PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

# SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE

*31st Session, 23-24 November 1998*

*Provisional Agenda Item 6*

SPP31/6 (Eng.)
15 October 1998
ORIGINAL: ENGLISH

## VIOLENCE AGAINST WOMEN IN THE AMERICAS

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## 1. Violence Against Women–An Important Public Health Problem in the Americas

Gender violence is not a new problem. It has been with us throughout recorded history. What is new is the recognition of violence against women as an abuse against human rights (Human Rights Conference, 1993). Since then the United Nations Declaration on Violence Against Women (1993), the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995), and the Inter-American Convention to Prevent, Sanction and Eradicate Violence (1995) have resulted in declarations ratified by the majority of governments, which are in turn reflected in national policies.

The United Nations defines violence against women as:

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

### 1.1 *The Gender Violence Situation in the Americas*

Although data on the prevalence and nature of gender violence is scarce, existing research shows that the existence, causes and consequences of gender violence are widespread throughout the Region.

Gender violence causes more death and disability among women aged 15 to 44 than cancer, malaria, traffic accidents and war (Panos 1998).

According to data compiled by the UN Statistical Office, between 20% and 60% of women report being hit by an intimate partner. An extensive review of existing research for the World Bank (Lori Heise 1994) included the following:

- A recent study in Chile showed that 60% of women in union suffer some type of domestic violence, more than 10% with aggravated violence.

- In Colombia more than 20% of women have been physically abused; 34% have been psychologically abused.

- In the marginal areas of Quito, Ecuador, 60% have been beaten by their partners.

- Of Argentine women beaten by their husbands, 37% have lived in violent situations for 20 years or more.

Most violent acts against women occur in the home; the majority are committed by partners or ex-partners. Various studies in the Americas Region indicate that 50% to 70% of violent acts are committed by partners or ex-partners (Americas Watch 1991, Dimenstein 1992).

Women are five to ten times more likely to be abused by family members than are men. A Brazilian study showed that only 10% of injured and murdered men involved family members, while for over 50% of female victims, family members—mostly spouses—were implicated (Americas Watch 1991).

Violence by partners or former partners is more likely to result in lesions. A US study concluded that 80% of conjugal aggression resulted in lesions compared to 54% by strangers (JAMA 1992). According to Americas Watch (1991), 40% of spousal abuse results in injury.

Violence against women is much less reported than other situations of violence. A US study showed that between 2% and 8% of sexual abuse against women was reported, versus 62% of all assaults and 83% of all robberies (Koss 1990).

A large proportion of hospitalization and forensic reports of lesions are for violent acts against women. The Forensic Institute of Bogotá reports that during the decade of the 1980s, 20% of reported injury and 94% of hospitalized injury was due to spousal violence (UN 1991).

A very high proportion of adolescent pregnancies are the result of forced sexual encounters, often by older adults and family members. A Costa Rican survey showed that 95% of pregnancies in adolescents 15 years of age or younger are due to incest (Treguear and Carro 1991).

For many women abuse starts or is aggravated during pregnancy. In Chile a study of battered women showed that 40% experienced increased abuse during pregnancy (Panos 1998).

Women in abusive situations have inferior physical and mental health. In the US abused women are four to five times more likely to use mental health services and to commit suicide; they are also more likely to abuse substances, and one third suffer from depression (Stark et al 1981).

## 1.2 *The Cost of Gender Violence*

Gender violence incurs financial and social costs. Only Canada, as part of its national anti gender violence campaign, has estimated the cost of domestic violence at US$ 1,600 million per year, which includes medical attention and lost productivity (IDB 1997). Studies in the US and Nicaragua estimate that abused women are two to three times more likely to use health services.

Although most other countries of the Region do not have data on the cost of gender violence, it is known that the greatest cost to society is women's lost productivity. According to the 1993 World Development Report (World Bank), women lose 9.5 life years or disability adjusted life years (DALY) due to violence. Violence rates among the top causes of women's life years lost.

| | |
|---|---|
| Maternity-related conditions | 29 |
| STD | 15.8 |
| Tuberculosis | 10.6 |
| Acquired immunodeficiency syndrome | 10.6 |
| Cardiovascular disease | 10.5 |
| Domestic and sexual violence | 9.5 |
| Cancer | 9 |

While the increased physical and mental illness of battered women affects their productivity, lack of income may aggravate their situation. A Nicaraguan study showed that 41% of women who earned no income were victims of serious battery, compared to 10% of those who worked out of the home and earned some income (IDB 1997).

There is also preliminary evidence that violence against women affects the health and development of their children. In a US study, abused pregnant women were more likely to seek prenatal care later—during the last trimester—and to have low birth-weight babies (McFarlane, 1992). A recent study of abused women in Nicaragua showed that 63% of their children repeated a school year, that their children dropped out four years earlier and were 100 times more likely to be hospitalized than the children of non-abused women. Moreover, domestic violence perpetuates itself among children who are victims or live in violent homes (PAHO 1998).

### 1.3 *Gender Violence is Preventable*

Societies can be free from domestic violence. In an ethnographic study of rural societies Levinson (1989) identified 16 that could be classified as free of gender violence. These societies had the following characteristics in common:

- women's control outside the home;
- active community participation in addressing violence;
- solidarity and advocacy by feminist groups;
- sanctuary from domestic violence.

Gender violence is endemic in much of the West and in developing countries and abusers and their victims come from all classes, nationalities and economic strata. While much research has focused on the personal characteristics of perpetrators, people's behavior is heavily influenced by the society they live in. Laws, cultural values, social structures, and local and family relationships determine whether its members are violent. They are the social constructs that can be changed.

Where domestic violence is endemic, government, the community and women's organizations should work together to devise and implement strategic interventions to save lives, reduce injury and to alleviate the victimization of women and their children. Existing interventions should be systematically evaluated and improved, and new approaches should be explored.

## 2. The Health Sector and Domestic Violence

Although domestic violence is globally recognized as a human rights abuse, in many countries of the Americas it is not perceived or addressed as a public health problem. In most of these countries the injuries of violence are treated as pathology by forensic doctors, who are often in short supply and often employed by the legal sector or the police. Little attention is paid in the health centers that abused women frequent most often.

### 2.1 *The Health Sector is an Important Entry Point for Women Affected by Violence*

Battered women are more likely to interact with the health sector, because of their increased risk for physical and mental illness, as well as for adverse reproductive health consequences. Health providers have not, however, been trained to recognize domestic violence risk among users, or to collect information on battery, risk and care. Some studies show that providers may see the same women multiple times for similar injuries without making the correlation. Other studies confirm reports that providers do not take women's complaints and symptoms of abuse seriously.

When health workers are trained and protocols for battery detection are implemented, identification of abuse increases. In Pennsylvania, USA, for instance, these measures led to a five–fold increase of identification of lesions among women patients—from 6% to 30% (McCleer and Anwar 1989).

The health sector has traditionally not collected morbidity and mortality data for gender violence and, therefore, does not take its prevalence and care into consideration when planning policies and programs. To many women's health advocates, these data and policies are key for addressing gender equity issues in health care programs and reform.

### 2.2 *Expanding the Role of the Health Sector to Address Violence Against Women*

The health sector should play a key role in designing, implementing and evaluating national policies for addressing domestic violence. Ministries of health can collect and include prevalence, user and cost information to monitor this process. They can identify research needs and funding for improving it. The health sector is also in a position to coordinate the efforts of other public and civil sector agencies at the national and community level.

Specific contributions of the health sector could be:

- In the short run implement a situation analysis and research to assess the prevalence of violence against women and to improve planning, implementation and monitoring of intervention strategies. Identify resources and organizations that address family violence at the national and community level to share innovative approaches and to coordinate efforts.

  PAHO's Women, Health, and Development Program (HDW) has developed an instrument, "The Critical Route Women Take in Dealing with Domestic Violence," to identify and coordinate with community organizations, individuals and resources that address domestic violence.

In the long run, include domestic violence indicators in the national health information system and in national health surveys.

- Reinforce and replicate successful efforts. Many NGOs have started programs that address the complex components of family violence, usually with few resources. Such programs should be supported and included in coalitions, community networks and in providing technical assistance.

- With other sectors, design and apply protocols for detecting, treating and referring battered women who seek health care in primary and emergency care services.

  As part of its Intra-Family Violence Prevention Project, HDW has developed a model protocol that has been adapted and applied in the 10 project countries of the Region.

- Train health care providers in the application of the protocol for screening, providing quality primary and mental health care, in processing legal evidence and in referring abused women to other community based or emergency services.

- The Intra-Family Violence Prevention Project is currently completing a model training module based on its 10 country experiences.

- To institutionalize the training of health personnel, include violence against women in the curricula of education and training institutions.

- Coordinate intersectoral coalitions to advocate for policies and programs that address violence in the public and civil sector, as well as in legislation and in health reform.

  Feminist organizations have traditionally been on the forefront in advocating for domestic violence prevention and are natural allies. Most countries have a ministry of women, gender or families; some have women/gender focal points in participating ministries; other public (labor, education, welfare) and civil sector stakeholders should also participate.

- Implement community-based, intersectoral approaches. In the US the community-based approach has been so effective that it has been replicated in more than 100 communities during the last decade. The health sector can mobilize community resources and organizations to coordinate their efforts in dealing with domestic violence in the community. The ministry of health can also play a key role in

providing common training, protocols and referral/information systems for the participants of the community networks.

PAHO's Women, Health, and Development Program has developed a community based, intersectoral model for intra-family violence that is discussed below.

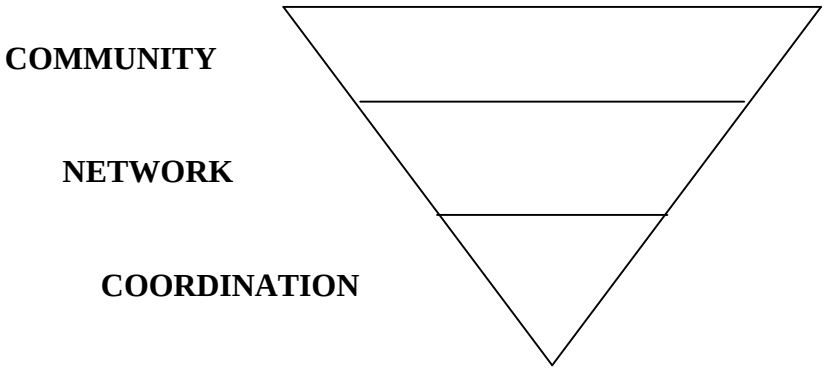
- Launch media, information and education campaigns to change tolerance of family violence.

- Include men and men's organizations in prevention programs.

## 3. The Community-Based Approach to Violence Against Women

During the 1990s PAHO's Women, Health, and Development Program has implemented a participative, community-based model in a total of 42 municipalities in 10 Latin American countries. The two subregional Intra-Family Violence Prevention Projects include all six Central American countries and Belize, and, in the Andes, Bolivia, Ecuador, and Peru.

The intra-family violence prevention model consists of community networks of organizations and individuals that provide care and support to battered women and their families. The following diagram illustrates the network's construction (Guido 1998):




The network in each municipality plans, implements and monitors its own community–based efforts and referral systems. In some countries the networks have been replicated at regional and national levels with members from local networks and national organizations, to influence policy and institutionalize efforts.

Project outcomes include: training modules for health care providers, police and the judicial system; situation analysis tools, including an instrument for identifying the services and people that women access in "The Critical Route Women Take in Dealing with Domestic Violence"; referral and information systems; national media campaigns and materials; advocacy materials and meetings; national norms and procedures; support groups for battered women and for perpetrators. The project is currently in its second phase to expand the model to other areas of each country and to institutionalize its achievements at the national level.

The intersectoral community-based model has the following components:

- Health services serve as initial detection point for women living in violent situations. Health care providers are trained to screen women during routine primary and reproductive health care visits and to apply protocol to assure quality service and data collection. In some cases providers are trained to collect judicial evidence.

- A task force with representatives from PAHO, the Ministry of Health and NGOs apply a situation analysis in the community to assess the prevalence of domestic violence, using available data from the health and the judicial system police, and existing surveys. They also apply "The Critical Route that Women take to Deal with Domestic Violence" instrument to identify organizations and people who help women address their situation.

- Based on this information, health sector workers mobilize community organizations and leaders to form support and service networks. These networks may consist of the police, the judicial system, community leaders, NGOs, women's organizations, schools, churches, and hospitals. The mix varies according to community.

- Each network meets regularly to plan, implement, monitor and coordinate activities that address the needs of abused women and their families. Intersectoral referral/information networks, training programs and support groups are set up to assure that women get quality care within their communities.

- Replication of networks at regional and national levels with representatives of local networks, national public (ministries of health, women's ministry and focal points, ministries of labor, education, welfare), and the civil sector. These networks advocate for policies (training, norms, information/referral systems), legislation and resources that address domestic violence at the national, regional, and local levels.

## 4. Conclusion

The Women, Health, and Development Program's model has been implemented in the 10 project countries, and has been replicated in six additional countries by the Inter-American Development Bank. The intersectoral, community-based approach is a way to reinforce existing efforts and to create new capacities to address a problem that affects a large part of the population.

Gender violence is different from other social violence in that it happens in the privacy of homes and in relationships, often by loved or former loved ones. Most of its battered victims are women who have limited access to income or power within or out of the home and who are not likely to consult existing health services regarding their battery. They do consult these services more, but for the physical, mental and reproductive health problems that are caused and aggravated by their situation.

Ultimately, violence against women is rooted in gender–based discrimination and, therefore, any attempt to address it must be linked to efforts that empower women. The Canadian Panel on Violence Against Women states that "it is abundantly clear that women will not be free from violence until there is equality, and equality can not be achieved until the threat of violence is eliminated from women's lives."

Preventing and addressing violence against women entails commitment from many sectors, as well as an integrated approach. Such commitment and efforts should focus on prevention as a human rights and a public health approach, in which the health sector, battered women, and their advocates actively participate.

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