

TJ 1.2

## VIOLENCE AGAINST WOMEN: THE MISSING AGENDA<sup>1</sup>

By: Lori Heise

There are two experiences that unite women across culture and class, those of giving birth to new life and fear of male violence. Violence against women is perhaps the most pervasive yet least recognized human rights abuse in the world. It is also a profound health problem sapping women's physical and emotional vitality and undermining their confidence--both vital to achieving widely held goals for human progress, especially in the developing world.

As yet there is no universal agreement on a definition of violence against women. At its most basic, gender violence includes any act of force or coercion that gravely jeopardizes the life, body, psychological integrity or freedom of women in service of perpetuating male power and control.<sup>1</sup> Included here would be rape, battery, homicide, incest, psychological abuse, forced prostitution, trafficking in women, sexual harassment, genital mutilation, and dowry-related murder. Also relevant would be various forms of medical violence such as gratuitous cesarean sections and forced sterilization.

A more expansive definition would move beyond individual acts of violence to include forms of institutionalized sexism that severely compromise the health and well-being of women. This wider framework includes discrimination against girl children in food and medical care, female foeticide, lack of access to safe contraception and abortion, and laws and social policy that perpetuate female subordination.

This chapter explores a subset of these abuses to help frame violence against women as an issue worthy of international action and concern. It details what we know about the prevalence and impact of different forms of violence and relates violence to issues already high on the international health agenda. Most importantly, the incredible amount of energy that third world women are investing in mobilizing against abuse. In multiple ways, women are saying that safety is a priority for them and they are acting on that conviction--setting up crisis centers, seeking law reform, and challenging the sexist attitudes and practices that undergird male violence.

### Domestic Violence

The most endemic form of violence against women is wife abuse, or more accurately, abuse of women by intimate male partners. Study after study has documented severe and ongoing woman abuse in almost every culture of the world save a handful of small-scale societies where wife beating occurs only rarely<sup>2</sup> (Levinson 1989; Counts et. al. 1991). While surveys document that women also hit men on occasion, it is usually in self-defense. The vast majority of injuries resulting from domestic violence are borne by women (Gelles and Cornell, 1990).

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<sup>1</sup> This article will appear as a chapter in Women's Health: A Global Perspective. Edited by Marge Koblinsky, Judith Timyan and Jill Gay. Forthcoming from Westview Press in 1992.

concern (See table 1.1). In the United States, for example, former Surgeon General C. Everett Koop (1989) estimated that 3 to 4 million American women are battered each year; roughly half of them are single, separated or divorced. Population-based surveys suggest that between 21 and 30 percent of U.S. women will be beaten by a partner at least once in their lives (National Committee 1989). Battering also tends to escalate and become more severe over time. Almost half of all batterers beat their partners at least three times a year (Straus et al. 1980).

A similar countrywide estimate is available for Colombia, which recently completed a national study of family violence as part of its Demographic and Health Survey (DHS Colombia 1991). The study shows that one out of every five Colombian women have been beaten by a partner; one out of every three have been emotionally or verbally abused. In Papua New Guinea (PNG) comparable figures are even higher: 67 percent of rural women and 56 percent of urban women have been physically abused, according to a survey conducted by the PNG Law Reform Commission (Bradley 1988a). And in Norway, 25 percent of female gynecology patients have been physically or sexually abused by their mate (Schei and Bakketeig 1989).

Table 1-1. Prevalence of Domestic Violence, Selected Studies<sup>a</sup>

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- o In Papua New Guinea, 67 percent of rural women and 56 percent of urban women have been victims of wife abuse, according to a national survey conducted by the PNG Law Reform Commission (Bradley 1988a).
  - o In a detailed family planning survey of 733 women in the Kissi district of Kenya, 42 percent said they were beaten regularly by their husbands (Raikes 1990).
  - o In one study of 109 households in an Indian village, 22 percent of higher caste husbands and 75 percent of Scheduled Castes (lower) husbands admitted to beating their wives. The Scheduled Caste wives reported that they were "regularly beaten" (Mahajan 1990).
  - o A survey done in Santiago, Chile indicates that 80 percent of women have suffered physical, emotional or sexual abuse by a male partner or relative; 63 percent report that they are currently being abused (Molledo 1989).
  - o A statistical survey conducted in Nezahualcoyotl, a city adjacent to Mexico City found that one in three women had been victims of family violence; twenty percent report blows to the stomach during pregnancy (Valdez Santiago and Shrader Cox 1991).
  - o A study, using children as informants, reported that 57 percent of wives in San Salvador were beaten by their husbands (Cañas 1990).
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The health consequences of such violence are immense. In the United States, battery is the greatest single cause of injury to women, accounting for more injury than auto accidents, muggings and rape combined (Stark and Flitcraft 1991). It also provides the primary context for many other health problems. Battered women are four to five times more likely to require psychiatric treatment and five times more likely to attempt suicide than non-battered women (Stark and Flitcraft 1991). About a third of battered women suffer major depressions and some go on to abuse alcohol or drugs.<sup>3</sup> Studies show, however, that most battered women begin to drink only after the onset of abuse, suggesting that women are using alcohol to escape an intolerable situation (Amaro et. al. 1990; Stark et. al 1981)

Data from developing countries also highlight a link between violence and health. A study from Lima, Peru documents that one out of every three women in the city's emergency rooms are victims of domestic violence (Byerly 1984). A United Nations case study on wife abuse in China reports that domestic violence is the cause of 6 percent of serious injuries and death in Shanghai (Wu Han 1986). And 18 percent of all wives surveyed in urban areas of Papua New Guinea had received hospital treatment for injuries inflicted by their husbands. As Christine Bradely (1988b) of the country's law reform committee observes, "In PNG where many women have enlarged spleens due to malaria, a single blow can kill them." Health professionals have not begun to contemplate what other conditions may act synergistically to exacerbate the impact of violence in Third World countries.

Indeed, one should not underestimate the lethality of violence against women. Through both forced suicide and murder, gender violence kills. After reviewing evidence from the United States, for example, Stark and Flitcraft (1989) conclude that "abuse may be the single most important precipitant for female suicide attempts yet identified."<sup>4</sup> One out of every four suicide attempts by women are preceded by abuse, as are half of all attempts by African American women (Stark 1984). A cross cultural survey of suicide by Counts (1987) draws the same conclusion, positing that in some Oceanic societies, female suicide operates as a culturally recognized behavior that enables the "politically powerless...to revenge themselves on those who have made their lives intolerable." Counts finds support for her argument in cultures from Africa, Peru, Papua New Guinea and other Melanesian islands. Among Fijian Indian families, for example, 41 percent cite marital violence as the cause of their loved one's suicide (Haynes 1984). Nor is suicide an inconsequential form of death. In Sri Lanka--a country with reasonably accurate mortality statistics--the rate of suicide death in young women aged 15 to 24 is five times that from infectious diseases and 55 times the rate of obstetric related deaths (WHO 1985).

The relationship between domestic violence and homicide, however, may be even more profound. In Bangladesh, for example, assassination of wives by husbands accounts for 50 percent of all murders (Stewart 1989). In Canada, 62 percent of women murdered in 1987 died as a result of domestic violence (Canadian Centre 1988). And in Papua New Guinea, almost three-fourths of women murdered were killed by their husband (Bradley 1988). Studies from a variety of cultures confirm that when women kill men, it is often in self defense, usually after years of persistent and escalating abuse (Browne 1987; Walker 1989). Ironically, in the United States and elsewhere, a woman is more likely to be assaulted, raped or killed by a male partner than any other assailant (Browne and Williams 1989).

## **Dowry Deaths**

On the Indian subcontinent, tradition has combined with greed to forge a particularly deadly form of wife abuse known locally as "bride burning" or "dowry deaths." Decades ago dowry referred to the gifts that a woman received from her parents upon marriage. Now dowry has become an important part of premarital negotiations and refers to the wealth that the bride's parents must pay to the groom and his family as part of the marriage settlement.

Once a gesture of love, ever-escalating dowry now represents a real financial burden to parents of unwed daughters. Increasingly, dowry is being seen as a "get rich quick" scheme by prospective husbands, with young brides suffering severe abuse if ongoing demands for money or goods are not met. In its most severe form, dowry harassment ends in the woman's suicide or her murder, freeing the husband to pursue a more lucrative arrangement.

Dowry deaths are notoriously undercounted, largely because the husband and his relatives frequently try to disguise the murder as a suicide or an accident and the police are loathe to get involved. A frequent scam is to set the woman alight with kerosene and then claim she died in a kitchen accident--hence the term bride-burning. In 1990 the police officially recorded 4,835 dowry deaths in all of India, but the Ahmedabad Women's Action Group estimates that 1,000 women may be burned alive annually in Gujarat State alone (Kelkar 1991; Crossette 1989).

A quick look at mortality data from India reveals the reasonableness of this claim. In both urban Maharashtra and greater Bombay, one out of every five deaths among women 15 to 44 are due to "accidental burns." For the younger age group 15 to 24, the proportion is one out of four (Karkal 1985). Also female deaths due to burns have been increasing since 1979, corresponding to the recent commercialization of dowry demands (Pawar 1990). Clearly, homicides and suicides are being recorded as "accidents" instead of intentional injuries. Women advocates from India are quick to point out, however, that "bride-burning" is but the most visible and sensational symbol of a continuum of violence. More hidden and less newsworthy is the everyday battering that plagues women everywhere.

## **Rape and Sexual Assault**

On July 10, 1991, 71 teenage girls were raped by their male classmates, and 19 others died in a night of dormitory mayhem at St. Kizito's co-ed boarding school in Meru, Kenya. Apparently the boys attacked the girls after the girls refused to join them in a protest strike against the school's headmaster. In a report splashed across the front page of the Kenya Times, the newspaper called the rape of St. Kizito co-eds a "common occurrence" sanctioned by the principal and his staff. The paper quoted the deputy principal as saying "The boys never meant any harm against the girls. They just wanted to rape." (Perlez 1991)

These are the attitudes that women around the world must face when seeking justice and compassion after being sexually violated. Rape is either seen as a man's prerogative or a crime against the honor of a woman's family or husband, not a violation against the woman. In fact, the Latin root of rape means "theft," and most cultural responses to such violence emphasize reclaiming the woman's lost value, not prosecuting the offender. In many countries--including Fiji, the Philippines, Thailand, Mexico, and Peru--the cultural "solution" to rape is to have the young woman marry her rapist, thus legitimizing the union and preserving the family honor.<sup>5</sup>

Due to the stigma and shame associated with rape, sexual assault may be one of the most underreported crimes. But even the official, undercounted figures are chilling. In the United States, the Department of Justice reports that every hour, 16 women confront rapists, and every six minutes a woman is raped. Studies indicate that one in five American women has been the victim of a completed rape (Sorenson et. al. 1988). Researchers estimate that only 34 percent of stranger rapes and 13 percent of acquaintance rapes are reported (Koss et. al. 1990).

Estimates of rape incidence are even more speculative in the developing world, but many countries--including Bangladesh, India, Korea, Malaysia, and South Africa--note dramatic increases in reported rape in recent years.<sup>6</sup> Rates of rape in South Africa appear to outstrip even those in the United States. Police reports document 19,308 rapes in 1988, but the National Institute of Crime Prevention and the Rehabilitation of Offenders estimates that only one in twenty rapes are reported, bringing the true total closer to 386,160 (Russel 1991; Vogelmann 1990). That figure averages one rape every minute and a half, or 34 rapes per 1,000 adult women compared to the U.S. rate of 18 per 1,000 women.<sup>7</sup>

Studies around the world also demonstrate a remarkable consistency in the demographics of sexual assault. Contrary to popular perception, the majority of rape survivors know their assailants, a reality confirmed by studies in Malaysia, Mexico, Panama, Peru and the United States (see table 1-2). Also, a large percentage of rapes (40 to 47 percent) are perpetrated against girls 15 years or younger, with a shocking percentage against girls younger than nine (See table 1-2). It may be that rapes of young girls are simply reported more often, but in the United States this is not the case: Girls under 18 are less likely to report their assault than older women (Ten facts 1990).

Sexual assaults can cause physical injury and profound emotional trauma. A study of rape in urban and rural areas of Bangladesh, for example, reports that 84 percent of victims suffered severe injuries and/or unconsciousness, mental illness or death following the rape incident (Shamim 1985). Survivors also run the risk of becoming pregnant or contracting STDs, including AIDS. In third world settings, the risk of unwanted pregnancy is high: Mexican rape crisis centers report 15 to 18 percent of their clients become pregnant because of the rape (COVAC 1990; CAMVAC 1985). Women raped in Mexico have more options than most--a new law requires judges to rule on a rape survivor's request for an abortion within five working days of her appeal. Thousands of others who live in countries where abortion is illegal must suffer the double humiliation of being raped and then having to bear the rapist's child.

Rape survivors also exhibit a variety of trauma-induced symptoms including sleep and eating disturbances, depression feelings of humiliation, anger and self blame, nightmares, fear of sex, and inability to concentrate. One study from the United States found that rape victims were nine times more likely than non-victims to have attempted suicide, and twice as likely to experience a major depression (Kilpatrick 1990).

Perhaps most devastating, however, are the cultural consequences of rape in societies that highly value a woman's virginity. Many Asian, Middle Eastern, and African cultures equate a young woman's worth with her virginity. As Vincent Faveau (1989) describes in his groundbreaking study of injury in rural Bangladesh, "Even when women are victims, a premarital sexual relation is said to spoil something intrinsic in their physical and moral

Even when the immediate threat of rape is gone, the stigma of violation lingers on. Many refugee women who have been raped are shunned by their families and isolated from other members of their community. As Richard Mollica (1989), Director of Harvard's Program in Refugee Trauma observes, "In Southeast Asian cultures, a husband will often reject his wife if she has been sexually violated because she is perceived as having been "used," "violated," or "left over" by the rapist(s)." A Vietnamese proverb regarding rape, summarizes this sentiment: "Someone ate out of my bowl and left it dirty."

Refugee workers also note a link between rape and subsequent domestic violence, especially by men whose wives or daughters have been raped in their presence. As Amy Friedman (1991) of the Washington-based, Refugee Women in Development (Ref-WID), observes, "Refugee men often feel victimized by their experience and feel that they have failed in their obligation to protect their families. This vulnerability, compounded by the frustration of resettlement, often leads refugee men to resort to domestic violence to recover power and control." Ref-WID has developed and tested a training program to help U.S. service providers to identify and respond to domestic violence within the refugee community.

## **Female Circumcision**

In parts of Africa and the Middle East, young girls suffer another form of violation, known euphemistically as female circumcision. More accurately, this operation--which removes all or part of the clitoris and other external genitalia---is a life-threatening form of mutilation. In its most severe form, known as infibulation, the clitoris and both labia are removed and the two sides of the vulva are sewn together except for a small opening to allow urine and menstrual blood to pass. According to the World Health Organization, more than 84 million women alive today have undergone sexual surgery in Africa alone (Rushwan 1990).

While female circumcision has its origin in the male desire to control female sexuality, today a host of other beliefs sustains the practice. Many Moslems mistakenly believe that it is demanded by the Islamic faith, although it has no basis in the Koran. Others believe the operation will increase fertility, affirm femininity or prevent still births. Ultimately what drives the tradition is that men will not marry uncircumcised women, believing them to be promiscuous, unclean and sexually untrustworthy (Mohamud 1991).

The medical complications of circumcision can be severe. A study from Sierra Leone, for example, found that 83 percent of all women circumcised required medical attention sometime in their life for problems related to the procedure (Hosken 1988). Immediate risks include hemorrhage, tetanus and blood poisoning from unsterile and often primitive cutting implements (knife, razor blade or broken glass), and shock from the pain of the operation, which is carried out without anesthesia. In Sudan where infibulation--the most extreme form of circumcision--is practiced, doctors estimate that 10 to 30 percent of young girls die from the operation, especially in areas where antibiotics are not available (Lightfoot-Klein 1989).

The long term effects, in addition to loss of sexual feeling, include chronic urinary tract infections, pelvic infections that can lead to sterility, painful intercourse and severe scarring that



can cause tearing of tissue and hemorrhage during childbirth. In fact, women who are infibulated must be cut open on their wedding night to make intercourse possible, and more cuts are necessary for the birth of a child. Among 33 infibulated mothers in Somalia's Benadir Hospital, all had to have extensive episiotomies during childbirth, their second stage labor was five times longer than normal, five of their babies died and 21 suffered oxygen deprivation due to the long and obstructed labor (Hosken 1988).

In recent years African women have begun to organize to combat circumcision and other traditional practices harmful to women and girls. In 1984, at a World Health Organization-sponsored conference in Dakar, Senegal, groups joined together to form the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, an umbrella organization of 22 national committees working to eradicate genital mutilation. In the words of Berhane Ras Work, the consortium's president: "Female circumcision is a clear example of social violence which women have to bear in silence as a price for marriage and social identity."

### **Discrimination Against Girl Children**

While less overt, the preference for male offspring in many cultures can be as damaging and potentially fatal to females as rape or assault. The same sentiment that once motivated infanticide, is now expressed in the systematic neglect of daughters--a neglect so severe that in India's Punjab state girls aged two to four die at nearly twice the rate of boys (Das Gupta 1987).

"Eighteen goddess-like daughters are not equal to one son with a hump," goes a proverb in China, a country that shares its strong preference for male children with the rest of Asia and the Indian sub-continent. In these cultures and others, sons are highly valued because only they can perpetuate the family line and perform certain religious rituals. Even more important, sons represent an economic asset to the family and a source of security for parents in their old age.

Studies confirm that where preference for sons is strong, girls receive less food and inferior medical care and education. In rural Bangladesh, for example, malnutrition was found to be almost three times more common among girls than among boys (Bhatia, 1985; Chen et. al. 1981). Not surprisingly this discriminatory treatment shows up in mortality statistics for girls and women. Among 45 developing countries for which recent data are available, there are only two where mortality rates for girls ages one to four are not higher than that of boys (UNICEF 1986).

In fact, the pressure to bear sons is so great in India, China and Korea that women have begun using amniocentesis and ultrasound as sex selection devices to selectively abort female fetuses. Until protests forced them to stop, Indian sex detection clinics boldly advertised that it was better to spend \$38 now on terminating a girl than \$3,800 later on her dowry. One study of amniocentesis in a large Bombay hospital found that 95.5 percent of fetuses identified as female were aborted (Ramanamma 1990).

### **Women Fight Back**

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Today, the vast majority of countries in Latin America, the Caribbean, Asia and the Pacific have at least a handful of non-governmental organizations dedicated to changing public attitudes toward violence and to providing services for victims of abuse. Some with more mature movements, such as Mexico, India, and Ecuador, have organized nationally to push for legal reform and to orchestrate major educational campaigns. A handful, including Brazil, Papua New Guinea, and Malaysia have initiated widespread reform and marshalled considerable government support for services and public education. Feminists in Brazil, for example, have successfully lobbied for the creation of all-female police stations to assist victims of violence. Brazil now has roughly 84 such stations, and the country's new constitution requires the state to "create mechanisms so as to impede violence in the sphere of family relationships" (Pitanguy 1991).

Women's resistance to violence has taken many forms. In India, activists are using street theater to raise women's consciousness around dowry, wife beating and women's low status in society (Patel 1989). In Kingston, Jamaica, women have formed a "Women's Media Watch" that monitors the media and agitates against imagery that contributes to sexual violence (Tribune Center 1991). And in San Juan de Miraflores, a shantytown of Lima, Peru, women carry whistles to summon other women in case of attack (Heise 1989). At least 30 developing countries also have shelters and/or crisis centers for survivors of violence, but most exist only in major urban centers.<sup>8</sup>

In Africa, organizing has focused more on genital mutilation than on other forms of abuse, although groups in Zimbabwe, Uganda, Nigeria, and Kenya have developed materials to raise awareness around wife beating and rape.<sup>9</sup> Some of the most innovative programs working to abolish female circumcision rely on mobilizing action at the grassroots. The National Association of Nigeria Nurses and Nurse-Midwives, for example, has orchestrated a series of regional workshops to train its own 60,000 members and other community leaders about the hazards of circumcision. Workshop members then develop a state plan of action, including health messages communicated through songs, comic books, and local theater groups (Adebajo 1991).

In recent years, individual country efforts have begun coalescing into a true international movement against gender violence. Through a series of regional and international conferences and networks, women have begun to share strategies and compare notes. Especially significant has been the contribution of Isis International, a women's resource center based in Santiago, Chile. With funding from the United Nations Fund for Women (UNIFEM), Isis has developed a computerized data base of information and organizations working against violence. The project's program directory lists 379 separate groups fighting violence in Latin America alone (Isis 1990a).

### **A Call to Action**

Despite the wealth of grassroots activity around violence there has been little recognition of the problem within mainstream development organizations, especially among those dedicated to health. The World Health Organization and a handful of NGOs, including the International Planned Parenthood Federation and the Population Crisis Committee have supported efforts to eliminate female circumcision, but abuses such as battery, rape and incest have largely been

ignored (The Canadian NGO, MATCH International is a notable exception). There are five compelling reasons, though, why the international health community should embrace the issue of gender violence and begin supporting research, services and prevention activities designed to combat it.

**1. Gender violence is a significant cause of morbidity and mortality among women.**

A simple but powerful illustration of the cumulative impact of discrimination and violence on women's health comes from Amartya Sen, an Indian economist now teaching at Harvard University. Dr. Sen compared the sex ratios between women and men in countries where both sexes receive similar care, such as North America and Europe, to countries where females are highly discriminated against, as in China and India. In more egalitarian countries the female/male ratio is about 1.05 or 1.06, reflecting women's biological advantage. But in South Asia, West Asia, North Africa and China the ratio is typically .94 or lower. If countries in these regions had the 1.05 ratio typical in other parts of the world (including some of Subsaharan Africa), the world would have 100 million more women alive today. In China alone, notes Dr. Sen, 50 million women are "missing," victims of female foeticide, selective malnourishment of girls, lack of investment in women's health, and various forms of violence (Sen 1990).

**2. Gender violence affects initiatives already high on the international health agenda, such as the Safe Motherhood and Child Survival Initiatives.**

**Safe Motherhood:** It is ironic that an international initiative on safe pregnancy and childbirth would include no mention of the "physical" safety of the mother and her child. Yet surveys suggest that pregnant mothers are prime targets for abuse. Preliminary results from a large, prospective study of battery during pregnancy in the United States indicate that one out of every six pregnant women are battered during their present pregnancy (McFarlane 1991). (The study, sponsored by the Centers for Disease Control, followed a stratified cohort of 1,200 White, African-American and Hispanic women for three years in Houston and Baltimore.) Other studies indicate that women battered during pregnancy run twice the risk of miscarriage and four times the risk of having a low birth weight baby compared with women who are not beaten (Stark et. al 1981; Bullock and McFarlane 1989) Low birth weight is a powerful predictor of a child's survival prospects in its first year of life (IOM 1985).

It is possible that battering during pregnancy would have an even greater impact on Third World mothers who are already malnourished and overworked. A survey of 342 randomly-sampled women in Mexico City revealed that 20 percent of those battered reported blows to the stomach during pregnancy (Valdez Santiago and Shrader Cox 1991). Extrapolating these results to the rest of the population suggests that almost 1 million Mexican women are at risk for battering during pregnancy.<sup>10</sup> In another study of 80 battered women who sought judicial intervention against their partner in San Jose, Costa Rica, 49 percent report being beaten during pregnancy. Of these, 7.5 percent reported miscarriages due to the abuse (Ugalde 1988).

Violence may also be responsible for a sizeable, but yet unrecognized, portion of maternal deaths, especially among young unwed mothers. Fauveau and Blanchet (1989) report that in Matlab Thana Bangladesh, homicide and suicide--motivated by stigma over unwed

pregnancy, beatings or dowry--accounted for 6 percent of all maternal deaths between 1976 and 1986.<sup>11</sup> The figure rises to 22 percent if one includes deaths due to botched abortions, many also related to shame over unwed pregnancies. Among all deaths of women aged 15 to 44 (not just maternal deaths), intentional injury accounts for 12.3 percent of deaths, with deaths due to homicide and suicide outnumbering those due to abortions.

**Child Survival.** Increasingly Unicef and other agencies involved with the Child Survival initiative are examining factors that affect the quality of children's lives not just their mere survival. Family violence should be on this agenda. Children who witness wife abuse are at risk of being assaulted themselves and of developing adjustment problems during childhood and adolescence. In one study of battered women presenting to the Institute of Legal Medicine in Bogotá, Colombia, 74 percent of those who had children said that their children were present during the attack. In 49 percent of cases the children were also injured (Berenguer 1984). Likewise, of 80 women presenting to the Medico Forense of San Jose, Costa Rica, 40 percent said that their children were also beaten by their partner (Ugalde 1988).

Perhaps even more significant than physical injury, is the impact that family violence has on a child's sense of security and developing personality. Two recent studies (Davis and Carlson, 1987; Jaffe et al. 1986) indicate that children who witness violence experience many of the same emotional and behavioral problems exhibited by abused children, including depression, aggression, disobedience, nightmares, poor school performance and somatic health complaints.<sup>12</sup> There is also evidence that suggests that children who witness or experience violence as a child are more likely to become abusive themselves as adults (Stordeur and Stille 1989).

But violence may affect child survival in another, more subtle way. It is now well established that female education is significantly and independently related to child survival. (Blumberg 1989; Floro and Wolf 1990). But how does education work to affect child health? There is increasing evidence that schooling works not by imparting new health knowledge or skills, but by eroding fatalism, improving women's self confidence and changing the power balance in the family (Lindernbaum 1985; Levine 1987; Caldwell 1979). In the words of Peter Adamson (1988), "Education erodes resignation and substitutes for it a degree of confidence, an awareness of choice, a belief that decisions can be made, circumstances changed, life improved." Using qualitative research techniques, Griffiths (1988) has identified some of the mechanisms by which maternal confidence and self-esteem operate to affect child health. Her research in Indonesia, Cameroon and India has demonstrated that mothers with higher self-esteem take a more assertive role in their child's feeding--they introduce weaning foods earlier, they take swifter action when a child is sick, and they persist in feeding even when a child refuses. Not surprisingly, more confident mothers have better nourished children.

If "education" is in fact a proxy for some intervening variable, like self confidence or esteem, than anything that undermines confidence will affect child health. Acts of violence and society's tacit acceptance of them stand as constant reminders to women of their low worth. Where women's confidence and status is critical to achieving a development goal--such as improving child survival--violence will remain a powerful obstacle to progress.

**Family Planning and AIDS Prevention.** The family planning literature is replete with examples of women who would like to use family planning but are afraid to do so without their husband's permission (Greenstreet 1990). The unspoken reality behind this fear is that women can be beaten if they disobey.

Violence or the threat of violence is an all too common dimension of women's sexual decision-making. Because of women's economic dependence and men's superior strength, women are often not free to decide with whom they have sex, when, how often, or with what kind of protection. Sometimes they are given no choice at all: In the United States, one out of every seven married women have been raped by their husband. (Russel 1982). In Seoul, Korea, the figure is two out of every three (Shim Young 1991).

Women's relative powerlessness to negotiate sex or condom use is a fact rarely acknowledged by AIDS education programs. Until programs confront this reality, prevention strategies will be doomed to failure. As a woman from Buwunga Uganda observed recently in a village discussion on AIDS, "If you advise your husband to use a condom, he may beat you and send you away. Where will you go then?" she asked (Perlez 1990).

Similar fears plague low-income and minority women in the United States. According to Dooley Worth (1989), an anthropologist working with an AIDS education project in New York City, "Women engage in sexual risk-taking mainly because of perceived threats to their social and economic survival, and a lack of power in sexual decision-making." Three-quarters of the women Worth surveyed have been physically abused as adults, primarily by their sexual partner. "Asking them to introduce condoms into their relationship," notes Worth, "can mean asking them to risk further abuse."

Clearly fear of economic or physical reprisal increases women's vulnerability to AIDS in comparison to men's. Women desperately need a new option for protecting themselves against sexually transmitted diseases--one that will allow them to control the decision to use it. And for Third World women, much of whose social status depends on childbearing, the technology must also permit conception. As Kathryn Carovano (1991) notes, "To provide women exclusively with HIV prevention methods that contradict most societies' fertility norms is to provide many women with no options at all."

### **3. Health care workers are best positioned to identify, counsel and refer victims of physical abuse.**

The health care system is the only institution that all women are likely to interact with sometime in their lives. Thus it is particularly well placed to identify and assist victims of violence. Regrettably, even in the United States, the health care system has not taken leadership on this issue.

Studies document that in a typical metropolitan emergency room in the United States, health care workers identify only one battered woman in 35, even though battered women have proven quite willing to admit abuse when questioned in private (Stark et. al. 1981; Stark 1984).<sup>13</sup> With proper training and protocols, however, health care facilities can greatly improve their staff's sensitivity to battered women. At the emergency department of the Medical College of Pennsylvania, for example, the percentage of women found to be battered increased

more than five-fold, from 5.6 percent to 30 percent after training and protocols were introduced (McCleer and Anwar 1989).

Such reforms remain uncommon in the United States, primarily because institutions seldom change without outside pressure, and battered women's advocates have invested most of their energy in opening shelters and working for justice system reform. But recently, advocates successfully lobbied the U.S. Joint Commission on Hospital Accreditation to include training and emergency room protocols on family violence among the criteria used to evaluate hospitals for accreditation (Heise and Chapman 1991). This should encourage increased attention to domestic violence within the medical community.

Health and family planning workers in developing countries are also well-suited to identify and counsel victims of abuse. Especially in politically repressive countries, women are unlikely to seek help from the police or other governmental authorities. But they may admit abuse when questioned gently, in private by a supportive health care provider. Providers can emphasize that no one deserves to be beaten or raped, and help women think through future options for protecting herself (e.g. seeking safety at a friend's). And in large urban areas, there are a growing number of women's crisis centers to which providers can refer women for legal or psychological support. But even where no external support exists, having a sympathetic individual acknowledge and denounce the violence in a woman's life offers considerable relief from isolation and self-blame.

#### **4. There is enormous pent-up demand for information and services related to gender violence.**

In myriad ways, women around the world are saying that violence is a priority issue for them, but their voices are not being heard. At a recent 12-country workshop on women's non-formal education held in China, participants were asked to name the worst aspect of being female: fear of male violence was the almost unanimous answer (Bradley 1990). In 1988, MATCH International, a Canadian NGO devoted to assisting Third World women's projects, surveyed women's groups worldwide about their priorities. The number one concern expressed was violence against women (Carrillo 1991). And in 1990, when the Foundation for International Community Assistance (FINCA), a grassroots banking and credit scheme for women, decided to provide educational materials on health during their weekly meetings, women bankers identified domestic violence as one of the issues they most wanted to receive information on. Other priority themes identified in focus groups were alcoholism, drug detection and prevention in children, parasites, and women's infections, including STDs and AIDS (Salamon and Velazquez 1991).

Clearly, violence against women is of primary concern to third world women, and they are acting on that concern--witness the 379 programs against violence in Latin America alone. But most of these groups are struggling to survive with little or no support from their own governments or mainstream health and development funders. Given both the indigenous demand for anti-violence programs and the links between violence and existing health and development priorities, there is a strong case for greater international investment in gender violence research and services.



## **5. Confronting Gender Violence Pushes the Women's Health Agenda Beyond Reproductive Health.**

Historically, the international health community has been interested in women only as a means to an end, such as controlling population growth or saving children's lives--rather than as human beings with independent needs. Even Maternal and Child Health (MCH) programs have concentrated almost exclusively on children, leading some observers to ask, "Where is the M in MCH?"

The Safe Motherhood Initiative represents a first step toward focusing more on the health of women, as does recent advocacy to broaden "family planning" to include the full range of women's reproductive health needs (Germain and Ordway, 1989). But even these programs ignore elements of women's physical and emotional well-being that go beyond their reproductive anatomy. Putting violence on the women's health agenda gives value on the quality of women's lives. Preliminary data suggest that gender violence may be among the most significant causes of morbidity and mental distress among women. If involuntary pregnancy were recognized as a form of violence, this would most certainly be the case.

### **IMPORTANT FIRST STEPS**

The international health community is well positioned to advance the fight against gender violence. The key is to identify opportunities to integrate training, information and questions about violence into on-going initiatives. For example, many countries are currently surveying individuals' sexual attitudes and practices to help design successful AIDS education campaigns. Several additional items could be added to the questionnaire to reveal the nature and extent of violence against women.

Likewise, training materials for family planning workers, health promoters and refugee workers could include information about how to identify and respond to rape and abuse. More and more countries are using entertainment media, including soap operas, radio shows, or songs, to promote family planning, AIDS awareness, and child survival. Messages about violence could be woven among these other themes.

But most importantly, international NGOs and development agencies can actively support the growing number of local groups fighting violence at the grassroots. Funders capable of making small grants should make it known that they are receptive to proposals related to violence, and large-scale funders should consider funding umbrella organizations that make grants directly to Third World groups. Canada's bi-lateral aid agency, CIDA, for example, funds Match International which in turn manages an entire grant program focused on violence against women.

In this age of dwindling resources, programs against violence are apt to be dismissed as an unaffordable luxury. But it is precisely now, when the survival of many families hinges on the mother's emotional and physical strength, that anti-violence programs are most desperately needed. More importantly, it is time that the international community recognizes that women have a right to live free from physical and psychological abuse. Gender violence is crippling, both physically and emotionally. A health agenda that values women as women could not ignore this all-too-common reality of women's lives.

## ENDNOTES

1. This definition was inspired by one offered for domestic violence by Carmen Antony and Gladys Miller in their work, "Estudio Exploratorio Sobre el Maltrato Fisico que es Victima Mujer Panamena." Panama: ICRUP/Ministerio de Trabajo y Bienestar Social, 1986.
2. Levinson's (1989) analysis of ethnographic data from 90 peasant and small-scale societies indicates that 86 percent experience violence against wives by husbands. Only 16, "can be described as essentially free or untroubled by family violence" (p. 452). In an analysis of ethnographic research on 14 cultures by female anthropologists using female informants, Counts et. al (1992) identifies only one society, the Wape of Papua New Guinea, that have little or no woman abuse.
3. A recent study by the Addiction Research Foundation in Toronto found that battered women's use of sedatives was 74 percent higher and their use of sleeping pills 40.5 percent higher than non-abused women (Groenveld and Shane 1989).
4. Stark (1984) reports that fully 26 percent of female suicide attempts presenting to Yale University hospital in 1979 were associated with abuse as were 50 percent of attempts made by African American women. The battered women also accounted for 42 percent of all traumatic attempts and were significantly more likely to attempt suicide more than once (20 percent vs. 8 percent).
5. Fiji reference from Shamima Ali, Women's Crisis Centre, Suva, Fiji Islands, private communication, June 6, 1991; Philippines reference from Nilda Ramonte, Center for the Pacific-Asian Family, Los Angeles, California, private communication June 7, 1991; Peru reference from Gina Cedamanos, Centro de la Mujer Peruana Flora Tristan, Lima Peru, private communication June 7, 1991; Mexico reference from Elizabeth Shrader Cox, Centro de Investigación y Lucha contra la Violencia Doméstica, A.C. (CECOVID), Mexico City, private communication, September 27, 1991.
6. Bangladesh from (Adanda and Shamim 1985). India data from (Kelkar 1991). Malaysia data from (Asian and Pacific Women's Resource and Collection Network 1989). South Africa from (Russel 1991).
7. The South African estimate of rape incidence in 1988 was calculated using the following information: number of rapes committed = 386,160; population of women 15 and older = 11,265,000. Population figures are from the United Nations, Assessment of World Population 1990. The U.S. rate is based on an estimate of rape incidence in 1986 made by Koss, Koss, and Woodruff who surveyed more than 2,291 adult working women in Cleveland, Ohio and calculated the rape rate using the same definition of rape used in the National Crime Survey. The incidence of rape over a 12 month period was 28 per 1,000 women which they adjusted to

18 per 1,000 women to allow for telescoping (the documented tendency for people to recall events forward in time). For more details see Koss, Mary P. "Rape Incidence: A Review and Assessment of the Data," Testimony presented before the Senate Judiciary Committee, United States Congress, August 29, 1990.

8. **Developing Countries with Shelters:** El Salvador, Paraguay, Uruguay, Egypt, Malaysia, Puerto Rico, Korea, Japan, Thailand. **With Rape Crisis Centers:** South Africa, Malaysia, Mexico, Philippines, St. Lucia, Trinidad and Tobago, Guyana, Nicaragua, Panama, Puerto Rico, Venezuela, Korea. **With General Women's Crisis Centers:** Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Dominican Republic, St. Lucia, Uruguay, Fiji, Thailand, Japan, Hong Kong, India, Korea, Sri Lanka, China, Jamaica.

9. For a description of programs see "Linking Global Struggles to End Violence" 1990. Ottawa: Match International and "Violence Against Women: Confronting Invisible Barriers to Development." June 1991. New York: International Tribune Center.

10. The study (Valdez Santiago and Shrader Cox 1991) indicated that 25 percent of women surveyed had been in an abusive relationship with a male partner or ex-partner. Of these women 66 percent report physical violence and of those, 20 percent report blows to the stomach during pregnancy. According to the United Nation's Assessment of World Population 1990, the number of women in Mexico aged 15 years and older was 28,206,000.  $28,206,000(.25) \times (.66) \times (.2) = 930,798$  women at risk of battering during pregnancy.

11. The World Health Organization (WHO) defines maternal mortality as a death during pregnancy or within 42 days afterward, from causes related to or aggravated by the pregnancy or its management.

12. The Davis and Carlson (1987) study found that 90 percent of abused boys and 75 percent of those witnessing violence (compared to 13 percent for controls), had behavior problem scores greater than one standard deviation above the norm.

13. When Planned Parenthood of Houston and Southeast Texas added four abuse-assessment questions to their standard intake form, 8.2 percent of women self-identified as physically abused (Bullock, et. al. 1989).

## BIBLIOGRAPHY

Acasadi, George and Johnson-Acsadi, Gwendolyn. 1990. "Safe Motherhood in South Asia: Socio-cultural and Demographic Aspects of Maternal Health." Background paper prepared for the Safe Motherhood South Asia Conference, Lahore, Pakistan, March 24-28.

Adebajo, Christine. 1991. "A Grassroots Project by Nurses and Midwives in Nigeria to Eradicate Female Circumcision." Paper presented at the 18th Annual NCIH International Health Conference, Arlington, VA.

Amaro, Hortensia et. al. 1990. "Violence During Pregnancy and Substance Use." American Journal of Public Health 80(5):575-579.

Adanda, Latifa and Shamim, Ishrat. 1985. Women and Violence: A Comparative Study of Rural and Urban Violence Against Women in Bangladesh. Dhaka, Bangladesh: Women for Women: A Research and Study Group.

Asian and Pacific Women's Resource Collection Network. 1989. Asian and Pacific Women's Resource and Action Series: Health. Kuala Lumpur, Malaysia: Asian and Pacific Development Centre.

Berenguer, Ana Maria. 1988. "Alternativas Desde la Medicina Legal y Experiencias Sobre la Violencia Intrafamiliar." In Violencia en la Intimidad. Bogotá, Colombia: Corporación Casa de la Mujer.

Blumberg, R. L. 1989. Making the Case for the Gender Variable: Women and the Wealth and Well-Being of Nations. Technical Reports in Gender and Development No. 2. Washington, D.C.: U.S. Agency for International Development, Office of Women in Development.

Bradley, Christine. 1988(a). "The Problem of Domestic Violence in Papua New Guinea." In Guidelines for Police Training on Violence Against Women and Child Sexual Abuse. London: Commonwealth Secretariat, Women and Development Programme.

Bradley, Christine. 1988(b). "How Can We Help Rural Beaten Wives? Some Suggestions from Papua New Guinea." Paper presented at the International Welsh Women's Aid Conference, Cardiff, Wales.

Bradley, Christine. 1990. "Why Male Violence Against Women is a Development Issue: Reflections From Papua New Guinea." Occasional Paper. New York, N.Y.: United Nations Fund for Women (UNIFEM).

Bhatia, S. 1985. "Status and Survival." World Health.

Browne, Angela. 1987. When Battered Women Kill. New York, NY: Free Press.

Browne, Angela and Williams, Kirk. 1989. "Exploring the Effect of Resource Availability and

the Likelihood of Female-Perpetrated Homicides." Law and Society Review 23(1).

Bullock, Linda F. and McFarlane, Judith. 1989. "The Birth-Weight/Battering Connection." American Journal of Nursing. Pp. 1153-1155.

Caldwell J.C. 1979. "Education As a Factor in Mortality Decline: An Examination of Nigerian Data." Population Studies 33(3):395-413.

CAMVAC. 1985. "Carpeta de Información Básica Para la Atención Solidaria y Feminista a Mujeres Violadas." Mexico City: Centro de Apoyo A Mujeres Violadas (CAMVAC).

Canadian Centre for Justice Statistics. 1988. Homicide in Canada 1987: A Statistical Perspective. Ottawa: Ministry of Supply and Services Canada.

Cañas, Mercedes. 1990. "Maltrato Físico A La Mujer Salvadoreña." Unpublished thesis, San Salvador. (Available from author).

Carolyn Byerly. 1984. "Contigo, Pan, Cebollas..Y También Golpes?" In VIVA, newsletter of the Centro de la Mujer Peruana Flora Tristan. Lima, Peru. No. 2.

Carovano, Kathryn. 1991 "More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women." International Journal of Health Services 21(1):131-142.

Carrillo, Roxanna. 1991. "Violence Against Women: An Obstacle to Development." Center for Women's Global Leadership, Rutgers University, New Brunswick, New Jersey.

Chen, Lincoln; Huq, Emdadul and Stan D'Souza. 1981. "Sex Bias in the Family Allocation of Food and Health Care in Rural Bangladesh." Population and Development Review 7(1):55-70.

Consumers Association of Penang. 1988. Rape in Malaysia. Penang, Malaysia.

Counts, Dorothy. 1987. "Female Suicide and Wife Abuse: A Cross-Cultural Perspective." Suicide and Life Threatening Behavior 17(3):194-205.

Counts, Dorothy et. al. (forthcoming). Sanctions and Sanctuary: Cultural Perspectives on the Beating of Wives. Boulder, Colorado: Westview Press.

COVAC. 1990. "Evaluación de Proyecto para Educación, Capacitación, y Atención a Mujeres y Menores de Edad en Materia de Violencia Sexual, Enero a Diciembre 1990." Mexico City: Asociación Mexicana Contra la Violencia a las Mujeres, A.C. (COVAC).

Crossette, Barbara. 1989. "India Studying 'Accidental' Deaths of Hindu Wives." New York Times. January 15.

Das Gupta, M. 1987. "Selective Discrimination Against Female Children in Rural Punjab, India." Population and Development Review 13(1):55-70.

- Davis, Liane V. and Carlson, Bonnie. 1987. "Observation of Spouse Abuse: What Happens to the Children?" Journal of Interpersonal Violence 2(3):278-291.
- Demographic and Health Survey (DHS Colombia). 1991. Colombia: Encuesta de Prevalencia, Demografía y Salud. Columbia, Maryland: Institute for Resource Development.
- Fauveau V. and Blanchet T. 1989. "Deaths from Injuries and Induced Abortion Among Rural Bangladeshi Women," Social Science and Medicine 29.
- Friedman, Amy. 1991. "Rape and Domestic Violence: The Experience of Refugee Women." Occasional Paper. Washington D.C.: Refugee Women in Development.
- Gelles, Richard and Cornell, Caire. 1990. Intimate Violence in Families. Newbury Park: Sage Publications.
- Germain, Adrienne and Ordway, Jane. 1989. "Population Control and Women's Health: Balancing the Scales. New York, N.Y.: International Women's Health Coalition with the Overseas Development Council.
- Greenstreet, M. "Education and Reproductive Choices in Ghana: Gender Issues in Population Policy." Development 1:40-47.
- Griffiths, Marcia. 1988. "Maternal Self-Confidence and Child Well-Being." Paper presented at the Society for Applied Anthropology Annual Meeting, Tampa, Florida, April 20-24.
- Groeneveld, J. and Shain, M. 1989. Drug Abuse Among Victims of Physical and Sexual Abuse: A Preliminary Report. Toronto: Addiction Research Foundation.
- Guenette, Louis and Heffeman, Tracy. 1989. "A Global Struggle Against Violence Against Women" Vis-a-Vis. Canadian Council on Social Development, Volume 7 (1).
- Haynes, R. H. 1984. "Suicide in Fiji: A Preliminary Study." British Journal of Psychiatry 145:433-438.
- Heise, Lori. 1989. "International Dimensions of Violence Against Women." Response to the Victimization of Women and Children 12(1):3-11.
- Heise, Lori and Chapman, Jane. 1991. "Reflections on a Movement: The U.S. Battle Against Woman Abuse." In Margaret Schuler, ed., Freedom from Violence: Women's Strategies from Around the World. Washington D.C.: OEF International. (Available through UNIFEM, New York, N.Y.).
- Hosken, Fran. 1988. "International Seminar: Female Circumcision Strategies to Bring About Change." Women's International Network News 14(3):24-37.
- Illinois Coalition Against Sexual Assault. 1991. "Sexual Assault Statistical Report." Springfield,

Ill: Illinois Coalition Against Sexual Assault.

International Women's Tribune Center. "Violence Against Women: Invisible Barriers to Development." The Tribune. No. 46.

Isis International. 1990a. Violencia en Contra de La Mujer en América Latina y El Caribe: Directorio de Programas. Santiago, Chile.

Isis International. 1990b. Violencia en Contra de La Mujer en América Latina y El Caribe. Informe Final. Santiago, Chile.

Jaffe, P. et al. 1986. "Similarities in Behavioral and Social Maladjustment Among Child Victims and Witnesses to Family Violence." American Journal of Orthopsychiatry 56:142-146.

Karkal, Malini. 1985. "How the Other Half Dies in Bombay." Economic and Political Weekly. p. 1424.

Kelkar, Govind. 1991. "Stopping the Violence Against Women: Issues and Perspectives from India." In Margaret Schuler, ed., Freedom From Violence: Women's Strategies from Around the World. Washington, D.C.: OEF International. (Available through UNIFEM, New York, N.Y.).

Kilpatrick, Dean. 1990. "Testimony Before the House Select Committee on Children, Youth and Families," as cited by Congressional Caucus for Women's Issues, "Violence Against Women Fact Sheet," Washington D.C.

Koop, C. Everett. 1989. "Violence Against Women: A Global Problem," Address by the Surgeon General of the U.S. Public Health Service at a conference of the Pan America Health Organization, Washington D.C., May 22.

Koso-Thomas, O. 1987. The Circumcision of Women: A Strategy for Eradication. London: Zed Books Ltd.

Koss, M.P., Gidycz, C.A. and N. Wisniewski. 1987. "The Scope of Rape: Incidence and Prevalence of Sexual Aggression and Victimization in a National Sample of Higher Education Students," Journal of Consulting and Clinical Psychology 55:162-170.

Koss, M.P., Koss, P and W.J. Woodruff. 1990. "Relation of Criminal Victimization to Health Perceptions among Women Medical Patients." Journal of Consulting and Clinical Psychology.

Levine, R. A. et al. 1987. "Schooling and Maternal Behavior in a Mexican City: The Effects on Fertility and Child Survival," Fertility Determinants Research Notes. No. 16.

Levinson, David. 1989. Violence in Cross-Cultural Perspective. Newbury Park: Sage Publications.

Londono, Melba Arias. 1990. Cinco Formas de Violencia Contra la Mujer. Bogota, Colombia:

Casa de la Mujer.

Lightfoot-Klein, Hanny. 1989. Prisoners of Ritual. Binghamton, New York: Harrington Park Press, Inc.

Mahajan, A. 1990. "Instigators of Wife Battering." In Violence Against Women. Edited by Sushma Sood. Jaipur, India: Arihant Publishers.

Mohamud, Asha. 1991. "Medical and Cultural Aspects of Female Circumcision in Somalia and Recent Efforts for Eradication." Paper Presented at the 18th Annual NCIH International Health Conference, Arlington, Virginia.

McCleer S. V. and Anwar R. 1989. "A Study of Women Presenting in an Emergency Department." American Journal of Public Health 79:65-67.

McFarlane, Judith. 1991. "Abuse During Pregnancy: A Cross-Cultural Cohort Study of Severity and Frequency of Injuries." Paper presented at the 18th Annual NCIH International Health Conference, Arlington, Virginia.

Mollica, Richard and Son, Linda. 1989. "Cultural Dimensions in the Evaluation and Treatment of Sexual Trauma: An Overview." Psychiatric Clinics of North America 12(2):363-379.

Molledo, Cecelia et. al. 1989. "Estudio Sobre Violencia Doméstica en Mujeres Pobladoras Chilenas." Santiago, Chile: CUSO.

National Committee for Injury Prevention and Control. 1989. Injury Prevention: Meeting the Challenge. New York: Oxford University Press.

Patel, Vibhuti. 1989. "Feminist Street Theatre in India." DIVA: A Quarterly Journal of Asian Women. Vol. 2(1) as cited in Linking Women's Global Struggles. 1990. Ottawa: MATCH International Centre.

Pawar, M.S. "Women and Family Violence: Policies and Programs." In Violence Against Women. Edited by Sushman Sood. Jaipur, India: Arihant Publishers.

Perez, Amelia Marquez. 1990. "Aproximación Diagnóstica a Las Violaciones de Mujeres en Los Distritos de Panamá y San Miguelito." Centro Para El Desarrollo de la Mujer, Universidad de Panamá.

Perlez, Jane. 1990. "For the Oppressed Sex, Brave Words to Live By," New York Times June 6.

Pitanguy, Jacqueline. 1991. "Brazil's Response to Violence Against Women." Presentation at the Ford Foundation, New York, N.Y., February 14.

Portugal, Ana Maria. 1988. "Crónica de una Violación Provocada?" Revista Mujer/Fempres.



Contraviolencia. Chile: FEMPRESS-ILET.

Raikes Alanagh. 1990. Pregnancy, Birthing and Family Planning in Kenya: Changing Patterns of Behavior. Copenhagen: Centre for Development Research.

Ramaanamma, A. 1990. "Female Foeticide and Infanticide: A Silent Violence," In Violence Against Women. Edited by Sushman Sood. Jaipur, India: Arihant Publishers.

Rushwan, Hamid. 1990. "Female Circumcision." World Health. April-May.

Russel, Diana. 1982. Rape in Marriage. New York: MacMillian.

Russel, Diana. 1991. "Rape and Child Sexual Abuse in Soweto: An Interview with Community Leader Mary Mabaso." Seminar presented at the Centre for African Studies. University of Cape Town, South Africa, March 26.

Salamon, Jill D. and Velazquez, Mary Luz. 1991. "Qualitative Needs Assessment of Women Village Bankers in Tijuana, Mexico and Development of Self-Educational Guide on Domestic Violence." Paper presented at the 18th Annual NCIH International Health Conference, Arlington, Virginia.

Schei, B. and Bakketeig L. 1989. "Gynecological Impact of Sexual and Physical Abuse by a Spouse: A study of a Random Sample of Norwegian Women." British Journal of Obstetrics and Gynecology 96:1379-1383.

Sen Amartya. 1990. "More Than 100 Million Women are Missing," The New York Review of Books. December 20.

Shim, Young-Hee et. al. 1991. "Sexual Violence and its Countermeasures in Korea: A Victimization Survey of Seoul Women." Summary of a report by the Korean Institute of Criminology as reprinted in the Information Booklet of the Korea Sexual Violence Relief Center. Seoul, Korea.

Shamim, Ishrat. 1985. "Kidnapped, Raped, Killed: Recent Trends in Bangladesh." Paper presented at the International Conference on Families in the Face of Urbanization, New Delhi, December 2-5.

Shrader Cox, Elizabeth. 1991. "Violence Against Women in Mexico: Legislative Reform and Service Innovations for Battered Women and Rape Survivors." Paper presented at the 18th Annual NCIH International Health Conference, Arlington, Virginia.

Sorenson, S.B., et. al. 1988. "Prevalence of Adult Sexual Assault: the Los Angeles Epidemiologic Catchment Area Study." American Journal of Epidemiology 126:1154-1164.

Stark, E. et. al.. 1981. Wife Abuse in the Medical Setting: An Introduction for Health Personnel. Monograph #7. Washington D.C.: Office of Domestic Violence.

Stark, E. 1984. "The Battering Syndrome: Social Knowledge, Social Policy and the Abuse of Women," (dissertation). SUNY-Binghamton.

Stewart, Denise. 1989. "The Global Injustice." Vis-a-Vis. Ottawa: Canadian Council on Social Development.

Straus, M. and Steinmetz, S.K. 1980. Behind Closed Doors: A Survey of Family Violence in America. New York: Doubleday.

"Ten Facts about Violence Against Young Women," compiled by the Senate Judiciary Committee. U.S. Congress. August 29, 1990.

Ugalde, Juan Gerardo. 1988. "Síndrome de la Mujer Agredida." In Mujer no. 5. San José, Costa Rica: Cefemina.

UNICEF. 1986. Statistical Review of the Situation of Children of the World. New York: UNICEF.

Valdez Santiago, Rosario and Shrader Cox, Elizabeth. 1991. "Violencia Doméstica: Características y Alternativas de Solución en México." Paper presented at "Leading the Way Out," an international conference on violence against women sponsored by the Global Fund for Women, Menlo Park, California.

Vogelman, Lloyd. 1990. "Violent Crime: Rape." In People and Violence in South Africa. Edited by Brian McKendrick and Wilma Hoffman. Cape Town: Oxford University Press.

Walker, Lenore. 1989. Terrifying Love: Why Battered Women Kill and How Society Responds. New York, NY: Harper & Row Publishers.

World Health Organization. 1985. World Health Statistics Annual. Geneva: WHO.

Worth, Dooley. 1989. "Sexual Decision-Making and AIDS: Why Condom Promotion among Vulnerable Women is Likely to Fail." Studies in Family Planning 20(6):297-307.

Wu Han. 1986. United Nations Case Study of China. Proceedings of the Expert Group Meeting on Violence in the Family with a Special Emphasis on its Effects on Women. Vienna, Austria. (U.N. Document BAW/EGM/86/CS.15).