Violence against Women: A Silent Pandemic

I became a doctor long before I became involved with women's groups. I had an excellent medical education, but formal education never taught me to handle cases of raped women and to look for signs of violence and abuse against women and children in the emergency rooms of our training hospital. It was only when I began to work with women who were desperately trying to deal with this hidden epidemic that I began to realise how neglected these women were. And, as I got a second education in the community, the biggest thing I had to do was to unlearn certain myths.

One myth states that violence against women is a minor problem perpetrated by a few misfit men. I realise now that many men are involved. As I began to understand the many forms that abuse might take, and the almost infinite variations in behaviour that constituted abuse, I realised that we would be hard pressed to isolate a particular action on the part of a particular man and said, 'this is pathologic, this is within the bounds of normal'.

Another myth that I had to deal with, was that violence was a problem of some other community, or some other country or some other region or some other class or race of people. But again, the statistics worldwide tell us the truth. Violence against women occurs in all societies, across all races and classes. It happens to women in both modern and traditional societies. Indeed, it is a global phenomenon and concern. In 1985, the United Nations passed its first resolution on violence against women. More recently, in 1993, the UN General Assembly passed a Declaration on Violence Against Women. Furthermore, in almost all major conferences sponsored by the UN in the nineties, from the human rights conference held in Vienna to the population conference in Cairo and the women's conference in Beijing, there has been recognition that violence against women is a serious problem and that governments must take steps to stop and prevent this violence.

Cause and Cure

The most critical lesson that I have learned with regards to the health problems of women, including the problems that arise out of violence, is that in order to be able to diagnose and finally heal, it is necessary to understand the larger context that spawns the violence. That context is the exploitation and oppression of women in many societies. It is a context that is also stated in Paragraph 118 of the 1995 Beijing Platform for Action:

... The fear of violence, including harassment, is a permanent constraint on the mobility of women and limits their access to resources and basic activities. High social, health and economic costs to the individual and society are associated with violence against women. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men ...

Yet, it is the effort to deal with this context that is most difficult, and therefore most likely to be neglected. The greatest difficulty is for men and women to accept that this oppression exists. This is why even the most battered of women may not tell their physician or take the necessary steps to end the violence in their relationship despite the dangers. This is also why despite the indisputable evidence, doctors, medical schools and the health profession as a whole have not responded adequately to the epidemic of violence against women. Hence, the understanding of this context is essential to all stages of diagnosis, therapy and prevention.

Only when one realises that the oppression of women is part of society is one able to understand that men's behaviour is skewed towards aggression.
She is a 62 year old woman who does housework and laundry and she has come to consult me, at the request of her employer, who knows of my work with economically disadvantaged women. The woman has asked me to tell her which of the lab examinations and medications prescribed for heart disease are truly important because she is poor. We go into history-taking, what happened and when. "It seemed to be just nerves," she says, "until one day last month my whole body went cold, I could not breath or move and they had to rush me to the hospital. That's when they gave me these lab requests and medications. They say it is for the heart disease," she continues, "I have not been able to buy any of them. I take her blood pressure. It is normal. She is not taking any hypertensives, nor can I detect anything unusual on chest examination.

I am puzzled but still respectful of another doctor's work. I tell her that we will help with the lab examinations but that I would like to get these done and see the results before I advise her on the drug therapy. But the old woman keeps saying, "You know, it may be just nervousness". This propels me to voice my own puzzlement over the diagnosis of heart disease, given the physical examination and her atypical history. I ask in my joking manner, "Maybe there is nothing wrong with you, maybe there is something wrong in your life, maybe with your husband's fist." I use the Filipino expression, "mabigat ang kamay. Literally translated, 'his hands are heavy'. She breaks out into a wry and weary smile. 'Ever since I married him,' she says, 'he would hurt me or the children whenever he has too much to drink. Now I only have to think of him drinking and I get nervous'.

I call her employer and urge that she be given time off for counselling with the Women's Crisis Centre, Manila, a women's group dealing with these issues. She leaves, still with the agreement to go through with the lab examinations, monitor her blood pressure and return with all results. And I am left wondering, I realise how narrowly I could have missed uncovering the woman's history of violence. I wish that I could say that this is an unusual case which deserves to be written up for a medical journal. But it isn't. I also wish that global statistics do not verify what my practice tells me: violence is a major health problem for women in all communities and women who have suffered from violence are not properly diagnosed by the medical profession most of whom are still blind about women's health issues.

against women and, therefore, it may be difficult to make the cut-off between men's normal actions and their hurtful ones. This is why the problem is so prevalent. The understanding of structural causes of violence is the basis for what is called in our profession a 'high index of suspicion' when it comes to this disease. In the same way that tuberculosis is so prevalent in poor societies because of the structural problems that lead to poverty and overcrowding, so do a society's gender inequalities lead to the violence that causes the ill-health of women. Women's groups worldwide have also learned that healing occurs for abused women when they realise they are not alone and when they are shown that they have a right as human beings to be free from harm. Healing and prevention can only occur when women not only understand their right to bodily integrity and health but find the strength to assert those rights.

Violence against women is a health problem that has pandemic proportions because of general ignorance and neglect as well as the refusal of some to change. But, like other pandemics, it can be stopped. Governments, professional bodies and people in general should recognise the problem, understand the causes, and begin to take the painful personal and societal changes that are necessary.

By Dr. Sylvia Estrada-Claudio, a medical doctor who works with NGOs struggling for social justice, national sovereignty and women's emancipation in the Philippines, particularly on health and reproductive rights. She also works with the secretariat of the East and Southeast Asian Women and Health Network.

ARROWS For Change is published three times a year and is a bulletin primarily for Asian-Pacific decision-makers in health, population, and family planning, and women's organisations. It provides:

- Women's and gender perspectives on women and health, particularly reproductive health
- A spotlight on innovative policy development and field programmes
- Monitoring of country activities post-ICPD, Cairo
- A gender analysis of health data and concepts
- Resources for action.

It is produced with inputs from women's organisations in Asia-Pacific and the ARROW Documentation Centre. The Swedish International Development Authority (SIDA) funds the bulletin, and the Documentation Centre is supported by Ford Foundation. Written contributions are most welcome. Please send them to:

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Sensitivity to Battered Women: Hospital-Based Interagency Crisis Services

Interview with Mr. (Dr.) Abu Hasan Asaari Abdullah

This is the only government hospital, not only in Malaysia but in Asia-Pacific, known by ARROW to provide services to battered women which go beyond medical treatment. The move is timely, especially as a sizeable number of battered women go to government hospitals for assistance (WAO. 1995. *Battered Women in Malaysia*). The Emergency Medical and Trauma (E&T) Department is the first place battered women go to for medical treatment and for obtaining a medical report if they want to pursue a legal case in future. Recognising the medical, social and legal needs of these women and the important role of women's groups, a one-stop centre for battered women was established in the E&T Department of the government general hospital in Kuala Lumpur in 1994 by Mr. Abu Hasan Asaari Abdullah, the Head of the E&T. New protocol and sensitivity training of the health personnel has resulted in better identification of battered women — an increase of nearly 50 per cent compared to the number identified before the setting up of the centre.

Moreover, there were inadequate counsellors and counselling space. At that point, there was only one medical social worker in charge of assault cases for the entire hospital of 3,000 beds.

**Meeting the Needs**

Based on this survey, Mr. Abu Hasan drew up a proposal for a special programme. The programme, called Interagency Networking for the Management of Battered Women was established in 1994 to handle cases of domestic violence collectively between the hospital, women's groups — Women's Aid Organisation Malaysia (WAO), TENAGANITA, and All Women's Action Society Malaysia (AWAM) — the Legal Aid Bureau, the police, the Islamic religious department, and the state social welfare department. The programme has brought together these various agencies, particularly the hospital and the women's groups.

A protocol for the inter-department management of the hospital was developed as a procedural guideline and also to define the roles of each department and participating agencies. For the first time, a specific policy and procedures to provide services to the women were introduced and implemented. With increased sensitivity of the health personnel and complemented by systematic procedures, better identification of battered women cases were documented.

Two levels of strategies are implemented — services provided during the crisis intervention period call Crisis Intervention Level One, and services during the rehabilitative phase known as Crisis Intervention Level Two.

**Recognising the Needs**

Alarm was raised by Mr. Abu Hasan and his medical team as the number of battered women admitted to the E&T ward and the severity of their injuries were on the rise. For example, a woman was admitted with a loss of a limb while another woman had experienced four recurrent miscarriages all due to battering. Also, hospital beds in the E&T ward were always in demand. Thus, patients although suspected of being victims of domestic battering were immediately discharged once they had received medical treatment.

Sensitivity to the needs of battered women led to a six-month pilot survey carried out in 1993 by the E&T Department, to systematically study the prevalence of battering and the nature of injuries sustained by battered women. Procedures were developed to identify battered women and document details of injuries, the number of recurring battering incidents, socioeconomic data, and current management strategies of each department which treats battered women.

In the six-month survey, 186 battered women were identified. However, the actual number of battered women was higher because this number did not include those who had minor injuries, and therefore, were not admitted to the E&T ward. The most common physical injuries identified were mild to moderate soft-tissue injuries. However, as mentioned earlier, the severity of the injuries also escalated into more serious bodily injuries. Furthermore, comparison made on the number of women who sought treatment (from this hospital) in this six-month survey to the total of only 446 police reports on battering made nationally in 1993, confirmed that many more women sought medical services than lodged reports at the police stations.

The survey findings pointed out that there was no proper plan for the department to meet the needs of battered women.
Crisis Intervention Level One

The patient, identified as a battered woman, is examined by a doctor and if necessary is provided a 24-hour shelter in the E&T ward. For treatment of physical injuries, depending on the severity and nature of the injuries, the woman will then be referred to the respective hospital department. The doctor will also refer her to the medical social worker and upon her agreement, to a counsellor from a women's group who is available 24 hours and can be brought immediately to the hospital. The counsellor will aim to meet the needs of the battered woman at that point in time as well as to discuss plans and steps which can be taken by her, such as assisting her in obtaining legal aid, contacting a lawyer, getting a protection order, or making an application for maintenance and custody of her children. TENAGANITA and AWAM provide counselling, while WAO provides both counselling and shelter.

Crisis Intervention Level Two

The centre assists those women who are filing for legal action by speeding up the processing of their medical reports. The report, therefore, will be completed by the doctor within one to two weeks instead of the usual three months. Each folder containing this priority case is marked with a red line for easier identification by the doctor. Other than the services offered, the normal fee of RM40 for the report is also waived.

Sensitivity of the Health Personnel

Two fundamental features are identified as key to the efficient running of this centre: a warm caring environment, and the ability to make accurate identification. For this, health personnel are trained to be more sensitive, so that they are alert to any inconsistency between the medical history and the physical injuries sustained by the women. This is fundamental because very rarely would the women voluntarily relate the battering incidents. In addition to this, the hospital health personnel are given training by the women’s groups on counselling skills to enable them to properly counsel the women right from their first contact.

The programme also introduces new protocols and guidelines. One of these is the new clerking format, in which, a standard form is used to document socioeconomic information of the battered women and the batterers, as well as the medical history of the women. Personnel are trained on how to work on the new form and to document accurately so that appropriate management and services can be provided to meet each woman’s needs.

Expansion

The interagency networking has given wide publicity to the centre and has encouraged battered women, not only from Kuala Lumpur but from other states in Malaysia, to seek help.

Once the infrastructure is developed, Mr. Abu Hasan Asaari plans to expand the programme nationwide. In preparation for this, his department is now in the process of synthesising information from the clerking form for the use of further studies to be carried out by the hospital. This is the first government health programme in Malaysia of any kind, that supports battered women.

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The Women's Crisis Centre, Manila: Empowering Survivors of Violence

Raquel Edralin-Tiglao and Rowena Martha S. Beltran

The Women’s Crisis Centre (WCC), Manila, is the first crisis centre for women survivors of rape, incest, wife battering, sexual harassment, prostitution, and sex trafficking in the Philippines. Formally established in 1989, it is an effort of a group of Filipino women committed to responding to the issues of violence against women. Central to the philosophy of the WCC are two important feminist principles which are that the personal is political, and that all human relationships must be based on egalitarian values. Women’s individual concerns and problems should not be viewed in isolation. In discussing individualised violence against women, the larger sociopolitical and cultural environment that reinforces oppressive conditions for women must be looked at. The WCC not only provides concrete assistance to abused women but also pursues the prevention and total elimination of violence against women.

Crisis Intervention Programme

 Paramount to working directly with Filipino women survivors is the provision and availability of services responsive to their specific needs. Foremost to providing these services is creating and sustaining a safe and supportive environment for women to express themselves. Over time, the existing programmes develop mainly from the learning gained from the survivors themselves, as well as from the WCC’s recognition of the need to respond to the issues of violence against women in a holistic manner. The
Crisis Intervention Programme is the core programme of direct services of the WCC. It includes feminist counselling, medical assistance and advocacy, survivors' support group, legal assistance and advocacy, stress management, and temporary shelter.

**Feminist Counselling** (telephone hotline and one-to-one) is a counselling process where trained feminist counsellors and women relate on egalitarian terms, both of them learning from and strengthening each other. The counsellor will assist women to get out of the trap of negative emotions such as fear, shame, self-denial, guilt and self-blame, as a process towards healing and empowerment. The women are also encouraged to express themselves and ask questions to develop awareness of their rights. The concept and practice of feminist counselling is the core of the WCC's services.

The **Medical Assistance and Advocacy Programme** assists women requiring medical treatment by accompanying them to clinics and hospitals. Counsellors also accompany women to crime-laboratories for medico-legal examinations to ensure that the women is accorded necessary support and that her privacy is assured.

The **Survivors' Support Group** is based on the feminist concept of consciousness raising that serves as a venue for women's individual and collective empowerment. Activities include group counselling sessions, educational, recreational and skills training. The women themselves identify their needs and determine what activities to undertake.

The **Legal Assistance and Advocacy Programme** responds to the needs of women who have decided to pursue court actions against abusers. Women are given the opportunity to consult with or be represented by the centre’s lawyer or to be referred to its network of partner lawyer organisations. They are also accompanied by their counsellors to court hearings, police stations, lawyers' offices and other government agencies. Realising that the judicial system and law-enforcement agencies are insensitive towards women — many are therefore discouraged by the situation and eventually back out — the WCC ensures that survivors are accompanied on these occasions to provide the needed emotional and psychological support, as well as information on how the judicial and law enforcement system operates.

The **Stress Management Programme**, specifically using Stress and Tension Reduction Therapy, evolves out of the need of the survivors to ease the physiological effects of the abuse. A trained therapist provides the women with physical treatments and teaches relaxation techniques which they can continue at home.

The WCC provides a temporary shelter to battered women and their children, as well as for mothers of young incest survivors. It is run and managed on a self-help basis.

**Complementary Services**

The WCC also functions as a resource centre and a training institute under its *Research, Documentation and Publication Programme* and the *Training Education Programme*. The information documented is utilised for research, educational materials, documentaries and television episodes to raise public awareness on violence against women, without compromising confidentiality and security of the women. The information is used by government agencies, legislators and policy makers. The WCC is actively involved in legislative and media advocacy, and it takes a strong activist position by challenging and proposing to policy makers and legislators to enact laws and institute mechanisms protecting survivors and penalising forms of violence against women.

The WCC has also received numerous requests to conduct training on feminist counselling, support group formation, volunteer-training, setting up of crisis centres and shelters, assertiveness training, and women's self-defence courses. To the WCC's credit, the training given has resulted in the establishment of women's desks in other groups, crisis centres, and shelters in the different regions of the Philippines.

**Linking-up with Health Services**

Presently, the WCC is undertaking a research project focussing on the impact of violence on women's health. It is also working on the convening of a Coalition of Asian Women against Violence against Women.

Furthermore, experience gained from its Medical and Advocacy Programme, has led the WCC to be chosen as the lead agency in assisting with the establishment of a government hospital-based crisis centre. The pilot programme called project HAVEN, is a collaboration of the Department of Health, the National Commission on the Role of Filipino Women and women’s organisations. Initially, it will help put in place the pressing needs for adequate health services for survivors of violence. Project HAVEN will eventually be replicated in all government hospitals.

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Altogether, 179 governments have voluntarily ratified the ICPD Programme of Action (POA). Thus, it is important to hold these governments accountable for the implementation of the POA, particularly as governments are the dominant actors in national decision-making on population and family planning. NGOs and donor agencies have acknowledged that the POA can be fully implemented only in partnership with governments. In this section, our correspondents have highlighted the prominent roles of the NGOs as well as donor agencies like the United Nations Population Fund (UNFPA) in assisting governments by providing inputs and sharing of experiences. A few governments in the region appear to recognise and act upon the need to collaborate. Let us hope, that the rest of the governments are taking similar measures.

Viet Nam

The Vietnamese government, with UNFPA's assistance, has translated the POA and other ICPD relevant materials into Vietnamese. These materials have been widely disseminated. The government, also with the UNFPA's assistance, has organised a number of workshops on the ICPD follow-up — including a general workshop on the new priorities and a more specific workshop on reproductive health and quality of care. Both workshops were attended by senior Ministers and officials from the population, health and various economic coordinating and planning ministries, as well as by a number of the emerging national women's and reproductive health NGOs in Viet Nam. Viet Nam is also one of the first countries to formulate a new five-year UNFPA-supported country programme following the ICPD. This has involved reviewing the current programme from the perspective of the ICPD, and the development of the new programme of UNFPA support to the government on priority issues of reproductive health, women's empowerment and integration of population and development concerns.

National and international NGOs have also been active both through their direct programme support to Viet Nam, as well as through the formation of a number of ongoing working groups, specifically on gender and reproductive health. These groups meet regularly to discuss and exchange ideas and experiences on issues like adolescent health, violence against women, and integrating STD services into family planning programmes. The working group meetings are attended by national and international NGOs, donor and government representatives.

India

Active lobbying by Health Watch (an NGO coalition specifically set up to monitor the implementation of the ICPD recommendations) for dialogue with the government has resulted in Health Watch being invited to participate during the meeting of the State Family Welfare Secretaries, on 3 April, 1995. The meeting was organised by the Ministry of Health and Family Welfare (MHWFW) which is responsible for family planning and maternal and child health care. In the meeting, each secretary confirmed the plan to implement a contraceptive target-free pilot project in at least one district of each state for the 1995-1996 programme year. The districts were chosen based on their high family planning performance as well as showing indicators of above state average in immunisation, couple year protection, female literacy and infrastructure. In the letter sent to all state secretaries, the chief-secretary of the MHWFW noted that the selected districts would not be given any contraceptive target for any of the four methods — the IUD, oral pill, sterilisation and the condom. Instead, indicators relating to qualitative aspects of family planning, maternal and child health care (MCH), and the number of acceptors of each contraceptive method would be collected. Health Watch has written to the chief-secretary of the MHWFW proposing for further dialogue between state secretaries and a wider group of NGOs at state level, to discuss, among others, matters pertaining to the monitoring of the performance indicators. In terms of strategy, Health Watch feels that it is important to work with the central government, particularly as state family planning budgets come from here.

Health Watch publishes the bulletin, Update, regularly to monitor national post-ICPD follow-up. For further information contact: Dr Lila Vakana, Director, Gujarat Institute of Development Research, Near Gota Char Rasta, Gota 382481, Ahmedabad, India. Tel: (79) 7474809-10 Fax: (79) 7474811

Pakistan

Changes are emerging at government policy and programme levels vis-à-vis women. In the past, health and population functioned in isolated ministerial compartments, with adverse results for women's health care. Now, their closer coordination has achieved a nationwide women's health care programme, with a workforce of 12,000 village-based family planning workers and 33,000 national health workers.

The government is also utilising its media service to reach out to the general public. State-owned radio and television stations now broadcast programmes more empathetic and gender-sensitive to women. Family planning advertisements are more
specific than in the past, with doctors and talk shows emphasising the need for women's health care. This move is very encouraging considering that the estimated level of contraceptive use in Pakistan was only 14 per cent (1992-93). HIV/AIDS awareness campaigns are also becoming more frequent.

As for the NGOs, the women's group Shirkat Gah has organised a post-Cairo workshop for all NGOs, to analyse relevant areas of the POA and work out common strategies for action. Environmental and health issues were identified as needing particular attention, and removal of discriminatory laws was agreed as fundamental to implementing the POA. Shirkat Gah with Panos Institute, London, is carrying out a detailed study on exactly how Pakistan’s discriminatory laws have affected women’s health.

Shirkat Gah, both on its own as well as in collaboration with other organisations, has also been actively involved in publishing reports relevant to the ICPD. These include *The Woman Not the Womb: Reproductive Rights in Pakistan: An Overview of Laws and Practices*, and *We Can’t Stop Now: Pakistan and the Politics of Reproduction*. Translation of materials into the national language, Urdu, are underway. These are *Private Decisions, Public Debate* and the report “Reproductive health and rights in Pakistan” in the *Rights to Know*, a publication of Article 19, International Centre Against Censorship, USA.

Meanwhile, the Family Planning Association of Pakistan (FPAP) has put into action plans for incorporating a wider perspective of family planning — with a major stress on communication strategies. These will soon be involving audio-visual components in addition to the FPAP present communication plans. The FPAP has also stepped up coordination with religious groups, so as to present true Qur'anic teachings.

**Sri Lanka**

Following the ICPD, the Family Planning Association of Sri Lanka (FPASL) has spearheaded an initiative to promote gender equity and empowerment of women by setting up a Women’s Task Force. Its first activity was the organising of a workshop attended by 35 participants from women’s organisations throughout Sri Lanka. They identified 20 key issues affecting women in the country. These included violence against women within the family and in the society; the rise in illegal abortions; inadequate knowledge and misinformation about the human reproductive system, family planning and other relevant facts on sexuality among both men and women; and sexual harassment within the family, in work places and in public transport. Several recommendations were put forward, whereby, the education and legal systems were identified as mechanisms to eliminate the perpetuation of unbalanced gender roles, male dominance and gender disparity. A large-scale campaign on legal awareness is necessary for women to be clear of their rights and the ways and means to obtain them. The participants proposed that priority be given to legal amendments for more stringent punishment for sexual harassment, and to lessen the hassles and embarrassment to rape victims. It was proposed that rape victims be legally questioned or heard in camera. A systematic family life education programme was put forward as a strategy to eliminate denial of women’s rights to choose contraceptive methods; the social stigma attached to the status of single women, widows and divorcees; fear regarding some family planning methods; male child preference; and the discrimination of the girl child.

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**INVITATION TO CONTRIBUTE**

How has your country responded to the ICPD Programme of Action (POA)? What activities have been carried out by governments, NGOs and donor agencies? *ARROWS For Change* wants to highlight activities taken up by countries of Asia-Pacific in implementing the POA. We welcome contributions from individuals and organisations. Please fax/mail the latest by 1 April, 1996, to:

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This paper is an abbreviated version of a 1993 Research Report on domestic violence in Korea prepared by the Korean Women’s Development Institute (KWDI) research team. The research objectives for the original study were to examine the severity of domestic violence in Korea and to look at the countermeasures needed to more effectively cope with domestic violence in the country. This paper summarises the research methodology and findings from the original study. The research team used secondary data, case studies, and information from relevant institutions to assess the severity of domestic violence, including ‘the onset of violence in a marriage’, ‘frequency’, ‘patterns of violence’ and ‘effects’. Most important to the study was formulating a set of countermeasures for action against domestic violence. The KWDI team believes the ultimate goal of countermeasures against wife-battering is to transform society’s attitudes, not reform institutions. In keeping with this ideal, the team proposed that new education programmes should be introduced in schools and the community to help with attitudinal reform toward gender equality; amend existing laws to better protect victims of domestic violence and more effectively deal with the perpetrators; and finally, to expand the social services network for the increased protection of and prevention against acts of violence in the home.

**Source**: *The Editor, Korean Women’s Development Institute, Eunpyong P.O.Box 156, Seoul 122-040, Republic of Korea.*


This publication is the first in a series jointly produced by WHO’s Division of Family Health and the Division of Mental Health. The aim of the series is to create a forum to debate issues related to women’s mental health, contribute to the general reappraisal of women’s health problems and identify future directions for research and action to address women’s health needs. The article, "The impact of physical and sexual abuse" featured in this publication is a review of selected research and clinical findings that document the impacts of sexual violence, and in particular childhood sexual abuse, on women’s mental health. The referenced studies are confined to research done in developed countries only. The various impacts, from depression to self-harm, to sexual dysfunction and drug abuse are described very briefly by the authors and highlighted with one or two statistical findings. In general, the research review indicates that physical and sexual violence, and in particular childhood sexual abuse, can lead to long-term mental health impairment.

**Source**: WHO, Division of Family Health and Division of Mental Health, CH-1211 Geneva 27, Switzerland.


In February 1991, the Ford Foundation’s Women’s Program Forum sponsored a day long international seminar in New York City on *Violence Against Women: Addressing a Global Problem*. The seminar featured a diverse group of panelists, primarily researchers and activists, from North, Central and South America. The panelists were given the task of focussing specifically on two strategic approaches: community responses to violence against women, and reforms in the criminal justice system. This publication is the edited transcript of the seminar presentations and the dialogue between the panelists and audience.

To address community responses, the panelists shared some ideas on ways to improve community-based responses to battered women; from increasing the number of shelters to improvements in hospital protocol for abuse cases, or setting up programmes for batterers, to name a few. Ideas for ‘reforms in the criminal justice system’ were varied as they reflected country-specific needs. Panelists from the USA, Mexico, and Brazil clearly advocated for reform in their own countries so that there would be better protection for abused women and the perpetrators appropriately dealt with.

**Source**: *Women’s Programe Forum, The Ford Foundation, 320 East 43rd Street, New York, NY 10017, USA.*


The 1994 International Conference on Population and
Development (ICPD) has been credited with influencing the population debate. The conference, together with the resulting Programme of Action (POA) witnesses for the first time a shift in thinking toward a gender analysis of population issues and a broader view of population and development. This paper examines the concept of gender analysis of population and development, and secondly, examines the prospects for implementation of the ICPD’s POA. Central to the concept of gender analysis of population and development is a woman’s right to bodily integrity and a woman’s reproductive rights.

At the ICPD, the international population agreed on the equality and equity of women and that reproductive health and reproductive rights are central to human rights. This re-orientation in thinking is the guiding principle behind the ICPD’s POA. The paper highlights a number of POA clauses but can only offer limited information on the successes or failure of implementation given the short time since the conference. However, a preliminary survey has been done by ARROW of changes post-Cairo in Indonesia and Thailand. Some of the findings are included in this paper. The author also elaborates on the problems and obstacles facing the implementation of the POA. In closing, the author voices her concern of the need to take a new gender perspective of population policies from the conceptual level down to an implementation level where changes can be felt by women around the world. She advocates for NGOs to continue to pressure at the policy and funding levels to implement the spirit of the ICPD.

Source: GAD Programme, Asian and Pacific Development Centre, Persiaran Dutta, P.O.Box 12224, 50770 Kuala Lumpur, Malaysia.


Domestic violence in Pakistan is a problem of immense magnitude and one that has been ignored by society at large, its government, and to an extent by local women’s groups. It seems the main reason for social indifference and inaction is a lack of comprehensive data that could bring to light the seriousness of this problem. This paper, an edited version of Ms. Hassan’s Master’s thesis, attempts to present a more comprehensive picture of the domestic violence situation in Pakistan. It provides details on the types of domestic violence affecting Pakistani women and some of the social, cultural and religious issues that exacerbate the problem. Actual cases of domestic violence have been included to exemplify some of the forms of abuse prevalent in Pakistan. The author then explores some of the avenues for protection open to Pakistani women who are victims of violence, at the same time sighting some of the shortcomings of these so-called protective measures. Finally, recommendations for action are made, that if implemented, will help to change the cycle of domestic violence in Pakistan.

Source: Shirkat Gah, Women Living Under Muslim Laws Coordination Office Asia, 38/B-Sawar Road, Lahore Cantt, Pakistan.


In late 1993, about 50 researchers, reproductive health practitioners and activists came together to share experiences and develop strategies to better document, understand and address the causes and consequences of gender-based abuse. This publication is a synthesis of the seminar and it is arranged into four chapters. The first chapter explores the multifaceted context and consequences of coercive sex for women’s reproductive health, and the implications for family planning/reproductive health services. The second chapter discusses the myths and science of male sexual aggression, hence, identifying what is changeable. The third chapter focuses on research issues and methodology, with emphasis on making the research process more relevant to the tasks of serving victims and preventing future abuse. The final section consists of recommendations on generic principles to guide research on sexual coercion globally, and on the role of health practitioners in responding to gender-based abuse. This publication would be very useful to those in the family planning/reproductive health field who wish to conduct research or implement programmes to address sexual violence and its impact on women’s reproductive health. It is easy to read, particularly with illustrations and diagrams highlighting core issues discussed during the seminar.

Source: The Population Council, One Dag Hammarskjold Plaza, New York, NY 10017, USA.


In virtually every nation, the government is a key
player in health and women's rights. Governments regulate and implement policies relevant to health and allocate funds to health care which have a profound effect upon the socioeconomic status of women. This report focuses attention on the national governments of Brazil, China, India, Germany, Nigeria, and the US, and the way they govern women's reproductive lives. The report summarises the laws and policies on an array of specific reproductive health and rights issues, which reflect the variations in socioeconomic conditions, cultures and legal systems. Some of the issues covered include population and family planning policies, abortion and sterilisation laws, and the status of specific health issues such as AIDS and STDs, to name a few. The selected list of issues covered in this report are reviewed for each country which allows the reader to make comparisons between nations. For example, two of the largest countries in the world, China and India, have explicit population stabilisation policies, and both are characterised as having comparatively liberal access to contraception and sterilisation. This publication, although written from a legal perspective is easy to read and provides up-to-date and important information on women's reproductive rights and issues from the North and South.

**Source:** The Center for Reproductive Law & Policy, International Program, 120 Wall Street, New York, NY 10005, USA.


Between 1990 and 1992, the Women's Aid Organisation (WAO), Malaysia, commissioned a research team to conduct the first national research study on battered women in Malaysia. The primary objectives of the research were to assess the extent of the problem of women battering in Malaysia and document the problems and obstacles experienced by battered women. This publication is a report on the findings of this national research study. The research was conducted by means of a nationally representative random survey of 1,221 people, in-depth interviews with 80 battered women, interviews with 77 police, hospital, and civil and religious legal personnel, the collection and analysis of official national statistics, and the analysis of 38 case records of WAO shelter residents. This report summarises the research team's qualitative and quantitative findings and analyses, provides some comparisons with similar national and international research on wife battering, and closes with key recommendations for action to address the problem of battering in Malaysia.

**Source:** Women's Aid Organisation Malaysia, P.O. Box 493, Jalan Sultan, 46760 Petaling Jaya, Selangor Darul Ehsan, Malaysia.

**ARROW's Publications**


What are the meanings of reproductive health and reproductive rights? Why are women critical of population and family planning programmes? What kind of reproductive health services do women want? What are the guidelines and models to follow when re-orienting population policies and programmes? These are amongst the questions addressed in the Information Package. The package comprises of three booklets: "Broadening the concept addressing the needs", "Ideas for action", and "An annotated bibliography".

**Price:** US$4.00 plus US$2.00 postal charges. Postal payment accepted in bank draft only.


The first in a series, this publication would be useful for those looking for more materials and information towards reappraising population policies and family planning programmes, particularly in the Asia-Pacific region. It is arranged in three sections of population and development, family planning programmes, and reproductive health and reproductive rights.

**Price:** US$5.00 plus US$2.00 postal charges. Postal payment accepted in bank draft only.

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**Expanding the Mailing List in Asia-Pacific**

ARROW wants to reach as many interested individuals and organisations as possible through our publications and Documentation Centre services. Can you recommend people or organisations from your country who need to be on our mailing list? Our priorities are people in health, population, family planning and women's organisations at policy and management levels. Write to the Editor with details.
The term ‘violence against women’ means 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 . . .


From the health perspective, violence has two principal aspects: physical and mental health. The physical consequences of violence — blows, kicks, stabbings, burns, rape, mutilation and the possibility of death — also harm the victim’s psyche, bringing on the depression, anxiety and low self-esteem that can lead to alcohol and drug abuse and even suicide. Studies also suggest that female victims of battering and abuse frequently have more sexual and reproductive health problems, including a high number of abortions.


While it is necessary to recognise that domestic violence is a problem shared by women all over the world it is also important to avoid seeing the experiences of women of developed countries as being representative of the experiences of women from developing countries. International patterns of violence are defined with the ‘western’ experience as the reference point, where the common conception of domestic violence is violence inflicted by a husband on a wife. This presumes a nuclear family with a specific power structure — conditions that exist in the West. But for many women of developing countries, family life involves a complex set of power relations with many different people (men as well as women) who may take part in the abuse of the woman in the home.

Data on Gender-Based Violence

Violence against women or gender-based violence is a serious public health problem, with mental and physical consequences for girls and women, and a burden on the health care system. Violent acts range from physical and psychological abuse by an intimate partner (domestic violence), sexual coercion and rape, and abduction of women for the purposes of trafficking (e.g. prostitution and forced marriage).

Rape and domestic violence are now recognised as a major cause of disability and death among women of reproductive age all over the world. In market economies, where maternal mortality and poverty-related diseases are under control, rape and domestic violence account for 16 per cent of lives lost to women aged 15 to 44 years (World Bank, World Development Report 1993). In Asia-Pacific, such countries include Korea, Japan, New Zealand, Australia, Malaysia, Hong Kong and Singapore.

The table shows available data for selected countries on the prevalence of gender-based violence. Prevalence rates are generally high, reaching 75 per cent in the Indian community study and 67 per cent of rural women in Papua New Guinea (PNG). Heise, Pitanguy and Germain (1994) reported in their survey of 35 countries, that domestic violence rates globally ranged from one-quarter to one-half of women. The most accurate estimate of prevalence can be made from nationally representative studies. However, few researches have been carried out globally. Malaysia and Papua New Guinea are the only known countries in the region to have done such research.

Data on the prevalence of rape appears even less available. Some countries rely on data from reported rape cases to the police (e.g. India, Malaysia and Thailand). Most raped women, however, do not make police reports due to fear of reprisal and shame, especially as more than half of rape perpetrators are known to their victims. Rape incidents are therefore very underestimated. Sample surveys interviewing women provide more accurate data, especially if they include information on both attempted and completed rape. The Korean and New Zealand survey data reveal that more than one in five women have ever been involved in a rape incident.

Data on the extensive health effects of violence against women has recently emerged. Micro studies done have documented that women are more at risk of being beaten by their husband during pregnancy which frequently leads to miscarriage or premature birth of low-birth weight babies (Heise, Pitanguy, Germain, 1994). In Asia-Pacific, the only known data is from Malaysia and it shows that a large number of battered women are beaten by their husbands during pregnancy (see table).

<table>
<thead>
<tr>
<th>Prevalence of Gender-Based Violence</th>
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<td>Country</td>
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Data Source:

- ibid. pp. 10. Note: completed and attempted rapes (community study).