, the sex of the perpetrators and the relationship of the abuser to the victim.

C. Sexual Coercion and Abuse: A Common Denominator in the Lives of Girls and Women

Although reliable population-based data on the incidence and prevalence of gender-based violence are scarce, especially for developing countries, a growing body of knowledge indicates that it is widespread and common (see Table 1). Sexual coercion and abuse are increasingly recognized as an all too common fact of life for many adolescent girls and may even begin when they are much younger. However, the culture of silence has made it that much more difficult to respond to the specific needs of this vulnerable group.

The prevalence of harmful cultural practices and traditions presents an equally important dimension of gender-based violence which results in irreparable damage to girls’ and women’s reproductive and sexual health.

Table 1. Percentage of Women Reporting Having Been Hit by an Intimate Partner			
Industrialized regions		Asia and the Pacific	
Belgium	25	India	22-75%*
Canada	25	Malaysia	39**
Japan	59*	Papua New Guinea	
Netherlands	21	Urban	58
New Zealand	17	Rural	60
Norway	25	Rep. of Korea	38**
United States	28	Sri Lanka	60*
Latin America and the Caribbean		Africa	
Antigua	30	Kenya (Kissi District)	42
Barbados	30	Uganda	46*
Chile (Santiago)	26	United Rep. of	
Colombia	20	Tanzania	60*
Costa Rica	54*	Zambia	40*
Ecuador	60*		
Guatemala	36*		
Mexico	34*		

Source: Survey data compiled by the United Nations Statistical Office, as cited by L. Heise in "Violence against Women," FRH/WHD/96.27 (Geneva, WHO, 1996).

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

**Percentage beaten within 12 months prior to interview date.

D. Gender-based Violence Defined

Another critical constraint to addressing gender-based violence effectively has been the lack of a clear and precise articulation of the issue that would facilitate appropriate policy and programming measures. The United Nations Declaration on Violence against Women was formulated to provide a common 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."²

² Economic and Social Council, "Report of the Working Group on Violence against Women," E/CN.6WG.2/1992/11.3 (Vienna, United Nations, 1992).

In an effort to establish the parameters of what constitutes gender-based violence, Article 2 of the Declaration presents the international community's view of what it essentially 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 (FGM) and other traditional practices harmful to women, non-spousal violence, violence related to exploitation, sexual harassment, and intimidation at work and in educational institutions, and trafficking in women, forced prostitution and violence perpetrated or condoned by the State.

The fundamental distinguishing feature of gender-based violence is that it emanates from the use of force or coercion, physical or psychological, that is socially tolerated and is carried out predominantly against women and girls at every stage of their life cycle. This is not to discount violence that is directed at boys and men but to underscore the singular difference: gender-based violence is essentially socially sanctioned and, by its nature, deep-rooted and pervasive in the lives of girls and women. It is a form of violence to which girls and women are subjected primarily because of their female gender identity. As females, they face systematic discrimination from an entrenched and rationalized system of gender-based power relations which then perpetuates an almost universal pattern of subordination that leaves girls and women highly vulnerable to acts of physical, sexual or psychological harm from male members of their families and communities, including husbands, lovers, brothers, fathers, teachers and employers.

In addition to the United Nations definition, other attempts have been made to articulate the complex dimensions of what constitutes gender-based violence. By being either too inclusive or too restrictive, however, none provides an adequate basis for a complete understanding of the issue. Of critical importance is the need for any definition to recognize explicitly the conceptual underpinning of gender-based violence. For the purposes of this publication and UNFPA programming guidelines, the definition that most satisfactorily reflects the issues involved is as follows:

"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 disproportionately. 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 explicitly addresses the social dimensions of gender-based violence. Moreover, it lends itself to focused and responsive policy and programming efforts to redress the complexities associated with gender-based violence.

II. FORMS OF GENDER-BASED VIOLENCE

Viewed from a human rights perspective, gender-based violence has been interpreted to include a wide spectrum of abuses and violations. To a large extent, much of the debate on the issue has been informed by the advocacy activities of women's rights groups and organizations. Now, with the shift to the need to address gender-based violence as a public health issue, and particularly as an RH issue, it is both strategic and pragmatic to narrow the focus on those concerns that have direct implications for policy and programming areas in the health, and particularly in the reproductive and sexual health, sector. For too long, policy makers and health practitioners have considered gender-based violence as being outside their mandate, perceiving it largely as a human rights issue. Yet, the physical and psychological consequences of violence against women have a direct bearing on the reproductive and sexual health status of girls and women.

A. Life-Cycle Perspective: A Full View

The life-cycle perspective provides a framework within which to account for the pervasiveness of gender-based violence in the lives of women and girls. This approach presents the wide spectrum of abuses that women and girls experience throughout their lives, delineating the specific form and scope of violence suffered by girls and women at each stage of the life cycle. This "mapping" of gender-based violence presents a compelling case for why this form of abuse urgently requires public policy initiatives, particularly in the area of RH.

Viewed from a life-cycle perspective, there are six basic phases in the lives of women and girls when they are likely to experience gender-specific forms of abuse and assault. These are: pre-birth, infancy, girlhood, adolescence, reproductive age and old age (see Box 2).³ Each of these phases contains critical entry points for addressing issues of violence against women and girls. However, there is need to move beyond specific acts of violence and to focus on some of the critical trends and patterns associated with gender-based violence in order to understand their implications for policy-making and programming.

B. Gender Bias in the Prenatal Period, Infancy and Early Childhood: The Case of "Missing" Females

Even before girls are born, they suffer the consequences of gender bias as expressed in a widely prevalent sociocultural disposition that favours boys over girls, otherwise known as "son preference". This attitude is perpetuated precisely because of the unequal nature of the

³L. Heise *et al.*, *Violence Against Women: The Hidden Health Burden*, World Bank Discussion Paper (Washington, D. C. , The World Bank, 1994).

Box 2. Gender-based Violence Throughout the Life Cycle

Phase	Type of Violence Present
Prenatal	Sex-selective abortion (China, India, Republic of Korea); battering during pregnancy (emotional and physical effects on women; effects on birth outcome); coerced pregnancy (for example, mass rape in war).
Infancy	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants.
Childhood	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution.
Adolescence	Dating and courtship violence (acid-throwing in Bangladesh; date rape in the United States); economically coerced sex (African schoolgirls having to take up with “sugar daddies” to afford school fees); sexual abuse in the workplace; rape; sexual harassment; forced prostitution; trafficking in women.
Reproductive	Abuse of women by intimate male partners; marital rape; dowry abuse and murders; partner homicide; psychological abuse; sexual abuse in the workplace; sexual harassment; rape; abuse of women with disabilities.
Old Age	Abuse of widows; elder abuse (in the United States of America, the only country where these data are now available, elder abuse mostly affects women).

Source: L. Heise *et al.*, *Violence Against Women: The Hidden Health Burden*, World Bank Discussion Paper, 1994.

gender division of social roles and power which assigns higher value to a boy child than a girl child. A 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. An analysis of the census show that the ratio of males to females has been rising since 1982.⁴ These findings also suggest that China’s one-child policy, which effectively translates into one chance to have a male heir, may indeed be an additional factor for the increased infanticide or sex-selective abortion of female foetuses. Other studies point to the role played by increased access to reproductive technology in promoting this particular form of gender-based violence. In China, India and the Republic of Korea, widespread access to amniocentesis and ultrasound may be contributing to increased foeticide. Evidence of this outcome is to be found in the pattern of higher male to female sex ratios in these countries.⁵

The cumulative impact of sex-selective abortions on women’s survival prospects was powerfully demonstrated in Amartya Sen’s ground-breaking work on “missing women”. Sen and his colleagues undertook a comparative analysis of sex ratios in countries in areas with relatively

⁴Terrence Hull, "Recent Trends in Sex Ratios at Birth in China," *Population and Development Review* 16(1):63-83.

⁵Heise *et al.*, *Violence Against Women*, p. 12.

higher levels of gender equality, such as Europe and North America, and with countries where the gender gap places serious constraints on women's and girls' development, such as China and India. The results indicate that female-male ratios in the first group of countries is about 1.05 or 1.06, reflecting women's biological advantage. In the second group of countries, in the areas of East Asia (China), South Asia and North Africa, the ratio was lower, ranging from a high of 0.94 to lesser values. He concluded that if these regions had similar sex ratios as the countries with less gender discrimination, there would be more than 60 million more females alive today.⁶

The practice of son preference continues to have an important and measurable impact on the lives of girls even after they are born. In resource-poor communities, this leads to the serious neglect of girls in their most formative and vulnerable years of childhood. Often, gender-based discrimination reduces and sometimes denies their entitlement to food, education and medical care. This discriminatory treatment is accurately characterized as a form of violence as it subsequently leads to a higher rate of mortality for girls than for boys. Evidence of this outcome is supported by data from developing countries indicating that the mortality rate among girls aged one to four is higher than that among boys in the same age group.⁷

C. A False Start: Child and Adolescent Sexual Abuse

The issue of sexual abuse of children is a difficult one to address given the sensitivity of the subject as well as the lack of adequate research and documentation, particularly for developing countries. However, sufficient indirect evidence points strongly to the prevalence of the problem. Much of this indicative information is extracted from patient records at treatment centres for sex-related diseases, crisis centres or maternity hospitals. For example, a 1988 study in Zaria, Nigeria, found that 16 per cent of the female patients seeking treatment for sexually transmitted diseases (STDs) were children under the age of 5 and another 6 per cent were children between the ages of 6 and 15 (9).⁸

The same pattern of sexual abuse of young girls emerges from a study based on the records of the Maternity Hospital of Lima. This study revealed that 90 per cent of young mothers age 12 to 16 had become pregnant because they had been raped. The vast majority had been victimized by their fathers, stepfathers 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.⁹

Cross-cultural data from rape crisis centres present another source of indirect evidence that substantiates the prevalence of sexual abuse of young girls. These centres report that 40 to 58 per

⁶Ansley Coale, "Excess Female Mortality and the Balance of the Sexes in the Population: An Estimate of the Number of Missing Females," *Population and Development Review* 17(3):517-523.

⁷United Nations Children's Fund, *Statistical Review of the Situation of Children of the World* (New York, UNICEF, 1986).

⁸Mere Kisekka and B. Otesanya, "Sexually Transmitted Disease as a Gender Issue: Examples from Nigeria and Uganda," paper presented at the AAWORD Third General Assembly on the African Crisis and the Women's Vision of the Way Out (Dakar, 1988).

⁹Roxanna Carillo, *Battered Dreams: Violence Against Women as an Obstacle to Development*, Fact Sheet on Gender Violence (New York, UNIFEM Publication, 1992).

cent of sexual assaults are committed against girls age 15 and under, including girls younger than 10 or 11 (see Table 2). Furthermore, in a pattern that fits most forms of gender-based violence, most of these rapes are perpetrated by family members or persons known to the victim. Significantly, available crime statistics as well as information from crisis centres clearly show that in more than 60 per cent of all rapes cases, the victim knows the assailant. 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 at training youngsters to be better child-care providers for their siblings. One of the notable conclusions of the meeting was that these children identified physical and sexual abuse as their priority health concern.¹⁰

Location	% of attackers known to victim	% of victims aged 15 or less	% of victims aged 10 or less
Lima, Peru	60	-	18 ^a
Malaysia	68	58	18 ^b
Mexico City, Mexico	67	38	23
Panama City, Panama	63	40	-
Papua New Guinea	-	47	13 ^c
United States of America	78	62	29

Source: L. Heise, "Violence against women: The hidden health burden," *World Health Statistics Quarterly*, Vol. 46(1), 1993.

Notes: The sex crimes reported in this table include attempted and completed rape and sexual assaults such as molestation, except for U.S. data, which is for completed rape only.

^a Percentage of survivors aged 9 or less.

^b Percentage of survivors aged 6 or less.

^c Percentage of survivors aged 7 or less.

D. Domestic Violence: An Abuse Without a Diagnosis

Domestic violence and, more specifically, partner/wife abuse is the most endemic form of gender-based violence. In every country where reliable, large-scale studies on gender-based violence are available, the results show that 20 to 67 per cent of women have been abused by the man they live with.¹¹ Recent studies based on research specifically focusing on domestic violence in 35 diverse countries confirm the pervasive pattern of abuse by male partners: one quarter to more than half of the women reported having been subjected to physical abuse by a present or former partner. Significantly, an even larger percentage pointed to ongoing emotional and

¹⁰Heise *et al.*, *Violence against Women*, p. 11.

¹¹World Health Organization, *Gender-Based and Sexual Violence*.

psychological abuse, a form of violence which many battered women viewed as worse than physical abuse.¹²

Research efforts on this issue are often hampered because women are socialized to accepting physical and emotional mistreatment as a normal part of marital relations. This, in turn, may limit women's perceptions of the range of behaviours they consider as being abusive, thereby resulting in an underestimation of the level of physical and psychological violence in intimate relationships. The other decisive factor in women's reluctance to come forward to report incidences of domestic violence is the underlying imbalance in the gender power relations between men and women that places serious constraints on women's options for redress. Besides the social stigma associated with it, women fear incriminating family members, particularly husbands with whom they have close relationships not only in emotional but also in financial terms. Women who do decide to leave abusive relationships have minimal safety nets at their disposal and limited opportunities for taking control of and rebuilding their lives.

E. Harmful Traditional Practices: Part of a Continuum of Gender-Based Abuse

Harmful traditional practices form a distinct group of socially sanctioned "rules of life", the heaviest burden of which falls on young girls. When enforced, these practices constitute a veritable form of gender-based violence. The more well-known and widespread of these practices are FGM and child marriage. These traditions are upheld to ensure that girls become acceptable brides for men, even if it means marrying off a child.

According to available data, it is estimated between 85 to 114 million women have undergone FGM.¹³ The largest proportions of these women live in Africa, the Arab States and Asia. FGM (sometimes referred to as "female circumcision") is an all-inclusive term applied to a wide range of practices involving the removal of all or part of the clitoris and other genitalia. Those who perform the extreme form, infibulation, remove the clitoris, both labia and close the two sides of the vulva. This leaves only a small opening to allow the passage of urine and menstrual blood. Other less radical forms include removing all or part of the clitoris — clitoridectomy — or the clitoris and inner lips — excision. About 85 per cent of women undergo one or the other of these less radical forms of the practice.

It is important that the thinking behind this terrible mutilation of women is clearly understood. It is based on a prevailing social consensus on the need to control female sexuality and to preserve the virginity of young girls until marriage. The ritual is reinforced by a collective social perception that men will not marry "uncircumcised" girls or women who they, in turn, view as unclean and sexually permissive.¹⁴

Child marriages operate on the same basic principle. Where virginity is given a high social value, young girls are married off at an extremely young age. This ensures their virgin status and

¹²Heise *et al.*, *Violence Against Women*, p. 4.

¹³Nahid Toubia, *Female Genital Mutilation: A Call for Global Action* (New York, Women's Ink, 1993).

¹⁴Asha Mohamad, "Medical and Cultural Aspects of Female Circumcision in Somalia and Recent Efforts for Eradication," paper presented at the 18th Annual National Council of International Health Conference, Arlington, VA (1991).

their eligibility for marriage to men many years their senior. Although data on child marriages tend to show a general decline, the practice is still very much in place as evidenced by the large percentage of young girls becoming brides before their fifteenth birthday.

Child brides face a disproportionately higher level of health risks precipitated by the fact that they are forced to engage in sexual relations with more mature partners. They are traumatized by the experience of adult sex and by having to assume reproductive functions such as child-bearing before they are physiologically ready. In this process, the “child” mother experiences a real physical violation as her young body is forced to deal with early sexual activity and the strains and pains of pregnancy and childbirth at such a premature age.

III. CONSEQUENCES OF GENDER-BASED VIOLENCE

A. Reproductive and Sexual Health Consequences at Various Stages of the Life Cycle

By all accounts, the largely hidden health consequences of violence against women take a heavy toll on the well-being of women (see Table 3). Ultimately, the resulting morbidity and sometimes mortality result in both tangible and intangible losses to their families and communities and the development of society.

Table 3. Health Consequences of Violence against Women	
Nonfatal outcomes	
Physical health outcomes:	Mental health outcomes:
# Injury(from lacerations to fractures and internal organs injury)	# Depression
# Unwanted pregnancy	# Fear
# Gynaecological problems	# Anxiety
# STDs including HIV	# Low self-esteem
# Miscarriage	# Sexual dysfunction
# Pelvic inflammatory disease	# Eating problems
# Chronic pelvic pain	# Obsessive-compulsive disorder
# Headaches	# Post-traumatic stress disorder
# Permanent disabilities	
# Asthma	
# Irritable bowel syndrome	
# Self-injurious behaviour (smoking, unprotected sex)	
Fatal outcomes	
# Suicide	
# Homicide	
# Maternal mortality	
# HIV/AIDS	

Source: World Health Organization, *Violence against Women: A Priority Health Issue*, WHO Briefing Kit on Violence and Health.

The life-cycle perspective discussed in Chapter II provides a framework for systematically and comprehensively determining the extent to which women’s and girls’ reproductive and sexual health status is affected by gender-based violence. It is especially instrumental in showing the scope and specific reproductive and sexual health risks faced by women at each stage of their life cycle. Because of the “gendered” nature of this form of violence against women and girls, they are likely to experience multiple episodes of abuse within their lifetime.

1. **Pre-Birth and Infancy**

C ***Effects of abuse during pregnancy: miscarriages, pre-eclampsia, premature labour, low birth weight***

Women who are pregnant find themselves especially vulnerable to gender-based violence. Surveys of battered women in the Latin American region point to a significant number experiencing beatings during pregnancy. The effects of battery on these women have been shown to include serious effects on their RH status. According to available studies, women who experience abuse during this critical stage in their reproductive life are likely to run twice the risk of miscarriage and four times the risk of having a low-birth-weight baby.¹⁵ These risks are further complicated because most 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.

C ***Effects of coerced pregnancy/rape: unwanted pregnancy, physical injury and emotional/psychological trauma, sexual dysfunction***

Coerced pregnancy, an extreme form of gender-based violence, is usually a result of the sexual victimization of women through rape or sexual assault. The effects of this particular form of violence against women and girls are both profound and long-lasting. Rape victims experience a double injury to their health: the physical consequences of sexual assault and the equally debilitating psychological hurt. The physical injuries range from cuts and bruises to more serious conditions such as broken bones and loss of consciousness. A study of rape victims in Bangladesh highlighted that 84 per cent suffered severe injuries resulting in unconsciousness or even death following rape.¹⁶

Information on the specific psychological pain of women victims of rape in developing countries is limited; yet there is sufficient evidence from indicative studies to establish the very real traumatic aftermath of sexual assault. These studies underscore that rape survivors have higher rates of persistent post-traumatic stress disorder (PTSD) and make up proportionately the largest single group diagnosed with PTSD. Consistent with this diagnosis is another disturbing trend: rape victims are nine times more likely than non-victims to have attempted 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.¹⁷

One of the most serious consequences of rape is the risk of unwanted pregnancy. As victims, women pay a high price in both the physical and the psychological implications of unwanted pregnancies. Ironically, 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. Often, they are presented with torturous choices of having either to complete the pregnancy or to resort to illegal methods to terminate the pregnancy.

¹⁵Evan Stark *et al.*, "Spouse Abuse" in *Violence In America: A Public Health Approach* (Oxford University Press, 1991).

¹⁶Carillo, *Battered Dreams*.

¹⁷Heise *et al.*, *Violence Against Women*, p. 19.

Women who have been raped not only endure the physical and emotional consequences of sexual violation but face an added potential RH risk. As unwilling participants in forced sex, they face increased exposure to infection from STDs as well as acquired immunodeficiency syndrome (AIDS). Although information on such cases is not readily available, reports from women's support centres provide substantial evidence that rape is one of the causes for the spread of these diseases.

2. Girlhood

C *Effects of FGM; child marriages and malnutrition; reproductive morbidity, including sterility; early pregnancy; vesico-vaginal and recto-vaginal fistulae*

For a significant number of girls, reaching puberty — a critical transition period from girlhood to womanhood — also means it is time to undergo FGM, an extremely painful rite of passage that results in serious mutilation of parts of their reproductive system and may cause infection and death. The practice of FGM exposes young girls to high health risks that affect the quality of their reproductive and sexual lives as adolescents and as full-grown women.

The medical complications arising from FGM can be severe, depending on the particular form that is performed. Of these, the 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 and often crude cutting implements. Complications that develop after the procedure are mainly due to the partial closing of the vaginal and urethral openings and include chronic urinary tract infections and repeated reproductive tract infections as well as back and menstrual pain. In some cases, these complications can lead to sterility, a devastating outcome especially for these women whose value is perceived largely in terms of their ability to bear children.¹⁸

Many young girls in developing countries face the prospect of marriage and child-bearing at an early stage in their reproductive lives. One of the more damaging effects of early child-bearing is vesico-vaginal or recto-vaginal fistulae. This complication, due to prolonged obstructed birth, leaves a potentially permanent scar on the health of these girls — loss of full control of their urine and/or faeces functions. Given the prevailing problem of lack of access to health care, particularly RH care, girls are unlikely to receive the proper treatment for this particular condition.

Child brides thus face especially serious RH consequences — physical and psychological as well as social — from giving birth at such an early age. In the worst cases, many become social outcasts and face the real possibility of divorce or abandonment even before they have biologically entered adulthood.

¹⁸"The Intimate Enemy: Gender Violence and Reproductive Health," Panos Briefing No 27 (March 1998), p. 5.

C ***Effects of sexual abuse of young girls: psychological trauma, early sexual experience, teenage pregnancies***

The sexual abuse of young girls raises a much wider spectrum of issues, including child pornography, child molestation and commercial sex work, and the problem of paedophilia, which is beyond the scope of this paper to address.

One of the surprising but instructive findings about the sexual victimization of young girls is that it is often perpetrated by male family members or friends. As a result, it is extremely difficult to identify and provide appropriate health-service support. One of the distinguishing features, as confirmed by studies in the United States of America, is that child sexual abuse victims suffer psychological effects which are long-lasting and carry into adulthood. This psychological trauma is often manifested as physical complaints such as pelvic pain, headaches, asthma and gynaecological problems.

From the very beginning of the life cycle, it is apparent that the sexual abuse of girls in their childhood years can be strongly linked to high-risk behaviour in adolescence and adulthood. Available studies provide credible evidence that early traumatic sexual experiences can result in, among other things, unprotected sex with multiple partners, commercial sex work and teen pregnancy. Findings of a community-based study show that 49 per cent of childhood sexual abuse victims reported having been battered in adult relationships.¹⁹

According to U.S.-based research findings, sexually abused girls initiated intercourse a year earlier and were more likely to use drugs and alcohol than were teens who became pregnant but had not been abused. Notably, they were also less likely to use family planning methods. The average age of first intercourse for abused women was 13.8 years as compared with the national average of 16.2 years. Only 28 per cent of these abused teens used family planning methods at first intercourse.²⁰

Early sexual victimization of young girls is also associated with incidences of incest. Little is known about this form of gender-based violence, which is a taboo topic in most developing countries. Yet, these incidences do occur and leave a profound psychological impact on the lives of the young victims. According to one study, 68 per cent of incest victims reported having been the victim of rape or attempted rape later in their lives.²¹ However, due to the prevailing culture of silence as regards sexual abuse of young girls, little help can be offered to these and other young victims of sexual violence.

¹⁹Debra Boyer and David Fine, "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 24(1):4-10.

²⁰Heise *et al.*, *Violence Against Women*, p. 21.

²¹*Ibid.*

3. Adolescence

C ***Effects of sexual abuse in adolescent years: exposure to STDs and AIDS; unwanted pregnancy***

Adolescent girls experience gender-based violence in ways that render them especially vulnerable at a formative stage in their lives. Given the hierarchy established by gender-based power relations, adolescent females find themselves occupying the lowest rung. They are no longer little girls under “protective” wings; neither have they achieved respectability through assuming the socially sanctioned roles of spouse or mother. Adolescent girls are disproportionately exposed to sexual abuse because the cards are stacked against them from the outset. Their opportunities for self-development and autonomy are limited, due to society’s gender-based differentiation in giving access to such critical resources as education, health care and gainful employment.

The relatively powerless position of adolescent girls *vis-à-vis* their more mature and well-off male partners exposes them to increased risks of infection from STDs and AIDS. In particular, it has been substantiated that older men deliberately seek out young girls in the mistaken belief that their chances of AIDS infection will be reduced. This trend is partly borne out by AIDS statistics indicating a rising rate of infection for young girls compared with that for boys.

C ***Effects of rape; illegal abortion; psychological trauma, including suicide***

Teenage pregnancy is another unwanted but sometimes unavoidable consequence of sexual abuse of female adolescents. Many teenage mothers are reported to have to bear the consequences of coerced sex as they 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 RH services.

Serious complications arise when young girls resort to illegal abortions to terminate their unwanted pregnancies. With few exceptions, abortions are prohibited by law and permitted only when the life of the mother is in danger. The RH risks associated with illegal abortions due to sexual coercion and assault present many gynaecological problems for which little RH support is available. Despite restrictive laws, young pregnant teens become exposed to the highly suspect and dangerous conditions that are commonly linked to illegal abortions. There is indirect evidence that many young women are dying because they were unable to receive proper treatment in time to respond to the associated complications of an aborted pregnancy. Unfortunately, these are reported on an ad hoc basis; there is little systematic research on the extent of the problem. Nevertheless, reports from clinical sources provide strong evidence of the severe medical complications caused by illegal abortions.

The consequences of rape for female adolescents are tragic, especially in many parts of Africa, the Arab States and Asia, where conservative social attitudes place a premium on a young girl’s virginity. The extent to which virginity in unmarried females is prized, regardless of the circumstances of sexual victimization, i.e., rape, is measured by the cruel and unusual punishment that is the fate of these girls. A study of the consequences of rape for young unmarried girls in rural Bangladesh highlights numerous cases of women beaten, murdered or driven to suicide because of the dishonour that rape or illegitimate pregnancy brings on the family. Significantly, 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.²² These findings strongly suggest a pattern of deliberate violence towards girls who are raped and become pregnant outside marriage. In Alexandria, Egypt, a study of female homicides showed that 47 per cent of the women and girls killed had been murdered by a relative after they had been raped.²³

4. Reproductive Years

C *Effects of abuse in domestic/marital relations: abortions, reproductive tract infections, recurrent vaginal infections, pelvic pain*

Abuse by intimate partners stands out as the most pervasive and debilitating form of gender-based violence against women in the reproductive stage of their life cycle. Notwithstanding the limited research and quantitative data on the health effects caused by abuse of women, indirect evidence from crisis centres, police reports and ethnographic studies establishes this form of violence as a significant cause of injury and ill-health. A wide spectrum of studies and surveys confirms the prevalence of domestic violence and its severe, and sometimes fatal, consequences for women. China's report to the United Nations Expert Group Meeting on Violence highlighted that fully 6 per cent of deaths and serious injuries in Shanghai in 1964 were a result of domestic violence. A survey in Alexandria, Egypt, indicated that domestic violence accounted for 28 per cent of all visits to area trauma units and was a major cause of injury to women. Another notorious form of domestic violence which causes loss of life is wife-burning related to dowry obligations, found mainly in India. More recently, acid-throwing has been reported in parts of Bangladesh and Latin America, resulting in serious disfigurement of women.²⁴

Moving beyond these statistics on the fatal outcomes of domestic violence, it is difficult to gauge the nature of the physical and mental effects of non-fatal outcomes of this form of abuse. However, it is instructive to look at studies from developed countries simply as a means of establishing benchmarks for the specific physical and mental-health effects of domestic violence. Abused women face a host of physical problems that include chronic complaints such as headaches, abdominal pains, muscle aches and sleeping and eating disorders. From an RH perspective, battered women are more likely to experience persistent miscarriages and recurrent vaginal infections.

²²Vincent Fauveau and Therese Blanchet, "Deaths from Injuries and Induced Abortion among Rural Bangladeshi Women," *Social Science and Medicine* 29 (9):1121-1128.

²³P. Graitcer and Youssef (eds.), *Inquiry in Egypt: An Analysis of Injuries as a Health Problem* (U.S. Agency for International Development and Cairo Ministry of Health, 1993).

²⁴Heise *et al.*, *Violence Against Women*, p. 21.

C ***Psychological problems***

Women facing abuse in a domestic setting point out that the psychological effects of abuse are often more debilitating than the physical consequences. Among the most common reactions to violence are fear, anxiety, fatigue and PTSD. The gender-based nature of domestic abuse also results in a more heightened sense of isolation and hopelessness. According to studies in the United States, battered women are more likely than non-battered women to require psychiatric treatment and five times more likely to attempt suicide. They are also likely candidates for alcohol abuse.

5. **Post-Menopausal Years**

C ***Effects of abuse: heightened vulnerability to disease, disability and poverty***

The RH needs of older women will become an increasing concern as the size of this population group grows in size. 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 of the community for support, leaving them vulnerable to abuse. In cultures where women have a low socio-economic status and no property rights, the problem is compounded. The seriousness of RH 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, they experience these illnesses from a profoundly disadvantaged position due to their extreme poverty, exposure to physical abuse and a total lack of any form of support services catering for their special needs.²⁵

B. **Effects of Gender-based Violence on Reproductive Health Decision-making and Choices**

Studies of the health consequences of abuse on women underscore that the psychological effects of abuse can be just as damaging as physical effects. These, in turn, have major implications for the RH behaviour and decision-making capacity of abused women and girls. The trauma of sexual coercion and assault experienced by women and girls at different stages of their life cycle leaves them with irreparable loss of self-worth and autonomy, leading to the acceptance of victimization as part of being “female”.

1. **Violence: A Deterrent to Using RH/FP Services**

Gender-based violence has a direct effect on women’s ability to exercise reproductive and sexual autonomy. Many women’s decision-making on contraceptive use is shaped by fear of violence from disapproving male partners. The prevailing view in many developing countries is that family planning provides protection against pregnancy and, hence, promotes promiscuity among women. A significant majority of 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 challenge to her partner’s masculinity. Studies from countries such as Bangladesh, Mexico and South Africa provide strong evidence that fear of abuse from male partners is a critical factor in women’s decision-making regarding contraceptive use.

²⁵Ibid.

In many countries, gender-based violence becomes inherently built into the “system”, because the law requires spousal permission before family planning is administered to women. These women are at increased risk of violence if they use family planning without the approval of their partners. According to Family Planning International Assistance (FPIA), women in Kenya are reported to have forged their partners' signatures rather than risk violence or abandonment by requesting permission to use family planning services. Focus-group discussions on sexuality in Mexico and Peru confirm that women feared violence, desertion or accusations of infidelity if they proposed family planning. When family planning providers in Ethiopia stopped requiring spousal consent, the use of the clinics' services increased by 26 per cent in a short period of time.²⁶

2. Limited Options for Protection against Reproductive Tract Infections, Acquired Immunodeficiency Syndrome and Violence against Women

Women's and girls' ability to protect themselves from HIV and STDs is greatly influenced by the threat of male violence. Violence promotes the risk factor for women by exposing them to forced and unprotected sex. Their ability to negotiate condom use by their male partners can be linked to the extent or degree of abuse in their relationship.

Many AIDS-prevention strategies are implemented on the basis of negotiated condom use between partners. However, this is based on the mistaken assumption that there is equality of power between men and women. Such programmes fail to take into account inequalities in the social relations based on gender that have a bearing even in consensual unions in which women lack full control over their sexual lives. Studies from Latin America and Asia suggest that women's lower bargaining power in married life is related to sexual and reproductive aspects.²⁷

C. Effects of Gender-based Violence on the Economics of Reproductive Health/Family Planning Service Delivery

An important dimension of gender-based violence that is yet to be fully recognized is the extent to which treatment of the symptoms of abuse impose additional demands on the already limited resources of most national public health care systems. The growing body of knowledge based on research findings, clinical reports and advocacy activities all point to the widespread prevalence of gender-based violence across class, cultural and geographical boundaries in all regions of the world. With this increased awareness has come the recognition that violence against women and girls represents a “hidden” health burden which has not been as yet fully grasped, particularly in its implications for the financial cost to the health-delivery system. The serious RH consequences of gender-based violence translate into an even higher demand for curative care in the RH services sector. This means that the culture of secrecy and silence concerning the causes of injury and pain suffered by many women and girls results in an inefficient use of available services, because treatment will provide only temporary reprieve unless the root causes are addressed directly.

²⁶Nancy Yiner, *Unmet Need for Family Planning: Reflecting Women's Perceptions* (International Center for Research on Women, April 1998).

²⁷Ibid.

In the context of the structural adjustment programmes that many developing countries are pursuing, reforms in the health sector have focused on streamlining and cost recovery of services. Given this policy environment, it is critical to look at points of “leakage” in the health-care system — that is, the lack of appropriate targeting of service provision in ways that are responsive to the specific needs of the client. This is the case for many victims of gender-based violence, who often do not receive adequate health-care support until a critical stage of disability is reached. By this time, the costs both in human morbidity and in medical care are unnecessarily high. Because of this gap in policy and practice in the public health sector, much of the responsibility for the care of abused women has been de facto delegated to small women’s organizations that have neither the resources nor the institutional capacity to meet the needs of such victims fully.

The toll of gender-based violence on the lives of women has been pinpointed as a result of innovative efforts of the World Bank to measure more precisely the extent of the health burden. The 1993 issue of *World Development Report*, focusing on health, highlights a modelling exercise developed by the Bank that estimated the health years of life lost to men and women due to adverse causes. Accordingly, every year lost due to premature death is counted as one disability-adjusted life year (DALY), and every year spent sick or incapacitated as a fraction of a DALY, with the value determined by the severity of the disability.²⁸ Significantly, the analysis emerging from this exercise, disaggregated by region and age group, indicates that rape and domestic violence is a major cause of disability and death among women of reproductive age in both developed and developing countries. 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. However, this percentage is lower than might be expected due to the overall greater burden of disease faced by women in developing countries. For example, in China, where the disease burden is on the decline, the healthy years lost due to rape and domestic violence increase to 16 per cent of the total burden.²⁹ Moreover, from a global perspective, the health burden from gender-based violence among women age 15 to 44 is comparable to the level posed by other risk factors and diseases that are high priority, including HIV, tuberculosis, sepsis, childbirth, cancer and cardiovascular disease (see Table 4).

These health burden percentages are important indicators of the demands that can potentially be generated on the health-care system. The physical and mental consequences of gender-based 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. Therefore, the process of reform in the health sector, and particularly in the FP/RH sector, needs to include more systematic study and to respond to the specific health-care support requirements of victims of gender-based violence. The economic arguments for cost-effective health-service delivery need to take into account specifically the impact of violence against women on women’s health. As the pressure for integrating and decentralizing services grows, it will be crucial to articulate policy reforms that respond to the gender-specific needs so that appropriate preventive as well as curative programmes can be put in place.

²⁸World Bank, *World Development Report 1993: Investing in Health* (New York, Oxford University Press, 1993).

²⁹"The Intimate Enemy."

Table 4. 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	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: Based on World Bank, World Development Report 1993: Investing in Health. Figures for rape and domestic violence, which are included for illustrative purposes, are cited in L. Heise et al., Violence Against Women: The Hidden Health Burden, World Bank Discussion Paper 225 (1994).

IV. POLICY REFORM PROCESS

The ICPD process and the resulting Programme of Action underscored important policy shifts aimed at more effectively addressing population and development concerns, particularly in reproductive and sexual health. Equally significant, the ICPD framework was instrumental in establishing a broad international consensus for adopting these new conceptual perspectives as integral parts of overall population and development goals and objectives. A ground-breaking achievement of ICPD was the clear articulation and linkage of gender equality and equity issues as central to successful population policies and programmes. Chapter IV of the ICPD Programme of Action points out that “population and development programmes are most effective when steps have simultaneously been taken to improve the status of women” (para. 4.1).

Given the clear policy parameters established by the ICPD, the reform process under way should ensure that the following key policy perspectives are addressed in a comprehensive and systematic manner. These are:

- C The integration of gender issues in population policies;
- C The linkage of reproductive and sexual health rights concerns to RH/FP programmes and services; and
- C The undertaking of policy-oriented research to fill in knowledge gaps on new and emerging issues such as gender-based violence.

A. Integration of Gender Planning and Analysis in Population Policies: The Real End-Game

The policy reform process as guided by the ICPD Programme of Action has established gender equality and equity issues as critical and substantive areas of programming in all three major areas of UNFPA’s population and development programmes: reproductive health/family planning; population and development strategies (PDS); and advocacy. Although the need to link gender equality and equity issues to population policy is now widely recognized, the application of this perspective to major areas of population policy-making remains a challenge. The conceptual shift to gender equality and equity concerns endorsed by the ICPD framework has yet to be translated into concrete changes in the making of policies on “women, population and development” issues. Furthermore, the integration of gender perspectives in all of population policy-making has yet to be systematically and comprehensively achieved. This is of special concern because policy reform processes to address the new parameters established by the ICPD are under way, but parallel efforts to ensure the mainstreaming of gender concerns in this same process are, at best, ad hoc if not totally lacking.

This gap in the policy reform process has serious implications for the policy environment in which such issues as gender-based violence can be effectively addressed. Research on this issue makes it clear that the causes of gender-based violence are an outcome of other important sociocultural, economic, legislative and political variables. Overall, these studies show that although violence against women is perpetrated at an individual level, such behaviour is heavily influenced by the society they live in. The key distinguishing features of a society, including its laws, cultural

values, social structures, local and family relationships, determine the potential for violence among its members. Other researchers point to a more specific factor. In less developed countries, societies that tend to have higher levels of gender-based violence are those in which women are economically dependent on men, or in which they have little room for manoeuvring, whether in the home or in the political sphere.³⁰

From a wider population perspective, it is strategic, therefore, to ensure that such agenda-setting instruments as population policies concretely and fully address gender equality and equity issues. The current conceptual basis of most population policies with regard to women's issues results in piecemeal and isolated programming efforts that provide little of the much needed value added to other core areas of population and development policy-making.

B. Creation of New Synergy: Linkage to Reproductive and Sexual Health Rights

The ICPD was a milestone in bringing about a crucial conceptual redefinition and extension of the population policy domain and in securing international commitment for its acceptance. In particular, the policy reform process as set out by the ICPD Programme of Action brought about the shift from a purely maternal and child health/family planning (MCH/FP) approach to the more inclusive and comprehensive reproductive and sexual health approach. This transition is an evolving one, particularly at the institutional level. The underlying principles of this new policy have been accepted; the more difficult structural and systemic changes have yet to take place. This transition period provides a window of opportunity for addressing issues of reproductive and sexual health rights as a critical aspect of the RH approach. The ICPD provides a strong mandate (Chapter VII) for viewing reproductive and sexual health rights as an essential dimension of reproductive and sexual health policy-making and programming.

The focus on reproductive rights is instrumental in bringing about needed attitudinal, behavioural and institutional changes for effectively dealing with gender-based violence within the realm of public health. The serious health consequences of gender-based violence have remained largely hidden from public view. One responsive measure for penetrating the wall of silence and secrecy is to link the principles of reproductive and sexual health rights to the practice of RH in all its facets. Health professionals, particularly those in RH/FP, are usually the front-line care providers for women and girls who are victims of violence. This is because the consequences of gender-based violence such as miscarriages, pregnancy, induced or illegal abortion and other gynaecological complications are within the domain of reproductive and sexual health. Health-care providers, therefore, need to be apprised of and conversant with reproductive and sexual rights and their application in service delivery systems.

In practice, because of the general lack of awareness and sensitivity among health workers as to the health risks, and particularly the RH risks, faced by victims of abuse, service providers are unable to provide but the minimum support or care. If, however, reproductive and sexual health policy was explicitly to incorporate a reproductive rights perspective as an integral part of the policy reform process, the serious neglect of abused women and girls could begin to be addressed. Such a synergistic linking would not only ensure adequate health-care support but provide it while fully preserving human dignity. Instruments such as the International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights and the Guidelines for its implementation in RH information and services will be key to such a linking.

³⁰Ibid.

Health-care providers, thus, have a key role to play in monitoring the effects of the implementation of nationally adopted international conventions on national service delivery systems as well as on RH status.

C. Policy-oriented Research: Filling the Knowledge Gap

One of the key constraints to addressing gender-based violence from a public health perspective is the serious gap in knowledge as regards its “hidden costs” in both human and material terms. Policy makers continue to see violence against women as a “private matter” to be resolved under the auspices of the family. Yet, many of them represent countries that are signatories to such international instruments as CEDAW and the Declaration on Violence Against Women, which specifically speak to the need for policy action. Indeed, the increased awareness as a result of the international mandate has generated important space for advocacy activities at the national and local levels to focus on a formerly taboo subject. These advocacy efforts have yielded substantial results. It is to the credit of women’s NGOs and groups that major strides have been achieved in the adoption of constitutional provisions and national legislation to criminalize acts of gender-based violence. However, the enforcement of these provisions remains a challenge — and the need for specific policy measures even more urgent.

The paucity of country-specific information as to the breadth and depth of violence against women has been a major barrier for policy-making and programming on this issue. In this regard, policy-oriented research with specific sectoral implications would provide the hard facts on the basis of which the highly “public” consequences of this “private” and family-related issue could be established. A key issue will be to develop modalities to ensure that the findings of such research are applied to the development of appropriate social support systems, including health-care delivery.

D. Inter-Agency Collaboration

To address the root cause of gender-based violence, i.e., gender inequality and inequity, requires simultaneous reinforcing actions across all developmental sectors, economic and social, including education, health, trade and labour; and NGO, private and public. The conclusions, recommendations, and programmes and plans of action agreed upon at international forums provide a framework within which agencies can conduct dialogue and develop concerted programmes that complement one another. The development of modalities such as the United Nations Development Assistance Framework and the World Bank’s Sector Wide Approach will serve to facilitate the implementation of coordinated agency support for national programmes aimed at the eradication of gender-based violence.

V. STRATEGIC ENTRY POINTS WITHIN UNFPA CORE PROGRAMME AREAS

This review of the RH effects of gender-based violence has been undertaken with a specific interest in the programme implications for UNFPA. Although the mandate to address gender-based violence as an RH issue was clearly established by the ICPD Programme of Action, the specific programme implications are still to be worked out. Given this context, this is an initial effort aimed at identifying strategic entry points within UNFPA's three core programme areas: Population and Development Strategies; Reproductive and Sexual Health/Family Planning and Advocacy (see Table 5)

Table 5. Programmatic Responses and UNFPA Core Programming Areas	
Programmatic Responses	UNFPA Core Programming Areas
Linkage of reproductive and sexual health rights/concerns to RH programmes	Reproductive Health Programmes # Institutional responses # Involvement of men # Involvement of youth # Community-based workers # Emergency situations response
Integrating gender planning and analysis in population	Population and Development Strategies # Data collection/research # Gender equality/equity # Women's participation
Policy-oriented research	Advocacy # Constituency-building # Legal reform # Enforcement of laws # Empowerment skills
Inter-agency collaboration	

A. Reproductive and Sexual Health

1. Strategies for an Institutional Response

Until recently, the RH sector remained largely outside the debate on gender-based violence. Yet, for some time, research findings in developed countries pointed to direct linkages between gender-based violence and its RH consequences. In developing countries, although official sources

of information are scant, indirect evidence provides strong indications for the prevalence of gender-based violence and its serious repercussions on the reproductive and sexual health status of women and girls around the world.

One of the major challenges to addressing gender-based violence in the RH sector is the need to develop partnerships with ongoing NGO initiatives and project-based activities to develop a more nationwide, institutionalized approach to the problem. The lack of institutional response is a reflection of the fundamental gap in policy and the lack of enforcement where protective laws and provisions exist. RH programmes are based within an institutional framework that has yet to address the reality of gender-based violence and provide the necessary institutional support.

A health-sector effort aimed at responding to domestic violence in a comprehensive and consistent manner would need to establish the following institutional mechanisms:³¹

C *Form a collaborative working group to promote change in institutional and management culture*

To respond effectively to the often silent needs of victims of gender-based violence, the institutional and management culture of hospitals and clinics that provide RH/FP services needs to be transformed. RH/FP programmes need to adopt a much wider perspective than the purely medical aspects of treating patients who are victims of abuse. One important strategy that would create an enabling environment is establishing strategic partnerships between local domestic violence service organizations, advocacy groups and health professionals from hospitals or clinics. Forming a collaborative working group on gender-based violence would enhance a more precise understanding and informed perspective on the special service needs of abused women and girls. At an operational level, this would build institutional support for addressing the issue and, secondly, ensure that training activities and referrals are well coordinated.

The working group should be multidisciplinary and composed of physicians, nurses, social workers and administrators so as to expand the number of stakeholders who will be fully committed to using their professional skills to helping victims of abuse regain their physical and mental health. The group's scope of activities can be more readily determined by taking the results of surveys of domestic violence in their respective contexts or by documenting cases within the hospital or clinic setting as well as by surveying service providers' knowledge, attitudes and behaviour about domestic violence. The working group should have close relationships with support groups in civil society such as the police and the judiciary as well as women's NGOs (see Box 3).

³¹M. Grambs, ed., *Best Practices: Innovative Domestic Violence Programmes in Health Care Settings* (Family Violence Prevention Fund, April 1997).

Box 3. Palestine: Establishment of a Women's Centre for Health Care, Social Assistance, Legal Counselling and Community Education in Gaza

The project is designed to provide multifaceted services to meet the critical RH care and social support needs of Palestinian refugee women in the Gaza strip. It is jointly implemented by the Italian Association for Women in Development (AIDoS) and the Culture and Free Thought Association (CFTA), a local women's NGO. Notably, in its situation analysis, the project points out that violence against women was identified as a serious social problem by local women's organizations which receive numerous requests for assistance from women in the community. From the outset, the problem of gender-based violence, including domestic violence, rape, battery and sexual harassment both within and outside the family, was specifically identified as a key area for UNFPA programme support.

To respond to the diverse needs of Palestinian women refugees, a Women's Health Centre was established in the Bureij Refugee Camp with the aim of providing an integrated package of services. The Centre was set up as a "one stop" service delivery point offering needed care in the following key areas: RH/FP support specifically focusing on pregnancy and postnatal monitoring; the screening and prevention of female cancers; the promotion of responsible sexual behaviour among teenagers; legal and psychological counselling to assist women experiencing domestic violence; social counselling to promote women's decision-making roles and awareness of gender equality issues; and a programme of gymnastics which has proved popular and which is a strategic entry point for promoting other project activities.

Overall, the project promotes a women-centred perspective and aims at raising women's awareness about the importance of their health and preventive care. It has a strong outreach component that cuts across all project-supported activities. An average of 15 to 20 monthly workshops focus on topics related to the project's major components: health, psychology and legal and social issues. These outreach activities have been successful because of the community-based participatory approach adopted by the project. Training is another catalytic activity of the project, contributing to capacity-building among health professionals both within and outside the project.

Source: UNFPA project files.

C Develop routine, site-specific screening

It is essential to establish a routine process of screening for gender-based violence. In so doing, it is important to take into account sociocultural sensitivities. A careful determination should be made in two important respects: the physical layout where the screening is to take place, ensuring that private space is made available; and the selection of the clinical staff responsible for interviewing the victim of abuse. All identified victims of violence should leave the clinical setting with some basic intervention having been made, including counselling on domestic violence, and safety planning and referrals, even if the patient is unwilling to pursue the referral. Consequently, all primary-care providers should be able to undertake these basic interventions with patients.

C Formulate protocols

The formulation of a protocol on gender-based violence would be an important indicator of the extent of institutional commitment to the issue. This would formalize procedures and processes that need to be implemented in order to provide appropriate service support to victims of violence. At a minimum, a protocol should include the following basic elements: a definition of domestic violence; screening questions; an identification of which clinical/hospital staff member will make inquiries; interviewing strategies; safety assessment and planning guidelines; discharge

instructions; clarification of legal requirements and procedures for the collection of evidence; medical record documentation; referral information; and a plan for staff education. These protocols would best be developed by a multidisciplinary team such as the working group on gender-based violence described above.

The human rights perspective is a critical dimension in RH/FP programme efforts to respond to gender-based violence. Recognizing reproductive rights as an integral part of the RH/FP support for victims of violence means recognizing an important human rights principle. Therefore, specific protocols on gender-based violence should reflect these important dimensions to women's health rights to provide consistent guidelines on how to deal with the special psychological and physical effects.

C Develop quality assurance mechanisms for RH service delivery

The successful screening and treatment of victims of abuse will depend largely on the quality and sensitivity of care extended by health providers. Therefore, a critical aspect of quality assurance reviews should be the level of appropriate response to patients who are victims of violence. Such reviews should encompass services addressing not only outpatient and surgical cases but also the management of complications of abortion; antenatal, delivery and postnatal care; and the management of STDs. They should also include the provision of emergency contraception, where appropriate.

The concept of quality of care in RH would need to be expanded and sub-indicators on gender-based violence and service delivery developed. Since the prevailing culture of silence and secrecy makes it difficult for women and girls to come forward and report the abuse, it becomes incumbent on health workers sensitively but firmly to identify signs of abuse. Service providers should be made aware that responding to any form of gender-based violence is part of standard care and no longer a matter of discretion. Information and services about domestic violence should be an integral part of RH services and should be linked by referral to legal and medical services for battered women. The result of ongoing quality assurance reviews can be used as baseline information to engage health professionals in setting specific goals and addressing obstacles.

From the viewpoint of management capacity, training opportunities for managers at regional training centres should provide them with specific communication and interpersonal skills. These skills would enhance the ability of managers to respond to the complex legal, psychological and physical issues raised by incidents of gender-based violence. Training specifically focusing on this issue would further legitimize treating gender-based violence as a public health problem.

C Institutionalize staff training on gender-based violence

A key institutional response to meeting the public health needs of victims of abuse is to raise the awareness of public health professionals at all levels. In particular, training for health workers in RH and sexual health should incorporate the health consequences of gender-based violence from a life-cycle perspective. To enhance the training process, gender-based violence advocates and survivors should be invited to participate. Interactive exercises, role playing and other "learner-centred" techniques which enable trainees to practice screening and explore personal responses to abuse are especially effective methods.

Another important step towards institutionalizing this issue would be the inclusion of reproductive rights perspectives in the training curricula of all health workers. The ICPD Programme of Action provides a useful framework for understanding the key concepts of this

approach, and the IPPF Charter on Sexual and Reproductive Rights is a useful guideline for curriculum development. Such changes to the training programme would represent strong indicators of policy commitment and institutional responsibility to this public health concern.

The information, education and communication (IEC) strategy for RH provides a strategic entry point for changing the culture of silence that is prevalent even among health and medical professionals. After all, health professionals are as much part of the establishment and have undergone the same process of socialization as other members in the society. Their ingrained views and understanding of gender-based violence can be a hindrance to their capacity to give needed health care to victims of violence. In particular, an IEC strategy is critical for reeducating health-care providers about deeply embedded social attitudes and practices that perpetuate different facets of gender-based violence.

C Develop a referral network and resource materials

Victims of violence are more often than not known to remain for long periods in abusive relationships. This can be explained partly by a sense of isolation and a perception that there are few options for a way out. As a result, victims of abuse are unlikely to be aware of information and support services available to them. RH/FP service providers are uniquely placed to offer valuable advice and to guide willing patients to sometimes life-saving “safe havens” specifically designated for women in crisis situations. Institutionally, to respond to battered women and assist them in addressing violence in their lives, providers need to be aware of services provided by local domestic violence shelters, legal assistance, counselling and support groups. This information should be collected in a referral list and made accessible to both health professionals and the patients (see Box 4).

To increase knowledge and understanding of gender-based violence, it is essential to develop resource materials for both health professionals and victims of abuse. Innovatively designed materials such as reminder stamps for screening, referrals lists and pocket reference cards for medical practitioners are useful. For patients, referral cards, brochures and booklets would help sensitize victims to their needs and rights.

Box 4. Philippines: “Women: Vanguard of Health” Project

The project "Women: Vanguard of Health" is aimed at delivering FP/RH services to women in poor urban communities in the municipalities of Malabon and Navotas in the Philippines. A key innovative strategy of this community-based project is the gender-sensitive approach to be adopted in the implementation of FP/RH information and service delivery activities. To achieve this objective, strategic linkages have been created between various stakeholders of the project, including the San Lorenzo Ruiz Women's Hospital, the Makatao Women's Center, the Department of Health and the barangay councils of Malabon and Navotas. Notably, the Makatao Foundation, a women's NGO, worked closely with the office of the Congressional representative of the region to establish the first women's hospital operated by Department of Health.

Specifically, the project aims at institutionalizing the life-cycle approach in the implementation of FP/RH services, seeking to respond to the health needs of women at all stages of their lives. The two-year period of support will focus on training activities, the undertaking of baseline and final FP/RH surveys, IEC activities and replication of IEC materials, and the provision of various equipment for data processing, medical and audiovisual purposes.

As an integral part of this gender-sensitive approach, the Makatao Women's Center provides legal and counselling services for women who are victims of abuse and violence. The synergy created by the strategic linkages established by the project is evident in the screening of hospital clients for abuse and violence and referral for more intensive care and follow-up by the women's centre. This institutional arrangement serves as a model of close collaboration between the Department of Health and a women's NGO.

Source: UNFPA project files.

C Develop partnerships with the community constituency

A strategic step for enhancing the institutional capacity of RH/FP service providers to respond to gender-based violence would be to establish a close working relationship with local organizations that run women's shelters or that undertake specific support programmes for women victims of violence. These community-based experts form an important knowledge base on local and state laws, civil and criminal justice responses and resource materials. They can also provide expertise for staff training programmes.

Participation in community-wide collaborative efforts to address various forms of gender-based violence is also an important outreach strategy to engage a larger audience. It provides an opportunity for the coordination of community resources as well as the collaboration of key community figures such as law enforcement personnel, prosecutors, judges, health-care services and advocates of gender-based violence.

IEC in RH/FP has an important role in opening up public debate on the issue of gender-based violence. The public debate would need to engage the media and strategic members of the community who are recognized as opinion makers — religious and community leaders, teachers, school administrators, politicians and entertainers. The debate would aim eventually at shifting from the perception of gender-based violence as a taboo issue and a private matter to one that it is a public policy issue (see Box 5).

Box 5. Uganda: The Reproductive, Educative and Community Health Programme

Uganda's Reproductive, Educative and Community Health Programme is an innovative project that goes beyond the usual approach of advocacy for preventive measures for FGM as one of many harmful traditional practices. This initiative focuses specifically on the reduction of FGM among the Kapchorwa community in Uganda. Two notable features of the project strategy stand out: the high level of community participation and partnership in the implementation of project activities and the interlinkages among key project components. The overall aim is to increase awareness of the negative consequences of FGM by all stakeholders in the community and to reach a consensus on alternative but equally important culturally valid ways of performing "rites of passage".

The multifaceted components of the project include:

- C **IEC programmes** that specifically target strategic members of the community including: women; community/religious leaders and opinion leaders; policy makers; health providers, including traditional birth attendants (TBAs); men (husbands); adolescents; and the circumcisors themselves;
- C **Research activities** to generate information and data on the extent and type of the practice and to establish the sociocultural reasons behind the practice. This is essential for the design of culturally appropriate and effective projects, particularly to develop IEC messages that will touch a responsive chord in the community;
- C **Policy and legislative initiatives** based on data collected and aimed at formulating legislative provisions to outlaw the practice of harmful traditional practices, particularly FGM;
- C **The training of health-care providers**, including TBAs, to recognize and treat complications (immediate and longer term) of FGM and to provide counselling;
- C **Psychological counselling** by health-care workers to provide counselling support to emotionally disturbed circumcised women and girls;
- C **Income-generation activities** to provide alternative sources of livelihood for the circumcisors who rely on FGM as a source of income;
- C **The strengthening of other positive traditional practices** such as the celebration of motherhood, dancing, singing and giving of gifts; and
- C **Resource mobilization** from both internal and external sources to support efforts to eradicate the practice of FGM.

The synergistic effect of all these activities was already evident at the end of the first year, when it was found that FGM had been reduced by 36 per cent in the communities where the project was implemented. This innovative and culturally sensitive approach is being replicated in other countries in the region, such as Mali.

Source: UNFPA project files.

2. Involvement of Men

It is especially important to promote the participation of men because a large part of the social acceptance of gender-based violence comes from the perception by males who essentially see abuse as a male prerogative. It is true that men are not singularly to blame for acts of gender-based violence. The root causes lie in a much more complex understanding of gender-based power relations. Still, men make up the majority of decision makers and community leaders, most perpetrators of gender-based violence are men, and women are more often than not the victims. Therefore, changing the mind-set of male partners is an important part of the equation for achieving harmony and mutual respect in gender relations, particularly as they relate to conjugal/marital and family life (see Box 6).

Box 6. Gender-based Violence and the Male Point of View

This innovative and possibly ground-breaking initiative explored the other side of the gender equality equation: male perspectives on issues of male sexuality, self-identity and power. A regional conference was held in June 1998 in Santiago, Chile, on the theme "Gender Equity in Latin America and the Caribbean: Challenges for Male Identities". The conference's objectives reveal the search for new paths to understanding the underlying dynamics of gender roles and relations and how these translate into gender-based power systems that affect all facets of social, economic and political life for men and women. The objectives were:

- C To promote a regional debate on male identities and the challenges implied in order to achieve gender equity, including the area of sexual and reproductive health and rights;
- C To contribute to the development of conceptual and methodological frameworks which will increase understanding of gender relationships and inequities from a male point of view;
- C To deliver state-of-the-art research on male identities in Latin America and the Caribbean;
- C To promote the exchange of knowledge and experiences between researchers on male identities and experts involved in programmes; and
- C To promote exchange of experiences in various countries of the region.

Source: UNFPA project files.

3. Involvement of Youth

Focusing on adolescent males will be especially important in order to assist them in overcoming deeply ingrained notions of how violence against women or girls is part of their birthright. Adolescent females, in turn, need to be helped to develop self-confidence, self-esteem and awareness of their reproductive rights and empowered to articulate those rights in personal relationships. Adolescents have few role models that provide real-life examples of male-female relations that are based on equality, mutual respect and harmony. Much of what they see only serves to shape their perceptions and behaviour in ways that reinforce gender-based violence as an acceptable part of their lives — for girls, it is being on the receiving end, while for boys, it means being "a man". Population/Family Life Education programmes and sex education programmes need to focus on these concerns (see Box 7).

Box 7. Caribbean Initiative

The current country programme (1997-2000) for the English- and Dutch-speaking Caribbean countries in its subprogramme for RH is providing for specific RH service support for victims of gender-based violence. In collaboration with the Caribbean Common Market (CARICOM), a minimum package of integrated sexual and RH services for adolescents and youth will be made available as a pilot effort in Guyana, Jamaica and Suriname. The pilot package will include delivery of family planning IEC and services: education on STDs, including HIV/AIDS; post-abortion counselling; and referral systems for cases of violence against women and children.

The programme's experience and results with adolescent and youth services will be disseminated throughout the region through CARICOM and other regional organizations. In collaboration with the Economic Commission for Latin America and the Caribbean (ECLAC), and as a component of pilot activities, a database on RH and youth-related issues will be developed that is gender sensitive and disaggregated by age, sex, ethnicity and socio-economic group. UNFPA will provide regional training for health providers concerned with youth RH focusing on improving adolescent counselling and awareness of gender equality concerns.

Source: UNFPA project files.

4. Community-based Workers and Traditional Birth Attendants

Reaching out to community-based workers, including social workers, is critical to any efforts to change social values at the community level. Indeed, monitoring of the follow-up of the Beijing Conference's Platform for Action indicates impressive gains in legislation concerning women's human rights and gender-based violence. Yet, implementation of these laws, which would make a difference in the lives of women, is weak if not absent. For these laws to be socially rooted, the values at the community level would have to change. This explains the prevailing legal contradictions faced by women in many countries, particularly as they relate to gender equality and equity issues, since the practice of customary laws supersedes the tenets of civil law. The result is a legal quandary which there is little political will to challenge.

Sensitizing "insiders" such as community-based workers and social workers to the health costs of gender-based violence may yield real dividends in eventually changing community values which go to the heart of gender-based violence. TBAs and traditional healers, for example, could be selectively trained as front-line agents in the bid to end the preventable RH consequences of violence against women. Given their intimate knowledge of the community, TBAs and traditional healers could well serve as "agents of change" by informing women about their reproductive and legal rights, and collaborating with health workers to reach out to the community at large.

5. Emergency Situations

In addressing violence among refugees, it is important to note the new social dynamic that may prevail: rape, forced commercial sex work, forced marriage and increased levels of FGM mutilation may occur among refugees as a means of cementing (and sometimes of eradicating) cultural identity, even if these practices were not prevalent in the home region. Women, in general, and young girls and the elderly, in particular, are the most vulnerable targets of violence; but men are often victimized by being strongly pressured to carry out violence.

In 1995, approximately 25 humanitarian and RH agencies, coordinated by the United Nations High Commissioner for Refugees (UNHCR) and including UNFPA, collaborated on the

development of a Minimum Intervention Service Package (MISP) for use during the acute (emergency) phase of civic unrest. The MISP includes home delivery kits, condoms, emergency contraception and educational materials. Increasing efforts are needed to address the psychosocial dimensions, both as a means of preventing the escalation of gender-based violence and as a means of treating victims, particularly adolescent girls. Encouraging the active participation of refugees in health-service planning and delivery is key to effective implementation of the MISP.

B. Population and Development Strategies

1. Data Collection and Research

All the key areas of PDS provide useful points of departure for creating an enabling environment for promoting the fight against gender-based violence. One particular area that stands out as an entry point for providing important and essential support to the work on gender-based violence is data collection and research. The lack of data collection and research on this issue represent a major gap in information and a serious hindrance to appropriate policy and programming responses. The scarcity of data has, in a sense, reinforced the view, for instance, that violence against women is a private family matter. Where recognition has been achieved, it has emerged as a human rights issue, one largely in the domain of human rights activists. Although this is a significant dimension of the struggle, it is equally important to move the debate into the public health domain so that victims of violence can receive the health-care attention they so desperately lack (see Box 8).

Box 8. Philippines: Women's Health Research Project

The Women's Health Research Project is a three-year research initiative notable for its innovative strategy of pursuing research through the participation of a consortium network of research and service organizations. The responsibility for managing this research network and ensuring project outputs rests with another strategic partner, the University of the Philippines Center for Women Studies Foundation. The project has three key components:

- C Gender-sensitive research focusing on Filipino women's perception of reproductive rights and fertility-regulating technologies and on understanding the health needs of women victims of abuses;
- C The development of participatory women-centred research methodologies and strategies in women's health and reproductive rights; and
- C Utilization of research results and databases for the development of user-focused advocacy materials to be disseminated to policy makers, planners, media professionals, women advocates and health practitioners.

The project is providing support to the Women's Crisis Center to undertake research and training activities on the impact of violence against women on women's health. It is the first attempt by the Center to undertake a comprehensive study of the links between violence against women and common health problems. The research provides an opportunity to systematize the information the Center has gathered in the course of six years of providing services to Filipino women victims of male violence.

Another notable feature of the project is that research results are to be translated into effective tools for advocacy. In the case of gender-based violence, it is envisaged that advocacy support will focus on three important areas for policy changes and legislative action: the formulation and/or amendment of laws on women's rights and RH; passage of the proposed anti-rape bill and a comprehensive anti-domestic violence bill being formulated by SIBOL, a consortium of women's NGOs; and adequate governmental responses to the needs of women victims of abuse through the provision of medical subsidy and other necessary services.

Source: UNFPA project files.

Given the sensitive nature of the subject, careful thought needs to be given to the data gathering methodology to ensure reliable and accurate data. The experience of women's NGOs and women's networks working with abused women should provide important insights on how best to manage the information gathering process. Given the social acceptance of gender-based violence as norm in marital life, women themselves may be unable to be readily forthcoming with information on the exact nature of the abuse. The public health sector, in particular, needs to review its health information database to incorporate the concept and consequences of gender-based violence in a comprehensive and systematic manner. This process of knowledge acquisition would empower the sector to begin to view gender-based violence as a critical public health concern (see Box 9).

Box 9. Gender Bias in China, the Republic of Korea and India: Causes and Policy Implications

The Harvard Center for Population and Development Studies conducted a study analysing the patterns, levels and trends in child mortality in three countries, China, India and the Republic of Korea. The study discusses the commonalities in the ways economic and cultural factors generate son preference and explores how country-specific factors influence the extent of gender bias.

The common element in these countries appears to be the similarity in their family systems, which are characterized by strong patrilineal lineage. This gives rise to a dichotomy between the value of a girl to her parents (very low) and the value of a woman to her husband's family (high). The study's findings led to the derivation of policy implications and suggestions for the girl child: revision of the Family Law; emphasis on gender equality and an ideological commitment to it; the potential of the mass media as a tool of social engineering; subsidies to reduce the costs of educating daughters; and the enforcement of laws on equal inheritance.

Source: T. Jafri, "Note on RAS/95/PO8: Draft Report on Gender Bias in China, South Korea and India: Causes and Policy Implications" (Unpublished, 1998).

2. National Strategies on Gender Equality and Equity

UNFPA programme support for PDS aims at ensuring that national development strategies integrate population and development perspectives in all key sectors. An equally important challenge is making sure that gender equality and equity issues are an integral part of a comprehensive national development strategy. This need has been given added impetus by the recommendations and action plans of the ICPD and the Beijing Conferences. The critical importance of establishing gender equality issues within the framework of national development strategies is that it provides legitimacy to them as bona fide development concerns rather than as simply "women's issues" to be addressed by women's groups. This, in turn, enhances the possibilities for receiving governmental institutional support, particularly in the allocation of financial resources, instead of the prevailing situation where much of the assistance for women's development activities is secured from external donor sources. This results in a lack of ownership by national entities. Questions about the sustainability of these project-based activities constitute a constraint to achieving real change in the lives of the women beneficiaries. Thus, gender equality issues need to be clearly integrated in national development plans which provide the parameters for setting priorities in policy and budgetary support (see Box 10).

Given this context for determining development policy, planning and programming, it becomes critical that the issue of gender-based violence is clearly articulated within the framework of the national strategy on gender and equity, setting out the country-specific features of the problem. The process of identifying gender-based violence as a development concern in the public domain of policy-making enhances opportunities for promoting policy reforms and programmatic action. Too often, the debate on gender-based violence and women's right to protection even within the "safety" of their homes is conveniently characterized as a "feminist" issue of interest to radical women's groups and organizations. The issue of gender-based violence is still far removed from the agenda of mainstream public health policy and practice.

Box 10. Algeria: Integration of Gender Equality in National Development

The new country programme for Algeria for the period 1998 to 2000 has a PDS subprogramme, one of the major objectives of which is the promotion of women's active participation in Algerian development and the reduction of inequality between the sexes. The programme strategy aims at strengthening the capacities of key institutions and organizations such as the Ministry for National Solidarity and the Family (MSNF) and women's NGOs to more effectively manage development projects and advocacy activities aimed at enhancing women's status in Algerian society.

As part of this strategy, one of the concrete activities envisaged is a survey on the prevalence of domestic violence and the establishment of a database on gender-sensitive indicators. In addition, a directory of women's NGOs and networks dealing with gender equality issues will be developed. These initiatives are expected to create a much needed knowledge base for designing appropriate development responses that meet the realities faced by Algerian women today.

Source: UNFPA project files.

A sustained and responsive programme of assistance for victims of gender-based violence can be achieved only if public institutions in the relevant sectors recognize their roles and responsibilities in addressing the problem. This recognition will be greatly facilitated if and when national gender strategies fully elaborate priority issues with respect to gender-based violence and identify specific areas for development support. This "road map" would permit a determination of the comparative advantages of both government institutions and NGOs in undertaking a wide range of activities, including advocacy, legal reform and support services such as shelters, hotline, crisis centres etc.

3. Participation of Women in Public Life

One of the fundamental characteristics of male-female gender relations is the almost universal pattern of male dominance. This unequal distribution of power based on the gender division of labour is often depicted as part of the "natural order of things". Women themselves have come to accept the status quo and play a decisive role in maintaining the order. This very process of socialization has resulted in the marginal if not negligible participation of women in public life. Therefore, male dominance in private life is reinforced by male dominance in public life. This, in turn, explains why, as a development issue, gender-based violence is one of the most difficult and intractable issues to address.

Studies show increasing trends of women's participation in public life, particularly in the political process. These patterns are based on affirmative action measures which guarantee quotas for women's participation. This is a necessary mechanism for ensuring a minimum level of representation. However, the quality of their participation in critical decision-making processes requires further attention. The capacity of elected or appointed officials to set or mobilize support for legislative agendas, particularly on issues such as gender-based violence, is limited. Women lack a political base or constituency to truly empower them as decision makers. Notably, in the areas of reproductive and sexual health, there has been little activism by women politicians to rally public opinion. The issue of gender-based violence stands out as a case in point.

Overall, the significant gap in power between men and women in all areas of public life — political, social, economic and legislative — becomes an important factor in efforts aimed at

eliminating gender-based violence. Moreover, women's continuing low level of participation in public life as decision makers, policy makers and managers also undermines their ability to change the gender balance of power.

C. Advocacy

Inasmuch as the reality of gender-based violence is veiled by the prevailing "culture of silence", advocacy becomes a critical tool for lifting the secrecy and denial associated with it. An advocacy strategy should be developed in close consultation with the strategic constituencies that would be expected to become the key players. These include the media, women's networks and groups, health professionals, politicians, religious leaders and educators. The aims of such an advocacy programme should include the empowerment of women and the promotion of gender equity and equality in all spheres of life.

1. Building a Constituency

The peculiar features of gender-based violence, high social acceptance and, therefore, low public visibility, except for some sensational cases, highlight the need for an advocacy programme aimed at building a critical mass of support. Creating a constituency for the elimination of gender-based violence would provide a pressure group to promote sustained and strategic campaigns and interventions to educate the public and to 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 rights need to be expanded, and their concerns need to become of interest to society as a whole. Therefore, the building of the institutional and organizational capacity of these small networks with limited resources becomes an important aspect of an advocacy strategy for gender-based violence (see Box 11).

2. Effecting Legal Reform

Advocacy is needed to change aspects of the legal system that are inimical to the interests of women victims of violence. Some countries have adopted progressive legislation incorporating many of the principles endorsed in international instruments on this issue. In other countries, much more intensive efforts will be required to produce needed openings in their legislative frameworks. Even in those where legislation on gender-based violence has been enacted, the actual prosecution of perpetrators is far from guaranteed. Moreover, court systems and procedures present a major hindrance for prosecuting the perpetrators of gender-based violence. Often, the forms of evidence required for submission and the process of testimony make it very difficult for women, particularly if the process involves husbands and male family members on whom they are dependent. In some countries, acts of gender-based violence are not considered as a specific criminal offence. This effectively diminishes the gravity of the offence and reinforces social acceptance of this form of violence.

Box 11. Regional Collaborative Advocacy Campaign on Gender-based Violence: Latin America and the Caribbean

The fiftieth anniversary of the Universal Declaration of Human Rights provided an opportune time for giving visibility to the issue of violence against women. Under an initiative spearheaded by the United Nations Development Fund for Women (UNIFEM) and in collaboration with UNFPA, the High Commissioner for Human Rights and the Economic Commission for Latin America and the Caribbean (ECLAC), a campaign was launched to coincide with International Women's Day (March 8) to demand an end to gender-based violence. The campaign's awareness-raising activities were envisaged to be strategically linked to other global observances such as the fifth anniversary of the Vienna Declaration, Human Rights Day and World Population Day.

UNFPA is implementing country-level campaigns to sensitize the public on every person's right to a life free of violence. In Jamaica, UNFPA sponsored Women's Day events, including a television programme on relations between the sexes, "The Man and Woman Story". Similar events were organized in Quito, Ecuador, where UNFPA supported the inauguration of a women's centre, Casa de las Tres Manueles, for victims of domestic violence. A book on gender, violence and health was also launched to be used by universities and health providers. In Cuba, events included media coverage on women's rights and interviews with UNFPA representatives on gender-based violence. Similar campaigns are under way in Chile and Guatemala and other are planned for Colombia and Venezuela.

Source: UNFPA project files.

3. Enforcing Laws

Due recognition is to be given to the legislative momentum generated concerning gender-based violence, particularly after the Cairo and Beijing Conferences. However, the enforcement of laws with respect to gender-based violence remains inadequate. The key enforcers of such laws, including judges, lawyers and police officers, have yet to fully accept violence against women as a criminal act. Domestic violence, rape, marital rape and sexual assault are largely viewed as beyond the reach of law enforcement officials. Sensitization of the law enforcement establishment to change its perceptions about the seriousness and criminal dimensions of violence against women is another important area of advocacy support. Effecting changes in social values, particularly at the community level, begins in a critical way with changes in the attitudes of the gatekeepers of social law and order. For gender-based violence to emerge from its veil of secrecy, it is essential that law enforcement officials at all levels assume a more visible and active role by taking the appropriate preventive as well as protective measures.

4. Fostering Adolescent Empowerment

A special advocacy effort should focus on the adolescent segment of the population. From an RH perspective, this group is paying an especially high price as a result of the serious and long-lasting consequences of gender-based violence. Viewed from the life-cycle perspective, adolescent girls are increasingly exposed to higher health risks from rape and sexual abuse. The evidence of their vulnerability is indicated by the higher levels of STD/HIV infection and high rates of teenage pregnancies and pregnancy complications due to illegal abortion. These are only a few of the many health complications that young girls face from the wide spectrum of gender abuses they experience at different stages of their life cycle.

Given the relative powerlessness of adolescent girls, it is critical that advocacy efforts aim at providing them with life-enhancing and life-preserving skills. This has to do with educating them about the nature of gender-based violence and, particularly, the socialization process that leads girls to accept gender-based violence as part of being female. Many adolescent girls — and boys, for that matter — need to develop communication and negotiation skills that will empower them to have intimate relations based on mutual respect and responsibility, particularly as regards reproductive and sexual life. Peer-based advocacy is an important means of reaching out to youth largely based on their specific experiences, insights and perceptions.

D. Programmatic Responses Based on Life-Cycle Stages

From the foregoing review of the scope and dimensions of gender-based violence, it is clear that the institution of adequate mechanisms to address the issue of gender-based violence and its RH effects goes beyond the purview of a single developmental sector and requires the concerted effort of civil society as a whole. Fundamental to the programmatic response is the concept of human rights; a recognition of reproductive rights as human rights; and a commitment to gender equity and gender equality as articulated in the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Table 6 indicates the types of programmatic responses that should be made to deal with each of the reproductive health effects of gender-based violence at various stages of the life cycle (discussed in Chapter II).

Table 6. Reproductive Health Effects and Programmatic Responses to Gender-based Violence: The Life Cycle Approach

Life-cycle stage	Type of gender-based violence present	Reproductive health effect	Programmatic response
Pre-birth	<p>C Female sex- selective abortion</p> <p>C Battery during pregnancy†</p> <p>C Coerced pregnancy††</p>	<p>< female foeticide</p> <p>< miscarriage</p> <p>< low birth weight</p>	<p># RH services for:</p> <ul style="list-style-type: none"> -quality maternity care -mgt of sexually transmitted disease -emergency contraception -mgt of complications of abortion -gender-sensitive supportive counselling(incl. case detection/referral) <p># Population and development strategies for:</p> <ul style="list-style-type: none"> -data collection and research -gender equity/equality -participation of women <p># Advocacy re Convention on the Rights of the Child; CEDAW; eradication of harmful beliefs/ practices; RH/reproductive rights; legal reform; prosecution of violators</p>
Infancy	<p>C Female infanticide</p> <p>C Emotional and physical abuse*</p> <p>C Differential access to food /medical care</p>	<p>< skewed sex ratio (“lost girls”)</p> <p>< girls impaired growth and development</p> <p>< girls impaired nutritional status</p> <p>< Emotional/psychological trauma†††</p>	<p># RH services for:</p> <ul style="list-style-type: none"> -community information/education <p># Population and development strategies for:</p> <ul style="list-style-type: none"> - Gender-sensitive parent education/social support systems - Gender- sensitive nutrition programmes - Gender-disaggregated data collection <p># Advocacy re girl child; monitoring of implementation of international agreements (e.g., CRC and CEDAW)</p>
Childhood	<p>C Female genital mutilation</p> <p>C Differential access to food/medical care*</p> <p>C Child marriage*</p> <p>C Sexual Abuse/early sexual experience(incl. incest)*</p> <p>C Child prostitution*</p>	<p>< haemorrhage, infection, urine retention, dyspareunia, difficult childbirth, fistulae.</p> <p>< psychological/emotional trauma</p> <p>< increased risk of RTIs incl. STDs</p> <p>. increased risk of unwanted pregnancies and illegal abortions</p> <p>< increased risk of maternal mortality and morbidity incl obstructed labour, VVF/RVF</p> <p>< increased risk behaviour (unsafe sex; substance abuse)</p>	<p># RH services for:</p> <ul style="list-style-type: none"> - Parent/community education re health risks and reproductive rights violation - Youth programmes - Quality maternal/gynaecological health care including nutrition -Supportive counselling for victims <p># Population and development strategies for:</p> <ul style="list-style-type: none"> - Social support systems for FGM eradication and delayed marriage <p># Advocacy re FGM and child marriage eradication; legal reform; punishment of perpetrators</p>

Table 6. Reproductive Health Effects and Programmatic Responses to Gender-based Violence: The Life Cycle Approach

Life-cycle stage	Type of gender-based violence present	Reproductive health effect	Programmatic response
Adolescence	<p>C Dating/courtship violence (incl. "date rape")*</p> <p>C Sexual abuse (incl. incest)*</p> <p>C Economically-coerced sex ("sugar daddy"; commercial sex work; trafficking)</p> <p>C Coerced pregnancy</p> <p>C Battery, homicide*</p>	<p>< emotional/psychological trauma (e.g. suicide, depression, PTSD)</p> <p>< increased risk of STDs incl. HIV/AIDS</p> <p>< adolescent pregnancy (incl. increased risk of pre-eclampsia; premature labour etc.)</p> <p>< unwanted pregnancy</p> <p>< increased risk of illegal abortion</p>	<p># RH services for: -adolescent RH (incl. maternal health care; emergency contraception; mgt of abortion complications; supportive counselling; sexuality and gender equality in schools)</p> <p># Population and development strategies for: -Social support systems for gender-sensitive adolescent health and development and responsible parenthood</p> <p># Advocacy re sexual abuse; age at marriage/child-bearing; life skills training; youth employment; gender equality and gender relations</p>
Reproductive Years	<p>C Domestic abuse (incl battery, marital rape; dowry abuse/murder)*</p> <p>C Sexual abuse (incl harassment; rape)*</p> <p>* Emotionally coerced sex (commercial sex work; trafficking)</p> <p>* Abuse of widows</p>	<p>< emotional/psychological trauma (incl. increased risk of substance abuse; PTSD)</p> <p>< gynaecological problems (back pain, recurrent vaginal infections, persistent miscarriages)</p> <p>< unwanted pregnancy</p> <p>< complications of unsafe abortion</p> <p>< RTIs (incl. STDs; HIV/AIDS)</p>	<p># RH services: gender-sensitive gynaecological care (incl. mgt. of STDs); emergency contraception; information, education on health, sexuality, gender equality</p> <p># Population and development strategies research on violence and RH social support systems for management of domestic violence (legal, judiciary, police, shelters)</p> <p># Advocacy and gender-sensitive social support systems re domestic violence eradication/management; IEC focusing on male involvement/participation</p>
Post-Menopausal Years	<p>C Abuse of widows (includes disinheritance and impoverishment)</p> <p>C Elder Abuse*</p>	<p>< Untreated chronic morbidity (e.g. breast/ cervical cancer; osteoporosis)</p>	<p># RH services for post-menopausal years</p> <p># Population and development strategies for: -development of gender-sensitive support systems for the elderly</p> <p># Advocacy for eradication of abuse; CEDAW</p>

Notes:

† In some instances, pregnancy is an increased risk factor for violence.

†† An unwanted pregnancy that the woman is compelled to carry to term.

††† Emotional and psychosocial effects have been documented at all stages of the life cycle.

* These events have been described to occur disproportionately in females.

VI. PATHWAYS FOR CHANGE

Gender-based violence has emerged as a major health and human rights issue. Most importantly, efforts to eliminate gender-based violence must recognize that it is a complex phenomenon, deeply rooted in gender-based power relations, sexuality, self-identity and sociocultural institutions. In this regard, the continued widespread vulnerability of women and girls to violence, perpetrated mostly by male partners, is explained by underlying social dynamics that, in effect, condone such abuse, as is evident in the rarity of cases prosecuted to the full extent of the law. An important indicator of this social reality is the statistically insignificant number of prosecutions and convictions of men who batter or rape women and girls.

In view of the multidimensional effort required to address the issue of gender-based violence fully and effectively, several strategic measures are recommended, as outlined below.

A. Building a Knowledge Base

Existing data, although sufficient to show the severity of violence against women, are inadequate to promote an in-depth understanding of the multifaceted aspects of gender-based violence. More information is needed specifically on the characteristics of the various forms of gender-based violence, on the physical and mental consequences and on the effectiveness of support services provided to victims of violence. In developing countries, in particular, there is a knowledge gap that needs to be addressed by large-scale population-based data on the prevalence of sexual assault, child sexual abuse and traditional harmful practices. Qualitative data on women's experiences of violence, their perception of what defines violence and their coping strategies would provide useful insights for designing relevant programme responses.

One of the concrete steps towards building a knowledge base is to establish a research agenda as a means of prioritizing the most critical areas for research focus and, ultimately, policy action. This process can be greatly facilitated by creating an enabling environment in which researchers and practitioners, those who are providing support services to victims of abuse, can work together to produce information that is relevant and policy oriented.

To provide a solid basis for effective advocacy support and policy action, the research agenda should, at a minimum, address some of the baseline information needs. The following activities in data collection and research are proposed:

- C Improve population-based data on the prevalence of gender-based violence that reflects violence at different stages of women's life cycle;
- C Undertake comprehensive analyses of hospital or clinic-based data to gauge the number of women victims of violence treated at these facilities;
- C Conduct studies on the economic effects of gender-based violence on the health-care system caused by the higher morbidity of battered women and increased use of health facilities;

- C Conduct studies on the impact of domestic violence and sexual assault on birth outcomes, pregnancy complications, illegal abortions, rates of miscarriage and low birth weight;
- C Investigate linkages between gender-based violence and RH issues such as safe motherhood, AIDS prevention and family planning;
- C Conduct studies that evaluate the effectiveness of programmatic responses to eliminating gender-based violence, including screening at primary-care facilities, violence-prevention curricula, skill-building for self-help groups' interventions; and
- C Prepare profiles of victims of gender-based violence reflecting the wide spectrum of abuses and characteristics of the abused.

B. Developing National Policy

The issue of gender-based violence is still perceived largely as a personal and private matter. Although numerous United Nations conventions and declarations recognize gender-based violence as a human rights issue, that recognition has yet to be fully translated into national policy. A case in point is CEDAW, which provides a comprehensive framework for addressing gender-based violence. Yet, 30 countries have yet to sign it; one third of those that signed it lodged substantive reservations; and 24 countries specifically lodged reservations against Article 16, a core provision that guarantees equality between men and women in marriage and family life.³²

For gender-based violence to emerge on the agenda of policy makers, it is critical that a well-defined and substantive national gender policy is articulated and its implementation closely monitored. Within this framework, the issue of gender-based violence must be formulated as a development issue requiring public policy debate and action. Given a specific policy framework for gender equality and equity, it normally follows that a national strategy is developed to set out the institutional and programmatic modalities by which the policy goals will be achieved. Similarly, for gender-based violence, it is essential that after a review of the available data, a strategy is set in place ensuring catalytic interventions that will facilitate a change in the culture of silence that renders the issue largely absent from the public domain.

C. Undertaking Legislative Initiatives

One of the strategic areas in which momentum for change can be promoted is engaging the legislative sector to institute reforms that will underscore the seriousness of acts of violence against women and girls. In particular, establishing legal grounds for the criminality of such abuse is urgently required both in bringing cases to prosecution and in achieving the conviction and punishment of perpetrators. Accordingly, the following areas for legislative support and action are suggested:

- C Enact laws that specifically criminalize domestic violence, marital rape and other forms of gender-based violence;

³² *The Intimate Enemy*, p. 12.

- C Reform existing laws to promote enforcement that would lead to the prosecution of gender-based crimes such as rape and domestic assault;
- C Develop training programmes on gender-based violence for police, lawyers and judges;
- C Increase gender balance in the law enforcement community by recruiting and promoting to senior levels women police officers, judges and prosecutors;
- C Promote NGO efforts to provide human rights education and legal literacy training for women and girls; and
- C Integrate gender-sensitive indicators in all crime statistics to highlight the gender nature of violent crime.

D. Establishing Institutional Responses to Gender-based Violence in the Reproductive Health Sector

In the long term, the most effective means for addressing gender-based violence is to institutionalize public-health and, in particular, RH responses to the problem. In the majority of cases, women victims of violence are silent about the real causes of their hurt and pain and report only somatic symptoms and injuries without adequate explanation. Given the reluctance to impart information about the abuse they are experiencing, it is up to health workers, and particularly those in RH services such as antenatal clinics, maternity services and family planning clinics, to be keenly alert to the possibility of gender-based violence among their clients. The critical features of institutional-based responses to gender-based violence should include the following:

- C Establishment of an information-sharing and coordination mechanism, such as an intersectoral working group made up of health professionals with diverse expertise and representatives from local organizations that provide service to victims of violence;
- C Development of specific protocols on domestic violence highlighting clinical profiles of victims; referral systems; screening questions and legal information;
- C Training of staff to enable them to acquire skills in counselling, examining victims and collecting legal evidence for prosecution;
- C IEC or RH efforts incorporating such protocols and training related to all forms of gender-based violence;
- C Incorporation of gender-based violence as a topic in the public health training curriculum of care providers, such as doctors, nurses and midwives; and
- C Establishment of partnerships with community-based experts and resource persons involved in gender-based violence programmes and services.

E. Creating a Public Will for Change

Real and lasting change in social perceptions of gender-based violence can come only from within. The evidence shows that community-based organizations are taking proactive measures to provide medical, legal and counselling services for victims of gender-based violence and to advocate for 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. To counter public tolerance of gender-based violence, a number of strategic advocacy and critical mass-building measures are proposed:

- C Develop alliances with strategic opinion makers such as parliamentarians, religious leaders, teachers and entertainers;
- C Engage the media establishment to promote positive images with regard to gender-defined roles and relations between men and women and remove existing biases;
- C Ensure that school curricula and teaching materials do not portray gender bias and gender stereotyping; and
- C Train teachers and educators to be sensitive to signs of gender-based violence in the school setting.

F. Conclusions

The culture of silence surrounding gender-based violence and its RH effects needs to be broken in order for effective preventive and remedial actions to be taken. This publication has attempted to describe what is known to date of the underlying aetiology, scope and RH effects of gender-based violence, demonstrating that violence comes most often from family and friends; that age is no protection; and that customs and traditions cannot be justified if they continue to violate the rights of individuals, in this case, women and children. Furthermore, the evidence shows that the RH effects of gender-based violence go beyond the immediate or short term and can have an impact that lasts for the rest of a person's life.

RH service providers need information and training to recognize, treat and refer for follow up victims of gender-based violence, the majority of whom will be women and children; in addition, legal, judiciary and social support systems need to be developed to prevent and promote the eradication of gender-based violence. Educational and vocational training programmes need to be revised to promote the concept of gender equity and equality as well as sexual and reproductive rights in future generations in order to improve the quality of life for all.

Application of the programmatic responses outlined in this publication to the core programmes will serve to strengthen UNFPA assistance for national programmes in ways that will directly support the goal of the ICPD to make RH services accessible to all by the year 2015.

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**United Nations
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