

Gender-based Violence and Sexual and Reproductive Health and Rights: Looking at the Health Sector Response in the Asia-Pacific Region

Gender-based violence (GBV) (*see Definitions, page 14*) violates human rights and affects sexual and reproductive health (SRH). Widely prevalent and socially silenced in most Asian-Pacific countries, GBV is increasingly recognised as a major public health concern in the region.

GBV restricts choices and decision-making of those who experience it, curtailing their rights across their life cycle to access critical SRH information and services. It is a risk factor for sexually transmitted infections (STI), including HIV, and unwanted pregnancy, in addition to causing direct physical and mental health consequences. A few examples from the region of GBV's impact on SRH include the following:

- Research in India show links

between experiencing physical violence, lower likelihood of adopting contraception and increased likelihood of unwanted pregnancies.¹ Studies in Kiribati, Samoa and the Solomon Islands show that women who experience intimate partner violence (IPV) were met with higher rates of opposition to contraception (*See Koziol-McLain, page 15*).

- Studies in many countries, including the Maldives² and Pakistan,³ have identified that physical abuse has been associated with higher rates of miscarriages, bleeding in late pregnancy, premature labour or delivery, still births, abortion and late entry to prenatal care.⁴

- Intimate partner violence (IPV) during pregnancy has been linked to maternal deaths. In Bangladesh, where the maternal mortality ratio (MMR) of 340 per 100,000 live births far exceeds the South Asian average of 280,⁵ an estimated 14% of maternal deaths are attributed to violence.⁶ In countries such as India and Sri Lanka, a significant proportion of violent deaths in pregnancy is recorded as due to homicide committed by the partner and suicide, which is often linked to IPV.^{7,8}

- Correlations between HIV transmission and GBV, and the underlying gender inequalities in preventing negotiation for safer sexual practices, have been established.⁹ GBV is a

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key driver of the HIV epidemic in Papua New Guinea.¹⁰ A study from Cambodia identified the linkages between the two epidemics and iterated the importance of cross-dialogue between the two professional communities dealing with these.¹¹

On the other hand, it should also be noted that linkages go both ways. Covert contraceptive use by women increases women's risk of violence, as shown in a study in India.¹² Some SRH issues, such as infertility, STI and HIV, may be used by perpetrators to propagate violence. Societal attitudes towards these conditions and to women's non-compliance to gender roles, which are mainly rooted in inequitable and unequal gender norms, compound the problem. More studies are needed to

further understand and provide effective responses.

All human rights, which are universal, indivisible and interdependent, make the State responsible for guaranteeing SRH and individual choices regarding reproduction and sexuality. However, the application of human rights in most Asian countries, particularly in the health sector, is challenging. There is little, though growing, experience in invoking human rights to ensure international commitments, such as those stated in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), International Conference on Population and Development Programme of Action (ICPD PoA) and the Millennium Development Goals (MDGs). Health professionals unfamiliar with human rights language may characterise them as an intrusion on national sovereignty or on their professional domains.

Nonetheless, the role of the health sector, as part of a multi-sectoral initiative to address GBV, cannot be emphasised enough. The health care system is an excellent entry point to initiate care for survivors, given that women are likely to visit a health professional some time during their life for SRH needs or for other illness. However, lack of awareness of human rights, gender and GBV, and lack of skills in responding to violence

frequently leads to gender bias and poor quality response.

Most Asia-Pacific countries are actively responding to this problem. However, there is a wide variation in the scale, scope, quantity and quality of health sector response and the level of integration that has been achieved in each country.¹³

- State-implemented health policies and decrees related to GBV are fundamental in initiating and sustaining health sector response to GBV, and countries such as Maldives, Nepal and Sri Lanka have health policies or ministerial decrees in place. For example, the Health Master Plan of Sri Lanka 2007-2016 recognises GBV as an important health issue and identifies different strategies to address it.

- Establishment of dedicated spaces (such as the One-Stop Crisis Centre or OSCC) to provide integrated services, including medical counselling and legal services, has been done by many countries in the region to varying degrees. For example, the Accident and Emergency or the Outpatient Department has been used in Maldives, Malaysia and Sri Lanka, as a less stigmatising and easier entrypoints for survivors to access services 24/7. Sustainability of these centres is, however, only ensured when they are fully institutionalised, as in Malaysia and Sri Lanka. Many countries face challenges in establishing and running these centres at sufficient locations throughout the country, including lack of financial and human resources, lack of committed leadership and the dearth of care providers whose services are prioritised elsewhere.

Other models and approaches that are being utilised in the region include integrating GBV into primary health care, reproductive health care, or family planning services. There are also NGO-led models, as in Papua New Guinea and the Philippines, which are done independently or in collaboration with government agencies. Many of these service points provide other SRH services, such as prophylaxis for STI and HIV, and emergency contraception to survivors. Many countries use a combination of models and approaches.

- Capacity building on responding to GBV is critical for health care providers. Many Asia-Pacific countries have done some capacity building programmes; however, most often these are not holistic and integrated.¹³ Moreover, integration of GBV into the medical curricula is still lacking in the region.¹³

- One of the main challenges faced by most countries is the lack of temporary shelters for survivors, mainly due to the high costs associated with establishing and running these centres. Where available, they are mostly managed by NGOs, although some service points in health institutions utilise beds reserved for other specialities to provide temporary accommodation for a few days. Every effort needs to be taken to ensure that all should conform to high standards, particularly on confidentiality and security.

- Documentation and management of data is an area which is weak in most countries. However, Thailand reports to have established a Management Information System (MIS), networking all the service points.¹³

- A few countries have initiated preventive strategies. In Sri

Lanka, a package on RH and GBV has been developed targeting the newlyweds, which is to be delivered through registrars of marriage and the public health staff, including midwives.

In order to enhance health sector response, community level awareness raising programmes done in a rights-based, gender-sensitive and culturally sensitive manner is essential. SRHR education in schools would also be a good opportunity for primary prevention. Developing resource pools of experts at national and international levels would be critical for capacity building.

Furthermore, political will needs to be strengthened and sustained in order to institutionalise a systemic GBV response into routine SRH care. Integration of GBV prevention and services into the health system needs to be achieved in a sustainable way in order to reach the most number of women, while effective project-based interventions need to be sustained. Most importantly, models need to use rights-based and gender-sensitive approach to addressing GBV. Monitoring and formal evaluations also need to be regularly conducted to assess which interventions really work.

It is also critical to address other gaps, including responding to violence in crises and post-crisis settings, addressing violence within the health system (given the inevitability that some health care workers are victims or perpetrators of violence), working with men and boys, and ensuring that marginalised groups are included in policies and programmes responding to GBV.

Addressing gender-based violence in the sexual and reproductive health and rights agenda is crucial for countries to achieve their commitments to ICPD and to reaching their MDG goals. Moreover, it is critical that GBV and SRHR be in the development agenda even after we reach 2014 and 2015, the initial deadlines set for ICPD and MDG.

Endnotes

- 1 Stephenson, R.; Koenig, M.A., & Ahmed, S. (2006). Domestic violence and contraceptive adoption in Uttar Pradesh, India. *Studies in Family Planning*, 37(2), 75-86.
- 2 Filu, E. (2007). Domestic Violence and Women's Health in Maldives. *Regional Health Forum*, 11(2): 25-32.
- 3 Fibree, F.F.; Bhatti, L.L. (1999). Domestic Violence and Health of Pakistani Women. *International Journal of Gynecology & Obstetrics*, 65(2), 195-201. Cited in ARROW, 2010. "Understanding Understanding the critical linkages between gender-based violence and sexual and reproductive health and rights: Fulfilling commitments towards MDG+15." Malaysia: ARROW & UNFPA.
- 4 WHO. (2002). *World Report on Violence and Health*. Geneva: WHO. <http://whqlibdoc.who.int/hq/2002/9241545615.pdf>
- 5 Center for Reproductive Rights. CEDAW Committee Expresses Concern over Bangladesh. <http://reproductiverights.org/cv/press-room/cdaw-committee-expresses-concern-over-bangladesh>
- 6 Government of Bangladesh & the United Nations Country Team in Bangladesh, Millennium Development Goals Progress Report 2005, at www.searo.who.int/LinkFiles/MDG_Reports_BangladeshMDG.pdf
- 7 Ganatra, B.R.; Coraji, K.J. & Rao, Y.N. (1998). Too far, too little, too late: A community-based control study of maternal mortality in rural west Madhya Pradesh, India. *Bulletin of the World Health Organization*, 76, 591-598.
- 8 Attygala, D. (2010). Presentation made at a scientific meeting on Suicide in Pregnancy in Sri Lanka at the Sri Lanka College of Obstetricians and Gynaecologists, with information gathered at the Maternal Mortality Reviews conducted by the Family Health Bureau.
- 9 UNAIDS. (2009). *HIV Transmission in Asia in Intimate Partner Relationships*. Switzerland.
- 10 UNDP (2010). Progress on MDG 6 and 3: Perspectives of women living with HIV in India, Philippines and Papua New Guinea, Bangkok, Thailand. In UNESCAP, ADB and UNDP. 2010. *Paths to 2015: MDG Priorities in Asia and the Pacific, Asia-Pacific MDG Report 2010/11*. UN.
- 11 Divucury, N. & Knoess, J. (2005). *Gender Based Violence and HIV/AIDS in Cambodia: Links Opportunities and Potential Responses*. Germany: GTZ.
- 12 Wilson-Williams, L., Stephenson, R., Jeevekar, S., & Andes, K. (2008). Domestic violence and contraceptive use in a rural Indian village, 14(10), 1181-98.
- 13 UNFPA APRO. 2010. *Health Sector Response to Gender-based Violence: An Assessment of the Asia Pacific*. Thailand.

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Pregnant women wait to see a doctor in an IDP camp in Pakistan. Thousands are displaced because of clashes between government security forces and Taliban militants in the northwestern Swat region. In emergencies, sensitised relief workers and strong preventive measures are critical to bringing services to women and girls. These may avert/curtail some forms of GBV, which together with empowering women and girls and sensitising men and boys, are an important step in ultimately ending violence and achieving sexual and reproductive health and rights.

Emergencies as Opportunities for Change? Addressing Gender-based Violence and Sexual and Reproductive Health and Rights in Situations of Displacement in South Asia

Introduction. Recent research has demonstrated that women and girls are particularly vulnerable to gender-based violence (GBV) in situations of displacement following conflicts and disasters, whether small or large.^{1,2} This is a matter of concern, given that South Asia has recently suffered from many emergencies that have displaced millions: 1.5 million in Sri Lanka due to the Asian tsunami (2005), 3.5 million due to Pakistan's earthquake (2005) and another 20 million due to floods in Pakistan (2010). Women form a large proportion of the survivors. In the 2010 floods in Pakistan, for example, 50% of the displaced were women.³

Humanitarian response to emergencies provides immediate relief. However, it tends to be blind to women and girls' specific needs or vulnerabilities. This is a reflection of socio-cultural norms that define women's status in society, whereby South Asian women, particularly adolescents, are denied rights like choice of marriage, contraceptive use and abortion, and are subjected to harmful customary practices.

GBV and SRHR in emergencies. Recent emergencies in Bangladesh, Pakistan and Sri Lanka have provided compelling evidence that GBV has a direct impact on women's and girls' SRHR,^{2,4} and that both are indeed two sides of the same coin. Studies during Pakistan's emergencies show that GBV and SRHR violations occur side by side. For instance, a rapid needs assessment following the 2005 earthquake revealed that GBV has an impact on a woman and girls' SRHR through forced sex, increased risk of unwanted pregnancies, sexually transmitted infections, sexual abuse and harassment, kidnapping, trafficking and forced marriages. Restrictions on mobility (even more

stringent in emergency situations) combine with destroyed health infrastructure, absence of female providers, transport and cost issues and physical insecurity to prevent women and girls from accessing services and supplies, including contraceptives, pre/post-natal care and childbirth. These findings were corroborated by studies after the 2010 flood.^{3,5}

Emergencies as opportunities? A big question is whether emergencies that heighten vulnerabilities and anxieties, and create alienation and isolation, can be turned into opportunities for gender-responsive social transformation. Can the humanitarian urge that surfaces during emergencies be mobilised to break some of societal bondages? And can spaces be created to introduce innovative and out-of-the-box measures?

If the principle that all people in emergency situations are entitled to have their rights and needs equally met⁶ is applied, then women and girls' specific needs related to GBV, as well as SRHR, must also be met. However, prevalent practice reveals that women, young people, children and marginalised groups are often left out, thus, violating the principle of non-discrimination that underpins the right of all survivors to receive assistance equally.

That focus can be shifted from conventional emergency relief provision to respond to women's and girls' specific needs was first discussed in the region following the Asian tsunami. The idea of 'Women-Friendly Spaces' was conceived in Sri Lanka to give women and adolescent girls unencumbered physical space within relief camps to meet freely, and discuss and address their issues.

This experience was brought to Pakistan in the aftermath

of the 2005 earthquake. Women had expressed in a Rapid Needs Assessment the desire for a place where they can “take down their hair and relax,” go to the toilet or bathe in peace. In response, Shirkat Gah helped establish six Women-Friendly Spaces, in two very diverse rural earthquake-affected geographical regions – one relatively developed, the other very conservative and remote. Not specifically conceptualised as addressing GBV or all dimensions of SRHR, the WFS in the relatively developed region became spaces for women to come into their own, gain confidence and take initiatives. Local female leadership emerged (young and old).⁷ Viewed initially with suspicion by community men of leading women ‘astray,’ they soon became acceptable due to their inclusiveness. Meanwhile, the WFS in the conservative and remote region provided much-needed refuge from domestic pressures. The WFS experiment demonstrated that relief work in emergencies needs to go beyond the immediate to longer-term goals of promoting women’s and girls’ rights to enable countering of GBV and assertion of SRHR.

GBV issues and women’s SRH needs were highlighted during the 2005 earthquake and the lessons from this period appear to have been internalised. It was observed in subsequent emergencies, and confirmed by various NGO reports, that there was more focused attention on women’s specific needs, from sanitary napkins to appropriate clothing, and from cooking stoves and distribution of relief goods to families via women. Many camps created safe spaces for women where they could relax, interact with other women, and where economic activities and health/hygiene information could be provided. Health camps with family planning/contraceptive services were organised in official and unofficial camps; safe childbirth and delivery were improved through better coordination between NGOs, government services and UN agencies; special relief packets were made for pregnant women, young mothers and children; and larger NGOs and INGOs set up camps with toilets for women, female doctors and security arrangements. Moreover, local women were mobilised to become part of relief efforts.

Despite these measures, a number of gender-based violations and SRHR concerns were reported during the emergencies: early and forced marriages, kidnappings and miscarriages (240,000 pregnant women in the 2011 flood) in many areas. The situation demands deeper examination of women’s and girls’ requirements, especially of personal security and dignity, and move beyond provision of relief goods. Interventions will have to focus on sustainability and creating opportunities for women and girls to make decisions and exercise agency.⁸

The way forward. For immediate responses to emergencies, it is important that:

- Affected/displaced women from across class and ethnic groups, as well as female heads of households, single women, widows, older women, adolescent and younger

women, women with disability, transgender people and others are involved in planning and implementation of policies and programmes related to conflict and disaster.

- A rights-based approach, focusing equally on the rights and needs of all displaced/affected, regardless of age, location, class, gender, marital status, sexual orientation, citizenship/migrant status, disability status, ethnicity or caste, are integrated in national planning processes, and in the implementation of policies and programmes.

- Multi-sector contingency plans are developed by all engaged in emergencies (government, UN, NGOs, INGOs, donors, local organisations, etc.). These should include strategies to address GBV and SRHR issues, beginning with but not limited to the Minimum Initial Service Package (MISP) in Reproductive Health in Emergencies.

For the longer term, it is imperative that:

- The unfinished agendas of ICPD and MDGs are continued and expanded to place greater emphasis on the elimination of GBV and full acceptance of SRHR;
- Regional inter-governmental bodies (SAARC, ASEAN and the Pacific Islands Forum) develop mechanisms to track progress on GBV and SRHR; and
- NGOs act as watchdogs and advocate for fulfilling the Cairo agenda and MDG 5 (a & b) targets.

The last word. One needs to remember that GBV and the denial of SRHR is a generic problem in the region that is deeply rooted in patriarchy. At the heart of both is the control of women’s sexuality and reproductive capacity. In emergencies, sensitised relief workers and strong preventive measures can bring services to women and girls. This may avert/curtail some forms of GBV – which are important steps in themselves – but are not enough to achieve comprehensive SRHR and eliminate GBV. Longer-term struggle using varied strategies must continue to mobilise women and girls, and help enable them to have confidence and ability to be their own agents and make decisions about their sexual and reproductive rights – including choices in marriage or (sexual) partner, number of children, spacing of births and contraceptive selection – and contest GBV.

Endnotes

- 1 United Nations Population Fund (UNFPA). (2010). *Health Sector Response to Gender-based Violence in the Asia Pacific Region: Assessment 2010*. Thailand.
- 2 Murthy, R. K. (2008). *Feminist and rights-based perspectives: Sexual and reproductive health and rights in disaster contexts*. *ARROWS for Change*, 14(3), 1-2. Malaysia: ARROW.
- 3 Internal Displacement Monitoring Centre (IDMC) and Norwegian Refugee Council (NRC). (2011). *Briefing paper on flood-displaced women in Sindh Province, Pakistan*. Switzerland.
- 4 Siddiqui, S. (2008). *Monitoring country activities: Bangladesh*. *ARROWS for Change*, 14(3). Malaysia: ARROW.
- 5 Shirkat Gah’s findings captured in its documentary, *Swollen River*.
- 6 Barry, J. (2006). *Relief in the human rights framework – Core Issues*. In Shirkat Gah, *Rising from the Rubble: Special Bulletin*, pp. 15-21. *The Brookings-Bern Project on Internal Displacement*. (1998). *Guiding Principles on Internal Displacement*. www.idpguidingprinciples.org
- 7 *These centres continue to work to date without UNFPA or Shirkat Gah support. They were so successful that one of the partners established 17 more WFS.*
- 8 *Shirkat Gah repeated its earlier intervention and set up six WFS across Pakistan, this time specifically focused on GBV and SRHR. See Shirkat Gah’s Report, Lessons Learnt (Forthcoming).*

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Empowering young women and engaging young men are core strategies to end gender-based violence by Yayasan Jurnal Perempuan, an Indonesian NGO with a youth-led programme on GBV and SRHR.



Photo source: Yayasan Jurnal Perempuan documentation

Reaffirming Young People's Roles in Addressing Gender-Based Violence and Sexual and Reproductive Health and Rights

Gender-based Violence (GBV)¹ and young people. Young people have the right to be free from violence and to fully attain their sexual and reproductive health and rights (SRHR). These rights have been affirmed by various international commitments signed by Asian governments.²

Yet, research data show how often these rights are not met. Globally, 7% to 48% of adolescent girls and 0.2% to 32% of adolescent boys report that their first sexual activity was coerced.³ In Southeast Asia, research also shows high numbers of sexual violence. In Thailand, for example, one in four young women had their first sexual intercourse due to pressure from their boyfriends.⁴ In the Philippines, 57% of first-time sex were unplanned or non-consensual.⁵ The WHO Multi-Country Study reveals that younger women, especially those aged 15-19 years, are at higher risk of experiencing intimate partner violence (IPV).⁶

In examining the issue of GBV, it is critical to recognise the diversity of young people. The definition of and perception about 'youth' is different across societies. It is influenced by the social, political, cultural and economic contexts of a society and determined by the location of an individual in terms of gender, class, caste, ethnicity, race and sexual orientation, amongst other aspects of social differentiation.⁷

GBV towards young people is not limited to young heterosexual men and women; violence towards lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) youth is also predominant. In the Philippines, a national fertility and sexuality study of young people revealed that 15.8% of gay and bisexual young men and 27.6% of lesbian and bisexual young women reported suicide ideation, compared with 7.5%

of heterosexual young men and 18% of heterosexual young women. This high risk of suicide is related to experiences of discrimination and sexual orientation-related violence, perceived stigma and internalised homophobia.⁸ Since laws and norms criminalise and stigmatise non-heterosexual relationships, young people who have different gender identities and sexual orientations have added difficulty reporting experiences of GBV.

Recognising diversity also means looking at experiences of young women living with disabilities. While there is dearth in data in the region on GBV and young women with disabilities, studies of women with disabilities show that they tend to be more vulnerable to experience sexual violence, domestic violence, exploitation in the workplace, as well as violations of sexual and reproductive rights. For example, a study in Orissa, India shows that all women and girls with disabilities have experienced physical abuse, 25% of women with intellectual disabilities have been raped, while 6% have been forcibly sterilised.⁹ The UN Convention on the Rights of Persons with Disabilities recognises "that women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation."¹⁰

GBV and SRHR linkages. Unwanted pregnancy is just one of the tangible consequences of sexual coercion and physical violence in intimate relationships. IPV is also linked to several SRHR issues, such as unsafe abortion, sexually transmitted infections (STIs), including HIV, maternal morbidity and mortality and psychological trauma.¹¹ This is concerning, given that more than 15 million girls aged 15

to 19 give birth yearly as a result of early marriage and early pregnancy. Further, currently, 50% of all new people living with HIV are young people between the ages of 15-24, of which over 60% are girls.¹²

A UNICEF study of nine countries, including Cambodia, found that girls who marry before 18 are more likely to experience domestic violence than peers who marry later.¹³ They have lower power in negotiating on their sexual and reproductive rights, such as deciding on whether to engage in sex, use contraceptives, continue pregnancy and have children. The inability to claim their rights put young women at higher risk of STIs, including HIV.³ They are also vulnerable to suffering and dying from injuries, infections and disabilities due to pregnancy and childbirth.¹⁴ For young women, all of these are potentially very limiting to their life choices.¹¹ These can severely curtail educational and employment opportunities and have long-term adverse impact on their own and their children's quality of life.¹² Aside from reproductive health vulnerability, in relationships with violence, young women are also not able to exercise their sexual rights, including to sexual pleasure.

Violence towards LGBTIQ youth, such as rape towards gay boys could also result to psychological trauma, STIs and HIV. In addition, 'corrective' rape among lesbian young women could result in additional complications of unwanted pregnancy and increased chances of unsafe abortion or maternal mortality and morbidity.

Empowering young women + Engaging young men = Cutting the cycle of violence. The causality of violence is complex, many of which are social, political and structural. Women and girls are often vulnerable to GBV because of social norms and beliefs that reinforce women and girls' subordinate status in many societies.¹⁵

Some Southeast Asian countries have social norms and beliefs that are integrated with strong religious values, which have an impact on laws, policies and programmes. For example, the Indonesian Marriage Law states that the required minimum age for women is 16 years old, younger than the required minimum age for men of 19 years old.¹⁶ This clearly shows society's low positioning of women, wherein women are considered ready to marry and give birth at a young age, despite the costs of early marriage and early childbearing on women and their children.¹⁷ This is compounded by the absence of a perspective that girls and women have the right to education, better employment and bodily integrity.

The belief that violence is acceptable on some grounds still persists in Southeast Asian society. Studies reveal that while exposure to violence may not necessarily lead to violent behaviour, it can shape young people's attitudes and beliefs of the acceptability of violence.¹⁸ Programmes for young people that challenge gender roles and power relations, promote young women's empowerment, respect for young women's equal rights, respect for the rights of LGBTIQ persons, and emphasise the unacceptability of violence can have a powerful impact in stopping the cycle of violence. Young people,

regardless of sex, gender identity and sexual orientation, can work together to make a world without violence.

From international commitments to national implementation. Considering that international commitments related to youth GBV have been existing for more than 10-15 years, national level implementation has been slow and uneven. While most of the countries in the region have domestic violence laws, majority of these are blind to the needs and realities of young people, and youth-friendly reporting mechanisms hardly exist. For example, in Indonesia, the law regulates domestic violence only within legal marriage, whereas in practice, there are many religious marriages commonly practiced by young people with no legal-base. The law does not cover these, nor other dating violence cases.

Lack of access to quality, scientific and non-judgmental information, and to youth-friendly sexual and reproductive health services and supplies, including access to contraception, emergency contraception and safe abortion, are big concerns. In many countries in Southeast Asia, abortion is illegal or highly restrictive, or even if allowed, there are many barriers to young women's ability to access it, including parental or spousal consent.

Urgent call for meaningful youth participation. While it is important to highlight and address the issue of GBV and SRHR among young people, it is also extremely critical that young people be consulted and involved in measures to address this urgent issue. As the group that directly experiences the problem, they comprehend it the most and would best understand what strategies would work.

What does 'meaningful youth participation' actually mean? Here are some characteristics: it mobilises other young people; focuses on youth input; provides spaces for youth to lead processes; builds and strengthens capacity of young people; has clearly defined roles for young people involved; is fully inclusive and accessible to all; has transparent processes; is visible and recognised by other stakeholders; includes an implementation and monitoring mechanism; takes national contexts into account and ensures local implementation of international decisions; and is connected to policy and impact, and to everyday realities.¹⁹ Moreover, participation should involve and give spaces for all types of youth, including youth living in rural area, youth with HIV, youth with disabilities, LGBTIQ youth and many more. Furthermore, young people should be involved not just in project activities, but as decision-makers sitting within project steering committees and in the governing structure, not just for reasons relating to rights of participation, but also to improve the quality of policies and services for youth.²⁰ Additionally, youth-adult partnership is critical, and effective models need to be studied and implemented.

Towards shaping the next development frameworks. As specific time-bound goals for ICPD and the MDGs are reached in 2014 and 2015, there is a need to reaffirm the role of young people, including youth-led organisations, as equal partners in development. Young people need to be seen

as keypoints to cutting the cycle of violence and achieving SRHR. They have to be meaningfully involved in policy making, programme planning, implementation, monitoring and evaluating at all levels. This means empowerment of young women, including providing them with rights-based education, as well as fulfilling the needs of young men and working with them to change gender and power relations. Finally, there is an urgent need for development frameworks that embrace youth diversity, are less biased against young people, are more equal and right on target.

Endnotes

- 1 While this article discusses intimate partner violence mainly due to space constraints, other forms of GBV experienced by young people that needs to be acknowledged as important, include sexual abuse by family members and strangers, sexual exploitation, sexual harassment, female genital mutilation and gender violence in school. All these kinds of GBV among youth vary across cultures, countries and regions.
- 2 These include the International Conference on Population and Development Programme of Action, the Beijing Platform of Action, and the Millennium Declaration and Development Goals.
- 3 ARROW. (2010). *Understanding the critical linkages between gender-based violence and sexual and reproductive health and rights: Fulfilling commitments towards MDG+15*. Malaysia: ARROW & UNFPA.
- 4 Gubbaju, B. (2002). *Adolescent Reproductive Health in Asia*. *Asia-Pacific Population Journal*, 17(4), 98-119.
- 5 University of the Philippines Population Institute (UPPI). (2002). *2002 Young Adult Fertility and Sexuality Study (YAFS) III*. Philippines: UPPI. Cited in Hain, 2009, *Too Young, Too Curious*, which is cited in ARROW's for Change Vol. 17 No. 2 Concept Note.
- 6 Garcia-Moreno, et. al. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women Initial Results on Prevalence, Health Outcomes and Women's Responses*. Switzerland: WHO. Cited in AFC Vol. 17 No. 2 Concept Note.
- 7 Angelina, M. (2010). *The ABC Approach Unpacked: Assumptions versus Lived Reality of Youth and Safe Sex in Sub-Saharan Africa*. "Best Student Essays of 2009/2010". Netherlands: Institute of Social Studies.

- 8 Manalastas, E. (2009). *Dyke Dialogues/Rainbow Exchange Series, Filipino LGB Youth and Suicide Risk: Findings from a National Survey*. The Philippines: University of the Philippines Diliman. Cited in *EnGendeRights*, 2009. *Shadow Letter to the Committee on the Rights of the Child: Supplementary information on the Philippines scheduled for review by the Committee on the Rights of the Child on 15 September*, which is cited in ARROW's for Change Vol. 17 No. 2 Concept Note.
- 9 United Nations. (2006). *Fact Sheet: Some Facts about Persons with Disabilities*. Cited in *Secretariat for the Convention on the Rights of Persons with Disabilities of the Department of Economic and Social Affairs; United Nations Population Fund & Wellesley Centers for Women*. (2008). *Disability Rights, Gender, and Development: A Resource Tool for Action*.
- 10 UN Convention on the Rights of Persons with Disabilities (Preamble, g).
- 11 International Institute for Population Sciences (IIPS) and Population Council. (2009). *Violence within marriage among young people in Tamil Nadu, Youth in India: Situation and needs 2006-2007*. Policy Brief No. 12. Mumbai: IIPS. Cited in AFC Vol. 17 No. 2 Concept Note.
- 12 The Working Group on Girls. (2006). *The right to protection: The girl child and gender-based violence*. www.girlsrights.org/fact_sheets_files/Violence.pdf
- 13 UNICEF. (2005). *Early marriage: A harmful traditional practice*. UNICEF: New York. Cited in ICRW. (2006). *Child marriage and domestic violence*. Washington, DC, USA: ICRW.
- 14 UN Women Virtual Knowledge Centre to End Violence against Women and Girls. Adolescents. www.endvawnow.org/en/articles/685-adolescents.html
- 15 CARE. (2010). *Bringing an end to gender-based violence*. USA.
- 16 UNICEF. *Adolescent and Youth: The Big Picture*. http://www.unicef.org/adolescence/index_bigpicture.html
- 17 Population Reference Bureau and Advocates for Youth. *Youth and marriage: Trends and challenges*. USA: National Academies Press.
- 18 Domestic Violence & Incest Resource Centre Victoria (DVIRC). (2005). *Young People and Domestic Violence Factsheet*. Australia: DVIRC.
- 19 Open Society Foundation and British Council. (2011). *Meaningful Participation by Young People in International Decision-making: Principles, Practice and Standards for the Future*. The London Symposium Report.
- 20 UNFPA and IPPF. (2004). *Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF: Synthesis Report*.

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Questioning the Roots: Shifting gender norms to create support for gender equality and non-violence

Underlying both adverse health outcomes and gender-based violence (GBV) are inequitable gender norms that shape expectations regarding individual behaviours of men and women, as well as the interactions between and among them. These norms curtail women's autonomy, assert men's decision-making authority and control over women, and tend to condone or justify the use of violence. At the same time, gender norms and expectations related to femininity undermine women's and girl's decision-making power and increase their vulnerability to negative sexual and reproductive health (SRH) outcomes and to violence.

An initiative called Gender Equity Movement in Schools (GEMS) worked with boys and girls aged 12-14 years in the school setting, towards making gender attitudes less rigid, more equitable and less tolerant of violence.¹ The study used a quasi-experimental design and was carried out in 45 randomly selected schools in Mumbai, India over two academic years (October 2008-March 2009 and September 2009-March 2011).

The schools were randomly and equally distributed across three groups: 1st with classroom sessions and campaigns, 2nd with only campaigns, and 3rd with no intervention. Around 8,000 students participated in the study.

Classroom sessions involved activities to engage students in critical reflection on gender and violence, and campaigns initiated public dialogue and created a non-threatening environment to discuss these issues within schools. The GEMS approach recognises the importance of going beyond life skills education to question the basic constructs of gender. Giving information is not enough; spaces for discussion and reflection need to be created to change beliefs. Unless this is done, schools as institutions that have an impact on early socialisation will continue to maintain the status quo, shaping values and behaviours that support gender inequality and the use of violence.

To measure the initiative's impact, quantitative data were collected at three time points: baseline, 1st follow-up after the first year of intervention, and 2nd follow-up at the end of the 2nd year. A total of 2,035

Photo by Jeannine Banton, ICRW



GEMS in the classroom.

students (1,100 girls and 935 boys) from grades VI and VII participated at baseline and 1st follow-up, while 754 grade VI students (426 girls and 328 boys) participated in all three rounds.

Evaluation results show a positive shift in attitudes toward gender norms, sexuality and violence. A number of statements² were asked to students to assess their support for gender norms.

Boys and girls in the intervention schools, particularly with classroom sessions, were less supportive of inequitable gender norms, whereas no change, less change or negative change was observed in the control group. Positive shift was more pronounced among girls than boys. For example, after the intervention, significantly higher proportion of students disagreed with the statement, “Since girls have to get married, they should not be sent for higher education,” (girls – 53% to 65%; boys – 48% to 57%) compared with the control group (girls – 44% to 43%; boys – 49% to 40%).

On sexuality-related statements, such as, “Girls provoke boys with short dresses,” while there is increase in proportion of students who disagreed with this statement at 1st follow-up in intervention schools (girls – 43% to 52%; boys – 27% to 35%), there was no change or a decrease in control schools. A similar pattern is observed over time on the perception of students regarding sexual violence and violence within relationships, as measured by statements, such as, “Sometimes it is appropriate for boys to beat their girlfriends.” These findings indicate that with time, students are more likely to get stereotypical messages on sexuality and sexual violence, unless interventions are made systematically at a younger age to sensitise them.

Increased demand for information on bodily changes

was noted in intervention schools as compared to control schools. The intervention also helped in improving confidence. After participating in the initiative, students reported feeling more confident in protesting and registering complaints against unwanted sexual advances (girls – 51% to 79%; boys – 48% to 66%), a finding that is encouraging for safety and health. Further, 78% of girls and 77% of boys reported that after participating in the GEMS intervention, they feel more comfortable with students of the opposite sex. Notions of sexuality and the way one relates to the opposite sex are important components of healthy sexual relationships.

These indicators on perceptions and self-efficacy are important, and are necessary precursors for better SRH and relationships. These are significant for laying the ground for communication between partners around several issues, including negotiating sex and contraceptive use. Similarly, increased confidence to talk and seek information is an important indicator for awareness and proactive action related to health.

This programme demonstrates the feasibility and potential of shaping gender norms towards more equitable relationships.

Endnotes

- ¹ GEMS was implemented by the International Centre for Research on Women (ICRW), CORO for Literacy and Tata Institute of Social Sciences (TISS) in select municipal schools of Mumbai, India.
- ² An adapted and modified version of the Gender Equity Men's Scale was used.

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Regional

Sexual violence (SV), such as rape and sexual exploitation, often increases in crisis situations, in cases of forced displacement and breakdown of law and order. In spite of this, sexual and reproductive health and rights (SRHR) often go unrecognised, leaving more women and girls in crisis vulnerable to preventable death and disability.

The SPRINT Initiative, led by the International Planned Parenthood Federation (IPPF) in collaboration with the United Nations Population Fund (UNFPA) and other national and international partners,¹ aims to improve health outcomes of crisis-affected populations by reducing preventable sexual and reproductive ill health, disability and death. It operates in Africa, South and South East Asia and the Pacific. SPRINT facilitates implementation of the Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP), the internationally accepted standard for SRH coordination and care in emergency settings.

Sexual violence prevention and medical care for survivors is one of the five priority components of the MISP.² The MISP includes adopting a multi-sector approach to ensure that women, men and youth have access to safe, confidential and culturally appropriate SRH services, such as emergency obstetric care, contraception, HIV and STI prevention and treatment, and psychosocial counselling for SV.

In Myanmar, despite challenging circumstances, the SPRINT-supported country team has pioneered care for sexual violence survivors during crises. Since Cyclone Nargis in 2008, SPRINT trainees, particularly from UNFPA, have trained over 200 health and humanitarian workers on GBV and clinical management of care for rape survivors. The establishment of national level inter-agency coordination groups, comprised of government, UN and civil society representatives has enabled, for the first time, issues of sexual violence and crises to be openly discussed. This has made it easier to provide SV services during subsequent crises such as Cyclone Giri in 2010. Given that SV in crises often goes unreported and unaddressed, preparedness for a GBV response is crucial in ensuring vulnerable populations affected by crises have access to life-saving care.

Meanwhile, in the Philippines, typhoons Pedring and Quiel ravaged Luzon Island in September 2011. The Family Planning Organisation of the Philippines (FPOP), supported by the IPPF East and South East Asia and Oceania Regional (IPPF ESEAOR) office and the SPRINT Initiative, provided much-needed access to reproductive health (RH) services to the typhoon-affected populations. Many of the more than 200,000 affected families had to be placed in temporary shelters hastily set up by the local government units. The humanitarian conditions in these centres were challenging, as these were overly crowded and devoid of basic amenities, including water and sanitation, electric power and sleeping mats. Women and girls become vulnerable in such precarious circumstances,

as risks associated with sexual violence and unwanted pregnancies, and subsequent unsafe abortions, increase.

FPOP, under the auspices of the health coordination team, established MISP coordination teams to support SRH response efforts in five of the worst-affected provinces. Sexual violence was raised by the public health units delivering services as an issue of significant concern but one they had little experience in dealing with. To improve response for SV survivors, FPOP provided orientation and medical supplies to government health providers on the clinical management and care of rape survivors. The Philippine National Police Women's Desk, health providers and the Social Work and Development Office were also brought into the coordination mechanisms to develop standard referral procedures between medical, psycho-social and legal services. Such systems enable women to access care without being shuffled back and forth between services, which is often a deterrent in coming forward. These efforts, led by FPOP in collaboration with government, UN and other NGOs, are critical steps in integrating SRH and SV services into the standard health response during crises.

The above case studies demonstrate that achievements have been and can be made in recognising the SRHR rights of crisis-affected populations. However, there is still a long way to go in meeting the SRHR of survivors of displacement and SV in emergency settings. Stigma, lack of trained health workers and awareness of available services continue to be some of the barriers to access. The SPRINT Initiative and its network of partners are committed to addressing these barriers before, during and after crisis, to ensure people affected by GBV in emergency settings have access to effective SRH services.

Source: Keya Saha-Chaudhury, Coordinator, SPRINT Initiative, IPPF ESEAOR, Malaysia. Email: KSaha@ippfeseaor.org

Kyrgyzstan

Ethnic and social patterns remain very strong in rural areas of Kyrgyzstan, affecting rural youth. One example of a cultural violation is the bride kidnapping practice, which has great implications on young women's rights, including their reproductive and sexual rights. If non-consensual, it is a form of violence against women, and violates women's and girls' rights to bodily integrity and to choice of partner, freedom of movement and freedom from violence.

Research³ shows that 50% of ethnic Kyrgyz women are married through bride kidnapping. While bride kidnapping covers a variety of actions, including consensual eloping, research finds that as many as two-thirds of them are non-consensual. Rape is often considered a common element of bride kidnapping. Combined with the social stigma attached to being an unmarried girl spending a night with a man and threats, it forces young women in many cases to stay with their abductors. In some cases, bride kidnapping

leads to young women being killed or committing suicide.⁴ Once forced to marry, in most cases, the girls cannot take control over their own sexuality and lives, and often lose opportunities for education, work and further advancement.

It is important to note that there is no cultural obligation to kidnap a bride. Bride kidnapping is closely tied to economics, social structure, family organisation and gender stratification. Non-consensual kidnapping is prohibited by Kyrgyz law as well as by international conventions that have been ratified by the Kyrgyz Republic. However, enforcement is lax and the practice remains widespread.

To help address the above issues, the Association of Rural Women (Alga)⁵ developed a comprehensive training programme, which has been adapted from the Stepping Stones training module on gender, SRHR, GBV, communications and relationship skills. Alga's training philosophy is grounded in a strong commitment to interactive, dialogue-based experiences that provide new pathways for learning. The training curricula and workshops have been designed for groups composed of people of different age and sex, ethnic groups and social status. This training programme includes discussions on bridekidnapping as a GBV and SRHR issue, as well as on the roots and impact of GBV. All issues are situated within a broader context of relationships with partners, families and community/society. Throughout the training, emphasis is also given on building communication skills, which is important since inability to communicate with young women is one of the reasons cited by young men for bridekidnapping. Additionally, Alga conducts a Young Parents' School and counselling for kidnapped women.

Alga has had some successes from these interventions. There are cases of young women refusing to accede to the bride kidnapping practice; childbirth with the involvement of male partners has become acceptable to local communities and local maternity hospitals; and 21 of Alga's trainees have become members of the local and district *kenesbes* (councils). Young leaders of Alga have also been invited to the development of a new national Youth Policy, where they will try to ensure that provisions related to gender, SRHR, and addressing GBV and bridekidnapping are included.

In order to get results in such a sensitive issue as gender-based violence and SRHR, appropriate communication approaches should be developed. All community stakeholders who can increase community dialogue on sensitive issues and create an enabling environment should be involved. Further, traditional, community and religious leaders should be mobilised around youth SRHR and prevention of GBV and SRHR violations. Additionally, gender equality should be a critical component of any youth education programme. Finally, Alga believes that youth should be involved in activities not just as passive receivers, but as active players in the planning and realisation of educational programmes.

Source: Aizhamal Bakashova, Rural Women's Association (Alga), Kyrgyzstan. Email: ngoalga@gmail.com

Nepal

Violence against women (VAW) is a manifestation of unequal power relations between women and men. In the current transitional phase in Nepal, VAW is disturbingly increasing. An existing culture of silence has further fuelled VAW and promoted the institutionalisation of impunity.

The Women's Rehabilitation Centre (WOREC) Nepal has been directly implementing its programme on VAW and SRHR in six districts in Nepal. Additionally, awareness activities, orientations and mobile workshops on women's health issues and VAW are carried out in other districts.

WOREC's initiatives to address VAW are directly tied to its continuous work since 1998 to address the health needs of women from marginalised and rural communities. WOREC has been training community women as barefoot gynaecologists and has formed 27 Women's Health Resource and Counselling Centres (WHRCC) across six districts. The WHRCCs have been effective ways to reach out to community women, and its screening programme has been critical in identifying women experiencing violence. The centres have become spaces to share and discuss issues, including how social inequality leads to ill health. Community women share their health problems and experiences, including on VAW, and get relevant knowledge, information and counselling, as well as treatment. WHRCCs have been instrumental to empowering women to gain control over their body and their health, and to recognise their rights.

Aside from the WHRCCs, WOREC has also established five safe houses for VAW survivors. Periodic health check-ups, as well as referrals to appropriate legal and medical help, are provided in safe houses.

This holistic approach of establishing WHRCCs, wherein both counselling and treatment services are provided by women health counsellors, and having safe houses, have been found to be effective to address GBV and SRHR. Importantly, this has enabled women to express their health problems and has supported them to live a healthy life free from violence.

Sources: Babu Ram Gautam and Shaurabha Subedi, WOREC.

Emails: womenhealth@worecnepal.org and worec.whrd@gmail.com

Endnotes

- 1 The SPRINT Initiative is funded by the Australian Government through AusAID.
- 2 For more information on the five objectives of the MISIP please go to www.rbrcc.org/rbr_basics/misipoverview.html
- 3 Kleinbach, R.; Babaiarova, G. & Orozobekova, N. (2009). "Reducing non-consensual bride kidnapping in Kyrgyzstan." http://faculty.philau.edu/kleinbach/new_page_14.htm
- 4 There were seven suicide cases in 2010 alone.
- 5 Alga was formed in 1995 by rural women, and aims to improve rural women's status and standards of living through stimulation of women's awareness of realities and develop their capabilities for self-actualisation, strengthening of the participation of rural women in development efforts and for the advocacy of their rights, development of empowering strategies and structures which promote the growth of economic and social status of women and communities.

Abramsky, T., et al. (2011). What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health*, 11(109), 1-17. www.ncbi.nlm.nih.gov/pmc/articles/PMC3049145/?tool=pubmed

This study examines data from ten countries included in the WHO Multi-country Study on Women's Health and Domestic Violence (which included Bangladesh, Japan, Samoa and Thailand). It aims to identify factors that are consistently associated with abuse across sites, in order to inform the design of IPV prevention programmes.



Asian-Pacific Resource and Research Centre for Women (ARROW). (2010). Understanding the critical linkages between gender-based violence and sexual and reproductive health and rights: Fulfilling commitments towards MDG+15. Malaysia: ARROW & UNFPA. www.arrow.org.my/publications/GBVBrief.pdf

This advocacy brief aims to inform policy-makers and decision-makers on the critical linkages between eliminating gender-based violence (GBV) and achieving the MDGs, particularly improving maternal health and providing universal access to reproductive health.

Devries, K.M., et al. (2010). Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *Reproductive Health Matters*, 18(36), 158-170.

This study describes the prevalence of intimate partner violence (IPV) during pregnancy across 19 countries, including Australia, Cambodia and the Philippines, and examines trends across age groups and regions. Findings suggest that IPV during pregnancy is common, and that global initiatives to reduce maternal mortality and improve maternal health must devote increased attention to violence against women (VAW), particularly violence during pregnancy.

García-Moreno, C. & Stöckl, H. (2009). Protection of sexual and reproductive health rights: Addressing violence against women. *International Journal of Gynecology & Obstetrics*, 106(2), 144-147.

This article gives an overview of VAW prevalence, risk factors and health consequences from studies across the globe. It also provides an assessment of progress and gaps in addressing violence against women globally in the last 15 years. Amongst other recommendations, it points to the need for health policies and services to address violence more systematically, particularly those related to sexual and reproductive health, and for health providers to take action. It also calls for support to interventions on VAW prevention.

Menon-Sen, K. (2011). *Monitoring and evaluating regional networks against violence: A thinkpiece for Partners for Prevention, GBV Prevention Network and Intercambios*. www.partners4prevention.org/files/resources/evaluation_thinkpiece_final_version__august_2011_0.pdf

This paper presents a conceptual framework, principles and guidelines for impact evaluation of regional initiatives on violence against women. Grounded in the experiences of three networks from Asia, Africa and Latin America, the publication aims to lead to better programming and more effective networking for ending VAW, and could be of use to other regional bodies working on social change.

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Office of the High Commissioner for Human Rights. (2011). Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity: Report of the United Nations High Commissioner for Human Rights (UN document number A/HRC/19/41).
www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41_English.pdf

This ground-breaking report is the first UN report to tackle discrimination and violence targeted against lesbian, gay, bisexual and transgender (LGBT) people. It affirms that governments have the duty to protect all persons from discrimination and violence based on sexual orientation and gender identity under international human rights law.



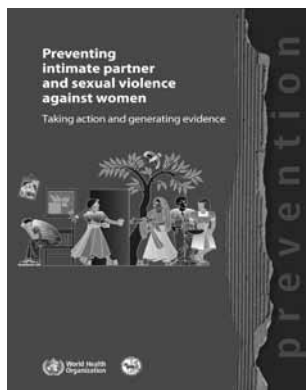
UNFPA Asia and the Pacific Regional Office. 2010. *Health Sector Response to Gender-based Violence: An Assessment of the Asia Pacific Region*. Thailand: UNFPA.
<http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2010/Assessment.pdf>

This report is a review of existing approaches to health sector responses to GBV in the Asia-Pacific

region. The report also includes normative frameworks for protocols, management and referral; provision of services; capacity building and multi-sectoral linkages to GBV. It also documents lessons learnt and presents key findings and recommendations on approaches and models of service; capacity building; protocols and guidelines; collaboration and referral; screening; and documentation and data management. It comes with a supplement of case studies that captures best practices in Bangladesh, Malaysia, Maldives, Papua New Guinea, the Philippines, Sri Lanka and Timor-Leste.

World Health Organisation (WHO) & London School of Hygiene and Tropical Medicine. 2010. *Preventing Intimate Partner and Sexual Violence against Women: Taking Action and Generating Evidence*. Switzerland: WHO. www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf

This publication aims to provide information for policy-makers and planners to develop data-driven and evidence-based programmes for preventing intimate partner and sexual violence against women.



Other Resources

ACQUIRE. (2008). *Engaging Boys and Men in GBV Prevention and Reproductive Health in Conflict and Emergency-Response Settings: A Workshop Module*. USA. www.rhrc.org/resources/Conflict%20Manual_CARE_for%20web.pdf

Ashford, L. & Feldman-Jacobs, C. [n.d.] The crucial role of health services in responding to Gender-Based Violence. USAID, IGWG & PRB. www.prb.org/igwg_media/crucial-role-hlth-srvices.pdf

Budiharsana, M.P. and Mai Quoc Tung. (2010). Improving the Health Care Response to Gender-based Violence—Phase II: Project Evaluation Report. Vietnam: Population Council. www.popcouncil.org/pdfs/2010RH_GBVIIReport.pdf

Columbini, M., et al. (2011). One stop crisis centres: A policy analysis of the Malaysian response to intimate partner violence. *Health Research Policy and Systems*, 9,25. www.health-policy-systems.com/content/pdf/1478-4505-9-25.pdf

Commonwealth of Australia. (2008). *Violence against Women in Melanesia and East Timor: Building on Global and Regional Promising Approaches*. Australia. www.ausaid.gov.au/publications/pdf/vaw_cs_full_report.pdf [Includes country supplements for Papua New Guinea, Solomon Islands, Fiji, Vanuatu and East Timor]

Decker, M.R., et al. (2009). Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: Findings from Indian husband-wife dyads. *Journal of Acquired Immune Deficiency Syndromes*, 51(5), 593–600.

De Dios, A.; Dungo, N. & Herrera, M. (2009). Violence against Women Is Not Inevitable: A Comprehensive Study on Gender-based Violence in CARAGA Region. Philippines: Miriam College.

Fuli, E. (2007). The Maldives Study on Women's Health and Life Experiences. Maldives: Ministry of Gender and Family. <http://minivannews.com/files/2010/10/Maldives-Study-on-Womens-Health-and-Life-Experiences-2007.pdf>

Garcia-Moreno, C. & Watts, C. (2011). Violence against women: An urgent public health priority. *Bulletin of the World Health Organisation*, 89,2. www.who.int/reproductivehealth/publications/violence/bulletin_88_12/en/index.html

The Global Coalition on Women and AIDS. (2011). Women who use drugs, harm reduction and HIV. Switzerland. www.womenandaids.net/CMSPages/GetFile.aspx?guid=74d74180-8cba-4b95-931e-90bd0c4abef4&disposition=inline

Gender and Development for Cambodia (GADC). (2010). *A Preliminary Analysis Report on Deoum Troung Pram Hath in Modern Cambodia: A Qualitative Exploration of Gender Norms, Masculinity and Domestic Violence*. Cambodia. www.partners4prevention.org/files/resources/a_qualitative_exploration_of_gender_norms_masc_and_dv_cambodia.pdf

Guttenbeil-Likiliki, O.L. (2010). Gender-based Violence and the MDGs in Tonga. *ARROWs for Change*, 16(1 & 2), 9-10.

Malaysia: ARROW. www.arrow.org.my/publications/AFC/v16n1&2.pdf

Interagency Gender Working Group (IGWG). (2010). Gender-based violence: Impediment to reproductive health. USA: Population Reference Bureau. www.prb.org/igwg_media/gbv-impediment-to-RH.pdf

International Institute for Population Sciences (IIPS) and Population Council. (2009). Violence within marriage among young people in Tamil Nadu, Youth in India: Situation and needs 2006–2007. www.popcouncil.org/pdfs/2009PGY_YouthInIndiaBriefViolenceTN.pdf

Kisekka, M.N. (2007). *Addressing Gender-based Violence in East and Southeast Asia*. Thailand: UNFPA APRO. <http://asiapacific.unfpa.org/public/cache/offonce/pid/1978;jsessionid=5750F214A93A684DB01EEE7D1E065057>

Miller, E., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81, 316–322. www.dvstats.org/pdf/reproduction/Pregnancy-Coercion-study.pdf

Miller, E. & Silverman, J.G. (2010). Reproductive coercion and partner violence: Implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics and Gynecology*, 5(5), 511–515.

Raifman, S., et al. (2011). The prevention and management of HIV and sexual and gender-based violence: Responding to the needs of survivors and those-at-risk. USA: Population Council. www.popcouncil.org/pdfs/2011_HIVSGBVBrief.pdf

Rani, M. & Bonu, S. (2009). Attitudes towards wife beating: A cross-country study in Asia. *Journal of Interpersonal Violence*, 24(8), p. 1371–1397.

Secretariat of the Pacific Community (SPC). (2007). *The Samoa Family Health and Safety Study. New Caledonia: SPC, UNFPA & Government of Samoa*. http://210.7.20.137/Publications/Talk_Gender/VAWC_Study_Samoa_Web.pdf

SPC. (2009). *Solomon Islands Family Health and Safety Study Report*. New Caledonia: Ministry of Women, Youth and Children Affairs & SPC. http://210.7.20.137/Publications/Talk_Gender/VAWC_Study_Solomons_Web.pdf

SPC. (2010). *Kiribati Family Health and Support Study Report*. New Caledonia: Ministry of Internal and Social Affairs & SPC. http://210.7.20.137/Publications/Talk_Gender/VAWC_Study_Kiribati_Web

UNFPA. (2010). *Swimming against the Tide: Lessons Learned from Field Research on Violence Against Women in Solomon Islands and Kiribati*. Fiji: UNFPA Pacific Sub-regional Office. http://210.7.20.137/Pages/Talk_Gender.html

UNIFEM. (2010). *Ending Violence against Women and Girls: Evidence, Data and Knowledge in the Pacific Island Countries, Literature Review and Annotated Bibliography*. Fiji: UNIFEM Pacific Sub-Regional Office. www.undp.org/fj/pdf/unp/evaw.pdf

ARROW Resources

ARROW. (1995–2011). *ARROWs for Change* Volumes 1–17. <http://arrow/index.php/publications/arrows-for-change.html>

ARROW. *ARROW Sexual and Reproductive Health and Rights (SRHR) Database of Indicators*. www.srhrdatabase.org

ARROW. (2011). *Reclaiming & Redefining Rights—Thematic Studies Series 4: Maternal Mortality and Morbidity in Asia*. 104p. US\$10.00

ARROW. (2011). *Reclaiming & Redefining Rights—Thematic Studies Series 3: Reproductive Rights and Autonomy in Asia*. 156p. US\$10.00

Ravindran, T.K.S. (2011). *Reclaiming & Redefining Rights—Thematic Studies Series 2: Pathways to Universal Access to Reproductive Health Care in Asia*. ARROW. 92p. US\$10.00

ARROW. (2011). *Reclaiming & Redefining Rights—Thematic Studies Series 1: Sexuality & Rights in Asia*. 104p. US\$10.00

ARROW. (2010). *ARROW Publications 1994–2010*. [DVD].

ARROW & WHRAP. (2010). *Making a Difference: Improving Women's Sexual & Reproductive Health & Rights in South Asia*. 126p.

ARROW. (2010). “Regional overview—MDG5 in Asia: Progress, gaps and challenges 2000–2010.” 8p.

ARROW. (2010). “Briefing paper: The Women and Health section of the Beijing Platform for Action.” 4p.

Thanenthiran, S. & Racherla, S.J. (2009). *Reclaiming & Redefining Rights: ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia*. ARROW. 162p. US\$10.00

ARROW. (2008). *Advocating Accountability: Status Report on Maternal Health and Young People's SRHR in South Asia*. 140p. US\$10.00

ARROW. (2008). *Surfacing: Selected Papers on Religious Fundamentalisms and Their Impact on Women's Sexual and Reproductive Health and Rights*. 76p. US\$5.

ARROW. (2007). *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights; Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project*. 216p. US\$10.00

ARROW. (2005). *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports*. 384p. US\$10.00

ARROW & Center for Reproductive Rights (CRR). (2005). *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia*. 235p. US\$10.00

ARROW. (2003). *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research*. 147p. US\$10.00

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Definitions¹

Gender-based Violence (GBV)

GBV is still an emerging and developing term and there is no single internationally accepted definition for it.^{2,3} The 1993 UN Declaration on the Elimination of Violence against Women uses GBV as part of the definition of “Violence against Women” (see *VAW*). UNIFEM states, “Gender-based violence can be defined as: violence involving men and women, in which the female is usually the victim and which arises from unequal power relationships between men and women.”⁴

Increasingly, the definition of GBV is also now expanding to include “all forms of violence that are related to social expectations and social positions based on gender and not conforming to a socially accepted gender-role.”²

GBV is often used interchangeably with VAW, given that “around the world, GBV has a greater impact on women and girls than on men and boys.” However, they are not synonymous, and men and boys may also experience GBV, especially sexual violence.⁵

GBV is also beginning to include violence and discrimination experienced by individuals due to their sexual orientation and gender identity (SOGI). The 2007 Yogyakarta Principles, which applies international human rights law in relation to SOGI, states, “The policing of sexuality remains a major force behind continuing gender-based violence and gender inequality.”⁶ In 2011, the Human Rights Council issued the historic Resolution on Human Rights, Sexual Orientation and Gender Identity (L.9/Rev.1), the first UN resolution that brings specific focus to human rights violations based on SOGI, particularly violence and discrimination.⁷

Intimate Partner Violence (IPV)/Partner Violence & Domestic Violence (DV)

While most countries use the term DV, IPV is increasingly used because it specifically refers to, without confusion, violence between partners, whether current or previous, rather than violence involving other family members.⁸ It also does not limit violence to a particular location. IPV can occur among heterosexual, same-sex and transgender couples.

Sexual Violence (SV)

The World Health Organisation⁹ defines sexual violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. A wide range of sexually violent acts can take place in different circumstances and settings.” It should be noted that SV is defined to include not just rape and sexual harassment, but also forced marriage or cohabitation, denial of the right to use contraception or to adopt other measures to protect against STIs and forced abortion.

Violence against Women (VAW)

The 1993 UN Declaration on the Elimination of Violence against Women¹⁰ defines VAW 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 in private life (Article 1).” VAW could be perpetrated by assailants of any gender, family members and even the State itself.

The Beijing Platform of Action (BPfA)¹¹ reiterates the above definition and expands it to include “violations of the rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy,” as well as “forced sterilisation and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.” It further recognises the particular vulnerabilities of “women belonging to minority groups, indigenous women, refugee women, women migrants, including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women, displaced women, repatriated women, women living in poverty and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars, terrorism, including hostage-taking.” Other forms of violence not included above are date rape, so-called ‘honour’ crimes and violence in cyber space.

Endnotes

- 1 For the definitions of Reproductive Health, Reproductive Rights, Reproductive Justice, Sexual Health and Sexual Rights, please see the Definitions page of *ARROWs for Change*, Vol. 15 Nos. 2 & 3 2009 (15 years after Cairo: Taking stock, moving forward in Asia and the Pacific). www.arrow.org.my/publications/AFC/V15n2&3.pdf
- 2 Titley, G. (Ed.). (2007). *Gender Matters: A manual on addressing gender-based violence affecting young people*. Hungary: Council of Europe.
- 3 Sida. (2008). *Action Plan for Sida's Work Against Gender-based Violence 2008-2010*.
- 4 UNIFEM Gender Fact Sheet No. 5. www.unifem-eseasia.org/resources/factsheets/UNIFEMSheet5.pdf, 2007-08-06.
- 5 Inter-Agency Standing Committee (IASC). (2005). *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. Geneva, Switzerland: IASC. http://humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsid-tf_gender-gbv. Also available in Arabic, Bahasa, French and Spanish.
- 6 The Yogyakarta Principles. www.yogyakartaprinciples.org.
- 7 International Service for Human Rights (ISHR). Joint NGO Release: Historic decision: Council passes first-ever resolution on sexual orientation & gender identity. www.ishr.ch/council/428-council-not-in-feed/1098-human-rights-council-adopts-landmark-resolution-on-lgbt-rights
- 8 United Nations Population Fund (UNFPA). (2010). *Health Sector Response to Gender-based Violence in the Asia-Pacific Region: Assessment 2010*. Thailand: UNFPA.
- 9 WHO. (2007). *WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*. Geneva, Switzerland: www.who.int/gender/documents/violence/9789241595681/en/index.html
- 10 United Nations. (1993). *UN Declaration on the Elimination of Violence against Women (A/RES/48/104)*. www.un.org/documents/ga/res/48/a48r104.htm
- 11 United Nations. (1996). *The Beijing Declaration and the Platform for Action: Fourth World Conference on Women: Beijing, China: 4-15 September 1995 (DPI/1766/Wom)*, paras. 114-116

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Intimate Partner Violence among Women and Reproductive Health in the Pacific: Putting It All Together

A recent sexual and reproductive health and rights (SRHR) report stated, “In civil society, there are often ‘gender people’ and ‘human rights people,’ but with little crossover.”¹ This article will attempt to move the agenda further by bringing together people from gender, human rights, reproductive health (RH) and violence against women (VAW) fields. Whether advocates, health workers, policymakers or researchers, people tend to identify with one of the above-listed specialities. Indeed, single-focused, vertical programmes are the norm rather than the exception. However, a woman who is being abused by her partner just wants and needs the violence to stop and to receive compassionate, sensitive and effective care for herself and her family. Working together to make that happen is everyone’s role.

In working together across sectors, clearly communicating with one another is important. Consistent definitions and terminologies are needed in developing policy, delivering services and monitoring progress. This article focuses on intimate partner violence (IPV), rather than gender-based violence (GBV) or VAW (see *Definitions section, page 14*).²

In the Pacific, recent data are available from country studies using the well-known WHO Multi-County Study Methodology. Studies on IPV and Women’s Health were conducted by the Secretariat of the Pacific Community as part of a UNFPA VAW programme in the Pacific. These were done in Samoa in Polynesia,³ in Solomon Islands in Melanesia⁴ and in Kiribati in Micronesia.⁵ Among ever-partnered women 15 to 49 years of age, the lifetime IPV prevalence rate of physical and/or sexual violence was 46%, 64% and 68% respectively (Figure 1). The sexual violence rates by an intimate partner in Solomon Islands and Kiribati were particularly concerning (55% and 46% respectively). In both Solomon Islands and Kiribati, the majority of women who experienced physical partner violence reported severe acts of violence such as being kicked, beaten up or having a weapon

used against them. For many women, the abuse was repetitive and resulted in injuries.

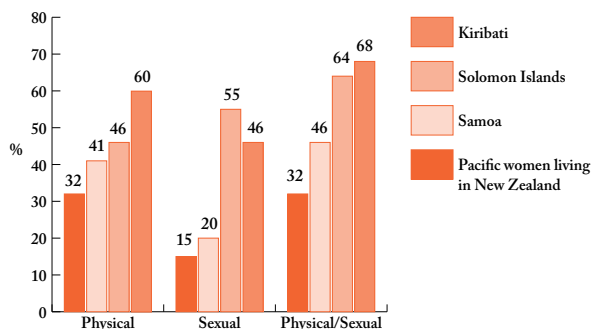
The data also provide information about the link between IPV and women’s RH issues. For example, among women who had ever been pregnant, 10%, 11% and 23% respectively reported they had been physically abused while pregnant. Among women abused while pregnant, 26%, 18% and 17% respectively were punched or kicked in the abdomen. Data about contraceptive use also provides evidence of the link between IPV and RH. In all three Pacific countries, women who had experienced IPV were two to three times more likely to report their partner had refused to use or tried to stop them from using a method of contraception. These findings are consistent with international literature documenting the association between intimate partner violence and a range of women’s reproductive health ills.^{7,8,9}

Despite important evidence collected to date, there is still inadequate research data. Most evidence linking IPV and RH is from cross-sectional studies. Unfortunately, cross-sectional studies do not increase understanding about causation, nor do they provide insight into the relationship between IPV and RH.

Similar to IPV, it is important to communicate consistently about reproductive health. Building on the Population Action International study of women’s reproductive risk,¹⁰ the Pacific Measure for the Future¹¹ takes a life-cycle approach, focusing on 10 indicators across the life stages of sex, pregnancy, childbirth and survival.¹² The composite Reproductive Risk Index (RRI), an average across the 10 indicators, can range from 0 (no risk) to 100 (high risk). The RRI for Samoa, Solomon Islands and Kiribati was 34 (moderate quartile), 44 (high quartile) and 53 (very high quartile) respectively.

While a very limited snapshot, Table 1 presents the prevalence of physical and/or sexual violence, being beaten while pregnant, partners’ opposition to contraception and the RRI across the three Pacific Countries. It is interesting to note the trend of country increased IPV prevalence and increased RH risk.

Fig. 1. Lifetime IPV in New Zealand, Samoa, Solomon Islands and Kiribati



Notes: While this article deals with national data due to limited space, it is important to consider within country variations (vulnerable populations, rural-urban, etc.). Pacific women living in New Zealand (Auckland and North Waikato) were added for comparison (age range 18-64 years).⁶

Table 1. Reproductive Risk Index and IPV

	RRI	Risk Quartile	Lifetime Physical or Sexual Violence	Beaten while Pregnant	Partner Opposed to Family Planning
Kiribati	53	Very High	68%	23%	23%
Solomon Islands	44	High	60%	11%	12%
Samoa	34	Moderate	46%	10%	15%

The relative contribution of IPV to RH, potential mediating and moderating factors, and the mechanisms accounting for the relationship (such as poverty and gendered social norms) require further study. Qualitative data collected in the Pacific country studies provides a glimpse of how beliefs about gender likely contribute to IPV and negative RH outcomes. Statements from men participating in focus groups included, “She must obey me at all times” and “Why would we obtain consent from our wives?” Demographic and Health Surveys, with Women’s Empowerment and Domestic Violence modules, are being measured in an increasing number of countries.¹³ Gathering rigorous data and sharing that data to inform prevention activities and service delivery is an important priority.

Appreciating an ecological framework, promoting women’s SRHR and preventing IPV require consideration of country context. Country, regional and international commitments are important components of the country context and their attention to human rights and justice. International commitments include the International Conference on Population and Development Programme of Action (ICPD PoA, 1994), the Beijing Declaration and Platform for Action (BPfA, 1995), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) and the Millennium Declaration (2000).

In the Pacific region, the Pacific Islands Forum Communiqués are particularly relevant. In the 2007 Tonga Communiqué, Pacific leaders first included gender equality in decision-making in their agenda. Then, in the 2009 Cairns Communiqué, they declared a commitment “to eradicate SGBV [sexual and gender-based violence] and to ensure all individuals have equal protection of the law and equal access to justice.”¹⁴ This is an important step towards meeting international commitments in addressing women’s rights in the Pacific region.

Yet there is still much work to be done, particularly in supporting countries to deliver on their commitments. The recent Beijing+15 report in the Pacific¹⁵ highlights important needs for the region. It calls on health, law and justice, education and community development sectors to include the elimination of VAW in their work. It advises the health sector to develop “clear step-by-step plan for actions to be taken when dealing with VAW cases.” All too often, despite the significant repercussions of physical, sexual and emotional violence on women’s health, health workers unknowingly care for women who are living in violent relationships, while maintaining silence around the issue.¹⁶ In light of the Pacific country data demonstrating the high prevalence of physical and sexual VAW and the associated health burden, this silence is not acceptable. The substantial rates of sexual abuse of girls before the age of 15 years in the Pacific (18% in Kiribati⁵ and 37% in Solomon Islands⁴) is likely to result in untreated sexually transmitted infections and unwanted pregnancies, along with a host of other health and social consequences. Furthermore, lack of access to emergency contraception and

safe and legal abortion in the Pacific is an area requiring dialogue.¹⁵

The elimination of VAW and promoting women’s sexual and reproductive rights can both be effectively integrated into health programmes. To do so requires a system response with the necessary building blocks.¹⁷ It is not enough to provide training to health workers in isolation of other programme elements. Leadership and governance, financing, appropriate medicines and environments, service delivery, information and health workforce development are all necessary. More high quality research is needed in the Pacific to inform understanding of IPV and the link to RH. Many RH indicators are poorly and infrequently collected. Little is known about primary prevention, programme effectiveness and engaging with men and boys.

While the evidence is being gathered, continuing to work towards creating a multi-sectoral, holistic response that meets the needs of people in communities is a must. To do this, sharing information and working in partnership with communities and across different silos is critical, as is welcoming more ‘people’ from other disciplines into our discussions. By keeping a human rights perspective, justice and dignity for all becomes the mantra in providing accessible, available, acceptable and high quality services to promote women’s SRHR, including the right to safety.

Endnotes

- 1 Reproductive Health Matters and Asian-Pacific Resource & Research Centre for Women (2011). *Repolicising Sexual and Reproductive Health and Rights: A Global Meeting*. Langkawi, Malaysia.
- 2 While this article focuses on violence against women by their male partners, IPV occurs among heterosexual, same-sex and transgender couples.
- 3 Data was gathered in 2000 as part of the original WHO study, but the final version was published in 2006. Secretariat of the Pacific Community (SPC). (2006). *The Samoa Family Health and Safety Study*. New Caledonia.
- 4 SPC. (2009). *Solomon Islands Family Health and Support Study: A Study on Violence Against Women and Children*. New Caledonia.
- 5 SPC. (2010). *Kiribati Family Health and Support Study*. New Caledonia.
- 6 Fanslow, J., Robinson, E., Crengle, S., & Peres, L. (2010). Juxtaposing beliefs and reality: Prevalence rates of intimate partner violence and attitudes to violence and gender roles reported by New Zealand women. *Violence Against Women*, 16(7), 812-831.
- 7 Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, 359(9314), 1331-1336.
- 8 Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H. & Garcia-Moreno, C. (2008). Intimate partner violence and women’s physical and mental health in the WHO multi-country study on women’s health and domestic violence: An observational study. *Lancet*, 371(9619), 1165-1172.
- 9 McCallum, D. (2009). *Known and suspected consequences of lifetime experiences of violence and abuse*. www.AVAHEALTH.org
- 10 Population Action International. (2007). *A Measure of Survival: Calculating Women’s Sexual and Reproductive Risk*. USA.
- 11 Family Planning International. (2009). *A Measure of the Future: Women’s Sexual and Reproductive Risk Index for the Pacific*.
- 12 These include: Chlamydia prevalence, adolescent fertility rate, female secondary school enrolment, median age at marriage, antenatal care coverage (at least one visit), births attended by a skilled health professional, use of modern contraceptive methods, abortion policies, maternal mortality ratio and the infant mortality rate.
- 13 Ministry of Health, Samoa (2010). *Samoa Demographic and Health Survey 2009*. Samoa.
- 14 Pacific Islands Forum Secretariat. (2009). *Final communiqué of 40th Pacific Islands Forum, Cairns, Fortieth Pacific Islands Forum, Cairns, Australia*.
- 15 SPC. (2010). *Beijing +15: Review of Progress in Implementing the Beijing Platform for Action in Pacific Island Countries and Territories*. New Caledonia.
- 16 Wilson, D. (2000). Care and advocacy: Moral cornerstones or moral blindness when working with women experiencing partner abuse? *J Nurs Law*, 7(2), 43-51.
- 17 World Health Organization (WHO). (2010). *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: WHO.

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