EUROPE

EUROPEAN STRATEGIES TO COMBAT VIOLENCE AGAINST WOMEN

Report of the first technical meeting

Copenhagen, Denmark
11–13 December 1997

Family and Reproductive Health

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HEALTH OF WOMEN

By the year 2000, there should be sustained and continuing improvement in the health of all women.

ABSTRACT

The Technical Meeting on European Strategies to Combat Violence against Women was held in Copenhagen on 11–13 December 1997. The WHO Regional Office for Europe acted on its commitment to combating violence against women by bringing together academic experts and representatives from health services and women's organizations from across the European Region of WHO, including many from central and eastern Europe and central Asia. The overall objective of the Meeting was to build on existing links between WHO and country-based networks and centres specializing in the issue of violence against women in an effort to draw up proposals for joint strategies at the European level and to strengthen future cooperation and coordination. The Meeting presented research studies, surveys and concrete projects from countries in the western and eastern parts of the Region. The Meeting made recommendations on epidemiology and data collection, addressing the consequences of violence against women for their mental health and providing appropriate health services.

The Meeting was a starting-point for exchanging experiences and sharing information on the extent and implications of the problem. The recommendations of the Meeting are intended to contribute to the adoption of formal guidelines and policies at both national and European levels that effectively combat violence against women.

KEYWORDS

BATTERED WOMEN
DOMESTIC VIOLENCE – prevention and control
WOMEN'S HEALTH
WOMEN'S HEALTH SERVICES
HFA STRATEGY COORDINATION
EUROPE
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Acknowledgements

The success of the WHO Regional Office for Europe Technical Meeting on European Strategies to Combat Violence against Women is due to the collaboration of all participants, who gave invaluable input during the preparation of the meeting through their papers, comments and suggestions.

Foreword

This document is the report from the first WHO Regional Office for Europe Technical Meeting on European Strategies to Combat Violence against Women, held on 11–13 December 1997. The meeting was organized by the Regional Office Sexual and Reproductive Health programme and the Women and Child Health programme, and brought together academic experts and representatives from health services and women's organizations from across the WHO European Region, including many from central and eastern Europe and Central Asia.

The overall objective of the meeting was to build on existing links between the WHO Regional Office for Europe with country-based networks and collaborating centres specializing in the issue of violence against women, in an effort to draw up proposals for joint strategies at European level and to strengthen future cooperation and coordination.

The December 1997 meeting was therefore a starting point for exchanging experiences and sharing information, and it is in this spirit that the programmes for sexual and reproductive health and for women and child health now have pleasure in issuing the report of the meeting, along with the texts of the papers presented and the names and addresses of those who took part.

It is hoped that this report will also reach people who were unable to attend the meeting, including many who may be unaware of the extent and implications of the problem, and that the recommendations made at the Meeting will contribute to the adoption of formal guidelines and policies at both national and European levels that effectively combat violence against women.

Section 1. The technical meeting

1. Introduction: scope and purpose of the meeting

Scope and purpose

Violence against women is now recognized as a major issue in international human rights and public health. World Health Assembly Resolution WHA50.19 calls upon Member States to make an effort to eliminate violence against women and children. The health consequences of violence against women include psychological trauma and depression, injuries, sexually transmitted diseases (STDs) and HIV, suicide and murder. Studies consistently report that domestic violence against women is a substantial burden on health care globally. In view of the severity of this problem, a task force on violence and health is being set up at WHO headquarters and a plan of action has been prepared. WHO's aim in this area is to work with partners to identify effective strategies for:

- prevention
- interventions to reduce the physical and mental repercussions of violence
- interventions to assist the victims to overcome the health consequences of violence.

In summer 1997, a WHO/International Federation of Gynaecologists and Obstetricians (FIGO) Pre-congress Workshop on "Elimination of Violence Against Women: in Search of Solutions" was organized on the occasion of a FIGO congress to encourage gynaecologists and obstetricians from all over the world to recognize and appropriately address signs of violence, and to understand that the victims of violence need help, not only medically but also psychologically and socially.

In WHO European Member States, of national authorities or voluntary organizations have undertaken a wide range of activities to eliminate violence against women. To strengthen coordination and cooperation on this issue and to identify a common strategy for the WHO European Region, the sexual and reproductive health and the women and child health programmes organized the Technical Meeting on European Strategies to combat Violence against Women, held on 11–13 December 1997.

Aims of the meeting

The aim of the meeting was to strengthen coordination and cooperation to combat violence against women and to identify common strategies in the European Region to conduct activities in the coming biennium. The intention of the meeting was neither advocacy nor policy, but the development of a plan of action. Rather than pursuing general and conceptual discussion, WHO identified three major priority areas for future interventions:

1. epidemiology and data collection on violence against women
2. addressing mental health consequences of violence against women
3. providing appropriate health services to respond to the physical and mental needs of victims of violence.

Experts in these areas were invited to assist the WHO Regional Office for Europe in designing

European strategies and activities to address these priority areas. The major objectives of the meeting were:

1. to share experience and information;
2. to draw a situation analysis on violence against women in the European Region regarding, epidemiology, physical and mental health consequences, and appropriateness of health services;
3. to identify needs for additional information, research and coordination in the above-mentioned priority areas and to identify WHO's role in addressing activities in the selected priority areas;
4. to identify among the participants those responsible for designing the European strategy in each of the priorities selected;
5. to endorse a set of recommendations on the above to Member States; and
6. to discuss fundraising for the implementation of future activities.

Participants were asked to be as concrete as possible in their presentations, to suggest and recommend methods to combat violence against women and to specify how they envisaged the role of the WHO Regional Office for Europe in this respect.

Description of the agenda

The Meeting comprised four major sessions on:

1. epidemiology and data collection
2. mental health consequences of violence against women
3. helping health services to elicit appropriate responses
4. addressing the issue of violence against women in war situations.

After the participants had given their presentations in the different sessions, according to their field of expertise, they formed three different working groups, one for each priority area, in order to draw conclusions and make recommendations.

Main outcomes

Representatives from many different countries of the European Region took part in the Meeting, including a significant number of people from central and eastern Europe and central Asia. They represented nongovernmental organizations (NGOs), women's associations, research institutes and international organizations. Their backgrounds and expertise were diverse and this mix of participants allowed for the development of an interesting and lively exchange of ideas and experiences.

The presentations included research studies, surveys and concrete projects from both western and eastern countries. They gave the participants the opportunity to learn what was going on in each country in the field of violence against women. The working groups were essential to obtain a deeper level of discussion in each of the three fields, and to make concrete recommendations.

The major outcome of the meeting was to establish links across regions among organizations working in the same field. This was a major success if one considers that violence against

women is still a hidden problem in many countries. The meeting was intended as the first stage of a continuing process and as a tool to prepare the way for further collaboration.

2. Main outcomes of the meeting

Recommendations from the working group on epidemiology

chaired by Karin Helweg-Larsen

Proposal for a transcultural study

The group agreed that WHO should recognize that violence against women as a political issue, as well as a major health issue. A consensus was reached on possible steps to promote a transcultural, cross-national, multicentre study on domestic and sexual violence. The primary aim was to ensure that WHO include in its reports on health status in European Member States surveys on violence and data on domestic violence and sexual assault, using the different indicators available.

The objectives of this transcultural study should be:

1. to develop epidemiological instruments to measure the prevalence of violence in different societies and thus to obtain internationally comparable data;
2. to make it possible to conduct follow-up studies to evaluate the consequences of violence on the health of women; and
3. to facilitate the evaluation of national prevention strategies.

The participants recognized that obtaining comparable data would not be simple. Good questionnaires needed to be developed, with clearly defined questions; should be validated in countries to be sure that they measure the same things, taking into account the ethnic and cultural differences in the various countries.

The major criteria identified for the study should be the following.

1. Violence must be seen in a socioeconomic and sociocultural context, so the questionnaire should elicit data describing the social, economic and cultural background of the person interviewed.

2. Minimum standardized questionnaires should be developed with a minimum number of questions to describe the problems in each population studied; all the questions should primarily be tested in pilot studies in different sociocultural settings.

3. Definitions must be based upon uniform criteria for physical and psychological violence.

Some methodological problems were identified; which required further discussion:

1. problems in classifying and defining the different types of violence, especially psychological violence (questionnaires should be developed in such a way that the questions explained the type of violence classified);
2. how to take account of differences between the cultural and ethnic settings when validating the questionnaires; and
3. whether the questionnaire should be followed up by a closed interview, or qualitative studies should be carried out.

As far as monitoring the consequences of violence against women is concerned, the following should be distinguished:

- physical or psychological consequences
- the psychosocial , and socioeconomic consequences
- changes in health behaviour due to repeated violence (such as smoking, high alcohol consumption and the use of licit and illicit drugs).

Proposal for a pilot study

No final decision was made about the number of countries that should be involved in the pilot study, but the participants recommended that countries from all parts of the Region be included. An agreement should be made on both the involvement of a collaborating centre in the Member States and the identification of partner organizations in the countries considered. Further, the pilot study would be based the studies that have already been carried out by centres already established in Member States.

Specific population studies should also be carried out. It was proposed to carry out studies based on questionnaires to be distributed to women in contact with the health system, to include all women attending pregnancy control centres, coming to outpatient clinics or registered in gynaecological departments in a number of countries and in a given period.

A number of practical problems regarding the pilot project were identified:

- when to start
- who to involve in the preparatory process
- who would be responsible (the WHO Regional Office for Europe or WHO headquarters)
- who would facilitate the process
- whether resources would be available in WHO.

The tasks of WHO, apart from the continuing activities, should be to facilitate the pilot study by setting up a research group that could work on possible questions and by setting up a network with members from both eastern and western Europe and enabling them to meet. Regarding the facilitation of the WHO pilot project, it was suggested that each centre use its own resources. WHO would facilitate the meetings and networking of the research group.

Participants requested administrative, technical and financial support. Once good, standardized questionnaires were finalized, software packages could be developed that could be distributed worldwide.

Debate

The following points emerged from the general discussion in the working group.

1. The relationship between WHO headquarters and the WHO Regional Office for Europe on this topic was unclear. Did each have its own pilot study?

2. Difficulties in eastern countries arose because they did not have national surveys on health, or the same level of awareness and information on the issue of violence against women in western countries. If the results obtained are that women are equally aggressive as men, this

unfavourable interpretation would be used against women.

3. Both qualitative and quantitative data should be gathered, as this permitted the estimation of the scale and frequency of the problem. There was a need to build strategies, to understand how violence occurred and understand the link between generations.

4. Women in war situations should be taken into consideration, so data collection methodology needed to be adjusted to include a qualitative survey and action research.

5. The level of country information should be taken into consideration. For example, most women in the Russian Federation did not want to report domestic violence to clinics or the police. How could this problem be dealt with, and did similar problems arise in other countries?

6. As a methodology should be developed, one of the major tasks of WHO should be to set up a working group to define the questions to be asked. Language was an issue; differences in meaning has to be considered in translating questionnaires into local languages. The first step was to define a set of questions in different languages that would be adequate for different countries and different circumstances.

7. Although the context for research and evaluation presented some difficulties, and touched on epidemiological issues, the necessary research should be placed in a broad context, and should not be carried out without looking at the other recommendations that were emerging. Research had to be a means to an end, not an end in itself. The first steps should be to collect any information that has been gathered on the topic, compare and test methodologies, gather the various surveys and then start to develop the tools.

8. Information on the rules and legislation in different countries should be provided (in the form of a booklet, for example).

Recommendations from the working group on the mental health consequence of violence against women –

chaired by Leila Gulcür

Framework

A framework needed to be set up to address the mental health consequences of violence against women in both war/post-war and normal situations.

- The mental health consequences of violence could only be understood in terms of its causes and multidimensional nature.

- Activities addressing the consequences of violence for mental health should not be implemented without prior elaboration of a model/policy and strategies.

- Appropriate mental health responses should be multidisciplinary, multidimensional, comprehensive, non-stigmatizing, ethical and population based. They should also include primary health care and community services.

Recommendations

The WHO Regional Office for Europe and WHO headquarters needed to cooperate in implementing the following recommendations as appropriate and necessary.

1. WHO should act as a resource centre to collect and disseminate, as requested, materials and modules that have already been developed and have proved to be effective, appropriate and ethical tools for identifying, supporting and caring for women who have experienced violence. In addition, WHO should provide, when necessary, technical support for the adaptation of these materials for use in different cultural and social settings. WHO should develop training materials addressed to health workers in services that are approached by women (such as doctors, family counselling services, psychologists, etc.).

2. Institutions and services should be sensitized to identify violence as a potential cause of symptoms that women present when they seek health services. WHO can provide and disseminate information on guidelines and intervention protocols to state agencies (such as ministries of health), NGOs (such as women's groups) and other organizations involved in health policy and service provision (such as national medical associations or local clinics, etc.) that women who have experienced violence inevitably approach.

3. WHO should support the creation of national/local task forces to develop guidelines where necessary. In other words, should existing guidelines not be adequate to support the development of further guidelines to recognize the consequences and provide care for victims of violence, WHO should collaborate with state agencies (such as ministries of health) and local women's groups and other NGOs to develop them.

4. WHO should facilitate information exchange and networking among service providers between and within different countries and regions. This networking would facilitate the exchange and dissemination of information on strategies and experiences, where health providers can benefit from the experience of others. More specifically, WHO can sponsor

periodic workshops that bring together health care providers (including those working in crisis intervention) from different countries whose clients are most likely to be women who have experienced violence.

5. WHO should provide technical and financial support to countries that recently developed general awareness and capacity for detection of violence and programmes of care, including working tools (such as protocols, qualitative and quantitative surveys, etc.). WHO should also assist groups and organizations working in this area to document and disseminate the knowledge and skills developed. WHO could support fundraising efforts by local organizations with valid projects.

6. WHO should provide technical support to initiatives integrating primary health care services for women victims of violence with community-based interventions. To be completely effective, treatment (such as therapy, support groups, crisis centres, etc.) needs to be integrated into community-based initiatives. A multidisciplinary, multidimensional approach is needed to introduce effective sanctions against violence. Sanctions are needed, as well as protection at the different levels, so that the community-based interventions, in addition to incorporating health services for women, would target law enforcement, the legal system, the educational system and the media for public education.

7. The WHO Regional Office for Europe and the Division of Mental Health and Prevention of Substance Abuse at WHO headquarters, including the programme on mental health of refugees, should provide technical and financial assistance for capacity building countries in which conflicts are occurring or have occurred. The financial assistance should cover the costs of implementing a pilot project combining general and gender-specific training in mental health and the elaboration of qualitative, population-based tools for the assessment of needs and resources. These projects could be piloted in Chechnya and Tajikistan; depending on results to be replicated elsewhere in the Region.

8. The WHO Regional Office for Europe and the Division of Mental Health and Prevention of Substance Abuse at WHO headquarters, including the programme on mental health of refugees, should provide technical and financial assistance for pilot testing an action-research project in a clearly delimited area in both Chechnya and Tajikistan, aiming at: defining the typology of violence against women, identifying local, individual and social coping mechanisms, and developing models for culturally appropriate, non-stigmatizing and ethical care. Depending on the results, a similar project could be replicated countrywide.

9. State bodies and NGOs at the national and local levels should assist WHO in implementing these recommendations.

Recommendations of the working group on health services

The discussions of the third working group focused on the levels where interventions might be necessary, identified some of them and then tried to outline the tasks of WHO. Recommendations were made for:

- governments
- parts of WHO
- the women's health network, which consists of existing contacts within WHO Member States (such as professionals and NGOs).

The priority recommendations were as follows.

1. Criteria for and principles for good practice and the means of implementation should be established before action is taken. It is important first to link the work that is going on at WHO headquarters to field work to avoid duplication of effort. The participants from Glasgow offered to coordinate some of these activities, but they needed somebody to advise them on the methodology of responding to violence against women in a conflict situation, as this area was outside their expertise.

2. WHO should further develop its role in negotiating with Member States about action on women's health. As part of such negotiations, Member States needed to start the process of introducing the topic of violence into that discussion. It would probably take some time, but a strategy was needed. Because negotiations needed to be associated with recommendations, it might be appropriate to look at the activities going on in some of the Member States that did not yet incorporate the problem of violence in women's health activities. Member States adopting methods that allowed them to incorporate work on violence should be encouraged to act as pilot countries.

3. WHO should establish a small programme (with consideration of its fundraising implications) to encourage small-scale projects to take account of other activities that were going on and further develop good practice.

4. WHO should make use of the new technologies being developed by some of the participants. This could be done through disseminating the information on current activities through an Internet home-page on violence that would enable all those interested to gain access to the material. The information should include activities of other organizations, not just WHO.

5. Rather than restricting the subject to women's health or reproductive health, WHO in general should undertake specific responsibilities regarding violence against women. This would be a difficult process, and effort should first be made to establish a partnership with the WHO programmes for healthy cities, health promoting hospitals and health promoting schools. These programmes should be encouraged to begin a process of negotiation whereby the issue of violence against women is recognized as important for their work.

6. A technical working group should be established to take forward the issue of linking training and interventions. Training should not be planned as an end in itself, but as part of

the determination of appropriate interventions; it should be used as a tool to make the interventions happen.

Discussion

The following points emerged from the discussion in the working group.

- Assessments of needs, resources and people's coping mechanism were needed before training is given. Training should not be limited to the dissemination of knowledge and skills.

- Criteria for evaluating the effects of programmes needed to be drawn up.

- How could research groups be promoted (especially in the countries of central and eastern Europe (CCEE) and the newly independent states (NIS) of the former USSR) and integrated in the network established at the Meeting?

- WHO headquarters' functioning in terms of fund raising and cooperation should be clarified.

- It would be necessary to subcontract partner organizations for the technical work.

General conclusions

A common question that emerged from all three working groups was how to make the best use of existing opportunities, how information can be better disseminated, and how activities may be better coordinated to maximize its effects.

The recommendations issued were aimed not just at WHO but at all participants of the Meeting. It was essential to share responsibilities for the implementation of recommendations, and local organizations in countries knew best how to mobilize resources and expertise.

The Meeting provided very good opportunities for participants to learn from each other. Western countries were running excellent projects and it was an opportunity for them to know what was going on in the CCEE and NIS. It was good to share and link the work in different countries.

It would be necessary for the participants of the Meeting to meet again, maybe once a year, to determine achievements and future steps. In particular, it was suggested that subgroups be set up on specific issues.

By way of a final conclusion, it is important to focus once again on the fact that WHO has explicitly addressed the issue of violence against women in its 1996 and 1997 World Health Assembly resolutions WHA49.25 and WHA50.19. WHO's work in this area is firmly based on the commitment expressed by the international community to eliminate such violence. This commitment has been expressed *inter alia* in the 1993 United Nations Declaration on the Elimination of Violence against Women and the appointment in 1994 of a United Nations special rapporteur on violence against women, its causes and consequences (see also the section on selected human rights documents, United Nations declarations and treaties in the folder *Violence against women – a priority health issue* (Geneva, Family and Reproductive Health Programme, World Health Organization, 1997).

Much significant work has already been done in Europe, not least by national health services, academic experts and NGOs. In 1994, the WHO Regional Office for Europe organized a meeting on the subject of violence against women in Vienna with ministries of health. The document contained a chapter on the elimination of violence against women, and a chapter on research, including behavioural research, and on recommendations for health services, including the psychosocial needs of women. The Beijing Conference adopted the Beijing Declaration and Platform for Action, which included a whole section on violence against women.

Much work still remained to be done, and the participants hoped that the recommendations included in this report would help to point the way for all parties, both in the European Region and further afield.

Summary and key recommendations

1. More knowledge is needed about the prevalence of abuse of women. A standardized definition of the various categories of violence and standardized epidemiological and statistical instruments are needed to improve the scientific basis of research and the comparability of findings in this area.

2. A transcultural, cross-national, multicentre study on domestic and sexual violence should be initiated to measure the prevalence of violence in different societies, to conduct follow-up studies to evaluate the consequences of violence on the health status of women, and to facilitate evaluation of national prevention strategies. Pilot projects should be conducted to this end.

3. The dissemination of information, training materials and guidelines in the area of violence against women must be based on established models of good practice and must be adapted to different sociocultural contexts. There should also be a distinction between conflict, post-conflict and normal situations.

4. The abuse of women in intimate relationships must be adequately reflected in health surveys and in its status within the priorities of the health services. The issue of sexual violence must be kept on the political agenda of governments and the health authorities.

5. The work of NGOs, independent women's organizations and volunteers needs to be acknowledged, supported and brought within the framework of a formal partnership between hospital/health services and community-based services. Overall responsibility for the treatment of abused women should lie at the highest administrative level of the health services.

6. Health systems should include low-threshold services, a place in the health care system where abused women can go without having first to go to the police, where disclosure of abuse can take place in safety and where any subsequent referral to specialized or psychiatric services does not carry the risk of stigmatization.

7. Criteria need to be developed for all professionals working with abused women, and more female professionals need to be recruited. These criteria should be integrated into formal training programmes. The responsibilities of different health care professionals

(gynaecologists, physicians, nurses and social workers) and NGOs need to be clearly defined.

8. The mental consequences of violence must be integrated into the medical treatment of victims. A protocol of intervention should be drawn up, covering medical examinations, counselling, the availability of contraception, treatment for STDs and safe legal abortion, and post-rape procedures. Lifestyle and social constraints need to be taken into account.

9. The interaction between the medical and legal systems needs to be addressed to promote the same awareness and sensitivity among the police and legal professions, thereby preventing secondary victimization and exercising a positive influence on court decisions in cases of violence.

10. A multidisciplinary approach to legal and community-based sanctions against abusers is needed, targeting law enforcement agencies, the legal system, the educational system and the mass media.

Section 2. Conference presentations

3. Opening address

Ms Carolyn Murphy

Ms Carolyn Murphy, Director, Department of Finance and Administration, WHO Regional Office for Europe, welcomed participants to Copenhagen and the Regional Office on behalf of the WHO Regional Director for Europe, Dr Jo E. Asvall.

Ms Murphy briefly described the work of the Regional Office for the benefit of any participants who were not already familiar with WHO, or the Regional Office and its work. The European Region has always been very broad – ranging from Iceland in the north to Turkey in the south, from Ireland in the west to the Pacific coast of the Russian Federation in the east. Over the last five or six years, the number of Member States has grown from 32 to 51: approximately 870 million people represented by governments with greater and more urgent needs. Nine of the new Member States have been involved in armed conflict during the same period. A number of the staff now working in the Region joined WHO to implement the huge emergency humanitarian assistance programme that the Regional Office has mounted in the countries that emerged from the former Yugoslavia, so the Regional Office and its staff have experienced the effects of organized violence on the victims, as well as on themselves and their colleagues.

Ms Murphy noted that the purpose of the present Meeting was to discuss strategies for dealing with violence from a gender perspective. Violence against women has emerged in the 1990s as a major health and human rights issue. Further to a 1996 resolution that declared the prevention of violence a public health priority, in May 1997 the World Health Assembly endorsed the plan of action drawn up by WHO headquarters. Its first concern was domestic violence against women and children.

A global task force has now been set up and WHO, along with partners outside the health system, will decide on strategies to prevent violence and strategies to mitigate the health consequences of violence, which are both psychological and physical and range from depression to suicide, physical injury to murder, and from the contraction of an STD to HIV infection.

Violence affects women worldwide, women of all ages and of all socioeconomic groups. Even here in Europe, where the status of women is relatively high and legal sanctions against aggressors exist, about 20% of all women have been victims of violence, most often in the home. At the 1996 meeting of the Global Commission on Women's Health, it was reported that assault causes more injuries to women in industrialized countries than traffic accidents. In the Russian Federation in 1993, 14 500 women were murdered by their husbands and another 56 000 disabled or seriously injured. In Norway, 25% of gynaecological patients have been sexually abused by their partners. In Denmark, 25% of divorced women point to violence as a reason for the break-up of the marriage. These are just a few figures.

In the summer of 1997, a workshop on the elimination of violence against women was organized by WHO with FIGO. The purpose was to draw the attention of gynaecologists and obstetricians to the problem and to encourage them to be aware of, and recognize and address signs of violence, with the knowledge that the victims not only need medical help but also psychological and social support.

All health workers need to be made aware of the problem. They also need to be trained to help women victims of violence. But this is more than a public health issue. While the health sector cannot, on its own, eliminate the causes or the incidence of violence, it can help make policy makers aware of the extent of the phenomenon. It will take the active and coordinated effort of the entire public sector, intergovernmental organizations (IGOs) and NGOs and the general public – men as well as women in all those areas – to prevent violence against women. It will entail improving the status of women in society, as well as promoting their education and economic independence. All this requires serious political commitment.

Ms Murphy concluded by saying that at this first meeting in the WHO Regional Office for Europe, participants were being asked to address three limited priorities:

1. data collection and the epidemiology of violence against women
2. the mental health consequences of violence
3. the provision of health care for the victims of violence.

The conclusions and recommendations would come just in time for inclusion in the Region's programme of work for 1998/1999. As part of WHO's integrated global programme and along with the measures to be taken by other international and national organizations, they would represent an initiative to improve the lot of women and therefore everyone in the twenty-first century. Ms Murphy wished the participants every success.

4. Session 1. Epidemiology and data collection

chaired by Dr Karin Helweg Larsen

Women's health and development report on the WHO multicentre study of violence against women

Dr Claudia Garcia Moreno

Background

In 1996, the Women's Health and Development unit (WHD) at WHO headquarters held a consultation with people active in the field of violence against women from several countries (researchers, health care providers and women's health advocates) to explore what may be the role of WHO in addressing the issue. The main recommendations urged WHO to support international research to explore the dimensions, health consequences and risk factors of violence. In response to this recommendation, WHD is developing methods and implementing a multicountry study on violence against women in families.

The rationale for this study is further supported by the Beijing Platform for Action, which recommended the promotion of:

> research and data collection on the prevalence of different forms of violence against women, especially domestic violence, and research into the causes, the nature and consequences of violence against women.

Study objectives

The population-based study will:

1. obtain reliable estimates of the prevalence of family violence against women in seven countries;
2. document the health consequences of family violence against women;
3. identify and compare risk and protective factors for violence within families, within and between settings; and
4. explore and compare the coping strategies used by women experiencing violence from family members.

This will provide important data on the prevalence, determinants and related risk factors, and health consequences of violence against women in a diverse group of countries. We are also committed to several corollary outcomes including: developing and testing new instruments for measuring violence cross culturally, increasing national capacity of researchers and women's NGOs working in this field and increasing sensitivity to the subject among researchers, policy-makers and health providers.

Methodology

The provisional participating countries are: Bangladesh, Brazil, Ghana, Namibia, Peru, the Philippines and Thailand. Other countries (Japan, Iran and Tunisia) have expressed an interest in participating in the study. Countries have been selected on the basis of the following criteria:

1. presence of local anti-violence groups positioned to use the data for advocacy and policy reform;
2. absence of existing population-based data;
3. presence of strong potential partners known to WHD;
4. receptive political environment that is open to taking up the issue;
5. absence of recent war-related conflict; and
6. regional representativeness.

Country study team

Within each participating country, the study will be implemented by a research team, in general consisting of two researchers, a statistician and a representative from women's organizations working on violence against women. The researchers will have experience in quantitative and qualitative research, and conducting research on sensitive issues.

An advisory group will be established within each country to support the implementation of the study and ensure dissemination of the results. Members of each country research team will regularly meet with this group to discuss emerging issues.

WHD has developed a core protocol for the study. The country study teams will develop implementation protocols, with the option to include additional modules to explore country specific areas of concern.

Quantitative data collection

The quantitative component of the study will consist of a cross-sectional household survey of women aged 15–49 years in urban and rural areas in the study locations. Much of the analysis will focus on documenting the patterns of violence experienced by women who have always been in a relationship. Interviews will be held in the local language by specially selected and trained female interviewers. Trained male interviewers will interview a smaller sample of men in each community.

Prevalence estimates for the occurrence of different forms of physical, sexual and psychological violence will be obtained by asking female respondents direct questions about whether they have experienced explicit violent behaviour over specified time frames. Follow-on questions will be used to explore whether the violence is continuing (occurring in the last year), to document its frequency in the last year and to identify the perpetrators of different forms of abuse. For validation, men will be asked about whether they have been physically violent towards their partners.

The survey will collect indicators of the female respondents' current physical and mental health status (through standard screening questionnaires), and measures of whether they have been ill and used health services in the last year. Multivariate analysis will be used to investigate the relationship between these indicators of health and women's reported experience of different forms of violence.

The survey will measure the presence or absence of a number of hypothetical risk and protective factors in each country. Potential risk and protective factors will be identified at the individual and community level. Individual factors include sociodemographic factors, witnessing family violence as a child, a history of previous victimization, and female access to and control of resources. Community factors include levels of male-on-male violence, levels of unemployment, male and female attitudes towards violence and the availability of services. For each cluster sampled, community indicators will be developed by aggregating responses from the individual questionnaires, supplemented by information collected using rapid appraisal techniques. Multilevel statistical analysis will be used to investigate the relationship between individual and community variables, and the reported forms and levels of violence by different perpetrators.

Women experiencing physical violence will be asked about forms and frequency of injury, health care and other support received, and where they would have liked to get more help. Information on the extent to which women seek help from different formal and informal sources, and make efforts to leave or change their relationships, will also be explored.

Study location

The survey will not aim to obtain national prevalence figures within each country. Instead, the study will aim to collect prevalence estimates from one or two regions, selected to incorporate one large urban centre, one small urban centre and a rural area. Within each location, cluster sampling will be used randomly to select households for interview. This will enable direct comparisons to be made between different strata in the same country, and between similar strata in different countries (such as between large urban areas in different countries). Preliminary calculations suggest that a total sample of 3000 women will be required. Detailed sampling regimes and sample size calculations will be made for each participating country.

Qualitative data collection

A range of complementary qualitative techniques will be used to help inform the development, interpretation and presentation of the quantitative research findings. This will include key informant interviews, focus group discussions exploring community attitudes towards violence with both men and women, and in-depth interviews with survivors of violence.

Project structure

WHD will provide strategic and technical oversight to the study through two means. The Chief of WHD will have overall responsibility for the study, first coordinating the input of an advisory board established to guide the development and implementation of the study. The board, consisting of international leaders in the field of violence against women, will meet three times over the two-year period of the study. In addition, WHD has established a core

technical assistance team of experts who will serve the needs of the seven country teams, along with the senior technical adviser from the London School of Hygiene and Tropical Medicine. The senior adviser is responsible for developing the study protocol, organizing semi-annual principal investigators' meetings, and coordinating other forms of technical support to the study teams, such as statistical methods. WHD staff will provide additional input as a technical officer on violence to serve as the link to other WHD and WHO work on violence and an administrative officer who will be responsible for developing management and financial systems and overseeing the financial reporting and contract management.

Current status of this initiative

The study will be implemented over a period of two years. The core protocol for this study is already under development and a note on ethical considerations was presented to the Scientific and Ethical Review Group (SERG) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) of the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), WHO and the World Bank. This core protocol will be reviewed by an advisory board at the end of February 1998 and then discussed at a research team meeting scheduled to take place in April 1998.

Country visits to identify potential principal investigators and other members for research teams have been made to Bangladesh, Namibia, Peru and Thailand, where research teams have been identified. Visits to Ghana and the Philippines have been scheduled for February 1998. Other countries may join the study over time.

Budget

WHD has already raised some funds for this research initiative, in particular for the development of the protocol and identification of research teams in seven countries. We are seeking additional support for the country studies and the cross-national data analysis.

Prevalence of domestic and sexual violence and the consequences of violence in Nordic countries

Dr Karin Helweg Larsen

Dr Karin Helweg Larsen presented a picture of the situation concerning injuries and violence in Scandinavian countries, from a Nordic joint study on violence against women.

Introduction

A number of studies have described violence against women and the impact of violence on women's health in the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, but we lack comparable data on the prevalence of violence, based on nation-wide representative epidemiological studies. The general attention of health personnel to violence against women needs to be strengthened, not least among physicians. The routines in the health system when meeting, examining, treating and counselling victims of violence could generally be improved. Some Nordic countries still lack special units or centres that meet the demands of victims of violence. Evidence-based protocols for clinical care, forensic examination and medical and psychological treatment must be developed to offer victims of sexual and domestic violence qualified care. Follow-up studies to evaluate different models of preventing sequelae to violence are requested to develop accessible, high-standard treatment in the national health system and in private crisis centres.

Although very high standards of care are offered in several open hospital emergency wards in Iceland, Norway and Sweden, such services have still not been established in the Danish national health system, and services are only available in few places in Finland.

A joint Nordic study of the prevalence of sexual and domestic violence and the consequences of this violence was initiated in June 1997. The background and the aim of the study are presented here. The major target is in general to improve women's health by reducing violence against women and through initiatives in the public health system to prevent sequelae of violence.

What do we actually know about the amount of domestic and sexual violence in the Nordic countries?

Up to now there are no comparable figures that enable us to analyse the possible extent of differences in socioeconomic and other factors in the different Nordic countries. Even though the social welfare systems in the Nordic countries are basically similar, great discrepancies exist regarding, for example, the length of parental leave and support to young families. The unemployment rate and the percentage of single parents also differ considerably between the Nordic countries. These factors and others might well influence the frequency of violence, both domestic and sexual.

Domestic violence

A relatively small number of studies have evaluated the prevalence of domestic violence in Denmark. Most data are based on a limited number of patients in contact with emergency departments in different regions of the countries. The risk of domestic violence was found to be highest in the Copenhagen area, with 3.4 cases per 1000 women per year, compared to 1.6 cases in the rural districts *(1).*

The frequency of visits to emergency wards in the Aarhus region has been described in a number of papers, including description of demographic characteristics of the victims. But these studies do not present any reliable figures or estimates of the prevalence of domestic violence in the total female population *(2,3).*

In 1991 the Danish Institute of Social Sciences conducted a study based on telephone interviews that found that 9% of all women had experienced one or more violent assault by spouse or former spouse. In 5% of cases, the violence was described as severe *(4).*

A similar study in Sweden proved that 66% of all violence against women took place indoors, and that the aggressor in most cases was the spouse. The Swedish crisis centres were contacted by 14 000 women out of a target population of 2 821 000 aged 15–64 years *(5).* In the early 1990s the Swedish government conducted a survey of violence against women, prior to the establishment of a national research centre on violence against women, situated in the University Hospital of Uppsala (Heimer).

A few years ago a governmental study of the prevalence of domestic and sexual violence was carried out in Iceland; 1.7% of all women reported having experienced severe violence during the last 12 months *(6).*

At present, questions about domestic violence are not included in the national health surveys that are repeatedly conducted in all Nordic countries. Nation-wide data based on representative samples exist only in Greenland. The Greenland health survey of 1993 included questions about domestic violence and sexual abuse experienced; 20% of all women reported having never notified cases of domestic violence to the police.

In the autumn of 1997 a Finnish nation-wide survey of violence against women, including sexual assaults, was started. The study is based on a postal questionnaire. The response rate one month after the start of the study was rather low, about 50%. Results of the study will be available during 1998. A similar but not nation-wide study will be started in Uppsala, Sweden, in some months' time.

Sexual violence

From the criminal statistics we know the number of notified sexual assaults, but these figures are believed to be much lower than the true number. In 1996 fewer than 400 rapes were notified to the police in Denmark, among 1 772 000 women aged 15–64 years; in Sweden the criminal statistics report about 1400 rape cases among 2 820 000 women. In 1996, in all 423 rapes and 91 attempted rapes were notified to the police in Norway, among 1 419 000 women aged 15–64 years. Thus the rate of notified rapes is higher in Norway than in Denmark. It has been reported that the number of notified rapes increased after the inauguration of the open rape trauma centres in the hospitals in Norway *(7).* In Iceland 20 to 35 rapes are reported to the police annually.

Estimates of the prevalence of rape in the Nordic countries are found in a few studies from Norway, Sweden and Denmark *(7,4,8–10).* International studies report varying frequency of sexual assaults in the adult female population, ranging from a few percentage points to about 33%. In the Nordic countries, based on clinical studies, a prevalence of 10–20% among women aged 20–49 years are reported. The figures are higher in Greenland, where 29% of all

women aged 18–24 reported having experienced forced sexual activities during their lifetime. In a nation-wide survey in Denmark, however, based on 700 women, only 3% reported ever having experienced rape *(3).*

The sequelae of violence against women

In 1985 a pilot project offering free psychological counselling was set up in Denmark to improve the clinical forensic examination in cases of notified rape. The project was closed after a few years, but the possible effect of the care and the psychological treatment was evaluated in 1990–1992 *(11).* Severe sequelae, of which about two thirds could be defined as post-traumatic stress syndrome, were reported by about 30% of the women three months after the assault. The psychological treatment was estimated to have played a role in preventing more chronic symptoms in some cases, but the number of victims included in the study was too small to permit any conclusions *(13).*

Similar results have been reported in the Swedish studies *(8)* and are being reported from the Swedish national centre for victimized women, which started in 1996.

In 1986 the first open rape trauma centre opened in Norway. Since then a number of studies have been published describing several aspects of sexual violence *(13–15).*

The acute symptomatology of the rape victims and the physical and psychological sequelae of assault have been analysed in several recent Norwegian studies *(16,17).* Norwegian studies have been shown that violence is frequent against women, even during pregnancy when it may severely influence the outcome *(18).*

At present, it is acknowledged that sexual and other violence have severe consequences for women's health, but the extent of these in the Nordic female population is unknown. We need nation-wide surveys, case–control studies and longitudinal follow-up studies to obtain more precise knowledge about the prevalence of physical and psychological symptoms in the female population that may be due to former violence.

The Nordic joint study of violence against women

In view of the need to obtain nation-wide and comparable data on the prevalence of violence against women in the Nordic countries, a group of female physicians established a research network in June 1997. Representatives from the different trauma centres in the national health systems in Finland, Norway and Sweden, and a group of Danish physicians comprise the network at present. The study is supported by the Nordic Council.

The major aim of the study is to obtain comparable data on the prevalence of sexual and domestic violence against women in the five Nordic countries and Greenland, and to measure the impact of violence on women's health. The project has three components:

1. epidemiology
2. clinical forensic medicine
3. clinical medicine and psychology

The epidemiological study

Questionnaires aimed at evaluating the prevalence of domestic violence and sexual offences in various populations must be based on strict criteria. The Nordic study will be based on a consensus about what is to be included in the definition of "domestic violence" and which

types of sexual assaults fulfil the definitions of “rape”, “sexual violence”, etc. Further, the questionnaires are going to be validated in different settings and in the countries to ensure that the data will be comparable

A number of international studies present very different estimates of the frequency of domestic violence, even though the studied populations are rather similar demographically and in the distribution of socioeconomic characteristics. These differentials might well be due to differences in the definition of domestic violence. Some studies seem to include more common acts such as “spouse talking very loudly” or “being pushed”, whereas other studies have stricter definitions. In the Nordic study three different levels of epidemiological studies are planned.

1. The national representative health surveys are in the future to include a limited number of questions about domestic and sexual violence. It will thus be possible to estimate the health consequences of violence in large samples, and the concurrent importance of other factors such as socioeconomic status, life style and attitudes. Further, these studies will make it possible to evaluate the trends in violence over the years.

2. A nation-wide study based on postal questionnaires will focus on present and past experiences of violence and abuse, and include a limited number of socioeconomic and demographic data. At present a Finnish study, based on the Canadian model, is being carried out. Based on standardized questionnaires, similar studies will be conducted in the other Nordic countries as soon as possible.

3. Interviews in clinical settings, including rating of physical and psychological symptoms, should be conducted in several regional hospital departments in all Nordic countries within a given period. The interviews should be based on standardized questions and rating scales, previously validated in the different centres. A pilot study has already been performed in Linköping in Sweden by Babro Wijma and her team.

The forensic study aims at developing standardized Nordic protocols for clinical forensic examination and documentation. A retrospective study is planned, on data from the different trauma centres and forensic institutes. In this study the judicial consequences of the medical reports will be evaluated, and possible differences in the Nordic countries will be described. Programmes for diploma courses in clinical forensic examination and documentation of violence will be developed and incorporated in the postgraduate medical curriculum.

The clinical study aims to describe the state of art in the care of victims of violence in the different trauma centres and to develop Nordic standards for centres in the national health services. Different models of psychological counselling and treatment will be compared. The acute symptoms and the sequelae of the different types of violence against women will be described by standardized rating scales including evaluation of the usefulness of these rating scales.

In addition, based on the experiences of the trauma centres, training courses will be offered to health personnel. The topics of these courses will include the symptomatology of violence and the treatment of victims of violence. Thus, we hope to strengthen the awareness of the problem in the health system.

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Domination and violence against women within the couple

Ms Lucienne Gillioz

Ms Lucienne Gillioz presented her survey on male dominance and violence against women within the family in Switzerland.

Introduction

I am going to present some results of a Swiss study on domination and violence against women within the couple. This research, completed in 1996, was financially supported by the Swiss National Science Foundation. Its main objectives were:

1. to measure the extent of violence perpetrated against women within the couple in Swiss society (prior to this date there were no statistics in Switzerland on the subject, not even an estimate of the extent of this phenomenon, as one can find in France);
2. to study the consequences of violence on the victims;
3. to understand the social and family factors that generate violence; and
4. to show the strategies used by women to cope with violence.

In order to achieve these objectives, we conducted:

- a national survey based on a representative sample of l500 women interviewed by telephone; and
- a qualitative study, based on 30 in-depth interviews with victims of violence.

This research was undertaken from a feminist perspective, according to which violence is a gender issue. Its focus is on husband-to-wife violence and not on the whole range of violent interactions in the family, as covered in studies conducted by family violence researchers. For us, violence against women in the family is a distinct issue, as it is for feminist researchers. Because of time limits, I will limit my presentation to the quantitative aspects of the study.

The quantitative survey

The sample

The sample consisted of 1500 women living in Switzerland, aged 20–60 years, currently living in a couple or having lived in a couple during the past 12 months.

Types of violence studied

Our study explored physical, sexual and psychological violence. To measure physical violence, we borrowed and adapted the indicators of a classic instrument, the conflict tactics scales, developed by Straus and his colleagues at the New Hampshire Family Research Laboratory (USA). Despite the fact that this instrument has been criticized, in particular because it examines acts of violence out of their context, it has been the most widely used to measure family violence. To overcome its limitations, we gathered in each case as much information as possible on the context in which the violence occurred.

Less is known about psychological violence, and it is therefore much more difficult to operationalize. For instance the word “humiliation” can refer to different acts according to the respondent. To my knowledge, no completely satisfactory instrument is currently available. Despite these uncertainties, we took the risk of studying this kind of violence. Nevertheless,

we limited ourselves to the study of its most obvious forms. Table 1 presents the indicators we selected for each type of violence.

Table 1. Forms and indicators of husband-to-wife violence

Physical violence
He threw something at her
He pushed, grabbed or shoved her
He slapped her
He kicked, bit or hit her with a fist
He hit her or tried to hit her with something
He beat her up
He choked her
He threatened to kill her
He threatened her with a knife or gun
He used a knife or fired a gun
Sexual violence
He used physical force or threats in order to have sexual intercourse with her
Psychological violence
He insulted or swore at her
He threw or broke or smashed or hit something
He threatened to hit or throw something at her
He locked her in the home
He locked her out of the home

Results

Our findings show that Switzerland is not spared the problem of domestic violence. During the past 12 months, 6% of the women interviewed were physically or sexually assaulted by their live-in partners; 26.2% of the women reported incidents of psychological aggression. Of the women who separated from their partners in the last 12 months, 20% reported having been physically or sexually assaulted by them during this period. One woman out of five said she had been physically or sexually abused during her life; two out of five said they were psychologically abused.

To place our results in an international perspective, we wanted to compare our findings with those of similar national surveys performed in other countries. The comparisons were not easy since there are few representative studies on a national level and because the categories used to present the results do not always coincide. This is why we could only make a few comparisons, which are summed up in Table 2. It shows that Switzerland has lower rates of violence than other countries.

How can we interpret these figures? Is Switzerland less violent than other countries or is violence against women underestimated in our study? Even though we cannot give a definitive answer, we believe that our data underestimate the reality of violence, for the following reasons.

Table 2. Prevalence of three types of violence in Switzerland and other countries

Physical violence in the last year		Physical/ sexual violence throughout life		Physical violence throughout life	
Switzerland (1994)	USA (1985)	Switzerland (1994)	Canada (1993)	Switzerland (1994)	Netherlands (1986)
5.6	11.6	20.7	25.0	12.6	26.3

- Our study focuses on women living in a couple or having separated in the last 12 months. It does not take account of divorced women or those who have been separated for more than one year, who, as shown previously, suffer higher rates of violence. In this way, our study underestimates the real extent of violence in Swiss society.

- The theme of domestic violence has been little explored in Switzerland and remains a taboo subject and thus difficult to talk about.

Indirect information on husband-to-wife physical violence

From the start, we knew it would be a challenge to obtain data from women who were victims of violence, so we made provisions to obtain indirect information by asking respondents whether they had acquaintances who are or had been hit by their partner (Table 3).

Table 3. Indirect information on husband-to-wife physical violence

Indicator	Percentage
Percentage of respondents who know a woman who is currently hit by her husband	21.7
How the respondent knows about the violence	
Directly	58.6
Through another person	35.9
Saw body marks	18.4
Heard screams	9.5
Other	9.8
Percentage of respondents who know a woman hit by her husband during the course of her life:	53

More than one out of five women know at least one other woman who is currently hit by her partner. In most cases, the respondents know about it directly. More than half of the respondents know at least one other woman who has been hit by her partner during the course of her life.

Our results show that violence against women within couples exists in all social categories; it is not limited to the lower classes, as is frequently believed. Moreover, we found no significant differences in the prevalence rates between young and old women, Swiss and foreigners, women living in towns or in the countryside.

As regards family factors, dominance is the most strongly associated with violence. By dominance, we mean strategies used by men with the goal or consequence of putting women in a position of inferiority. These strategies include the following:

1. influence in decision-making
2. control over the wife's daily life
3. criticism of the wife.

We have constructed an index of dominance that integrates these three dimensions. The correlation between dominance and violence is obvious: the values of the dominance index are medium to high for 79% of violent men, low to zero for 79% of non-violent men. We also found other factors that are correlated with violence, such as lack of communication in the couple, isolation, experience of violence in the family of origin and the husband's consumption of alcohol.

In the quantitative survey, we could not study this aspect in depth, because we were limited to 20 to 25 minutes of telephone interview time. Our questions were based on self-evaluation in three areas:

1. state of health
2. feeling of wellbeing
3. feeling of self-esteem and being in control.

We also examined medication and alcohol use. The results are as follows:

Women who are victims of physical, sexual and psychological violence have an inferior state of health compared to other women. Their feeling of wellbeing is lower. They say less frequently that they enjoy what they do, that they feel full of energy. They say more frequently that they feel tired. Their feeling of sadness and anxiety is striking. One out of four says she often or always feels sad; one out of four says she often or always feels anxious. These women also say more often that they have little influence over their own life. Their feel less self-esteem. They consume more soporifics, tranquillizers and antidepressants. While they consume a little more alcohol than other women, alcohol is not for them a specific coping strategy.

Conclusion

The results I presented here were used in a national campaign called "Stop violence against women within the couple". It was organized in May 1997 by the Swiss Offices for Equal Opportunities between Men and Women. The figures on violence were widely published by the media and seem to have an impact on public opinion.

The first step to combating domestic violence is to become aware of how widespread it is and to understand the phenomenon better. This is why it needs to be scientifically studied and must become visible through statistics. In my opinion, statistics should be developed in three directions:

- criminal statistics ought to include a category on domestic violence;
- statistics of cases treated by medical and social institutions as well as by the criminal justice system should be developed; and
- the prevalence of domestic violence in the community could be assessed, although it is necessary to be cautious when evaluating the results of statistics referring to the whole population.

Of course, statistics on the whole population do help to measure the number of victims of violence who have never sought help. The methods used, such as the conflict tactics scales, however, could be misleading because they do not distinguish between the violence of the

perpetrator and the violence of the victim (for example, when acting in self-defence). This is why some studies done in the United States have come to the conclusion that women are as violent as men. After three years working on the theme of domestic violence, I have learned that its meaning can only be grasped within the relationship where it takes place. The violence of the dominator can not be equated to the violence of the dominated.

Further studies need to be conducted to achieve a better understanding of the phenomenon of domestic violence. In my opinion, these should include:

1. the study of sexual and psychological violence, requiring the development of specific instruments;
2. the analysis of the effects of violence on the physical and mental health of women and their children;
3. the assessment of the institutional responses given by society to violence within the couple, and their adequacy from the point of view of the needs of women;
4. the evaluation of the costs of domestic violence for society; and
5. the study of the link between masculinity, as a social construction, and violence.

A survey on domestic violence in the Russian Federation: methodology and results

Ms Marina Pisklakova

Ms Marina Pisklakova presented a survey on domestic violence in the Russian Federation.

Until very recently, violence against women in the Russian Federation was still a taboo subject. People had never heard the terms “domestic violence” or “rape” in conversations or in the mass media. Neighbours silently tolerated screams; doctors accepted excuses for broken bones, and the government confidently claimed that women were emancipated and on an equal level with men.

In 1995–1996 the Russian Association of Crisis Centres for Women (RACCW)conducted a survey on the issues of domestic violence and rape. The primary goals of the RACCW surveys were to raise public awareness about the themes of domestic violence and rape; to determine how various Russian audiences understand violence in their personal lives; and to measure the extent of assaults. Representatives from regional crisis centres conducted the surveys in a range of settings, including secondary schools (10th and 11th grades), pedagogical institutes, hospitals, orphanages, government hotlines, a women’s prison, and a local prosecutor’s office. After filling out the survey, which was both confidential and anonymous, groups had the opportunity to discuss their feelings, ask questions and learn about the local crisis centre. While audiences were generally interested in the theme and did not object to filling out the survey, they also found some of the questions difficult to answer (often answering “I don’t know” or leaving spaces blank) and many were hesitant to engage in discussion on this so-called private issue. Most people said that they had never had the opportunity to talk about violence before, and that they were attempting to define these issues for the first time. Almost all of the audiences surveyed expressed an interest in participating in future educational programmes.

In total 849 people participated in the survey, including 555 women and 294 men. Most questions were posed in closed form (Yes/No/I don’t know or multiple-choice answers) with only two open-ended questions.

- How do you define violence in the family?
- How do you define rape?

Audiences generally found these open-ended questions the most difficult to answer. This inability to articulate a personal definition is in itself indicative of a lack of previous opportunity to talk about personal violence in a public setting. Answers often revealed differences in male and female experience and ways of thinking. Men were more likely to describe domestic violence as a concrete action, for example, “as relaxation” or “a way to force a woman to do something”. Men also tended to give textbook definitions for rape, such as “look in the criminal code of article 117”. Women tended to explain domestic violence in a more general way, seeing it as the consequence of misunderstandings and conflicts, as striving to control and dominate. They were also more likely to write of their personal experience: “domestic violence is when the weaker one is guilty ... it is unbearably painful, and when the fateful minute arrives, powerless, you agree to anything ...”

The survey posed a range of questions concerning views of violence in general and family violence in particular, as well as questions to define violence, how often it happens in partner relationships, and external factors that may stimulate violence. Many contradictions in answers demonstrate that there is no certain level of awareness about the problem of domestic violence. For example 80.5% of women and 63.6% of men consider domestic violence as a crime yet at the same time 41.4% of women and 55.% of men believe that women provoke violence in a family; 30.6% of women and 53.1% of men think that domestic violence is not a frequent phenomenon in the Russian Federation.

Other general conclusions from the survey are the following.

- While 82.2% of women and 63.3% of men do not think battering in a family is a private matter, men (3.5%) are more likely then women (16.8%) consider it so.

- As to whether domestic violence is a crime, 80.5% of women and 63.6% of men said Yes.

- Men (42.5%) are more likely then women (28.15%) to think domestic violence should be considered a family matter, while 45.2% of men and 47.6% of women disagreed.

As we can see from these results there is a tendency to consider domestic violence as a social and legal problem. Women are more direct in this attitude toward violence in a family.

It is also interesting how women and men identify victims of domestic violence:

children	67.2% of women and 68.4% of men
older people	5% of women and 8.8% of men
women	19.3% of women and 37.8% of men
men	0.7% of women and 2.4% of men

When a man beats his wife, the guilty party is most often:

the woman	19.3 % of women and 73.7% of men (7% – do not know)
the man	37.8% of women and 53.4% of men (8.8% – do not know)

Respondents think that the following factors influence the existence of violence in a family (Table 4).

Table 4. Factors influencing violence in a family

Factor	Women (%)	Men (%)
Alcoholism	88.8	85.4
Lack of communication skills	65.4	58.2
Violence in childhood	53.9	46.9
Dissatisfaction with sex life	49.4	
Violence in the mass media	46.7	
Bad economic situation		47.6
Housing problems		39.5

We see that women and men consider alcoholism and lack of communication skills as the two main problems influencing violence. The difference between women and men is that women see the whole atmosphere of violence in society as a reason for domestic violence, while men find the reasons in more material things such as a cramped/lack of living space and low salary.

In addition to questions on domestic violence, the survey posed a range of questions exploring common myths and perceptions about rape. In answer to the open-ended question on how to define rape, men tended to answer in precise and official terms, often invoking the criminal law code. Women (the majority of whom are young women) were more likely to consider the emotional and moral consequences of rape, describing their personal experiences and placing it in the moral category of sin, tragedy, and/or emotional and physical humiliation.

More than half of those surveyed (men slightly more than women) agreed with a range of myths about rape.

A rapist is most often someone that the victim does not know. Men (60.9%) were more likely than women (55.9%) to believe this myth; 4.1 % of men and 3.9% of women responded "I don't know".

Women who are out late at night or in isolated places are more likely to be raped. Most respondents (74.8% of women and 68.6% of men) agreed with this statement, but 11.5% of women and 1. 3 % of men answered "I don't know".

Most rape victims are young and attractive. While more than half of men (56.1%) agreed with this myth, only 42% of women agreed; 34.4% disagreed with this statement, and a large number of women (23.6%) answered "I don't know".

Most rapes happen to women who talk with strangers. While 78% of men and 54% of women agreed with this myth, women are much less sure about this idea, with 30% disagreeing and 16% answering "I don't know." Men had a tendency to be more categorical, with only 21.2% disagreeing and none answering "I don't know".

Most rapes happen to women who wear provocative clothing. Here the myth is believed by half of the women (53.3%) and two thirds of the men (60.2%); women are more likely to disagree (36%) or answer "I don't know" (10.7%) than men (31% and 8.8%, respectively).

Every woman secretly wants to be raped. Only 6.1% of women agreed with this statement, about one third of men (34.0%) agreed; 2.9% of women and 5.0% of men answered "I don't know".

There were significant differences in how men and women answered questions related to victim blaming in rape. Women's answers showed that Russian women have largely accepted the blame for being raped, an idea that is widely propagated by official institutions and society in general. Nevertheless, women were more likely than men to answer "I don't know", indicating once again women's internal conflict between society's judgement of violence against women and their personal experience.

In 1996 another sociological survey was conducted in the Russian Federation. It was a joint project of the Institute for Socioeconomic Studies of Population, Russian Academy of Science

and the University of Cincinnati (USA). The main goal of this survey was to define the influence of the transition in the Russian Federation on Russian families. A number of questions addressed were about conflicts between spouses and violence. The survey was conducted in Moscow and two rural areas. The very preliminary results are the following.

Women report that 1% of those who currently live in a marriage and 20% of divorced women experience physical violence. At the same time, according to their own reports about physical violence toward a spouse, 5.9% of married women and 10.8% of divorced women said that they sometimes use physical violence.

Among women who experienced physical abuse (25% of all married women respondents and 42.6% of divorced women), 15.9% of married women and 16.9% of divorced women said that they began the verbal attack in the last conflict. At the same time, 7.7% of married women and 14.1% of divorced women said that verbal attack was initiated by the husband.

As regards physical attacks, there is a more significant difference. For married women, according to 6.9% of answers, women started an attack and 6.9% of men started physical abuse. Among divorced women, 7.1% replied that they began the violence and 21.4% said it was the husband. This difference may be explained by two factors. One is that women currently living in abusive relationships experience cycles of violence with a husband. At the point of most tension they can start the abuse themselves in order to get the violence over with as soon as possible. Another reason, connected to the first, is that they take responsibility for the husband's behaviour.

In general, the results seem to indicate a tendency for women to use verbal abuse more, and for men to use physical abuse more. Tables 5 and 6 summarize the other results.

Table 5. Answers to a question

How often does (did) your spouse	Married respondents (%)		Divorced respondents (%)	
	Women	Men	Women	Men
Raise his/her voice?				
Never	20.8	15.5	20.8	26.8
Sometimes	62.7	69.6	34.1	29.0
Frequently	15.7	12.7	43.0	43.0
Insult you?				
Never	58.4	60.1	43.9	38.0
Sometimes	34.0	33.8	26.3	31.1
Frequently	6.9	3.8	25.7	29.5

Another question was addressed only to women.

Table 6. Answers to a question addressed to women

How often does (did) your husband	Married women(%)	Divorced women (%)
Shove or push you?		
Never	79.8	59.2
Sometimes	18.0	29.3
Frequently	1.3	9.7
Slap or strike you?		
Never	86.6	63.6
Sometimes	12.1	23.9
Frequently	0.4	10.9

Beat you?		
Never	92.2	68.0
Sometimes	5.8	19.6
Frequently	1.4	10.7
Force himself upon you sexually?		
Never	88.3	82.7
Sometimes	9.1	9.7
Frequently	1.5	3.1

In conclusion, I would like to underline that this is still a very new issue for discussion in the Russian Federation. To create a strategy to combat violence against women, it is important to support the existing network of independent women's organizations providing direct services for women. There are different types of intervention existing in the Russian Federation. The ANNA Crisis Centre for Women offers different services:

- telephone line for women;
- counselling centre (lawyer, psychologists, support groups, advocacy);
- educational programmes;
- national educational campaign;
- training programmes for professionals (police, judges, prosecutors, medical doctors, social workers); and
- training programmes for other Crisis Centre groups in different regions across the Russian Federation.

The main points for future discussion are the current problem of data collection, and how to proceed with data collection.

5. Session 2. Mental health consequences of violence against women

chaired by Ms Mary Petevi

The session was chaired by Ms Mary Petevi, and comprised three presentations.

Violence against women and its psychosomatic consequences –

presented by Ms Regina Lackner

Ms Regina Lackner, on behalf of Professor Beate Wimmer-Puchinger, Ludwig Boltzman-Institut for Women Health Research, presented a study on the psychosomatic consequences of violence against women in Austria.

Violence against women is one of the major social and public health issues in our societies. Violence against women has many faces, encompassing physical violence such as slaps, battering or throwing something or using a weapon; sexual violence such as unwanted sex and rape; and psychological and verbal violence, such as calling a woman names, threatening her, making her anxious and so on.

Many times physical violence goes hand-in-hand with sexual and psychological violence. Finkelhor and Brownie have shown that a third of battered women are also sexually abused by their partners.

Violence against women is a very complex issue with a broad range of causes and a series of somatic and psychological consequences.

Violence against women is not an isolated issue. Moreover, it has to be seen in a broad social context. Thus, it is very closely linked to the situation of and attitudes towards women in society.

In addition, violence against women is also linked to violence against children. On the one hand, a woman's partner frequently batters not only her but also her child is by. On the other hand, men who become abusive and violent often have a history of abuse in their own childhood. Thus, violence against children may contribute to violent behaviour later in life.

Violence against women may be a single act, but it mostly occurs within intimate relationships. Thus, it may become a part of the dynamics of a relationship. A frequently seen pattern is that violence occurs after a period of tension between the partners, which is mostly caused by a man. The violence is followed by a period called a honeymoon.

Very often the violence develops over time – often years. The change between periods with and without violence, the latter being marked by the partner's promises never to be violent again, is crucial to the situation of an abused woman, particularly the psychological and thus psychosomatic consequences. The change from violent to non-violent behaviour often leads the woman to hope that her partner will change. Many battered women feel very confused

about their partners and report mixed feelings such as hatred, fear, anger, shame, guilt, love and hope. Among other aspects, these feelings often lead abused women to stay with their partners, and cause psychological and somatic symptoms.

Possibilities for effective help for battered women: the example of the Vilnius Crisis Centre for Battered Women

Ms Lilija Vasiliauskiene

My presentation will be concerned with the possibilities of effective help for battered women in conditions that are characteristic of Lithuania as it is now – a country facing all kinds of social and economic problems.

As our experience of one year of the Crisis Centre's activities has shown, we can help female victims of domestic violence even when we cannot provide them with a new flat or take them out of an abusive home situation for any lengthy period.

Our experience proves that a woman's chance to share with the Crisis Centre's day workers and volunteers the experiences she has in violent relationships often makes a psychologically significant breakthrough in her situation, and enables her to seek new solutions and make new decisions. Just staying in touch with the Crisis Centre, through phone calls and/or coming in for a conversation and consultation, can be a real help.

There are examples of women becoming stronger and being able to exercise their own autonomy and authority in their homes, when they understand their rights and learn – step by step, with our help – to make use of institutions such as the police, medical care and lawyers.

There is a saying that secrets kill, and perhaps they do, as abusers want to call the violent behaviour a family matter and keep it all a family secret. As the cultural taboo on speaking aloud about family violence is lifted, a woman can seek and find real help. As she learns more about her civil rights, her dignity is restored. Reciprocally, the abuser starts to realize that he can be punished for what he does; earlier, he felt free to do whatever he chose.

For a woman, the mere possibility of calling the Centre and always being listened to by another woman who believes what she says, has a symbolic meaning. It means that she is not alone, that she has rights and can come to make use of them and effectively defend herself and her children from a violent partner or husband.

As the syndrome of helplessness and hopelessness is known to be a highly morbid one and an agent for the development of various psychosomatic problems, the Crisis Centre, where women are helping women, makes a significant contribution to the female population's mental health care and improves the physiological and psychosocial functioning of many women.

The mental health consequences of violence and the responses of the health sector

Dr Elvira Reale and Ms Vittoria Sardelli

Our work began in 1977 in the Frullone Public Mental Hospital in Naples. A year later we started to organize an alternative treatment for women in closer cooperation with the district in which they lived.

This led to the organization of a mental health service for women only, and to the proposal of a methodology specifically created for and applied to women's welfare. At the same time, in 1978, Law No. 180 on mental health care was implemented in Italy. As a result of this Law, many mental hospitals have been closed and psychiatric care is organized on the basis of territorial and outpatient mental health centres.

Up to this time, over 4000 women have been treated in our mental health service. From an epidemiological point of view, this population corresponds to the general female population of Italy. It consists mainly of adult married women with children. Among the main symptoms are anxiety, depression, and/or psychosomatic troubles. In recent years, the demand for care has been growing, from younger women, aged between 16 and 25, as well as older ones.

The methodological background of our mental health work can be summed up by the following four points.

1. everyone is subjected to different kinds of pressures (economical, political, cultural, psychological, etc.) that can contribute to psychological trouble;
2. gender and sexual difference are additional causes of general pressure on women;
3. the sociological notion of female role implies a number of rules for private and public behaviour aiming to create and increase social and psychological subordination; and
4. the oppression caused by this role can become unbearable for the woman; when this happens, psychological trouble may emerge as the only possible expression of her suffering, whose source she cannot recognize.

As an outcome of our clinical observation and experience, we can state that oppression linked to the female role is the main risk factor for women's mental health.

The analysis of daily life is the basis of our clinical and therapeutic intervention. It shows that two main factors contribute to the oppression linked to the female role:

- the burden and stress connected with motherhood
- the pressures exercised by the social and family environment, which lead the woman towards role behaviour, and induce her to the global burden of motherhood.

The analysis of the role of mother and its characteristics (that is, responsibility, expectations, models, tirelessness, psychological dependence on the satisfaction of the needs of others, etc.) can form the central point of observation of the risk factors of mental illness for women.

Maternal characteristics are part of gender identity and do not apply only or specifically to the women who have children. Maternity is a social model that determines a woman's behaviour

and makes her neglect her personal needs to serve other people's needs. Maternity is the prototype of a relationship of dependence, within which a person who is defined as socially in need of protection is given a series of tasks to do, which are not considered as work but as services provided in the interests of personal realization.

The job of being a mother appears most stressful, since it implies a deep sense of responsibility, not comparable with that inherent in other types of work or the job of being a father. Even the expectations are not comparable with those of other jobs or roles: mothers are the women who always manage to cope. Expectations regarding this role cannot be precisely defined and can be overestimated. The woman cannot respond properly to all the expectations and requirements. This produces a sense of inadequacy and incapacity in her.

The maternal role offers the possibility of understanding how a certain type of female dependence is built up; this is revealed in situations in which the woman, although not originally deprived of personal resources, becomes dependent because she makes herself totally available for the needs of others.

The maternal job (with the main function of being available to satisfy the needs of others) can be seen in various situations: in marriage, both with and without children, and in unmarried women, both adolescents and adults. The most common situation is undoubtedly that of being married with small children, when the woman is expected to take on several specific and general functions.

All these cases entail the possibility that the carrying out of such functions will mean sacrificing important aspects of personal fulfilment. These functions exist for both full-time and part-time housewives (the latter being women who also work outside the home), for both the so-called emancipated and traditional woman. Being a mother can create conditions of isolation, suppression of personal needs, lack of friends and of their help, etc.

Work within the family is essentially non-work, since it is part of women's social and individual identities. This work does not have breaks, and is unlimited: a woman, conforming to the idea that a mother always manages to cope, increases her own tiredness. This burden of tiredness can increase to an extent that harms her physical and psychological health. Women often suffer and accept tiredness as an inevitable part of life. In this way, it does not cause alarm or alert the woman to her need to change. The fatigue and tiredness of being a mother are correlated with mental distress. If the tiredness is not attributed to overwork, the woman is thought to be ill.

The maternal role with its unlimited burden of work and responsibility is the first risk factor of mental illness for women. The second risk factor is the violent pressures exerted by the social and family environment. Violence is the most typical instrument of pressure on women. It can assume various form such as:

- sexual violence in the form of rape
- physical violence and threats
- verbal and psychological violence (insults, humiliation and denial of autonomy).

Rape takes place more often outside the family, in connection with external relationships. Verbal and psychological violence take place more often within the family environment.

We shall now consider family violence by males to point out its link with mental health. In the family, the woman is subjected to verbal and psychological violence consisting of abuse and critical judgements that tend to reduce her autonomy and self-confidence, while making her more available to others.

It is not by chance that insults always refer to what she has not done – or to what she has not done well – to be considered respectable, reliable and a good mother. Insults, criticism and physical violence make her question her possible faults; she is therefore induced to suffer and accept anything and to wonder whether she is at fault.

Violence, combined with a sense of guilt and a feeling of being responsible, at first prevents her from considering it an unfair action and behaviour, as a serious violation of her rights, as an assault on her liberty and dignity. Violence, denigration and insults form a powerful and specific risk factor for depression. A depressed woman has lost her self-confidence, no longer trusts her capacity to be autonomous, continuously questions herself and her actions, and feels responsible for everything, even when she is the target of abuse.

If the burden of work is a powerful element of stress for the woman's general health, the lack of positive comment, the erosion of her self-esteem, and the use of violence as a form of pressure in everyday life are specific risk factors for depression. Women do not consider that their tiredness results from their being overburdened. Moreover, they can find no support or understanding in the social and family context; in fact, others easily dismiss their tiredness as imaginary.

When they are tired, women tend to reduce their work, to give up the tasks connected to their female role and sometimes to ask for help, support and understanding. This behaviour creates a conflict between the woman and her partner and context, and it often produces violence as a means to force her back into her role and into the burden of work she is required to bear to cope with other people's needs.

The man or the family and social circle present the violence as caused by the woman's inadequacy to conform to the female model. When the woman accepts that point of view, she cannot react to violence; she cannot even recognize it as such and she hides it from others because she feels guilty. When a woman believes that she has provoked violence, she feels ashamed and hides herself from others. Many times, so-called domestic accidents tend to hide an experience of violence; 70% of women who need to go to hospital as a consequence of so-called domestic accidents do not declare the real cause: violence from their partners. Relatives often advise women to hide violence because the punishment of a violent partner could have serious consequences for the children (a financial and affective loss).

Let us now take a closer look at the effects that denied and hidden violence can have on women and their lives. Most often, the woman continues her relationship with the violent man and submits herself to his demands and behaviour. As a consequence:

- she feels despised and worthless;
- she is forced to increase her tasks or to cope with unpleasant tasks, conforming to her partner's desires and orders; and
- she tends to limit, even to cancel her own needs.

Depression is therefore the result of the powerful combination of all these risk factors:

1. an increase of the burden of family duties;
2. a reduction or total loss of personal interests and space;
3. a reduction or total loss of external relationships (the woman has less time to spend outside the family and, above all, she would feel ashamed to tell other people what she is forced to suffer at home);
4. the failure of her personal hopes concerning particularly the emotional side of her life (an aspect that is of great importance to women) and the painful disappointment of all her expectations of love, support, trust and understanding from her partner;
5. reduction or total loss of her self-esteem, with a simultaneous feeling of responsibility and guilt for the way she is treated and judged;
6. negative judgements and strong pressures coming from the family context; and
7. an increase of feelings such as tiredness, lack of motivation, anxiety, uncertainty and fear for the future.

All these factors determine the perception of being unable to cope or put up with the situation, combined with the awareness of being unable to modify the situation (in cases in which the woman has already made an unsuccessful attempt to change). All these perceptions lead the woman towards mental illness and depression.

The feelings of tiredness, fear and anxiety eventually lose their connection with the unbearable condition of life, which the woman considers unchangeable and against which she has given up any attempt to fight. Those feelings then become symptoms, signs of an illness and a discomfort totally disconnected from the woman's life. Most cases of female depression refer to women who feel guilty for having been insulted or assaulted.

Medicine and psychiatry can constitute an additional risk factor for women's mental health. Physicians often cannot understand the reasons behind a woman's tiredness, fear, lack of motivation, sadness and lack of self-confidence, and can only confirm or certify to her that she suffers from depression and anxiety, thus hiding and silencing the real reasons for malaise and distress. The suffering is then converted into pathology that prevents the recognition of its real nature and impedes any change in the woman's lifestyle.

Medicine and psychiatry, as they are today, are obviously inadequate to support women properly. The requests of women using mental health services have no priority whatsoever; moreover, the services provided are inadequate to the women's needs and their private lives are not taken into consideration. Women with mental health problems more often turn to general practitioners, who are more inclined to send them to a psychiatrist with a diagnosis of depression and anxiety and where tranquillizers are prescribed more easily.

Our experience, as psychologists and clinical researchers, suggests that it is necessary to plan preventive health interventions to reveal the problems hidden behind the symptoms, the true nature of the suffering diagnosed as mental troubles. This preventive intervention must take proper consideration of:

- the overload connected with domestic work;
- the violence that is often hidden behind a woman's sense of guilt;
- the negative criticism from the social and family context that tends to undermine women's self-confidence in their own capacities; and

- the condition of isolation in which women live, depriving them of any support from other kinds of relationships.

Our clinical work with individual women suggests the need to use a specific protocol of intervention that:

- analyses the woman's everyday life and her personal history to discover external impositions on her choices;
- discovers how many external requests and pressures have been imposed on her to obtain certain behaviour and services;
- finds out the capacities and resources that the woman is no longer aware of; and
- helps and supports her in the difficult task of changing her lifestyle, by planning with her a new kind of life of which she is the centre and where she can therefore reaffirm her rights to her own spaces, interests and personal relationships, and new life goals.

This clinical and psychological support to the woman should consider, when necessary, the possibility of her departure from the place where she usually lives.

In these cases it is necessary to bring to the surface the sense of guilt – which can be rooted in previous cases of mothers who were also victims – and gradually lead women to the recognition not only of the external violence but also of their own self-image as a beaten, humiliated woman and as a loser.

In the cases of depressed women, their tale of violence comes out after some time, as if they see it for the first time. This is very painful and they refuse to accept it, considering it their own fault and failure. Thus they unintentionally become accomplices of violent men. This unintentional complicity between the woman and her abuser, caused by a mistaken concept of the female role as it is generally affirmed in the social context, provokes an increase in violence. The violent man learns for himself (in addition to what the traditional models have taught him) that he faces no opposition and that violence pays.

The other kind of situation this intervention has to consider is that of women traumatized by a single episode or act of violence. The intervention has to be adequate to face situations of women who, after an act of violence, acknowledged as such and publicly declared, worsen their usual lifestyle and show anxiety and depression symptoms that tend to last for some time. Our experience in these cases is that a single act of violence, apart from its traumatic effect, can often be related to previous situations characterized by unacknowledged violence (criticism, oppression, etc.).

The exposure to violence of one or more members of the family is a strong risk factor of psychological destabilization not only for women but also for children, especially daughters. Our work with adolescents shows that, in contexts that are coercive and violent, daughters (usually the eldest ones) are led to help and support their mothers, both psychologically and materially, and/or to play the role of moderators in conflicts between their parents. Thus, they assume an adult attitude, taking on a burden of responsibility that is too heavy for their age and can be very dangerous for their psychological development. In fact, this alliance creates a sort of identification with their mothers and of adaptation to their patterns of submission and passivity, which are then transmitted from generation to generation.

Beyond psychological interventions with individuals or groups of women who have been subjected to violence, it is necessary to plan wider preventive interventions. These must have an informative and a formative character and may be addressed to two main categories: women at risk of violence and its psychological consequences and health personnel working in the services open to requests of help from women. The form of these interventions should be:

- the modification of domestic work models in the sense of a reduction of women's overload and a sharing of the tasks and responsibilities normally attributed to women;
- the modification of the image of women as individuals dependent on other people's needs and the affirmation of a positive model of women as people who can develop their capacities freely, without the limits imposed and referred to gender;
- training to identify the risk factors of mental illness present in women's everyday life (special attention must be given to the ability to deal with requests and violent behaviour from the family and social circle); and
- training to develop social and psychological self-protection, such as maintaining a network of relationships outside the family, which can be a major solution to the condition of isolation that favours the woman's dependence on violent relatives.

Aims and proposals

Our clinical work and the results of our research on women's mental health needs have confronted us with two kinds of problems, concerning methodology and content.

From a methodological point of view, we know that the good experiences of research and of clinical intervention in favour of women are not enough and cannot spread without good benefits. We think, then, that only a high-level representative body can disseminate the information about research and clinical experiences, and that WHO is the most suitable and authoritative place to represent everybody's interest in health.

We are therefore ready to propose some guidelines to disseminate preventive rules agreed on by others, including those taking part in this Meeting. We can suggest at least three lines in particular to be promoted in WHO Member States:

1. research
2. information
3. services.

Research

We intend to develop some methods of analysis in the field of the health research (about the risks of illness) that focus on:

1. the daily life and the interconnection among several risk factors
2. gender difference
3. researchers from cross-disciplinary backgrounds.

Medical and sociological research must always distinguish the subjects of its studies by sex. Public research, paid for by women as well as men, must collect data in such a way as to distinguish between the sexes, and to present the results according to this distinction.

Research must focus on the link between illness and everyday life, and particularly on the: analysis of:

- the external as well as family work
- the use of verbal, psychological and physical violence in both external and family relationships.

Research must link facts, events and relationships of everyday life to show the degree of interdependence, such as the model of maternity that orients and organizes itself around every other female daily experience. Study of the connection between illness and social roles must be carried out on several parallel levels: work, expected role, responsibility, concrete possibilities of fulfilling the obligations of the role, advantages to be gained and ideologies referring to gender, social class and ethnic group.

Researchers coming from different countries should share the development of their own studies with their foreign colleagues. International research should then be funded to develop interconnected methods of analysis to increase the available resources and to support the exchange of experiences and information.

Information and training

Training interventions on daily lifestyle should be developed and addressed to both women and health workers. First, they should be informed about certain aspects of the crisis surrounding the female role. Inadequate solutions to this problem would increase the risk of mental illness. The goal of an informative approach is to raise women's awareness of:

- how to combat stress and other pathological problems linked to the female role
- how to change the pattern of subordination and dependence
- how the absence of reaction to violence is linked to psychological illness and other troubles.

Then training should be developed for medical and social workers who come into contact with women's problems:

- to reduce/eliminate the use of psychopharmacological drugs
- to stimulate a medical and psychological approach that explains the connection between illness, disturbances and everyday life (domestic work and violent pressure from the family context).

To reach these two goals, Member States should organize:

- information programmes on prevention aimed at housewives and female workers exposed to the risks of violence or mental and physical disorders (female adolescents, women with excessive burdens, external work as well as housework, small children, etc.), providing information through seminars, follow-up courses and other courses addressed to women who have responsibility in the educational, political and work environment; and
- seminars and training courses for public health workers who should be interested in the public budget and in the planning of refresher courses.

Services

Some women suffer from unsustainable life conditions: isolation, separation, widowhood, unemployment, lack of economic support, family problems, etc. Others are ill, anxious or depressed; they no longer speak about the difficulties linked to everyday life; neither are they able to recognize oppression, violence, fatigue and tiredness.

We propose two types of service for these women. The first addresses women who have not yet developed an illness. It attempts to prevent specific situations of distress; the goal of the consultation service should be the reduction of the damage caused by subordination and violence in everyday life. It should take account of women's life problems and promote awareness, abilities and skills for problem solving in women. The service could organize:

1. listening centres, training courses, social and psychological support groups, etc. for women with specific problems:
   - women who have given up work during maternity and/or subsequent child-rearing years;
   - women having difficulties in social relationships, in organizing both housework and external work;
   - women who are ill treated and abused;
   - those who abuse alcohol, etc.

2. programmes for health education with a view to:
   - increasing women's ability to communicate and express their emotions;
   - increasing their ability to analyse their lifestyles;
   - improving their image and their self-esteem;
   - reducing the risks of mental pathologies.

The second type of service is addressed to women who have already begun to develop an illness and manifest symptoms, and who have already had psychiatric treatment. This service should encourage women to understand how their daily lives have led them to illness by using a method that must be necessarily different from that traditionally adopted in psychiatry.

The specialized service should offer practical help and necessary support by creating a concrete alternative to hospitals and to psychiatric cures. The service should have the following goals:

- to reduce or eliminate the use of specific therapeutic means, such as hospitalization, drugs, or any other strategy that tends to impede or delay women's comprehension of the concrete and tangible causes of their illness;
- to consider the symptoms of mental illness as signs of unbearable life conditions; and
- to create new lifestyles for the benefit of women, in keeping with their interests, aptitudes and emotions.

6. Session 3. Helping health services to elicit appropriate responses

chaired by Dr Nils-Otto Sjömberg

The reproductive health consequences of violence

Dr Berit Schei

Introductory comments

The field of violence against women is an important one; it is distinctive in that it is entered not just with the brain or for theoretical reasons but with the heart. It is important to acknowledge this fact because, unlike many other medical and social topics, violence is an emotional issue that affects us all differently.

To briefly introduce myself: I am a member of the Norwegian Board of Health and of the Faculty of Medicine of Trondheim University, where I hold the Atkinson Chair in Women's Health Research. I am currently working at the Centre for Research in Women's Health in Toronto, a WHO collaborating centre that has chosen research into violence as one of its main specializations.

I have a clinical background in dealing with abused and raped women, covering psychosocial obstetrics and gynaecology, health care of rape victims, partnerships between health care centres and women's shelters and work experience with abused women in Bosnia and Herzegovina. My research has been interdisciplinary, including both clinical research and population-based studies in Norway making use of interviews and questionnaires.

I will be addressing four main questions today.

1. How common is violence against women?

2. What are the reproductive health consequences of abuse?

3. What are the medical and legal consequences of abuse?

4. What are the future challenges?

Before we start, I think it is important to be specific in defining the types of abuse. Some women have a history of abuse, dating back to childhood. For others, abuse can occur in the form of rape by strangers or acquaintances, but also in intimate relationships, in the form of physical, sexual and psychological abuse. Women can become trapped in what I call painful love, characterized by early verbal and physical dominance by the man, isolation or actual imprisonment, fear arousal and the maintenance of fear, guilt induction and the contingent expression of love. Women in this situation can display enforced loyalty to the aggressor and self-denunciation, or powerlessness and helplessness. They are the victims of a pathological expression of jealousy, combined with hope-instilling behaviour. Above all, they are required to maintain secrecy. These different types of abuse can be interrelated, because women with a history of abuse are at a higher risk of entering into abusive relationships.

How common is violence against women?

We conducted a survey in Trondheim in 1990 in an attempt to discover the prevalence of abuse of women in intimate relationships *(1)*. Women in the community were invited to participate, providing the population-based sample, as were women from the women's shelter and the hospital emergency department. In an effort to assess the prevalence of a lifetime history of abuse within an intimate relationship, it emerged that 17% of women had experienced one or more episodes of abuse. As defined according to the scale of Strauss, 13% had experienced repeated violence, 11% repeated violence and fear of the partner, and 9% repeated violence and sexual abuse *(2)*.

This was a small-scale, localized study, but it still remains the single published study referred to in the Nordic countries. Another study has recently been completed in Iceland, but so far has only been published in Icelandic, though it is being translated into English so that the findings can reach a wider audience. There is also a study under way in Finland. Thus, there is still a need for a larger-scale study to document the various types of abuse.

What are the reproductive health consequences of abuse?

The most commonly occurring and difficult problem is that of chronic pelvic pain, which is reported much more frequently in abused women. In our survey of abused women, it was found that 12% sought treatment from their family physician (6% in the control group), 6% went to a gynaecologist or outpatient clinic (1% in the control group) and 8% were hospitalized (2% in the control group) *(3)*. There are therefore significant differences between women with a history of abuse, compared with the control group.

The reasons why abused women suffer from chronic pelvic pain are still not fully known because there have been no thorough studies on the subject, although some studies have been published in the last five years. The findings would indicate that the possible causes are:

1. sequel after direct trauma to the pelvic region;
2. undiagnosed pelvic infections;
3. pelvic inflammatory disease;
4. depression (chronic pain is part of a depressive picture);
5. part of post-traumatic stress, including fragmentation of memory and flashbacks from triggers, where the trauma suffered is conveyed as somatic rather than psychological symptoms;
6. symbolic; and
7. protective (women have reported that they hoped their husbands would not rape them if they said they were in pain, though a number said they were forced to take pain killers).

Another significant, emerging area is that of the relationship between sexually transmitted disease and abuse. Research has shown that abused women are more likely to be hospitalized for the treatment of chronic pelvic inflammatory disease (20% of abused women compared with 4% in the control group) *(4)*. Pelvic inflammatory disease is therefore linked to abuse, and abuse in turn is a significant factor in the treatment.

Not only abusive relationships but also a history of child sexual abuse are clearly linked to pelvic pain, vaginal discharges and gynaecological surgery. According to the results of a study

in the primary health care setting, in which a primary care physician interviewed women about their abuse, one of the most astonishing findings was that abused women with a history of child abuse were four times more likely to have undergone gynaecological surgery than other women *(5)*. The interpretation could be that abused women visit their physician or gynaecologist without their history being revealed and the difficult causal web being disentangled. They may therefore be undergoing unnecessary surgery in some cases.

Other studies have also confirmed that abuse can lead to a higher incidence of genital infections – among a population of students, sexual abuse in childhood was clearly linked to pelvic pain and pelvic infections *(6)*. Abused women in intimate relationships are at a higher risk of genital infections for a number of reasons. There is a higher risk of sexual abuse within the relationship. Prior sexual abuse means that revictimization is more likely.

Further, abused women frequently fail to comply with treatment – in the light of case histories, even when instructed to take drugs by their physician, many women are afraid to take the drugs home for fear that their discovery would lead to accusations of having extramarital sex and further beatings. It is therefore difficult to treat abused women for genital infections. Also, women who have been declared HIV positive have been subject to violence when they have told their partners, and clinics now recommend that abused women should not be forced to tell their partners because of the dangers that this could incur.

Abusers are more likely to have multiple partners.

I turn now to the question of abused women and pregnancy. In general, maternal mortality has fallen significantly in developed western countries. It would seem inconceivable that pregnant women, who are almost sacred in many cultures, could possibly be at risk of abuse, but the reality is that, even when pregnant, women can suffer violence. Abused women are at risk of spontaneous abortions – this is well documented in case studies but also epidemiologically. The exact causes are not really known, but the psychological stress of living with an abuser and the direct trauma suffered might be the cause for the increased risk.

A number of studies have been conducted in the United States that document the prevalence of abuse during pregnancy. Outside the United States, however, there is only scattered information. In a study in Toronto in 1993, 7% of the women had been abused during pregnancy. In a study conducted in Brisbane, Australia, the figure was 9%; an ongoing study by a sociologist in Gothenburg in Sweden also cites a figure of 9% during pregnancy and the previous year, with violence being defined to include threats of abuse.

The main issues that arise in the case of pregnant women are whether they have control of:

- their sexual lives
- contraception
- the outcome of an unwanted pregnancy.

Abused women often report that they are either forced to have an abortion, or forcibly prevented from having an abortion. In other words, they do not have control of the situation.

Apart from some studies conducted in the United States, little research has asked how abuse affects the outcome of pregnancy. In a case–control study in Trondheim, 1.3% of women were estimated to be at risk of giving birth to a baby weighing less than 2.5 kg *(7)*. Thus, abuse

might be a risk factor in low birth weight, but the difference might also be due to chance. Other studies in this area have been inconclusive.

Nevertheless, case studies have documented that abuse can have affect maternal and infant health in a number of other ways:

- battered fetus syndrome;
- "abruptio placenta", where the placenta becomes partially detached from the wall of the uterus;
- premature rupture of the membranes;
- premature birth;
- genital infections; and
- intrauterine growth retardation.

Abuse can also have influence maternal and infant health in other, more indirect ways. An abusive partner may force a women into an unhealthy lifestyle during pregnancy. The main focus of antenatal care in the western world is lifestyle, the aim being for pregnant women to have a healthy lifestyle. Abused women are more likely to have an unhealthy lifestyle, with the control exercised by their partner affecting their access to antenatal care. In the Nordic countries, almost every woman attends an antenatal care centre. In the United States, the figures are lower; partly for economic reasons, antenatal care is less readily available, and it has been shown that abused women are less likely to attend. According to the findings of one recent study, abused women with a high level of education are a high-risk group for entering antenatal care at a very late stage. The interpretation must be that they are afraid of revealing that they are in an abusive relationship. This is therefore a very important element: failure to identify abuse may increase the total risk of ill health in both the mother and the newborn. If the physician is unaware of the abuse, this may result in ineffective treatment or, at worst, incorrect treatment.

What are the medical and legal consequences of abuse?

Gynaecologists encounter the problem of abuse in a variety of settings in the health care system: in the acute phase, working in a rape crisis centre, in the emergency room of the hospital or in the course of following up the victims of rape. Women may also present when they have difficulty in undergoing a routine gynaecological examination, because of fears of setting off triggers. Abuse may therefore be a cause of the presenting problem.

What is needed is a best practice model for rape victims. This could be the subject of a whole conference in its own right, as existing models vary very widely even among the Nordic countries. For example, Sweden has a hospital-based team for acute victims, programmes for abused women and national centres, while Denmark has none of these. A model with an integrated approach is needed to ensure medical treatment and the avoidance of revictimization. It is important to ensure that a medical examination does not put the woman at risk of being symbolically abused when she enters the medical system. A model is needed that can simultaneously handle the collection of forensic evidence and the provision of psychosocial support.

A recent study conducted in Trondheim related medical findings to the legal outcome. It concluded that the documentation carried out in the rape centre (reporting of severe violent acts, general injuries, documented genital injuries and the presence of sperm) did affect the

legal outcome, and such a case would be taken to court and a conviction secured. One surprising – and disappointing – finding was the role of any reported alcohol consumption: such cases would most likely be dismissed and not brought to court *(8)*. Although Norway may seem to be an enlightened society in many ways, the Norwegian courts are still prejudiced and still take account of the victim's credibility.

What are the future challenges?

To sum up, in terms of health service consequences, there are huge needs for education and the criteria for professional qualifications; there are organizational challenges in designing special integrated services, and there are a number of lessons to be learned.

As regards the educational challenges, programmes specific to the different professions must be designed. I know something of the frustrations of trying to teach physicians to deal with abused women, and only physicians can really define the aspects and cases that are important for them and their colleagues. Professional responsibility must be more clearly defined: the responsibility of nurses, for example, is different from that of physicians, social workers, volunteers and NGOs. All the relevant groups need to come together to define and delineate their various areas of professional responsibility.

The interaction between the medical and legal systems needs examination. There is a broad interface in documentation, but a special language may need to be devised to communicate more effectively. My impression of the legal system is that human beings are somewhere on the other side of the world. The medical and legal systems must work together more closely. In addition, it is important to address the question of attitudes to abuse, the skills involved in collecting forensic evidence while giving social support, and the improvement of the theoretical knowledge of the whole issue.

As to professional qualifications, the responsibilities of the different health care professionals need definition to establish borders and criteria. Is mere interest sufficient to work in this field? Specialized courses need to be incorporated into the formal training courses of the different professionals involved. In Norway, for example, all gynaecologists take a course in social gynaecology, including abuse and rape.

As for the organizational question of introducing special, integrated services, what is needed is a partnership between the health services and community-based services. I often tell the story of how I came to work in this field: in 1980 a group of women wanting to set up a shelter for abused women came to me, as the only female gynaecologist in a hospital, because they wanted to learn more about rape and abuse. Traditionally, interest in the issue of violence against women has come from outside the health system, although we really need to work together. It is also important to develop a very specific referral system within the hospital. In Uppsala, Sweden, for example, a specialized centre is based in the department of obstetrics and gynaecology. At the same time, low-threshold services need to be set up: places in the health care system to which women can address themselves without having to go to the police first, and without running the risk of being stigmatized through a formal referral.

Finally, looking at the lessons to be learned, violence against women is a very difficult area because so many different issues are entangled here. Rape is a trauma with medical consequences, including the risk of infection and mental health implications. One cannot address the medical aspects first and the mental ones later. They must be integrated. The most

important indicator of whether the victim will develop trauma later on is the way in which she is met by health care professionals. In the health care setting, there are no mental health workers.

Even though the abuse of women in intimate relationships is far more deadly than maternal complications in many parts of the world, this is not reflected in the status and priorities within the health care services. If this status were given, it might prevent further violence in the individual woman's life and prevent others from being abused. This is the bottom line for becoming involved in the field of abuse. In Sweden, 0–3 women die per year as a result of maternal complications, while 30–40 die as a result of violence. When compared with the efforts made in antenatal care, the lack of care for the victims of abuse just does not fit. Professionals' task is to make sure that it does fit.

Services for abused and raped women often rely on volunteer work by a few dedicated people. This situation has to change. The care of abused women must become an officially recognized task within hospital and community-based services, and it must be integrated within the health planning and administrative quality assurance procedures. I would like the Norwegian Board of Health, for example, to ask its counties what kind of services they provide, and, if they provide none, they should be required to set them up within a given time. The responsibility for ensuring that such services are available should be placed high in the health administration. Health services cannot solve the problem alone, but they can definitely make a difference for many women.

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Helping health services: report on a pilot project in Dublin

Monica O'Connor

This was an example of a community-based approach linked into the health care system.

Many years ago, I worked for seven years in a crisis refuge for abused women and their children in Dublin. During that time, one of the women who I was working with had been raped six days after her baby was born, and the doctor in question (an army doctor) had brought her back to the hospital and had to restitch her. I remember wondering why the doctor said did not ask how it happened, why or anything about her situation.

Fortunately, there has been a huge change in Ireland in the last 5–7 years. Health care professionals have at least begun to understand their responsibilities in the area of violence against women.

I have also been working on a government task force in Ireland, the first of its kind in the country, which has produced a comprehensive document on the Irish government's responsibility in handling the issue of gender-based violence in every section of society. Reaching that stage has been a huge success for the women's movement in Ireland.

What I am going to deal with today is a few points about the lessons I have learned as a trainer of health care professionals. I shall discuss the guiding principles of our work, where we start in terms of agreed analysis and understanding, and how ultimately we respect the rights of women who have experienced abuse.

The historical role of the women's movement in Ireland: solidarity

I am going to start, as I always do, by acknowledging the history of women's movement in the area of violence against women. I think it is an opportune time to reflect that we campaigned on the issue of gender-based violence in Ireland for 25 to 30 years. Based on my experience during that time, I think it is crucial for my work with health care professionals to understand that we cannot assume that people come from the same place. When one is training people (the police, health care professionals, etc.) and trying to understand their behaviour and their attitude, one cannot assume that they have a philosophy of respect for the autonomy and independence of women.

When we started, we were a very clearly apolitical activist movement whose main aim was the autonomy of women in Irish society. We saw male violence very much as a function of the control of women, necessary to control women's sexual and reproductive rights, and their economic position. In both the private and the public world, those two things were very closely linked. Domestic violence, rape and sexual assault began to be disclosed in the private world of the family. In that context, refuges and rape crisis centres began their work and began to respond to the needs of the women and children, who were constantly disclosing that this was happening in their lives. It is essential to recognize that many of the models of good practice came from that movement of women leaving home and coming to live in shelters. Models of good practice need to be re-examined in terms of how they deal with women. Models of good practice must be based on solidarity with and empowerment of women. Although these words are now almost clichés, they are an essential basis for the practice of all professionals, wherever they are placed, in responding to the needs of women.

When I started to work in the hospital I was quite naïve, and I went there with a very simple idea to work in obstetrics and emergency units. I had an idea that I could educate – I think the word educate is fundamental, and I will come back to that. What we succeeded in doing was facilitating safe disclosure in the hospital, creating a space where women could safely disclose abuse, and where we could record and document it, and refer women back into community-based services that are essential to good practice.

Attitudes and education

Nevertheless, I learned that changing the behaviour of systems and institutions, such as the police force, hospitals or social services, is one thing, but actually educating them on the issues is quite a different one. The first lesson I learned was that they did not come from the same place as I did. They did not share a feminist or structural analysis of the issue. Religious impulses had a huge influence on the medical profession in Ireland, and I am sure most of you are aware of the problems with securing reproductive rights in the last ten years and today. Two weeks ago, the government took a case to court on behalf of the fetus of a 13-year-old rape victim who was trying to leave the country for an abortion. The medical and legal professions went into court and tried to stop her leaving the country. They held her in the country for 14 weeks, until finally the Supreme Court decided that, because she was suicidal (this is the second such case), it would allow her to leave the country. If she had not been suicidal, she would have been held in custody in the health care system, and forced to continue a pregnancy that was a result of a brutal rape. This gives some idea about the background to our work of educating people about the issue of violence against women.

The other problem is that agencies can hold oppressive attitudes to women in general. When I was working with the police force last week, I was talking to a young woman police officer who is trying to deal with domestic violence calls in the station. She said that she could not take coffee breaks in the police station, because her male colleagues were playing pornographic videos during the breaks. She asked how she could deal with the situation. The attitude of the agency – in this case, the police – very much affects its response to abused women and their children.

The other major issue that I think we should look at in terms of developing good practice by health services is that the class, race, colour, legal status, and sexual orientation of the woman can have a very definite and serious influence on how she is treated. How the health services and other agencies perceive a woman – particularly her behaviour, her status, her respectability, her sexual history, whether she has been, in their terms, a good mother or a good wife – has a major impact on whether they view her as responsible for what has happened to her. A failure to address this issue leads to good practice and good response only to some women: those whom health professionals or the police perceive as not responsible for being abused.

Further, protocols and guidelines and the absolute need for professional responsibility can and should be clarified to everyone who is in a position to help abused women. Battered women are not a homogeneous group. They share the experience of male violence, but their lives and the contexts of their lives are as complex as those of all other women. I have seen the danger of labelling and stigmatizing women through the terminology used describe the issue of violence against women.

The need directly to address the problem of male violence

Another danger is that models of work based on a professional–client relationship can medicalize the issue of violence against women in such a way that the woman becomes the visible problem. The referral mechanism is very often to a psychiatric service. I have real problems with the idea that a woman who is seeking help in an abusive situation is being prescribed medication. Over 50% of abused women have at least some kind of contact with psychiatric services. This tends to have an extremely negative impact on their capacity to make decisions and to free themselves from violence. The issue of referral is a crucial one and must be addressed. That is why I want to look at the community-based approach.

If a woman comes from a dysfunctional family, or is undergoing family therapy, there may seem to be two problem people – the violent male partner and the woman – and this is a very risky road to travel. The notion of any kind of equality in a relationship where only one person has power and using violence is dangerous, and can result in all of the institutions dealing with the couple colluding in the violence. At that point, male violence becomes invisible. This is the problem that I have with any single-agency approach dealing only with the battered woman, because the batterer becomes invisible and so does the problem. I welcome the work being done with violent men, but connections between the legal and judicial systems, and the medical and health professionals must be maintained. I think the latter can play a very large role in enabling women to use the criminal justice system, but again I raise the problem that the judiciary – in my country certainly – comprises the professionals who hold the most oppressive attitudes to women, and yet women are expected to go to them to seek justice. While the work of dealing with health care professionals' attitudes towards gender and violence was difficult, similar work has yet to start in the judicial system.

Finally, it is my experience that all of the services that have not evolved from rape crisis centres and shelters underestimate women's risks of serious injury and homicide. I think one of the reasons is that workers in shelters deal every day with the level and impact of violence; nevertheless, I find a very serious lack of understanding of the risk faced by women of physical injury and even murder by an intimate partner. This seems to be very little acknowledged within the health care system, which sees the health consequences but does not recognize that the disclosure point is a very risky time. In the past two years, murders of battered women have risen to levels ten times any previous rate, and the vast majority of the victims have been murdered by their husbands, increasingly in the process of separation.

The community-based approach to abusers and the victims of abuse

One of the main features of our new project is to move back into the community. The hospital is usually the disclosure point, and we are working in a very big hospital in a local community that has a very sizeable marginalized population, with up to 80% unemployment and poverty.

One of the things we are doing is to focus on male violence as an issue for the community, in both education and institutions. We are looking at how the community deals with the male; that is the starting point: he is creating a situation of difficulty for the women of that community, and both community-based sanctions and legal sanctions are needed. We have therefore set up an interagency task force to examine the possible sanctions in a community and the law, before we begin to look at the issue of hospital disclosure. The police force is closely involved in this. The batterer's behaviour should deny him choices, freedom and power in the community, but in my experience the opposite happens. Very often, the violent male is able to use such services as marriage counselling, the social services and the legal

services. He automatically gets the best legal team, and in fact is organizing very well to increase his level of power, choices and freedom to operate within the community. All institutions must challenge this.

We are also working with the abused women in the community; here the community's role is obviously to give them power and to ease the impact of violence on them and their children. The role of a community, linked into the hospital, should be to enable the hospital to work with the legal and judicial system, but also to work with the community to protect the woman after disclosure, so that any disclosure that happens in the hospital can be linked to the dual system of sanctions for him and protection for her. We are just starting to document and evaluate whether women have found this approach effective. One of the problems in research (I have been involved in the research for a national study in Ireland for the last three years, and am about to start a new piece of research on the criminal justice system) is evaluation of the effectiveness of institutional responses to women in abusive situations. Have women found themselves to be safer, and to have more power, more choices and more freedom at the end of the interventions and the interaction with any of the systems from which she was seeking help?

Strategic approach to influencing health services in a city

Ms Sue Laughlin and Ms Siobhan McCartney

Ms Sue Laughlin and Ms Siobhan McCartney, Greater Glasgow Health Board, presented a national study on domestic violence.

The extent of domestic violence and its subsequent effect on the health and wellbeing of women makes it a significant public health issue with implications for health services. Extrapolations from the range of available studies suggest that between 260 000 and 700 000 Scottish women may be experiencing domestic violence.

The definition of domestic violence used for this report is: psychological, emotional and economic, as well as physical and sexual abuse of women by male partners or ex partners. Women who experience domestic violence are more likely than those who do not to have poor health, chronic pain problems, depression, addictions and difficulties in pregnancy, and to attempt suicide.

Domestic violence has serious effects on children. There is evidence to link perpetrators of domestic violence with physical and sexual abuse of children in the same family. A range of emotional difficulties have been identified among children in these families.

Women present to any of a range of health service settings, with primary care as a key first contact point, either as a direct result of domestic violence or where it is a factor in the presenting problem. The National Health Service (NHS) is not in a position to solve the problem of domestic violence but needs to define its role clearly. Making an informed assessment of the implications for the NHS requires consideration of both why and how women use different health service settings, as well as their experiences in using them.

Research in different health service settings has shown that there are a number of prerequisites for improving service delivery to women who have experienced domestic violence. These are as follows.

- attitudes to and knowledge of domestic violence vary greatly, affecting service delivery;
- protocol introduction may overcome these variables but the support of senior management is required for training (which explores attitudes to domestic violence and current practice of operational stuff);
- once agreement has been reached to introduce change, this needs to be communicated effectively to all staff members; and
- service providers need to consult on domestic violence with specialist services such as Women's Aid in order to set up appropriate training and to provide appropriate referral information to women.

Women with health problems related to domestic violence are potentially consuming large quantities of health service each year. If health professionals and the NHS as a whole could respond more systematically and effectively to women attending for health care, there is a potential to create either a better quality of service or to release some of resources for use in other, equally beneficial activities.

The NHS is part of society and an employer of large numbers of staff, the majority of whom are women. It is therefore likely that general prevalence rates for domestic violence will also be found within workforce, with consequent effects on the health of the individuals involved.

Maximizing health gain at a local level requires a national framework for action on domestic violence to support the activity of health boards and trusts. A multiagency approach is considered essential to ensure an improvement in the health of women experiencing domestic violence and the NHS could act as a catalyst for change with these other agencies. The NHS, with a major role in providing health care, has a similarly important role in referring women to other agencies and in working with these agencies on a common plan for effective intervention and support in the community.

Summary of recommendations

The current levels of knowledge awareness are such that action around domestic violence in a health service context have led the Scottish Needs Assessment Programme group on domestic violence to make the following recommendations.

1. Domestic violence should be adopted as a key health service issue, using the definitions and principles outlined in this report.

2. The Scottish Office, health boards, trusts and primary health care professionals should take responsibility for addressing domestic violence as a health service issue.

3. The Scottish Office should be responsible for the development of a national framework for addressing domestic violence that makes clear roles and responsibilities of local agencies.

4. Health boards should use their influence at the national level to ensure national policy and guidance on the issue of domestic violence.

5. All health care organizations should accept ownership of the issue at a senior level by and identify a lead officer to develop and coordinate planning. These should be matched in local agencies.

6. Locally appropriate systems should be devised for involving women who have experienced domestic violence in service planning and delivery.

7. Pilot projects should be set up to establish a national recording and monitoring framework and to develop a methodology for needs assessment.

7. Session 4. Addressing the issue of violence against women in war situations

chaired by Dr Annemiek Richters

Sexual violence in war: psychosociocultural wounds and healing processes: the example of the former Yugoslavia

Dr Annemiek Richters

Introduction: the need for a new language

The *Indian journal of gender studies* included recent articles on rape *(1)* and responses to sexual violence *(2)*. In combination, they signify for me that, historically, rape has been conceived as something self-evident in patriarchal societies, not warranting moral comment, but that the time has finally come when rape is being considered as a human rights issue as well as a health and development issue *(3)*. Because rape as a major form of sexual violence against women has been overlooked for so long, however, we are only beginning to understand what it means for women to be raped, what the causes and consequences are in various sociocultural circumstances, and how we should respond to rape in a curative as well as a preventive sense. One of the first steps to be taken on the way to such a response is the development of a language concerning the social and symbolic aspects of rape and the physical and psychological effects of rape for individual women.

In western societies, women have started to develop such a language during the last few decades. The question at issue for my contribution to a rethinking of the trauma of war is whether that same language is appropriate for the understanding of sexual violence in other sociocultural contexts, particularly in war situations, and subsequently what is the relevance of the western therapeutic approach to rape trauma in so-called times of peace to responses to the traumas of survivors of sexual violence practised in the context of recent wars.

I will address the questions raised by starting to point out some of the similarities and differences between the trauma of sexual violence in civilian life and in situations of war. Of the various forms of sexual violence – such as incest, compulsory nudity, electroshock to the nipples and vagina, suspension by the breast, mutilation of sexual body parts, vaginal or anal rape with objects, and the threat of such acts – rape conceived as forced vaginal penetration by a penis is singled out for discussion. Efforts to document wartime rape reveal that women are its overwhelmingly most frequent targets. Rape of men, however, proves to be more difficult to document, which means that we know less about it. Sexual violence against men raises different issues that merit attention. While in cases of rape of women the penis can be considered as just another rapid destruction weapon, in cases of castration the penis may be seen as, for instance, just another weapon to be destroyed. These and other specifics of sexual abuse of men are not considered here.

From the relatively few studies done on women's experience of sexual violence one can concluded that anyone who wishes to understand the effect the crime of rape has on women and who wants to support survivors in their recovery from the sexual trauma needs to take account of

the sociocultural environment in which the victim experienced the violence. In order to illustrate the kind of linkages that may exist between the social, cultural, political, psychological, physical and experiential aspects of rape in wartime, I have chosen to focus in particular on rape in the context of one specific conflict: that in the former Yugoslavia. With reference to a number of support programmes for traumatized women, I argue that such programmes should address those linkages and as such contribute to context-specific healing processes. I was not actively involved as an aid worker in the programmes discussed. My knowledge comes from my work as a consultant at a distance, talking with Dutch women who contributed to those programmes as trainers, and from written reports.

During the conflict in the former Yugoslavia I worked in Sarajevo for MSF (Médicins sans frontières – Doctors without Borders) from March to November 1994. During that time I laid the foundations for a mental health counselling programme by developing and coordinating a three-month training course and setting up five counselling centres, each run by a multidisciplinary group of ex-trainees. After my departure the programme expanded and was consolidated. Owing to unforeseen circumstances (not a rarity in Sarajevo at the time) the subject of women and war did not receive attention in the first phase of the MSF programme, as was originally planned. Besides, rape was not a prominent issue in Sarajevo at that time. This explains why direct references to my work in Sarajevo will be sparse in this paper.

A comparison between various aspects of rape in civilian life and in situations of war

The study of all forms of psychotrauma has revealed that the destabilization and reconstruction of meaningful structures is one of the primary psychological processes shaping the response process. A study of the struggle of a sample of women in the United States to make sense of their experience of being raped indicates, for instance, that their rape experience made them aware of the so-called little rapes that plague women on a daily basis. These are events that the women encountered before their rape (such as sexist jokes and pornography), but interpreted as negative only after the experience of actual rape, as a result of recognizing their similarity to the rape itself. The rape experience made the women realize that their living environment was full of the symbols of objectification and degradation of women, and laden with the continuing threat of repeated rape. A critical examination of that sociocultural context with its degrading constructions of women and sexuality enabled these women to stop blaming themselves, to acknowledge their victimization and to become angry. The women in the study associated this process with steps towards some resolution of the trauma *(4)*.

Most survivors of sexual violence in peace, as well as war, seek the resolution of their traumatic experience within the confines of their personal lives. As a result of the trauma, however, a significant minority feel called upon to care for other traumatized women or to engage in social action addressing wrongs in the wider world. Such people transcend their personal tragedy and focus instead on the general public order that, in their view, has been thrown out of gear and must be restored. In the process, emotions such as anger and a wish for revenge are often channelled into a desire for justice and, for instance, human rights activities. The sense of participation in meaningful social action, such as public truth telling or testimony, has proven to be a great help in handling the psychological problems due to the traumatic experience of violence, according to Herman *(5)* who writes about the United States. Her observations correspond with those of a study of Mayan Indian war widows in Guatemala *(6)*. The widows who were best off were those who began to comprehend the violence in political terms through participation in human rights agencies and women's groups.

During the last 10–20 years, public truth telling and testimony have resulted in the placement of sexual violence, formerly seen as a private event, on the political agenda. Simultaneously, knowledge has been generated about:

1. women's experiences of sexual violence;
2. sexual violence as a private and a public issue as well as a psychological and a sociocultural phenomenon; and
3. counselling and therapeutic approaches that should help women to cope with their sexual traumas.

At first the source of this knowledge lay primarily in the Western world – a world at relative peace during the last 50 years. It is only of late that more information has trickled in from other parts of the world; a development that was initiated by women's activism within the context of the international women's movement. It is even more recently that sexual violence in wartime has begun to get the attention it deserves. The public outrage in the west about rape in the latest Balkan conflict has resulted in numerous trauma or psychosocial projects directed at survivors of this crime, not only in the former Yugoslavia, but also in a selected number of countries in other parts of world. The problem is that remedies developed for abused western women are often transplanted in the form of trauma programmes to (former) conflict zones without understanding the complexity of the motivation of rape in war and without anticipating possible sociocultural differences in the response to sexual violation.

In general, the difference between rape per se in peace and in war seems to be only a matter of degree. Rape is used to regulate power relations between the sexes and/or between competing groups. Rape reminds women that they are vulnerable, are not equal with men and exist only by men's good graces. Even where rape is not an acute problem, terror of rape works symbolically to maintain or restore hierarchical order in society, that is to say, the kind of order that particularly benefits those in power. Rape confirms women's place as women; it confirms female powerlessness and male power *(7)*. Marcus *(8)* defines rape accordingly as a sexualized and gendered attack that imposes sexual difference along the lines of violence. Rapists do not beat women at the game of violence, but aim to exclude them from playing the game altogether. Rapists place women in a sexualized, gendered position of passivity.

According to a number of sources consulted by Seifert *(9,10)*, psychological and sociopsychological studies on rapists in civilian life come to the unanimous conclusion that rape is not primarily a sexual but an aggressive act. In the perpetrator's psyche, rape does not fulfil sexual functions. Rape has nothing to do with sexuality in itself but with power. It is an act of extreme violence implemented, of course, by sexual means. The source of satisfaction for the perpetrator is the humiliation and degradation of the victim and the feeling of power and supremacy. Offenders hardly ever talk about a sexual experience. Whether these findings concerning the psyche of the rapist also apply to wartime rape is, as far as I know, as yet not confirmed by systematic study among the attackers.

Thomas & Ralph *(11)* state that, in some documented instances of rape in war, the abuse appears to serve not only strategic or political functions but also the sexual proclivities of the attacker. One of the examples mentioned is the rape of so-called comfort women during the Second World War. What should be questioned, in my opinion, is whether and how the power-related social and symbolic aspects of wartime rape are linked to what goes on in the psyche of rapists. In what follows I will mainly focus on these social and symbolic aspects.

Characteristics of wartime rape

The use of the penis as a weapon of war has, with a few exceptions, always occurred in situations of violent conflict. Exact figures, however, are never available; neither, in most cases, are in-depth studies. What is new is not the practice of mass rape but the extent of its relatively recent publicity and the recognition of its human rights, development and health aspects. Of the latter rape's consequences for public health in an era of HIV are found particularly worrisome.

What is of interest in the case of former Yugoslavia is the fact that there were women who – because of their positions in politics, academia, science and the media, and because of their connections with women's movements all over the world – were able to make rape in war a political issue and to question the established, marginalizing explanations that had been offered. This happened at a time when women worldwide were preparing to get sexual violence against women on the agenda of the World Conference on Human Rights in June 1993 in Vienna.

In many wars, rape occurs on a massive scale and as a matter of orchestrated policy, although it may also occur in an apparently indiscriminate fashion and not in the service of an overarching strategic policy. A number of theses concerning the function and meaning of rape in situations of organized violence have been have been forwarded by Seifert *(12)*, Thomas & Ralph *(11)*, Card *(13)*, and others.

1. Orgies of rape originate in a culturally ingrained hatred of women that is acted out in extreme situations (rape as misogyny).

2. Rape has always been part of the rules of the game of war. It is a right mainly conceded to the victors (rape as reward).

3. In military conflicts the abuse of women is part of male communication. What counts is not the suffering of the women, but the effect it has on men (rape as terror). Rape can be considered the final symbolic expression of the humiliation of the male opponents who are not able to protect "their" women (rape as the messenger of defeat).

4. Rape is also a result of the construction of masculinity that armies offer their soldiers, and of the idolization of masculinity that is a concomitant of war in western cultures. In wars men graduate to manhood. Rape is used as a tool for initiation and social bonding (rape to boost morale).

5. Rapes committed in war are aimed at destroying the adversary's culture. Because of women's cultural position and their important role within the family structure they are a principal target if one intends to destroy a culture and community (rape to destroy a culture).

6. Rape can also be used in war propaganda to underline the gruesome nature of the enemy. This kind of propaganda is used by the holders of power to stir up hatred of the enemy and thereby get support for their war from their own people (rape as propaganda).

In each case of organized rape it remains to be seen which of the above theses apply. The case studies of organized rape that are available demonstrate that rape indeed is always an instrument to restore hierarchical order in society. The precise patterning of the function(s) and meaning(s)

of rape, however, can vary across cultures. What also varies is the way the trauma of rape relates to other traumas. More often than not, women suffer from multiple traumatization. What they experience as most traumatic can vary with their culture and depends on the intersection of factors such as gender, race, class, religion, ethnicity and nationality.

In the above six theses women are depicted as merely pawns in men's war games. A number of case studies from Latin America, however, teach that women can also be actively involved in fighting or opposing military regimes *(14–17)*. In these situations, rape can be used directly to punish women. It figures largely in patterns of punishment designed by military regimes specifically for women who are (perceived as) actively fighting against or in any other way resisting the oppression and exploitation visited upon their peoples by dictatorial governments. In this context, organized sexual violence against women often aims at restoring traditional gender relations in the community. Whether organized rape has a similar function in wars on other continents is a question to be addressed in future studies.

Rape in the recent conflict in the former Yugoslavia

In most descriptions and analyses of sexual violence during the recent conflict in the former Yugoslavia, all the motives for wartime rape discussed thus far are mentioned as playing a role, except the motive of rape as punishment for women's active role in the fighting. Women are portrayed as passive victims of men's war, and not as actors who played an active, immediate political role.

What was new in this conflict was that the parties used rape for the first time to solicit support for their cause not only from their own people but also from the outside world. In particular, news about the establishment of camps explicitly intended for sexual torture raised worldwide indignation. The media gave estimates of the number of women raped, in and outside those camps, ranging from 10 000 to 100 000. In the course of time, the worldwide media coverage of rape and other events and the cleverly orchestrated, biased information supplied greatly influenced the outcome of the conflict.

It has often been said that what was specific to this conflict was that ethnic rape was an integral part of the official policy in the genocidal campaign for political control and destruction of the other's culture. Serbs were portrayed as the main aggressors. Declarations by Amnesty International, Human Rights Watch and the Red Cross during the conflict, which indicated that all the warring parties were guilty of rape and that there was no particular system in Serbian activities, were generally ignored.

Unfortunately, the United Nations troops who were in Bosnia and Herzegovina to protect its people were guilty of misuse of women. There are reports of refugee women being forced to give sexual services to these troops in order to receive aid *(18)*. In Sarajevo it was a public secret that the United Nations troops had a brothel where young women would offer their services in exchange for food for their families. My informants did not seem to be bothered by this.

In the meantime, Brouwer *(19)* claims that all stories about Serbian rape detention centres have been refuted. Research confirmed that the number of well documented rape cases was much lower than officially reported. It is also now known that not only men but also women played an active role in providing biased information concerning rape. In short, many authors agree, women's assault was manipulated for political ends. The danger is that this manipulation, including deliberate acts of disinformation, may produce doubt about the credibility of women's

individual testimonies, cast suspicion on a lot of literature about the scale of women's abuse, and distract attention from the severity of the consequences of sexual violence for the abused women as individuals and for their families.

The effect of rape was often that women and their families fled with the intention never to return. Forcible impregnation resulted in infections (ranging from ordinary infections to HIV), physical trauma, induced abortion or childbirth, and psychological distress. Serb soldiers and paramilitary troops who raped women told them that they would give birth to "little Chetniks", or Serbian soldiers, who would grow up to kill them. Other Croat or Muslim women were told that if a woman carries a Serbian baby, then she, too, is a Serb *(20)*. Many women considered the fetus conceived by rape as "a thing", as "an unnatural body"; children conceived by rape were often abandoned immediately after birth *(21,22)*.

There have also been reports that soldiers on leave or ex-soldiers raped the women of their own ethnic group in the village or town where they live. Sometimes they excused themselves to the victims, reasoning that they as men had served their country and suffered at the front, so women at home should contribute to the war effort by letting men who deserve some catharsis use them. In addition, some women are raped by their own husbands; having come home from the front enraged, frustrated and often numb, these men vent their frustrations on their wives.

Further, women's bodies were supposed to serve the nationalist cause in other ways. In the Federal Republic of Yugoslavia (Serbia and Montenegro), women's reproductive rights, such as access to contraceptives and abortions, were no longer guaranteed. Legislation was proposed that, after the tenth week of pregnancy, required a pregnant woman to have a medical reason to get an abortion. Rape would not be an adequate reason. Nationalist ideology called for women to do their duty to the country by having more babies and willingly sacrificing their sons. Maternity came to be seen as an obligation, no longer as a free option for women. Many nationalists have seen restricting abortion as the most effective way of encouraging (or coercing) women to carry out their so-called responsibilities for national regeneration, not just by bearing babies but by bearing fighters *(23)*.

In sum, the collective anti-female violence during the conflict in the former Yugoslavia must be interpreted within the context not only of the destruction of the adversary's culture but also of the formation of national identities and conservative gender arrangements.

Rape and the trauma of conflict in Sarajevo

During the time I spent in Sarajevo in 1994, violence against women as a war strategy seemed not to be of immediate concern. Sniper fire and shelling came from positions outside the city. The siege of Sarajevo made it unlikely that women there would be assaulted by the besiegers by means of rape. One woman, who lived 30 m from the front, however, told me of her fear that the enemy would cross the front line and rape her. I do not know if anything of the kind ever happened or how widespread this fear was.

During the needs assessment phase of my work I was told about a special centre providing abortion to raped women. The women who used this service were raped by the enemy in the countryside. They came to Sarajevo through a tunnel. After about 60 women had been treated, the centre was closed. The reason given to me was that women who opted for an abortion experienced the threat of being stigmatized as a result of having to make use of that centre as a great barrier. The opinion was that raped women should be treated by regular services and come

for psychological support to the counselling centres that were open to everybody. At this point, one of my key informants, a female psychiatrist, stressed that an expert on women's position in society and on rape was essential in a future training programme.

As the conflict progressed, the number of refugees in Sarajevo increased rapidly. They must have been included women who had experienced rape. Being a refugee in Sarajevo, however, implied living with a number of losses, not just the loss of physical and psychological integrity due to rape. The struggle for mere survival in a town without many necessities of life appeared to be the first priority.

During summer 1994, when travelling in and out of town over land was a bit easier than before, a seminar on trauma (one of many) was held in Sarajevo with the participation of aid workers from other towns in Bosnia and Herzegovina. This time, the issue of rape triggered a fierce discussion. This was not so surprising, since people from other parts of the country had been more directly confronted with rape and its consequences. The general opinion was that raped women were the heroes of the war. Society should therefore have to learn how to deal with the stigma of rape. Women should be given the status of soldiers. That would signify their contribution to the war. Not much more was said about raped women, and soon the discussion moved to the children born as a result of rape. It was stressed that they should be given material support. Since adoption of children is forbidden in Islam, some participants thought that those children should be accommodated in a special centre. This raised great indignation from other participants. A separate seminar was called for devoted to this particular issue.

During the MSF training course in which I was involved, rape was discussed occasionally. Only in follow-up training sessions (in particular the ones given by Admira) was more systematic attention paid to the trauma of sexual violence. One of the things that struck me at the time was that the trainees found it inconceivable that Bosnian men were also guilty of rape. This issue was a taboo subject.

Women's support programmes for female survivors of sexual violence in former Yugoslavia

Feminists in Belgrade recognized that all the parties in the conflict were guilty of rape, while acknowledging that many more rapes were been committed by Serbian than by Croatian and Bosnian forces. They have maintained the position that all survivors of rape must receive care. On 8 March 1990, (International Women's Day) women in Belgrade founded the SOS Hotline for all Women and Children Victims of Violence *(24)*. In December 1992 women from the SOS Hotline started the Group for Women Raped in War. On International Human Rights Day, 10 December 1993, this group began the Autonomous Women's Centre against Sexual Violence. Women of the Centre analysed and responded to rape at the individual, social and political levels. Their goal was to meet the basic needs (including the emotional needs) of rape survivors, and to comprehend and condemn the use of sexual violence as a method to keep women powerless in society and as a political and military weapon. The Centre organized women's counselling, worked on women's rights campaigns, networked with different women's groups in the country and ran a continuing public campaign to "make sexual violence against women socially visible". An additional aim of the Centre was to maintain communication with feminists and activists contesting violence against women in Bosnia and Herzegovina and Croatia.

The feminist women in the Federal Republic of Yugoslavia refused to be victims, although some had been victimized. They decided to transform their powerlessness and despair into a feminist

women's movement of resistance to nationalism, militarism and sexism. Through their organizing and activism the women resisted being silenced and separated from those who have been defined as others, such as Croats and Muslims *(25)*.

What these women teach us is that the response to rape trauma should be comprehensive. Rape trauma is but one aspect of a conglomeration of traumas. The response was directed at not only psychological pain but also the social and cultural damage caused by the conflict. The women protested against the instrumentalization of women according to national interests, interests that were repeatedly redefined according to changing priorities. Women opposed to the policies of the regime (the "Women in Black") reclaimed the rhetoric of motherhood and used it against the imperatives of state nationalism and militarism. By doing so, they attended to not only the consequences for women but also the ideologies that fuelled the conflict. They must be considered pioneers in comparison to the women to whom Draculic *(26)* and Milic *(27)* refer. These authors *(26, 27)* contend women in the former Yugoslavia need to learn to take active roles, rather than passively waiting for the government to act, as they were trained to do by a system in which everything came from above. They must begin to define emancipation in their own terms, to defend their existing rights and to prevent the manipulation of women's bodies.

A different type of comprehensive, multidisciplinary support project for abused, raped and otherwise traumatized women was started in April 1993 in the Women's Therapy Centre Medica in Zenica, Bosnia and Herzegovina. The idea of the Centre was a combined approach of emergency gynaecology and psychological crisis intervention. Soon a general practice was added to the gynaecological surgery. Often women would first talk about their suffering with the doctors and nurses, who could then suggest a talk with the psychologist. The interdisciplinary cooperation meant that the medical staff had to learn the meaning and effects of trauma to avoid secondary traumatization. The inpatient psychological department gave women and children above all the opportunity to find some rest in a protective environment. In this setting, the psychologists could begin their counselling work of crisis intervention. It was soon recognized that, to build a new life, women would need a material base for their future. Gradually provisions were made that could provide this base.

In the so-called post-conflict period, the work started to focus more and more on long-term effects of trauma, as well as domestic violence and child abuse. The staff – 70 women of varied backgrounds in Zenica and 8 women in Cologne, Germany (in summer 1997) – developed many other activities that reach out into the field of women's rights and justice, including close cooperation with the war crimes tribunal in The Hague. Basically, however, the idea of combining medical and mental health in a caring and supportive environment still forms the kernel of the Centre *(28–31)*.

Multilateral cooperation and assistance

Women's projects in the former Yugoslavia as described above could only operate on the scale and with the intensity they did owing to financial and moral support from abroad and various kinds of expertise offered by foreign women's organizations. While the manipulation of women's assault by the media for political ends contributed to women's victimization, the same media attention resulted for the first time in history in special programmes to assist survivors of wartime rape in coping with their traumas.

The German gynaecologist Monika Hauser took the initiative for the Medica project in Zenica after she had seen reports in the international media about widespread rape in Bosnia and

Herzegovina at the end of 1992. In Zenica she met committed local women who were already actively helping the refugees. They immediately took up her idea of creating a centre for gynaecological and psychological care for women. Hauser was able to raise the necessary funds in Germany in a short time, starting with donations from friends, and could therefore make a quick start to realize her plans.

In the Netherlands, the Admira Society was founded in 1993 for the support of people and organizations in the former Yugoslavia involved in aid to women who were victims of rape and other forms of sexual abuse. As domestic violence strongly increased, owing to social destabilization resulting from the conflict, it was also included in the package. Admira could build on:

1. the specific methodologies, expertise and training capacity for aid to victims of sexual abuse and domestic violence developed systematically in the Netherlands over the last 15–20 years;
2. cross-cultural knowledge developed in health care for refugees in the Netherlands; and
3. Dutch experience with care for victims of persecution and warfare during the Second World War.

After a long period of preparation, concrete activities in the former Yugoslavia finally started in 1994. The delay arose partly because Admira, in contrast to Medica, went through official channels to fund a project that was unfamiliar to potential donors. In the meantime, funding has been guaranteed until the year 2000.

Admira concentrates on the dissemination of know-how concerning treatment and care for traumatized women and girls. Its pool of trainers comprises psychotherapists, social workers, organization consultants, medical doctors and a gynaecologist, all of them women. Admira initially offered support only to women's organizations in Croatia, Bosnia and Herzegovina and Serbia, including the Autonomous Women's Centre against Sexual Violence in Belgrade and Medica Zenica. Gradually, however, Admira started to offer training to the regular welfare and health care organizations and many foreign IGOs and NGOs that appear in practice to be rather insensitive to women's sexual traumatization, and do not know how to approach it.

The continuing support to women's organizations in particular is motivated by the view that the consequences of sexual violence for women and girls in the former Yugoslavia require continuous attention, particularly since violence against women has become a non-issue in the aftermath of the conflict for the governing bodies of the new states. A powerful women's movement is the only chance women have to keep the issue of sexual violence on the agendas of welfare organizations, the media and the authorities. Admira has therefore chosen a multi-track policy that includes support of learning processes aimed at conflict resolution and at democratic institution building, and advice on working with traumatized women and girls.

One of the experiences of Admira is that women who have lived through an authoritarian regime, the current political system and the latest conflict have hardly any experience of democratic principles and structures, feelings of individual responsibility, positive identities, notions of psychological and relational boundaries, the necessity to learn how to compromise, respect for and some acceptance of being different, and the acceptance of disappointment. Finding leaders or coordinators in the organizations often proves difficult. The hatred against authorities is so deep that women find it difficult to be leaders themselves or accept the authority of other women. They lack in-depth insight into power mechanisms, misuse of power and

complicated dependency patterns. This insight is needed for not only democratic institutional development but also an understanding of the effect that sexual violence has on its victims and the relationship between therapist and survivors of violence *(32)*.

Trauma programmes as learning experience

The proliferation of psychosocial and trauma programmes during and after the conflict in the former Yugoslavia was an entirely new phenomenon in the emergency aid response. Local health professionals recognized that they were unable to cope with the traumatized population. The problem was not only quantitative but also qualitative. The indigenous health professionals, as well as the population, were familiar with a medicalizing approach to mental health problems. With a few exceptions, care in the form of psychotherapy and counselling as known in western and northern Europe was unfamiliar territory. There was enough awareness, however, to welcome assistance in this field.

Most of the experts who flew in to offer psychological assistance were unfamiliar with the situation they encountered: its history, the political and economic system, former and current power structures, the health care system, the psychology of the local people differentiated by nationality, sex, age, religion, place of birth and traditional ways of coping with all sorts of losses. The various experts came in as part of a large-scale aid operation that, just like the conflict, albeit in different ways, perplexed people and disrupted relations between them. I perceived people's reaction to foreign aid given as a mixture of gratitude, resistance and sometimes anger. All this often raised many doubts in me about the purpose of my own work in Sarajevo and the way to proceed. It proved very difficult to share those doubts with other expatriates, who were busy saving lives in an emergency that left them no time for critical reflection about the relevance and possible negative implications of their deeds for the people and community concerned.

I encountered a somewhat similar attitude among the so-called experts in mental health who came for short visits to teach people some of the tricks of their trade. Of course, they did not come to save lives, and they knew that they had no quick fix to offer. In my opinion, however, they often underestimated the complexity of their mission: the profound gaps (hidden at first) in culture, psychological make-up, and moral outlook between themselves and the various groups with which they came to work. Such gaps existed before the conflict, but may have been deepened by it. Just like medicine, psychology is too often presumed to be a universally applicable science with the same results everywhere.

Because of continuous evaluation of the training sessions in the Admira project, some knowledge is being developed concerning the relevance and limitations of the approaches used and the repeated need for adjustments. Apparently the women in the different women's organizations supported by Admira very much appreciate the respect with which Admira trainers approached them and the working methods used. Instead of being told what they need and what they should do, they feel enabled to find their own solutions to issues that they themselves have identified as problems.

It is too early to judge, however, the impact of projects such as those of Admira and Medica Zenica in the former Yugoslavia. I am sure that much has been learned in the process thus far and that many women have benefited from the projects. What I regret is that no in-depth multidisciplinary evaluations have yet described what precisely has been learned thus far and what issues have been overlooked, from the point of view of various insiders and outsiders.

Many questions remain to be answered on all aspects of the projects presented. Only with some answers, no matter how preliminary they may be, can we start to discuss the possible relevance for other parts of the world of the kind of psychosocial and trauma programmes developed in the former Yugoslavia.

Multitrack healing and prevention of complex wounds

One reason for being cautious concerning the generalization of what has been learned about sexual violence related to the conflict in the former Yugoslavia is that we know little about how rape is perceived and experienced in various parts of the world, and how women living in different sociocultural circumstances have coped, successfully or unsuccessfully, with their experiences during the centuries.

We also know little about how women have managed to resist or prevent assault. To develop this knowledge, "survivorological enquiries" *(33)* need to challenge the one-sidedness of the victimology discourse. In the identification of physical, mental, sexual and reproductive health consequences of rape for women, we have to be aware of cross-cultural differences in, for instance: definitions of coercion and consent related to sexual behaviour, the place and meaning of sexuality in a particular society, idioms of distress, health-seeking behaviour, power relations between the sexes and obstacles to disclosure of information.

The trauma of wartime rape is often part of a conglomerate of traumas with long-lasting consequences. What these consequences will be in the former Yugoslavia we can only guess for the time being. A study of Ugandan women who were teenagers during the last conflict (ending in 1986) showed that their war experience included losing parents, becoming refugees, rape, forced early marriages, domestic slavery, participation in war as combatants and dropping out of school. This meant that most of these girls had such a bad start in life that traumatic events kept happening to them after the conflict. Not having family and/or kinship protection, for instance, made life difficult for those women, particularly socially. For them, the reconstruction of communities by the church, and their reintegration in such a community may have more priority than support as envisioned in western trauma therapy (M. Mugyenyi, unpublished data, 1997). After, all rape was only one part of the traumatic events they suffered.

The case studies at least make clear that support by health workers to trauma victims, in particular after the emergency phase is over, should be integrated in more comprehensive, interdisciplinary projects for sustainable development and the promotion of human rights. An in-depth knowledge of the culture concerned is required to establish priorities in psychosocial relief programmes *(3,34)*. In a refugee camp in Kenya where I participated in an assessment study concerning the possibilities for a psychotrauma programme, a female leader told me that the women needed good gynaecological services, not psychological support. I should have explored the rationale for this request further, but in the relatively short time available I kept focusing on the psychological consequences of war trauma *(35)*. With the wisdom of hindsight, I consider this a mistake.

General guidelines for intervention in the area of sexual violence and women should be adapted to particular sociocultural contexts on the basis of long-term action and participatory research that take account of the gender dimensions of the culture and society concerned before, during and after war. Nevertheless, one should not see gender as the unifying element of the community of all women, since issues pertaining to class, nationality, race, ethnicity, religion or sexuality

usually intersect with those of gender. All influence the role that sexual violence plays in the different phases of conflict, and the experiences of women (and men) of sexual violence.

My last note of caution concerns the new language that is needed to understand rape in all its complexity and to craft remedies that are responsive to this understanding. This language should contribute to exposing and thus strategically demobilizing the cultural scripts that perpetuate the fiction of the unassailably powerful penis and constitute women as always powerless and vulnerable to rape in civil life *(8,13,36)* as well as in war *(7,37)*. A deconstruction of these myths can help development organizations to facilitate processes that lead to women's empowerment in society and to realizing women's potential to contribute to conflict resolution and prevention. This in itself may be an important contribution to the healing of rape trauma and the prevention of wartime rape.

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Immediate appropriate medical answers to women victims of sexual violence in refugee situations

Dr Daniel Pierotti

Introduction

Reproductive health for refugees or internally displaced populations has been overlooked for a long time, as it is not considered as such a vital issue as shelter, food, clean water and prevention of epidemics. nevertheless, prenatal care, safe delivery and infant care have always been provided for refugee and internally displaced populations. More recently, condoms began to be provided, as well.

The concept of reproductive health was developed during the 1994 population conference held in Cairo. It consists of an overall approach covering the following themes:

- prenatal and postnatal care
- reduction of childbirth risk
- screening for and prevention of STDs
- appropriate family planning methods
- promotion of responsible sexual behaviour among adolescents
- treatment of abortion complications
- prevention and treatment of sexual violence.

Sexual violence in refugee situations

Sexual violence is a very complex issue. Sexual violence is unfortunately inherent in any situation of warfare or conflict. Women are its prime victims and rape is the most atrocious form of sexual violence.

Sexual violence has always existed. As a result, the International Planned Parenthood Federation (IPPF) launched a programme of mini-abortion by menstrual regulation, which appeared more acceptable to the local authorities than the traditional curetting methods.

The occurrence of organized rape appears to have increased recently, partly as a result of the proliferation of regional and internal conflicts, but also owing to the speed of media communications, which report such atrocities worldwide practically as they occur. In many situations, military authority disintegrates with a loss of control over the behaviour of troops, who may quickly reorganize as armed militias or groups of bandits looking for any opportunity for fast money and immediate pleasure, far from any political, religious or ideological goal. Rape may be used in a systematic way as a symbol to demoralize and render enemies insecure. Often, however, it is simply a question of opportunities, domination, imposing oneself on vulnerable prey.

During a conflict, sexual violence is a constant factor in a refugee situation at the time of the exodus, during the establishment of camps and within the family and community. Violence may be brutal and direct, may take the more insidious forms of forced prostitution or sex for services, or be hidden under different forms of intimidation. Rapists may be soldiers, members of the community or family, or even the people in charge of protecting the refugees.

In some situations, the problem has become so serious that it has been necessary to set up a special programme for the protection and defence of raped women. Such was the case in the Somali refugee camps in northern Kenya (Dadaab), where in 1992 the Office of the United Nations High Commissioner for Refugees (UNHCR) set up a programme of assistance to women who were the victims of violence. In the conflict in the former Yugoslavia, one NGO, Marie Stopes International, having difficulty identifying raped women, came to the conclusion that rape, however dramatic and degrading, represented only one trauma among many others, such as the death of the husband, dispersed children, sons at the front, departure from the country, destruction of the home, and loss of job and resources. All these factors created a series of traumas, in which rape was only one element.

One response consisted in opening special centres (women's homes) for refugee women. These centres gave women an opportunity, in a place designed with them and for them, to start to recover by helping each other. As an accompanying measure, specialized medical and psychological assistance was available for those who needed it.

In 1995, UNHCR issued a guide on the prevention of and responses to sexual violence. The various aspects of this approach are now well known and include a variety of means of protecting women, guaranteeing their rights, defending them in court and offering them appropriate medical responses. One of the most promising advances was made in the form of a 1993 report by the United Nations Secretary-General to the Security Council, which extended crimes against humanity to include systematic rape against civilian populations. It may be remembered that planned, systematic rape is recognized as such by the international tribunals for the former Yugoslavia and Rwanda. WHO has just published a manual on the mental health of refugees, in which a chapter deals with responses to rape victims.

While rape is always a tragic event, in some cultures the psychic trauma of rape may be aggravated by rejection by the husband or father, the family at large and the community. Sometimes suicide may appear the only way out.

The purpose of this presentation is to look in detail at the medical and surgical response to rape in refugee situations. One of the major problems for a woman who has been raped is to establish a personal contact with a health professional who can help her. This is a difficult step to take, requiring a great deal of courage and the active support of relatives and women's groups before the women concerned will accept being identified as rape victims. In fact, there are five major problems: time, the laws of the host country, the sensitivity and training of health personnel, the availability of medical supplies and correct information on the type of and access to services for the women.

Protocol for medical consultation in case of rape

Usually women do not want to be identified as victims of rape (for every raped woman consulting, ten more will never dare to come). Suitable treatment responses now exist to answer and adequately orient women regarding information, medical examinations and the treatment and prevention of STDs. Access to these services should be facilitated.

Medical consultations should be treated confidentially, anonymously and as part of regular reproductive health services. A relationship of mutual trust must be established between the woman concerned and the medical personnel.

It is essential to recruit female staff to assist women. One staff member, at least, should be fully trained and acquainted with the medical treatment protocols for rape. All staff should be sensitized and trained to be able to identify, answer and adequately inform the victim.

The woman should be received and examined as soon as possible. She should be referred to a specialist if the medical officer in charge is unable to deal with this type of patient. Let us assume now that women know about the services available, agree to use them and use them in the period when medical treatment may act efficiently.

What kind of medical services can we offer to raped women in such a situation?

The health provider confronts with a multiplicity of issues. First, rape is an emergency and a tragedy that necessitates the full attention and care of the professional health staff. From the start, the woman should be reassured: she is the victim and deserves full respect from her family and community.

In medical terms, the health provider could help by using the following classical protocol within a three-day period after the rape. The usual protocol consists of:

1. taking the history of the event
2. making a general examination
3. performing a gynaecological examination
4. taking vaginal swabs
5. collecting all elements of evidence
6. treating any potential STDs
7. providing emergency contraception

The key measures to focus on are:

1. repairing the tears and other genital injuries
2. avoiding unwanted pregnancy
3. treating potential STDs
4. delivering a medical certificate.

Repairing lacerations or genital tears should be done in a surgical environment after complete assessment of the injuries.

Preventing unwanted pregnancy will consist of proposing emergency contraception under the following forms and conditions. Emergency contraceptive pills (ECPs) can be taken within 72 hours after unprotected sex (Table 7).

Table 7. Options for emergency contraceptive pills

Type of pill	1st dose	2nd dose (12 hours later)
Combined-pill regimen:		
IPC4: 50 mcg of ethinylestradiol + 0.5 mg of levonorgestrel	2	2
30 mcg of ethinylestradiol + 0.15 mg of levonorgestrel	4	4
Progestin-only regimen:		
Postinor2: 0.75 mg levonorgestrel	1	1

Note: It should be remembered that regular micro-dosed combined contraceptive pills could be used if nothing else is available, by taking 4 pills together then 4 more 12 hours later.

An emergency intrauterine device (IUD) should be inserted by a trained health care provider within 5 days after unprotected sex (only for women who meet normal IUD screening criteria).

Third is treating potential STDs, by giving doxycycline tablets 100 mg twice a day for 7 days, together with metrodinazole tablets 250 μg twice a day for 10 days.

The final task is delivering the medical certificate to the woman and liaising with security staff to start legal procedures.

What about the issue of abortion?

Any health provider may receive raped women requesting an abortion.

Abortion is in no circumstance a contraceptive method. Only in cases of medical and surgical emergency are physicians expected to complete abortions that have already been started or to treat ensuing complications. This general policy was ratified at the 1994 Cairo conference. Nevertheless, an abortion should always be carried out in the safest medical environment and using the most appropriate method (manual aspiration should be made available).

Where refugees are concerned, international agencies and NGOs always comply with the laws and policies of the host countries. There are no legal provisions for female refugees who have been victims of rape. During the conflict in the former Yugoslavia, abortion was legal. A woman wanting an abortion could obtain it if the material circumstances and the medical facilities were such that it could be performed in conditions of safety and good care. On the other hand, raped women in Kenya or Zaire desiring an abortion are confronted with only two alternatives: either continuing an unwanted pregnancy resulting from rape, or undergoing an abortion conducted illegally and too often unsafely, outside a safe medical environment. In such cases, when complications arise, the woman becomes an obstetrical emergency and may require medical/surgical treatment.

Let us look now, at the laws on legal abortion country by country (190 in total) by taking two specific aspects:

- abortion permitted to save the life of the pregnant woman
- abortion permitted for victims of rape or incest.

The law in each country varies. The information on abortion policies published in 1994 by the United Nations Department for Economic and Social Information and Policy Analysis has reviewed the grounds on which abortion is permitted. Worldwide, out of 190 countries:

- 173 countries (91%) permit an abortion to save the life of the women
- only 81 (42.6%) permit an abortion for a victim of rape or incest.

An analysis of the situation region by region reveals tremendous discrepancies (Table 8). There is clearly no equity or common treatment worldwide for raped women to obtain a legal abortion, and the situation varies from country to country. Ideally, in all countries, rape should be dealt with in the same way as attempted murder. As a consequence, voluntary safe abortion following rape should be systematically available as an alternative for women, who would be free to choose, as is the case in countries where abortion is legal.

Table 8. Countries where abortion is allowed to save the life of the woman or for victims of rape/incest

Region (number of countries)	To save life	Rape/incest
Africa (53)*	48 (90.5%)	12 (22.6%)
Asia (46)	43 (93.4)	18 (39.1%)
Europe (43)	42 (97.6%)	33 (76.7%)
Americas & Caribbean	32 (96.9%)	23 (65.7%)
Oceania	12 (92.3%)	2 (15.4%)

Conclusion

There is still a long way to go to deal with the medical issues in connection with rape in a proper, immediate and efficient way. There is still some reluctance to consider rape as an emergency and a human tragedy, although the situation is beginning to change. For the first time, the 1998 revised version of emergency health kits designed by specialized international agencies and NGOs have included emergency contraceptive pills in individual packages. UNFPA is providing a specific kit for sexual violence, including emergency contraceptive pills and antibiotics for STDs.

Emergency contraception should be available and provided through sensitized health staff. Women should be informed of the availability of these services. Post-rape protocols should be generalized. The attitude of health personnel should change. Rapes always exist in a conflict situation; health personnel should not disregard or minimize them. When legal, abortions have to be performed safely, and complications arising from abortions must be treated like any other emergency. We may expect that in the future women will be able to utilize emergency contraception in non-conflict situations through their regular family planning programme. They will then know about emergency contraceptives and will not hesitate to request – even demand – appropriate services.

Of course, the immediate medical approach after rape represents only one aspect of the whole issue of rape. Other aspects include: developing preventive protection measures, organizing and involving the whole family and community in protecting their most vulnerable members from sexual violence, pursuing the perpetrators in the courts, providing income-generating activities for women and, last, including as a priority the treatment of the long-term effects of rape in the rehabilitation phase of social and health programmes.

Management of rape victims

Patients need to be seen as soon as possible. They should be seen by a fully registered government medical practitioner, if possible together with a junior doctor. If any specific problem arises, so that the registrar/government medical officer is unable to deal with the case, the patient should immediately be referred to a gynaecologist.

Management of recent rape victims (< 24 hours)

The physician should:

- see the patient in hospital;
- put in writing the whole history, examination and treatment on the outpatient card in addition to filling in the rape form; and
- provide a rape kit.

If a kit is not available, the physician still needs to see and treat the patient, and can take an ordinary high vaginal swab (HVS).

The history should include questions as to:
- when the rape occurred
- how many times
- whether penetration was thought to have occurred
- whether ejaculation occurred
- time of last menstrual period, sexual activity other than rape
- contraception
- any injury, bleeding etc.

The examination should be:

1. general: checking for injuries and general state;
2. gynaecological: checking for evidence of genital injury (bruises, scratches, abrasions, cuts), which includes:

    - if the patient is not sexually active, checking whether the hymen is intact, and for present, recent or old tears;
    - if the patient is sexually active, checking for tears;
    - checking the anus;
    - checking for evidence of infection, ulcers, vaginal discharge;
    - taking HVS;
    - doing vaginal swab two times (provided by rape kit) for presence of sperm;
    - offering to check for HIV.

The rape kit contains:
1. plastic bags for soiled clothes (obviously only to be used if patient has a change of clothes);
2. external and internal swabs (these should be taken on the vulva and inside the vagina, respectively; the swabs need to be smeared out on the glass slides and these should be air-dried; the swabs themselves are replaced in the plastic tubes and kept (sent back to police));
3. bag for pubic hair combing (combing might retrieve as any pubic hair of the rapist);
4. bag for nail scrapings; and
5. blood bottle for grouping of victim/DNA typing if available.

All this should be given to the investigating police officer.

Treatment should include the following:

- even if there is no evidence of infection, give doxycycline 100 mg x 7/7 Merrorddazole 200 mg tid 7/7); and
- if there is any evidence of infection, treat as deemed necessary.

Postcoital contraception to all patients at risk of pregnancy includes 2 doses of 4 tablets each of Lofeminal 12 hours apart (give 4 exam tablets in case of vomiting).

Patients should have a withdrawal bleed a few days after this treatment. The doctor should review the case 7–10 days later, and, if no bleeding has occurred, arrange for pregnancy testing. The doctor should offer termination of pregnancy if positive, following a court order. If the pregnancy test is negative, the doctor should review the case 2 weeks later, and, if there is still no bleeding, repeat pregnancy test.

An IUD can be inserted within up to 7 days if no evidence of infection. This can be done at any family planning clinic in the major centres.

Patients raped over 24 hours ago:

- should be seen in OPD;
- should have postcoital IUD inserted immediately if this is the method chosen;
- should have their history taken, etc. as above;
- should be offered treatment of any infection;
- if pregnant, should discuss possibility of termination of pregnancy (a court order can be issued very quickly to authorise this in closed chambers by contacting the prosecutor general); and
- should be followed up.

All patients should be reviewed 1 week after the initial visit to check for infection (especially VDRL – Syphilis nonvenereal test), conduct pregnancy tests, etc. The doctor should offer adequate family planning.

Patients raped over 7 days ago:

- should be seen in OPD (no need for vaginal smear, pubic hair combing, nail clipping);
- should be offered RIV testing and should receive VDRL, HVS if infection is present;
- should be offered pregnancy test and/or contraception as appropriate;
- if pregnant, should discuss possibility of termination of pregnancy;
- should be followed up.

All patients should be reviewed 1 week after the initial visit to give HIV results in OPD, check whether infection appropriately treated, etc.

Normally, patients should always be accompanied by a police officer, who should take the rape form and rape kit back to the police station. If there is no police officer, the doctor should examine the patient and treat as appropriate, but request the investigating police officer to collect the forms and rape kit.

In all cases, where possible, the doctor should arrange for psychological support and counselling for the patient.

The Khujand Women's Centre "Gulruxor"

Ms Sanavbar M. Sharipova

Ms Sanavbar M. Sharipova presented the case study of a crisis centre in Tajikistan.

Why is this programme important?

Women are among those who have suffered most in the economic crisis in Tajikistan since the break-up of the USSR and the civil conflict of 1992. The symptoms of the crisis include worsening health, unemployment, depression and marital breakdown. The decline in security has led to a growth in rape cases without any help or legal advice available for victims. There is a lot of confusion and misunderstanding about violence – what it is, who suffers from it, who commits it and why. Women experience violence regardless of their social group, class, age, race, state of health, sexuality and lifestyle – it knows no boundaries. Domestic violence can take a number of forms such as physical assault, sexual abuse, rape and threats. Women have nowhere to go to find help with these problems. The project expected to allow the women using the Khudjand Women's Centre to solve some of the basic problems that prevent them from developing as productive members of society.

How does the programme work?

The Centre is run by women for women. The main target group of the project are women with limited access to basic social services. The aim of the Khujand Women's Centre is to ensure that as many women as possible receive support, assistance and practical help, so that they can assume their rightful and productive place in society. The Centre offers counselling, advice, phone and face-to-face counselling to women and girls who have been subjected to violence. This counselling empowers women to take control of their own lives. The service is involved in campaigns that aim to raise awareness of the issues surrounding violence against women. The Centre also offers a comprehensive training package for any women's group, family planning advice and marriage and legal counselling, and regularly delivers leaflets and fact sheets on important problems. All help given is free and confidentially.

Project components include:

- rape crisis services (hot-line, psychological and legal counselling), a new type of urgent medical assistance and advice to the victims of rape;
- family planning services;
- marriage counselling;
- legal advice;
- research on gender issues; and
- publications and information.

Significant results include the following.

1. Hot-line and face-to-face counselling are absolutely new form of services in Tajikistan, and save a great number of women from possible depression.

2. Family planning services help to increase family stability.

3. Marriage counselling helps to reduce the number of divorces and to prepare young couples for the responsibilities of parenthood.

4. Seminar networking helps to solidify regional women's cooperation and specifically led to the formation of the Women's Discussion Club.

5. Tests administered before and after the training show that participants scored an average rate of improvement of nearly 65%.

6. Surveys conducted by social workers and volunteers identified the main basic needs of women. The comments were published in the local newspaper. Regular surveys will be made amongst the female population of Khudjand to ensure that the Centre continues to meet real needs.

7. Specialists and the members of the Centre have compiled a list of suggested legislative changes on women's issues and forwarded it to the local government for review.

8. Information is a vital element of the project. Simple brochures (giving basic information about the Centre) and fact sheets reach a larger population than through direct contact at the Centre.

The challenges and prospects for the future are:

- to extend the activity of the Centre, and encourage the establishment of small women's groups throughout the region;
- to cooperate with various government authorities, particularly with the departments of health, social affairs and justice;
- to publish a magazine discussing research, studies and statistics relating to women's activities in the region;
- to set up and develop a refuge, which will provide support, practical help and short-term accommodation for women escaping violence; and
- to present special programmes on women's issues on local television.

Annex 1

Documents showing WHO political commitment in the field of violence against women

1. *International Conference on Population and Development (IDPD) 1994. Summary of the Programme of Action of the ICPD*. New York, United Nations, 1995.
2. *User-friendly guide to health issues in the Beijing Declaration and Platform of Action (Fourth World Conference on Women 4–15 September 1995)*. Geneva, World Health Organization 1996 (document WHO/HDP/96.2).
3. WHO Regional Office for Europe. *Manual of women's health institutions in Europe. Women's Health Counts: First European Meeting on Women's Health Institutions, 22–23 September 1995*. Vienna, Ludwig-Boltzmann-Institute for Health Psychology of Women, 1995.
4. *Highlights on women's health in Europe*. Copenhagen, WHO Regional Office for Europe, 1995 (document).

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