

RESPONDING TO VIOLENCE
AGAINST WOMEN



Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



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'We need to stop viewing violence against women as a problem which only affects women. In its entirety it is a grave social and public health issue, due to both its magnitude and the serious repercussions it carries for the collective safety and health of families and society'.

Violence against women is a manifestation of the historically unequal relationship between men and women. Such violence has perpetuated itself throughout history, through socialization and legitimization as an acceptable way of resolving conflict.

In 1981 activists for the rights of women lobbied for the 25th of November, the date in 1961 when the three Mirabel sisters were murdered, to be chosen as the day to focus particularly on violence against women. In 1999, the General Assembly of the United Nations designated the 25th of November as the International Day for the Elimination of Violence against Women. This resolution is the result of a growing international movement to halt violence against women motivated by the 16 Days of Action against Gender Violence, which this year calls on all governments to address the links between violence against women and the HIV/AIDS pandemic, which is supported by the United Nations as a strategy to successfully reach the Millennium Development Goals.

As president of the World Health Assembly 2005 I proposed, at the inaugural meeting of the 58th Assembly, that the greatest challenge of this century should be the fight against the inequalities of health. Women comprise more than half of the world's population and have an important role as health activists within families and communities. To effectively

combat inequalities of health promotion, prevention, treatment and care and research in health should take into consideration the situation of the female population. Many of the world's women and girls live and experience situations of violence; female genital mutilation is performed on thousands of women, women are obliged to marry men against their will or choice, women suffer maltreatment and sexual exploitation and also coercion and domestic violence.

Depending on the country, between 10 to 69 percent of the world's women experience physical abuse by a man who they were or still are sexually intimate with at some point in their life. Half of the women who die from homicide are killed by their husbands or present or previous partners. This figure approaches nearly 70 percent in some countries. In their lifetime one in four women will be the victims of sexual violence by their partner. These numbers represent only the tip of the iceberg, underneath there are many more unreported cases of physical, sexual and psychological violence occurring.

Violence against women is a Transcultural phenomenon, present in all countries and at all social levels. It has been present with various characteristics throughout all human history. But it is not an insolvable problem. We can and we need to improve our knowledge of the causes and characteristics. We need to recognize risk factors and detect the manifestation of violence at an early stage.

We need to stop viewing violence against women as a problem which only affects women. In its entirety it is a grave social and public health issue, due to both its magnitude and the serious repercussions it carries for the collective security and health of families and society. Firstly it is necessary to have zero tolerance for this type of abuse. All forms of violence against women need to be rejected, and support for those who have been abused should be available. We need a clear and decisive answer from the health sector, in collaboration with women's organizations and other related

public powers.

Secondly, health professionals need to be aware of these risk situations and need to document and report all detected cases. Some countries have created protocols for this and have distributed them to medical professional (physicians and nurses) at the primary care level. These protocols should also be distributed within paediatrics and include an analysis of risk factors for the early detection of physical or psychological violence against girls and adolescents within the family environments and schools.

Thirdly, we should guarantee adequate treatment of the physical and psychological consequences of violence against women. This treatment should be considered a priority and we need to assure that no personal, religious, financial or other conditions exist, which limit women's access to such care. A factor, which may facilitate this, is to have more female physicians and nurses in positions of responsibility and assistance who understand the importance of these problems and who are trained to prevent and detect them.

The public health response is one of the answers to the problem. This is not a substitute for the actions of other sectors (educational, judicial, political, social services and other) but should rather be complimentary. This is not a simple task, but it is an indispensable one, not only for the health of women, but for the health and well being of all.

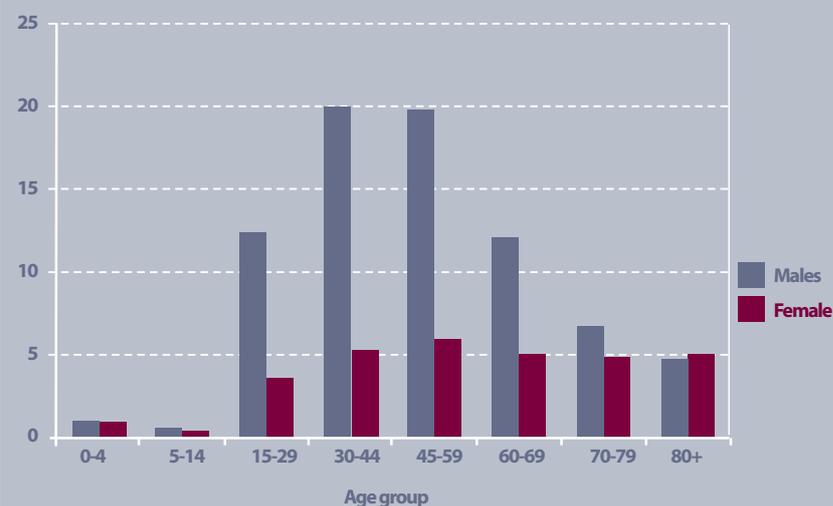
Elena Salgado
Minister of Health, Spain

VIOLENCE AGAINST WOMEN IN THE WHO EUROPEAN REGION – AN OVERVIEW

Interpersonal violence

In the WHO European Region, which is made up of 52 Member States reaching from Iceland in the north-west to Tajikistan in the south-east, a wide variation exists regarding the prevalence of interpersonal violence, i.e. the intentional threat or use of physical force against another person (child, partner, elder, acquaintance, stranger) that results in injury, death, psychological harm, mal-development or deprivation (1). In 2002 a registered 73 000 people of all ages and both sexes were killed by interpersonal violence in the WHO European Region. The differences in the Region are striking. When country income is compared males have thrice the risk of dying from homicides than females in low and middle-income countries (LMIC) and twice the risk in high-income countries (HIC) (see figure 1). The risk of dying from homicide in the country with the highest death rate (28.0 deaths per 100 000 in the Russian Federation) is 32 times that in the country with one of the lowest (0.9 per 100 000 in the United Kingdom) (2). Besides the fact that more males in the Region are victim to interpersonal violence resulting in death or serious injuries, they are also more likely to be the perpetrators of violence – of violence against men, and, of violence against women.

Figure 2: Age- and gender-specific mortality rates from interpersonal violence in the WHO European Region, 2002



Source: Global Burden of Disease 2002 estimates [web site] (2)

Commentary: Death data presented here are proxies and also include deaths caused by acquaintances and strangers.

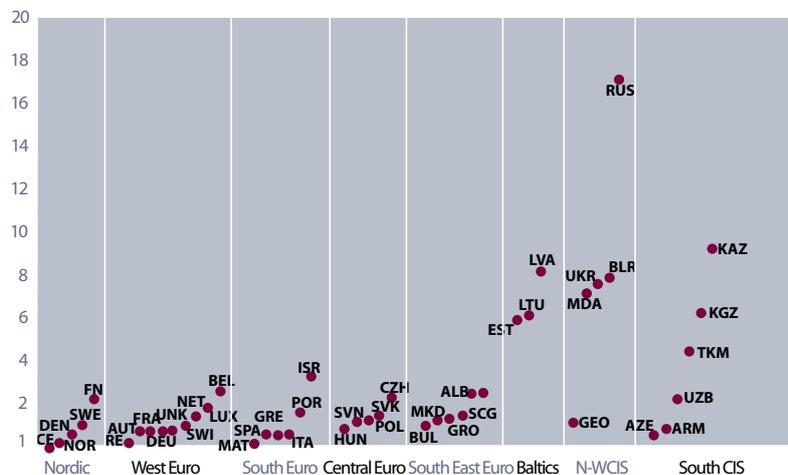
Violence against Women

The UN definition of violence against women is: “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life” (The UN Declaration on the Elimination of Violence against Women, December 1993).

Death figures for the Region reveal that contrary to homicide among male (which peaks in adolescence and young adult life), femicide occurs at a stable level in all age groups, starting from adolescence ranging into old age (see Figure 2). Femicide, that is the death of a woman as a result of interpersonal violence, is only the visible tip of the vast dimension of violence against women which ranges from injury to forced sex to humiliation and intimidation.

Violence against women is prevalent in and across the Region: surveys from countries as diverse as Albania, France, Finland, Germany, Sweden, Tajikistan and the United Kingdom suggest that 10–60% of women have been assaulted by an intimate partner at some time in their lives (1). In population based demographic and reproductive health surveys in Eastern and Central Eastern Europe between 15 and 29 % of women reported to have ever suffered abuse and 8 to 10 % reported abuse in the previous year (see figure 3).

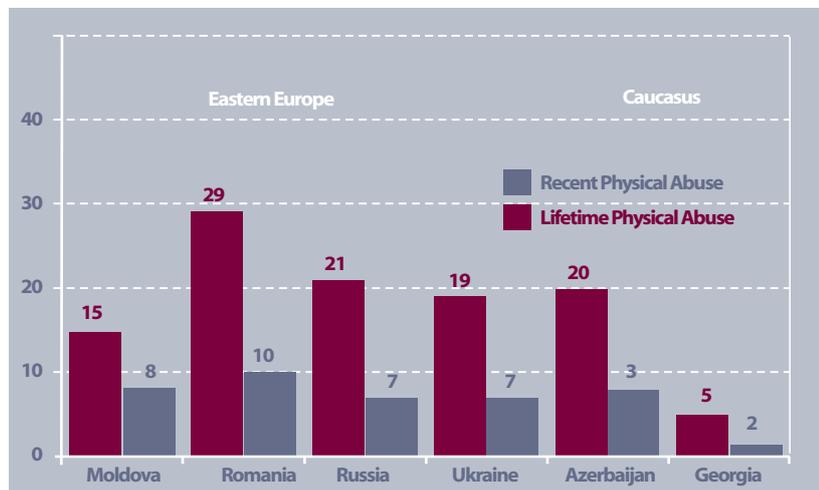
Figure 1: Mortality rates for interpersonal violence in females aged 30–44 by country and sub-region in the WHO European Region, 2002.



Source: Global Burden of Disease 2002 estimates [website] (2)



Figure 3: Percentage of ever-married women who reported lifetime and current physical abuse by a partner



Source: International Reproductive Health Surveys and Comparative Reports: Eastern Europe and Eurasia (4).

Intimate partner violence – key facts (9)

- Intimate partner violence (also known as “domestic violence”) is endemic in all cultures, and the lifetime prevalence of assault is 10–64% in the WHO European Region.
- Femicide is the eighth leading cause of death (5200 deaths) due to injuries and the thirteenth leading cause of disability in women aged 30–45 years.
- Women in low and middle-income countries (LMIC) have 10 times the risk of violent death than those in high-income countries (HIC). Mortality rates are highest in the Baltic countries and the Commonwealth of Independent States (CIS), and lowest in the Nordic countries and Western Europe.
- Intimate partner violence may remain hidden and can occur over long periods, whether physical, sexual and/or psychological.
- Victims have an increased risk of suicidal behaviour, depression, anxiety and psychosomatic disorders.
- Children are affected by intimate partner violence in the family, as witnesses and/or victims.
- The criminal justice and health sectors often appear to be reluctant to target intimate partner violence.
- Risk factors are: having witnessed violence in the family, received poor parenting, had a poor education, and inequalities in wealth, concentrations of poverty, wide availability of firearms and alcohol and substance abuse.

While media draw attention to youth violence, intimate partner violence (and violence in other close relationships) is notoriously hidden from view. The weapons used are less likely to be guns and knives, but rather fists, feet, other objects and intimidating behaviour.

Abuse can occur over a long period and women may experience more than one form of violence, including sexual coercion and psychological abuse such as intimidation, humiliation and controlling behaviour. Violence against women can remain undetected for many years and most victims may not seek help or report to the authorities. For example, official estimates from the Russian Federation suggest that there are 250 000 violent crimes against women annually, but that most go unreported (9). While pregnancy can be a time of protection from violence, it may increase the risk of violence too (5).

Despite a strong human rights and gender equality frame in the region, justice systems are still more likely to take action against violence in the community than that in the home, whether on intimate partner violence, child or elder abuse. Also, the cultural context influences what is considered as acceptable behaviour.

Sexual violence, which may occur in an intimate partnership or be commit-

ted by an acquaintance or a stranger, is prevalent: for example, nearly one in four women in the United Kingdom report victimisation (6). Data collected by the criminal justice system underrepresents the size of the problem, as it is estimated that on average only 5–25% of women report rape to the police (6). Reasons for under-reporting and not seeking help include shame, stigma and fear of social exclusion, re-victimization, rejection and punishment. Women from ethnic minority groups and migrant communities may encounter even greater difficulties in reporting violence, sexual exploitation and trafficking and are at greater risk of facing reproductive health problems, including HIV/AIDS infection. Female genital mutilation (FGM) is posing young girls at risk to a practice conducted in the name of tradition and cultural practice (on violence and HIV/AIDS, and FGM in Europe see separate articles in this magazine).

The consequences of violence against women

A life-course perspective on violence against women reveals a link between sexual or physical abuse in childhood and intimate partner violence in later life: more women who experience violence (compared to those who do not) report having been victim to violence in their childhood. These findings shed light on the inter-generational aspect of violence and risk of re-victimisation or perpetration. Longitudinal studies show that long-term consequences of child abuse reach far into adult life: including self-rated ill health, high-risk behaviour (such as smoking, drinking, drug abuse, unprotected intercourse, multiple intimate partners), and chronic illness. Children who often witness intimate partner violence suffer from this experience too, the consequences reaching far into later life. In 50% of the known cases of domestic violence they directly suffer abuse too (6).

Sexual violence - key facts (9)

- Sexual violence occurs in the home and family, in workplaces, schools, prisons and other institutions.
- Sexual violence profoundly affects the mental and physical health of women, impairs their sexual and reproductive health and their right to control it.
- Trafficking of women for sexual exploitation is a major problem in some of the countries in the European Region.
- Little is known about vulnerability (e.g. of mentally or physically disabled women, illegal or trafficked women) and risk factors (illegal status, imprisonment, drug abuse).
- Sexual violence includes date rape, sexual coercion in marriage, sexual harassment, rape by strangers, child sexual abuse, systematic rape during armed conflict and forced prostitution and trafficking. While males perpetrate most acts on females, sexual violence of men by men and coercion of boys by women also occur.

Violence against women seriously impacts health and burdens public health

For every death from interpersonal violence an estimated 20-40 hospital admissions with serious injuries occur; for every hospital admission multiple visits to a practitioner (like family doctor, gynaecologist, maternal and child health service providers), often repeatedly. An unknown number of cases are self-treated and not revealed to a health professional.

The visible physical consequences of violence against women are injuries. However, the health effects extend beyond physical injuries and include sexual and reproductive ill health, unwanted pregnancy, sexually transmitted infections (STIs) and HIV/AIDS. Psychological consequences include depression, anxiety, phobias, substance abuse, and sleep and psychosomatic disorders (1). Intimate partner violence results in increased suicidal behaviour. Few studies measure costs, but in the United Kingdom it was estimated that the costs of domestic violence are at nearly 33 billion per year, or 2.2% of the gross domestic product (7).

Risk factors

Individual-level factors that influence whether a man assaults a woman include a history of violence in his family, poor

parenting, witnessing abuse of his mother, harmful alcohol use and poor educational attainment. Alcohol is a risk factor for violence against women in the Region (8,9). A study from a Moscow centre providing psychological support for battered women found that 33% of cases of violence were triggered by the husband's alcohol abuse.

Certain groups such as sex workers are at high risk of sexual violence. Factors such as young age, alcohol and drug consumption, a past history of sexual violence and having many sexual partners are associated with increased risk.

Relationship factors include low income, socio-economic distress and poverty, discord in the relationship. Violence may also be linked to a woman's inability to leave her partner. Minor events that threaten power relations between the sexes can trigger violence too, including a woman disobeying or arguing with a man, questioning him about money or girlfriends, not having food ready on time or refusing to have sex, and a man's suspecting a woman of infidelity.

Community and societal factors like rigid gender roles, inequalities in power relationship between men and women, and economic constraints are factors that may determine violence and may make it difficult for a woman to leave her partner. The increase in intimate partner violence in societies in transition has been attributed to the high consumption of alcohol and drug abuse, family conflicts caused by poverty and changes in earning capacity and gender roles, and the loss of social capital and networks.

Responses to violence against women

Responses to intimate partner violence have concentrated mainly on providing services and support for victims, preventive interventions have concentrated on legal reforms and on raising awareness. Systematic evaluations of programmes are few.

Prevention at the individual level works to change the attitudes and behaviour of people who have already become violent,

and includes programmes that aim to alter rigid gender roles and promote responsible partnership, and involve men more strongly in reproductive health issues, family and child health.

Community-level programmes include raising public awareness, stimulating community action and providing care and support for victims. These involve training health professionals, police and lawyers in better recognizing violence and providing care, support and referral to shelters and other services.

Primary prevention programmes in schools and in the community aim to prevent date rape, increase awareness on sexual violence, honour crimes and FGM and promote gender equality have had some promising results. The same is true for family planning, parental training and home visitation or reducing the availability of alcohol.

Despite the success and good practices in and across the WHO European Region, a number of challenges remain to be tackled in future.

Challenges

- Violence against women is often "bottled" by policy makers, neglecting the fact that it has a far deeper impact than the immediate harm caused.
- Health professionals (reproductive health professionals included) are still reluctant to recognise their crucial role in responding to violence against women, even though the opportunities are clear: they are repeatedly in contact with women and children, from childhood until late into reproductive life.
- Gender equality has been given increasing attention in global targets (like the Millennium Development Goals and in poverty reduction strategies), recognising the linkage between health, gender equality and social development. However progress will depend to a large extent on the ability to mainstream, i.e. integrate, gender concerns into relevant programmes and policies and assure appropriate resource allocation (as known from

- Gender budgeting).
- Networking and partnerships are the basis for successful prevention strategies and victim support, however all too often vertical approaches create invisible boundaries, which hamper successful action. Better linkage between public and private (civil society) initiatives, between the health sector and social services, shelters, and other victim support structures could increase women's trust to expose themselves and seek help.
 - Involvement of men in gender equality, in sexual and reproductive health issues and services across the region and targeting men to address underlying risk factors for violence against women have been neglected fields of interest. As a consequence too little is known about high-risk groups or the social determinants of violence by men against women and children.
 - Adolescence is associated with risk taking behaviour and experimentation: bullying and violence at schools, violent sexual experiences like date rape, or the consumption of alcohol or drugs are problems which affect male and female adolescents. Are health promotion, sexual and reproductive health, as well as HIV/AIDS prevention strategies and services sufficiently reaching young men and women, and do they realise their potential in preventing harm and ill-health (ranging from injuries and suicide to violence and STIs)?

Key messages for programme managers and policy makers

- Health and reproductive health services have a key role to play: they can identify women and their children at risk of suffering violence; they can provide appropriate services and refer to shelters and other services;
- A comprehensive health sector response to violence against women integrates measures addressing violence in all areas of health care (such as reproductive health services, maternal and child health, mental health, HIV/AIDS, emergency care);
- The health sector needs to work closely with the other sectors such as justice, education and leisure, and has a unique role to play in advocacy, surveillance and coordinating a multisectoral response to prevent violence;
- The training of health professionals is crucial to create greater awareness about the problem of sexual violence. HIV/AIDS prophylaxis is increasingly used following rape. Guidelines for managing cases and collating evidence have been used to improve standards;
- Proper medico-legal documentation can play a role in successful prosecution. Forensic examination should be made available;
- Strengthened capacity for data collection and research will provide evidence on the scale and consequences of violence against women, and determine "what works and what does not" in primary prevention and victim support;
- Prevention includes programmes that alter rigid gender roles at the individual and community level and promote responsible partnership and positive parenting;
- More attention to the prevention and early identification of child sexual abuse will help to avoid long-term consequences;
- Multi-sectoral national plans of action to address violence against women need to be established, implemented and monitored; they should be linked to other action plans (like poverty reduction, HIV/AIDS prevention, reproductive/women's health, gender equality, child and adolescent health);

For more information about the WHO Regional Office for Europe's activities on the prevention of violence, please visit the website of Violence and Injury Prevention at www.euro.who.int/violenceinjury

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STRATEGIES FOR FEMALE GENITAL MUTILATION PREVENTION IN EUROPE

The situation of female genital mutilation in Europe

To date, there is no reliable data available on the practice of female genital mutilation (FGM) in Europe, neither on the total number of women and girls who have undergone the practice, nor on the number of girls at risk.

Anecdotal data is available from some European countries (1): in France, estimations vary from 4500 to 7000 girls at risk, and from 13 000 to 30 000 women who have been mutilated. Approximately 21 000 women with FGM live in Germany and an estimated 5500 girls might be at risk. In 1994, the Italian Ministry of Internal Affairs estimated that 28 000 women and 4000-5000 girls with FGM live in the country. Approximately 6700 girls at risk of FGM and/or women who have undergone the procedure live in Switzerland. In the UK, 86 000 first generation immigrant refugees/asylum-seeking women and girls, have undergone FGM.

WHO classification of different types of FGM

Type 1: Excision of the prepuce, with or without the excision of part or the entire clitoris;

Type 2: Excision of the clitoris, with partial or total excision of the labia minor;

Type 3: Excision of part or all external genitalia and stitching/narrowing of the vaginal opening (infibulation);

Type 4: Unclassified; included piercing, or incising of the clitoris and/or labia, cauterisation, scraping, or cutting of vaginal tissue etc.

Source: WHO factsheet No 241. What is Female Genital Mutilation. June 2000. <http://www.who.int/mediacentre/factsheets/fs241/en/>

These operations are all irreversible. Acute complications include death, haemorrhage, shock, infection and severe pain. In addition, women can suffer severe long-term damage to their reproductive and sexual health, risk HIV infection, and are often left with psychological scars.

However, establishing the magnitude of the problem of FGM in Europe is paramount to ensure an adequate and strategic response, measure changes in behaviour (2), as well as to monitor the increase or decrease of the number of women with FGM and girls at risk (3).

National laws in Europe with regard to FGM
Legal provisions pertaining to FGM are found

in a variety of sources, including criminal laws and child protection laws. In Europe, some countries developed specific legislation on FGM; in other countries FGM is prosecutable under the general penal code.

In six European countries, specific criminal law provisions have been developed: Austria, Belgium, Denmark, Spain, Sweden and the United Kingdom. With the exception of Sweden and the UK, all laws have been developed very recently. In none of these countries, cases have been brought to court under these specific criminal law provisions.

In the former 15 European Member States, FGM is forbidden under general criminal law. In all Member States, other laws exist that can be used against FGM. Child protection procedures and laws with regard to professional secrecy are the two most important legislative texts that are indirectly tackling the practice of FGM.

Research (2) on the implementation of legal provisions in five European countries showed that laws pertaining to FGM have been implemented: cases of FGM and girls at risk have been reported, investigations were initiated and child protection measures have been taken. However, no cases have been brought to court, except for France, where more than 30 cases have reached the courtroom. The research also showed that the reporting of cases of already performed FGM or cases of girls at risk of FGM has proven to be problematic as well as finding sufficient evidence to bring a case to court. The implementation of laws is further exacerbated by the fact that in some countries those health professionals, authorities and police officers who need to be alert to the problem of FGM, have a lack of knowledge about the practice in general and about the legal provisions and procedures to follow in particular. Furthermore, all these actors have their own attitudes towards migrant populations and towards the practice of FGM, which further hampers an adequate implementation of laws.

Education and prevention in Europe
NGOs working towards the eradication of FGM in Europe emerged in the early nineteen eighties. NGOs and community-based organisations have either focused their work solely on FGM or adopted a holistic approach by incorporating the issue in their work on women's issues,

health issues, or migrant/refugee issues.

For example in Sweden, Denmark, Germany, the United Kingdom, Italy, and the Netherlands, a wide range of actors work at different levels of society to prevent FGM: at health care level, within the police, the media, at community level, in schools, etc. The activities of the NGOs are devoted to prevention work, lobbying and advocacy. They provide information, education, and communication activities towards practicing communities and towards the western audience. These include the production of training programs for professionals, developing educational material, and developing awareness-raising campaigns aimed at different target groups.

Health care services in Europe (4)

In Europe three main health interventions dealing with health issues related to FGM have been put in place.

In some European countries, hospitals and/or Ministries of Health have developed technical guidelines for the clinical management of women with FGM. These guidelines mainly deal with health complications of FGM and provide technical assistance for the management of cases of defibulation, that is the opening of the infibulated genitalia, and care at the time of delivery, as well as antenatal and postpartum care.

Codes of conduct are mainly developed by professionals' organisations, such as the British Medical Association and the Royal College of Midwives of England. These codes go beyond the clinical management of women with FGM, as they also outline the provision of ethnically sensitive care, and give insights in the ethical and legal issues with regard to FGM and the health services.

In the UK, specialist midwives are working in African Well Woman Clinics that have care, support, information, advice and counselling to women and their partners. They also offer defibulation, where appropriate, to both pregnant and non-pregnant women, and training for health care professionals.

Specialized health services for women who have undergone FGM, however, are more the exception than the rule in Eu-

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rope and guidelines and codes of conduct are not provided for in all health services.

Most general health services in Europe are unfamiliar with the consequences of FGM. This can result in inadequate care (for example unnecessary caesarean sections in cases of infibulation) and discourages women from seeking appropriate care for their FGM-related problems. Personal emotions and feelings of the health professional, such as feelings of powerlessness (as some FGM procedures are irreversible) or anger (cutting genitals is alien to western practice), can also hamper the provision of adequate care. The lack of knowledge of needs and expectations of the affected communities regarding health care is also apparent.

In order to provide appropriate and sensitive health care for women with genital mutilation, the needs and health seeking behaviour of affected communities has to be assessed. Furthermore, health care professionals' training needs have to be addressed and should take into account various levels, including clinical care, prevention of FGM, counselling, communication, attitudes and ethical issues. Guidelines on counselling services, on referral mechanisms for girls at risk or women with genital mutilation, on successful communication, on clinical care and ethical questions such as re-infibulation and medicalisation need to be developed.

Health care professionals encounter women, their husbands and other family members around birth of a child and during routine check-ups. These encounters provide opportunities for counselling on the health and well-being of the girl child and may influence decision-making against FGM among the second generation of immigrants. And last but not least, the operational coherence between health and other agencies that are dealing with FGM should be improved by multi-sectoral collaboration, in order to provide adequate holistic care for women with FGM.

Research on FGM in Europe

Research on FGM in Europe, either on clinical aspects or on social and behavioural aspects of FGM in relation to a

European setting, is scarce. Such research is however paramount for any EU Member States' FGM policy initiatives, as such initiatives need to be based on rigorous evidence-based research if they are to be effective (6).

Conclusions

Although recently many initiatives have been taken to tackle the problem of FGM in Europe, several issues remain. First of all, more data are needed on the magnitude of the problem of FGM in Europe, to guide evidence-based interventions and to monitor progress.

To improve the effectiveness of legal provisions that deal with FGM, more attention has to be paid on the implementation of existing laws. The identification of cases and the provision of evidence to bring a case to court deserves special interest. Furthermore, more attention needs to be paid to protective measures in order to prevent girls from FGM.

With regard to education and prevention initiatives in Europe, issues that need further attention include cooperation at national and European level, evaluation of educational material, and collaboration with specific target groups such as religious leaders, youth and men.

The need for evidence-based research and baseline needs assessments is paramount if actions are to be effective. Research in Europe should focus on performing evaluations of existing interventions to determine their effectiveness. Assessing determinants of behaviour changes could also support the development of more effective interventions.

Health services in Europe need to address the training needs of their professionals, develop appropriate guidelines and discuss ethical issues. The health care needs of the affected communities need to be assessed in order to develop culturally sensitive health care.

Finally, there is a need for a better coherence between all agencies working towards the abandonment of FGM. The Resolution of the European Parliament from 2001 on FGM made some useful suggestions for developing a European policy with regard to FGM and it has the potential to guide the design and imple-

mentation of a common approach to deal with FGM in Europe.

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VIOLENCE AND TRAFFICKING AGAINST WOMEN IN EUROPE: A PRIORITY FOR HIV PROGRAMMING?

The relationship between violence against women and HIV/AIDS is rapidly gaining currency within the health community. Yet, the present and future implications of these links within Europe have not been well examined. Is intimate partner violence relevant solely in sub-Saharan Africa, or could it be fuelling current heterosexual HIV transmission in Europe?

Is the sexual coercion of adolescent girls important to HIV transmission rates in Europe? How much credence should be given to fears that the trafficking of women into sex work might be contributing to a European HIV epidemic? Are these impending crises or overstatements?

Women and the HIV epidemic in Europe

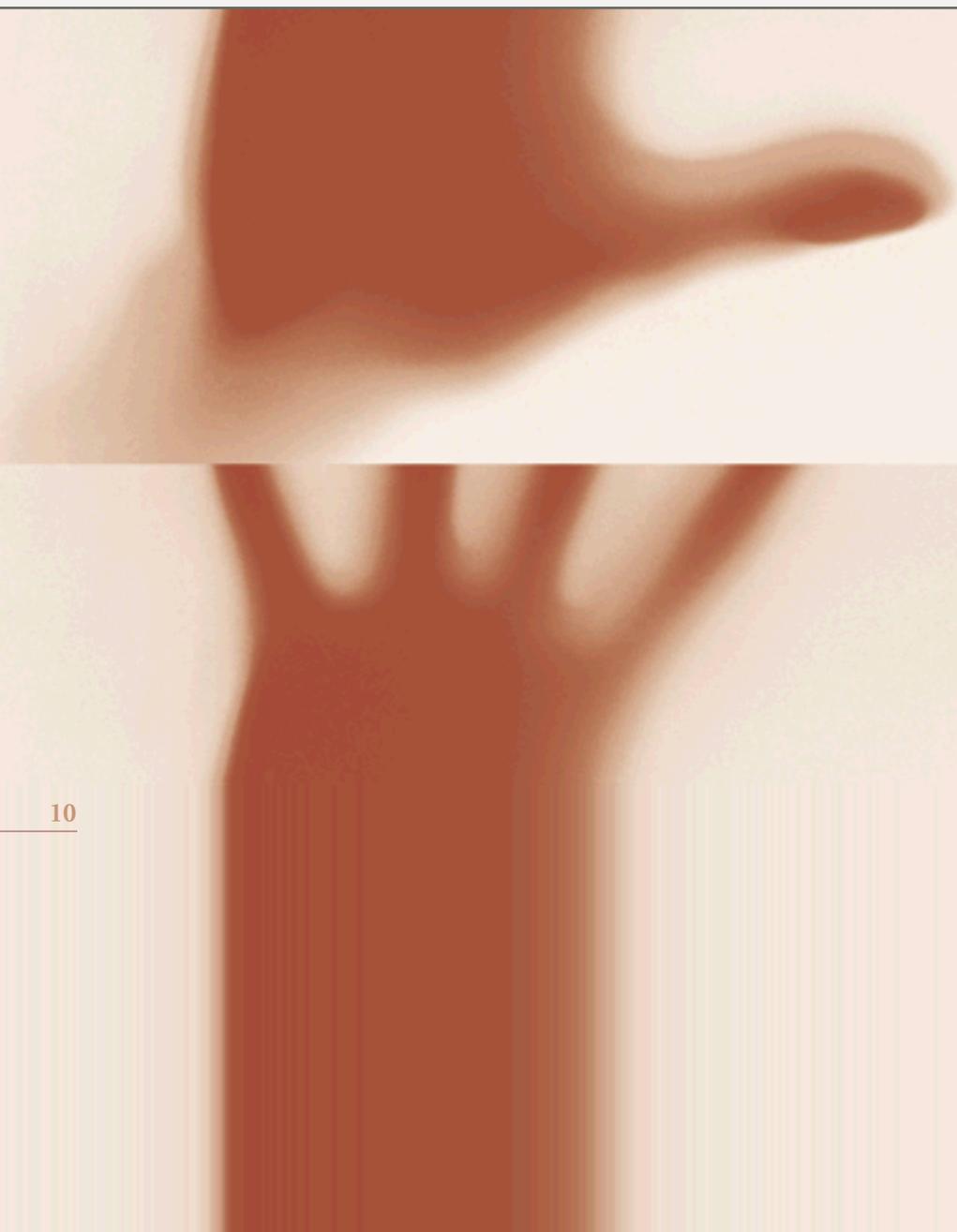
The HIV epidemic shows substantial heterogeneity within and between nations in Europe, with injecting drug use representing the main mode of transmission in eastern Europe, while heterosexual and homosexual sex is more important in other European settings. Despite these differences, throughout Europe, a substantial proportion of newly diagnosed HIV infections are in women (37%, 31% and 38% in western, central and eastern Europe in 2003) (1). HIV rates often vary within countries. High rates are frequently found among vulnerable groups such as sex workers or injecting drug users – some of the same groups that are vulnerable to violence.

Violence against women in Europe

Violence against women covers many forms of abuse, including physical and emotional abuse perpetrated by an intimate male partner, rape, child sexual abuse and neglect and the trafficking of women.

Sex-workers routinely face physical and sexual violence from clients and others, such as pimps, club owners and law enforcement personnel. A survey of 240 sex workers in Leeds, Glasgow and Edinburgh found that 26% to 50% reported some form of violence by clients in the past six months.

Accurate figures on the trafficking in women within and into Europe have not been gathered. In 2001, the European Commission estimated that 120 000 women and children are being trafficked into Western Europe every year (2) and in 2003, the International Organization for Migration's estimates suggested that as many as 500 000 women are being trafficked into the EU (3). However, research



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is increasingly showing the profound and enduring harm to women's physical and psychological health.

Although there is limited data available on drug users and violence from Europe, in the United States, lifetime rates of partner violence among women in substance abuse treatment programmes range from 60% to 75% (4) – these rates are two to three times higher than the 21–34% range found in national surveys of general populations of women (4) and (5).

Common features occur across most forms of violence. For example, violence is commonly perpetrated by men known to the woman, violence is frequently hidden, victims are usually younger versus older women, non-physical forms of coercion are common in sexual abuse, and social forces play a role in constructing women's vulnerability, male-dominating behaviours, and in stigmatising victims.

Violence against women and HIV: linked or parallel epidemics?

Across the European Region, physical and sexual violence may appear more generalized than HIV, but in fact, there seem to be many intersections, particularly those related to risk. Increasingly, ecological models are being used to help identify characteristics of the larger society, the immediate social context, and the personal history and individual characteristics associated with risk.

At the biological individual level, coerced or forced sex of women of any age may increase the likelihood of abrasions and tears to the vagina, and therefore may facilitate the transmission of HIV and other STIs: in various studies between 40% and 87% of women who were sexually assaulted showed signs of genital injury (6).

At an individual level, studies have found associations between male severe alcohol use or male drug use and partner violence, and show the links between unprotected sex and drug and alcohol use.

At a structural level, factors such as, economic crises, social unrest, and gender inequality, are generating HIV-related risk contexts and perpetuating violence against women.

Early experiences of violence and links to later risk of HIV infection

There is growing evidence that early experiences of violence act as a precursor to later behaviours that put women and men at risk of HIV infection. Child sexual abuse has been associated with poor mental health, difficulty with intimacy, agency and sexuality, multiple sexual partnerships and involvement in prostitution, future risk of further victimisation and drug and alcohol misuse. For example, a Vancouver cohort study of injecting drug users found that 33% of women, and 13% of men had been sexually abused as a child, with 68% of women and 13% of men reporting a life history of sexual violence (7).

Migrant populations from sub-Saharan Africa

Mobile populations are increasingly identified as a primary source of change in regional HIV prevalence rates, as individuals move between different epidemiological environments. Migrant populations from sub-Saharan Africa in Western Europe, account for 26% of HIV infections diagnosed in 2003 (8). Evidence from sub-Saharan Africa suggests for example, that partner violence is a risk factor for HIV infection.

Trafficking of women and girls and HIV/AIDS

Discussions on health and trafficking have hinted at the potential for it to fuel the HIV epidemic. Trafficked women rarely have control over the type of sexual encounter that takes place or access to health information or services. Findings from women in seven service settings in the United Kingdom, Italy, Belgium, Czech Republic, Bulgaria, Ukraine and Moldova show that nearly 70% never had a sexual health check while trafficked, and 80% reported having "never" been free to do what they wanted or go where they wanted (9). Nevertheless, it is important to recognize that being trafficked does not universally result in becoming HIV infected. While in some settings, infection rates may be quite high, trafficking

assistance centres in Europe have thus far encountered relatively low prevalence.

Women living with HIV

In addition to putting women at greater risk of HIV, it is notable that violence or increased violence may also be a consequence of becoming infected. Particularly for a woman in an abusive relationship, disclosure of her HIV status may increase her susceptibility to sexual and physical violence. Moreover, women living with HIV may be less likely to access services, either due to stigma, marginalised status, or violence at home. For example, migrant and other marginalised populations often face logistical or practical access problems, including difficulties of language, finances, awareness, legal rights to services, and transport problems.

Challenges of including violence against women in HIV programming

The many dimensions of the relationship between violence against women and HIV are not yet clear. Neither are the routes to policies and programmes that might address both safely and efficiently. Further qualitative and longitudinal research is needed to explain the complex links between violence against women and different aspects of HIV risk.

Despite the lack of data, existing evidence of the extent of violence paints a compelling case for the strong linkages between the two epidemics of HIV/AIDS and violence against women, and the need for further action. The late and limited attention given to violence against women by many groups working on HIV/AIDS reflects a profound oversight of key aspects of men and women's relationships.

The prevalence of violence against women requires that organizations carrying out HIV programmes explicitly address the issue of violence in culturally appropriate ways, and identify practical strategies to integrate the issue into prevention messages and activities. Inattention to the reality of gender-based violence in the promotion of healthy

sexuality and safer sex makes messages of abstinence, partner communication and condom negotiation seem irrelevant, naïve, if not ludicrous, to those women and girls experiencing violence. Such activities are likely to be synergistic – reducing violence and/or addressing the consequences of abuse are both likely effective means of reducing vulnerability to HIV. Moreover, given the priority that women of all ages place on protecting themselves from violence, by integrating the subject of gender-based violence into HIV programming, HIV messages and services will accrue added relevancy among an especially vulnerable segment of women.

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Mainstreaming prevention of violence against women into HIV/AIDS programming

“The number of women living with HIV has increased in every region of the world” (2005 report of the Special Rapporteur on violence against women, its causes and consequences). There is growing evidence from different countries that gender-based violence can be both a cause and a consequence of HIV/AIDS. However, this initial understanding of the significant link between gender inequalities, and gender-based violence and HIV/AIDS, has not yet translated into systematic programming. In addition, most donors currently have vertical funding streams for both these issues, making it difficult for organisations or partnerships interested in crosscutting projects to identify the appropriate funding opportunities. Building on several years of experience in combating HIV/AIDS and gender-based violence, the German Agency of Technical Cooperation (GTZ) has committed itself to fostering the international dialogue on the connection between these two areas. In line with its mandate to strengthen national coordination and increase equitable access to health services, the GTZ has initiated support to interventions that address the linkages between HIV/AIDS and violence prevention and develop innovative approaches to access global funds. This initiative provides an innovative model to be followed by others: to help strengthen the health sector response and public health approach to violence against women.

SECURING SHELTER AND SUPPORT FOR FEMALE VICTIMS OF VIOLENCE



Rosa Logar

WAVE is a European network of women's shelters and women's help organisations. It was founded in 1994 and has since followed its aim of combating violence against women and children. Having started off with just six organisations, WAVE currently has a network of about 2400 non-governmental organisations and experts in all European countries that all in their work mainly focus on eliminating and preventing violence against women and children. The main network activities are carried out with the support of 63 so-called WAVE Focal Points in 42 countries, which themselves are key organisations in their own countries.

The network's main working fields are to raise public awareness about violence against women as a grave social problem, to facilitate the exchange of information among the members and to support national governments and international organisations to set measures for combating violence against women and their children.

Since 1994 WAVE has carried out several projects and activities: In 1998 WAVE established a European Information Centre on violence against women based on the creation of a database that is updated on a daily basis. The WAVE database is an ambitious on-going project, which includes the most important aspects of combating violence against women. We therefore not only collect contacts to women's support services but also detailed information on prevention activities in individual countries as well as across borders, particularly in the field of research. Thematically, the WAVE database originally focused on domestic violence/male violence in intimate relationships but has since been expanded to include other forms of violence against women.

WAVE developed a training manual for different professionals, including medical and judicial professionals, which is used in training seminars organised by WAVE. One of the last projects titled 'Away from Violence – guidelines for setting up and running a women's refuge' was funded by the European Commission DAPHNE programme.

Currently, WAVE is carrying out a DAPHNE project called 'Bridging gaps

– models of co-operation between women's organisations and state authorities to prevent violence against women'. The main focus of this project is on the multi-agency co-operation in the field of tackling domestic violence. The objective is to exchange experience and knowledge on co-ordinated co-operation between women's support services and public authorities (like the police, the judiciary and/or the health sector). The project aims at developing a catalogue of standards and guidelines for good co-operation – a tool for starting and guiding a process of coordinated cooperation.

Guiding principle: Safety first!

As regards victim support WAVE focuses on preventive measures and on lobbying for sufficient safe places for women. In order to protect a woman who is affected by violence, the first and most important measure is to provide her with a safe place. In such a place she can start recovering from her traumatic experiences – physically and mentally, and she can find time to think about further steps to free herself from the violent relationship. A women's shelter is an example of such a safe place, as women's shelters guarantee the basic right of victims – the right to safety. It is therefore important to establish a sufficient number of women's shelters all over Europe. According to the recommendation from the Council of Europe Expert Group in 1997 there should be one shelter place per 7500 persons of the population (1).

The next important measure is to offer women health support. The right to health is of paramount importance to a victim of violence. Care is essential to restore the feeling of human dignity and the consciousness of the right to live without violence. Finally, it is essential that women receive crisis support. It is a matter of principle that women in need of these services can come to the shelter at any time, even during the night, as no woman in acute danger is to be turned away or forced to stay with/return to the violent partner. When there is only one women's shelter in a given region this shelter must be open around the clock to admit women and their children. Transport should be available at the lowest possible



The Wave-team

cost (preferable free of charge) to enable women and their children to get to the shelter without having to worry about costs. After the immediate needs are met, the focus must be on preventing further violence.

Considerable efforts will have to be made in the future in order to provide efficient help to women who suffer violence and to eliminate all forms of violence against women and their children. WAVE contributes in the effort to remind international and national bodies to fulfil their human rights obligations and supports individual NGOs in their efforts to help the victims and to combat violence against women and their children. Information about all projects is available on: www.wave-network.org.

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For guidance on setting up and running a women's shelter see the manual "Away from Violence" at the WAVE website, on www.wave-network.org

CO-ORDINATED ACTION

Working through a network

Sabine Bohne



Renate Klein



The Co-ordination Action on Human Rights Violations (CAHRV) is a collaborative effort of 22 research institutions in 14 European countries, national and trans-national policy networks, and individual researchers from 23 countries. This research network addresses human rights violations in the context of interpersonal relationships.

Even in societies not burdened by armed conflict, physical, sexual and psychological violence are widespread in homes, in schools, at work and in the streets. Such violations of basic human rights are also a major cause of health problems, block achievement in education and at work, restrict social networks and may severely limit social and political participation. Most perpetrators are men, but the study of masculinity has only begun to explore the roots of such gendered practices. Similarly, research on protective environments and the effects of societal changes is rudimentary.

The aim of CAHRV is to:

- integrate different approaches to the study of violence,
- unify the theoretical and empirical basis for policy,
- survey a wide territory with a case study approach, and
- structure co-operation through sub-networks.

Thematic areas

CAHRV focuses on four thematic areas, each addressed by a group of researchers with relevant expertise (see Box). One group focuses on identifying and profiling victimization and on developing reliable, comparable data on the prevalence of interpersonal violence and its health impact. A second group concerns the roots of interpersonal violence and the role of masculinities and men's gendered practices in everyday life. The third focuses on intervention practices in different national and cultural contexts, in particular justice system responses. The fourth area concerns circumstances and behaviours that protect against interpersonal violence, in particular the organization and dynamics of work, households, and social networks.

Sub-network 1: Identifying and profiling victimisation (Co-ordinator: Manuela Martinez, University of Valencia, Spain, manuela.martinez@uv.es)

- Overview report on European studies of the prevalence of interpersonal violence and its health and human rights impact
- Comparative re-analyses of research data from ten countries
- Development of estimates of prevalence and impact where representative surveys are not practicable
- Development of indicators for monitoring

Sub-network 2: The roots of interpersonal violence: gendered practices, social exclusion and violation (Co-ordinator: Keith Pringle, Aalborg University, Denmark, keithpringle6@aol.com)

- Social constructions of masculinity, men's gendered practices, social hierarchy and marginalisation
- Interplay of social structure and the psychology of the individual
- Expansion of base-line of data in the European Documentation Centre on Men <http://www.cromenet.org>.

- Development of a comparative research methodology on men's violence

Sub-network 3: Addressing gender-based human rights violations (Co-ordinator: Jalna Hanmer, University of Sunderland, UK, jh@jhanmer.fsnet.co.uk).

- Language and practice of intervention and policy
- Systems responses and good practices
- Research outline across European countries on the justice system as an arena for the protection of human rights
- Country reports on legal response in eleven countries

Sub-network 4: Protective environmental factors securing human rights (Co-ordinator: Ralf Puchert, Dissens e.V., Germany, ralf.puchert@dissens.de)

- Research maps of protective factors
- Focus on work, family, households of choice and social networks
- Family support strategies, informal social networks, intergenerational solidarity
- Gender impact of work environment

The added value of CAHRV

CAHRV promotes awareness of knowledge generated in different countries through transnational collaboration and multilingual information about published research. It builds a better European knowledge base through analyzing existing data for comparability across countries. In addition it promotes effective responses to interpersonal violence across Europe through modelling research that attends to locally specific findings while putting them into a wider European context.

CAHRV capitalizes on one of the great assets of European collaboration: linguistic, social, and cultural diversity. Although it can be challenging to address such diversity, it will enhance the value of research for local communities across Europe.

CAHRV disseminates its findings to the public through its website, publications, and conferences. Annual conferences serve to inform the public about ongoing work in the four thematic areas, and to highlight research findings on violence in the host country. In 2004 a conference

in Osnabrueck, Germany, focused on new German prevalence and evaluation research on violence against women. In 2005, a conference in Paris presented French and European violence research to the French public.

For more information

Conference papers and presentations, the CAHRV newsletter, and links to relevant research are posted to the CAHRV website as they become available. Please go to <http://www.cahrv.uni-osnabrueck.de>.

Individual researchers with relevant expertise are invited to contact the respective sub-network coordinators for further information and networking.

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BREAKING THE SILENCE ON VIOLENCE IN LATVIA

Violence against women: the case of Latvia

Aiga Rurane



Liva Biseniece



Since 1997 the number of women in Latvia experiencing violence has tripled. One out of 10 women in 1997 admitted physical violence (1). In 2003 already three out of 10 women claimed physical assault. Most often women in Latvia who suffer violence from their intimate partners rarely report the battering to the police.

The latest Latvia Human Development Report produced by the United Nations Development Programme (UNDP) revealed disturbing levels of human insecurity in Latvia (2). Individuals, experiencing current physical abuse within the family, reported the highest anxiety levels.

The UN response: involve the public, mobilise stakeholders and the media

Considering the growing problem of violence against women and children and taking into account the implications on human security, UN agencies in Latvia (UNDP, UN Children's Fund Latvian National Committee (UNICEF LNC) and the World Health Organization (WHO)) started a yearlong campaign against violence on 14 March 2005. The UN initiative in Latvia was mainly based on the intellectual output of the WHO World report on violence and health (2002) and the visual message of the WHO Global campaign for violence prevention.

The objective of the campaign was to raise public awareness on the causes and consequences of violence. The campaign was designed to initiate a dialogue with governmental institutions, municipalities and non-governmental organizations in order to bring out gaps in the violence prevention and provision of assistance to victims of violence.

The UN country team approached the problem of violence against women from several angles. First, the general public was addressed by displaying posters produced in the framework of the WHO global campaign in the four largest cities in Latvia. The emotionally loaded and artistically intense outdoor posters reflected the impact of violence on the life and health of women and immediately attracted the attention of people.

Second, organisers partnered with the local non-governmental organisation Skal-

bes, which provides support to victims of violence. In the framework of the campaign the NGO trained a new team of volunteers to service the hotline. As predicted, the number of people turning for help increased during the campaign and assistance and directions for further help to people in need was provided.

The third component of the campaign was the strengthening of cooperation between agencies responsible for prevention of violence and for provision of assistance to the victims of violence. The UN agencies in cooperation with the Training Centre for Local Municipalities organised seminars for teams of representatives of local authorities about ways in which to prevent violence against women and how to help women who have suffered. The Association of Medical Students of Latvia joined the campaign and conducted series of lectures for students on physical and mental implications of violence and legal procedures for recognising and reporting cases of violence.

Finally, the organiser of the campaign launched a massive media campaign to promote resurfacing of the violence issue in printed and electronic media. The organisers produced fact sheets on the most acute issues of violence, provided reference experts, involved opinion leaders. The response from media was high both in terms of the quality and quantity of publications and TV programmes.

Results

The UN campaign gave impetus to a closer cooperation among various governmental, municipal and civil society organisations working with the issue of violence against women. Public discussions, meetings with the government counterparts and publications in the media strongly positioned violence as a serious public health problem in Latvia.

The organisers of the campaign paid special attention to the cooperation with municipalities. Regional launches of the campaign were followed up by discussions with policy makers on particular regional issues. As a result, national problems were discussed from the regional perspective with possible local solutions.

The campaign provided an opportunity to increase skills and knowledge of professionals working with the issues of violence. Representatives from municipal social service institutions, police, courts, and leaders of local communities from 27 regional units in Latvia attended a series of seminars on how to coordinate efforts to fight violence against women.

A tipping point

The UN campaign grew in strength thanks to a generous support of the private sector and media. The international outdoor media company ClearChannel provided a free of charge display of the posters. The visual material of the campaign was given a massive display during the first month of the campaign.

In addition to that, the magazine *Cosmopolitan* volunteered to run its own public awareness initiative, encouraging women to express their experiences. The magazine provided a broad overview of services for women suffering from violence.

The way ahead

During the course of the campaign, the UN agencies in Latvia identified several issues, which need to be addressed in the national legislation. The last months of the campaign will be devoted to analysing outcomes of the campaign and to formulating proposals to the Parliament to ensure that women receive adequate protection from the suspected offender after reporting cases of domestic violence as well as professional psychological support.

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THE SOCIAL CONTEXT OF VIOLENCE AMONG ADOLESCENTS



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Violence among young people has received growing attention in the western world in the last decades. One reason for the growing interest in violence among adolescents is that important areas of violence that have remained hidden from the public eye, and have not been a part of public discourse, have been brought out in the open, indicating the vast scope of the problem.

Adolescents experience violence in different forms in various contexts. They are confronted with it in the media, in interaction with their peers in school, and even at home. Violence may arise as result of self-presentation in a masculine peer culture, as a dispute in a public place, or in the context of illegal activities involving drugs, prostitution and crimes of profit. The various social contexts may affect both the use of violence and victimization both directly and indirectly through violent lifestyles.

One type of violent victimization, that has received increasing attention, is sexual violence. Along with unwanted teenage pregnancy it has been identified as a central social problem with serious consequences for youth and society at large. The issues involved are complex, involving biological, psychological, social and cultural factors. Focusing solely on the social and the cultural aspects of the problem in this article does not mean that other aspects should be ignored. On the contrary, this contribution aims to highlight that the social and cultural aspects are important since, they offer opportunities for prevention. For example, preventive work intended to reduce unwanted sexual experiences and pregnancies among adolescents relies on the

expert knowledge of those working in this area. Awareness of the wider social context that influences violence among adolescents may benefit preventive work in the area of sexual and reproductive health. Thus the aim of this paper is to draw attention to the wider social context of violence among adolescents.

The social and the cultural context of violence among adolescents

There is no single theoretical perspective or research tradition that explains the social and the cultural roots of violence among youth. But most theories share the basic premise that organizational factors characterize communities, neighborhoods or particular social groups that explain variations in violence not solely attributable to individual characteristics. These theories may be divided into two groups. First, there are theories that focus on the social structure of communities, emphasizing low socioeconomic status, poverty, residential instability and disorganization. Communities that exhibit these characteristics may leave youth much more at risk for alcohol and drug use, unprotected sex, delinquency and violence. From this perspective violence is seen as part of a more general delinquent lifestyle that may involve drug use, vandalism, risk taking and a continuous search for excitement. In this context it may be pointed out that countries, such as the east European countries, which are going through a rapid social change are more vulnerable than the more stable countries in Western Europe. Youth in these countries is therefore at the greatest risk.

The second group of theories hold that there are cultures that are prone to violence because they involve values that encourage such behavior. These values may produce violent behavior through socialization determining individual make up, or they may operate through mechanisms of formal and informal social control regardless of personal commitment to these values. Differences exist between the sexes, so much so that male rather than female adolescents may resort to violent behavior to prove themselves



in the eyes of their friends. When violent values are widespread in the peer group, violence may be a way to protect social identity and status within the group. From this perspective adolescent violence is seen as a result of peer processes that involve peer pressure, suggestion and social learning in peer groups that adhere to violent values and norms. Thus, strong collective themes that are widely felt among group members may lead to acts of violence on part of individuals because of social pressure rather than of personal preference.

Violence and sexual victimization

The social context that contributes to violence in general also increases the risk of sexual violence, rape and violence against women. Thus we would expect higher rates of sexual violence in communities that are characterized by poverty, residential instability and disorganization. In the same vein we would expect higher rates of sexual violence among adolescents, where violent norms are widespread in the peer group. The use of alcohol is a contributing risk factor for sexual and non-sexual violence alike. This is especially the case, where adolescents involved tend to get drunk (drink relatively much alcohol at a time). Thus unwanted sexual experience and unprotected sex tends to be higher in countries like the United Kingdom and the Nordic countries where 'getting drunk' or 'binge drinking' is more common than in many other European countries.

It should be emphasized that females in general are much less likely to commit acts of violence than males and also less likely to be victimized by acts of nonsexual violence. However, the social context and the risk factors reveal a similar picture for men and women. The picture changes somewhat when we focus on sexual violence indicating that there are also social factors that relate more specifically to sexual violence and gender.

Preventing violence among adolescents

Preventive work specifically aimed at

reducing sexual violence including rape and unwanted sexual experiences is of vital importance. It includes sex education directed at adolescents. It also includes peer education and campaigns teaching young people about responsible partnerships and the harmful consequences of sexual violence. Targeting sexual violence as a specific problem, isolated from the social conditions that influence violence among adolescents, may, however, not be the best strategy.

First, the research on adolescents shows that the same risk factors that predict violence predict sexual violence. There is a high correlation between sexual and non-sexual violence. Second, prevention will have to address these general conditions of violence as well as the more specific issues related to sexual behavior. Thus, for example, a social context involving aggressive values and norms may evolve in all kinds of violence including sexual violence. This tends to be found in communities that are characterized by social inequalities, poverty, residential instability and disorganization. The process of drift towards adolescent violent behaviour may also be part of the pursuit of adventure, fun, thrill and excitement. Violence may be an important way for group members of a particular peer subculture to assert or defend valued social identities and to gain status and power. In the same manner, violence may be an accepted way to solve conflicts or deal with problems.

Adolescents are subjected to a variety of structural and cultural constraints that they have little possibilities of circumventing. The structure of their community, the local peer culture, as well as the social and economic position of their family, is generally beyond their control. They have, in most cases, no independent avenues of actual social or geographical mobility. Reaching out to them means that we must work within their social and cultural context, their community. One way of doing that is to activate the various networks within the community and bring them to work with young people, as well as increase youth participation in decision-making at community level. This

approach attempts to mobilize youth and adult groups directly at the local level. Emphasis is given to parents and schools, as well as youth workers. This includes parental organizations, youth and sport clubs, school based programs and young people that are organizing special events for adolescents. Since research indicates that the same risk factors predict different forms of delinquency in a similar manner, preventive effort along these lines will reduce violence along with substance use, vandalism and other kinds of nonviolent delinquency.

In addition to encouraging communities to mobilize against violence, through integrating grassroots strategies of this sort, partnerships with agencies of formal institutions, such as police, social workers and health professionals is important. At the same time we must recognize that local efforts along these lines where residents work collectively to solve their own problems does not capture the whole picture. Poverty, socioeconomic factors linked to the wider political economy and unequal opportunities, that beset many communities, need also to be considered.

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ADDRESSING VIOLENCE DURING PREGNANCY IN THE REPUBLIC OF MOLDOVA

Partner violence during pregnancy is widespread and has significant consequences for maternal health. A review of research on the prevalence and consequences of abuse during pregnancy published in 2004 found that prevalence ranged from 4% to 32%, with rates being considerably higher in developing countries .

The review found that in at least two industrialized countries with low overall maternal mortality rates, the United Kingdom (UK) and the United States of America (USA), partner violence was a significant cause of maternal death – in fact, in three major cities in the USA, it was the leading cause, responsible for as many as 20% of maternal deaths (1).

During recent years there has been a growing awareness in the Republic of Moldova of both domestic violence and its significance as one component of a wider problem of gender-based violence. This has occurred at various levels, and has been facilitated internally by NGOs who have worked to raise this awareness, and by external pressures on the government to recognize the nature and extent of the issue. A number of legislative initiatives took place during the recent years, and steps were taken in the Republic of Moldova to develop and promote gender equality policies, incorporating gender dimensions into strategic papers and actions. Given the fact that pregnancy is often a time when women are vulnerable to abuse, the Ministry of Health of the Republic of Moldova found the idea of integrating this issue into maternity care interesting. As a first step, WHO support was requested to include this issue in the training packages already available to staff.

Background

Violence against women is reported to be endemic in Moldova, despite the absence of official statistics (2,3,4). At government level violence against women has been acknowledged as a significant problem; according to the Ministry of Labour, Social Protection and Family:

“At present, the frequency of domestic violence, whose victims are women and children, is acquiring alarming proportions. Unfortunately, it is very difficult for the state to control domestic violence since in most of the cases it is reported only when there are severe consequences to the violence, the other cases being considered just family conflicts” (3).

The deepening economic crisis in the country has exacerbated this situation whilst also contributing to a huge increase in trafficking of women and children. Moldova is now one of the key countries for the origin and transition of trafficking in women and children in Europe (5). There is a correlation between this and domestic violence since available evidence suggests some women are trafficked when they are fleeing abuse and poverty.

In the Reproductive Health Survey undertaken by the Centre for Disease Control and Prevention (US Department of Health) in 1997, 22% of women interviewed reported experience of domestic violence at some point in their lives – 14% of them in the previous 12 months (6). Women in rural areas were significantly more likely to experience (or report) abuse – 27% compared with 17% of women in urban areas. Severe levels of abuse were more likely to be reported by women who had subsequently left the abusive relationship. The majority of women had not disclosed the abuse to anyone; 30% told a family member or friend, whilst only 9% had told a health-care provider. Given this reluctance to report it is likely that the foregoing figures are an underestimate, particularly in relation to sexual violence.

WHO interventions

In 2003, the Making Pregnancy Safer Programme (MPS) and the Gender

Mainstreaming Programme (GMP) of the WHO Regional Office for Europe identified the need for closer collaboration in their work. Given the prevalence of domestic violence during pregnancy, and the fact that domestic violence is one of the most sensitive indicators of gender inequality, this was considered to be an area in which such collaboration would be productive. As a pilot state for the MPS initiative, the Republic of Moldova presented the opportunity for developing such an approach. Following discussions between the WHO Regional Office for Europe and the Ministry of Health in the Republic of Moldova it was agreed that integration of this issue into maternity care could address the needs of pregnant women experiencing abuse, and if successful, provide an example for other countries experiencing similar levels of difficulty as Moldova.

To explore the potential for developing an integrated model, a field visit was organized in June 2003 by the experts of the WHO Glasgow Collaborating Centre on Gender Mainstreaming. A number of key themes emerged from this mission:

- Staff described a number of barriers to working on abuse, both personal and professional i.e. time constraints, lack of training and skills, poor morale, inadequate supports within organizations, lack of understanding of issue, fear of encroaching into ‘personal and private business’, lack of guidance and lack of knowledge re existing community supports for women experiencing abuse.
- Lack of integration with developing work around child protection.
- Difficulties with training already provided – had included one module but this was felt to be insufficient.
- Health providers are missing opportunity to respond to women experiencing abuse.
- A lot of demand on staff.

In response to the points identified through interviews and consultations, it was agreed that a number of steps would be taken to begin the process of assisting staff in the detection and management of

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domestic violence. These were as follows:

- (I) Development of a Training of Trainers Course on Domestic Violence and Pregnancy.
- (II) Development of a training module for staff on domestic violence and pregnancy.
- (III) Identification of a recording mechanism to ensure abuse is documented appropriately.
- (IV) Draft protocol to be drawn up for ratification by Ministry of Health and key stakeholders.

Training of trainers course on domestic violence and pregnancy

In line with the recommendations of the above described consultations, a trainers of trainers course on domestic violence during pregnancy was organized in Chisinau, Moldova, on 12-13 April, 2005. This course was designed for trainers and educators, who have the responsibility to train family doctors, students or practicing midwives, obstetricians and gynaecologists on maternity care. It is also designed for psychology- and social work educators or trainers linked into maternity care.

The objective of the training course was to ensure that trainers were equipped to provide training on domestic violence and pregnancy, and thereby this activity contributed to the Making Pregnancy Safer Programme in relation to domestic violence and pregnancy.

Since the course was only of two days duration, the focus was primarily around materials designed to increase knowledge, change attitudes and promote awareness of the role of healthcare workers in the appropriate identification and management of domestic violence. The following issues were included – definition of abuse, understanding domestic violence, impact on children and child protection, why women stay, domestic violence and pregnancy, consequences of abuse, role of health worker, identifying and responding to abuse, legal position re domestic violence and the responsibilities of health staff around reporting, safety planning

& risk assessment. A variety of methods were utilized: interactive, role-play, scenarios discussion, in large and small groups, presentations. A training manual and CD ROM were also provided.

The protocol on domestic violence was finalized. Participants were also consulted on their views around implementation of the training and protocol, and what issues still required to be addressed.

Next steps

Awareness of the issue of violence against women is clearly growing in Moldova and there is a gathering momentum for change which is encouraging, particularly in view of the ongoing economic crisis. The health service is in a unique position to address abuse given its engagement with women over their lifespan, and particularly during pregnancy. While of central importance to women experiencing abuse, it cannot meet all of their needs. This requires a coordinated, multi-sectoral response to maximize health gain and integrate policy planning and service delivery. The health sector accordingly has to work in partnership with other key agencies to realize the goal of tackling gender-based violence.

There are two components to be addressed in seeking to improve the health-care response:

- (I) Harmonize the different levels of initiatives and strategies/plans, which have impact on this issue and have direct or indirect relevance for healthcare providers. An intersectoral collaboration will yield the best results bringing together different areas of expertise and widening what potentially could be a very narrowly focused medical model of care. This should be in relation to the three areas identified earlier: Maternal and Child Health, Child Protection and Sexual & Reproductive Health.
- (II) Identification of the specific activities that need to be undertaken within the health sector regarding training on domestic violence and implementation of the protocol.

It was considered that the coordination of this activity should be done by agencies that already have the expertise and lead role. It was agreed among the MoH, UN agencies and NGOs that an implementation plan should be developed targeting the identified areas.

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VIOLENCE AGAINST WOMEN IN TURKEY

Turkish women, due to their poor socio-economic status and gender inequality, have serious reproductive health problems such as high rates of maternal mortality and pregnancies among adolescents. These problems bear a high cost on society and should therefore be dealt with seriously as a public health problem.

Although informally acknowledged to be widespread, domestic violence did not appear on the public agenda in Turkey until the women's movement gained momentum in the 1980's. The first campaign about violence against women in the family in Turkey was held in 1987 after the results of one court case in particular, in which the judge was quoted as saying "no woman should be without a child in her womb and a stick on her back."

The situation of violence against women

The importance of violence against women in Turkey has been underestimated and at worst ignored. This is due to a range of factors, which include the deeply rooted patriarchal stereotypes of Turkish culture, which are characteristic of the country. Additionally there is a problem accepting domestic violence against women as a violation of basic human rights of women.

Despite the widespread problem, violence against women in Turkey is not receiving attention as a serious public health problem. Furthermore, community attitudes are rooted in cultural perceptions and habits that are tolerant of violence against women, which are frequently shared by politicians, judges, senior government officials, mass media, common people and most of the women themselves in society. Tolerance and experience of domestic violence form significant barriers to the empowerment of women and women's autonomy in all spheres of social life and have adverse consequences for women's health, health-seeking behaviour, and the health of their children. In the National Health Survey from 2003 it is reported that 40% of Turkish women accept that their husbands beat them. Younger women, currently married women and women with

high number of children are more likely than their counterparts to think that wife beating is justified. This survey revealed that women are most likely to think that wife beating would be justified in cases when the woman argues with the husband (29%), spends too much money (27%) or neglects the children (23%)(1).

In addition to these common forms of violence against Turkish women, other kinds of violence involve traditional practices, including "crimes of honour", forced marriage, early marriage, berdel (the barter of women to avoid paying dowries and other marriage expenses) and be ik kertmesi (a form of arranged marriage in which families barter newborn daughters, forcing them to marry as soon as they are considered old enough); punishment via cutting nose; polygamy; marriages with very old men as a second or third wife; virginity testing; tubal ligation without consent of women and incest (2). Some of the most serious forms of violence against women are committed in the name of "honour". "Honour crimes" are particularly prevalent in the Eastern and South-eastern regions of Turkey but they have also been reported in the other regions and in other countries like Germany where Turkish people have immigrated. The killing of women occur when a woman allegedly steps outside her socially prescribed role, especially, but not only, with regard to her sexuality and to her interaction with men outside her family. The killing is usually committed by a male and youngest member of the family (3). In Turkey, according to mass media news, more than 54 women were killed due to 'honour' during a two-year period.

Statistical information about the extent of violence against women in Turkey is limited and unreliable. There is a strong need for national data about the extent, types and health consequences of violence against women. The first data collection was conducted in 1994 in a survey, which covered 12 provinces in five geographical regions in Turkey, 30% of the 2479 women interviewed indicated they had been physically abused by their husbands, while 34% of the 1147 men questioned admitted that they had physically abused their wives (4). A

previous study from 1988 found that 75% of women reported having been physically abused by their husbands (5). Further to this 140 married women, who had applied for counselling at the Istanbul University Medical Center, were interviewed, and it was found that 57% reported stories of abuse by their husbands (6).

According to a study from 1998 quoted in the World Report on Violence and Health of WHO, the proportion of women physically ever assaulted by a partner was 58% of the 599 women between 14-75 years living in East and South-East Anatolia (7).

Responding to violence against women

Two decades after the campaign 'Stop Battering' Turkish society has reached some achievements. The Turkish government has publicly acknowledged that violence against women is a human rights violation and has established an internal working group on domestic violence. In addition, a national government awareness campaign has been initiated with football players, celebrities, media companies and religious leaders; government has established 13 guesthouses for victims of violence against women.

In January 1998 a new law, entitled "The Law to Protect the Family", was approved by the Turkish parliament, which mandated the establishment of protection orders for women subjected to domestic violence. Under the new law, any member of a family subjected to domestic violence can file a court case for what is known as a "protection order" against the perpetrator of the violence. Violation of the protection order can be used as grounds for arrest and a jail sentence. The revised Civil Code passed in 2001, brought Turkish family law in line with the European Union, Convention on the Rights of the Child and Convention on the Elimination of all forms of Discrimination Against Women. The new Penal Code bill passed by Parliament on 26 September 2004 contains an improved protection of women's human rights. The new law takes preventive measures to eradicate honour killings, prohibits marital rape and does not discriminate between married and unmarried women. A major change lies in the



classification of sexual crimes as “Crimes Against Persons”, rather than “Crimes Against Society”. Draft legislation exists to encourage service provision particularly as regards building of shelters for victims of violence.

Non-governmental coalitions are being formed to address domestic violence (including national and international NGO’s and private media companies). Meetings are conducted on a yearly base to discuss issues related to violence against women and to form a communication platform between the NGO’s in Turkey. The national reproductive health programme in Turkey will support two projects aimed to study domestic violence in the next biennium.

A recent activity on violence against women was initiated in May 2005 in Diyarbakır and Mardin by the women’s center ‘KAMER’. The campaign entitled “Do Not Turn A Blind Eye To Honour Killings”, aimed at raising awareness about honour killings.

Challenges

Despite the fact that violence against women no longer is a taboo in Turkey, there are still challenges, which need to be overcome. The recent murder of a Turkish woman in Berlin in Germany in February 2005 by her brothers’ shows that deep-rooted gender issues and cultural beliefs still prevail in society. In addition the lack of a referral system for victims causes trouble for officers, physicians and victims themselves, as this makes it even harder for victims to access relevant services. Finally, although it is well known that violence has severe consequences on health of women and their children, the Ministry of Health has dedicated very little attention to the issue.

The way forward

In order to combat domestic violence effectively, Turkey needs to develop a national action plan for violence against women addressing the problems and strategies. Both government and non-government institutions have to be part of the response and it is clear that the issue has to be dealt with multisectorally and include the legal system, police, health, education - naturally

women themselves should be part of the development process. The national plan has to contain aims and strategies to increase awareness against violence against women; to collect comprehensive data across all regions of Turkey, which systematically measures the nature and extent of violence against women; to take steps to prevent violence against women by funding a sufficient number of shelters; to develop a mechanisms to monitor the activities; to enforce laws that protect women, such as the Family Protection Law and Penal Code, to ensure that members of the judiciary and other government officials receive training on violence against women; to develop a referral system and treatment protocols for victims of violence in health institutions and training programmes for health professionals to take part in prevention and early screening of violence against women; to create safe communities where women live free from violence and its consequences and acknowledge and support NGO’s working to prevent violence against women.

Fortunately, just recently, a nationwide research has been planned to be carried out on violence against women in Turkey and furthermore, a commission was established at the Parliament to deal with all the above-mentioned issues and to prepare a plan of action for Turkey to prevent violence against women in the country. It is the hope that this high policy level commitment will prove to be more effective than before and will ensure that the advocacy activities will be maintained until violence against women is eliminated from the entire Turkish society.

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CREATING A GENDER-BASED VIOLENCE PREVENTION NETWORK IN THE RUSSIAN FEDERATION

The article is based on experience of the project “Involving Health Care Sector into the Fight Against Gender-based Violence” conducted between 2002-2004 in the Russian Federation.



The Project was jointly implemented by the Focus Foundation and the Italian Association for Women in Development – AIDOS, with support of TACIS, which provides grant-financed technical assistance to 12 countries of Eastern Europe and Central Asia (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan), and the United Nations Population Fund (UNFPA). It was designed to address gender-based violence in collaboration with women’s non-profit organizations from several Russian cities, like Moscow, St. Petersburg, Tver, Tula, Voronezh, Naberezhniye Chelni, Pskov and Murmansk. Moreover, doctors and administrators of several Moscow clinics also became project partners.

Surveying violence against women

Prior to the commencement of the project an on-line survey was conducted, which was responded to by 964 women from all over Russia, of whom 62% were under 30 years of age. The survey showed that most of the women either worked or studied and that most respondents assessed their emotional well-being as good. In this “successful” group of professional women, 75% of the women reported having experienced violence at least once in their life, while 40% reported having been repeatedly abused. More than half of them faced repeated violence in the form of psychological pressure or continuous emotional abuse and every fourth woman was subjected to physical violence, and over 13% reported having been raped.

Creating the network

One of the purposes of the project was to develop a network among medical care institutions, crisis centers, socio-psychological and legal centers/services, which aim was to help victims of gender-based violence. Ensuring systematic support to women, who had experienced violence, required the involvement of various services, since the survey showed that victims of gender-based violence need practical advice from professionals, such as lawyers, doctors, psychologists and psychotherapists. Women suffering from violence furthermore need to know how they can get support from the crisis centers and hot lines. It is useful for them to have an opportunity to discuss their situation with other women, and such opportunity is provided to them by therapeutic groups.

For this reason the project focused on involving appropriate services, especially health care facilities, into joint efforts undertaken under the gender based violence prevention network. The emphasis was placed on health care institutions because women, suffering gender-based violence, have specific health problems. When a health problem arises, a woman typically consults the doctor who is in a position to identify whether the woman experiences violence. If she does, he/she can address the issue of gender-based violence and refer her to appropriate services and support like a psychotherapist, a psychologist, a lawyer or a crisis center, depending on her needs. However, this will only work if doctors have the required capacity and will to ask questions related to gender-based violence. Secondly, doctors need to know, where to refer victims of gender-based violence.

The methodology for integrating help to victims of gender-based violence into medical services was developed with support of the UNFPA, and introduced to all the partners by AIDOS. It took some time to adapt this approach to the Russian conditions, and here, the recommendation of doctors and administrators of the network clinics proved to be invaluable. This approach has been extended among health care workers who have been directly involved in providing health care services to victims.

In a joint effort, information was collected about organizations, services and specialists who agreed to provide help to victims of gender based violence. A reference book, containing all the information about them, is now available in every project city. Every health care facility, participating in the project, also has such a reference book, which facilitates creating referral system. The general referral information system, which can be found at our internet sites www.woman.ipd.ru and www.crisis.ipd.ru, is directed at women in emergency situations.

As regards care-seeking behaviour of women, the survey showed that a lot depends on the attitude of women themselves. The survey revealed that despite the fact that many women overall emotionally feel good, they feel a low level of responsibility for their own life and well-being. Women do not take their health seriously and are not always ready to stand by their rights, for instance to consult a doctor, lawyer or psychologist. Therefore, it is crucial to develop programmes designed to raise awareness among women about their personal values and rights.

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The main achievements of the project

1. Attracted attention of the city administrations to issues of gender-based violence
2. Created a system of medical, psychological and legal help to victims of gender-based violence
3. Developed recommendations for health care staff and clinic administrators, using best international practices tailored to Russian conditions
4. Improved skills and knowledge of medical workers about gender issues and communication with victims of gender-based violence. Increased motivation of medical professionals to work with victims of gender-based violence
5. In some cities medical workers organized "Violence-free society" groups, in others – municipal working groups were created to address violence
6. Broad coverage of gender-based violence and the project activities by the mass media and local TV
7. Developed and disseminated information and advocacy materials and posters: "There is no room for violence in your life"
8. Conducted sociological surveys on gender-based violence

An example from the project site: routine screenings by health professionals

In Voronezh activities under the project were coordinated by the public movement "In defence of Women". Information and reference materials on gender-based violence were disseminated in five health care facilities. In addition, from January to March 2004 ten medical doctors regularly asked their patients questions related to gender-based violence and, if necessary, referred them to other specialists. During the three months, the routine screening revealed 1208 cases of domestic violence; 72 rape cases, 527 women were referred to a help line, 881 to a psychologist and 181 to a lawyer. The survey was selective and was conducted among women "arousing suspicion".

What makes this project innovative?

In a number of countries projects have aimed at integrating support to victims of gender-based violence into the general system of health care services. However, most of them were carried out on the basis of one centre – a family planning association or a crisis facility. This project has chosen a completely different network model, which allows to significantly improve the quality of services provided to victims of gender-based violence with minimum additional resources. Over 60 crisis centers, medical institutions, associations that provide legislative, social, psychological and psychotherapeutic help, were united into the network.

Another innovative feature of the project is that it was not limited to research, dissemination of information and training designed to sensitize health care workers to the issue of gender based violence. The project went beyond the preparatory stage - various institutions and services, working under the Network, created a precedent of actual service delivery to the population.

Difficulties encountered by the Project

One of the challenges encountered by the project was to motivate doctors who were already overloaded with work and statistics to question their patients on the subject of gender-based violence and to refer them to other specialists without any additional compensation. To a large extent this problem was solved as a result of our partners' commitment to their work and faith in what they were doing. This work produced results, which impressed both doctors and patients. Another challenge faced by the project was the lack of intersectoral coordination and cooperation, a traditional plague of the Russian Federation.

What has happened since 2004 after the project ended?

It was planned that the establishment of the network for addressing gender-based violence would ensure the sustainability of the project. In addition to creating local 'anti-gender-based violence' networks, "Focus" continued to work on developing models, which can be used for correcting destructive patterns of gender behaviour, both at the individual and cultural levels.

The project implemented by "Focus" aimed to strengthen the local networks and to develop methods for changing the personal perception of women towards violence. The underlying concept of these project activities is to raise awareness and help people take more responsibility of their lives. The hope is that this will contribute to decreasing aggression and tension, and thereby foster more harmonious relationships. For this purpose, the personal development training for women "Awakening of the Goddess" was developed by the project. Unfortunately, these projects were financed by grants, which cannot be sustained. Addressing the challenge of gender-based violence requires the development of a governmental system, using lessons learnt and best practices of the project, and what is important for success and sustainability is the support of activities from federal resources.

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VIOLENCE AGAINST WOMEN IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

The Annual Report of the Helsinki Committee for Macedonia in 2002 as well as the statistics from NGOs show that eight of ten women were victims of physical violence.

Book Feature of 'Intimate Partner Abuse and Health Professionals - New Approaches to Domestic Violence' edited by Gwenneth Roberts, Kelsey Hegarty and Gene Feder, Elsevier, September 2005.



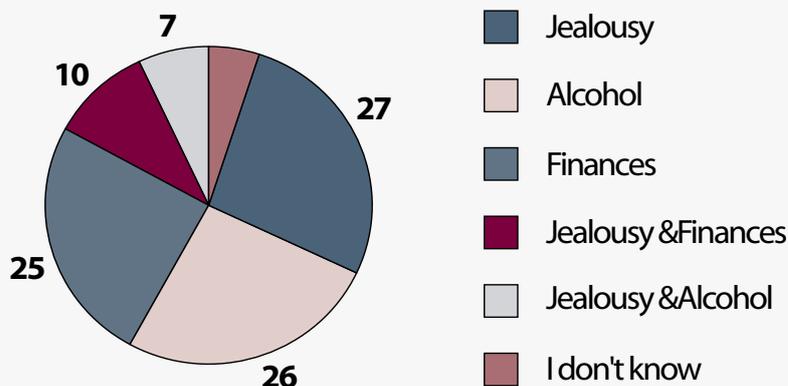
"This book does not address primary prevention such as community awareness programmes. Preventing the onset of abuse is a large political and cultural challenge to which health services do not

directly contribute, other than reflecting the unacceptability of intimate partner abuse and helping make it a visible problem"

For health professionals or practitioners this would be an interesting and relevant book to read. Not only does this book provide a good insight into the complexities of intimate partner abuse (IPA) it also provides information, which is practically applicable for health professionals. The book, which is written by international researchers from various health disciplines, is split up into three sections: the first section deals with the history of IPA as well as provides the reader with a conceptual and theoretical background of IPA, section two focuses on the impact of IPA on physical and mental health, education of health professionals, how to identify IPA and how health professionals can intervene and support people experiencing IPA. Finally, the last four chapters are about cultural diversity and IPA and deals with gay and lesbian relationships and indigenous people among others.

The book can be ordered from: <http://www.intl.elsevierhealth.com/catalogue/title.cfm?ISBN=0443074933> for a price of £24.99 plus additional delivery charges

Common reasons for domestic violence



Source: Survey conducted by Roma Association of women and youth, Luludi, 2004

The Former Yugoslav Republic of Macedonia (in the following referred to as "Macedonia") is a signatory to and implements the international acts on protection of the human rights and prevention of discrimination, torture and maltreatment, which are incorporated in the national legislation, such as The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In 2003 and 2004 the State made amendments on the actual Law on Family and Law for Social Protection as well as on the Crime Code as regards second prevention, particularly sanctioning the perpetrators and protection of victims of domestic violence.

Burden of violence against women

Despite the lack of official data on domestic violence against women and children, the Annual Report of the Helsinki Committee for Macedonia in 2002 as well as the statistics from NGOs show that eight of ten women were victims of physical violence. The official data from the police showed that in 2004 there were 2434 complaints for domestic violence, out of which 1000 victims were wives, 460 parents, 175 children and other family members. In most of the cases violence was linked to alcohol abuse. Violence

against women in Macedonia is thus a severe health, rights and public health problem of high priority.

Centers for social work have provided services to 409 victims of family violence in 2004 and 2005 and 85 victims of violence were accommodated in the four shelter centers in Skopje, Kochani, Bitola and Strumica.

A survey on domestic violence conducted by the NGO for Emancipation Solidarity and Equality of women (ESE) on a sample of 850 rural and urban women (1.3% of the total female population in Macedonia) in 2000 showed that 61.5% of the interviewed women reported psychological violence, 23.9% physical violence and 5% sexual violence. Poor economic status and unemployment of woman were identified as the main causes for violence against women as well as alcohol abuse (every fourth perpetrator).

Women in the age 25-40 are most exposed to violence while male perpetrators are between 40-44 years old. Ethnic differences in violent behaviour seem to exist: Roma women reported being mostly exposed to physical violence while Albanian women reported being exposed to psychological violence. A survey conducted in 2004 by the NGO Roma

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association of women and children shows that among Roma women the dominant form of violence is psychological violence (61.5%), physical violence makes up 33.5% and sexual violence 5%. Half of the women who had experienced violence were without education or with primary education and 82% were unemployed. The main reasons for violence as stated by the perpetrator or reported by the women are presented in the diagram (see opposite page).

Prevention of violence against women – the state response

There is a lack of systematic follow-up and a poor recording system of the data regarding the victims of violence, within the health, social, educational and other institutions in the country. The state is in the process of preparing a specific protocol for victims of violence to prevent second and tertiary victimisation. The development of the protocol for victims of violence is a joint project between the Ministry of Health, Ministry of Labour and Social Policy, Ministry of Interior and two NGOs for women (Zdruzenska and ESE) supported by UNIFEM.

The Ministry of Labour and Social Policy has taken some initial steps for the prevention of domestic violence. The first shelter centre was opened in 2004 in Skopje for the protection of victims of violence. The process was followed by the opening of five more centres in the country and a national SOS line. More training is needed to strengthen the capacity of the existing centres.

The Republic of Macedonia has adopted the WHO strategy “Health for all in 2000” and later on the strategy “Health for all in the 21 century” and has oriented its strategic health activities to achieve the set targets. An important strategic step consists of addressing violence together with unintentional injuries, as both share a number of underlying determinants (e.g. economic, social, political and environmental) and risk factors (e.g. alcohol and drugs), especially among women and children. Multisectoral approaches are required when developing programmes

dealing with common risk factors, such as alcohol.

The Macedonian Ministry of Health and the Republic Institute for Health Protection has put violence prevention high on its agenda starting the National Campaign against Violence in collaboration with WHO, UNICEF, Open Society Institute and NGO ESE – launching the WHO World Report on Violence and Health and campaigning with a series of posters against violence, on November 25 2003. Furthermore the Department for Injury and Violence Control and Prevention in the Republic Institute for Health Protection Skopje was established in May 2004 as a leading national agency in the health sector for injury and violence prevention.

Violence has been one of the priorities in the Biennial Country Agreement 2004 - 2005 between the Macedonian Ministry of health and WHO, with an established inter-ministerial and multidisciplinary national task force with representatives from the Ministry of Health, Justice, Family and Social Affairs, Education and Interior, WHO, NGOs and the media is working on the assessment and preparation of a national report on violence and health with special emphasis on women and children.

Future challenges

The key challenges in prevention of violence against women in Macedonia in the near future will be to implement the amended law on family and crime code for the prevention of domestic violence as well as the recommendations of the WHO World Report on Violence and Health through the following activities:

- To improve data collection, needs assessment and safety promotion research for violence among women
- To develop an integral information system for violence surveillance
- To develop a national health policy: develop a strategy for violence prevention and a national action plan focusing on violence against women
- To develop and implement the pro-

tolocol for support and follow-up of victims of violence

- To develop capacity among professionals in government organisations as well as in non-governmental organisations for violence prevention at all levels focusing on primary prevention
- To promote gender and social equality and empowerment
- To start regional initiatives and strengthen networking

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ATTITUDES AND EXPERIENCES OF SEXUAL ABUSE AMONG ESTONIAN ADOLESCENTS

The article is based on research, carried out in Estonia in spring 2003, with the objective to provide an overview of sexual behaviour of adolescents, their personal abuse experiences and their attitudes to sexual abuse as a phenomenon.

This is the first inquiry in this field in Estonia with such a numerous and representative sample, and of international dimension, also involving six other countries besides Estonia : Sweden, Norway, Iceland, Poland, Russia, and Lithuania. The international aspect gives an opportunity to compare the outcomes and as a result design effective strategies to combat child abuse in the Baltic Sea region. In Estonia the sample included 1942 respondents, of them 45% males, 55% females; 70% Estonians, 30% Russians; 67% students of schools of general education, 33% students of vocational schools; 76% urban youth, 24% rural youth.

Attitudes of adolescents towards sexual abuse

The tool used in studying adolescents' (16-19 years) attitudes towards child abuse and towards sexual relationship between children and grown-ups was that of Brier and Henschel Attitudes Toward Sexual Abuse Scale. The results of the survey showed that the attitudes of young people to sexual relationships between child (a person under 18 as defined in the Convention on the Rights of the Child) and adult as well as to sexual abuse of children was diverse. Each statement got all possible ratings, from fully agreeing to strongly disagreeing. The majority of respondents disapproved of children being touched on their private parts while being talked to about sexual intercourse. Furthermore, it was felt that a sexual relationship with a child would have negative impact on children and suggested that

abusers should be incarcerated.

The respondents were divided into two counter groups – that of conservative and of liberal attitudes. Conservative respondents (53%) insisted more frequently that a sexual relationship with a child is harmful, they disapproved of any sexual relation between adult and child, and expressed that these relationships must be seen as a crime. Liberal respondents (47%) were more prone to state that sexual relationships between adult and child (esp. 12-14 years of age) should be accepted and not prohibited if unforced and wished by both parties. Likewise, they did not see such relations to be criminal. Respondents with a liberal attitude felt that it was highly likely that they themselves would enter into sexual relations with a child, aged 12 to 14.

The survey furthermore showed that Russian boys have the most liberal attitude towards this issue, and Estonian girls are the most conservative. Respondents, who admitted having been sexually abused, did not have different attitudes towards sexual relations between adults and children than other respondents, who have not been abused. However, adolescents who admit behaving abusively, have significantly more liberal attitudes than non-abusive respondents. These respondents, who have sexual experiences and believe they are more experienced in sexual life, tend to present far more liberal attitudes. At the same time liberal adolescents are prone to substance abuse and to delinquent behaviour.

Respondents were also asked to assess the following statements: "Assault

victims tend to be easy women with a bad reputation" or "Many women have hidden desire to become raped, and they may unconsciously create a situation in which they are likely to become assaulted". The research showed that nearly half of all respondents believe that almost all victims of rape have easy manners or have hidden desire to become raped. However this belief is more common among males than among females.

Sexual abuse experience of adolescents

In this research experiences of sexual abuse were estimated by responses to six questions, which can be seen in Table 1. It should be taken into account that all the answers to these questions are subjective valuations of the respondents. The results showed that females (44%) experience sexual abuse considerably more often than males (15%). Estonian respondents (34%) have reported abusive experiences more frequently than Russian respondents (25%). The results of this research also show that Estonian adolescents more often have become victims of sexual exploitation (i.e. being exposed to naked adults or being touched in unpleasant ways) and Russian adolescents have been more often victims of sexual violence (i.e. being forced to masturbate or forced into oral or anal sex or sexual intercourse). Almost every fifth respondent (apart from sex, nationality, and lodging) has indicated one, 9% of respondents have experienced two different types of sexual abuse.

Table 1. Prevalence of sexual abuse among adolescents

| | N | % |
|--|-----|------|
| Someone was exposed naked to the respondent | 207 | 10,8 |
| Someone has touched the respondent unpleasantly | 489 | 25,3 |
| Someone has forced the respondent to masturbate | 18 | 0,9 |
| Respondent has been forced to be in sexual intercourse | 79 | 4,1 |
| Respondents has been forced into oral sex | 40 | 2,1 |
| Respondent has been forced into anal sex | 22 | 1,1 |



The students of vocational schools have suffered from sexual abuse far more often than others. Almost every fifth female student of vocational schools has reported having experienced sexual abuse, and especially that of forced sexual intercourse. Only 7% of female students who study in secondary schools have admitted the same. 55% of the respondents stated that they have been persuaded or forced to sexual intercourse once, 7% of respondents reported that they have experienced sexual abuse more than five times. Russian adolescents (31%) reported more often than their Estonian peers (10%) of several abusers at the first time. Most of the respondents, who reported having suffered sexual abuse, described this occurring at the age of 14-17 rather than experiencing sexual abuse in childhood, under the age of 12 (6%). In case the abuse incident took place during the adolescence of the victim, the offender was usually an acquaintance or a relative. When the abuse occurred in childhood, the offender was usually a family member or relative. The victims of sexual abuse more often reported about male offenders (87%) than about female offenders (13%). All girls (53% of all abused girls) who reported about their offenders stated that the offenders were males. 9% of all abused boys reported about male offenders, 28% of them reported that females committed the abuse. In most cases the offender was aged 17-23 years. In the case of male victims the offender was younger than that of female victims. On average the offender was seven years older than the victim, in 9% of the cases the offender was of the same age than the victim. 37% of the respondents admitted that they had been affected by alcohol or drugs during their first abuse experience. Almost in all cases when the respondent was drunk, the offender was also drunk.

Characterising the victims of sexual abuse in general, it is obvious that negative feelings are more familiar to them than to non-victims. Likewise, they have faced significantly more problems at school – this is particularly true among females. Adolescents, who have reported

sexual experience, have also committed far more delinquencies, are frequently addicted to substances and smoke cigarettes. Adolescents who have started sexual life earlier and have had several sexual partners have usually experienced abusive situations more often. The primary risk factors of becoming sexually abused are physical and mental abuse experience at home, insufficient interaction with parents and consuming alcohol or drugs. An important risk factor for males was delinquent behaviour and for females drug consumption.

Violence prevention

Based on this research it seems that adolescents need earlier (since age of 11) and regular education on sexuality and sexual abuse, including values and qualities, teaching the concepts of right and wrong, one's body and boundaries and negotiating skills. Adolescents must be encouraged to ask for help from professionals. Likewise, there is a need for preventive work on risk behaviours, consumption of alcohol and substance abuse. As regards educational activities the peer approach should be applied. Greater attention should be paid to adolescents from rural surroundings and vocational school students. Additionally, attention has to be paid to educating parents about the issues of sexuality, sexual abuse and risk behaviours so that they would be able to talk to their children about sexually related issues, recognize sexual abuse and would know how and where to find help. Parents need education on communication skills to ensure supportive and close relations between family members and to protect children from psychological and physical violence. Special attention must be paid to the high risk families (isolated, with clashing communication patterns, a difficult economical situation, etc.). Regular work with media will contribute to raise public awareness and educate the community as well as to discuss problematic issues.

A round-the-clock crises help system for children has to be established in addition to prevention. In Estonia there

are two centres prepared to help abused children and their family members: Tartu Child Support Centre and Tallinn Child Support Centre. Currently specialists of the Tartu Child Support Centre are conducting (with the support of Ministry of Social Affairs) in-service training for psychologists of each county to raise their competence in child abuse issues. In helping abused children it is essential to base the support on an interdisciplinary approach, involving social workers, pedagogues, medical practitioners, police officers and psychologists. Institutions that use an interdisciplinary approach provide children as well as their families with the most efficient and comprehensive help. Additionally to regular counselling activity therapy has proved to be fruitful. Nowadays help for adolescents should also be provided through hot-lines and internet, as internet and hot-line services enable youth of different regions to get help; on the other hand, anonymity facilitates active referral of adolescents.

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Please contact Ms. Kadri Soo (e-mail: kettym@hotmail.ee) for a copy of the full survey (in Estonian language) or go to "http://www.childcentre.info" www.childcentre.info (research – research programmes; click on Estonian flag)

EUROPE AGAINST VIOLENCE TOWARDS CHILDREN, YOUNG PEOPLE AND WOMEN

The Daphne II Programme



Ingrid Bellander

The Daphne II Programme is a European Community action programme, managed by the European Commission, with the objective to prevent and combat violence against children, young people and women and to protect victims and groups at risk (1). It was established in 2004, as a continuation of the Daphne Initiative (1997-1999) and the Daphne Programme (2000-2003), and is running for five years with a total budget of 50 million.

The overarching objective of the Daphne Programme is to provide European citizens with a high level of protection from violence, including protection of physical and mental health. The programme focuses on the victims, recognising that violence constitutes a breach of the fundamental rights to life, safety, freedom, dignity and physical and emotional integrity. Actions implemented under the programme tackle violence comprehensively from the angles of prevention, protection, support and rehabilitation. The programme covers all types of violence against children, young people and women and all aspects of this phenomenon.

An important characteristic of the Daphne Programme is the promotion of transnational multidisciplinary networks of organisations working to prevent and combat violence and/or to protect and support victims. The Programme is open to participation by non-profit making private organisations and local public authorities and institutions (mainly NGOs but also municipalities, university departments and research centres) from the 25 EU Member States, the EFTA/EEA countries (Norway, Iceland and Liechtenstein) and the candidate countries Bulgaria, Romania and Turkey. The Commission will fund only projects involving a partnership of at least two organisations from two different participating countries. In this way, the Commission encourages the creation or strengthening of European networks of organisations active in this field. These partners get the opportunity to share their expertise with like-minded organisations in other countries when designing targeted actions to combat violence, and will thus provide a 'European added-value' to their

usual actions. The results of Daphne actions implemented in a few EU countries or regions can then be disseminated to other countries and regions and thus have a true European impact. In this way, Daphne is complementary to existing national programmes in the EU Member States.

Since 1997, Daphne has funded around 420 projects that have worked to protect from, and to prevent, various areas of violence including physical assault, sexual violence, emotional and verbal abuse, exclusion and quasi-structural violence, coercion and exploitation, virtual violence, psychological violence, gender-based violence and violent cultural practices (such as female genital mutilation). About half of these projects have focused on the prevention of violence against women or the support of women victims of violence. A number of such projects have covered specifically the public health perspective of violence against women. Some examples:

Project identifying and responding to the health needs of women and girls trafficked to EU countries (2000) followed by a project on health interventions for trafficked women and adolescents – examining care provision and practices (2002) by the London School of Hygiene and Tropical Medicine (with partners from the UK, Italy, The Netherlands, Belgium, the Czech Republic, Bulgaria and associate partners from Ukraine, Albania, Thailand as well as the WHO and IOM). These successful research projects managed to put health issues arising from trafficking on the agenda, in this way adding to the range of possible lenses through which trafficking is viewed at the policy level. The findings from this research can be found on: <http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf>.

Project on the creation of a European indicators database on intimate partner violence (2003) by the French organisation Psytel (with partners from Austria, Denmark, Spain and Greece). The project examined the main statistical data available at national level that measure the phenomenon of intimate partner violence and rape in Europe (EU-15). It resulted in a set of 17 descriptive indicators to measure such violence and developed a data collection methodology that can be used

in all Member States.

The Daphne Programme, its projects and its results are recognised throughout Europe and beyond as a unique contribution to the fight against violence and as a model of good practice in this area. In part this is because the Daphne Programme has never set limits on the definition of violence but has encouraged those preparing projects to explore violence in all its diversity and impact. Another key to success is the Commission's active encouragement for participating organisations to network and create European cross-border multidisciplinary partnerships. By recognising that grassroots organisations can offer services which the national authorities very often do not have the power or the ability to provide, the Commission can contribute to increased awareness of violence, preventive measures and stronger responses for victims of violence, by helping experienced organisations share and disseminate their ideas and programmes throughout Europe. By supporting such partnerships, it has been acknowledged that the Commission has achieved, with relatively modest resources allocated, impressive impact and outputs in the fight against violence in Europe (2).

For more information:

If you want to know more about calls for proposals and how to apply for funding please visit the EC Daphne Programme website: http://europa.eu.int/comm/justice_home/funding/daphne/funding_daphne_en.htm. To access the Daphne Toolkit (website with information and documentation on all Daphne-funded projects) please see www.daphne-toolkit.org

References

1. Council and European Parliament Decision No. 803/2004/EC of 21 April 2004, EU Official Journal No. L-143, p.1.
2. Conclusion of external evaluation of the first seven years of Daphne activities, 2004.

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WHO

www.euro.who.int/violenceinjury

www.who.int/gender

www.who.int/reproductive-health

www.who.int/violence_injury_prevention/en/

OTHER USEFUL SITES FOR THE REGION



STOPVAW

The Stop Violence Against Women website (STOPVAW) is a forum for information, advocacy and change. Minnesota Advocates for Human Rights developed this website as a tool for the promotion of women's human rights in the countries of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS), Mongolia, and the U.N. Protectorate of Kosovo.

www.stopvaw.org



Eldis guide

This Eldis guide examines the links between violence against women (VAW) and HIV and AIDS, highlighting key issues, research and resources. It outlines how HIV and AIDS is a consequence of VAW, how VAW is precipitated by HIV, the economic factors that increase women's vulnerability and the interaction between VAW and conflict. It also offers strategies and actions for ending VAW and reducing HIV and AIDS infection.

www.eldis.org/hivaids/vaw_consequences.htm



UNICEF

Sexual exploitation of children is a global phenomenon: Girls are sold to dealers or clients and are sexually exploited. Pornographic images are produced and sold on the Internet worldwide. In many countries, children are openly offered to tourists. UNICEF estimates the number of children and young people affected worldwide at two million. Poverty, the weak social position of women and children and a high level of demand are just some of the factors behind this flourishing industry.

The global scale of the problem requires international cooperation between the victims' countries of origin and destination. Prevention, rehabilitation and reintegration of the victims, and criminal law reforms are important stages in combating this serious violation of human rights. The optional Protocol to the UN Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography is an important human rights basis for protecting and promoting children.

www.unicef.org/protection/index_exploitation.html



BBC World Service

BBC World Service has just launched its website for the "season on violence prevention". The website has been accompanied by a series of radio programmes during recent weeks. It makes extensive use of WHO messages and material (posters, World report, etc).

www.bbc.co.uk/worldservice/violence/

RESOURCES

Selected resources on violence against women



Milestones of a global campaign for violence prevention 2005 – changing the face of violence prevention, WHO, 2005.

This document summarizes the main achievements since the launch of the World Report on Violence and Health in 2002. It documents how commitment towards fighting violence against women has increased both in terms of human and financial resources. The report can be downloaded from: whqlibdoc.who.int/publications/2005/9241593555_eng.pdf



WHO multi-country study on women's health and domestic violence against women - initial results on prevalence, health outcomes and women's responses, WHO, 2005

The Multi-Country Study on Women's Health and Domestic Violence is a key research initiative undertaken by WHO in collaboration with local institutions. The Study is policy and action oriented and is being carried out in partnership with research institutions and/or national ministries and women's organizations working on issues related to violence in eight countries. A diverse group of countries was selected to represent a range of cultures and regions: Bangladesh, Brazil, Japan, Namibia, Peru, Serbia-Montenegro, Tanzania and Thailand. Samoa also implemented the Study. For more information about this study please visit: www.who.int/gender/violence/multicountry/en/

Women, violence and health, Amnesty International, 2005

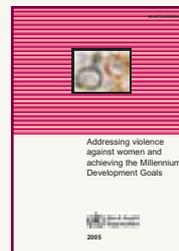
In March 2004, Amnesty International commenced a long-term campaign to stop violence against women. This paper forms part of this campaign and looks at the links between violence against women and women's health. The paper reviews the forms that gender-based violence takes, the context in which it occurs, and the health consequences of violence against women. The paper ends with some recommendations for action. The paper can be downloaded from: web.amnesty.org/library/Index/ENGACT770012005?open&of=ENG-398



Preventing violence: a guide to implementing the recommendations of the world report on violence and health, WHO, 2004.

The document provides conceptual, policy and practical suggestions on how to implement each of the six country-level activities, and promotes a multi-sectoral, data-driven and evidence-based approach. Should the resources for achieving certain aspects of the recommendations be lacking, the information contained in the guide will still be useful for planning purposes. Since plans usually precede actions (and are often used to generate the resources needed to implement actions), the guide will therefore be of use even in areas where violence prevention resources are currently scarce.

Hard copies of Preventing violence: a guide to implementing the recommendations of the World report on violence and health are available for free and can be ordered by sending an email request to violenceprevention@who.int indicating the number of copies required and the address for mailing.



Addressing violence against women and achieving the MDGs, WHO gender and women's health, 2005.

This document highlights the connections between the Millennium Development Goals (MDGs) and the prevention of violence against women by showing how: 1) working towards the MDGs will reduce violence against women; and 2) preventing violence against women will contribute to achieving the MDGs. The document concludes that many MDG targets will be missed if violence against women – one of the most blatant manifestations of gender inequality is not addressed. It aims to clarify the links between violence against women and the MDGs, and to help translate these links into action. The document can be downloaded from: www.who.int/gender/documents/MDGs&VAWSep05.pdf



State of world population, 2005 – The promise of equality, gender equity, reproductive health and the millennium development goals, UNFPA 2005.

The report, The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals, explores the degree to which the global community has fulfilled pledges made to the world's most impoverished and marginalized peoples. It tracks progress, exposes shortfalls and examines the links between poverty, gender equality, human rights, reproductive health, conflict and violence against women and girls. It also examines the relationship between gender discrimination and the scourge of HIV/AIDS. It identifies the vulnerabilities and strengths of history's largest cohort of young people and highlights the critical role they play in development.

The report can be ordered or downloaded from: www.unfpa.org/swp/swpmain.htm

Information Bulletin Series from The Global Coalition on Women and AIDS and WHO, Information Bulletin Number 1 and 2

(‘Violence Against Women and HIV/AIDS: Critical Intersections – Intimate Partner Violence and HIV/AIDS’ and ‘Sexual violence in conflict settings and the risk of HIV’)

These two fact sheets describe and discuss the links between violence against women and HIV/AIDS in relation to intimate partner violence and in conflict situation and provide recommendations on how violence against women and HIV programming can be integrated in both of these areas. The fact sheets can be downloaded from:

www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf

and,
www.who.int/hac/techguidance/pht/InfoBulletinconflict.pdf

Addressing violence against women: piloting and programming, UNFPA and AIDOS, 2003.

This report summarizes several years’ work of UNFPA to confront the issue of violence in a meaningful and practical way and provides concrete recommendations as regards programming and policy actions, particularly in the areas of research and standardization, policy and advocacy and services and communities.

The report can be downloaded from:

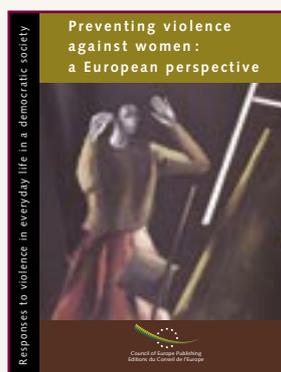
www.unfpa.org/upload/lib_pub_file/361_filename_gbv_report.pdf

Violence against women: the health sector responds, PAHO, 2003.

Violence against Women: The Health Sector Responds provides a strategy for addressing this complex problem and concrete approaches for carrying it out, not only for those on the front lines attending to the women who live with violence, but also for the decision-makers who may incorporate the lessons in the development of policies and resources. For those communities where support for women does not yet exist, the authors hope that this book will motivate health providers and leaders to more directly confront the issue of gender-related violence and ensure support to affected women.

The report can be ordered or downloaded from:

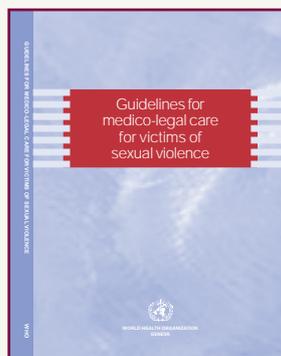
www.paho.org/English/DPM/GPP/GH/VAWhealthsector.htm



Reid, S. Preventing violence against women – a European perspective, Council of Europe Publishing, Strasbourg, 2003. ISBN: 92-871-5291-8.

The author has reviewed recent Council of Europe reports, publications and legal texts in order to identify common principles and best practice. The book covers understanding the problem, prevention, protection, provision of services and lessons learned. The book can be ordered from the Council of Europe Online Bookshop:

book.coe.int/EN/ficheouvrage.php?PAGEID=36&lang=EN&produit_aliasid=1694

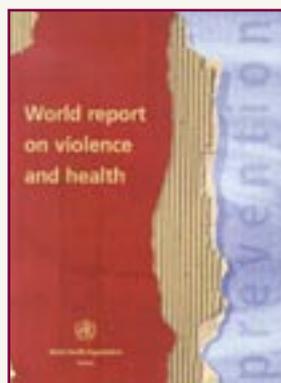


Guidelines for medico-legal care for victims of sexual violence, 2003

The guidelines aim to improve professional health services for all individuals who have been victims of sexual violence by providing health care workers with the knowledge and skills that are necessary for the management of victims; standards for the provision of both health care and forensic services to victims; and guidance on the establishment of health care and forensic services for victims.

The guidelines can be downloaded from:

www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/



World report on violence and health, including executive summary, WHO, 2002.

The first comprehensive review of the problem of violence on a global scale – what it is, whom it affects and what can be done about it. The report benefited from the participation of over 160 experts from around the world, receiving both peer-review from scientists and contributions and comments from representatives of the entire world.

The report can be downloaded from:

www.who.int/violence_injury_prevention/violence/world_report/en/

Entre Nous

*The European Magazine
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