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Women, violence and health

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The epidemic of violence directed at women and girls constitutes a major human rights scandal and a public health crisis. Around the world women are regularly beaten and sexually abused by intimate partners, family members, neighbours, and by people not known to them. They also suffer gender-based violence during and after conflicts and wars. The impact on women's health goes far beyond bruises, broken bones or even death. As well as causing physical suffering to women, such violence has a profound impact on women's psychological well-being, on their sexual and reproductive health and on the well-being and security of their families and communities. The cost in human terms is huge and also has an economic dimension.[1]

An understanding of violence against women is necessary to formulate a human rights response and to convince governments that there is a need for the kind of public health response that is mounted in the face of other health crises.

Moreover, there is also a greater need for awareness and skills development among health professionals in order that:

- they can better identify victims/survivors and ensure that appropriate care is given;
- they can refer survivors of violence to appropriate support services;
- they can contribute effectively and appropriately to the woman's need for safety and for justice;
- they can cooperate effectively with other sectors of society to better protect women and respond to their needs;
- they can advocate more effectively the right of women to the highest attainable standard of health.

In March 2004, Amnesty International commenced a long-term campaign to stop violence against women. This paper forms part of that campaign and looks at the links between violence against women and women's health. It is published in advance of the ten year review of the Beijing Declaration and Platform for Action which will review, among other themes, women and violence and women's health.[2] Taken

[1] WHO. *World Report on Violence and Health*. Geneva: World Health Organization, 2002; Waters H et al. *The Economic Dimensions of Interpersonal Violence*. Geneva: World Health Organization, 2004.

[2] The 49th session of the CSW, 28 February-11 March 2005, will undertake a review and appraisal of the Beijing Declaration and Beijing Platform for Action, adopted at the Fourth UN World Conference on Women in 1995. The Beijing Platform for Action highlights 12 areas of 'particular urgency as priorities for action' by governments, the international community and civil society. Amnesty International is focusing on four of these: violence against women, women and armed conflict, women and health, and women's human rights. For a further Amnesty International discussion of this review process see: *No turning back – full implementation of women's human rights now!* AI Index: IOR 41/002/2005. Available at: http://web.amnesty.org/library/Index/IOR410022005

together with the Millennium Development Goals[3], the Beijing Platform for Action offers clear objectives for the improvement of women's health and human rights.

The paper reviews the forms that gender-based violence takes, the contexts in which it occurs and the health consequences of violence against women. The paper ends with some recommendations for action by governments and professional bodies.

The problem of gender-based violence

Gender-based violence[4] is one of a range of categories of violence. Violence in its wider sense has been defined by the World Health Organization as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.[5]

Reflecting this, violence against women is defined in the Declaration on the Elimination of Violence against Women as constituting:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.[6]

The Declaration notes that gender-based violence:

> encompasses, but is not limited to, physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

Violence against women gives rise to a cluster of physical and psychological consequences (including those touching on emotional and sexual health) reflecting not only the mechanism of the violence but also the interconnectedness of the human response to violence. Thus physical violence against the individual may give rise to serious psychological reactions such as fear, anxiety or depression, while emotional and sexual abuse may give rise to physical symptoms such as chest pain and tachycardia, as well as behavioural changes such as substance abuse.

International human rights standards against gender-based violence

- The Declaration on the Elimination of Violence against Women (1993) calls for states to condemn violence against women and not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women.[7]
- The Convention of the Elimination of all Forms of Discrimination against Women (CEDAW), adopted in 1979, requires States parties to take action to protect women against violence of any kind occurring within the family, at the work place or in any other area of social life.[8]
- General Recommendation 19 of the CEDAW committee which monitors the Convention noted that "[g]ender-based violence … impairs or nullifies the enjoyment by women of human rights and

[3] The Millennium Declaration and Millennium Development Goals were agreed at the Millennium Summit of the United Nations, which took place in September 2000, and will be reviewed at the 60th session of the UN General Assembly in September 2005. See: http://www.un.org/millennium/summit.htm;

[4] Gender-based violence against women is violence "directed against a woman because she is a woman or that affects women disproportionately". CEDAW, General Recommendation No.19, 1992, UN Doc. A/47/38, para.6.

[5] WHO Global Consultation on Violence and Health. *Violence: a public health priority*. Geneva, World Health Organization, 1996 (document WHO/EHA/SPI.POA.2).

[6] Declaration on the Elimination of Violence against Women. New York, United Nations, 23 February 1994 (Resolution No. A/RES/48/104). Available at: http://www.un.org/womenwatch/daw/cedaw/recommendations.htm

[7] Declaration Article 4

[8] The text of the Convention is available at: http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

fundamental freedoms under general international law or under human rights conventions" and was a form of discrimination.[9]

- The Vienna Declaration and Platform of Action of the World Conference on Human Rights, Vienna, 14-25 June 1993 noted that "the World Conference on Human Rights stresses the importance of working towards the elimination of violence against women in public and private life, the elimination of all forms of sexual harassment, exploitation and trafficking in women…[10]
- The Cairo Programme of Action (1994) concluded that "Advancing gender equality and equity and the empowerment of women and the elimination of all kinds of violence against women … are cornerstones of population and development-related programmes."[11]
- The Beijing Declaration and Platform of Action of the Fourth World Conference on Women (1995) concluded that "Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms…"[12]
- The Inter-American Convention to Prevent, Punish and Eradicate Violence against Women (1994) states that "Every woman has the right to be free from violence in both the public and private spheres"[13]
- The African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) states that "Every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited"[14]

[9] General recommendation 19, para. 7, available at:: http://www.un.org/womenwatch/daw/cedaw/cedaw.htm
[10] Conference platform adopted 25 June 1993, Section II B 3, article 38. http://www.ohchr.org/english/law/vienna.htm
[11] United Nations International Conference on Population and Development (ICPD), 5-13 September 1994, Cairo, Egypt, Programme of Action, Principle 4. See: http://www.iisd.ca/cairo.html
[12] Beijing Platform of Action, D. Violence against Women, para. 112. See: http://www.un.org/womenwatch/daw/beijing/platform/violence.htm
[13] Article 3. See: http://www.oas.org/cim/English/Convention%20Violence%20Against%20Women.htm
[14] Article 4. Protocol is available at the "official documents" link at: http://www.africa-union.org

Forms of violence against women

Violence against women can take various forms.

Physical violence

The types of gender-based physical violence to which women are subjected include slaps, punches, choking and kicks, to beating with sticks, clubs or whips, the use of fire or acid to inflict pain and long term harm, through to homicide.[15]

Sexual violence

Rape

Definitions of rape vary from jurisdiction to jurisdiction.[16] However over the past decade there have been important developments in international law regarding the definition and understanding of rape. As the then Special Rapporteur on violence against women, Radhika Coomaraswamy[17], has noted, "explicit language [in the Rome Statute of the International Criminal Court (ICC)] now prohibits all types of sexual [violence against women] during wartime". In particular, "rape … or other forms of sexual violence of comparable gravity constitute crimes against humanity when the constituent elements of the crime are present"[18]. Article 8 of the Statute has the same effect with regard to war crimes during international conflicts[19] and during internal conflicts.[20] In addition, the definition of torture given in article 7 is broad enough to include acts of sexual violence perpetrated by private actors.[21] She notes

[15] Amnesty International. *It's in our Hands: Stop Violence against Women*, London, 2004.
[16] See, for example, discussion in Temkin J. *Rape and the Legal Process* (Oxford Monographs on Criminal Law and Criminal Justice). Second Edition. Oxford: OUP, 2002. At a minimum, definitions usually refer to vaginal penetration of a female by a male in the absence of consent. This definition is evolving to reflect the violent nature of rape, a widening of the understanding of sexual penetration and the inclusion of males as possible victims of rape.
[17] Radhika Coomaraswamy held the position of Special Rapporteur on violence against women, its causes and consequences from 1994 to 2003.
[18] Radhika Coomaraswamy. *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women.* UN Document E/CN.4/2003/75, 2003, para 17, citing International Criminal Court Statute Article (7) (1) (g).
[19] ICC Statute Article (8) (2) (b) (22)
[20] Statute Article (8) (2) (e) (6)
[21] Statute Article (7) (2) (e)

other cases arising from the International Criminal Tribunals for Rwanda and Former Yugoslavia have also provided important legal rulings.[22]

National legislation varies in the extent to which its conceptualisation of rape offers adequate protection to women. In many countries women are not protected from rape within marriage. In others, the crime of rape can be "resolved" by the rapist marrying the victim.[23] Even legislation which introduces positive reforms can fail to get to deal adequately with aspects of rape.[24]

Amnesty International and other NGOs have also held that rape carried out or condoned by a state official is a form or method of torture which inflicts severe suffering and attacks a woman's identity and integrity. Rape perpetrated by non-state actors can also constitute torture.[25]

Other forms of sexual violence

Women are subjected to a range of other forms of sexual violence. These include acts referred to in the *Declaration on the elimination of violence against women* cited above.[26]

[22] See discussion of the Foca, Furundzjia and Akeyesu cases, UN Document E/CN.4/2003/75, 2003. paras. 19,20.
[23] WHO. *World Report on Violence and Health*, Geneva, 2002, p.163.
[24] For example, the bill amending the sexual offences law in South Africa in 2003 revised the definition of rape to "include anal as well as vaginal genital penetration, describe victims of the crime in gender-neutral terms and remove the emphasis placed on absence of valid consent by the victim to focus instead on the actions of the perpetrator." However Amnesty International and Human Rights Watch were concerned that the new law failed to "cover penetration by objects or by body parts other than genital organs or involving penetration of the mouth" and recommended that these be included in the definition of rape. See: *Submission to the Parliamentary Portfolio Committee on Justice and Constitutional Development, Parliament of South Africa, on the draft Criminal Law (Sexual Offences) Amendment Bill, 2003, from Amnesty International and Human Rights Watch*. AI Index: AFR 53/006/2003, 15 September 2003. Available at: http://web.amnesty.org/library/Index/ENGAFR530062003
[25] See discussion in Amnesty International, *Combating torture: a manual for action*, 2003; *Human Rights are Women's Right*. London, 1995; and *It's in our Hands: Stop Violence Against Women*. London, 2004. See also Peel M. *Rape as a Method of Torture*. London: Medical Foundation for the Care of Victims of Torture, 2004. http://www.torturecare.org.uk/publications/reportRape.htm)
[26] The spectrum of sexual violence is discussed in Amnesty International. *It's in our Hands: Stop Violence against Women*. London, 2004.

Psychological or emotional violence

Threats, demeaning comments, sexist language and humiliating behaviour are a frequent component of violent behaviour towards women which can impact on the psychological or emotional well-being of the women. All physical and sexual violence also has an effect on the mental state of the victim.

Economic or other forms of deprivation

Millions of women around the world are dependent on men for economic support and security. Men therefore can have a direct impact on the woman's well-being by granting or withholding the means for food, clothing and other daily needs. But the impact can be even more pervasive than that. In some cultures, when a husband divorces a wife she can be left impoverished and stigmatised. If he should die, then she may be forced to marry her husband's brother ("wife inheritance") or become vulnerable to exploitation or abuse by others in her husband's family or clan group. As the UN Task Force on Women, Girls and HIV/AIDS in Southern Africa put it:

> Without the enforceable right to own or inherit land and property, women and girls face destitution after the death of their husbands, partners or parents, while poverty and economic dependence leave them exposed to increased sexual exploitation and violence.[27]

Contexts of violence

While violence occurs in all societies and between men, women and children; between young and old; between healthy and debilitated, women form the overwhelming majority of victims of gender-based violence. As Amnesty International reported at the launch of its campaign to stop violence against women:

> From birth to death, in times of peace as well as war, women face discrimination and violence at the hands of the state, the community and the family. Female infanticide deprives countless women of life itself. Rape and sexual abuse by relatives, other men, security officials or armed

[27] *Facing the Future Together: Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*. Geneva: UNAIDS, 2004, p.35. Available at: http://womenandaids.unaids.org.

combatants are inflicted on millions of girl and women every year. Some forms of violence, such as forced pregnancies, forced abortions, bride-burning and dowry-related abuses, are unique to women. Others, such as domestic violence…are disproportionately suffered by women.[28]

Domestic violence

Domestic violence[29] usually refers to abuse at the hands of a partner and ranges from verbal and physical aggression, to sexual violence and marital rape[30], through to homicide. Domestic violence can include an economic component. Usually the perpetrator is male and the victim female.

"For European women aged 16-44, violence in the home is the primary cause of injury and death, more lethal than road accidents and cancer. Between 25% and 50% of women are victims of this violence. In Portugal 52.8% of women say that they have been violently treated by their husbands or partners. In Germany almost 300 women a year - or three women every four days - are killed by men with whom they used to live. In Britain one woman dies in similar circumstances every three days. In Spain it is one every four days. In France six women die this way every month: 33% of them are knifed, 33% shot, 20% strangled and 10% beaten."[31]

Domestic violence is a major cause of injury and death for women in all cultures.[32] Pregnant women are not spared from sexual violence and several studies document the scale and outcome of partner violence during pregnancy.[33] Apart from the physical and mental suffering arising from abuse, victims may also feel silenced – unable to talk about their experiences to other family members or carers – through fear or because they may blame themselves for the violence; or may feel constrained in their ability to change their situation because of financial dependence, social stigma and powerlessness.

Violence in the community

As Radhika Coomaraswamy has noted, the community is both a site of the denial of women's rights as well as a nurturing space.[34] However, the supportive role of the community can be dependent on women upholding community concepts of "honour".

> Communities, therefore, "police" the behaviour of their female members. A woman who is perceived to be acting in a manner deemed to be sexually inappropriate by communal standards is liable to be punished. Such punishments range from eviction from the community to corporal punishment, such as flogging and stoning, and death. In many cases, the restrictions on women's sexuality, as defined by the community, are sanctioned by the State through the promulgation of laws and policies reflecting the communal values.[35]

Violence in the community (as well as violence in the home) has two important consequences. The first is the physical and mental injury resulting from such attacks and the second is the impact the threat of such attacks has on women's sense of safety and security. While all women may feel, or may be, at risk, some women are at heightened risk. As will be discussed below, these include women from marginalised communities, young women, institutionalised women and refugees.

[28] Amnesty International. *It's in our Hands: Stop Violence against Women*. London, 2004, pp.1-2.
[29] Other terms commonly used in this discussion include "violence in the family" and "intimate partner violence". The definitions are sometimes understood to refer only to partners and sometimes to include other family or household members. For discussion of definitions see *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy.* E/CN.4/1996/53, 6 February 1996.
[30] Bennice JA, Resick PA. Marital rape: history, research, and practice. *Trauma Violence & Abuse* 2003; 4(3):228-46.
[31] Ramonet I. Violence begins at home. *Le Monde Diplomatique*, [English edition] July 2004.
[32] WHO. *World Report on Violence and Health,* chapter 4.
[33] See for example: Coker AL, Sanderson M, Dong B. Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatric and Perinatal Epidemiology* 2004;18(4):260-9; Peedicayil A, Sadowski LS, Jeyaseelan L, Shankar V, Jain D, Suresh S, Bangdiwala SI; IndiaSAFE Group. Spousal physical violence against women during pregnancy. *British Journal of Obstetrics and Gynaecology* 2004;111(7):682-7; Bacchus L, Mezey G, Bewley S. Domestic violence: prevalence in pregnant women and associations with physical and psychological health. *European Journal of Obstetrics, Gynecology and Reproductive Biology* 2004;113(1):6-11. See also p.21 below.
[34] Coomaraswamy R. *Report of the Special Rapporteur on violence against women, its causes and consequences,* UN document E/CN.4/1997/47, 1997.
[35] Ibid. para.8.

Violence in conflict and post-conflict situations

Conflicts in the past decade in the Balkans, in Central Africa, in West Africa and elsewhere have been characterised by high levels of sexual and other violence targeted at women and by the breakdown (or absence) of effective healthcare systems.

Women are at risk not only in their own communities when conflict rages but during flight from combat zones.[36] During the conflicts in West Africa which ended in 2002, a 35-year-old woman who had fled first Liberia and then Sierra Leone to arrive in Guinea was raped while trying to escape members of armed political groups and Guinean forces. She was among a group of 17 people who fled from a displaced persons camp when it was attacked by both rebels and the Guinean military in September 2000. The group, including the woman's 65-year-old mother, her six children and three stepchildren, was caught by rebel forces. All of the refugees were forced to strip, and searched for money and weapons. The women were subjected to abusive vaginal searches, then raped.[37]

Amnesty International documented numerous similar stories of women abused while fleeing danger in West and Central Africa and elsewhere.[38] Médecins sans Frontières (MSF) has reported on the experiences of their clinic in Baraka, East Congo.

Sexual violence during the refugee cycle[39]

Phase	*Type of violence*
During conflict, prior to flight	Physical and sexual abuse by people in authority; sexual violence by government or opposition combatants, or civilians
During flight	Sexual attack by bandits, border guards, pirates; capture and trade by traffickers
In the country of asylum or refuge	Sexual abuse by people in authority; sexual abuse of fostered girls; domestic violence; sexual attack when collecting wood, water etc; coerced trading of sexual favours for survival
During repatriation	Sexual abuse of women and girls who have been separated from family; sexual abuse by persons in power; sexual attack by bandits, border guards
During re-integration	Returnees may suffer sexual abuse as retribution; sexual extortion in order to obtain legal status; domestic violence

Between August 2003 and January 2004, the clinic saw more than 550 victims of sexual violence. MSF believed that hundreds more were cut off from help in inaccessible areas. They reported that the:

> medical consequences of sexual violence are many, including increased transmission of [HIV] and serious complications in reproductive health. Fear, nightmares, and psychosomatic body pain are just some of the psychosocial problems experienced by victims of sexual violence. For

[36] *ICRC Study on the Impact of Armed Conflict on Women*. Geneva: ICRC, 2001. The report makes the important point that women in armed conflicts are not solely "victims" in need of assistance and protection. The report notes that "women take part in armed conflicts as members of the regular armed forces or armed groups and in their support services. Women are also politicians, leaders of non-governmental organizations, social and political groups, and active participants in peace campaigns. As members of the civilian population, they have important and often crucial social and household economic roles and skills which enable them to deal with the increased stresses and burdens placed on them in wartime. For example, women have initiated small enterprises and income-generating projects with meagre resources within their devastated communities and within camps for the displaced. Women in wartime show tremendous courage and resilience as survivors and as heads of households – a role for which many of them have had little or no preparation for and which is made more difficult by the social constraints often imposed on them. The terms 'vulnerable' and 'victim' are not synonymous with 'women"'. Executive summary, p.20.

[37] Amnesty International. *Guinea and Sierra Leone: No place of refuge*. AI Index: AFR 05/006/2001, October 2001.

[38] See, for example, Amnesty International. *Burundi: Rape - the hidden human rights abuse*. AFR 16/006/2004, February 2004; *Sudan - Darfur: Rape as a weapon of war: sexual violence and its consequences*. AFR 54/076/2004, July 2004. Reports by Amnesty International on sexual violence against women in the Democratic Republic of Congo and on militarization and women will be published later in 2004.

[39] Table is adapted from: UNHCR. *Prevention and Response to Sexual and Gender-Based Violence in Refugee Situations: Inter-Agency Lessons Learned. Conference Proceedings, 27-29 March 2001*, Geneva.

women, rape often means rejection by their husband and even the community as a whole.[40]

Women crossing borders are at particular risk of sexual exploitation as they try to negotiate safe passage for themselves and their children. (See box above.)

The toll of conflict on health is high on all those involved but weighs particularly heavily on women and children. A recent Amnesty International report on Burundi noted:

> the past ten years of insecurity have taken their toll on the health of the population in a number of ways: physical wounds caused by war-related injuries; degraded health due to diminished access to fields and markets…; vulnerability to disease aggravated by sleeping outdoors, often in the cold or rain, repeated displacements, fatigue, malnutrition …; destruction of health centres and inaccessibility to healthcare due to insecurity; looting of pharmaceuticals; widespread sexual violence and the attendant transmission of [HIV] and other diseases.[41]

Evidence suggests that "in many countries that have suffered violent conflict, the rates of interpersonal violence remain high even after the cessation of hostilities – among other reasons because of the way violence has become more socially acceptable and the availability of weapons."[42]

Trafficking and enforced prostitution

The trafficking of women is defined in the Palermo Protocol.[43] Article 3 provides four elements of definition covering the nature of the recruitment, deception and exploitation of those who are trafficked; the issue of consent and the protection of children.[44]

Trafficked women and girls are deprived of fundamental human rights and face considerable risks. During transit to their destination country they may face rape by those transporting them or by others; at the point of arrival they risk rape by their new "owners", who use rape as a means of control and coercion. Violence is part of the process of coercion. Trafficked women are repeatedly subjected to psychological abuse. This can include intimidation and threats, lies and deception, emotional manipulation and blackmail, in particular threatening to tell their family about the nature of their work or making threats regarding the safety of their family. Traffickers keep women insecure by making their lives unpredictable and their environment unsafe. Once in their destination country they are forced into exploitative work.

It is not surprising that this culture of coercion and violence as well as the nature of the sexual abuse to which they are routinely exposed has an impact on health[45]. Because in many cases the trafficked women have been brought into the country illegally, as well as their general fears and exposure to threats and

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[40] MSF. *"I have no joy, no peace of mind": Medical, Psychosocial and Economic Consequences of Sexual Violence in Eastern DRC.* Amsterdam: Médecins Sans Frontières (MSF)-Holland, March 2004.

[41] Amnesty International. *Burundi. Rape: the hidden human rights abuse.* London 2004, available at: http://web.amnesty.org/library/Index/ENGAFR160062004

[42] WHO. *World Report on Violence and Health*, p.15.

[43] UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, (the Trafficking Protocol), supplementary to the UN Convention against Transnational Organized Crime. UN Document A/55/383, 2000.

[44] The definition comprises the following:

(a) "Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs;
(b) The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used;
(c) The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth in subparagraph (a) of this article;
(d) "Child" shall mean any person under eighteen years of age. (See: Annex 2 of UN document A/55/383. Available at: http://www.unodc.org/palermo/theconvention.html)

[45] Zimmerman C, Yun K, Shvab I, Watts C et al. *The health risks and consequences of trafficking in women and adolescents. Findings from a European study.* London: London School of Hygiene and Tropical Medicine, 2003; Hynes HP, Raymond JG. Put in Harm's Way: The Neglected Health Consequences of Sex Trafficking in the United States. In: Silliman J, Bhattacharjee A (eds.) *Policing the National Body: Sex, Race, and Criminalization.* Cambridge, MA: South End Press, 2002.

coercion, they may not have access to services which are available to others, including health care. One study cited by Amnesty International suggested that as few as 10% of trafficked women in Kosovo had regular health care[46]. The risks faced by such women have implications for the professional ethical responsibilities of human rights and health investigators who must give appropriate attention to the security of the women.[47]

Sexual violence in the military

Women working within the armed services are at risk of sexual violence at the hands of male colleagues. Reports suggest that at least 37 female service members sought sexual-trauma counselling and other assistance from civilian rape crisis organizations after returning to the USA from war duty in Iraq, Afghanistan, Kuwait, and other overseas stations[48] and female personnel in the US military have reported more than 175 cases of sexual assault or misconduct by male soldiers.[49] However, the problem of sexual violence against female service members has been documented over a long period. A study by the *Denver Post* noted that "nearly 5,000 accused sex offenders in the military, including rapists, have avoided prosecution, and the possibility of prison time, since 1992, according to Army records" by being administratively disciplined rather than tried under court-martial. Figures for the air force, navy and marines were incomplete or not available. The paper cited a 1988 Pentagon survey which found that more than 90 percent of military sexual-harassment victims did not report the abuse, some because they feared they would be blamed.[50]

An earlier study concluded that women's exposure to sexual harassment in the military is much more prevalent than previously believed. Of a population being treated for post-traumatic stress disorder (PTSD), 63 percent reported sexual harassment during military service and 43 percent reported rape. Exposure to sexual stress (to use the authors' term) was found to be particularly significant in the development of PTSD.[51] Another US study found that of more than 500 women who completed the research interview, half had experienced violence during military service, including rape, physical assault, or both. The authors concluded that women who were physically assaulted or raped reported significantly lower health-related quality of life.[52]

Girls and women fighting within armed opposition groups can face serious sexual violence. For example, in a report of 2002 the Special Rapporteur on Violence against Women noted that "testimonies provided by former combatants [in Colombia] show how, while they were members of an armed group, they were subject to different types of violence because of their gender, such as sexual abuse and/or harassment by superiors" as well as infringements of their reproductive rights.[53]

Forced marriage

Human rights standards make clear that marriage should be a voluntary union between partners.[54] In

[46] Amnesty International. *'Does that mean I have rights?': Protecting the human rights of women and girls trafficked for forced prostitution in Kosovo*. London: EUR 70/010/2004, 6 May 2004, p.16. A study by Physicians for Human Rights on the situation of migrant and trafficked women and girls in Thailand remarked on their lack of access to health care. See *No Status: Migration, Trafficking and Exploitation of Women in Thailand.* Boston: PHR, July 2004. Barriers to health care identified in the PHR study included lack of access to health workers, fear of arrest and other security issues, cost of transport and the travel distances involved. Many migrant women were found to have a poor health status before entering Thailand (p.38).

[47] *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*. Geneva: WHO, 2003. Available at: http://www.who.int/gender/documents/en/ . There are parallels with some of the ethical issues arising in domestic violence research. See: Ellsberg M, Heise L. Bearing witness: ethics in domestic violence research. *Lancet* 2002; 359: 1599–604.

[48] Herdy A, Moffeit M. *Camouflaging Criminals: Sexual Violence Against Women in the Military*. Amnesty International USA, New York, Spring 2004. Available at: http://www.amnestyusa.org/amnestynow/camouflaging_criminals.html

[49] *Denver Post*. 'Pentagon to address sex assaults.' 2 June 2004.

[50] *Denver Post*, 'Betrayal in the ranks'; three part series 16-18 November 2003. Available online at: http://63.147.65.175/justice/tdp_betrayal.pdf

[51] Fontana A, Rosenheck R. Duty-related and sexual stress in the etiology of PTSD among women veterans who seek treatment. *Psychiatric Services* 1998; 658-62.

[52] Sadler AG, Booth, BM, Nielson D, Doebbeling BN. Health-related consequences of physical and sexual violence: women in the military. *Obstetrics and Gynecology* 2000; 96: 473-480.

[53] Report of the Special Rapporteur on violence against women. Addendum: Mission to Colombia (1-7 November 2001)/ United Nations, E/CN.4/2002/83/Add.3, para. 55 and 56. Available at: http://www.womenwarpeace.org/colombia/docs/srvawvisit.pdf

[54] The Universal Declaration of Human Rights states, at article 16: "(1) Men and women of full age, without any limitation

some countries and cultures women – particularly young women – are forced to marry men who have been chosen for them by their parents or guardians and whom they do not wish to marry. This breach of human rights can lead to marital conflict and violence from the husband. If the woman tries to leave the relationship she can risk violence at the hand of the husband's relatives or her own family which may feel dishonoured by such behaviour[55].

Dowry- or bride-price-related violence

Payments can occur on marriage either *to* the bride's family by the husband (e.g. in parts of Africa) or *by* the bride's family to the husband or his family (in south Asia and elsewhere). In cultures which require the bride's family to pay a fee to the husband's family at marriage, disputes can occur about the size of the fee or supposed failings on the part of the wife, resulting in the woman being subjected to various forms of violence. (The supposed failings of the wife can also result in violence in cultures where the man's family pays a fee.) In some cases the wife is murdered. In India, thousands of women have died in dowry-related killings in the past decade.[56]

Bride price custom can place women's health at risk by, for example, weakening her capacity to negotiate sexual relations or to agree the number of children the couple will have. In some cultures, the brother of a deceased man can "inherit" his wife. Customs such as these are believed to place women at higher risk of HIV infection, according to women's rights advocates.[57]

Coercive measures relating to reproductive health

A number of practices relating to reproductive health have an impact on the security and well-being of women. During the Balkans wars in the 1990s, women were systematically raped leading in many cases to unwanted and forced pregnancy. In other countries women have been forced to terminate a pregnancy against their will. This can happen as a result of state policy restricting the number of children people are allowed to have or because of a non-consensual medical intervention.[58] A third coercive measure is involuntary sterilization. This practice appears to be linked either to national population policy, to the control the reproduction of minorities or to control of the fertility of women with learning disabilities.[59]

In Nigeria and some other jurisdictions, women can be subject to a state-ordered death sentence if they are found to have had a termination of pregnancy. During a research visit to Nigeria in March 2003, Amnesty International interviewed seven women detained at Katsina prison, Katsina State, and found that one of the women had already

due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. (2) Marriage shall be entered into only with the free and full consent of the intending spouses." See also the Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages, *Article 1:* 'No marriage shall be legally entered into without the full and free consent of both parties, such consent to be expressed by them in person after due publicity and in the presence of the authority competent to solemnize the marriage and of witnesses, as prescribed by law."

[55] Amnesty International. *It's in our Hands: Stop Violence against Women*. London, 2004; See also *Swaziland: Human rights at risk in a climate of political and legal uncertainty*. AI Index: AFR 55/003/2004, 2004. In some areas of conflict, a phenomenon often called "forced marriage" represents a form of sexual enslavement of women by occupying soldiers though it differs from the practice described above. In May 2004, the Trial Chamber of the Special Court for Sierra Leone approved by majority decision a motion by prosecutors to add the new count of "forced marriage" to indictments against six defendants alleged to have been leaders of former military forces in the country. The approval of the new indictment by the Chamber marks the first time that "forced marriage" in the context of conflict will be prosecuted as a crime against humanity under international law. (Special Court for Sierra Leone. Trial Chamber Approves New Count of Forced Marriage. Press Release, Freetown, Sierra Leone, 7 May 2004. http://www.sc-sl.org/pressrelease-050704.html)

[56] Jutla RK, Heimbach D. Love burns: An essay about bride burning in India. *Journal of Burn Care &Rehabilitation* 2004;25:165-70. Prosecutions for such killings are relatively rare. Injustice in the context of wife killing is seen elsewhere. See for example See also: WLSA - Swaziland, *Multiple Jeopardy: Domestic Violence and Women's Search for Justice in Swaziland*, Mbabane, 2001.

[57] Wendo C. African women denounce bride price. *Lancet* 2004; 363: 716. See, more generally, Amnesty International. Women, HIV/AIDS and Human Rights. AI Index: 77/084/2004, November 2004.

[58] See, for example, 'Surgeon reprimanded for aborting baby without consent', *London Independent*, 31 May 2002.

[59] Cook RJ, Dickens BM, Fathalla MF. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Clarendon Press, 2003, pp.237-8.

been convicted of "culpable homicide" and sentenced to death by hanging for having had an abortion. Of the women still awaiting trial, three had been charged with the capital offence of culpable homicide. Two of the women had been charged or convicted under the Penal Code and one under the *Shari'a* penal code of Katsina.[60] In many other jurisdictions women are punished for seeking or having terminations of pregnancy.[61]

Virginity tests

In some cultures which place a high value on female "chastity", young women may be required by their family, by a potential husband's family or by others to "prove" their virginity. As a result, doctors or nurses are sometimes asked to carry out so-called virginity tests – inspection of the external female genitalia – to determine if there has been any sexual activity on the part of the woman.

In 1994, Human Rights Watch reported that high school girls throughout Turkey were forced to submit to virginity control examinations. These examinations were also performed on "female political detainees, women charged with 'immodest behavior', hospital patients, state dormitory residents, and women applying for government jobs".[62]

The attempted suicides of five Turkish school girls who were being threatened with forcible examination led to a ban on the practice in 1999. However its revival was proposed in 2001 before a definitive ruling against tests of school girls was announced in February 2002.[63]

A 1999 study in Turkey found that 118 forensic doctors surveyed reported conducting nearly 6000 examinations in the previous 12 months. Most had been conducted because of alleged sexual assault[64] but some 1800 were carried out for social reasons. Although 68% of forensic physicians indicated that they believed "virginity examinations" are inappropriate in the absence of an allegation of sexual assault, 45% had conducted examinations for social reasons. A large majority of the doctors surveyed (more than 90 percent) agreed that the examinations are psychologically traumatic for the patient. In addition, more than half the doctors reported that the majority of patients undergo examinations against their will.[65]

Other countries also have a long record of the use of virginity testing. An entire subspecialty of forensic medicine in Iraq deals with virginity according to an Iraqi forensic pathologist cited in a recent article. He noted that the current lack of security in Iraq and high levels of violent deaths there has led to less effort to cover-up the killing of women for reasons of "honour".[66]

Genital mutilation

As many as 136 million girls and women are affected by the cultural practice of cutting/mutilating the external genitalia.[67] While having roots in long-

[60] Amnesty International. *The Death Penalty and Women under the Nigeria Penal Systems*. AI Index: AFR 44/001/2004, 2004. Available at: http://web.amnesty.org/library/Index/ENGAFR440012004

[61] CEDAW General Recommendation No. 24, para. 31(c) states that: "When possible, legislation criminalising abortion could be amended, to remove punitive measures imposed on women who undergo abortion." Available at: http://www.un.org/womenwatch/daw/cedaw/recomm.htm

[62] Human Rights Watch. *A Matter of Power: State Control of Women's Virginity in Turkey*. New York, 1994. Available at: http://www.hrw.org/reports/1994/turkey/TURKEY.pdf

[63] BBC. Turkey scraps virginity tests. http://news.bbc.co.uk/2/hi/europe/1845784.stm, 28 February 2002. Amnesty International reported on the use of "virginity tests" in the context of political repression. One woman in Mersin "was allegedly beaten and sexually abused by male police officers during a search. She was forced to undergo a 'virginity test', and the doctor was reportedly threatened by police not to issue a medical report detailing her torture." See: *Turkey: End sexual violence against women in custody!* AI Index: EUR 44/006/2003, p.20. Available at: http://web.amnesty.org/library/Index/ENGEUR440062003

[64] A forensic examination following a rape examination should not be confused with a "virginity test". A forensic examination should be more wide-ranging and not focus – and certainly not *solely* – on the state of the hymen. See Amnesty International. Protecting the human rights of women and girls: a medico-legal workshop on the care, treatment and forensic medical examination of rape survivors in Southern and East Africa. AI Index: AFR 53/001/2002.

[65] Frank MW, Bauer HM, Arican N, Fincanci SK, Iacopino V. Virginity examinations in Turkey: role of forensic physicians in controlling female sexuality. *JAMA* 1999;282:485-490

[66] Packer G. Letter from Baghdad: Caught in the crossfire. *New Yorker,* 17 May 2004. See: http://www.newyorker.com/fact/content/?040517fa_fact. According to Packer, prior to the current war, "the family [of the victim] would have burned or drowned the woman to disguise the murder".

[67] Magoha GA, Magoha OB. Current global status of female genital mutilation: a review. *East African Medical Journal* 2000;77:268-72; Henrion R. Mutilations génitales féminines, mariages forcés et grossesses précoces [Female genital

existing traditional practice and explained variously as a product of culture, religion, aesthetic values or patriarchy, it is increasingly being seen as breaching the human rights of those upon whom it is imposed.[68] The practice has both acute and long-term consequences including during the woman's sexual and reproductive life. In the immediate period after the procedure the wound can haemorrhage or become infected and lead to generalised sepsis. Death can follow in either event. The girl or woman may also experience problems with urination. The effects of female genital mutilation (FGM) can be damaging for the woman later in her life when intercourse, pregnancy and childbirth can be painful and, in the case of childbirth, life-threatening (see table above).[69]

Categories of female genital mutilation

The World Health Organization categorises the practice as follows:

Type I: Excision of the prepuce [or clitoral hood] with or without excision of part or all of the clitoris
Type II: Excision of the clitoris together with partial or total excision of the labia minora
Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
Type IV: Unclassified: Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping … of the vaginal orifice or cutting … of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the [WHO] definition of FGM….[70]

Possible complications and consequences of female genital mutilation

Immediate and short-term:
Haemorrhage, infection, urinary dysfunction, shock, death

Long-term:
Urinary complications, scarring, pain, infection, infertility, painful intercourse

Obstetric
Tearing, wound infections, postpartum haemorrhage, sepsis, death

Numerous local and international groups have been working against this practice for the past quarter century. A number of strategies are being used including community mobilisation, legal action, health education, and development of alternative forms of ceremony to mark a girl's "rite of passage". One response to these risks has been to medicalize the procedure, thus involving medical practitioners in a non-medical mutilating procedure.[71] Such involvement is widely opposed by health professional organisations.[72]

Women at particular risk

All women and girls can be targeted for gender-based violence but a number of factors increase the risk. The major factor in sexual violence is living with a male partner. However other factors influencing the risk of sexual violence include: "being young; consuming alcohol or drugs; having previously been raped or sexually abused; involvement in sex work; and poverty.[73]

Prisoners

Sexual and other violence against women in prisons and detention centres is a significant problem. Amnesty International and other human rights organizations have documented violence against women detainees in numerous countries, carried out

mutilation, forcible childhood marriage and adolescent pregnancies]. *Bull Acad Natle Méd.* 2003;187:1051-66.
[68] Amnesty International. INCLUDE INAH'S paper here. See also: *Female genital mutilation: a human rights issue*. London 1997; Cook RJ, Dickens BM, Fathalla MF. Female genital cutting (mutilation/circumcision): ethical and legal dimensions. *International Journal of Gynaecology and Obstetrics* 2002;79(3):281-7.
[69] Nour NM. Female genital cutting: clinical and cultural guidelines. *Obstetrics and Gynecology Survey* 2004; 59:272-9. For a comprehensive review of studies on the effects of FGM see: World Health Organization. *A Systematic Review of the Health Complications of Female Genital Mutilation including Sequelae in Childbirth*. Document WHO/FCH/WMH/00.2, Geneva, 2000. Amnesty International will publish a report on FGM in 2004.
[70] WHO. Fact sheet N°241: *Female genital mutilation*. Geneva, June 2000.

[71] See, for example, Siringi S. Kenyan health professionals participate in female circumcision. *Lancet* 2002 ;360:2057.
[72] See, for example, International Council of Nurses, opposes FGM the procedure "and any moves to 'medicalise' [it]". See: ICN. Elimination of female genital mutilation: http://www.icn.ch/psgenital.htm
[73] WHO. *World Report on Violence and Health*, Geneva, 2002, p.157.

by prison guards and security personnel, but also by fellow prisoners.[74]

Amnesty International has documented the persistent abuse of women in prisons in Turkey. In March 2002, Hamdiye Aslan, a 37-year-old Kurdish woman was held at the Anti-Terror branch of Mardin police headquarters for two days during which she was blindfolded and threatened. According to reports, police officers poured cold water over her whilst an air-conditioner blew cold air over her. She was stripped and anally raped with a truncheon. The Turkish Medical Chamber opened a case against two doctors who wrote reports stating that she had not experienced torture. She was transferred to a prison until she was released by a court nearly three weeks after her arrest. Following her formal complaint about her treatment she had further medical reports which recorded injuries consistent with her allegations of torture.[75] Rape and sexual violence against women in custody in Turkey continue to be reported.

As in most countries, women prisoners in Brazil account for only a small percentage – around 5% – of the total prison population. However these women are at risk of ill-treatment. In some places of detention, they suffer torture and ill-treatment by police and prison officers. Women held in police stations endure extreme overcrowding and lack of privacy. Adequate sanitary facilities and medical care are unavailable and there is a lack of attention to women's health care needs in prison, particularly those related to pregnancy and childbirth and to their family responsibilities.[76]

Sexual and other abuse of female prisoners is a long-standing concern in US prisons. In October 1998, Florence Krell hanged herself from her cell door at Jefferson Correctional Institution in Florida. Before her death she wrote to the judge who had sentenced her and to her mother, complaining of abuse from guards and other forms of ill-treatment, including being left naked in her cell and observed by male officers.[77]

Searching of women prisoners can give rise to sexual abuse. In 2003, Valley State Prison for Women (VSPW) in California, the state's largest women's prison, reinstated the practice of allowing male officers to physically search women. The new policy allowed male guards to conduct unsupervised searches of female prisoners which involve touching the breast and crotch areas – a procedure that was banned in VSPW in 1998 after years of protests by women of suffering groping and other sexual abuse at the hands of male guards. Among those being searched in this way were women prisoners with histories of being physically or sexually abused before their incarceration.[78] The policy was ended on 15 October 2003, shortly after a campaign against the practice commenced.

Women can also be exposed to sexual humiliation when *visiting* prisoners. In Argentina, women visitors were subject to vaginal inspections until a 1996 case before the Inter-American Commission on Human Rights led to a ruling that the inspections constituted an invasion of the girls' and women's bodies and violated the applicants' rights to privacy, physical and psychological integrity, the protection of the family and the rights of the child.[79]

Institutionalised women

Women held in state-run or state-sanctioned institutions risk being deprived of many basic rights. While medical and other healthcare staff are obliged to act in the best interests of the women, there is nevertheless evidence that such women are

[74] Amnesty International. *Broken bodies, shattered minds: Torture and ill-treatment of women*. London, 2001; "prison authorities are responsible for protecting inmates, and if they fail to ensure compliance with rules such as the separation of women and men, this can be tantamount to acquiescence in sexual violence." (p.48). See also Amnesty International. *Combating torture: A Manual for Action*. London, 2003.)

[75] Amnesty International. *Turkey: End sexual violence against women in custody!* AI Index: AI Index: EUR 44/006/2003. http://web.amnesty.org/library/Index/ENGEUR44062003

[76] Amnesty International. *Brazil: "No one here sleeps safely": human rights violations against detainees.* AI Index: AMR 19/009/1999. See section 6.4.

[77] Amnesty International. *United States of America: "Not Part of My Sentence" -Violations of the Human Rights of Women in Custody,* AI Index AMR 51/001/1999. Available at: http://web.amnesty.org/library/Index/ENGAMR510011999

[78] Amnesty International. *USA: Degrading treatment for women at Valley State Prison*. London: AI Index: AMR 51/135/2003. http://web.amnesty.org/library/Index/ENGAMR511352003

[79] Cabal L, Roa M, Sepulveda-Oliva L. What role can international litigation play in the promotion and advancement of reproductive rights in Latin America? *Health and Human Rights* 2003; 7: 51-88. The ruling (Report Nº 38/96, Case 10.506) is available in English at: http://www.cidh.org/annualrep/96eng/Argentina11506.htm and in Spanish at: http://www.cidh.org/annualrep/96span/IA1996CapIIIa.htm.

vulnerable to abuse by, or with the knowledge of, care workers.

In 2001, Amnesty International reported that mentally disabled women in Bulgaria being held at a state institution in the village of Sanadinovo were being subjected to conditions that amounted to cruel, inhuman and degrading treatment. Some inmates were being held in a cage, because the staff claimed that "they had misbehaved". Independent experts quoted by Amnesty International described conditions in such institutions as "a slow death".[80] The institution was subsequently closed down by the government after international protest.

The NGO, Mental Disability Rights International (MDRI), received reports about cases of sexual harassment, exploitation, rape, or other forms of violence at institutions in Kosovo: Shtime, Prishtina University Hospital, and an institution known as the Elderly Home. The management of the institution and UN authorities were informed about cases of abuse at Shtime, a facility for those with mental disabilities, yet known abusers had not subsequently been removed from day-to-day contact with former victims. At Prishtina University Hospital, MDRI has received reports about sexual abuse of women by staff.[81] A year later MDRI continued to express concern at the lack of progress in effectively addressing abuses.[82]

Women who are institutionalised for reasons of mental illness elsewhere have been reported to have been affected by sexual violence though not necessarily within the institution. Women inpatients at a mental hospital in southern India reported coerced sexual activity in which the perpetrator was their spouse (nearly half of cases), a friend or acquaintance (a quarter of cases), and a relative such as an uncle or cousin (a fifth of cases). Most experiences occurred in the women's homes.[83]

[80] Amnesty International. *Urgent Action: Bulgaria*. London, AI Index: EUR 15/001/2001

[81] MDRI. *Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo*. Washington DC, 2002.

[82] See: http://www.mdri.org/takeaction/kosovo.htm [accessed 2 June 2004]

[83] Chandra PS, Deepthivarma S, Carey MP, Carey KB, Shalinianant MP. A cry from the darkness: women with severe mental illness in India reveal their experiences with sexual coercion. *Psychiatry* 2003; 66(4):323-34.

Domestic workers

Female domestic workers – those who work in the homes of wealthier families in the developing or developed world – are at risk of sexual abuse from their employers and members and friends of the employer. Those who travel abroad to enter domestic work are at particular risk. Women who have entered the country without documentation, or who have had their documentation taken by their employers, often cannot seek legal redress for the abuses they have suffered. This can arise because of concern that they will be in breach of local laws with consequent fears with regard to their employment, their home, and their safety. Employers can use this fear to silence the woman. Domestic workers can face legal restrictions on changing employment, and can face language difficulties and the fear of deportation if they protest at their mistreatment.[84]

Refugees and internally displaced women/girls

Women refugees and asylum-seekers fleeing from one dangerous situation can find themselves in new situations of serious risk. Government officials (such as immigration officials or border guards), traffickers, members of armed groups, male refugees or other migrants, have all been known to abuse refugee women while they are in transit.

In a number of countries, asylum-seekers are detained in prisons or prison-like detention facilities where they live like convicted criminals. Amnesty International and other human rights organizations have documented incidents of abuse of women and girl refugees and asylum-seekers in detention, and of conditions which amount to cruel, inhuman or degrading treatment.[85]

Immigrant women (and women from minority groups) also face difficulties in taking action when they suffer domestic violence. A Canadian study identified a "complex set of issues, attitudes, barriers and gaps in service that make immigrant and visible minority women uniquely vulnerable and impeded in

[84] See: Lin Chew. Programme Consultation Meeting on the Protection of Domestic Workers Against the Threat of Forced Labour and Trafficking: Discussion Paper. London: Anti-Slavery International, January 2003; Amnesty International. Saudi Arabia: Gross Human Rights Abuses Against Women. London, 2000.

[85] See, for example, Amnesty International. *Lost in the Labyrinth: Detention of Asylum-Seekers*. London, 1999,

obtaining the support they need when faced by domestic violence".[86]

Even when women feel it safe enough to return to their countries of origin (or where they have been returned involuntarily), they may find themselves living alongside the perpetrators of the abuses that forced them to flee. Returning from internal displacement or foreign exile, women and girls may also encounter a new set of problems including continuing high levels of violence.[87] The breakdown of community structures and traditional roles that often results from conflict and flight presents new challenges in a post-conflict society.[88]

Evidence from recent years suggests that refugee women and girls are not even safe from sexual and other exploitation by humanitarian aid workers. Reports in 2002 by the Office of the UN High Commissioner for Refugees (UNHCR), together with Save the Children-UK, documented serious allegations of sexual abuse and exploitation of women and children by humanitarian workers in camps for refugees and displaced people in Sierra Leone, Liberia and Guinea. Allegations included humanitarian workers deliberately withholding food and services in order to extort sexual favours.[89]

In Nepal, it was acknowledged by UNHCR that Bhutanese refugees in camps were found, in at least 18 cases, to have been victims of sexual abuse and exploitation by refugee aid workers. The victims included a seven-year-old girl and a woman with disabilities.[90] In 2004, further allegations were made about UN peace-keepers in the Democratic Republic of Congo.[91]

> *"If I go and see the [UN] soldiers at night and sleep with them, then they sometimes give me food, maybe a banana or a cake…I have to do it with them because there is nobody to care, nobody else to protect Joseph [her son] except me. He is all I have and I must look after him."* Faela, aged 13
>
> *"I go over the fence when I need food …. Nothing bad happens to us over there – the soldiers are kind and they give us things. In this camp there isn't much. I came to Bunia to be safe and to get away from soldiers who attacked my village…. The UN soldiers help girls like me – they give us food and things if we go [have sex] with them."* Maria, aged 15, Democratic Republic of Congo[92]

Responding to the levels of sexual violence faced by female refugees the World Health Organization has published a manual on the clinical management of rape among refugees and internally displaced persons.[93]

Lesbian, bisexual and transgender women

Lesbian, bisexual and transgender women face gender-based violence within the community as well as at the hands of state officials.

A Ugandan lesbian and gay rights activist, Christine [not her real name], and four of her friends formed a human rights group in early 1999. All five faced particular obstacles in Uganda where "carnal knowledge of any person against the order of nature" is an offence which can carry a sentence of life imprisonment. Christine and the other four were arrested and they were tortured in a secret detention centre. Christine was raped after being left alone in a room with three male detainees. She was detained

[86] Smith E. *Nowhere to Turn? Responding to Partner Violence against Immigrant and Visible Minority Women.* Canadian Council on Social Development, March 2004. Available at: http://www.ccsd.ca/pubs/2004/nowhere/

[87] WHO. *World Report on Violence and Health*, Geneva, 2002, p.15.

[88] "Conflict can completely change the role of women in their family, the community and in the 'public' domain. It regularly forces women to become household heads and breadwinners, taking over the responsibility for earning a livelihood, caring for farm and animals, trading and being outside the home – activities traditionally carried out by men." Bouta T, Frerks G. *Women's Roles in Conflict Prevention, Conflict Resolution and Post-Conflict Reconstruction: Literature Review and Institutional Analysis.* Conflict Research Unit, Netherlands Institute of International Relations, The Hague, 2002, p.36.

[89] *Note for Implementing and Operational Partners By UNHCR and Save the Children-UK on Sexual Violence & Exploitation: The Experience of Refugee Children in Guinea, Liberia and Sierra Leone based on Initial Findings and Recommendations from Assessment Mission 22 October - 30 November 2001.* Geneva, February 2002 [available at http://www.unhcr.ch]

[90] Amnesty International, Human Rights Watch. *Nepal: Sexual Abuse Reports Highlight Plight of Bhutanese Refugees*, AI Index: ASA 31/071/2002, 22 November 2002. Available at: http://web.amnesty.org/library/Index/ENGASA310712002

[91] *Independent* (London). 'UN troops buy sex from teenage refugees in Congo camp', 25 May 2004.

[92] *Ibid.*

[93] WHO. *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations*, Geneva 2001. See http://www.who.int/reproductive-health/publications/rhr_02_8/clinical_management.pdf.

solely because she was a lesbian who was active in human rights in a country in which homosexuality is a criminal offence. She later said, "coming midnight, they said 'we want to show you something'. They took my clothes off and raped me. I remember being raped by two of them, then I passed out …"[94]

Sex workers

Those who sell sexual services, either independently or under the control of a "manager" or pimp, are often at high risk of violence. They may face violence to coerce them into sex work; violence to maintain them in it; violence at the hands of clients; and violence should they fail in any attempt to escape from the control of a pimp. For some their main concern is violence from clients.[95] Trafficked women are at a particularly high risk of violence (see pages 6-7 above.)

Sex workers who are raped may find that their complaints are not listened to or not understood. Health workers are among those who are not always sympathetic to those selling sex. In India, sex workers have encountered a coercive insistence by health workers on an HIV-test instead of finding out what health problems the woman has.[96]

Health consequences of violence against women

The health consequences of violence are felt at many different levels. These include the outcomes felt by the individual; the effects on the family; the impact of violence on the community; the implications for the medico-legal system; and the impact of violence for the perpetrator. While the following section considers, separately, physical injury, mental health consequences and the impact of disease arising from violence against women, it should be noted that there is a complex interplay between these aspects and examining each aspect separately does not convey the complexity of the total effect of violence.

Health consequences of intimate partner violence[97]

Physical
Abdominal/chest injuries
Bruises, lacerations, abrasions
Chronic pain syndromes
Disability
Fractures
Gastro-intestinal disorders
General health status lower, or number of symptoms higher, than average

Sexual and reproductive
Gynaecological disorders
Infertility
Miscarriage
Pelvic inflammatory disease
Pregnancy-related problems
Sexual dysfunction
Sexually transmitted infections including HIV
Unsafe abortion
Unwanted pregnancy

Psychological and behavioural
Anxiety, fear, depression
Feelings of shame and guilt
Disturbed sleep
Eating disorders
Poor self-esteem
Post traumatic stress disorder (PTSD)
Self harm
Substance use and abuse
Suicidal thinking
Unsafe sexual behaviour

Physical injury

Studies in all continents have documented the physical harm sustained by women as a result of gender-based violence. The *World Report on Violence*

[94] Amnesty International. *Crimes of hate, conspiracy of silence: Torture and ill-treatment based on sexual identity*. London: AI Index: ACT 40/016/2001. Available at: http://web.amnesty.org/library/Index/ENGACT400162001

[95] Green ST, Goldberg DJ, Christie PR, Frischer M, Thomson A, Carr SV, Taylor A. Female streetworker-prostitutes in Glasgow: a descriptive study of their lifestyle. *AIDS Care* 1993;5:321-35; Church S, Henderson M, Barnard M, Hart G. Violence by clients towards female prostitutes in different work settings: questionnaire survey. *British Medical Journal*, 2001, 322:524–525.
See also: Romero-Daza N, Weeks M, Singer M. "Nobody gives a damn if I live or die": violence, drugs, and street-level prostitution in inner-city Hartford, Connecticut. *Medical Anthropology* 2003;22:233-59.

[96] Misra G, Mahal A, Shah R. Protecting the rights of sex workers: the Indian experience. *Health and Human Rights* 2000; 5: 89-115.

[97] Adapted from WHO. *World Report on Violence and Health*, Geneva 2002, p.101. See also Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002; 359: 1331-36.

and Health reviews the global toll on women[98].

The effects of violence against women are both immediate and long-lasting. A Swedish study of nearly 400 middle-aged women showed that health problems among women were 11 times more likely among those who had been abused as children, and seven times more likely among those who experienced abuse as adults.[99]

In one US study, Valera and Berenbaum examined 99 battered women and found that almost three quarters of the women had sustained at least one partner-related brain injury, and half sustained multiple partner-related brain injuries[100].

Non-consensual penetrative sex can result in a number of gynaecological complications including vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections.[101] (See table above.)

Neither pregnancy nor age protects women from violence and the effects of violence. A study in the USA showed the prevalence of physical violence against pregnant women was around 11%. Women reporting violence were more likely than matched controls (that is, women having similar characteristics but who have not reported violence) to deliver by caesarean section and be hospitalized before delivery for maternal complications such as kidney infection, premature labour, and trauma due to falls or blows to the abdomen.[102]

A review of studies of violence against pregnant women in developing countries found that prevalence ranged from 4% to 29%. Main risk factors for abuse during pregnancy included low-income status, low education in both partners, and pregnancy being unplanned. Low birth weight of the baby was seen as a consequence of violence.[103]

Health service needs of women who are victims of sexual violence

Treatment of injuries
Psychosocial counselling
Testing and/or prophylaxis for sexually-transmitted diseases
Pregnancy testing
Pregnancy prevention (emergency contraception)
Counselling and advice concerning pregnancy
Medical documentation for legal purposes
Referral to non-medical services such as social welfare and legal aid

Disease

HIV/AIDS

The predominant forms of serious disease resulting from violence against women are sexually transmitted. Of these, human immunodeficiency virus (HIV) is one of the most serious[104] but research is lacking on the link between rape and transmission of the virus. It has been estimated that single episode transmission rates during non-violent unprotected sexual intercourse are around 0.03 to 0.56 percent (i.e. 3-56 incidents of seroconversion per 10,000 acts of intercourse)[105]. However there can be no doubt that

[98] WHO. *World Report on Violence and Health*, Geneva 2002, chapters 4 and 6. (These chapters deal with intimate partner violence and sexual violence. While these forms of violence are not experienced by women only, it is women who are the principal victims of such violence.) Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/

[99] Krantz G, Ostergren P. The association between violence, victimisation and common symptoms in Swedish women. *Journal of Epidemiology and Community Health* 2000; 54: 815-21.

[100] Valera EM, Berenbaum H. Brain injury in battered women. *Journal of Consulting & Clinical Psychology* 2003; 71(4): 797-804.

[101] WHO. *World Report on Violence and Health*. Geneva, 2002, p.162.

[102] Cokkinides VE, Coker AL, Sanderson M, Addy C, Bethea L. Physical violence during pregnancy: maternal complications and birth outcomes. *Obstetrics and Gynecology*. 1999; 93:661-6.

[103] Nasir K, Hyder AA. Violence against pregnant women in developing countries: review of evidence. *European Journal of Public Health* 2003;13(2):105-7.

[104] As the UN Secretary General's Task Force points out in a recent report, HIV can also be the cause of violence by a man against his female partner when she reveals her HIV status. See: *Facing the future together. Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*, 2004, p.33. Available at: http://www.sarpn.org.za/documents/d0000839/index.php

[105] Estimated rates of transmission are subject to many variables including changing patterns of sexual behaviour. The figures cited here refer to vaginal intercourse. The estimated transmission risk for unprotected receptive anal intercourse is higher and other risk factors such as existing STIs and use of violence increase the risk for both vaginal and anal intercourse. See Royce RA, Seña A, Cates W, Jr, et al. Sexual transmission of HIV. *New England Journal of Medicine* 1997; 336: 1072-1078; Vittinghoff E, Douglas J, Judson F, McKirnan D, MacQueen K, Buchbinder SP. Per-contact risk of human

rape puts women at higher risk of infection with the virus in countries with a high prevalence rate of the virus and high levels of sexual violence. [106]

Other forms of violence also have a bearing on HIV infection. Studies suggest that women with, or at risk of, HIV come from populations that are also at risk of violence. For a small proportion of women, violence may occur around disclosure of HIV status or in response to negotiations around condom use.[107]

Gender-based violence as a risk factor for HIV (after adjustment for women's own high-risk behaviours, themselves a possible product of male violence). A recent study[108] of nearly 1400 women presenting for antenatal care at four health centres in Soweto, South Africa, found that intimate partner violence and high levels of male control in a woman's current relationship were associated with HIV seropositivity. The authors concluded that women with violent or controlling male partners are at increased risk of HIV infection over their life-time. They suggested that abusive men are more likely to have HIV and impose unsafe sexual practices on partners, and they called for further research to clarify connections between social constructions of masculinity, intimate partner violence, male dominance in relationships, and HIV risk behaviours in men.

A study in Chennai in India showed that community gender norms tacitly sanction domestic violence and this in turn impedes the adoption of behaviours which prevent HIV transmission.[109] The authors suggest that given the choice between the immediate threat of violence and the more distant threat of HIV, women often accede to sexual demands that may increase their risk of contracting HIV. This implies that AIDS-prevention interventions must incorporate gender-related aspects in settings where husbands strictly enforce their control. HIV-prevention messages targeting men may effectively reduce women's exposure to HIV/AIDS.

"The medical consequences of sexual violence are devastating. The physical injuries can be life threatening and many rape victims are at risk of contracting sexually transmitted diseases, including HIV…. This risk is significantly increased during rape because forced sexual intercourse results in injuries and bleeding, thereby facilitating transmission of the virus.

Unwanted pregnancies as a result of rape can force women to seek medically unsupervised abortions. MSF has seen cases of pelvic inflammatory infections and septicaemia arising from such procedures. Other reproductive health problems include interruptions or abnormalities to the menstrual cycle or delayed conception."

Médecins sans Frontières, March 2004 [110]

In Rwanda, a study carried out in 2000 by AVEGA, an association for widows who survived the 1994 genocide, found that two thirds of 1125 women who survived rape during the genocide were HIV-positive. According to a UN report cited by Amnesty International, at least 250,000 women were raped during the genocide, a large number of whom were subsequently killed.[111] Of the survivors, 70% are estimated to have been infected with HIV.

It was in this context that medical researchers and NGOs in South Africa advocated a policy of post-exposure prophylaxis (PEP) in cases of rape[112]. While there is increasing advocacy of the use of PEP there has been limited rigorous research into its

immunodeficiency virus transmission between male sexual partners. *American Journal of Epidemiology* 1999;150(3):306-11.

[106] Amnesty International. *Women, HIV/AIDS and human rights.* London, November 2004. Available at: http://web.amnesty.org/library/Index/ENGACT770842004

[107] Koenig LJ, Moore J. Women, violence, and HIV: a critical evaluation with implications for HIV services. *Maternal and Child Health Journal.* 2000;4:103-9.

[108] Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet* 2004; 363:1415-21.

[109] Go VF, Sethulakshmi CJ, Bentley ME, Sivaram S, Srikrishnan AK, Solomon S, Celentano DD. When HIV-prevention messages and gender norms clash: the impact of domestic violence on women's HIV risk in slums of Chennai, India. *AIDS and Behavior* 2003; 7:263-72.

[110] MSF. Consequences of rape. In: Sexual violence as a weapon of war. Brussels, March 2004. Available at: http://www.msf.org/content/page.cfm?articleid=E16B6E3F-4E4E-4D13-BFE78E2539E6EAFD

[111] Amnesty International. *"Marked for Death", rape survivors living with HIV/AIDS in Rwanda.* London, 2004. Available at: http://web.amnesty.org/library/index/engafr470072004

[112] Kim JC, Martin LJ, Denny L. Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa. *Reproductive Health Matters*. 2003;11:101-12; AIDS Law Project, Centre for the Study of Violence and Reconciliation. *Preventing HIV after Rape - The PEP Booklet.* Johannesburg: ALP, 2003; Amnesty International. *Protecting the Human Rights of Women and Girls: A medico-legal Workshop on the Care, Treatment and Forensic Medical Examination of Rape Survivors in Southern and East Africa.* London, 2002; Human Rights Watch. *Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence.* New York: HRW, 2004. Available at: http://hrw.org/reports/2004/southafrica0304/

effectiveness in the case of both medical accidents and possible sexual transmission[113]; anecdotal results are encouraging though it may not be a certain form of protection following non-occupational exposure.[114] In January 2005 a revised policy on non-occupational PEP (nPEP) by the Centers for Disease Control in the USA suggested that post-exposure prophylaxis should be implemented "when persons seek care within 72 hours after exposure, the source is known to be HIV infected, and the exposure event presents a substantial risk for transmission". The policy suggested that other cases be evaluated on a case-by-case basis.[115]

"I was in Nyanza during the war, and my husband was killed. The militia raped me and my sisters-in-law. Those who talked back were killed. I was shy, so I survived...I was already pregnant at the time, now my child is ten years old...My second husband is out of his mind, and I have gotten sicker because of the worries he gives me. He abandoned me when he learned I had HIV, which is why I am crying so much now. He denigrated me in front of the neighbourhood, so now my neighbours also make fun of me. Maybe my husband is healthy, so that's why he did it. He refuses to get tested. I am worried because I have no property, no money for food for the children, and we live badly. I am always sick and we are too poor...I don't get help from the government because I didn't lose enough people during the genocide".

Rape survivor, Kigali, Rwanda[116]

Because women frequently have little or no control over the use of condoms by male partners, there has been increasing attention paid to the development of microbicides.[117] It is because microbicides offer protection to women, independently of male control, that they are potentially so important. The Global Campaign for Microbicides has suggested that microbicides could have a substantial impact on the HIV epidemic. It cites research showing that if a small proportion of women in lower income countries used a 60% efficacious microbicide in half the sexual encounters where condoms are not used, 2.5 million HIV infections could be averted over three years[118]. The importance of microbicides lies in the fact that they are a protective measure which can be used by women independently of men.

PEP: post-exposure prophylaxis for HIV

What is it?	A 28 day course of one, two or three anti-retroviral drugs to prevent the virus establishing an infection
Who should receive it?	People who have, or are likely to have, been exposed to HIV but who are HIV negative and thus vulnerable.
When should it be administered?	The PEP should be started within 72 hours of possible exposure.
Who should *not* receive PEP?	People not exposed to unsafe sex People who have not had sex with an infected person. People who are already HIV positive[119].

Campaigning by NGOs, as well as action in court, has led to greater political commit to the availability of anti-retroviral drugs and contributed to a greater commitment to delivering necessary drugs to those in

[113] Roland M. Prophylaxis following nonoccupational exposure to HIV. February 2004. Available at: http://hivinsite.ucsf.edu/InSite.jsp?page=kb-07&doc=kb-07-02-07 (accessed 10 July 2004).

[114] Fournier S, Maillard A, Molina JM. Failure of postexposure prophylaxis after sexual exposure to HIV. *AIDS* 2001;15:430; Cordes C, Moll A, Kuecherer C, Marcus U. HIV transmission despite HIV post-exposure prophylaxis after non-occupational exposure. *AIDS* 2004; 18:582-4.

[115] Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. Recommendations from the U.S. Department of Health and Human Services. *MMRW* 2005 (21 January) 54(RR02);1-20, available online at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

[116] Cited in *ibid.*

[117] Microbicides are preparations such as gels or creams which can be used topically in the vagina to inactivate viruses – particularly HIV – or bacteria. See: http://www.global-campaign.org/

[118] Public Health Benefits Working Group. *The Public Health Benefits of Microbicides in Lower-income Countries: Model Projections*. A Report by the Public Health Working Group of the Microbicide Initiative. Undated [post-2002]. Available at the Rockefeller Foundation web-site: http://www.rockfound.org/Documents/488/rep7_publichealth.pdf.

[119] For further discussion of PEP see the presentations given at the conference "Indications for and use of post-exposure prophylaxis (PEP) following sexual assault: a two-day workshop" held in South Africa, September 2002. November 2002, available at: http://hivinsite.ucsf.edu/InSite?page=pr-rr-07; Roland M. Prophylaxis following non-occupational exposure to HIV. HIV InSite Knowledge Base Chapter, February 2004. Available at: http://hivinsite.ucsf.edu/InSite.jsp?page=kb-07-02-07

need.[120] The WHO aims to deliver life-long antiretroviral treatment to 3 million people living with HIV/AIDS in poor countries by the end of 2005. The organization has stated that its core principles include urgency, equity and sustainability.[121]

Other sexually transmitted infections (STIs)

Women subjected to rape are also vulnerable to the bacterial infections syphilis, gonorrhea, chlamydia; the viral infections hepatitis B, herpes simplex (genital herpes), and papilloma virus (genital warts); trichomoniasis (caused by single-celled protozoa) and the problems caused by pubic lice and scabies.[122]

Sexually transmitted infections

Viral	Bacterial	Protozoan	Insect
Cytomegalovirus	Chlamydia	Trichomonas	Pubic lice ("crabs")
HIV/AIDS	Gonorrhea		Scabies
Hepatitis virus	Syphilis		
Herpes simplex			
Human papilloma virus			

Mental health consequences of violence

Violence has the effect of rupturing a woman's sense of personal security. Sexual violence adds to this a deep attack on a woman's most intimate being. Women experience a range of psychological and behavioural consequences of violence (see box, page 17). These include: anxiety, fear, depression, feelings of shame and guilt, disturbed sleep, eating disorders, poor self-esteem, post traumatic stress disorder (PTSD), self harm, substance use and abuse, suicidal thinking, unsafe sexual behaviour.

HIV/AIDS has added an additional factor in relation to psychological and behavioural reaction to assault. According to one study, sexual assault survivors reported greater anxiety, depression, and symptoms of borderline personality and were significantly more likely to report recent unprotected intercourse than persons who had not been sexually assaulted.[123]

Depression, anxiety and fear

Women who have been subjected to violence may experience depression, increased anxiety and fear about personal security, routine life and about health.[124] Depression is one the most prevalent negative mental health consequence of domestic or intimate partner violence.[125]

While anxiety and fear are common consequences of violence, fear and apprehension among women and girls in the community are not solely related to experiences of attack but reflect a feeling of lack of safety. An Australian study which found that 70% of women feared walking in the street after dark, noted that women with partners had higher levels of fear than those living without partners[126]. UK surveys reported that 37% of young women aged 16-29 are worried about rape and half of all women feel unsafe when walking home at night.[127] While fear can be an appropriate reaction to imminent danger it can have the effect of controlling women's behaviour and limiting their movement even when the risk of violence is lower than feared.

Behavioural changes

The behaviour of women and girls can display significant change as a result of physical and sexual

[120] Prominent among such NGOs is the Treatment Action Campaign (TAC), based in Cape Town. TAC was awarded the 2003 Nelson Mandela Health and Human Rights Award.
[121] WHO. *Treating 3 million by 2005: Making it happen*. Geneva, 2003. Available at: http://www.who.int/3by5/publications/documents/isbn9241591129/en/
[122] Jackson D, Dallabetta G, Steen R. Sexually transmitted infections: prevention and management. *Clinics in Occupational and Environmental Medicine.* 2004;4(1):167-88.
[123] Kalichman SC, Sikkema KJ, DiFonzo K, Luke W, Austin J. Emotional adjustment in survivors of sexual assault living with HIV-AIDS. *Journal of Traumatic Stress* 2002;15(4):289-96.
[124] Stein MB, Lang AJ, Laffaye C, Satz LE, Lenox RJ, Dresselhaus TR. Relationship of sexual assault history to somatic symptoms and health anxiety in women. *General Hospital Psychiatry* 2004; 26(3): 178-83; Coid J, Petruckevitch A, Chung WS, Richardson J, Moorey S, Feder G. Abusive experiences and psychiatric morbidity in women primary care attenders. *Br J Psychiatry* 2003 ;183:332-9; 340-1.
[125] Dienemann J, Boyle E, Baker D, Resnick W, Wiederhorn N, Campbell J. Intimate partner abuse among women diagnosed with depression. *Issues in Mental Health Nursing* 2000;21(5):499-513.
[126] Carcach C, Mukherjee S. *Women's Fear of Violence in the Community.* Australian Institute of Criminology. Publication No. 135, 1999. http://www.aic.gov.au/publications/tandi/ti135.pdf
[127] Kershaw C, Budd T, Kinshott G, Mattinson J, Mayhew P, Myhill A. The 2000 British Crime Survey England and Wales. *Home Office Statistical Bulletin*, 18/00, 2000; Mirrlees-Black C, Mayhew P, Percy A. The 1996 British Crime Survey England and Wales. *Home Office Statistical Bulletin*, 19/96, September 1996.

abuse. These include risk-taking[128], substance-abuse[129], disturbed sleep[130], eating disorders[131] and self-harming behaviour.[132] Suicidal thinking and attempted suicide can also follow abuse.[133] Sexual assault can have an impact on a woman's sexual behaviour through response-inhibiting problems, including fear and dysfunctions in arousal and desire. A number of factors can mitigate this, including strong partner support.[134]

Traumatic stress reactions

Women (and men) who have been subjected to life-threatening violence or sexual assault may react in a number of different ways which taken together constitute a traumatic stress reaction. *Acute stress reaction* is a transient condition in response to a traumatic event. The symptoms begin at the time of the traumatic event and may disappear within days. Symptoms include a narrowing of attention, disorientation, depression, withdrawal and anxiety. More commonly noted – because of its duration and severity – is *post-traumatic stress disorder* (PTSD).

Although this diagnostic category is not without its critics[135] it does reflect widely observed patterns of reaction to violence and particularly to rape. (See the box below, for a summary of the diagnostic elements of PTSD as suggested by the World Health Organization and the American Psychiatric Association.)

Post-traumatic stress disorder

Diagnostic criteria of the WHO

A. The person has been exposed to a stressful event or situation of exceptionally threatening or catastrophic nature
B. There is persistent remembering or "reliving" of the stressor in intrusive "flashbacks"….
C. There is avoidance circumstances resembling or associated with the stressor…
D. There is either or both of (i) inability to recall some important aspects of the period of exposure to the stressor; (ii) persistent symptoms not present for exposure including two of difficulty in falling or staying asleep; irritability or outbursts of anger; difficulty in concentrating; hypervigilance; exaggerated startle response
E. Criteria B, C, and D are met within six months of the stressful event or of the end of a period of stress.

See: WHO. *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.* World Health Organization, Geneva, 1992.

Diagnostic criteria of the APA

Elements similar to those described above (with some additional factors) are contained in the APA definition of PTSD. (See: *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition *[DSM-IV]*. Washington DC: American Psychiatric Association, 1994.

Numerous studies have documented the incidence, epidemiology, pre-disposing factors and approaches to therapy of PTSD. The evidence is clear that PTSD represents a major mental health consequence of rape and other traumatic assaults on women.[136]

[128] Campbell R, Sefl T, Ahrens CE. The impact of rape on women's sexual health risk behaviors. *Health Psychology* 2004 Jan;23(1):67-74. Risk-taking behaviours can include increased frequency of sexual activity, number of sexual partners, infrequency of condom use, and frequency of using alcohol and/or drugs during sex.
[129] Choquet M Darves-Bornoz JM, Ledoux S, Manfredi R, Hassler C.. Self-reported health and behavioral problems among adolescent victims of rape in France: results of a cross-sectional survey. *Child Abuse & Neglect* 1997; 21:823–32. Substance abuse also a predictor of sexual assault. King G, Flisher AJ, Noubary F, Reece R, Marais A, Lombard C. Substance abuse and behavioral correlates of sexual assault among South African adolescents. *Child Abuse & Neglect* 2004;28(6):683-96.
[130] Clum GA, Nishith P, Resick PA. Trauma-related sleep disturbance and self-reported physical health symptoms in treatment-seeking female rape victims. *Journal of Nervous and Mental Diseases* 2001 Sep;189(9):618-22.
[131] Walsh JMW, Wheat ME, Freund K. Detection, evaluation, and treatment of eating disorders: the role of the primary care physician. *Journal of General Internal Medicine* 2000;15(8): 577-90. Available at: http://www.blackwell-synergy.com/links/doi/10.1046/j.1525-1497.2000.02439.x/full/
[132] Cavanaugh RM. Self-mutilation as a manifestation of sexual abuse in adolescent girls. *Journal of Pediatric and Adolescent Gynecology* 2002;15(2):97-100.
[133] Ullman SE, Brecklin LR. Sexual assault history and suicidal behavior in a national sample of women. *Suicide and Life-Threatening Behaviour* 2002;32(2):117-30.
[134] van Berlo W, Ensink B. Problems with sexuality after sexual assault. *Annual Review of Sex Research* 2000;11:235-57.
[135] Summerfield D. The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal* 2001;322:95-98.
[136] Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal of Family Violence* 1999; 14: 99-132.

Disability

Violence against women can result in physical disability. During the genocide in Rwanda and in the civil conflicts in West Africa, women – and men – suffered amputation of the hands and arms carried out by opposition combatants. They also suffered gender-targeted injuries. In several conflicts women have been subjected to hacking off of breasts and serious damage to their reproductive organs. One particularly socially-isolating injury to women resulting from violent rape is a fistula – a rupture of the walls between the vagina and the bladder or rectum. The victim is left incontinent and is usually socially isolated and excluded from participation within the community. The injury can be rectified by surgery if the woman can get access to a suitable hospital[137].

The psychological problems resulting from exposure to violence can be sufficient to constitute a disability, inhibiting the capacity of the women to function effectively.

Forcible sterilization

In a five year period (1996-2000), more than 250,000 women, overwhelmingly poor and from remote, rural areas, underwent coerced sterilization, without a proper consent process, during the implementation of a family planning policy in Peru.[138] A test case brought against the government of Peru was settled before the Inter-American Commission on Human Rights in October 2002 when the government accepted that there had been breaches of several applicable human rights conventions.[139]

In the Slovak Republic, women from the Roma minority were alleged to have been sterilised without their consent during the communist government period and during the 1990s.[140] Although the government said that it would investigate the allegations, Amnesty International expressed its concern in mid-2003 that, in spite of its repeated appeals, the investigation into the allegations was not being conducted independently, thoroughly and impartially as required by international law. Furthermore, Amnesty International was concerned about the continued reported harassment and intimidation of victims, witnesses, and human rights defenders.[141] Campaigning continued over the following year to ensure that the government's investigation met the required standard.

Pregnancy

Pregnancy is both an outcome of sexual violence and a factor in the perpetration of intimate partner violence.[142] The pregnancy rate from rape is difficult to document for several reasons, such as the fact that most incidents of rape are unreported. Moreover some women are subjected to systematic and repeated rape which would increase the likelihood of pregnancy as an outcome. Stewart and Trussel[143] estimated that, in the USA in 1998, around 25,000 conceptions followed rape. Some 330,000 assaults were reported in that year though the actual number would certainly be higher. An earlier US-based study estimated the national rape-related pregnancy rate at 5.0% per incident of rape [i.e. on average, five women in one hundred would become pregnant] following rape among victims of reproductive age (aged 12 to 45). They estimated that among adult women some

[137] Muleta M, Williams G. Postcoital injuries treated at the Addis Ababa Fistula Hospital, 1991-97. *Lancet* 1999;354:2051-2.
[138] Miranda JJ, Yamin AE. Reproductive health without rights in Peru. *Lancet* 2004; 363: 68-69; Bathelemy F. Peru: the scandal of forced sterilisation. *Le Monde Diplomatique* May 2004; Amnesty International. *Peru: The Truth and Reconciliation Commission – a first step towards a country without injustice.* AI Index: AMR 46/003/2004, August 2004.
[139] Report No. 66/00 of the Inter-American Commission on Human Rights of the Organization of American States, Case 12,191, María Mamérita Méstaza Chávez, Peru, 3 October 2000; following acknowledgment of the breaches in 2002 the cased was formally settled in 2003: Report No. 71/03, Case 12,191, Friendly Settlement, María Mamérita Méstaza Chávez, Peru, 22 October 2003. See discussion in Cook RJ, Dickens BM, Fathalla MF. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Clarendon Press, 2003, pp.172-3.
[140] Center for Reproductive Rights and Poradňa pre občianske a ludské práva (Center for Civil and Human Rights), *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia*, New York, 2003, p.60.
[141] Amnesty International. *Slovakia: Failing to ensure an impartial and thorough investigation into allegations of illegal sterilization of Romani women.* AI Index: EUR 72/002/2003. Available at: http://web.amnesty.org/library/Index/ENGEUR720022003.
[142]Forced pregnancy is also, of itself, a form of abuse. It is included as one of a number of forms of "sexual violence also constituting a grave breach of the Geneva Conventions" considered by the Rome Statute of the International Criminal Court as constituting a war crime. ICC Statute Article 8 (2) (b) (xxii).
[143] Stewart FH, Trussell J. Prevention of pregnancy resulting from rape: a neglected preventive health measure. *American Journal of Preventive Medicine* 2000; 19:228-9.

32,000 pregnancies result from rape each year.[144] Data for other countries is lacking.

There is no generally accepted right to abortion in international human rights law .[145] However international human rights conferences and the inter-governmental bodies that interpret human rights treaties are increasingly indicating support for the position that, where it is legal, abortion should be safe and accessible and, further, that it should be permitted in cases where pregnancy results from rape.[146] International human rights bodies have also urged states to remove criminal sanctions on abortion; that is, women should not be jailed for having an abortion.[147]

Evidence suggests that illegal abortions have, on average, a higher complication and death rate than those carried out legally in a clinic.[148] In Brazil, women's organizations and obstetrics and gynaecology societies have been pressing for the availability of safe termination services within the current Brazilian law to avoid the fatal consequences of illegal abortions[149], and the World Health Organization has addressed the issue in a recent report.[150]

Studies of violence against pregnant women have shown rates of violence of 1.2% to 21% of populations studied.[151] Coker and colleagues in the USA found that abuse during pregnancy was associated with perinatal deaths and preterm low birthweight deliveries and that risk increased with increased frequency of abuse.[152] Researchers in Saudi Arabia reported a rate of physical violence of 21% in the study cohort; they found that women experiencing such violence were more likely to be hospitalized ante-natally for maternal complications such as trauma to the pregnant abdomen, pre-term labour and kidney infections. There was a positive statistical association between physical violence during pregnancy and caesarean section, foetal distress, and premature delivery.[153]

A recent study conducted in Canada found a lower rate of physical violence – 1.2% – but confirmed earlier researchers' work including an association of physical abuse during pregnancy with intrauterine growth retardation and, in addition, an association of violence with higher rates of ante-partum haemorrhage and perinatal death.[154]

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144 Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. *American Journal of Obstetrics and Gynecology* 1996:320-4; also discussion at: 324-5.

145 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women is the first international treaty to explicitly provide for access to abortion as a means of protecting women's reproductive rights. See Article 14 (2) (c), available at: http://www.achpr.org/english/_info/women_en.html

146 See Paragraph 8.25 of the Programme of Action of the 1994 Cairo International Conference on Population and Development. CEDAW has commented, in response to the 2nd and 3rd periodic reports from the Government of Panama, that: "The Committee recommends that multidisciplinary measures should be taken to provide special care to the victims of sexual violence which should include legal and psychological assistance for the victim. It also recommends that Panamanian women who are pregnant as a result of rape should be granted the opportunity to seek termination of such pregnancies." UN Document A/53/38/Rev.1 (Part II), paras. 182-205, para.201.

147 See: CEDAW General Recommendation No. 24. (Note paragraph 31(c) "When possible, legislation criminalizing abortion could be amended, to remove punitive measures imposed on women who undergo abortion".)

148 WHO reports that 19 million women experience an unsafe abortion worldwide each year; 18.5 million of these occur in developing countries. Some 68 000 women die from complications of unsafe abortion each year - all in developing countries. (Figures are for the year 2000.) See: http://www.who.int/reproductive-health/unsafe_abortion/

149 Faundes A, Andalft J. Sexual violence against women. The role of gynecology and obstetrics societies in Brazil. *International Journal of Gynaecology and Obstetrics* 2002;78 Suppl 1:S67-73; *Vieira Villela W, de Oliveira Araújo MJ.* Making legal abortion available in Brazil: partnerships in practice. *Reproductive Health Matters* 2000*;* 8(16):77-82.

150 WHO. *Safe abortion: technical and policy guidance for health systems.* Geneva: WHO, 2003.

151 Petersen R, Gazmararian JA, Spitz AM, Rowley DL, et al. Violence and adverse pregnancy outcomes: a review of the literature and directions for future research. *American Journal of Preventive Medicine* 1997 Sep-Oct;13(5):366-73; see also Stenson K, Heimer G, Lundh C, Nordstrom ML, Saarinen H, Wenker A. The prevalence of violence investigated in a pregnant population in Sweden. *Journal of Psychosomatic Obstetrics and Gynaecology* 2001;22:189-97[reporting rates of 1.3% at time of pregnancy to 21% life-time risk of violence.]

152 Coker AL, Sanderson M, Dong B. Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatric and Perinatal Epidemiology* 2004;18(4):260-9.

153 Rachana C, Suraiya K, Hisham AS, Abdulaziz AM, Hai A. Prevalence and complications of physical violence during pregnancy. *European Journal of Obstetrics, Gynecology and Reproductive Biology* 2002;103:26-9.

154 Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD. Intimate partner violence and adverse pregnancy outcomes: a population-based study. *American Journal of Obstetrics and Gynecology*. 2003;188:1341-7.

A study in Nicaragua concluded that physical abuse by a partner during pregnancy was an independent risk factor for low birth weight infants[155], an outcome confirmed in a Costa Rican study by Nuñez *et al*[156], a US studies by Lipsky and co-workers among adults[157] and by Covington and colleagues among US teenagers.[158]

Death

Women are at risk of death at the hands of a male partner and at a rate considerably higher than the risk faced by men assaulted by a female partner. Studies in several countries including the US and Australia showed that 40-70% of murdered women had been killed by male partners. In US and Australia, 4-9% of male murder victims had been killed by female partners.[159] In the UK 37% of female homicide victims were killed by current or former partners: 92 women, representing nearly two women per week on average.[160] New research in South Africa has found that on average a woman is killed every six hours by an intimate partner – a rate of 28 deaths per week. According to the report, this is the highest rate in the world where the phenomenon has been studied.[161] The study found that 50% of all women murdered in South Africa by known perpetrators in 1999 were killed by men with whom they had an intimate relationship.

In some countries women are at risk of death because of cultural practices which impose death for women who are viewed as failing to conform to, or rebelling against, social norms. In countries in the east Mediterranean and the Indian sub-continent, women are killed with impunity if they are seen as offending against either male "honour" through perceived sexual misbehaviour or wider community values defining what is deemed to be women's proper behaviour. A report by Human Rights Watch documented the situation of women in Jordan who run the risk of violence if they talk to an unrelated man, marry someone without family approval, have pre-marital sex, or become pregnant outside of marriage. In 2003, at least 17 women died in so-called "honour" killings while 22 died in 2002[162] and at least 19 in 2001.[163]

However, while men accused of "honour" killings tend to be treated leniently, women threatened with "honour" crimes can be sent to prison "for their own safety." Once there she will not be permitted to leave prison until a male family member states that he will guarantee her safety.[164]

In Pakistan, hundreds of women, of all ages, in all parts of the country and for a variety of reasons connected with perceptions of "honour" are killed every year. The victims include young pre-pubescent girls, unmarried young girls and women, old women, including grandmothers, married women and widows. The alleged misbehaviour which is perceived as bringing "dishonour" is usually sexual.[165]

In the Indian sub-continent, numerous women die each year of burns caused by attacks by male partners or relatives using fire or acid. A forensic study of deaths due to burning documented the terrible nature of the practice. The majority of the murdered women were 16-25 years of age at the time of the attack – commonly doused with kerosene and set alight – and

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155 Valladares E, Ellsberg M, Pena R, Hogberg U, Persson LA. Physical partner abuse during pregnancy: a risk factor for low birth weight in Nicaragua. *Obstetrics and Gynecology* 2002; 100: 700-5.

156 Nuñez Rivas HP, Monge Rojas R, Grios Davila C, Elizondo Urena AM, Rojas Chavarria A. La violencia física, psicológica, emocional y sexual durante el embarazo: riesgo reproductivo predictor de bajo peso al nacer en Costa Rica. [Physical, psychological, emotional, and sexual violence during pregnancy as a reproductive-risk predictor of low birthweight in Costa Rica]. *Revista panamericana de salud pública* 2003; 14:75-83.

157 Lipsky S, Holt VL, Easterling TR, Critchlow CW. Impact of police-reported intimate partner violence during pregnancy on birth outcomes. *Obstetrics and Gynecology*. 2003;102:557-64.

158 Covington DL, Justason BJ, Wright LN. Severity, manifestations, and consequences of violence among pregnant adolescents. *Journal of Adolescent Health* 2001;28:55-61.

159 WHO. *World Report on Violence and Health*, Geneva 2002, p.93.

160 UK Home Office statistics. See: http://www.homeoffice.gov.uk/crime/domesticviolence/index.html.

161 Mathews S, Abrahams N, Martin LJ, Vetten L, van de Merwe L, Jewkes R. *'Every six hours a woman is killed by her intimate partner': A national study of female homicide in South Africa*. MRC Policy Brief No. 5, June 2004. Available at: http://www.mrc.ac.za/policybriefs/woman.pdf

162 Human Rights Watch. *Honoring the Killers: Justice Denied for "Honor" Crimes in Jordan*. New York, 2004. Available at: http://hrw.org/reports/2004/jordan0404/

163 Amnesty International *Report 2002*. London, 2002.

164 Human Rights Watch. *Honoring the Killers* (seen note 162 above).

165 Amnesty International. *Pakistan: Violence against women in the name of honour*. AI Index: ASA 33/017/1999, September 1999. Available at: http://web.amnesty.org/library/Index/ENGASA330171999

sustained more than 70% total body surface area burn injuries.[166]

The use of sulphuric or nitric acid to cause appalling injury and suffering on women has been documented in Bangladesh.[167] The motivation for these attacks appears to be revenge for spurned sexual advances or marriage proposal or reasons relating to family conflict. An NGO, the Acid Survivors Foundation, works on behalf of victims of this form of violence.[168]

Being in a hospital is not necessarily a protection for the woman marked as bringing "dishonour" to her family. In February 2004, weeks after the birth of an illegitimate child, Guldunya Toren, a Turkish woman aged 22, was shot and wounded in the street by her two brothers. From her hospital bed in Istanbul, she pleaded for the police to save her. However she was left without protection and, late one night, her brothers entered the unguarded hospital and shot her in the head, killing her.[169]

In the other case, Mehmet Halitogullari confessed to strangling his 14-year-old daughter, Nuran, in April 2004, after she had been kidnapped by a man on her way home and raped over several days. Police arrested the man and returned Nuran home, where she was killed by her father. He is currently on trial for murder.[170]

Women who have been victims of sexual violence in Turkey are placed in an intolerable position. A Turkish doctor said: "Women who are raped have four choices under the current law [in Turkey]: Marry the rapist, commit suicide, become a prostitute or be killed."[171] A recent Amnesty International report on Turkey revealed that around half of women surveyed in the south and south-east of Turkey had neither been consulted about their choice of marriage partner or were married without their consent. The report also illustrated the point made by the doctor cited above:

> A convicted rapist in Samsun, northern Turkey, was released from custody and his sentence of nearly seven years' imprisonment was postponed after he agreed to marry the 14-year-old girl he had raped. The girl told the court that she could not walk around in her village or talk to anyone after the rape because she was so ashamed.[172]

Effect on children of violence against women

In a family in which violence is a regular occurrence, children may be direct victims and suffer physical, psychological or sexual abuse.[173] However children also suffer as a result of the violence directed at their natural or adoptive mother. Children who witness parental violence are at higher risk of anxiety, depression, low self-esteem, nightmares, and other problems such as persistent aggressivity.[174]

Such children often develop problems which are similar to those of children who are themselves abused.[175] Moreover, there is abundant evidence that a significant proportion of adult sexual abusers have been exposed to violence and sexual abuse as children[176].

Treating victims of violence

Victims of violence can seek treatment from a variety of sources – by traditional healers, physicians, nurses, mental health specialists and others – or may not seek help at all, relying on their own resources or the support of friends. In some cases, women present to health clinics seeking help for one health problem

[166] Kumar V, Tripathi CB. Burnt wives: a study of homicides. *Medicine, Science and the Law* 2004;44:55-60.
[167] Faga A, Scevola D, Mezzetti MG, Scevola S. Sulphuric acid burned women in Bangladesh: a social and medical problem. *Burns* 2000;26(8):701-9. See also: Anwary A. Acid violence and medical care in Bangladesh: women's activism as carework. *Gender & Society* 2003; 17: 305-313; Begum AA. Acid violence: a burning issue of Bangladesh – Its medicolegal aspects. *American Journal of Forensic Medicine and Pathology* 2004, 25(4):321-323; and Amnesty International. *Broken Bodies, Shattered Minds: Torture and Ill-treatment of Women*. London, 2001, p.11.
[168] See: http://www.acidsurvivors.org
[169] Amnesty International. *Turkey: Women confronting family violence*. London AI Index: EUR 44/013/2004. Available at: http://web.amnesty.org/library/Index/ENGEUR440132004
[170] Ibid.
[171] Dr Adem Sozuer quoted in *Radikal*; cited *Toronto Star*, 16 May 2004.
[172] Amnesty International. *Turkey: Women confronting family violence*. (See note 169 above).
[173] Johnson CF. Child sexual abuse. *Lancet* 2004; 364: 462-70.
[174] Kernic MA, Wolf ME, Holt VL, McKnight B, Huebner CE, Rivara FP. Behavioral problems among children whose mothers are abused by an intimate partner. *Child Abuse & Neglect* 2003, 27: 1231-46.
[175] Edleson JL. Children witnessing of adult domestic violence. *Journal of Interpersonal Violence* 1999; 14: 839-70.
[176] See, for example, Kellogg ND, Menard SW. Violence among family members of children and adolescents evaluated for sexual abuse. *Child Abuse and Neglect* 2003; 27:1367-76.

with other violence-related problems emerging in the course of the consultation.

A major issue is the availability of appropriate health and psycho-social services to women who have been subjected to violence. In many conflict and post-conflict situations basic medical services are lacking. In some cases, government economic policies which impose costs on those seeking medical care may act as a barrier for those seeking health care.[177] In others service provision is patchy or non-existent. In countries experiencing conflict conditions may prevent those in need from reaching the existing services. However even in countries where security is not an issue there may be inadequate services for women who have experienced violence.

Nevertheless there is an experienced body of health care specialists with particular skills for addressing women's health needs and a growing literature on the documentation and treatment of women who have been tortured, raped, or otherwise subjected to violence and human rights abuses. The scope of this treatment is too extensive to readily summarise here and the reader is referred to existing literature on this subject[178].

Medico-legal and documentation issues

The effective prosecution of the crime of rape or other acts of violence depends on the effective gathering of evidence, the investigation and subsequent arrest of the person(s) believed to be responsible and their prosecution in a court of law[179]. In practice this usually does not happen. This may be because the woman does not report the crime for reasons of fear, stigma, or a desire to put the attack behind her and move on.[180] Or it may be that efforts to obtain medical evidence are delayed or not done by health care workers who feel they lack competence or the equipment necessary for evidence-gathering.[181]

The role of evidence in prosecution

Considerable thought and analysis has gone into the design of examination protocols and evidence-gathering in the case of sexual violence within the framework of forensic medicine and nursing.[182] Over the recent past, efforts have been increased to effectively gather relevant medical evidence to allow for identification of the perpetrator and successful conviction in court.

The rate of reporting, charging and conviction in rape cases is persistently low. Most cases are not reported to police. Of those that are reported, not all result in the apprehension of the alleged offender; and where charges are laid, there is a significant number of acquittals.

A number of forensic researchers have developed increasingly rigorous protocols in an attempt to strengthen the quality and impact of forensic evidence of sexual assault. Drawing on these as well as its own expertise, the World Health Organization has sponsored the development of a manual on the investigation and documentation of sexual violence intended to strengthen the gathering of evidence. [183]

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[177] *Burundi: Rape – the hidden human rights abuse*. London, Amnesty International: AFR 16/006/2004. Conditions placed on governments by international lenders may limit their options with regard to health expenditure and cost-recovery policy.

[178] Hinshelwood G. The sexual abuse of females. In: Peel M, Iacopino V (eds). *The Medical Documentation of Torture*. London: Greenwich, 2002, 172-7. Peel M (ed). *Rape as a Method of Torture*. London: Medical Foundation for the Care of Victims of Torture, 2004. Herman J. *Trauma and Recovery*. New York: Basic Books, 1992:276pp. See also: Cantu M, Coppola M, Lindner AJ. Evaluation and management of the sexually assaulted woman. *Emergency Medicine Clinics of North America* 2003; 2(3):737-50.

[179] Such proceedings should respect the defendant's right to a fair trial but also guard against the re-traumatisation of the victim.

[180] Myhill A, Allen J. Rape and sexual assault of women: findings from the British Crime Survey. Home Office Findings No. 159 (reporting that around 20% of the survey group reported their assault to the police). In South Africa, Jewkes and co-workers also found low reporting rates (Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science and Medicine* 2002; 55: 1231-44) but that younger women were significantly more likely to report rape than older women (Jewkes R *et al*. Rape of girls in South Africa. *Lancet* 2002; 359: 319-20).

[181] It was to address this problem that the Mumbai-based health NGO, CEHAT, produced a "sexual assault kit" containing information, equipment and forms necessary for documentation. See: http://www.cehat.org/publications/sexualassaultkit.html

[182] See, for example, Girardin B, Faugno DK, Howitt J. Adult sexual assault: practical management. In Payne-James J, Bussitil A, Smock W (eds). *Forensic Medicine: Clinical and Pathological Aspects*. London: Greenwich Medical Media, 2003, pp.409-51.

[183] World Health Organization. *Guidelines for Medico-legal Care for Victims of Sexual Violence*. Geneva: WHO, 2004; available at: http://www.who.int/violence_injury_prevention/resources/publications/med_leg_guidelines/en/

The value of detailed forensic evidence has been confirmed by a number of studies. McGregor and Dumont and colleagues in Canada found that evidence of rape-related trauma contributed to the conviction of accused perpetrators[184], a finding confirmed by Wiley *et al.*[185] For this reason considerable effort has been made in several countries in recent years to (i) increase the capacity of forensic services to respond to cases of sexual assault, including by the introduction of sexual assault nurse examiners (SANE)[186]; (ii) to develop more standardized examination protocols and (iii) expand training and awareness of the importance of forensic documentation.[187] While increasing the forensic capacity to respond to sexual violence, as well as to harmonise the relationship between crime investigators and medical practitioners, has been beneficial, some research has suggested that there are limits to the effectiveness of increasing efforts to gather forensic detail, particularly evidence of virtually invisible micro-trauma sustained by the woman. This did not appear to result in an increased conviction rate.

Both doctors involved in sexual assault documentation and SANE practitioners are reported to have expressed, explicitly or implicitly, a sense of conflict between the roles of clinical care provider and forensic evidence gatherer. [188] In resource-poor environments this conflict would become more acute and evidence given to AI suggests that doctors working in the conflict zones of central Africa feel overwhelmingly that their priority is in providing clinical services to women rather than in evidence gathering.

An important issue arising from the work done so far on documentation of rape is the prevention of secondary victimisation of rape survivors in the criminal justice system.[189] One way of minimising this kind of additional trauma is to minimise the repetition of fact-finding interviews and to provide medical examination in a dedicated location with the possibility of counselling.[190]

Role of health professionals

Health professionals can contribute much to the struggle to address violence against women. This can start at the most basic level of ensuring that there is no violence against women within health care practices. d'Oliveira and colleagues suggest that violence perpetrated in health care settings comprises "neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain-relief when technically indicated; and sexual violence."[191] They suggest that steps need to start during student training and that communication skills are an important element in violence reduction. A

[184] McGregor MJ, Le G, Marion SA, Wiebe E. Examination for sexual assault: is the documentation of physical injury associated with the laying of charges? *Canadian Medical Association Journal,* 1999; 160:1565–1569, available at: http://www.cmaj.ca/cgi/reprint/160/11/1565; McGregor MJ, Du Mont J, Myhr TL. Sexual assault forensic medical examination: Is evidence related to successful prosecution? *Annals of Emergency Medicine* 2002; 39: 639-64.

[185] Wiley J, Sugar N, Fine D, Eckert LO. Legal outcomes of sexual assault. *American Journal of Obstetrics and Gynecology* 2003; 188:1638-41.

[186] Houmes BV, Fagan MM, Quintana NM. Establishing a sexual assault nurse examiner (SANE) program in the emergency department. *Journal of Emergency Medicine* 2003;25:111-21; Regan L, Lovett J, Kelly L. *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Development & Practice Report 31. London: Home Office, 2004

[187] In August 2002, Amnesty International joined with the Independent Medico-Legal Unit based in Durban to sponsor a four day workshop on the application of forensic skills to the documentation of rape and other abuses in southern and east Africa. See: Amnesty International. *Protecting the Human Rights of Women and Girls: A medico-legal Workshop on the Care, Treatment and Forensic Medical Examination of Rape Survivors in Southern and East Africa.* London, 2002. See also McQuoid-Mason D, Pillemer B, Friedman C, Dada M. *Crimes Against Women and Children: A Medico-Legal Guide*. Dundee University and the Independent Medico-Legal Unit, Durban (IMLU), 2002.

[188] See: Du Mont J, Parnis D. The doctor's dilemma: caregiving and medicolegal evidence collection. *Medicine and Law*, 2004; 23(3):515-29; Du Mont J, Parnis D. Forensic nursing in the context of sexual assault: comparing the opinions and practices of nurse examiners and nurses. *Applied Nursing Research* 2003;16(3):173-83.

[189] Suffla S, Seedat M, Nascimento A. Evaluation of medico-legal services in Gauteng: implications for the development of best practices in the after-care of rape survivors. Medical Research Council [South Africa], December 2001.

[190] McLean I, Balding V. Some characteristics of 7,289 cases of rape and sexual assault seen at St. Mary's Sexual Assault Referral Centre since 1986. *Health Psychology Update*, 2003; 12(4), 56-61; Kerr E, Cottee C, Chowdhury R, Jawad R, Welch J. The Haven: a pilot referral centre in London for cases of serious sexual assault. *British Journal of Obstetrics and Gynaecology*. 2003;110:267-71.

[191] d'Oliveira AFPL, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. *Lancet* 2002; 359:1681-85.

policy of holding staff to account for acts of violence and sexual exploitation is necessary but also improved working conditions to allow staff time to interact effectively with patients. The role of international professional bodies was also seen as important.

> *"We must provide effective training programmes for health personnel on how to care for victims of sexual violence, and we must ensure that local organizations and women' groups are actively involved each step of the way. We do not need a few good women here and there; we need gender parity so women in positions of power can stop abuses of power."*
>
> *"It is urgent that survivors of sexual violence receive quality legal, psychosocial and reproductive health services to address the horrifying violence they have endured. We must take action to implement programmes aimed at the public and community leaders on the importance of not stigmatizing victims of sexual violence and take action to empower women and girls and enable them to seek help and adequate support."*
>
> *UNFPA, October 2004* [192]

Those responsible for health policy should ensure effective service provision with regard to emergency contraception, control of sexually transmitted diseases, medico-legal evidence gathering, and referral of women for specialist care or counselling.

On a wider scale, health professionals can promote a preventive approach to violence against women, which links health professionals with others in the social welfare sector, women's organizations as well as the criminal justice system and the wider community.

Health professionals can encourage and contribute to more research on the origins, effects and responses to violence against women. The outcome of such research can contribute to policy-making, law reform, and health care development.

Training of health professionals

There is an ongoing need for effective training of health professionals to deal with violence against women. Despite this need, there is relatively little literature on the training of health professionals on dealing with violence in the family. A recently-published Mexican study on the knowledge and attitudes of physicians and medical specialists revealed that 90% lacked training on violence against women. Family doctors were more sensitive to the issue than specialists and female physicians were more sympathetic to battered women. The authors recommended training at all levels of the health system.[193]

> *"Health services are increasingly recognised as being able to play an important role in addressing the more common forms of violence, especially in secondary and tertiary prevention. A consensus is also growing on the need to assess and identify effective health sector interventions to convince health providers and policy makers of the value of these interventions. … An effective response from the health sector to women living with violence will include regular training of health workers that addresses their own values and attitudes and provides specific skills…*
>
> Dr Claudia Garcia-Moreno, WHO[194]

A British study[195] of the effectiveness of training given to midwives found that participants in the training course reported greater awareness and understanding of domestic violence as a result, and an increased likelihood of identifying and supporting women, partly through improved knowledge of other helping agencies. However, there were issues which posed difficulties including confidentiality and documentation which raised uncertainties in participants. Practical issues such as time and privacy were also raised by participants. A study of medical students entering medical residency in Arizona suggested an inadequate level of awareness of domestic violence; the authors recommended that "content of undergraduate medical education about [domestic violence] should be strengthened".[196]

[192] UNFPA. United Nations Security Council Open Debate on Security Council Resolution 1325, Women, Peace and Security. Responding to the Needs of Victims of Gender-Based Violence. Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA, 28 October 2004. Available at: http://www.unfpa.org/news/news.cfm?ID=523&Language=1

[193] Méndez-Hernández P, Valdez-Santiago R, Viniegra-Velázquez L, Rivera-Rivera l, Salmerón-Castro J. Violencia contra la mujer: conocimiento y actitud del personal médico del Instituto Mexicano del Seguro Social, Morelos, México [Violence against women: knowledge and attitudes of healthcare providers at the Mexican Institute of Social Security in Morelos, Mexico]. *Salud Pública de México* 2003;45;472-482.

[194] Garcia-Moreno G. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet* 2002; 359:1509-14.

[195] Protheroe L, Green J, Spiby H. An interview study of the impact of domestic violence training on midwives. *Midwifery* 2004;20:94-103.

[196] Miller AW, Coonrod DV, Brady MJ, Moffitt MP, Bay RC. Medical student training in domestic violence: a comparison of

Kim and Motsei, working in South Africa, have made the point that health professionals bring their own attitudes regarding gender to work with victims of gender-based violence – in particular the acceptance by female primary health care (PHC) nurses of gender-based violence as an permissible cultural reality. [197] They suggest that "there is an urgent need to understand and address the lived experiences of the nurses [in South Africa], and the duality of their roles as professionals and as community members, before promoting the training of nurses as an effective strategy for dealing with gender-based violence".

Screening for domestic violence

There has been a vigorous discussion in the medical literature about screening in hospital and medical practice for evidence of domestic violence.[198] In arriving at a policy, decision-makers have attempted to balance (i) the level of abuse in the community (and hence the level of possible detection); (ii) the potential positive outcomes such as exposure of violence and implementation of protective measures and (iii) the potential negative outcomes of routine screening such as reprisal violence by men when women seek intervention or failure to detect abuse through a failure of the screening process. While screening has its advocates, there are equally medical bodies and researchers who suggest that there is insufficient evidence to support routine screening.[199]

At the same time, there is also a wide-spread recognition that health workers are in a strong position to detect abuse and to take steps to help women facing such abuse. Anglin and Sachs, reviewed the situation in the hospital emergency department. They noted that because of the paucity of outcomes research on the evaluation of screening and interventions in the hospital emergency department, there is insufficient evidence for or against domestic violence screening. However, they suggested, "because of the high burden of suffering caused by domestic violence, health care providers should strongly consider routinely inquiring about violence as part of the history, at a minimum for all female adolescent and adult patients."[200]

Professional bodies are divided and vary between those favouring systematic screening such as the American Medical Association[201] and those who are agnostic or opposed.[202] Even where professional bodies recommend screening it is not necessarily the case that practitioners undertake such screening.[203] Nevertheless the opportunities open to health professionals to identify and to act on signs of

students entering residency training in 1995 and 2001. *Teaching and Learning in Medicine* 2004; 16:3-6.

[197] Kim J, Motsei M. "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science and Medicine* 2002;54:1243-54.

[198] Screening is a technique in which all those at risk of a potential hazard are routinely given a consensual test for signs of exposure to the hazard. It is most effective when there is a significant risk of finding evidence strongly indicative of the hazard and becomes less effective the rarer or more ambiguous the evidence (or, as in the case of HIV, where positive findings are associated with stigma and discrimination). In the context of domestic violence screening would require health professionals routinely interviewing women about their exposure to violence.

[199] Guo SF, Wu JL, Qu CY, Yan RY. Domestic abuse on women before, during, and after pregnancy. *International Journal of Gynaecology and Obstetrics* 2004;84:281-6. ("Routine screening for abuse in the maternity services setting is advocated to decrease the effect of abuse on women and their children."); Nelson HD, Nygren P, McInerney Y, Klein J; US Preventive Services Task Force. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the US Preventive Services Task Force. *Annals of Internal Medicine* 2004 ;140:387-96. ("Although the literature on family and intimate partner violence is extensive, few studies provide data on detection and management to guide clinicians."); Webster J, Holt V. Screening for partner violence: direct questioning or self-report? *Obstetrics and Gynecology*. 2004; 103: 299-303. ("A self-report checklist is an effective alternative to direct questioning in detecting women who are experiencing partner violence and is acceptable to women."); Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal* 2002;325:314 ("Although domestic violence is a common problem with major health consequences for women, implementation of screening programmes in healthcare settings cannot be justified.").

[200] Anglin D, Sachs C. Preventive care in the emergency department: Screening for domestic violence in the emergency department. *Academic Emergency Medicine* 2003, 10:1118-27.

[201] American Medical Association Council on Scientific Affairs. Violence against women: relevance for medical practitioners. *JAMA* 1992; 267(23):3184-9.

[202] Wathen CN, MacMillan HL, with the Canadian Task Force on Preventive Health Care. Prevention of violence against women: Recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal* 2003; 169: 582-4. The Task Force concluded that there was insufficient evidence "for or against routine universal screening".

[203] Bair-Merritt MH, Giardino AP, Turner M, Ganetsky M, Christian CW. Pediatric residency training on domestic violence: a national survey. *Ambulatory Pediatrics* 2004 ;4:24-7.

violence against women are important and have given rise to a number of suggested approaches to carrying this out.[204]

Should reporting of domestic violence by health practitioners be mandatory?

Although the idea of requiring health carers to report instances of violence against women may seem a plausible reform (in a similar way to the mandatory reporting of child abuse which is required in many jurisdictions), there appears to be no or little support for this. One of the reasons suggested for the lack of support for mandatory reporting of violence is the potential breach of patient-physician confidentiality, a fundamental basis of medical care provision.[205] However, underlying the confidentiality principle is the risk which may be posed to the woman if her abuser learns that she may be seeking medical care from a health professional who might report the abuse. While mandatory reporting finds little favour, the need to improve detection and strengthen protection for women consulting health professionals is the subject of continuing discussion.

Impact of VAW on health professionals

Women working in the health sector can themselves become victims of violence – like all women, within personal relationships, or from strangers, but also at the hand of workplace colleagues or patients.

Moreover, women staff caring for victims of violence may bear additional burdens arising from their clinical role. A study in Victoria, Australia, noted the views of both male and female doctors that women doctors were more empathic which had the unintended consequence that **"**because of their empathy with victims' suffering [female doctors] expressed more sadness, feelings of frustration, and distress that they had no 'magic' remedy. Some consequently felt powerless or demoralised."[206]

Professional bodies

In recent years here has been a significant increase in the number of professional bodies taking a human rights stand on women and violence.

At an international level the nurses' professional body, the International Council of Nurses, has adopted a number of relevant declarations. In 2002, for example, the ICN resolved to support "the protection of women's rights and deplore[d] sexual exploitation and trafficking of women and girls for prostitution, and all forms of violence against women including female genital mutilation."[207]

The World Medical Association adopted a position on family violence in 1996 in which it called, among other things, for "all physicians [to] receive adequate training in the medical, sociological, psychological and preventive aspects of all types of family violence."[208]

The International Federation of Gynaecology and Obstetrics (FIGO) has a standing committee on sexual and reproductive rights[209] and in 1997 adopted a statement on violence against women. It continues to speak against violence against women.[210]

At national level, numerous medical, nursing, psychological and psychiatric organizations, as well as

[204] See: Taket A, Nurse J, Smith K, Watson J, Shakespeare J, Lavis V, Cosgrove K, Mulley K, Feder G. Routinely asking women about domestic violence in health settings. *BMJ* 2003;327:673–6. See also "rapid responses" to this paper at: http://bmj.bmjjournals.com/cgi/eletters/327/7416/673 (accessed 10 July 2004.) See also: Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. *JAMA* 2003;289:589-600; and Taket A, Wathen CN, Macmillan H. Should health professionals screen all women for domestic violence? *PLoS Medicine* 2004 Oct;1(1):e4.

[205] Braude M. Psychiatrists and mandatory reporting of domestic violence. *Psychiatric Times* April 2002. Dr Braude notes that because of physicians' adherence to the Hippocratic tradition, "physician organizations including the American Medical Association, the American Medical Women's Association, the American College of Emergency Physicians, and the American College of Obstetricians and Gynecologists have taken positions against [mandatory reporting]. The American Psychiatric Association has no position."

[206] Taft A, Broom DH, Legge D. General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ* 2003; 328: 618-21. The key finding of the study was that general practitioners managing partner abuse needed to be more familiar with, and apply, the central principles of confidentiality and safety of women and children. See: http://bmj.bmjjournals.com/cgi/content/full/bmj;328/7440/618

[207] ICN. Women's Health. Adopted 1996, revised 2002. Available at: http://www.icn.ch/pswomen.htm

[208] World Medical Association Declaration on Family Violence. Adopted 1996. Available at: http://www.wma.net/e/policy/f1.htm

[209] International Federation of Gynaecology and Obstetrics (FIGO). Resolution on Violence against Women 1997.

[210] Benagiano G, Schei B. A FIGO initiative for the 21st century: eliminate all forms of violence against women worldwide. *International Journal of Gynecology & Obstetrics* 2004; 86(2): 328-334.

medical NGOs, have made statements bearing on the issue of violence against women. National bodies have also taken active positions on matters related to violence against women and the role of medical professional bodies in providing assistance.[211]

However women seeking help from health professionals do not always feel that they get the support they need[212]. A study carried out in the UK found that very few women voluntarily disclosed domestic violence to a health professional and even fewer were asked directly about domestic violence by one. They suggested that it is important for health professionals to enquire sensitively about domestic violence and to provide an appropriate response meeting the complexity of women's needs. Training is necessary to equip health professionals with the knowledge and skills they need to respond to domestic violence more effectively.[213]

Conclusions and recommendations

Governments

Governments must recognise that violence against women is a major public health issue as well as a human rights crisis. They should take the following steps to protect women and to guarantee their health and well being.

Reforming the law

Governments should ensure:

- the abolition of all laws that
  - facilitate impunity for the rape, murder or other acts of violence against women;
  - criminalize consensual sexual relations in private; arbitrarily restrict a women's right to choose her partner; and
  - restrict women's access to reproductive health care and family planning as provided for in international standards and consensus documents.
- that laws are adopted and enforced to protect women, to ensure that violence in the family is treated as seriously as assaults in other contexts, and that rape and other violence against women is criminalized
- that there is better protection for institutionalised women through
  - raising their awareness of their rights;
  - creating appropriate inspection programmes;
  - establishment of an ombudsperson role;
  - training of staff; and
  - insisting on proper accountability for management and staff
- that perpetrators of violence against women – in the home, in the community, in the military, in the health care sector – are investigated, prosecuted and punished in line with international standards.

Resources

Governments should ensure that

- adequate resources are provided for the healthcare and counselling needs of victims of violence. This should include specific provision at stages such as immediately after an assault has been reported to police or health personnel; during the investigation of the assault; and during the prosecution of the alleged perpetrator;
- NGOs and self-help organizations working with women who have been subjected to violence are encouraged and supported;
- HIV/AIDS is recognised as a major risk associated with violence against women; and that:

[211] See, for example, Faundes A, Andalft J. Sexual violence against women. The role of gynecology and obstetrics societies in Brazil. *International Journal of Gynaecology and Obstetrics* 2002;78 Suppl 1:S67-73; British Medical Association. *Domestic violence: a health care issue?* London: BMA, 1998; American Academy of Pediatrics Committee on Child Abuse and Neglect. (1998). The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics* 1998; 101:1091-1092. Available at: http://pediatrics.aappublications.org/cgi/reprint/101/6/1091

[212] McCauley J, Yurk RA, Jenckes MW, Ford DE. Inside "Pandora's box": abused women's experiences with clinicians and health services. *Journal of General Internal Medicine* 1998;13:549-555; Rodriguez MA, Quiroga SS, Bauer HM. Breaking the silence. Battered women's perspectives on medical care. *Archives of Family Medicine* 1996;5:153-158.

[213] Bacchus L, Mezey G, Bewley S. Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health & Social Care in the Community* 2003;1:10-18.

- HIV services to women are strengthened;
- protective measures and post-exposure prevention are made available to those who need them and their availability is given publicity;
- anti-retroviral medication be made available to women on the basis of need;

- measures are taken to address women's poverty and vulnerability to violence by eliminating discrimination against women in their access to economic and social rights. This means, amongst other things, guaranteeing women's right to inherit property from their husbands as well as ensuring other property rights.

Training

Governments should ensure that health personnel, custodial personnel, and those working in institutions are given access to gender-sensitive training on violence against women, including the appropriate handling of complaints of sexual violence.

Governments should ensure that the developing protocols and methodologies for the documentation of sexual violence ("best practice") are integrated into the professional practice of law enforcement agencies and forensic services.

Public education programs should be implemented to ensure that it is widely accepted that violence against women is wrong and contrary to law.

Ratifying international instruments protecting women's rights

Governments should:

- ratify and implement the UN Convention on the Elimination of all Forms of Discrimination against Women and its Optional Protocol, without reservations;
- ratify and implement relevant regional standards which protect women's rights;
- ratify the Rome Statute of the International Criminal Court (ICC) and adopt implementing national legislation so that the ICC can be a potential means to end impunity for violence against women in situations where it has jurisdiction;
- agree on an international Arms Trade Treaty to stop the proliferation of weapons used to commit violence against women.

Involving men in respecting, protecting and promoting the rights of women

Governments should institute educational programs to raise men's awareness of the effects of violence on women and to encourage their participation in violence reduction strategies.

Professional bodies

Professional associations should:

- continue to promote women's rights and awareness of human rights violations against women;
- adopt policies explicitly addressing sexual and other violence and the steps which health professionals can take to prevent and respond to them;
- encourage further investigation of the measures needed to effectively identify and help those at risk;
- encourage governments to adopt policies which prevent violence against women and the negative health outcomes which flow from it.